
# The WFNJ SAI/BHI ASAM Criteria Manual

## Third Edition, 2013

## Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions

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# NCADD-NJ ASAM Advanced Training Manual
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# The Addiction Severity Index (ASI)

## CRITICAL OBJECTIVE ITEMS BY SECTION

| SECTION | ITEM | DESCRIPTION |
|---|---|---|
| Medical | | |
| | M1 | Lifetime Hospitalizations |
| | M3 | Chronic Problems |
| Employment / Support | | |
| | E1 & E2 | Education and Training |
| | E3 | Skills |
| | E6 | Longest Full-time Job |
| | E10 | Recent Employment Pattern |
| Drug / Alcohol | | |
| | D1-D13 | Abuse History |
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| | D17-D18 | OD's and DT's |
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| Legal | | |
| | L3-L16 | Major Charges |
| | L17 | Convictions |
| | L24-L25 | Current Charges |
| | L27 | Current Criminal Involvement |
| Family / Social | | |
| | F2-F3 | Stability/Satisfaction – Marital |
| | F5-F6 | Stability/Satisfaction – Living |
| | F10 | Satisfaction with Free Time |
| | F30-F31 | (in 5th edition, formerly 10 A&B) serious Conflicts |
| | F18-F26 | Lifetime Problems with Relatives |
| Psychiatric | | |
| | P1-P2 | Lifetime Hospitalizations |
| | P4-P10 | Present and Lifetime Symptoms |

# ASI & Severity Scores

## Overview

The Addiction Severity Index (ASI) is a structured clinical interview designed to collect all the information needed at intake to be able to develop an appropriate treatment plan for an individual seeking substance abuse treatment. The interview typically covers seven areas of life functioning: medical, employment, drug/alcohol, family history, family & social relationships, legal and psychiatric.

After completing each section of the interview (with the exception of the family history section), a severity rating is calculated based on the clinician's judgment and the client's self-assessment. These ratings indicate whether problems exist in those areas and whether such problems are severe enough to warrant further consideration.

## Scoring & Severity Ratings:

Two scales or severity ratings are used during the ASI interview: client ratings and interview ratings.

*Client Ratings:* At the end of each section of the interview, the client is asked to indicate on a 5-point scale: (1) how bothered he or she has been in the past 30 days by the problems identified during the interview and (2) how important he or she thinks it is to undergo treatment for these problems. The 5-point scale for each of these two suggestions ranges from 0-4 (0-Not at all, 1-Slightly, 2-Moderately, 3-Considerably, 4-Extremely).

*Interviewer Severity Ratings:* The interviewer is asked to enter a severity rating at the end of each of the seven areas covered by the ASI. (Exception: note that no rating is given for the Family History section and two ratings are given for the Family/Social section and two ratings are given for the Drug/Alcohol Use section). The ratings, which emphasize a client's unmet need for treatment, are based on a scale ranging from 0-9.

The first step in determining a rating is the interviewer's selection of a 3-point range. To aid this selection, specific questions in a problem area have been highlighted as critical objective items. Interviewers are advised to pay particularly close attention to client's responses to these questions, as they should determine the 3-point range.

The interviewer takes into account the client's rating of the problem's severity to then select a single number from the 3-point range. A low client rating (0 or 1) guides the interviewer to select the low score in his or her 3-point range. A high rating (3 or 4) guides the interviewer to select the high score in the 3-point range. An intermediate score (2) guides the interviewer to select the intermediate value in the 3-point range.

This final score is the severity rating; it indicates whether or not the treatment plan should include objectives and strategies for addressing problems in that area. In general, a score of 6 or above should alert staff that a problem is serious enough to require attention.

# ADDICTION SEVERITY INDEX RATING SCALES

## CLIENT / CLIENT RATING SCALE

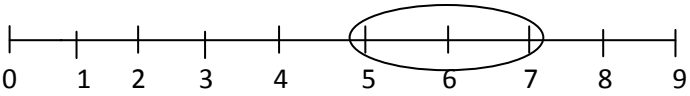
| | |
|---|---|
| 0 | Not at All |
| 1 | Slightly |
| 2 | Moderately |
| 3 | Considerably |
| 4 | Extremely |

## INTERVIEWER RATING SCALE

| | |
|---|---|
| 0-1 | No real problem<br>Treatment Not Indicated |
| 2-3 | Slight Problem<br>Treatment probably Not Necessary |
| 4-5 | Moderate Problem<br>Some Treatment Indicated |
| 6-7 | Considerable Problem<br>Treatment Necessary |
| 8-9 | Extreme Problem<br>Treatment Absolutely Necessary |

**EXHIBIT 1:**
**Example of How Severity Ratings are Calculated**

**Step 1:** Counselor selects a 3-point range on the following scale:




No Problem — Serious Problem

**Step 2:** Client rates how severe the problem is and how important the need for treatment is on the following scale:

| | |
|---|---|
| 0 | Not at all |
| 1 | Slightly |
| 2 | Moderately |
| 3 | Considerably |
| 4 | Extremely |

**Step 3:** Counselor determines severity rating by selecting one point from the 3-point range set in Step 1. This selection is guided by the client's rating. The meaning of the resultant final rating is as follows:

| | |
|---|---|
| 0-1 | No problem, treatment not necessary |
| 2-3 | Slight problem, treatment probably not necessary |
| 4-5 | Moderate Problem, treatment probably necessary |
| 6-7 | Considerable problem, treatment necessary |
| 8-9 | Extreme problem, treatment absolutely necessary |

Client selects "0" Not at all; In this case, the severity rating is 5.

**EXHIBIT 2:**
**Table of Severity Ratings**

| Client Rating | Interviewer Severity Rating Range | Interviewer Severity Rating |
|---|---|---|
| 0 | 0 | 0 |
| 0 | 0 1 2 | 0 |
| 0 | 1 2 3 | 1 |
| 0 | 2 3 4 | 2 |
| 0 | 3 4 5 | 3 |
| 0 | 4 5 6 | 4 |
| 0 | 5 6 7 | 5 |
| 0 | 6 7 8 | 6 |
| 0 | 7 8 9 | 7 |
| 1 | 0 | 0 |
| 1 | 0 1 2 | 0 |
| 1 | 1 2 3 | 1 |
| 1 | 2 3 4 | 2 |
| 1 | 3 4 5 | 3 |
| 1 | 4 5 6 | 4 |
| 1 | 5 6 7 | 5 |
| 1 | 6 7 8 | 6 |
| 1 | 7 8 9 | 7 |
| 2 | 0 | 0 |
| 2 | 0 1 2 | 1 |
| 2 | 1 2 3 | 2 |
| 2 | 2 3 4 | 3 |
| 2 | 3 4 5 | 4 |
| 2 | 4 5 6 | 5 |
| 2 | 5 6 7 | 6 |
| 2 | 6 7 8 | 7 |
| 2 | 7 8 9 | 8 |
| 3 | 0 | 0 |
| 3 | 0 1 2 | 2 |
| 3 | 1 2 3 | 3 |
| 3 | 2 3 4 | 4 |
| 3 | 3 4 5 | 5 |
| 3 | 4 5 6 | 6 |
| 3 | 5 6 7 | 7 |
| 3 | 6 7 8 | 8 |
| 3 | 7 8 9 | 9 |
| 4 | 0 | 0 |
| 4 | 0 1 2 | 2 |
| 4 | 1 2 3 | 3 |
| 4 | 2 3 4 | 4 |
| 4 | 3 4 5 | 5 |
| 4 | 4 5 6 | 6 |
| 4 | 5 6 7 | 7 |
| 4 | 6 7 8 | 8 |
| 4 | 7 8 9 | 9 |

## Guidelines for drug / alcohol severity scores for clients on Methadone

| 3-Point Range | Rule of Thumb Criteria |
|---|---|
| 1-2-3 | On methadone 1 or more years, clean and stable without any other drug or alcohol use. |
| 2-3-4 | On methadone clean and stable at least 3-4 months without using any other substances (including alcohol). |
| 3-4-5 | On methadone, occasional alcohol or other drug use that might even meet abuse criteria, with limited history of treatment failures. |
| 4-5-6 | On methadone, abusing other substances with a history of repeated treatment failures. May have inconsistent methadone attendance. |
| | -OR- |
| 5-6-7 | On methadone, probably dependent on another substance, with repeated failed treatment attempts. |
| 6-7-8 | Not quite the worst case. |
| 7-8-9 | The absolute worst case you can imagine. |

## ASI Training Vignettes

## The following vignettes are based on the same client (MJ):

**MEDICAL SECTION:**

MJ is a 46-year-old male who reported that he has been hospitalized multiple times in his life for various medical issues. He reported that he has chronic asthma and has been hospitalized when he does not have his medication. He was in a serious car accident in 1997 when he sustained back injuries, which caused him to have chronic back pain. He is not currently taking any medication for pain. He reported that he has cirrhosis of the liver, which flares up occasionally but has not bothered him for several months. He reported that he has experienced back pain 27 out of the past 30 days.

Patient severity ratings: Troubled or bothered: 4
Need for treatment: 4

Interviewer severity range:

Final Severity Rating:

**EMPLOYMENT/SUPPORT SECTION:**

MJ reported that he has a GED and most of his experience has been in construction. His driver's license was suspended and he hasn't been able to address this yet. He has worked full time; the longest 4 years at a time. For the past 3 years, he has mostly been working on and off part-time when he can find full-time work. He reported working under the table 5 out of the past 30 days. He didn't recall how much he earned as he had to spend it right away. He stated that he just applied for GA benefits and is awaiting his case to be opened. He stated that he's always looking for work and would like something stable. Client reported that he's been bothered daily due to not being able to find a stable job.

Patient severity ratings: Troubled or bothered: 2
Need for treatment: 0

Interviewer severity range:

Final Severity Rating:

**DRUG AND ALCOHOL SECTIONS:**

MJ reported that he began drinking alcohol at age 16. He started to drink on weekends and by the age of 21 he started to drink more regularly; sometimes daily. He stated that there were periods of time where he did not drink; longest voluntary abstinence was 2 years. He stated that he had attended a 30-day inpatient program prior to this clean time. He reported that in the past 30 days, he drank 10 times but denied intoxication or a problem. He also reported that he has smoked marijuana in the past when he was younger and then on and off again over the years. He reported that he smoked it maybe three times in the past 30 days when a friend gave it to him. He also reported that he has taken pills "here and there." He reported that he did take Percocet that belonged to his mother five times in the past 30 days. He reported that he only used marijuana and Percocet 5 times in the past month for the back pain. He reported that he started using heroin when he was 33 years old and then by the age of 36 he was using it daily but has had periods of abstinence; same as the alcohol. He reported that he used heroin 10 days in the past 30 days. He did not really feel his drug or alcohol use was a problem as long as he could find a job. He reported that in the past 30 days he wasn't really troubled/bothered by alcohol and drug issues; he was troubled 10 out of the past 30 days by both alcohol and drug use.

| | | |
|---|---|---|
| Patient severity ratings (for both A/D): | Troubled or bothered: 2<br>Need for treatment: 2 | |
| Interviewer severity range: | Alcohol:<br>Drugs: | |
| Final Severity Ratings: | Alcohol:<br>Drugs: | |

**LEGAL:**

MJ had one previous DWI and was arrested for assault both of which resulted in incarceration for 6 months each. He stated that he is currently on probation for possession of marijuana. He reported that in the past 30 days, he was troubled/bothered 15 out of the last 30 days by legal issues.

| | |
|---|---|
| Patient severity ratings: | Troubled or bothered: 3<br>Need for treatment: 2 |
| Interviewer severity range: | |
| Final Severity Rating: | |

**Family/Support Section:**

MJ is a single, never married male. He has had "an off and on again" relationship with his current girlfriend for about 10 years. He currently resides with a friend but he is pending homelessness if he cannot pay the rent. He reported that he would like to seek his own housing once welfare opens his case. He reported that he does have minimal support from family and friends. He reported that his significant other does not use drugs or alcohol. He has used alcohol and drugs with co-workers and peers in the past. He reported that he has two adult children whom he has a "decent" relationship with but he does not get to see or speak to them regularly as they have their own lives and families. The client denied any history of emotional/physical/sexual abuse; he stated that his father was at times strict but does not consider him to have been abusive. He reported that in the past 30 days, he was troubled/bothered by family/support issues 5 of the last 30 days.

Patient severity ratings: Troubled or bothered: 1
Need for treatment: 1

Interviewer severity range:

Final Severity Rating:

**PSYCHIATRIC SECTION**:

MJ reported that he has been hospitalized once for depression with suicidal ideation. He stated having episodes of depression when he is unemployed, has unstable housing, and when he was in the serious car accident. He stated that during those times, he feels hopeless and he struggles with anxiety. He reported that he was discharged with medications after the hospitalization but he wasn't able to get them filled due to lack of insurance at the time. He stated that he was never involved with any other mental health treatment. He reported that he has fleeting thoughts that sometimes he wished that his life was over but he never had a plan or intent. He reported that sometimes he does have episodes of anger; usually after he's had a few drinks. He reported that in the past 30 days, he has experienced some depression and anxiety. The client reported that the depression and anxiety bothered him about 15 in the last 30 days.

