

DSM-5 AND ASAM CRITERIA

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MODULE I: GOALS & OBJECTIVES

- What is your experience with using ASAM and DSM 5 criteria?
- What are your learning expectations for today?

GOAL FOR TRAINING

- To develop and/or enhance the knowledge and skills to make more informed and accurate clinical decisions and write concise clinical justifications for those decisions using the DSM-5 and ASAM Criteria 3rd Edition.

OBJECTIVES

- Identify and explain rationale and benefits of using the ASAM Criteria to make patient placements
- Identify characteristics and differentiate between various levels of care
- Identify and differentiate between ASAM's six dimensions of assessment
- Identify information to formulate a dimension risk rating
- Learn how dimension risk rating and clinical justification directly drive treatment planning

CRITICAL THINKING

- Practitioners who are willing to call into question the assumptions underlining their customary, habitual ways of thinking and acting, and are ready to think and act differently on the basis of critical questioning.....

TRAINING IS NOT



- Designed to answer all of your questions regarding the assessment, placement and treatment of persons with addictive disorders
- Sufficient to make you competent in the use of ASAM criteria, but rather an introduction to it. Further practice, training and supervision is required to learn how to use the criteria successfully.

MODULE 2: CHALLENGES FACING THE FIELD

1. Standardization in the collection of client information
2. Consistency of the interpretation of data collected for patient placement and treatment planning purposes
3. Matching of appropriate evidence based, proven and effective treatment interventions to the client's identified problems
4. Correct implementation of evidenced based interventions
5. Development and implementation of policies and procedures to monitor the above.

MODULE 3: RATIONALE & BENEFITS OF STANDARDIZED ASSESSMENT CRITERIA

WHAT DOES THE RESEARCH SAY?

- Clients that are mismatched to treatment have lower retention rates and poorer outcomes.
-  Less treatment is **NOT** Good.
-  More treatment is **NOT** Good.

WHAT'S HAPPENING IN 'SOME' PROGRAMS

- Client's are being referred to wrong levels of care.
- Client's assessed are referred to, and treated in the agency conducting the assessment
- Assessments' don't justify the recommendations being made.
- Clinical justifications are provided

WHAT IF.....

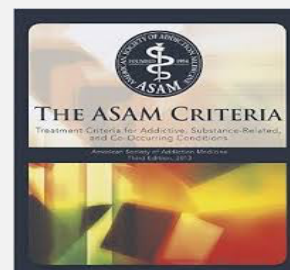
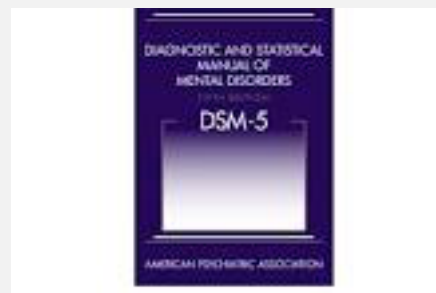
- We asked 200 Counselors to make a patient placement decision and provide a clinical justification for that decision?
- All given the same case.

WHAT DO YOU THINK HAPPENED?



BENEFITS OF USING EVIDENCE BASED CRITERIA

- Improve Performance and Treatment Outcomes
- Increase Motivation, Engagement and Retention Rates
- More Efficient and Effective Utilization Reviews
- Use of a common language



IMPORTANT!

- Tools and Criteria's are **NOT** substitutes for **GOOD Clinical Judgment.**
- Tools and Criteria's support, guide and enhance **GOOD Clinical Judgment.**

MODULE 4: ASAM CRITERIA

- The ASAM Criteria describes in detail an “**IDEAL**” continuum of care with the various services and interventions provide at each levels.

