ASAM Criteria

American Society of Addiction Medicine
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ASAM meanings...

Association for Solidarity with Asylum Seekers and Migrants....Aviation Safety Action Message...Advanced Software Acquisition Management...Association for Standardization of Automation and Measuring Systems....Advanced Surface - to Air Missile....

American Society of Addiction Medicine (ASAM) History

1950 Percodan, a combination of oxycodone and aspirin, is released to American physicians for prescription

1951: New York City Medical Committee on Alcoholism established. (Under NCA; Marty Mann, Ruth Fox collaboration).

First jet passenger trip, October 10, Joseph Stalin accuses Soviet Union of having atomic bomb

1954: New York City Medical Society on Alcoholism's (NYCMSA) first scientific meeting, September 16, 1954 at New York Academy of Medicine) ***First mass inoculation of polio (Pittsburgh) with Salk vaccine***

1986 Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals participating in Medicare to screen and stabilize all persons who use their emergency rooms regardless of ability to pay.

1988 (A-88): ASAM is approved and accepted into membership by the House of Delegates of the American Medical Association (AMA) as a national medical specialty society.

1989: The Texas Medical Board adopts language to support wider use of painkillers by doctors. Fourteen states follow in its footsteps.

ASAM History (continued)

1990 (A-90): The AMA House of Delegates acts to assign addiction medicine a code as a self-designated practice specialty in the AMA Physician Masterfile by approving a resolution inspired by ASAM and introduced by the California Medical Association. ASAM Board approves the ASAM Guidelines for Fellowship Training Programs in Addiction Medicine (amended 1992), developed by the ASAM Fellowship Committee.: Principles of Addiction Medicine published, documenting the scientific and clinical foundations of the specialty.

Federal funding for the war on drugs reached $17.1 billion dollars. In a Gallup poll, 34% of Americans admitted to having tried marijuana.

1996: Content of Addiction Medicine developed, to outline the multi-disciplinary content of the specialty of addiction medicine.

1996: Purdue Pharma releases OxyContin.

ASAM History (continued)

2006: The ASAM Board approves the ASAM Strategic Plan to "establish addiction medicine as a primary specialty" (Mission Statement), "a recognized ABMS medical specialty" (ASAM's Goals: 2006-2010); and to "develop standards for appropriate content on addictive disorders for use in residency training programs, and compile and disseminate information on the Addiction Medicine content of residency training programs" (Goal 1).

2006: MSAG (Medical Speciality Action Group) holds its first face-to-face meeting at Hazelden in Minnesota, and with the selection of Chairs of three MSAG Committees (Outreach, Training, and Finance), the MSAG Steering Committee composition is completed.

Medicare Part D Drug benefit goes into effect.

ASAM Criteria Principles:

- **Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry.**
- **ASAM criteria provide guidelines for helping patients manage their chronic, relapsing remitting disease, by placing them in the least restrictive setting in which they can learn and apply coping skills and accountability of their disease**
- **ASAM criteria are not just about placement. They are about treatment, and management.**
- **ASAM criteria consider co -occurring substance abuse and mental health conditions**
- **ASAM is compatible with DSM-V.**

ASAM Criteria Principles

- **Evidence Based Treatment: Motivational Interviewing, Enhancement**
- **No "first fail" admission criteria for higher levels of care**
- **Fluid, with many levels of care**
- **Multi-dimensional treatment planning, looking at person as a whole**
- **Individualized care**
- **Clinical focus, not program focus, clinical justification for level of care**
- **Provides universal language across addiction systems**
- **Admission criteria for each level of care, continued stay criteria or extension criteria, discharge criteria**
- **Least restrictive with best opportunity for change. Consideration of safety, patient's right to choose, refuse care**

ASAM Criteria Dimensions

1. **Acute intoxication and/or withdrawal potential**
2. **Biomedical conditions and complications**
3. **Emotional/behavioral/cognitive conditions and complications**
4. **Readiness to change (Stages of Change)**
5. **Relapse, continued use/continued problem potential**
6. **Recovery environment**

