Understanding the ASAM PPC-2R

ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders

OptumHealthSM
NEW MEXICO

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Learning Objectives

At the completion of this module, the Utilization Manager will be able to accomplish the following with the use of job aids:

- Understand the different assessment dimensions of ASAM PCC-2R and its importance in determining care for the consumer.

- Identify the level of functioning for consumers with substance abuse issues.

- Recognize the criteria used to differentiate the levels of care for consumers with substance abuse disorders.

- Utilize the ASAM PPC-2R level of care guidelines for substance abuse effectively to assist in making decisions around authorization of benefits.

- Locate the ASAM PCC-2R level of care guidelines on inSite.
“Mental health and substance abuse recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.”

- SAMHSA Consensus Statement
OptumHealth New Mexico Mission and Vision

- **Mission**: We help people live their lives to the fullest.

- **Vision**: We build our business by being a constructive, transformative force in public sector healthcare systems, driven by a team of talented, empathic and passionate individuals.

- Benefits for behavioral health services are authorized, reviewed and managed through OptumHealth New Mexico.
Guiding Principles

- Guiding principles to keep in mind when coordinating care, plus natural and community resources for the consumers and their families:

  - Strengths-based assessments
  - Consumer-centered and directed
  - Family-focused
  - Community-based
  - Multi-system
  - Culturally competent
  - Least intrusive
OptumHealth New Mexico Utilization Management Program

- OptumHealth New Mexico has a formal utilization management system designed to process pre-service, concurrent and post-service requests for authorization of services.

- Our commitment to the consumer and their family consumers is to partner with them to identify the most appropriate care and services, with qualified providers in a timely manner.

- As part of that process the Utilization Manager gathers all pertinent clinical information including cultural, linguistic, psychosocial, behavioral/substance abuse, risk factors, and medical needs.

- Uses the OHNM level of care guidelines and/or ASAM PPC-2R guidelines to guide the decision on whether the clinical information provided matches the request for services and intensity of level of care
  - Identify whether the consumer’s psychosocial, cultural, and behavioral health needs are being met adequately with the given request
  - Explore alternative treatment options available, if deemed necessary.
### Role of Utilization Manager and Peer Reviewers

- Utilization Manager is an advocate to the consumer.

- Utilization Manager ensures that the consumer and family consumers are receiving the most appropriate care and information they need to make informed decisions about treatment options.

- Our goal is to assist the consumer and family consumers reach their goals of recovery and resiliency.

- OptumHealth New Mexico’s emphasis on care advocacy de-emphasizes denials of authorizations and promotes barrier-free access to the least restrictive level of care that is clinically appropriate to the consumer’s needs.
Role of Utilization Manager and Peer Reviewers

- Bases UM determinations on the following:
  - appropriateness of care and services
  - individual consumer needs including current condition
  - history of the problem/illness
  - desired outcomes and effectiveness of prior treatment, if any
  - the availability of community resources
  - the consumer’s and/or family’s or consumer-identified representative’s choices concerning available services and practitioners (Advance Directives, WRAP plans and recovery/resiliency goals)
  - benefit coverage
  - available funding sources

- Utilizes established OHNM mental health level of care guidelines or ASAM PPC-2R to help guide their decisions along with the information above.
The Role of Utilization Manager vs. Care Coordinator and Peer/Family Specialists

- Utilization Managers will not deny authorization to higher levels of care unless an appropriate lower level of care is available.
- Reconsider that in making level of care decisions, you as a Utilization Manager will consider the consumer’s psychosocial needs, cultural and linguistic needs, advance directives, WRAP plans as well as physical and behavioral health needs.
- Care Coordinators’ and Peer/Family Specialists’ role with hospitalized consumers is to assist the consumers and family consumers in coordinating care and available resources that they want upon their return to the community, in hearing their concerns about going home, in developing crisis plans, and establishing recovery goals.
Role of Peer and Family Specialist with consumers hospitalized

- Peer Specialists work with any consumer over the age of 21 – even if a request comes from a family consumer, it is the consumer who is the client – as long as the consumer is over the age of 21.
- Family Specialists work with families and children, youth and young adults under the age of 21.
- Utilization Managers in reviewing cases with facility utilization reviewers will at times recognize that a consumer or family consumer is not responding to attempts to engage them in care and recovery and will seek the help of the Peer Specialist or Family Specialist to reach out to the consumer or family consumer.
- Utilization Manager will send requests via Linx worklists to the Peer and/or Family Specialist to reach out to the consumer/family to create WRAP plans, recovery goals and advance directives/crisis plans.
- The Peer Specialist will use a variety of ways - including face to face contact when indicated – to engage the consumer using peer support techniques. All interactions will be documented on the care coordination screens.
Role of Care Coordinator with Hospitalized Consumers

- Care Coordinator, in conjunction with Utilization Managers brings together the facility treatment team, the Core Service agencies/providers working with consumer, consumer and family consumers and any pertinent agency (CYFD care coordinator) to develop a comprehensive recovery plan.

