NEI AS

“ The ASAM Criteria for Substance-Related, Co-Occurring and Addictive Disorders in order to Provide Quality, Cost-Effective Treatment”

6/10/15
Worester, MA
Disclosures for Gerald Shulman

Consultant to Alkermes, maker of Vivitrol
Consultant to Prevention Research Institute
Trainer for American Addiction Centers
(formerly Treatment Solutions Network)
Former Clinical Advisory Board Member, CRC Health Group
Consultant/Trainer for Lifescape Solutions
It takes two things to be a consultant - 
Gray Hair and Hemorrhoids.

The Gray Hair makes you look distinguished - 
The Hemorrhoids make you look concerned.
HAVING FUN IN SUNNY FLORIDA
WISH YOU WERE HERE
Bird Flu
Dear Participants:
I know when you are texting in class. Seriously, no one just looks down at their crotch and smiles.
Our Kinds of Folks
“Did you bring the weed?”
Doctors confirm: Two glasses of wine daily has health benefits.
It is as important to understand the person who has the disease, as the disease the person has.
CARE SHOULD BE MANAGED

.....in fact......

"the Hallmark of Quality Treatment is the Management of Care"
SCREENING
Screening instruments are “quick, cheap and easy” and their purpose is to:

- Rule individuals “out” or
- Rule individuals “in” for further assessment
Screening for Alcohol Problems

**CAGE**

1. Have you ever felt the need to **CUT** down on your drinking?  
   Yes _____  No _____

2. Have you ever felt **ANNOYED** by someone criticizing your drinking?  
   Yes_____  No_____ 

3. Have you ever felt **GUILTY** about your drinking?  
   Yes___  No____

4. Have you ever felt the need for an **EYE OPENER** to get you started in the morning?  
   Yes___  No____
**UNCOPE**

**U** “In the past year, have you ever drank or used drugs more than you intended to?”

**N** “Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?”

**C** “Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?”

**O** Has anyone objected to your drinking or drug use?

**P** “Have you ever found yourself preoccupied with wanting to use alcohol or drugs?”

**E** “Have you ever use alcohol or drugs to relieve emotional discomfort?”
TI CS

1. In the last year, have you ever drunk or used drugs more than you meant to?
2. Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

Detected current substance use disorders with nearly 80% sensitivity and specificity and particularly sensitive to polysubstance use disorders.

Respondents who gave 0, 1, and 2 positive responses had a 7.3%, 36.5%, and 72.4% chance of a current substance use disorder, respectively.
# CRAFFT

**Brief Screening Test for Adolescent Substance Abuse**

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C</strong> - Have you ever ridden in a <strong>CAR</strong> w driven by someone (including yourself) who was “high” or had been using alcohol or drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>R</strong> - So you ever use alcohol drugs to <strong>RELAX</strong>, feel better about yourself or fit in?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A</strong> - Do you ever use alcohol/drugs while you are by yourself, <strong>ALONE</strong>?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>F</strong> - Do your family or <strong>FRIENDS</strong> ever tell you that you should cut down on your drinking or drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>F</strong> - Do you ever <strong>FORGET</strong> things that you did while using alcohol or drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>T</strong> - Have you gotten into <strong>TROUBLE</strong> while you were using alcohol or drugs?</td>
<td></td>
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</tr>
</tbody>
</table>

* 2 or more yes answers suggests a significant problem*
COMPREHENSIVE ASSESSMENT
Everyone needs the same treatment.
Why Do In-Depth Assessment?

• To avoid the preceding

  and to:

  • Best match patients to type and intensity of care
  • Enhance outcome
  • Provide the most cost-effective treatment
  • Defend clinical decisions
Assessment

At the Beginning, middle, and end.....

And at all points in between!
ASSESSMENT is an ongoing process that is PART of treatment, NOT simply an activity that determines treatment.
The Quality of Treatment Delivered Can Never Rise Above the Quality of Assessment on Which It Is Based
The Goal

Making The **RIGHT** Placement(s) Providing:

- the **RIGHT** services
- in the **RIGHT** amount
- at the **RIGHT** intensity level
- with the **RIGHT** structure & support
- to the **RIGHT** people
- at the **RIGHT** time
- in the **RIGHT** place
- at the **RIGHT** price

...to achieve the **RIGHT** outcomes
Diagnostic Assessment
OLD DSM-IV
MULTIAXIAL ASSESSMENT

• Axis I - Clinical Disorders
  Other Conditions That may Be a Focus of Clinical Attention

• Axis II - Personality Disorders/Mental Retardation

• Axis III - General Medical Conditions

• Axis IV - Psychosocial and Environmental Problems

• Axis V - Global Assessment of Functioning
The DSM-IV Five Axis Diagnostic Structure

- Goes away for purposes of diagnosis
- Replaced with list of diagnoses
- Recommendation #1: Keep the 5 Axis system “in your head” as a way of organizing your assessment
- Recommendation #2: “Continue using Axes III, IV and V for purposes of informing the assessment”
Old Axis 3
General Medical Conditions

• A common reason for relapse to opioid dependence is a chronic pain disorder
• Chronic pain disorders would be coded on Axis 3
• Don’t use the Axis 3 term – describe in a narrative form your findings
Old Axis 4
Psychosocial and Environmental Problems

- A review of these problems can help to develop a substance use or mental disorder relapse prevention plan.
- Don’t use the Axis 4 term – describe in a narrative form your findings.
Old Axis 5
Global Assessment of Functioning

- Assess for current level of functioning
- Assess for highest level of functioning in the past year
- Determines whether the patient’s functioning is deteriorating, improving or remain stable
- Questions about the GAF Scale number and admission to residential or inpatient treatment?
- Don’t use the Axis 5 term – describe in a narrative form your findings
Old Axis IV: Psychosocial Stressors and Environmental Problems & Dimensions 5 & 6

- Problems related to the social environment — e.g., death or loss of friend; inadequate social support; living alone; difficulty with acculturation; discrimination; adjustment to lifestyle transition (such as retirement); social support system made up of other substance using, abusing or selling people; living with an active addict; living with a dealer; rampant drug use/sale in neighborhood; rampant drug use/sale at work site/school; pressure to use substances by peers; employer not supportive of recovery efforts
Axis IV: Psychosocial Stressors

- problems related to the social environment
- death or loss of friend
- inadequate social support
- living alone
- difficulty with acculturation
- discrimination
- adjustment to lifestyle transition (such as retirement)
- social support system made up of other substance using, abusing or selling people
- living with an active addict
- living with a dealer
- rampant drug use/sale in neighborhood
- pressure to use substances by peers
- employer not supportive of recovery efforts
Axis V

• Global Assessment of Functioning
Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

<table>
<thead>
<tr>
<th>Code</th>
<th>(Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.</td>
</tr>
<tr>
<td>90</td>
<td>Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).</td>
</tr>
<tr>
<td>80</td>
<td>If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument), no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).</td>
</tr>
<tr>
<td>70</td>
<td>Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.</td>
</tr>
<tr>
<td>60</td>
<td>Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).</td>
</tr>
<tr>
<td>50</td>
<td>Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).</td>
</tr>
<tr>
<td>40</td>
<td>Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).</td>
</tr>
<tr>
<td>30</td>
<td>Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).</td>
</tr>
<tr>
<td>20</td>
<td>Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).</td>
</tr>
<tr>
<td>10</td>
<td>Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.</td>
</tr>
<tr>
<td>0</td>
<td>Inadequate information.</td>
</tr>
</tbody>
</table>
Individualized Treatment

• The Four Ps
  – Patient Problems/Priorities
  – Plan
  – Progress

• Match *Severity or Level of Functioning* (Assets and Obstacles to Improvement) *With Intensity of Service* (Treatment Modalities, Strategies and Site of Care)
The DSM-5 Diagnostic Criteria for Substance Use Disorders
The DSM-5 Diagnostic Criteria in the New ASAM Criteria

The new ASAM Criteria language is consistent with the DSM-5 Criteria
The DSM-5

Changes from DSM-IV

• Use of the term “addiction”
• No longer diagnoses of “abuse” or “dependence”
• “Substance Use Disorders” (DSM-IV) > “Substance Use and Addictive Disorders” (DSM-5)
• The seven criteria from the DSM-IV for dependence and the four for abuse are collapsed into 11 criteria
• Substance-related legal problems (from abuse criteria) has been removed
• A new criteria of craving, strong desire or urge to use a substance has been added
Removal of “Legal Problems”

**Pro:**
- Discrimination based on race and socioeconomic status
- Misuse of a DWI/DUI as equivalent to old “abuse”
- However, deaths due to drunk driving (alcohol) is only reported 14% of the time
- Geographic inequalities (crossing Colorado state line)
- A criterion that carried the least weight in making the diagnosis

**Con:**
- For some, serves an SBIRT function, as early intervention
- May function as the impetus for treatment (drug courts)
- 54% of DUI offenders who received an abuse diagnosis under the DSM-IV will receive no diagnosis under the DSM-5 – what will this mean in terms of reoffending?
DSM-5 Criteria for Substance Use Disorders

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by two (or more) of the following, occurring at any time in the same 12-month period:

(2) withdrawal
(3) the substance taken in larger amounts or over a longer period of time than was intended
(4) there is a persistent desire or unsuccessful attempts to cut down or control substance use
(5) a great deal of time spent is in activities necessary to obtain the substance, use the substance, or recover from its effects
(6) important social, occupational or recreational activities are given up or reduced because of substance use
(7) substance use is continued despite knowledge of having persistent or recurring physical or psychological problems that are likely to have been caused or exacerbated by the substance
(8) Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home
(9) Recurrent substance use in situations in which it is physically hazardous
(10) Craving
(11) Continuing substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
Changes in the DSM-5 Diagnostic Criteria for Substance Use Disorders

Changes from DSM-IV

• Meeting 0-1 of the 11 criteria results in no diagnosis
• Meeting 2-3 criteria qualifies as *Mild* (akin to old “abuse”)
• Meeting 4-5 criteria qualifies as *Moderate* (akin to old “abuse” or “dependence”)
• Meeting 6 or more qualifies as *Severe* (akin to old “dependence”)
Changes in Course Specifiers

- Early remission
  - From 1 month but less than 12 months in DSM-IV to from 3 months in DSM-5, no criteria met except craving

- Early partial remission

- Sustained full remission
  - No symptoms for 12 months except craving

- Sustained partial remission

- On agonist maintenance therapy

- In a controlled environment
The Conundrums

• Alcoholism/addiction is a chronic, relapsing brain disease

• Alcoholism is an insidious, progressive, incurable and fatal disease and if the person doesn’t stop drinking, they will end up either dead or institutionalized

• Yet some alcoholics are able to go back to “social” (non-problem) drinking???
The Issue of Criteria “Weight”

- All of 11 criteria weighted equally in the DSM
- Some provide greater severity other than simply numbers
- Criteria most likely to be associated with Moderate or Severe categories
  - Withdrawal
  - Rule setting
  - Time spent using
  - Role fulfillment
  - Compulsion
  - Preoccupation
ALCOHOL DSM-5 CRITERIA

- All criteria are not equal in implications
- Some criteria are found almost exclusively among those in the severe alcohol use disorder designation
- Other criteria are more common among the mild to moderate alcohol use disorder group
- *Tolerance and dangerous use* are actually common among those with no diagnosis
The SUD Criteria Found Primarily in the Severe Designation

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
ALCOHOL 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 those above
SAMPLE HYPOTHESES

• **Hypothesis #1**: Clients positive on three or more of the “big five” (withdrawal, rule setting, sacrificing activities, role fulfillment failure, and craving/compulsion to use) will find recovery more difficult (e.g., higher relapse rates)

• **Hypothesis #2**: Clients in mild or moderate designations without any positive findings on the “big five” may be able to moderate use
CLINICAL IMPLICATIONS

• Most of those in the “mild” designation can probably benefit from moderation and related harm reduction strategies (outpatient placement)

• Those in the “severe” designation will require more intensive and extended services where abstinence is essential to recovery (residential/inpatient or structured outpatient, IOP or PHP placement depending on the ASAM severity profile)

• The “moderate” group may contain cases that fit the mild or severe characteristics (placement dependent on the results of the ASAM severity profile)
Implications of New Criteria

- In the DSM-IV, a “Substance Abuse” diagnosis required meeting one of four criteria.
- These folks were not considered “addicted”.
- In the DSM-5, the minimum number of criteria to meet the diagnostic threshold is now 2 but meeting 2 is considered a mild severity of an addiction.
- It is estimated by some economists that this change could characterize 20 million “substance abusers” as “addicts” (although “Mild”).
Characteristics of Addiction

• Compulsion
• Loss of control
• Continued use in spite of negative consequences
• Craving
Comparing Diagnoses – DSM-IV and DSM-5

• 95% with no diagnosis under DSM-IV will still have no diagnosis under DSM-5

• Almost all with a DSM-IV diagnosis of Dependence will fall into the “severe substance use disorder” category in DSM-5

• The major difference is with those who currently have a “Substance Abuse” diagnosis
  – 30% will have no diagnosis
    • Largely due to elimination of legal problems
  – 20% will fall into the severe categorization
    • Will have 1 or 2 positive old dependence criteria

• Remaining 50% will fall into the “moderate” category
Rethinking the Continuum of Substance Use

A FOUR PHASE RISK MODEL

A New Way of Conceptualizing Substance Use
# Phases of Substance Use

<table>
<thead>
<tr>
<th>Phase</th>
<th>Characteristics</th>
<th>Outcomes</th>
<th>Response</th>
</tr>
</thead>
</table>
| **Phase 1**<br>D SM-5 Severity Level 0-1 "Orphan" (no dx) | Low Risk Choices | • No significant increase in tolerance  
• Do not use illegal drugs  
• Use medications only as prescribed  
• Use results in no problems | Continue to make low risk choices ("If it ain’t broke, don’t fix it") |
<table>
<thead>
<tr>
<th>Phase 2</th>
<th>Characteristics</th>
<th>Outcomes</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSM-5 Severity Level 2-3 – Mild “abuse”</td>
<td>• Makes high risk choices (e.g., driving while impaired) • Drinks high risks amounts</td>
<td>• May develop social dependence • State dependent learning begins • Abstract thinking skills may become impaired, e.g., illicit drug use • Beginning</td>
<td>Return to Phase 1 to make low risk choices</td>
</tr>
</tbody>
</table>
### Phases of Substance Use

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<tr>
<th>Phase</th>
<th>Characteristics</th>
<th>Outcomes</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 3</td>
<td>• Development of psychological dependence</td>
<td>• Substance-related health or impairment problems</td>
<td>• Return to low-risk drinking choices <em>MAY</em> still be possible</td>
</tr>
<tr>
<td></td>
<td>• Substance use more integrated into life</td>
<td>• Blackouts</td>
<td>• May require outside help to change choices</td>
</tr>
<tr>
<td></td>
<td>• State dependent learning</td>
<td>• Drinking to cure hangovers</td>
<td>• 50% are able to return to low-risk choices</td>
</tr>
<tr>
<td></td>
<td>• High risk choices become more important than relationships</td>
<td>• Continued use likely to lead to Phase 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Defense of choices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSM-5</td>
<td>Moderate: old “abuse” or “dependence”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity</td>
<td>4-5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level</td>
<td>Moderate</td>
<td></td>
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<th>Characteristics</th>
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</thead>
</table>
| **Phase 4**<br>DSM-5 Severity Level 6+ Severe - old “dependence” | • Physical addiction  
• Withdrawal  
• Loss of control  
• Compulsion  
• Tolerance continues to increase  
• Like AA’s “invisible line” | • More negative, more severe outcomes than in Phase 3  
• Drinking to manage withdrawal  
• Possible imprisonment or death | • Return to low-risk choices no longer possible  
• Requires abstinence  
• Usually requires outside help |
Individualized Treatment
ASAM Criteria

Dimensional Assessment
Changes in the New ASAM Criteria

- Section on four Special Populations:
  - People in the criminal justice system
  - Older adults
  - Parents with children
  - People in safety-sensitive occupations
- No change in levels of care
  - Made consistent with SUD diagnoses in DSM-5
- Opioid Maintenance Treatment (OMT) now Opioid Treatment Services (OTS)
- Section on working with managed care
- Section on Tobacco Use Disorder
- Section on Gambling
It's only a gambling problem if you're losing.
Changes in the New ASAM Criteria

- Criteria more strength-based, empowering and recovery-oriented
- Language changes
- No change in levels of care
- Level of care numbering system changed from Roman to Arabic
- Name for Level 3.3 changed from “Clinically-Managed, Moderate Intensity Residential Treatment” to “Clinically-Managed, High Intensity, Population-Specific Residential Treatment”
- Opioid Maintenance Treatment (OMT) now Opioid Treatment Services (OTS)
- Section Tobacco Use Disorders
Changes in the New ASAM Criteria

• Criteria more strength-based, empowering and recovery-oriented

• Section Tobacco Use Disorders
Tobacco Use Disorders

• Change from Nicotine Use Disorders in the DSM-IV

• Special attention because:
  – Of its lethality
  – It is rarely treated in SUD programs
  – BUT . . . nicotine is the determinant of addiction to tobacco

• While it is mood altering, it is not associated with the same behavioral disruption and social and legal consequences as other drugs
Tobacco Use Disorder

- More people die from the use of tobacco and second hand smoke than die from the use of alcohol, heroin, cocaine, homicide, suicide, automobile accidents and WW II casualties combined

  - Smoking serves as a trigger for relapse to other drugs
  - When the route of administration of the drug of choice is smoking (e.g., “crack”), the risk is increased
Latest Information

• CDC estimates 10% of high school and 3% of middle school students used e-cigarettes in 2012
This facility is smoke free.
Implementing Tobacco Treatment
Success vs. Failure

• NOT tobacco cessation – don’t separate RECOVERY from substance use disorder
• Should be no different than cannabis use in the facility in someone with a severe alcohol use disorder
• The problem is not the drug of choice . . . It is reliance on psychoactive substances to cope
• Tobacco use disorder treatment should be reflected in the:
  - Assessment
  - Treatment plan
  - Progress notes
“People who say it cannot be done should not interrupt those who are doing it”

- George Bernard Shaw
Tobacco Withdrawal

Within 24 hours of cessation of use by 4 or more of the following:

• Irritability, frustration or anger
• Anxiety
• Difficulty concentrating
• Increased appetite
• Restlessness
• Depressed mood
• Insomnia

Criterion of “Decreased heart rate” from DSM-IV out
Perception of Smoking By Many

"Are you crazy man? Smokin' will kill you!"
Smoking and Mental Health Disorders

• 2009-2011 among people with cute mental illness, 36.1% were current smokers compared with 21.4% of adults with no mental illness

• Tobacco use in patients in substance use treatment programs ranges from 65-97%
Recent Study

• Psychiatric patients who took part in a smoking-cessation program while they were in the hospital for treatment of mental illness were more likely to quit smoking and less likely to be hospitalized again for mental illness, a new study shows.

