

ASAM Criteria-(A) Training
An Introduction to the Application of ASAM Criteria
For Substance-Related and Co-Occurring Disorders
June 30, 2017: 9:00 AM – 3:00 PM

Trainer:

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UCLA-ISAP

Course Description

This training is designed for Substance Abuse Program Analyst and Administrative Staff interested in understanding and learning the skills to use the ASAM criteria for establishing medical necessity, assessing treatment needs, and determining appropriate level of care placements for consumers with substance abuse issues. The training format will include lecture with a focus on transfer of knowledge to immediate workplace application.

Learning Objectives

- 1) Understand the clinical and cost-effective benefits of utilizing the ASAM Criteria
- 2) Know the six dimensions utilized to assess medical necessity and patient need profiles
- 3) Identify and recognize distinguishing characteristics of the recognized ASAM levels of care
- 4) Demonstrate an ability to apply dimensional criteria information to determine treatment decisions, including Level of Care placement

Training Agenda

- 9:00-10:00 I. Introduction:
- A. Development of and Rationale for Patient Placement Criteria
 - B. ASAM criteria as a model for chronic addiction disease management
- 10:00-11:00 II. The Six Dimensions: Multidimensional Assessment Criteria and the relationship to treatment decisions
- 12:00-1:00 LUNCH
- 1:00-3:00 III. Classifying Levels of Care—Aligning Levels of Care with Treatment Regulations and Standards.
- A. Level 0.5 Early Intervention
 - B. Level 1 Outpatient
 - C. Level 2 Intensive Outpatient
 - a. Level 2.1 Intensive Outpatient Services
 - b. Level 2.5 Partial Hospitalization Services
 - D. Level 3, Residential
 - a. Level 3.1 Clinically Managed Low-Intensity
 - b. Level 3.3 Clinically Managed Low-Intensity (Special Populations)
 - c. Level 3.5 Clinically Managed High-Intensity
 - d. Level 3.7 Medically Monitored High-Intensity (Inpatient)

Understanding the American Society of Addiction Medicine (ASAM) Criteria in the Context of the California Treatment System

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David Geffen School of Medicine at UCLA

Pacific Southwest Addiction Technology Transfer Center

Disclosures

- The following planners and faculty disclosed no relevant financial relationships with commercial interests:
 - Gary Tsai, MD, Larissa Mooney, MD, Thomas E. Freese, PhD, Christine Oh, PhD, Richard Rawson, PhD, Darren Urada, PhD, Beth Rutkowski, MPH, Holly McCravey, MA, Lydia Becerra, and Donna K. Lee-Liu
- There was no commercial support for this activity.
- All presenters have signed a conflict of interest form and have declared that there is no conflict of interest and nothing to disclose for this presentation.

The Mission of the ASAM Criteria

- To help clinicians, counselors, and care managers develop patient-centered service plans and make objective decisions about patient admission, and transfer/discharge for individuals with substance-use disorders and co-occurring conditions,
- To implement and apply the criteria effectively to a variety of patient populations in a wide range of care settings,
- To encourage the development of comprehensive continuum of care,
- To help improve patient outcomes through their multidimensional assessment and the continuum of care.

The ASAM criteria offer a system for improving the “modality match” through the use of multidimensional assessment and treatment planning that permits more objective evaluation of patient outcomes.

Guiding Principles of the ASAM Criteria

- Moving from one-dimensional to multidimensional assessment
- Clarifying the goals of treatment, and “Medical Necessity”
- Focusing on treatment outcomes while moving away from using previous “treatment failure” as an admission prerequisite
- Moving toward an interdisciplinary, team approach to care and clarifying the role of the physician
- Engaging with “informed consent”
- Incorporating ASAM’s definition of addiction
- Identifying adolescence specific needs

Assessment and Treatment Planning

Program-Driven versus **Individualized**


Program-Driven Plans

- Services received and anticipated length of stay are determined primarily by the philosophy, design, and model of treatment
- Such programs are often for a fixed length of stay from which a patient graduates and is said to then have completed treatment.

