


# ASAM Criteria Training

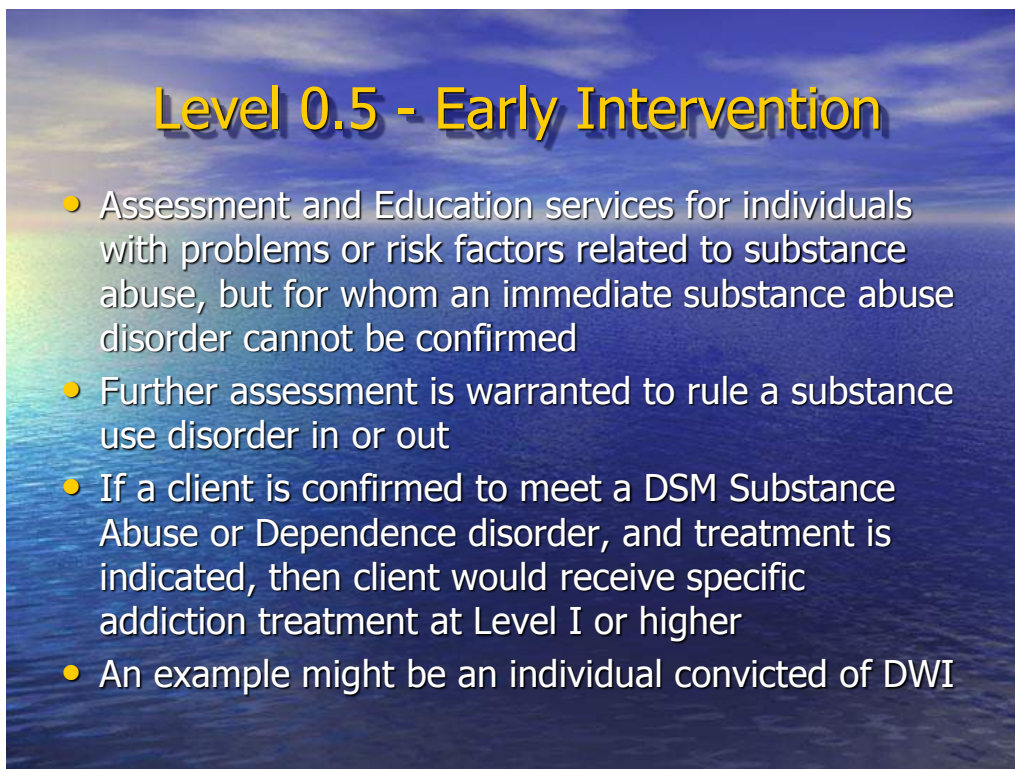


## Levels of Care

### 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

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## 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

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### **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

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### **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



## ASAM Criteria Training

### Residential/Inpatient Levels of Care

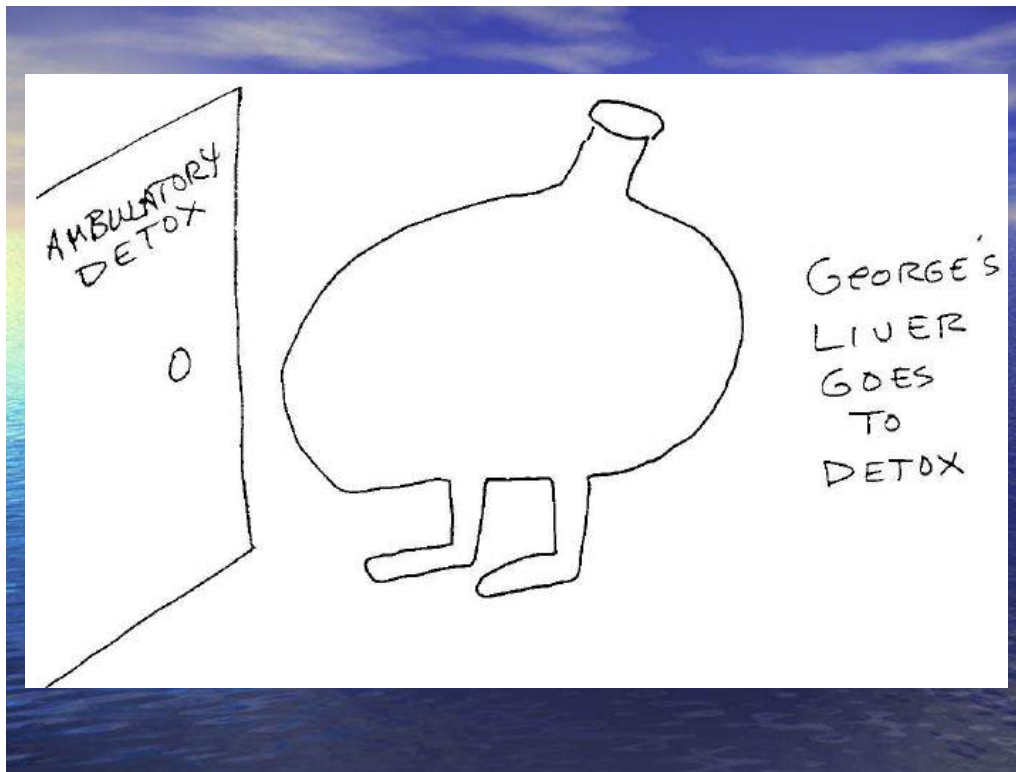
- Level 3: Residential/Inpatient Services
  - Level 3.1- Clinically Managed Low-Intensity Residential Services (e.g. halfway house)
  - Level 3.3- Clinically Managed, Population-Focused, High-Intensity Residential Services (e.g., *Therapeutic Rehabilitation Facility*)
  - Level 3.5- Clinically Managed 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

