Addiction Assessment and the ASAM Patient Placement Criteria

Paul H. Earley, M.D., FASAM
Medical Director, Talbott Recovery
Atlanta, Georgia
USA

George Kolodner, M.D.
Chair, Steering Committee of the Coalition for National Clinical Criteria

Talk Outline

- Diagnostic Assessment versus Assessment of Treatment Needs
- The complexities of implementing assessments with addictive disorders
- Patient Placement Criteria (PPC) History
- The basic principles of the PPC-2R
- Download this talk at: www.paulearley.net go to menu item: Download / Presentation Handouts

Assessments

- Diagnostic
  - CAGE
  - DSM Checklist
  - AUDIT
  - MAST or BMAST (DAST for drugs)
  - Time Line Follow Back
  - Clinical Interview

Assessments

- Treatment Needs and Planning
  - Addiction Severity Index (ASI)
  - Time Line Follow Back
  - PPC-2R
  - DAPPER (Evince)
  - Recovery Support Services Questionnaire

CAGE Questionnaire (Alcohol)

1. Have you ever felt you should ***cut*** down on your drinking?
2. Have people ***annoyed*** you by criticizing your drinking?
3. Have you ever felt bad or ***guilty*** about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (***eye-***opener)?

DSM-IV Checklist

- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
  - Markedly diminished effect with continued use of the same amount of alcohol.
- Withdrawal, as defined by either of the following:
  - The characteristic withdrawal syndrome for alcohol (refer to DSM-IV for further details).
  - Alcohol is taken to relieve or avoid withdrawal symptoms.
- Alcohol is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or there are unsuccessful efforts to cut down or control alcohol use.
- A great deal of time is spent in activities necessary to obtain alcohol, use alcohol or recover from its effects.
- Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
- Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the alcohol (e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

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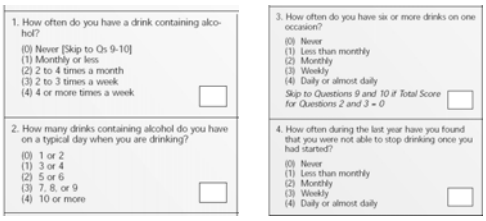
AUDIT

- Alcohol only
- Can be self-administered or by interview
- 10 items administered in 5 minutes



Michigan Alcoholism Screening Test (MAST)

- One of the oldest assessments for alcoholism
- Twenty-two self report items
- Provides year long review of alcohol related difficulties
- Accurate test will come from an honest self report.
- A derivative questionnaire is the Drug Abuse Screening Test (DAST)

Addiction Severity Index

- Best studied and validated addiction evaluation tool.
- Developed by Tom McLellan, PhD and the Treatment Research Institute
- Used worldwide, translated into many languages
- By assessing impairment in work, social, medical, family functioning provides a data that can be used for treatment planning.
- http://www.tresearch.org/ASI.htm

Problems with Assessment Tools

- Major difficulty comes from “denial” – a defense mechanism used for many maladies, but especially prominent in addictive diseases.
- In addiction treatment, “denial” is a defined slightly differently than in the psychiatric literature:
  - Includes repression and minimization (commonly)
  - Includes dissociative drug use, use in blackouts (somewhat less commonly)
  - A continuum between unconscious and intentional deception is part of addiction-related denial

The Clinical Interview

- The clinical interview by a seasoned clinician remains superior to standardized instruments.
- Techniques to increase accuracy of interview:
  - Motivational interviewing
  - Syntax analysis of patients response
  - Deception analysis using body cues
  - Discussion of future body fluid analysis

Expanded Evaluation

- Collateral data collection from family, work, friends
- Body fluid analysis
  - Urine (including EtG)
  - PEth
  - Hair testing
- Polygraph analysis

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ASAM Patient Placement Criteria
Second Edition, Revised
PPC-2R

The Addiction Treatment Dilemma

- In the US, treatment outcome has not been studied and is poorly defined; this has promulgated skepticism and pessimism about the field.
- Such a scenario existed in the field of cancer treatment 30 years ago, the skepticism and pessimism about cancer treatment has changed; so can addiction treatment.

Unanswered Questions about Addiction

- What defines addiction severity (how do you stage the illness)?
- What are the non-addiction factors that contribute to the disease, modify the treatment and affect the outcome?
- What is treatment anyway?
- What defines a good outcome or a bad outcome?

Addiction treatment needs to match the qualities of the patient's disease

- Need to match intensity of treatment to intensity of disease.
- Need to differentiate and match types of using a given patient's:
  - Biomedical complications
  - Emotional and Psychiatric complications
  - Environmental factors
  - Motivational status

How do we Quantify Treatment?

- Treatment is quantified by:
  - Types of treatment moieties
  - Intensity of treatment
  - Duration of treatment
- Quantification needs are difficult to determine without computerized assessment, rich but standardized treatment protocols and outcome measures.

ASAM PPC History

1987 - Northern Ohio Chemical Dependency Treatment Directors Association utilized a team of consultants to develop "The Cleveland Criteria."

