What’s New in DSM-5 and The New ASAM Criteria?: New Directions, New Criteria

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Select the Best Answer:

1. In DSM-5:
   (a) The multiaxial system (Axes I-V) stays the same, but changes to Axes 1-5 (Arabic numbers)
   (b) Substance Abuse and Substance Dependence merge into Substance Use Disorders (SUD) with legal problems being a new criterion
   (c) Internet Disorder is a new diagnosis in the Substance-Related & Addictive Disorders chapter
   (d) All of the above
   (e) None of the above
Select the Best Answer:

2. 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
Select the Best Answer:

3. What’s new in DSM-5 is:
   (a) New diagnoses of Cannabis Withdrawal & Caffeine Withdrawal; & Caffeine Use Disorder
   (b) A new criterion on craving in Substance Use Disorders
   (c) A new criterion on legal problems
   (d) Severity specifiers in SUD of mild, moderate, severe and chronic and extreme
   (e) None of the above
Select the Best Answer:

4. The six assessment dimensions of 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
Select the Best Answer:

5. 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
Select the Best Answer:

6. Assessment of a person’s goals & motivation is important to:

(a) Match treatment to the client’s readiness to change
(b) Ensure residential care is not wastefully utilized
(c) Avoid confrontational approaches that alienate the client
(d) Individualize the referral and treatment plan
(e) All of the above
Select the Best Answer:

7. To ask a consumer what s/he really wants:
   (a) Is unnecessary as their judgment is poor
   (b) Is as important as assessing what the consumer needs
   (c) Gives the false impression that they should have choice about treatments
   (d) Leads to disrespect of the clinician’s authority and expertise
   (e) Usually reveals unrealistic goals that should be ignored
Select the Best Answer:

8. The 2013 edition of The ASAM Criteria includes:
   (a) Changing all the Admission Criteria for all the levels of care
   (b) New sections on sex and internet addiction
   (c) Adding sections on the application of Criteria to older adults and parents with children
   (d) Changing the names of the six assessment dimensions on The ASAM Criteria
9. ASAM’s Definition of Addiction is incorporated in the new edition as follows:
   (a) It provides guidelines to have all addiction services be provided by addiction physicians
   (b) It encourages all the levels of care to be used for chronic disease management
   (c) It describes addiction as an acute illness that makes Dimensions 1, 2 and 3 paramount
   (d) It requires all patients to have a chaplain involved for the spiritual aspects of treatment
Select the Best Answer:

10. Changes in the new edition include:
   (a) Changing the designations of levels of care from Arabic numbers to Roman numerals
   (b) New sections on Gambling Disorder and Tobacco Use Disorder
   (c) Merging all the adolescent criteria into the adult criteria
   (d) Adding an assessment dimension on spirituality
Select the Best Answer:

11. In an era of healthcare reform:
   (a) The ASAM Criteria’s primary goal is to keep addiction separate and safe from mental health.
   (b) Accountable care organizations and health homes will pay attention to addiction even less now
   (c) The ASAM Criteria can help integrate addiction into general healthcare
   (d) None of the above
Select the Best Answer:

12. The true spirit and content of The ASAM Criteria ensures that:
   (a) All withdrawal management occurs in a medically-monitored level to provide maximum safety
   (b) The length of stay is variable depending on the severity of illness and the patient’s progress
   (c) The patient stays and graduates from each level of care as determined by the primary counselor
   (d) Long-term residential treatment is always necessary if the client lives in a toxic environment
Select the Best Answer:

13. The following terminology changes are made in The ASAM Criteria:

(a) “Patient Placement” was removed in the book title, as the book no longer has placement criteria
(b) Opioid Maintenance Therapy (OMT) was changed to Office-Based Opioid Treatment (OBOT)
(c) Merging all the adolescent criteria into the adult criteria
(d) “Detoxification” changed to “Withdrawal Management”. The liver detoxifies, but clinicians manage withdrawal
Indicate True or False:

14. It is not the severity or functioning that determines the treatment plan, but the diagnosis, preferably in DSM terms

15. Gambling Disorder is in DSM-5 and the new ASAM Criteria

16. There are six broad levels of care in the ASAM Criteria

17. Dimension 5 focuses on internal attitudes, beliefs and coping skills to deal with relapse
Indicate True or False:

18. A diagnosis is necessary, but not sufficient to determine level of care

19. The level of care placement is the first decision to make in the assessment

20. Dimension 4, Readiness to Change, applies only to motivation for abstinence

21. The Tobacco Use Disorder section encourages all programs to become tobacco-free
Indicate True or False:

22. In criminal justice populations, it is important to ensure patients “do treatment” not “do time” just focused on how long they have to stay

23. The ASAM Criteria helps increase access to care and use resources efficiently

24. The co-occurring disorders section added a “complexity capable” description

25. Clients in early stages of change need relapse prevention strategies
DSM - Why Diagnostic Criteria?

• Need for classification of mental disorders has been clear throughout history of medicine

• Little agreement on which disorders should be included; and optimal method for their organization

• Many nomenclatures (naming systems) have been developed during past 2,000 years - differed in their relative emphasis on phenomenology, etiology, and course as defining features
Why Diagnostic Criteria? (cont.)