“One size fits all”

Program-driven plans

- Client needs are important and will be addressed through the standard treatment program elements
- Plan often includes only services that the program offers (e.g., group, individual sessions)
- Little difference among clients' treatment plans



Client will . . .


1. "Attend 3 Alcoholic Anonymous meetings a week"
2. "Complete Steps 1, 2, & 3"
3. "Attend group sessions 3 times/week"
4. "Meet with counselor 1 time/week"
5. "Complete 28-day program"

"Still don't fit right"



- Often include only those services immediately available in agency
- Often do not include referrals to community services (e.g., parenting classes)

"ONLY wooden shoes?"



A paradigm shift

Truly Individualized Treatment



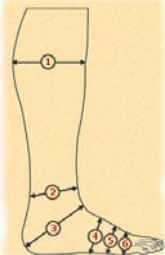
- Many colors/styles available -



- Custom style & fit -



Individualized Treatment




- Treatment is **person-centered** and **collaborative**
- Services that are directly related to **specific, unique** multidimensional assessment
- Services are designed to meet a patient's **specific needs** and **preferences**

"Sized" to match client's problems and needs

Individualized Treatment

Requires Comprehensive Assessment

- What are the patient's immediate needs and is there imminent danger?
- What risk is associated with intoxication and/or withdrawal?
- How are they functioning across multiple dimensions?
- Where are their greatest risks, and what does this indicate about treatment needs?



Individualized Treatment Plans have been shown to...

- Increase retention, leading to improved outcomes
- Empower the patient and provide additional focus to counseling sessions



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Six Dimensions of Multidimensional Assessment

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral, or Cognitive Conditions and Complications
4. Readiness to Change
5. Relapse, Continued Use, or Continued Problems Potential
6. Recovery and Living Environment

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Assessment Dimensions	Assessment and Treatment Planning Focus
1. Acute Intoxication and/or Withdrawal Potential	
2. Biomedical Conditions and Complications	
3. Emotional, Behavioral or Cognitive Conditions and Complications	

Assessment Dimensions	Assessment and Treatment Planning Focus
4. Readiness to Change	
5. Relapse, Continued Use, or Continued Problem Potential	
6. Recovery Environment	

ASAM Dimensions

- Acute Intoxication and/or Withdrawal Potential
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ASI* Domains

- Alcohol, Drugs
- Medical
- Psychiatric
- Alcohol, Drugs
- Employment support, Legal, Family social

*ASI: Addiction Severity Index, most commonly used assessment in California

What guides placement?

- "... the highest severity problem, with specific attention to Dimensions 1, 2, and 3 should determine the patient's entry point into the treatment continuum."
- Resolution of any acute problem(s) provides an opportunity to shift the patient down to a less intensive level of care.

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Assessing “Immediate Needs” and “Imminent Danger “

- Immediate Need can be assessed in person or over the phone
- Should address each of the six dimensions
- Includes three components:
 - The strong probability that certain behaviors will occur (i.e., continued alcohol or drug use, etc.).
 - That such behaviors will present a significant risk of serious adverse consequences to individual and/or others (i.e., driving while intoxicated, neglect of child, etc.).
 - The likelihood these events will occur in the very near future (within hours or days, not weeks or months).

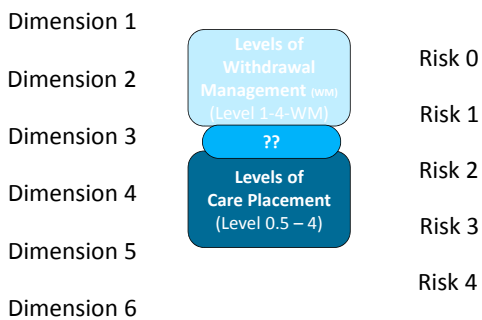
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Assessing Risk for Each Dimension

- 4 Utmost severity. Critical impairments/symptoms indicating imminent danger
- 3 Serious issue or difficulty coping. High risk or near imminent danger
- 2 Moderate difficulty in functioning with some persistent chronic issues
- 1 Mild difficulty, signs, or symptoms. Any chronic issue likely to resolve soon
- 0 Non-issue, or very low-risk issue. No current risk and any chronic issues likely to be mostly or entirely resolved

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So, what do we do with all of this information?



