

## SELECTING APPROPRIATE TREATMENT: PATIENT PLACEMENT CRITERIA

*About 50 million lives are in the hands of companies across the globe which state that they use ASAM 'patient placement criteria' to authorise addiction treatment. What are these criteria? And how can they help give happier results for more people when there is also a need to cut spending?*

### TREATMENT 'MATCHING' EVOLVES.

Matching patients to treatment services has evolved through at least four approaches.

**COMPLICATIONS-DRIVEN TREATMENT** gives cursory attention to the diagnosis of a substance-use disorder. Rather than actively treating the primary alcohol or other drug disorder causing a patient's symptoms, only secondary complications or *sequelae* are addressed. For example, gastritis is controlled, depression is medicated, fractures are splinted – but care for the addictive disorder is superficial or nonexistent.

**DIAGNOSIS, PROGRAMME-DRIVEN TREATMENT**, in contrast, recognises the substance-use disorder but diagnosis alone drives the treatment plan. For example, by policy, a diagnosis of substance abuse might assign someone to outpatient treatment, of substance dependence to inpatient treatment, without regard to a patient's 'service needs'. Patients are assigned fixed lengths of stay in static approaches, often in response to a mandated referral, policy guidelines or available funding.

**INDIVIDUAL, ASSESSMENT-DRIVEN TREATMENT** – assessment, treatment matching, level of care placement, and progress evaluation through assessment – is an ideal approach to care. Its multidimensional assessment identifies and prioritises problems in the context of the patient's severity of illness, interference with treatment or recovery and level of functioning. Treatment services are matched to the patient's needs over a continuum of care. Ongoing assessment of progress and treatment response influence future treatment recommendations.

**OUTCOMES-DRIVEN TREATMENT**, the most recent approach, adds measurement of outcomes in real time. The focus on "during-treatment" feedback of outcomes, patient engagement and therapeutic alliance allows real-time modification of the treatment plan. Tracking the most salient outcomes and measures of alliance and patient engagement inform decisions about which problems should be prioritised and what changes made in strategies and level of care.



Perhaps the Addiction Recovery Foundation was before its time, or perhaps it takes a new government for change to happen. When the National Treatment Agency for Substance Misuse was created, this charity asked in vain for a common assessment tool for patients/clients. Professionals needed a proven quality aid for their work, patients needed to be diagnosed correctly and placed in appropriate care paths, and researchers needed commonalities of measurement. Such an assessment and referral tool is the tried-and-tested Patient Placement Criteria developed by the American Society of Addiction Medicine.

Over the years since, we brought to the UK and gave workshops to creators of ASAM's Patient Placement Criteria: David Mee-Lee, Gerald Shulman, Norman Hoffmann and Dr Michael Miller; David Gastfriend attending.

With a new drugs policy due soon, we highlight why the PPC should be integral – along with a 'Prep Week' to be unveiled in the September issue of *Addiction Today*.

What ingredients make these Patient Placement Criteria so effective?

Four features characterise them:

- comprehensive, individualised treatment planning
- ready access to services
- attention to multiple treatment needs, and
- ongoing reassessment/modification of the plan.

Four important missions underlie them:

- enable patients to receive the most appropriate and highest-quality treatment services
- encourage the development of a continuum of comprehensive care
- promote effective, efficient use of care resources
- help protect access to and funding for care.

Correctly applied and implemented, the ASAM criteria can assist patients in accessing a much broader continuum of care and menu of services than is typically available.

As to research, the ASAM criteria are the most intensively studied set of addiction placement criteria. A considerable body of work exists on them, including at least nine evaluations involving 3,641 subjects.



### RESEARCH BEHIND THE CRITERIA.

Agencies – including the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism and the Center for Substance Abuse Treatment – have invested over \$7million in research on PPC.

Several controlled studies found that treatment based on PPC are linked to less morbidity, better client functioning, and more efficient service utilisation than mismatched treatment. At the end of this article, there are details of where to find references and more information.

