

**Training of Trainers: Helping Improve Skills in Assessment, Treatment Planning and  
Application of the Revised ASAM Criteria (ASAM PPC-2R), Including  
Criteria for Co-Occurring Mental and Substance-Related Disorders**

David Mee-Lee, M.D. Davis, CA  
(530) 753-4300; Voice Mail (916) 715-5856  
DAVMEELEE@aol.com www.DMLMD.com

February 13-14, 2007 Oklahoma City, OK

**A. Train the Trainers**

- Why train the trainers? – The need for more consistent and present support and reminders for changing the way we assess, plan treatment, document and apply the ASAM Criteria
- Level of consensus and buy-in to ASAM PPC – A present and consistent “champion” on site can help the team implement the ASAM PPC
- Role of the supervisor/peer supervisor in facilitating change – Parallel process as with facilitating change with clients

**B. Where Participants Are and Needs Assessment**

- Clinical and/or Supervisory Role?
- Managed care experience and reimbursement issues
- Implementation issues - staff, services, training issues

**Common Misconceptions about ASAM PPC**

- Placement criteria are seen as treatment matching criteria
- ASAM PPC must require more staff, expense, and administration to provide all the levels
- ASAM PPC is a medical model and requires everyone to hire a medical director
- ASAM PPC is biased to advocate for more inpatient treatment
- ASAM PPC is biased to advocate for more outpatient treatment
- ASAM PPC is not useful because the many levels of care and detoxification service don't exist locally
- PPC is not useful since managed care or other payers don't recognize or fund all the levels

**C. Review of Basic Principles and Planning the Schedule**

Select the Best Answer:

1. The best treatment system for addiction is:

- (a) A 28-day stay in inpatient rehabilitation with much education.

- (b) A broad continuum of care with all levels of care separated to maintain group trust.
- (c) Not possible now that managed care has placed so much emphasis on cost-containment.
- (d) A broad range of services designed to be as seamless as possible for continuity of care.
- (e) Short stay inpatient hospitalization for psychoeducation.

2. The six assessment dimensions of the ASAM Criteria:
- (a) Help assess the individual's comprehensive needs in treatment.
  - (b) Provide a structure for assessing severity of illness and level of function.
  - (c) Requires that there be access to medical and nursing personnel when necessary.
  - (d) Can help focus the treatment plan on the most important priorities.
  - (e) All of the above.
3. A multidimensional assessment in behavioral health treatment:
- (a) Should include psychosocial factors such as readiness to change.
  - (b) Is ideal, but not necessary within a managed care environment.
  - (c) Should include biomedical and psychiatric problems, but not motivation or relapse potential.
  - (d) Is best done after detoxification is completed.
  - (e) Should be completed by the primary therapist only.
4. Criteria for Co-Occurring Mental and Substance-Related Disorders:
- (a) Helps define the kinds of programs that could meet the needs of dual diagnosis patients.
  - (b) Introduces a "future directions" matrix to match services to individual needs.
  - (c) Encourages addiction treatment providers to broaden access to care for dual diagnosis.
  - (d) Provides a common language for both mental health and addiction treatment systems.
  - (e) All of the above.

Indicate True or False:

- |  | T   | F   |
|--|-----|-----|
| 5. It is not the severity or functioning that determines the treatment plan, but the diagnosis, preferably in DSM terms. | ( ) | ( ) |
| 6. Dimension 5 focuses on internal attitudes, beliefs and coping skills to deal with relapse.                            | ( ) | ( ) |
| 7. The level of care placement is the first decision to make in the assessment   | ( ) | ( ) |
| 8. All programs should at least be Dual Diagnosis Capable (DDC)  | ( ) | ( ) |
| 9. Dimension 4, Readiness to Change, applies only to motivation for abstinence   | ( ) | ( ) |

10. Clients in early stages of change need relapse prevention strategies  
( )

( )

---

## D. Training of Trainers Overview

- **Context** - role of Placement Criteria in the current healthcare environment
- **Concepts** - underlying rationale and concepts that guided the development, structure and implementation of the ASAM Criteria
- **Content and Criteria** - the structure, format, assessment dimensions and levels of service that provide a common language of multidimensional assessment and a continuum of care
- **Clinical Application and Cases** - methods and strategies for using the ASAM Criteria to place client-participants in the most efficient and effective level of service
- **Conflicts** - major areas of potential disagreement in the concepts, content and application of the ASAM Criteria and how to address and resolve these
- **Continuing Support for Implementation** - ways to receive and give ongoing supervision, consultation and team support to understand and implement a paradigm shift from program-driven treatment/recovery to client centered, individualized, assessment-driven treatment/recovery services

## Context

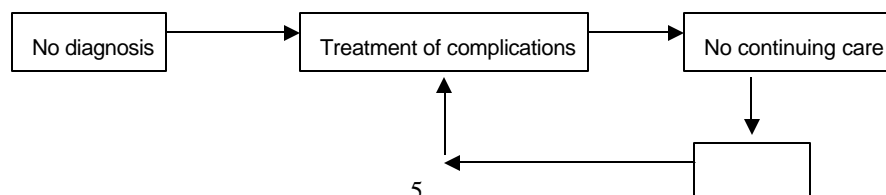
### A. The Current Environment

- \* Inpatient to outpatient; hospital to community
- \* Shortened lengths of intensive treatment
- \* Increased utilization and performance reviews
- \* Decreased reimbursement
- \* Increased accountability, responsibility and risk
- \* “Professionalization” of addictions treatment
- \* Expansion of treatment options and modalities
- \* Individualized, clinically-driven treatment

### B. Generations of Clinical Care in Addiction Treatment

#### (a) Complications-driven Treatment

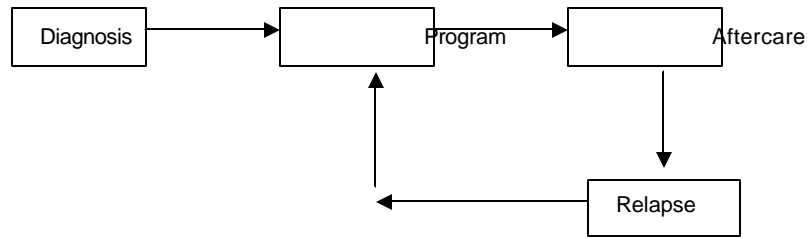
- No diagnosis of Substance Use Disorder
- Treatment of complications of addiction with no continuing care
- Relapse triggers treatment of complications only



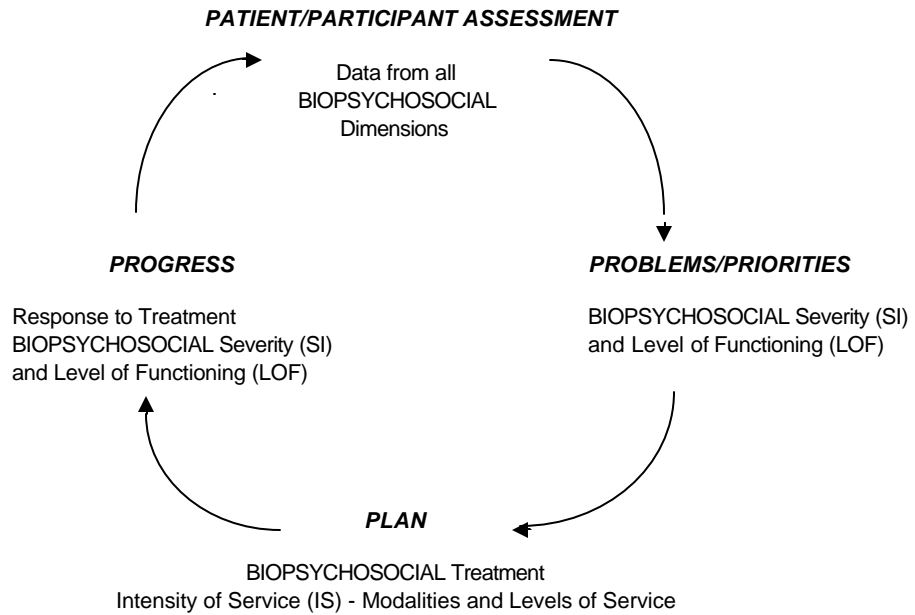
Relapse

(b) Diagnosis, Program-driven Treatment

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

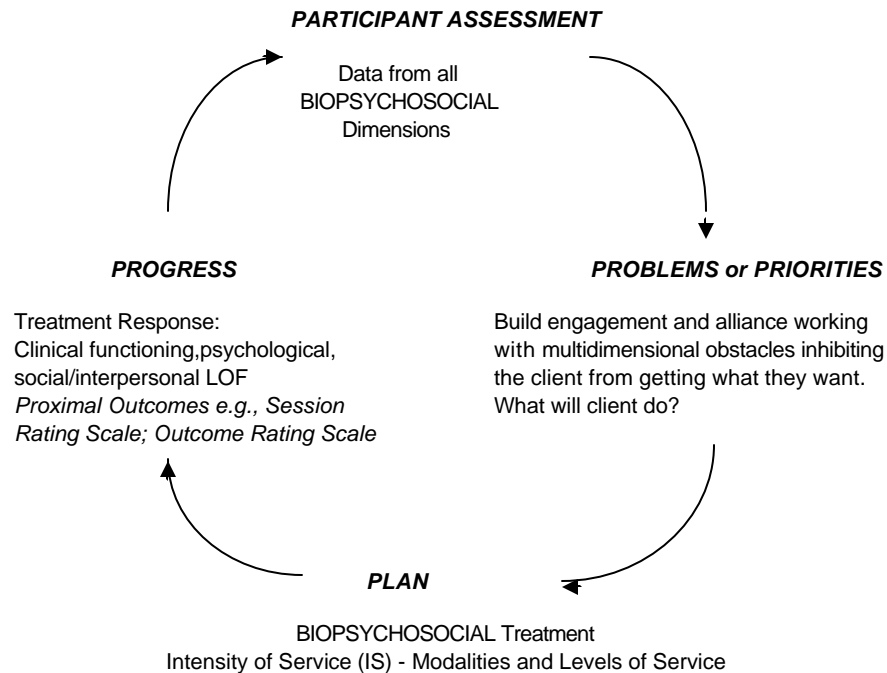


(c) Individualized, Clinically-driven Treatment



(d) Client-Directed, Outcome-Informed Treatment

***The Individual -Process Outcomes - Individualized, Outcomes-Driven Treatment***



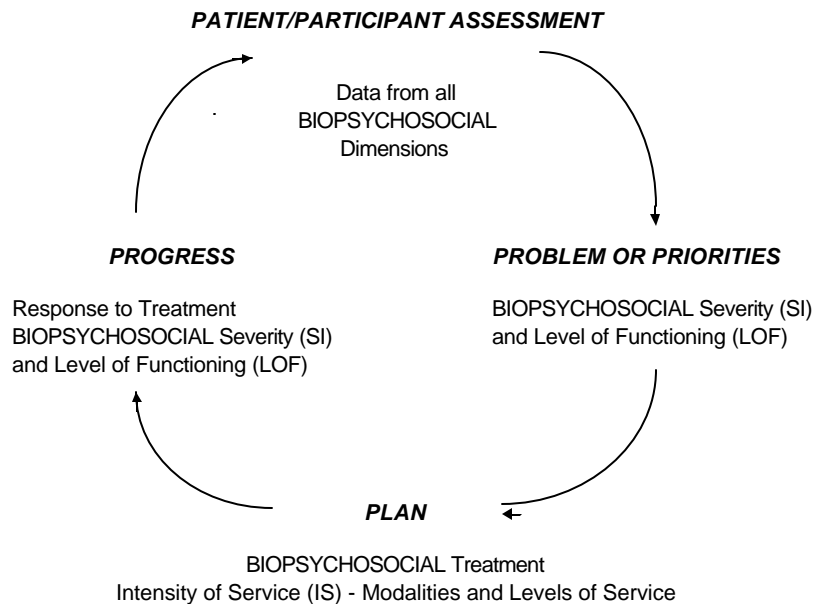
**C. Brief History of the ASAM Patient Placement Criteria**

- 1987 Cleveland Criteria and the NAATP Criteria published
- 1991 ASAM PPC-1 published
- 1992 Coalition for National Clinical Criteria established
- 1994 ASAM Criteria Validity Study funded by NIDA
- 1995 “The Role and Current Status of Patient Placement Criteria In the Treatment of Substance Use Disorders” The Recommendations of a Consensus Panel. Co-Chairs: Lee Gartner and David Mee-Lee, M.D. Treatment Improvement Protocol. The Center for Substance Abuse Treatment.
- 1996 ASAM PPC-2 published
- 1998 – 1999 ASAM PPC endorsed by >20 states, DoD, VA, ValueOptions
- 1999 NIAAA funds Assessment Software project
- 2001 ASAM PPC-2R published

## **Concepts**

### **1. Individualized Treatment**

A diagnosis is a necessary, but not sufficient determinant of treatment. A patient is matched to services based on clinical severity, not placed in a set program based only on having met diagnostic criteria.



### **2. Multidimensional Assessment**

Because substance-related disorders are biopsychosocial disorders in etiology, expression and treatment, assessment must be comprehensive and multidimensional to plan effective care. The common language of the six assessment dimensions of the ASAM Patient Placement Criteria are used to determine clinical severity for both mental and addiction disorders.

