Questions Asked During the Live Webinar Broadcast on 3/14/12

Q: How much does the 1 11.1 and 11.5 require?
A: Level I, Outpatient Services is less than nine hours of clinical service per week in the Adult Criteria; and less than six hours per week for the Adolescent Criteria. Level II.1, Intensive Outpatient is nine or more hours per week (Adult), six or more hours per week (Adolescent). Level II.5, Partial Hospitalization is 20 hours or more of clinical services per week for both Adolescents and Adults. There is some detail in the Word file of the presentation you can download from NAADAC and lots more detail if you purchase ASAM Second Edition Revised (ASAM PPC-2R) from www.asam.org.

Q: Does ASAM-PPC 2 still have the .5 Education Level of Care?
A: Yes, ASAM PPC-2R has Level 0.5, Early Intervention, for people who have not been diagnosed with a Substance-Related Disorder, but who need risk advice and education due to some beginning problems with their substance use e.g., a first DUI or early problems in school when experimenting with alcohol or other drugs.

Q: Is the ASAM Criteria evidence-based per outcomes of service levels recommended? In other words, has there been research done that the level of service recommended by ASAM criteria delivers successful outcomes?
A: The ASAM Patient Placement Criteria has had about ten years of research on it and a good summary is in a book that David Gastfriend edited. When Dr. Gastfriend was at Massachusetts General Hospital in Boston, he led much of the research. The National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the Center for Substance Abuse Treatment (CSAT)—have invested more than $7 million in research on eth ASAM Criteria.

1. Here is the reference:
"Addition 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.haworthpressince.com).


Journal of Addiction Medicine:
September 2009 - Volume 3 - Issue 3 - pp 139-150
“Factors Associated With Use of ASAM Criteria and Service Provision in a National Sample of Outpatient Substance Abuse Treatment Units”
Chuang, Emmeline BA; Wells, Rebecca PhD; Alexander, Jeffrey A. PhD; Friedmann, Peter D. MD; Lee, I-Heng MA

Abstract

Standardized patient placement criteria such as those developed by the American Society of Addiction Medicine are increasingly common in substance abuse treatment, but it is unclear what factors are associated with their use or with treatment units’ provision of related services. This study examined these issues in the context of a national survey of outpatient substance abuse treatment units. Regressions using 2005 data revealed that both public and private managed care were associated with a greater likelihood of using American Society of Addiction Medicine criteria to develop client treatment plans. However, only public managed care was associated with a greater likelihood of offering more resource-intensive services. Associations between client population severity and resource-intensive service provision were sparse but positive.

3. Another reference is:
Journal of Addiction Medicine:
June 2007 - Volume 1 - Issue 2 - pp 79-87

“No-Show for Treatment in Substance Abuse Patients with Comorbid Symptomatology: Validity Results from a Controlled Trial of the ASAM Patient Placement Criteria”
Angarita, Gustavo A. MD; Reif, Sharon PhD; Pirard, Sandrine MD; Lee, Sang BSc; Sharon, Estee PsyD; Gastfriend, David R. MD

Abstract

Purpose: Mismatched placement, according to the American Society of Addiction Medicine’s (ASAM) Patient Placement Criteria (PPC), promotes no-shows to treatment; however, little is known about the impact on patients with psychiatrically comorbid substance use disorder.
Methods: In a multisite trial, public-sector treatment-seeking adults (N = 700), following a computer-assisted ASAM PPC-1 structured interview, were blindly scored and randomly assigned to Level-of-Care (LOC)-II (intensive outpatient) or LOC-III (residential) settings. Patients scored as needing LOC-II but assigned to LOC-III were, by definition, overmatched.
Results: Among 143 overmatched patients, no-shows were significantly higher in comorbid versus noncomorbid (54% versus 28%; P < 0.01). Among overmatched comorbs, patients who no-showed compared with patients who showed were more likely to be females (70.4% versus 34.8%; P < 0.05), to have anxiety (63% versus 17.4%; P < 0.01), or have supportive family/social environments (81.5% versus 34.8%; P < 0.01).
Conclusions: The data support the validity of the PPC for matching comorbid patients. Mismatching increases no-show rates in general with undermatching, but it does so in particular with overmatching in patients with comorbid psychiatric symptomatology. Comorbidity interacts with gender, overmatched status, presence of anxiety, and supportive environment as predictors of treatment no-shows (odds ratios = 2.69, P < 0.05; 3.27, P < 0.05; 5.32, P < 0.001; and 3.12, P < 0.05, respectively).

