

**GUIDANCE FOR APPLICATION
OF
ASAM IN
PENNSYLVANIA'S
SUBSTANCE USE DISORDER
(SUD) SYSTEM OF CARE**

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GUIDANCE INTRODUCTION

In order to move the Pennsylvania substance use disorder (SUD) system of care to a more client-centered, outcomes-driven, evidence-based approach in level-of care-determination and clinical decision making, Pennsylvania is transitioning from the use of the Pennsylvania Client Placement Criteria (PCPC) to *The ASAM Criteria, 2013*¹. While DDAP-approved, formal training is essential for implementing The ASAM Criteria² with integrity and fidelity, this document will assist assessors and clinicians in aligning the clinical guidance with the regulations, contractual requirements, and available SUD services in Pennsylvania.

In conducting holistic evaluations, assessors should make placement determinations that consider culturally and linguistically appropriate needs (utilization of National Standards for CLAS), as well as the referral to specialty care services based upon specific considerations such as gender identification, sexual orientation, engagement in the criminal justice system, parenting status, etc. Evaluation of history and needs is also important in matching an individual with a provider that may offer a specialized service or therapeutic approach, e.g., trauma-informed care. Considerations for “special populations” or the specific interventions require the assessor to be well informed about the regional treatment network, services available, and providers who can deliver such specialized services. As always, it is essential that assessors be aware of all the service providers to which they make referrals so that individuals being referred are appropriately matched to the provider/facility that can best meet the level of functioning and intensity of need for each individual.

The ASAM Criteria, 2013 “do not purport to set medical or legal standard of care and may not encompass all the levels of service options that may be available in a changing health care field or within any particular state”, (ASAM, p. ix). Additionally, the descriptions are intended to provide a more comprehensive understanding of each level of care (LOC); and “are not intended to replace or supersede the relevant statutes, licensure, or certification requirements of any state or federal jurisdiction” (ASAM, p. 19).

The ASAM Criteria is individually-focused, rather than program-focused. It is DDAP’s expectation that persons, in any LOC, will be offered highly individualized treatment interventions specific to their level of functioning and intensity of need, ensuring that services are provided in a client-centered manner and lengths of stay are developed with the program’s structure to best meet the individual’s needs, or through a referral to a specialized provider.

While *The ASAM Criteria, 2013* addresses co-occurring disorders within every LOC throughout the continuum of care (ASAM, p. 22), specific direction regarding how to make such referrals and placement decisions in Pennsylvania is found in this guidance document on page 24.

¹ “*The ASAM Criteria, 2013*” used throughout this document is referencing the full ASAM text: Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies®, 2013.

² “The ASAM Criteria” without date or italics is used throughout this document when making a general reference to the ASAM admission criteria.

Because the transition to the utilization of *The ASAM Criteria, 2013* is an ongoing process, this guidance is likely to change and be updated as needed. Any revisions will be noted by date on the title page and be posted to DDAP’s website. Changes will also be communicated to the local Single County Authorities (SCAs) and Managed Care Organizations who will assure dissemination across their provider network.

NOTE: This narrative guidance document and the ASAM Crosswalk with PA’s System of Care (separate document) should be used in tandem when making decisions for admission to a LOC. This guidance is not to be used absent of, or as a substitution for, *The ASAM Criteria, 2013*. Only those services/LOC requiring specific guidance other than that which is delineated in *The ASAM Criteria* are addressed below.

While this guidance document focuses specifically on admission criteria, *The ASAM, 2013* should be consulted in addressing continued stay, progression through the levels of service, and discharge. Portions of the text entitled “Service Planning and Placement” (ASAM, pp. 105 – 112) and “Continued Service and Discharge Criteria” (ASAM, 299 – 306) will be especially beneficial when considering these aspects of care. These topics will be incorporated into future DDAP trainings.

Unless otherwise noted, page references found throughout this document are for the corresponding references in *The ASAM Criteria, 2013*.

TREATMENT LEVELS OF SERVICE (*The ASAM Criteria, 2013, pp. 106-107*) WITHDRAWAL MANAGEMENT

ASAM Criteria Level of Withdrawal Management Services for Adults	LEVEL	Note: There are no separate Withdrawal Management Services for Adolescents
Ambulatory Withdrawal Management without Extended On-Site Monitoring (pp. 132 – 134)	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 (pp. 134 – 136)	2-WM	Moderate withdrawal with all day WM support and supervision; at night, has supportive family or living situation; likely to complete WM.
Clinically Managed Residential Withdrawal Management (pp. 137 – 139)	3.2-WM	Moderate withdrawal, but needs 24-hour support to complete WM and increase likelihood of continuing treatment or recovery.
Medically Monitored Inpatient Withdrawal Management (pp. 139 – 141)	3.7-WM	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete WM without medical, nursing monitoring.
Medically Managed Intensive Inpatient Withdrawal Management (pp. 141 – 143)	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify WM regimen and manage medical instability.

