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

101

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

102

103

104

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

105

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

106

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107

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)

108

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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 devlopment and increasing use of antagonist drugs, e,g, oral naltrexone, extended release, injectable naltrexone (Vivitrol) and acamprosate (Campral)
- Opioid Treatment Services (OTS) includes voth agonist and antagonist drugs

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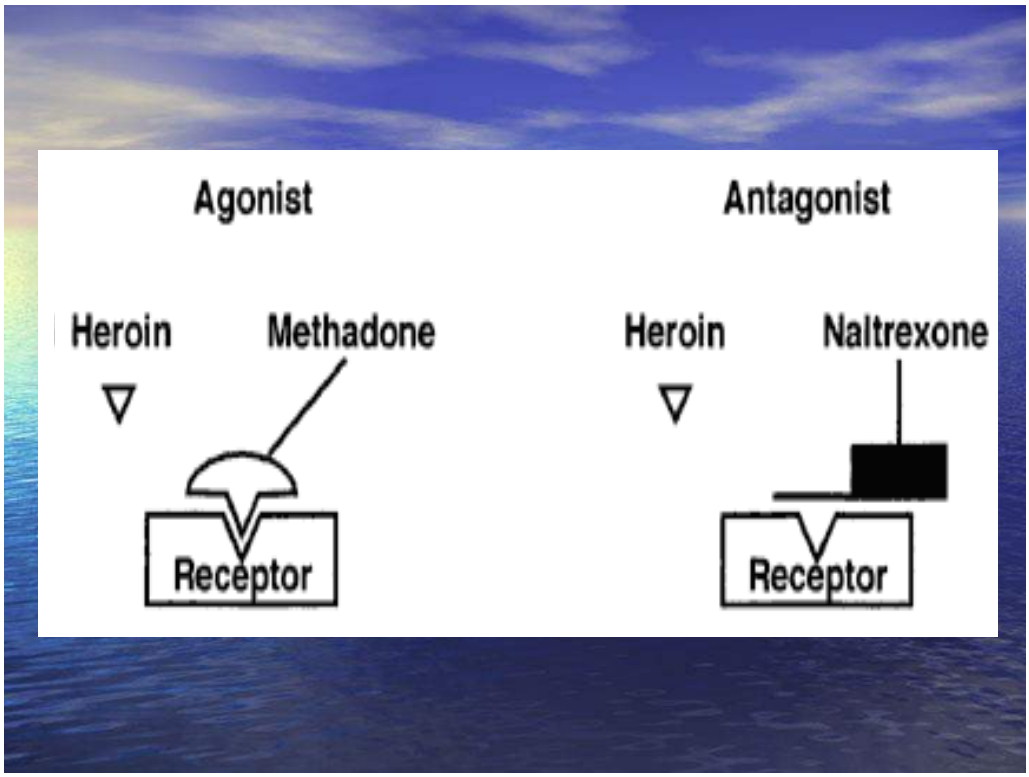

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Agonist Treatment Can Be Further Broken Down

- Opioid Treatment Program (OTP)
  - An example of this would be the classic methadone maintanence 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 thetreatment of opiod withdrawal or the management of pain, only an OTP can disprense it for maintanence

111

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 though an 8-hour training
  - There is a 30-patient limit but the DEA can authorize 100 patients after the first year

112

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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 Addictve, 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"

113

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

114

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115

ASAM Criteria Dimensional Assessment

116

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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

117

Dimension 1 Change in Language

The term "Detoxification" changed to "Withdrawal Management"

- Livers detoxify patients
- Clinicians manage the process

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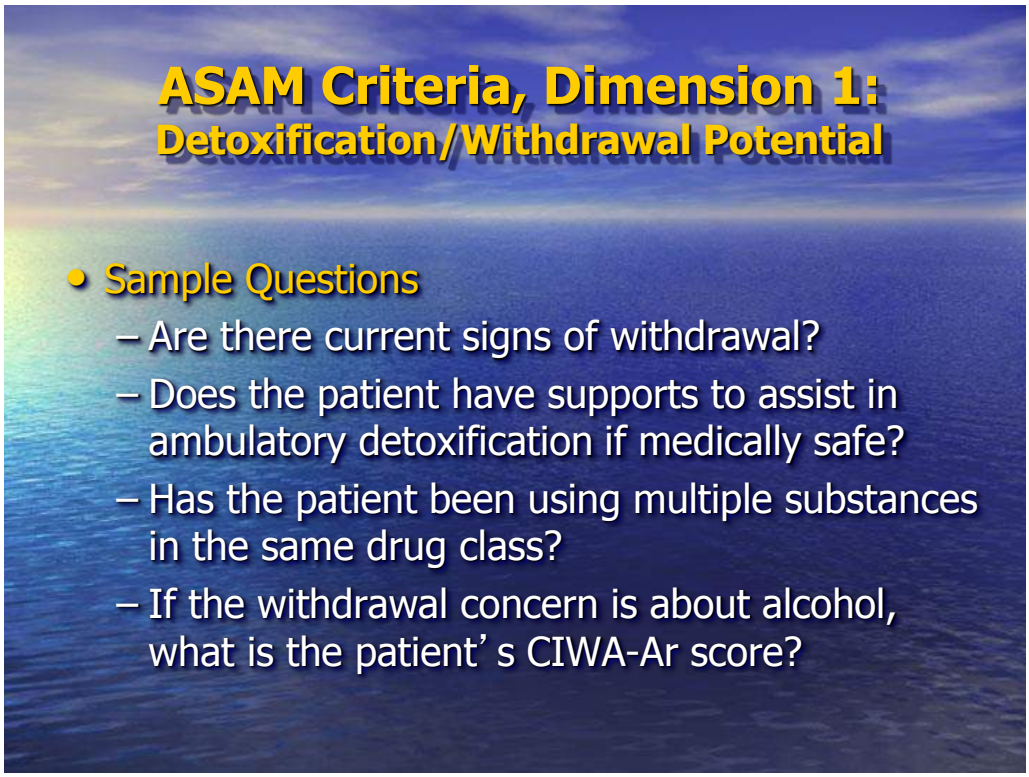

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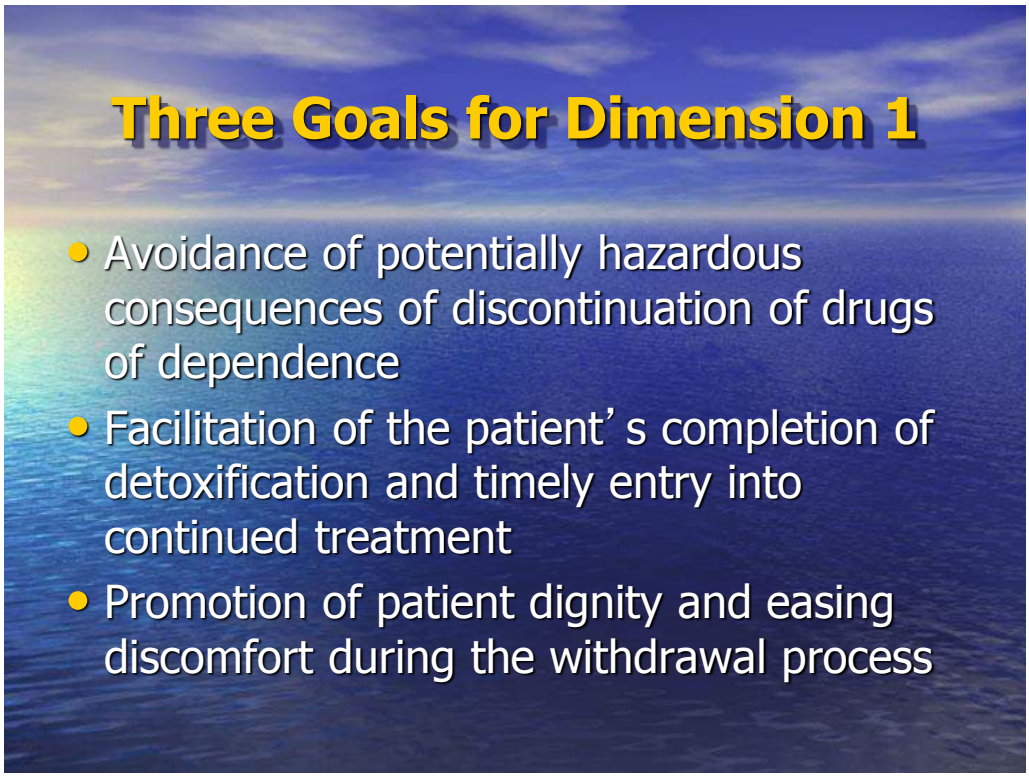

120

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: _____

121

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

122

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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

123

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

124

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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?

125

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)?

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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)

127

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?

128

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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?

