

# Overview of the ASAM Patient Placement Criteria, Second Edition Revised (ASAM PPC-2R)

David Mee-Lee, M.D.  
Chief Editor, ASAM PPC-2R  
[www.DMLMD.com](http://www.DMLMD.com)

# Brief History of ASAM Patient Placement Criteria

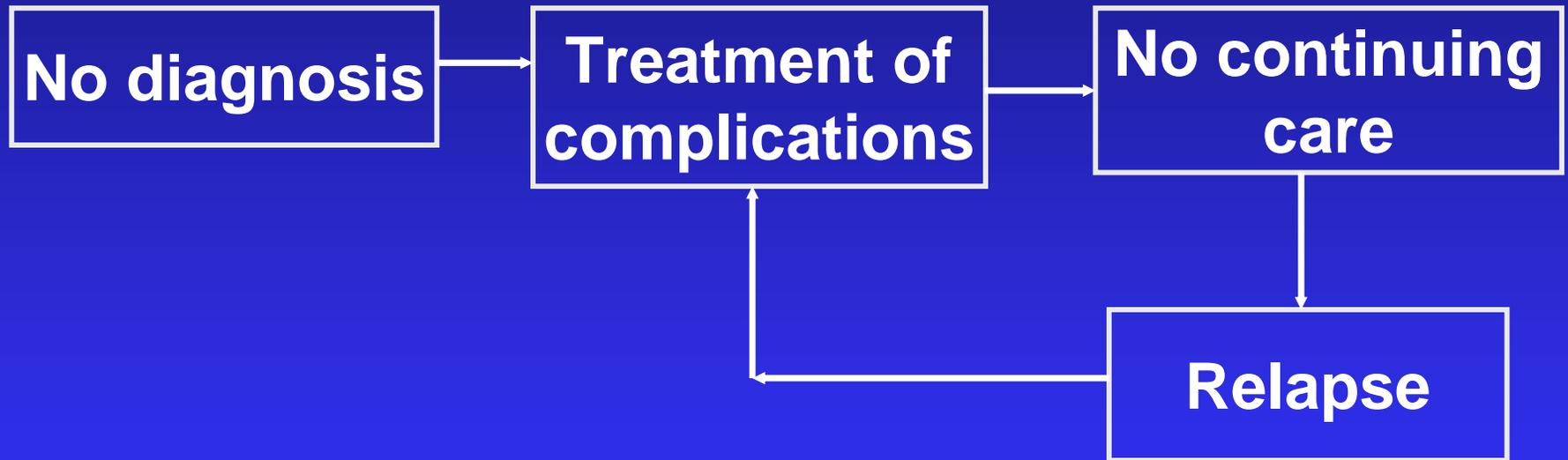
- 1987 Cleveland Criteria and NAATP Criteria published
- 1991 ASAM PPC-1 published
- 1992 Coalition for National Clinical Criteria established
- 1994 ASAM Criteria Validity Study funded by NIDA

# Brief History (cont.)

- 1995 “The Role and Current Status of Patient Placement Criteria In the Treatment of Substance Use Disorders” Treatment Improvement Protocol. The Center for Substance Abuse Treatment
- 1996 ASAM PPC-2 published
- 1998 – 1999 ASAM PPC endorsed by 30 states, DoD, VA, ValueOptions and other MCOs
- 1999 NIAAA funds Assessment Software project
- 2001 ASAM PPC-2R published