• Some systems have included only handful of diagnostic categories; others have included thousands

• Various systems for categorizing mental disorders have differed with their principal objective for use in clinical, research, or statistical settings

• Creates a common language for communication between clinicians about the diagnosis of disorders
History of DSM

- **1952** – First edition. Since then DSM reviewed and revised four times
- **1968** – DSM-II
- **1975** - Like DSM-I and DSM-II, development of DSM-II was coordinated with development of ICD-9 published in 1975 and implemented in 1978
- **1980** – DSM-III published after work had began on DSM-III in 1974
- **DSM-III** introduced important methodological innovations, including explicit diagnostic criteria, multiaxial system, and descriptive approach that attempted to be neutral regarding theories of etiology
History of DSM (cont.)

• This effort was facilitated by extensive empirical work then under way on construction and validation of explicit diagnostic criteria and development of semi structured interviews
• ICD-9 did not include diagnostic criteria or multiaxial system largely because primary function of international system was to delineate categories to facilitate collection of basic health statistics
• In contrast, DSM-III was developed with additional goals of providing medical nomenclature for clinicians and researchers
History of DSM (cont.)

- Experience with DSM-III revealed number of inconsistencies in system and number of instances in which criteria were not entirely clear

- 1987 – Publication of DSM-III-R after APA appointed Work Group to revise and correct DSM-III
- 1994 – Publication of DSM-IV
- 2000 – Publication of DSM-IV- Text Revision
- 2013 – Publication of DSM-5
Development and Use of DSM-IV and DSM-5

- DSM-III represented major advance in diagnosis of mental disorders and greatly facilitated empirical research.

- Development of DSM-IV benefited from substantial increase in research on diagnosis that was generated in part by DSM-III and DSM-III-R.
Development and Use of DSM (cont.)

• Most diagnoses now have an empirical literature or available data sets relevant to decisions regarding revision of diagnostic manual

• Task Force on DSM-IV and DSM-5 its Work Groups conducted three-stage empirical process that included 1) comprehensive and systematic literature reviews, 2) re-analyses of already-collected data sets, and 3) extensive issue-focused field trials
Definition of Mental Disorder – DSM-5

• Syndrome characterized by **clinically significant disturbance** in individual’s cognition, emotion regulation, or behavior

• Reflects **dysfunction** in psychological, biological, or developmental processes underlying mental functioning

• Mental disorders usually associated with significant **distress or disability** in social, occupational, or other important activities

• **Expectable or culturally approved** response to common stressor or loss (death of a loved one) is **not** a mental disorder

• **Socially deviant behavior** (e.g., political, religious, or sexual) and conflicts primarily between individual and society are **not** mental disorders unless deviance or conflict results from dysfunction in individual, as described above.
Chapter Organization, Enhancements

• **Lifespan approach** – disorders diagnosed in childhood e.g., neurodevelopmental disorders placed at beginning of manual and disorders more applicable to older adulthood e.g., neurocognitive disorders at end
Dimensional Approach to Diagnosis

- Structural problems in previous DSM - large number of narrow diagnostic categories in clinical practice, research
- Substantial use of “not otherwise specified” NOS diagnoses - When full criteria not met, consider whether symptom presentation meets criteria for “other specified” e.g., “other specified depressive disorders, depressive episode with insufficient symptoms or “unspecified” designation
- Previous DSM - each diagnosis categorically separate from health and from other diagnoses. Did not capture sharing of symptoms and risk factors across disorders (mood swings in bipolar and substance use disorders)
- Most human ills, mental disorders heterogeneous - genetic risk factors to symptoms e.g., 65 yo social drinker forced to retire versus 20 yo whose family history and role models point to heavy addiction at young age
No More Multiaxial System

- DSM-5 moved to **nonaxial** documentation of diagnosis
- **Multiaxial** distinction between Axis I, II and III did not imply fundamental differences - that mental disorders are unrelated to physical and biological factors or processes, or that general medical conditions unrelated to behavioral or psychosocial factors or processes
- In DSM-5 Axis III **combined** with Axes I and II, with separate notations for important psychosocial and contextual factors (formerly Axis IV) and disability (formerly Axis V)
- Elimination of multiaxial diagnoses enhances a more holistic and integrative system
Elements of a Diagnosis

Diagnostic Criteria and Descriptors

• Diagnostic criteria offered as guidelines for making diagnoses, and use should be informed by clinical judgment.