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### ASAM Levels of Care (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

## ASAM Criteria Training



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### 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)

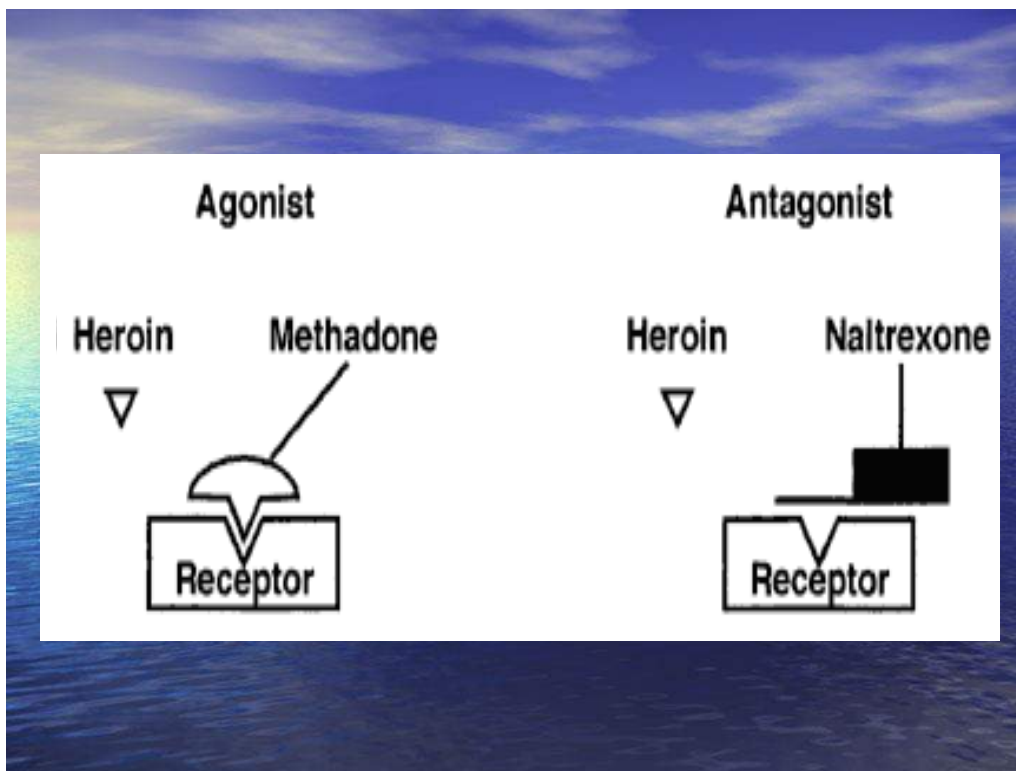


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### OMT ---> OTS

- 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 form 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

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### 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

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### 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



# ASAM Criteria Training

## 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”

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## 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

## ASAM Criteria Training

### 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"

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## ASAM Criteria Dimensional Assessment



## ASAM Criteria Training

### 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

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### Dimension 1 Change in Language

The term “Detoxification” changed to  
“Withdrawal Management”

- Livers detoxify patients
- Clinicians manage the process

## ASAM Criteria Training

### 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?

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### 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



## ASAM Criteria Training

### Drug and Alcohol History

Drug Name	Route of Administration	First Use	First Problem	Amount	Frequency	Last Use	Tolerance

Drug of Choice: \_\_\_\_\_ Longest Abstinence: \_\_\_\_\_ When: \_\_\_\_\_ Circumstances: \_\_\_\_\_

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**THE BEST PREDICATOR OF  
CURRENT AND FUTURE  
WITHDRAWAL PROBLEMS  
ARE PAST  
WITHDRAWAL PROBLEMS**

## ASAM Criteria Training

### **The CIWA-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

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### 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 Training

### **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?

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### **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)?

