Improving Skills in Assessment Using and Understanding The ASAM Criteria

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Needs Assessment

- Clinical and/or Supervisory and/or administrative role? Working with infants, youth, adults, older adults?
- How familiar with the Integrated Behavioral Health assessment tool?
- Implementation issues – multidimensional assessment skills?
- Identify some of your goals for this training

“This training will meet my needs if…”

A. Underlying Principles and Concepts of The ASAM Criteria

1. 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

   ![Diagram of Generations of Clinical Care](image-url)
(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) Measurement-Based Practice (Feedback Informed Treatment)
B. Overview of ASAM Assessment Dimensions and Levels of Care

1. Assessment of Biopsychosocial Severity and Function (The ASAM Criteria 2013, pp 43-53)
   The common language of six ASAM Criteria dimensions determine needs/strengths in behavioral health:
   
   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

<table>
<thead>
<tr>
<th>Assessment Dimensions</th>
<th>Assessment and Treatment Planning Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute Intoxication and/or Withdrawal Potential</td>
<td>Assessment for intoxication and/or withdrawal management. Withdrawal management in a variety of levels of care and preparation for continued addiction services</td>
</tr>
<tr>
<td>2. Biomedical Conditions and Complications</td>
<td>Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services</td>
</tr>
<tr>
<td>3. Emotional, Behavioral or Cognitive Conditions and Complications</td>
<td>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</td>
</tr>
<tr>
<td>4. Readiness to Change</td>
<td>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</td>
</tr>
<tr>
<td>5. Relapse, Continued Use or Continued Problem Potential</td>
<td>Assess skills to cope with cravings, triggers, impulses, mental health flare-ups. to use. May or may not be ready for relapse prevention services. If still at early stages of change, focus on raising consciousness of consequences of continued use or problems with motivational strategies.</td>
</tr>
<tr>
<td>6. Recovery Environment</td>
<td>Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services</td>
</tr>
</tbody>
</table>

2. Biopsychosocial Treatment - Overview: 5 M’s
   * Motivate - Dimension 4 issues; engagement and alliance building
   * Manage - the family, significant others, work/school, legal
   * Medication – withdrawal management; HIV/AIDS; anti-craving anti-addiction meds (MAT); 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 (The ASAM Criteria 2013, pp 106-107)
   
   0.5 Early Intervention
   1 Outpatient Services
   2 Intensive Outpatient/Partial Hospitalization Services
   3 Residential/Inpatient Services
   4 Medically-Managed Intensive Inpatient Services
### C. How to Organize Assessment Data to Understand the Integrated BH Assessment

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 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.

<table>
<thead>
<tr>
<th>ASAM Criteria Level of Withdrawal Management Services for Adults</th>
<th>Level</th>
<th>Note: There are no separate Withdrawal Management Services for Adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Withdrawal Management without Extended On-Site Monitoring</td>
<td>1-WM</td>
<td>Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery</td>
</tr>
<tr>
<td>Ambulatory Withdrawal Management with Extended On-Site Monitoring</td>
<td>2-WM</td>
<td>Moderate withdrawal with all day WM support and supervision; at night, has supportive family or living situation; likely to complete WM.</td>
</tr>
<tr>
<td>Clinically-Managed Residential Withdrawal Management</td>
<td>3.2-WM</td>
<td>Moderate withdrawal, but needs 24-hour support to complete WM and increase likelihood of continuing treatment or recovery</td>
</tr>
<tr>
<td>Medically-Monitored Inpatient Withdrawal Management</td>
<td>3.7-WM</td>
<td>Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete WM without medical, nursing monitoring</td>
</tr>
<tr>
<td>Medically-Managed Inpatient Withdrawal Management</td>
<td>4-WM</td>
<td>Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify WM regimen and manage medical instability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ASAM Criteria Levels of Care</th>
<th>Level</th>
<th>Same Levels of Care for Adolescents except Level 3.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Intervention</td>
<td>0.5</td>
<td>Assessment and education for at risk individuals who do not meet diagnostic criteria for Substance-Related Disorder</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>1</td>
<td>Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>2.1</td>
<td>9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>2.5</td>
<td>20 or more hours of service/week for multidimensional instability not requiring 24 hour care</td>
</tr>
<tr>
<td>Clinically-Managed Low-Intensity Residential</td>
<td>3.1</td>
<td>24 hour structure with available trained personnel; at least 5 hours of clinical service/week</td>
</tr>
<tr>
<td>Clinically Managed Population-Specific High-Intensity Residential Services (Adult criteria only)</td>
<td>3.3</td>
<td>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</td>
</tr>
<tr>
<td>Clinically-Managed High-Intensity Residential</td>
<td>3.5</td>
<td>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</td>
</tr>
<tr>
<td>Medically-Monitored Intensive Inpatient</td>
<td>3.7</td>
<td>24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. Sixteen hour/day counselor ability</td>
</tr>
<tr>
<td>Medically-Managed Intensive Inpatient</td>
<td>4</td>
<td>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</td>
</tr>
<tr>
<td>Opioid Treatment Services</td>
<td>OTS</td>
<td>Opioid Treatment Program (OTP) – agonist meds: methadone, buprenorphine; Office Based Opioid Treatment (OBOT); antagonist medication - naltrexone</td>
</tr>
</tbody>
</table>
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. **Imminent Danger** (*The ASAM Criteria* 2013, pp. 65-58) - Three components:

1. A strong probability that certain behaviors (such as continued alcohol or other drug use or addictive behavior relapse) will occur.

2. The likelihood that such behaviors will present a significant risk of serious adverse consequences to the individual and/or others (as in reckless driving while intoxicated, or neglect of a child).

3. The likelihood that such adverse events will occur in the very near future, within hours and days, rather than weeks or months.

3. **Rating Risk on a Scale of 0 - 4** (*The ASAM Criteria* 2013, pp 57, 74-89)

<table>
<thead>
<tr>
<th>RISK RATING</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>This rating would indicate issues of <strong>utmost severity</strong>. The patient would present with critical impairments in coping and functioning, with signs and symptoms, indicating an <strong>&quot;imminent danger&quot;</strong> concern.</td>
</tr>
<tr>
<td>3</td>
<td>This rating would indicate a <strong>serious issue</strong> or difficulty coping within a given dimension. A patient presenting at this level of risk may be considered in or near <strong>&quot;imminent danger;&quot;</strong></td>
</tr>
<tr>
<td>2</td>
<td>This rating would indicate <strong>moderate difficulty</strong> in functioning. However, even with moderate impairment, or somewhat persistent chronic issues, relevant skills or support systems may be present.</td>
</tr>
<tr>
<td>1</td>
<td>This rating would indicate a <strong>mildly difficult issue</strong>, or present minor signs and symptoms. Any existing chronic issues or problems would be able to be resolved in a short period of time.</td>
</tr>
<tr>
<td>0</td>
<td>This rating would indicate a <strong>non-issue or very low-risk issue</strong>. The patient would present no current risk and any chronic issues would be mostly or entirely stabilized.</td>
</tr>
</tbody>
</table>
What Does the Client Want? Why Now?

Does client have immediate needs due to imminent risk in any of the six assessment dimensions?

Conduct multidimensional assessment

What are the DSM/ICD diagnoses?

Multidimensional Severity /LOF Profile

Identify which assessment dimensions are currently most important to determine Tx priorities

Choose a specific focus and target for each priority dimension

What specific services are needed for each dimension?

What “dose” or intensity of these services is needed for each dimension?

Where can these services be provided, in the least intensive, but safe level of care or site of care?

What is the progress of the treatment plan and placement decision; outcomes measurement?

(The ASAM Criteria 2013, p 124)
### D. Improving Skills in Assessing Each Dimension to Complete the Integrated BH Assessment

1. **Developing the Treatment Contract** *(The ASAM Criteria 2013, page 58)*

<table>
<thead>
<tr>
<th>What?</th>
<th>Client</th>
<th>Clinical Assessment</th>
<th>Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>What does client want?</td>
<td>What does client need?</td>
<td>What is the Tx contract?</td>
<td></td>
</tr>
<tr>
<td>Why is the level of commitment?</td>
<td>What is the Tx contract?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How?</td>
<td>How will s/he get there?</td>
<td>How will you get him/her to accept the plan?</td>
<td>Does client buy into the link?</td>
</tr>
<tr>
<td>Where?</td>
<td>Where will s/he do this?</td>
<td>Where is the appropriate setting for treatment?</td>
<td>Referral to level of care</td>
</tr>
<tr>
<td>When?</td>
<td>When will this happen?</td>
<td>When? How soon?</td>
<td>What is the degree of urgency?</td>
</tr>
<tr>
<td>How quickly?</td>
<td>What are realistic expectations?</td>
<td>What are milestones in the process?</td>
<td>What is the process?</td>
</tr>
<tr>
<td>How badly does s/he want it?</td>
<td>What are milestones in the process?</td>
<td>What are the expectations of the referral?</td>
<td></td>
</tr>
</tbody>
</table>

2. **Readiness to Change - Dimension 4**

(a) **Definitions of Compliance and Adherence**

Webster’s Dictionary defines “**comply**” as follows: to act in accordance with another’s wishes, or with rules and regulations. It defines “**adhere**”: to cling, cleave (to be steadfast, hold fast), stick fast.

