ASAM PPC-2R

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

Excerpt of Dimensions Section

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American Society of Addiction Medicine, Inc.
Chevy Chase, Maryland
2001

The correct bibliographic citation for this book is 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.

Dimension 1: Acute Intoxication and/or Withdrawal Potential. The goals of care in Dimension 1 remain the same as in the first and second editions of the *Patient Placement Criteria*, with some important additions:

1. Avoidance of the potentially hazardous consequences of discontinuation of alcohol and other drugs of dependence;

2. Facilitation of the patient's completion of detoxification and linkages and timely entry into continued medical, addiction or mental health treatment or self-help recovery as indicated; and

3. Promotion of patient dignity and easing of patient discomfort during the withdrawal process.

Assessment considerations include: What risk is associated with the patient's current level of acute intoxication? Is there significant risk of severe withdrawal symptoms or seizures, based on the patient's previous withdrawal history, as well as the amount, frequency, chronicity and recency of discontinuation of (or significant reduction in) alcohol or other drug use? Are there current signs of withdrawal? Does the patient have supports to assist in ambulatory detoxification, if medically safe?

While the First Edition of the *Patient Placement Criteria* addressed only inpatient detoxification services, which are considered Level IV, or sometimes Level III, the *PPC-2R* incorporates criteria developed for the Second Edition, which match a patient's severity of illness along Dimension 1 (Acute Intoxication and/or Withdrawal Potential) with five intensities of detoxification service, described herein as Level I- D, Level II-D, Level III.2-D, Level III.7-D, and Level IV-D. The qualifier "D" is used to designate a detoxification service within the broad division (such as III.2-D, Clinically Managed Residential Detoxification services or Social Setting Detoxification).

A particular detoxification service can be provided separately ("unbundled") from other treatment services. When such services are provided separately, a sufficiently comprehensive biopsychosocial screening assessment and linkage to non-detoxification services are essential to avoid the syndrome in which alcoholics and drug addicts revolve through acute care facilities in repeated cycles of recovery and relapse (the "revolving door syndrome").

For detoxification provided in conjunction with treatment for additional problems identified in the comprehensive biopsychosocial screening assessment, the *PPC-2R* calls for the patient to be placed in the level of care appropriate to the most acute problem.

While the *PPC-2R* describes five levels of detoxification, staffing at any given level may be structured to provide a range of intensities of service. For example, detoxification of some patients can be carried out in the office (Level I-D) or in more structured outpatient settings (Level II-D) without the use of beds or intensive nursing monitoring. Other patients may need to be monitored for a period of time before an appropriate determination can be made. (Such monitoring can, at times, be carried out in an outpatient setting, but may require an even more structured setting, such as a "23-hour observation bed".) Some programs that are described as Level III may have the capacity for more or less intensive medical monitoring of detoxification. For example, Level III.2-D includes Social Setting Detoxification, which may provide minimal medical monitoring.

The number of hours allocated to other treatment services at Level I and Level II is separate from, and does not include, those to be allocated for detoxification in an ambulatory setting. Hence the intensity of detoxification services need not match the intensity of other treatment services in Level I or Level II.

For patients who require a higher level of care because of assessments in other dimensions, it may be more expedient to carry out detoxification in that higher level of care. On the other hand, some patients who enter treatment do not require detoxification. Nevertheless, they should be assessed in Dimension 1, Acute Intoxication and/or Withdrawal Potential.

Dimension 2: Biomedical Conditions and Complications. There are no changes in Dimension 2 from the Second Edition.

Assessment considerations include: Are there current physical illnesses, other than withdrawal, that need to be addressed because they create risk or may complicate treatment? Are there chronic conditions that affect treatment?

Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications *(such as psychiatric conditions, psychological or emotional/behavioral complications of known or unknown origin, poor impulse control, changes in mental status, or transient neuropsychiatric complications)*. In the *PPC-2R*, Dimension 3 has been expanded to encompass cognitive conditions and complications, reflecting the fact that there are clinical presentations that are not captured by emotional or behavioral descriptors alone. New subdomains of assessment have been added to address co-occurring mental and substance-related disorders or dual diagnosis issues in more detail.