## ASAM Criteria Training

### 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)

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### 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 Training

### **ASAM Criteria Dimension 3: Emotional/Behavioral/Cognitive Conditions and Complications (Cont.)**

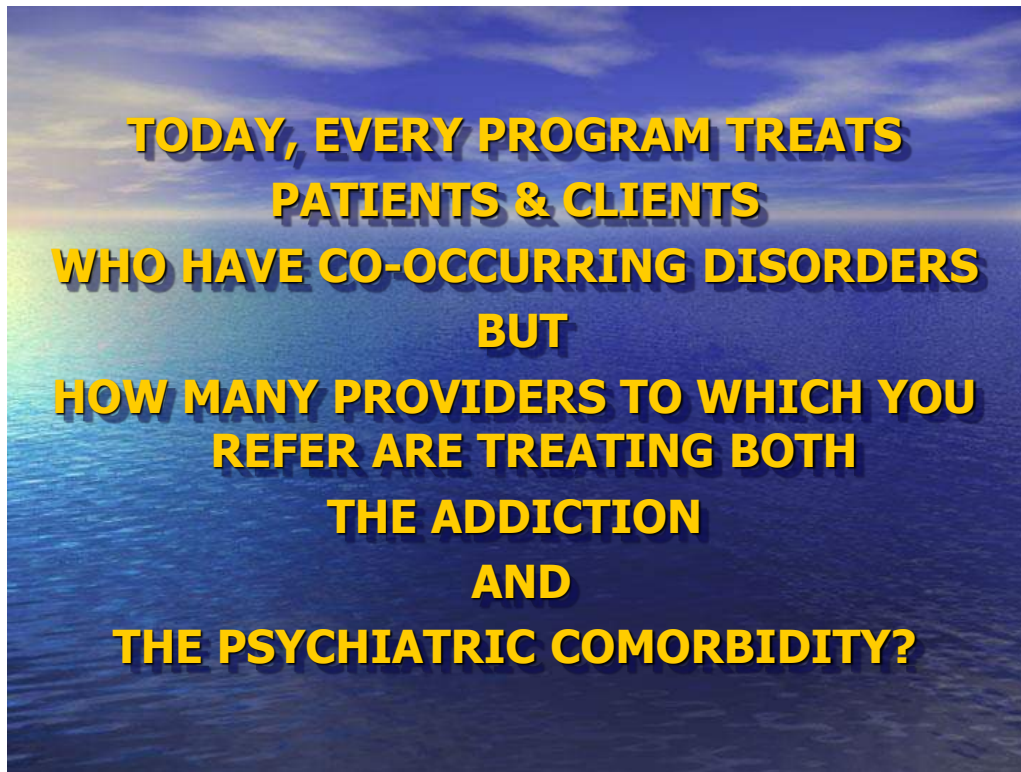
- Sample Questions
  - Even if connected to addiction, are they severe enough to warrant specific mental health treatment?
  - Is the patient suicidal, and if so, what is the lethality?
  - If the patient has been prescribed psychiatric medications is he/she compliant?

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### **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

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### ADHD



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### 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 are higher among people with SUDs