Dimension 1: Acute Intoxication/Withdrawal Risk

- **What are the risks associated with the patient's current level of intoxication?**
- **What are the risks of the patient's withdrawal from the substance, including seizure risk from withdrawal of benzodiazepines, alcohol or barbiturates?**
- **If ambulatory detoxification is medically safe, does the patient have support to get back and forth to where they need to go?**

Dimension 1: Withdrawal Management

- **New to ASAM: Withdrawal Management, as opposed to Detoxification**
  - **Level 1 WM:** **Ambulatory Withdrawal Management without Extended On-Site Monitoring**
  - **Level 2 WM:** **Day hospital service with extended monitoring (Partial Hospitalization)**
  - **Level 3.2 WM:** **Clinically managed residential withdrawal treatment**
  - **Leve 3. 7 WM:** **Medically monitored inpatient withdrawal management (residential)**
  - **Level 4 WM:** **Medically managed intensive inpatient withdrawal management *hospital bed***

Dimension 1. Severity Ratings

0 ___ Individual fully functioning w/ good ability to tolerate, cope with withdrawal discomfort
___ No signs or symptoms of withdrawal present or are resolving and if alcohol, a CIWA-Ar score of less than 3
___ No signs or symptoms of intoxication

1 ___ Adequate ability to tolerate or cope with withdrawal discomfort.
___ Mild to moderate intoxication, or signs, symptoms interfere w/daily functioning, but not a danger to self or others
___ Minimal risk of severe withdrawal resolving and if alcohol, a CIWA-Ar score of 3-7
___ Sub intoxication level

2 ___ Some difficulty tolerating and coping w/withdrawal discomfort
___ Intoxication may be severe, but responds to treatment so individual does not pose imminent danger to self or others
___ Moderate signs and symptoms with moderate risk of severe withdrawal
___ Somewhat intoxicated
___ If alcohol, a CIWA-Ar score if 8-11

3 ___ Demonstrates poor ability to tolerate and cope with withdrawal discomfort.
___ Severe signs and symptoms of intoxication indicating possible imminent danger to self & others
___ Severe signs and symptoms or risk of severe but manageable withdrawal; or withdrawal is worsening despite detoxification at less intensive level of care
___ Very intoxicated
___ If alcohol, a CIWA-Ar score if 12-15

4 ___ Incapacitated, with severe signs and symptoms of withdrawal
___ Severe withdrawal presents danger (e.g. seizures)
___ Continued use poses an imminent threat to
___ Stuporous
___ If alcohol, a CIWA-Ar score over 15

Dimension 2: Biomedical Conditions

- **Does your patient have physical conditions/illnesses that impact withdrawal?**
  - **Abscesses, potential for infection, sepsis**
- **Does your patient have chronic illnesses (hypertension, diabetes)?**
  - **Hepatitis C**
- **Does your patient have symptoms, such as chronic pain, associated with illness?**
  - **Fibromyalgia, cancer, arthritis**

Dimension 2: Severity Ratings

0 ___ Fully functioning with good ability to tolerate or cope w/ physical discomfort
___ No biomedical signs or symptoms are present, or biomedical problems stable
___ No biomedical conditions that will interfere with treatment or create risk
1 ___ Demonstrates adequate ability to tolerate and cope with physical discomfort
___ Mild to moderate signs or symptoms interfere with daily functioning, but would likely not interfere with recovery treatment nor create risk

2 ___ Some difficulty tolerating and coping with physical problems and/or has other biomedical problems
___ Has a biomedical problem, which may interfere with recovery treatment
___ Has a need for medical services which might interfere with recovery treatment (e.g., kidney dialysis) ___ Neglects to care for serious biomedical problems
___ Acute, non-life threatening medical signs and symptoms are present