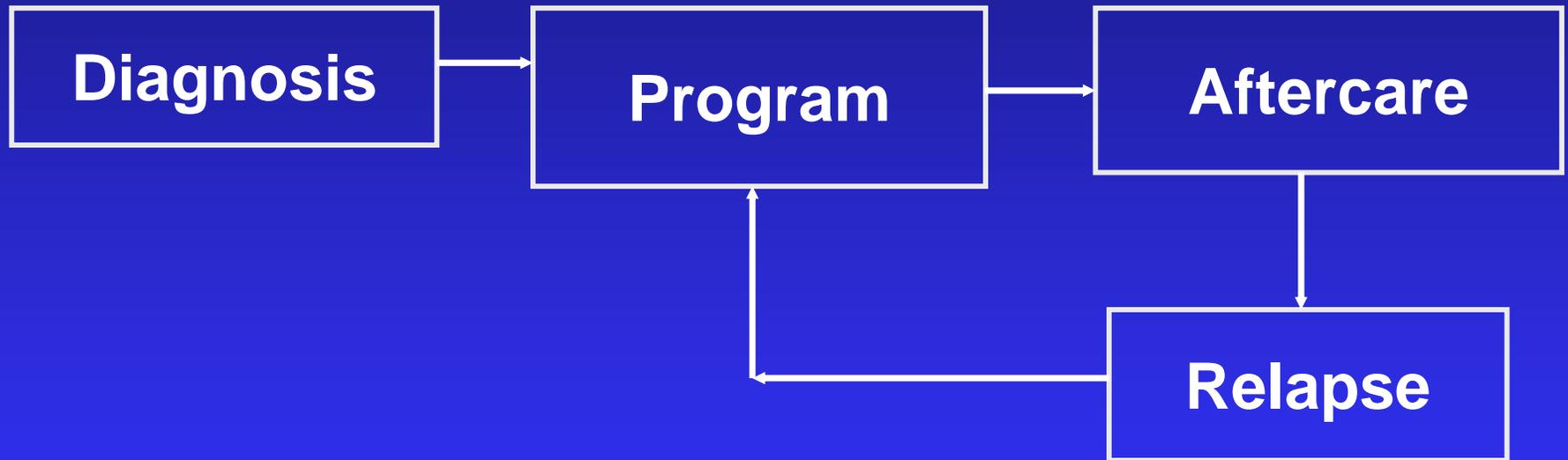
# Generations of Clinical Care

## 1. *Complications-driven Treatment*



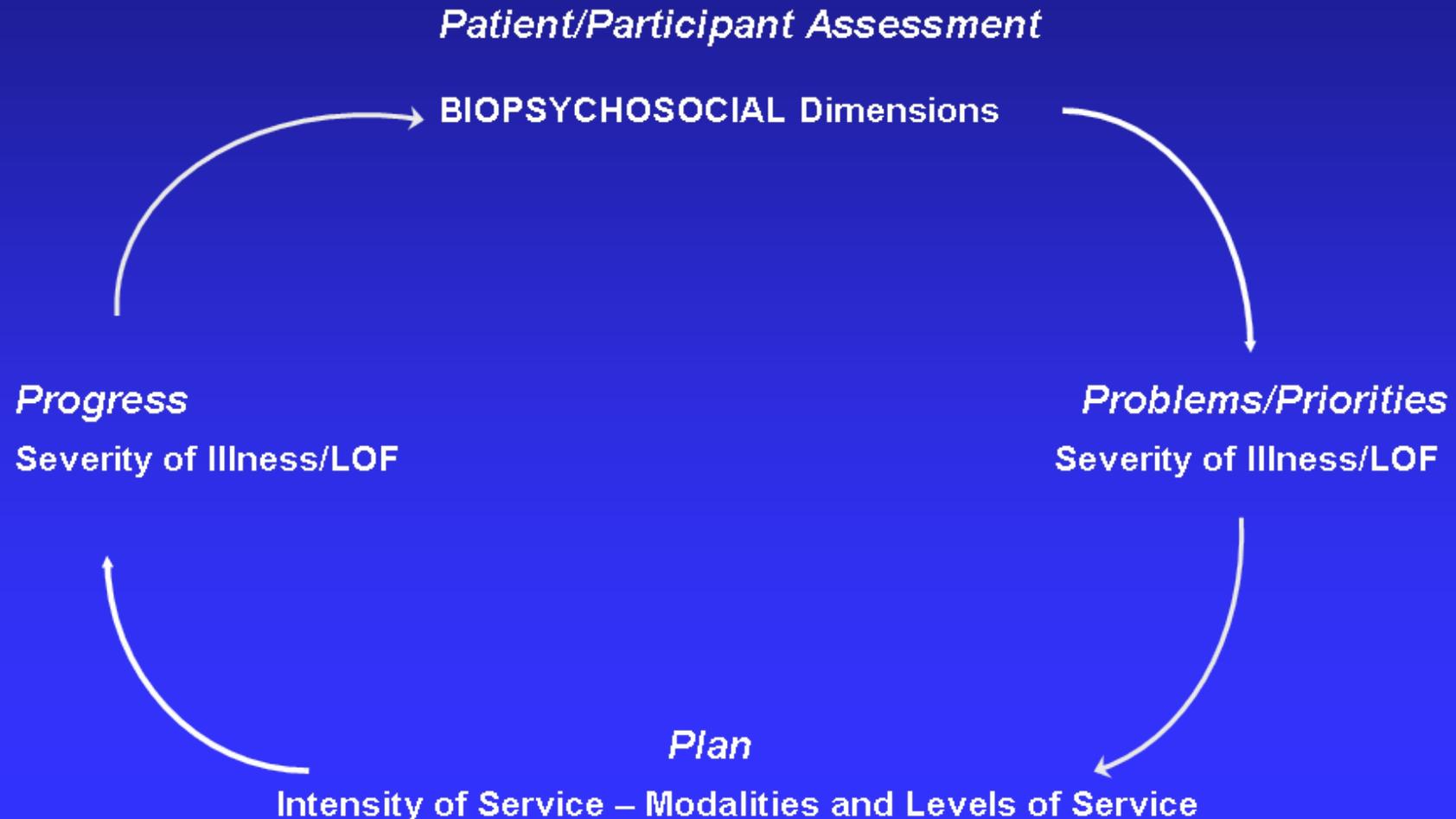
# Generations of Clinical Care

## 2. *Diagnosis-driven Treatment*



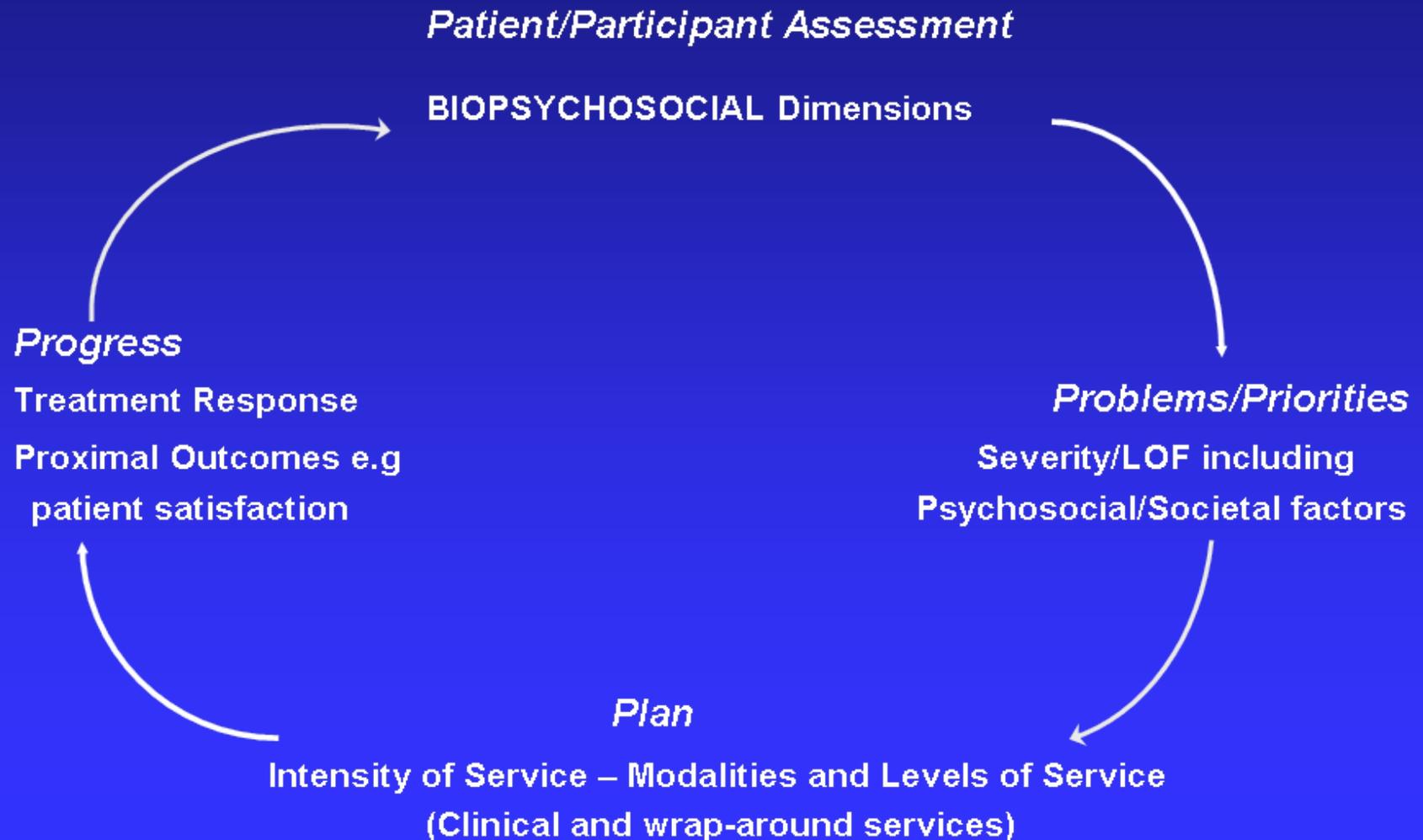
# Generations of Clinical Care

## 3. Individualized, Clinically-driven Treatment



# Generations of Clinical Care

## 4. *Clinical Outcomes-driven Treatment*



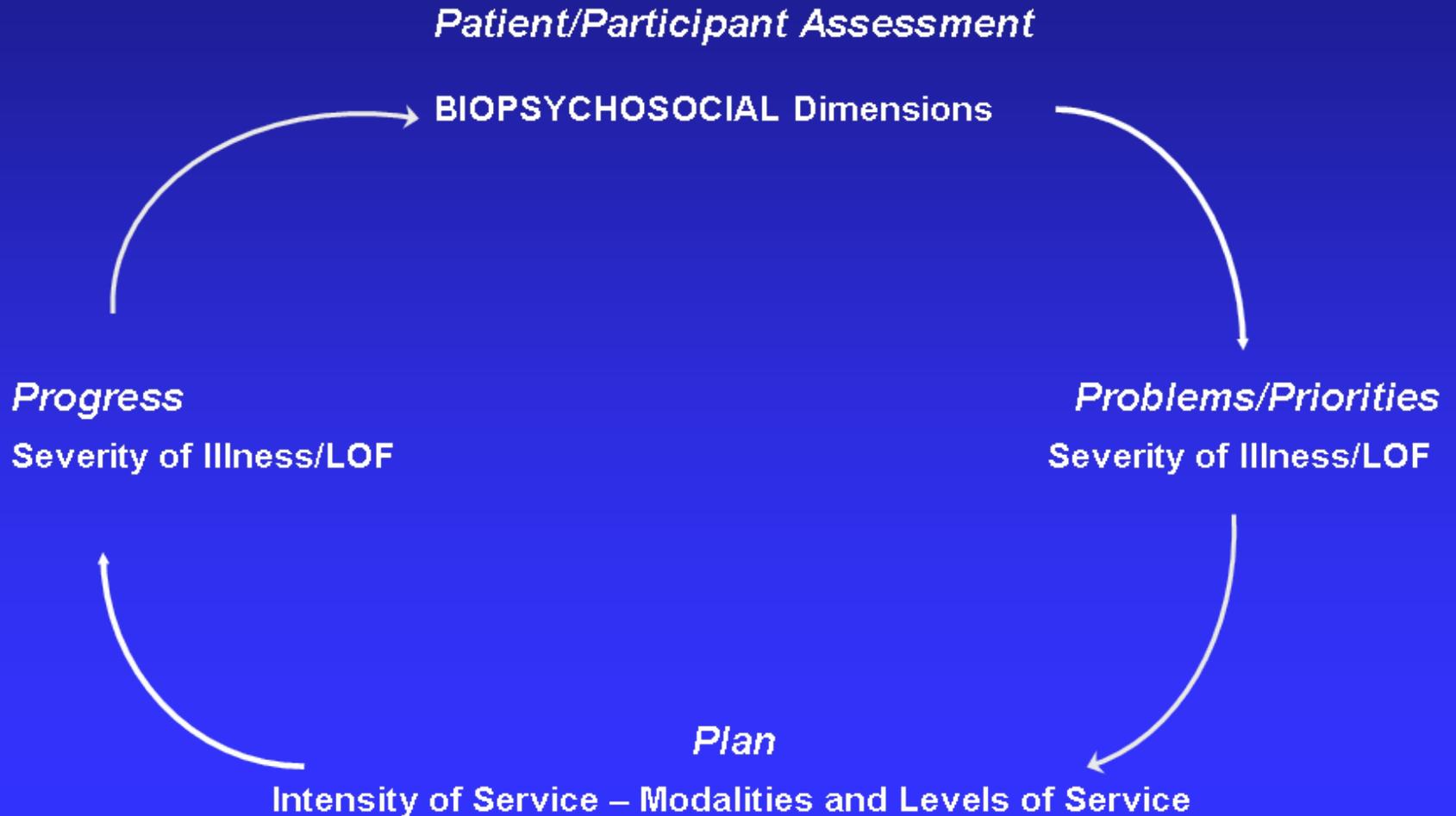
# Underlying Concepts of ASAM PPC

## *Biopsychosocial Perspective of Addiction*

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

# Underlying Concepts (cont.)

## *Individualized Treatment*



# Underlying Concepts (cont.)

## *Multidimensional Assessment*

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