## ASAM Criteria Training

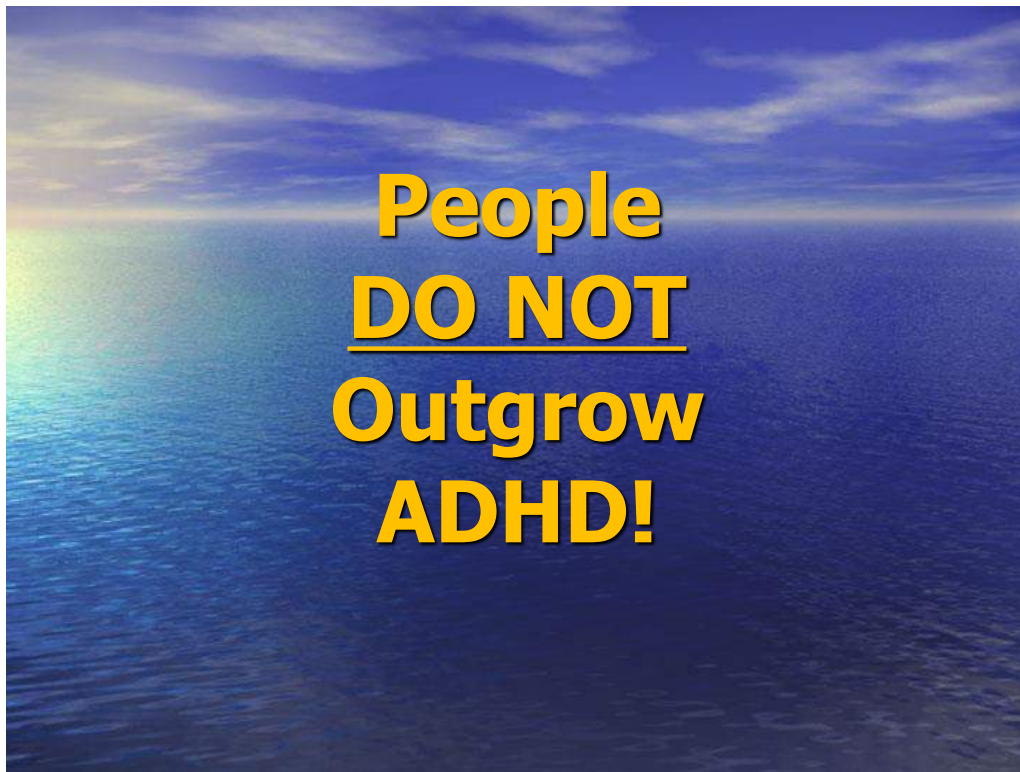


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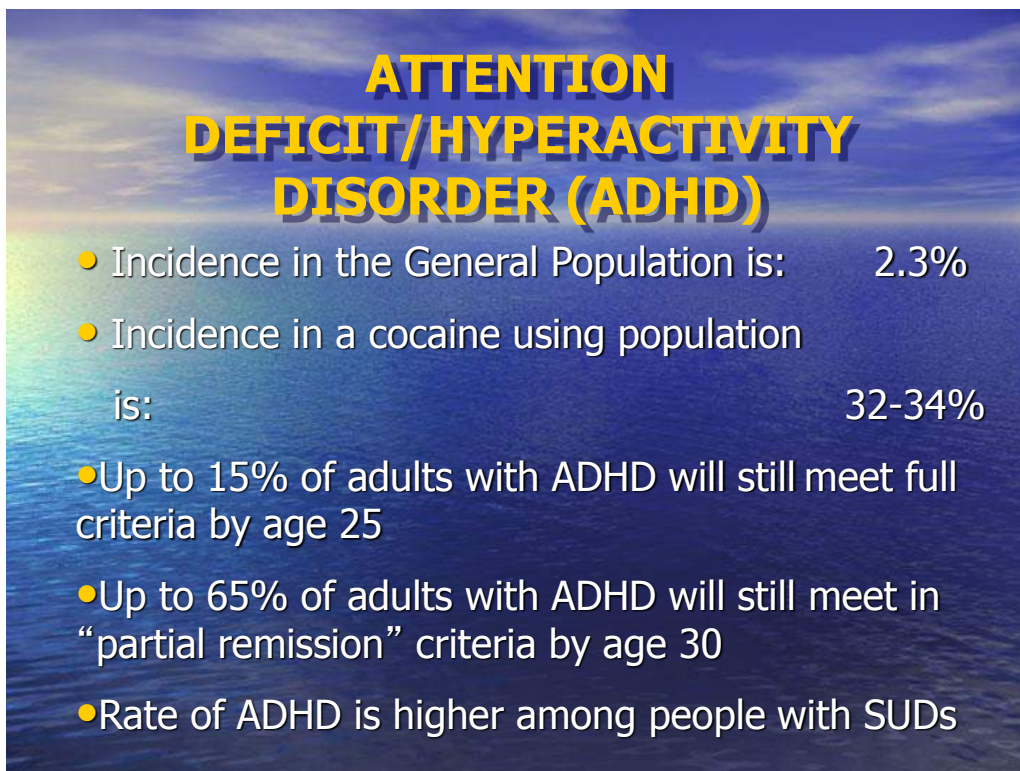




