

## The ASAM Criteria: Implications for Adult Problem Solving Courts

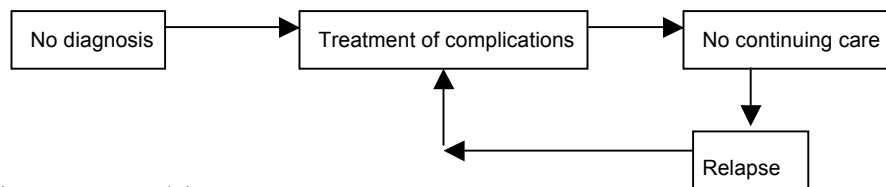
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Team Workshops: May 10, 2017 8:30 -10 AM or 3:15 – 4:45 PM New Orleans, LA  
 Louisiana Association of Drug Court Professionals –LADCP 2017

### A. Generations of Clinical Care (Mee-Lee, D (2001)

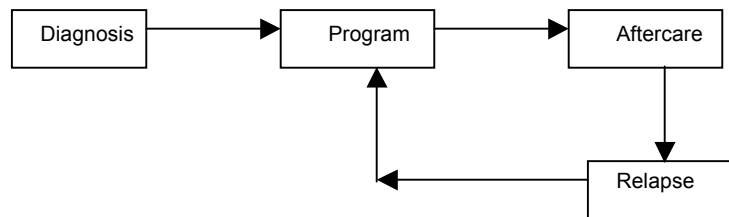
#### (a) Complications-driven Treatment

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

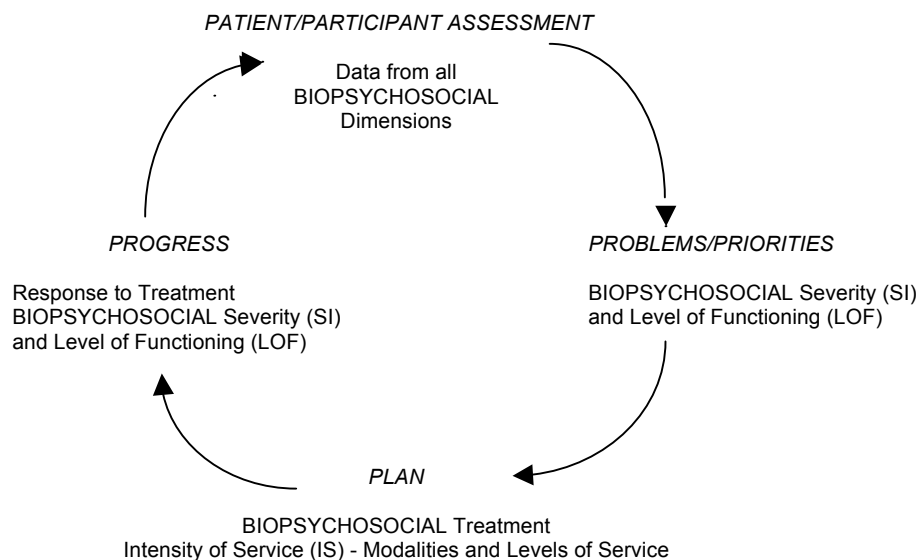


#### (b) Diagnosis, Program-driven Treatment

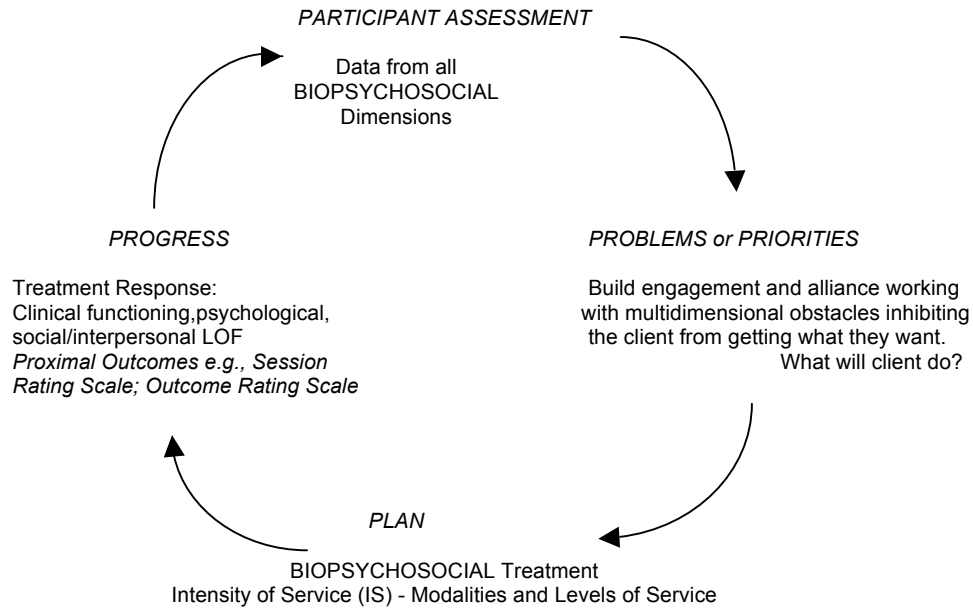
- ⤴ Diagnosis determines treatment
- ⤴ Treatment is the primary program and aftercare
- ⤴ Relapse triggers a repeat of the program



