Understanding and Utilizing the ASAM Placement Criteria

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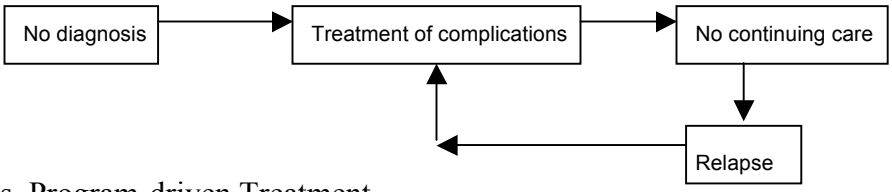
A. Generations of Clinical Care

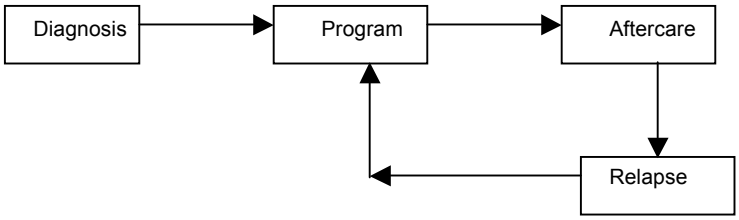
(a) Complications-driven Treatment

- No diagnosis of Substance Use Disorder
- Treatment of complications of addiction with no continuing care
- Relapse triggers treatment of complications only