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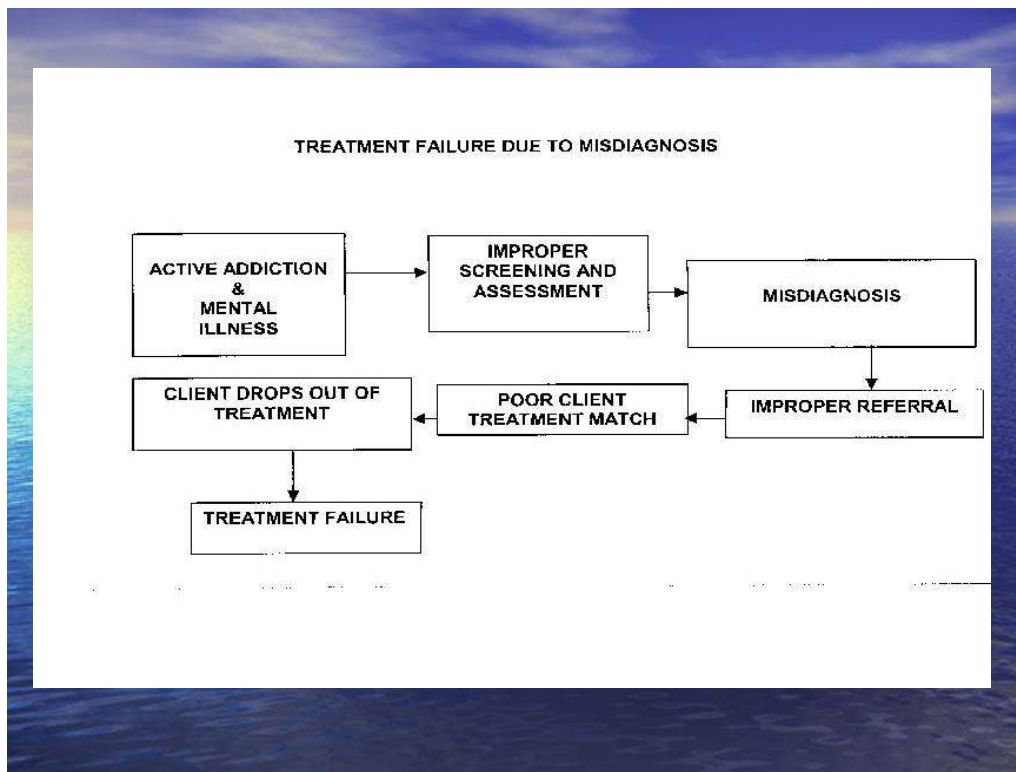
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A slide with a background of a blue sky and ocean. The title "ATTENTION DEFICIT/HYPERACTIVITY DISORDER (ADHD)" is written in bold, yellow letters. Below the title, there is a list of statistics in white text.

**ATTENTION DEFICIT/HYPERACTIVITY DISORDER (ADHD)**

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- Rate of ADHD is higher among people with SUDs

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## ASAM Criteria Training

### 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

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No Harm  
Contracts  
Do Not Work

## ASAM Criteria Training

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*

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### Psychiatric Diagnoses

- *May be indicative of nothing*
- *What is schizophrenia?*
- John Nash, Nobel prize in mathematics while suffering from paranoid schizophrenia "A Beautiful Mind"
- Temple Grandin, autism, invented a new restraint system that included a well-lit area for the animals to see, a nonslip floor to reduce injuries and minimal noise to frighten the livestock. Temple Grandin's center-track animal restraint system is now used to handle nearly half of the cattle in North America.



## ASAM Criteria Training

### Mental Health 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.

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### 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

# ASAM Criteria Training

## 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

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## 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.



# ASAM Criteria Training

## **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.*

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## **Dimension 3** **Subdomains**

A subdomain  
is an assessment subcategory  
within  
Dimension 3  
(Emotional, Behavioral or Cognitive  
Problems),  
as described below:

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## Subdomains

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

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## 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.



# ASAM Criteria Training

## 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

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## 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

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### **“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*

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### **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?



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### 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?

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***“Resistance  
is  
Ambivalence  
in Drag”***

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## ASAM Criteria Training

### **RESISTANCE & NON-COMPLIANCE**

Are characteristic of all chronic illnesses/disorders,  
not only substance use disorders!!

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### **EXTERNAL vs. INTERNAL MOTIVATION**

(Motivation to Enter Treatment  
vs.  
Motivation to Recover)

## ASAM Criteria Training

### RESISTANCE & NON-COMPLIANCE

Are characteristic of all chronic illnesses/disorders, not only substance use disorders!!