• After assessment of diagnostic criteria, clinicians should consider application of disorder subtypes and/or specifiers as appropriate.

• Severity and course specifiers should be applied to denote individual’s current presentation, but only when full criteria met.
Elements of a Diagnosis

Diagnostic Criteria and Descriptors

- Where applicable, specific criteria for defining severity (mild, moderate, severe, extreme), descriptive features (with good to fair insight; in a controlled environment; and course (in partial remission, in full remission, recurrent) provided with each diagnosis

- Combination of: clinical interview, text descriptions, criteria, and clinical judgment – a diagnosis
Elements of a Diagnosis
Subtypes and Specifiers

• Subtypes and specifiers (some of which are coded in the fourth, fifth or sixth digit) provided for increase specificity.

• *Subtypes* define mutually exclusive and jointly exhaustive phenomenological subgroupings within diagnosis and indicated by instruction “*Specify whether*” in criteria set.

• *Specifiers* are not intended to be mutually exclusive or jointly exhaustive, and as consequence, more than one specifier may be given.
Elements of a Diagnosis
Subtypes and Specifiers

• Specifiers provide an opportunity to define more homogeneous subgrouping of individuals with disorder who share certain features e.g., major depressive disorder with mixed features

• Convey information relevant to management of individual’s disorder e.g., with other medical comorbidity specifier in sleep-wake disorders

• DSM-5 diagnosis usually applied to individual’s current presentation. Previous diagnoses from which individual has recovered should clearly be noted as such e.g., specifiers indicating course e.g., in partial remission, in full remission may be listed after the diagnosis
Elements of a Diagnosis (con’t)
Subtypes and Specifiers

• Where available, **severity specifiers** provided to guide clinicians in rating intensity, frequency, duration symptom count, or other severity indicator of disorder. Indicated by instruction “Specify current severity”

• **Descriptive features specifiers** have also been provided in criteria set and convey additional information that can inform treatment planning e.g., obsessive-compulsive disorder, with poor insight

• **Not all disorders** include course, severity, and/or descriptive features specifiers
DSM-5 Substance-Related and Addictive Disorders (Gambling Disorder)

• “dependence” – as label for addiction confusing; only for physiological dependence

• Patients with normal tolerance and withdrawal labeled as “addicts.”, which is normal response to repeated doses of many medications (beta-blockers, antidepressants, opioids, anti-anxiety agents and other drugs)

• Tolerance and withdrawal symptoms not counted as symptoms for diagnosis of substance use disorder when occurring in context of appropriate medical treatment with prescribed medications
DSM-5 Substance-Related and Addictive Disorders (Gambling Disorder)

• Organized according to substance versus according to diagnosis e.g., Hallucinogen Disorders vs Substance Intoxication or Substance Abuse or Dependence

• One criterion dropped, legal problems because: (a) very low prevalence in adult and many adolescent population samples; (b) low discrimination – legal problems doesn’t separate out distinctly who has SUD versus just social problems (developmental risk taking or antisocial personality, psychosis, mania and other mental health issues); (c) poor fit with other SUD criteria; (d) little added information in item response theory analyses. No patients had legal problems as their only criterion and none “lost” a DSM-5 SUD Dx.
DSM-5 Substance-Related and Addictive Disorders (Gambling Disorder)

• One criterion added, craving because: (a) behavioral, imaging, pharmacology and genetic studies indirectly support this criterion; (b) craving and its reduction can be central to diagnosis and treatment; (c) craving is in ICD-10 dependence criteria so this increases consistency between the nosologies; (d) fits well with other SUD criteria; (e) clinically useful

• Also Internet Gaming Disorder for Section III. Substance-Induced Dissociative Disorder removed
DSM-5 Substance-Related and Addictive Disorders (Gambling Disorder)

• Cannabis withdrawal and caffeine withdrawal were both added.

• Tobacco Use Disorder aligned with criteria for other substance use disorders.

• New severity specifiers and updated remission specifiers
Substance Use Disorder

Substance use disorder is defined by the following criteria in DSM-5:

A. A **problematic pattern** of substance use leading to clinically significant **impairment or distress** as manifested by at least two of the following occurring in a **12-month period**:
Substance Use Disorder

**Substance use disorder** is defined by the following criteria in DSM-5:

A. A problematic pattern of substance use leading to clinically significant impairment or distress as manifested by at least two of the following occurring in a 12-month period:

1. Substance is often taken in larger amounts or over a longer period than was intended

2. There is a persistent desire or unsuccessful efforts to cut down or control substance use
Substance Use Disorder (cont.)