129

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

130

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TODAY, EVERY PROGRAM TREATS
PATIENTS & CLIENTS
WHO HAVE CO-OCCURRING DISORDERS
BUT
HOW MANY PROVIDERS TO WHICH YOU REFER ARE TREATING BOTH
THE ADDICTION
AND
THE PSYCHIATRIC COMORBIDITY?

131

When Co-Occurring Addiction and Mental Health Disorders Exist,
Treating Either Without the Other
Will Lead to Successful Outcome When:

132

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ADHD

133

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

134

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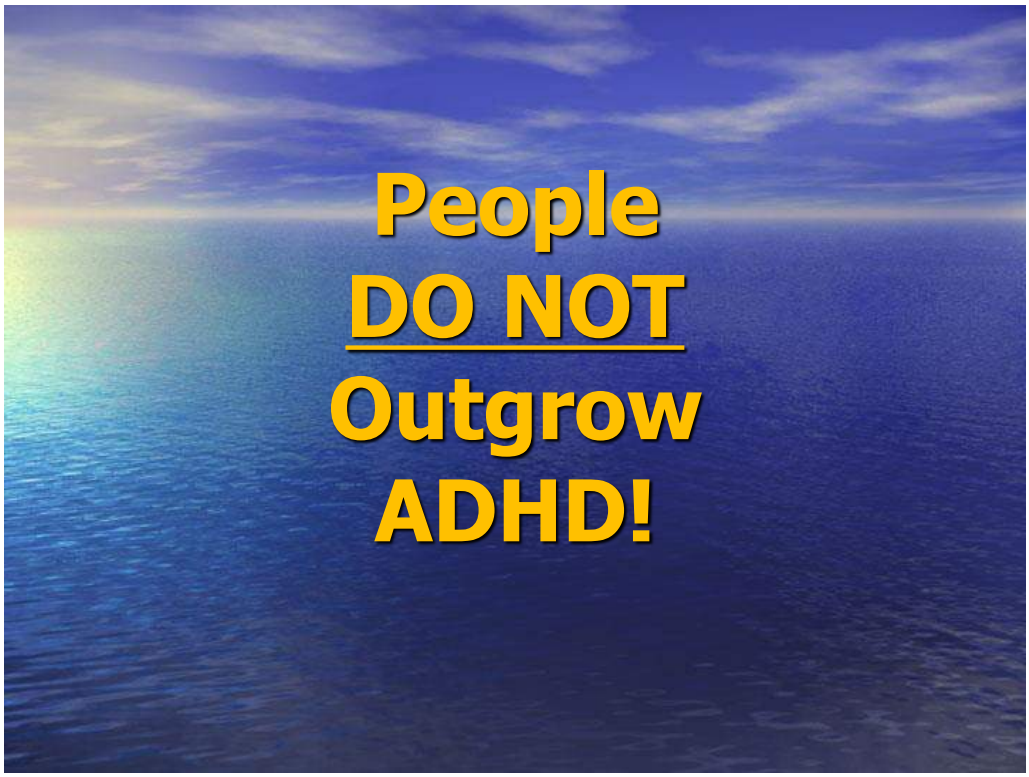

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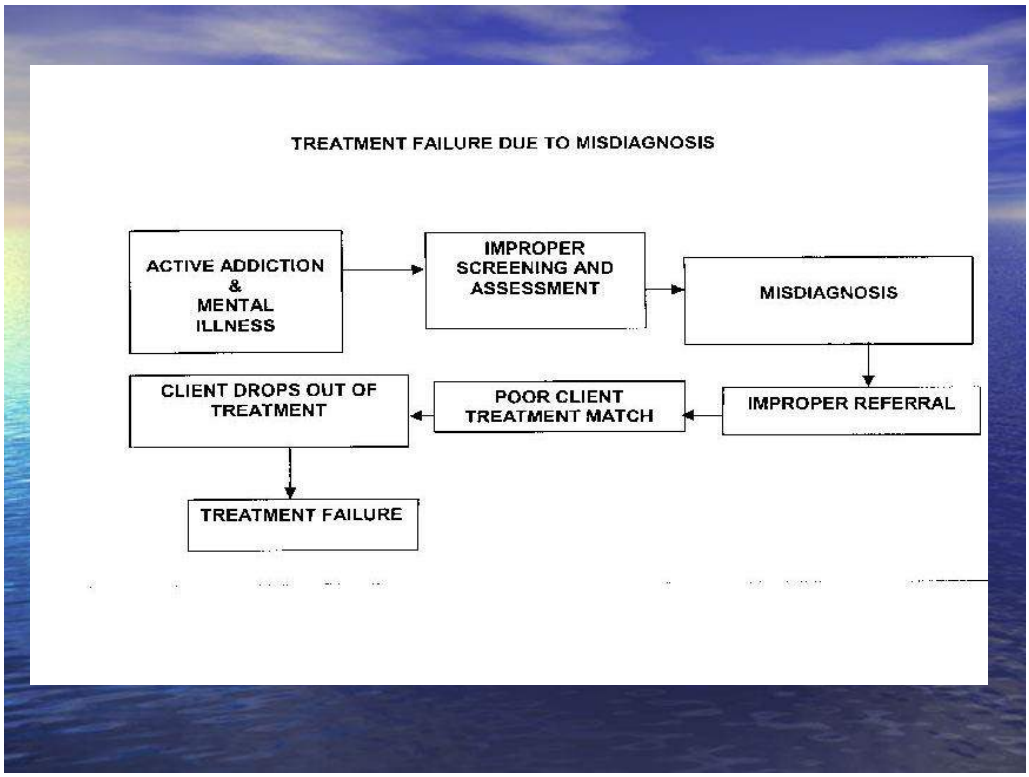
138

ASAM Criteria Training



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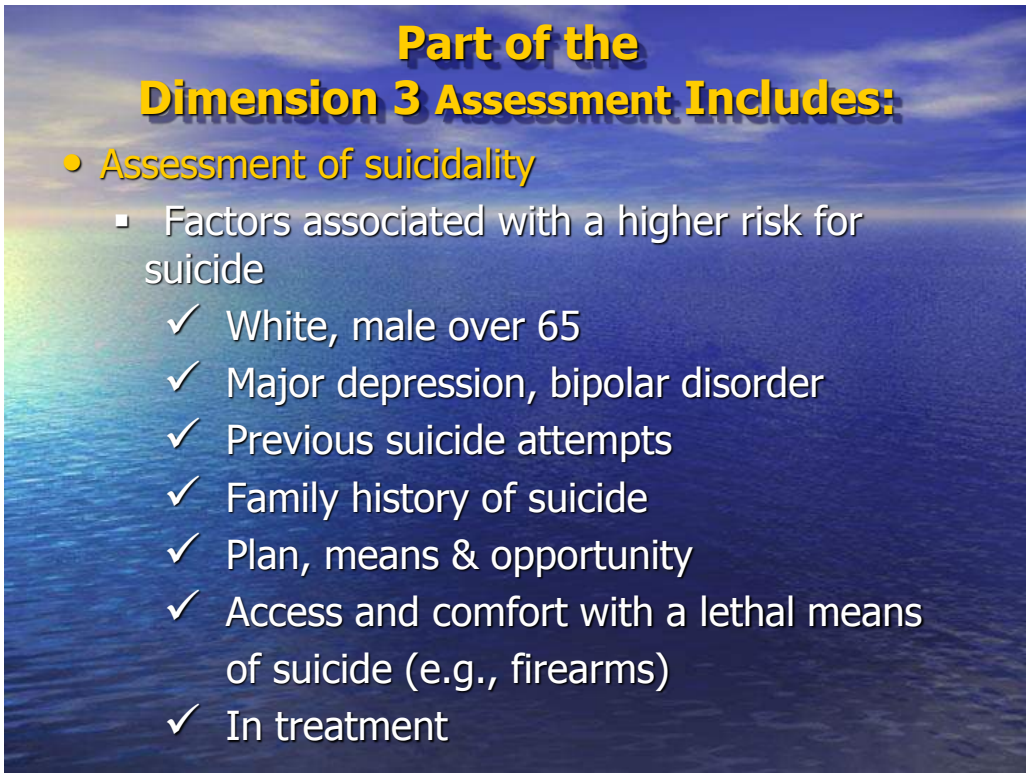