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

### **3. Biopsychosocial Treatment - Overview: 5 M's**

- \* Motivate - Dimension 4 issues; engagement and alliance building
- \* Manage - the family, significant others, work/school, legal
- \* Medication - detox; HIV/AIDS; anti-craving anti-addiction meds; 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

4. Treatment Levels of Service

- I Outpatient Services
- II Intensive Outpatient/Partial Hospitalization Services
- III Residential/Inpatient Services
- IV Medically-Managed Intensive Inpatient Services

---

## **Content and Criteria**

### **A. ASAM Criteria, Second Edition Revised (ASAM PPC-2R)**

- Mee-Lee D, Shulman GD, Fishman M, Gastfriend DR, and Griffith JH, eds. (2001). 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, Inc.
- Title “Substance-Related Disorders” refers to DSM-IV’s Substance-Induced Disorders and the Substance Use Disorders (Abuse and Dependence)

### **B. Development Process**

- questionnaires, roundtables, Coalition for National Clinical Criteria, feedback from the field since 1991 identified gaps and areas for improvement
- subcommittees of the Coalition, ASAM members, prepared drafts of revised sections or new additions distributed for field review
- reviewers from a wide variety of organizations and field interests
- revisions to the drafts made by small working group
- approval by the Executive committee of the Board of Directors of ASAM

## **Principles Guiding ASAM PPC Development and Implications**

<b>Principle</b>	<b>Implications</b>
Objectivity	<ol style="list-style-type: none"><li>1. The criteria are as objective, measurable and quantifiable as possible.</li><li>2. Certain aspects of the criteria require subjective interpretation.</li><li>3. Like other medical or psychiatric conditions – diagnosis, assessment and treatment is a mix of objectively measured criteria and experientially based professional judgments.</li></ol>
Choice of Treatment Levels	<ol style="list-style-type: none"><li>1. Referral to specific level of care is based on a multidimensional assessment of the patient.</li><li>2. The goal is a level of care that is least intensive that can accomplish the treatment objectives while providing safety and security.</li><li>3. Levels presented as discrete, but represent benchmarks or points along a continuum of treatment services used in a variety of ways depending on a patient’s needs and response.</li><li>4. Patient enters the continuum at any level and moves through levels of care in consecutive order or skipping levels as needed.</li></ol>

Continuum of Care	<ol style="list-style-type: none"><li>1. Within and across the levels of care, there is a continuum of the severity of illnesses treated; and the intensities of services provided.</li><li>2. Funding and reimbursement needs to match this continuum of care and intensities of service.</li><li>3. If only one of many levels of care is offered, movement between levels requires linking patient with providers of other levels of care whenever indicated by the assessment of the patient's needs and progress.</li></ol>
Length of Stay (LOS)	<ol style="list-style-type: none"><li>1. No fixed LOS</li><li>2. LOS depends on severity of illness and progress/response to treatment</li></ol>

**C. Terminology**

- Decimal point system
- Assessment dimensions – use regular Arabic numbers
- Levels of Service - Levels I-IV since 1991 to maintain common language – Roman numerals
- DSM-IV diagnoses - Substance-Induced and Substance Use Disorders; Diagnostic Admission Criteria
- “Clinically-Managed”
- “Residential” versus “Inpatient”
- “Continued Service and Discharge Criteria”
- “Length of Service”
- Expanded glossary

**D. Levels of Care**

<b>ASAM PPC-2R Adult Detoxification Services</b>	<b>Level</b>	<b>Note: There are no separate Detoxification Services for Adolescents in ASAM PPC-2R</b>
Ambulatory Detoxification without Extended On-Site Monitoring	I-D	Mild withdrawal with daily or less than daily outpatient supervision; likely to complete detox. and to continue treatment or recovery
Ambulatory Detoxification with Extended On-Site Monitoring	II-D	Moderate withdrawal with all day detox. support and supervision; at night, has supportive family or living situation; likely to complete detox.
Clinically-Managed Residential Detoxification	III.2-D	Moderate withdrawal, but needs 24-hour support to complete detox. and increase likelihood of continuing treatment or recovery
Medically-Monitored Inpatient Detoxification	III.7-D	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete detox. without medical, nursing monitoring
Medically-Managed Inpatient Detoxification	IV-D	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify detox. regimen and manage medical instability
<b>ASAM PPC-2R Levels of Care</b>		
<b>ASAM PPC-2R Levels of Care</b>	<b>Level</b>	<b>Description of ASAM Levels of Care</b>
Early Intervention	0.5	Assessment and education for at risk individuals who do not meet diagnostic criteria for Substance-Related Disorder
Outpatient Services	I	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/ strategies
Intensive Outpatient	II.1	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability
Partial Hospitalization	II.5	20 or more hours of service/week for multidimensional instability not requiring 24 hour care
Clinically-Managed Low-Intensity Residential	III.1	24 hour structure with available trained personnel; at least 5 hours of clinical service/week
Clinically-Managed Med-Intensity Residential	III.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	III.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	III.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	IV	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 Maintenance Therapy	OMT	Daily or several times weekly opioid medication and counseling available to maintain multidimensional stability for those with opioid dependence

---

**Levels of Care and Service in ASAM PPC-2R:**

**Level 0.5: Early Intervention Services** - Criteria for assessment and education services for individuals with problems or risk factors related to substance use, but for whom an immediate Substance Related Disorder cannot be confirmed. Further assessment is warranted to rule in or out addiction.

**Opioid Maintenance Therapy (OMT)** - Criteria for Level I Outpatient OMT, with discussion that OMT can be in all levels of service, and not restricted to only being an outpatient treatment modality.

**Detoxification Services for Dimension 1 (Adult Criteria only)**

- I-D - Ambulatory Detoxification without Extended On-site Monitoring
- II-D - Ambulatory Detoxification with Extended On-site Monitoring
- III.2-D - Clinically-Managed Residential Detoxification Services (Social Detoxification)
- III.7-D - Medically-Monitored Inpatient Detoxification Services
- IV-D - Medically-Managed Inpatient Detoxification Services

**Level I Outpatient Services**

- I - Outpatient Treatment (<9 hours/week for Adults; <6 hours/week for Adolescents)

**Level II Intensive Outpatient/Partial Hospitalization Services**

- II.1 - Intensive Outpatient Treatment (9 hours/week for Adults; 6 hours/week for Adolescents)
- II.5 - Partial Hospitalization Treatment

**Level III Residential/Inpatient Services**

- III.1 - Clinically-Managed, Low Intensity Residential Treatment (Halfway House; Support. Living Envir.)
- III.3 - Clinically-Managed, Medium Intensity Residential Treatment (Therapeutic Rehabilitation Facility)  
(This level is not in the Adolescent Criteria continuum of care)
- III.5 - Clinically-Managed, Medium/High Intensity Residential Treatment (Therapeutic Community, Residential Treatment Center)
- III.7 - Medically-Monitored Intensive Inpatient Treatment (Inpatient Treatment Center)

**Level IV Medically-Managed Intensive Inpatient Services**

- IV - Medically-Managed Intensive Inpatient Treatment

---

## **E. Selected ASAM PPC-2R Changes**

### **1. Improving Level I, Outpatient Services**

The additional admission criteria for Dimension 4, Level I services (page 52, 2001) are as follows:

*“(c) The patient is ambivalent about a substance-related and/or mental health problem. He or she requires monitoring and motivating strategies, but not a structured milieu program. For example, the patient has sufficient awareness and recognition of a substance use and/or mental health problems to allow engagement and follow-through with attendance at intermittent treatment sessions as scheduled; or*

*(d) The patient may not recognize that he or she has a substance-related and/or mental health problem. For example, he or she is more invested in avoiding a negative consequence than in the recovery effort. Such a patient may require monitoring and motivating strategies to engage in treatment and to progress through the stages of change.”*

### **2. Changes to Continued Service and Discharge Criteria**

In the process of patient assessment, certain problems and priorities are identified as justifying admission to a particular level of care. The resolution of those problems and priorities determines when a patient can be treated at a different level or discharged from treatment. The appearance of new problems may require services that can be provided effectively at the same level of care, or they may require a more or less intensive level of care.

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.

### 3. **ASAM PPC-2R's Approach to Co-Occurring Disorders**

#### (a) **Historical context of the ASAM PPC**

- Dimension 3 – 1991: “Emotional/Behavioral Conditions and Complications” versus “Psychiatric Conditions”, which would keep Dimension 3 too focused on mental health treatment and dual diagnosis; and diminish interest in mental health issues as an expected part of addiction and recovery
- “Conditions” refers to co-occurring mental disorders (dual diagnosis)
- “Complications” refers to addiction-related, mental health problems that can distract the client's attention from primary addiction recovery treatment

#### (b) **Terminology Used**

The addiction and mental health fields have not yet reached consensus on terminology to describe individuals who are experiencing simultaneous addictive and mental health disorders. Clearly, this issue requires further discussion and consensus-building. In the interim, the *ASAM PPC-2R* has adopted the term "Co-Occurring Mental and Substance-Related Disorders" in formal titles so as to remain consistent with the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association. Throughout the text, however, the term "dual diagnosis" is used for the sake of simplicity and because it appears to have the widest acceptance nationally. (The authors recognize that "dual diagnosis" is an inexact term and that it fails to accommodate populations other than those with mental and

substance-related disorders—such as persons with coexisting addictive and biomedical or developmental disorders—but the advantages of simplicity and wide acceptance were judged to outweigh these deficits. We expect to revisit this decision in future editions of the *Patient Placement Criteria*.)

---

(c) **Adult versus Adolescent Criteria Differences**

- Dimension 3 Subdomains
- Assumptions about Adolescent Criteria – developmental issues; co-occurring emotional, behavioral and cognitive issues and the need for a more clinically-sophisticated staff
- More focus on mental health issues for adolescents who often have co-occurring emotional/behavioral issues. No AOS, DDC or DDE descriptions in adolescent criteria

(d) **Dual Diagnosis Program Descriptions – AOS, DDC, DDE**

When the first edition of the *ASAM Patient Placement Criteria (ASAM PPC-1)* was published in 1991, the criteria generally were designed for programs that offered only addiction treatment services. However, the *PPC-1* also acknowledged that some patients had co-occurring mental and substance use problems and thus included Dimension 3, Emotional/Behavioral Conditions and Complications. Such patients are not adequately treated in programs that offer only addiction treatment services.

The *ASAM PPC-2R* describes three types of services: those that offer Addiction-Only Services (AOS), those that are Dual Diagnosis Capable (DDC), and those that are Dual Diagnosis Enhanced (DDE). Programs capabilities are defined as follows:

**1. Programs that offer Addiction-Only Services (AOS)**

- Cannot accommodate patients with psychiatric illnesses that require ongoing treatment, however stable the illness and however well functioning the individual. Such programs are said to provide Addiction-Only Services (AOS).
- The policies and procedures typically do not accommodate co-existing mental disorders: for example, individuals on psychotropic medications generally are not accepted, coordination or collaboration with mental health services is not routinely present, and mental health issues are not usually addressed in treatment planning or content.

**2. Dual Diagnosis Capable (DDC) Programs**

- Dual Diagnosis Capable (DDC) programs routinely accept individuals who have co-occurring mental and substance-related disorders.
- DDC programs can meet such patients' needs so long as their psychiatric disorders are sufficiently stabilized and the individuals are capable of independent functioning to such a degree that their mental disorders do not interfere with participation in addiction treatment.
- DDC programs address dual diagnoses in their policies and procedures, assessment, treatment planning, program content, and discharge planning.
- They have arrangements in place for coordination and collaboration with mental health services.
- They also can provide psychopharmacologic monitoring and psychological assessment and consultation on site; or by well-coordinated consultation off-site.

**3. Dual Diagnosis Enhanced (DDE) Programs**

- DDE programs can accommodate individuals with dual diagnoses who may be unstable or disabled to such an extent that specific psychiatric and mental health support, monitoring and accommodation are necessary in order for the individual to participate in addiction treatment.
- Such patients are not so acute or impaired as to present a severe danger to self or others, nor do they require 24-hour, psychiatric supervision.
- DDE programs are staffed by psychiatric and mental health clinicians as well as addiction treatment professionals. Cross-training is provided to all staff. Such programs tend to have relatively high

—

- ratios of staff to patients and provide close monitoring of patients who demonstrate psychiatric instability and disability.
- DDE programs typically have policies, procedures, assessment, treatment planning and discharge planning that accommodate patients with dual diagnoses.

- Dual diagnosis-specific and mental health symptom management groups are incorporated into addiction treatment. Motivational enhancement therapies are more likely to be available (particularly in outpatient settings)
- Ideally, there is close collaboration or integration with a mental health program that provides crisis back-up services and access to mental health case management and continuing care.

Characteristics of Co-Occurring Disorders	
Patients	Services
<b>Addiction-Only Patients:</b> Individuals who exhibit substance abuse or dependence problems without co-occurring mental health problems or diagnosable Axis I or II disorders	<b>Addiction Only Services (AOS):</b> Services directed toward the amelioration of substance related disorders without services for the treatment of co-occurring mental health problems or diagnosable disorders. Such services are clinically inappropriate for dually diagnosed individuals.
<b>Patients with Co-Occurring MH Problems of mild to moderate severity:</b> Individuals who exhibit (1) sub-threshold diagnostic (i.e., traits, symptoms) Axis I or II disorders or (2) diagnosable but stable Axis I or II disorders (i.e., bipolar disorder but compliant with and stable on lithium).	<b>Dual Diagnosis Capable (DDC):</b> Primary focus on substance use disorders but capable of treating patients with sub-threshold or diagnosable but stable Axis I or II disorders. Psychiatric services available on-site or by consultation; at least some staff are competent to understand and identify signs and symptoms of acute psychiatric conditions.
<b>Patients with Co-Occurring MH Problems of moderate to high severity:</b> 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	<b>Dual Diagnosis Enhanced (DDE):</b> Psychiatric services available on-site or closely coordinated; all staff cross trained in addiction and mental health and are competent to understand and identify signs and symptoms of acute psychiatric conditions and treat mental health problems along with the substance use disorders. Treatment for both MH and SA disorders is integrated. This service is most similar to a traditional “dual diagnosis” program

Reference: Developed from information in ASAM PPC-2R, pages 9 – 11.  
 (Mee-Lee D, Shulman GD, Fishman M, Gastfriend DR, and Griffith JH, eds. (2001). 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, Inc.)