• 224 patients at a smoke-free psychiatric hospital in California.

• Eighteen months after leaving the hospital, 20 percent of those in the treatment group had quit smoking, compared with 7.7 percent of those in the control group.

• Forty-four percent of patients in the treatment group and 56 percent of those in the control group had been readmitted to the hospital.
Schizophrenia & Tobacco Use Disorder

• Addiction to nicotine is the most common form of substance abuse in people with schizophrenia
• They are addicted to nicotine at three times the rate of the general population
Smoking & Outcomes

• Treatment of tobacco use disorder enhances substance use disorder outcomes
• Treatment of tobacco use disorder enhances mental health disorder outcomes
• Tobacco cessation results in less fluctuations of many psychiatric medications
Where Are You RE: Behavioral Health Patients Continuing Tobacco Use?
Changes in the New ASAM Criteria

- Criteria more strength-based, empowering and recovery-oriented
- Section Tobacco Use Disorders
- Section on four Special Populations:
  - People in the criminal justice system
  - Older adults
  - Parents with children
  - People in safety-sensitive occupations
- No change in levels of care
  - Made consistent with SUD diagnoses in DSM-5
- Opioid Maintenance Treatment (OMT) now Opioid Treatment Services (OTS)
Special Populations
People in the Criminal Justice System

• Includes individuals incarcerated, under community-based supervision such as correctional halfway houses or under probation or parole or participation in drug court programs

• Because of varying security levels, the ASAM Criteria may not have applicability

• Conflict frequently ensues because for treatment providers, recovery has the highest priority but for criminal justice, the highest priority is public safety

• Different priorities can be complementary by the artful application of the ASAM Criteria
Special Populations
People in the Criminal Justice System

• Goals of reduced/eliminated substance use, reduced recidivism and improvement in functional areas of the individual’s life are often the same for both
Challenges

- Expecting movement through the Stage of Change in an inappropriately short time frame
- Judges determining length of stay and level of care instead of clinicians
- Due to limited resources, CJ system often has to make decisions based on what is available rather than offender’s needs
Challenges

• CJ emphasis is on criminogenic Risk, Need and Responsivity (RNR) rather than SUD recovery

• CJ response to SUD treatment may be in conflict with CJ expectations (e.g., positive UA in treatment)

• High caseloads in CJ treatment

• More emphasis at discharge or transfer on Dimension 6 for offenders
Changes in the New ASAM Criteria

• Criteria more strength-based, empowering and recovery-oriented

• Section Tobacco Use Disorders

• Section on four Special Populations:
  – People in the criminal justice system
  – Older adults
  – Parents with children
  – People in safety-sensitive occupations

• No change in levels of care
  • Made consistent with SUD diagnoses in DSM-5

• Opioid Maintenance Treatment (OMT) now Opioid Treatment Services (OTS)
Special Populations
Older Adults

• Many of the criteria in the DSM-5 for a diagnosis of a Substance Use Disorder may not be applicable to older adults

• This inapplicability will at least skew severity downward resulting in inappropriate placement
DSM-5 Criteria for Substance Use Disorders

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by two (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance
2. Withdrawal
3. The substance taken in larger amounts or over a longer period of time than was intended
4. There is a persistent desire or unsuccessful attempts to cut down or control substance use
5. A great deal of time spent is in activities necessary to obtain the substance, use the substance, or recover from its effects
(6) important social, occupational or recreational activities are given up or reduced because of substance use

(7) substance use is continued despite knowledge of having persistent or recurring physical or psychological problems that are likely to have been caused or exacerbated by the substance

(8) Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home

(9) Recurrent substance use in situations in which it is physically hazardous

(10) Craving

(11) Continuing substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
Special Populations
Older Adults

• Because of mobility problems, treatment settings and recovery group attendance can present problems

• Many older adults do not drive at all at night (12 step meetings)

• Reimbursement restrictions (e.g., Medicare does not reimburse for residential treatment)
Changes in the New ASAM Criteria

• Criteria more strength-based, empowering and recovery-oriented

• Section Tobacco Use Disorders

• Section on four Special Populations:
  – People in the criminal justice system
  – Older adults
  – Parents with children
  – People in safety-sensitive occupations

• No change in levels of care
  • Made consistent with SUD diagnoses in DSM-5

• Opioid Maintenance Treatment (OMT) now Opioid Treatment Services (OTS)
Special Populations
Parents with Children

• Note: NOT women with children
• Includes pregnant, post-partum women, custodial parents, both men and women and non-custodial parent
• Specially designed programs including programming for children
• Any level of care
• Dimension 6 is key
Changes in the New ASAM Criteria

- Criteria more strength-based, empowering and recovery-oriented
- Section Tobacco Use Disorders
- Section on four Special Populations:
  - People in the criminal justice system
  - Older adults
  - Parents with children
  - People in safety-sensitive occupations
- No change in levels of care
  - Made consistent with SUD diagnoses in DSM-5
- Opioid Maintenance Treatment (OMT) now Opioid Treatment Services (OTS)
Special Populations
Persons in Safety-Sensitive Occupations

• Have a responsibility to the public
  – Have the potential for serious harm to others because of their impairment
  – Implied public trust in their occupation

• These two factors color decision about type of treatment, setting and length of treatment

• Aggressive treatment and continued monitoring do more than assure safety of public at large
  – E.g., a police officer who relapses may have an adverse effect on public safety, peers, the department, government officials and public opinion may reactively punish subsequent officers
Special Populations
Persons in Safety-Sensitive Occupations

- Examples of safety-sensitive workers include:
  - physicians
  - nurses
  - veterinarians and animal workers
  - other healthcare professionals
  - truck and bus drivers; railroad engineers
  - pilots
  - attorneys
  - nuclear plant workers
  - police officers
Special Considerations

• Healthcare workers have access to drugs, sometimes the very drugs they used
• Undercover police officers have access to gray and black market drugs as may attorneys
• Healthcare workers commonly have difficulty adopting the role of “patient”
  - The more responsibility the person has in his or her day-to-day life, the more difficulty
Treatment Issues

• Healthcare workers work in a “hostile” environment and they need to develop refusal skills
• Safety sensitive workers should discontinue work and should not go back until:
  - Public risk issues have been addressed
  - All work regulations, licenses and legal issues have been addressed and a permit to return to work
Treatment Issues (cont.)

- Safety sensitive workers should discontinue work and should not go back until:
  - Work cues and triggers have been delineated and a management plan is in effect
  - The work environment has made appropriate alterations to maximally encourage to sustained recovery. . . Especially true for those who have steady personal access to their previously addictive drugs
  - Supervisory personnel have training to address profession-specific workplace issues
Treatment Issues (cont.)

• Need professional-specific therapy groups in order to talk openly and to resist the role of “junior therapist”

• Need professional-specific support groups

• Should address pragmatic, logistical and emotional problems the patient will face in recovery including possibility of no income for an extended period of time

• Long term follow up and body fluid or or tissue analysis
Changes in the New ASAM Criteria

• Criteria more strength-based, empowering and recovery-oriented
• Section Tobacco Use Disorders
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• No change in levels of care
  • Made consistent with SUD diagnoses in DSM-5
• Opioid Maintenance Treatment (OMT) now Opioid Treatment Services (OTS)
Levels of Care (PPC-2R)
Overall Structure of Levels of Care & Service

• Level 0.5 – Early Intervention
• Level 1 - Outpatient
• Level 2 - Intensive Outpatient/Partial Hospitalization
• Level 3 – Residential/Inpatient Treatment
• Level 4 - Medically Managed Intensive Inpatient Treatment
Level 0.5 - Early Intervention

- Assessment and Education services for individuals with problems or risk factors related to substance abuse, but for whom an immediate substance abuse disorder cannot be confirmed.
- Further assessment is warranted to rule a substance use disorder in or out.
- If a client is confirmed to meet a DSM Substance Abuse or Dependence disorder, and treatment is indicated, then client would receive specific addiction treatment at Level I or higher.
- An example might be an individual convicted of DWI.
Level 0.5 is NOT a level of care or treatment but the combination of psychoeducation and assessment. If the assessment indicates the need for treatment, the individual may receive treatment at the conclusion of the 0.5 service or concurrently.
Outpatient Levels of Care & Service