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Levels of Withdrawal Management

Withdrawal Management	Level	Description
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 withdrawal management support and supervision; at night, has supportive family or living situation; likely to complete withdrawal management
Clinically Managed Residential Withdrawal Management	3-WM	Moderate-severe withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery
Medically Managed Intensive Inpatient Withdrawal Management	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability

ASAM Levels of Care

- 0.5 Early Intervention
1. Outpatient Treatment
 2. Intensive Outpatient and Partial Hospitalization
 3. Residential/Inpatient Treatment
 4. Medically-Managed Intensive Inpatient Treatment

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Engage the person in their own care!


What?



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What does it look like with clients/patients?

- **18 year old (y/o) unemployed male with a two year history of intravenous heroin use**
- **Criminal convictions for shoplifting**
- **Has attempted outpatient detox on two previous occasions with methadone, the most recent treatment episode lasted 4 months and he has not maintained sobriety more than 1 month post-detox**
- **Living with his parents who are unaware of his dependence**
- **Denies use of alcohol, benzos or other substances**
- **Reports that he felt stable on methadone though has financial concerns and lacks insurance**



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What does it look like with clients/patients?

- **42 y/o female reports daily alcohol use and occasional use of other substances**
- **Divorced, currently lives with her 12 y/o son and her mother**
- **Mother has found bottles of vodka hidden in closets**
- **Patient reports feeling extremely tired and trouble making decisions or "getting motivated to do anything"**
- **and difficulty sleeping at night related to trauma (as a child)**
- **Acknowledges drinking or taking a pill to help her get to sleep.**



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Let's meet Mr. U.



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What does it look like with clients/patients?

- **Mr. U is a 68 year-old male who was brought to the clinic by Ms. M his 40 y/o daughter because he did not pick up his 10 y/o grandson from school last Friday as he does on a daily basis. Ms. M was called away from work to pick her son up. Upon arriving at home, Ms. M found Mr. U slumped over the workbench in the garage with an empty bottle of vodka nearby. Mr. U reports drinking to intoxication, complains of always feeling tired, has little or no appetite, and is not motivated to do anything.**
- **Mr. U retired three years ago, after a lengthy career working as a design engineer in the automotive industry. His wife of 43 years passed away five years ago after a relatively brief battle with cancer.**



What does it look like with clients/patients?

- Mr. U reports no health related issues other than heartburn on a daily regular basis, but believes it is due to his liking spicy foods.
- He reports drinking to intoxication, complains of always feeling tired, has little or no appetite, and is not motivated to do anything. Mr. U acknowledges that he has little or no interest in most activities that used to bring him pleasure and is bothered by his recurrent thoughts of death.
- Mr. U was embarrassed and apologetic, as he appreciates living with his family and adores his daughter and grandchildren.
- Mr. U lives with his daughter, her husband who Mr. U likes, and their three children, ages 18, 16, and 10. They are supportive and concerned about his wellbeing.



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Six Dimensions of Multidimensional Assessment

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Assessing Risk for Each Dimension

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- 0 Non-issue, or very low-risk issue. No current risk and any chronic issues likely to be mostly or entirely resolved

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Dimension 1 Assessment Considerations

1. Acute Intoxication and/or Withdrawal Potential

Exploring an individual's past and current experiences of substance use and withdrawal

- ❖ What risk is associated with current level of intoxication?
- ❖ Are intoxication management services needed?
- ❖ What is the risk of severe withdrawal symptoms, seizures or other medical complications?
- ❖ Are there current signs of withdrawal?
- ❖ What are the scores of the standardized withdrawal rating scales?
- ❖ What are the patient's vital signs?
- ❖ Does the patient have support to complete an ambulatory withdrawal, if medically safe to consider?

