How The ASAM Criteria Promotes Whole Person Integrated Care: Principles, Practices and Policies

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A. Current Trends that Focus on Addiction as a Brain Disease

- New and emerging information about neurobiology, medication assisted treatment and recovery. Addiction affects neurotransmission and interactions within reward structures of the brain, including the nucleus accumbens, anterior cingulate cortex, basal forebrain and amygdala.
- Google - "Addiction as a Brain Disease": 24,500,00 results in 0.54 seconds (3/5/17)
- Google - "Addiction as a Biopsychosocial Disease": About 186,000 results in 0.48 seconds (3/5/17); and George Engel first introduced "biopsychosocial" in 1977 – 40 years ago.

1. Revamped definition of addiction - American Society of Addiction Medicine (ASAM)

- Short Definition begins: **"**Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry." (August 15, 2011)
- Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations.
- Pathologically pursuing reward and/or relief by substance use and other behaviors.
- A major thrust of the ASAM definition is that it is not the substances a person uses that causes addiction, nor is it even the quantity or frequency of use. It is about what happens in a person's brain when they are exposed to rewarding substances or rewarding behaviors.
- These substances and behaviors "turn on" the reward circuitry in the brain and related brain structures.

B. System Re-Design Priorities in the Context of Health Care Reform

- Whatever happens to the ACA that was fully enacted in 2014, health care reform continues
- Move from fee for service to capitation and shared risk
- Move from volume to value (quality and cost = value)
- Sick-care to health care to wellness and wellbeing
- Individual care to population management

C. Difficulty Changing Lifestyle and Behavior Drives a Sick-Care System and Costs

- Chronic disease treatment accounts for over 75% of national healthcare expenditures.
- Half of adults do not receive recommended preventive care and screening tests (guidelines for age and sex).
- On average, 50% of people with chronic diseases do not comply with their treatment plan.
- Individual lifestyle determines 50% of health status and 60-75% of health costs.

D. Getting back to "Biopsychosocial" - finding the balance between the "bio" and the "psychosocial"

- George Engel believed "that to understand and respond adequately to patient's suffering – and to give them a sense of being understood – clinicians must attend simultaneously to the biological, psychological, and social dimensions of illness." (Borrell-Carrió, Suchman, Epstein, 2004)
- Biopsychosocial model = a holistic alternative to the prevailing biomedical model that had dominated industrialized societies since the mid-20th century. (Engel, 1977)
- Engel championed his ideas both as a scientific proposal and a fundamental ideology that wished to bring more empathy and compassion; empowerment of patients and a more participatory clinician-patient relationship. (Borrell-Carrió, Suchman, Epstein, 2004)

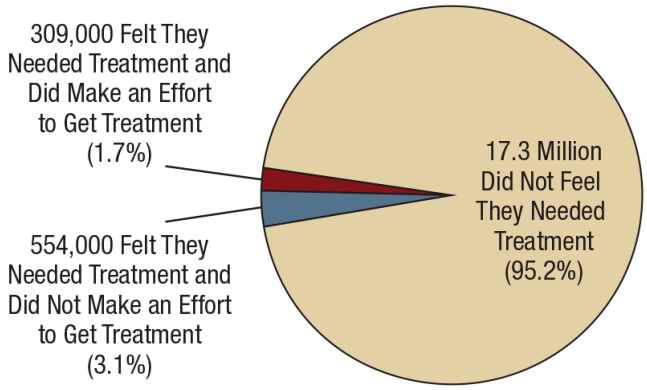
1. Biopsychosocial in Etiology, Clinical Presentation and Treatment

- Addiction is not just a brain disease. It is biopsychosocial in the etiology of addiction; the way addiction manifests itself and affects people and families; and in promoting treatment that is holistic and person-centered that touches the physical, mental, social and spiritual aspects clients.
- There are genetic and biochemical origins to addiction. But there are psychiatric and psychological underpinnings to addiction as well as public health principles that contribute to addiction e.g., the more available a drug and the lower the price, the more widespread are the health and social costs of addiction to those drugs.
- Who crosses the line into addictive illness depends on their own recipe of biopsychosocial factors. Some people can have little genetic predisposition and family history of addiction, but succumb to overwhelming psychosocial factors. Others can have a strong genetic predisposition, multiple family problems and role models for using substances as a way of living; live in a drug "ghetto" with drugs on every corner; and at 20 years old now has a 5-year history of heavy drug problems.
- A holistic, multidimensional perspective in understanding and treating addiction. The American Society of Addiction Medicine's (ASAM) Criteria describes six assessment dimensions that are holistic, biopsychosocial and multidimensional.