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### The Resistance/Confrontation Escalator





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**Higher Resistance and Denial**  
***Do Not ALONE***  
**Indicate the Need for,**  
**or Clinical Appropriateness Of**  
**A Higher Intensity Level of**  
**Treatment**

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**EVERY patient**  
**who presents for**  
**assessment or**  
**treatment is**  
**motivated**

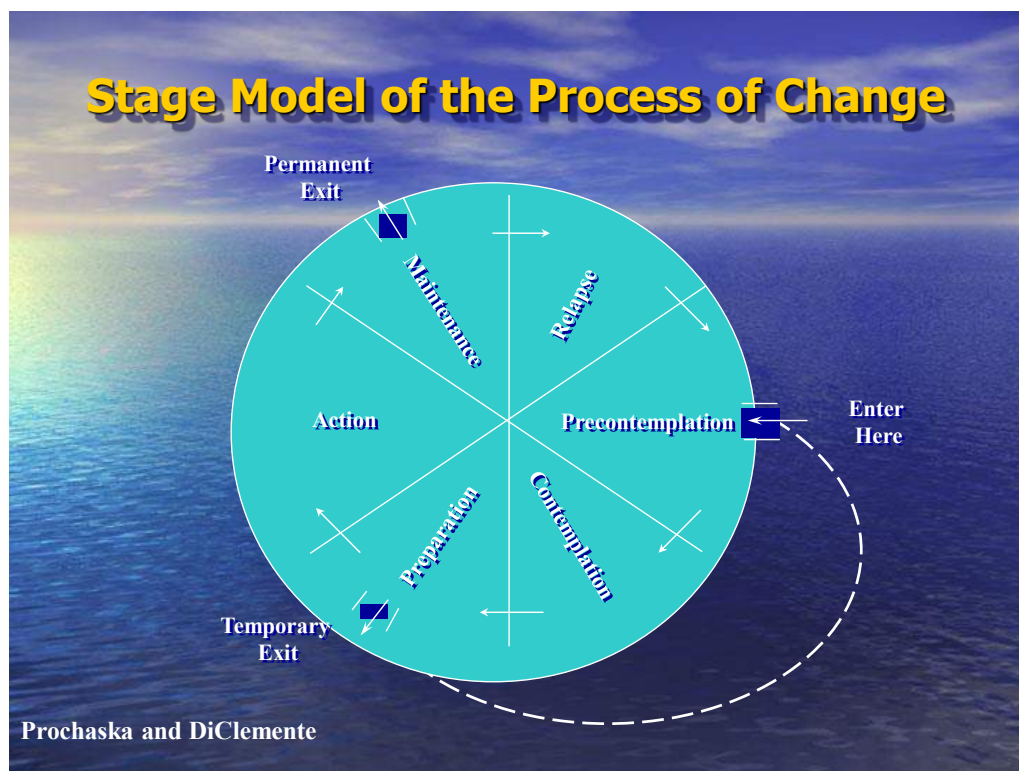
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### Transtheoretical Stages of Change (Prochaska & DiClemente)

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse and Recycling
- Termination

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### Stage Model of the Process of Change





## ASAM Criteria Training

### PRE-CONTEMPLATION

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

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### 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

## ASAM Criteria Training

### 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.

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### 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.



## ASAM Criteria Training

### 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.

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### 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.

## ASAM Criteria Training

### 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.

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### Decisional Balancing

	Advantages	Disadvantages
C H A N G I N G		
N O T C H A N G I N G		



## ASAM Criteria Training

### Stages of Change and Therapists' Tasks

CLIENT STAGE	THERAPIST'S MOTIVATIONAL TASKS
Precontemplation	Raise doubt – increase the client's perception of risk and problems with current behavior
Contemplation	Tip the balance – evoke reasons to change, risks of not changing; strengthen the client's self-efficacy for change of current behavior
Preparation	Help the client to determine the best course of action to take in seeking change
Action	Help the client to take steps toward change
Maintenance	Help the client identify and use strategies to prevent relapse
Relapse	Help the client renew the process of contemplation, preparation and action, without becoming stuck or demoralized because of relapse

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### 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 Training

### **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?

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### **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?



## ASAM Criteria Training

### 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

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### 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!"*)

## ASAM Criteria Training

### **Factors associated with an increased risk of relapse**

- severity of the SUD at admission
- having more service needs at admission
- the presence of an active mood, anxiety, or personality disorder (or symptoms)
- perceived high rates of stress,
- being unemployed or having employment problems

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### **Factors associated with an increased risk of relapse**

- no high school diploma or GED
- being of a minority status
- having less coping resources or a low sense of self-efficacy
- low income or being indigent
- having a PTSD or ADHD disorder at admission
- actively participating in drug-related leisure activities

