ASAM

American Society *of* Addiction Medicine

ASAM, founded in 1954, is a professional medical society representing over 7,000 physicians, clinicians and associated professionals in the field of addiction medicine. ASAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction.

ASAM Criteria

An Evidence Based Approach to Co-Occurring Treatment

AMERICAN SOCIETY OF ADDICTION MEDICINE
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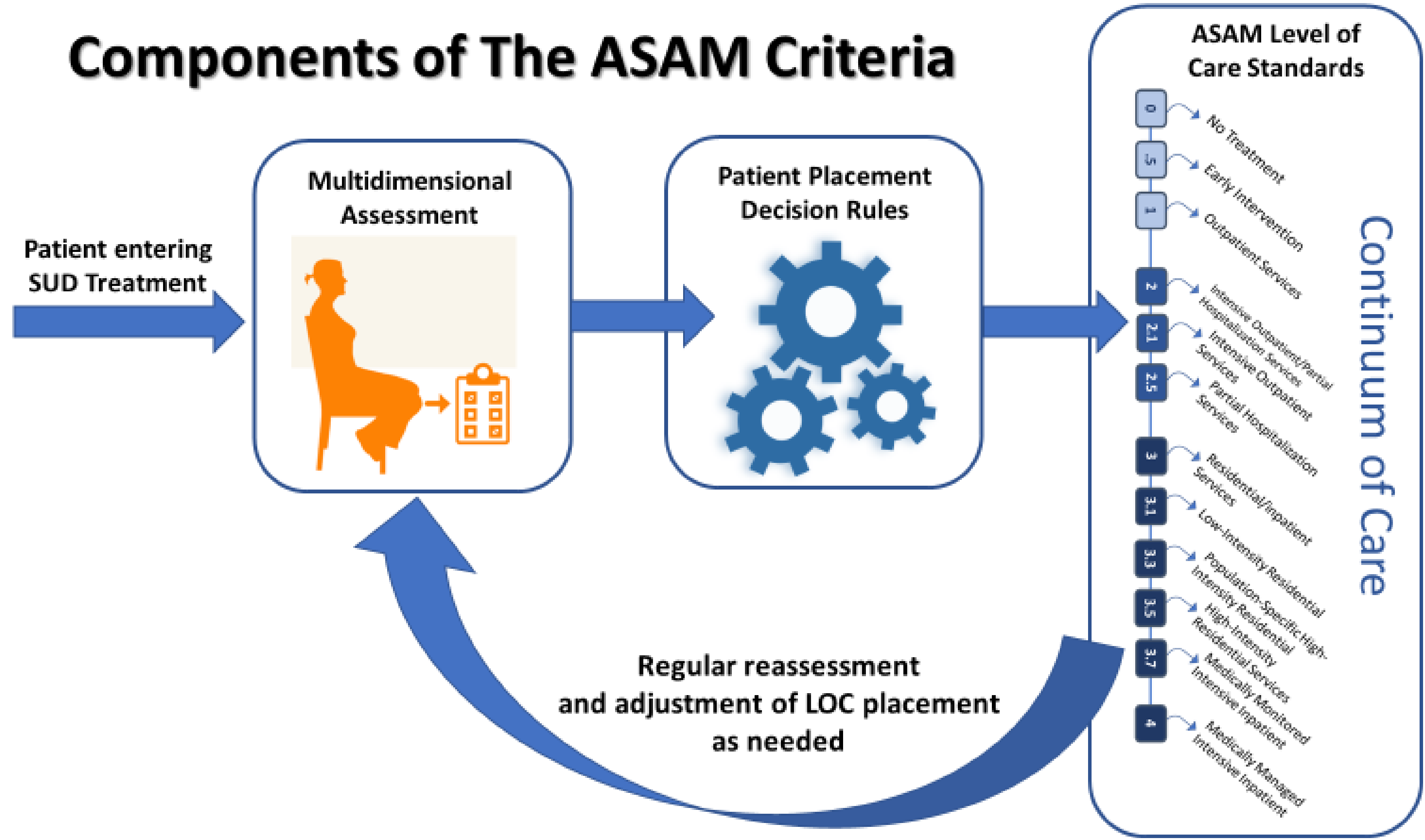
SPEAKER

Dr. Orlando Wright is a behavioral scientist who holds a Master of Social Work from the University of Connecticut and a Ph.D. in Advance Studies in Human Behavior from Capella University. Dr. Wright is the Director of Partnerships and Innovation at the American Society of Addiction Medicine (ASAM) where he oversees national partnerships with commercial and Medicaid payers, states, and other public entities. 20 + years of experience in management, clinical service delivery, complex behavioral health systems, & dynamic partnership development.