2. A Broader Perspective on Substance Use Problems and Addiction Illness

The people who actually get to specific addiction treatment program are a tiny sliver of the estimated 18.91million people 18 years old and above needing, but not receiving addiction treatment.The huge unmet need for addiction treatment. The latest results of the 2015 National Survey on Drug Use and Health were released in September 2016. https://nsduhweb.rti.org/respweb/homepage.cfm

Figure 14. Perceived Need for Substance Use Treatment among Adults Aged 18 or Older Who Needed Substance Use Treatment but Did Not Receive Substance Use Treatment in the Past Year: 2015



18.1 Million Adults Needed but Did Not Receive Substance Use Treatment

- Most people getting antidepressants for depression get them from primary care physicians because that's where those with depression often are. Same is true for where people with substance use problems and addiction are.

- Impacting addiction will need much more partnership with primary care and health systems, not just behavioral health integration.

So what to make of these data? Here are some challenges to ponder:

- How will addiction treatment agencies increase access to care when we already have waiting lists and can't even meet treatment-on-demand now for the 1.7% of people who did make an effort to get addiction treatment?

- 17.3 million people did not receive addiction treatment and were either not screened and diagnosed and/or if told, did not agree with the diagnosis of addiction so did not seek help. How will we ever reach these reluctant "customers" for addiction treatment when we already have big caseloads in specialty programs and find time and resources to reach out to general healthcare where the vast majority of people with addiction really are?

- What can addiction treatment professionals do to increase access to affordable care; reach out to general and mental health care systems to help identify and attract into recovery people who are now not treated; and collaborate with Medical and Health Homes and accountable care organizations (ACO)? ACOs, hospitals and clinics are increasingly being held accountable to focus on outcomes and become truly "health care" rather than "sick care" organizations.

System Re-Design Priorities:

- Eliminate or significantly reduce waiting lists and increase access to care.
- Utilize a broad continuum of care from screening and brief intervention, referral to treatment (SBIRT) to easy linkage to a seamless array of services designed for chronic disease management.
- Bring treatment to the people and link not refer:

One Study to Bring Addiction Treatment Where People are At

"Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence
A Randomized Clinical Trial" Gail D'Onofrio,MD, MS; Patrick G. O'Connor,MD, MPH; Michael V. Pantalon, PhD; et al. *JAMA*. 2015;313(16):1636-1644. doi:10.1001/jama.2015.3474

IMPORTANCE Opioid-dependent patients often use the emergency department (ED) for medical care.

OBJECTIVE To test the efficacy of 3 interventions for opioid dependence: (1) screening and referral to treatment (referral); (2) screening, brief intervention, and facilitated referral to community-based treatment services (brief intervention); and (3) screening, brief intervention, ED-initiated treatment with buprenorphine/naloxone, and referral to primary care for 10-week follow-up (buprenorphine).

DESIGN, SETTING, AND PARTICIPANTS A randomized clinical trial involving 329 opioid-dependent patients treated at an urban teaching hospital ED from April 7, 2009 - June 25, 2013.

INTERVENTIONS After screening, 104 patients were randomized to the referral group, 111 to the brief intervention group, and 114 to the buprenorphine treatment group.

MAIN OUTCOMES AND MEASURES Enrollment in and receiving addiction treatment 30 days after randomization was the primary outcome. Self-reported days of illicit opioid use, urine testing for illicit opioids, human immunodeficiency virus (HIV) risk, and use of addiction treatment services were the secondary outcomes.