3. A great deal of time is spent in activities necessary to obtain substance, use, or recover from the substance’s effects

4. Craving or a strong desire or urge to use the substance

5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home

6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
Substance Use Disorder (cont.)

7. Important social, occupational, or recreational activities are given up or reduced because of substance use.

8. Recurrent substance use in situations in which it is physically hazardous.

9. Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
Substance Use Disorder (cont.)

10. Tolerance, as defined by either of the following:
   (a) a need for markedly increased amounts of substance to achieve intoxication or desired effect
   (b) markedly diminished effect with continued use of the same amount of the substance

11. Withdrawal, as manifested by either of the following:
   (a) The characteristic withdrawal syndrome for substance
   (b) Substance is taken to relieve or avoid withdrawal symptoms
Severity and Course Specifiers

In early remission:
• Full criteria for SUD were previously met
• None of the criteria for SUD have been met for at least 3 months, but for less than 12 months
• Except for Criterion 4, “Craving or a strong desire or urge to use a specific substance”

In a sustained remission:
• Full criteria for SUD were previously met
• None of the criteria for SUD have been met at any time during a period of 12 months or longer,
• Except for Criterion 4, “Craving or a strong desire or urge to use a specific substance”
Severity and Course Specifiers

• The following specifier applies as a further specifier of remission (e.g. “early remission in a controlled environment”, and “sustained remission in a controlled environment”) if the individual is in remission and in a controlled environment:

• **In a Controlled Environment.** This additional specifier is used if the individual is in an environment where access to alcohol and controlled substances is restricted. Examples of these environments are closely supervised and substance-free jails, therapeutic communities, and locked hospital units.
Severity Scale DSM-5

The Severity of each Substance Use Disorder is based on:

• 0 criteria or 1 criterion: No diagnosis
• 2-3 criteria: Mild Substance Use Disorder
• 4-5 criteria: Moderate Substance Use Disorder
• 6 or more criteria: Severe Substance Use Disorder
Example in DSM-5

Alcohol-Related Disorders:

- 305 Alcohol Use Disorder, severe
- 303 Alcohol Intoxication with use disorder, severe
- 291.81 Alcohol Withdrawal, with perceptual disturbances
- Other Alcohol-Induced Disorder
- 291.9 Unspecified Alcohol-Related Disorder
Recording Procedures for SUD

• Use the code that applies to the class of substances but record the name of the *specific substance* e.g., record 304.10 (F13.20 – ICD-10)

• moderate alprazolam use disorder rather than moderate sedative, hypnotic, or anxiolytic use disorder; or 305.70 (F15.10) mild methamphetamine use disorder rather than mild stimulant use disorder.
Co-Occurring and Substance-Induced Mental Disorders

• SUD and mental disorders frequently co-occur - many symptoms e.g., insomnia being criteria for intoxication, withdrawal syndrome, or other mental disorders

• DSM-IV: “primary” mental disorders if began prior to substance use or persisted > than 4 weeks after cessation of acute withdrawal or severe intoxication

• DSM-IV: Substance-induced mental disorders defined: occur during periods of substance intoxication or withdrawal or remitting within 4 weeks thereafter; Sxs need exceed expected severity of intoxication or withdrawal; expected to remit within days to weeks of abstinence – to improve poor reliability and validity
Co-Occurring and Substance-Induced Mental Disorders

- DSM-5 reversed these DSM-IV standardization criteria and implemented a flexible approach that lacked specific symptom duration requirements and included addition of disorder-specific approaches:

  Criterion A: Disorder represents clinically significant symptomatic presentation of relevant mental disorder.
Co-Occurring and Substance-Induced Mental Disorders

Criterion B: Evidence from history, physical exam, or laboratory findings of both of following:

1. The disorder developed during or within 1 month of substance intoxication or withdrawal or taking a medication; and

2. The involved substance/medication is capable of producing the mental disorder.
Co-Occurring and Substance-Induced Mental Disorders

Criterion C: Disorder not better explained by independent mental disorder (i.e. one that is not substance-or medication-induced). Such evidence of independent mental disorder could include following:

1. Disorder *preceded* onset of severe intoxication or withdrawal or exposure to the medication; or

2. Full mental disorder *persisted* for substantial period of time (e.g., at least 1 month) after cessation of acute withdrawal or severe intoxication or taking medication. Criterion does *not apply* to substance-induced neurocognitive or hallucinogen persisting perception disorders, which persist beyond cessation of acute intoxication or withdrawal.
Co-Occurring and Substance-Induced Mental Disorders

Criterion D: The disorder does not occur exclusively during the course of a delirium

Criterion E: The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
DSM-5 Gambling Disorder

Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by four (or more) of the following in a 12-month period.