(b) **Stages of Change and How People Change**

* 12-Step model - surrender versus comply; accept versus admit; identify versus compare

* Transtheoretical Model of Change (Prochaska and DiClemente):
  
  **Pre-contemplation**: not yet considering the possibility of change although others are aware of a problem; no interest in change; seldom appear for treatment without coercion; could benefit from non-threatening information to raise awareness of a possible “problem” and possibilities for change.

  **Contemplation**: ambivalent, undecided, vacillating between whether he/she really has a “problem” or needs to change; wants to change, but this desire exists simultaneously with no interest in changing; may seek professional advice to get an objective assessment; motivational strategies useful at this stage, but aggressive or premature confrontation produces discord and defensive behaviors; many Contemplators have indefinite plans to take action in the next six months or so.

  **Preparation**: takes person from decisions made in Contemplation stage to the specific steps to be taken to solve the problem in the Action stage; increasing confidence in the decision to change; certain tasks that make up the first steps on the road to Action; most people planning to take action within the very next month; making final adjustments before they begin to change their behavior.

  **Action**: specific actions intended to bring about change; overt modification of behavior and surroundings; most busy stage of change requiring the greatest commitment of time and energy; care not to equate action with actual change; support and encouragement still very important to prevent drop out and regression in readiness to change.
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**Maintenance:** sustain the changes accomplished by previous action and prevent relapse; requires different set of skills than were needed to initiate change; consolidation of gains attained; not a static stage and lasts as little as six months or up to a lifetime; learn alternative coping and problem-solving strategies; replace problem behaviors with new, healthy life-style; work through emotional triggers.

**Relapse and Recycling:** expectable, but not inevitable setbacks; avoid becoming stuck, discouraged, or demoralized; learn from relapse before committing to a new cycle of action; comprehensive, multidimensional assessment to explore all reasons for relapse.

**Termination:** this stage is the ultimate goal for all changers; person exits the cycle of change, without fear of relapse; debate over whether certain problems can be terminated or merely kept in remission through maintenance strategies.

(c) **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.

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!”

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. Continued Skill-Building to Complete the Integrated Behavioral Health Assessment

1. 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 to 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. Transitional Age Youth (TAY) (The ASAM Criteria 2013, pp 109-110)
   
   - The definition of adolescence is better understood as a matter of a dimensional developmental stage, rather than a categorical cut-off of chronological age.
   
   - Some youth transition out of adolescence into more adult-like functioning earlier than average, some later.
In general, most regulatory definitions encompass the ranges of 13-18 or 13-21, with some local variation. From a clinical perspective, these ranges should be viewed flexibly.

Although payers may sometimes choose to apply a definition based on a rigid application of an age cut-off, such as age 18, there are many cases where individual variation and the functional immaturity of a particular patient dictate that the adolescent criteria would be more appropriately applied to a 20 or 21 year old than the adult criteria.

There are another whole set of issues that distinguish an intermediate group of young people – young adults or transitional age youth. These are a group of older, maturing adolescents, and younger “20-somethings” who have a foot in both worlds, adolescence and adulthood, and are making a messy, inexact transition.

The age range might roughly be considered 17-26, with a great deal of individual variation, depending on functional maturity level.

They often are simultaneously emerging into independence while still relying in large part on the support of parents or other caregiving adults.

The mixed features of both adolescence and adulthood for transition age youth require a special approach. Some providers have begun to develop specialized programming for this group and its unique clinical needs.

Eventually, the separation of a third category (adolescent, adult, and transition age youth) of developmental programming may become standard. The tensions inherent in their transition often require a balancing act, especially between emerging independence and persistent dependence.

For example, issues of confidentiality versus open sharing of information with parents/caregivers are common. Other common issues include financial support, shared living environments with parents, extension of standard insurance coverage under parental policies until age 26 with the Affordable Care Act.