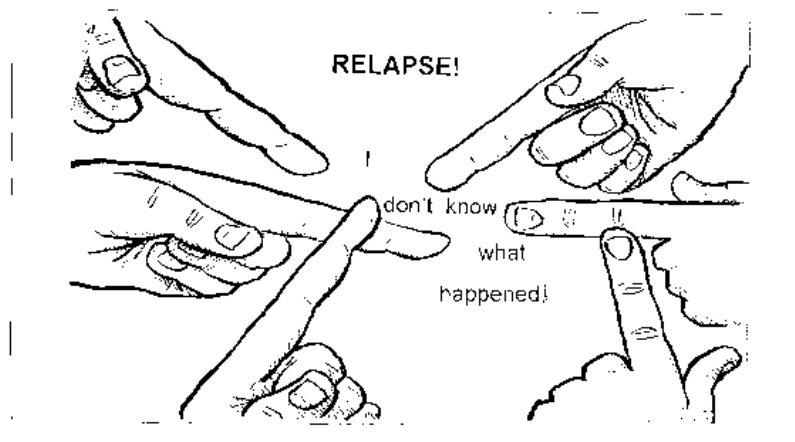


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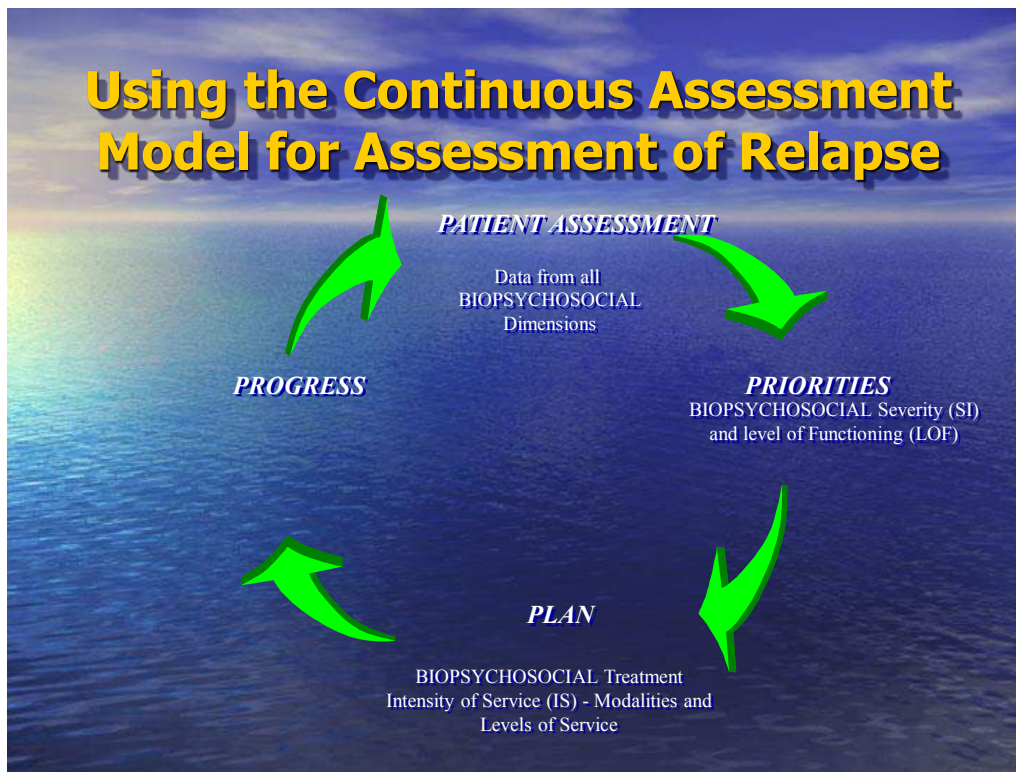
### In the New ASAM Criteria

- 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

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## ASAM Criteria Training



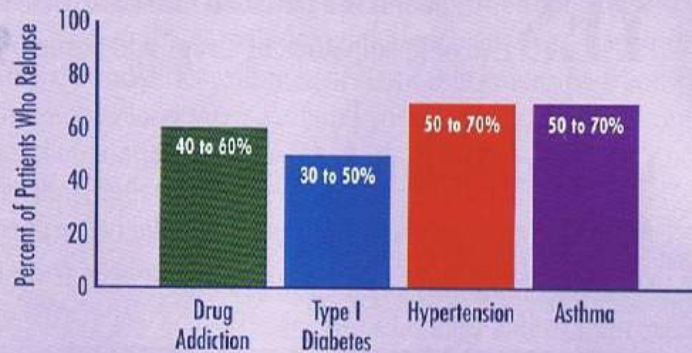
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## ASAM Criteria Training

COMPARISON OF RELAPSE RATES BETWEEN  
DRUG ADDICTION AND OTHER CHRONIC ILLNESSES



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.

Source: McLellan et al., JAMA 284:1689-1695. 2000.