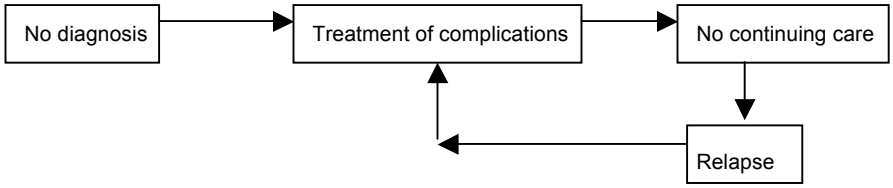
CONCLUSIONS and RELEVANCE Among opioid-dependent patients, ED-initiated buprenorphine treatment vs brief intervention and referral significantly increased engagement in addiction treatment, reduced self-reported illicit opioid use, and decreased use of inpatient addiction treatment services but did not significantly decrease the rates of urine samples that tested positive for opioids or of HIV risk.

E. **Underlying Principles and Concepts of the ASAM Criteria**

1. Generations of Clinical Care

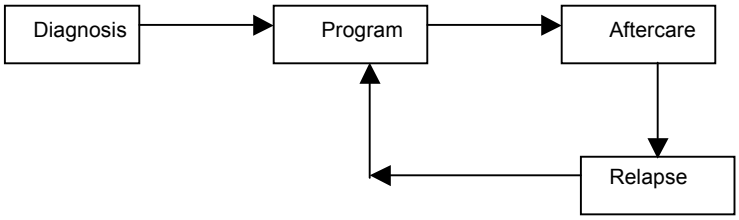
(a) Complications-driven Treatment

- No diagnosis of Substance Use Disorder
- Treatment of complications of addiction with no continuing care
- Relapse triggers treatment of complications only