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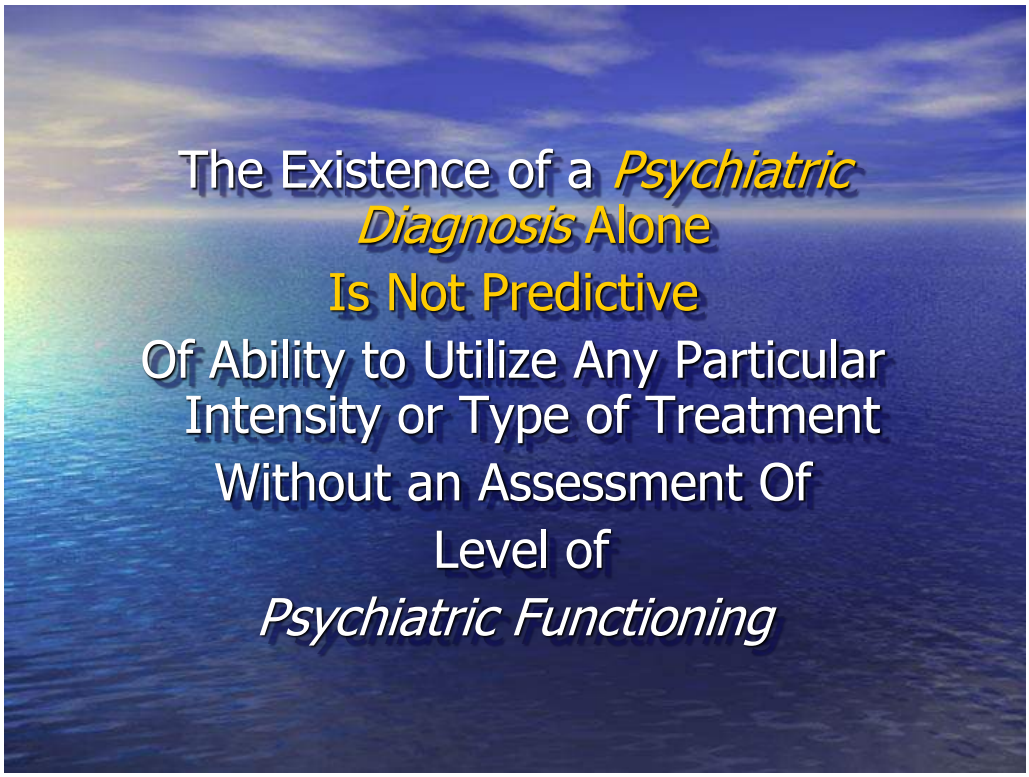

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Psychiatric Diagnoses

- *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.

144

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Mental Heath Problem and Mental Health Disorders

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

145

The New Paradigm for Co-Occurring Disorders

Characteristics of Co-Occurring Disorders

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

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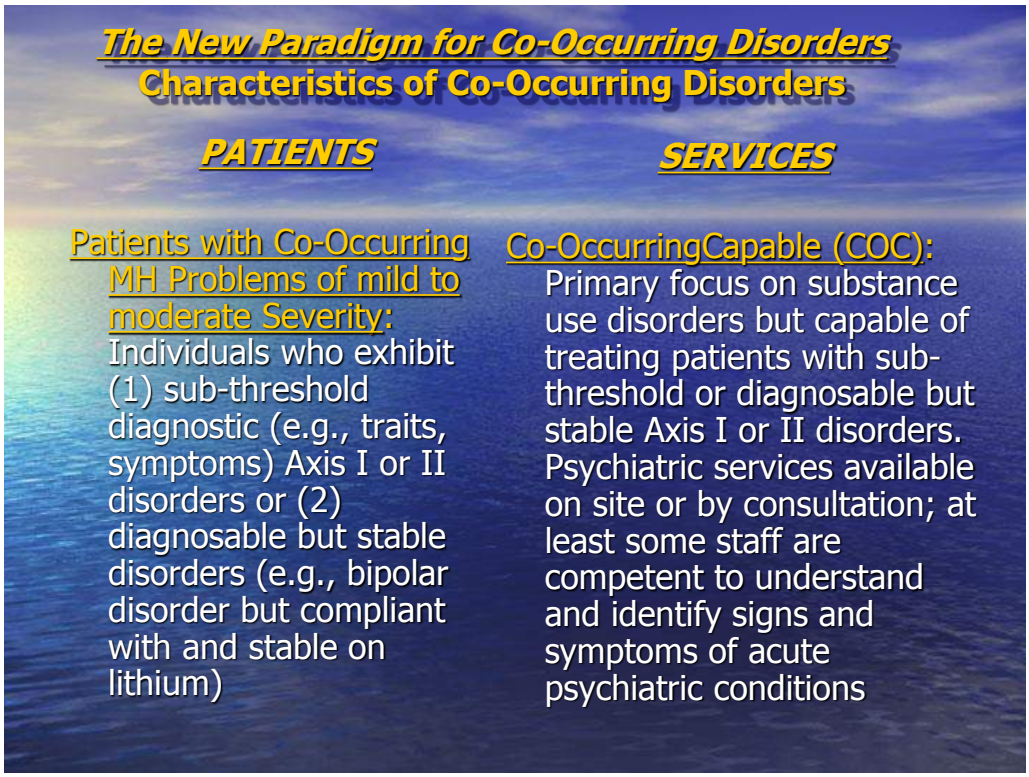

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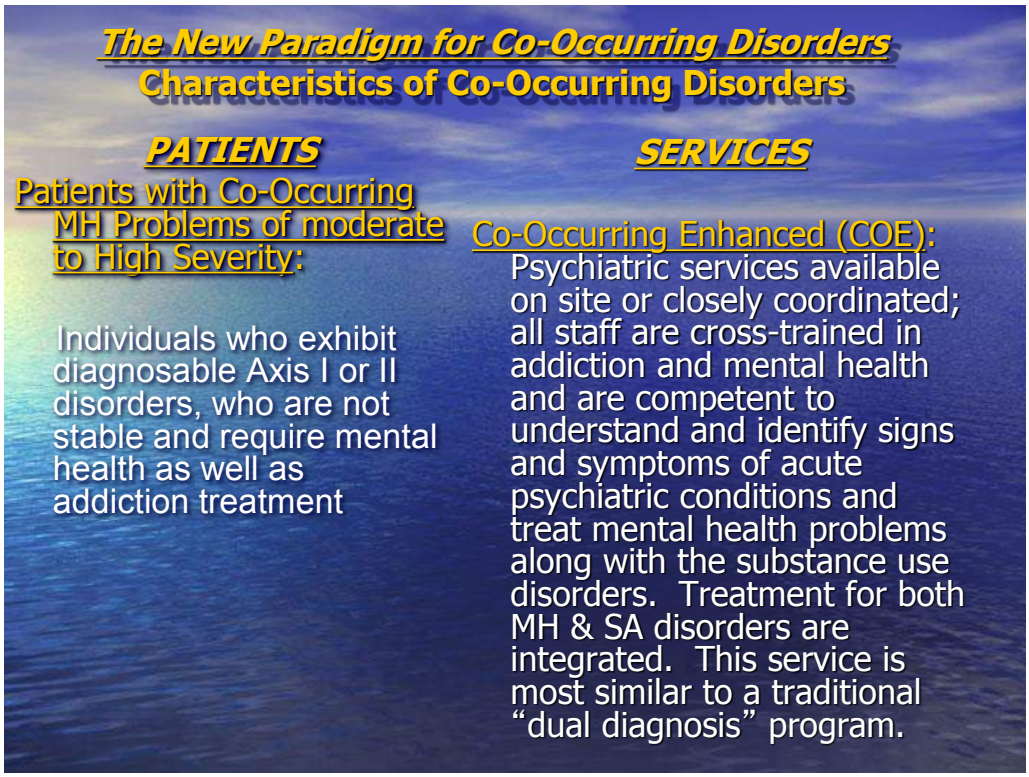

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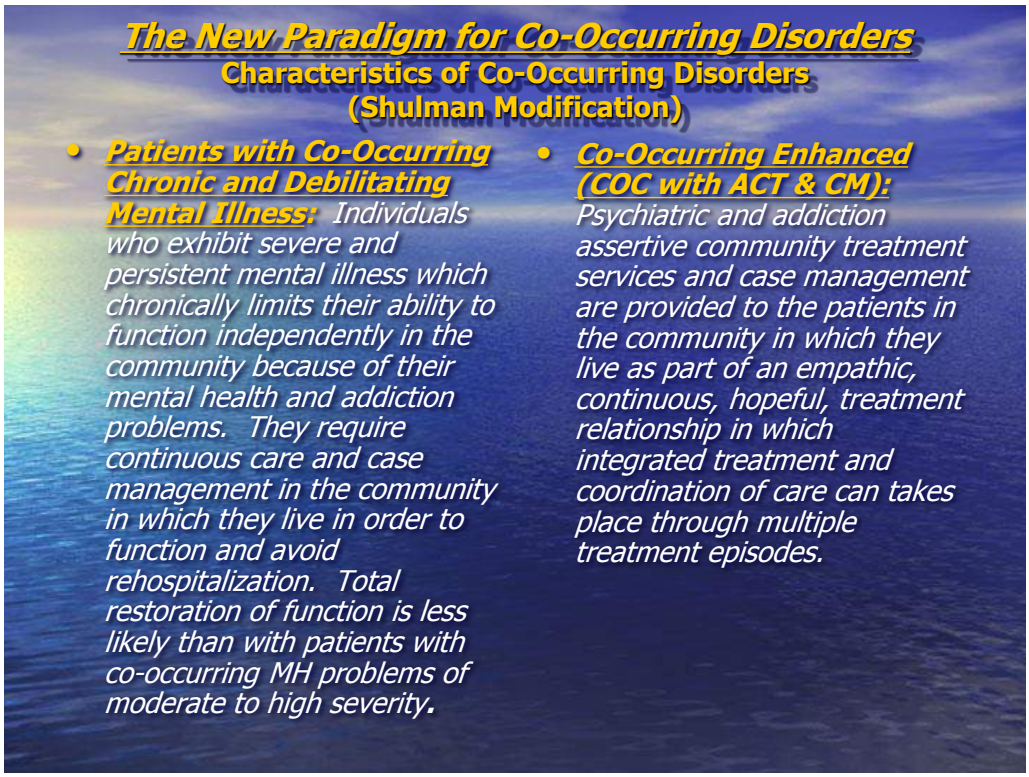