Patient severity ratings: Troubled or bothered: 3
Needs treatment: 3

Interviewer severity range:

Final Severity Rating:

# Understanding and Using the Third Edition of the ASAM Criteria (2013)

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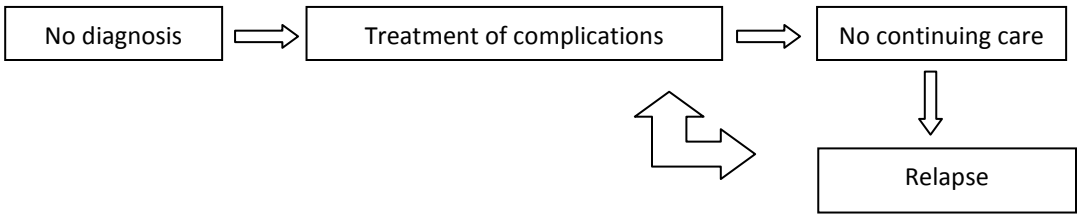
## A. Brief History of the ASAM Criteria

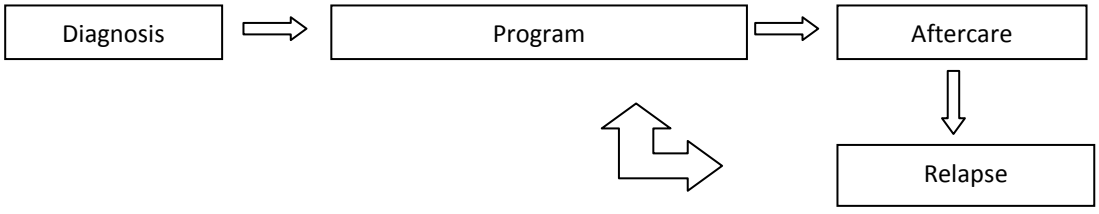
- 1987 Cleveland Criteria and the NAATP Criteria published
- 1991 ASAM PPC-1 published
- 1992 Coalition for National Clinical Criteria established
- 1994 ASAM Criteria Validity Study funded by NIDA
- 1995 "The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders" The Recommendations of a Consensus Panel. Co-Chairs: Lee Gartner and David Mee-Lee, M.D. Treatment Improvement Protocol. The Center for Substance Abuse Treatment.
- 1996 ASAM PPC-2 published
- 1998 – 1999 ASAM PPC endorsed by >25 states, DoD, VA, ValueOptions
- 1999 NIAAA funds Assessment Software project
- 2001 ASAM PPC-2R published
- 2013 The ASAM Criteria, *Treatment for Addictive, Substance-Related, and Co-Occurring Conditions*, Third Edition 2013

## B. Generations of Clinical Care

1. Complications –driven Treatment
   - No diagnosis of Substance Use Disorder
   - Treatment of complications of addiction with no continuing care
   - Relapse triggers treatment of complications only

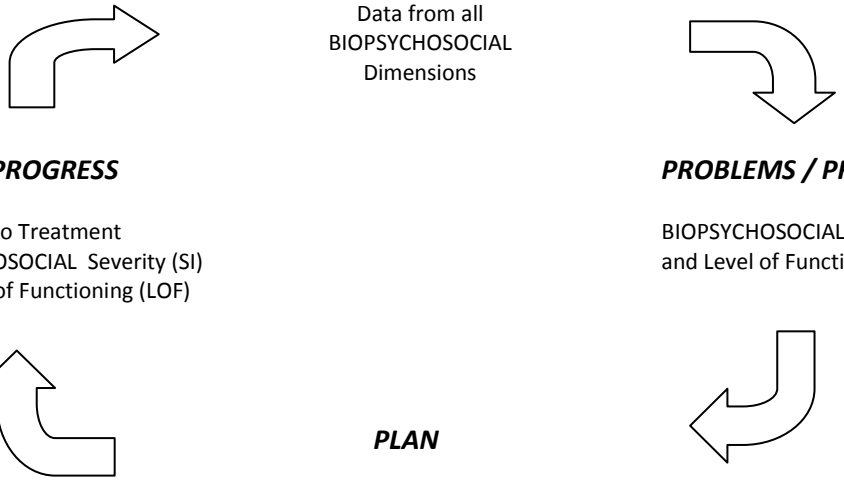



2. Diagnosis, Program-driven Treatment
   - Diagnosis determines treatment
   - Treatment is the primary program and software
   - Relapse triggers a repeat of the program



3. Individualized, Clinically-driven Treatment

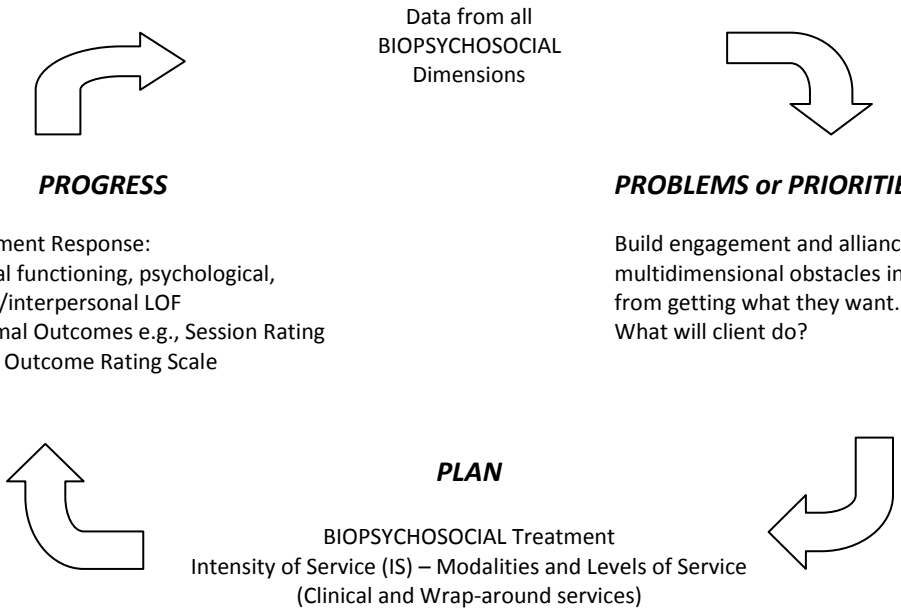
***PATIENT / PARTICIPANT ASSESSMENT***




4. Clinical, Outcomes-driven Treatment

***The Individual*-Process Outcomes – Individualized, Outcomes-Driven Treatment**

***PATIENT / PARTICIPANT ASSESSMENT***



## Underlying Concepts of ASAM Criteria

Assessment of Biopsychosocial Severity and Function - The common language of six ASAM dimensions determine needs/strengths in behavioral health services:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral/*cognitive* conditions and complications
4. *Readiness to Change* (formerly Treatment acceptance/resistance)
5. *Relapse/Continued Use / Continued Problem* potential
6. Recovery environment

## ASAM Assessment Dimensions

| Assessment Dimensions | Assessment and Treatment Planning Focus |
|---|---|
| 1.Acute Intoxication and/or Withdrawal Potential | Assessment for intoxication and/or withdrawal management. Detoxification in a variety of levels of care and preparation for continued addiction services. |
| 2.Biomedical Conditions and Complications | Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services. |
| 3.Emotional, Behavioral or Cognitive Conditions and Complications | Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services. |
| 4.Readiness to Change | Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change. |
| 5.Relapse, Continued Use or Continued Problem Potential | Assess readiness for relapse prevention services and teach where appropriate. If still at early stages of change, focus on raising consciousness of consequences of continued use or continued problems as part of motivational enhancement strategies. |
| 6.Recovery Environment | Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services. |

1. Biopsychosocial Treatment – Overview: 5 M's

   - Motivate – Dimension 4 issues; intervention; "raising the bottom"; motivational enhancement
   - Manage – the family, significant others, work/school, legal
   - Medication – detox; anti-craving meds
   - Meetings – AA, NA, Al-Anon; Smart Recovery, Secular Organization for Sobriety, etc.
   - Monitor – continuity of care; relapse prevention; family and significant others

2. Treatment Levels of Service (The ASAM Criteria 2013)

   - 1 Outpatient Services
   - 2 Intensive Outpatient / Partial Hospitalization Services
   - 3 Residential / Inpatient Services
   - 4 Medically-Managed Intensive Inpatient Services

## ASAM LEVELS OF CARE

| ASAM Criteria Level of Detoxification Service for Adults | LEVEL | Note: There are no separate Detoxification Services for Adolescents |
|---|---|---|
| Ambulatory Detoxification without extended on-site Monitoring | I-WM | Mild withdrawal with daily or less than daily outpatient supervision; likely to complete detox, and to continue treatment or recovery |
| Ambulatory Detoxification with extended on-site Monitoring | 2-WM | Moderate withdrawal with all day detox, support and supervision; at night, has supportive family or living situation; likely to complete detox |
| Clinically-Managed Residential Detoxification | 3.2-WM | Moderate withdrawal, but needs 24-hour support or complete detox, and increase likelihood of continuing treatment or recovery |
| Medically-Monitored Inpatient Detoxification | 3.7-WM | Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete detox, without medical, nursing monitoring |
| Medically-Managed Intensive Inpatient Detoxification | 4-WM | Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify detox, regimen and manage medical instability |
| **ASAM Criteria LEVELS OF CARE** | **LEVEL** | **Same Levels of Care for Adolescents except Level 3.3** |
| Early Intervention | 0.5 | Assessment and education for at risk individuals who do not meet diagnostic criteria for Substance-Related Disorder |
| Outpatient Services | 1 | Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies |
| Intensive Outpatient | 2.1 | 9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability |
| Partial Hospitalization | 2.5 | 20 or more hours of service/week for multidimensional instability not requiring 24 hour care |
| Clinically-Managed Low-Intensity | 3.1 | 24 hour structure with available trained personnel; at least 5 hours of clinical service/week |
| Clinically-Managed Med-Intensity | 3.3 | 24 hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community |
| Clinically-Managed High-Intensity | 3.5 | 24 hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community |
| Medically-Monitored Intensive Inpatient | 3.7 | 24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. Sixteen hour/day counselor ability. |
| Medically-Managed Intensive Inpatient | 4 | 24 hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2 or 3. Counseling available to engage patient in treatment. |
| Opioid Treatment Services | OTS | Opioid Treatment Program (OTP) – agonist meds: methadone, buprenorphine; Office Based Opioid Treatment (OBOT); antagonist medication - naltrexone |

# ASAM SEVERITY PROFILE

| Biopsychosocial Assessment | Severity of Illness | | |
|---|---|---|---|
| NCI=Not Clinically Indicated | **Low**<br>**Low risk or non-issue** | **Moderate**<br>**Difficulty in functioning** | **High**<br>**In or near imminent danger** |
| Dimension 1:<br>Acute Intoxication / Withdrawal Potential | | | |
| Dimension 2:<br>Biomedical Conditions and Complications | | | |
| Dimension 3:<br>Emotional / Behavioral / Cognitive Conditions and Complications | | | |
| Dimension 4:<br>Readiness to Change "***BELIEF"*** | | | |
| Dimension 5:<br>Relapse / Continued Use / Continued Problem Potential ***"USE"*** | | | |
| Dimension 6:<br>Recovery / Living Environment | | | |

## CORRELATION BETWEEN ASAM CRITERIA AND ASI

| ASAM Dimension | ASI Life Area |
|---|---|
| 1. Acute Intoxication and/or Withdrawal | NO direct correlation; past only (last 30 days; lifetime);<br>ALCOHOL/DRUGS: some overlap |
| 2. Biomedical Conditions and Complications | MEDICAL STATUS (all by history) |
| 3. Emotional/Behavioral/Cognitive Conditions and Complications | LEGAL STATUS (possible if due to an Axis 1 or 2 disorder);<br>PSYCHIATRIC STATUS |
| 4. Readiness to Change | ALCOHOL/DRUGS: some overlap;<br>LEGAL STATUS: some overlap |
| 5. Relapse/Continued Use/Continued Problem Potential | ALCOHOL/DRUGS: some overlap;<br>LEGAL STATUS: some overlap |
| 6. Recovery Environment | EMPLOYMENT/SUPPORT STATUS;<br>FAMILY/SOCIAL RELATIONSHIPS |

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## CLINICAL ASSESSMENT AND PLACEMENT SUMMARY

**Name:** _____ **Date:** _____

**Immediate Need Profile:** Assessor considers each dimension and with just sufficient data to assess immediate needs, checks "yes" or "no" in the following table:

| Dimension | Questions | Yes | No |
|---|---|---|---|
| 1.Acute Intoxication and/or withdrawal Potential | 1(a) Past history of serious withdrawal, life-threatening symptoms or seizures during withdrawal? | | |
| 1.As above | 1(b) Currently having similar withdrawal symptoms? | | |
| 2.Biomedical Conditions/Complications | 2 Any current severe physical health problems? | | |
| 3.Emotional/Behavioral/Cognitive Conditions/Complications | 3(a) Imminent danger of harming self or someone else? | | |
| 3.As above | 3(b) Unable to function and safely care self? | | |

***Yes to questions 1a, 1b, 2 and/or 3a, 3b requires that the caller/client immediately be referred for medial and/or mental health evaluation, depending on which dimension(s) involved.**

| | | | |
|---|---|---|---|
| 4.Readiness to Change | 4(a) Does client appear to need alcohol or other drug treatment/recovery, but ambivalent or feels it unnecessary? E.g., severe addiction, but client feels controlled use still OK | | |
| 4.As above | 4(b) Client been coerced, mandated or required to have assessment and/or treatment | | |

***Yes to questions 4a and/or to 4b alone, requires staff to begin immediate intervention and motivational strategies appropriate to client's stage of readiness to change.**

| | | | |
|---|---|---|---|
| 5.Relapse/Continued Use Potential | 5(a) Is client currently under the influence or intoxicated? | | |
| 5.As above | 5(b) Is client likely to continue use of alcohol and/or other drugs, or to relapse, in an imminently dangerous manner? | | |

***Yes to question 5a requires caller/client be considered for withdrawal potential. Yes to question 5a and/or 5b, individual may need to be considered for 24 hour structure or care.**

| | | | |
|---|---|---|---|
| 6.Recovery Environment | 6. Are there any dangerous family, sig. others, living/work/school situations threatening client's safety, immediate well-being, and/or sobriety? | | |

***Yes to Dimension 6, without any Yes in questions 1, 2 and/or 3, requires that the caller/client be assessed for the need of a safe or supervised environment.**

### LEVEL OF FUNCTIONING/SEVERITY:

Using assessment protocols that address all six dimensions, assign a severity rating of **High, Medium or Low** for each dimension that best reflects the client's functioning and severity. Place a check mark in the appropriate box for each dimension.

| Level of Functioning/Severity | Intensity of Service Need | 1.Intox. With | 2.Bio-Med. | 3.Emot Behave | 4.Read-Ness | 5.Rel-apse | 6.Rec. Environ |
|---|---|---|---|---|---|---|---|
| **Low Severity –** minimal, current difficulty or impairment. Absent, minimal, or mild signs and symptoms. Acute or chronic problem mostly stabilized; or soon able to be stabilized and functioning restored with minimal difficulty | **L –** No immediate services or low intensity of services needed for this dimension. Treatment strategies usually able to be delivered in outpatient settings | | | | | | |
| **Moderate Severity –** Moderate difficulty or impairment. Moderate to serious signs and symptoms. Difficulty coping or understanding, but able to function with clinical and other support services and assistance. | **M** – Moderate intensity of services, skills training, or support needed for this dimension. Treatment strategies may require intensive levels of outpatient care. | | | | | | |
| **High Severity** – Severe difficulty or impairment. Serious, gross or persistent signs and symptoms. Very poor ability to tolerate & cope with problems. | **H -** High intensity of services, skills training, or supports needed. More immediate, urgent services may require inpatient or residential settings; or closely monitored case management services at a frequency greater daily | | | | | | |

## CLINICAL ASSESSEMENT AND PLACEMENT SUMMARY

**Name:** _____ **Date:** _____

**PLACEMENT DECISIONS:** Indicate for each dimension, the least intensive level consistent with sound clinical judgment, based on the client's functioning/severity and service needs.