HISTORY: UNDERLYING PRINCIPLES CLINICAL CARE

- Complications-driven Treatment
 - No diagnosis of Substance Use Disorder
 - Treatment of Complications of the addiction with no continuing care
 - Relapse Triggers treatment of complications only.
-
- [www.Change Companies.net](http://www.ChangeCompanies.net)

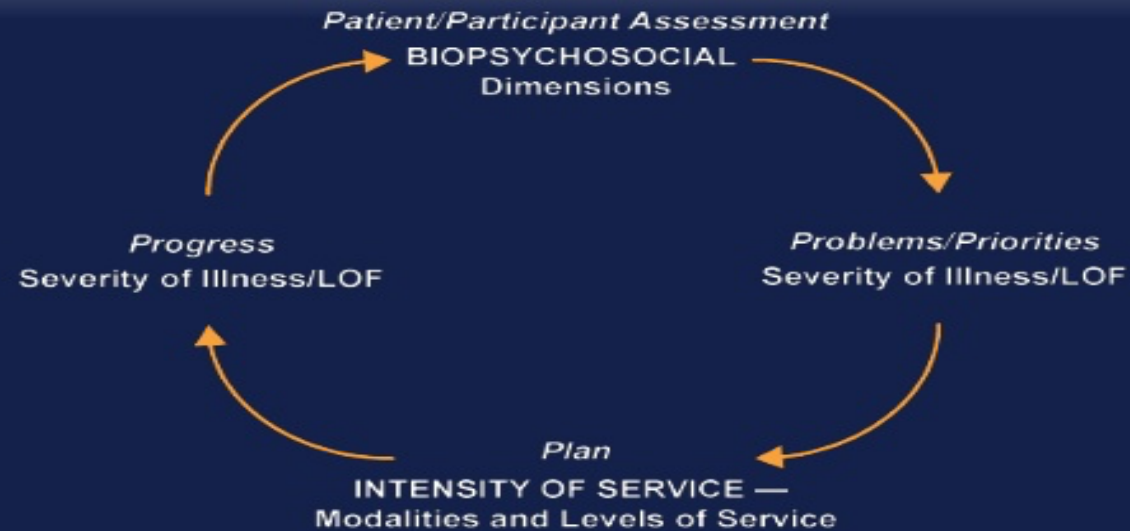
DIAGNOSIS, PROGRAM-DRIVEN TREATMENT

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

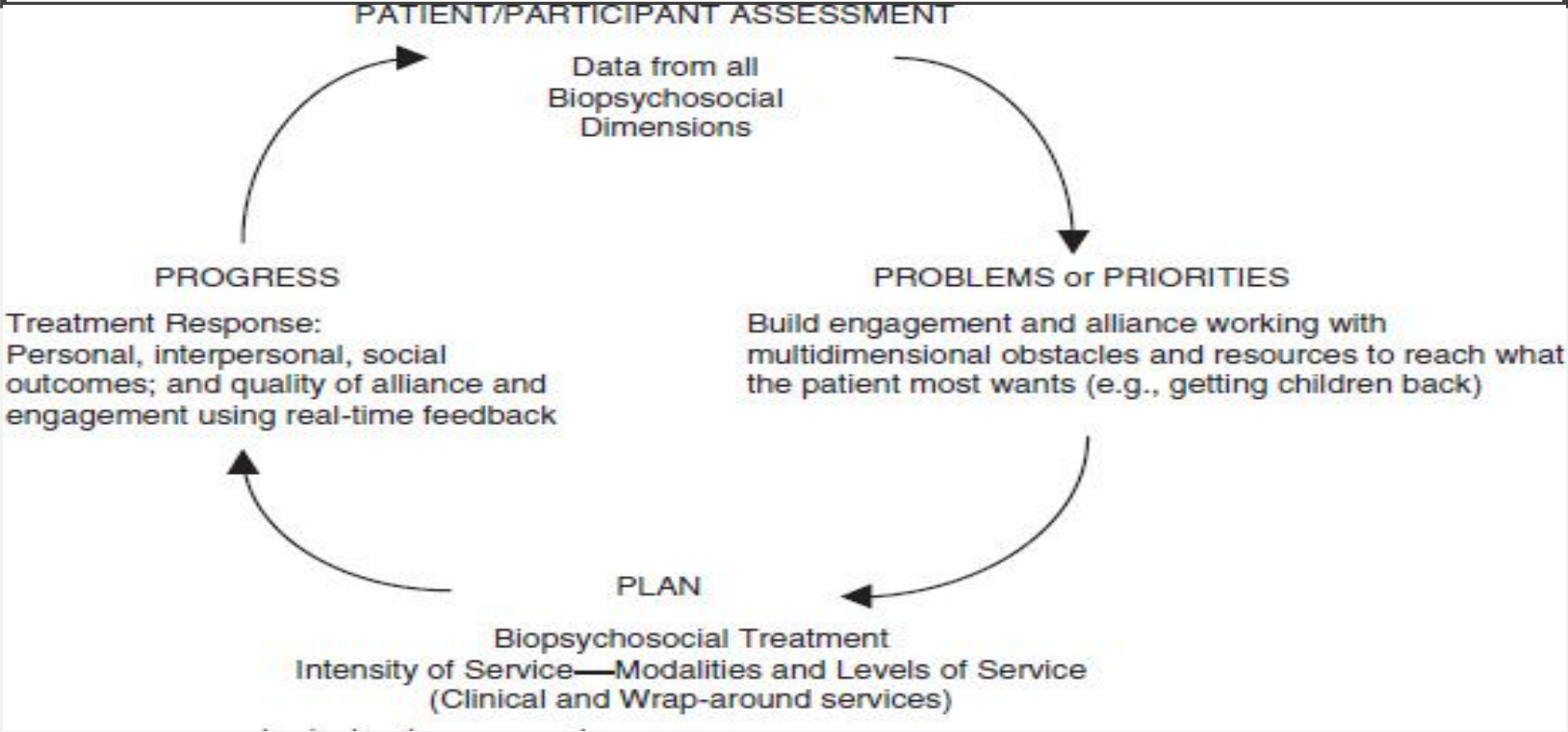
- [www.Change Companies.net](http://www.ChangeCompanies.net)