• Level 0.5 – Early Intervention
• Level 1 - Outpatient
  – Less than 9 Contact Hours/Week
• Level 2 - Intensive Outpatient/Partial Hospitalization
  ❖ Level 2.1 - 9 or More Contact Hours/Week in a *Structured* Program (6 hrs. for adolescents)
  ❖ Level 2.5 - 20 or More Contact Hours/Week in a *Structured* Program
Residential/Inpatient Levels of Care

• Level 3: Residential/Inpatient Services
  - Level 3.1- Clinically Managed Low-Intensity Residential Services (e.g. halfway house)
  - Level 3.3- Clinically Managed, Population-Focused, High-Intensity Residential Services (e.g., Therapeutic Rehabilitation Facility)
  - Level 3.5- Clinically Managed High-Intensity Residential Services (e.g., therapeutic community, Residential Treatment Center)
  - Level 3.7- Medically Monitored Intensive Inpatient Treatment

• Level 4: Medically Managed Intensive Inpatient Treatment
ASAM PPC-2R (Dimension 1 - Detoxification Services)

- **Level 1-WM**: Ambulatory Detoxification without Extended On-site Monitoring (e.g., physician office practice/home health care)
- **Level 2-WM**: Ambulatory Detoxification with Extended on-site Monitoring (e.g., detoxification on a partial hospitalization program)
- **Level 3-WM**: Residential/Inpatient Detoxification
  - **Level 3.2-WM**: Clinically Managed Residential Detoxification (e.g., social detox)
  - **Level 3.7-WM**: Medically Monitored Inpatient Detoxification
- **Level 4-WM**: Medically Managed Inpt. Detoxification
In a little known annex of the Betty Ford Clinic, discarded tequila worms dry out.
Changes in the New ASAM Criteria

• Criteria more strength-based, empowering and recovery-oriented

• Section Tobacco Use Disorders

• Section on four Special Populations:
  – People in the criminal justice system
  – Older adults
  – Parents with children

• No change in levels of care
  • Made consistent with SUD diagnoses in DSM-5

• Opioid Maintenance Treatment (OMT) now Opioid Treatment Services (OTS)
OMT ---> OTS

- In the PPC-2R, Opioid Maintenance Treatment (OMT) referred specifically to methadone maintenance
- Since that time, there have been other agonist drugs developed, e.g., buprenorphine, in its two forms Subutex and Suboxone) and development and increasing use of antagonist drugs, e.g., oral naltrexone, extended release, injectable naltrexone (Vivitrol) and acamprosate (Campral)
- Opioid Treatment Services (OTS) includes both agonist and antagonist drugs
Agonist Treatment Can Be Further Broken Down

- Opioid Treatment Program (OTP)
  - An example of this would be the classic methadone maintenance program (although many are also now using buprenorphine as well)
  - These are heavily regulated by federal agencies
  - Although methadone can be prescribed by any licensed physician for the treatment of opioid withdrawal or the management of pain, only an OTP can dispense it for maintenance
Agonist Treatment Can Be Further Broken Down

- Office-Based Opioid Treatment (OBOT)
  - An office-based practice in which the physician can prescribe buprenorphine or any of the antagonist drugs
  - In order for the physician to prescribe buprenorphine he or she must go through an 8-hour training
  - There is a 30-patient limit but the DEA can authorize 100 patients after the first year
Other Changes in the New ASAM Criteria

• Change in title
  From:
  “The ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders”
  To:
  “The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions”

• New level of care numbering system from Roman to Arabic numbers (e.g. Level II > Level 2)

• Change in name of Level 3.3 from Clinically Managed, Medium Intensity Residential Services to Clinically Managed, Population- Focused, High-Intensity Residential Services”
Other Changes in the New ASAM Criteria

• Re-ordered to be more user-friendly and follow the flow from Historical Foundations to Guiding Principles to Assessment, Service Planning and Placement decisions

• ADOLESCENT CRITERIA NO LONGER SEPARATE/STAND-ALONE: consolidated Adult and Adolescent content to minimize redundancy while preserving adolescent-specific content

• Section on working with managed care

• Updated Dimension 1 information reflecting more recent research
Changes in the New ASAM Criteria

• Change in title
  From: “The ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders”
  To: “The ASAM Criteria: Treatment Criteria for Substance-Related, Co-Occurring Conditions and Addictive Disorders”

• New level of care numbering system from Roman to Arabic numbers (e.g. Level II > Level 2)

• Change in name of Level 3.3 from Clinically Managed, Medium Intensity Residential Services to Clinically Managed, Population- Focused, High-Intensity Residential Services”
Dimensional Criteria Assessment

• Dimension 1: Acute Intoxication/Withdrawal Potential
• Dimension 2: Biomedical Conditions & Complications
• Dimension 3: Emotional/Behavioral/Cognitive Conditions & Complications
• Dimension 4: Readiness to Change
• Dimension 5: Relapse/Continued Use/Continued Problem Potential
• Dimension 6: Recovery Environment
Dimension 1 Change in Language

The term “Detoxification” changed to “Withdrawal Management”

- Livers detoxify patients
- Clinicians manage the process
Ambulatory Detox

George's Liver Goes to Detox
ASAM Criteria, Dimension 1: Detoxification/Withdrawal Potential

• Sample Questions
  - Are there current signs of withdrawal?
  - Does the patient have supports to assist in ambulatory detoxification if medically safe?
  - Has the patient been using multiple substances in the same drug class?
  - If the withdrawal concern is about alcohol, what is the patient’s CIWA-Ar score?
Dimension 1 Change in Language

The term “Detoxification” changed to “Withdrawal Management”

- Livers detoxify patients
- Clinicians manage the process
George's liver goes to detox.
Three Goals for Dimension 1

- Avoidance of potentially hazardous consequences of discontinuation of drugs of dependence
- Facilitation of the patient's completion of detoxification and timely entry into continued treatment
- Promotion of patient dignity and easing discomfort during the withdrawal process
# Drug and Alcohol History

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Route of Administration</th>
<th>First Use</th>
<th>First Problem</th>
<th>First Amount</th>
<th>Frequency</th>
<th>Last Use</th>
<th>Tolerance</th>
</tr>
</thead>
</table>

Drug of Choice: ______ Longest Abstinence: ______ When: _____ Circumstances: ___________________
THE BEST PREDICATOR OF CURRENT AND FUTURE WITHDRAWAL PROBLEMS ARE PAST WITHDRAWAL PROBLEMS
The CI WA-Ar* 
(Clinical Institute Withdrawal Assessment of Alcohol, Revised)

- It requires **under two minutes** to administer
- It requires no medical knowledge
- It provides you with a quantitative score that predicts the severity of withdrawal from alcohol

*Downloadable from Internet without cost*
Addiction Research Foundation Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-Ar)

NAUSEA AND VOMITING: Ask “do you feel sick to your stomach? Have you vomited?
Observation

0  No Nausea and no vomiting
1  Mild Nausea with no vomiting
2
3
4  Intermittent nausea with dry heaves
5
6
7  Constant nausea, frequent dry heaves and vomiting

TREMOR: Arms extended and fingers spread apart.
Observation

0  No tremor
1  Not visible but can be felt fingertip to fingertip
2
3
4  Moderate, with patient’s arm extended
5
6
7  Severe, even with arms not extended
ASAM Criteria Dimension 2: Biomedical Conditions and Complications

• Sample Questions
  - Are there current physical illnesses other than withdrawal, that need to be addressed or which complicate treatment?
  - Are there chronic illnesses which might be exacerbated by withdrawal, e.g., diabetes, hypertension?
ASAM Criteria Dimension 2: Biomedical Conditions and Complications (Cont.)

- Sample Questions
  - Is there a need for medical services which might interfere with treatment (e.g., chemotherapy or kidney dialysis)?
  - Are there conditions which might interfere with treatment (e.g., chronic pain with narcotic analgesics, pain associated with acute pancreatitis)?
Two Types of Medical Conditions and Complications

• Conditions which place the patient at Risk (e.g., esophageal varices, unstable hypertension or diabetes)

• Conditions which interfere with treatment (e.g., the need for kidney dialysis, chronic pain, pain from acute pancreatitis)
ASAM Criteria Dimension 3: Emotional/Behavioral/Cognitive Conditions and Complications

Sample Questions

- Are there current psychiatric illness or psychological, behavioral or emotional problems that need to be addressed or which complicate treatment?
- Are there chronic conditions that affect treatment?
- Do any emotional/behavioral problems appear to be an expected part of addiction illness or do they appear to be separate?
ASAM Criteria Dimension 3: Emotional/Behavioral/ Cognitive Conditions and Complications (Cont.)

• Sample Questions
  – Even if connected to addiction, are they severe enough to warrant specific mental health treatment?
  – Is the patient suicidal, and if so, what is the lethality?
  – If the patient has been prescribed psychiatric medications is he/she compliant?
Co-Occurring Disorders

• Depending on the group, co-occurring disorders range up to 10x what is found in community samples, with corrections and methadone populations being the highest.

• In general, it is estimated that 50 – 60 of persons with a SUD have a co-occurring mental health disorder.