1990 - The National Association of Addiction Treatment Providers (NAATP) utilizing all existing sets of criteria available, implemented in 210 public and private treatment facilities to measure impact on outcomes.

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ASAM PPC History

1991 - NAATP & ASAM Collaboration: Recruited a representative group of addiction experts to develop adult and adolescent criteria that resulted in the ASAM PPC.

1996 - Coalition for National Clinical Criteria (ASAM PPC-2) ASAM expanded the PPC to additional levels of care, and a deepened its breadth of assessment.

ASAM PPC History

2001 - ASAM expanded the PPC to include dual diagnosis issues and new treatment types, resulting in the ASAM PPC-2R (revised). The PPC-2R uses DSM-IV terminology.

ASAM PPC History

2004 – Development of the PPC-2R Assessment Software for Research in a collaborative effort between ASAM, the Massachusetts General Hospital's Addiction Research Program, and private industry

2008 – The standard for determining level of care in most states in the United States. The PPC-R is the subject of international research.

2010: PPC Supplement on Pharmacotherapies for Alcohol Use Disorders

Additional history available at: http://paulearley.net/ASAM-PPC-Articles/ppc-history.html

Coalition Member Organizations

- ASAM (8 members)
- AAAP
- Department of Defense
- Managed Behavioral Healthcare
- NAADAC
- NAATP
- NASADAD
- NCADD
- Veterans Administration

The ASAM PPC

- An expert consensus document that looks at the spectrum of the disease and maps it to a spectrum of care.
- Criteria for Adults and Adolescents
- Begins the process of "Unbundling" treatment
- At times complicated to implement, but the core concept is excellent.

The ASAM PPC

- One good way of visualizing the PPC from 20,000 feet is that it places the illness and treatment on a matrix grid:
  - Treatment types are placed along the X-axis
  - The characteristics of the disease are placed along the Y-axis

Addiction Assessment and the ASAM PPC-2R

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The ASAM PPC – Disease Axis

Dimension 1: Acute Intoxication and/or Withdrawal Potential

Dimension 2: Biomedical Conditions / Complications

Dimension 3: Emotional, Behavioral or Cognitive Conditions / Complications

Dimension 4: Readiness to Change

Dimension 5: Relapse, Continued Use or Continued Problem Potential

Dimension 6: Recovery/Living Environment

The ASAM PPC – Treatment Axis

Describes treatment as a ***continuum*** marked by five basic levels of care:

Level 0.5 - Early Intervention
Level I - Outpatient Treatment
Level II - Organized Outpatient
Level III - Residential Services
Level IV - Inpatient Treatment

The ASAM PPC – Treatment Axis

Roman numerals and decimals (.1 to .9) provide a nomenclature for describing the continuum of addiction services. The higher the number, the greater the intensity of service within that Level of Care.

Level 0.5 Early Intervention
Level I Outpatient Treatment
Level II.1 Intensive Outpatient
Level II.5 Partial Hospitalization
Level III.1 Clinically Managed Low Intensity Residential Services
Level III.3 Clinically Managed Medium Intensity Residential Treatment
Level III.5 Clinically Managed High Intensity Residential Treatment
Level III.7 Medically Monitored Intensive Inpatient Treatment
Level IV Medically Managed Intensive Inpatient Treatment

The ASAM PPC – Treatment Axis

- Within the treatment axis, sub-specifiers exist that delineate concomitant medical treatment and detoxification. These sub-specifiers include:
  - D – Detoxification
  - OMT – The program provides Opioid Maintenance Treatment
  - BIO – Capable of managing complex medical comorbidity

The ASAM PPC – Treatment Axis

- Within the treatment axis, additional sub-specifiers exist that delineate the centers ability or the patient's need for psychiatric comorbidity. These sub-specifiers include:
  - AOD – Alcohol or Drug treatment only
  - DDC – Dual diagnosis capable (able to identify dual diagnosis problems. Capable of referral to outside provider if psychiatric comorbidity is identified as problematic in treatment
  - DDE – Dual Diagnosis Enhanced capable on-site of managing patients who have addiction and current confounding psychiatric

Quick Test

- You are told by your counselor that a new patient needs initial care in a a Level IV-D followed by a II.5-DDE
- What are the needs of this patient?
- What kind of care did he obtain?

Addiction Assessment and the ASAM PPC-2R

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The PPC-2R Matrix

	Levels of Care								
	0.5	I	II.1	II.5	III.1	III.3	III.5	III.7	IV
Dimension 1									
Dimension 2									
Dimension 3									
Dimension 4									
Dimension 5									
Dimension 6									

Dimension 1: Detoxification/Withdrawal Potential

- What risk is associated with the patient's current level of acute intoxication?
- Serious risk of severe withdrawal symptoms or seizures based on previous history?
- Recent discontinuation or significant increase or reduction of alcohol/drug use?
- Does the patient have responsible supports to assist in ambulatory detoxification if medically safe?
- "The best predictor of current and future withdrawal problems, are past withdrawal problems!"