Assessment considerations include: Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed because they create risk or complicate treatment? Are there chronic conditions that affect treatment? Do any emotional, behavioral or cognitive problems appear to be an expected part of the addictive disorder, or do they appear to be autonomous? Even if connected to the addiction, are they severe enough to warrant specific mental health treatment? Is the patient able to manage the activities of daily living? Can he or she cope with any emotional, behavioral or cognitive problems?

It is important to note that, in assessing co-occurring disorders, a mental health or substance- related disorder should be considered secondary only if it shows improvement as a result of stabilization in the other disorder.

Dimension 4: Readiness to Change. Dimension 4 has been retitled "Readiness to Change" to reflect Prochaska and DiClemente's Stages of Change model (Prochaska, DiClemente & Norcross, 1992; Prochaska, Norcross & DiClemente, 1994), thus moving the criteria beyond the concepts of denial and resistance. This is based on the concept that an individual's emotional and cognitive awareness of the need to change and his or her level of commitment to and readiness for change indicate his or her degree of cooperation with treatment, as well as his or her awareness of the relationship of alcohol or other drug use to negative consequences.

In fact, resistance to treatment is not unexpected and does not automatically exclude a patient from receiving treatment. Rather, it is the *degree* of readiness to change that helps to determine the setting for and intensity of motivating strategies needed, rather than the patient's eligibility for treatment itself. Moreover, acceptance or resistance to treatment are more subjective and less easily measured than readiness to change. They also are subject to greater variation in interpretation, based on clinician and program ideology, clinician knowledge and skill in engagement strategies, availability of a variety of motivational enhancement therapies and levels of service, and the degree of commitment to patient-centered, participatory treatment planning.

Dimension 5: Relapse, Continued Use or Continued Problem Potential. Dimension 5 has been retitled "Relapse, Continued Use or Continued Problem Potential" to encompass mental health problems. For example, a psychotic, paranoid individual who is fearful of being poisoned and thus fails to take his or her medications would be described as having a high "Relapse or Continued

Problem Potential." This indicates that the patient is at high risk for becoming acutely psychotic and/or increasingly paranoid. Such a patient also is at high risk of relapse to substance use. The assignment of a level of care after a patient has relapsed should be made on the basis of both history and an assessment of current problems, and not merely history alone. The patient is not automatically assumed to require a higher level of care than the one at which relapse occurred.

Dimension 5 also is better understood through expanded constructs offered to assist in assessment. There are four domains that are not inconsistent with earlier versions of Dimension 5, but which offer a conceptually clearer sequence of factors that contribute to relapse potential. The sequence involves the historical phenomenon of relapse, the acute pharmacologic response to substance(s), second-order behavioral responsivity that may mediate the preceding factors, and third-order personality or learned responses that may modify the preceding factors.

Assessment considerations include: Is the patient in immediate danger of continued severe mental health distress and/or alcohol or drug use? Does the patient have any recognition or understanding of, or skills in coping with, his or her addictive or mental disorder in order to prevent relapse, continued use or continued problems such as suicidal behavior? How severe are the problems and further distress that may continue or reappear if the patient is not successfully engaged in treatment at this time? How aware is the patient of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use or impulses to harm self or others?

Dimension 6: Recovery/Living Environment. There are no significant changes in Dimension 6. At Level 0.5, Dimension 6 has been retitled "Living Environment" to reflect the fact that, at this level, an individual has not been assessed as in need of treatment and may need only education and advice on managing risk.

Assessment considerations include: Do any family members, significant others, living situations, or school or work situations pose a threat to the patient's safety or engagement in treatment? Does the patient have supportive friendships, financial resources, or educational or vocational resources that can increase the likelihood of successful treatment? Are there legal, vocational, social service agency or criminal justice mandates that may enhance the patient's motivation for engagement in treatment? Are there transportation, child care, housing or employment issues that need to be clarified and addressed?