If you want more detail on the research, you can contact David Gastfriend:

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4. Here is an excerpt of a chapter I co-authored on the ASAM PPC:

The ASAM Criteria are the most intensively studied set of addiction placement criteria. A considerable body of work exists to date on the ASAM PPC including at least nine evaluations involving a total of 3,641 subjects. Federal agencies—including the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Center for Substance Abuse Treatment—have invested more than $7 million in this research (12). Several controlled studies have found that treatment based on the ASAM PPC are associated with less morbidity, better client functioning, and more efficient service utilization than mismatched treatment (13).

A prospective, naturalistic study examined the validity and impact of the PPC, comparing the placement of 287 adults within Washington State versus 240 adults within Oregon, where a statewide Patient Placement Criteria training model was fully implemented. Results showed that the use of standardized criteria such as the PPC showed good potential for changing treatment planning behavior, increasing individualization, and improving utilization of new levels of care (14).

Given the complexity of the PPC multidimensional branching logic, researchers at the Massachusetts General Hospital Addiction Research Program implemented the ASAM Criteria as a comprehensive computerized interview (15). It consists of a sequence of questions and scoring options for real-time use by the counselor or research assistant. This real-time, computerized method yielded good inter-rater reliability for the level-of-care assignment (inaclass correlation coefficient = 0.77; P < 0.01) (16).

To date, three prospective studies have tested this method in three different samples (public system Medicaid and uninsured patients, insured patients, and Veterans) using three different outcomes (acute no-show to treatment, 90-day drinking rates, and long-term hospital utilization) – but all three trials used the same computerized algorithm to implement the PPC-1 in a standardized fashion (15). The first prospective study, a multisite trial in Massachusetts, is the only randomized, controlled trial of placement...
criteria to be conducted to date. In this project, 700 subjects were randomized to Level II or Level III treatment, either matched or mismatched according to the recommendation of the PPC-1 algorithm. Results showed good concurrent validity (15) and evidence for predictive validity, because higher acute no-show rates occurred in patients who were mismatched to a lower level of care than was recommended overall and in subsamples with high-frequency cocaine use (17) and in the subset of patients with comorbid symptomatology – which also had higher no-show rates when mismatched to higher level of care than recommended (18).

These results support the predictive validity and cost-effectiveness of the use of Patient Placement Criteria. They also indicate that the Patient Placement Criteria have valid clinical decision-making guidelines, good feasibility and reliability through standardized computer assessment instruments, and good concurrent validity in treating patients throughout the multidimensional assessments (19). The ultimate goal of this ongoing research work is revision of the PPC that will emerge not simply from the current expert consensus process but also through the findings from multiple national and international research studies.

REFERENCES
**Q: Is the presumed goal of ASAM full abstinence?**

A: If a person has actually developed Substance Dependence, the most likely necessary, but not sufficient goal to ensure a good outcome and a life of recovery is to work for abstinence. However, one of the reasons the ASAM Criteria has Dimension 4, Readiness to Change, is to recognize not everyone with an addiction is ready to embrace abstinence and recovery from day one of treatment. So while we always want to be abstinence-oriented for people who are yet to be attracted into recovery, stage-matched treatment should not be abstinence-mandated from day one of treatment. A person may need motivational enhancement therapy and motivational interviewing to attract them into abstinence and recovery. The clinician should always start with what the client is at Action for. If such a person is intent on trying the “cutting back, no problem” treatment plan; is not in any immediate danger; and does not agree with the education you give them about the importance of abstinence, then the treatment should start with where the client is at. Then hold the client accountable for whether they can stay out of substance-related trouble or not.

For public health reasons when a person is sharing “dirty” needles and spreading HIV or Hepatitis C, a case can be made for harm reduction and harm minimization as a public health safety strategy.