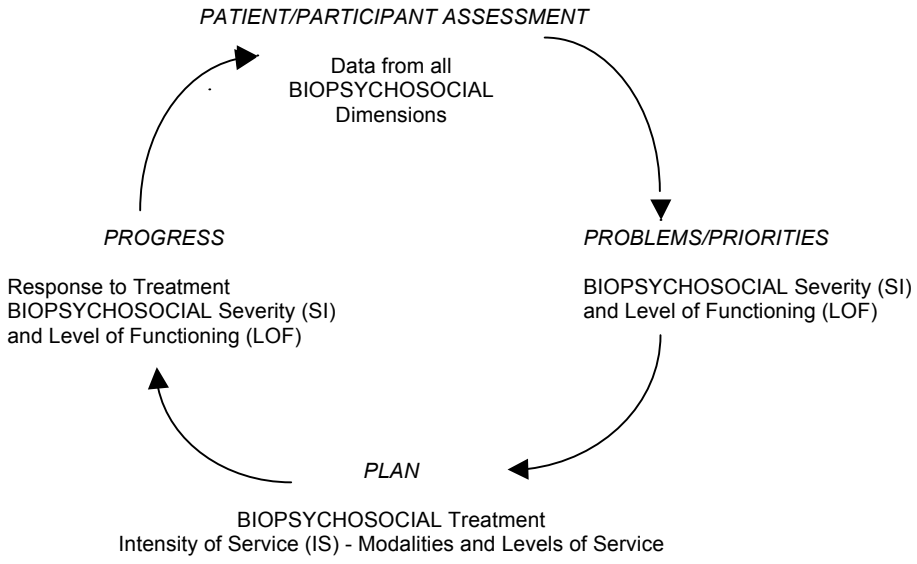


(b) Diagnosis, Program-driven Treatment

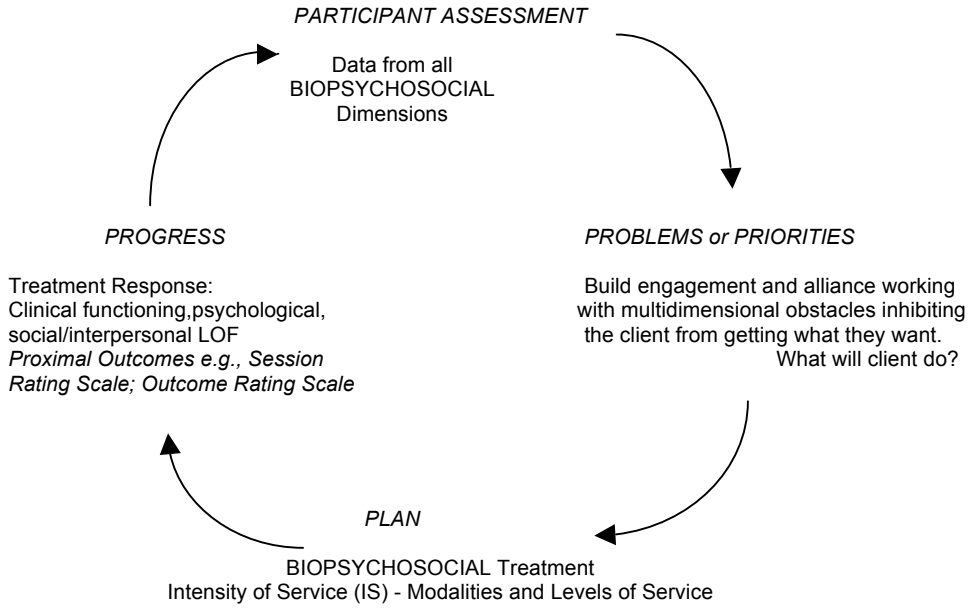
- Diagnosis determines treatment
- Treatment is the primary program and aftercare
- Relapse triggers a repeat of the program



(c) Individualized, Clinically-driven Treatment



(d) Feedback-Informed, Measurement-based Treatment



2. Assessment of Biopsychosocial Severity and Function *(The ASAM Criteria* 2013, pp 43-53)

The common language of six ASAM Criteria dimensions determine needs/strengths in behavioral health services:

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

Assessment Dimensions	Assessment and Treatment Planning Focus
1. Acute Intoxication and/or Withdrawal Potential	Assessment for intoxication and/or withdrawal management. Withdrawal management in a variety of levels of care and preparation for continued addiction services
2. Biomedical Conditions and Complications	Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services
3. Emotional, Behavioral or Cognitive Conditions and Complications	Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services
4. Readiness to Change	Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change
5. Relapse, Continued Use or Continued Problem Potential	Assess readiness for relapse prevention services and teach where appropriate. If still at early stages of change, focus on raising consciousness of consequences of continued use or problems with motivational strategies.
6. Recovery Environment	Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services

3. Biopsychosocial Treatment - Overview: 5 M's
    * Motivate - Dimension 4 issues; engagement and alliance building
    * Manage - the family, significant others, work/school, legal
    * Medication – withdrawal management; HIV/AIDS; MAT - anti-craving anti-addiction meds; disulfiram, methadone; buprenorphine, naltrexone, acamprosate, psychotropic medication
    * Meetings - AA, NA, Al-Anon; SMART Recovery, Dual Recovery Anonymous, etc.
    * Monitor - continuity of care; relapse prevention; family and significant others

4. Treatment Levels of Service *(The ASAM Criteria* 2013, pp 106-107)
    1 Outpatient Services
    2 Intensive Outpatient/Partial Hospitalization Services
    3 Residential/Inpatient Services
    4 Medically-Managed Intensive Inpatient Services

ASAM Criteria Level of Withdrawal Management Services for Adults	Level	Note: There are no separate Withdrawal Management Services for Adolescents
Ambulatory Withdrawal Management without Extended On-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery
Ambulatory Withdrawal Management with Extended On-Site Monitoring	2-WM	Moderate withdrawal with all day WM support and supervision; at night, has supportive family or living situation; likely to complete WM.
Clinically-Managed Residential Withdrawal Management	3.2-WM	Moderate withdrawal, but needs 24-hour support to complete WM and increase likelihood of continuing treatment or recovery
Medically-Monitored Inpatient Withdrawal Management	3.7-WM	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete WM without medical, nursing monitoring
Medically-Managed Inpatient Withdrawal Management	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify WM regimen and manage medical instability
ASAM Criteria Levels of Care	Level	Same Levels of Care for Adolescents except Level 3.3
Early Intervention	0.5	Assessment and education for at risk individuals who do not meet diagnostic criteria for Substance-Related Disorder
Outpatient Services	1	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/ strategies
Intensive Outpatient	2.1	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability
Partial Hospitalization	2.5	20 or more hours of service/week for multidimensional instability not requiring 24 hour care
Clinically-Managed Low-Intensity Residential	3.1	24 hour structure with available trained personnel; at least 5 hours of clinical service/week
Clinically Managed Population-Specific High-Intensity Residential Services (Adult criteria only)	3.3	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	3.5	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	3.7	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	4	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 Treatment Services	OTS	Opioid Treatment Program (OTP) – agonist meds: methadone, buprenorphine; Office Based Opioid Treatment (OBOT); antagonist medication – naltrexone