### Data gathering when clinically-indicated level of care not available

*(The ASAM Criteria* 2013*,* p 126)

- Policy, payment and systems issues cannot change quickly. However, as a first step towards reframing frustrating situations into systems change, each incident of inefficient or in adequate meeting of clients' needs can be a data point that sets the foundation for strategic planning/change
- Finding efficient ways to gather data as it happens in daily care of clients can help provide hope and direction for change:

### PLACEMENT SUMMARY

| |
|---|
| **Level of Care/Service Indicated** - Insert the ASAM Level number that offers the most appropriate level of care/service that can provide the service intensity needed to address the client's current functioning/severity; and/or the service needed e.g., shelter, housing, vocational training, transportation, language interpreter |
| **Level of Care/Service Received** - ASAM Level number -- If the most appropriate level or service is not utilized, insert the most appropriate placement or service available and circle the Reason for Difference between Indicated and Received Level or Service |
| **Reason for Difference** - Circle only one number -- 1. Service not available; 2. Provider judgment; 3. Client preference; 4. Client is on waiting list for appropriate level; 5. Service available, but no payment source; 6. Geographic accessibility; 7. Family responsibility; 8. Language; 9. Not applicable; 10. Not listed (Specify): |
| **Anticipated Outcome If Service Cannot Be Provided** – Circle only one number - 1. Admitted to acute care setting; 2. Discharged to street; 3. Continued stay in acute care facility; 4. Incarcerated; 5. Client will dropout until next crisis; 6. Not listed (Specify): |

# Dimensional Considerations for Continuing Service Reviews

The Continuing Service Review will result in one of the following outcomes:

- Client is making progress toward but **has not yet met all treatment goals** as indicated in the most recent ASAM review; **treatment continues at this level of care.**
- Client has **met all treatment goals** as indicated in the most recent ASAM review; however, **new problems have emerged** in the treatment processes that indicate **continuing treatment at this level of care.**
- Client has **met all treatment goals** as indicated by the most recent ASAM review; however, ASAM indicates the **need for continuing treatment at a less intense level of care**. Care Coordinator/Case Manager completes an ASAM *Continuing Care Review* and arranges placement for the client at a **less intensive level of care.**
- The ASAM review indicates the **need for a more intense level of care.** Care Coordinator/Case Manager completes an ASAM review and arranges placement for the client at a **more intense level of care.**
- The client **has not met all treatment goals**; however, further services are not likely to result in additional treatment progress.

## Dimension 1: Acute Intoxication/Withdrawal Potential

- Client's last use of drugs/alcohol.
- Quantity of most recent use.
- Frequency of recent use.
- Possible potentiating (addictive effects) combinations.
- Level of current intoxication (Physical and Mental symptoms.)
- Level of withdrawal (Physical and Mental symptoms.)
- History of withdrawal problems, including seizures.
- Does the client require detox at this time?
- Does the client think that he/she needs detox at this time?

## Dimension 1: Review for clients who had been placed in detox

- Is the detox complete?
- Was the detox free of complications (e.g., seizures; medical)?
- Meds administered?
- What is the discharge from detox plan/date?

Dimension 1 Problem: _____

Dimension 1 Plan: _____

## Dimension 2: Biomedical Conditions and Complications

- Does the client have a medical diagnosis?
- Is the medical condition mild, acute, chronic?
- Is the client pregnant? If so, how many months pregnant is she and does she have prenatal care?
- If the client recently had a baby, has the client gone to her postnatal check-up?
- Does the client have a prescription for meds?
- Does the client adhere to medical requirements?
- Does the client require medical management/stabilization?
- When was the last time the client had a thorough physical exam?
- When was the last time that the client went to the dentist?
- When was the last time the client had an OBGYN exam? Mammogram*?*
- If the client has a chronic illness, what is the status of the illness?
- Is the client in the process of applying for SSI/medical deferment?
- Is the client physically able to work?

Dimension 2 Problem: _____

Dimension 2 Plan: _____

## Dimension 3: Emotional/Behavioral/Cognitive Conditions and Complications

- Does the client have a psychiatric diagnosis?
- Prescription medications for psychiatric diagnosis?
- Is the client adherent to medication requirements?
- Do you observe feelings of anger, guilt, shame, and/or anxiety connected to his/her addiction?
- Does the client report a history of physical, sexual or emotional abuse?
- Does the client present with visual/auditory hallucinations or paranoid ideation?
- What is the client's violence potential? Describe.
- Is the client a danger to himself/herself or others? Does the client have a serious desire/intent to harm himself/herself or others?
- Describe the client's cognitive/intellectual functioning. (Slight deficit or severe?)
- Describe the client's ability to focus on treatment.
- Describe the client's social functioning (e.g., ability to relate to others).
- Describe the client's ability to care for himself/herself.
- Describe the client's ability to care for his/her children.
- Is the client work deferred or presently in the process of applying for SSI?
- Is the client able to work?

Dimension 3 Problem: _____

Dimension 3 Plan: _____

## Dimension 4: Readiness to Change

- **Attends treatment sessions at least 75% of the time? Attendance report***
- Does this attendance report reflect an improvement in attendance?
- Would you say that the client has actively engaged in treatment? Describe the level of participation.
- Has the client been court/DCP&P mandated to treatment since our last review?
- Voices awareness of drug/alcohol/mental health problems.
- Describe client's acceptance of responsibility for behavior; does he/she accept responsibility or blame others for his/her problems?
- Does the client have an interest in changing?
- Does he/she have confidence in the ability to change?
- Is the client willing to ask for help for change?
- Describe the client's personal treatment goals.
- Does the client follow-through with plans for change?
- What would it take to move the client into the action stage of change?

Dimension 4 Problem: _____

Dimension 4 Plan: _____

## Dimension 5: Relapse/Continued Use/Continued Problem Potential

- **What are the client's most recent UDS results?***
- Does the UDS report reflect an improvement in UDS results?
- What would it take for the client to be successful in getting negative UDS results?

***Requires mandatory response***

- Is the client experiencing any cravings? If yes, how frequently?
- Describe the client's ability to resist cravings and impulses to use.
- Describe the client's coping skills to manage emotions and cravings.
- Describe the client's knowledge/use of refusal skills.
- Does the client display relapse behavior? Describe.
- Is the client a high risk for relapse? If so, is the high risk connected to a mental health problem?
- Does the client have a relapse prevention plan in place?
- What action is the client taking to prevent relapse?
- Relate the client's description of his/her relapse triggers.

Dimension 5 Problem: _____

Dimension 5 Plan: _____

## Dimension 6: Recovery Environment

- How would you describe the client's social skills? Does the client make friends easily or are his/her social skills limited?
- Does the client engage in isolative behaviors?
- On a scale of 0-4 with 0 being very supportive and 4 being "no support," how would you rate the client's network of recovery support from family and friends?
- Does the client have any family/friends that don't use drugs and/or alcohol?
- In what ways does the family's use of alcohol/drugs impact the client's recovery efforts?
- Describe the client's living situation/neighborhood/work environment with regards to recovery support.
- Describe the client's ability to deal with his/her environment.
- Does the client report having any sober leisure or recreational activities?
- Does the client attend 12 Step meetings? Does the client report gaining relief from 12 Step meeting attendance? Does the client have a sponsor?
- Describe how the client utilizes his/her sponsor as a means of support.
- If the client does not attend a Twelve Step group, does the client have an alternative support (e.g., church) to 12 Step Meetings? Describe.
- Do the client's environment/social contacts put the client at risk for emotional, physical or sexual abuse?
- Does the client have unresolved legal problems?
- Describe the client's ability to get a job and keep it.
- Is there a spiritual dimension to the client's life? Describe.
- Is the client presently involved with DCP&P? History of DCP&P involvement?
- Is the client experiencing any stress related to child custody/visitation problems?
- Is there a reunification plan for this DCP&P-involved client?
- Do you get the sense that the client's children are in a safe environment?
- Do you get the sense that the client is in a safe living environment? Is there a restraining order in effect?
- If the client recently had a baby, is the client complying with well baby checkups?
- Does the client have a work activity?
- Is the client presently working?
- Are there any vocational plans in order for this client?

Dimension 6 Problem: _____

Dimension 6 Plan: _____

# CHANGING FOR GOOD

**By Prochaska, Norcross and Diclemente**

The Stages of Change

### Precontemplation Stage

Characteristics:

- Can't see the problem
- Blames others for faults and failures
- Doesn't want to change or see the need to change
- Gives up on abilities to change
- Wants everyone else to change
- Denies responsibility
- Rarely takes responsibility for the negative consequences of action
- Shows up at therapy to get others to stop nagging him/her
- When their problem comes up in conversation he/she shifts the subject
- Lack info on his/her problem and intends to maintain ignorant bliss
- Demoralized and feels that the situation is hopeless
- Talk to the hand!

### Contemplation Stage

Characteristics:

- "I want to stop feeling so stuck"
- Wishful thinking
- Wants to change but is simultaneously resistant to it
- Substitute worry for working
- Can see the problem and begins to think about resolving it
- Struggles to understand the causes and cures
- Lacks commitment
- Knows their destination and how to get there but not yet ready to go
- Spends years telling himself/herself that someday he/she is going to change
- Fear of failure
- Eternally substitutes thinking for action
- One therapist in contemplation stage + one client in contemplation stage = years of therapy ("Chronic Contemplator")

### Preparation Stage

Characteristics:

- Plans to take action in the very next month
- Public announcement of intended change
- Committed to action but still ambivalent about it
- Awareness is high

**Action Stage**

Characteristics:

- Makes the move for which he/she has been preparing (i.e., stop smoking cigarettes, rid of the house of sweets)
- Grieves losses
- Commitment of time and energy
- Changes are visible to others

**Maintenance Stage**

Characteristics:

- Works to consolidate the gains
- Struggles to prevent lapses and relapse

**Termination Stage**

Characteristics:

- The ultimate goal
- Former problem presents no temptation or threat

# THE SPIRAL OF CHANGE

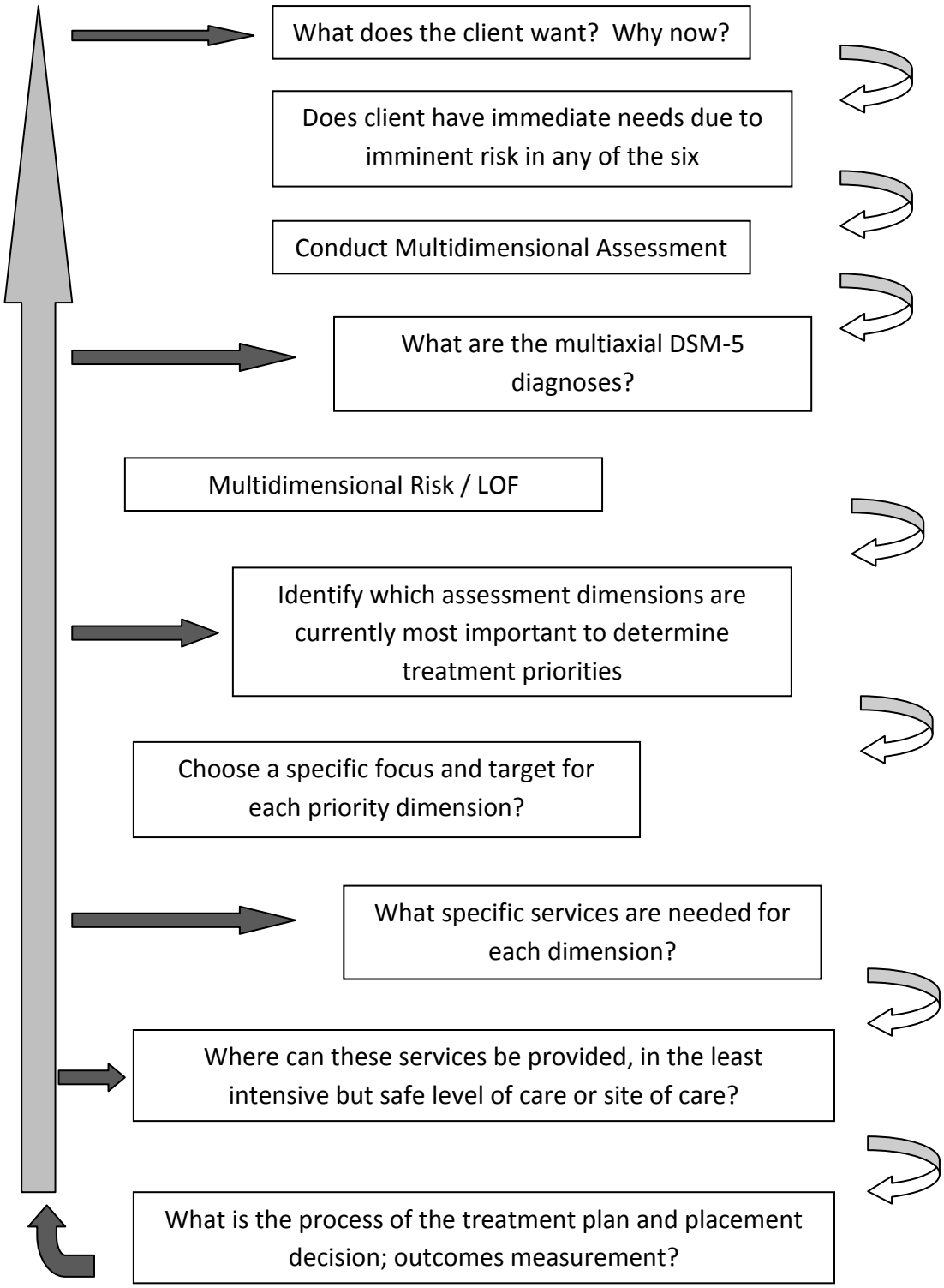

**STAGES OF CHANGE IN WHICH PARTICULAR CHANGE PROCESSES ARE MOST USEFUL**


From page 49, 54: Prochaska, JO; Norcross, JC; DiClemente, CC: "Changing for Good" Avon Books, New York, 1994 (First Avon Books Printing, September, 1995)

Developing the Treatment Contract – What Does the Client Want?