- Care Coordinators ensure that services and resources are available for the consumer and family when the consumer is ready to leave the hospital.
In the following slides, you will be introduced to the ASAM PPC-2R level of care guidelines for substance abuse used to make decisions around authorization of benefits.

The ASAM PPC-2R provides a comprehensive approach in treatment considerations when working with individuals who are dealing with substance abuse.

The components of the ASAM PPC-2R work with the whole person for the purposes of improving an individuals’ functioning, promoting management of illness(s), and facilitating recovery.

The ASAM PPC-2R works on the premise that individuals proceed toward goal attainment at their own pace and continue attaining their goals at varying levels of intensity during which they may move among different stages in their recovery.
In 2006, 23.6 million persons aged 12 or older needed treatment for an illicit drug or alcohol abuse problem (9.6 percent of the persons aged 12 or older). *

Of these, only 2.5 million—10.8 percent of those who needed treatment—received it at a specialty facility. *

Nearly 14 million Americans meet criteria for alcohol abuse or alcoholism diagnosis.

40% of Americans have direct family experience with substance abuse or dependence.

About 1 in 4 children in the US are exposed to alcohol abuse or dependence in the family

*According to the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) National Survey on Drug Use and Health
An Opportunity

- Being able to see past the vacuum of lack of knowledge or skills, and the stigma that clouds recognition and treatment of substance use problems, provides for the astute clinicians a tremendous opportunity—an opportunity to intervene and arrest the havoc caused by generations of untreated addiction.
Key Concepts About Addiction
## Key Concepts About Addiction

- Alcoholism and chemical dependence are biopsychosocial-spiritual in nature.
  - In etiology, expression and treatment
  - As a consideration in differential diagnosis
Key Concepts About Addiction

- Denial and resistance are major signs and symptoms characteristic of alcoholism and chemical dependence.
  - Conscious lying
  - Organic amnesia
  - Unconscious survival mechanism
  - Implications for history-taking and treatment planning
Key Concepts About Addiction

- **Family disease concept**
  - All consumers of the identified client’s social systems are affected and in need of active intervention.
  - Children, spouses, and significant others may
    - act to maintain and prolong addiction.
    - need to engage in a personal recovery.
Key Concepts About Addiction

- Treatment/Recovery is a process, not an event.
  - Motivation
  - Relapse
  - Levels of Care
Focused, Targeted Treatment

- Move from program-driven treatment to assessment-based, clinically and outcomes driven treatment.

- Biopsychosocial Perspective of Addiction
  - A common view allows a common language of assessment and treatment

- Individualized Treatment
  - A diagnosis is necessary, but not sufficient to determine treatment.
Underlying Concepts to the ASAM PPC-2R

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Using the ASAM PPC-2R

- ASAM Criteria should be utilized to:
  1. Assign the appropriate level of service and level of care
  2. Do effective treatment planning and documentation
  3. Make decisions about continued service or discharge by ongoing assessment and review of progress notes
Using the ASAM PPC-2R

- The ASAM PPC-2R includes placement criteria for both Adults and Adolescents.

- The main difference is that there are no separate Detoxification Services for Adolescents in the ASAM PPC-2R.

- It also contains Continued Service and Discharge Criteria and a separate section on Opioid Maintenance Therapy.
Underlying Concepts

- Biopsychosocial Perspective of Addiction
  - Biopsychosocial in etiology, expression, treatment
  - Comprehensive assessment and treatment
  - Explains clinical diversity with commonalities
  - Promotes integration of knowledge

- Individualized Treatment
  - Match severity, or level of functioning with intensity of service
  - 4P’s –
    - Patient/participant assessment
    - Problems/priorities
    - Plan
    - Progress
Underlying Concepts (cont’d)