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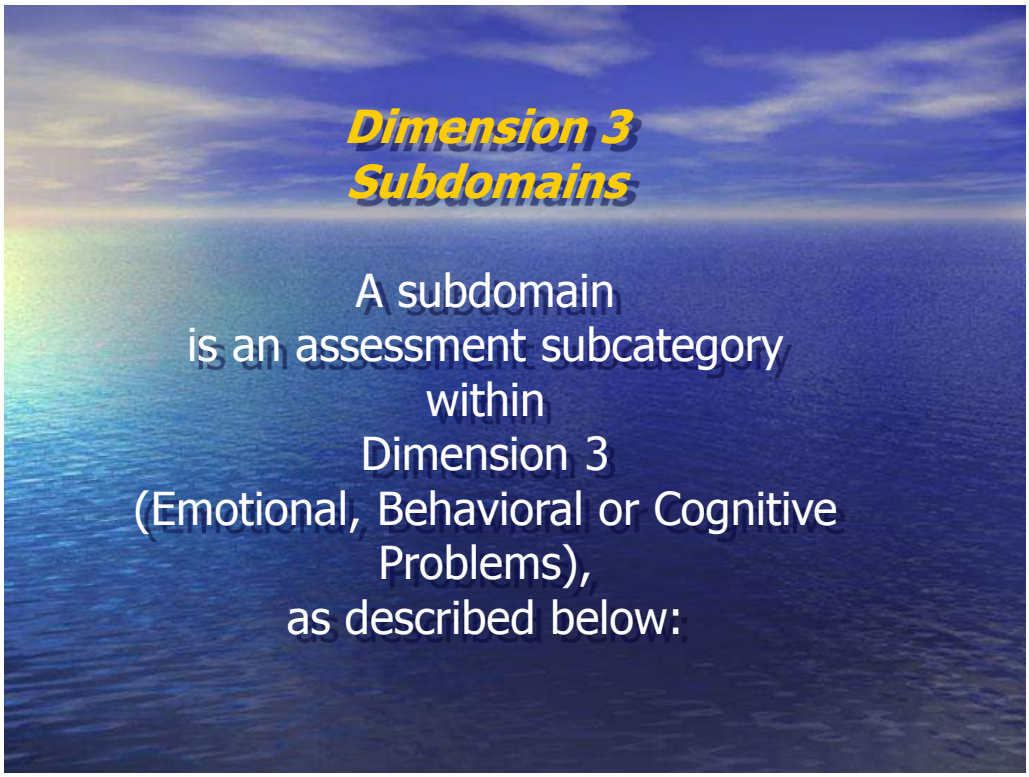

150

Subdomains

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

151

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.

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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

153

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

154

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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

155

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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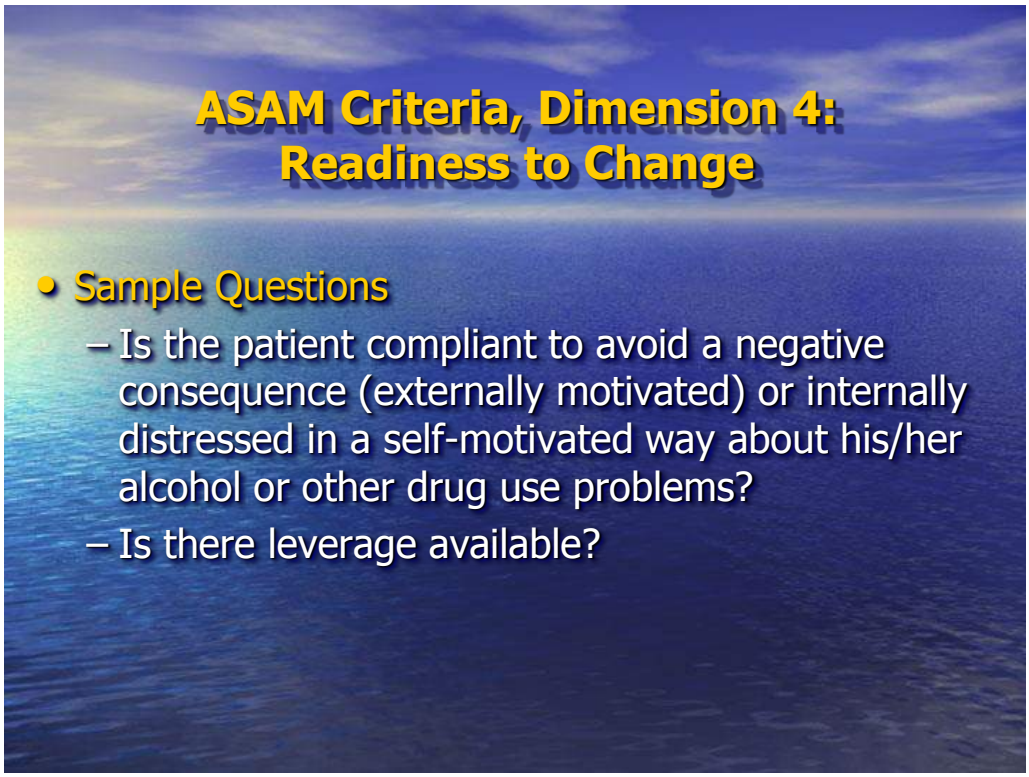

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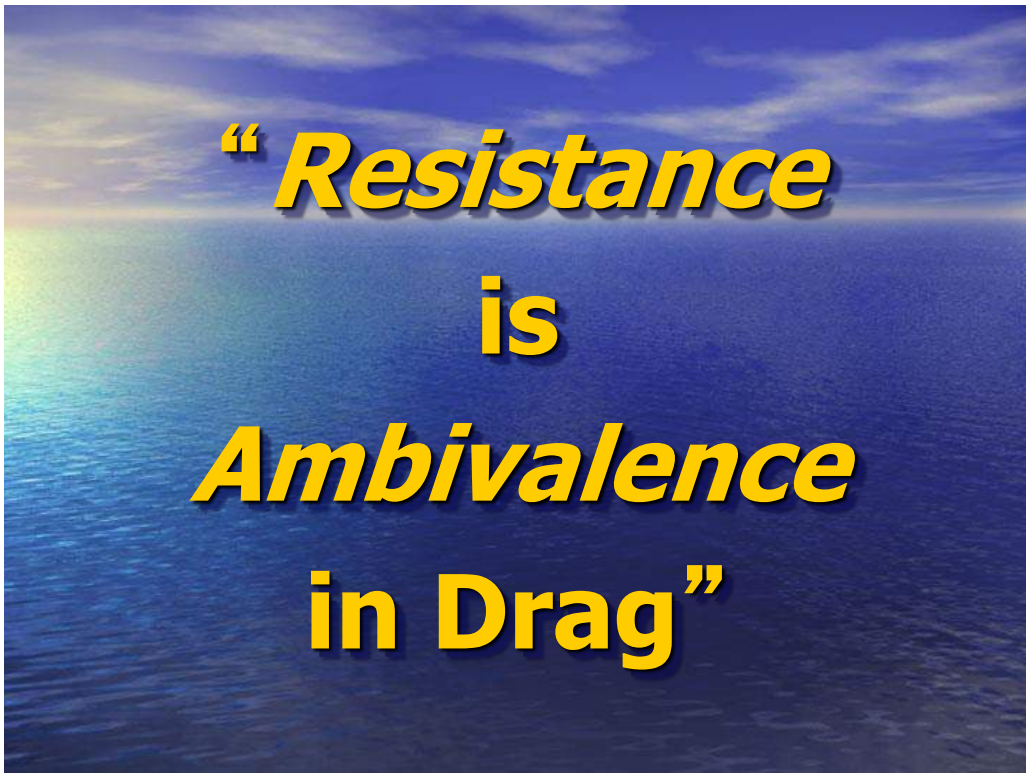