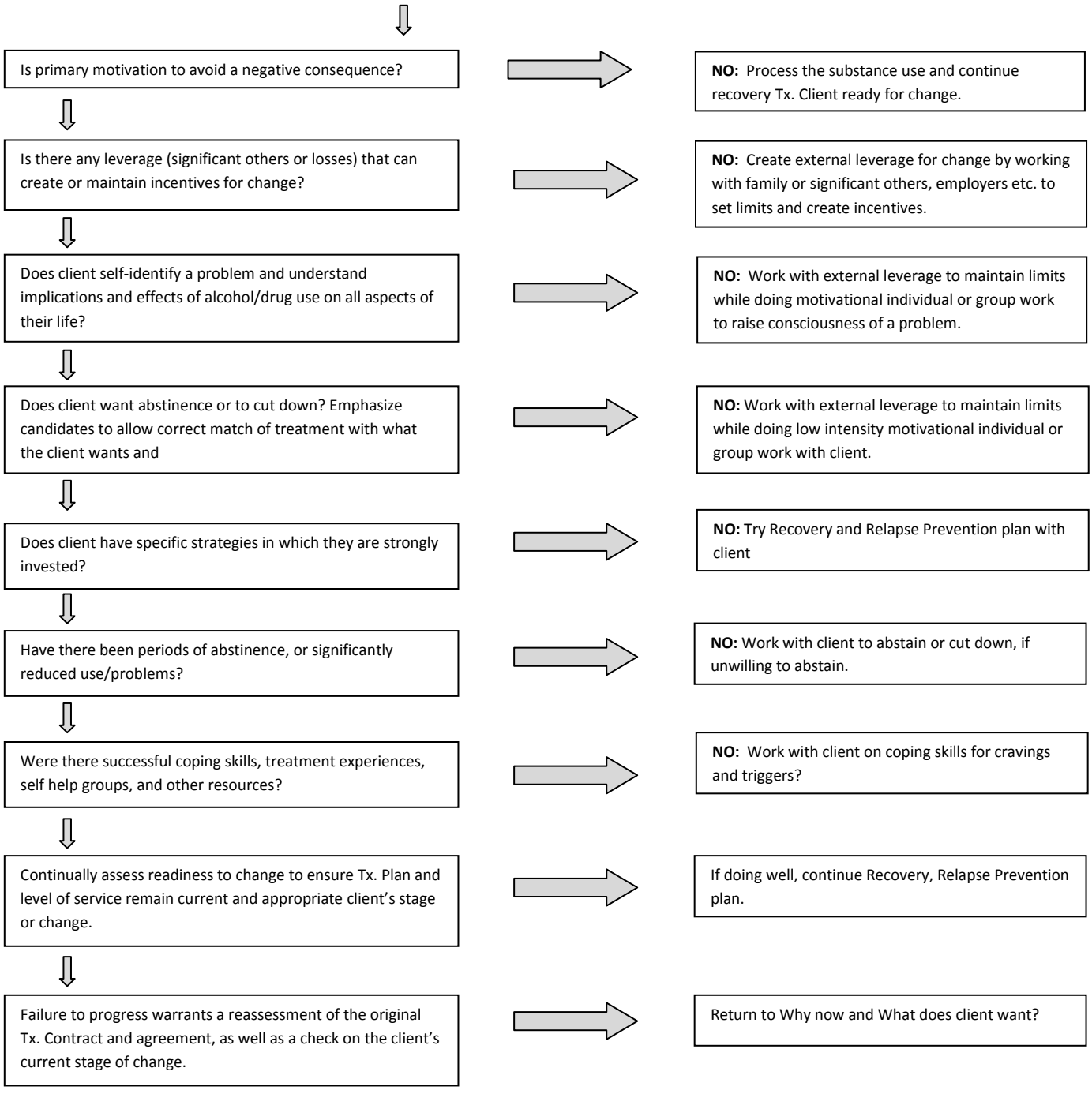
| | Client | Clinical Assessment | Treatment Plan |
|---|---|---|---|
| What? | What does client. want? | What does client need? | What is the Tx contract? |
| Why? | Why now? What's the level of commitment? | Why? What reasons are revealed by the assessment data? | Is it linked to what client wants? |
| How? | How will s/he get there? | How will you get him/her to accept the plan? | Does client buy into the link? |
| Where? Where will s/he do this? | | Where is the appropriate setting for treatment? What is indicated by the placement | Referral to level of care |
| When? When will this happen? How quickly? How badly does s/he want it? | | When? How soon? What are realistic expectations? What are milestones in the process? | What is the degree of urgency? What is the process? What are the expectations of the referral? |

## Decision Tree: How to Organize Assessment Data to Focus Treatment



## How to Engage the Reluctant Client

### Why Now and What does the client want?



**USING THE ASAM CRITERIA AND ASI TO PRESENT CASES AND DEVELOP A COMMON LANGUAGE**

Using the ASAM Criteria and ASI problem area to focus data – to help clients focus on the most important priorities and to promote simple, realistic and achievable treatment goals and treatment plans, use the dimensions of the ASAM Criteria and ASI to concentrate on the most severe areas first

## Case Presentation Format

**Before presenting the case, please state why you chose the case and what you want to get from the discussion**

I. Identifying Client Background Data

Name
Age
Ethnicity and Gender
Marital Status
Employment Status
Referral Source
Date Entered Treatment
DSM diagnoses
Level of Service Client Entered Treatment
Current Level of Service

Stated or Identified Motivation for Treatment *(What is the most important thing the client wants you to help them with?)*

**First state how severe you think each assessment dimension is and why (focus on brief relevant history information and relevant here and now information):**

II. Current Placement Dimension Rating — Has It Changed?

1.

2.

3.

4.

5.

6.

(Give a brief explanation for each rating, note whether it has changed since the client entered treatment and why or why not?)

III. What problem(s) with High and Moderate severity rating are of greatest concern at this time?

Specificity of the problem

Specificity of the strategies/interventions

Efficiency of the intervention (Least intensive, but safe, level of service)

## Case Presentation Format

**Before presenting the case, please state why you chose the case and what you want to get from the discussion.**

***This case was chosen to be presented to highlight the progress that can be made when various systems work together.***

1. Identifying Client Background Data

***The client is a 22-year-old separated Hispanic female who is currently residing in a DCP&P TC facility. She is the mother of two children, one 3 years and the other 2 months. Currently her 3 year old is in the custody of his father. She was originally referred to the SAI by DCP&P for allegations of marijuana use. At the time of the assessment in June of '13, the client admitted to a 5-year history of marijuana use and a 3-year history of alcohol use. She reported that both of these were social use however, all urine drug screens since the assessment have been positive for marijuana. Other than normal prenatal and now postnatal care, there are no other medical concerns. The client denied any psychological concerns including any suicidal/homicidal ideation or plan. Based on observation, the client appears to be emotionally immature. The client has an 8th grade education and has attempted to attain her GED but has failed to complete the course. She has limited work experience and no legal issues other than DCP&P.***

Name ***Maria P.***
Age ***23***
Ethnicity and Gender ***Hispanic, Female***
Marital Status ***Separated***
Employment Status ***Unemployed***
Referral Notice ***DCP&P***
Date Entered Treatment ***1/3/14***
Level of Service Client Entered Treatment (if this case presentation is a treatment plan review) ***3.5***
Current Level of Service (if this case presentation is a treatment plan review) ***3.5***
DSM Diagnosis: Cannabis Use Disorder, Severe 304.30
Alcohol Use Disorder, Mild 305.00

Stated or Identified Motivation for Treatment (What is the most important thing the clients wants you to help them with?) ***The most important thing to the client at this time is not losing her newborn to DCP&P.***

**First state how severe you think each assessment dimension is and why (focus on brief relevant history information and relevant here and now information):**

2. Current Placement Dimension Rating (See Dimension below 1-6)

***As of 12/27/13***

1. ***No evidence or history of withdrawals – NCI***
2. ***7 months pregnant, receiving prenatal care – Low (1)***
3. ***None reported, presents as emotionally immature –Low (1)***
4. ***Doesn't see marijuana as a problem, willing to go inpatient so she doesn't lose custody of her child –High***
5. ***Continued use of marijuana, unable to attain abstinence in outpatient setting – High (3.5)***
6. ***Open DCP&P, Unemployed, 8th grade Edu., no outside supports, peers use, facing eviction – High 3.1***

(Give a brief explanation for each rating, note whether it has changed since the client entered treatment and why or why not)

***The client entered a residential Mommy & Me program on 1/3/14:***

1. ***No change. NCI***
2. ***Gave birth on 1/31/14, attending all postpartum appointments – Low***
3. ***In addition to emotional immaturity, client is upset over the loss of custody of her 3-year-old, avoids family issues, leaves infant unattended often – Low (1)***
4. ***The client remains in treatment due to knowing the consequences if she leaves – High***
5. ***Since in residential, client has attained first period of abstinence ever. Possibly just going through the motions to look good for DCP&P – High (3.5)***
6. ***Open DCP&P, limited family and social support, lacks GED – Low (1)***

**This last section we will talk about together:**

What problem(s) are of greatest concern at this time?
Specificity of the problem

***Dimensions 4 (High) as stated above, the client's decisions continue to be based on the consequences attached to those actions. She has yet to internally want to remain abstinent.***

***Dimension 3 (Low) The client's immaturity and stunted emotional growth will continue to pose a problem as it directly affects her views on triggers, recovery, parenting, etc.***

***Dimension 5 (High) although she has attained abstinence, it may only be due to the substance not being available in residential treatment. Working on refusal skills and identifying triggers.***

Specificity of the strategies / intervention

***Since this client is strictly motivated by consequences, it was very helpful for DCP&P to align with the SAI in the treatment recommendation. Most clients are motivated by the actions of Welfare; however, since the client was medically exempt from any sanction due to pregnancy, an alternative reinforcement was needed. The client's continued motivation has been her children. Therefore DCP&P threatened the removal of her children if she did not adhere with the treatment recommendation.***

Efficiency of the intervention (Least intensive, but safe, level of service)

A. **Guiding Principles of *The ASAM Criteria* 2013 (***The ASAM Criteria*** 2013, pp 3-11)**

- Moving from one-dimensional to multidimensional assessment
  *The ASAM Criteria* continues to encourage moving away from treatment based on diagnosis alone (i.e., seeing a diagnosis as a sufficient justification for entering a certain modality or intensity of treatment) toward treatment that is holistic and able to address multiple needs. A diversity of clinical offerings and intensities reflect the diversity of patients who may have needs in a number of clinical and functional dimensions. ASAM's six assessment dimensions were created in order to address this guiding principle.

- Moving from program-driven to clinically driven and outcomes-driven treatment
  Rather than focusing on "placement" in a program, often with a fixed length of stay, *The ASAM Criteria* supports individualized, person-centered treatment that is responsive to specific needs and the patient's progress in treatment.

- Moving from fixed length of service to variable length of service
  Outcomes research in addiction treatment has not provided a scientific basis for determining precise lengths of stay for optimum results. Thus, addiction treatment professionals recognize that length of stay must be individualized, based on the severity and level of function of the patient's illness, as well as based on their response to treatment, progress, and outcomes. At the same time, research does show a positive correlation between longer treatment in the continuum of care and better outcomes. While length of service is still presented as variable, based on patients' complex needs and outcomes in the current edition, both sides of this discussion (fixed versus variable lengths) are raised within these criteria in order to increase awareness of length of stay issues.

- Moving from a limited number of discrete levels of care to a broad and flexible continuum of care Treatment is delivered across a continuum of services that reflect the varying severity of illnesses treated and the intensity of services required. Referral to a specific level of care must be based on a careful assessment of the patient with an alcohol, tobacco and/or other substance use disorder; and/or a gambling disorder. A primary goal underlying the criteria presented here is for the patient to be placed in the most appropriate level of care. For both clinical and financial reasons, the preferable level of
  Care is that which is the least intensive while still meeting treatment objectives and providing safety and security for the patient. Moreover, while the levels of care are presented as discrete ranks, in reality they represent benchmarks or points along a continuum of treatment services that could be harnessed in a variety of ways, depending on a patient's needs and responses. A patient may begin at a required level and move to a more or less intensive level of care, depending on his or her individual needs.

- Identifying adolescent-specific needs
  Adolescents who use alcohol, tobacco and/or other drugs differ from adults in significant ways. While substance use disorders in adolescents and adults may have common biopsychosocial elements of etiology, they are different in many aspects of their expression and treatment. Adolescence affords a unique opportunity to modify risk factors that are still active and not yet complete in their influence on development. Adolescents must be approached differently from adults because of differences in their stages of emotional, cognitive, physical, social and moral development. Examples of these fundamental developmental issues include the extremely potent influences of the adolescent's interactions with family and peers, the expected immaturity of most adolescents' independent living skills, and the fact that some amount of testing limits is a normative developmental task of adolescence.

  *The ASAM Criteria* distinguishes and highlights adult and adolescent treatment information, where appropriate.

- Clarifying the goals of treatment
  Treatment that is tailored to the needs of the individual and guided by an individualized treatment plan, developed in consultation with the patient, is helpful in establishing a therapeutic alliance and therefore contributing significantly to treatment outcomes. The individualized plan should be based on a comprehensive biopsychosocial assessment of the patient and, when possible, a comprehensive evaluation of the family as well.

  Patient-centered care includes documentation showing where and how the treatment plan:

  - Identifies problems or priorities, such as obstacles to recovery, knowledge or skill deficits that inhibit achievement of the patient's overall reason for seeking treatment.
  - Includes strengths, skills and resources, such as coping strategies to deal with negative affects and stressors, successful exercise routines, medications that have been effective, positive social supports, and a strong connection to a source of spiritual support.
  - States goals that guide realistic, measurable, achievable, and short-term resolution of priorities or reduction of the symptoms or problems.
  - Lists methods or strategies that identify the personal actions of the patient and the treatment services to be provided by staff, the site of those services, staff responsible for delivering treatment, and a timetable for follow-through with the treatment plan that promotes accountability.

- Is written so as to facilitate measurement of progress. As with other disease processes, length of service should be linked directly to the patient's response to treatment (for example, attainment of the treatment goals and degree of resolution regarding the identified clinical problems or priorities).
- The goals of intervention and treatment (including safe and comfortable withdrawal management, motivational enhancement to identify the need for recovery, the attainment of skills to maintain abstinence, etc.) determine the methods, intensity, frequency and types of services provided. The clinician's decision to prescribe a type of service, and subsequent discharge or transfer of a patient from a level of care, needs to be based on how that treatment and its duration will not only influence the resolution of the dysfunction, but also positively alter the prognosis for long-term recovery and outcome for that individual patient.

- Moving away from using "treatment failure" as an admission prerequisite
  Another concern that guided the development of this publication is the concept of "treatment failure." This term has been used by some reimbursement or managed care organizations as a prerequisite for approving admission to a more intensive level of care (for example, "failure" in outpatient treatment as a prerequisite for admission to inpatient treatment). In fact, the requirement that a person "fail" in outpatient treatment before inpatient treatment is approved is no more rational than treating every patient in an inpatient program or using a fixed length of stay for all. It also does not recognize the obvious parallels between addictive disorders and other chronic diseases such as diabetes or hypertension. For example, failure of outpatient treatment is not a prerequisite for acute inpatient admission for diabetic ketoacidosis or hypertensive crisis.

- Moving toward an interdisciplinary, team approach to care
  *The ASAM Criteria* maintains and builds on ASAM's previous efforts to respond to ongoing changes and needs within the special field of addiction treatment. It also recognizes that with health reform, more services to persons with addiction will be delivered outside of a separate (and separately funded) specialty treatment system for addiction and will be delivered inside of general medical and general behavioral health settings. Addiction care has always been built around services involving interdisciplinary teams of professionals, including and sometimes led by physicians. With health reform, addiction care as well as mental health care will increasingly be delivered by clinicians working in interdisciplinary teams of not only "addiction professionals" but also general medical care professionals.

  The expansion of the Patient Centered Health Care Home model for delivering comprehensive, integrated care for patients and families—including "behavioral healthcare" (mental health and substance related disorders care)—will mean that persons making decisions about how and where to offer

treatment to persons with addiction and related conditions will need to envision new treatment models and settings. Such models and settings will be unfamiliar to many clinicians who have been practicing in, and who likely received their clinical training in, specialty settings for addiction care. They will need to incorporate new skills of greater collaboration with other non-addiction treatment professionals; and inclusion of peers and peer supports.

The current edition of *The ASAM Criteria* recognizes that a broad trend in healthcare is for addiction and related disorders to be increasingly recognized and embraced by physicians—both general medical providers and physicians in a wide range of medical and surgical specialties, and an expanding number of physicians trained and certified (e.g., by the American Board of Addiction Medicine and the American Board of Psychiatry and Neurology) as specialists in addiction care.