ORLANDO WRIGHT, PHD, LCSW-C

Director, Partnerships & Innovation


Components of The ASAM Criteria
Patient entering SUD Treatment
Multidimensional Assessment
Patient Placement Decision Rules
ASAM Level of Care Standards
0
No Treatment
.5
Early Intervention
1
Outpatient Services
2
Intensive Outpatient/Partial Hospitalization Services
2.1
Intensive Outpatient Services
2.5
Partial Hospitalization Services
3
Residential/Inpatient Services
3.1
Low-Intensity Residential
3.3
Population-Specific High-Intensity Residential
3.5
High-Intensity Residential Services
3.7
Medically Monitored Intensive Inpatient
4
Medically Managed Intensive Inpatient
Continuum of Care
Regular reassessment and adjustment of LOC placement as needed

Fourth Edition

1. Intoxication, Withdrawal, and Addiction Medications
2. Biomedical Conditions
3. Psychiatric and Cognitive Conditions
4. Substance Use Related Risks
5. Recovery Environment Interactions
6. Person-Centered Considerations

Person-centered care

Dimension 1: Document rationale based on clients needs in this dimension
Subdimensions: Intoxication & associated, acute withdrawal & associated risks

Dimension 2: Document rationale based on clients needs in this dimension
Subdimensions: **Physical Health Concerns (Including Pain), Pregnancy-related Concerns**

Dimension 3: Document rationale based on clients needs in this dimension
Subdimensions: **Active Psychiatric Symptoms, Persistent Disability**

Dimension 4: Document rationale based on clients needs in this dimension
Subdimensions: **Likelihood of Engaging in Risky Substance Use, Likelihood of Engaging in Risky SUD-related Behaviors**

Dimension 5: Document rationale based on clients needs in this dimension
Subdimensions: **Ability to Function Effectively in Current Environment, Safety in Current Environment, Support in Current Environment**

Dimension 6: Document rationale based on clients needs in this dimension
Subdimensions: **Barriers to Care, Individual Preferences, Need for Motivational Enhancement**

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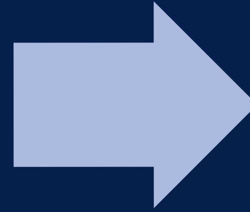
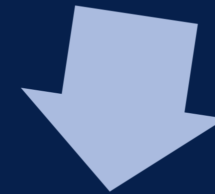
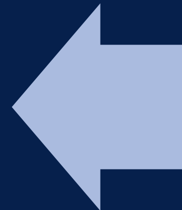
Screening, identifying, and documenting the presence of any co occurring psychiatric concerns, whether or not the individual has a related psychiatric diagnosis based on ASAM Multidimensional assessment



Treatment planning should be individualized using S.M.A.R.T goals & objectives



Explore barriers to treatment and/or the need for motivational enhancements/use Harm Reduction techniques



Document rationale for acuity and severity of impairment using a six dimensions outline

Screening

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: ______________________ DATE:____________

Over the last 2 *weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more	0	1	2	3

GAD-7 Anxiety

Over the <u>last two weeks</u>, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _______

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

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Harm Reduction Principles

Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe use to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others

Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm

Affirms people who use drugs (PWUD) themselves as the primary agents of reducing the harms of their drug use and seeks to empower PWUD to share information and support each other in strategies which meet their actual conditions of use

Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with illicit drug use

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Case Example

Reason for referral

Following a recent outburst with a co-worker, Angela has been referred to a counselor. The 46-year-old works as a manager of a restaurant and remarks that her job causes her a great deal of stress, but "that's the job." Angela lives with her 20-year-old daughter, whom she has raised by herself for the past ten years following separation and eventual divorce from her daughter's father.

History of Presenting Illness

Angela takes risperidone and valproic acid for bipolar disorder, which she was diagnosed with ten years ago after "three waves of getting high playing the market and then getting really depressed when [she] lost." She admits that her impulsivity with the stock market has "eaten away at" her savings. Her 20-year-old daughter lives with her while attending the local state university because Angela "can't afford" to pay for tuition elsewhere.

Angela has attempted suicide three times over the past seven years. Her first attempt seven years ago went unreported, but two more recent attempts—four years ago and, most recently, ten months ago—required hospitalization.

Presently, Angela smokes cigarettes (with a 40 pack-year history), consumes one to two alcoholic drinks per week, and smokes methamphetamine two to three times per week. She notes that she has used methamphetamine "on-and-off for the past 15 years." Angela also acknowledges experimenting with cocaine and marijuana in high school but denies any further use. She reports no other substance use, current or historical.

