

Understanding and Using the Co-Occurring Disorders Criteria of the Revised Second Edition ASAM Patient Placement Criteria (ASAM PPC-2R)

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A. Brief History of the ASAM Patient Placement Criteria

- 1987 Cleveland Criteria and the NAATP Criteria published
- 1991 ASAM PPC-1 published
- 1992 Coalition for National Clinical Criteria established
- 1994 ASAM Criteria Validity Study funded by NIDA
- 1995 “The Role and Current Status of Patient Placement Criteria In the Treatment of Substance Use Disorders” The Recommendations of a Consensus Panel. Co-Chairs: Lee Gartner and David Mee-Lee, M.D. Treatment Improvement Protocol. The Center for Substance Abuse Treatment.
- 1996 ASAM PPC-2 published
- 1998 – 1999 ASAM PPC endorsed by >20 states, DoD, VA, ValueOptions
- 1999 NIAAA funds Assessment Software project
- 2001 ASAM PPC-2R published

B. Underlying Concepts of ASAM Criteria

1. Treatment follows Theory

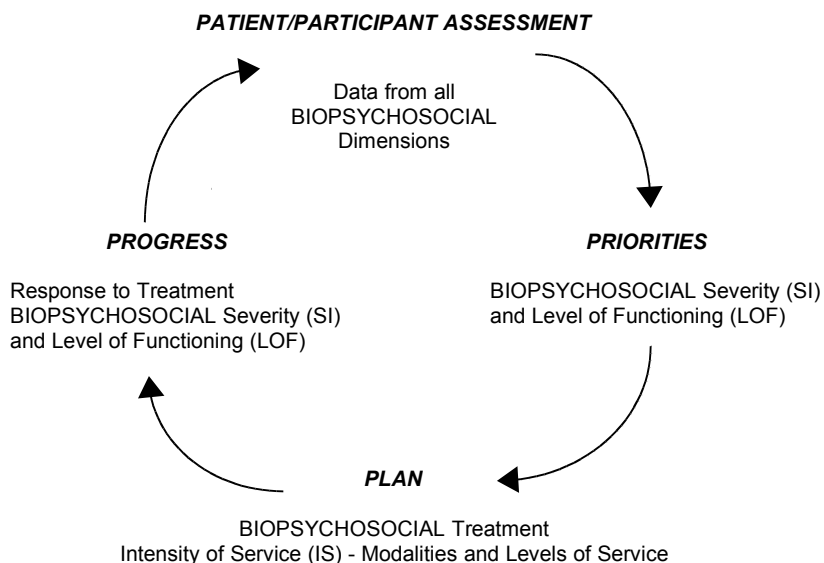
- * schools of thought: disease concept; behaviorist perspective; public health view; psychiatric theories of addiction
- * need for an understanding about alcohol/drug problems that takes into account knowledge from all different theories

2. Biopsychosocial Perspective of Addiction and Mental Disorders

- * biopsychosocial in etiology, expression and treatment
- * necessitates comprehensive assessment and treatment
- * explains clinical diversity while preserving commonalities
- * promotes productive integration of knowledge from all theories

3. Individualized Treatment

- * 4 P’s - patient/participant assessment; problems/priorities; plan; progress
- * match severity, or level of functioning (assets and obstacles to improvement with intensity of service (modalities/strategies and site of care)



4. Treatment follows Assessment - Biopsychosocial Severity

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
5. Relapse/Continued Use/Continued Problem potential
6. Recovery environment

5. Biopsychosocial Treatment - Overview: 5 M's

- * Motivate - Dimension 4 issues; intervention; "raising the bottom"; motivational enhancement
- * Manage - the family, significant others, work/school, legal
- * Medication - detox; anti-craving meds
- * Meetings - AA, NA, AI-Anon; Smart Recovery, Secular Organization for Sobriety, etc.
- * Monitor - continuity of care; relapse prevention; family and significant others

6. Treatment Levels of Service

- I Outpatient Services
- II Intensive Outpatient/Partial Hospitalization Services
- III Residential/Inpatient Services
- IV Medically-Managed Intensive Inpatient Services