INDIVIDUALIZED, CLINICALLY-DRIVEN

Underlying Concepts of *The ASAM Criteria:* Individualized, Clinically-driven Treatment



CLIENT-DIRECTED, OUTCOME INFORMED



GUIDING PRINCIPLES OF THE ASAM CRITERIA 2013

- **Moving from one-dimensional to multidimensional assessment**

PRINCIPLE #2

- Moving from program-driven to clinically driven and outcomes-driven treatment

PRINCIPLE #3

- Moving from fixed length of service to variable length of service

PRINCIPLE #4

- Identifying adolescent-specific needs

PRINCIPLE #5

- Clarifying the goals of treatment

PRINCIPLE #6

- Moving away from using “treatment failure” as an admission prerequisite

PRINCIPLE #7

- Moving toward an interdisciplinary, team approach to care

PRINCIPLE #8

- Clarifying the role of the physician

PRINCIPLE #9

- Focusing on treatment outcomes

PRINCIPLE #10

- Engaging with “Informed Consent”

PRINCIPLE #11

- Clarifying “Medical Necessity”

PRINCIPLE #12

- Harnessing ASAM's Definition of Addiction

MODULE 5: WHATS NEW IN DSM-5

- II Criteria for Substance-Related and Addictive Disorders
- DSM 5 Severity
- How to code using new manual

CRITERIA 1-4: IMPULSE CONTROL

- 1. Use in larger amounts or longer than intended
- 2. Desire or unsuccessful effort to cut down
- 3. Great deal of time using or recovering
- 4. Craving or strong urge to use

CRITERIA 5-7: SOCIAL IMPAIRMENT

- 5. Role obligation failure
- 6. Continued use despite social/interpersonal problems
- 7. Sacrificing activities to use or because of use

CRITERIA 8-9: RISKY USE

- 8. Use in situations where it is hazardous
- 9. Continued use despite knowledge of having physical or psychological problem caused or exacerbated by use

CRITERIA 10-11: PHARMACOLOGICAL

- 10. Tolerance
- 11. Withdrawal

SUD CRITERIA PRIMARILY IN SEVERE DESIGNATION ONLY

- **The Big Five:**
- Wanting to cut down/unable to do so
- Craving with compulsion to use
- Sacrifice activities to use
- Failure at role fulfillment due to use
- Withdrawal symptoms

CRITERIA PREVALENT IN MILD & MODERATE GROUPS

- Unplanned use
- •Time spent using
- •Medical/psych. consequences of use
- •Use where impairment is dangerous
- •Interpersonal conflicts
- •Legal problems and use to relieve emotional distress similar in distribution to these

CLINICAL IMPLICATIONS

- Most of those in the 'mild' designation can probably benefit from moderation and harm reduction strategies
- Those in the 'severe' designation will require more intensive and extended services where abstinence is essential to recovery
- The 'moderate' group may have characteristics that fit the mild or severe characteristics.