3 ___ Demonstrates poor ability to tolerate and cope with physical problems and/or general health is poor
___ Has serious medical problems he/she neglects during outpatient treatment that require frequent medical attention
___ Severe medical problems are present but stable.
___ Medical problem(s) present that would be severely exacerbated by a relapse
___ Medical problem(s) present that would be severely exacerbated by withdrawal (e.g., diabetes, hypertension)
___ Medical problems that require medical or nursing services

4 ___ Incapacitated, with severe medical problems
___ Severe medical problems that are life threatening risk

Dimension 3:Emotional/Behavioral/Cognitive

- **Does your patient have current psychiatric illnesses or psychiatric, behavioral or emotional problems that need to be addressed; or that complicate treatment? Will those issues complicate your patient's addiction treatment?**
  (e.g. personality disorder, schizophrenia) Did they exist before the patient's addiction?
- **Do the emotional/behavioral problems seem to be secondary to the addiction, or are they separate issues? Did they exist before the addiction? Personality issues take a long time to treat, and are essentially behavioral. They require a high skill level (psychiatric) to treat**
- **Assess the patient's suicide risk.**

Dimension 3. Severity Ratings

0 ___ No or stable mental health problems

1 ___ Sub-clinical mental disorder
___ Emotional concerns relate to negative consequences and effects of addiction.
___ Suicidal ideation without plan
___ Social role functioning impaired, but not endangered by substance use; mild symptoms that do not impair role functioning (e.g. social, school, or work
___ Mild to moderate signs and symptoms with good response to treatment in the past.
___ Or past serious problems have long period of stability or are chronic, but do not pose high risk of harm

2 ___ Suicidal ideation or violent impulses require more than routine monitoring
___ Emotional, behavioral, or cognitive problems distract from recovery efforts.
___ Symptoms are causing moderate difficulty in role functioning (e.g. school, work)
___ Frequent and/or intense symptoms with a history of significant problems that are not well stabilized, but not imminently dangerous
___ Emotional/behavioral/cognitive problems/symptoms distract from recovery efforts
___ Problems with attention or distractibility interfere with recovery efforts
___ History of non-adherence with required psychiatric medications

Dimension 3. Severity Ratings (continued)

3___ Frequent impulses to harm self or others which are potentially destabilizing, but not imminently dangerous
___ Adequate impulse control to deal with thoughts of harm to self or others
___ Uncontrolled behavior and cognitive deficits limit capacity for self-care, ADL's
___ Acute symptoms dominate clinical presentation (e.g. impaired reality testing, communication, thought processes, judgment, personal hygiene, etc.) and significantly compromise community adjustment and follow through with treatment recommendations

4___ Individual has severe and unstable psychiatric symptoms and requires secure confinement
___ Severe and acute psychotic symptoms that pose immediate danger to self or others (e.g. imminent risk of suicide; gross neglect of self-care; psychosis with unpredictable, disorganized, or violent behavior) ___ Recent history of psychiatric instability and/or escalating symptoms requiring high intensity services to prevent dangerous consequences

Dimension 4: Patient Stage of Change

- **Has your patient been coerced into treatment by family, employer or the court system?**
- **Who is paying for their treatment?**
- **What does your patient want? Do they want to be sober?**
- **Are they homeless? Without income?**
- **Is your patient willing to accept treatment? Accept the diagnoses given to him by the psychiatrist/addiction treatment team?**
- **Is your patient only compliant to avoid negative consequences, or does he/she have a deeper motivation to change (such as 'I need to address my depression, I've been fight it for years)?**
- **External vs internal Motivation**

Dimension 4 (continued)

Prochaska and DiClemente: Stages of Change

Precontemplation: Person either doesn't think they have a problem, or hasn't thought about change

Contemplation: Ambivalence

Preparation

Action

Maintenance

Termination

Relapse and Recycling can occur at any stage.