#### (c) Individualized, Clinically-driven Treatment



(d) Client-Directed, Outcome-Informed Treatment – Feedback Informed Treatment



**B. Overview of ASAM Criteria Assessment Dimensions and Levels of Care**

1. Assessment of Biopsychosocial Severity and Function (*The ASAM Criteria* 2013, pp 43-53)

The common language of 6 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

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

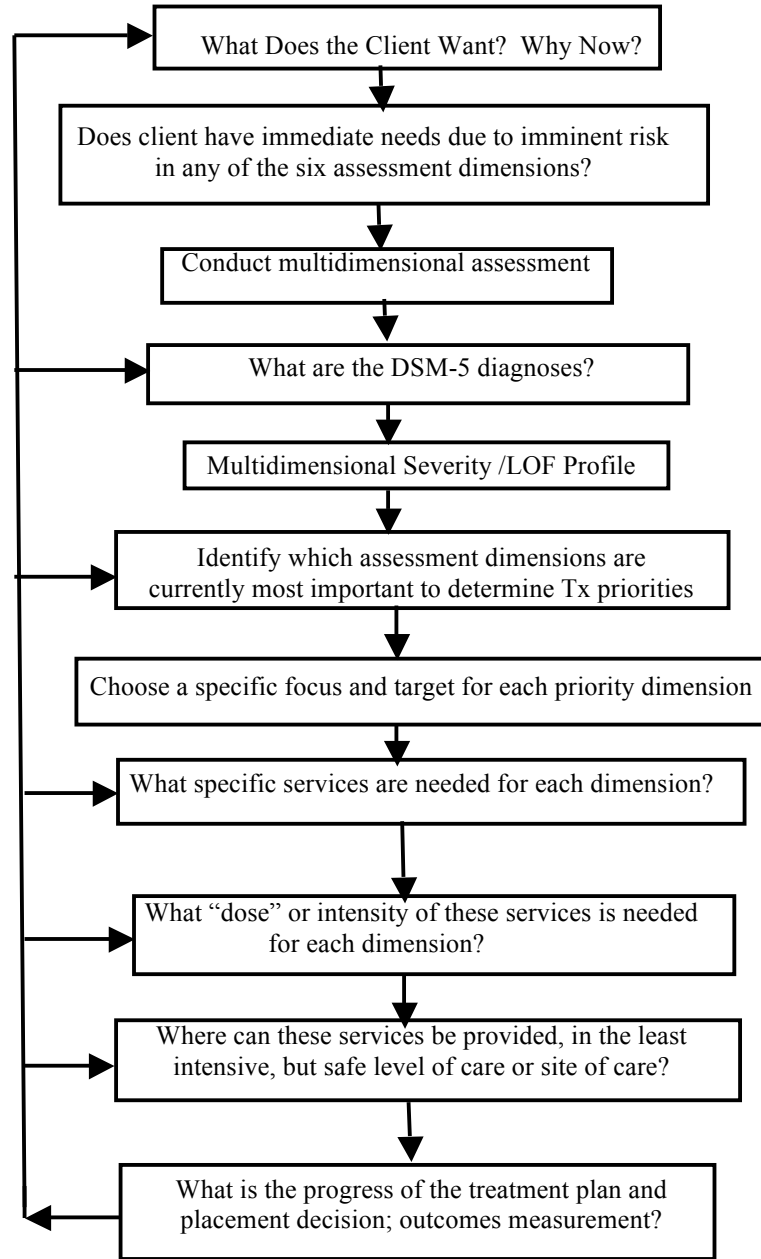
- \* Motivate - Dimension 4 issues; engagement and alliance building
- \* Manage - the family, significant others, work/school, legal
- \* Medication – withdrawal management; HIV/AIDS; anti-craving anti-addiction meds – MAT; disulfiram, methadone; buprenorphine, naltrexone, acamprosate, psychotropic 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)