F. **Co-occurring Disorders or Conditions** *(The ASAM Criteria* 2013*,* pp 22-30)

For the sake of consistency with national trends, *The ASAM Criteria* has adopted the term "co-occurring mental health and substance-related conditions and disorders". Throughout the text, the term "co-occurring disorders or conditions" refers to mental health and substance related conditions, unless specifically otherwise stated. A more extensive discussion related to co-occurring disorders or conditions, including expanded definitions for terms such as "Co-Occurring Capability," "Co-Occurring Enhanced," and "Complexity Capability."

1. Co-Occurring Capable (COC) Programs
    - Co-Occurring Capable (COC) programs routinely accept individuals who have co-occurring mental and substance-related disorders.
    - COC 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; and vice versa
    - COC programs address co-occurring disorders in their policies and procedures, assessment, treatment planning, program content, and discharge planning.
    - They have arrangements in place for coordination and collaboration between chemical and mental health services.
    - They also can provide addiction consultation, psychopharmacologic monitoring and psychological assessment and consultation on site; or by well-coordinated consultation off-site.

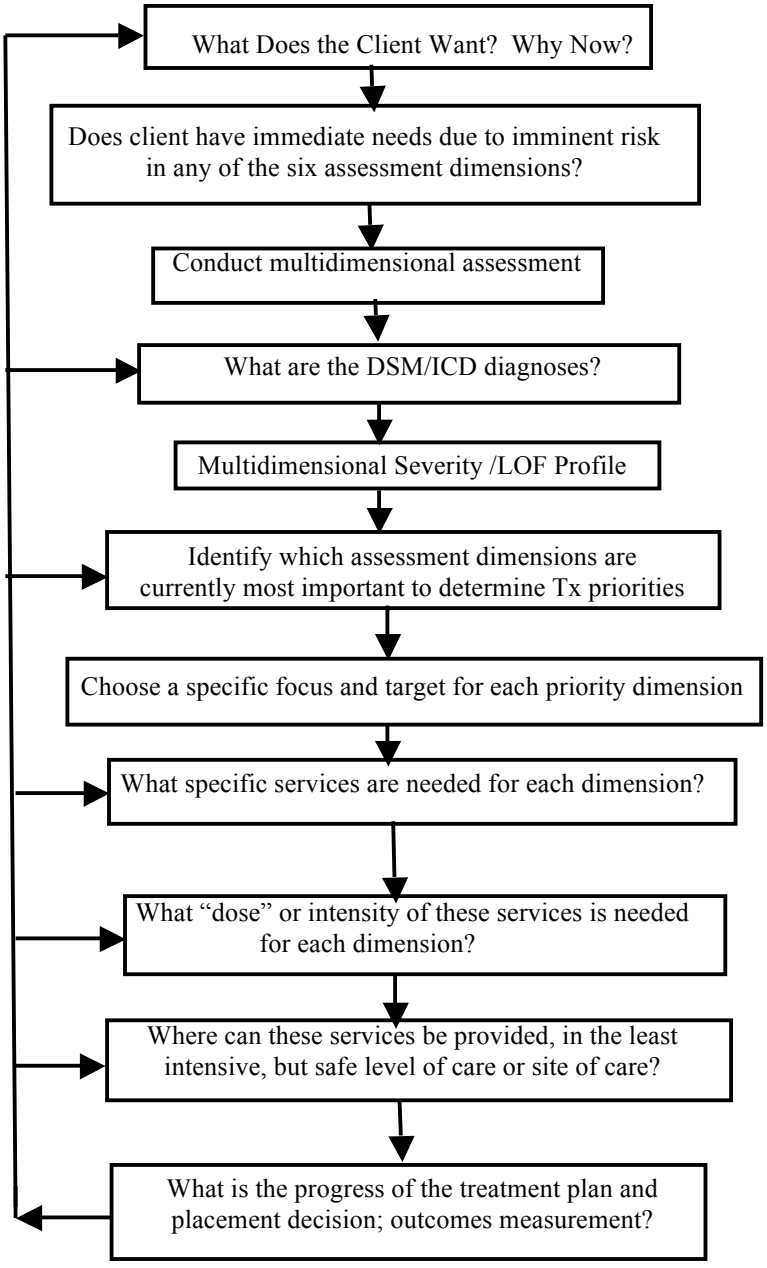
2. Co-Occurring Enhanced (COE) Programs
    - COE programs can accommodate individuals with co-occurring disorders who may be unstable or disabled to such an extent that specific psychiatric and mental health support, monitoring and accommodation are necessary in order for the individual to participate in addiction treatment.
    - COE 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.
    - COE programs typically have policies, procedures, assessment, treatment planning and discharge planning that accommodate patients with co-occurring disorders.
    - Co-Occurring disorder-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.