These tensions and the dynamic interplay between youth and parents is dramatized in the caricatured quotes: “I’m old enough to take care of myself…” versus “You may think you’re all grown up, but as long as you’re living under my roof…”

It is likely that these in-between youth need services and service doses somewhere in between adolescents and adults. For example, for a given problem, they may need more intensity than the typical adult, but less than the typical adolescent.
3. **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

4. **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/direction for change

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**PLACEMENT SUMMARY**

<table>
<thead>
<tr>
<th>Level of Care/Service Indicated</th>
<th>- 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</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Care/Service Received</td>
<td>- 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</td>
</tr>
<tr>
<td>Anticipated Outcome If Service Cannot Be Provided</td>
<td>– 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):</td>
</tr>
</tbody>
</table>

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**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.

Dimension 2, Biomedical Conditions/Complications: she is not on any medications, has been healthy physically and has no current complaints.

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.

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.

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.

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 Profile:

<table>
<thead>
<tr>
<th>Dimension</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Services Needed: 

Site of Care: 

Angela, a 28 y/o, pregnant (1st trimester), mother of 2 and is being referred to drug treatment by Child Welfare and Probation.

The referral states Angela was arrested for driving under the influence while her children were in the car (2 y/o, 4 y/o). Angela’s children were unrestrained, unkept, and not clothed appropriately for the cold weather. When Angela was pulled over, she was arrested due to a previous warrant and the children were immediately removed and placed in foster care. Angela’s toxicology screen at the time of her arrest was positive for alcohol and methamphetamine. Angela spent 30 days in jail and is reporting abstinence since her release 4 days ago.

Child Welfare reports that the client has a history of psychiatric hospitalizations and does not want to take her Bipolar medications because of the pregnancy. Prior to her arrest, she and her children were homeless for 2 months.

During your intake, Angela reports feeling that substances are not an issue for her and she does not need a drug treatment program. Client states, “I was clean in jail and since getting out I have not used.”

Questions:

1. What does Angela want that will drive the assessment and treatment process?

2. To assess severity in each of the 6 ASAM Criteria assessment dimensions, what clinical information for each dimension do you need, if missing in this vignette? Indicate which dimension has missing information and specify what more information you want.
**Roger**, a 53 y/o male client presents for a substance use treatment screening at the request of his probation officer. Information obtained from probation indicates the client has been prescribed Opioid medications for chronic pain due to injuries he sustained after a motorcycle accident 3 years ago. The client was recently involved in a DUI and found to be in possession of narcotics that were not prescribed to him. The client shares with you that he would be interested in talking to someone about the death of his mother 4 months ago and tearfully states his life has “fallen apart again” and that “everything has gotten worse.”

The client goes on to express anger at his probation officer and primary care doctor for wanting him to find “different ways to manage the pain.” The client states that if people felt as bad as he did “they would need the pills too.” Client’s self-report indicates that he drinks alcohol 3 times per week, 3-5 beers each time, and feels that the police may have “set him up.” The client alleges that it was “not possible” that his blood alcohol was over the legal limit and that “the pills for pain don’t impact my driving.” The client reports that he takes 8-12 Oxycodone tablets per day and used to “borrow” pills from his mother when he was “feeling really bad.” The client states that he knows his probation officer is requiring him to attend treatment, but he does not really want to.

**Questions:**

1. What two goals for treatment are most important to Roger?

2. To assess severity in each of the 6 ASAM Criteria assessment dimensions, what clinical information for each dimension do you need, if missing in this vignette? Indicate which dimension has missing information and specify what more information you want.

**Carl**

Carl is a 15 y.o. male who you suspect meets DSM criteria for Alcohol and Cannabis Use Disorder, with occasional cocaine (crack) use on weekends. He reports no withdrawal symptoms, but then he really doesn’t think he has a problem and you are basing your tentative diagnosis on reports from the school, probation officer, and older sister.

Carl has been arrested three times in the past eighteen months for petty theft/shoplifting offenses. Each time he has been acting intoxicated but says he has not been using any drugs. The school reports acting up behavior, declining grades and erratic attendance, but no evidence of alcohol/drug use directly. They know he is part of a crowd that uses drugs frequently.

Yolanda, Carl’s 24 y.o. sister, has custody of Carl following his mother’s death from a car accident eighteen months ago. She is single, employed by the telephone company as a secretary, and has a three y.o. daughter she cares for. She reports that Carl stays out all night on weekends and refuses to obey her or follow her rules. On two occasions she has observed Carl drunk. On both occasions he has been verbally aggressive and has broken furniture. A search of his room produced evidence of marijuana and crack, which Carl says he is holding for a friend.