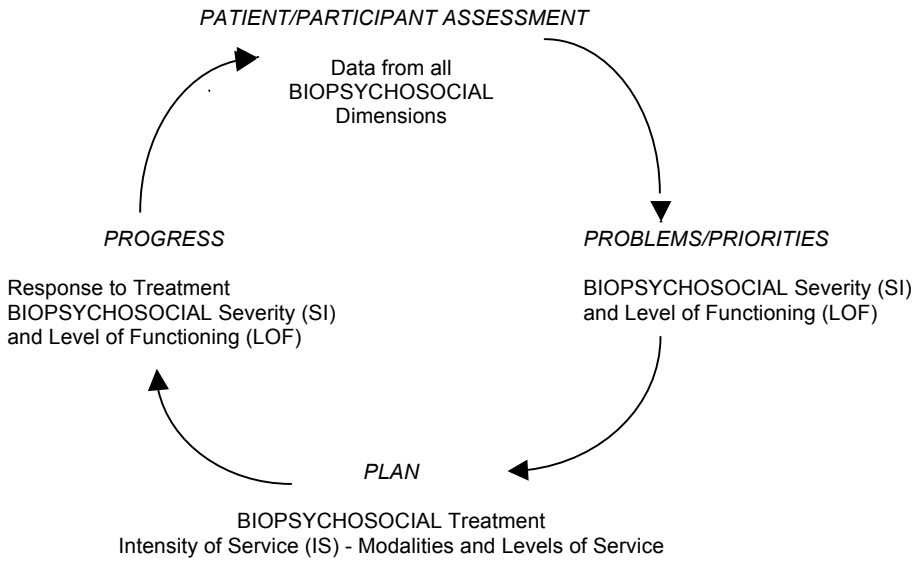


(b) Diagnosis, Program-driven Treatment

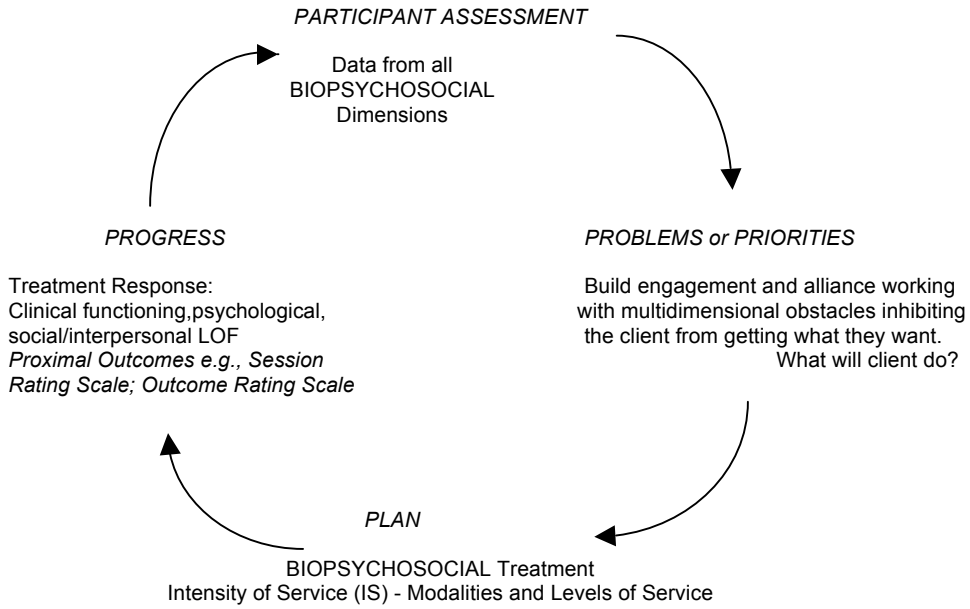
- Diagnosis determines treatment
- Treatment is the primary program and aftercare
- Relapse triggers a repeat of the program



(c) Individualized, Clinically-driven Treatment



(d) Client-Directed, Outcome-Informed Treatment



B. **Underlying Concepts**

1. Assessment of Biopsychosocial Severity and Function (ASAM PPC-2R, pp 5-7)

The common language of six PPC 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
5. Relapse/Continued Use/Continued Problem potential
6. Recovery environment

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 problems with motivational strategies.
6. Recovery Environment	Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services

2. Biopsychosocial Treatment - Overview: 5 M's
    * Motivate - Dimension 4 issues; engagement and alliance building
    * Manage - the family, significant others, work/school, legal
    * Medication - detox; HIV/AIDS; anti-craving anti-addiction meds; disulfiram, methadone; buprenorphine, naltrexone, acamprosate, psychotropic medication
    * Meetings - AA, NA, Al-Anon; Smart Recovery, Dual Recovery Anonymous, etc.
    * Monitor - continuity of care; relapse prevention; family and significant others

3. Treatment Levels of Service (ASAM PPC-2R, pp 2-4)
    I Outpatient Services
    II Intensive Outpatient/Partial Hospitalization Services
    III Residential/Inpatient Services
    IV Medically-Managed Intensive Inpatient Services

Levels of Care and Service in ASAM PPC-2R: (ASAM PPC-2R, pp 2-4)

Level 0.5: Early Intervention Services (ASAM PPC-2R, pp 41-44; pp 205-208) - Criteria for assessment and education services for individuals with problems or risk factors related to substance use, but for whom an immediate Substance Related Disorder cannot be confirmed. Further assessment is warranted to rule in or out addiction.

Opioid Maintenance Therapy (OMT) (ASAM PPC-2R, pp 137-143) - Criteria for Level I outpatient treatment modality.

Detoxification Services for Dimension 1 (Adult Criteria only) (ASAM PPC-2R – pp 145-146)

I-D - Ambulatory Detoxification without Extended On-site Monitoring

II-D - Ambulatory Detoxification with Extended On-site Monitoring

III.2-D - Clinically-Managed Residential Detoxification Services (Social Detoxification)

III.7-D - Medically-Monitored Inpatient Detoxification Services

IV-D - Medically-Managed Inpatient Detoxification Services

Level I Outpatient Services (ASAM PPC-2R, pp 45-56; pp 209-219)

I - Outpatient Treatment (<9 hours/week for Adults; <6 hours/week for Adolescents)

Level II Intensive Outpatient/Partial Hospitalization Services (ASAM PPC-2R, pp 55-69; pp 217-233)

II.1 - Intensive Outpatient Treatment (9 hours/week for Adults; 6 hours/week for Adolescents)

II.5 - Partial Hospitalization Treatment

Level III Residential/Inpatient Services (ASAM PPC-2R, pp 71-126; pp 235-269)

III.1 - Clinically-Managed, Low Intensity Residential Treatment (Halfway House; Support. Living Envir.)