**PATIENT PARTICIPANT ASSESSMENT**
Data from all BIOPSYCHOSOCIAL Dimensions

**PROGRESS**
Response to Treatment
BIOPSYCHOSOCIAL Severity (SI)
And Level of Function

**PRIORITIES**
BIOPSYCHOSOCIAL Severity (SI)
And Level of Function (LOF)

**PLAN**
BIOPSYCHOSOCIAL Treatment
Intensity of Service (IS)-Modalities & Levels of Service
Multidimensional Assessment

The common language of the six assessment dimensions of the ASAM Patient Placement criteria can be used to determine multidimensional assessment of severity and level of function of addiction disorders:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral/cognitive conditions and complications
4. Readiness to change (Stages of Change)
5. Relapse/continued use/continued problem potential
6. Recovery environment
Underlying Concepts (cont’d)

- Biopsychosocial Treatment—5 M’s
  - **Motivate**
    - Motivational enhancement (Dimension 4)
  - **Manage**
    - The family, significant others, work/school, legal (all six dimensions)
  - **Medication**
    - Detox, anti-craving meds, Antabuse, opioid antagonists, methadone, LAAM, buprenorphine, psychotropic, dual diagnosis medications, etc. (Dimension 1,2,3,5)
  - **Meetings**
    - AA, NA, Al-Anon, Smart Recovery, Dual Recovery Anonymous, Secular Organization for Sobriety, etc. (Dimensions 2,3,4,5,6)
  - **Monitor**
    - Continuity of care; relapse prevention; family and significant others (All six dimensions)
Underlying Concepts (con’t)

- Treatment Levels of Service –
  - Levels of care/service to match severity of the problems:
    - Outpatient services
    - Intensive Outpatient/Partial Hospitalization
    - Residential/Inpatient Services
    - Medically-managed Intensive Inpatient Services
    - Detoxification Services
    - Opioid Maintenance Therapy
## ASAM Assessment Dimensions

<table>
<thead>
<tr>
<th>Assessment Dimensions</th>
<th>Considerations</th>
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</thead>
<tbody>
<tr>
<td><strong>1. Acute Intoxication and/or Withdrawal Potential</strong></td>
<td>▪ Past history of serious, life-threatening withdrawal</td>
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<tr>
<td></td>
<td>▪ Currently having similar withdrawal symptoms</td>
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<tr>
<td><strong>2. Biomedical Conditions and Complications</strong></td>
<td>▪ Any current severe health problems</td>
</tr>
<tr>
<td><strong>3. Emotional, Behavioral or Cognitive Conditions and Complications</strong></td>
<td>▪ Imminent danger of harm to self/others</td>
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<td></td>
<td>▪ Unable to function ADL’s - imminent danger</td>
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<tr>
<td>Assessment Dimensions</td>
<td>Considerations</td>
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<td>------------------------------------------------------------</td>
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<tr>
<td>4. Readiness to Change</td>
<td>▪ Ambivalent or feels treatment unnecessary&lt;br&gt;▪ Coerced, mandated, required assessment/Treatment</td>
</tr>
<tr>
<td>5. Relapse, Continued Use or Continued Problem Potential</td>
<td>▪ Currently under the influence&lt;br&gt;▪ Continued use/problems imminently dangerous</td>
</tr>
<tr>
<td>6. Recovery Environment</td>
<td>▪ Immediate threats to safety, well-being, sobriety</td>
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ASAM Level of Functioning
## Level of Functioning/Severity

<table>
<thead>
<tr>
<th>Level of Functioning/Severity</th>
<th>Definition</th>
<th>Intensity of Service Need</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low Severity</strong></td>
<td>Minimal, current difficulty or impairment. Absent, minimal or mild signs and symptoms. Acute or chronic problem mostly stabilized; or soon able to be stabilized and functioning restored with minimal difficulty</td>
<td><strong>L</strong> no immediate services or low intensity of services needed for this Dimension. Treatment strategies usually able to be delivered in outpatient settings.</td>
</tr>
<tr>
<td><strong>Medium Severity</strong></td>
<td>Moderate difficulty or impairment. Moderate to serious signs and symptoms. Difficulty coping or understanding, but able to function with clinical and other support services and assistance</td>
<td><strong>M</strong> Moderate intensity of services, skills training, or supports needed for this Dimension. Treatment strategies may require intensive levels of outpatient care.</td>
</tr>
<tr>
<td><strong>High Severity</strong></td>
<td>Severe difficulty or impairment. Serious, gross or persistent signs and symptoms. Very poor ability to tolerate &amp; cope with problems.</td>
<td><strong>H</strong> High intensity of services, skills training, or supports needed. More immediate, urgent services may require inpatient or residential settings; or closely monitored case management services at a frequency greater than daily</td>
</tr>
</tbody>
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ASAM Levels of Care
### ASAM Levels of Care