#### 4. Experimental Matrix and Co-Occurring Disorders

##### Definitions of Terms in the "Future Directions" Matrix for Matching Multidimensional Risk with Type and Intensity of Necessary Services

**Risk Description.** The risk descriptions and ratings within each assessment dimension help staff determine the immediacy and scope of the service plan by guiding what types and modalities of service are needed. They also indicate the intensity or level of service at which the patient can be treated with safety and efficacy.

**Risk Domains.** A Risk Domain is an assessment subcategory within Dimension 3, as described below:

- ***Dangerousness/Lethality.*** This Risk Domain describes how impulsive an individual may be with regard to homicide, suicide, or other forms of harm to self or others and/or to property. The seriousness and immediacy of the individual's ideation, plans and behavior—as well as his or her ability to act on such impulses—determine patient's risk rating and type/intensity of services needed

- 
- **Interference with Addiction Recovery Efforts.** This Risk Domain describes the degree to which a patient is distracted from addiction recovery efforts by emotional, behavioral and/or cognitive problems and, conversely, the degree to which a patient is able to focus on addiction recovery. (High risk and severe impairment in this domain do not, alone, require services in a Level IV program.)
  - **Social Functioning.** This Risk Domain describes the degree to which an individual's relationships (e.g., coping with friends, significant others or family; vocational or educational demands; and ability to meet personal responsibilities) are affected by his or her substance use and/or other emotional, behavioral and cognitive problems. (Note that high risk and severe impairment in this domain do not, in themselves, require services in a Level IV program.)
  - **Ability for Self Care.** This Risk Domain describes the degree to which an individual's ability to perform activities of daily living (such as grooming, food and shelter) are affected by his or her substance use and/or other emotional, behavioral and cognitive problems. (Note that high risk and severe impairment in this domain do not, in themselves, require services in a Level IV program.)
  - **Course of Illness.** This Risk Domain employs the history of the patient's illness and response to treatment to interpret the patient's current signs, symptoms and presentation and predict the patient's likely response to treatment. Thus, the domain assesses the interaction between the chronicity and acuity of the patient's current deficits. A high risk rating is warranted when the individual is assessed as at significant risk and vulnerability for dangerous consequences either because of severe, acute life-threatening symptoms, or because a history of such instability suggests that high intensity services are needed to prevent dangerous consequences.

For example, a patient may present with medication adherence problems, having discontinued antipsychotic medication two days ago. If a patient is known to rapidly decompensate when medication is stopped, his or her rating is high. However, if the patient slowly isolates without any rapid deterioration when medication is stopped, the risk rating would be less. Another example is the patient who has been depressed and socially withdrawn. If this has been a problem for six weeks, the risk rating is much higher than for a patient who has been chronically withdrawn and isolated for six years with a severe and persistent schizophrenic disorder.

## **5. Revised Constructs for Dimension 5: Relapse/Continued Use Potential**

### **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 the 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?

**Clinical Application and Cases**

**A. The Six Assessment Dimensions and Implications**

- expanded meaning - Dimensions 4, 5 and 6: improve knowledge and assessment skills
- assessing severity - sample questions: improve inter-rater reliability
- dimensional criteria and “unbundling”: provide or coordinate a mix of services

**ASAM Assessment Dimensions**

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 continued problems as part of motivational enhancement strategies.

---

6. Recovery Environment	Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services
-------------------------	---

To assist in understanding the assessment dimensions and assessment of severity of each dimension, examples of brief questions include, but are not limited to, the following:

**Dimension 1, Acute Intoxication and/or Withdrawal Potential:** Is acute intoxication and/or withdrawal potential contributing to, or complicating the patient's condition? What risk is associated with the patient's current level of acute intoxication? Is there serious 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? Are there current signs of withdrawal? Does the patient have supports to assist in ambulatory detoxification if medically safe?

**Dimension 2, Biomedical Conditions and Complications:** Are there current physical illnesses other than withdrawal, that are contributing to, or complicating the patient's condition that need to be addressed? e.g., pregnancy, bleeding, cancer, heart disease etc. Are there chronic conditions that affect treatment? e.g., wheel chair bound; chronic pain with narcotic analgesics.

**Dimension 3, Emotional/Behavioral/Cognitive Conditions and Complications:** Are there one or more psychiatric disorders contributing to, or complicating the patient's condition? Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed? Are there chronic conditions that affect treatment because of continued symptoms or disability? e.g., stable, but chronic schizophrenic, affective or personality disorder problems. Do any emotional, behavioral or cognitive problems appear to be an expected part of addiction illness or do they appear to be separate? Even if connected to addiction, are they severe enough to warrant specific mental health treatment?

**Dimension 4, Readiness to Change:** Does the patient feel coerced into treatment or actively object to receiving treatment? How ready is the patient to change? If willing to accept treatment, how strongly does the patient disagree with others' perception that s/he has a mental health or a substance problem? Is the patient compliant to avoid a negative consequence, or internally distressed in a self-motivated way about his/her mental health or alcohol or other drug use problems? Is the patient at a different stage of change for the substance problem versus the mental health problem

**Dimension 5, Relapse/ Continued Use or Continued Problem Potential:** Is the patient in immediate danger of continued severe distress and/or drinking/drugging behavior? Does the patient have any recognition and understanding of, and skills for how to cope with his/her mental health and/or addiction problems and prevent relapse or continued problems and/or continued use? What severity of problems and further distress will potentially continue or reappear, if the patient is not successfully engaged into treatment at this time? How aware is the patient of relapse dangers, triggers, ways to cope with reappearance of psychiatric symptoms and/or cravings to use and skills to control impulses harmful to self or others and/or prevent continued alcohol/drug use?

**Dimension 6, Recovery Environment:** Are there any dangerous family, significant others, living or school/working situations threatening treatment engagement and success? Does the patient have supportive friendship, financial or educational/vocational resources to improve the likelihood of successful

—  
treatment? Are there legal, educational, vocational, social service agency or criminal justice mandates that may enhance motivation for engagement into treatment?

---

## B. How to Organize Assessment Data

\* Immediate Need Profile. Assessor considers each dimension and with just sufficient data to assess immediate needs, checks “yes” or “no” for the following questions:

### 1. Acute Intoxication and/or Withdrawal Potential

(a) Past history of serious withdrawal, life-threatening symptoms or seizures during withdrawal? e.g., need for IV therapy; hospitalization for seizure control; psychosis with DT’s; medication management with close nurse monitoring and medical management? \_\_\_No\_\_\_Yes; (b) Currently having similar withdrawal symptoms? \_\_\_No\_\_\_Yes

### 2. Biomedical Conditions/Complications

Any current severe physical health problems? e.g., bleeding from mouth or rectum in past 24 hours; recent, unstable hypertension; recent, severe pain in chest, abdomen, head; significant problems in balance, gait, sensory or motor abilities not related to intoxication. \_\_\_No\_\_\_Yes

### 3. Emotional/Behavioral/Cognitive Conditions/Complications

(a) Imminent danger of harming self or someone else? e.g., suicidal ideation with intent, plan and means to succeed; homicidal or violent ideation, impulses and uncertainty about ability to control impulses, with means to act on. \_\_\_No\_\_\_Yes; (b) Unable to function in activities of daily living, self with imminent, dangerous consequences? e.g., unable to bath, feed, groom and care for self due to psychosis, organicity or uncontrolled intoxication with threat of imminent safety to self, others as regards death or severe injury \_\_\_No\_\_\_Yes

### 4. Readiness to Change

(a) Does client appear to need alcohol or other drug treatment/recovery and/or mental health treatment, but ambivalent or feels it unnecessary? e.g., severe addiction, but client feels controlled use still OK; psychotic, but blames a conspiracy \_\_\_No\_\_\_Yes; (b) Client has been coerced, mandated or required to have assessment and/or treatment by the criminal justice system, health or social services, work/school, or family/significant other? \_\_\_No\_\_\_Yes

### 5. Relapse/Continued Use/Continued Problem Potential

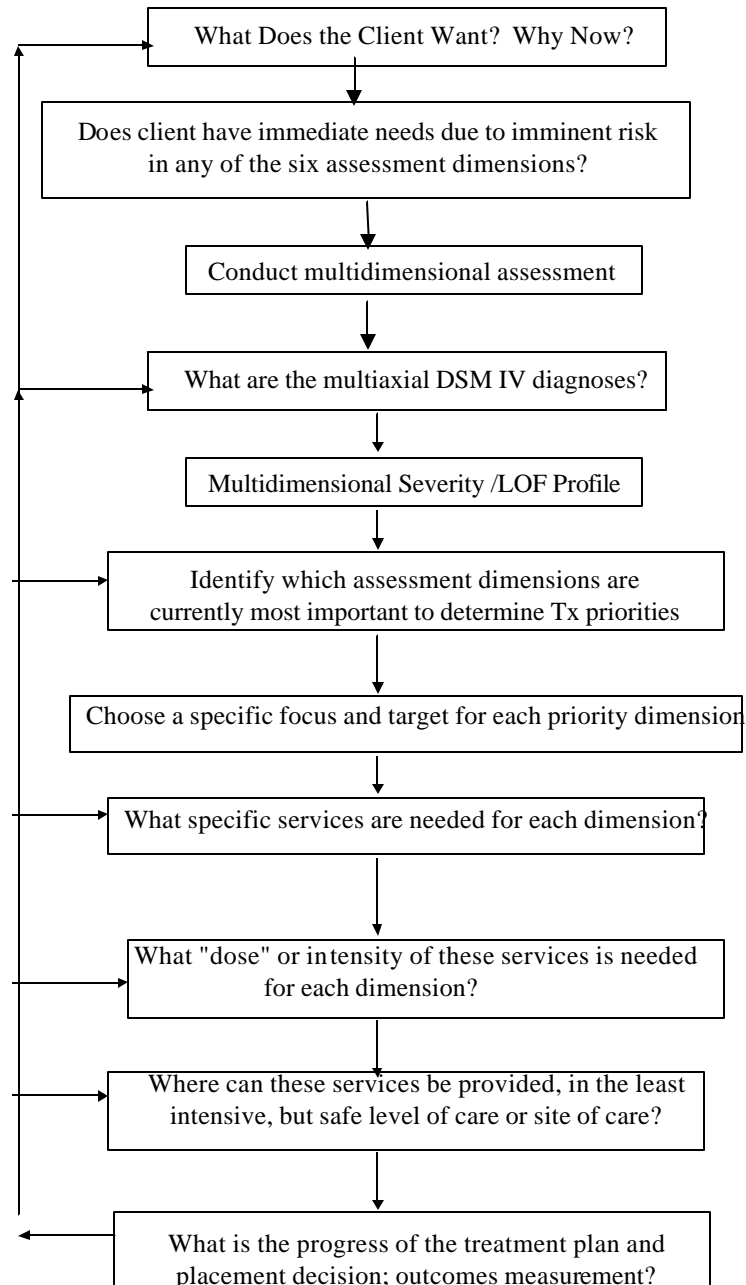
(a) Is client currently under the influence? \_\_\_No\_\_\_Yes; (b) Is client likely to continue to use or relapse in an imminently dangerous manner, without immediate care? (c) Is client’s most troubling, presenting problem(s) that brings the client for assessment, dangerous to self or others? (See examples above in dimensions 1, 2 and 3) \_\_\_No\_\_\_Yes

### 6. Recovery Environment

Are there any dangerous family, sig. others, living/work/school situations threatening client’s safety, immediate well-being, and/or sobriety? e.g., living with a drug dealer; physically abused by partner or significant other; homeless in freezing temperatures \_\_\_No\_\_\_Yes

C. **How to Target and Focus Service Priorities**

**Decision Tree to Match Assessment and Treatment/Placement Assignment**



---

**D. Skill Building in Assessment, Treatment Planning and Placement**

**1. Presenting Cases - Case Presentation Format**

**Before presenting the case, please state why you chose the case and what you want to get from the discussion**

**I. Identifying Client Background Data**

Name

Age

Ethnicity and Gender

Marital Status

Employment Status

Referral Source

Date Entered Treatment

Level of Service Client Entered Treatment (if this case presentation is a treatment plan review)

Current Level of Service (if this case presentation is a treatment plan review)

DSM Diagnoses

Stated or Identified Motivation for Treatment (What is the most important thing the clients wants you to help them with?)

**First state how severe you think each assessment dimension is and why (focus on brief relevant history information and relevant here and now information):**

**II. Current Placement Dimension Rating (See Dimensions below 1 - 6)**

1.

2.

3.

4.

5.

6.