Dimension 4. Severity Ratings

0 ___ Willingly engaged in treatment as a proactive participant, is aware of/admits to having an addiction problem and is committed to addiction treatment and changing substance use and adherence with psychiatric medications
___ Can articulate personal recovery goals
___ Willing to cut negative influences
___ Is in Preparation or Action Transtheoretical Stage of Change

1 ___ Willing to enter treatment and explore strategies for changing AODA use or dealing with mental health disorder but is ambivalent about need for change (is in Contemplation Stage of Change)
___ Willing to explore the need for treatment and strategies to reduce or stop substance use
___ Willing to change AODA use but believes it will not be difficult or will not accept a full recovery treatment plan or does not recognize that he/she has a substance use problem

2 ___ Reluctant to agree to treatment for substance use or mental health problems but willing to be compliant to avoid negative consequences or may be legally required to engage in treatment
___ Able to articulate negative consequences of AODA use but has low commitment to change use of substances
___ Low readiness to change and is only passively involved in treatment
___ Variably compliant with outpatient treatment, self help or other support groups

Dimension 4. Severity Ratings (continued)

3 ___ Exhibits inconsistent follow through and shows minimal awareness of AODA or mental health disorder and need for treatment
___ Appears unaware of need to change and unwilling or only partially able to follow through with treatment recommendations

4 ___ Unable to follow through, has little or no awareness of substance use or mental health problems and associated negative consequences
___ Not willing to explore change and is in denial regarding illness and its implications
___ Is not in imminent danger or unable to care for self – no immediate action required
___ Unable to follow through with treatment recommendations resulting in imminent danger of harm to self/others or inability to care for self

Precontemplative

Dimension 5: Relapse/Continued Use/ Continued Problem Potential

- **Are they in immediate danger because of their drug and alcohol use?**
- **Does the patient have any recognition or understanding of, and skills for how to cope with his/her addiction?**
- **What severity or problems or distress will potentially occur if the patient continues to use drugs and alcohol?**
- **How much insight does the patient have regarding cravings and triggers to use, and the dangers of their continued use?**

Dimension 5. Severity Ratings

0___ No potential for further AODA or MH problems
___Low relapse or continued use potential and good coping skills
___ Is engaged with ongoing recovery/support groups
___ Has positive expectancies about treatment
___ No use of illicit drugs
___ Has no demographic risk factor (under 25 years of age, never married or having lived as married, unemployed, no high school diploma or GED)
___ No current craving
___ No impulsivity noted
___ Appropriately self-confident
___ Not risk-taking or thrill-seeking
___ No psychiatric medication required or adherent with psychiatric medications

1 ___ Minimal relapse potential with some vulnerability
___ Some craving with ability to resist
___ One or two changeable demographic risk factors
___ Marginally affected by external influences
___ Mostly non-impulsive
___Mostly confident
___Low level of risk- taking or thrill seeking
___Fair self – management and relapse prevention skills
___Needs support and counseling to maintain abstinence, deal with craving, peer pressure, and lifestyle and attitude changes
___Mostly adherent with prescribed psychiatric medications
___Episodic use of alcohol (less than weekly)
___Sporadic use of drugs (<1/week) Not IV

Dimension 5. Severity Ratings (continued)

2___Impaired recognition and understanding of substance use relapse issues
___Difficulty maintaining abstinence despite engagement in treatment
___ Able to self-manage with prompting
___ Some craving with minimal/sporadic ability to resist
___ One or two durable demographic risk factors
___ Moderately affected by external influences
___ Neither-impulsive nor deliberate
___ Uncertain about ability to recover or ambivalent
___ Moderate level of risk-taking or thrill-seeking
___ Mostly adherent with prescribed psychiatric medications with failure likely to result in moderate to severe problems
___ Regular use of alcohol (once or twice a week)
___ Moderate use of drugs (1-3X/week), not injected