ASAM PPC-2R Level of Detoxification Service for Adults	Level	Note: There are no separate Detoxification Services for Adolescents
Ambulatory Detoxification without Extended On-Site Monitoring	I-D	Mild withdrawal with daily or less than daily outpatient supervision; likely to complete detox. and to continue treatment or recovery
Ambulatory Detoxification with Extended On-Site Monitoring	II-D	Moderate withdrawal with all day detox. support and supervision; at night, has supportive family or living situation; likely to complete detox.
Clinically-Managed Residential Detoxification	III.2-D	Moderate withdrawal, but needs 24-hour support to complete detox. and increase likelihood of continuing treatment or recovery
Medically-Monitored Inpatient Detoxification	III.7-D	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete detox. without medical, nursing monitoring
Medically-Managed Inpatient Detoxification	IV-D	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify detox. regimen and manage medical instability
ASAM PPC-2R Levels of Care		
ASAM PPC-2R Levels of Care	Level	Same Levels of Care for Adolescents except Level III.3
Early Intervention	0.5	Assessment and education for at risk individuals who do not meet diagnostic criteria for Substance-Related Disorder
Outpatient Services	I	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies
Intensive Outpatient	II.1	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability
Partial Hospitalization	II.5	20 or more hours of service/week for multidimensional instability not requiring 24 hour care
Clinically-Managed Low-Intensity Residential	III.1	24 hour structure with available trained personnel; at least 5 hours of clinical service/week
Clinically-Managed Med-Intensity Residential	III.3	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
Clinically-Managed High-Intensity Residential	III.5	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
Medically-Monitored Intensive Inpatient	III.7	24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. Sixteen hour/day counselor ability
Medically-Managed Intensive Inpatient	IV	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
Opioid Maintenance Therapy	OMT	Daily or several times weekly opioid medication and counseling available to maintain multidimensional stability for those with opioid dependence

C. ASAM PPC-2R's Approach to Co-Occurring Disorders

1. Historical context of the ASAM PPC

- Dimension 3 – 1991: “Emotional/Behavioral Conditions and Complications” versus “Psychiatric Conditions”, which would keep Dimension 3 too focused on mental health treatment and dual diagnosis; and diminish interest in mental health issues as an expected part of addiction and recovery
- “Conditions” refers to co-occurring mental disorders (dual diagnosis)
- “Complications” refers to addiction-related, mental health problems that can distract the client’s attention from primary addiction recovery treatment

2. Terminology Used

ASAM PPC-2R has adopted the term "Co-Occurring Mental and Substance-Related Disorders" in formal titles consistent with DSM –IV. Throughout the text, however, the term "dual diagnosis" is used for the sake of simplicity and because it appears to have the widest acceptance nationally.

3. Adult versus Adolescent Criteria Differences

- Dimension 3 Subdomains
- Assumptions about Adolescent Criteria – developmental issues; co-occurring emotional, behavioral and cognitive issues and the need for a more clinically-sophisticated staff
- More focus on mental health issues for adolescents who often have co-occurring emotional/behavioral issues. No AOS, DDC or DDE descriptions in adolescent criteria

D. Dual Diagnosis Program Descriptions – AOS, DDC, DDE

The *ASAM PPC-2R* describes three types of services: those that offer Addiction-Only Services (AOS), those that are Dual Diagnosis Capable (DDC), and those that are Dual Diagnosis Enhanced (DDE). Programs capabilities are defined as follows:

1. **Programs that offer Addiction-Only Services (AOS)**

- Cannot accommodate patients with psychiatric illnesses that require ongoing treatment, however stable the illness and however well functioning the individual. Such programs are said to provide Addiction-Only Services (AOS).
- The policies and procedures typically do not accommodate co-existing mental disorders: for example, individuals on psychotropic medications generally are not accepted, coordination or collaboration with mental health services is not routinely present, and mental health issues are not usually addressed in treatment planning or content.