(Give a brief explanation for each rating, note whether it has changed since the client entered treatment and why or why not)

**This last section we will talk about together:**

**III. What problem(s) with High and Medium severity rating are of greatest concern at this time?**

Specificity of the problem

Specificity of the strategies/interventions

Efficiency of the intervention (Least intensive, but safe, level of service)

2. Treatment Planning and Documentation Skills

- \* counterproductive attitudes - 3 I's: irrelevant; irritating; insurance-driven
- \* productive attitudes - 3 C's: concentrate treatment; communicate; cont.-of-care

\* problem identification - “2x4”:

- A – Appropriate to diagnosis (addiction vs mental health)
- A - Achievable: time, place, person
- B - Brief;
- B - Behavioral
- C - Care: level of care e.g. acute-care oriented, time, place, person;
- C - Caring: expressed in accepting, non judgmental words
- D - Different: for each patient; what different strategy; time, place, person;
- D - Dimension: which of the multidimensional assessment areas does this problem address  
 e.g. Dimension 1

\* “What Made Me Say That?”

**E. Improving the Range and Use of Treatment Services**

1. Ways to develop service tracks that would match a patient’s readiness to change.

- Some clinicians and referral sources, still feel uneasy about “individualized” treatment - that it is so individualized that there’s no accountability and patient’s can use whenever they want; come whenever they want; and basically “run” treatment while we helplessly watch self-will run riot.
- Such is not assessment-based, clinically-driven, individualized treatment, but it sometimes feels that way as while still developing services and skills. In the days of fixed programs, everyone knew what they contained; and what would happen if a patient didn’t do it our way and used etc., it was reassuring and clear to everyone what the rules were. Now it’s not as clear and we’re in a system’s developmental stage that requires we start to codify, clarify and specify clearer procedures, tools, service content and assessment and treatment skills necessary to keep the innovations working.

**Dimension 4, Readiness to Change Assessment and Matching**

<u>Stage of Change</u>	<u>Service Track</u>	<u>Treatment Processes Used</u>	<u>PPC-2R Level</u>
Precontemplation	Discovery Track	Consciousness-Raising, Social Liberation	Level 0.5 or I
Contemplation	Discovery Track	As above, plus Emotional Arousal, Self-Evaluation	Level I
Preparation	Mix of Discovery & Recovery Tracks	Emotional Arousal, Self-Evaluation, Commitment	Levels I - II.5
Action	Recovery Track	Commitment, Reward, Countering, Environment Control, Helping Relationships	Levels I - II.5

Relapse, Recycling

Relapse Track

Based on assessed Stage of  
Change to which client has  
regressed or recycled

Levels I - III.5

---

Definition of Terms and Comments:

1. Discovery Track - Mix of individual, group and self/mutual help experiences that utilize the change processes combined in the frequency and intensity negotiated with the patient that will most likely be: complied with; succeed in moving the patient toward further stages of change without losing the patient through drop out or increased resistance; discussed openly and honestly e.g. "I didn't go to the AA meeting I said I would"; measurable to reinforce accountability e.g., it would not be useful to have a plan that calls for a trial of abstinence if you have no way of verifying compliance such as random urines or contacts with supervisor or family.

There would not be the expectation for declaring the desire for total abstinence; for recovery; or even that there is yet an active alcohol or other drug problem. This would be the goal of the Discovery Track, to discover if there is a problem that the client is willing to continue work on changing. However the patient is still accountable for following the negotiated treatment plan frequency and intensity. A treatment plan review process is necessary, similar to the procedure outlined in *Dealing with Recovery and Psychosocial Crises*. (See above).

2. Recovery Track - Mix of individual, group and self/mutual help experiences that utilize the change processes that would have the same expectations above of being most like complied with; moving to further change; honesty and accountability. But, in addition, there would be the expectation of total abstinence unless prescribed or approved by the team; of attendance at AA/NA meetings; and transfer from this track if there was persistent alcohol/drug use or non-attendance at sessions or AA/NA meetings not responsive to perhaps two changes in the treatment plan to alleviate the difficulty.

For example, if a patient did not attend meetings because of a transportation problem, the treatment plan would be reviewed and changed with then patient to decide new transportation plans to ensure attendance. Or if a patient used trying to do 12 Step calls on drug using friends too early in recovery, the plan would be changed to have the patient stay away from old friends and help out at NA meetings instead.

If the patient again had the same problem and did not follow the treatment plan, the plan would be reviewed again with the patient and changed again to increase chances of success in getting to meetings or sessions or staying abstinent. But it would be indicated that were the problem were to continue, this may indicate the patient is not ready for recovery and needs to be transferred to the Discovery Track.

3. Mix of Discovery and Recovery Tracks - Since clients in Preparation Stage of Change are still not fully in Action, they may require a combination of experiences to reinforce and build their commitment to change. Such clients might be, at times, mixed with those in both Tracks to allow for encouragement to Discovery Track clients and to be reinforced by Action/Recovery Track peers.

4. Relapse, Recycling Track - Mix of individual, group and self/mutual help experiences that utilize the change processes that would again, have the same expectations of being most like complied with; moving to further change; honesty and accountability. But this track would be a mix of experiences depending on whether, for example, the patient had slipped all the way back to questioning whether they even had a problem (Precontemplation) or was, for example, still in Action, but had particular difficulties with staying sober due to a co-existing chronic pain problem or psychiatric difficulty.

Such patients might need elements of the Discovery Track in the first example or specific pain management of dual diagnosis treatment in the other examples. Depending on the chronicity and response to changes in the treatment plan, the level of service might vary from Level I all the way through to Level III.5.

## 2. Engaging the Client as a Participant in Treatment

	<b>CLIENT</b>	<b>CLINICAL ASSESSMENT</b>	<b>TREATMENT PLAN</b>
<b>WHAT?</b>	What does client. want?	What does client. need?	What is the treatment contract?
<b>WHY?</b>	Why now? What's the level of commitment?	Why? What reasons are revealed by the assessment data?	Is it linked to what the client wants?
<b>HOW?</b>	How will s/he get there? How quickly?	How will you get him/her to accept the plan?	Does the client buy into the link?
<b>WHERE?</b>	Where will s/he do this?	Where is the appropriate setting for treatment? What is indicated by the placement criteria?	Referral to level of care
<b>WHEN?</b>	When will this happen? How quickly? How badly does s/he want it?	When? How soon? What are realistic expectations? What are milestones in the process?	What is the degree of urgency? What is the process? What are the expectations of the referral?

(David Mee-Lee, MD, 1996)

## 3. Example Policy and Procedure to Deal with Recovery and 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, as follows:

1. Slip/ using alcohol or other drugs while in treatment;
2. Suicidal, and the individual is feeling impulsive or wanting to use alcohol or other drugs;
3. Loss or death, disrupting the person's recovery and precipitating cravings to use or other impulsive behavior;
4. Disagreements, anger, frustration with fellow patients or therapist.

The following procedures provide steps to assist in implementing the principle of re-assessment and modification of the treatment plan:

1. Set up a face to face appointment as soon as possible. If not possible in a timely fashion, follow the next steps via telephone.
2. Convey an attitude of acceptance; listen and seek to understand the patient's point of view rather than lecture, enforce "program rules", or dismiss the patient's perspective.
3. Assess the patient's safety for intoxication/withdrawal and imminent risk of impulsive behavior and harm to self, others, or property. Use the six ASAM assessment dimensions to screen for severe problems and identify new issues in all biopsychosocial areas.

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral/cognitive conditions and complications
4. Readiness to Change
5. Relapse/Continued Use/Continued Problem potential
6. Recovery environment

4. 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, if there appears to be resistance to developing a modified treatment plan in step 5 above.
7. Determine if the modified strategies can be accomplished in the current level of care; or need a more or less intensive level of care in the continuum of services.
8. If, on completion of step 6, the patient recognizes the problem/s; 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.
9. Document the crisis and modified treatment plan or discharge in the medical record.

#### **F. Personnel and Policy Implications**

\* Personnel; Programs; Payment; Public/Private Sectors:

##### **1. Personnel**

- \* Better training in biopsychosocial theories, modalities of treatment, assessment and documentation skills
- \* Increased interdisciplinary functioning and team work
- \* Increased individualized treatment and thorough case management
- \* Increase curiosity and research

##### **2. Programs**

- \* Flexible lengths-of-service in all levels of service
- \* Overlapping levels of care - better continuity and efficiency
- \* Expanded intensities of service
- \* More modalities of treatment - biopsychosocial
- \* Innovative program structure - milieu; individualized treatment

##### **3. Payment**

- \* Reimburse or fund all levels of service
- \* Increase incentives for less costly care
- \* Fund thorough case management

##### **4. Public/Private Sectors**

- \* One quality and system of care
- \* One common set of criteria - clinically-based not program-based
- \* Increase interdependence - improve incentives and equalize over/under capacities

**Conflicts**

**A. Dealing with Disagreements over Treatment Plan and Level of Care**

- Use Case Presentation Format to concisely review the biopsychosocial data and focus the discussion
- Use the Decision Tree to Match Assessment and Treatment/Placement Assignment
- Improve communication with payers, managed care, utilization reviewers and care managers
- Different perspectives on what recovery is for mental health versus addiction treatment

**Recovery in Addiction**

“Recovery is the process through which severe alcohol and other drug problems (here defined as those problems meeting DSM-IV criteria for *substance abuse or substance dependence*) are resolved in tandem with the development of physical, emotional, ontological (spirituality, life meaning), relational and occupational health.”

(White, W. & Kurtz, E. (2005). “The Varieties of Recovery Experience”. Chicago, IL. Great Lakes Addiction Technology Transfer Center. Posted at <http://www.glatc.org>)

**Recovery in Mental Health**

“Recovery occurs when people with mental illness discover, or rediscover, their strengths and abilities for pursuing personal goals and develop a sense of identity that allows them to grow beyond their mental illness”

(Pat Deegan, a consumer leader and psychologist with schizophrenic disorder defines recovery from serious mental illness)

**B. Inconsistencies in Attitudes and Practice**

<b>Person’s Attitudes and Behavior</b>	<b>Recovery Process in 12 Step Programs and other Recovery Groups</b>	<b>Traditional Addiction Treatment Attitudes and Practice</b>
1. Ambivalent about abstinence and recovery	1. “Keep coming back” – do the research; you don’t have to get the program; it will get you; stages of change and cognitive behavioral approach (SMART Recovery)	1. Client must agree to abstinence as a precondition of admission into treatment; or “come back when you are ready”
2. Reluctant to attend recovery meetings and groups	2. Outreach with 12-Step calls; offer to be a sponsor; assist with transportation; welcoming and “attraction not promotion”	2. Access to care is difficult; long waiting lists; recorded messages and complicated intake procedures
3. Shows up to a meeting after a few drinks	3. “Keep coming back” – “There but for the grace of God go I”; a good “remember when”	3. Leave and come back when you are sober. Sign a contract that you will not come to treatment if you have used

—

4. Feels will power will fix addiction and trouble accepting suggestions	4. “Powerlessness” and helping people understand the paradox of surrender and power; unmanageability and making amends	4. Counselors act as if powerful and able to confront and coerce recovery; work harder for recovery than client
5. Involves family and significant others in a web of pain and loss	5. “Detachment” – Al-Anon, Alateen; Naranon; help the family develop serenity and their personal recovery	5. Act as if we will stop addiction; work as hard as the family did to stop addiction; compassion fatigue and staff burnout

Person's Attitudes and Behavior	Physical and Mental Health Recovery Approach	Addiction Treatment Recovery Approach
1. Relapse or re-occurrence of signs and symptoms of disorder	1. Viewed as a poor outcome or crisis requiring a timely response; assessment and treatment plan change	1. Viewed as willful misconduct with exclusion from treatment that day and possible discharge from treatment. "Punitively discharge clients for becoming symptomatic" (W.White, 2005)
2. Psychosocial crisis; treatment adherence problems; acute exacerbation of the disorder	2. Discussed as lack of progress and a poor outcome requiring a change in treatment strategies e.g., individual, group, family therapy, pharmacotherapy, case management	2. Discussed as the need for "consequences", sanctions and possible discharge or transfer to another treatment team and setting
3. Persistent treatment adherence problems	3. Variety of proactive strategies – Assertive Community Treatment (ACT teams); Intensive Case Management (ICM); supported housing and employment; variety of "wet", "damp" and "dry" shelters; mental health crisis teams to enhance natural and community supports	3. Blacklist client from readmission to the facility; discharge and send notice of case closed; refer to extended residential and inpatient care away from the person's community with poor continuing care and reintegration into the community; invoke legal sanctions and remove from treatment
4. Severe and chronic illness	4. Utilize levels of care including acute hospitalization; day treatment; outpatient and community-based services; group and independent housing options. No fixed length of stay. Illness, disease and recovery management model.	4. Utilize predominantly fixed length of stay residential programs for those who can pay. Utilize predominantly low intensity outpatient services in the public sector. "Serial episodes of self-contained, unlinked interventions....Relegate post-treatment continuing care services to an afterthought" (W.White, 2005) Repeated episodes of acute care for detox; stabilization; discrete fixed program stay; "treatment completion"; "graduation"
5. Poor outcomes	5. Viewed as the need for more intensive case and care management and community outreach	5. Blame the client for denial and "stinking thinking"; non-compliance; stubbornness to take suggestions

**C. Terminology and its Effect on Practice** – Do you really believe in recovery and illness management?

1. "Negative consequences" – In addiction treatment clinicians often say that if a person uses while in treatment there needs to be "negative consequences". But if a person gets depressed again and cuts herself; or manic and spends a lot of money; or psychotic because of not taking medication, do we say there need to be "negative consequences"?
2. "Graduation" – Clients and counselors talk of "graduation" from the program. But when does a person graduate from diabetes treatment? Or from Bipolar Disorder treatment? Or from hypertension or asthma treatment?
3. "Complete the program" – Similarly, when does a person complete the depression program; or complete the Schizophrenic Disorder program? On what basis is the decision to discharge or

- transfer a person from successful treatment made? Is it based on a set time and/or number of sessions? Or do you focus on the level of function and the quality of the person's recovery?
4. "How long is your program?" or "How long do I have to stay?" – The same issue is raised here. Do we really believe we are managing long-term illnesses; or do we act more like there is a set of program expectations and monitoring compliance with rules and expectations.