III.3 - Clinically-Managed, Medium Intensity Residential Treatment (Therapeutic Rehabilitation Facility) (This level is not in the Adolescent Criteria continuum of care)

III.5 - Clinically-Managed, Medium/High Intensity Residential Treatment (Therapeutic Community, Residential Treatment Center)

III.7 - Medically-Monitored Intensive Inpatient Treatment (Inpatient Treatment Center)

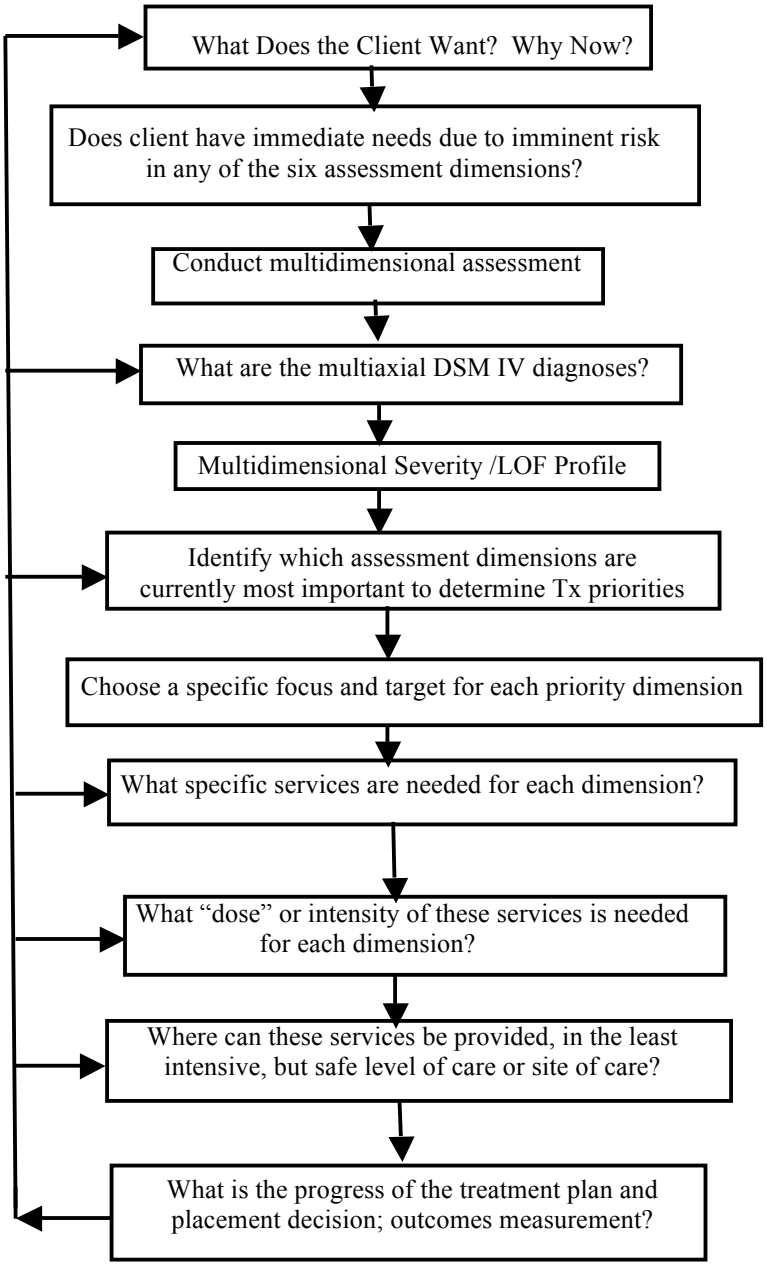
Level IV Medically-Managed Intensive Inpatient Services (ASAM PPC-2R, pp 127-135; pp 271-278)

IV - Medically-Managed Intensive Inpatient Treatment

ASAM PPC-2R Level of Detoxification Service for Adults	Level	Note: There are no separate Detoxification Services for Adolescents
Ambulatory Detoxification without Extended On-Site Monitoring	I-D	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	II-D	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	III.2-D	Moderate withdrawal, but needs 24-hour support to complete detox. and increase likelihood of continuing treatment or recovery
Medically-Monitored Inpatient Detoxification	III.7-D	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete detox. without medical, nursing monitoring
Medically-Managed Inpatient Detoxification	IV-D	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify detox. regimen and manage medical instability