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Dimension 2 Assessment Considerations

2. Biomedical Conditions and Complications

Exploring an individual's health history and current physical condition

- ❖ Other than withdrawal, what are the current physical illnesses that should be addressed?
- ❖ What are the chronic conditions that need to be stabilized?
- ❖ Is there a communicable disease present that could impact the well-being of the client, other patients, or staff?
- ❖ Is the patient pregnant? What is her pregnancy history?

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Dimension 3 Assessment Considerations

3. Emotional, Behavioral, or Cognitive Conditions and Complications

Exploring an individual's thoughts, emotions, and mental health issues

- ❖ Are there psychiatric, psychological, behavioral, emotional or cognitive conditions needing to be addressed?
- ❖ What if any chronic conditions need to be stabilized (eg, bipolar disorder or chronic anxiety)?
- ❖ Are the behavioral or cognitive symptoms part of the addictive disorder?
- ❖ If related to the substance use, do the emotional, cognitive, or behavioral conditions require mental health care (eg, suicidal ideation and depression)?
- ❖ Is the patient able to participate in daily activities?
- ❖ Can she/he cope with the emotional, behavioral, or cognitive conditions?

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Dimension 4
Assessment Considerations

4. Readiness to Change

Exploring an individual's readiness and interest in changing

- ❖ How aware is the patient of the relationship between her/his substance use and behaviors involved in the pursuit of reward or relief of negative life consequences?
- ❖ How ready, willing or able does the patient feel to make changes to her/his behaviors?
- ❖ How much does the patient feel in control of his or her treatment service?

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Dimension 5
Assessment Consideration

5. Relapse, Continued Use, or Continued Problems Potential

Exploring an individual's relapse experiences/history of continued use

- ❖ Is the patient in immediate danger of continued mental health distress or substance use?
- ❖ Does the patient have any understanding of how to manage his mental health condition, in order to prevent continued use?
- ❖ What is her/his experience with addiction and/or psychotropic meds?
- ❖ How well can she/he cope with protracted withdrawal, craving, or impulses?
- ❖ How well can the patient cope with negative affects, peer pressure, and stress?
- ❖ How severe are the problems that may continue or reappear if the patient isn't successfully engaged in treatment for substance use or mental health treatment?
- ❖ Is the patient familiar with relapse trigger and does she/he possess the skills to control her/his impulses to use or harm her/himself?

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Dimension 6
Assessment Considerations

6. Recovery and Living Environment

Evaluating the individual's living situation, environmental resources and challenges, including family and friends

- ❖ What in the individual's environment poses a threat to the person's safety or ability to engage in treatment?
- ❖ What are the environment resources the individual can draw upon, including family, friends, education, or vocational that can support her/his recovery?
- ❖ Are there any legal, vocational or social mandates that may enhance treatment engagement?
- ❖ What are environmental barriers that need to be addressed, including transportation, child care, housing, employment, etc.?

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Six Dimensions
of Multidimensional Assessment

ASAM Levels of Care

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- 0.5 Early Intervention
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Decisional Flow to Match Assessment and Treatment Placement

- What does the patient want and why now?
- What are the patient's immediate needs or imminent risk in each of the dimensions?
- What is the Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis?
- Intake and Assessment

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Decisional Flow to Match Assessment and Treatment Placement

- Multidimensional severity/Level of function
- Prioritize which dimensions are most important
- Specify a target for each priority
- What services are needed
- Service Planning and Placement

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Decisional Flow to Match Assessment and Treatment Placement

- What intensity of services is needed?
- Where are these services located (least intensive, but appropriate level of care)?
- What is the patient's progress regarding the established treatment plan and placement decision?