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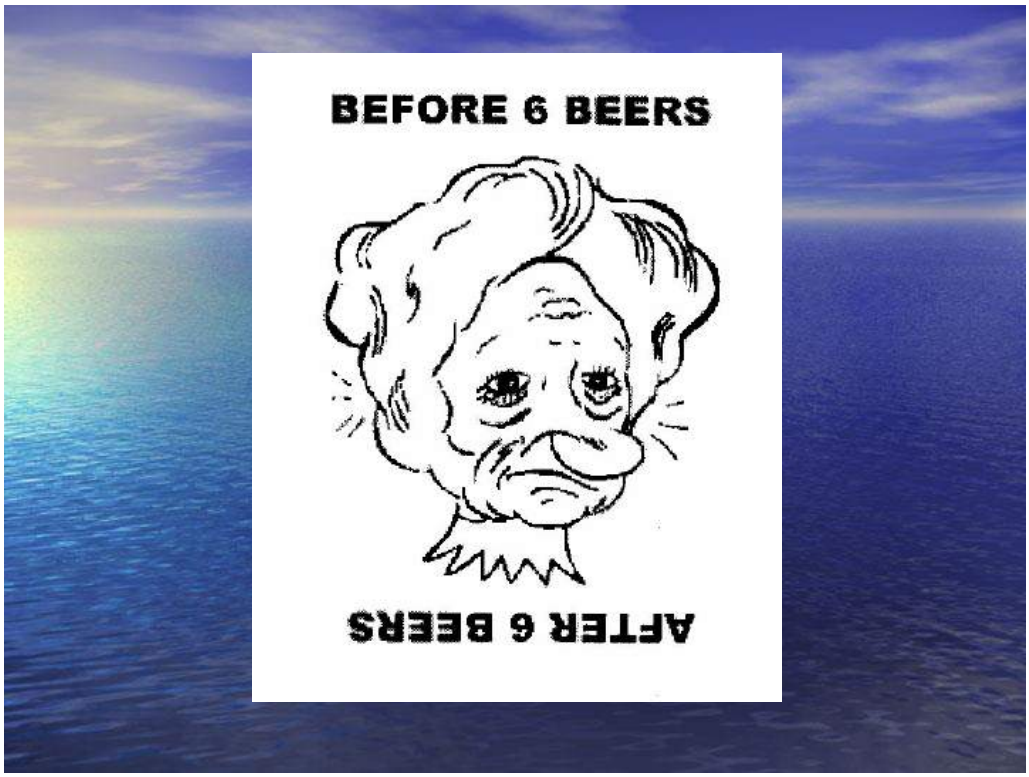

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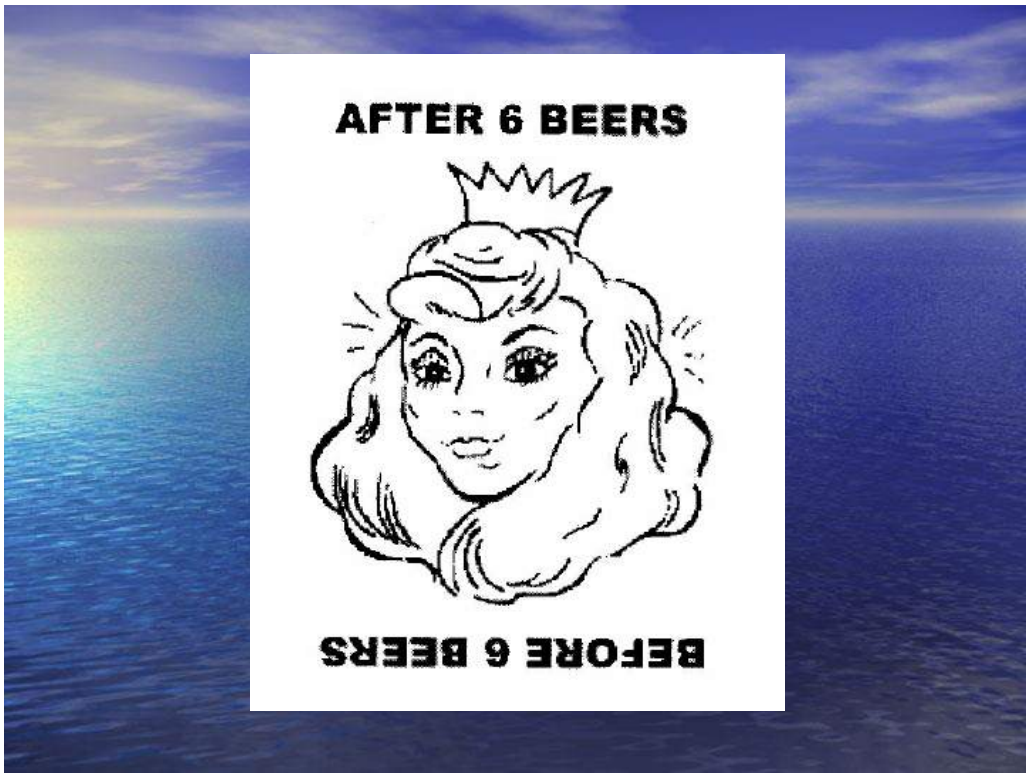

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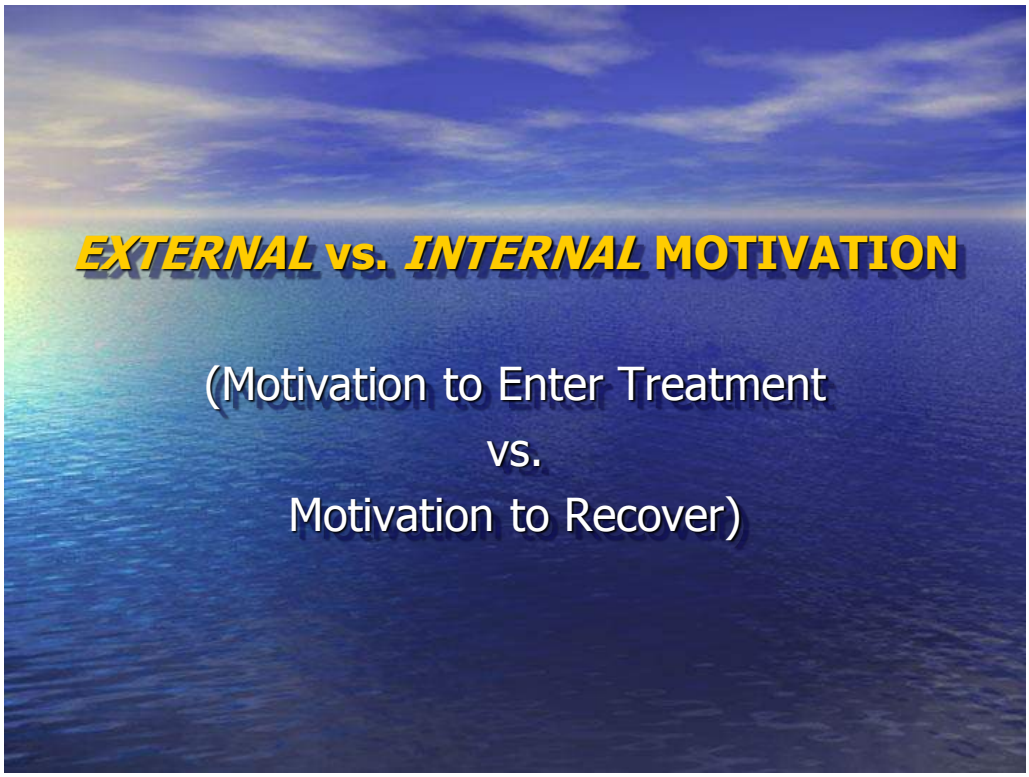