- Clarifying the role of the physician
  Due to their prevalence, substance use and addictive disorders are health conditions that have significant impact on public health. Physicians are an essential part of the healthcare delivery system for addiction, as well as for all acute and chronic medical and surgical conditions. Increasingly, teams of professionals are working in a coordinated fashion to deliver healthcare. While mental health care has been offered through interdisciplinary teams for decades, especially in public sector settings, general medical care is only recently developing models to involve a range of health, social services, rehabilitation, and other professionals to manage chronic diseases. The Patient Centered Health Care Home model is a prominent example of this.

  There are many patients with substance use and other addictive disorders, and many more with high- risk substance use and addictive behaviors, who could benefit from the care interventions described as Level 0.5, Early Intervention Services, in *The ASAM Criteria*. Such interventions include Screening, Brief Intervention, Referral and Treatment (SBIRT), risk advice and education. Because so few physicians have had special addiction training, this approach cannot be universally applied.

- Focusing on treatment outcomes
  Increasingly, funding for practitioners and programs will be based not on the service provided, but on the outcomes achieved. Treatment services and reimbursement based on patient engagement and outcome is consistent with trends in disease and illness management, especially when conducted in real-time during the treatment experience, as with the management of hypertension or diabetes. With these chronic illnesses, changes to the treatment plan are based on treatment outcomes and tracked by real-time measurement at every visit (e.g., blood pressure or blood sugar levels are monitored to determine the success of the current treatment regimen). While there has been increased

attention on Evidence-Based Practices (EBP), more focus on patient engagement and outcomes-driven services is still needed.

While EBPs contribute to positive outcomes in treatment, the quality of the therapeutic alliance and the degree to which hope for recovery is conveyed to the patient contribute even more to the outcome. (Wampold, Mondin, Moody, Stich, Benson, & Ahn, 1997; Orlinsky, Grawe, & Parks, 1994; Bachelor & Horvath, 1999; Duncan et al., 2004; Wampold, 2001; Mee-Lee, McLellan, Miller, 2010).

- Engaging with "Informed Consent"
  Treatment adherence and outcomes are enhanced by patient collaboration and shared decision-making. To engage people in treatment and recovery, person-centered services encompass clear information to patients. Certain sections of *The ASAM Criteria* mention directly or draw upon the concept of "informed consent." Healthcare requires informed consent, indicating that the adult, adolescent, legal guardian, and/or family member has been made aware of the proposed modalities of treatment, the risks and benefits of such treatment, appropriate alternative treatment modalities and the risks of treatment versus no treatment.

- Clarifying "Medical Necessity"
  Other sections may mention or draw upon the term of "medical necessity." This concept is central to judgments for third-party payers and managed care organizations to determine appropriateness of care. Because substance use, addictive and mental disorders are biopsychosocial in etiology and expression, treatment and care management are most effective if they, too, are biopsychosocial. The six assessment dimensions identified in *The ASAM Criteria* encompass all pertinent biopsychosocial aspects of addiction and mental health that determine the severity of the patient's illness and level of function.

  For these reasons, *The ASAM Criteria* asserts that "medical necessity" should pertain to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. It should not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs as in Dimension 2; or Dimension 3 psychiatric issues (such as imminent suicidality). Rather, "medical necessity" encompasses all six assessment dimensions so that a more holistic concept would be "Necessity of Care," or "clinical appropriateness."

- Harnessing ASAM's Definition of Addiction
  When it was first published in 1991, ASAM's *Patient Placement Criteria* was considered a guide for linking severity of illness to intensity of service,

specifically for when the health condition was a "Psychoactive Substance Use Disorder." This first edition was published only two years after ASAM adopted its current name as a national medical specialty society, the American Society of Addiction Medicine. At the time, bringing together physicians interested in treating alcoholism with physicians interested in treating opioid and other drug addictions, along with physicians interested in treating nicotine addiction, was revolutionary in its own way.

But still, the focus of this new society was on the prevention and treatment of, and medical education and research about, specific forms of "chemical dependency." Conditions such as "pathological gambling" were well known, but over the years ASAM repeatedly declined to redefine itself as an organization that would address "non-substance-related addiction" in its policies, education, or advocacy activities. ASAM chose not to identify its mission as including "behavioral addictions."

There is a "short version" definition of addiction (shown below), as well as a "long version" definition (available at http://www.asam.org/for-the-public/definition-of-addiction), which serves as more of a description of the condition. In April of 2011, these two versions were unanimously adopted as official ASAM statements.

ASAM Definition of Addiction

"Short Version"

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Notice how this "short version" definition uses the singular term "addiction" to describe a condition that is "primary" and "chronic." So although this definition explains how compulsive, impulsive, or out-of- control substance use can be present, addiction can also involve impaired control over behaviors (such as gambling) that do not involve psychoactive substance use.

B. **What's New in *The ASAM Criteria*** *(The ASAM Criteria* 2013*,* pp 11-14)

- *The ASAM Criteria* now expands on prior understanding and applications to serve a wider and more diverse population. This broader population includes people with addiction who are older adults, parents with children, and also those working in safety sensitive occupations. The current edition also branches out to explore addiction within criminal justice settings.

- In addition, new information has been included to assist in applying *The ASAM Criteria* in managed care, in utilization management, and in the context of mental health and addiction parity and federal healthcare reform. Finally, additional sections have been added to this edition to respond to the request of users—clinicians, care managers, and public and private sector payers— to make information more applicable to the "real world" in which providers deliver care and payers and third parties authorize and manage care.

Other key highlights of this new edition include, but are not limited to:

- Synchronization with *The ASAM Criteria Software*, such that the definitions and specifications in this text for the dimensions, levels of care and admissions decision rules serve as the reference manual for *The ASAM Criteria Software*, released by SAMHSA.

- Incorporation of the latest understanding of Co-occurring Disorders Capability (formerly termed Dual Diagnosis Capability), and what might better be termed "complexity capability," to acknowledge the range of service needs beyond just addiction and mental health treatment. The need for persons with substance use disorders to be assessed and treated for co-occurring infectious diseases is but one clear example of this concept. Programs and practitioners increasingly understand the need for trauma informed care and primary health/behavioral health integration, as core features of all addiction treatment programs.

  As the treatment field has learned more about the complexities of the people we serve, it increasingly is becoming more trauma-informed and responsive to the needs of people with co- occurring mental and substance use disorders. Services that are "co-occurring capable or enhanced" and "complexity capable" are described.

- Inclusion of the conceptual framework of Recovery Oriented Systems of Care to facilitate understanding of addiction treatment services within a recovery-oriented "chronic disease management" continuum, rather than as repeated, disconnected "acute episodes of treatment" for the acute complications of addiction; and/or repeated and disconnected readmissions to addiction or

mental health programs that employ rigid lengths of stay in which patients are "placed."

- Updated Diagnostic Admission Criteria for the levels of care to be consistent with the American Psychiatric Association's 2013 publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

- A new chapter on Gambling Disorder that is consistent with ASAM's definition of addiction, asserting that the pathological pursuit of reward or relief can involve not just the use of psychoactive substances, but also the engagement in certain behaviors. The inclusion of a Gambling Disorder section also reflects shifts in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which includes Gambling Disorder in the Substance Use and Addictive Disorders chapter.

- A new chapter on Tobacco Use Disorder reflects a decision to address the treatment field's inconsistencies in, and even ambivalence about, viewing this addiction as similar to alcohol and other substance use disorders.

- An updated opioid treatment section to incorporate new advances, named Opioid Treatment Services (addressing opioid antagonist pharmacotherapy in addition to opioid agonist pharmacotherapy). Previous editions and supplements of ASAM's criteria have described care offered in what this edition is naming Opioid Treatment Programs (utilizing methadone to treat opioid use disorder in Level 1 and previously called Opioid Maintenance Therapy, OMT.) *The ASAM Criteria*, Third Edition, is the first to address the growing use of office-based opioid treatment, utilizing buprenorphine products to treat opioid addiction.

- Updates to better assess, understand and provide services for all six ASAM criteria dimensions to reflect current science and research. This can be seen in sections such as "Addressing Withdrawal Management" and Appendix B, "Special Considerations for Dimension 5 Criteria."

- Reformatted levels of care numbers. Traditionally listed using Roman numerals, levels of care have been reformatted using Arabic numbers to adjust for 21st century communication and technologies.

- A user-friendly format. In the publication design and delivery of this content, much attention has been paid to make the use of *The ASAM Criteria* book user-friendly so that information is more easily retrieved and cross-referenced.

C. **New Terminology** *(The ASAM Criteria* 2013*,* pp 14-16)

**"Individual," "Person," "Participant," "Patient"**

In addiction and mental health services there is a wide variety of terminology used to describe the people served: patients, clients, consumers, participants, residents, persons, individuals, customers, etc. In *The ASAM Criteria,* various terms will be used at different times, depending what seems to flow best in the context. "Individual," "person," "participant," and "patient" will be used most often. The use of the term "patient" implies the highest biopsychosocial values of the helping professions: to serve as the patient's agent and support, to care for the patient as we would want ourselves and our loved ones to be treated, healing where possible but always seeking to reduce suffering.

In order to limit complexity in terms, client, consumer and customer will not be used. It should be noted, however, that regardless of the term given, *The ASAM Criteria* always supports and promotes a collaborative, participatory process of assessment and service planning. This approach is consistent with evidence-based practices and the outcomes research that find the quality of the therapeutic alliance with the participant to have a significant impact on achieving effective outcomes, and person-centered services to improve adherence to treatment.

**"The ASAM Criteria"**

The title of this 2013 edition is *The ASAM Criteria* with the subtitle *"Treatment Criteria for Addictive, Substance-Related, Addictive and Co-Occurring Conditions."* This is the third edition of ASAM's criteria. The 2001 edition was named "*ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised* (ASAM PPC-2R)" which was seen as so long and complicated that many would say "Do you use the ASAM?" Suggested terminology for this edition is:

- "The ASAM Criteria" to reinforce that these criteria are the official, accepted criteria of ASAM and not associated with any of the various state adaptations or interpretations also in existence. Also, *The ASAM Criteria*, Third Edition, now directly and specifically relates to and supports *The ASAM Criteria Software*, which is the only authorized implementation of these decision rules.

- The new title broadens the reach of the Criteria beyond "patients" and "placement" to speak to and encourage other non-medical disciplines to use *The ASAM Criteria*. It is this movement beyond "placement" which will challenge the perpetuated idea that placing people in programs is a primary and sufficient goal. The essential focus is on matching services to each patient's unique multidimensional needs. Placement is simply where this individualized treatment can efficiently and effectively be delivered.

- The subtitle connotes that these criteria address conditions related to substance use and other addictive disorders. However, not every person is suffering from the disease of addiction. Certain people may just need Early Intervention (Level 0.5) or Screening, Brief Intervention, Referral and Treatment (SBIRT).

- In addition, there are other health conditions that are not necessarily related to substance use or gambling, but that co-occur and need physical and/or mental health services. Some of these may be sub-diagnostic and therefore "conditions" rather than disorders. Thus the subtitle of *The ASAM Criteria* is intended to cover the broader range of conditions to help with integration into general healthcare (under healthcare reform) and into behavioral health with co-occurring disorders.

**"Co-occurring Disorders or Conditions"**
For the sake of consistency with national trends, *The ASAM Criteria* has adopted the term "co-occurring mental health and substance-related conditions and disorders". Throughout the text, the term "co-occurring disorders or conditions" refers to mental health and substance related conditions, unless specifically otherwise stated. A more extensive discussion related to co-occurring disorders or conditions, including expanded definitions for terms such as "Co-Occurring Capability," "Co-Occurring Enhanced," and "Complexity Capability."

D. **Fidelity to the Spirit and Content of *The ASAM Criteria*** *(The ASAM Criteria* 2013*,* pp 21-22) Issues often persist in today's "real world" of treatment, indicating that clinicians and programs still struggle with understanding the full intent of ASAM's criteria. These ongoing issues include:

- Some programs still describe their services as a fixed length of stay program, as evidenced by description of the program as a "Thirty Day Inpatient Program or "24 session IOP." Or if the program claims no fixed length of stay, check what clients say if you ask: "How long do you have to be here?" An answer involving fixed numbers of sessions or weeks reveals regression to a program-driven model.

  Such programs also may reveal their length of stay rigidity through the language used. Wording like "extended residential" may refer to a fixed program, since length of stay should be decided by tracking severity, function and progress, not by a predetermined decision that the patient needs a certain extended length of stay in a residential setting. Likewise, "graduating" and "completing a program" also reveals a focus on a fixed plan and program, rather than on functional improvement as the determinant of level of care and ongoing chronic-disease management (with certain episodes of care being

offered with increased intensity for a relatively brief span of time) being what is needed for most patients with a substance-related or co-occurring disorder.

- A misunderstanding of residential treatment. In *The ASAM Criteria,* admission criteria for residential treatment encompass such severity and imminent danger that a 24-hour treatment setting is necessary. Yet, individuals are sometimes assessed as requiring residential treatment and then placed on a waiting list. The patient may need a 24-hour living support, such as Level 3.1 plus some outpatient intensity of services (Levels 1, 2.1 or 2.5). By definition, it is a misunderstanding of residential treatment to place a person on a waiting list.

- Funding limited to certain levels of care. States and counties that fund only a few levels of care can discourage a seamless continuum of care. Licensure and contractual arrangements that keep levels of care in fixed programs can discourage or even forbid flexible overlapping of levels (e.g., a public sector entity may contract only for Level 3.7-WM which forces the program to staff for and document on every patient as if they are continually at a 3.7-WM severity). In fact, a patient may need that intensity of withdrawal management for only two days and could then be safely treated by seamlessly continuing in 3.2-WM or even overlapping 2-WM services within the structure of the withdrawal management facility.

- Limited levels of withdrawal management. Available levels of withdrawal management are often only 4-WM or 3.7-WM, which drives up cost and allows only brief lengths of stay in high-intensity settings. This leads to rapid relapse when the patient has not had their acute withdrawal adequately managed. An ambulatory level of care for withdrawal management might be both more clinically appropriate and less costly. Full use of the five levels of withdrawal management as described in *The ASAM Criteria* would allow longer lengths of stay for the same or less resources. Underutilization of ambulatory withdrawal management and a continuum of withdrawal management levels are due partly to benefit management design that often puts medical withdrawal management in a general health benefit split out from the behavioral health benefit. It is also due to provider and payer inexperience with ambulatory withdrawal management and hesitancy over risk management concerns.

1. Assessing Severity and Level of Function *(The ASAM Criteria* 2013*,* pp 54-56)

To determine the multidimensional severity or level of function profile, consider each of the six ASAM Criteria dimensions as regards pertinent assessment data organized under the three H's - History, Here and Now, How Worried Now.

The *History* of a client's past signs, symptoms and treatment is important, but never overrides the *Here and Now* of how a client is presenting currently in signs and symptoms. e.g., if a person has by History had severe alcohol withdrawal with seizures, but has not been drinking Here and Now at a rate or quantity that would predict any significant withdrawal; and as you look at them, they are not shaky or in withdrawal so you are not Worried about severe withdrawal - then there is no significant Dimension 1 severity.

