ASAM Criteria

American Society of Addiction Medicine
David Mee-Lee, MD

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 patients who use their emergency rooms regardless of ability to pay.
1988-1989: 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: 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” (Vision 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 Specialty 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
- Multidimensional 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 Site Monitoring
  - Level 2 WM: Day hospital service with extended monitoring (Partial Hospitalization)
  - Level 3.7 WM: Clinically managed residential withdrawal treatment
  - Level 4 WM: Medically monitored inpatient withdrawal management (residential)

Dimension 1: Severity Ratings

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Individual fully functioning w/ good ability to tolerate and 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.</td>
</tr>
<tr>
<td>1</td>
<td>Adequate ability to tolerate or cope with withdrawal discomfort. Some difficulty tolerating and coping with 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.</td>
</tr>
<tr>
<td>2</td>
<td>Demonstrates poor ability to tolerate and cope with withdrawal discomfort. Severe signs and symptoms of intoxication indicating possible imminent danger to self &amp; others. Severe signs and symptoms of withdrawal and incomplete detoxification at less intensive level of care.</td>
</tr>
<tr>
<td>3</td>
<td>Incapacitated, with severe signs and symptoms of withdrawal that pose imminent threat to life.</td>
</tr>
<tr>
<td>4</td>
<td>Severe withdrawal presents danger (e.g. seizures)</td>
</tr>
</tbody>
</table>

Dimension 2: Biomedical Conditions

- Does your patient have physical conditions/diseases that impact withdrawal?
  - Abcesses, potential for infection, sepsis
  - 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 with physical discomfort
___ No biomedical signs or symptoms are present, or biomedical problems stable
___ No biomedical conditions that will interfere with treatment or create risk
___ No substantial signs or symptoms may require special intervention to manage 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 or create risk
___ Has a biomedical problem, which may interfere with recovery treatment
___ Has a biomedical problem, which may interfere with recovery treatment, but would likely not interfere with recovery treatment or create risk
___ Has a need for medical services which might interfere with recovery treatment

2 ___ Some difficulty tolerating and coping with physical problems and/or has other biomedical problems
___ Moderate signs or symptoms interfere with daily functioning, but could potentially interfere with recovery treatment or create risk
___ Has a biomedical problem, which may interfere with recovery treatment
___ Has a medical problem(s) which may interfere with recovery treatment
___ Has an acute, non-life threatening medical condition

3 ___ Demonstrates poor ability to tolerate and cope with physical problems and/or general health is poor
___ Severe medical problems exist
___ Severe medical problems exist that need to be addressed
___ Severe medical problems exist that need to be addressed and are life threatening
___ Severe medical problems exist that need to be addressed and are life threatening

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

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 these 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
___ No or stable mental health problems
___ No or stable mental health problems
___ No or stable mental health problems
___ No or stable mental health problems

1 ___ Subclinical mental disorder
___ Subclinical mental disorder
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2 ___ Suicidal ideation or violent impulses require more than routine monitoring
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3 ___ Severe mental disorders
___ Severe mental disorders
___ Severe mental disorders
___ Severe mental disorders
___ Severe mental disorders

4 ___ Severe mental disorders
___ Severe mental disorders
___ Severe mental disorders
___ Severe mental disorders
___ Severe mental disorders
Dimension 3. Severity Ratings (continued)

3. ___ Frequent impulses to harm self or others which are potentially destabilizing, but not imminently dangerous
   ___ Distress-related verbalization in regard to 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 ability to 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 diagnosis 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 fighting 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 having an addiction problem and is committed to addiction treatment and changing substance use and adherence with psychiatric medications.
   ___ Can articulate personal recovery goals
   ___ Is in Preparation or Action Transcendental Stage of Change

1. Willingly in treatment and explores strategies for changing AODA use or dealing with mental health disorders, is ambivalent about need for change. Is in Contemplation Stage of Change.
   ___ Willing to explore the need for treatment and strategies to reduce substance use.
   ___ Willing to change AODA use but believes it will be difficult or not acceptable and recovery treatment plan 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.
   ___ Bids to change behavior, consequence of AODA use, but has low motivation to change use of substances.
   ___ Low readiness to change and is only minimally involved in treatment.
   ___ Variably compliant with treatment recommendations and either support groups.