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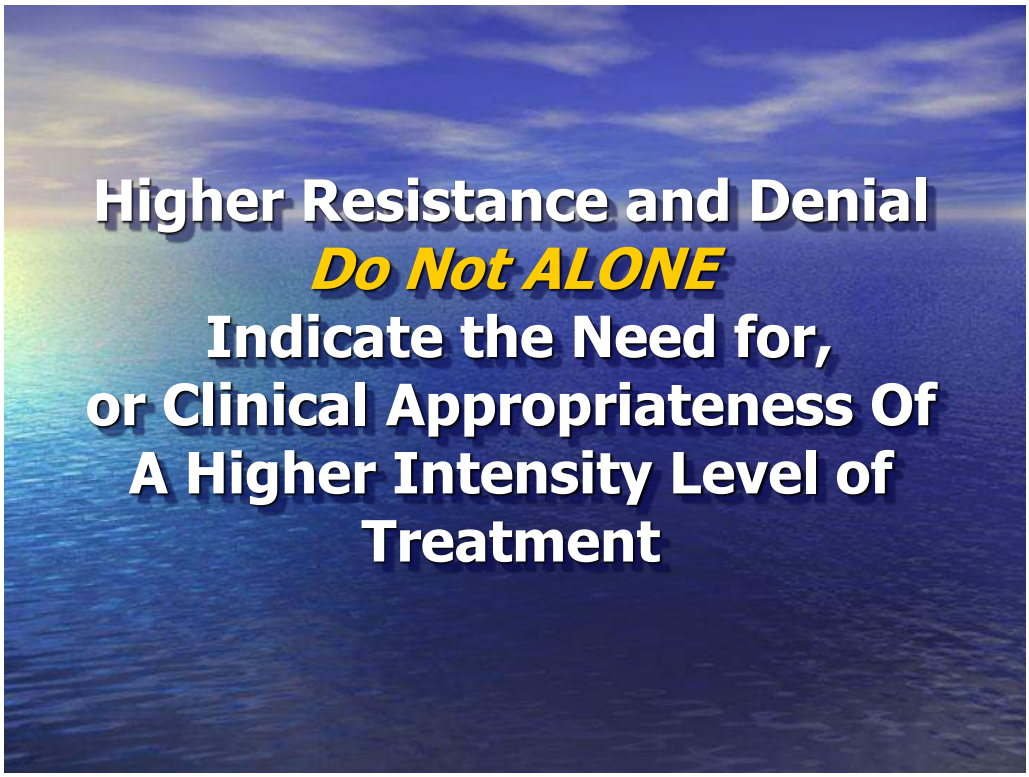


165

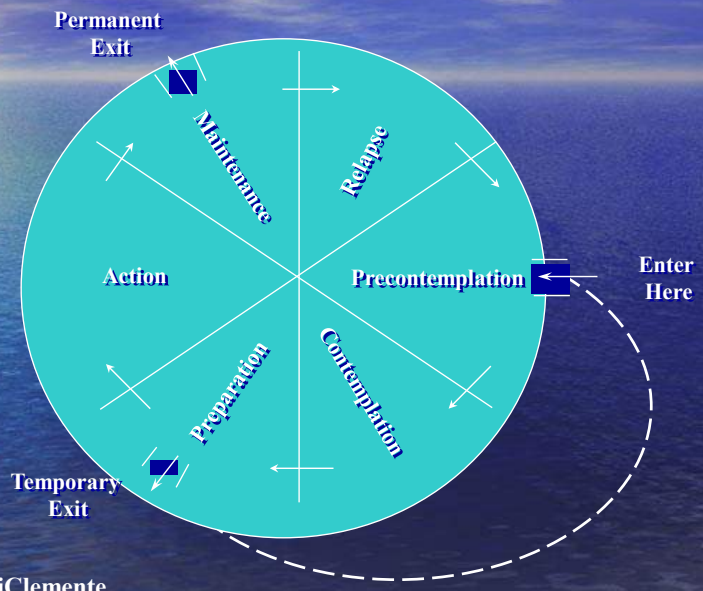
166

Transtheoretical Stages of Change (Prochaska & DiClemente)

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

167

Stage Model of the Process of Change



Prochaska and DiClemente

168

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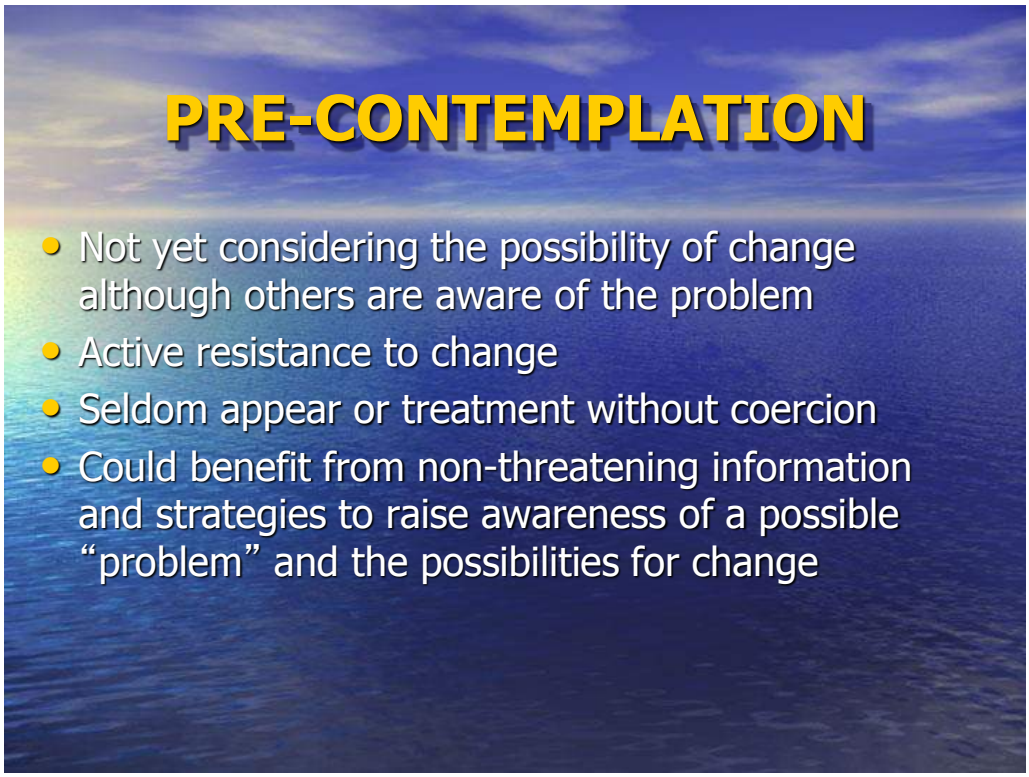

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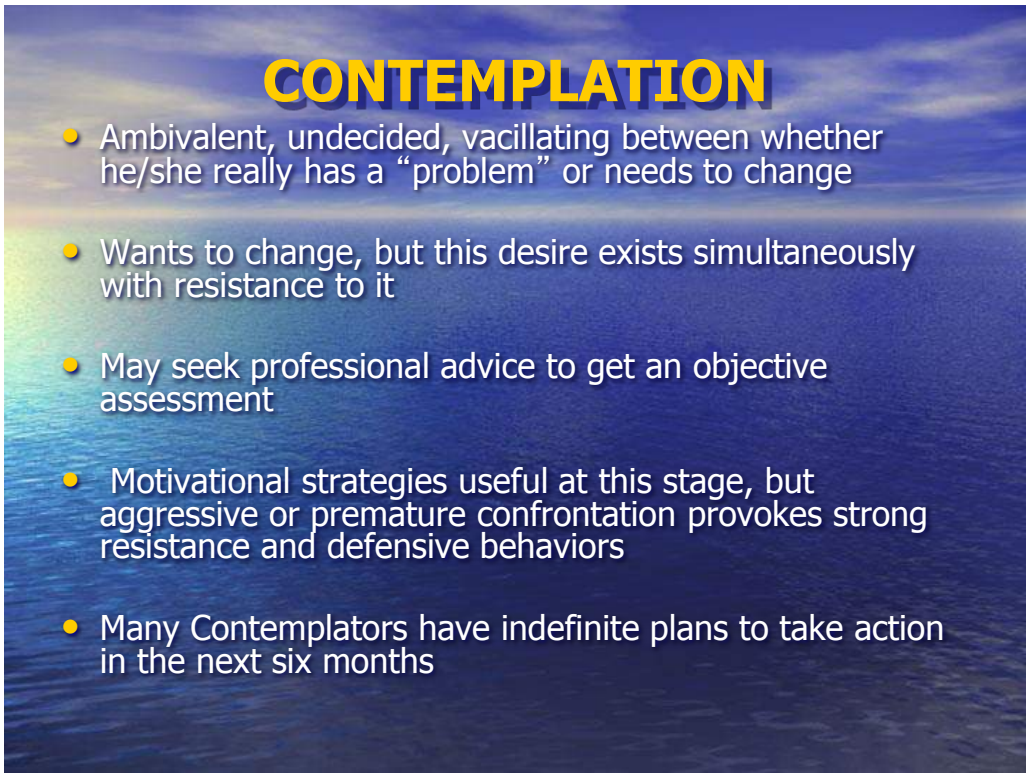

170

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.

171

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.