2. **Dual Diagnosis Capable (DDC) Programs**

- Dual Diagnosis Capable (DDC) programs routinely accept individuals who have co-occurring mental and substance-related disorders.
- DDC programs can meet such patients' needs so long as their psychiatric disorders are sufficiently stabilized and the individuals are capable of independent functioning to such a degree that their mental disorders do not interfere with participation in addiction treatment.
- DDC programs address dual diagnoses in their policies and procedures, assessment, treatment planning, program content, and discharge planning.
- They have arrangements in place for coordination and collaboration with mental health services.
- They also can provide psychopharmacologic monitoring and psychological assessment and consultation on site; or by well-coordinated consultation off-site.

3. **Dual Diagnosis Enhanced (DDE) Programs**

- DDE programs can accommodate individuals with dual diagnoses who may be unstable or disabled to such an extent that specific psychiatric and mental health support, monitoring and accommodation are necessary in order for the individual to participate in addiction treatment.
- Such patients are not so acute or impaired as to present a severe danger to self or others, nor do they require 24-hour, psychiatric supervision.
- DDE programs are staffed by psychiatric and mental health clinicians as well as addiction treatment professionals. Cross-training is provided to all staff. Such programs tend to have relatively high ratios of staff to patients and provide close monitoring of patients who demonstrate psychiatric instability and disability.
- DDE programs typically have policies, procedures, assessment, treatment planning and discharge planning that accommodate patients with dual diagnoses.
- Dual diagnosis-specific and mental health symptom management groups are incorporated into addiction treatment. Motivational enhancement therapies are more likely to be available (particularly in outpatient settings)
- Ideally, there is close collaboration or integration with a mental health program that provides crisis back-up services and access to mental health case management and continuing care.

E. **Experimental Matrix and Co-Occurring Disorders**

Matrix for Matching Services to Needs

Risk Rating and Description	Types of Services and Modalities Needed	Intensity of Service/ Level of Care/Setting
Assess severity and level of function to identify needs for services in all six ASAM assessment dimensions	Identify what variety of services are required to address priority needs based on the risk assessment in each dimension	Determine what type of service setting and level of care can efficiently, safely provide the needed intensities of service
Risk ratings are benchmarked on a scale of 0 to 4 with 0 indicating full function and no risk in this assessment dimension	If 0 , no specific services are needed in this assessment dimension	Intensity of services are benchmarked on a scale of 0 to 4 with 0 , indicating that no specific level of care or treatment setting is needed in this assessment dimension
If risk rating is 1-4 , the severity and risk level rises with the higher number in whatever assessment dimension is being assessed	Specific services in an individualized treatment plan are designed to match the severity, level of function and risk in this assessment dimension	The intensity of services will rise with the higher risk rating in Dimensions 1 - 3, but will be variable for Dimensions 4-6 depending on the mix of services in the middle column

Definitions of Terms in the "Future Directions" Matrix for Matching Multidimensional Risk with Type and Intensity of Necessary Services

Risk Description. The risk descriptions and ratings within each assessment dimension help staff determine the immediacy and scope of the service plan by guiding what types and modalities of service are needed. They also indicate the intensity or level of service at which the patient can be treated with safety and efficacy.

Risk Domains. A Risk Domain is an assessment subcategory within Dimension 3, as described below:

- ***Dangerousness/Lethality.*** This Risk Domain describes how impulsive an individual may be with regard to homicide, suicide, or other forms of harm to self or others and/or to property. The seriousness and immediacy of the individual's ideation, plans and behavior—as well as his or her ability to act on such impulses—determine patient's risk rating and type/intensity of services needed
- ***Interference with Addiction Recovery Efforts.*** This Risk Domain describes the degree to which a patient is distracted from addiction recovery efforts by emotional, behavioral and/or cognitive problems and, conversely, the degree to which a patient is able to focus on addiction recovery. (High risk and severe impairment in this domain do not, alone, require services in a Level IV program.)
- ***Social Functioning.*** This Risk Domain describes the degree to which an individual's relationships (e.g., coping with friends, significant others or family; vocational or educational demands; and ability to meet personal responsibilities) are affected by his or her substance use and/or other emotional, behavioral and cognitive problems. (Note that high risk and severe impairment in this domain do not, in themselves, require services in a Level IV program.)
- ***Ability for Self Care.*** This Risk Domain describes the degree to which an individual's ability to perform activities of daily living (such as grooming, food and shelter) are affected by his or her substance use and/or other emotional, behavioral and cognitive problems. (Note that high risk and severe impairment in this domain do not, in themselves, require services in a Level IV program.)