• In general, it is estimated that 35 – 50 of persons with a mental health disorder have a co-occurring SUD.
TODAY, EVERY PROGRAM TREATS PATIENTS & CLIENTS WHO HAVE CO-OCCURRING DISORDERS BUT HOW MANY PROVIDERS TO WHICH YOU REFER ARE TREATING BOTH THE ADDICTION AND THE PSYCHIATRIC COMORBIDITY?
When Co-Occurring Addiction and Mental Health Disorders Exist, Treating Either Without the Other Will Lead to Successful Outcome When:
ATTENTION
DEFICIENCY/ HYPERACTIVITY
DISORDER (ADHD)

• Incidence in the General Population is: 2.3%
• Incidence in a cocaine using population is: 32-34%
• Up to 15% of adults with ADHD will still meet full criteria by age 25
• Up to 65% of adults with ADHD will still meet in “partial remission” criteria by age 30
• Rate of ADHD are higher among people with SUDs
So much easier than parenting.

RITALIN
Because the American Psychiatric Association and the National Institute of Mental Health have decided that childhood is a Mental Disease.

seen at www.watchersweb.com
People DO NOT Outgrow ADHD!
ATTENTION
DEFICIT/ HYPERACTIVITY DISORDER (ADHD)

• Incidence in the General Population is: 2.3%
• Incidence in a cocaine using population is: 32-34%
• Up to 15% of adults with ADHD will still meet full criteria by age 25
• Up to 65% of adults with ADHD will still meet in “partial remission” criteria by age 30
• Rate of ADHD is higher among people with SUDs
ADHD Often Co-Occurs with Learning Disabilities including Dyslexia

"I'd like to join your onion!"
TREATMENT FAILURE DUE TO MISDIAGNOSIS

ACTIVE ADDICTION & MENTAL ILLNESS

IMPROPER SCREENING AND ASSESSMENT

MISDIAGNOSIS

CLIENT DROPS OUT OF TREATMENT

POOR CLIENT TREATMENT MATCH

IMPROPER REFERRAL

TREATMENT FAILURE
When

eHarmony
goes wrong
Part of the Dimension 3 Assessment Includes:

- Assessment of suicidality
  - Factors associated with a higher risk for suicide
    - White, male over 65
    - Major depression, bipolar disorder
    - Previous suicide attempts
    - Family history of suicide
    - Plan, means & opportunity
    - Access and comfort with a lethal means of suicide (e.g., firearms)
    - In treatment
The Existence of a *Psychiatric Diagnosis* Alone Is Not Predictive Of Ability to Utilize Any Particular Intensity or Type of Treatment Without an Assessment Of Level of *Psychiatric Functioning*
Mental Heath Problem and Mental Health Disorders

• Mental health problems exist on a continuum which includes sub-diagnostic threshold symptoms and traits
• At some point there are enough symptoms and traits to meet diagnostic criteria
• In common use, “mental health problems” includes both sub-threshold and diagnosable problems
• Generally, the more criteria an individual meets beyond what is necessary to meet the diagnosis, the more severe the problem.
Anger Management Problems

Anger management:
When angry with someone, it helps to sit down and think about the problem...
The New Paradigm for Co-Occurring Disorders

Characteristics of Co-Occurring Disorders

**PATIENTS**

Addiction-Only Patients:
Individuals who exhibit substance abuse or dependence problems without co-occurring mental health problems or diagnosable Axis I or II disorders

**SERVICES**

Addiction Only Services (AOS):
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
The New Paradigm for Co-Occurring Disorders
Characteristics of Co-Occurring Disorders

**PATIENTS**

Patients with Co-Occurring MH Problems of mild to moderate Severity:
Individuals who exhibit (1) sub-threshold diagnostic (e.g., traits, symptoms) Axis I or II disorders or (2) diagnosable but stable disorders (e.g., bipolar disorder but compliant with and stable on lithium)

**SERVICES**

Co-OccurringCapable (COC):
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
The New Paradigm for Co-Occurring Disorders
Characteristics of Co-Occurring Disorders

**PATIENTS**

Patients with Co-Occurring MH Problems of moderate to High Severity:

Individuals who exhibit diagnosable Axis I or II disorders, who are not stable and require mental health as well as addiction treatment

**SERVICES**

Co-Occurring Enhanced (COE):
Psychiatric services available on site or closely coordinated; all staff are 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 & SA disorders are integrated. This service is most similar to a traditional “dual diagnosis” program.
The New Paradigm for Co-Occurring Disorders
Characteristics of Co-Occurring Disorders
(Shulman Modification)

- **Patients with Co-Occurring Chronic and Debilitating Mental Illness:** Individuals who exhibit severe and persistent mental illness which chronically limits their ability to function independently in the community because of their mental health and addiction problems. They require continuous care and case management in the community in which they live in order to function and avoid rehospitalization. Total restoration of function is less likely than with patients with co-occurring MH problems of moderate to high severity.

- **Co-Occurring Enhanced (COC with ACT & CM):** Psychiatric and addiction assertive community treatment services and case management are provided to the patients in the community in which they live as part of an empathic, continuous, hopeful, treatment relationship in which integrated treatment and coordination of care can take place through multiple treatment episodes.
<table>
<thead>
<tr>
<th>Quadrant 1</th>
<th>Quadrant 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less severe mental disorder/less severe substance disorder</td>
<td>More severe mental disorder/less severe substance disorder</td>
</tr>
<tr>
<td>Quadrant 3</td>
<td>Quadrant 4</td>
</tr>
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</tr>
</tbody>
</table>
Dimension 3
Adolescent Subdomains
Subdomains

1) Dangerousness/Lethality
2) Interference with Addiction Recovery Efforts
3) Social Functioning
4) Ability for Self-Care
5) Course of Illness
Adolescent Subdomain Description

Dangerousness/Lethality:

• Impulsivity with regard to homicide, suicide or other behaviors that pose a risk to self or others and/or to property;
• Seriousness and immediacy of the individual’s ideation, plans and behavior
• Ability to act on such impulses

Interference with Addiction Recovery Efforts:

• Degree to which patient is distracted from addiction recovery efforts by emotional, behavioral and/or cognitive problems;
• Conversely, the degree to which the patient is able to focus on addiction recovery.
Adolescent Subdomain Description

**Social Functioning:**
- Degree to which an individual’s relationships are affected by his or her substance use and/or other emotional, behavioral and cognitive problems;
- Look at ability to cope with:
  - Friends
  - Significant others or family
  - Vocational or educational demands
  - Ability to meet personal responsibilities

**Ability for Self-Care:**
- The degree to which an individual can perform activities of daily living;
- Look at such things as:
  - Personal grooming
  - Obtaining food and shelter
Adolescent Subdomain Description

Course of Illness:

• Employs the history of the patient’s illness and response to past treatment to help to interpret the patient’s current signs, symptoms and presentation;

• To predict the patient’s likely response to future treatment;

• Assess interaction between chronicity and severity of current difficulties
“IMMINENT DANGER”

1. A strong probability that certain behaviors will occur (e.g., continued alcohol or drug use or relapse or non-compliance with psychiatric medications)

2. The likelihood that these behaviors will present a significant risk of serious adverse consequences to the individual and/or others (as in a consistent pattern of driving while intoxicated)

3. The likelihood that such adverse events will occur in the very near future

In order to constitute “imminent danger,” ALL THREE ELEMENTS must be present
ASAM Criteria, Dimension 4: Readiness to Change

• Sample Questions
  - Does the patient feel coerced into treatment or actively object to receiving treatment?
  - How ready is the patient to change (stage of “readiness to change”)?
  - If willing to accept treatment, how strongly does the patient disagree with others’ perception that s/he has an addiction problem?
ASAM Criteria, Dimension 4: Readiness to Change

• Sample Questions
  - Is the patient compliant to avoid a negative consequence (externally motivated) or internally distressed in a self-motivated way about his/her alcohol or other drug use problems?
  - Is there leverage available?
“Resistance is Ambivalence in Drag”
BEFORE 6 BEERS

AFTER 6 BEERS
AFTER 6 BEERS
BEFORE 6 BEERS
RESISTANCE & NON-COMPLIANCE

Are characteristic of all chronic illnesses/disorders, not only substance use disorders!!
EXTERNAL vs. INTERNAL MOTIVATION

(Motivation to Enter Treatment vs. Motivation to Recover)
RESISTANCE & NON-COMPLIANCE

Are characteristic of all chronic illnesses/disorders, not only substance use disorders!!
The Resistance/Confrontation Escalator
Higher Resistance and Denial

*Do Not ALONE*

Indicate the Need for, or Clinical Appropriateness Of A Higher Intensity Level of Treatment
EVERY patient who presents for assessment or treatment is motivated
ACCIDENTALLY LISTENED TO MY MOTIVATION TAPES BACKWARDS AND BECAME A FAILURE. PLEASE HELP.
Transtheoretical Stages of Change (Prochaska & DiClemente)

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse and Recycling
- Termination
Stage Model of the Process of Change

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse

Here
Temporary Exit
Permanent Exit
PRE-CONTEMPLATION

• Not yet considering the possibility of change although others are aware of the problem
• Active resistance to change
• Seldom appear or treatment without coercion
• Could benefit from non-threatening information and strategies to raise awareness of a possible “problem” and the possibilities for change
CONTEMPLATION

