ASAM Levels of Service

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Outline

- Overview of ASAM Treatment Criteria
- Levels of Treatment & Assessment Criteria
- Red Flags
- Context for individuals in criminal justice system
- Screening tools

ASAM

- American Society of Addiction Medicine
- Founded in 1954

ASAM Treatment Criteria

- Formerly known as “patient placement criteria (PPC)”
- The result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-orientated and results-based care in the treatment of addiction.

Overview

- The criteria have become the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.
- ASAM's criteria are required in over 30 states.

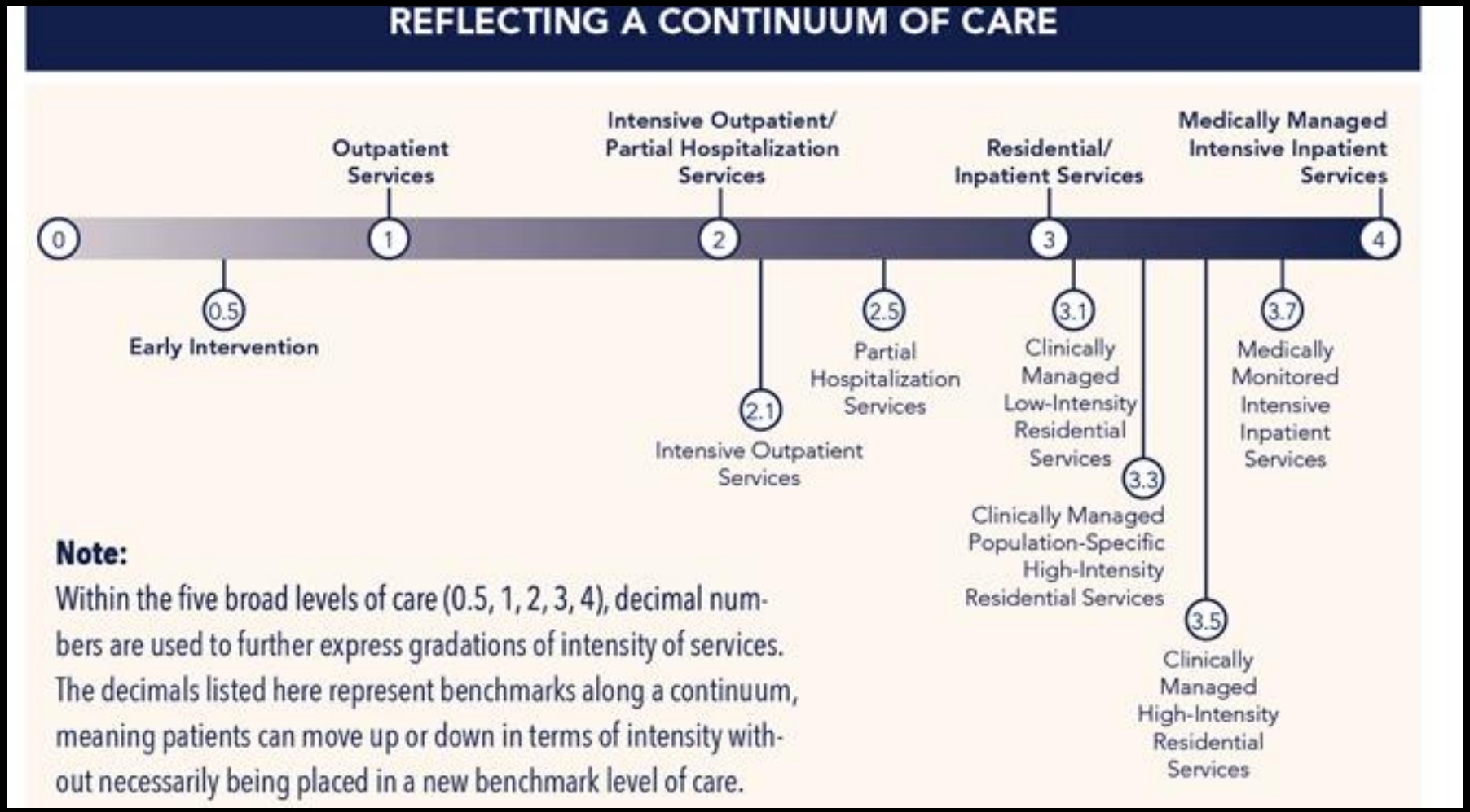
Overview

- New version published in 2013
- Separate placement criteria for adolescents and adults
- Used to create an individual's treatment plan
- Assesses an individual over 6 dimensions to determine ASAM treatment placement