# Underlying Concepts (cont.)

## *Treatment Matching - Modalities*

- Motivate - Dimension 4
- Manage – All Six Dimensions
- Medication – Dimensions 1, 2, 3, 5
- Meetings – Dimensions 2, 3, 4, 5, 6
- Monitor- All Six Dimensions

# Underlying Concepts (cont.)

## *Treatment Levels of Service*

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

# Level 0.5 and OMT

## **Level 0.5: Early Intervention Services -**

Individuals with problems or risk factors related to substance use, but for whom an immediate Substance -Related Disorder cannot be confirmed

## **Opioid Maintenance Therapy (OMT) -**

Criteria for Level I Outpatient OMT, but OMT in all levels

# Detoxification Services for Dimension 1

I-D - Ambulatory Detoxification without  
Extended On-site Monitoring

II-D - Ambulatory Detoxification with  
Extended On-Site Monitoring

# **Detoxification Services for Dimension 1 (continued)**

III.2-D - Clinically-Managed Residential  
Detoxification

III.7-D - Medically-Monitored Inpatient  
Detoxification

IV-D - Medically-Managed Inpatient  
Detoxification

# Level I and II Services

Level I      Outpatient Treatment

Level II.1   Intensive Outpatient  
Treatment

Level II.5   Partial Hospitalization

# Level III Residential/Inpatient

Level III.1 Clinically-Managed, Low Intensity Residential Treatment

Level III.3 Clinically-Managed, Medium Intensity Residential Treatment (Adult Level only)