- **Course of Illness.** This Risk Domain employs the history of the patient's illness and response to treatment to interpret the patient's current signs, symptoms and presentation and predict the patient's likely response to treatment. Thus, the domain assesses the interaction between the chronicity and acuity of the patient's current deficits. A high risk rating is warranted when the individual is assessed as at significant risk and vulnerability for dangerous consequences either because of severe, acute life-threatening symptoms, or because a history of such instability suggests that high intensity services are needed to prevent dangerous consequences.

For example, a patient may present with medication adherence problems, having discontinued antipsychotic medication two days ago. If a patient is known to rapidly decompensate when medication is stopped, his or her rating is high. However, if the patient slowly isolates without any rapid deterioration when medication is stopped, the risk rating would be less. Another example is the patient who has been depressed and socially withdrawn. If this has been a problem for six weeks, the risk rating is much higher than for a patient who has been chronically withdrawn and isolated for six years with a severe and persistent schizophrenic disorder.

F. Skill-Building in Multidimensional Assessment and Treatment

Immediate Need Profile. Assessor considers each dimension and with just sufficient data to assess immediate needs, checks “yes” or “no” for the following questions:

1. Acute Intoxication and/or Withdrawal Potential

(a) Past history of serious withdrawal, life-threatening symptoms or seizures during withdrawal? e.g., need for IV therapy; hospitalization for seizure control; psychosis with DT's; medication management with close nurse monitoring and medical management? ___No___Yes; (b) Currently having similar withdrawal symptoms? ___No___Yes

2. Biomedical Conditions/Complications

Any current severe physical health problems? e.g., bleeding from mouth or rectum in past 24 hours; recent, unstable hypertension; recent, severe pain in chest, abdomen, head; significant problems in balance, gait, sensory or motor abilities not related to intoxication. ___No___Yes

3. Emotional/Behavioral/Cognitive Conditions/Complications

(a) Imminent danger of harming self or someone else? e.g., suicidal ideation with intent, plan and means to succeed; homicidal or violent ideation, impulses and uncertainty about ability to control impulses, with means to act on. ___No___Yes; (b) Unable to function in activities of daily living, self with imminent, dangerous consequences ? e.g., unable to bath, feed, groom and care for self due to psychosis, organicity or uncontrolled intoxication with threat of imminent safety to self, others as regards death or severe injury ___No___Yes

4. Readiness to Change

(a) Does client appear to need alcohol or other drug treatment/recovery and/or mental health treatment, but ambivalent or feels it unnecessary? e.g., severe addiction, but client feels controlled use still OK; psychotic, but blames a conspiracy ___No___Yes; (b) Client has been coerced, mandated or required to have assessment and/or treatment by the criminal justice system, health or social services, work/school, or family/significant other? ___No___Yes