<table>
<thead>
<tr>
<th>ASAM PPC-2R Levels of Care</th>
<th>Level</th>
<th>Description of ASAM Levels of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Intervention</td>
<td>0.5</td>
<td>Assessment and education for at risk individuals who do not meet diagnostic criteria for Substance-Related Disorder</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>1</td>
<td>Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/ strategies</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>II.1</td>
<td>9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>II.5</td>
<td>20 or more hours of service/week for multidimensional instability not requiring 24 hour care</td>
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</tbody>
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### ASAM Levels of Care – cont’d

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<tr>
<td>Clinically Managed Low-Intensity Residential</td>
<td>III.1</td>
<td>24 hour structure with available trained personnel; at least 5 hours of clinical service/week</td>
</tr>
<tr>
<td>Clinically-Managed Medium-Intensity Residential</td>
<td>III.3</td>
<td>24 hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community</td>
</tr>
<tr>
<td>Clinically-Managed High Intensity Residential</td>
<td>III.5</td>
<td>24 hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community</td>
</tr>
<tr>
<td>ASAM PPC-2R Levels of Care</td>
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</tr>
<tr>
<td>Medically-Monitored Intensive Inpatient</td>
<td>III.7</td>
<td>24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. Sixteen hour/day counselor ability</td>
</tr>
<tr>
<td>Medically-Managed Intensive Inpatient</td>
<td>IV</td>
<td>24 hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2 or 3. Counseling available to engage patient in treatment</td>
</tr>
<tr>
<td>Detoxification</td>
<td>I-D</td>
<td>24 hour nursing care and services provided by a licensed hospital only to address medical or psychiatric needs</td>
</tr>
<tr>
<td>Opioid Maintenance Therapy</td>
<td>OMT</td>
<td>Daily or several times weekly opioid medication and counseling available to maintain multidimensional stability for those with opioid dependence</td>
</tr>
</tbody>
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Detoxification Services

Comparison of Detoxification Services Across Treatment Levels
## Detoxification Services

<table>
<thead>
<tr>
<th>ASAM PPC-2R Adult Detoxification Services</th>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Detoxification without Extended On-Site Monitoring</td>
<td>I-D</td>
<td>Mild withdrawal with daily or less than daily outpatient supervision; likely to complete detoxification and to continue treatment or recovery</td>
</tr>
<tr>
<td>Ambulatory Detoxification with Extended On-Site Monitoring</td>
<td>II-D</td>
<td>Moderate withdrawal with all day detoxification support and supervision; at night, has supportive family or living situation; likely to complete detoxification.</td>
</tr>
<tr>
<td>Clinically-Managed Residential Detoxification</td>
<td>III.2-D</td>
<td>Moderate withdrawal, but needs 24-hour support to complete detoxification and increase likelihood of continuing treatment or recovery</td>
</tr>
<tr>
<td>Medically-Monitored Inpatient Detoxification</td>
<td>III.7-D</td>
<td>Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete detoxification without medical, nursing monitoring</td>
</tr>
<tr>
<td>Medically-Managed Inpatient Detoxification</td>
<td>IV-D</td>
<td>Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify detoxification regimen and manage medical instability</td>
</tr>
</tbody>
</table>

*There are no separate Detoxification Services for Adolescents in ASAM PPC-2R*
What are the multiaxial DSM IV Diagnosis?

Multidimensional Severity/ LOF Profile

Identify which ASAM PPC-2R assessment dimensions are currently most important to determine Tx priorities

Choose a specific focus and target for each priority dimension

What specific services are needed for each dimension?

What “dose” of services is needed for each dimension?

Where can these services be provided-in the least intensive, safest level?

What is the progress of the treatment plan and Placement decision, outcomes measurement?
Continued Service & Discharge Criteria
Continued Service

After the admission criteria for a given level of care have been met, the criteria for continued service, discharge or transfer from that level of care are as follows:

**Continued Service Criteria** – it is appropriate to retain the patient at the present level of care if:

1. The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;  
   or
2. The patient is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working on the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;  
   and/or
3. New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the patient’s new problems can be addressed effectively.