# Level III Residential/IP (Continued)

Level III.5 Clinically-Managed, Medium/High Intensity Residential Treatment

Level III.7 Medically-Monitored Intensive Inpatient Treatment

# Level IV Services

Level IV      Medically-Managed Intensive  
Inpatient Treatment

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

1. Level of Service versus Matrix Structure
2. Terminology – Co-Occurring Mental and Substance-Related Disorders; “dual diagnosis”

MICA; CAMI; MISA; SAMI; MICD; ICOPSS; dual disorders; dual diagnosis; coexisting; co-morbid; co-occurring; multiple vulnerabilities

# **ASAM PPC-2R's Approach to Co-Occurring Disorders (cont.)**

## **3. Description of Services**

- Addiction-Only Services – AOS**
- Dual Diagnosis Capable – DDC**
- Dual Diagnosis Enhanced – DDE**

# Addiction-Only Services (AOS)

- Cannot accommodate psychiatric illnesses however stable and however well functioning the individual
- Policies and procedures do not accommodate dual diagnosis e.g., psychotropic medications not accepted; coordination/collaboration with mental health not routinely present; mental health issues not addressed in treatment

# Dual Diagnosis Capable (DDC) Programs

- Routinely accept co-occurring disorders
- Can meet needs if psychiatric disorders sufficiently stable; independent functioning so mental disorders do not interfere with addiction treatment
- Address dual diagnoses in policies, procedures, assessment, treatment planning, program content, and discharge planning

# Dual Diagnosis Capable (DDC) Programs (Cont.)

- Have arrangements for coordination and collaboration with mental health services
- Can provide psychopharmacologic monitoring and psychological assessment/consultation on site; or well-coordinated off-site

# Dual Diagnosis Enhanced (DDE) Programs

- Can accommodate unstable/disabled needing specific psychiatric, mental health support, monitoring and accommodation necessary to participate in addiction treatment
- Not so acute/impaired to present severe danger to self/others, nor need 24-hour, psychiatric supervision

# Dual Diagnosis Enhanced (DDE) Programs (cont.)

- Psychiatric, mental health and also addiction treatment professionals. Cross-training for all staff. Relatively high staff to patient ratios; close monitoring of instability and disability
- Policies, procedures, assessment, treatment and discharge planning accommodate dual diagnoses

# Dual Diagnosis Enhanced (DDE) Programs (cont.)

- Dual diagnosis-specific, mental health symptom management groups incorporated in addiction treatment. Motivational enhancement therapies more likely (particularly in outpatient settings)
- Close collaboration/integration with mental health program for crisis back-up services and access to mental health case management and continuing care

# Co-Occurring Mental and Substance-Related Disorders

## *Risk Domains*

- Dangerousness/Lethality
- Interference with Addiction Recovery Efforts
- Social Functioning
- Ability for Self Care
- Course of Illness

# Six Assessment Dimensions

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral or Cognitive Conditions and Complications
4. Readiness to Change
5. Relapse/Continued Use, Continued Problem Potential
6. Recovery Environment

# **Assessing Immediate Needs**

## ***Behavioral Health Assessment***

### **1. Acute Intoxication and/or Withdrawal Potential**

- Past history of serious, life-threatening withdrawal
- Currently having similar withdrawal symptoms

### **2. Biomedical conditions and complications**

- Any current severe health problems

# Assessing Immediate Needs

## *Behavioral Health Assessment (cont.)*

### **3. Emotional/Behavioral/Cognitive conditions**

- Imminent danger of harm to self/others
- Unable to function ADL's - imminent danger

### **4. Readiness to Change**

- Ambivalent or feels treatment unnecessary
- Coerced, mandated, required assessment/Tx