The *Here and Now* presentation of a client's current information of substance use and mental health signs and symptoms can override the *History* e.g., if a person has never had serious suicidal behavior before by History; and in the Here and Now is indeed depressed and impulsively suicidal, you would not dismiss their severe suicidality just because they had never done anything serious before. Especially if you talked with them now and you are *Worried* that they could not reach out to someone if they became impulsive, then the Dimension 3 severity would be quite high.

*How Worried Now* you are as the clinician, counselor or assessor determines your severity or level of function (LOF) rating for each ASAM dimension. The combination of the three H's: History; Here and Now; and How Worried Now guides the clinician in presenting the severity and LOF profile.

2. Continued Service and Discharge Criteria *(The ASAM Criteria* 2013*,* pp 299-306)

After the admission criteria for a given level of care have been met, the criteria for continued service, discharge or transfer from that level of care are as follows:

Continued Service Criteria: It is appropriate to retain the patient at the present level of care if:

1. The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;

or

2. The patient is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working on the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;

and/or

3. New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the patient's new problems can be addressed effectively.

To document and communicate the patient's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the patient's existing or new problem(s), the patient should continue in treatment at the present level of care. If not, refer the Discharge/Transfer Criteria, below.

Discharge/Transfer Criteria: It is appropriate to transfer or discharge the patient from the present level of care if he or she meets the following criteria:

1. The patient has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the current level of care;

or

2. The patient has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated;

or

3. The patient has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated;

or

4. The patient has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the patient's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the patient should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.

3. Relapse/Continued Use/Continued Problem Potential - Dimension 5 *(The ASAM Criteria* 2013*,* pp 401-410)

A. Historical Pattern of Use

1. Chronicity of Problem Use

- Since when and how long has the individual had problem use or dependence and at what level of severity?

2. Treatment or Change Response

- Has he/she managed brief or extended abstinence or reduction in the past?

B. Pharmacologic Responsivity

3. Positive Reinforcement (pleasure, euphoria)
4. Negative Reinforcement (withdrawal discomfort, fear)

C. External Stimuli Responsivity

5. Reactivity to Acute Cues (trigger objects and situations)
6. Reactivity to Chronic Stress (positive and negative stressors)

D. Cognitive and behavioral measures of strengths and weaknesses

7. Locus of Control and Self-efficacy

- Is there an internal sense of self-determination and confidence that the individual can direct his/her own behavioral change?

8. Coping Skills (including stimulus control, other cognitive strategies)
9. Impulsivity (risk-taking, thrill-seeking)
10. Passive and passive/aggressive behavior

- Does individual demonstrate active efforts to anticipate and cope with internal and external stressors, or is there a tendency to leave or assign responsibility to others?

Example Policy and Procedure to Deal with Dimension 5 Recovery/Psychosocial Crises

Recovery and Psychosocial Crises cover a variety of situations that can arise while a patient is in treatment. Examples include, but are not limited to, the following:

1. Slip/ using alcohol or other drugs while in treatment.
2. Suicidal and the individual is feeling impulsive or wanting to use alcohol or other drugs.
3. Loss or death, disrupting the person's recovery and precipitating cravings to use or other impulsive behavior.
4. Disagreements, anger, frustration with fellow patients or therapist.

The following procedures provide steps to assist in implementing the principle of re-assessment and modification of the treatment plan:

1. Set up a face-to-face appointment as soon as possible. If not possible in a timely fashion, follow the next steps via telephone.

2. Convey an attitude of acceptance; listen and seek to understand the patient's point of view rather than lecture, enforce "program rules," or dismiss the patient's perspective.

3. Assess the patient's safety for intoxication/withdrawal and imminent risk of impulsive behavior and harm to self, others, or property. Use the six ASAM assessment dimensions to screen for severe problems and identify new issues in all biopsychosocial areas.

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral/cognitive conditions and complications
4. Readiness to Change
5. Relapse/Continued Use/Continued Problem potential
6. Recovery environment

4. If no immediate needs, discuss the circumstances surrounding the crisis, developing a sequence of events and precipitants leading up to the crisis. If the crisis is a slip, use the 6 dimensions as a guide to assess causes. If the crisis appears to be willful, defiant, non-adherence with the treatment plan, explore the patient's understanding of the treatment plan, level of agreement on the strategies in the treatment plan, and reasons s/he did not follow through.

5. Modify the treatment plan with patient input to address any new or updated problems that arose from your multidimensional assessment in steps 3 and 4 above.

6. Reassess the treatment contract and what the patient wants out of treatment, if there appears to be a lack of interest in developing a modified treatment plan in step 5 above. If it becomes clear that the patient is mandated and "doing time" rather than "doing treatment and change," explore what Dimension 4, Readiness to Change motivational strategies may be effective in re-engaging the patient into treatment.

7. Determine if the modified strategies can be accomplished in the current level of care, or a more or less intensive level of care in the continuum of services or different services such as Co-Occurring Disorder Enhanced services. The level of care decision is based on the individualized treatment plan needs, not an automatic increase in the intensity of level of care.

8. If, on completion of step 6, the patient recognizes the problem/s, and understands the need to change the treatment plan to learn and apply new strategies to deal with the newly-identified issues, but still chooses not to accept treatment, then discharge is appropriate, as he or she has chosen not to improve his/her treatment in a positive direction. Such a patient may also demonstrate his/her lack of interest in treatment by bringing alcohol or other drugs into the treatment milieu and encouraging others to use or engage in gambling behavior

while in treatment. If such behavior is a willful disruption to the treatment milieu and not overwhelming Dimension 5 issues to be assessed and treated, then discharge or criminal justice graduated sanctions are appropriate to promote a recovery environment.

9. If, however, the patient is invested in treatment as evidenced by collaboration to change his/her treatment plan in a positive direction, treatment should continue. To discharge or suspend a patient for an acute reoccurrence of signs and symptoms breaks continuity of care at precisely a crisis time when the patient needs support to continue treatment. For example, if the patient is not acutely intoxicated and has alcohol on his/her breath from a couple of beers, such an individual may come to group to explore what went wrong to cause a recurrence of use and to gain support and direction to change his/her treatment plan. Concerns about "triggering" others in the group are handled no differently from if a patient was sharing trauma issues, sobbing and this triggered identification and tearfulness in other group members. Such a patient with Posttraumatic Stress Disorder would not be excluded from group or asked to leave for triggering others. Group members and/or other patients in a residential setting are best helped to deal with such "triggering" with the support of peers and a trained clinician. To protect fellow patients from exposure to relapse or recurrence of signs and symptoms excludes the opportunity to learn new coping skills, In addition, it jeopardizes the safety of the patient at the very time he or she needs more support and guidance in such a crisis, rather than rejection, discharge, or transfer.

10. Document the crisis and modified treatment plan or discharge in the medical record.

E. **How to Apply The ASAM Criteria**

1. Application to Adult Special Populations *(The ASAM Criteria* 2013*,* pp 307 -356)

There have been concerns raised from some quarters that ASAM's criteria do not apply readily to certain populations of persons with substance-related and co-occurring disorders. Heretofore, there have not been specific criteria for the following special populations, who may be in need of care for a substance-related condition, where usual assessment and treatment variables may require modification:

- Older Adults
- Parents or Prospective Parents Receiving Addiction Treatment Concurrently with their Children
- Persons in Safety Sensitive Occupations
- Persons in Criminal Justice Settings

2. Persons in Criminal Justice Settings *(The ASAM Criteria* 2013*,* pp 350 -356)

**SETTINGS** - Settings can include:

- Jails (offenders who most often are sentenced to 2½ years or less, and non-sentenced offenders/detainees awaiting trial in a jail).
- Prisons (maximum, medium, or minimum security level).
- Pre-release such as work-release centers.
- Other criminal justice mandated supervised settings where movement is monitored and controlled.
- Community corrections-involved offenders on probation or parole. Many such offenders are given intermediate or alternative diversionary sanctions, intensive supervision (which may include electronic monitoring of their location or status), or are mandated to a community-based addiction treatment service stemming from a judge's order, a condition placed by a probation or parole officer, from an appearance before a specialty drug/mental health court, or as a step-down from a jail or prison.

3. The Coerced Client and Working with Referral Sources

The mandated client can often present as hostile and resistant because they are at "action" for staying out of jail; keeping their driver's license; saving their job or marriage; or getting their children back. In working with referral agencies whether that is a judge, probation officer, child protective services, a spouse, employer or employee assistance professional, the goal is to use the leverage of the referral source to hold the client accountable to an assessment and follow through with the treatment plan.

Unfortunately, clinicians/programs often enable criminal justice thinking by blurring the boundaries between "doing time" and "doing treatment". For everyone involved with mandated clients, the 3 C's are:

- Consequences – It is within criminal justice's mission to ensure that offenders take the consequences of their illegal behavior. If the court agrees that the behavior was largely caused by addiction and/or mental illness, and that the offender and the public is best served by providing treatment rather than punishment, then clinicians provide treatment not custody and incarceration. The obligation of clinicians is to ensure a person adheres to treatment; not to enforce consequences and compliance with court orders.
- Compliance – The offender is required to act in accordance with the court's orders; rules and regulations. Criminal justice personnel should expect compliance. But clinicians are providing treatment where the focus is not on compliance to court orders. The focus is on whether there is a disorder needing treatment; and if there is, the expectation is for adherence to treatment, not compliance with "doing time" in a treatment place.

- Control –The criminal justice system aims to control, if not eliminate, illegal acts that threaten the public. While control is appropriate for the courts, clinicians and treatment programs are focused on collaborative treatment and attracting people into recovery. The only time clinicians are required to control a client is if they are in imminent danger of harm to self or others. Otherwise, as soon as that imminent danger is stabilized, treatment resumes collaboration and client empowerment, not consequences, compliance and control.

The clinician should be the one to decide on what is clinically indicated rather than feeling disempowered to determine the level of service, type of service and length of service based on the assessment of the client and his/her stage of readiness to change. Clinicians are just that, not right arms of the law or the workplace to carry out mandates determined for reasons other than clinical.

Thus, working with referral sources and engaging the identified client into treatment involves all of the principles/concepts to meet both the referral source and the client wherever they are at; to join them in a common purpose relevant to their particular needs and reason for presenting for care. The issues span the following:

- Common purpose and mission – public safety; safety for children; similar outcome goals
- Common language of assessment of stage of change – models of stages of change
- Consensus philosophy of addressing readiness to change – meeting clients where they are at; solution-focused; motivational enhancement
- Consensus on how to combine resources and leverage to effect change, responsibility and accountability – coordinated efforts to create and provide incentives and supports for change
- Communication and conflict resolution - committed to common goals of public safety; responsibility, accountability, decreased legal recidivism and lasting change; keep our collective eyes on the prize "No one succeeds unless we all succeed!"

4. Working Effectively with Managed Care *(The ASAM Criteria* 2013*,* pp 119 -126)

- Clinical discussion, not game playing - Improve communication between consumers, clinicians, providers payers, managed care, utilization reviewers and care managers

- Use Case Presentation Format to concisely review the biopsychosocial data and focus the discussion

- Follow through Decision Tree to Match Assessment and Treatment/Placement Assignment to guide the clinical discussion

- Identify where the points of disagreement are: severity rating; priority dimension or focus of treatment;
- service needs; dose and intensity of services; placement level

- Offer alternative clinical data: severity rating and rationale; priority dimension or focus of treatment; service needed; dose and intensity of services; placement level

- Appeal if still no consensus

5. Dealing with "Resistant" Providers/Payers Who Are at Different Stages of Change

- Individualized Staff Development Plans based on what the clinician wants
- Individualized Agency Development Plans – expectations for progress and change
- Individualized Payer Development Plan – reaching consensus on criteria, "Medical Necessity", design of Benefit Plans
- Incentives and leverage to facilitate continuing change and development

6. Tobacco Use Disorder *(The ASAM Criteria* 2013*,* pp 367-392)

***TH is a 50-year-old addiction counselor who works at a residential addiction treatment center.*** *The center has decided that they are going to begin treating tobacco addiction along with all other addictions. The staff is not going to be able to smoke at all at work, and will not be allowed to come to work smelling of tobacco smoke. TH is in recovery from addiction to alcohol and pain medications. He has been sober for23 years and always felt that tobacco was not part of his disease. He feels that he has extra rapport with patients since he goes out smoking with them on breaks. TH has often advised patients who wanted to stop smoking that they should wait at least a year before they even consider stopping, because "it is too hard to quit more than one thing at a time." TH has been told by his doctor that his frequent bouts of bronchitis are directly related to his smoking, and that he needs to stop before he does permanent damage to his lungs.TH is about 40 lbs. overweight and fears that if he stops smoking, he will gain even more weight. He has never tried to quit, and is angry about his workplace forcing him to stop.*

TH is in the precontemplation stage of change. He needs education about nicotine addiction and motivation for tobacco cessation. If TH will accept treatment, he may benefit from combination pharmacotherapy

taking into account his concern about weight gain. Outpatient counseling (Level 1) is the most appropriate place to begin, with additional online resources and quit-line assistance. TH may find Nicotine Anonymous helpful, since he will be able to use the same philosophy and skills to quit tobacco that he used to enable recovery from alcohol and pain medications in the past. Group support at work will help motivate TH and enable his tobacco cessation attempts to be successful. TH's primary care physician should monitor his tobacco cessation and weight, and give positive feedback about improvements in his bronchitis and lung function.

F. **Gathering Data on Policy and Payment Barriers** *(The ASAM Criteria* 2013*,* p 126)

- Policy, payment and systems issues cannot change quickly. However, as a first step towards reframing frustrating situations into systems change, each incident of inefficient or in adequate meeting of a client's needs can be a data point that sets the foundation for strategic planning and change
- Finding efficient ways to gather data as it happens in daily care can provide hope and direction for change

## PLACEMENT SUMMARY

| |
|---|
| **Level of Care/Service Indicated** - Insert the ASAM Level number that offers the most appropriate level of care/service that can provide the service intensity needed to address the client's current functioning/severity; and/or the service needed e.g., shelter, housing, vocational training, transportation, language interpreter |
| **Level of Care/Service Received** - ASAM Level number -- If the most appropriate level or service is not utilized, insert the most appropriate placement or service available and circle the Reason for Difference between Indicated and Received Level or Service |
| **Reason for Difference** - Circle only one number -- 1. Service not available; 2. Provider judgment; 3. Client preference; 4. Client is on waiting list for appropriate level; 5. Service available, but no payment source; 6. Geographic accessibility; 7. Family responsibility; 8. Language; 9. Not applicable; 10. Not listed (Specify): |
| **Anticipated Outcome If Service Cannot Be Provided** – Circle only one number - 1. Admitted to acute care setting; 2. Discharged to street; 3. Continued stay in acute care facility; 4. Incarcerated; 5. Client will dropout until next crisis; 6. Not listed (Specify): |

# Alcohol Use Disorder: A Comparison Between DSM–IV and DSM–5

In May 2013, the American Psychiatric Association issued the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM–5). Although there is considerable overlap between DSM–5 and DSM–IV, the prior edition, there are several important differences:

### *Changes Disorder Terminology*

- DSM–IV described two distinct disorders, alcohol abuse and alcohol dependence, with specific criteria for each.
- DSM–5 integrates the two DSM–IV disorders, alcohol abuse and alcohol dependence, into a single disorder called alcohol use disorder (AUD) with mild, moderate, and severe sub-classifications.