1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
2. Is restless or irritable when attempting to cut down or stop gambling.
3. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.
4. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).
DSM-5 Gambling Disorder (cont.)

5. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).

6. After losing money gambling, often returns another day to get even ("chasing" one’s losses).

7. Lies to conceal the extent of involvement with gambling.

8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.

9. Relies on others to provide money to relieve desperate financial situations caused by gambling.
DSM-5 Gambling Disorder (cont.)

B. The gambling behavior is not better accounted for by a manic episode.

**Course Specifiers**
- Episodic
- Persistent
- In early remission
- In sustained remission

**Current Severity:**
- Mild: 4-5 criteria met
- Moderate: 6-7 criteria met
- Severe: 8-9 criteria met
Implications to Daily Work

• What is the role of diagnosis in your daily work?

• How do you talk to clients about their diagnosis and the implications for their daily life

• Tracking diagnosis over time – past history and previous episodes and service reviews

• Using rule-out diagnoses to consider differential diagnoses
Generations of Clinical Care

1. Complications-driven Treatment

- No diagnosis
- Treatment of complications
  - No continuing care
    - Relapse
Generations of Clinical Care

2. Diagnosis-driven Treatment

- Diagnosis
- Program
- Aftercare
- Relapse
Generations of Clinical Care

3. Individualized, Clinically-driven Treatment

Patient/Participant Assessment

BIOPSYCHOSOCIAL Dimensions

Progress
Severity of Illness/LOF

Problems/Priorities
Severity of Illness/LOF

Plan

INTENSITY OF SERVICE — Modalities and Levels of Service
Generations of Clinical Care

4. Client-directed, Outcome-informed

- **Patient/Participant Assessment**
  - Biopsychosocial Dimensions

- **Progress**
  - Treatment Response
  - Proximal Outcomes, e.g.
  - Session Rating Scale (SRS)
  - Outcome Rating Scale (ORS)

- **Plan**
  - Intensity of Service — Modalities and Levels of Service
    (Clinical and wrap-around services)

- **Problems/Priorities**
  - Build alliance working with Multidimensional Assessment
Underlying Concepts (cont.)

Multidimensional Assessment

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
Underlying Concepts (cont.)

*Treatment Matching - Modalities*

- **Motivate** - Dimension 4
- **Manage** – All Six Dimensions
- **Medication** – Dimensions 1, 2, 3, 5
- **Meetings** – Dimensions 2, 3, 4, 5, 6
- **Monitor** – All Six Dimensions
Underlying Concepts (cont.)

*Treatment Levels of Service*

I → 1  Outpatient Treatment

II → 2  Intensive Outpatient and Partial Hospitalization

III → 3  Residential/Inpatient Treatment

IV → 4  Medically-Managed Intensive Inpatient Treatment
Level 0.5 and OMT

**Level 0.5: Early Intervention Services** - Individuals with problems or risk factors related to substance use, but for whom an immediate Substance-Related Disorder cannot be confirmed.

**Opioid Maintenance Therapy (OMT)** - Criteria for Level I Outpatient OMT, but OMT in all levels → Opioid Treatment Program (OTP) with Opioid Treatment Services (OTS) = antagonist meds (naltrexone) and Office-Based Opioid Treatment (OBOT) - buprenorphine.
Detoxification → Withdrawal Management Services for Dimension 1

I-D → 1-WM - Ambulatory Withdrawal Management without Extended On-site Monitoring

II-D → 2-WM - Ambulatory Withdrawal Management with Extended On-Site Monitoring
Withdrawal Management Services for Dimension 1 (continued)

III.2-D → 3.2- WM- Clinically-Managed Residential Withdrawal Management

III.7-D → 3.7- WM - Medically-Monitored Inpatient Withdrawal Management

IV-D → 4-WM - Medically-Managed Inpatient Withdrawal Management
Level I and II → Level 1 and 2 Services

Level I → 1 Outpatient Treatment

Level II.1 → 2.1 Intensive Outpatient Treatment

Level II.5 → 2.5 Partial Hospitalization
Level III → Level 3 Residential/Inpatient

Level III.1 → 3.1- Clinically-Managed, Low Intensity Residential Treatment

Level III.3 → 3.3- Clinically-Managed, Medium Intensity Residential Treatment → Clinically Managed Population-Specific High Intensity Residential Treatment

(Agent Level only)
Level III → Level 3 Residential/Inpatient (cont.)