5. Relapse/Continued Use/Continued Problem Potential

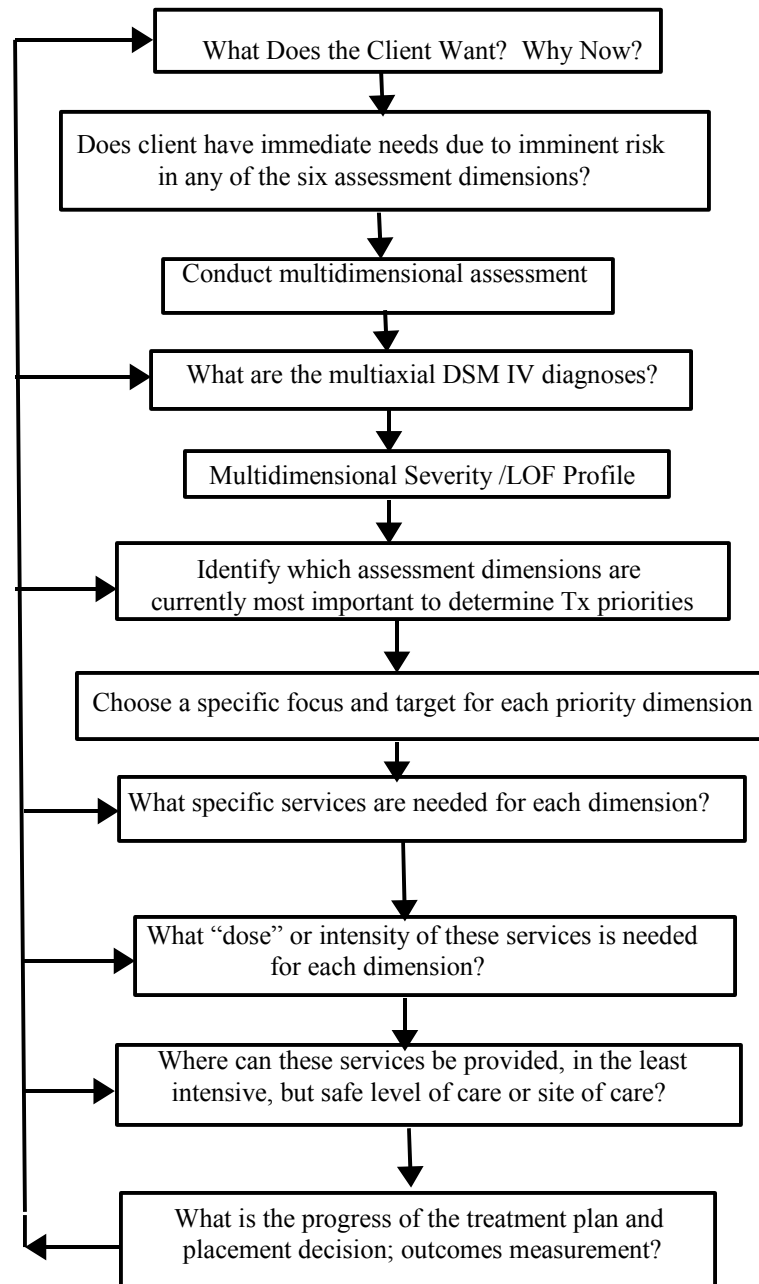
(a) Is client currently under the influence? ___No___Yes; (b) Is client likely to continue to use or relapse in an imminently dangerous manner, without immediate care? (c) Is client's most troubling, presenting problem(s) that brings the client for assessment, dangerous to self or others? (See examples above in dimensions 1, 2 and 3) ___No___Yes

6. Recovery Environment

Are there any dangerous family, sig. others, living/work/school situations threatening client's safety, immediate well-being, and/or sobriety? e.g., living with a drug dealer; physically abused by partner or significant other; homeless in freezing temperatures ___No___Yes

G. **How to Target and Focus Service Priorities** - Match Assessment, Treatment, Placement

E.



Case Presentation Format

Before presenting the case, please state why you chose the case and what you want to get from the discussion

I. Identifying Client Background Data

- Name
- Age
- Ethnicity and Gender
- Marital Status
- Employment Status
- Referral Source
- Date Entered Treatment
- Level of Service Client Entered Treatment (if this case presentation is a treatment plan review)
- Current Level of Service (if this case presentation is a treatment plan review)
- DSM Diagnoses
- Stated or Identified Motivation for Treatment (What is the most important thing the clients wants you to help them with?)

First state how severe you think each assessment dimension is and why (focus on brief relevant history information and relevant here and now information):

II. Current Placement Dimension Rating (See Dimensions below 1 - 6)

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

(Give a brief explanation for each rating, note whether it has changed since the client entered treatment and why or why not)

This last section we will talk about together:

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)

H. Improving Services for Co-Occurring Disorders

- Review of Provider Network - AOS, DDC or DDE?