### USES OF PLACEMENT CRITERIA.

ASAM criteria provide a multidimensional assessment structure, initially to generate a service plan which leads to appropriate placement, then a formal treatment plan which meets the patient's assessed needs and improves the prospects for a positive outcome once in treatment. They are intended to enhance the efficient use of limited resources, increase patient retention in treatment, improve outcome and prevent relapse. Thus they advocate for individualised, assessment-driven treatment and the flexible use of a broad continuum of care.

The criteria also offer a nomenclature and guidelines to describe an expanded set of treatment options and promote the use of a wider continuum of services.

Increasingly, however, treatment must be driven not only by assessment but by the outcome of treatment measured in real time. No single treatment is appropriate for all people at all times. So matching treatment settings, interventions and services to each individual's particular problems and needs is critical to his or her success in returning to productive functioning in the family, workplace and society.

Measurement during treatment that tracks real-time outcomes and the quality of the patient's engagement and therapeutic alliance allows for modification of the strategies and level of care depending on patient progress – or lack of it.

### MATCHING FOR SUCCESS.

The six assessment 'dimensions' of patient placement criteria are outlined in the panel below.

To engage the patient in a collaborative therapeutic alliance, the assessment is in the service of what the patient wants – such as “get my children back”. It identifies obstacles and resources, liabilities and strengths in each of the assessment dimensions: see table below.

The criteria are as objective, measurable and quantifiable as possible. They are 'scored' numerically – and this helps to remove subjective

heat or arguments from decisions. Some PPC aspects do need subjective interpretation – but that is no different from biomedical or psychiatric conditions in which diagnosis/assessment/treatment are a mix of objectively measured criteria and clinical judgment.

### GOALS OF TREATMENT.

The goals of intervention and treatment – including safe and comfortable detoxification, motivational enhancement to accept the need for recovery, the attainment of skills to maintain abstinence,

### ASSESSMENT DIMENSIONS

- 1 Acute intoxication and/or withdrawal potential
- 2 Biomedical conditions and complications
- 3 Emotional, behavioural or cognitive conditions and complications
- 4 Readiness to change
- 5 Relapse, continued use or continued problem potential
- 6 Recovery environment

### ASSESSMENT AND TREATMENT PLANNING FOCUS

- Assessment for intoxication or withdrawal management. Detoxification in a variety of levels of care and preparation for continued addiction services.
- Assess and treat cooccurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services.
- Assess and treat co-occurring diagnostic or subdiagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services.
- 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.
- Assess readiness for relapse prevention services and teach where appropriate. Identify previous periods of sobriety or wellness and what worked to achieve this. If still at early stages of change, focus on raising consciousness of consequences of continued use or continued problems as part of motivational enhancement strategies.
- Assess need for specific individualised family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services. Identify any supports and assets in any or all of the areas.

and the like – determine the methods, intensity, frequency and types of services provided.

The decision to prescribe a type of service and subsequent discharge of a patient from a level of care is based on how that treatment and its duration will influence resolution of the dysfunction and improve the patient's prognosis. So the treatment might extend beyond resolution of observable symptoms to the achievement of overall healthier functioning, the difference between abstinence alone and recovery. The patient demonstrates a response to treatment through new insights, attitudes and behaviours.

Addiction treatment programmes have as their goal not simply stabilising a patient's condition but altering the course of the patient's substance-use disorder and overall functioning.

#### INDIVIDUALISED TREATMENT PLAN.

Treatment should be tailored to the needs of each patient and guided by an individualised treatment plan developed in collaboration with the patient. Such a plan should be based on the patient's goals for treatment, a comprehensive biopsychosocial assessment of the patient and, when possible, a comprehensive evaluation of the family. The treatment plan should list:

- problems prioritised by obstacles to treatment and risks and arranged according to severity – such as obstacles to recovery, knowledge or skill deficits, dysfunction or loss
- strengths – such as readiness to change, a positive social support system and a strong connection to a source of spiritual support
- goals – a statement to guide realistic, achievable, short-term resolution or reduction of the problems
- methods or strategies – treatment services to be provided, site of those services, staff responsible for delivering treatment
- a timetable for follow-through with the treatment plan, which promotes accountability.

The plan should be written to facilitate measurement of progress.