- 
5. “More willing to follow rules and compliant with treatment activities”; “Compliant participation in group” – These are examples of Progress Notes that focus on a client’s doing time, not doing treatment. They do not speak of harnessing a client’s positive efforts and energy. It promotes passive behavior to please others or to jump through certain hoops.
  6. “Serious and persistent” – This phrase has no counterpart in general medicine care, which describes general illnesses with similar consequences as “severe” and “chronic” as opposed to “mild” and “acute.” It is not common for example, to talk about “serious” cancers. The term “persistent” could connote a lack of belief in the ability to improve and recover. There is a less pejorative and clinically useful way to categorize individuals with mental illnesses that have chronic functional limitations. It might be to refer to them as having mild, moderate, or severe disability associated with a mental illness symptom or diagnosis, rather than to refer to them as the “seriously” mentally ill. (“Improving the Quality of Health Care for Mental and Substance-Use Conditions” pp. 86-87 Institute of Medicine. The National Academies Press, Washington, D.C. 2005)

### **Continuing Support for Implementation**

- Follow-up training for skill building and training strategies
- Peer supervision opportunities
- Call or e-mail David Mee-Lee with questions, concerns or other implementation issues

### **Kim**

Kim is a 29-year-old, Caucasian, single mother, unemployed woman who was referred because of depression with suicidal and homicidal ideation, but no specific plan or means to follow through.

The client appeared depressed and had made verbal threats towards the Child Protective Services office as well as suicidal threats and feelings, if she did not get her children back.

Two months earlier, her two sons, who are two and a half and eight were put in a foster home because she supposedly left them unattended. She says that her boyfriend of fourteen years actually pushed her down some steps and she fell and was unconscious for four days. She had taken two hits of crystal methamphetamine and says that as a result of the "dirty" urine test, her children were taken away from her and she is very angry and depressed about this. Her boyfriend who is now in jail for parole violation is apparently being charged with attempted murder because of the incident.

Kim has been depressed over wanting to get her children back and angry at "the system" because she feels she has been wronged. She says that she has not used any drugs other than one day two month’s ago, for nearly three years and was very active in Alcoholics Anonymous having a sponsor and being involved up until eight months ago. Kim has drifted away from Alcoholics Anonymous and feels that this may have caused her relapse in two months earlier. She wants to get her life together but also has been feeling angry about the difficulty of getting public assistance and has been making verbal threats of wanting to "blow people's brains out" and also feelings of wanting to give up and "that she is cracking up".

Kim denies any current use of alcohol or other drugs although admits in the past to having significant problems with cocaine and marijuana. She has had a previous psychiatric hospitalization four years ago, when she had cut her wrists and needed a couple of sutures after an argument with her boyfriend.

Kim has been having no trouble with sleep and has had an increased appetite with a slight increase in weight but her energy and libido have been decreased and she has had suicidal feelings. She has been having some trouble with constipation, poor hearing in her left ear and occasional headaches perhaps related to the fall two months ago. Her menstrual periods have been normal and she smokes a pack of cigarettes every two days. She does want help, however, mainly though to get her children back.

---

Cindy

A 45 year old, divorced, local, female, groundskeeper was referred for treatment by a Substance Abuse Professional (SAP) who assessed Cindy as meeting diagnostic criteria for alcohol dependence and cocaine abuse with symptoms of depression. The SAP assessment was triggered by the patient's alleged refusal for a random urine drug screen at work. Since she had shown a positive cocaine result on a random drug screen eight months earlier, this refusal constituted an automatic second positive, as refusal is interpreted as a positive. The patient disputes she was told to take a random test before leaving work sick for the day.

Cindy admits to an alcohol problem, but feels it is no longer a problem as she claims to have stopped drinking January 1 this year (five months ago). She claims she's never had a cocaine problem and just used with a boyfriend that once, the night before the first random urine test at work. She complains of depression over the past five or six months, but has not had suicidal thoughts, or impulses to harm herself.

She faces loss of her job of 17 years if she does not comply with treatment and the question is what level of care and plan of care should be sought or authorized ?

The clinician evaluates the biopsychosocial data and organizes the information under the following six assessment of the Patient Placement Criteria of the American Society of Addiction Medicine (ASAM):

Dimension 1, Acute Intoxication/Withdrawal Potential: Last use - alcohol 5 months ago; cocaine 8 months ago. No previous detox or severe withdrawal. In no distress; alert, oriented, with no tremors; skin warm and dry; nothing to suggest any severe withdrawal danger.

Dimension 2, Biomedical Conditions/Complications: no physical complaints; not on any medications and is healthy.

Dimension 3, Emotional/Behavioral/Cognitive Conditions/Complications: depressed for past 5-6 months; oriented, mood appropriate, slightly depressed, and no evidence of psychosis or suicidality; some anxiety about job and dispute that the union is grieving. No previous psychiatric history.

Dimension 4, Readiness to Change: admits alcohol was her drug of choice, but feels she has it under control and that cocaine never was a problem. Mainly wanting to keep her job, but does complain of some problems with depression and her alcohol use in the past; willing to be involved in treatment but feels she only needs urine monitoring and low intensity outpatient support and counseling for her depression.

Dimension 5, Relapse/Continued Use/ Continued Problem Potential: poor skills to consistently avoid further drinking problems, but sufficiently concerned about job to control immediate drinking/drugging behavior; not imminently dangerous to self or others; not in AA/other self help group.

Dimension 6, Recovery Environment: lives alone in an apartment; job issues a stress, but also an asset to provide leverage to help engage patient into examining her drinking and drugging behavior; supervisors supportive and report good job performance except for the drug screens; has hobbies of making and selling souvenirs to tourists.

Severity Profile:                      Dimension:      1      2      3      4      5      6  
(High, Medium, Low)                      Severity:

Services Needed:

Level of Care:

---

**Patient Progress and Treatment Plan Review:**

After six sessions in a group setting, it became clear that Cindy was confirmed in her belief that she was in control of any alcohol or other drug use. Her depression began improving with some mental health counseling. A case conference was conducted to review her treatment progress and continued service needs. The patient felt she did not need intensive treatment and although the treatment team disagreed based on their assessment that she had more of an addiction problem than she realized, it was agreed that she would have random urine monitoring and an individual session weekly.

However, if she was not able to demonstrate abstinence from cocaine and alcohol that she claimed she desired and had already achieved, then that would be evidence that she was more severe than she thought and might require more intensive treatment. Since she had just had a urine test for work, to be cleared to return, the counselor ordered a random test straight after the conference suspecting that she may have been using. As it turned out she was indeed positive for cocaine. Cindy then admitted use, but did not feel it was because she was out of control with a drug problem. Friends had come by straight after the return to work drug screen and she used a little with them. She felt it would be unsociable to refuse their visit and the cocaine and unable to know how to set any limits on them.

Having assessed and observed the patient to be more unaware of how to avoid continued use than she had thought; lacking coping skills to avoid use; and as having little understanding of addiction, treatment was intensified. Reassessment of her progress will then determine if she is responding to the more intensive treatment or whether she is reverting to a random monitoring approach.

**Carl**

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

Carl has been arrested three times in the past eighteen months for petty theft/shoplifting offenses. Each time he has been acting intoxicated but denies use. The school reports acting up behavior, declining grades and erratic attendance, but no evidence of alcohol/drug use directly. They know he is part of a crowd that uses drugs frequently.

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

**Tracy**

A 16-year-old young woman is brought into the emergency room of an acute care hospital. She had gotten into an argument with her parents and ended up throwing a chair. There was some indication that she was

intoxicated at the time and her parents have been concerned about her coming home late and mixing with the wrong crowd. There has been a lot of family discord and there is mutual anger and frustration between the teen and especially her father. No previous psychiatric or addiction treatment.

---

The parents are both present at the ER, but the police who had been called by her mother brought her. The ER physician and nurse from the psychiatric unit who came from the unit to evaluate the teen, both feel she needs to be in hospital given the animosity at home, the violent behavior and the question of intoxication.

Using the six ASAM assessment dimensions, the biopsychosocial clinical data is organized as follows:

Dimension 1, Intoxication/Withdrawal: though intoxicated at home not long before the chair-throwing incident, she is no longer intoxicated and has not been using alcohol or other drugs in large enough quantities for long enough to suggest any withdrawal danger.

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

Dimension 3, Emotional/Behavioral/Cognitive: complex problems with the anger, frustration and family discord; chair throwing incident this evening, but is not impulsive at present in the ER.

Dimension 4, Readiness to Change: willing to talk to therapist; blames her parents for being overbearing and not trusting her; agrees to treatment, but doesn't want to be at home at least for tonight.

Dimension 5, Relapse/Continued Use/Continued Problem Potential: high likelihood that if released to go back home immediately, there would be a reoccurrence of the fighting and possibly violence again, at least with father.

Dimension 6, Recovery Environment: parents frustrated and angry too; mistrustful of patient; and want her in the hospital to cut down on the family fighting.

Severity Profile:    Dimension:    1    2    3    4    5    6  
(High, Medium, Low)    Severity:

Services Needed:

Site of Care:

## **Stephen**

Stephen is 51 years old and is accompanied by his wife. He wants help, but is depressed. During his intake interview for this, his second DUI arrest, he looks disconsolate and he speaks in a monotone as he wonders if his wife will leave him. His alcohol use has resulted in alienation from his children, guilt feelings and his job may now be threatened, as he has been warned by his supervisor about his poor attendance and performance. Most of his friends drink, but none of them think he is an alcoholic.

He has not had any previous addiction treatment other than DUI classes after his first DUI four years ago. He attended AA for six months on and off and did have a sponsor, but felt more and more that he wasn't as bad as others at AA and gradually stopped going.

Stephen has been alcohol-free for three weeks. He has used cocaine (snorting) about three times per month over the past four years, but stopped two months ago. He has had no legal or financial problems related to cocaine. Stephen has continued on diazepam (Valium) 5 mg. qid which he has taken for five years to relax him because of mild hypertension. He has no other chronic physical problems but has lost 10 pounds weight over the past month and has been sleeping poorly. He wishes he could sleep and get away from all his problems but denies any organized suicidal plans and says he wants help.

---

**Laura**

Laura is a 46 year-old single Caucasian, female who lives with her 13 year-old daughter. She is employed by the County, as a worker in the tax assessor's office. She presented as a self-referral, though this was doubted as she presented as very closed, very angry, severely confrontational, made no eye contact, and attempted to answer in as short a manner as possible. There seemed to be some unnamed motivating factor behind the evaluation.

She first presented for an evaluation on October 7. The following information was reported or discerned during the evaluation:

Cocaine use daily for approximately three months - in binge fashion.  
She was clean for six years, having relapsed on alcohol January 1; on crack cocaine in July.  
Crack cocaine use became out of control almost immediately.

No biomedical, physical health complaints or conditions.

Significant mental health symptoms, though patient minimizes/denies they exist

- observed anxiety
- observed depression
- history of mood swings, unknown if they exist presently
- mentally clouded: tangential, distracted, agitated
- ongoing suicidality: "I wanted to die" the other day, and was going to "take some pills and go to sleep and never wake up."
- at the time of the evaluation, was unable to state why she did not take the pills and was minimally able to contract for the future
- affect was entirely flat during the evaluation with one exception: when asked about addiction in the family, Laura replied the "whole damn family" (is addicted), using expression for the only time

Laura was not willing to discuss specific behaviors committed related to using/obtaining crack cocaine, but did acknowledge high-risk behavior occurred.

Claims treatment was her idea, but could not state why.

Made no mention of secondary or external motivating factors, yet did briefly mention work-related problems.

Relapse potential: Did inpatient rehabilitation July to August, eight years ago – completed.

No manageable period since January when relapsed at New Year's party.

Tremendous cravings, both in and out of her home environment - used before work, and on occasion, at work.

Though Laura was active in a 12-Step program during her period of recovery, lessened and then stopped her meetings as her recovery progressed.

Reports became more active in her church.

Laura is now no longer active in either group, or in anything else that would foster abstinence, growth, or recovery.

Recovery environment: No apparent support.

Laura reports dysfunctional relationship with 13 year old daughter.

Unable to mother, as she is not home or sober to do so.

Laura is unable to walk in own immediate neighborhood without being exposed to crack cocaine.

—

No reported or observed ability to delay using crack cocaine once it is offered and once she uses, she uses in binge-like fashion.

---

## **Using the Decision Tree to Match Assessment and Treatment/Placement Assignment**

1) DSM Axes:

- I Cocaine Dependence; Alcohol Dependence; (Mental disorders deferred)
- II R/O Anti-personality Disorder
- III None
- IV Primary Support, Occupational, Financial, Social
- V GAF: 43; highest past year: ?

2) The risk factor (H/M/L severity) for each ASAM dimension:

- 1: Medium (due to post-cocaine depression)
- 2: Low
- 3: High
- 4: Low
- 5: High
- 6: High

3) Which dimensions are the most concerning?: Dimensions 3, 5, and 6.