Level III.5 → 3.5- Clinically-Managed, Medium/High Intensity Residential Treatment

Level III.7 → 3.7- Medically-Monitored Intensive Inpatient Treatment
Level IV ➔ Level 4 Services

Level IV ➔ Level 4 Medically-Managed Intensive Inpatient

- One-dimensional to multidimensional assessment
- Program-driven to clinically & outcomes-driven treatment
- Fixed length of service to variable length of service
- Limited number of discrete levels of care to broad and flexible continuum of care
- Identifying adolescent-specific needs
- Clarifying the goals of treatment

- From using “treatment failure” as admission prerequisite
- Interdisciplinary, team approach to care
- Clarifying role of physician
- Focusing on treatment outcomes
- Engaging with “Informed Consent”
- Clarifying “Medical Necessity”
- Harnessing ASAM’s Definition of Addiction
Addiction

• Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry

ASAM’s Revamped Definition of Addiction

August 15, 2011
What’s New in *The ASAM Criteria*

- Application to broader population
- Managed care, parity and healthcare reform
- *The ASAM Criteria Software*
- Co-Occurring Capable, Enhanced, Complexity Capable
- Recovery-Oriented Systems of Care, disease management
- DSM-5
- Gambling Disorder and Tobacco Use Disorder
- OTS = OTP + OBOT + antagonist medication (naltrexone)
- Withdrawal management and Dimension 5 considerations
- Roman numerals → Arabic numerals
- User-friendly format
Co-Occurring Capable (COC) Programs

• Routinely accept co-occurring disorders

• Can meet needs if psychiatric disorders sufficiently stable; independent functioning so mental disorders do not interfere with addiction treatment and vice versa

• Address co-occurring disorders in policies, procedures, assessment, treatment planning, program content, and discharge planning
Co-Occurring Capable (COC) Programs (Cont.)

- Have arrangements for coordination and collaboration with mental health services and addiction services

- Can provide psychopharmacologic or addiction monitoring and psychological or addiction assessment/consultation on site; or well-coordinated off-site
Co-Occurring Enhanced (COE) Programs

• Can accommodate unstable/disabled needing specific psychiatric, mental health support, monitoring and accommodation necessary to participate in addiction treatment

• Not so acute/impaired to present severe danger to self/others, nor need 24-hour, psychiatric supervision
Co-Occurring Enhanced (COE) Programs (cont.)

- Psychiatric, mental health and also addiction treatment professionals. Cross-training for all staff. Relatively high staff to patient ratios; close monitoring of instability and disability

- Policies, procedures, assessment, treatment and discharge planning accommodate co-occurring disorders
Co-Occurring Enhanced (COE) Programs (cont.)

- COD-specific, mental health symptom management groups incorporated in addiction treatment. Motivational enhancement therapies more likely (particularly in outpatient settings)

- Close collaboration/integration with addiction and mental health program for detox and crisis back-up services and access to addiction and mental health case management and continuing care
Complexity Capable (CC) Programs

• Concept of “co-occurring capability” has evolved to address more than just mental health and addiction

• Individuals and families with multiple co-occurring needs are an expectation, not an exception. They not only have substance use and mental health issues, they frequently have general medical issues, including HIV and other infectious disease issues, legal issues, trauma issues, housing issues, parenting issues, educational issues, vocational issues and cognitive/learning issues.

• These individuals and families are culturally and linguistically diverse. In short, these are people and families who are characterized by “complexity,” and they tend to have poorer outcomes and higher costs of care.
Complexity Capable (CC) Programs

• Staffed by psychiatric and mental health clinicians as well as addiction treatment professionals; care managers; peer specialists; staff who can address culturally and linguistically diverse people.

• Patient-Centered Healthcare Homes have been conceptualized—and implemented—to recognize the multidimensional, biopsychosocial needs of patients and to address the complex needs of patients and families.
Engage the Client as Participant

Treatment Contract

## Identifying the Assessment and Treatment Contract

<table>
<thead>
<tr>
<th>Client</th>
<th>Clinical Assessment</th>
<th>Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHAT?</strong> What does client want?</td>
<td>What does client need?</td>
<td>What is the treatment contract?</td>
</tr>
<tr>
<td><strong>WHY?</strong> Why now? Why’s the level of commitment?</td>
<td>Why? What reasons are revealed by the assessment date?</td>
<td>Is it linked to what client wants?</td>
</tr>
<tr>
<td><strong>HOW?</strong> How will s/he get there?</td>
<td>How will you get him/her to accept the plan?</td>
<td>Does client buy into the link?</td>
</tr>
<tr>
<td><strong>WHERE?</strong> Where will s/he do this?</td>
<td>Where is the appropriate setting for treatment? What is indicated by the placement criteria?</td>
<td>Referral to level of care</td>
</tr>
<tr>
<td><strong>WHEN?</strong> When will this happen? How quickly? How badly does s/he want it?</td>
<td>When? How soon? What are realistic expectations? What are milestones in the process?</td>
<td>What is the degree of urgency? What is the process? What are the expectations of the referral?</td>
</tr>
</tbody>
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Focus Assessment and Treatment

What Does the Client Want?