3. Exhibits inconsistent follow through with treatment recommendations for AODA or mental health disorder and need for treatment.
   ___ Approaches need to change behavior and 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 problem and associated negative consequences.
   ___ Not willing to explore change and not aware regarding therapy and its implications.
   ___ Unable to follow through with treatment recommendations resulting in imminent danger of harm to self or others, or inability to care for self.
### 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?

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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 ___, Severely working with no ability to repair
___ Poor in one or more significant demographic roles
___ Very inner-directed
___ Very promiscuous
___ Very promiscuous but inappropriately conditions ability to access but in not imminent danger or unable to care for self – no immediate action required
___ Drug-free level of drug use in final setting
___ Not at all adherent to prescribed problem reduction interventions with either medical societal or recovery program
___ Twelve step group membership for at least one year
___ 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
___ Very passive support in environment and social support system needs to be used to promote successful recovery
___ Poor ability of family to support 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 intelligence to obtain a positive social support system
___ capable of taking action to secure the dry, drug-free home
___ Family & drug readiness obtained
___ Significant others demonstrating abusive actions
___ Limited/insufficient structure conducive to recovery available
___ Repetitive use of emotional or verbal abuse
___ Logical barriers to treatment in recovery center usually overcome
___ Treatment is not supported by additional recovery, but with clinical structure individual is able to cope most of the time
___ Significant others are not interested in supporting addiction recovery
___ Not at all adherent to prescribed problem reduction interventions with either medical societal or recovery program
___ Twelve step group membership for at least one year
___ Is in imminent danger or unable to care for self
___ Eleven steps group membership for at least one year
___ Logical barriers to treatment in recovery center but insurmountable
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, and 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

...include consideration of patients’ family in ASAM

Level of Care Per ASAM

![Diagram reflecting a continuum of care]
Level of Care Per DHS 75

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Hours/Wk</th>
<th>Clinical Management</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5</td>
<td>Prevention (Early Intervention)</td>
<td>0</td>
<td>Clinically Managed</td>
<td>DHS 75.12</td>
</tr>
<tr>
<td>1.0</td>
<td>Outpatient</td>
<td>0</td>
<td>Clinically Managed</td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>IOP Intensive Outpatient</td>
<td>9</td>
<td>Clinically Managed</td>
<td></td>
</tr>
<tr>
<td>2.5</td>
<td>Partial Hospitalization</td>
<td>20</td>
<td>Clinically Managed</td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>Low Intensity Residential Services</td>
<td>24-7</td>
<td>Clinically Managed</td>
<td></td>
</tr>
<tr>
<td>3.3</td>
<td>Medium Intensity Residential Services</td>
<td>24-7</td>
<td>Clinically Managed</td>
<td></td>
</tr>
<tr>
<td>3.5</td>
<td>High Intensity Residential Services</td>
<td>24-7</td>
<td>Clinically Managed</td>
<td></td>
</tr>
<tr>
<td>3.7</td>
<td>Medically Monitored Intensive Inpatient Treatment</td>
<td>24-7</td>
<td>Clinically Managed</td>
<td></td>
</tr>
</tbody>
</table>

**Clinically Managed Definition**

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.

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).

Individual, clinically driven program will have varying lengths of stay for patients.
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: it 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 Gonski: wonderful writing about relapse.

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Documentation. Tell The Story

Dimension 2: 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 progress.

Dracula 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 – risk assessment.

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 rid of it”. Dimension 6 & 5 – assertion that clients are in precontemplation (Dimension 5).

Document how he felt about this: “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 (Dimension 4 & 6 – behavior changes).

Dimension 6: Mr. Smith is slowly improving. His cravings have reduced from “all the time” to about four days. He is more engaged in treatment and during both individual and group sessions, and has identified high-risk triggers for use (anger and fights with his wife and boss and being around old neighbors frequently). He is doing well in group sessions. His cravings are monitored regularly, along with his coping techniques and triggers, which have significantly reduced (Dimension 6 – monitoring progress and the nature of the treatment).

Document how the patient is doing and what changes have been made in the treatment plan.

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...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 lower 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

Mee-Lee, David Ed. The ASAM Criteria: Treatment for Addictive, Substance-Related and Co-Occurring Conditions, 3rd Ed. 2013

