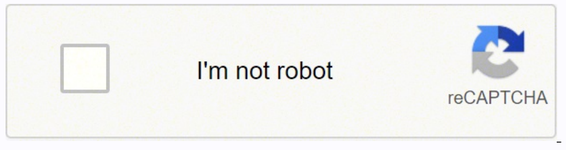

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What is the patient's current level of craving and how successfully can he or she resist using? With this release, ASAM and UCLA hope to increase the quality and consistency of patient assessments and treatment recommendations. With improved outcome analysis driving treatment decisions, the problem of access to care and funding of treatment can be championed more effectively. For both clinical and financial reasons, the preferred level of care is the least intensive level that meets treatment objectives, while providing safety and security for the patient. Overall, the early studies have shown adequate reliability, good concurrent validity, and some degree of predictive validity (Gastfriend, Lu et al., 2000). Co-Occurring Disorders. They are staffed 24 hours a day. Thus, the ASAM criteria provides the addiction field with a nomenclature for describing the continuum of addiction services, as follows: Level 0.5: Early Intervention Level I: Outpatient Services Level II: Intensive Outpatient/Partial Hospitalization Services Level III: Residential/Inpatient Services Level IV: Medically Managed Intensive Inpatient Services Within each level, a decimal number (ranging from .1 to .9) expresses gradations of intensity within the existing levels of care. The resident's readiness for discharge or transfer and the staff's attempts to implement a clinically appropriate placement should be noted in the clinical record, and the treatment plan should be updated in a manner that provides the resident with the opportunity to continue the recovery process at the same level of care even though it could be continued at a less intensive level of care. An initial evaluation of the psychosocial dimensions of the American Society of Addiction Medicine criteria for inpatient vs. For the continuum to work most effectively, it is best distinguished by three characteristics: (1) seamless transfer between levels of care, (2) philosophical congruence among the various providers of care, and (3) timely arrival of the patient's clinical record at the next provider. SOURCE: Mee-Lee D, Shulman GD, Fishman M et al. Use of the second edition (ASAM PPC-2; Mee-Lee, Shulman et al., 1996) has been mandated or recommended to publicly funded treatment programs in nearly 30 states, by the U.S. Department of Defense, and by two large health maintenance organizations. Does the patient have supportive friendships, financial resources, or educational or vocational resources that can increase the likelihood of successful treatment? A major factor has been the growing body of scientific evidence pointing to addictive disorders as diseases of the brain; another is the development of pharmacotherapies for addiction. Such multidimensional assessment ensures comprehensive treatment. The same recognition of chronicity should be applied to the treatment of addictive disorders, for which appropriate criteria would involve reductions in the intensity or severity of symptoms, the duration of symptoms, and the frequency of symptoms. The ASAM criteria function best when individuals are assessed in each dimension independently and also in terms of the interaction across dimensions. Treatment is provided 24 hours a day, and the full resources of a general acute care hospital or psychiatric hospital are available. Continued Service and Discharge Criteria. Ongoing assessment of progress and treatment response influences future treatment recommendations. Mee-Lee D (1998). Thus, in addiction treatment, the treatment may extend beyond simple resolution of observable biomedical distress to the achievement of overall healthier functioning. In the latter two approaches (assessment-driven treatment and outcomes-driven treatment), however, placement criteria play an integral role by providing a structure for assessment that focuses on the patient's assessed needs. No one expects that simply because a patient has been treated on one occasion for his or her hypertension, there will never be another episode. Skip sidebar navigation Read Announcement The ASAM Criteria® Assessment Interview Guide is the first publicly available standardized version of the ASAM Criteria assessment. If the court order or other mandate cannot be amended, the individual may be continuing treatment at a level of care or for a length of stay greater than is clinically indicated. The ASAM Placement Criteria and Matching Patients to Treatment David Mee-Lee, M.D. Gerald R. Principles of Drug Addiction Treatment—–A Research Based Guide. The ASAM Criteria: A benefit to EAPs. EAP Digest 13(4):26-28. They are housed in, or affiliated with, permanent facilities where patients can reside safely. It is the resolution of those problems and priorities that determines when a patient can be treated at a different level of care or discharged. (1996). What should be avoided is the notion of "averaging" severity across dimensions to arrive at a placement determination. Level IV: Medically Managed Intensive Inpatient Treatment. Length of Stay: The length of stay or service is determined by the patient's progress toward achieving his or her treatment plan goals and objectives. Logistical problems can arise anywhere, but are found most frequently in rural and underserved inner-city areas. Level I encompasses organized, non-residential services, which may be delivered in a wide variety of settings. Such a continuum may be offered by a single provider or multiple providers. Such services are delivered under a defined set of policies and procedures and has permanent facilities that include inpatient beds. Patients are assigned to fixed lengths of stay in programs with static approaches, often in response to available funding or benefit structures. The lesson here is that assessments are most accurate when they take into account all of the factors (dimensions) that affect each individual's receptivity and ability to engage in treatment at a particular point in time. Excerpted by permission of the publisher from: Principles of Addiction Medicine, Third Edition AW Graham, TK Schultz, MF Mayo-Smith,RK Ries & BB Wilford, eds. About The ASAM Criteria The ASAM Criteria is the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer of patients with addiction and co-occurring conditions. What is the patient's ability to remain abstinent or psychiatrically stable, based on history? The appearance of new problems may require services that can be effectively provided at the same level of care, or that require a more or less intensive level of care. Treatment of Drug-Dependent Individuals With Comorbid Mental Disorders (Research Monograph 172). Choice of Treatment Levels: Referral to a specific level of care must be based on a careful assessment of the patient. Subsequent resolution of this problem creates an opportunity to transfer the patient to a less