### *Changes Diagnostic Thresholds*

- Under DSM–IV, the diagnostic criteria for abuse and dependence were distinct: anyone meeting one or more of the ~~a~~buse" criteria (see items 1 through 4) within a 12-month period would receive the ~~a~~buse" diagnosis. Anyone with three or more of the ~~d~~ependence" criteria (see items 5 through 11) during the same 12-month period would receive a ~~d~~ependence" diagnosis.
- Under DSM–5, anyone meeting any two of the 11 criteria during the same 12-month period would receive a diagnosis of AUD. The severity of an AUD—mild, moderate, or severe—is based on the number of criteria met.

### *Removes Criterion*

- DSM–5 eliminates legal problems as a criterion.

### *Adds Criterion*

- DSM–5 adds craving as a criterion for an AUD diagnosis. It was not included in DSM–IV.

### *Revises Some Descriptions*

- DSM–5 modifies some of the criteria descriptions with updated language.

## DSM History and Background

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) initially developed out of a need to collect statistical information about mental disorders in the United States. The first attempt to collect information on mental health began in the 1840 census. By the 1880 census, the Bureau of Census had developed seven categories of mental illness. In 1917, the Bureau of Census began collecting uniform statistics from mental hospitals across the country.

Not long afterwards, the American Psychiatric Association and the New York Academy of Medicine collaborated to produce a —na~~i~~onally acceptable psychiatric nomenclature" for diagnosing patients with severe psychiatric and neurological disorders. After World War I, the Army and Veterans Administration broadened the nomenclature to include disorders affecting veterans.

In 1952, the American Psychiatric Association Committee on Nomenclature and Statistics published the first edition of the *Diagnostic and Statistical Manual: Mental Disorders* (DSM–I). The DSM–I included a glossary describing diagnostic categories and included an emphasis on how to use the manual for making clinical diagnoses. The DSM– II, which was very similar to the DSM–I, was published in 1968. The DSM–III, published in 1980, introduced several innovations, including explicit diagnostic criteria for the various disorders that are now a recognizable feature of the DSM. A 1987 revision to the DSM–III, called the DSM–III–R, clarified some of these criteria and also addressed inconsistencies in the diagnostic system. A comprehensive review of the scientific literature strengthened the empirical basis of the next edition, the DSM–IV, which was published in 1994. The DSM–IV–TR, a revision published in 2000, provided additional information on diagnosis. Since 1952, each subsequent edition of the DSM aimed to improve clinicians' ability to understand and diagnose a wide range of conditions.

| | DSM–IV | | DSM–5 | |
|---|---|---|---|---|
| Any 1 = ALCOHOL ABUSE | Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to alcohol use; alcohol-related absences, suspensions, or expulsions from school; neglect of children or household. | 1 | Alcohol is often taken in larger amounts or over a longer period than was intended. (See DSM– IV, criterion 7.) | The presence of at least 2 of these symptoms indicates an **Alcohol Use Disorder (AUD).** The severity of the AUD is defined as: **Mild:** The presence of 2 to 3 symptoms **Moderate:** The presence of 4 to 5 symptoms **Severe:** The presence of 6 or more symptoms |
| | Recurrent alcohol use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by alcohol abuse). | 2 | There is a persistent desire or unsuccessful efforts to cut down or control alcohol use. (See DSM–IV, criterion 8.) | |
| | Recurrent alcohol-related legal problems (e.g., arrests for alcohol-related disorderly conduct). ****This is not included in DSM–5**** | 3 | A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects. (See DSM–IV, criterion 9.) | |
| | Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the alcohol (e.g., arguments with spouse about the consequences of intoxication, physical fights). | 4 | Craving, or a strong desire or urge to use alcohol. ****This is new to DSM–5**** | |
| Any 3 = ALCOHOL DEPENDENCE | Tolerance, as defined by either of the following:<br>a) A need for markedly increased amounts of alcohol to achieve intoxication or desired effect<br>b) Markedly diminished effect with continued use of the same amount of alcohol | 5 | Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home. (See DSM–IV, criterion 1.) | |
| | Withdrawal, as manifested by either of the following:<br>a) The characteristic withdrawal syndrome for alcohol<br>b) Alcohol is taken to relieve or avoid withdrawal symptoms | 6 | Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol. (See DSM–IV, criterion 4.) | |
| | Alcohol is often taken in larger amounts or over a longer period than was intended. | 7 | Important social, occupational, or recreational activities are given up or reduced because of alcohol use. (See DSM–IV, criterion 10.) | |
| | There is a persistent desire or unsuccessful efforts to cut down or control alcohol use. | 8 | Recurrent alcohol use in situations in which it is physically hazardous. (See DSM–IV, criterion 2.) | |
| | A great deal of time is spent in activities necessary to obtain alcohol (e.g., driving long distances), use alcohol, or recover from its effects. | 9 | Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol. (See DSM–IV, criterion 11.) | |
| | Important social, occupational, or recreational activities are given up or reduced because of alcohol use. | 10 | Tolerance, as defined by either of the following:<br>a) A need for markedly increased amounts of alcohol to achieve intoxication or desired effect<br>b) A markedly diminished effect with continued use of the same amount of alcohol (See DSM–IV, criterion 5.) | |
| | Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption). | 11 | Withdrawal, as manifested by either of the following:<br>a) The characteristic withdrawal syndrome for alcohol (refer to criteria A and B of the criteria set for alcohol withdrawal)<br>b) Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms. (See DSM–IV, criterion 6.) | |

## Alcohol Use Disorder

## Determining Diagnostic Impressions using the DSM-5

### Alcohol Use Disorder Vignettes

**William** is a 56-year-old Puerto Rican male referred by the board of social services for a substance abuse assessment. He reported a 34-year history of alcohol use; his current use between five and six 12-oz beers daily but stated that up until 2 months ago he was drinking 24 beers daily. He stated that he cut down because he did not want to drink so much. The client identified that alcohol is a problem for him and needs treatment in order to stop. The client reported that he has never experienced DTs, but does experience withdrawal symptoms of nausea, anxiety, and dizziness when he does not drink. He reported a diagnosis of seizure disorder and liver disease. He stated that he lives with his wife and is satisfied with this situation, but then reported that he must stay in the basement of the house due to his alcohol use.

**Vincent** is a 29-year-old African-American male referred by the board of social services after they smelled alcohol on his breath on two occasions during his work activity. The client reported that he first drank alcohol at the age of 16. He reported that he would drink beer and brandy, to intoxication, 4 times weekly. He stated that he did not drink between age 22 and 23, and denied alcohol use while incarcerated from 2005-2010. The client reported social use of alcohol at the time of assessment, stating that he drinks on the weekends, 2 40-oz beers on Saturdays and sometimes Sundays. He denied that alcohol is a problem for him. He did state that he tries to avoid his children when he is drinking. The client denied any medical or psychiatric problems. He agreed to an extended evaluation but tested positive for alcohol on the date of assessment. He then agreed to attend IOP, the 2 UDS that have been received since have been negative. DCPP Central Screening was called after the positive UDS and an investigation was conducted. The DCP&P case was subsequently closed, as the division had no concerns about the children's well-being.

**Darren** is a 58-year-old African American male referred by the board of social services for a substance abuse assessment. He reported that his first use of alcohol was age 14 and he began drinking daily to intoxication at the age of 16 (12 beers and 1-pint liquor or wine per day). The client reported that he cut down on his drinking 2 years ago because he was introduced to drugs. His current use at time of assessment is 1 6-pack beer or 1 bottle of liquor or wine every two to three days. He reported that when he does not drink he experiences hot flashes, gastrointestinal upset, and becomes shaky and dizzy. He does believe that alcohol is a problem for him. He stated during the assessment that he is tired of losing money to alcohol and tired of living the lifestyle. He reported that he lost his most recent job due to calling out sick frequently, which he admitted was due to his alcohol use. He has been to detox/residential treatment 3 times in his

life but has not been able to achieve any significant periods of abstinence outside of a controlled environment.

**Anthony** is a 54-year-old Caucasian male referred by the board of social services at his request for substance abuse treatment. The client reported a 40-year history of alcohol use, beginning with weekend use at age 14 and increasing to daily shots and beers in bars at age 16 with binge episodes on the weekends. He reported that his current use at time of assessment was 12 beers daily, with his last use the day prior to assessment. The client reported a history of shakes and tremors when he stops drinking; he denied seizures and DTs, but did admit to numerous blackouts when under the influence of alcohol. The client reported that he has been in various substance abuse treatment programs more than 15 times over the last 30 years but reported that his longest period of abstinence outside a controlled environment was 7 months in 1998, which did not involve any official treatment program; he "did it on his own." He reported that he has tried to stop on his own recently but has not been successful and believes that he needs treatment to stop drinking. This is client's 8th EOC; in previous EOCs, the client had a pattern of completing SRWM and SR then relapsing immediately and not following through on the aftercare plan. Client reported medical issues of liver damage from chronic alcohol use as well as an injury he sustained 2 days prior to the assessment while under the influence of alcohol, leading to bruised ribs and back pain. The client reported a past diagnosis of depression but does not believe that treatment is necessary and stated that he is only depressed when he is not drinking. The client has a 10th grade education and experience working in a factory for 10 years. His last job ended in 2000 and he has been unable to sustain employment for any significant length of time due to his continued alcohol use.

# Alcohol Use Disorder Checklist

| DSM-5 criteria | William | Vincent | Darren | Anthony |
|---|---|---|---|---|
| Alcohol is often taken in larger amounts or over a longer period of time than was intended. | | | | |
| There is a persistent desire or unsuccessful efforts to cut down or control alcohol use. | | | | |
| A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects. | | | | |
| Craving, or a strong desire or urge to use alcohol. | | | | |
| Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home. | | | | |
| Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol. | | | | |
| Important social, occupational, or recreational activities are given up or reduced because of alcohol use. | | | | |
| Recurrent alcohol use in situations in which it is physically hazardous. | | | | |
| Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol. | | | | |
| **Tolerance, as defined by either of the following: (a)** A need for markedly increased amounts of alcohol to achieve intoxication or desired effect, or **(b)** A markedly diminished effect with continued use of the same amount of alcohol. | | | | |
| **Withdrawal, as manifested by either of the following: (a)** The characteristic withdrawal syndrome for alcohol, or **(b)** Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms. | | | | |
| Number of criteria met: | | | | |
| Mild, Moderate, or Severe AUD? | | | | |

**ALCOHOL USE DISORDER (AUD) •Mild**: 2-3 symptoms (305.00) **•Moderate**: 4-5 symptoms (303.90) **•Severe**: 6+ symptoms (303.90)

# Alcohol Use Disorder Checklist

| DSM-5 criteria | | | | | ALCOHOL USE DISORDER (AUD) •**Mild**: 2-3 symptoms (305.00) •**Moderate**: 4-5 symptoms (303.90) •**Severe**: 6+ symptoms (303.90) |
|---|---|---|---|---|---|
| Alcohol is often taken in larger amounts or over a longer period of time than was intended. | | | | | |
| There is a persistent desire or unsuccessful efforts to cut down or control alcohol use. | | | | | |
| A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects. | | | | | |
| Craving, or a strong desire or urge to use alcohol. | | | | | |
| Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home. | | | | | |
| Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol. | | | | | |
| Important social, occupational, or recreational activities are given up or reduced because of alcohol use. | | | | | |
| Recurrent alcohol use in situations in which it is physically hazardous. | | | | | |
| Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol. | | | | | |
| **Tolerance, as defined by either of the following: (a)** A need for markedly increased amounts of alcohol to achieve intoxication or desired effect, or **(b)** A markedly diminished effect with continued use of the same amount of alcohol. | | | | | |
| **Withdrawal, as manifested by either of the following: (a)** The characteristic withdrawal syndrome for alcohol, or **(b)** Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms. | | | | | |
| Number of criteria met: | | | | | |
| Mild, Moderate, or Severe AUD? | | | | | |

| DSM-5 criteria | Where is it on the ASI/ASAM Note? |
|---|---|
| Alcohol is often taken in larger amounts or over a longer period of time than was intended. | |
| There is a persistent desire or unsuccessful efforts to cut down or control alcohol use. | |
| A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects. | |
| Craving, or a strong desire or urge to use alcohol. | |
| Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home. | |
| Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol. | |
| Important social, occupational, or recreational activities are given up or reduced because of alcohol use. | |
| Recurrent alcohol use in situations in which it is physically hazardous. | |
| Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol. | |
| **Tolerance, as defined by either of the following: (a)** A need for markedly increased amounts of alcohol to achieve intoxication or desired effect, or **(b)** A markedly diminished effect with continued use of the same amount of alcohol. | |
| **Withdrawal, as manifested by either of the following: (a)**The characteristic withdrawal syndrome for alcohol, or **(b)** Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms. | |

## Case Vignette: Tracy

A 16-year-old young woman is brought into the emergency room of an acute care hospital. She had gotten into an argument with her parents and ended up throwing a chair. There was some indication that she was intoxicated at the time and her parents have been concerned about her coming home late and mixing with the wrong crowd. There has been a lot of family discord and there is mutual anger and frustration between the teen and especially her father. No previous psychiatric or addiction treatment. The parents are both present at the ER, but the police who had been called by her mother brought her. The ER physician and nurse from the psychiatric unit who came from the unit to evaluate the teen, both feel she needs to be in hospital given the animosity at home, the violent behavior and the question of intoxication.