- To document and communicate the patient’s readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed.
- If the criteria apply to the patient’s existing or new problem(s), the patient should continue in treatment at the present level of care. If not, refer the Discharge/Transfer Criteria, below.
Discharge/Transfer Criteria: It is appropriate to transfer or discharge the patient from the present level of care if he or she meets the following criteria:

1. The patient has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the current level of care;  
   Or
2. The patient has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated;  
   Or
3. The patient has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated;  
   Or
4. The patient has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

- To document and communicate the patient’s readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed.
- If the criteria apply to the existing or new problem(s), the patient should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.
Opioid Maintenance Therapy (OMT)
Opioid Maintenance Therapy (OMT)

- Opioid Maintenance Therapy
  - Encompasses a variety of pharmacological and non-pharmacological treatment modalities.
  - Therapeutic use of specialized opioid compounds such as methadone and LAAM (levo-alpha-acetylmethadol).
  - Separate service that can be provided at many levels of care, depending on the consumer’s status in Dimensions 1-6.
  - Adjunctive non-pharmacological interventions are essential and may be provided in the clinic or through coordination with another addiction treatment provider.
OMT – Treatment Level

- Treatment Level
  - Usually ambulatory
  - Delivered by addiction-trained personnel or addiction-credentialed clinicians
  - Individualized treatment, case management, and health education
  - Nature of the services, such as dose, level of care, length of service or frequency of visits) is determined by the consumer’s clinical needs
  - Usually include regularly scheduled psychosocial treatment sessions and daily or other scheduled medication visits within a structured program
OMT – Treatment goals

- Treatment with methadone or LAAM is designed to:
  - Address the consumer’s need to achieve changes in level of functioning
  - Elimination of illicit opiate and other alcohol or drug use
  - Treatment plan must address lifestyle, attitude and behavioral issues
In OMT programs, necessary support systems include:

- Psychological, medical and psychiatric consultations
- Emergency medical and psychiatric care
- Evaluation and ongoing primary medical care
- Laboratory and toxicology tests
- Physicians for evaluation, prescription and monitored use of methadone or LAAM; nurses/pharmacists for dispensing and administering methadone or LAAM
- Transportation arrangements for consumer
OMT – Staff & Therapies

- Staff of OMT programs include
  - Interdisciplinary team
    - Addiction professionals
    - Medical director
    - Counselors
    - Nurses, pharmacy staff
    - Psychologists
    - Physician

- Therapies included in OMT programs include:
  - Individual assessment and treatment
  - Medication management
  - Monitored urine testing
  - Counseling
  - Case Management
  - Psychoeducation
In OMT programs, the assessment and treatment plan review include:

- Comprehensive medical history
  - Physical examination
  - Laboratory tests
- Biopsychosocial assessment
- Monitored dose of methadone or LAAM
- Continuing evaluation and referral for any serious biomedical problems
- Individualized treatment plan which are reviewed and revised as needed
The consumer’s use of alcohol or drugs is heavy and continuous, and is associated with symptoms of mild to moderate withdrawal that do not include evidence of seizures or delirium tremens, and require monitoring and management.

The consumer’s history of use or presenting condition indicates that mild to moderate withdrawal is imminent and requires monitoring and management.

A Clinical Institute Withdrawal Assessment Scale (CIWA-Ar) score of 8 to 15.
Co-Occurring Disorders
Definition & Description of Services
Co-Occurring Disorders - Definition

Definition

- Co-Occurring Disorders typically defined as:
  - A) at least one Substance Abuse disorder plus
  - B) at least one major Mental disorder such as Major Depression, Bipolar disorder, Schizophrenia/psychotic disorder
Co-Occurring Disorders - Terminology

Terminology
- Co-Occurring— preferred terminology because there may be more than 2 disorders present
- Dual diagnosis
- Dual disorders
- Dual diagnosis
- Coexisting
- Co-morbid
- Multiple vulnerabilities
Co-Occurring Disorders - Services

- Description of Services
  - Addiction-Only Services  –  AOS
  - Dual Diagnosis Capable  –  DDC
  - Dual Diagnosis Enhanced  –  DDE
## Description of Services