Does client have immediate needs due to imminent risk in any of six dimensions?

Conduct multidimensional assessment
Focus Assessment and Treatment (cont.)

- DSM-5 diagnoses?
- Multidimensional Severity/LOF Profile
- Which assessment dimensions are most important to determine Tx priorities
Focus Assessment and Treatment (cont.)

Specific focus/target for each priority dimension

What specific services needed for each dimension

What “dose” or intensity of these services needed
Focus Assessment and Treatment (cont.)

Where can these services be provided in least intensive, but “safe” level of care?

What is progress of Tx plan and placement decision; outcomes measurement?
DSM-5 diagnoses?

Multidimensional Severity/LOF Profile

Which assessment dimensions are most important to determine Tx priorities

Specific focus/target for each priority dimension

What specific services needed for each dimension

What “dose” or intensity of these services needed

Where can these services be provided in least intensive, but “safe” level of care?

What is progress of Tx plan and placement decision; outcomes measurement?
Severity/LOF Assessment
The 3 H’s

- HISTORY
- HERE AND NOW
- HOW WORRIED NOW
Models of Stages of Change

• 12-Step model - surrender versus comply; accept versus admit; identify versus compare

• Transtheoretical Model of Change - Pre-contemplation; Contemplation; Preparation; Action; Maintenance; Relapse and Recycling; Termination

• Readiness to Change - not ready, unsure, ready, trying, doing what works
Criminal Justice’s View of Presenting Problem and Solution

3 C’s
Consequences
Compliance
Control
Coerced Clients and Working with Referral Sources

• Common purpose and mission
• Common language of assessment of stage of change
• Consensus philosophy of addressing readiness to change
• Consensus on how to combine resources and leverage to effect change, responsibility and accountability
• Communication and conflict resolution
A Word About Terminology

_Treatment Compliance vs Adherence_

Webster’s Dictionary defines:

- **“comply”**: to act in accordance with another’s wishes, or with rules and regulations
- **“adhere”**: to cling, cleave (to be steadfast, hold fast), stick fast
Continued Service Criteria (ASAM Criteria)

Retain at the present level of care if:

1. Making progress, but not yet achieved goals articulated in individualized treatment plan. Continued treatment at present level of care necessary to permit patient to continue to work toward his or her treatment goals; or
Continued Service Criteria (ASAM Criteria) (cont.)

2. Not yet making progress but has capacity to resolve his or her problems. Actively working on goals articulated in individualized treatment plan. Continued treatment at present level of care necessary to permit patient to continue to work toward his or her treatment goals; and/or
Continued Service Criteria (ASAM Criteria) (cont.)

3. New problems identified that appropriately treated at present level of care. This level is least intensive at which patient’s new problems can be addressed effectively.
Discharge/Transfer Service Criteria (ASAM Criteria)

Transfer or discharge from present level of care if he or she meets the following criteria:

1. Has achieved goals articulated in his or her individualized treatment plan, thus resolving problem(s) that justified admission to current level of care; or
Discharge/Transfer Service Criteria (ASAM Criteria) (cont.)

2. Has been unable to resolve problem(s) that justified admission to present level of care, despite amendments to treatment plan. Treatment at another level of care or type of service therefore is indicated; 

or
3. Has demonstrated lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated; or
Discharge/Transfer Service Criteria (ASAM Criteria) (cont.)

4. Has experienced intensification of his or her problem(s), or has developed new problem(s), and can be treated effectively only at a more intensive level of care
Revised Constructs for Dim. 5

A. Historical Pattern of Use or Mental Health Problems
   1. Chronicity of Problem Use or MH problems
   2. Treatment or Change Response

B. Pharmacologic Responsivity
   3. Positive Reinforcement (pleasure, euphoria)
   4. Negative Reinforcement (withdrawal discomfort, fear)
Revised Constructs for Dim. 5 (cont.)

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
Revised Constructs for Dim. 5 (cont.)