Using the six ASAM assessment dimensions, the biopsychosocial clinical data is organized as follows:

**Dimension 1,** Intoxication/Withdrawal: though intoxicated at home not long before the chair-throwing incident, she is no longer intoxicated and has not been using alcohol or other drugs in large enough quantities for long enough to suggest any withdrawal danger.
**Severity:** *Low*
**Services Needed:** NCI
**Site/Level of Care:** NCI

**Dimension 2**, Biomedical Conditions/Complications: she is not on any medications, has been healthy physically and has no current complaints
**Severity:** *Low*
**Services Needed:** NCI
**Site/Level of Care:** NCI

**Dimension 3,** Emotional/Behavioral/Cognitive: complex problems with the anger, frustration and family discord; chair throwing incident this evening, but is not impulsive at present in the ER.
**Severity:** *Moderate*
**Services Needed:** Family therapy
**Site/Level of Care:** Level I

**Dimension 4,** Readiness to Change: willing to talk to therapist; blames her parents for being overbearing and not trusting her; agrees to treatment, but doesn't want to be at home at least for tonight.
**Severity:** *High*
**Services Needed:** Tracy does not think she has a problem and wants her parents off her back. Her parents believe that Tracy is their problem and they want to learn how to make Tracy behave. *Motivate treatment participation by giving each party what they want (Get my parents off my back treatment plan) and a "Make Tracy behave treatment plan".*

**Dimension 5**, Relapse/Continued Use/Continued Problem Potential: high likelihood that if released to go back home immediately, there would be a reoccurrence of the fighting and possibly violence again, at least with father.
**Severity:** *High*

**Services Needed:** How can we take care of them? There is an element of dangerousness here; therefore, the severity is high. Separation is what is needed but no need for medical monitoring or management. Tracy could go and stay the night with a friend or relative or one parent can stay with her in a motel. Possibly experimental use. Tracy would benefit from 1:1 or group counseling focused on Discovery.
**Site/Level of Care:** Level 1

**Dimension 6,** Recovery Environment: parents frustrated and angry too; mistrustful of patient; and want her in the hospital to cut down on the family fighting
**Severity:** *Moderate*
**Services Needed:** Family counseling to improve the environment of distrust.
**Site/Level of Care:** Level 1

**Assessed Level of Care: Level 1**
**Placed Level of Care: Level 1**

## Case Vignette: Co-occurring Disorder

**Ann**

Ann, a 32-year-old divorced female, came in for assessment for the first time ever. She has been abstinent for 48 hours from alcohol and reports that she has remained so, for up to 72 hours during the past three months. When she has done this she states she has experienced sweats, internal tremors and nausea, but has never hallucinated, experienced D.T.'s or seizures. She states she is in good health except for alcoholic hepatitis for which she was just released from the hospital one week ago. Her doctor referred her for assessment. She smokes up to 3 or 4 joints a day, but stopped yesterday. In addition to the above, Ann describes two past suicide attempts using sleeping pills, but the most recent attempt was three years ago and she sees a psychiatrist once a month for review of her medication. She takes Prozac for the depression and doesn't report abuse of her medication. Ann reported that she lives in a rented apartment and has very few friends since moving away after her divorce a year ago. She is currently unemployed after being laid off when the supermarket she worked at closed. She has worked as a waitress, check-out person and sales person before and says she has never lost a job due to addiction. Ann appears slightly anxious, but is not flushed. She speaks calmly and is cooperative. Ann shows awareness of her consequences from chemical use, but tends to minimize it and blame others including her ex-husband who left her without warning. She doesn't know much about alcoholism/chemical dependency, but wants to learn more. She has one son, age 11, who doesn't see any problems with her drinking and doesn't know about her marijuana use.

**DSM-5 Diagnosis: 303.90** Alcohol Use Disorder, moderate and **305.20** Cannabis Use Disorder, mild; **296.31** Major Depression, Recurrent, mild, without psychotic features

**ASAM Assessment**

Biopsychosocial clinical data organized on the six ASAM dimensions as follows:

**Dimension 1,** Intoxication/Withdrawal: Reported no use of alcohol for 48 hours prior to the assessment and she stopped use of marijuana the day before the assessment.
**Severity:** Low
**Services Needed:** Insure that the client is all right; check in for discomfort from possible reaction withdrawal from marijuana and alcohol.
**Site/Level of care:** 1 WM

**Dimension 2,** Biomedical Conditions/Complications: She reports good health except for alcohol hepatitis for which she was just released from the hospital one week ago.
**Severity:** Moderate
**Services Needed:** Alert the doctor that the client has been drinking since she left the hospital. The doctor will want to know if she looks all right. Depending on your response, the doctor may want the client to come to his office or be sent to the ER.
**Site/Level of care:** Level 1

**Dimension 3,** Emotional/Behavioral/Cognitive: Diagnosed with Major Depressive Disorder and currently has a prescription for Prozac.
**Severity:** Low
**Services Needed:** Psychiatric services and medication monitoring
**Site/Level of care:** Level 1

**Dimension 4,** Readiness to Change: Ann minimizes a problem with alcohol and blames others for her chemical use; she does want to learn more about chemical dependency.
**Severity:** Moderate
**Services Needed:** Motivational strategies to influence contemplative thoughts of change; education about chemical dependency.

**Dimension 5,** Relapse/Continued Use/ Continued Problem Potential: Ann reported current use of alcohol and marijuana and reported that she does not abuse her psych meds; need a UDS to confirm non-use. High relapse potential.
**Severity:** High
**Services Needed:** Urine Drug Screen; Ann only recently stopped using and she has never had more than 72 hours of clean time. She drank alcohol as soon as she left the hospital. What is the likeliness of her using again?
**Site/Level of care:** 2.5 Partial Care. Since Ann is at risk for use, she would do well to make arrangements to stay at a relative or friend's house until she enters treatment.

**Dimension 6,** Recovery Environment: Ann has few friends; she was recently divorced, is unemployed and lives alone with her 11 year old son. She does not believe that her son knows about her alcohol and marijuana use.
**Severity:** Moderate
**Services Needed:** Check out the safety of the son by having him attend a family program at the provider. Family Support services are needed to meet the family's needs; possible financial support for continued services and possibly transportation; involvement in Twelve Step meetings with sponsor; job skills as she is a single mother and will need a job to support her family.
**Site/Level of care:** Outpatient services Level 1

**Assessed level of care:** 2.5
**Placed level of care**: 2.5

## Case Vignette: Mood Disorders

### Jane

Jane is a 34 year old married, white, female, bank executive who was brought for evaluation by her husband. According to the husband, Jane was in excellent health until 2 weeks ago, when she began staying up later at night. Initially, he was not too concerned, until she began awakening him to talk about the "revolutionary new ideas" she had about creating an international bank cartel. He noted she was "full of energy" and talked rapidly about the many ideas she had. He became quite concerned when at 3:00 am Jane telephoned the president of the bank where she worked to discuss her ideas. When her husband confronted her about the inappropriateness of her phone call, she became enraged and accused him of purposely attempting to sabotage her venture.

On examination Jane's speech was quite rapid and she jumped quickly from one subject to another. She stated that she was about to revolutionize banking and control the world currency market. When questioned about the likelihood of achieving this goal, she became irritable and threatened to leave. She admitted to auditory hallucinations that are telling her how to corner the market on gold. She was on no medications, had no prior psychiatric history (including no depressive episodes), and denied drug abuse. Family history was positive for Mood disorders. Her younger brother had a severe depression 2 years ago that required hospitalization, and her mother was diagnosed as Manic-Depressive many years ago. Her physical examination was normal and toxic screen for drugs was negative.

**DSM-5 diagnosis and the symptoms that lead to the diagnosis:** 296.04 Bipolar I, severe, single manic episode with mood congruent psychotic features

Episode lasting longer than one week
Flight of ideas
Grandiosity
Decreased need for sleep
Rapid speech
Quickly changes subject
Expansive mood characterized by unceasing enthusiasm for occupational interactions
Mood became irritable when her wishes were thwarted
Auditory hallucinations
Episode is not related to substance use or medical condition
No prior depressive or manic episodes
Not accounted for by another diagnosis
Severity specifier is used to qualify that she has an observable disability that would prevent her from working in her current condition.

**ASAM Assessment**

Biopsychosocial clinical data organized on the six ASAM assessment dimensions as follows:

**Dimension 1,** Intoxication/Withdrawal: Reported non-use of drugs and toxic screen for drugs was negative.
**Severity:** Low
**Services Needed:** NCI
**Site/Level of care:** NCI

**Dimension 2,** Biomedical Conditions/Complications: Her physical examination was normal.
**Severity:** Low
**Services Needed:** NCI
**Site/Level of care:** NCI

**Dimension 3,** Emotional/Behavioral/Cognitive: The client admitted to auditory hallucinations, she had rapid speech, was full of energy and stayed up all night to "revolutionize banking." *(3Hs: History, Here and Now, How worried am I?)* No prior psychological history (no depressive episodes); family history of mood disorders; no current medications and little sleep; manic symptoms and they are likely to continue without help.
**Severity:** High
**Services Needed:** Psychiatric hospitalization/assessment
**Site/Level of care:** Psychiatric hospital or Crisis Unit level 4

**Dimension 4,** Readiness to Change: Jane does not believe she has a mental health problem and she was brought to the assessment by her husband.
**Severity:** High
**Services Needed:** Motivational strategies to influence change

**Dimension 5,** Relapse/Continued Use/ Continued Problem Potential: The likeliness of the manic symptoms continuing without help is high.
**Severity:** High
**Services Needed:** Psychiatric stabilization for several days with medication assistance.
**Site/Level of care:** Psychiatric hospital or Crisis Unit Level 4

**Dimension 6,** Recovery Environment: Jane's spouse is very supportive and willing to assist in any way possible.
**Severity:** Low
**Services Needed:** Family Support services to meet the family's needs; possible financial support for continued services and transportation
**Site/Level of care:** Outpatient services Level 1

**Assessed Level of Care**: 4
**Placed Level of Care**: 4

## Case Vignette: Mood Disorders

### Tom

Tom is a 28 year old single, black male, government employee referred by his family physician for evaluation. He reported a 3 month history of worsening anxiety that is especially bad early in the morning. "I wake up at 3:00 in the morning and I can't get back to sleep. My thoughts torment me." He also reported decreased energy, inability to concentrate at his job, decreased appetite with a 10 pound weight loss, and suicide ideation with no current plan. "I feel so hopeless that suicide seems like an option." He also stated, "There is nothing in my life that I enjoy." Tom lives alone, he has no friends and isolates from his family that is supportive.

Tom was tearful during the evaluation. He lacked animation and his mood was quite depressed. He denied prior hypo manic or manic episodes. Mental status exam revealed slow thinking and no evidence of psychosis. He did report two previous depressive episodes, one in late adolescence and another during his senior year in college. During the latter episode, his symptoms were severe enough that he was unable to attend classes. "I almost failed that semester." Both depressive episodes remitted in a few months without treatment; he "felt like normal" during remission. He denied drug and alcohol use and had no medical problems. The family history is positive for depression in a paternal grandfather, and in his father, and he reported that a depressed uncle committed suicide about 10 years ago.

**DSM-5 diagnosis and the symptoms that led to the diagnosis:** 296.33 Depressive Disorder, Recurrent, severe, without psychotic features

Three month increase in anxiety related to mood
Tormenting thoughts
Decreased energy
Cannot concentrate
Decreased appetite resulting in 10 pound weight loss
Suicidal ideation
Loss of pleasure
Hopelessness and tearful
Depressed mood
Slowed thinking
Family history of mood disorders
Two prior depressed moods
No prior hypo manic or manic episodes
Not accounted for by another diagnosis
Episode is not related to substance use or medical condition
Severity specifier is used to qualify suicidal ideation and intervention is required to prevent injury to self

**ASAM Assessment**

Biopsychosocial clinical data organized on the six ASAM assessment dimensions as follows:

**Dimension 1,** Intoxication/Withdrawal: The client reported no drug or alcohol use.
**Severity:** Low
**Services needed:** NCI
**Site/Level of Care:** NCI

**Dimension 2,** Biomedical Conditions/Complications: The client reported no medical problems.
**Severity:** Low
**Services needed:** NCI
**Site/Level of Care:** NCI

**Dimension 3,** Emotional/Behavioral/Cognitive: The client appeared to be depressed with decreased energy and appetite, inability to concentrate, increased anxiety, suicide ideation and no plan. (*3 Hs: History, Here & Now, How worried am I?)* The client reported two previous depressive episodes; family history of depression. No evidence of psychosis, denied prior hypo manic or manic episodes. No current plan to hurt himself and does not appear to be impulsive at this time.
**Severity:** Moderate
**Services needed:** Psychiatric evaluation and medication monitoring.
**Site/Level of Care:** Outpatient services; level 1

**Dimension 4,** Readiness to Change: The client wants help and knows that he has a problem with depression.
**Severity:** Low
**Services needed:** Motivational strategies to encourage continued treatment efforts.

**Dimension 5,** Relapse/Continued Use/ Continued Problem Potential: It is likely that the client is willing to seek help and continue in treatment. No immediate need to contain him due to the suicide ideation.
**Severity:** Moderate
**Services needed:** Individual counseling and education to address the depression and suicide ideation.
**Site/Level of Care:** Outpatient services; Level 1

**Dimension 6,** Recovery Environment: The client has a good job, family physician and supportive family. He reportedly has no friends and tends to isolate from his family.
**Severity:** Moderate
**Services needed:** Community resources and support groups for depressed individuals.
**Site/Level of Care:** Outpatient services; Level 1

**Assessed Level of Care**: 1
**Placed Level of Care**: 1

**NOTE!!** ***Notice how the severity level changes when this same client, Tom, reports having suicide ideation and a plan.***

**ASAM Assessment given that Tom had suicide ideation and a plan**
Biopsychosocial clinical data organized on the six ASAM assessment dimensions as follows:

**Dimension 1,** Intoxication/Withdrawal: The client denied drug or alcohol use.
**Severity:** Low
**Services needed:** NCI
**Site/Level of Care:** NCI

**Dimension 2,** Biomedical Conditions/Complications: The client reported no medical problems.
**Severity:** Low
**Services needed:** NCI
**Site/Level of Care:** NCI

**Dimension 3,** Emotional/Behavioral/Cognitive: The client appeared to be depressed with decreased energy and appetite, inability to concentrate, increased anxiety, suicide ideation and a viable plan. *(3 Hs: History, Here & Now, How worried am I?)* The client reported two previous depressive episodes; family history of depression. No evidence of psychosis, denied prior hypo manic or manic episodes. Current plan to hurt himself by overdosing on sleeping pills is detailed and well thought out as to place and time. He had not slept in days and appeared to be highly agitated and anxious regarding the possibility of losing his job.
**Severity:** High
**Services needed:** Psychiatric hospitalization/assessment and close observation
**Site/Level of Care:** Crisis Unit or Psychiatric hospital level 4

**Dimension 4,** Readiness to Change: Although the client wants help and knows that he has a problem with depression, he may feel hopeless given his situation.
**Severity:** Moderate
**Services needed:** Motivational strategies to encourage continued treatment efforts.

**Dimension 5,** Relapse/Continued Use/ Continued Problem Potential: It is not likely that the client will seek help and continue in treatment, given his current state. There is an immediate need to contain him due to the detailed suicide ideation and plan; client is impulsive.
**Severity:** High
**Services needed:** Psychiatric hospitalization/stabilization
**Site/Level of Care:** Psychiatric hospitalization Level 4

**Dimension 6,** Recovery Environment: The client has a good job, family physician and supportive family. He reportedly has no friends and tends to isolate from his family.
**Severity:** Moderate
**Services needed:** Community resources and support groups for depressed individuals.
**Site/Level of Care:** Outpatient services; Level 1

**Assessed Level of Care: 4**
**Placed Level of Care: 4**

## LITERATURE REFERENCES

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Arlington, VA, American Psychiatric Association, 2013.

Mee-Lee D, Shulman GD, Fishman MJ, and Gastfriend DR, Miller MM eds. (2013). The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. Third Edition. Carson City, NV: The Change Companies. For more information on the new edition: www.ASAMcriteria.org

Mee-Lee, David with Jennifer E. Harrison (2010): "Tips and Topics: Opening the Toolbox for Transforming Services and Systems". The Change Companies, Carson City, NV

Mee-Lee, David (2013): "The ASAM Criteria: Getting Up to Date." Advances in Addiction & Recovery Fall 2013. Vol.1., No. 3 pp 20-21.

Mee-Lee, David (2013): "The New Edition of the ASAM Criteria: What's New and Why" Counselor Vol.14. No.4 pp18-19. August 2013.

Prochaska, JO; Norcross, JC; DiClemente, CC (1994): "Changing For Good" Avon Books, New York.

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