Methods to Use ASAM Criteria

- Book ($95)
- Continuum (Computer Guided interview): produces 3-5 page report
- eTraining ($25-$7400)
- DMHA: In process of developing a crosswalk between CANS/ANSA and ASAM

5 Broad Levels of Treatment



Withdrawal Management

- 1-4 WM
- Ambulatory w/wo onsite monitoring
- Clinically managed residential (24 hour support)
- Medically monitored (24 hour nursing care)
- Medically managed (24 hour nursing, daily physician)

Risk Rating Matrices

- Pp 147-164
- Broken down according to alcohol, sedative hypnotics, opioids
- Generate Risk Rating and then that maps onto Service needs/level of care
- Tobacco, marijuana, stimulants mentioned as mainly WM Level 1
- Examples provided: Suggest trying lower levels first

ASAM on 12-step, peer support, self-help

- AA etc are not formal treatment programs
- Value as lifelong support systems
- Many providers integrate these modalities into all levels of care
- Viewed as adjunct to treatment

Definition of Terms

- **Clinically managed:** Directed by non physician addiction specialist rather than medical personnel. Appropriate for individuals whose primary problems involve emotional, behavioral, cognitive, readiness to change, relapse or recovery environment concerns. Intoxication/withdrawal/biomedical concerns are all minimal if they exist at all.
- **Medically Monitored:** Services provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialist and other health and technical personnel under the direction of a licensed physician. Medical monitoring is provided through appropriate mix of direct patient contact, review of records, team meetings, 24 hour coverage by a physician and a quality assurance program.
- **Medically Managed:** Services that involve daily medical care, where diagnostic and treatment services are directly provided an/or managed by an appropriately trained and licensed physician.

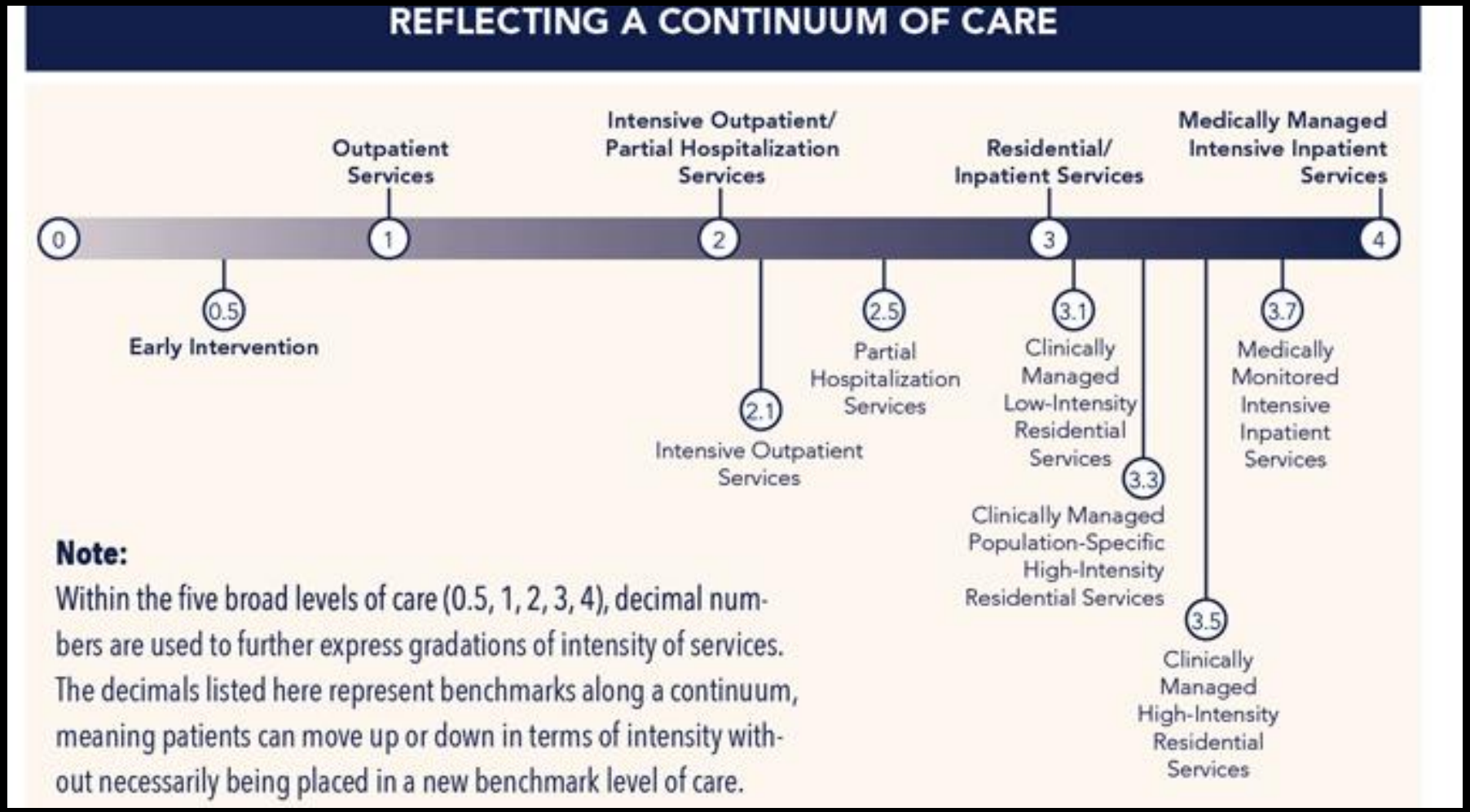
ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:

1	DIMENSION 1	**Acute Intoxication and/or Withdrawal Potential** Exploring an individual's past and current experiences of substance use and withdrawal
2	DIMENSION 2	**Biomedical Conditions and Complications** Exploring an individual's health history and current physical condition
3	DIMENSION 3	**Emotional, Behavioral, or Cognitive Conditions and Complications** Exploring an individual's thoughts, emotions, and mental health issues
4	DIMENSION 4	**Readiness to Change** Exploring an individual's readiness and interest in changing
5	DIMENSION 5	**Relapse, Continued Use, or Continued Problem Potential** Exploring an individual's unique relationship with relapse or continued use or problems
6	DIMENSION 6	**Recovery/Living Environment** Exploring an individual's recovery or living situation, and the surrounding people, places, and things

The Differences Between Inpatient, Residential and Outpatient with Supportive Living

Inpatient	Residential	O.P. w/Supportive Living
Provides 24-hour structure & support Provides 24-hour access to medical & nursing services Patients in "Imminent Danger"	Provides 24-hour structure & support (except 3.1<24 hrs) Primary medical services not necessary Patients in "Immienent Danger" (except 3.1)	Provides structure & Support Primary medical services not necessary Patients not in "Imminent Danger"

5 Broad Levels of Treatment

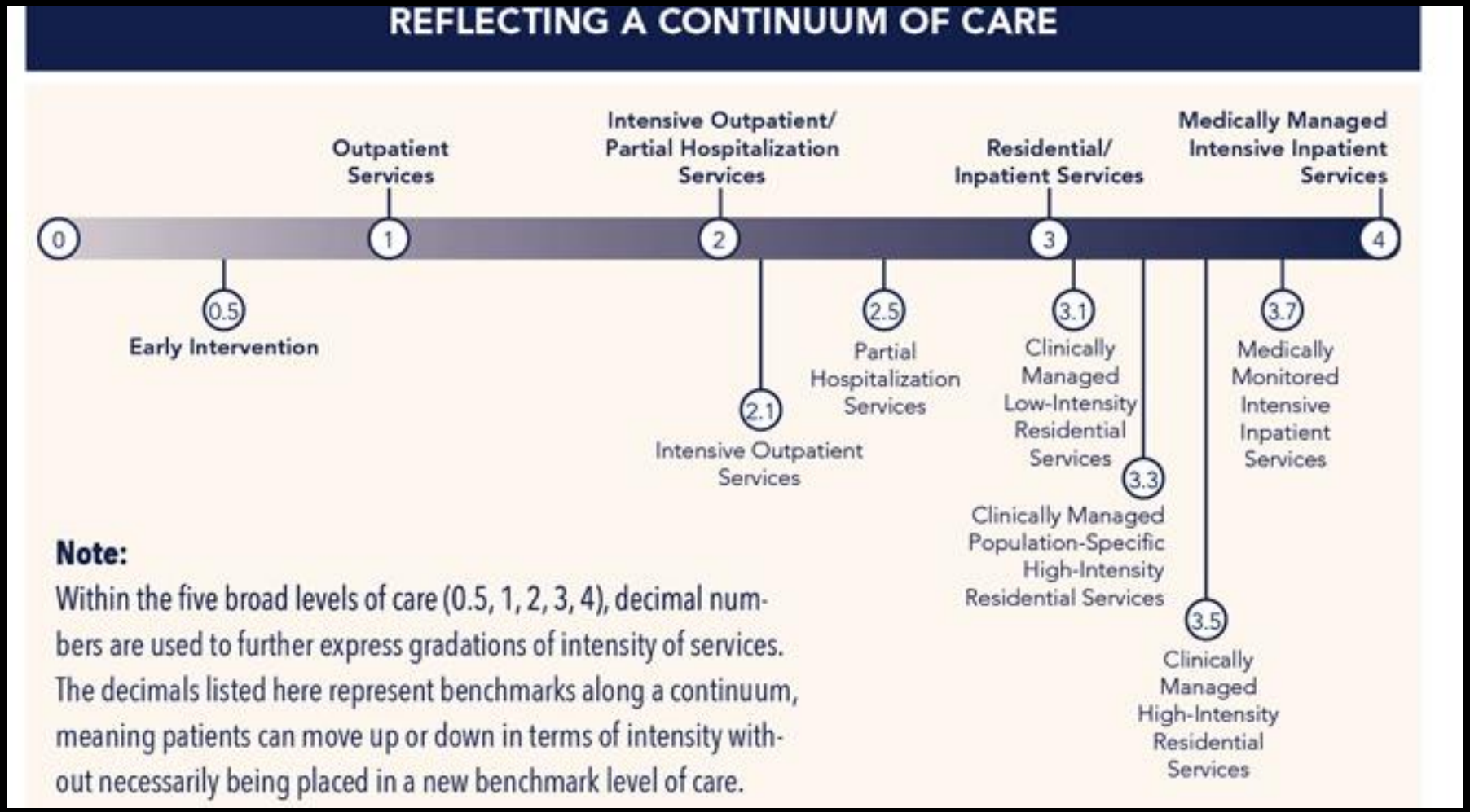


Level 0.5 is NOT a level of care or treatment but the combination of psycho-education and assessment. If the assessment indicates the need for treatment, the individual may receive treatment at the conclusion of the 0.5 service or concurrently
(examples: SBIRT in PCP office, DUI course)

Outpatient Levels of Care & Services