1. What does Carl want that will drive engagement, collaborative treatment planning and treatment adherence?

2. How would you word one Problem Statement in Carl’s Treatment Plan that would make sense to him?
**Ann**

DSM-5 Diagnosis: Alcohol Use Disorder, severe; and Cannabis Use Disorder, severe; Major Depression

Ann, a 32-year-old white, 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 far 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 salesperson 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 addiction 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.

**Cathy**

Age: 27

Occupation: Waitress

Chief Complaint: “I’m a junkie”

History:

* Twenty-seven year old, single, female waitress with long history of using multiple substances presenting because of withdrawal symptoms, accompanied by her parents.

* Started marijuana at age 15 with weekend alcohol and other drug use until college.

* In college, used marijuana heavily almost daily and LSD once a month.

* A year ago, began a methamphetamine binge, which terminated three months later with a methamphetamine-induced psychosis. After a seven-day psychiatric hospitalization, she did well for two months.

* Began marijuana again and also heroin. She spends $40-$50/day which she finances by waitressing. Some occasional cocaine use. No legal problems.

* Around age 18, she was diagnosed with a panic disorder and began on clonazepam (Klonopin) and has been maintained on 3 - 4 mg./day ever since. This diagnosis was made approximately one year after the birth of a child resulting from a rape. Incident was kept secret from parents until she was close to labor.

* Has tried to quit using twice recently in the last month but was too physically ill. Came for help because a drug-using friend is also trying to quit and called her parents to tell them of their daughter’s drug use.
* No previous addiction treatment but did attend four Narcotics Anonymous meetings with NA friend but felt she wasn’t as bad as everyone there.

* Complaints of muscle aches, irritability, anxiety, tremulousness, tearfulness, abdominal cramps and nausea. Also heavy menstrual bleeding and feeling tired and weak.

* Last use of heroin morning of evaluation.

**Past Medical History:**

* Two heroin overdoses resulting in respiratory arrest, but one of her shooting buddies was a registered nurse who administered CPR.

* History of heavy menstrual bleeding and pelvic inflammatory disease.

**Family History:**

* Both grandfathers suffered from alcohol use disorder.
* Father somewhat distant, but is the disciplinarian.
* Mother “enabling”.
* No other psychiatric illness in family.
* Only child.

**Social History:**

* Single; never married and has boyfriend who drinks addictively and two good friends in NA.
* Lives with parents, who supplement her income and give free room and board.
* Has not seen child since giving him up for adoption at age 17.
* Waitress.
* Family not religious. No religious affiliation.

**Review of Systems and Physical and Mental Status Examination:**

* Symptoms of abdominal cramps, nausea and diffuse muscle aches.

* Pale and still some menstrual bleeding.

* Anxiety, tremulousness and irritability, but not suicidal nor homicidal, and is cooperative, wanting to feel better and please her parents. Would like to get “clean and sober” to perhaps see her child, or at least get married and have another baby. But also doesn’t know if she can stop using or whether she would attend NA.

* Physical and mental status exam: BP 110/70; Pulse 90; Respirations 18. Mild discomfort; IV track marks in right antecubital fossa; increased bowel sounds; some dilatation of pupils.

* Laboratory data: CBC, Chem 20, HIV negative; not pregnant.

**Diagnoses:**

Opioid Use Disorder; Methamphetamine Use Disorder; Cannabis Use Disorder. Panic Disorder Without Agoraphobia.
February 18

The following is a report on C.W. The consultation issue involved the question of whether primary alcohol dependence or primary psychiatric interventions were needed; and also recommendation for level of care and treatment plan given this patient’s three hospitalizations since age 15 with the current admission involving high risk suicidal behavior. CW is a 19 year-old, single, unemployed tire worker who was admitted 2/13 intoxicated on alcohol and also positive for marijuana in his drug screen. He was depressed and suicidal and had cut his chest; written “Die” on his chest; and taken an overdose of Prozac.

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: www.haworthpress.com)

Bureau of Justice Assistance (BJA) training video on The ASAM Criteria that can be viewed by creating an account and going to the Adult Drug Court Lessons. The system can be found at www.treatmentcourts.org and this video was initiated by Dennis Reilly at the Center for Court innovation.


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