Angela's husband left her ten years ago, citing drug use and domestic violence. This prompted her to seek treatment for her methamphetamine use; however, she left the residential treatment facility after one week due to feelings of shame around the intensity of her cravings. She has not sought any other treatment for her substance use in the intervening decade.

Angela has a broad affect and is cooperative with the interview. Cognitive screening shows deficits in episodic memory and executive function—specifically, working memory, cognitive flexibility, inhibitory control, and sustained attention—as well as increased suicidality.

S.M.A.R.T Treatment Planning

Draw upon the individual's strengths to build an attainable treatment plan

Specific

Measurable

Attainable

Relevant

Time-based

Dimensional Drivers

- Dimension 3: Psychiatric and Cognitive Conditions
  - Active psychiatric symptoms
  - Longstanding diagnosis of bipolar disorder treated with risperidone and valproic acid
  - Current increased suicidal ideation with three prior suicide attempts, two of which required hospitalization
  - Recent verbal outburst with a professional client and history of domestic violence toward her ex-husband
- Persistent disability
  - Impulsivity affecting personal finances
  - Deficits in episodic memory and executive function—specifically, working memory, cognitive inflexibility, inhibitory control, and sustained attention—on cognitive screening

- She has a multitude of **strengths or protective factors**. They include:

  - Being in the Action stage of change
  - Steady employment
  - Financial stability
  - Awareness of substance use issues
  - Stable and supportive family
  - Desire to pursue clear goals Setting and pursuing goals
  - Faith
  - Connected to her daughter

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What to document?

Dimensional Admission Criteria

Dimension 1 minimal

- No withdrawal risk, minimal intoxication risk = x.7 not necessary

Dimension 2

- No identified concerns

Dimension 3 is the dimensional driver—necessitates COE

- Diagnosed severe mental illness requiring psychotropic medication management
- Suicidal ideation with past attempts
- Impulsivity affecting personal finances and home life (domestic violence toward ex-husband) and possibly now creeping into professional life (outburst with client)
- Cognitive screening— Deficits in episodic memory and executive function—specifically, working memory, cognitive inflexibility, inhibitory control, and sustained attention

Dimension 4 minimal

- Methamphetamine and alcohol—long-term weekly use but not daily suggests fair self-management skills
- Some recognition and understanding of SUD impact—sought treatment in response to husband leaving
- Tobacco—negative but not dangerous consequences

Dimension 5

- No specific needs, high functioning in professional life

Dimension 6

- Risk of interference with career may motivate toward readiness

Document rationale based on clients' dimensional needs

Implementation of a treatment modality

Patient's response to mental health and SUD treatment in each note

Subsequent responses to continued stay or transfer

The use of instruments [i.e. GAD 7, PHQ , CIWA-AR, COWS)

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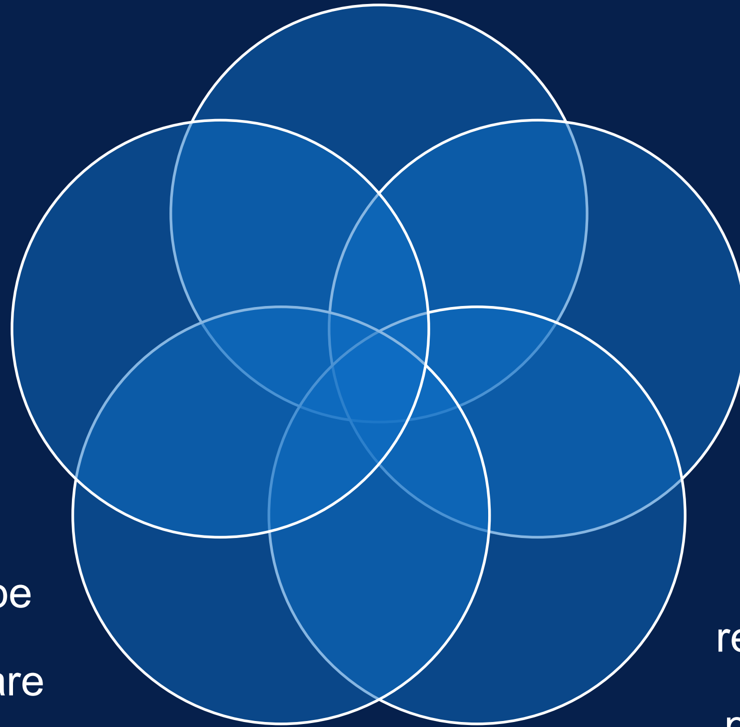
Documentation should include sufficient clinical detail to justify the Risk Ratings, including:

which Dimensional Admission Criteria were met within each subdimension for the requested level of care,

which concerns represent Dimensional Drivers for the patient's admission to the requested level of care,