SEVERITY SCALE DSM-5

- The severity of each Substance Use Disorder is based on:
- 0 criteria or 1 criteria: 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

- 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

SEVERITY AND COURSE SPECIFIERS

- In early remission:
- Full criteria for SUD was previously met
- None of the criteria for SUD have been met for at least 3 months, but for less than 12 months
- Except for Criteria 4 (Craving or a strong desire to use)

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 Criteria 4 (Craving or a strong desire to use)

IN A CONTROLLED ENVIRONMENT

- This additional specifier is used if the individual is in an environment where access to alcohol or controlled substances is restricted. Examples of these environments are closely supervised and substance-free jails, therapeutic communities and locked hospital units.

HOW TO CODE

- Diagnosis code for specific substance such as Alcohol Use, followed by any medical conditions, psychosocial stressors, followed by a severity rating of mild, moderate or severe based on criterion met.
- Other specifiers would include “in early remission, sustained remission, on maintenance therapy and in controlled environment”.

DIAGNOSTIC STRATEGIES

- **Assessing for substance use disorder:** In assessing for substance use disorder, one initially attempts to determine whether the patient's substance use is causing negative consequences. If such consequences are significant and recurrent in a 12 month-period, then diagnosis of substance use disorder is warranted.

DIAGNOSTIC STRATEGIES CONT....

- Even if client does not meet criteria for substance use disorder, there may be substance-induced withdrawal or intoxication; or variety of substance-induced disorders including anxiety, depression, psychosis, sleep disorder or sexual dysfunction.

MODULE 6: WHAT'S **NOT NEW** IN ASAM

- The six assessment dimensions
- The overall levels of care (though not Roman numerals) for addiction management
- The “decision rules,” which link Intensity of
- Service back to the Severity of Illness
- maintained except for some updates in
- Withdrawal Management (“Detox”)

WHAT'S **NEW** IN ASAM

- New Title: The ASAM Criteria – Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions
- Shift away from “placement” criteria to “treatment” criteria: it’s more than just “placement”

WHAT'S **NEW** IN ASAM

- Diagnostic Admission Criteria terminology changed to be compatible with DSM-5
- Section on working with managed care
- Table of contents Re-ordered to be more user-friendly
- Follows the flow from Historical Foundations to Guiding Principles to Assessment, Service Planning, and Placement decisions

WHAT'S **NEW** IN ASAM

- Adolescent Criteria Still separate criteria for adolescents
- Consolidated Adult & Adolescent content on principles to minimize redundancy, while preserving adolescent-specific content

WHAT'S **NEW** IN ASAM

- Appendices
- Withdrawal Management instruments
- Dimension 5 constructs
- Glossary

WHAT'S **NEW** IN ASAM

- Withdrawal Management
- The wording in the Levels of Care
- Former section “Detoxification” becomes “Withdrawal Management”
- Levels are now called WM-1, WM-2, WM-3, and WM-4
- New approaches described to support increased use of less intensive levels of care for safe/effective management of withdrawal

WHAT'S **NEW** IN ASAM

- Withdrawal Management
- New approaches described to support increased use of less intensive levels of care for safe/effective management of withdrawal
- A broader range of severity of withdrawal syndromes is discussed in The Criteria as being able to be safely and appropriately managed on an outpatient basis

WHAT'S **NEW** IN ASAM

- Updated/revised terminology
- Contemporary, strength-based, recovery oriented:
- “dual diagnosis” becomes “co-occurring disorders”
- “inappropriate use of substances” becomes “high risk use of substances”

WHAT'S NEW IN ASAM

- Opioid use disorder specialized services
- Opioid Maintenance Therapy” (OMT) becomes “Opioid Treatment Services” (OTS)
- *Opioid antagonist medication (naltrexone)*
- *Opioid agonist medications (methadone, buprenorphine)*
- *Their use in OTPs (regulated “Opioid Treatment Programs” for methadone) or in office-based opioid treatment (OBOT for buprenorphine)*

NEW CONTENT AND SECTIONS

- Additional text to improve application to address addiction treatment for Special Populations:
 - Older Adults
 - Persons in Safety Sensitive Occupations
 - Parents with Children and Pregnant Women
 - Persons in the Criminal Justice System (CJS)

NEW CONTENT AND SECTIONS

- Additional text to address treatment of conditions not traditionally included in specialty addiction treatment services:
 - Tobacco Use Disorder
 - Gambling Disorder

NEW CONTENT AND SECTIONS

- Revision of the text to address emerging issues:
- Healthcare Reform and the integration of addiction treatment into general medical care
- The role of physicians on the care team, addiction specialist physicians in particular (addiction medicine physicians, addiction psychiatrists)

NEW CONTENT AND SECTIONS

- Inclusion of Recovery Oriented System of Care to facilitate understanding of addiction treatment with a recovery oriented “chronic disease management” continuum, rather than as a repeated, disconnected “acute episodes of treatment” for acute complications of addiction and/or repeated and disconnected admissions to programs that employ ‘rigid’ lengths of stay in which patients are placed.