3___ Little recognition and understanding of substance use relapse
___ Has poor skills to cope with and interrupt addiction problems, or to avoid or limit relapse or continued use
___ Severe craving with minimal/sporadic ability to resist
___ Three demographic risk factors
___ Substantially affected by external influences
___ Somewhat impulsive
___ Dubious about ability to recover
___ High level of risk-taking or thrill-seeking
___ Mostly non-adherent with prescribed psychiatric medications with failure likely to result in moderate to severe problems
___ Frequent use of alcohol (3 or more times a week)
___ Frequent use of drugs (more than 3X/week) and/or smoking drugs

Dimension 5. Severity Ratings (continued)

4___ Repeated treatment episodes had little positive effect on functioning
___ No skills to cope with and interrupt addiction problems or prevent/limit relapse or continued use ___ Severe craving with no ability to resist
___ Four or more significant demographic risks
___ Totally outer-directed
___ Very impulsive
___ Very pessimistic or inappropriately confident about ability to recover but is not in imminent danger or unable to care for self – no immediate action required
___ Dangerous level of risk-taking or thrill-seeking
___ Not at all adherent with prescribed psychiatric medications with failure likely to result in severe problems
___ Daily intoxication
___ Daily use of illicit drugs and/or IV drug use
___ Is in imminent danger or unable to care for self

Dimension 6: Recovery Environment

- **Your patient's recovery environment is highly critical.**
- **Who is in their family is supportive of their recovery?**
  - **Is there anyone dangerous to your patient's recovery in their home/work environment?**
  - **With whom does your patient live?**
  - **Does anyone they live with use drugs and alcohol as well?**
  - **Is someone shaming your patient for their addiction?**
- **Educational Problems**
- **Housing Problems**

Dimension 6. Severity Ratings

0 ___ Has a supportive environment or is able to cope with poor supports
___ Living in a dry, drug-free home
___ Few liquor outlets/no overt drug dealing
___ Subcultural norms strongly discourage abusive use
___ Positive leisure/recreational activities not associated with use
___ No risk for emotional, physical or sexual abuse
___ No logistical barriers to treatment or recovery
1 ___ Has passive support in environment; family/significant other support system need to learn techniques to support the individual's recovery effort (e.g. limit setting, communication skills, etc.)
___ Significant others are not interested in supporting addiction recovery, but individual is not too distracted by this situation, and is able to cope with the environment
___ Individual demonstrates motivation and willingness to obtain a positive social support system
___ Safe supportive living situation in a non-dry or non drug-free home
___ Alcohol & drugs readily obtainable
___ Subcultural norms discourage abusive use
___ Leisure/recreational activities conducive to recovery available
___ Some risk for emotional, physical or sexual abuse
___ Logistical barriers to treatment or recovery can be readily overcome
2 ___ Environment is not supportive of addiction recovery, but with clinical structure, individual is able to cope most of the time
___ Living alone
___ Ready access to alcohol & drugs near home
___ Subcultural norms inconsistent about abusive use
___ Leisure/recreational activities neutral for recovery
___ Above average risk for emotional, physical or sexual abuse
___ Logistical barriers to treatment or recovery serious but resolvable

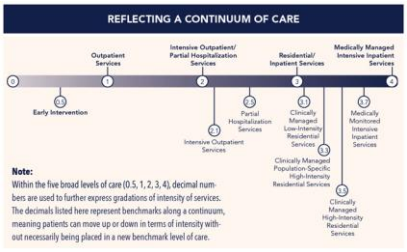
Dimension 6. Severity Ratings (continued)

3 ___ Environment is not supportive of addiction recovery, and coping is difficult, even with clinical structure
___ Someone in the household currently dependent or abusing
___ Bars/liquor stores/dealers prevalent
___ Subcultural norms encourage abusive use
___ Alcohol and drugs readily available at preferred leisure/recreational activities
___ Substantial risk for emotional, physical or sexual abuse in current environment
___ Substantial logistical impediments to treatment or recovery