intensive level of care. The unbundling concept thus is designed to maximize individualized care and to encourage the delivery of necessary treatment in any clinically feasible setting. Individualized, assessment-driven treatment emphasizes multidimensional assessment. This concept is particularly relevant today, as the range of patient needs and clinical variability continues to broaden. The prognosis for resolution of problems in the various dimensions depends on the clinician's knowledge of problem severity and the level of difficulty in resolving these problems. National Institute on Drug Abuse (NIDA) (1994). American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders: An Analysis. Miller WR & Rollnick S (1991). American Psychologist 47:1102-1114. However, poor treatment outcomes also may be related to a provider's failure to provide services tailored to the patient's needs. Gaithersburg , MD : Aspen Publishers, Inc., 225-266. If the lengths of stay correspond to payer type, then the program is payment-driven rather than offering individualized treatment. In reality, there is considerable interaction across dimensions. intensive outpatient substance abuse rehabilitation. Gastfriend DR (1999). If on psychotropic medications, is the patient compliant? Dimension 2: Biomedical Conditions and Complications. Level II: Intensive Outpatient Treatment/Partial Hospitalization. Research on the ASAM Criteria Since the publication of the first edition, there has been over a decade of experience with the ASAM criteria. The expansion thus can enhance access to care and facilitate earlier engagement of patients in treatment, thereby allowing better utilization of resources and improving the effectiveness of recovery efforts. Factors contributing to this clinical reality include the expansion of substance use and substance-related disorders in younger populations; greater sensitivity to substance use problems in the mental health, welfare, and criminal justice systems; and increased commitment to earlier intervention in substance use disorders in preference to fragmented services and incarceration. It defines the standards for assessing patients with substance use disorder to determine the type and intensity of treatment needed. Chevy Chase , MD : American Society of Addiction Medicine. Gartner L & Mee-Lee D, eds. Patient-treatment matching: A conceptual and methodological review, with suggestions for future research. 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 of the identified clinical problems). Mee-Lee D, Shulman GD & Gartner L (1996). The ASAM criteria conceptualize treatment as a continuum marked by five basic levels of care, which are numbered in Roman numerals from Levels 0.5 through Level IV. McKay JR, Cacciola JS, McLellan AT et al. Gastfriend DR & McLellan AT (1997). Correctly applied and implemented, the ASAM criteria can assist in improving the "placement match" by redesigning the place of treatment and the level of care. The goal of this resource is to increase the quality and consistency of patient assessments and substance use treatment recommendations. While this does not constitute universal acceptance, there clearly is movement toward the common language they provide to the providers and managers of care, as well as a strong focus on multidimensional assessment and individualized care. Level IV programs provide care to patients whose mental and substance-related problems are so severe that they require primary biomedical, psychiatric and nursing care. Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders (PPC-1). For all the current rhetoric about outcomes, performance measures, accountability, and evidence-based treatment, this approach to addiction treatment is only just beginning to be articulated and actualized. Rockville , MD : Center for Substance Abuse Treatment. The intensity of the strategies incorporated in the treatment plan helps to determine the most efficient and effective level of care that can safely provide the care articulated in the individualized treatment plan. When the first edition of the ASAM criteria was published in 1991, the criteria were designed for programs that offered only addiction treatment services. However, even that early edition also acknowledged that some patients come to treatment with medical (Dimension 2) and psychiatric (Dimension 3) disorders that coexist with their substance-related problems. Implementing the ASAM criteria in community treatment centers in Illinois : Opportunities and challenges. National Institute on Drug Abuse (NIDA) (1997). Unpublished paper prepared for the California Office of Alcohol and Drug Programs. Psychiatric Rehabilitation Skills 5(1):52-79. Journal of Addictive Diseases 19(2):109-116. May WW (1998). Individualized Treatment Plan: Treatment should be tailored to the needs of the individual and guided by an individualized treatment plan that is developed in consultation with the patient. Rawson RA & Ling W (n.d.). Addressing the individual's recovery needs thus may involve a sequence of services across several levels of care (involving a "step down" or "step up process"). These standards describe six dimensions that should be assessed, including:Acute intoxication and/or withdrawal potentialBiomedical conditions and complicationsEmotional, behavioral, and cognitive conditions and complicationsReadiness to changeRelapse, continued use, or continued problem potentialRecovery/living environmentThe ASAM Criteria also provides standards for rating the patient's risks in each dimension and dimensional admission criteria for determining the least intensive, but safe level of care for meeting the patient's individual treatment needs. Resources Project TeamUCLAAnne B. A field application of the ASAM Placement Criteria in a 12-step model of treatment for chemical dependency. Hoffman NG, Halikas JA, Mee-Lee D et al. Even if connected to the addiction, are they severe enough to warrant specific mental health treatment? To be effective, treatment must address any associated medical, psychological, social, vocational, and legal problems. 