4) What are the priorities for each dimension (what am I worried about?):

Dimension 3: her level of functioning. – claims to be self-motivated, yet presentation contradicts –observed levels of depression and anxiety, reports of recent suicidal plan, and current SI with limited ability to contract --reported level of violent behavior (unspecified if related to drug use or not) –obvious anger and rigidity –unwillingness to discuss losses, and her reactions to them

Dimension 5: significant cravings, with no reported to identify their source, or to manage them --no clean period since relapsed in January –accelerated out-of-control behavior subsequent to crack relapse in July – no treatment or counseling since 1994, when completed inpatient rehabilitation – no sober support, stopped 12-step involvement, apparently long before relapsing (does not remember last meeting)

Dimension 6: no identified social or environmental support –lives with daughter, but no peers who provide support – reports cannot leave the house without being accosted to buy/use crack cocaine –refuses to discuss what she does to obtain drugs, yet must be significant, as reports has lost everything –unspecified work related problem, so even that cannot be assumed to be a structured + environment presently

5) What specific services are needed for each dimension (what will I do in treatment?):

Dimension 3: I want a psychiatric evaluation for Laura, as soon as is reasonable –want her in a dual-diagnosis program to address the suicidality, and other symptoms mentioned above –want to address her resistance to determine if it is tied into her MH symptoms

Dimension 5: Laura presents as though relapse (or in her case, continued using) is inevitable –but is it, really –is there a chance she’d respond to developing a relapse prevention plan if she were away from her regular environment for a period of time –as she stabilizes, I would want to focus on what she did during her clean time that worked –I’d want to look at what coping skills she used before

Dimension 6: Laura claims there is no recovery environment at all –yet there was possibly enough of one to sustain her during the clean period –as she stabilizes, I want to examine in closer detail what her recovery environment looked like before (--I also have concerns about the daughter, but that is secondary) - she does not explicitly report any victimization in her environment, yet is scared by it, so I would want to explore this area

6) What ‘dose’ of services does she need for each dimension? What made me identify a particular level of severity?

Dimension 3: I believe she needs round-the-clock services, psychiatric as well as to assess safety and stability

Dimension 5: She needs to have repeated, structured services away from her regular surroundings so that she can begin the process of identifying positive relapse prevention coping mechanisms

Dimension 6: She needs to be off the streets –recovery environment is so poor, and feels so isolated/abandoned in her environment, cannot put into any positive perspective until removed from it

7) Where can services be provided in the least intensive, but safest, level of care?

Based on all the above information, the most appropriate ASAM treatment recommendation was considered. Due to the severity of dimensions, 3, 5, and 6, an inpatient level of treatment seemed the most appropriate treatment consideration.

Laura’s psychiatric condition is unstable; she is at least a moderate risk to endangering herself - needs to be considered for psychotropic meds

She is in a crisis state presently, posing potential danger – she is also unable to apply relapse prevention skills now, also posing potential danger

Due to the severity of her present condition, Laura is unable to care for herself, even for limited periods.

Looking at Laura’s present situation, even a III.5 treatment setting does not appear to be intense enough. Laura needs to begin treatment in a III.7 setting, and upon stabilization, can be moved to a lower level of care. ASAM PPC-2R supports this treatment recommendation, in the following dimensions:

- Dimension 3.a, 3.b; DDE 3.a; 3.b, 3.d

- Dimension 5.a; DDE criteria
- Dimension 6.c (possibly 6.a also)

When I attempted to precertify this case with the managed care company for Inpatient (Level III.7), the initial reviewer did not feel comfortable authorizing that level of care. She wanted to discuss the case with a physician. She was careful to stress that this was not a physician review, but rather a consultation on her part. After discussing the case, she returned to the phone, stating that she could only authorize Partial Hospital level of care, with an independent psychiatric evaluation.

Given the severity of Laura's presentation, I did not want her to start in Partial. It was nowhere near the level of intensity that she needed. I wanted the patient to be in our dual treatment program, and to the psychiatrist ASAP. There was a question of a personality disorder also (antisocial?). When the doctor called, interestingly, it was the same doctor who had done the "consultation" with the initial reviewer. He maintained that her psychiatric condition did not necessitate an inpatient stay. I reiterated her frequent degree of suicidality, including her own statements. I also discussed her Dimensions 5 and 6 concerns.

He agreed they were severe, but also stated that she had had no treatment since eight years ago, and had not recently failed Partial Hospital level of care. I asked him if that was really necessary, given the degree of symptoms.

Before I conducted the physician review I was prepared to do what I usually do: whack him over the head with criteria, and hope that that, coupled with my sterling presentation, would have him agree with my treatment recommendation. A haphazard approach at best, and one with a lot of potential for frustration, but used nevertheless.

Instead, I tried the new approach. We agreed that Dimensions 3, 5, and 6 were the most important. I wanted the dose to be daily, with her out of her milieu, to get some perspective about possible changes she can make, recovery tools she can employ, etc. I also wanted the psychiatric involvement, from the evaluation to the monitoring due to the suicidality. When he asked me why not Partial Hospital level of care with an independent psychiatric evaluation, I asked him how he would address all of the issues presented at a lower level of care. He asked me what I meant, and I replied - not in an in-your-face-ASAM way, but to put the onus back on him, as to how he would provide the necessary services in a Partial level of care. Bottom line is he agreed. She is now inpatient dual diagnosis Level III.7.

The case took care of itself, and was win-win. He actually asked in my 'honest opinion' would putting her in Partial be de facto a failed Partial level of care. I told him I honestly thought so and why and he reversed himself to authorize the inpatient stay.

No fighting. Just talking.

**CLINICAL ASSESSMENT AND PLACEMENT SUMMARY Page 1 of 2**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Immediate Need Profile:** Assessor considers each dimension and with just sufficient data to assess immediate needs, checks “yes” or “no” in the following table:

Dimension	Questions	Yes	No
1. Acute Intoxication and/or Withdrawal Potential	1(a) Past history of serious withdrawal, life-threatening symptoms or seizures during withdrawal?		
1. as above	1(b) Currently having similar withdrawal symptoms?		
2. Biomedical Conditions/Complications	2 Any current severe physical health problems?		
3. Emotional/Behavioral/Cognitive Conditions/Complications	3(a) Imminent danger of harming self or someone else?		
3. as above	3(b) Unable to function and safely care self?		

**. Yes to questions 1a, 1b, 2 and/or 3a, 3b requires that the caller/client immediately be referred for medical and/or mental health evaluation, depending on which dimension(s) involved.**

4. Readiness to Change	4(a) Does client appear to need alcohol or other drug treatment/recovery, but ambivalent or feels it unnecessary? e.g., severe addiction, but client feels controlled use still OK		
4. as above	4(b) Client been coerced, mandated or required to have assessment and/or treatment		

**. Yes to questions 4a and/or to 4b alone, requires staff to begin immediate intervention and motivational strategies appropriate to client’s stage of readiness to change.**

5. Relapse/Continued Use Potential	5(a) Is client currently under the influence or intoxicated?		
5. as above	5(b) Is client likely to continue use of alcohol and/or other drugs, or to relapse, in an imminently dangerous manner?		

**. Yes to question 5a requires caller/client be considered for withdrawal potential. Yes to question 5a and/or 5b, individual may need to be considered for 24-hour structure or care.**

6. Recovery Environment	6. Are there any dangerous family, sig. others, living/work/school situations threatening client’s safety, immediate well-being, and/or sobriety?		
-------------------------	---	--	--

**. Yes to Dimension 6, without any Yes in questions 1, 2 and/or 3, requires that the caller/client be assessed for the need of a safe or supervised environment.**

**LEVEL OF FUNCTIONING/SEVERITY:** Using assessment protocols that address all six dimensions, assign a severity rating of **High, Medium or Low** for each dimension that best reflects the client’s functioning and severity. Place a check mark in the appropriate box for each dimension.

Level of Functioning/Severity	Intensity of Service Need	1. Intox With	2. Bio- med	3. Emot/ Beha	4. Readi- -ness	5. Rel- apse	6. Rec. Envir
<b>Low Severity</b> – Minimal, current difficulty or impairment. Absent, minimal, or mild signs and symptoms. Acute or chronic problem mostly stabilized; or soon able to be stabilized and functioning restored with minimal difficulty	<b>L</b> No immediate services or low intensity of services needed for this Dimension. Treatment strategies usually able to be delivered in outpatient settings						
<b>Medium Severity</b> - Moderate difficulty or impairment. Moderate to serious signs and symptoms. Difficulty coping or understanding, but able to function with clinical and other support services and assistance	<b>M</b> Moderate intensity of services, skills training, or supports needed for this Dimension. Treatment strategies may require intensive levels of outpatient care						

---

<p><b>High Severity</b> - Severe difficulty or impairment. Serious, gross or persistent signs and symptoms. Very poor ability to tolerate &amp; cope with problems.</p>	<p><b>H</b> High intensity of services, skills training, or supports needed. More immediate, urgent services may require inpatient or residential settings; or closely monitored case management services at a frequency greater than daily</p>						
---	---	--	--	--	--	--	--

© David Mee-Lee, M.D. 1998 davmeelee@aol.com 530.753.4300

**CLINICAL ASSESSMENT AND PLACEMENT SUMMARY (cont.)**

**Page 2 of 2**

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**PLACEMENT DECISIONS:** Indicate for each dimension, the least intensive level consistent with sound clinical judgment, based on the client's functioning/severity and service needs

<b>ASAM PPC-2R Level of Detoxification Service</b>	<b>Level</b>	<b>Dimen. 1 Intoxic/ Withdr.</b>					
Ambul. Detox without Extended On-Site Monitor.	I-D						
Ambul. Detox with Extended On-Site Monitoring	II-D						
Clinically-Managed Residential Detoxification	III.2-D						
Medically-Monitored CD Inpatient Detoxification	III.7-D						
Medically-Managed Intensive Inpatient Detox.	IV-D						
<b>ASAM PPC-2R Level of Care for Other Treatment and Recovery Services *</b>	<b>Level *</b>		<b>Dimen. 2 Biomed.</b>	<b>Dimen. 3 Emot/ Behav.</b>	<b>Dimen. 4 Readiness</b>	<b>Dimen. 5 Relapse/ Cont Use</b>	<b>Dimen. 6 Recov. Environ.</b>
Early Intervention / Prevention	0.5						
Outpatient Services / Individual	I						
Intensive Outpatient Treatment (IOP)	II.1						
Partial Hospitalization (Partial)	II.5						
Apartments /Clinically-Managed Low-Int. Res. Svcs.	III.1						
Clinically-Managed Med-Intens. Residential Svcs.	III.3						
Clinically-Managed High-Intens. Residential Svcs	III.5						
Medically-Monitored Intens. Inpatient Treatment	III.7						
Medically-Managed Intensive Inpatient Services	IV						
Opioid Maintenance Therapy	OMT						

**PLACEMENT SUMMARY**

<b>Level of Care/Service Indicated</b> - Insert the ASAM Level number that offers the most appropriate level of care/service that can provide the service intensity needed to address the client's current functioning/severity.	
--	--

<b>Level of Care/Service Received</b> - ASAM Level number -- If the most appropriate level is not utilized, insert the most appropriate placement available and circle the Reason for Difference between Indicated and Received Level	
<b>Reason for Difference</b> - Circle only one number -- <b>1.</b> Service not available; <b>2.</b> Provider judgment; <b>3.</b> Client preference; <b>4.</b> Client is on waiting list for appropriate level; <b>5.</b> Service available, but no payment source; <b>6.</b> Geographic accessibility; <b>7.</b> Family responsibility; <b>8.</b> Language; <b>9.</b> Not applicable; <b>10.</b> Not listed.	