There are various assessment considerations for determination of withdrawal management needs including the individual’s personal withdrawal history, course of illness, substances being used, current withdrawal symptoms, medical and mental health complications, etc.; therefore, assessors should be fully familiar with the specific details outlined in *The ASAM Criteria, 2013* (pp. 127 – 173), including the Dimensional Criteria Decision Rules by substance, the Risk Rating Matrix (ASAM, pp. 73 - 104), Immediate Need and Imminent Danger Profile (ASAM, p. 66), as well as the Withdrawal Management Instruments found in the Appendices (ASAM, pp. 393 – 400).

[1 WM \(ASAM, pp. 132-134\) or 2 WM \(ASAM, pp. 134- 136\): Ambulatory Withdrawal Management](#)

Either of these types of withdrawal management can be delivered through an Office Based Opioid Provider or an Opioid Treatment Provider/Narcotic Treatment Provider (OTP/NTP), during which an individual may also be engaged in other therapeutic/clinical services.

[3.2 WM: Clinically-Managed Residential Withdrawal Management](#)

Currently, there are no licensed residential treatment providers within the Commonwealth of Pennsylvania that provide a “social setting detoxification” that is characterized by peer and social support.

PENNSYLVANIA LICENSED CLINICAL SUD TREATMENT SERVICES

Early Intervention – Level 0.5 (pp. 181 – 182)

Assessment and education for at risk individuals who do not meet diagnostic criteria for Substance-Related Disorder

Outpatient (OP) Services – Level 1 (pp. 191 – 193)

ADULT DIMENSIONAL ADMISSION CRITERIA – OP Services

Admission is appropriately assessed as meeting specifications in **all** of the 6 dimensions:

- **DIM 1:** Patient has no signs or symptoms of withdrawal, or withdrawal needs can be safely managed in Level 1 setting;
- **DIM 2:** Biomedical conditions and problems, if any, are sufficiently stable to permit participation in OP treatment.
- **DIM 3:**
 - a) No symptoms of a co-occurring mental disorder, or any symptom are mild, stable, fully related to a substance use or addictive disorder (SUD) and do not interfere with the patient's ability to focus on treatment; *OR*
 - b) Patient's psychiatric symptoms (i.e., anxiety, guilt, or thought disorders) are mild, mostly stable, and primarily related to either a SUD, or to a co-occurring cognitive, emotional, or behavioral condition. Mental health monitoring is needed to maintain stable mood, cognition, and behavior; *AND*
 - c) Mental status does not preclude ability to (1) understand information presented and (2) participate in treatment planning and the treatment process; *AND*
 - d) Not at risk of harm to self or others and is not vulnerable to victimization by another.
- **DIM 4:**
 - a) Patient expresses willingness to participate in treatment planning and to attend all scheduled activities in the treatment plan; *AND*
 - b) Patient acknowledges a substance-related or addictive disorder and/or mental health condition and wants help to change; *OR*
 - c) Patient is ambivalent about substance-related or addictive disorder and/or mental health condition. Monitoring and motivation strategies are required, but not a structured milieu program; *OR*
 - d) Patient may not recognize a substance-related or addictive disorder and/or mental health problem and requires monitoring and motivating strategies to engage in treatment and progress through stages of change.
- **DIM 5:** Able to achieve or maintain abstinence and related recovery goals, or is able to achieve awareness of a substance or other addiction problem and related motivational enhancement goals only with support and scheduled therapeutic contact; including assistance with ambivalence about preoccupation with use; addictive behaviors; cravings, peer pressure; and lifestyle and attitude changes.
- **DIM 6:**
 - a) Psychosocial environment is sufficiently supportive that OP treatment is feasible, e.g., support by significant others, a supportive work environment or legal coercion; adequate transportation; accessible support meetings; *OR*
 - b) Patient does not have an adequate primary or social support system, but has demonstrated motivation and willingness to obtain support; *OR*
 - c) Patient's family, guardian, or significant others are supportive but require professional interventions to improve the chance of treatment success and recovery, e.g., assistance in limit-setting, communication skills, reduction in rescuing behaviors, etc.

Intensive Outpatient (IOP) Services – Level 2.1 (pp. 202-204)

ADULT DIMENSIONAL ADMISSION CRITERIA – IOP Services

Admission is advisable if specifications are met in dimension 2 (if any conditions exist) **and** dimension 3 (if any conditions exist), as well as at least **one** of dimensions 4, 5 or 6:

- **DIM 1:** Patient has no signs or symptoms of withdrawal, or withdrawal needs can be safely managed.
- **DIM 2:** Biomedical problems are stable or are being addressed concurrently and will not interfere with treatment.
- **DIM 3:** If emotional, behavioral, or cognitive conditions are present, patient must be admitted to either a co-occurring capable or co-occurring enhanced program if one exists or an appropriate referral to a separate program to address these conditions concurrently. *see “Co-Occurring,” p. 24
- **DIM 4:**
 - a) Patient requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another level of care have failed; *OR*
 - b) Patient's perspective inhibits his or her ability to make behavioral changes without repeated, structured, clinically directed motivational interventions
- **DIM 5:**
 - a) Patient is experiencing an intensification of symptoms of the substance-related disorder despite participation in a less intensive level of treatment; *OR*
 - b) There is a high likelihood that the patient will continue to use or relapse to use without close outpatient monitoring and structured therapeutic services
- **DIM 6:**
 - a) Patient's continued exposure to current school, work, or living environment will render recovery unlikely; *OR*
 - b) Patient lacks skills, social contacts, has unsupportive social contacts that jeopardize recovery.