• Ambivalent, undecided, vacillating between whether he/she really has a “problem” or needs to change

• Wants to change, but this desire exists simultaneously with resistance to it

• May seek professional advice to get an objective assessment

• Motivational strategies useful at this stage, but aggressive or premature confrontation provokes strong resistance and defensive behaviors

• Many Contemplators have indefinite plans to take action in the next six months
PREPARATION

• Takes person from decisions made in Contemplation stage to the specific steps to be taken to solve the problem in the Action stage

• Increasing confidence in the decision to change

• Performs certain tasks that make up the first steps on the road to Action

• Most people planning to take action within the very next month

• Making final adjustments before they begin to change their behavior.
ACTION

• Specific actions intended to bring about change

• Overt modification of behavior and surroundings

• Most busy stage of change requiring the greatest commitment of time and energy

• Care not to equate action with actual change, or activity with action

• Support and encouragement still very important to prevent drop out and regression in readiness to change.
MAINTENANCE

• Sustain the changes accomplished by previous action and prevent relapse

• Requires different set of skills than were needed to initiate change

• Consolidation of gains attained

• Not a static stage and lasts as little as six months or up to a lifetime

• Learn alternative coping and problem-solving strategies

• Replace problem behaviors with new, healthy life-style

• Work through emotional triggers of relapse.
RELAPSE AND RECYCLING

• Likely, but not inevitable setbacks

• Avoid becoming stuck, discouraged, or demoralized

• Learn from relapse before committing to a new cycle of action

• Comprehensive, multidimensional assessment to explore all reasons for relapse.
TERMINATION

• This stage is the ultimate goal for all changers

• Person exits the cycle of change, without fear of relapse

• Debate over whether certain problems can be terminated or merely kept in remission through maintenance strategies.
## Stages of Change and Therapists’ Tasks

<table>
<thead>
<tr>
<th>CLIENT STAGE</th>
<th>THERAPIST’S MOTIVATIONAL TASKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>Raise doubt – increase the client’s perception of risk and problems with current behavior</td>
</tr>
<tr>
<td>Contemplation</td>
<td>Tip the balance – evoke reasons to change, risks of not changing: strengthen the client’s self-efficacy for change of current behavior</td>
</tr>
<tr>
<td>Preparation</td>
<td>Help the client to determine the best course of action to take in seeking change</td>
</tr>
<tr>
<td>Action</td>
<td>Help the client to take steps toward change</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Help the client identify and use strategies to prevent relapse</td>
</tr>
<tr>
<td>Relapse</td>
<td>Help the client renew the process of contemplation, preparation and action, without becoming stuck or demoralized because of relapse</td>
</tr>
</tbody>
</table>
ASAM Criteria, Dimension 5: Relapse/Continued Use/Continued Problem Potential

Sample Questions

• How aware is the patient of relapse triggers, ways to cope with cravings and skills to control impulses to use?

• What is the patient’s ability to remain abstinent or psychiatrically stable based on history?

• What is the patient’s level of current craving and how successfully can they resist using?
ASAM Criteria, Dimension 5: Relapse/Continued Use/Continued Problem Potential (cont.)

- If on psychiatric medications, is the patient compliant?
- If the patient had another chronic disorder (e.g., diabetes), what is the history of compliance with treatment for that disorder?
- Is the patient in immediate danger of continued severe distress and drinking/drugging or other high risk behavior due to co-occurring mental health problems?
ASAM Criteria, Dimension 5: Relapse/Continued Use/Continued Problem Potential (cont.)

- Does the patient have any recognition and skills to cope with addiction and/or mental health problems and prevent relapse or continued use/continued problems?
- What severity of problems and further distress will potentially continue or reappear, if the patient is not successfully engaged into treatment at this time?
Description of a Relapse

• A return to the use of psychoactive substances after a period of at least ______ (?) months of abstinence/recovery,

• in an individual who has completed a course of inpatient or outpatient treatment or has had extensive recovery group experience,

• as a result of which that patient/client has made and internalized certain changes in functioning,

• which had allowed the patient to cope without resorting to the use of psychoactive substances in the interim period.
Notes to Relapse

• It is assumed that the relapse process begins long before that actual substance use.

• RELAPSE implies that the patient acquired and internalized certain coping skills and strategies and then something happened which brought about a return to the active addiction.

• CONTINUED USE is just that (“You can’t fall off the wagon if you never got on it!”).
In the New ASAM Criteria

- The term “relapse” remains unchanged

- **BUT** attention is paid to the facts that:
  - The term is not used in medicine for chronic diseases, instead using “exacerbation” or “return of symptoms”
  - The term is sometimes used judgmentally with a conscious or unconscious blaming of the patient
RELAPSE!

I don't know what happened!
Using the Continuous Assessment Model for Assessment of Relapse

**PATIENT ASSESSMENT**
Data from all BIOPSYCHOSOCIAL Dimensions

**PROGRESS**

**PRIORITIES**

**PLAN**
BIOPSYCHOSOCIAL Treatment
Intensity of Service (IS) - Modalities and Levels of Service
Relapse rates for drug-addicted patients are compared with those suffering from diabetes, hypertension, and asthma. Relapse is common and similar across these illnesses (as is adherence to medication). Thus, drug addiction should be treated like any other chronic illness, with relapse serving as a trigger for renewed intervention.

For some Patients/ Clients the issue is *Habilitation* rather than *Rehabilitation*.
Level of Care Placement after relapse should be based on an assessment of history and “here & now” and NOT on the assumption that if a patient relapsed after having been treated, then the previous level of care was not intense enough!
Comprehensive Alcohol Dependence Treatment

Why Psychosocial Treatments Alone Are Limited in Effectiveness
For alcohol dependence, consideration should always be given to anti-addiction medications along with psychosocial treatment

- Disulfiram ("Antabuse")
- Acamprosate ("Campral")
- Naltrexone ("Revia" & "Depade")
- Sustained release injectable naltrexone ("Vivitrol")
For opioid dependence, consideration should be given to anti-addiction medications along with psychosocial treatment:

- Methadone
- Suboxone (buprenorphine + naloxone)
- Subutex (buprenorphine)
- Sustained release injectable naltrexone ("Vivitrol")
Implications of Language

• Pharmacotherapy is often called “Medication Assisted Treatment” or MAT
• When someone with the chronic disease of diabetes uses insulin, we don’t call it Medication Assisted Treatment
• For some, MAT equals Methadone or Buprenorphine Maintenance (agonists)
• The belief that if you on an agonist, “you are still addicted” is incorrect . . . You remain physiologically dependent!
Pharmacotherapy should be considered a treatment tool as others like group therapy or CBT.
The greatest problem with pharmacotherapy is the lack of compliance!
Pharmacy Claims for Oral Naltrexone

Figure 1
Trends in the total number of days that naltrexone was supplied among members of a large mid-Atlantic health insurer

Half of patients never refilled – despite Insurance coverage

Effects of Medication Treatment on Cue-Induced ...
Some Research Results
VIVITROL – Significantly Reduces Drinking Days\textsuperscript{1,2}

Results are from a post hoc subgroup analysis of a 6-month multicenter, double-blind, placebo-controlled clinical trial of alcohol dependents who were abstinent for 4 or more days prior to treatment initiation.
Results 2006-2008
Reduced Average Number of Admissions

Number of Admissions by Time Periods
Before and After AR Program

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Before AR Program</th>
<th>After AR Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>90 Days</td>
<td>0.5</td>
<td>0.2</td>
</tr>
<tr>
<td>180 Days</td>
<td>1.0</td>
<td>0.5</td>
</tr>
<tr>
<td>1 Year</td>
<td>1.5</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Florida Advancing Recovery/RWJ Foundation—Demonstration Project
N=29 patients; non-randomized; no comparison group
Results 2006-2008
Motivation To Quit by Injection

Average Motivation to Quit Score

Mean Motivation Score

Florida Advancing Recovery/RWJ Foundation– Demonstration Project
N=29 patients; non-randomized; no comparison group
VI TROL Reduced Holiday Drinking

Among patients who were abstinent for 4 or more days prior to treatment initiation, similar findings were observed among patients who were abstinent 7 days prior to treatment initiation (n=53).