NEW CONTENT AND SECTIONS

- A new section on Gambling Disorder that is consistent with ASAM's definition of addiction
- “Pathological pursuit of reward or relief can involve not just the use of psychoactive substances but other certain behaviors..
- Tobacco Disorder chapter to reflect on the treatment field's inconsistencies in, and even ambivalence about, viewing this addiction as similar to alcohol and substances.

MODULE 7: ASAM LOC

- Level 0.5 Early Intervention
- Level 1 Outpatient Services
- Level 2.1 Intensive Outpatient Services
- Level 2.5 Partial Hospitalization Services
- Level 3.1 Clinically Managed Low-Intensity Residential
- Level 3.3 Clinically Managed Population-Specific High-Intensity Residential (Adult Only)
- Level 3.5 Clinical Managed High-Intensity Residential Services (Adult Criteria)
- Level 3.5 Clinical Managed Medium-Intensity Residential Services (Adolescent Criteria)

LEVELS CONT.

- Level 3.7 Medically Monitored Intensive Inpatient Services (Adult Criteria)
- Level 3.7 Medically Monitored High-Intensity Inpatient Services (Adolescent Criteria)
- Level 4 Medically-Managed Intensive Inpatient Services
- Opioid Treatment Services (OTS)
- Withdrawal Management

WITHDRAWAL MANAGEMENT

- Level 1-Withdrawal Management (Outpatient), ambulatory withdrawal management without extended on-site monitoring
- Level 2-Withdrawal Management (Intensive Outpatient and Partial Hospitalization), ambulatory withdrawal management with extended on-site monitoring
- Level 3.2-Withdrawal Management (clinically-managed) residential withdrawal management
- Level 3.7-Withdrawal Management (medically-monitored) residential withdrawal management. Inpatient detox is ASAM Level 4-Withdrawal Management and is medically managed. Inpatient detox is a service provided in an inpatient hospital setting.
- Level 4-Withdrawal Management Intensive Inpatient Withdrawal Management

INFORMED CONSENT

- “Proposed modalities”
- “The risks and benefits”
- “Appropriate alternative treatment”
- “Risks of treatment versus no treatment”

EXCEPTIONS TO THE PLACEMENT

- Lack of availability of services
- Failure of a patient to progress at a given level of care
- State laws that differ from *ASAM* criteria

RISK RATING SYSTEM

- High, Medium, Low pgs 56-57
- 0-4 Point Scale, Page 57
 - 0: Low Risk
 - 1: mild
 - 2: moderate
 - 3: serious
 - 4: utmost severity

MATCHING DIMENSIONAL SEVERITY

- Step 1: Risk of Imminent danger
- Step 2: Determine risk rating in each dimension
- Step 3: Identify appropriate types of services
- Step 4: Development of initial treatment plan
- Step 5: Ongoing Utilization Management throughout continuum of care

DIMENSION I: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

- What risk is associated with the patient's current level of acute intoxication?
- Are intoxication management services needed?
- Is there significant risk of severe withdrawal symptoms, seizures or medical complications?
- Are there current signs of withdrawal?
- Standardized withdrawal scale score?
- Vital signs?
- Does the patient have supports to assist in ambulatory withdrawal management?

DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS

- Are there current physical illnesses, other withdrawal that need to be addressed?
- Are there chronic conditions that need stabilization or ongoing disease management?
- Is there a communicable disease present?
- Is the patient pregnant, what is her pregnancy history?

DIMENSION 3: EMOTIONAL, BEHAVIORAL, COGNITIVE COMPLICATIONS

- Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed?
- Are there chronic conditions that affect treatment such as bipolar or anxiety?
- Do any emotional, behavioral, or cognitive signs or symptoms appear to be an expected part of the addictive disorder?