- Level of Care Placement including:
 - Withdrawal management
 - Level of Care Placement
 - Special Populations

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Six Dimensions of Multidimensional Assessment

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ASAM Levels of Care

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Ok...So it's a little more complicated than that, but only in the specific

ASAM	Title	Description	Provider
0.5	Early Intervention	Screening, Brief Intervention, and Referral to Treatment (SBIRT).	Managed care or fee-for-service (FFS) provider
1	Outpatient Services	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies	Department of Health Care Services (DHCS) Certified Outpatient Facilities
2.1	Intensive Outpatient Services	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability	DHCS Certified Intensive Outpatient Facilities
2.5	Partial Hospitalization Services	20 or more hours of service/week for multidimensional instability not requiring 24-hour care	DHCS Certified Partial Hospitalization Facilities

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Ok...So it's a little more complicated than that, but only in the specific

ASAM	Title	Description	Provider
3.1	Clinically Managed Low-Intensity Residential Services	24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment.	DHCS Licensed and DHCS/ASAM designated Residential Providers
3.3	Clinically Managed Population-Specific High-Intensity Residential Services	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 and prepare for outpatient treatment.	DHCS Licensed and DHCS/ASAM designated Residential Providers
3.5	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate/use full milieu or therapeutic community	DHCS Licensed and DHCS/ASAM designated Residential Providers

Ok...So it's a little more complicated than that, but only in the specific

ASAM	Title	Description	Provider
3.7	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 hour/day counselor availability	Chemical Dependency Recovery Hospitals; Hospital, Free Standing Psychiatric hospitals
4	Medically Managed Intensive Inpatient Services	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	Recovery Hospitals, Hospital; Free Standing Psychiatric hospitals
OTP	Opioid Treatment Program (OTP)	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder	DHCS Licensed OTP Maintenance Providers, licensed prescriber

All Levels of Care include, where appropriate,

- Medication Management and Addiction Pharmacotherapy
- Support for families

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Why is a Continuum of Care Important?

- Levels of care provide a terminology for describing the Continuum of “recovery-oriented” addiction services;
- Designed to create a seamless continuum of flexible services;
- Improved efficiency and effectiveness of services;
- Through regular assessment, patients can be shifted to the appropriate level of care, thereby effectively extending the care they receive.

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What is “Regular Assessment?”

- Includes assessment across all six dimensions
 - Acute care facilities-daily or multiple times per day;
 - Residential settings-once weekly or more often if the patient is unstable;
 - Outpatient settings-every six sessions.

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Progression through the Levels of Service

0.5 Early Intervention

1. Outpatient Treatment
2. Intensive Outpatient and Partial Hospitalization
3. Residential/Inpatient Treatment
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Required County Service Under Drug Medi-Cal (DMC) Waiver

- The following services must be provided, as outlined, to all eligible Drug Medi-Cal Organized Delivery System (DMC-ODS) beneficiaries for the identified level of care as follows.
- DMC-ODS benefits include a continuum of care that ensures that clients can enter substance use disorder (SUD) treatment:
 - At a level appropriate to their needs and,
 - Be able to step up or down to a different intensity of treatment based on their responses.

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Required County Service Under DMC Waiver

Service	Required	Optional
Early intervention (SBIRT)	(Provided through Fee-for-Service (FFS) Managed Care)	
Outpatient Services	Outpatient Intensive Outpatient	Partial Hospitalization
Residential	At least one level initially. Within 3 years 3.1, 3.3, and 3.5 required	Additional levels
OTP	Required	
Withdrawal Management	At least one level of service	Additional levels
Additional Medication Assisted Treatment (MAT)		Optional
Recovery Services	Required	
Case Management	Required	
Physician Consultation	Required	

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What do services under the new Drug Medi-Cal Waiver Require?

- Upon State approval, counties may implement
 - a regional model with other counties or,
 - contract with providers in other counties in order to provide the required services.

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A note regarding residential services

- The only facilities DHCS will be designating are residential facilities that are licensed by the department and for only levels 3.1, 3.3, and 3.5 of the ASAM Levels of Care.
- DHCS will not be designating levels of Withdrawal Management. At least one level of service must be provided.
- Counties must provide required services and may provide optional service, but the specific facilities will not be designated by DHCS.

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What does all of this mean?