1. Personnel and Policy Implications

(a) Personnel

- * Better training in biopsychosocial theories, modalities of treatment, assessment and documentation skills
- * Increased interdisciplinary functioning and team work
- * Increased individualized treatment and thorough case management
- * Increase curiosity and research

(b) Programs

- * Flexible lengths-of-service in all levels of service
- * Overlapping levels of care - better continuity and efficiency
- * Expanded intensities of service
- * More modalities of treatment - biopsychosocial
- * Innovative program structure - milieu; individualized treatment

(c) Payment

- * Reimburse or fund all levels of service
- * Increase incentives for less costly care
- * Fund thorough case management

(d) Public/Private Sectors

- * One quality and system of care
- * One common set of criteria - clinically-based not program-based
- * Increase interdependence - improve incentives and equalize over/under capacities

Stephen

Stephen is 51 years old and is accompanied by his wife. He wants help, but is depressed. During his intake interview for this, his second DUI arrest, he looks disconsolate and he speaks in a monotone as he wonders if his wife will leave him. His alcohol use has resulted in alienation from his children, guilt feelings and his job may now be threatened, as he has been warned by his supervisor about his poor attendance and performance. Most of his friends drink, but none of them think he is an alcoholic.

He has not had any previous addiction treatment other than DUI classes after his first DUI four years ago. He attended AA for six months on and off and did have a sponsor, but felt more and more that he wasn't as bad as others at AA and gradually stopped going.

Stephen has been alcohol-free for three weeks. He has used cocaine (snorting) about three times per month over the past four years, but stopped two months ago. He has had no legal or financial problems related to cocaine. Stephen has continued on diazepam (Valium) 5 mg. qid which he has taken for five years to relax him because of mild hypertension. He has no other chronic physical problems but has lost 10 pounds weight over the past month and has been sleeping poorly. He wishes he could sleep and get away from all his problems but denies any organized suicidal plans and says he wants help.

Tracy

A 16-year-old young woman is brought into the emergency room of an acute care hospital. She had gotten into an argument with her parents and ended up throwing a chair. There was some indication that she was intoxicated at the time and her parents have been concerned about her coming home late and mixing with the wrong crowd. There has been a lot of family discord and there is mutual anger and frustration between the teen and especially her father. No previous psychiatric or addiction treatment.

The parents are both present at the ER, but the police who had been called by her mother brought her. The ER physician and 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, the violent behavior and the question of intoxication. Using the six ASAM assessment dimensions, the biopsychosocial clinical data is organized as follows:

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

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.

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, 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.

<u>Severity Profile:</u> (High, Medium, Low)	<u>Dimension:</u>	1	2	3	4	5	6
	<u>Severity:</u>						

Services Needed:

Site of Care:

CLINICAL ASSESSMENT AND PLACEMENT SUMMARY **Page 1 of 2**

Name: _____ Date: _____

Immediate Need Profile: Assessor considers each dimension and with just sufficient data to assess immediate needs, checks “yes” or “no” in the following table:

Dimension	Questions	Yes	No
1. Acute Intoxication and/or Withdrawal Potential	1(a) Past history of serious withdrawal, life-threatening symptoms or seizures during withdrawal?		
1. as above	1(b) Currently having similar withdrawal symptoms?		
2. Biomedical Conditions/Complications	2 Any current severe physical health problems?		
3. Emotional/Behavioral/Cognitive Conditions/Complications	3(a) Imminent danger of harming self or someone else?		
3. as above	3(b) Unable to function and safely care self?		

. **Yes to questions 1a, 1b, 2 and/or 3a, 3b requires that the caller/client immediately be referred for medical and/or mental health evaluation, depending on which dimension(s) involved.**

4. Readiness to Change	4(a) Does client appear to need alcohol or other drug treatment/recovery, but ambivalent or feels it unnecessary? e.g., severe addiction, but client feels controlled use still OK		
4. as above	4(b) Client been coerced, mandated or required to have assessment and/or treatment		

. **Yes to questions 4a and/or to 4b alone, requires staff to begin immediate intervention and motivational strategies appropriate to client’s stage of readiness to change.**

5. Relapse/Continued Use Potential	5(a) Is client currently under the influence or intoxicated?		
5. as above	5(b) Is client likely to continue use of alcohol and/or other drugs, or to relapse, in an imminently dangerous manner?		