Bohn MJ. Poster presented at: Annual Meeting of the American Psychiatric Association; May 19-24, 2007; San Diego, CA.
Impact on Participation in Counseling and Mutual Support Groups

Northeast Recovery Division (CRC)  
Vivitrol Client Outcomes

Includes clients admitted and discharged between 1/1/11 through 9/30/11 at White Deer Run - Allenwood, Cove Forge, Bowling Green at Brandywine, Wilmington Treatment Center and Life Center of Galax

<table>
<thead>
<tr>
<th></th>
<th>Opiate Clients Enrolled</th>
<th>Opiate Clients Denied</th>
<th>All Other Opiate Clients</th>
<th>Variance (Denied)</th>
<th>Variance (All Other)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Clients:</td>
<td>358</td>
<td>460</td>
<td>8,053</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Average Length of Stay:</td>
<td>23.11</td>
<td>17.96</td>
<td>15.94</td>
<td>29%</td>
<td>45%</td>
</tr>
<tr>
<td>% Treatment Complete:</td>
<td>87.3%</td>
<td>69.8%</td>
<td>66.5%</td>
<td>25%</td>
<td>31%</td>
</tr>
<tr>
<td>% AMA:</td>
<td>10.7%</td>
<td>24.6%</td>
<td>26.6%</td>
<td>57%</td>
<td>60%</td>
</tr>
<tr>
<td>Readmission Rate:</td>
<td>8.0%</td>
<td>13.4%</td>
<td>15.8%</td>
<td>40%</td>
<td>49%</td>
</tr>
</tbody>
</table>
Of all of the FDA approved medications for the treatment of opioid dependence, Vivitrol is the only one that does not produce or continue physiological dependence. However, it does require initial abstinence of 7-10 days.
If the Science Is There, Why Isn’t It Used More Commonly?”
Erroneous Beliefs

• Erroneous beliefs that:
  ✓ Vivitrol is meant to replace psychosocial treatments
  ✓ Vivitrol is incompatible with AA/NA
  ✓ Vivitrol is psychoactive or addictive
Innovations don’t sell themselves . . .

• In 1601...
  Capt. James Lancaster evaluates the effectiveness of lemon juice to prevent scurvy. Results excellent.

• In 1747...
  Dr. James Lind carries out a second study. Results excellent.

• In 1796 ...
  British Navy finally adopts use of lemon juice to prevent scurvy.
H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director, Center for Substance Abuse Treatment (CSAT)

At the opening plenary session of the 2011 Cape Cod Symposium on Addictive Disorders (1,100 attendees), Dr. Clark said the following:

“Failing to offer and use Medication Assisted Treatment, particularly Vivitrol, is tantamount to malpractice!”
The Veteran’s Administration

• The VA has determined that the use of pharmacotherapy in the treatment of addictions:

IS THE STANDARD OF CARE!
“A particular form of ill-treatment and possibly torture of drug users is the denial of opiate substitution treatment,” the report says, adding this is considered a human rights violation when it occurs in jails and prisons.
There Is No Magic Bullet!

All of the oral anti-craving medications and Vivitrol work best in conjunction with psychosocial treatment and/or recovery support services.


Oral Naltrexone and Vivitrol Are SUPPLEMENTS, Not REPLACEMENTS!
IF I really believe that Addiction is a chronic, relapsing brain disease, THEN I will treat it as a chronic disease which means consideration of the use of medications as would occur with other chronic diseases such as hypertension and diabetes.
Screening Instrument for Gambling Disorder, an Often Overlooked Co-Occurring Disorder

• “Lie-Bet”
  1. Have you ever felt the need to bet more and more money?
  2. Have you ever had to lie to people important to you about how much you gambled?
ASAM Criteria, Dimension 6: Recovery Environment

• Sample Questions
  - 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?
ASAM Criteria, Dimension 6: Recovery Environment (Cont.)

- Sample Questions
  - Are there barriers to access to treatment such as transportation or child care responsibilities?
  - Are there legal, vocational, social service agency or criminal justice mandates that may enhance motivation for engagement into treatment?
  - Is the patient able to see value in recovery?
HOMELINESSNESS

alone is **NOT**
sufficient reason
for a Level III Placement!
I admire people

Who barely have anything but share it nevertheless
Dimension 6 Issues As or More Important Than Treatment

- Housing
- Education
- Literacy
- Employment
  - Ex-Felons
- Child Care
- Re-entry from prison
- Opportunity
The more disadvantaged and complicated the patient, the more important is CASE MANAGEMENT

- Co-occurring medical and psychiatric disorders
- Adolescents
- Ex-Felons
- Older Adults
- Welfare/disability clients
- Financial problems needs
- Parenting needs
Without these needed services, here is where we are:
Demographic Predictors of Poor Treatment Outcome (both MH & SA)

1. Under 25 years of age
2. Never married or having lived as married
3. Unemployed
4. No high school diploma or GED
WHAT MATTERS MOST IS HOW YOU SEE YOURSELF.
“Discharge Planning” is part of treatment planning, NOT a discrete activity

(90 meetings in 90 days is NOT a discharge plan!)
What kind of discharge planning are your providers doing?
Problem Determination & Prioritization
Individualized Treatment

PATIENT ASSESSMENT

SERVICE PLAN

Data from all BIOPSYCHOSOCIAL Dimensions

BIOPSYCHOSOCIAL Severity (SI) and level of Functioning (LOF)

BIOPSYCHOSOCIAL Treatment Intensity of Service (IS) - Modalities and Levels of Service

Response to Treatment

PLACEMENT
Service Plan

• A determination of needed services and interventions
• Followed by the selection of level of care where those services are available
• Not a formal treatment plan
Placement
It is as important to understand the person who has the disease, as the disease the person has.
Levels of Care (PPC-2R)
Overall Structure of Levels of Care & Service

• **Level 0.5** – Early Intervention
• **Level 1** - Outpatient
• **Level 2** - Intensive Outpatient/Partial Hospitalization
• **Level 3** – Residential/Inpatient Treatment
• **Level 4** - Medically Managed Intensive Inpatient Treatment
Level 0.5 - Early Intervention

• Assessment and Education services for individuals with problems or risk factors related to substance abuse, but for whom an immediate substance abuse disorder cannot be confirmed

• Further assessment is warranted to rule a substance use disorder in or out

• If a client is confirmed to meet a DSM Substance Abuse or Dependence disorder, and treatment is indicated, then client would receive specific addiction treatment at Level I or higher

• An example might be an individual convicted of DWI
Level 0.5 is NOT a level of care or treatment but the combination of psychoeducation and assessment. If the assessment indicates the need for treatment, the individual may receive treatment at the conclusion of the 0.5 service or concurrently.
Outpatient Levels of Care & Service

• Level 0.5 – Early Intervention
• Level 1 - Outpatient
  – Less than 9 Contact Hours/Week
• Level 2 - Intensive Outpatient/Partial Hospitalization
  ❖ Level 2.1 - 9 or More Contact Hours/Week in a *Structured* Program (6 hrs. for adolescents)
  ❖ Level 2.5 - 20 or More Contact Hours/Week in a *Structured* Program
Residential/Inpatient Levels of Care

• Level 3: Residential/Inpatient Services
  - Level 3.1- Clinically Managed Low-Intensity Residential Services (e.g. halfway house)
  - Level 3.3- Clinically Managed, Population-Focused, High-Intensity Residential Services (e.g., Therapeutic Rehabilitation Facility)
  - Level 3.5- Clinically Managed High-Intensity Residential Services (e.g., therapeutic community, Residential Treatment Center)
  - Level 3.7- Medically Monitored Intensive Inpatient Treatment

• Level 4: Medically Managed Intensive Inpatient Treatment
Level 1.D: Ambulatory Detoxification without Extended On-site Monitoring (e.g., physician office practice/home health care)

Level 2-D: Ambulatory Detoxification with Extended on-site Monitoring (e.g., detoxification on a partial hospitalization program)

Level 3-D: Residential/Inpatient Detoxification
  - Level 3.2D: Clinically Managed Residential Detoxification (e.g., social detox)
  - Level 3.7D: Medically Monitored Inpatient Detoxification

Level 4-D: Medically Managed Inpatient Detoxification
In a little known annex of the Betty Ford Clinic, discarded tequila worms dry out.
Continued Service and Discharge Criteria in the ASAM PPC-2R

• The patient meets continued service criteria if he or she:
  ✓ has not yet resolved the problems that justified admission but is working on them and making progress
  ✓ Has resolved the problems that justified admission but new problems which can only be dealt with safely at the current level of service have surfaced
The patient meets discharge criteria is he or she:

- has resolved the problems that justified admission and can now be treated at a less intensive level of service
- is unable to resolve the problems and requires different services that can be provided at the same level of care or a different level of care (e.g., an individual in a Level III.5 becomes acutely suicidal and must be transferred to a Level IV, Dual Diagnosis Enhanced service)
- has resolved the problems but new problems have arisen which require different services or a different level of care (e.g., an individual in a Level III.5 becomes acutely suicidal and must be transferred to a Level IV, Dual Diagnosis Enhanced service)
CASE STUDIES
Assessment for Severity Must Be Done *Within and Between* Dimensions

• High severity in one dimension can increase severity in one or more other dimensions

• Low severity in one dimension can decrease severity in one or more other dimensions
The Three H’s of Assessment