D. Cognitive and behavioral measures of strengths and weaknesses (cont.)

8. Coping Skills (stimulus control, other cognitive strategies)
9. Impulsivity (risk-taking, thrill-seeking)
10. Passive and passive/aggressive behavior
Recovery and Psychosocial Crises

- Slips/using substances while in treatment
- Suicidal – impulsive or wanting to use
- Loss or death – cravings or impulsive
- Disagreements, anger, frustration with fellow clients or therapist
Policy and Procedure

Implements principle of re-assessment and modification of treatment plan:

1. Face to face or telephone appointment ASAP

2. Attitude of acceptance; listen for patient’s point of view, rather than lecture, enforce “program rules”; or dismiss their perspective

3. Assess safety and immediate needs in all six ASAM assessment dimensions
ASAM Six Assessment Dimensions

1. Acute Intoxication and/or Withdrawal Potentia
2. Biomedical Conditions and Complications
3. Emotional, Behavioral or Cognitive Conditions and Complications
4. Readiness to Change
5. Relapse/Continued Use, Continued Problem Potential
6. Recovery Environment

*The ASAM Criteria* (2013) Pages 43-53
Policy and Procedure (cont.)

4. Discuss circumstances surrounding the crisis, develop a sequence of events/precipitants

5. Modify participatory treatment plan to address new or updated problems

6. Reassess treatment contract and what patient wants if any lack of interest in modifying Tx. Plan

7. Determine if modified strategies need same level of care; or more or less intense level
8. If patient recognizes the problem/s; understands need to change, but still chooses no further treatment, then discharge

9. If patient is invested in treatment, then Tx continues

10. Document crisis and modified treatment plan or discharge in the medical record
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
- Current Level of Service (if case presented for Tx. Plan review)
- DSM Diagnoses
- Stated or Identified Motivation for Treatment
ASAM Six Assessment Dimensions

1. Acute Intoxication and/or Withdrawal Potentia
2. Biomedical Conditions and Complications
3. Emotional, Behavioral or Cognitive Conditions and Complications
4. Readiness to Change
5. Relapse/Continued Use, Continued Problem Potential
6. Recovery Environment

The ASAM Criteria (2013) Pages 43-53
Case Presentation Format (cont.)

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
   Has It Changed?

1.
2.
3.
4.
5.
6.

(Brief explanation for each rating, note whether it has changed since client
entered treatment -why or why not)
Case Presentation Format (cont.)

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)
Working Effectively with Managed Care

• Clinical discussion, not game playing - Improve communication between consumers, clinicians, providers, payers, managed care, utilization reviewers, care managers
• Use Case Presentation Format to concisely review biopsychosocial data and focus the discussion
• Follow through Decision Tree on How to Organize Assessment Data to guide clinical discussion
• Identify where points of disagreement are: severity rating; priority dimension or focus of treatment; service needs; dose and intensity of services; placement level
Working Effectively with Managed Care (cont.)

• Offer alternative clinical data: severity rating and rationale; priority dimension or focus of treatment; service needed; dose and intensity of services; placement level

• Appeal if still no consensus
Dealing with “Resistant” Providers and Payers Who Are at Different Stages of Change

• Individualized Staff Development Plans based on what the clinician wants
• Individualized Agency Development Plans – expectations for progress and change
• Individualized Payer Development Plan – reaching consensus on criteria, “Medical Necessity”, design of Benefit Plans
• Incentives and leverage to facilitate continuing change and development
Fidelity to Spirit and Content of The ASAM Criteria

• If you were a Clinical Director, what would be the main staff, program and documentation issues you would re-design or maintain in your program?

• If you were a contract compliance and quality assurance person, what would you look for to verify fidelity to The ASAM Criteria?

• If you were a patient, client or consumer, how would you know if an agency was true to the spirit of The ASAM Criteria?

• If you were writing a brochure or information pamphlet to educate consumers about what to ask and look for in choosing a program consistent with The ASAM Criteria, what would you include?
Data to Identify Gaps

• Systems issues cannot change quickly. Each incident of inefficient or inadequate care can be a data point that promotes systems change.

• Finding efficient ways to gather data as it happens in daily care of clients can provide hope, direction for change.
Data to Identify Gaps (cont.)

PLACEMENT SUMMARY

<table>
<thead>
<tr>
<th>Level of Care/Service Indicated</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Care/Service Received</td>
<td></td>
</tr>
</tbody>
</table>
Data to Identify Gaps (cont.)

PLACEMENT SUMMARY

Reason for Difference - Circle only one number -- 1. Level of care or Service not available; 2. Provider judgment; 3. Client preference; 4. Client is on waiting list for appropriate level/service; 5. Level of care or Service available, but no payment source; 6. Geographic inaccessibility etc.
Anticipated Outcome If Service Cannot Be Provided - Circle only one number --

1. Admitted to acute care setting; 2. Discharged to street;
3. Continued stay in acute care facility;
4. Incarcerated; 5. Client will dropout until next crisis; 6. Not listed (Specify):
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