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

<b>ASAM Criteria Level of Withdrawal Management Services for Adults</b>	<b>Level</b>	<b>Note: There are no separate Withdrawal Management Services for Adolescents</b>
Ambulatory Withdrawal Management without Extended On-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery
Ambulatory Withdrawal Management with Extended On-Site Monitoring	2-WM	Moderate withdrawal with all day WM support and supervision; at night, has supportive family or living situation; likely to complete WM.
Clinically-Managed Residential Withdrawal Management	3.2-WM	Moderate withdrawal, but needs 24-hour support to complete WM and increase likelihood of continuing treatment or recovery
Medically-Monitored Inpatient Withdrawal Management	3.7-WM	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete WM without medical, nursing monitoring
Medically-Managed Inpatient Withdrawal Management	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify WM regimen and manage medical instability
<b>ASAM Criteria Levels of Care</b>	<b>Level</b>	<b>Same Levels of Care for Adolescents except Level 3.3</b>
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 Residential	3.1	24 hour structure with available trained personnel; at least 5 hours of clinical service/week
Clinically Managed Population-Specific High-Intensity Residential Services (Adult criteria only)	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 Residential	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

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



(The ASAM Criteria 2013, p 124)

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**D. Understanding 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.

## **E. 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 person's recovery and precipitating cravings to use/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-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 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.
10. Document the crisis and modified treatment plan or discharge in the medical record.

## **F. Proximal and Distal Goals**

- Traditionally: Abstinence is a “distal” goal for participants with addiction (dependence – they need treatment); but a “proximal” goal for those with Substance Abuse (assumes substance use is voluntary)
- Traditionally: Those with complex needs, “regimen compliance” is “proximal” goal. Better still “treatment adherence”
- Traditionally: Increase treatment for substance use early in treatment for participants with addiction; but punish with sanctions once engaged in treatment and some sustained sobriety
- Traditionally: For non-addicted participants, use escalating sanctions in initial phases to end voluntary use and not “reward” use

**Recommendations:**

- This all based on a behavior modification approach when addiction is biopsychosocial-spiritual
- If participant has addiction, treatment is needed. If not, education, risk advice and escalating legal consequences (like speeding fines and DUI)
- Abstinence is a “proximal” or “distal” goal for participants with addiction depending on their stage of change regarding abstinence assessed in treatment
- Use escalating sanctions in initial and/or later phases of treatment for lack of good faith effort in treatment. Don’t sanction for signs and symptoms of addiction flare-ups and poor outcomes.

## LITERATURE REFERENCES AND RESOURCES

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