ASAM PPC-2R Levels of Care	Level	Same Levels of Care for Adolescents except Level III.3
Early Intervention	0.5	Assessment and education for at risk individuals who do not meet diagnostic criteria for Substance-Related Disorder
Outpatient Services	I	Less than 9 hours of service/week (adults); less than 6 hours/week (adolesecents) for recovery or motivational enhancement therapies/ strategies
Intensive Outpatient	II.1	9 or more hours of service/week (adults); 6 or more hours/week (adolesecents) to treat multidimensional instability
Partial Hospitalization	II.5	20 or more hours of service/week for multidimensional instabilty not requiring 24 hour care
Clinically-Managed Low-Intensity Residential	III.1	24 hour structure with available trained personnel; at least 5 hours of clinical service/week
Clinically-Managed Med-Intensity Residential	III.3	24 hour care with trained counselors to stablize 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 Residential	III.5	24 hour care with trained counselors to stablize multidimensional imminent danger and preapre for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community
Medically-Monitored Intensive Inpatient	III.7	24 hour nursing care with physician availablity for significant problems in Dimensions 1, 2 or 3. Sixteen hour/day counselor ability
Medically-Managed Intensive Inpatient	IV	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

C. **How to Organize Assessment Data to Focus Treatment**



D **How and When to Use the Criteria**

1. Continued Service and Discharge Criteria (PPC-2R, pp. 7, 35-40; pp 199-204)

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.

2. Care management and Communication with Providers

Presenting Cases

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
Level of Service Client Entered Treatment (if this case presentation is a treatment plan review)
Current Level of Service (if this case presentation is a treatment plan review)
DSM Diagnoses
Stated or Identified Motivation for Treatment (What is the most important thing the clients 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 (See Dimensions below 1 - 6)

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)

This last section we will talk about together:

III. What problem(s) with High and Medium 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)

E. **Application to Clinical Situations and Implications for Systems of Care**

1. Example Policy and Procedure to Deal with Recovery and 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, as follows:

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. 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-compliance 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, if there appears to be resistance to developing a modified treatment plan in step 5 above.

7. Determine if the modified strategies can be accomplished in the current level of care; or need a more or less intensive level of care in the continuum of services.

8. If, on completion of step 6, the patient recognizes the problem/s; 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.

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

2. 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 be 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.

Criminal justice professionals such as judges, probation and parole officers untrained in addiction and mental health run the risk of thinking that mental health and addiction issues can be addressed from a criminal justice model. They can see mandated treatment for addiction and mental health problems as a criminal justice intervention e.g., mandate the client to a particular level of care of addiction treatment for a fixed length of stay as if ordering an offender to jail for a jail term of three months.

Unfortunately, clinicians and programs often enable such criminal justice thinking by blurring the boundaries between "doing time" and "doing treatment". Clinicians say that they cannot provide individualized treatment since they have to comply with court orders for a particular program and level of care and length of stay. For everyone involved with mandated clients, the 3 C's are important:

3 C's

- 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 and concepts above 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 now at this point in time. 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 incentives for change and provide supports to allow 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!"

F. Gathering Data on Policy and Payment Barriers

- 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 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):	

LITERATURE REFERENCES

"Addiction Treatment Matching – Research Foundations of the American Society of Addiction Medicine (ASAM) Criteria" Ed. David R. Gastfriend has released 2004 by The Haworth Medical Press. David Gastfriend edited this special edition that represents a significant body of work presented in eight papers. The papers address questions about nosology, methodology, and population differences and raise important issues to continually refine further work on the ASAM PPC. (To order: 1-800-HAWORTH; or www.haworthpress.com)

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American Society of Addiction Medicine - 4601 Nth. Park Ave., Arcade Suite 101, Chevy Chase, MD 20815. (301) 656-3920; Fax: (301) 656-3815; www.asam.org; To order ASAM PPC-2R: (800) 844-8948.

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