2. Level I outpatient services are designed to treat the individual's level of clinical severity and to help the individual achieve permanent changes in his or her alcohol- and drug-using behavior and mental functioning. Failure of a patient to progress at a given level of care, so as to warrant a reassessment of the treatment plan with a view to modifying the treatment approach. Criteria also provide a nomenclature to describe an expanded set of treatment options and guidelines to promote the use of a broader continuum of services. Decisions concerning continued service, transfer, or discharge involve review of the treatment plan and assessment of the patient's progress. Washington , DC : American Society of Addiction Medicine. The use of placement criteria in treatment planning thus represents far more than a narrow utilization review or case management process. McLellan AT & Alterman AI (1991). Placement criteria are irrelevant to the first two approaches to patient placement (complications-driven and program-driven treatment). Such expectations are recognized as inappropriate in the treatment of other chronic disorders, such as diabetes or hypertension. The Concept of "Unbundling." At present, most addiction treatment services are "bundled," meaning that a number of different services are packaged together and paid for as a unit. For example, problems with relapse potential (Dimension 5) may be offset by a high degree of readiness to change (Dimension 4) or a very supportive recovery environment (Dimension 6). Greater understanding of the uses and effects of psychosocial and cognitive-behavioral strategies also has heightened awareness of a broadened range of modalities to meet individual needs. Assessment instruments. Is the patient suicidal, and if so, what is the lethality? Professional services for early intervention constitutes a service for specific individuals who, for a known reason, are at risk of developing substance-related problems or for those for whom there is not yet sufficient information to document a substance use disorder. They are staffed by designated addiction-credentialed physicians, including psychiatrists, as well as other mental health- and addiction-credentialed clinicians. Strategies for Case-Mix Adjustments in Addictions Treatment Evaluations: Prognostic Indicators in Public Sector Populations. The interview guide helps providers conduct full assessments and implement the criteria in clinical interviews. The criteria are as objective, measurable, and quantifiable as possible. Is there need for medical services that might interfere with treatment? Washington , DC : National Academy Press. Alcohol Health & Research World 20(1):36-44. Such mandated or court-ordered referrals may not be based on clinical considerations and thus may be inconsistent with a placement decision arrived at through the ASAM criteria. Turner WM, Turner KH, Reif S et al. The principle here is that the highest severity problem (particularly those in Dimensions 1, 2 or 3) should determine the patient's initial placement. In fact, such a requirement is no more rational than treating every patient in an inpatient program or using a fixed length of stay for all. Certain aspects of the criteria require subjective interpretation. There have been two naturalistic studies and one randomized controlled trial of placement criteria (the results of which are not yet published). How aware is the patient of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use or impulses to harm self or others? This resource can also help assist states looking to facilitate continuity and consistency in substance use disorder (SUD) treatment delivery and coverage. Journal of Studies on Alcohol 58(5):239-252. The interaction of these factors may result in a lower level of severity than is seen in any dimension alone. Dimension 4: Readiness to Change. The expansion reflects recent knowledge of and experience with cognitive behavioral therapies such as motivational interviewing, motivational enhancement, solution-focused therapy, and stages of change work, all of which may be appropriate for patients who previously would have been turned away as not ready for treatment, or in denial and thus in need of coerced intensive treatment. Uses of Placement Criteria. Effective implementation of the newest version of the ASAM criteria (ASAM PPC-2R) will require a shift in thinking toward outcomes-driven case management. The health care professional's decision to prescribe a type of service, and subsequent discharge of a patient from a level of care, are based on how that treatment and its duration will influence the resolution of the dysfunction and positively alter the prognosis for the patient's long-term outcome. Treatment planning for dual disorders. What risk is associated with the patient's current level of acute intoxication? Clinical versus Reimbursement Considerations: The ASAM criteria describe a wide range of levels and types of care. Dimension 5: Relapse, Continued Use or Continued Problem Potential. Can he or she cope with any emotional, behavioral or cognitive problems? If he or she is willing to accept treatment, how strongly does the patient disagree with others' perception that she or he has an addictive or mental disorder? Finally, there is a concern that some benefit managers require that a patient "fail" at one level of care 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). Such a patient needs placement in a residential program that offers clinical staff and services 24 hours a day in order to respond to the patient's issues that pose the imminent danger. Gastfriend DR, Lu S & Sharon E (2000). Some patients may require immediate stabilization of their psychiatric symptoms before they can be engaged in ongoing addiction treatment and recovery. Individuals with such co-occurring disorders (often referred to as "dual diagnoses") can be conceptualized as belonging to one of two general categories: Moderate Severity Disorders: Such persons present with stable mood or anxiety disorders of moderate severity (including resolving bipolar disorder), or with personality disorders of moderate severity (although some persons with severe levels of antisocial personality disorder may be appropriately placed in this group), or with signs and symptoms of a mental health disorder that are not so severe as to meet the diagnostic threshold. This continuous quality improvement cycle—assessment, treatment matching, level of care placement, and progress evaluation through assessment (see Figure 1)—represents an approach to care that much of the addiction treatment field still struggles to implement (Mee-Lee, 1998). Four important missions underlie the ASAM criteria: (1) to enable patients to receive the most appropriate and highest quality treatment services, (2) to encourage the development of a broad continuum of care, (3) to promote the effective, efficient use of care resources, and (4) to help protect access to and funding for care. Placement criteria and patient-treatment matching. Chevy Chase , MD : American Society of Addiction Medicine. In 1994, the National Institute on Drug Abuse (NIDA) funded the first randomized controlled trial using the ASAM criteria, and it is hoped that clinical outcomes research will drive future revisions of the criteria. Mandated Level of Care or Length of Service. Do any family members, significant others, living situations, or school or work situations pose a threat to the patient's safety or engagement in treatment? Lack of availability of appropriate, criteria-selected care; 2. Thus the ASAM criteria describe gradations within each level of care. Because it is paper-based, offered free to all, and