- Level 0.5- Early Intervention
- Level 1- Outpatient
  - Less that 9 contact Hours/Week
- Level 2- Intensive Outpatient/Partial Hospitalization
  - Level 2.1 IOP- 9 or More Contact Hours/Week in a *Structured P*rogram (6 hrs. for adolescents)
  - Level 2.5 PHP- 20 or More Contact Hours/Week in a *Structured* Program

5 Broad Levels of Treatment



Residential/Inpatient Levels of Care

- Level 3: Residential/Inpatient Services: Serve individuals who need safe and stable living environments
  - Level 3.1- Clinically Managed Low-Intensity Residential Services (*e.g., halfway house*)
  - Level 3.3- Clinically Managed Medium- Intensity residential Services (*e.g., Therapeutic Rehabilitation Facility*): Focus on individuals with cognitive impairments, not adolescents
  - Level 3.5- Clinically Managed High-Intensity Residential Services (*e.g., Therapeutic Community, Residential Treatment Center*) Can include adolescents
  - Level 3.7- Medically Monitored Intensive Inpatient Treatment, can include adolescents
- Level 4: Medically Managed Intensive Inpatient Treatment

Options for Withdrawal Management (Detoxification) Services

- Level 1: Ambulatory Detoxification without Extended On-site Monitoring (e.g., physician office practice/home health care)
- Level 2: Ambulatory Detoxification with Extended On-site Monitoring (e.g., detoxification on partial hospitalization program)
- Level 3: Residential/Inpatient Detoxification
  - Level 3: Clinically Managed Residential Detoxification (e.g., social detox)
  - Level 3: Medically Monitored Inpatient Detoxification
- Level 4: Medically Managed Inpatient Detoxification: 24 hour medically directed evaluation, care and treatment in acute care inpatient.
- OTP: Severe OUD