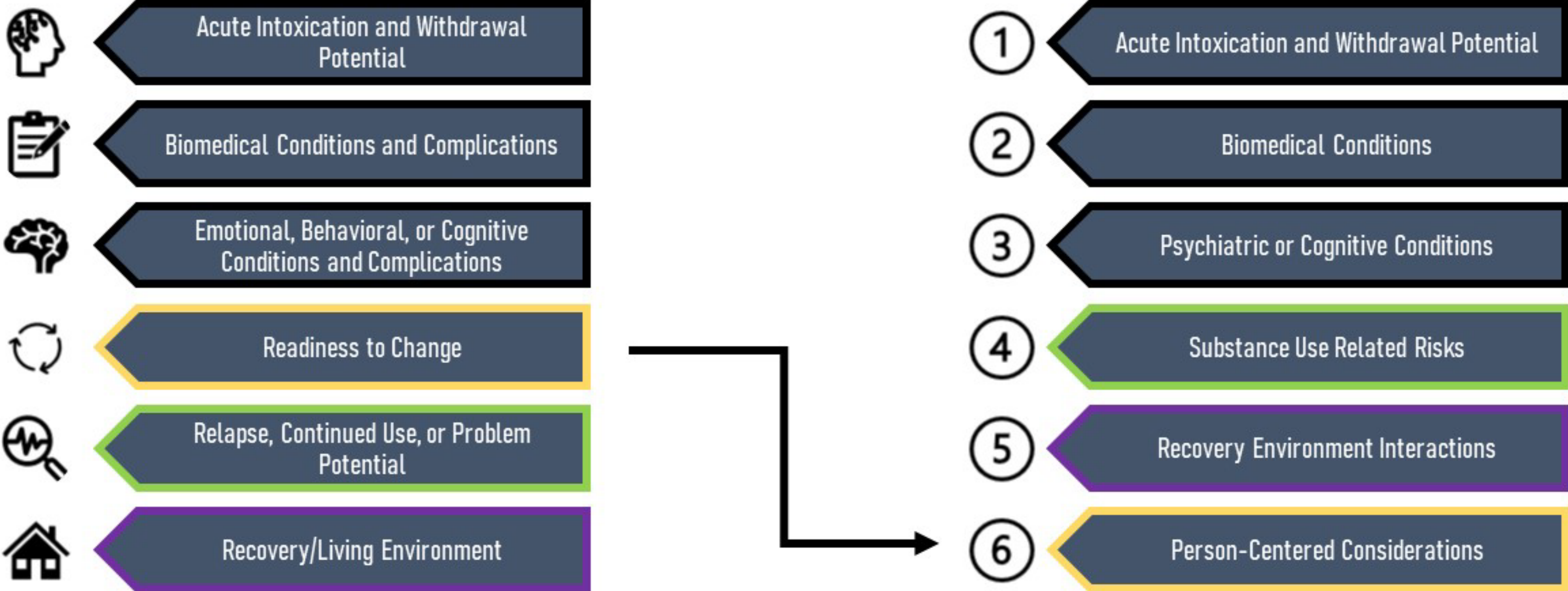
which services will be provided in the requested level of care to address the identified Dimensional Drivers, and

what the anticipated timeline to see progress could be.



Changes in the 4th edition

DIMENSIONS



ASAM CARE CONTINUUM

The ASAM Care Continuum for Addiction Treatment – Adult

Level			
Level 4 – Inpatient			4 Medically Managed Inpatient
Level 3 – Residential	3.1 Clinically Managed Low-Intensity Residential	3.5 Clinically Managed High-Intensity Residential	3.7 Medically Managed Residential (+BIO)
Level 2 – Intensive Outpatient/HIOP	2.1 Intensive Outpatient	2.5 High Intensity Outpatient	2.7 Medically Monitored Intensive Outpatient
Level 1 – Outpatient	1.0 Long term remission monitoring	1.5 Outpatient Therapy	1.7 Medically Monitored Outpatient

References

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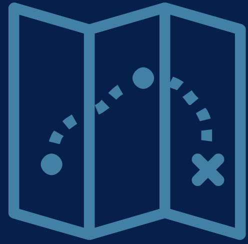

ADDRESS

11400 Rockville Pike,
Suite #200
Rockville, MD 20852

PHONE

Phone: (301) 547-4138
Fax: 301-656-3815

ONLINE

www.ASAM.org