can be used in many different clinical contexts, the interview guide enhances public utility of The ASAM Criteria's multidimensional assessment approach for the addiction treatment community. In AW Graham & TK Schultz (eds.) Principles of Addiction Medicine, Second Edition. Gastfriend DR (1994). Medical Clinics of North America 81(4):945-966. Principles of Drug Addiction Treatment: A Research-Based Guide. Mee-Lee D (2001b). Many programs claim to provide individualized care, but how is the referring clinician to know that such care actually is provided? In this regard, the assessment and treatment of substance-related disorders is no different from biomedical or psychiatric conditions in which diagnosis or assessment and treatment is a mix of objectively measured criteria and experientially based professional judgments. In some cases, an individual is referred for treatment at a specific level of care and/or for a specific length of service (for example, an offender in the criminal justice system may be given a choice of a prison term or a fixed length of stay in a treatment center). Is there a withdrawal scale score available? This structure allows improved precision of description and better "inter-rater" reliability by focusing on five broad levels of care. A detailed discussion of the adolescent criteria is found in Section 13 of this text.) Dimension 1: Acute Intoxication and/or Withdrawal Potential. In the process of patient assessment, certain problems and priorities are identified as justifying admission to a particular level of care. Patients with Co-Occurring Mental Health Problems of Moderate to High Severity: Individuals who exhibit moderate to severe diagnosable Axis I or II disorders, who are not stable and require mental health as well as addiction treatment. The plan should be written so as to facilitate measurement of progress. Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. Does the patient feel coerced into treatment? The treatment is specific to mental and substance-related disorders; however, the skills of the interdisciplinary team and the availability of support services allow the conjoint treatment of any co-occurring biomedical conditions that need to be addressed. Journal of Studies on Alcohol 58:7-29. Treatment matching: Theoretic basis and practical implications. In contrast, diagnosis, program-driven treatment recognizes the primacy of the substance use disorder, but the diagnosis alone drives the treatment plan, rather than the specific assessed needs of the patient. No services are available the treatment of co-occurring mental health problems or diagnosable disorders. The assessment process for continued service or discharge/transfer is the same as for admission, with the reassessment of multidimensional severity determining the treatment priorities, intensity of needed services and the decision about ongoing level of care. A patient could begin at a more intensive level and move to a more or less intensive level of care, depending on his or her individual needs. Is there significant risk of severe withdrawal symptoms or seizures, based on the patient's previous withdrawal history, amount, frequency, and recency of discontinuation or significant reduction of alcohol or other drug use? Similarly, the first edition of the ASAM criteria "bundled" clinical services with environmental supports in fixed levels of care. Does the patient have supports to assist in ambulatory detoxification, if medically safe? For example, a patient who is assessed in Dimension 2 as hypertensive should be placed in a Level III.7 or Level IV program to stabilize his or her medical condition, before being transferred to a Level I program for treatment of the addictive disorder. Treatment for the mental and substance disorders is integrated (similar to a traditional "dual diagnosis" program). For example, a II.1 level of care provides a benchmark for intensity at the minimum description of Level II care (also see the Rapid Reference section of this text for a summary crosswalk of the levels of care). Washington , DC : American Psychiatric Press. Gregoire TK (2000). National Institute on Drug Abuse (NIDA) (1999). In outcomes-driven treatment, which is the newest approach, the promise of matching patients to treatment has yet to be fully realized. Presented at the CSAT TIP Meeting, April 21, 1994 . Are there transportation, child care, housing, or employment issues that need to be clarified and addressed? The patient demonstrates a response to treatment through new insights, attitudes and behaviors. To accomplish this, services must address major lifestyle, attitudinal, and behavioral issues that have the potential to undermine the goals of treatment or inhibit the individual's ability to cope with major life tasks without the non-medical use of alcohol or other drugs. (2001). The ASAM Criteria Assessment Interview Guide is the first publicly available, standardized version of The ASAM Criteria assessment and was developed by ASAM in collaboration with the University of California, Los Angeles Integrated Substance Abuse Programs (UCLA ISAP). In RW Pickens, CG Leukefeld & CR Schuster (eds.) Improving Drug Abuse Treatment (Research Monograph 106). The ASAM PPC-2R thus incorporates criteria that address the large subset of individuals who present for treatment with co-occurring Axis I substance-related disorders and Axis I/Axis II mental disorders. Level III encompasses organized services staffed by designated addiction treatment and mental health personnel who provide a planned regimen of care in a 24-hour live-in setting. (1997). Do any emotional, behavioral or cognitive problems appear to be an expected part of the addictive disorder, or do they appear to be autonomous? At what point is the patient in the stages of change? Dimension 6: Recovery Environment. In the current edition (ASAM PPC-2R), Level I has been expanded to promote greater access to care for dual diagnosis patients, unmotivated patients who are mandated into treatment, and others who previously only had access to care if they agreed to intensive periods of primary treatment. Such services adhere to defined sets of policies and procedures. If a patient has problems in Dimensions 4 and 5 that require 24-hour supervision and treatment interventions (such as boundary setting), without which treatment services cannot be effectively delivered, and/or the individual is in imminent danger, then the mere addition of room and board would be inadequate to meet the individual's needs. Fixed length of stay or program-driven treatment is not individualized and does not respond to the particular problems of a given patient. The ASAM Criteria assessment addresses the broad biological, psychological, and social factors that influence the patient's prognosis, evaluating the patient's needs related to substance use and co-occurring physical and mental