- **H**istory
- **H**ere and Now
- **H**ow uncomfortable are you?
Ann, a 32 year old white, divorced female, came in for assessment for the first time ever. She has been abstinent for 48 hours from alcohol and reports that she has remained so for up to 72 hours during the past three months. When she has done this she states she has experienced sweats, internal tremors and nausea, but has never hallucinated, experienced D.T.’s or seizures.
She states she is in good health except for alcoholic hepatitis for which she was just released from the hospital one week ago. Her doctor referred her for assessment. She smokes up to 2 joints a day, but stopped yesterday. In addition to the above, Ann describes two past suicide attempts using sleeping pills, but the most recent attempt was three years ago and she sees a psychiatrist once a month for review of her medication. She takes Prozac for the depression and reports taking her medication as prescribed.
Ann reported that she lives in a rented apartment and has very few friends since her divorce a year ago. She is currently unemployed after being laid off when the department store she worked at closed. She has worked as a waitress, check-out person and sales person before and says she has never lost a job due to addiction.
Ann appears slightly anxious, but is not flushed. She speaks calmly and is cooperative. Ann shows awareness of her consequences from chemical use, but tends to minimize it and blame others including her ex-husband who left her without warning. She doesn’t know much about alcoholism/chemical dependency, but wants to learn more. She has one son, age 11, from a previous marriage, who doesn’t see any problems with her drinking and doesn’t know about her marijuana use.
<table>
<thead>
<tr>
<th>ASAM Dimension</th>
<th>Risk Rating</th>
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<tbody>
<tr>
<td></td>
<td>(0)</td>
</tr>
<tr>
<td></td>
<td>No Problem</td>
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Dimension 1: Acute Intoxication and/or Withdrawal Potential

Dimension 2: Biomedical Conditions & Complications

Dimension 3: Emotional, Behavioral, Cognitive Conditions & Complications

Dimension 4: Readiness to Change

Dimension 5: Relapse, Continued Use, Continued Problem Potential

Dimension 6: Recovery Environment
Ann – Four Months Later

At a follow-up visit four months later, Ann reports that she has been abstinent from alcohol for almost four months. She has transitioned well to less intensive levels of outpatient care, has been discharged from a Level I program, and is attending self-help group meetings two to three times a week. She has not used marijuana for the past two weeks. Her liver function test results are within normal limits.
Ann – Four Months Later

However, Ann discloses that her sister, from whom she had been estranged, died recently, before they could reestablish their relationship. She feels guilty that she was unable to bring about a rapprochement. She also has become involved in a relationship that she describes as being “madly in love.” The man in question moved in with her, but after coming home from an AA meeting she discovered him in bed with a friend. She has fallen into a deep depression even though she continues to use her anti-depressant medication.
Ann reports that, for the first time in three years, she occasionally thinks about suicide, although she says she does not have an active plan and is willing to make a safety contract. She reports that she is barely able to care for her son. She started a new job as a salesperson, but is still in her initial probationary period and has called in sick for the past three days.
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<td>(2) Moderate</td>
<td>(3) Significant</td>
</tr>
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<td>(4) Severe</td>
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</tr>
<tr>
<td><strong>Dimension 6: Recovery Environment</strong></td>
<td></td>
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</tbody>
</table>
Second Time Around Sam
Referred for DWI Assessment

A 43 year old male, heating and air conditioning technician with 19 years of service with the company was referred to EAP after being cited for DWI. He has had a recent (last two months) pattern of tardiness and coworkers have noticed the smell of alcohol on him on several occasions. BAC for the DWI was 0.24gms/\%.
The patient reports that he has been in a 28 day inpatient alcoholism rehabilitation center seven years ago after which he abstained from alcohol for 1 and 1/2 years. He claims current daily usage is 5 - 7 beers on weekdays and up to 12 beers/day on the weekends. He has recently been diagnosed with pancreatitis. He does not admit to being alcoholic but is willing to enter treatment to keep his job.
He lives with his two daughters, ages 17 and 15. He has been divorced for four years, has custody of the children and admits that his alcohol use was a contributor to the divorce. He does not currently have a significant other nor does he date much. Stressors include a new job, a custody suite initiated by his ex-spouse and an upcoming 6 month redeployment to another job site 250 miles away. He admits to feeling stressed, somewhat depressed which creates cravings to drink and he has experienced fleeting suicidal ideation.
On evaluation he was found to be anxious and states his use of alcohol is to alleviate depression and loneliness. He had no periods of abstinence from alcohol exceeding two days in the past five years. When he does stop drinking, he experiences moderate to severe shakes and describes passing out, which upon further assessment has likely been a withdrawal seizure. He has not attempted to stop drinking and describes his social support system as "weak."
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Dimension 1: Acute Intoxication and/or Withdrawal Potential

Dimension 2: Biomedical Conditions & Complications

Dimension 3: Emotional, Behavioral, Cognitive Conditions & Complications

Dimension 4: Readiness to Change

Dimension 5: Relapse, Continued Use, Continued Problem Potential

Dimension 6: Recovery Environment
During Sam’s third week in treatment, there was an exacerbation of his depressive symptoms. He began to talk about being overwhelmed by all the problems that he had, his fears of losing his daughters and expressed serious doubts about whether he could recover as he did before. His suicidal ideation has increased and while he still has no plan, he claims to be thinking about suicide on a daily basis.
<table>
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Dimension 1: Acute Intoxication and/or Withdrawal Potential

Dimension 2: Biomedical Conditions & Complications

Dimension 3: Emotional, Behavioral, Cognitive Conditions & Complications

Dimension 4: Readiness to Change

Dimension 5: Relapse, Continued Use, Continued Problem Potential

Dimension 6: Recovery Environment
The parents are both present at the emergency room (ER), but she was brought by the police who had been called by her mother. The ER physician and a 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, especially with her father; the violent behavior; and the question of intoxication.
Using the six ASAM assessment dimensions, the ER physician and psychiatric nurse organized the biopsychosocial clinical as follows:

- **Dimension 1, Acute Intoxication/Withdrawal Potential:** 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 Conditions and Complications:** complex problems with the anger, frustration and family discord; history of chair throwing, but is not impulsive at present if separated from parents.
Dimension 4, Readiness to Change: willing to talk to therapist; blames her parents for being overbearing and not trusting her; agrees to come into treatment, but does not want to be at home near father, 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.

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.
<table>
<thead>
<tr>
<th>Dimension</th>
<th>Risk Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dimension 1: Acute Intoxication</td>
<td>(2) Moderate</td>
</tr>
<tr>
<td>and/or Withdrawal Potential</td>
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</tr>
<tr>
<td>Dimension 2: Biomedical Conditions</td>
<td>(3) Significant</td>
</tr>
<tr>
<td>&amp; Complications</td>
<td></td>
</tr>
<tr>
<td>Dimension 3: Emotional, Behavioral, Cognitive Conditions &amp; Complications</td>
<td>(4) Severe</td>
</tr>
<tr>
<td>Dimension 4: Readiness to Change</td>
<td></td>
</tr>
<tr>
<td>Dimension 5: Relapse, Continued</td>
<td>(0) No Problem</td>
</tr>
<tr>
<td>Use, Continued Problem Potential</td>
<td></td>
</tr>
<tr>
<td>Dimension 6: Recovery Environment</td>
<td></td>
</tr>
</tbody>
</table>
**Initial Response:** Based on Tracy’s recent history of violent acting out (chair throwing), the ER physician and the psychiatric nurse recommended admission to the psychiatric unit, at least for the night.

**Discussion:** Tracy’s acting out occurred when she was intoxicated, which she no longer is and the major conflict appears to be a family issue, especially between her and her father. There is also no current indication of any severe or imminently dangerous biomedical, emotional, behavioral or cognitive problems requiring the resources of a medically managed intensive inpatient setting.
Revised Response: The initial goal is to separate Tracy and her father, which might be done by having Tracy stay with a relative or family friend overnight, or by having Tracy and her mother stay at a motel for the night or having father do that. Based on the current information, Tracy’s behavior and the conflict with her parents may be more reflective of an adolescent struggling to negotiate this very difficult period of life rather than psychopathology. Outpatient family counseling should be considered. A family therapy session for early the next day keeps the focus on the need for family interventions and avoids labeling Tracy as having the pathology. A

This revised plan avoids the use of unnecessary, high intensity, high cost resources.
Sandy

• This 26 year old, white female contacted the clinic herself asking for help. An assessment by the counselor revealed the following:

• She has been snorting cocaine off and on for about four years, and for the last year, 3-4 times a week, 1-2 lines at a time.

• She drinks 2-3 drinks at a time, 2-3 times a week, with occasional drinking to intoxication on the weekends.

• She smokes marijuana, 1-2 joints at a time, 1-2 times a week.
Sandy

- She claims to want help to stop using all the psychoactive substances, but especially the cocaine, because while she likes some of the psychoactive effects, she doesn’t like being ”out of it,” even minimally. She had a DUI about two years ago (she does not know what her BAC was). Recently Sandy found herself wandering in a park near her home and does not remember how she got there. This has frightened her.
Sandy

- She has no medical problems of significance that would interfere with treatment. During the assessment, Sandy appeared somewhat anxious and mildly depressed, most of which may be accounted for by the assessment situation.
- Sandy and her husband have been separated twice, once for three weeks and once for one month in the last two years after she moved out. She has been able to stay off all drugs and alcohol during the time they were separated and for about one month each time after she returned from the marital separations. She states that her husband supports her in her attempts to get help for her substance use.
## ASAM Dimension Severity Worksheet

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It is as important to understand the person who has the disease, as the disease the person has.
"It is not the strongest of the species that survives, nor the most intelligent that survives. It is the one that is most adaptable to change."

Charles Darwin
"Some days you just have to look at the world in a different way!"
Hey! Don't just have a good day. Instead have a Fantastic, Great, Super-Duper, Totally Awesome, Wonderful Day!