**COMMENTS:**

**Matrix for Matching Services to Needs**

<b>Risk Rating and Description</b>	<b>Types of Services and Modalities Needed</b>	<b>Intensity of Service/ Level of Care/Setting</b>
Assess severity and level of function to identify needs for services in all six ASAM assessment dimensions	Identify what variety of services are required to address priority needs based on the risk assessment in each dimension	Determine what type of service setting and level of care can efficiently, safely provide the needed intensities of service
Risk ratings are benchmarked on a scale of <b>0 to 4</b> with <b>0</b> indicating full function and no risk in this assessment dimension	If <b>0</b> , no specific services are needed in this assessment dimension	Intensity of services are benchmarked on a scale of <b>0 to 4</b> with <b>0</b> , indicating that no specific level of care or treatment setting is needed in this assessment dimension
If risk rating is <b>1-4</b> , the severity and risk level rises with the higher number in whatever assessment dimension is being assessed	Specific services in an individualized treatment plan are designed to match the severity, level of function and risk in this assessment dimension	The intensity of services will rise with the higher risk rating in Dimensions 1 - 3, but will be variable for Dimensions 4-6 depending on the mix of services in the middle column

<p><b>Adult Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications</b></p> <p><b>Risk Rating and Description, by Risk Domains (a)</b></p> <p><i>(NOTE: A higher number indicates a greater level of severity or intensity and individuals need not match descriptions in all of the subdomains within any one risk category)</i></p>	<p><b>Types of Services and Modalities Needed (b)</b></p>	<p><b>Intensity of Service/ Level of Care/Setting (c)</b></p>
<p><b>Risk Rating: 0</b> = The patient either has no mental health problems or has a diagnosed but stable mental disorder.</p> <p><b>Dangerousness/Lethality:</b> Good impulse control and coping skills.</p> <p><b>Interference with Addiction Recovery Efforts:</b> Ability to focus on recovery, identify appropriate supports and reach out for help.</p> <p><b>Social Functioning:</b> Full functioning in relationships with significant others, work and friends, et al.</p> <p><b>Ability for Self Care:</b> Full functioning, with good personal resources and skills to cope with emotional problems.</p> <p><b>Course of Illness:</b> No emotional or behavioral problems, or problems identified are stable (e.g., depression that is stable and managed with antidepressants). No recent serious or high-risk vulnerability.</p>	<p>No immediate mental health services are needed.</p>	<p><b>Intensity: 0</b> = Does not affect the placement decision.</p>

<p><b>Adult Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications</b></p> <p><b>Risk Rating and Description, by Risk Domains (a)</b></p> <p><i>(NOTE: A higher number indicates a greater level of severity or intensity and individuals need not match descriptions in all of the subdomains within any one risk category)</i></p>	<p><b>Types of Services and Modalities Needed (b)</b></p>	<p><b>Intensity of Service/ Level of Care/Setting (c)</b></p>
<p><b>Risk Rating: 1</b> = The patient has a diagnosed mental disorder that requires intervention, but does not significantly interfere with addiction treatment.</p> <p><b>Dangerousness/Lethality:</b> Adequate impulse control and coping skills to deal with any thoughts of harm to self or others.</p> <p><b>Interference with Addiction Recovery Efforts:</b> Emotional concerns relate to negative consequences and effects of addiction. The patient is able to view these as part of addiction and recovery.</p> <p><b>Social Functioning:</b> Relationships or spheres of social functioning (as with significant others, friends, work) are being impaired but not endangered by patient's substance use (e.g., no imminent divorce, job loss, or patient is coping even though in a homeless situation). The patient is able to meet personal responsibilities and maintain stable meaningful relationships despite the mild symptoms experienced (e.g., mood or anxiety symptoms subthreshold for DSM-IV diagnosis or, if meeting diagnostic criteria, patient is able to continue in essential roles).</p> <p><b>Ability for Self Care:</b> Adequate personal resources and skills to cope with emotional or behavioral problems.</p> <p><b>Course of Illness:</b> Mild to moderate signs and symptoms (e.g., dysphoria, relationship problems, work or school problems, or problems coping in the community, with good response to treatment in the past. Any past serious problems have a long period of stability (e.g., serious depression and suicidal behavior 15 years ago) or past problems are chronic but not severe enough to pose any high risk vulnerability (e.g., superficial wrist scratching, but no previous hospitalization or life-threatening behavior).</p>	<p>Low intensity mental health services are needed, including case management to coordinate addiction and mental health care, medication monitoring, psychoeducation about mental disorders and psychotropic medications, and self/mutual help and dual diagnosis support and recovery groups to deal with emotional aspects of recovery.</p>	<p><b>Intensity: 1</b> = Level I outpatient services.</p> <p><b>LOC/Setting:</b> Outpatient primary care, or an addiction or mental health service that incorporates specific services for "dual diagnosis" patients, or addiction treatment services with psychiatric integration, consultation/liaison and/or collaboration; or mental health care with addiction integration, consultation/liaison or collaboration – Dual Diagnosis Capable (DDC) services</p>

<p><b>Adult Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications</b></p> <p><b>Risk Rating and Description, by Risk Domains (a)</b></p> <p><i>(NOTE: A higher number indicates a greater level of severity or intensity and individuals need not match descriptions in all of the subdomains within any one risk category)</i></p>	<p><b>Types of Services and Modalities Needed (b)</b></p>	<p><b>Intensity of Service/ Level of Care/Setting (c)</b></p>
<p><b>Risk Rating: 2</b> = Patients are of two types. The first exhibits this level of impairment only during acute decompensation. The second demonstrates this level of decompensation at baseline. This Risk Rating implies persistent mental illness, with symptoms and disability that cause significant interference with addiction treatment, but do not constitute an immediate threat to safety and do not prevent independent functioning.</p> <p><b>Dangerousness/Lethality:</b> Suicidal ideation; violent impulses; significant history of suicidal or violent behavior requires more than routine monitoring.</p> <p><b>Interference with Addiction Recovery Efforts:</b> Emotional, behavioral or cognitive problems distract the patient from recovery efforts.</p> <p><b>Social Functioning:</b> Relationships or spheres of social functioning (as with significant others, friends, work) are being impaired by substance use, and may be linked to a psychiatric disorder (e.g., a patient with depression or anxiety disorder is unable to sleep or socialize). Symptoms are causing moderate difficulty in managing relationships with significant others, social, work or school functioning, or coping in the community, but not to a degree that they pose a significant danger to self or others, or that the patient is unable to manage activities of daily living or basic responsibilities in the home, work, school, or community.</p> <p><b>Ability for Self Care:</b> Poor personal resources, with moderate or minimal skills to cope with emotional or behavioral problems.</p> <p><b>Course of Illness:</b> Frequent and/or intensive symptoms (e.g., frequent suicidal or homicidal ideation; vegetative signs; agitation or retardation; inconsistent impulse control), with a history that indicates significant problems that are not well stabilized (e.g., psychotic episodes with frequent periods of decompensation). Acute or acute-on-chronic problems pose some risk of harm to self or others, but the patient is not imminently dangerous (e.g., hallucinations and delusions invoke homicidal ideation, but the patient has no plan or means to harm others).</p>	<p>Moderate intensity mental health services are needed, including case management to ensure monitoring and evaluation of emotional, behavioral, and cognitive status as part of the treatment plan. Medication management and monitoring, and medical and nursing monitoring and management as needed.</p> <p>For acute decompensation patients, activities to address the substance use disorder may need to be postponed until the patient's mental health symptoms are more stable.</p> <p>For baseline patients, the patient's substance use disorder may be addressed in psychiatrically enhanced addiction services, staffed by mental health professionals with smaller caseloads.</p> <p>For patients with high Risk Ratings in Dimension 4, motivational enhancement therapies may be integrated into ongoing mental health services.</p>	<p><b>Intensity: 2</b> = Level II.1 intensive outpatient or Level II.5 partial hospitalization services.</p> <p><b>LOC/Setting:</b> Intensive mental health treatment with integrated addiction services, or "dual diagnosis" intensive outpatient services. Partial hospitalization mental health treatment with integrated addiction services, or "dual diagnosis" partial hospitalization services – Dual Diagnosis Enhanced (DDE) services</p> <p>For baseline patients, the range of settings may include outpatient case management to intensive outpatient, partial hospitalization and Level III.1 for supportive living.</p>

<p><b>Adult Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications</b></p> <p><b>Risk Rating and Description, by Risk Domains (a)</b></p> <p><i>(NOTE: A higher number indicates a greater level of severity or intensity and individuals need not match descriptions in all of the subdomains within any one risk category)</i></p>	<p><b>Types of Services and Modalities Needed (b)</b></p>	<p><b>Intensity of Service/ Level of Care/Setting (c)</b></p>
<p><b>Risk Rating: 3</b> = Patients are of two types. The first exhibits this level of impairment only during acute decompensation. The second demonstrates this level of decompensation at baseline. This Risk Rating is characterized by severe psychiatric symptomatology, disability and impulsivity, but the patient has sufficient control that he or she does not require involuntary confinement.</p> <p><b>Dangerousness/Lethality:</b> Frequent impulses to harm self or others, which are potentially destabilizing, but the patient is not imminently dangerous in a 24-hour setting.</p> <p><b>Interference with Addiction Recovery Efforts:</b> Recovery efforts are negatively affected by the patient's emotional, behavioral or cognitive problems in significant and distracting ways, up to and including inability to focus on recovery.</p> <p><b>Social Functioning:</b> Significant functional impairment, with severe symptoms (e.g., disorganized thinking; depression with significant vegetative signs; agitation or retardation; poor impulse control). Symptoms seriously impair the patient's ability to function in family, social, work, or school settings, or (in chronic populations) to function in shelters, homeless and other community situations.</p> <p><b>Ability for Self Care:</b> Insufficient or severe lack of capacity to cope with emotional or behavioral problems. Uncontrolled behavior, confusion or disorientation, which limit the patient's capacity for self care. Inadequate activities of daily living.</p> <p><b>Course of Illness:</b> Acute course of illness dominates the clinical presentation so that symptoms may involve impaired reality testing, communication, thought processes, judgment, or attention to personal hygiene, which significantly compromise the patient's ability to adjust his or her life in the community, or previous treatment has not achieved stabilization or complete remission of symptoms. The patient has limited ability to follow through with treatment recommendations, thus demonstrating risk of and vulnerability to dangerous consequences.</p>	<p>Moderately high intensity mental health services are needed, including daily monitoring and ready access to medical management, and medication management if symptoms become acute but not dangerous. Discharge planning for assertive case management and community outreach are needed for the severely and persistently mentally ill patient. Supportive living arrangements, with 24-hour supervision, are needed.</p> <p>For acute decompensation patients, activities to address the substance use disorder (other than detoxification and discharge planning) may need to be postponed until the patient's mental health symptoms are stabilized.</p> <p>For baseline patients, the patient's substance use disorder may be addressed in addiction-treatment enhanced mental health services.</p> <p>For patients with high Risk Ratings in Dimension 4, motivational enhancement therapies may be integrated into ongoing mental health services.</p>	<p><b>Intensity: 3</b> = Level III.5 clinically managed residential services or Level III.7 medically monitored inpatient services.</p> <p><b>LOC/Setting:</b> A free-standing residential "dual diagnosis" service, or subacute residential psychiatric unit with medical monitoring and integrated addiction services – Dual Diagnosis Enhanced (DDE) services</p>

<p><b>Adult Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications</b></p> <p><b>Risk Rating and Description, by Risk Domains (a)</b></p> <p><i>(NOTE: A higher number indicates a greater level of severity or intensity and individuals need not match descriptions in all of the subdomains within any one risk category)</i></p>	<p><b>Types of Services and Modalities Needed (b)</b></p>	<p><b>Intensity of Service/ Level of Care/Setting (c)</b></p>
<p><b>Risk Rating: 4</b> = Patients have severe psychiatric symptomatology, disability and impulsivity, and requires involuntary confinement.</p> <p><b>Dangerousness/Lethality:</b> Severe psychotic, mood or personality disorder, which presents acute risk to the patient, such as immediate risk of suicide, psychosis with unpredictable, disorganized or violent behavior, or gross neglect of self care.</p> <p><b>Interference with Addiction Recovery Efforts:</b> Risk in this domain does not influence type and intensity of services needed.</p> <p><b>Social Functioning:</b> Risk in this domain does not influence type and intensity of services needed.</p> <p><b>Ability for Self Care:</b> Risk in this domain does not influence type and intensity of services needed.</p> <p><b>Course of Illness:</b> High risk and significant vulnerability for dangerous consequences. The patient exhibits severe and acute life-threatening symptoms (e.g., dangerous or impulsive behavior or cognitive functioning) that pose imminent danger to self or others. Symptoms of psychosis include command hallucinations or paranoid delusions. History of instability is such that high intensity services are needed to prevent dangerous consequences (e.g., the patient is not responding to daily changes in medication at less intensive levels of service, with escalating psychosis).</p>	<p>High intensity mental health services are needed, including 24-hour medical and nursing monitoring and management, medication management, ECT or secure services, and close observation more often than hourly.</p> <p>Appropriate addiction services (such as detoxification and motivational enhancement therapies) can be integrated into mental health services.</p>	<p><b>Intensity: 4</b> = Level IV medically managed intensive inpatient services.</p> <p><b>LOC/Setting:</b> A psychiatric acute inpatient unit.</p> <p>For addicted patients who are somewhat ready to engage in recovery, a dual diagnosis specialty unit is ideal – Dual Diagnosis Enhanced (DDE) services</p>

**NOTES:**

- (a) Consider dangerousness and/or lethality, interference with addiction recovery efforts, social functioning, capacity for self-care, and course of illness (history of present illness—the pattern of symptoms and response to treatment up to, and including, the present illness—and pattern of treatment response).
- (b) Consider acute stabilization, medical management and monitoring, mental health consultation and integration of mental health and addiction services, skills training, case management, medication management and monitoring, and systems intervention and coordination.
- (c) Consider traditional addiction and mental health services, availability of addiction services coordinated with mental health services or mental health services coordinated with addiction treatment, integrated inpatient or outpatient "dual diagnosis" services, assertive case management and community outreach services.