health problems, as well as social and environmental factors that influence risk. Rockville , MD : National Institute on Drug Abuse. Psychotherapy 25:356-364. The appearance of new problems may require services that can be provided effectively at the same level of care, or transfer of the patient to a more or less intensive level of care. Level III encompasses four types of programs: Level III.1: Clinically Managed Low-Intensity Residential Treatment; Level III.3: Clinically Managed Medium-Intensity Residential Treatment; Level III.5: Clinically Managed High-Intensity Residential Treatment; and Level III.7: Medically Monitored Inpatient Treatment. It is most helpful if providers envision admitting the patient into the continuum through their program rather than admitting the patient to their program. Drug and Alcohol Dependence 55:35-43. Proceedings of the AAAP Tenth Annual Meeting & Symposium. The defining characteristic of all Level III programs is that they serve individuals who need safe and stable living environments in order to develop their recovery skills. Problems are identified and prioritized in the context of the patient's severity of illness and level of function. In N Miller (ed.) Principles of Addiction Medicine, First Edition. In the earliest such study (Plough, Shirley et al., 1996), counselors used a simple, one-page summary of the criteria. High Severity Disorders: Such persons present with schizophrenia-spectrum disorders, severe mood disorders with psychotic features, severe anxiety disorders, or severe personality disorders (such as fragile borderline conditions). Level II programs can provide comprehensive biopsychosocial assessments and individualized treatment plans, including formulation of problem statements, treatment goals and measurable objectives—all developed in consultation with the patient. A solution has been developed to address the problem of interviewer ease of use of criteria, and this solution has been tested in three prospective studies. There also have been two retrospective studies: one applied an abbreviated PPC-1 algorithm to telephone survey data (Morey, 1996), while the other implemented only the psychosocial dimensions (McKay, Cacciola et al., 1997). The ASAM Criteria and State Licensure or Certification. Determinants of chemical dependency treatment placement: Clinical, economic, and logistic factors. Assessment of Imminent Danger. The systems currently in use for billing, reimbursement, and funding would not support unbundled treatment. Nevertheless, the descriptions are not requirements and are not intended to replace or supersede the relevant statutes, licensure or certification requirements of any state. Logistical Impediments. National Institute on Drug Abuse (1999). In such situations, movement between levels might mean referring the patient out of the provider's own network of care. Heatherton B (2000). Are there current signs of withdrawal? Substance Use & Misuse 35(12-14):2191-2213. The goal that underlies the criteria is the placement of the patient in the most appropriate level of care. Several important principles have guided development of the ASAM criteria. Patient placement criteria: Linking typologies to managed care. If the patient has been prescribed psychotropic medications, is he or she compliant? Treatment Failure: Two incorrect assumptions are associated with the concept of "treatment failure." The first is that the disorder is acute rather than chronic, so that the only criterion for success is total and complete amelioration of the problem. Such a strategy potentially puts the patient at risk because it delays care at a more appropriate level of treatment, and potentially increases health care costs if restricting the appropriate level of treatment allows the addictive disorder to progress. If the criteria only covered the levels of care commonly reimbursable by private insurance carriers, they would not address many of the resources of the public sector and, thus, would tacitly endorse limitations on a complete continuum of care. Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications (diagnosable mental disorders or mental health problems that do not present sufficient signs and symptoms to reach the diagnostic threshold). The criteria are based in a philosophy that effective treatment attends to multiple needs of each individual, not just his or her alcohol or drug use. Addiction or mental health treatment personnel provide professionally directed evaluation, treatment and recovery service. References American Psychiatric Association (APA) (1994). Hoffmann NG, Floyd AS, Zywiak WH et al. Lee, LCSWCheryl Teruya, PhDDarren Urada, PhDElise Tran, BALarissa Mooney, MDTom Freese, PhDValerie P Antonini, MPHASAMDavid Mee Lee, MD, DFASAMDavid Gastfriend, MD, DFASAMCorey Waller, MD, MS, FACEP, DFASAMAnna Pagano, PhDPlease provide feedback on the Guide at asamcriteria@asam.org. Because it is paper-based, offered free to all clinicians, and can be used in many different clinical contexts, the Guide enhances the public utility of The ASAM Criteria's multidimensional assessment approach for the addiction treatment community. Rockville , MD : NIDA (NIH Publication # 99-4180). For programs that receive reimbursement from multiple payers, compare lengths of service with sources of payment. When logistical considerations are an impediment to the indicated services (for example, lack of available transportation is a barrier to a patient's access to an indicated outpatient program), an outpatient service combined with unsupervised/minimally supervised housing may be an appropriate treatment intervention. Patients may, however, worsen or fail to improve in a given level of care or with a given type of program. Factors associated with level of care assignment in substance abuse treatment. Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed because they create or complicate treatment? Plough A, Shirley L, Zaremba N et al. Controlling Cost and Changing Patient Care: The Role of Utilization Management. (1991). In such a case, the provider should make reasonable attempts to have the order amended to reflect the assessed clinical level or length of service. In the adult ASAM Placement Criteria, detoxification services can be provided at any of five levels of care. For example, when assessing an individual for severity, a history of moderate or severe withdrawal without any current intoxication or withdrawal, or current intoxication without a history of significant withdrawal problems should generate a lesser level of concern than a combination of a history of moderate or severe withdrawal with current symptoms of intoxication or withdrawal. Depending on the severity of their symptoms, such patients may require referral to medical and/or psychiatric services outside the ASAM PPC-2R levels of care (see Table 1). (Such a program is clinically inappropriate for