3. Complexity Capable (CC) Programs
    - CC programs can accommodate individuals with multiple co-occurring needs such as general medical issues e.g., HIV and other infectious diseases, legal issues, trauma issues, housing, parenting educational, vocational and cognitive/learning issues.
    - CC programs are staffed by psychiatric and mental health clinicians as well as addiction treatment professionals; care managers; peer specialists; and staff that can address culturally and linguistically diverse people.
    - CC programs organize everything done at every level of care to focus scarce resources on the complex needs of the people and families seeking help.
    - Patient Centered Health Care Homes have been conceptualized to recognize multidimensional, biopsychosocial needs of patients; and to address the complex needs of patients and families.
    - Some systems have begun to use terminology of "complexity capable" to reflect this broader perspective; and likely in the future to replace "co-occurring capable."

G. **Applying The ASAM Criteria to Rethink Design and Delivery of Services**

1. Developing the Treatment Contract *(The ASAM Criteria* 2013, page 58)

WHAT does the client want?
WHY now?
HOW – Does the client know how to get what s/he wants; what is their plan?
WHERE do they want to do treatment? What level of care? Groups or individual?
WHEN do they want treatment? Now? Soon? Ambivalent?



(The ASAM Criteria 2013, p 124)

2. Relapse/Continued Use/Continued Problem Potential - Dimension 5 *(The ASAM Criteria* 2013, pp 401-410)

A. Historical Pattern of Use

1. Chronicity of Problem Use

- Since when and how long has the individual had problem use or dependence and at what level of severity?

2. Treatment or Change Response

- Has he/she managed brief or extended abstinence or reduction in the past?

B. Pharmacologic Responsivity

3. Positive Reinforcement (pleasure, euphoria)
4. Negative Reinforcement (withdrawal discomfort, fear)

C. External Stimuli Responsivity

5. Reactivity to Acute Cues (trigger objects and situations)
6. Reactivity to Chronic Stress (positive and negative stressors)

D. Cognitive and behavioral measures of strengths and weaknesses

7. Locus of Control and Self-efficacy

- Is there an internal sense of self-determination and confidence that the individual can direct his/her own behavioral change?

8. Coping Skills (including stimulus control, other cognitive strategies)
9. Impulsivity (risk-taking, thrill-seeking)
10. Passive and passive/aggressive behavior

- Does individual demonstrate active efforts to anticipate and cope with internal and external stressors, or is there a tendency to leave or assign responsibility to others?

Example Policy and Procedure to Deal with Dimension 5 Recovery/Psychosocial Crises

Recovery and Psychosocial Crises cover a variety of situations that can arise while a patient is in treatment. Examples include, but are not limited to, the following:

1. Slip/ using alcohol or other drugs while in treatment.
2. Suicidal, and the individual is feeling impulsive or wanting to use alcohol or other drugs.
3. Loss or death, disrupting recovery and precipitating cravings to use or other impulsive behavior.
4. Disagreements, anger, frustration with fellow patients or therapist.