DIMENSION 3CONT.

- Are they severe enough to warrant specific mental health treatment, even if symptoms are caused by substance use?
- Is the patient able to manage the activities of daily living?
- Can he or she cope with any emotional, behavioral or cognitive problems?

DIMENSION 3 RISK DOMAINS

- Dangerousness/Lethality
- Interference with Addiction Recovery Efforts
- Social Functioning
- Ability for Self-Care
- Course of Illness

DIMENSION 4: READINESS TO CHANGE

- How aware is the patient of the relationship between his or her alcohol, tobacco, or other drug use or behaviors involved in the pathological pursuit of reward or relief and his or her negative life consequences?
- How ready, willing, or able does the patient feel to make changes?
- How much does the patient feel in control of his or her treatment services?
- Assess each treatment issue for separate stage of change.

DIMENSION 5: RELAPSE/CONTINUED USE

- Historical Pattern of Use
- Pharmacologic Responsivity
- External Stimuli Responsivity
- Cognitive and Behavioral Measures of Strengths and Weaknesses
- ★ What are your policy and procedures to deal with Dim 5 situations?

DIMENSION 5: RELAPSE, CONTINUED USE OR POTENTIAL

- Is the patient in immediate danger of continued severe mental health distress and/or alcohol, tobacco and/or drug use?
- Does the patient have any recognition or understanding of, or skills in coping with his or her addictive, co-occurring, or mental disorder?
- Have addiction and/or psychotropic medications assisted in recovery before?
- What are the person's skills in coping with protracted withdrawal, cravings, or impulses?

DIMENSION 5 CONT.

- How well can the patient cope with negative effects, peer pressure, and stress without recurrence of addictive thinking and behavior?
- How severe are the problems and further distress that may continue or reappear if the patient is not successfully engaged in treatment?
- How aware is the patient of relapse triggers and skills to control addiction impulses or impulses to harm self or others?

DIMENSION 6: RECOVERY ENVIRONMENT

- Do any family members, significant others, living situations, or school work situations pose a threat to the patient's safety or engagement in treatment?
- Does the individual have supportive friendships, financial resources, or educational or vocational resources that can increase the likelihood of successful recovery?
- Are there legal, vocational, regulatory (eg professional licensure), social service agency, or criminal justice mandates that may enhance the person's motivation for engagement in treatment if indicated?
- Are there transportation, childcare, housing, or employment issues that need to be clarified and addressed?

DECISION HIERARCHY

- Dimensions 1, 2, 3, generally help indicate Inpatient or Outpatient
- Dimensions 4, 5, 6 generally help indicate the intensity of outpatient
- (there are often times that Dim 5 and 6 will indicate inpatient treatment.
- Each dimension receives a Risk Rating

CASE PRACTICE

- Dimension Severity?
- Services Needed?
- Level of Care Recommendation?

LENGTH OF STAY AND DISCHARGE

- **Clinically Driven**
- **NOT**
- **Program Driven**

LOC RECOMMENDATION PROCESS

- Interpret the Assessment Information
 - Select Risk Rating and Write Clinical Justification for each Dim
- Assess if the Risk Status on some of Dimensions Influence/Increase the risk of other Dimensions
 - Assess Recovery & Other Support Services Available
 - Level of Care/Service Recommendation
 - Treatment Planning

5 M'S

- **Motivate** - Dimension 4
- Manage** – All Six Dimensions
- Medication** – Dimensions 1, 2, 3, 5
- **Meetings** – Dimensions 2, 3, 4, 5, 6 •
- **Monitor**- All Six Dimensions

SEVERITY OF ASSESSMENT THE 3 H'S

- **HISTORY**
- **HERE AND NOW**
- **HOW WORRIED NOW**

CLINICAL JUSTIFICATION

- Risk Rating Clinical Justification- each dimensional summary includes a statement indicating severity/risk rating.
- Level of Care Clinical Justification

LEVEL OF CARE RECOMMENDATION

- 1. Clinical justification is a summary of the evidence that supports and justifies a clinical decision.
- 2. Clinical justifications generally include symptoms that meet established criteria: ASAM, DSM5 other tools
- Treatment professionals are responsible for documenting clinical decisions and justifying them with evidence.

THANK YOU!



REFERENCES

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