dually diagnosed individuals.) Patients with Co-Occurring Mental Health Problems of Mild to Moderate Severity: Individuals who exhibit (1) sub-threshold diagnostic (traits, symptoms) Axis I or II disorders or (2) diagnosable but stable Axis I or II disorders (for example, bipolar disorder but compliant with and stable on medication). Progress Through the Levels of Care: As a patient moves through treatment in any level of care, his or her progress in all six dimensions should be continually assessed. Harrison PA, Hoffmann NG, Hollister CD et al. Assessment of risk should guide the decision. There are at least three efficient ways to determine whether a program is providing truly individualized treatment: 1. Project MATCH Research Group (1997). Are there current physical illnesses, other than withdrawal, that need to be addressed because they are exacerbated by withdrawal, create risk or may complicate treatment? Overall, the placement criteria are intended to enhance the efficient use of limited resources, increase patient retention in treatment, prevent dropout and relapse, and thus improve patient outcomes. The second assumption is that responsibility for treatment "failure" always rests with the patient (as in, "The patient was not ready"). Continuum of Care: In order to provide the most clinically appropriate and cost-effective treatment system, a continuum of care must be available. In rural and other underserved areas, options could include (1) the creation of a supervised housing situation by using unused treatment beds, (2) assertive community treatment models in which the treatment is brought to rural areas (such as Native American settlements) and provided in weekend intensive models at sites such as community centers and churches, (3) vans that are sent out to pick up patients and bring them to a treatment site, and (4) using a van or motor home as an office or group therapy room Need for a Safe Environment. For appropriately selected patients, such programs provide essential education and treatment components while allowing patients to apply their newly acquired skills within "real world" environments. Level II is an organized outpatient service that delivers treatment services during the day, before or after work or school, in the evening or on weekends. Through its six assessment dimensions, the ASAM criteria underscore the importance of multidimensional assessment and treatment (Figure 2). By expanding the criteria to incorporate outpatient care, especially for those in early stages of readiness to change, the ASAM criteria have helped to reduce waiting lists for residential treatment and thus have improved access to care. Assuring Individualized Treatment. Shulman, M.A., M.A.C., FACATA When considering treatment matching, treatment planning, and the use of patient placement criteria, certain distinctions and definitions must be clarified, particularly the distinction between "placement matching" and "modality matching." In placement matching, a patient is referred to a particular setting, such as intensive outpatient or residential care, while modality matching attempts to match a patient's needs to a specific treatment approach (such as motivational enhancement therapy), regardless of setting. Unique clinical presentations or extenuating circumstances require some flexibility in application of the criteria to ensure the safety and welfare of the patient. Morey LC (1996). (Note that the information given here is for the adult criteria only. A transition to unbundled treatment would require a paradigm shift in state program licensure and reimbursement. For example, significant problems with readiness to change (Dimension 4), coupled with a poor recovery environment (Dimension 6) or moderate problems with relapse or continued use (Dimension 5), may increase the risk of relapse. Such situations may require transfer to a specialized program at the same level of care or to a more intensive or less intensive level of care to achieve a better therapeutic response; and State laws regulating the practice of medicine or licensure of a facility that require the use of different criteria. Dual Diagnosis Enhanced (DDE): Psychiatric services are available on-site or closely coordinated; all staff are crosstrained in addiction and mental health disorders and are competent to understand and identify signs and symptoms of acute psychiatric conditions and to treat mental health problems along with the substance use disorders. Shulman GD (1993). Clinicians who make placement decisions are expected to supplement the criteria with their own clinical judgment, their knowledge of the patient, and their knowledge of the available resources. Broadening the Base of Treatment for Alcohol Problems. Such services are provided in regularly scheduled sessions and follow a defined set of policies and procedures or medical protocols. Addiction Only Services (AOS):Services are directed toward the amelioration of substance-related disorders. TABLE 1. Feasibility of multidimensional substance abuse treatment matching: Automating the ASAM Patient Placement Criteria. Report prepared for the State of Wisconsin under CSAT Contract 270-95-0023. (1999). The converse also is true. This change was made in recognition of the fact that, in the process of patient assessment, certain problems and priorities are identified as justifying admission to a particular level of care. The ASAM criteria identify the following problem areas (dimensions) as the most important in formulating an individualized treatment plan and in making subsequent patient placement decisions. Goals of Treatment: The goals of intervention and treatment (including safe and comfortable detoxification, motivational enhancement to accept the need for recovery, the attainment of skills to maintain abstinence, and the like.) determine the methods, intensity, frequency, and types of services provided. Such a plan should be based on a comprehensive biopsychosocial assessment of the patient and, when possible, a comprehensive evaluation of the family as well. Is the patient actively resisting treatment? Institute of Medicine (IOM) (1990). In search of how people change: Applications to addictive behaviors. In EC Ross (ed.) Managed Behavioral Health Care Handbook. Once stabilization has been achieved, the initial placement for recovery services should reflect an assessment of the patient's status in all six dimensions. ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition (ASAM PPC-2). Matching Patients with Co-Occurring Disorders to Services Addiction-Only Patients: Individuals who exhibit substance abuse or dependence problems without co-occurring mental health problems or diagnosable Axis I or II disorders. Understanding the ASAM Patient Placement Criteria The criteria also advocate for a system in which treatment is readily available, because patients are lost when the treatment they need is not immediately available and readily accessible. Individuals whose co-occurring mental disorders best fit within the category of moderate severity disorders are appropriately treated in programs designed to treat primary substance use disorders. Another commonly seen combination involves problems in Dimension 2 (such as chronic pain which distract the patient from the recovery process) coupled with problems in Dimensions 4, 5 or 6. Such living environments may be housed in the same facility where treatment services are provided or they may be in a separate facility affiliated with the treatment provider. The plan should list problems (such as obstacles to recovery, knowledge or skill deficits, dysfunction or loss), strengths (such as readiness to change, a positive social support system, and a strong connection to a source of spiritual support) and priorities (such as obstacles to treatment and risks, identified within the list of problems and arranged according to severity), goals (a statement to guide realistic, achievable, short-term resolution or reduction of the problems), methods or strategies (the treatment services to be provided, the site of those services, the staff responsible for delivering treatment), and a timetable for follow-through with the treatment plan that promotes accountability. Exceptions to the Patient Placement Criteria. In a departure from earlier editions, the current edition of the criteria (ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised [ASAM PPC-2R]; Mee-Lee, Shulman et al., 2001) contains only admission criteria, leaving the decisions about continued service, transfer, or discharge to general guidelines and the judgment of the treatment professional. Persons with addictive disorders, system failures, and managed care. The resolution of those problems and priorities determines when a patient can be treated at a different level of care or discharged from treatment. Even those using the ASAM criteria regularly encounter "real world" dilemmas surrounding access, reimbursement, funding, resource allocation, and availability of services, particularly for patients with co-occurring medical or psychiatric disorders. How severe are the problems and further distress that may continue or reappear if the patient is not successfully engaged in treatment at this time? Specific criteria, organized by drug class (alcohol, sedative-hypnotics, opioids, et al.) guide the decision as to which detoxification level is safe and efficient for a patient in withdrawal. Does the patient appear to be compliant only to avoid a negative consequence, or does he or she appear to be internally distressed in a self-motivated way about his or her alcohol or other drug use or mental health problem? Mutual and self-help group meetings generally are available on-site. It consists of a comprehensive implementation designed by Gastfriend and his associates to offer the counselor a sequence of questions and scoring options on the screen of a microcomputer (Turner, Turner et al., 1999). Clinical reality suggests that programs and practitioners who are committed to meeting the total needs of the patients they serve must be able to meet the needs of these "dual diagnosis" patients. Level III: Residential/Inpatient Treatment. Gastfriend DR, Najavits LM & Reif S (1994). When this happens, changes the level of care or program should be based on a reassessment of the treatment plan, with modifications to achieve a better therapeutic response. The process of matching patients to treatment services has evolved through at least four approaches, each with a fundamentally different philosophy (Mee-Lee, 2001). The goals for each problem may need to be reviewed from the standpoint of resolution of the acute crisis and/or alteration of the course of the chronic illness. Placement Matching: Challenges and Technical Progress. Prochaska JO, DiClemente CC & Norcross JC (1992). Complications-driven treatment gives only cursory attention to the diagnosis of substance use disorder. Such programs typically have active affiliations with other levels of care, and their staff can help patients access support services such as child care, vocational training and transportation. Today, however, there is increasing recognition that clinical services can be and often are provided separately from environmental supports. A variety of treatment agencies will need to make this shift, including regulatory agencies, clinical and medical staff, and referral sources (such as courts, probation officers, child protective services, employers, and employee assistance professionals (Heatherton, 2000). In terms of treatment, there would no longer be "programs" but rather a constellation of services to meet the needs of each patient. When placement matching is disconnected from modality matching, treatment is likely to be less effective because it fails to respond to the individual needs of the patient. When a patient lives in a recovery environment that is so toxic as to preclude recovery efforts (as through victimization or exposure to an active addict) and a Level I or II outpatient service is indicated, the patient may need referral to a safe place to live while in treatment, as well as to treatment itself. Dual Diagnosis Capable (DDC): The primary focus is on substance use disorders, but the program is capable of treating patients with sub-threshold or diagnosable but stable Axis I or II disorders. NADCP is pleased to share a new resource for treatment providers from the American Society of Addiction Medicine (ASAM): a paper-based interview guide to support more consistent and effective implementation of The ASAM Criteria. With unbundling, the type and intensity of treatment are based on the patient's needs and not on limitations imposed by the treatment setting. The ASAM criteria offer a system for improving the "modality match" through the use of multidimensional assessment and treatment planning that permits more objective evaluation of patient outcomes. Is the patient in immediate danger of continued severe mental health distress and/or alcohol or drug use? Level 0.5: Early Intervention. The gastritis or bleeding esophageal varices are controlled; the depression is medicated; fractures are splinted or pinned, but care for the addictive disorder is superficial or non-existent. In this approach, rather than actively treating the primary alcohol or other drug disorder that is causing the patients symptoms, only the secondary complications or sequelae are addressed. Patients whose biomedical or psychiatric disorders are so severe that stabilizing them is the highest priority are most appropriately treated in a medical or psychiatric facility or unit before addiction treatment is initiated. Selecting an Appropriate Treatment Evolving Approaches to Treatment Matching. Objectivity. Addiction treatment programs have as their goal