Withdrawal Types

- Potentially Dangerous/Life Threatening:

Alcohol

Benzodiazepines

- Uncomfortable:

Opioids

Nicotine

- Minor:

Cannabis

Cocaine

Individualized Treatment

- The four P's
  - Patient/Participant Assessment
  - Problems/Priorities
  - Plan
  - Progress
- Match *Severity or Level of Functioning* (Assets and Obstacles to Improvement) With *Intensity of Service* (Treatment Modalities, Strategies and Site of Care)

Level of Care Placement after relapse
should be based on an assessment of history and “here & now” and
<u>NOT</u>
on the assumption that if a patient relapsed after having been treated, then the previous level of care was not intense enough!

Red Flags

- Imminent Danger
- Immediate Need

“Imminent Danger”

1. A strong probability that certain behaviors will occur (e.g., continued alcohol or drug use or relapse or non-compliance with psychiatric medications)
2. The likelihood that these behaviors will present a significant risk of serious adverse consequences to the individual and/or others (as in a consistent pattern of driving while intoxicated)
3. The likelihood that such adverse events will occur in the very near future

In order to constitute “imminent danger” ALL THREE ELEMENTS must be present

Immediate Need Profile

Dimension #1: Acute Intoxication/Withdrawal Potential:

(a) Have you ever has life-threatening withdrawal signs or symptoms? ___ No ___Yes

(b) If yes, are you currently having similar withdrawal symptoms? ___No ___Yes

Dimension #2: Biomedical Conditions and Complications:

Do you have any current, untreated severe physical problems? ___No ___Yes

Dimension #3: Emotional/Behavioral Conditions & Complications:

Do you feel that you are imminently in danger and could harm yourself or someone else? ___No ___Yes

Immediate Need Profile (con' t)

Dimension #4: Treatment Acceptance/Resistance:

(a) Do you feel that you are in immediate need of alcohol/drug treatment? __No __Yes

(b) Have you been referred or required to have an assessment and/or enter treatment by the criminal justice system, health or social services, work/school, or family/significant other? __No __Yes

Immediate Need Profile (con' t)

Dimension #5: Relapse/Continued Use Potential

(a) Are you currently under the influence? __No __Yes

(b) Are you likely to continue use of alcohol and/or other drugs, or to relapse, in an imminently dangerous manner? __No __Yes

Dimension #6: Recovery Environment:

Are there any dangerous family, significant others, living/working situations threatening your safety, immediate well-being and/or sobriety? __No __Yes

Responses to Immediate Need Profile

<u>Yes to Dimension 1, 2, and/or 3 Questions:</u>

Requires that the caller/client immediately receive medial or psychiatric care

<u>Yes to Dimension 4 Alone:</u>

Caller/client to be seen for an assessment within 48 hours, and perferably earlier, for motivational strategies, unless patinet imminently likely to walk out and needs containment strategies

<u>Yes to Dimension 5, Question (a):</u>

Requires the caller/client receive assessment for withdrawal potential

<u>Yes to Dimension 5 and/or 6 without Yes in Dimensions 1, 2, and/or 3:</u>

Requires the caller/client be referred to a safe or supervised environment

- ASAM recommends starting with lower levels of intensity and moving to higher levels
- We estimate that many people with OUD, arguably the majority, will be appropriate for less intensive levels of care such as outpatient.

When should people be treated with regard to opioid withdrawal?

- Buprenorphine cannot be started until at least mild withdrawal is present (possibly even more severe if long acting opioids have been used)
- Naltrexone cannot be initiated until no opioid use has taken place for approximately 7 days, ideally in a confined unit
- However, opioid withdrawal is inevitable with moderate-severe OUDs, so if the clinical picture is such that the person clearly has an OUD, admission is warranted before withdrawal is present. If the diagnosis is uncertain, it may be necessary to confirm with withdrawal (rare).
- We want to “strike while the iron is hot” to begin treatment when people are motivated.

Note on alcohol/benzodiazepine

- We do not want to wait until withdrawal is severe, especially in individuals with prior withdrawal.

How to access care?

- 211
- Open Beds
- Managed Care: Care Managers