# Assessing Immediate Needs

## *Behavioral Health Assessment (cont.)*

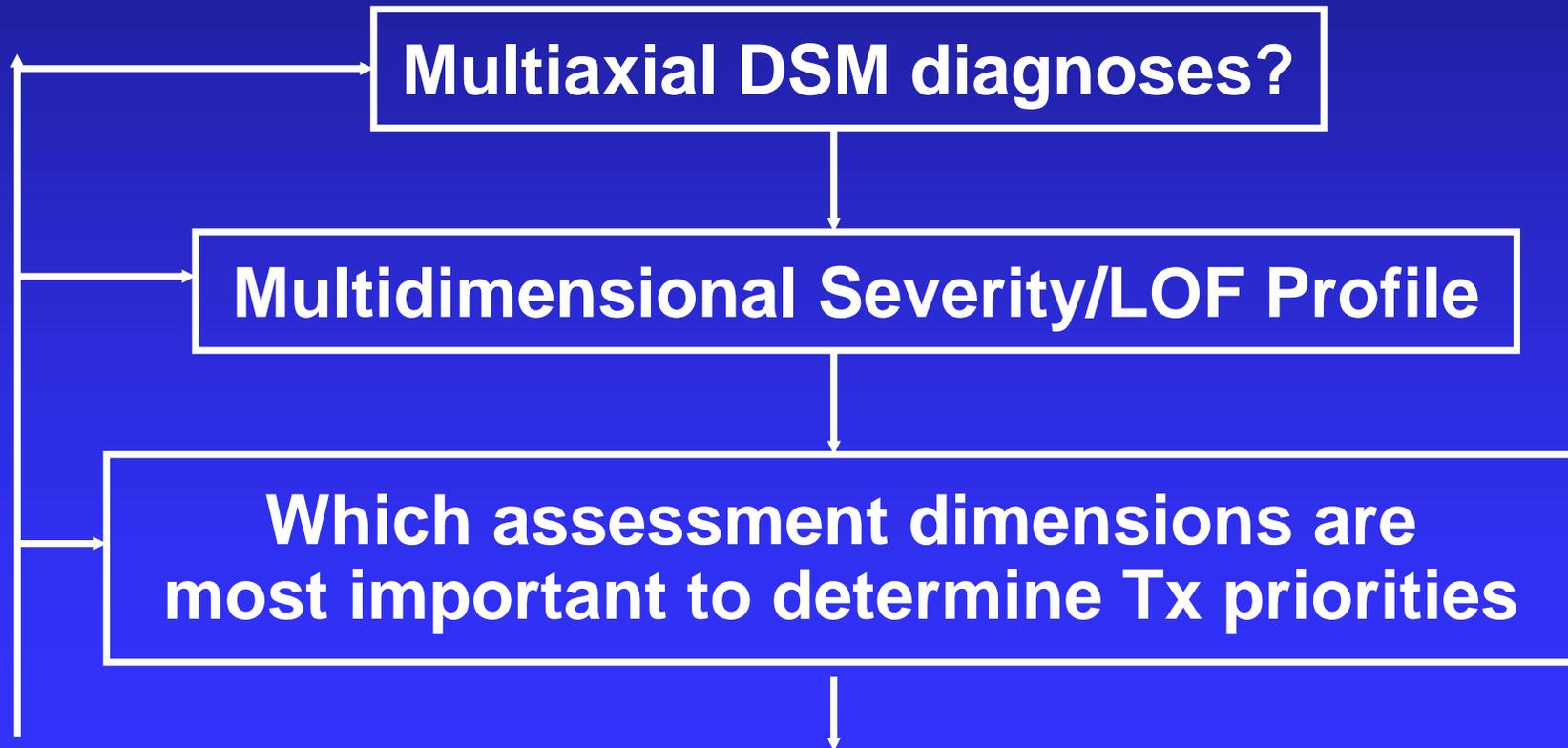
### **5. Relapse/Continued Use/Continued Problem potential**