- If you're already implementing ASAM Criteria in your services—You don't need to change anything right now.
- If you're not—
 - Learning the Criteria can be overwhelming because they look complicated (0.5, 3.1 with 1-WM, step down from 3.2 to 2.5).
 - Take a deep breath and remain calm...The good news is that our system already contains most of these elements.

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So, what will change?

- The State and Los Angeles County systems are in the process of developing a process to respond to the requirement of using ASAM criteria.
- There will likely be some new assessment procedures that allow for clearer and quicker determination of placement.
- There will likely be changes in how clients flow from one level of care to the next so that we facilitate utilization of the most appropriate care.
- Some providers will continue services as they are, activating new partnerships to facilitate movement from one level of care to the next (to other providers).
- Other providers will develop and implement new services that will allow them to broaden the scope of care they provide.

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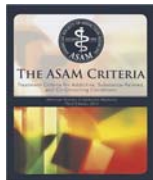
So, what will change?

- More information will be provided and trainings will be offered to ensure that providers are equipped with the information and skill needed to respond to this developing service delivery system.
- So...let's look at some examples of current implementation of the ASAM criteria.

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References and Resources

- Mee-Lee, David. (Eds.) (2013) *The ASAM criteria :treatment for addictive, substance-related, and co-occurring conditions* Chevy Chase, Md. : American Society of Addiction Medicine
- ASAM www.asamcriteria.org
- The Change Companies: www.changecompanies.net
- Center for Integrated Behavioral Health Solutions www.cibhs.org
- UCLA Integrated Substance Abuse Programs (ISAP) Pacific Southwest Addiction Technology Transfer Center www.psattc.org



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Case Presentation

Mr. U

Mr. U is a 68 year-old male who was brought to the clinic by Ms. M his 40 year old (y/o) daughter because he did not pick up his 10y/o grandson from school last Friday as he does on a daily basis. Ms. M was called away from work to pick her son up. Upon arriving at home, Ms. M found Mr. U slumped over the workbench in the garage with an empty bottle of vodka nearby. Mr. U reports drinking to intoxication, complains of always feeling tired, has little or no appetite, and is not motivated to do anything.

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Mr. U reports no health related issues other than heartburn on a daily regular basis, but believes it is due to his liking spicy foods.

Ms. M. reports that her father drinks to intoxication, complains of always feeling tired, has little or no appetite, and is not motivated to do anything. Mr. U acknowledges that he has little or no interest in most activities that use to bring him pleasure, and is bothered by his recurrent thoughts of death.

Mr. U was embarrassed and apologetic for his not picking up his grandson. He appreciates living with his family, and adores his daughter and grandchildren.

Mr. U lives with his daughter, her husband who Mr. U likes, and their three children, ages 18, 16, and 10. They are supportive and concerned about his wellbeing.

ASAM Criteria – Multidimensional Assessment

Dimension #1: Acute Intoxication and/or Withdrawal Potential Risk Rating: _____

Rationale: _____

Dimension #2: Biomedical Conditions and Complications Risk Rating: _____

Rationale: _____

Dimension #3: Emotional, Beh. or Cog. Conditions and Complications Risk Rating: _____

Rationale: _____

Dimension #4: Readiness to Change Risk Rating: _____

Rationale: _____

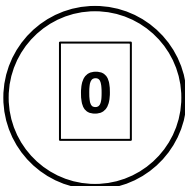
Dimension #5: Relapse, Cont. Use, or Continued Problem Potential Risk Rating: _____

Rationale: _____

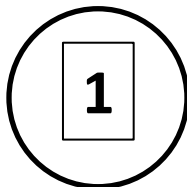
Dimension #6: Recovery/Living Environment Risk Rating: _____

Rationale: _____

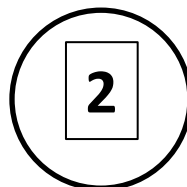
Non-issue
Very low Risk



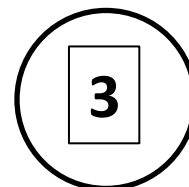
Mild difficulty
chronic issues
Likely to resolve