**Q: What dimension could you classify an adult male heroin and some prescription drug user?**

A: Such a client could have issues in any or all of the six ASAM Criteria assessment dimensions. In Dimension 1, Acute Intoxication and/or Withdrawal Potential, the client may be intoxicated with cross-interaction of both drugs’ effects; or be withdrawing from one or both drugs and be needing a detox. facility. Or in Dimension 2, Biomedical Conditions or Complications, there may be injection site abscesses from IV heroin use; or other physical health problems caused by the addiction; and/or physical health problems like chronic pain that is causing the prescription drug user. In Dimension 3, Emotional, Behavioral or Cognitive Conditions and Complications, such a substance user could have mood swings that look like Bipolar Disorder; or other substance-related mental health presentations. In Dimension 4, Readiness to Change, a person may be at Action to stop one of the drugs, but be at Contemplation, the stage of ambivalence, for stopping the other drug. In Dimension 5, Relapse, Continued Use/Continued Problem Potential, continued use or actual relapse may be a danger for one or both drugs especially if the person is ambivalent about abstinence or has never had any experience with skills to counteract cravings to use. In Dimension 6, Recovery Environment, there may be family issues related to the substance use; liaison with the prescribing physician needed to make sure the physician is aware of the patient’s heroin use; legal, work and financial issues may all need assessment and treatment.

Bottom line: Unless I misunderstood your question, there is not just one dimension involved.

**Q: What is the recommendation to implement ASAM into a new program run by a certified peer support specialist?**
A: Even though peer support specialists are not doing clinical assessments and providing clinical treatment, it would still be very useful for them to understand the six assessment dimensions of the ASAM Criteria and also the broad continuum of care and all the levels of care. There are a couple of client journals (workbooks) from The Change Companies, that would be very instructive and useful for peer support specialists to facilitate with consumers. The facilitation does not need to be done just by clinicians. Go to www.changecompanies.net or www.asamcriteria.com and look at the first journal “Understanding the Dimensions of Change” and the second one “Moving Forward” which builds on the six dimensions to develop a program service plan that can be tracked for progress.

Q: When there is a client in a controlled environment such as a pre-release center and haven’t used for 1 or more years, how can this be handled when they are "told" to enter treatment.

A: Unfortunately, many people are mandated by the criminal justice system to enter treatment and especially residential treatment, not based on a clinical assessment of need, but rather for public safety and other social, not addiction treatment reasons. A person may have maintained abstinence for a year or more due to the structure of the setting. Treatment may well be indicated, but what service plan and what level of care should be based on assessment of the six ASAM Criteria dimensions. This should be a clinical assessment and assignment to a level of care, not a judicial decision based on non-clinical issues if treatment is what is being mandated. Working together with criminal justice, providers need to stand up for clinical decision-making, asking judges and others to mandate assessment and treatment adherence, not a particular level of care and a particular length of stay, which is not a clinically-driven assignment of treatment.

A client who has been in a controlled environment might need a 24 hour residential setting if it is assessed, for example, that the person’s Dimension 5, Relapse, Continued Use, Continued Problem Potential is very high because the client has no idea how he would resist cravings to use and peer pressure to celebrate “freedom” once released into the community away from the heavy structure of prison. In addition the client has no place to live other than his old friends who are still dealing drugs and engaged in criminal activity (Dimension 6 high severity); and has no job skills, nor job prospects.

On the other hand, another client soon to be released may have excellent relapse prevention skills having been active in recovery groups while incarcerated; is set up to live with his AA sponsor who owns a construction company where the client has a job upon release into the community. Such a client would not need a residential program and providers should not passively accept such a court order as if they have no ability to present the assessment and matching level of care placement and advocate for a clinically-driven placement decision.

Q: Why is there not a III.5-D?

A: Because III.2-D covers a Social Detox setting managed by clinicians, not nursing or medical staff. Such a Social Detox setting has protocols to know when to call a nurse or
physician or have the client be evaluated for more intensive detox services, if not progressing well. III.7-D has 24 hour nursing with a physician available to see the client if necessary. Level IV-D has 24 hour nursing and daily physician visits because the withdrawal is so unstable that medication and other treatment changes may be necessary daily. If a Level III.5 program wanted to do detox in that residential setting, they could do so. The client would be designated in III.2-D since he or she would likely be well enough to participate in the full active milieu of III.5, but is getting more intensive services than 5 hours of clinical service a week, which is the minimum intensity of service in III.1. This is why the detox level was given a decimal point intensity of III.2, less than what a person gets in a Level III.3 program, but more than what is received in III.1.