- Currently under the influence
- Continued use/problems imminently dangerous

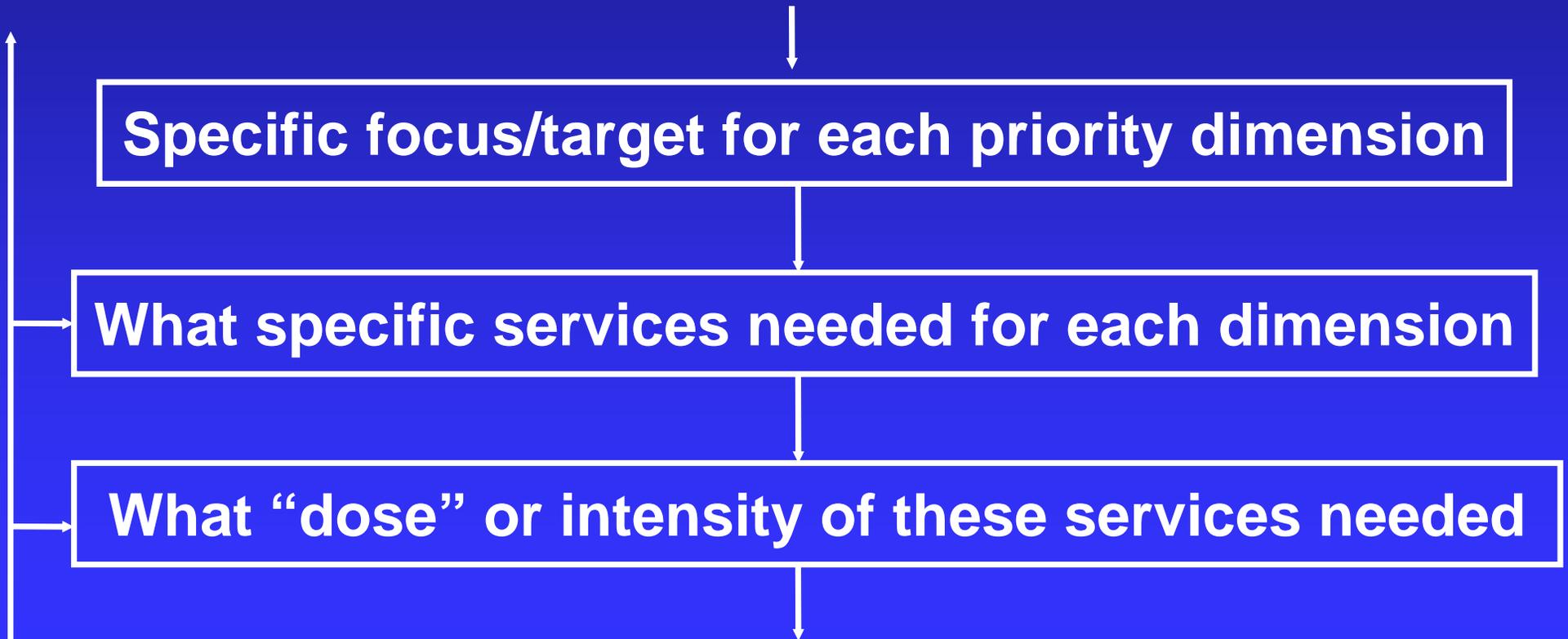
### **6. Recovery Environment**

- Immediate threats to safety, well-being, sobriety

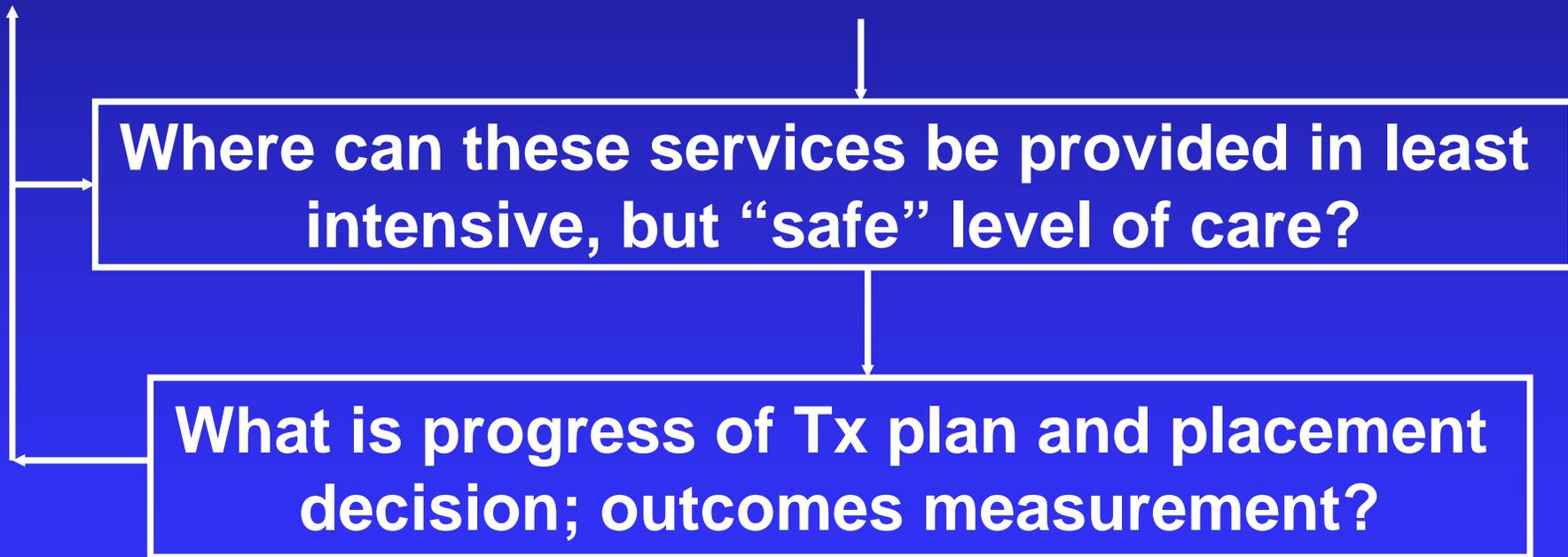
# Focus Assessment and Treatment

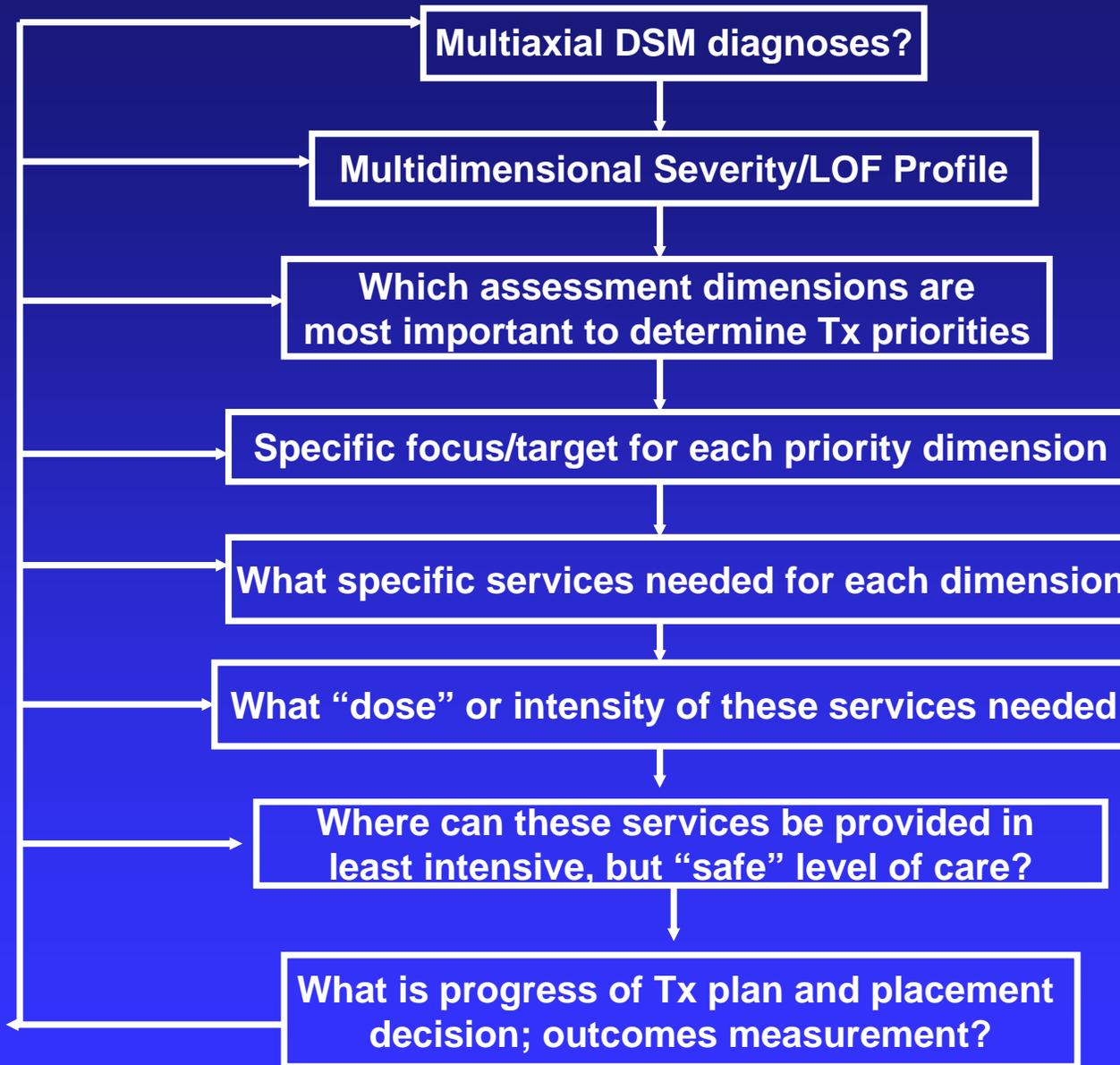


# Focus Assessment and Treatment (cont.)



# Focus Assessment and Treatment (cont.)





# Tracy

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

# Tracy (cont.)

- Parents both present at ER, but police who had been called by mother brought Tracy. ER physician and nurse who came from psychiatric unit to evaluate Tracy, both feel she needs to be in hospital given animosity at home, violent behavior and question of intoxication. Using the six ASAM assessment dimensions, the biopsychosocial clinical data is organized as follows:

# Tracy (cont.)

- Dimension 1, Intoxication/Withdrawal: though intoxicated at home not long before the chair-throwing incident, she is no longer intoxicated and has not been using alcohol or other drugs in large enough quantities for long enough to suggest any withdrawal danger.
- Dimension 2, Biomedical Conditions/Complications: she is not on any medications, has been healthy physically and has no current complaints

# Tracy (cont.)

- 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.

# Tracy (cont.)

- Dimension 5, Relapse/Continued Use/Continued Problem Potential: high likelihood that if released to go back home immediately, there would be reoccurrence of fighting and possibly violence again, at least with father.
- Dimension 6, Recovery Environment: parents frustrated and angry too; mistrustful of patient; and want her in the hospital to cut down on the family fighting.

# Case Presentation Format

## I. Identifying Client Background Data

- Name
- Age
- Ethnicity and Gender
- Marital Status
- Employment Status
- Referral Source
- Date Entered Treatment
- Level of Service Client Entered Treatment
- Current Level of Service
- Stated or Identified Motivation for Treatment

# Case Presentation Format (cont.)

## II. Current Placement Dimension Rating Has It Changed?

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

- (Brief explanation for each rating, note whether it has changed since client entered treatment -why or why not)

# Case Presentation Format (cont.)

**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)