Moderate difficulty
Persistent chronic issues



Serious Issue
Near Imminent
danger



Utmost severity
Imminent Danger



Six Domains of Multidimensional Assessment

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ASAM Levels of Care

1. Outpatient Treatment
2. Intensive Outpatient and Partial Hospitalization
3. Residential/Inpatient Treatment
4. Medically-Managed Intensive Inpatient Treatment

ASAM PPC-2R RISK RATING CROSSWALK

ASAM Patient Placement Criteria^{RRE+} for the Treatment of Substance-Related Disorders - Adult*

	0	1	2	3	4
1 <i>Acute Intoxication and/or Withdrawal Potential</i>	Fully functioning, no signs of intoxication or withdrawal present.	Mild to moderate intoxication interferes with daily functioning, but does not pose a danger to self or others. Minimal risk of severe withdrawal.	Intoxication may be severe, but responds to support; not posing a danger to self or others. Moderate risk of severe withdrawal.	Severe s/s of intoxication indicates an imminent danger to self or others. Risk of severe but manageable withdrawal; or withdrawal is worsening.	Incapacitated, with severe signs and symptoms. Severe withdrawal presents danger, as of seizures. Continued use poses an imminent threat to life (e.g., liver failure, GI bleed ^E or fetal death).
2 <i>Biomedical Conditions and Complications</i>	Fully functioning and able to cope with any physical discomfort or pain.	Adequate ability to cope with physical discomfort. Mild to moderate symptoms (such as mild to moderate pain) interfere with daily functioning.	Some difficulty tolerating physical problems. Acute, non-life threatening medical symptoms are present. Serious biomedical problems are neglected.	Serious medical problems are neglected during outpatient treatment. Severe medical problems are present but stable. Poor ability to cope with physical problems.	The patient is incapacitated, with severe medical problems.
3 <i>Emotional, Behavioral or Cognitive (EBC) Conditions and Complications</i>	Good impulse control and coping skills and sub-domains (dangerousness/lethality, interference with recovery efforts, social functioning, self-care ability, course of illness).	There is a suspected or diagnosed EBC condition that requires intervention, but does not significantly interfere with tx. Relationships are being impaired but not endangered by substance use.	Persistent EBC condition, with symptoms that distract from recovery efforts, but are not an immediate threat to safety and do not prevent independent functioning.	Severe EBC symptomatology, but sufficient control that does not require involuntary confinement. Impulses to harm self or others, but not dangerous in a 24-hr setting.	Severe EBC symptomatology; requires involuntary confinement. Exhibits severe and acute life-threatening symptoms (e.g., dangerous or impulsive behavior or cognitive functioning) posing imminent danger to self and others.
4 <i>Readiness to Change</i>	Willing, engaged in treatment.	Willing to enter treatment, but is ambivalent about the need for change. Or willing to change substance use, but believes it will not be difficult to do so.	Reluctant to agree to treatment. Able to articulate negative consequences of usage but has low commitment to change use. Only passively involved in treatment.	Unaware of the need for change, minimal awareness of the need for treatment, and unwilling or only partially able to follow through with recommendations.	Not willing to explore change, knows very little about addiction, and is in denial of the illness and its implications. Unable to follow through with recommendations.
	<i>Mental Health</i> Willingly engaged in tx* as a proactive, responsible participant; willing to change mental functioning & behavior.	<i>Mental Health</i> Willing to enter tx and explore strategies for changing mental functioning but is ambivalent about the need for change. Willing to explore the need for strategies to deal with mental disorders. Participation in mental health tx is sufficient to avert mental decompensation. <i>Ex: ambivalent about taking meds but generally follows tx recommendations.</i>	<i>Mental Health</i> Reluctant to agree to tx for mental disorders. Is able to articulate the negative consequences of mental health problems but has low commitment to therapy. Has low readiness to change and passively involved in tx. <i>Ex: variable attendance to therapy or with taking medication.</i>	<i>Mental Health</i> Exhibits inconsistent follow through and shows minimal awareness of mental disorder or need for tx. Unaware of the need for change and is unwilling or partially able to follow through with recommendations.	<i>Mental Health</i> A. No immediate Action Required: Unable to follow through has little or no awareness of a mental disorder or negative consequences. Sees no connection between suffering and mental disorder. Is not imminently dangerous or unable to care for self. Unwilling to explore change and is in denial regarding their illness and its implications. B. Immediate Action Required: Unable to follow