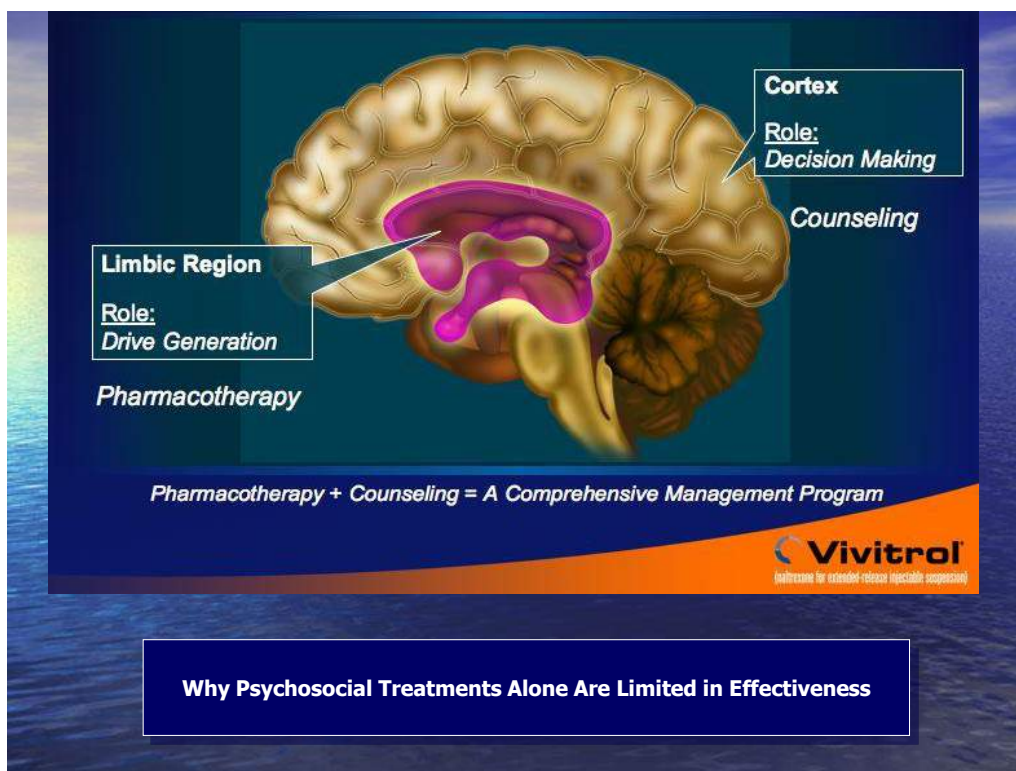
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For some Patients/Clients  
the issue is  
***Habilitation***  
rather than  
***Rehabilitation***

## ASAM Criteria Training

*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!*

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## ASAM Criteria Training

**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”)

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**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”)

## ASAM Criteria Training

### 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!

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**Pharmacotherapy  
should be considered  
a treatment tool  
as others  
like group therapy or CBT**



## ASAM Criteria Training

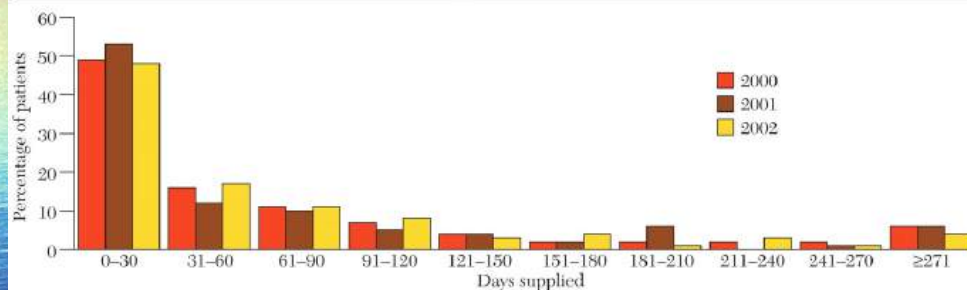
The greatest problem  
with pharmacotherapy  
is the lack of compliance!

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### 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



Pharmacy claims for NTX-PO in a plan with 1.5 million insureds for 3 years  
(2000-2002)

**Half of patients never refilled – despite Insurance coverage**

Stephenson et al. *Effects of Medication Treatment on Cue-Induced ...*  
*American Academy of Addiction Psychiatry. 2006*

## ASAM Criteria Training

# Some Research Results

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### VIVITROL – Significantly Reduces Drinking Days<sup>1,2</sup>



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.

O' Malley SS, et al. *J Clin Psychopharmacol.* 2007;27:507-512.