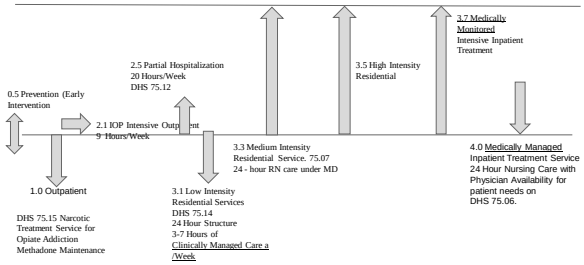
4 ___ Environment is not supportive of addiction recovery and is hostile and toxic to recovery or treatment progress
___ Unstable residence, living in shelter or mission, homeless
___ Extensive drug dealing/solicitation
___ Subcultural norms strongly encourage abusive use
___ Leisure/recreational activities poise severe risks
___ Currently being emotionally, physically or sexually abused
___ Extreme logistical impediments to treatment or recovery
___ Unable to cope with negative effects of the living environment on recovery - **no immediate action required**
___ Environment is not supportive of addiction recovery, and is actively hostile to recovery, posing an immediate threat to safety and well-being - immediate action required

...include consideration of patients' family in ASAM

Level of Care Per ASAM



Level of Care Per DHS 75



Chapter DHS 75

DHS 75.05 Emergency outpatient service.

DHS 75.06 Medically managed inpatient detoxification service.

DHS 75.07 Medically monitored residential detoxification service.

DHS 75.08 Ambulatory detoxification service.

DHS 75.09 Residential intoxication monitoring service.

DHS 75.10 Medically managed inpatient treatment service.

DHS 75.11 Medically monitored treatment service.

DHS 75.12 Day treatment service.

DHS 75.13 Outpatient treatment service.

DHS 75.14 Transitional residential treatment service.

Clinically Managed: Definition

Clinically Managed:

Care that is provided by someone other than medical personnel. Patients should have minimal intoxication or withdrawal risks. For a person with primarily emotional

Level 3.1 : Halfway House or Sober Living= **Clinically Managed Low Intensity Residential**

Level 3.5 Residential Treatment Facility= **Clinically Managed High Intensity Residential Services**

Patient has no needs on Dimension 1: only a few on Dimension 2 and Dimension 3. For the most part the patient needs care in Dimensions 4, 5 and 6.

Medically Monitored Definition

Services provided by an interdisciplinary staff including nurses, counselors, social workers, addiction specialists and other technically certified staff (behavioral health technicians, for example) under the direction of a licensed physician.

Medical Monitoring is provided by a mixture of patient contact, record review, team meetings, 24 - hour coverage by a physician and quality assurance team.

Level 3.7: Short Term Residential

Medically Monitored vs Medically Managed

- **Note the wording: Medically *Monitored* vs Medically *Managed* Intensive Inpatient**
  - **Monitored = 24 hour nursing care, under the supervision of a physician**
  - **Managed = 24 hour nursing care, physician management and all the resources of the hospital**
- **In general medically monitored denotes residential care; medically managed denotes inpatient care**
- **The stronger the biopsychosocial assessment, the better you can apply ASAM criteria effectively**
- **Treatment level 3. 5 used to be thought of as a 30 day stay; this is not always the case, depending on the program, providers, and insurance company authorizing care.**
- **A program should never cite exactly how many days their program lasts; this suggests a lack of individualization of care.**

Level of Care Placement After Relapse

- **Base assessment on the HERE and NOW for the patient: Don't assume that because the patient relapsed, their previous level of care wasn't enough**
- **Adjusting the treatment plan is the appropriate approach: not necessarily increasing the level of care.**
- **Treatment should never be a punishment.**

Individual, clinically driven program will have varying lengths of stay for patients.

Program driven by the program content (rather than the individual patient) will have a set number of days everyone is in treatment (28 days, or 30 days).

Relapse and Shame

Relapse is not a separate stage of change.

Relapse is expected but not inevitable

Help patients avoid feeling demoralized, discouraged or stuck by relapse.