*GI bleed: gastrointestinal bleeding

*tx: treatment

					through with recommendations. Behavior represents an imminent danger of harm to self and others. Unable to function independently or engage in self-care.
5 Relapse, Continued Use, or Continued Problem Potential	Low or no potential for relapse, good coping skills.	Minimal relapse potential, with some vulnerability, and has fair self management and relapse prevention skills.	Impaired recognition and understanding of substance use relapse issues, but is able to self manage with prompting.	Little recognition and understanding of substance use relapse issues, and poor skills to interrupt addiction problems, or to avoid or limit relapse.	No skills to cope with addiction problems, or to prevent relapse. Continued addictive behavior places self and/or others in imminent danger.
	<i>Mental Health</i>	<i>Mental Health</i>	<i>Mental Health</i>	<i>Mental Health</i>	<i>Mental Health</i>
	No potential for further mental health problems or low potential and good coping skills.	Minimal relapse potential with some vulnerability and fair self management & relapse prevention skills.	Impaired recognition & understanding of mental illness relapse issues, but is able to self-manage.	Little recognition or understanding of mental illness relapse issues & poor skills to cope with mental health problems.	A. No immediate action required: Repeated tx episodes with little positive effect. No skills to cope with or interrupt mental health problems. Not in imminent danger and is able to care for self. B. Immediate action required: No skills to arrest the mental health disorder or relapse of mental illness. Psychiatric disorder places them in imminent danger.
6 Recovery Environment	Supportive environment and/or able to cope in environment.	Passive support or significant others are not interested in patient's addiction recovery, but is not too distracted by this and is able to cope	The environment is not supportive of addiction recovery but, with clinical structure, able to cope most of the time.	The environment is not supportive of addiction recovery and the patient finds coping difficult, even with clinical structure.	The environment is chronically hostile and toxic to recovery. The patient is unable to cope with the negative effects of this environment on recovery, and the environment may pose a threat to the patient's safety.
	<i>Mental Health</i>	<i>Mental Health</i>	<i>Mental Health</i>	<i>Mental Health</i>	<i>Mental Health</i>
	Has a supportive environment or is able to cope with poor supports.	Has passive supports or significant others not interested in improved mental health but they are able to cope.	Environment is not supportive of good mental health but, with clinical structure, they are able to cope most of the time.	Environment is not supportive of good mental health and they find coping difficult, even with clinical structure.	A. No immediate action required: Environment is not supportive and is chronically hostile and toxic to good mental health Able to cope with the negative effects of the environment on their recovery. B. Immediate Action Required: Environment is not supportive and is chronically hostile to a safe mental health environment posing an immediate threat to their safety and well being. (ex

					lives with a abusive alcoholic partner.)
	No Risk	Low	Moderate	High	Severe

- **Level III Residential Treatment** typically has a one “3” or “4” in Dimension 1, 2 or 3; and an additional “3” or “4” in Dimensions 1 through 6. For dimension 1, risk rating of “3” or “4” within past 2 weeks.

- **Level II Partial Hospitalization** typically has a risk rating of “1” or “0” in Dimension 1; a “2” or “3” in Dimension 2; a “2 or 3” in Dimension 3; and one “3 or 4” in Dimensions 4 through 6.

- **Level II Intensive Outpatient** typically has a “0” or “1” in Dimensions 1 and 2; a “1 or 2” in Dimension 3; and a “3” or “4” in Dimension 4, 5, or 6.

- **Level I Outpatient treatment** typically has a risk rating of “0” or “1” in all Dimensions.

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