<table>
<thead>
<tr>
<th>Services</th>
<th>Description</th>
<th>Consumer profile</th>
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<tbody>
<tr>
<td><strong>Addiction Only Services (AOS)</strong></td>
<td>§ Cannot accommodate psychiatric illnesses</td>
<td>Individuals who exhibit substance abuse or dependence problems without co-occurring mental health problems or diagnosable Axis I or II disorders</td>
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<tr>
<td></td>
<td>§ Policies and procedures do not accommodate dual diagnosis; e.g., psychotropic medications not accepted; coordination/collaboration with mental health not routinely present; mental health issues not addressed in treatment</td>
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</table>
## Description of Services – cont’d

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</thead>
<tbody>
<tr>
<td><strong>Dual Diagnosis Capable (DDC)</strong></td>
<td>- Routinely accept co-occurring disorders</td>
<td>Individuals who exhibit:</td>
</tr>
<tr>
<td></td>
<td>- Can meet needs if psychiatric disorders sufficiently stable; independent</td>
<td>1) sub-threshold diagnostic (i.e., traits, symptoms) Axis I or II disorder or</td>
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<tr>
<td></td>
<td>functioning so mental disorders do not interfere with addiction treatment</td>
<td>2) Diagnosable but stable Axis I or II disorders (i.e., bipolar disorder but compliant with and stable on lithium)</td>
</tr>
<tr>
<td></td>
<td>- Address dual diagnoses in policies, procedures, assessment, treatment</td>
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<tr>
<td></td>
<td>planning, program content, and discharge planning</td>
<td></td>
</tr>
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</table>
| **Dual Diagnosis Enhanced (DDE)**  | ▪ Have arrangements for coordination and collaboration with mental health services  
▪ Can provide psychopharmacologic monitoring and psychological assessment/consultation on site; or well-coordinated off-site  
▪ Can accommodate unstable/disabled needing specific psychiatric, mental health support, monitoring and accommodation necessary to participate in addiction treatment  
▪ Psychiatric, mental health and also addiction treatment professionals  
▪ Close collaboration/integration with mental health program for crisis back-up services and access to mental health case management and continuing care | Individuals who exhibit moderate to severe diagnosable Axis I or II disorders, who are not stable and require mental health as well as addiction treatment |
Co-Occurring Mental and Substance-Related Disorders

Risk Domains

- Dangerousness/Lethality
- Interference with Addiction Recovery Efforts
- Social Functioning
- Ability for Self Care
- Course of Illness
Clinical Example and Case Presentation

Applying the ASAM PPC-2R
16-year-old young woman brought to emergency room of acute care hospital. She had gotten into an argument with parents and ended up throwing a chair. Some indication she was intoxicated at the time and parents have been concerned about her coming home late and mixing with wrong crowd. A lot of family discord and mutual anger and frustration between Tracy and especially father. No previous psychiatric or addiction treatment
Parents both present at ER, but police who had been called by mother brought Tracy. ER physician and nurse who came from psychiatric unit to evaluate Tracy, both feel she needs to be in hospital given animosity at home, violent behavior and question of intoxication. Using the six ASAM assessment dimensions, the biopsychosocial clinical data is organized as follows.
Tracy – cont’d

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

- **Dimension 2-Biomedical Conditions/Complications**: she is not on any medications, has been healthy physically and has no current complaints
Tracy – cont’d

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

- **Dimension 6-Recovery Environment**: parents frustrated and angry too; mistrustful of patient; and want her in the hospital to cut down on the family fighting.
Dimension 3-Emotional/Behavioral/Cognitive: complex problems with the anger, frustration and family discord; chair throwing incident this evening, but is not impulsive at present in the ER.

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

- Name
- Age
- Ethnicity and Gender
- Marital Status
- Employment Status
- Referral Source
- Date Entered Treatment
- Level of Service Client Entered Treatment
- Current Level of Service
- Stated or Identified Motivation for Treatment
II. Current Placement Dimension Rating
Has It Changed?

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

(Brief explanation for each rating, note whether it has changed since client entered treatment -why or why not)
III. What problem(s) with High and Medium severity rating are of greatest concern at this time?

- Specificity of the problem
- Specificity of the strategies/interventions
- Efficiency of the intervention (Least intensive, but safe, level of service)
<table>
<thead>
<tr>
<th>Severity Profile (High, Medium, Low)</th>
<th>Dim 1</th>
<th>Dim 2</th>
<th>Dim 3</th>
<th>Dim 4</th>
<th>Dim 5</th>
<th>Dim 6</th>
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<tbody>
<tr>
<td>Services Needed</td>
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<td>Site of Care</td>
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The End

Questions?