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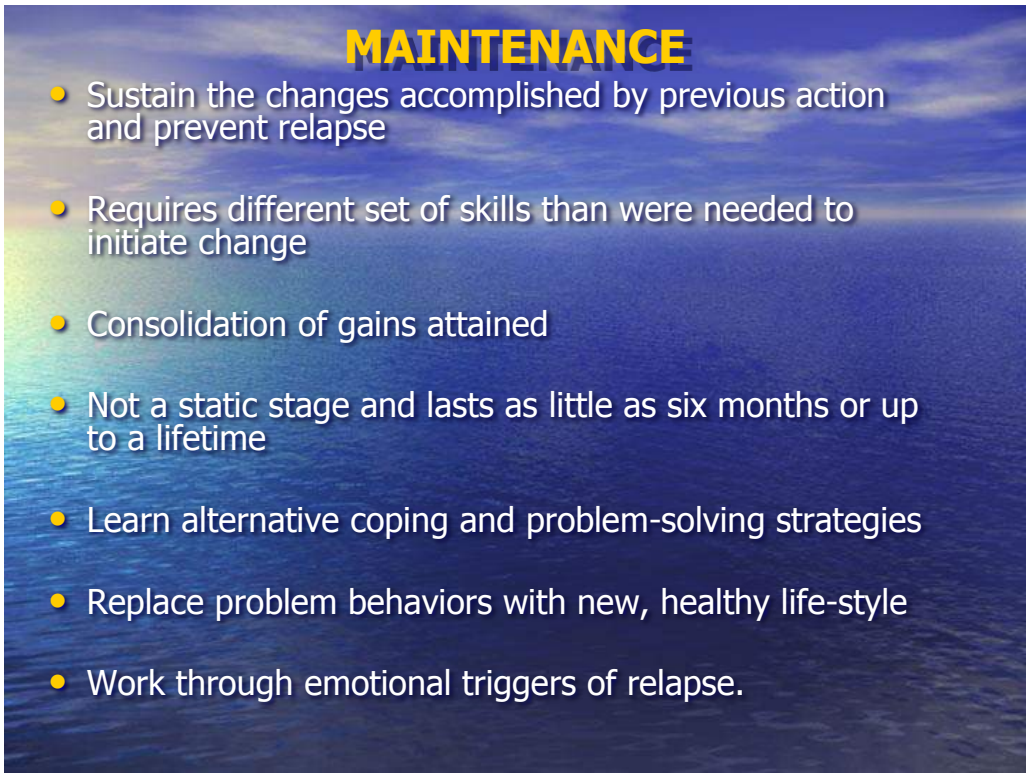

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174

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.

175

Decisional Balancing

	Advantages	Disadvantages
CHANGING		
NOT CHANGING		

176

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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 takes 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

177

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?

178

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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?

179

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?

180

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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

181

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!")*

182

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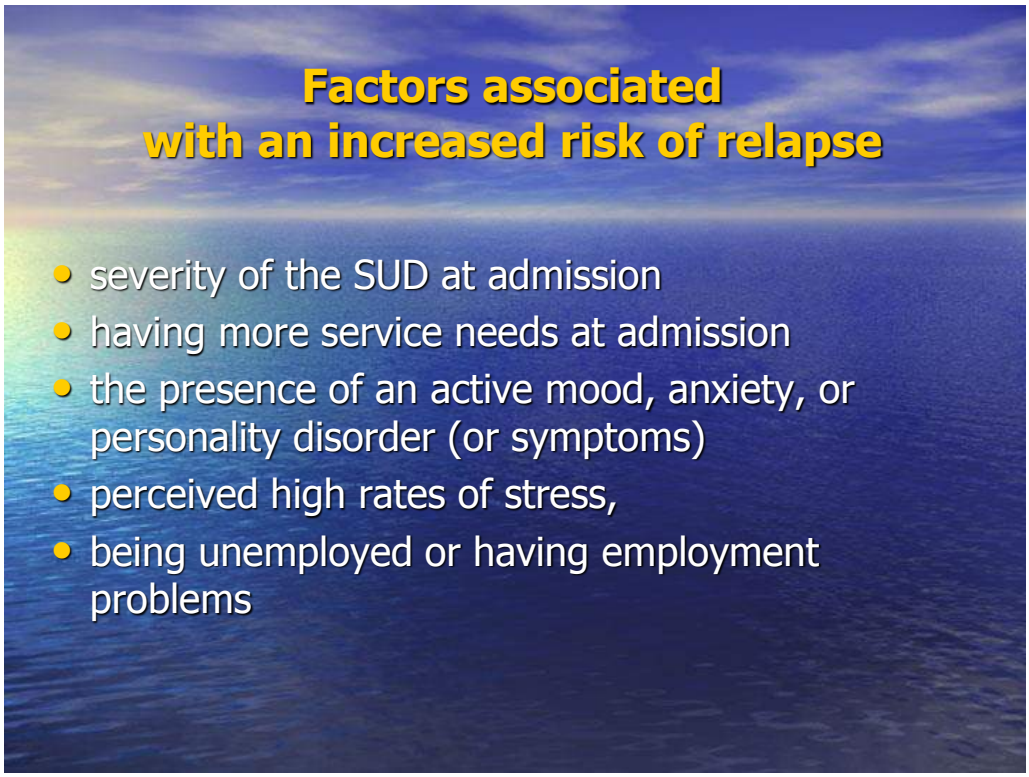

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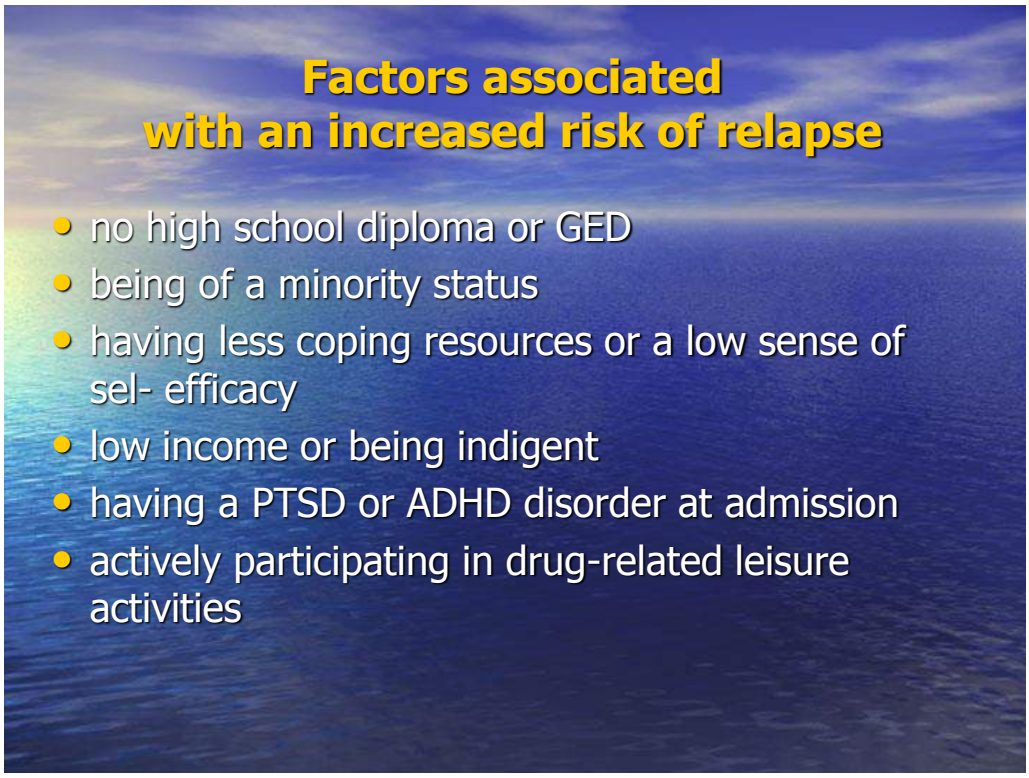
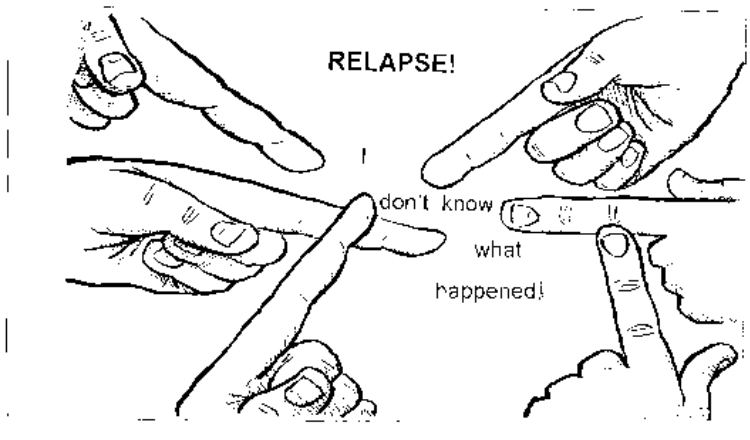