The following procedures provide steps to assist in implementing the principle of re-assessment and modification of the treatment plan:

1. Set up a face-to-face appointment as soon as possible. If not possible in a timely fashion, follow the next steps via telephone.

2. Convey an attitude of acceptance; listen and seek to understand the patient's point of view rather than lecture, enforce "program rules," or dismiss the patient's perspective.

3. Assess the patient's safety for intoxication/withdrawal and imminent risk of impulsive behavior and harm to self, others, or property. Use the six ASAM assessment dimensions to screen for severe problems and identify new issues in all biopsychosocial areas.

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

4. If no immediate needs, discuss the circumstances surrounding the crisis, developing a sequence of events and precipitants leading up to the crisis. If the crisis is a slip, use the 6 dimensions as a guide to assess causes. If the crisis appears to be willful, defiant, non-adherence with the treatment plan, explore the patient's understanding of the treatment plan, level of agreement on the strategies in the treatment plan, and reasons s/he did not follow through.

5. Modify the treatment plan with patient input to address any new or updated problems that arose from your multidimensional assessment in steps 3 and 4 above.

6. Reassess the treatment contract and what the patient wants out of treatment, if there appears to be a lack of interest in developing a modified treatment plan in step 5 above. If it becomes clear that the patient is mandated and "doing time" rather than "doing treatment and change," explore what Dimension 4, Readiness to Change motivational strategies may be effective in re-engaging the patient into treatment.

7. Determine if the modified strategies can be accomplished in the current level of care, or a more or less intensive level of care in the continuum of services or different services such as Co-Occurring Disorder Enhanced services.. The level of care decision is based on the individualized treatment plan needs, not an automatic increase in the intensity of level of care.

8. If, on completion of step 6, the patient recognizes the problem/s, and understands the need to change the treatment plan to learn and apply new strategies to deal with the newly-identified issues, but still chooses not to accept treatment, then discharge is appropriate, as he or she has chosen not to improve his/her treatment in a positive direction. Such a patient may also demonstrate his/her lack of interest in treatment by bringing alcohol or other drugs into the treatment milieu and encouraging others to use or engage in gambling behavior while in treatment. If such behavior is a willful disruption to the treatment milieu and not overwhelming Dimension 5 issues to be assessed and treated, then discharge or criminal justice graduated sanctions are appropriate to promote a recovery environment.

9. If, however, the patient is invested in treatment as evidenced by collaboration to change his/her treatment plan in a positive direction, treatment should continue. To discharge or suspend a patient for an acute reoccurrence of signs and symptoms breaks continuity of care at precisely a crisis time when the patient needs support to continue treatment. For example, if the patient is not acutely intoxicated and has alcohol on his/her breath from a couple of beers, such an individual may come to group to explore what went wrong to cause a recurrence of use and to gain support and direction to change his/her treatment plan. Concerns about "triggering" others in the group are handled no differently from if a patient was sharing trauma issues, sobbing and this triggered identification and tearfulness in other group members. Such a patient with Posttraumatic Stress Disorder would not be excluded from group or asked to leave for triggering others. Group members and/or other patients in a residential setting are best helped to deal with such "triggering" with the support of peers and a trained clinician. To protect fellow patients from exposure to relapse or recurrence of signs and symptoms excludes the opportunity to learn new coping skills, In addition, it jeopardizes the safety of the patient at the very time he or she needs more support and guidance in such a crisis, rather than rejection, discharge, or transfer.

10. Document the crisis and modified treatment plan or discharge in the medical record.

3. Definitions of Compliance and Adherence

Webster's Dictionary defines "**comply**" as follows: to act in accordance with another's wishes, or with rules and regulations. It defines "**adhere**": to cling, cleave (to be steadfast, hold fast), stick fast.

4. The Coerced Client and Working with Referral Sources

The mandated client is at "action" for staying out of jail; keeping their driver's license; saving their job or marriage; or getting their children back, not for recovery. In working with referral agencies whether that be a judge, probation officer, child protective services, a spouse, employer or employee assistance professional, the goal is to use the leverage of the referral source to hold the client accountable to an assessment and follow through with the treatment plan.