Punishment and shame serve no purpose

Use of multidimensional assessment critical. What is keeping the patient from getting sober? If they continue using, but also continue showing up for treatment, they are ambivalent, and we can work with this: is the difference between addiction professionals and the rest of the world: it's where we come in; we step in and guide the patient toward change, once they set foot in the door.

Readiness to Change:

Terrance Gorski: wonderful writing about relapse.

Documentation. Tell The Story

Dimension 3: Emotional: Mood Stability (monitoring of attention, concentration, anxiety).
Dracula's mood remains mostly flat, but he laughed when talking about Halloween and a humorous incident during a group counseling session during which he slipped and revealed that he, in fact, is the Real Dracula.

Dimension 5: Relapse risk information, objective measure for monitoring progressDracula states that his cravings for blood remain strong, and states that "about 6 times a day" he still thinks about leaving residential treatment to scour his old neighborhood for victims, someone he can sink his teeth into (Dimension 5 –). Mr. Smith states that after 5 weeks, he's finally "comfortable "speaking in group and believes that treatment is helping (Dimension 4 & 5 – client progress). He wants to stay clean from heroin, and believes he's "better", but still says, "I'm not strong enough; I still can't stop thinking about the feeling of using and still have trouble getting it out of my head" (Dimension 4 & 5 – statement that speaks to justification for continued LOC). But overall, he states that he's "getting better" because during the last visit with his wife, he said that for the first time he apologized for "giving her grief" and they had a good visit (Addresses Dimension 4 & 6 – behavior changes).

Dimension 6: CMr. Smith is slowly improving. His cravings have reduced from "all the time" to about 6x a day. He is more engaged in treatment and during both individual and group sessions, and has identified high-risk triggers for use (anger, fights with his wife and boss, and being around old neighborhood). He is learning to use his coping skills (relaxation, practicing delay and examining the evidence when he's angry) and reports he now likes going to men's NA meetings because he feels like the men "get it" and "understand me" (Specific measurable progress). However, given his 30-year history of heroin use and strong cravings, he needs more time solidifying the use of his coping skills, along with learning new skills to manage cravings and his intense emotions which have previously been triggers to use. (Justification for ongoing treatment at his current LOC). Given his ongoing challenges and the severity/frequency/duration of his heroin use, he may be an appropriate candidate for medication-assisted treatment (MAT). Although he initially said that he wasn't interested in considering the use of medications to help with his treatment, he now says he's like to know more after using motivational interviewing techniques to engage the client and speaking with him about the pros and cons of MAT and how it may help him achieve his recovery goals (Dimension 4 – description of how MI intervention were used to advance client through stages of change). P (Plan) – Factoring in all the considerations outlined in the assessment of the case, counselor/clinician outlines the plan to achieve the client's recovery goals, both in terms of the client and the counselor/clinician - Provided additional literature and information regarding MAT for discussion during next session. - Will continue motivational interviewing techniques with regard to MAT by discussing how MAT might assist client with his goals (stop fighting with his wife, get job back, etc). - Will request additional 30-day extension of residential treatment to address ongoing cravings, and the fact that positive progress is being made with current interventions. - Will Introduce CBT interventions to show the cycle of anger. - Plan to continue family sessions with wife, who is strongly supportive of recovery. - Will continue to monitor client and relapse potential closely.

..a combination of circumstances...tell the story

Helpful Points..

- Is your recommendation appropriate; does it balance the least restrictive level of care, without putting the patient at severe overdose or withdrawal risk?
- Do you utilize DSM-V?
- Criminal history should be included in your assessment of level of risk : for example, a patient who continues to drive under the influence of alcohol, though not in immediate withdrawal, should be considered for a minimum of Partial Hospitalization.
- Your documentation must reflect your line of reasoning.
- Raising the level of care isn't always the answer. It is more likely that the treatment plan needs to be adjusted, with a focus on readiness/motivation to change. If a patient relapsed after a lesser level of care, such as IOP, there is no guarantee that by putting the patient in Partial Hospitalization will result in a longer recovery without also focusing on the treatment plan.

References

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