**Adult Dimension 4: Readiness to Change**

<p><b>Adult Dimension 4: Readiness to Change</b>  <b>Risk Rating and Description</b></p> <p><i>(NOTE: A higher number indicates a greater level of severity or intensity.)</i></p>	<p><b>Types of Services and Modalities Needed</b></p>	<p><b>Intensity of Service/Level of Care/Setting</b></p>
<p><b>Risk Rating: 0 =</b>  <b>Substance Use Disorders:</b> The patient is willingly engaged in treatment as a proactive, responsible participant, and is committed to change his or her alcohol and/or other drug use.  <b>Mental Disorders:</b> The patient is willingly engaged in treatment as a proactive, responsible participant, and is committed to change his or her mental functioning and behavior.</p>	<p>No immediate engagement or motivational enhancement strategies or services are needed.</p>	<p><b>Intensity: 0 =</b> Self/mutual help groups support referral into an appropriate addiction treatment service, depending on Risk Ratings in the other dimensions.</p> <p>For dual diagnosis patients with a Dimension 3 Risk Rating of 2 or higher at baseline, active addiction treatment may be integrated into a mental health setting, according to the intensity of service required by the patient's Risk Ratings in Dimensions 5 and 6.</p>

<p><b>Adult Dimension 4: Readiness to Change            Risk Rating and Description</b></p> <p><i>(NOTE: A higher number indicates a greater level of severity or intensity.)</i></p>	<p><b>Types of Services            and Modalities Needed</b></p>	<p><b>Intensity of Service/            Level of Care/Setting</b></p>
<p><b>Risk Rating: 1 =</b>  <b>Substance Use Disorders:</b> The patient is willing to enter treatment and to explore strategies for changing his or her substance use, but is ambivalent about the need for change. He or she is willing to explore the need for treatment and strategies to reduce or stop substance use (e.g., the patient views his or her substance use problem as caused by depression or another psychiatric diagnosis). Or the patient is willing to change his or her substance use, but believes it will not be difficult to do so, or will not accept a full recovery treatment plans.</p> <p><b>Mental Disorders:</b> The patient is willing to enter treatment and to explore strategies for changing his or her mental functioning, but is ambivalent about the need for change. He or she is willing to explore the need for treatment and strategies to deal with mental disorders. The patient's participation in mental health treatment is sufficient to avert mental decompensation (e.g., a bipolar patient who is ambivalent about taking mood-stabilizing medications, but who generally follows through with treatment recommendations).</p>	<p>In any addiction/dual diagnosis setting, low intensity engagement or motivational strategies are needed. These include education about the illness(es), education of family and significant others, and legal, work or school system reinforcement of the need for treatment.</p> <p>For patients with impairment in Dimension 3, motivational enhancement is integrated into continuing care management at any degree of intensity, as well as into specific treatment episodes.</p>	<p><b>Intensity: 1 =</b> Level I outpatient services for motivational enhancement strategies.</p> <p><b>LOC/Setting:</b> An outpatient addiction or mental health service.</p>

<p><b>Adult Dimension 4: Readiness to Change                      Risk Rating and Description</b></p> <p><i>(NOTE: A higher number indicates a greater level of severity or intensity.)</i></p>	<p><b>Types of Services                      and Modalities Needed</b></p>	<p><b>Intensity of Service/                      Level of Care/Setting</b></p>
<p><b>Risk Rating: 2 =</b>  <b>Substance Use Disorders:</b> The patient is reluctant to agree to treatment for substance use problems. He or she is able to articulate the negative consequences of substance use, but has low commitment to change his or her use of alcohol or other drugs. The patient is assessed as having low readiness to change and is only passively involved in treatment, is variably compliant with attendance at outpatient sessions or meetings of self/mutual help or other support groups.  <b>Mental Disorders:</b> The patient is reluctant to agree to treatment for mental disorders. He or she is able to articulate the negative consequences of his or her mental health problems, but has low commitment to therapy. The patient is assessed as having low readiness to change and is only passively involved in treatment (e.g., is variable in follow through with use of psychotropic medications or attendance at therapy sessions).</p>	<p>Moderate intensity engagement or motivational strategies are needed, with active support from family, significant others, legal, work or school systems to set and follow through with clear, consistent limits and consequences. Assertive case management or assertive community treatment (ACT) may be needed.</p> <p>For patients who face legal consequences, court-mandated treatment (as through drug court) may be indicated. For patients with Dimension 3 baseline Risk Ratings of 2 or higher, intensive case management may be required to integrate motivational enhancement therapies and continuing mental health care.</p>	<p><b>Intensity: 1-2 =</b> Level I outpatient services for motivational enhancement strategies, coupled with Level II services for assertive case management if the case management involves more than 9 hours per week.</p> <p><b>LOC/Setting:</b> An outpatient addiction or mental health service, with assertive case management or an assertive community treatment (ACT) team.</p> <p>High-intensity residential addiction services are not recommended, unless appropriate legal consequences promote patient motivation. The patient may require outpatient motivational enhancement therapies in an addiction or mental health treatment setting, with coordinated mental health care (Dimension 3, Risk Rating 1), or outpatient motivational enhancement therapies and active treatment integrated into a mental health setting (Dimension 3, Risk Ratings 2 to 3).</p>

<p><b>Adult Dimension 4: Readiness to Change</b>  <b>Risk Rating and Description</b></p> <p><i>(NOTE: A higher number indicates a greater level of severity or intensity.)</i></p>	<p><b>Types of Services            and Modalities Needed</b></p>	<p><b>Intensity of Service/            Level of Care/Setting</b></p>
<p><b>Risk Rating: 3 =</b>  <b>Substance Use Disorders:</b> The patient exhibits inconsistent follow-through and shows minimal awareness of his or her substance use disorder and need for treatment. He or she appears unaware of the need to change, and thus is unwilling or only partially able to follow through with treatment recommendations.  <b>Mental Disorders:</b> The patient exhibits inconsistent follow-through and shows minimal awareness of his or her mental disorder and need for treatment. He or she appears unaware of the need to change, and thus is unwilling or only partially able to follow through with treatment recommendations.</p>	<p>Moderately high intensity engagement or motivational enhancement strategies are needed to engage the patient in treatment. Effort should be focused on any available systems leverage (family, school, work, or legal system) to align incentives that promote treatment engagement and investment by the patient.</p> <p>If treatment resistance is caused by psychosis, IM injections of a depot antipsychotic may be needed. Assertive case management or assertive community treatment (ACT) may be needed.</p> <p>For patients with a Dimension 3 Risk Rating of 2 to 4, intensive case management or assertive community treatment (ACT) may be required.</p>	<p><b>Intensity: 1 =</b> Level I outpatient services for motivational strategies with families and significant others, and/or Level II services for education and engagement strategies and for assertive case management with the patient (if the case management involves more than 9 hours per week).</p> <p><b>LOC/Setting:</b> An outpatient addiction or mental health service, or an outpatient "dual diagnosis" service, with assertive case management or an assertive community treatment (ACT) team.            High-intensity residential addiction services are not recommended. Instead, the patient may require outpatient motivational enhancement therapies integrated into ongoing treatment.</p>

<p><b>Adult Dimension 4: Readiness to Change            Risk Rating and Description</b></p> <p><i>(NOTE: A higher number indicates a greater level of severity or intensity.)</i></p>	<p><b>Types of Services            and Modalities Needed</b></p>	<p><b>Intensity of Service/            Level of Care/Setting</b></p>
<p><b>4a (No Immediate action needed) –</b>  <b>Substance Use Disorders</b> The patient is unable to follow through; has little or no awareness of substance use problems and any associated negative consequences; knows very little about addiction; and sees no connection between his/her suffering and substance use. Not imminently dangerous or unable to care for self; not wanting or willing to explore change; denial of illness and its implications e.g., patient blames others for legal or family problems, and rejects treatment  <b>Mental Disorders</b> The patient is unable to follow through; has little or no awareness of a mental disorder, and any associated negative consequences; knows very little about mental illness; and sees no connection between his/her suffering and mental health problems. Not imminently dangerous or unable to care for self; not wanting or willing to explore change; denial of illness and its implications e.g., mentally-ill, intoxicated, homeless individual</p>	<p>High intensity of engagement or motivational strategies to try to engage the patient as a participant in treatment. Work with any systems leverage if available (family, school/work, legal) to align incentives that promote treatment engagement and investment of patient. Any individual engagement and motivational strategies are practical ACT team interventions rather than intensive therapy techniques aimed at “breaking through” denial.</p>	<p><b>1</b> - Level I, Outpatient Services for motivational strategies with family and significant others; and/or Level II.1 services for education and engagement strategies with the patient if necessary, and for assertive case management (if the case management involves more than nine hours per week)</p> <p><b>Setting:</b> OP addiction or mental health service; OP “dual diagnosis” service; assertive case management or ACT teams.</p>
<p><b>Risk Rating: 4b = (Immediate action required.)</b>  <b>Substance Use Disorders:</b> The patient is unable to follow through with treatment recommendations. As a result, his or her behavior represents an imminent danger of harm to self or others, or he or she is unable to function independently and to engage in self-care. For example, the patient repeatedly demonstrates inability to follow through with treatment and continues to use alcohol and/or other drugs and to become violent or suicidal or to drive dangerously.  <b>Mental Disorders:</b> The patient is unable to follow through with treatment recommendations. As a result, his or her behavior represents an imminent danger of harm to self or others, or he or she is unable to function independently and to engage in self care. For example, the patient refuses all medications and is overtly psychotic, so that his or her judgment and impulse control is severely impaired.</p>	<p>The patient needs containment for stabilization while imminently dangerous. If treatment resistance is caused by psychosis, involuntary commitment and placement in a secure unit may be necessary.</p> <p>If treatment resistance is caused by severe, acute intoxication, close observation may be needed until the patient is less toxic.</p>	<p><b>Intensity: 4</b> = Level IV medically managed intensive inpatient services, or Level III.3 clinically managed medium-intensity residential services, or Level III.7 medically monitored intensive inpatient services may be required.  <b>LOC/Setting:</b> A hospital-based acute care unit may be required if a secure unit is needed. The patient also may be placed in a freestanding residential dual diagnosis service or a sub acute inpatient psychiatric unit with medical monitoring and integrated addiction services.</p>

---

## **LITERATURE REFERENCES**

“Addiction Treatment Matching – Research Foundations of the American Society of Addiction Medicine (ASAM) Criteria” Ed. David R. Gastfriend has released 2004 by The Haworth Medical Press. David Gastfriend edited this special edition that represents a significant body of work presented in eight papers. The papers address questions about nosology, methodology, and population differences and raise important issues to continually refine further work on the ASAM PPC. (To order: 1-800-HAWORTH; or [www.haworthpress.com](http://www.haworthpress.com))

Mee-Lee D, Shulman GD, Fishman M, Gastfriend DR, and Griffith JH, eds. (2001). 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, Inc.

Mee-Lee, David (2001): “Treatment Planning for Dual Disorders”. Psychiatric Rehabilitation Skills Vol.5. No.1, 52-79.

Mee-Lee D, Shulman GD (2003): “Use of Patient Placement Criteria in Matching and Planning Treatment”, Section: Overview of Addiction Treatment in “Principles of Addiction Medicine” Third Edition. American Society of Addiction Medicine Inc., Chevy Chase, MD.

Miller, William R; Rollnick, Stephen (2002): “Motivational Interviewing - Preparing People for Change” Second Edition, New York, NY. Guilford Press.

Prochaska, JO; Norcross, JC; DiClemente, CC (1994): “Changing For Good” Avon Books, New York.

## **REFERENCE FOR ASAM PPC-2R AND RESOURCES FOR ASAM PPC**

“Addition Treatment Matching – Research Foundations of the American Society of Addiction Medicine (ASAM) Criteria” Ed. David R. Gastfriend. The Haworth Medical Press. 2004.

Mee-Lee D, Shulman GD, Fishman M, Gastfriend DR, and Griffith JH, eds. (2001). 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, Inc.

American Society of Addiction Medicine - 4601 Nth. Park Ave., Arcade Suite 101, Chevy Chase, MD 20815. (301) 656-3920; Fax: (301) 656-3815; [www.asam.org](http://www.asam.org); To order ASAM PPC-2R: (800) 844-8948.

## **RESOURCE FOR ASSESSMENT INSTRUMENTS**

Level of Care Index (LOCI-2R): Checklist tool listing ASAM PPC-2R Criteria to aid in decision-making and documentation of placement.

Dimensional Assessment for Patient Placement Engagement and Recovery (DAPPER): Severity ratings within each of the six ASAM PPC-2R dimensions.

To order: The Change Companies at 888-889-8866

For clinical questions or statistical information about the instruments, contact Norman Hoffmann, Ph.D. at 828-454-9960 in Waynesville, North Carolina; or by e-mail at [evinceassessment@aol.com](mailto:evinceassessment@aol.com)

---

## **RESOURCE FOR HOME STUDY AND ONLINE COURSES**

1. **“Dilemmas in Dual Diagnosis Assessment, Engagement and Treatment”** By David Mee-Lee, M.D.  
This home study or online course (with CEU’s) is designed to improve practitioners’ abilities to assess, engage, and treat people with co-occurring mental health and substance use problems. Practical strategies and methods are offered to help change interviewing methods, treatment planning and documentation, program components, range of services, and policies to better engage the dually diagnosed client.

Professional Psych Seminars, Inc. Agoura Hills, CA Toll-free phone: (877) 777-0668. Website:  
[www.psychsem.com](http://www.psychsem.com)

2. **“ASAM 101: Basics on Understanding and Using ASAM Patient Placement Criteria, Revised Second Edition (ASAM PPC-2R)”**

A 3-hour course that will introduce students to key concepts and issues of the ASAM Patient Placement Criteria. Clinicians involved in planning and managing care often lack a common language and systematic assessment and treatment approach that allows for effective, individualized services. The Patient Placement Criteria of the American Society of Addiction Medicine (ASAM) first published in 1991, provided common language to help the field develop a broader continuum of care. They were updated and the second edition (ASAM PPC-2) was published in April 1996. A revised second edition was published in April 2001.

The Distance Learning Center for Addiction Studies (DLCAS) is an internet based educational service that provides comprehensive training and information in the field of addiction studies. It is a joint presentation of the Betty Ford Center and the Distance Learning Center, LLC. Toll-free phone: 866 471-1742. Website:  
[www.dlcas.com/course59.html](http://www.dlcas.com/course59.html)

## **FREE MONTHLY NEWSLETTER**

“TIPS and TOPICS” – Three sections: Savvy, Skills and Soul and additional sections vary from month to month: Stump the Shrink; Success Stories and Shameless Selling. Sign up on [www.DMLMD.com](http://www.DMLMD.com) or here at the workshop.