Unfortunately, clinicians/programs often enable criminal justice thinking by blurring the boundaries between "doing time" and "doing treatment". For everyone involved with mandated clients, the 3 C's are:

- Consequences – It is within criminal justice's mission to ensure that offenders take the consequences of their illegal behavior. If the court agrees that the behavior was largely caused by addiction and/or mental illness, and that the offender and the public is best served by providing treatment rather than punishment, then clinicians provide treatment not custody and incarceration. The obligation of clinicians is to ensure a person adheres to treatment; not to enforce consequences and compliance with court orders.

- Compliance – The offender is required to act in accordance with the court's orders; rules and regulations. Criminal justice personnel should expect compliance. But clinicians are providing treatment where the focus is not on compliance to court orders. The focus is on whether there is a disorder needing treatment; and if there is, the expectation is for adherence to treatment, not compliance with "doing time" in a treatment place.

- Control –The criminal justice system aims to control, if not eliminate, illegal acts that threaten the public. While control is appropriate for the courts, clinicians and treatment programs are focused on collaborative treatment and attracting people into recovery. The only time clinicians are required to control a client is if they are in imminent danger of harm to self or others. Otherwise, as soon as that imminent danger is stabilized, treatment resumes collaboration and client empowerment, not consequences, compliance and control.

The clinician should be the one to decide on what is clinically indicated rather than feeling disempowered to determine the level of service, type of service and length of service based on the assessment of the client and his/her stage of readiness to change. Clinicians are just that, not right arms of the law or the workplace to carry out mandates determined for reasons other than clinical.

Thus, working with referral sources and engaging the identified client into treatment involves all of the principles/concepts to meet both the referral source and the client wherever they are at; to join them in a common purpose relevant to their particular needs and reason for presenting for care. The issues span the following:

- Common purpose and mission – public safety; safety for children; similar outcome goals
- Common language of assessment of stage of change – models of stages of change
- Consensus philosophy of addressing readiness to change – meeting clients where they are at; solution-focused; motivational enhancement
- Consensus on how to combine resources and leverage to effect change, responsibility and accountability – coordinated efforts to create and provide incentives and supports for change
- Communication and conflict resolution - committed to common goals of public safety; responsibility, accountability, decreased legal recidivism and lasting change ; keep our collective eyes on the prize "No one succeeds unless we all succeed!"

H. **The ASAM Criteria Software Decision Engine - CONTINUUM™**

- *The ASAM Criteria* book and *The ASAM Criteria Software* now branded as *Continuum*™ are companion text and application
- The text delineates the dimensions, levels of care, and decision rules that comprise *The ASAM Criteria*
- The software provides an approved structured interview to guide adult assessment and calculate the complex decision tree to yield suggested levels of care, which are verified through the text
- www.asamcontinuum.org; Brendan McEntee at ASAM: bmcentee@asam.org
- David Gastfriend, M.D., Chief Architect of The ASAM Criteria Software: gastfriend@gmail.com

continuum™
THE ASAM CRITERIA DECISION ENGINE
American Society of Addiction Medicine

I. Gathering Data on Policy and Payment Barriers *(The ASAM Criteria* 2013*,* p 126)

- Policy, payment and systems issues cannot change quickly. However, as a first step towards reframing frustrating situations into systems change, each incident of inefficient or in adequate meeting of a client's needs can be a data point that sets the foundation for strategic planning and change.

- Finding efficient ways to gather data as it happens in daily care can provide hope and direction for change.

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; and/or the service needed e.g., shelter, housing, vocational training, transportation, language interpreter	
Level of Care/Service Received - ASAM Level number -- If the most appropriate level or service is not utilized, insert the most appropriate placement or service available and circle the Reason for Difference between Indicated and Received Level or Service	
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 (Specify):	
Anticipated Outcome If Service Cannot Be Provided – Circle only one number - 1. Admitted to acute care setting; 2. Discharged to street; 3. Continued stay in acute care facility; 4. Incarcerated; 5. Client will dropout until next crisis; 6. Not listed (Specify):	

LITERATURE REFERENCES AND RESOURCES

"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.haworthpress.com)

D'Onofrio G, O'Connor, PG, Pantalon MV et al (2015): "Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence - A Randomized Clinical Trial" *JAMA*. 2015;313(16):1636-1644.

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