. **Yes to question 5a requires caller/client be considered for withdrawal potential. Yes to question 5a and/or 5b, individual may need to be considered for 24-hour structure or care.**

6. Recovery Environment	6. Are there any dangerous family, sig. others, living/work/school situations threatening client’s safety, immediate well-being, and/or sobriety?		
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. **Yes to Dimension 6, without any Yes in questions 1, 2 and/or 3, requires that the caller/client be assessed for the need of a safe or supervised environment.**

LEVEL OF FUNCTIONING/SEVERITY: Using assessment protocols that address all six dimensions, assign a severity rating of **High, Medium** or **Low** for each dimension that best reflects the client’s functioning and severity. Place a check mark in the appropriate box for each dimension.

F. Level of Functioning/Severity	Intensity of Service Need	1.	2.	3.	4.	5.	6.
		Intox With	Bio-med	Emot/ Beha	Read i-ness	Rel-apse	Rec. Envir
Low Severity – 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	L No immediate services or low intensity of services needed for this Dimension. Treatment strategies usually able to be delivered in outpatient settings						
Medium Severity - 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	M Moderate intensity of services, skills training, or supports needed for this Dimension. Treatment strategies may require intensive levels of outpatient care						
High Severity - Severe difficulty or impairment. Serious, gross or persistent signs and symptoms. Very poor ability to tolerate & cope with problems.	H 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						

CLINICAL ASSESSMENT AND PLACEMENT SUMMARY (cont.)

Page 2 of 2

Name: _____

Date: _____

PLACEMENT DECISIONS: Indicate for each dimension, the least intensive level consistent with sound clinical judgment, based on the client's functioning/severity and service needs

ASAM PPC-2R Level of Detoxification Service	Level	Dimen. 1 Intoxic/ Withdr.						
Ambul. Detox without Extended On-Site Monitor.	I-D							
Ambul. Detox with Extended On-Site Monitoring	II-D							
Clinically-Managed Residential Detoxification	III.2-D							
Medically-Monitored CD Inpatient Detoxification	III.7-D							
Medically-Managed Intensive Inpatient Detox.	IV-D							
ASAM PPC-2R Level of Care for Other Treatment and Recovery Services *	Level *		Dimen. 2 Biomed.	Dimen. 3 Emot/ Behav.	Dimen. 4 Readiness	Dimen. 5 Relapse/ Cont Use	Dimen. 6 Recov. Environ.	
Early Intervention / Prevention	0.5							
Outpatient Services / Individual	I							
Intensive Outpatient Treatment (IOP)	II.1							
Partial Hospitalization (Partial)	II.5							
Apartments /Clinically-Managed Low-Int. Res. Svcs.	III.1							
Clinically-Managed Med-Intens. Residential Svcs.	III.3							
Clinically-Managed High-Intens. Residential Svcs	III.5							
Medically-Monitored Intens. Inpatient Treatment	III.7							
Medically-Managed Intensive Inpatient Services	IV							
Opioid Maintenance Therapy	OMT							

PLACEMENT SUMMARY

Level of Care/Service Indicated - Insert the ASAM Level number that offers the most appropriate level of care/service that can provide the service intensity needed to address the client's current functioning/severity.	
Level of Care/Service Received - ASAM Level number -- If the most appropriate level is not utilized, insert the most appropriate placement available and circle the Reason for Difference between Indicated and Received Level	
Reason for Difference - Circle only one number -- 1. Service not available; 2. Provider judgment; 3. Client preference; 4. Client is on waiting list for appropriate level; 5. Service available, but no payment source; 6. Geographic accessibility; 7. Family responsibility; 8. Language; 9. Not applicable; 10. Not listed.	

COMMENTS:

LITERATURE REFERENCES

“Addiction Treatment Matching – Research Foundations of the American Society of Addiction Medicine (ASAM) Criteria” Ed. David R. Gastfriend has released 2004 by The Haworth Medical Press. David Gastfriend edited this special edition that represents a significant body of work presented in eight papers. The papers address questions about nosology, methodology, and population differences and raise important issues to continually refine further work on the ASAM PPC. (To order: 1-800-HAWORTH; or www.haworthpressince.com)

Mee-Lee D, Shulman GD, Fishman M, Gastfriend DR, and Griffith JH, eds. (2001). ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R). Chevy Chase, MD: American Society of Addiction Medicine, Inc.

Mee-Lee, David (2001): “Treatment Planning for Dual Disorders”. Psychiatric Rehabilitation Skills Vol.5. No.1, 52-79.