184

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

185



186

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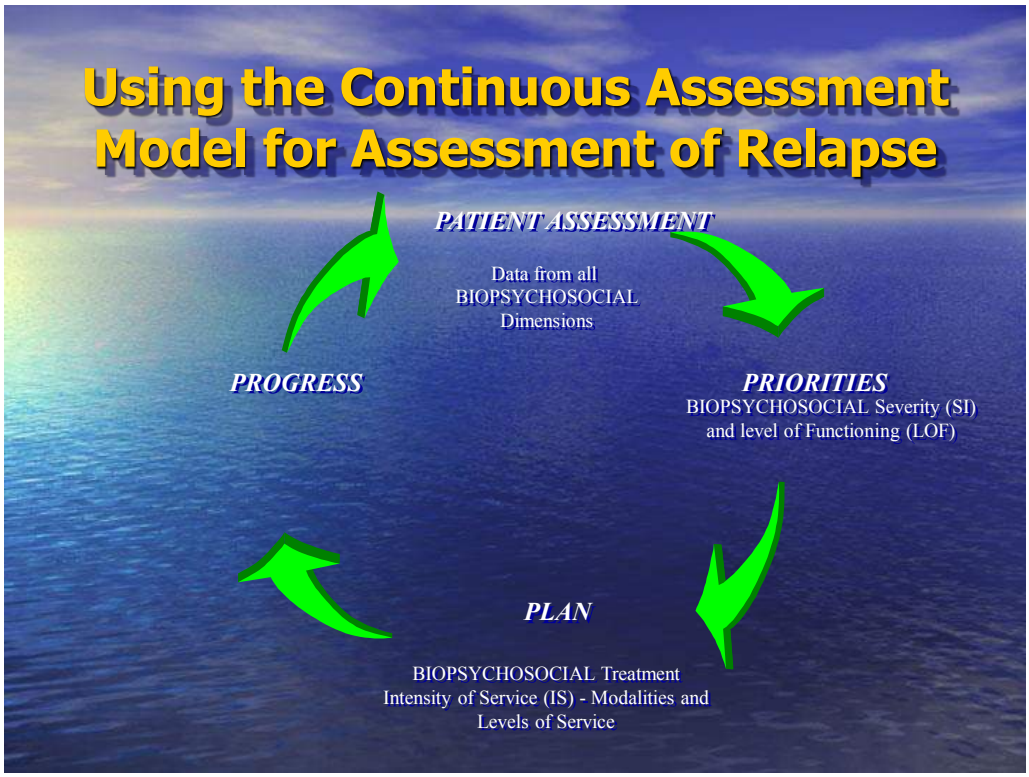

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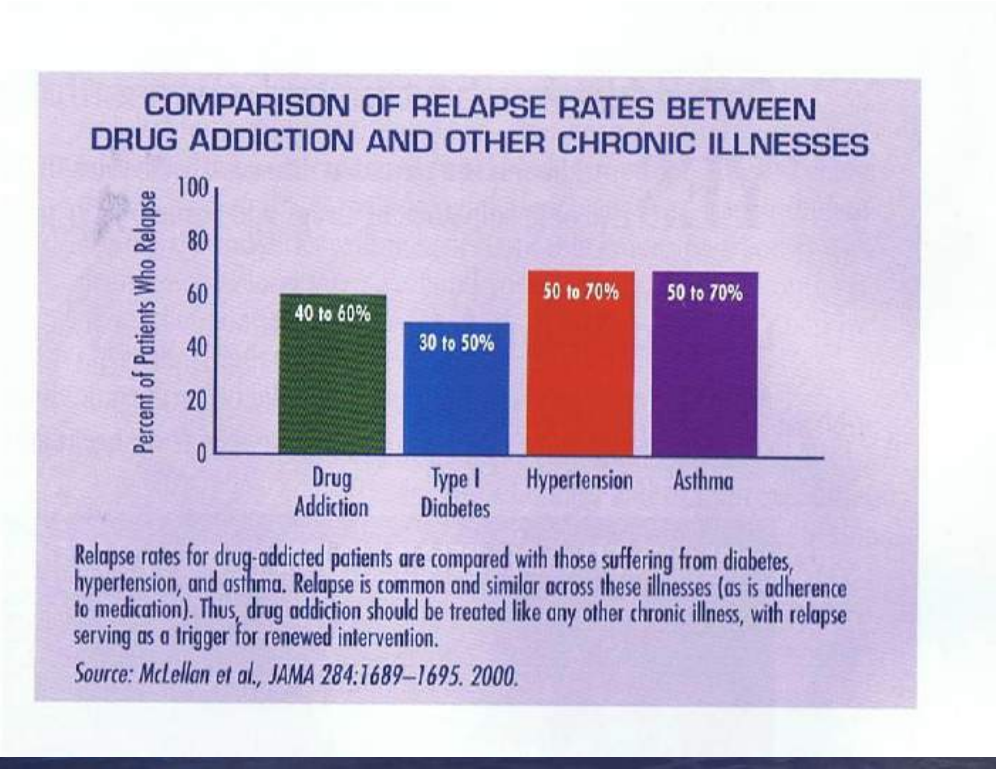
188

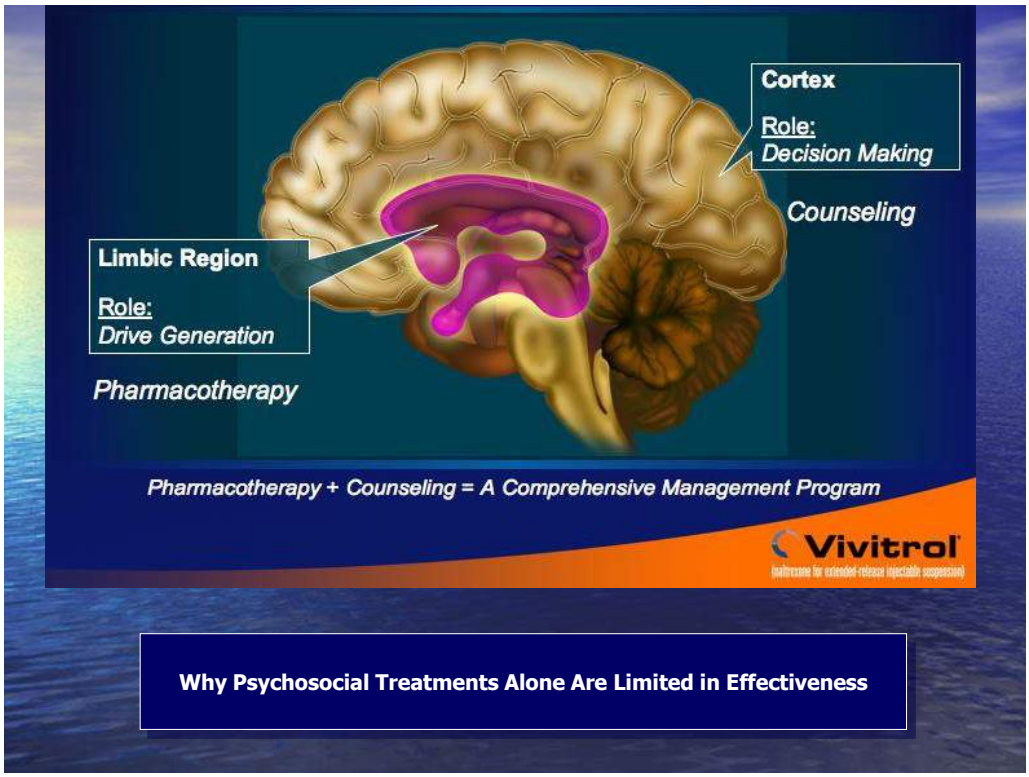


189

190

*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!

191



192

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193

194

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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!

195

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

196

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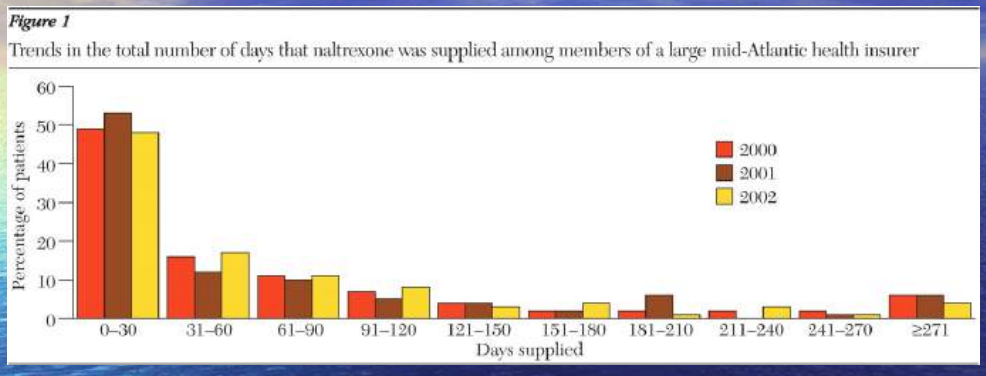
The greatest problem with pharmacotherapy is the lack of compliance!

197

Pharmacy Claims for Oral Naltrexone



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**

198

Some Research Results

199

VIVITROL – Significantly Reduces Drinking Days[1,2]

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

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

200