Dimension 2: Medical Conditions & Complications

- 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)?
- Are there chronic conditions that affect treatment, (e.g. chronic pain treated with analgesics)?

Evaluate for the following:

1. Conditions that place the patient at risk (e.g. seizure disorder).
2. Conditions that interfere with treatment (e.g., the need for kidney dialysis).

Dimension 3: Emotional / Behavioral / Cognitive Conditions & Complications

- Current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed or which complicate treatment?
- Chronic conditions that affect treatment? (chronic schizophrenia, affective or personality disorder problems, developmental, aging, or other problems with cognitive efficiency)
- Do any of these problems appear to be an expected part of addiction illness or are they separate?
- If connected to addiction are they severe enough to warrant specific mental health treatment?
- If the patient is suicidal, what is the lethality? Weapon? Plan?

Dimension 4: Readiness For Change

- Does the patient feel coerced into treatment or actively object to receiving treatment?
- At what "Stage of Change" would you currently assess them to be? (Pre-contemplation, Contemplation, Planning, Action, etc.)
- If willing to accept treatment, how strongly does the patient disagree with others' perception that s/he has an addiction problem?
- Is the patient compliant to avoid a negative consequence (external motivation) or internally distressed in a self-motivated way about their substance use/abuse?

STAGES OF CHANGE MODEL

1. **PRECONTEMPLATION** – not yet considering possibility of change, active resistance to change, seldom appear for change without coercion.
2. **CONTEMPLATION** – ambivalent, undecided, vacillating between whether the need exists for change or not, wants to change but also resists the changes needed.
3. **PREPARATION** – takes client from decisions made in contemplation to the steps needed to change. Increasing confidence in the decisions needed for change.
4. **ACTION** – specific actions intended to bring about change, overt modification of behavior and environment. Support/encouragement is essential at this stage to prevent dropout & regression.
5. **MAINTENANCE** – Sustaining the changes begun. Consolidate gains, learn alternative coping & problem-solving strategies, recognize emotional triggers for relapse.
6. **RELAPSE & RECYCLING** – Possible but not inevitable setbacks. Avoid becoming stuck and learn from mistakes to determine new cycle of change.
7. **TERMINATION** – Ultimate stage for all changers, person exits cycle of change without fear of relapse. Some problems terminated while others are kept in remission through ongoing maintenance efforts.

(Prochaska, Norcross & DiClemente, 1994)

Dimension 5: Relapse, Continued Use or Continued Problem Potential

- Is the patient in immediate danger of continued severe distress and drinking/drugging behavior?
- Does the patient have any recognition & understanding of, and skills for how to cope with his/her addiction problems and prevent relapse or continued use?
- What severity of problems and further distress will potentially continue or reappear, if the patient is not successfully engaged in treatment at this time?
- What is the pt's ability to remain abstinent based on history? Do they have any awareness of relapse triggers?
- What is the current level of craving and how successfully can they cope with this?

Dimension 6: Recovery Environment

- Are there dangerous family, peers, school, or work conditions threatening treatment engagement and success?
- Does the patient have supportive friendships, financial, educational, or vocational resources to improve the likelihood of successful treatment?
- Are there barriers to accessing treatment such as transportation or childcare responsibilities?
- Are there vocational, social service agency or criminal justice mandates that may enhance motivation (external) for engagement into treatment?

Risk Assessment Matrix

- Introduced in Appendix to PPC-2R
- Expanded in 2010 Supplement on Alcohol Pharmacotherapies

Risk Assessment Process

- Assign numerical risk rating for each dimension
  - 0: None
  - 1: Mild
  - 2: Moderate
  - 3: Significant
  - 4: Severe
  - Adjust risk for interaction between dimensions
- Determine type and modality of services needed
- Determine appropriate level of care
- Reassess as treatment proceeds

Case Example

- 43 year old plumber, mildly elevated LFTs
- Hypertension
- Previous quit attempts, no treatment, negative AA experience
- Morning drinking, 1/5 vodka daily, past history of seizure
- BAL = 0.12%, mild-moderate tremor, 150/100, P=92, afebrile, mild depression, (CIWA=16)
- Supportive wife

Case Example Risk Matrix

Dimension	RR-0 None	RR-1 Mild	RR-2 Moderate	RR-3 Significant	RR-4 Severe
1. Intoxication & Withdrawal				X	
2. Biomedical		X			
3. Emotional, Behavioral & Cognitive		X			
4. Readiness to Change			X		
5. Relapse Potential				X	
6. Recovery Environment		X			

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What does the PPC-2R do?

- Provides a multidimensional assessment model to assign the appropriate level of service and level of care.
- Helps the clinician make decisions about continued service or discharge by ongoing assessment and review of progress.
- Increases the relevance of treatment planning and documentation.

Education and Consultation

- Contact:
  - Web site: www.paulearley.net
  - Email paul.earley@uhsinc.com
  - Phone: 678 251 3188