Mee-Lee D, Shulman GD (2003): “Use of Patient Placement Criteria in Matching and Planning Treatment”, Section: Overview of Addiction Treatment in “Principles of Addiction Medicine” Third Edition. American Society of Addiction Medicine Inc., Chevy Chase, MD.

Miller, William R; Rollnick, Stephen (2002): “Motivational Interviewing - Preparing People for Change” Second Edition, New York, NY. Guilford Press.

Prochaska, JO; Norcross, JC; DiClemente, CC (1994): “Changing For Good” Avon Books, New York.

REFERENCE FOR ASAM PPC-2R AND RESOURCES FOR ASAM PPC

“Addition Treatment Matching – Research Foundations of the American Society of Addiction Medicine (ASAM) Criteria” Ed. David R. Gastfriend. The Haworth Medical Press. 2004.

Mee-Lee D, Shulman GD, Fishman M, Gastfriend DR, and Griffith JH, eds. (2001). ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R). Chevy Chase, MD: American Society of Addiction Medicine, Inc.
American Society of Addiction Medicine - 4601 Nth. Park Ave., Arcade Suite 101, Chevy Chase, MD 20815. (301) 656-3920; Fax: (301) 656-3815; www.asam.org; To order ASAM PPC-2R: (800) 844-8948.

CLIENT WORKBOOKS AND INTERACTIVE JOURNALS

1. “Successful Living with a Dual Disorder” – Motivational, Educational and Experiential (MEE) Journal System. Interactive journaling for clients. This Journal is designed specifically for individuals who are suffering with a dual disorder. It provides important information that allows clients to understand the facts and challenges regarding their addiction and mental disorder.

To order: The Change Companies at 888-889-8866. www.changecompanies.net.

2. Foundations Co-Occurring Disorders Series Co-Occurring - The Recovery Workbook Series Workbook series on treating addictions and mental health conditions.

To order: Foundations Associates at 888.869.9230. www.dualdiagnosis.org

RESOURCE FOR ASSESSMENT INSTRUMENTS

A variety of proprietary assessment instruments for identifying substance use disorders, psychiatric diagnoses for adults and adolescents. To order: The Change Companies at 888-889-8866.
www.changecompanies.net.

For clinical questions or statistical information about the instruments, contact Norman Hoffmann, Ph.D. at 828-454-9960 in Waynesville, North Carolina; or by e-mail at evinceassessment@aol.com

RESOURCE FOR HOME STUDY AND ONLINE COURSE

1. “Dilemmas in Dual Diagnosis Assessment, Engagement and Treatment” By David Mee-Lee, M.D. This home study or online course (with CEU’s) is designed to improve practitioners’ abilities to assess, engage, and treat people with co-occurring mental health and substance use problems. Practical strategies and methods are offered to help change interviewing methods, treatment planning and documentation, program components, range of services, and policies to better engage the dually diagnosed client.

Professional Psych Seminars, Inc. Agoura Hills, CA Toll-free phone: (877) 777-0668. Website: www.psychsem.com

2. “ASAM 101: Basics on Understanding and Using ASAM Patient Placement Criteria, Revised Second Edition (ASAM PPC-2R)”

A 3-hour course that will introduce students to key concepts and issues of the ASAM Patient Placement Criteria. Clinicians involved in planning and managing care often lack a common language and systematic assessment and treatment approach that allows for effective, individualized services. The Patient Placement Criteria of the American Society of Addiction Medicine (ASAM) first published in 1991, provided common language to help the field develop a broader continuum of care. They were updated and the second edition (ASAM PPC-2) was published in April 1996. A revised second edition was published in April 2001.

The Distance Learning Center for Addiction Studies (DLCAS) is an internet based educational service that provides comprehensive training and information in the field of addiction studies. It is a joint presentation of the Betty Ford Center and the Distance Learning Center, LLC. Toll-free phone: 866 471-1742. Website: www.dlcas.com/course59.html

3. Hazelden's Clinical Innovators Series

"Applying ASAM Placement Criteria" DVD and 104 page Manual with more detail based on the DVD with Continuing Education test (10 CE hrs), 75 minute DVD

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