not simply stabilizing the patient's condition, but altering the course of the patient's disease. Does the patient have any recognition or understanding of, or skills in, coping with his or her addictive or mental disorder in order to prevent relapse, continued use or continued problems such as suicidal behavior? Is the patient able to manage the activities of daily living? Many providers of treatment services offer only one of the many levels of care described. Good treatment planning thus combines modality matching (for all pertinent problems and priorities identified in the assessment) with placement matching (which identifies the least intensive level of care that can safely and effectively provide the resources that will meet the patient's needs (Mee-Lee, 1998). CSAT Target Cities Demonstration Final Evaluation Report. Kansas City , MO : AmericanAcademy of Addiction Psychiatry, 19-20. Is there leverage for change available? Has the patient been using multiple substances in the same drug class? Each time the patient's response to treatment is assessed, new priorities for recovery are identified. If the patient has another chronic disorder (e.g., diabetes), what is the history of compliance with treatment for that disorder? In making treatment placement decisions, three important factors override the patient-treatment match with regard to levels of care: 1. The results suggested that use of even a primitive version of the ASAM criteria is associated with improved treatment retention. ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition-Revised (ASAM PPC-2R).Chevy Chase , MD : American Society of Addiction Medicine. ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition-Revised (ASAM PPC-2R). Not all of these services are available in all locations, nor are they covered by all payers. Mee-Lee D, Shulman GD, Fishman M et al. Rockville , MD : NIDA, National Institutes of Health. This information should be useful to providers who are preparing to serve a particular group of patients, as well as to clinicians who are making placement decisions. Moreover, while the levels of care are presented as discrete levels, in reality they represent benchmarks or points along a continuum of treatment services that could be used in a variety of ways, depending on a patient's needs and response. Chevy Chase , MD : American Society of Addiction Medicine. Treatment services are matched to the patient's needs over a continuum of care (Shulman, 1994). Take 10 closed clinical case records and compare the treatment plans. Are there chronic conditions that affect treatment? Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). Are there legal, vocational, social service agency or criminal justice mandates that may enhance the patient's motivation for engagement in treatment? 3. Review the progress notes and determine whether they relate back to the objectives or strategies to the treatment plan. Mee-Lee D (1994). In cities or towns, such a domiciliary option might be found in a group living situation (such as a Salvation Army program, motel accommodations, YMCA/YWCA or mission). Mee-Lee D (2001a). Unbundling is a practice that allows any type of clinical service (such as psychiatric consultation) to be delivered in any setting (such as a therapeutic community). Psychiatric services are available on-site or by consultation; at least some staff are competent to understand and identify signs and symptoms of acute psychiatric conditions. Level IV programs provide a planned regimen of 24-hour medically directed evaluation, care and treatment of mental and substance-related disorders in an acute care inpatient setting. Those with concurrent high severity mental disorders, on the other hand, generally are best managed in dual diagnosis specialty programs that can offer integration mental health and addiction treatment approaches. That is, they involve the same type of multidimensional assessment process that led to admission to the current level of care. Journal of Addictive Diseases 17(2):77-91. Indeed, many managed care companies and public treatment systems are suggesting that treatment modality and intensity be "unbundled" from the treatment setting. Boston , MA : Office for Treatment Improvement. While fixed length of stay programs are more convenient and predictable for the provider, they may be less effective for individuals. This knowledge then forms the basis for the clinician and patient participating together in establishing a mutually agreeable treatment plan. Copyright 2003; all rights reserved. Level I: Outpatient Treatment. Placement matching: Challenges and technical progress. (1988). Download Guide & Print Download Fillable Guide Read Project Announcement What is the ASAM Criteria®The ASAM Criteria defines the standards for conducting a comprehensive biopsychosocial assessment to inform patient placement and treatment planning. Formal research into the criteria also is encouraged. Programs have the capacity to arrange for medical and psychiatric consultation, psychopharmacological consultation, medication management, and 24-hour crisis services. Institute of Medicine (IOM) (1989). (1995). While lack of reimbursement for some levels of care, or lack of availability of other levels of care may render this impossible at present, the goal of these criteria is to stimulate the development of effective services that can be made available to all patients. New York , NY : Guilford Press, 1991. Motivational Interviewing: Preparing People to Change Addictive Behavior. The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders (Treatment Improvement Protocol No. 13). Mental Health Assessment and Diagnosis of Substance Abusers (Clinical Report Series). Use of patient placement criteria in the selection of treatment. Anticipated problems facing ASAM patient placement criteria. Interactions Across Dimensions in Assessing for Level of Care. Journal of Substance Abuse Treatment 18:241-248. How ready is the patient to change? All of these obstacles are reasons for delaying an abrupt change to the new paradigm, but the ASAM criteria encourage exploration of unbundling by suggesting ways to match risk and severity of needs with specific services and intensity of treatment. Principles Guiding the Criteria. The ASAM criteria contain descriptions of treatment programs at each level of care, including the setting, staffing, support systems, therapies, assessments, documentation, and treatment plan reviews typically found at that level. The ASAM criteria are not intended as a reimbursement guideline, but rather as a clinical guideline for making the most appropriate placement recommendation for an individual patient with a specific set of symptoms and behaviors. (2003). If the reviewer cannot clearly distinguish patients by their treatment plans, the treatment is not individualized.

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