#### PROGRESS THROUGH LEVELS OF CARE.

As a patient moves through treatment in any level of care, his or her progress in all six dimensions should be continually assessed to ensure that treatment is addressing changing needs. Certain problems and priorities are thus identified as justifying admission to a particular level of care. The resolution of those problems and priorities determines when a patient can be treated at a different level of care or discharged from treatment.

Should a patient drink or use drugs during treatment, the immediate response should be to revise the treatment plan rather than automatically change the level of care or administratively discharge the patient.

Also, some funders might require that a patient be “motivated for sobriety” as a requirement for admission to a programme. Given the characteristic symptoms of denial and lack of readiness to change in addiction disorders, the only requirement should be that the patient is willing to enter treatment. Clinicians then facilitate the patient's self-change process along the stages of change.

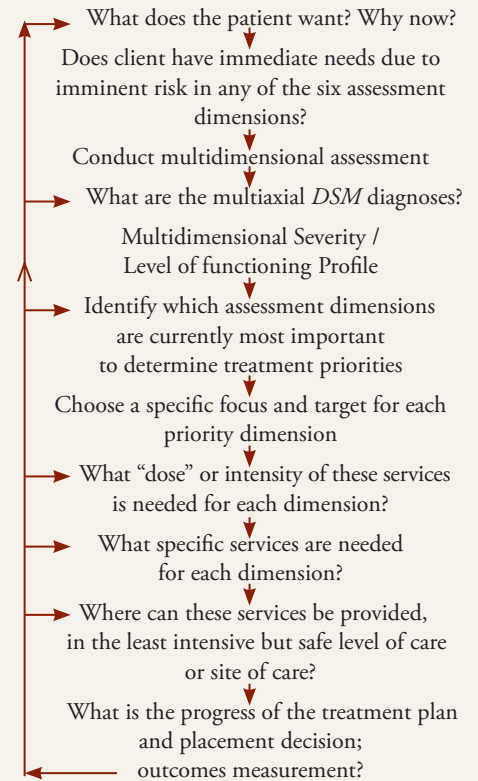
#### CHANGE TO A CULTURE OF SUCCESS.

Effective implementation of the ASAM patient placement criteria will require a shift in thinking toward outcomes-driven case planning.

A variety of agencies will need to make this shift, including regulatory agencies, purchasers of services, clinical and medical staff including throughout the NHS, and referral sources such as courts, probation officers, child protective services and employers.

The patient placement criteria offer a system to improve patient-centred, comprehensive care through multidimensional assessment and treatment planning that permits more objective evaluation of patient outcomes. With improved outcome analysis driving treatment decisions, the problems of access to care and funding of treatment can be championed more effectively.

#### DECISION TREE: MATCH ASSESSMENT & TREATMENT/ PLACEMENT ASSIGNMENT



#### MORE INFORMATION.

*Applying ASAM Placement Criteria* DVD & manual (10 CE hrs) by David Mee-Lee and Kathylene M Tomlin - order from [www.hazelden.org](http://www.hazelden.org)

*ASAM101: Basics on Understanding and Using ASAM Patient Placement Criteria*, 2nd edition is a 3-hour online course at [www.dlccas.com/course59.html](http://www.dlccas.com/course59.html)

*ASAM Patient Placement Criteria: implications for assessment and treatment of patients with co-occurring disorders* - read at [www.changecompanies.net/assets/pdfs/ArticleASAM.pdf](http://www.changecompanies.net/assets/pdfs/ArticleASAM.pdf)

*Level of Care Index (LOCI-2R)*: Checklist tool listing criteria to aid in decision-making and documentation of placement

*Dimensional Assessment for Patient Placement Engagement and Recovery (DAPPER)*: Severity ratings in the six ASAM PPC-2R dimensions

To order: [www.changecompanies.net](http://www.changecompanies.net)

For clinical questions or statistical information about the instruments, contact Norman Hoffmann PhD at [evincesassessment@aol.com](mailto:evincesassessment@aol.com).

Article by **DEIRDRE BOYD**, from documents supplied by ASAM PPC author **DAVID MEE-LEE**.

Images: Scott Maxwell