Partial Hospitalization (PHP) Services – Level 2.5 (pp. 213 – 215)

ADULT DIMENSIONAL ADMISSION CRITERIA – PHP Services

*Admission is advisable if specifications are met in dimension 2 (if conditions exist) **and** in dimension 3 (if conditions exist) as well as in at least **one** of dimensions 4, 5, or 6:*

- **DIM 1:** Patient has no signs or symptoms of withdrawal, or withdrawal needs can be safely managed.
- **DIM 2:** Biomedical problems are stable or are being addressed concurrently and will not interfere with treatment.
- **DIM 3:** If emotional, behavioral, or cognitive conditions are present, patient must be admitted to either a co-occurring capable or co-occurring enhanced program if one exists or an appropriate referral to a separate program to address these conditions concurrently. *see “Co-Occurring,” p. 24
- **DIM 4:**
 - a) Patient requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another level of care have failed; *OR*
 - b) Patient's perspective and lack of impulse control inhibit his or her ability to make behavioral changes without repeated, structured, clinically directed motivational interventions.
- **DIM 5:**
 - a) Patient is experiencing an intensification of symptoms of the substance-related disorder despite participation in a less intensive level of treatment; *OR*
 - b) There is a high likelihood that the patient will continue to use or relapse to use without close outpatient monitoring and structured therapeutic services.
- **DIM 6:**
 - a) Patient's continued exposure to current school, work, or living environment will render recovery unlikely. The patient lacks the resources or skills to maintain adequate functioning; *OR*
 - b) Family member and/or significant others who live with the patient are not supportive of his/her recovery.

Clinically-Managed Low-Intensity Residential Services, i.e., Halfway House (HWH) – Level 3.1 (pp. 228 -231)

ADULT DIMENSIONAL ADMISSION CRITERIA – HWH Services

Admission is appropriate when specifications are met in **each** of the 6 dimensions:

- **DIM 1:** The patient has no signs or symptoms of withdrawal, OR his or her withdrawal needs can be safely managed in a Level 3.1 setting.
- **DIM 2:**
 - a) If present, the patient’s biomedical problems are stable and do not require medical monitoring, and the patient is able to self-administer medication; *OR*
 - b) a current biomedical condition is not severe enough to warrant inpatient treatment but is sufficient to distract from treatment or recovery efforts.
- **DIM 3:** The patient may not have any significant problems in this dimension. However, if any of the Dimension 3 conditions are present, the patient must be admitted to a co-occurring capable or co-occurring enhanced program (depending on his or her level of function, stability, and degree of impairment). In Pennsylvania, these admission criteria can be satisfied by an admission into a co-occurring capable, a co-occurring enhanced program, a program with a Certificate of Approval as meeting the criteria in the co-occurring disorder competent bulletin, or through a client referral to a mental health provider. As noted on p.45: “If the emotional, behavioral or cognitive signs & symptoms are part of addiction, then Dimension 3 needs may be safely addressed as part of addiction treatment.” *see “Co-Occurring,” p. 24
 - a) Patient has no significant problems in this area, or the condition is assessed as sufficiently stable to allow the patient to participate in the therapeutic interventions provided at this level of care and to benefit from treatment; *AND*
 - b) The psychiatric condition is stable; *OR*
 - c) The patient’s symptoms and functional limitations, when considered in the context of his or her home environment, are sufficiently severe that he or she is assessed as not likely to maintain mental stability and/or abstinence if treatment is provided in a nonresidential setting; *OR*
 - d) The patient demonstrates an inability to maintain stable behavior over a 24-hour period without the structure and support of a 24-hour setting; *OR*
 - e) The patient’s co-occurring psychiatric, emotional, behavioral, or cognitive conditions are being addressed concurrently through appropriate psychiatric services.

While ASAM’s primary focus in DIM 3 is mental status due to a psychiatric condition, The Criteria recognizes that thought disorders, anxiety, guilt and/or depression may be related to SUD problems, that are currently stable but may lead to relapse if not in a structured environment, (ASAM, p. 228).

- **DIM 4:** At least one of the following:
 - a) The patient acknowledges the existence of a psychiatric condition and/or substance use problem;

- b) The patient is assessed as appropriately placed at Level 1 or 2 (Please note: for MH treatment - since in PA, one would not be in Level 3.1 and receiving services in Level 1 or 2 unless these are OP MH services) and is receiving Level 3.1 concurrently;
- c) The patient requires a 24-hour structured milieu to promote treatment progress and recovery because they are not likely to succeed in OP;
- d) The patient's perspective impairs his or her ability to make behavior changes without the support of a structured environment.

(Note: while some states may use the 3.1 LOC as "discovery, dropout prevention", PA's licensing regulation and DDAP's description of the service type is only for those individuals whose SUD symptoms have been previously stabilized (in detox or a higher level of residential service), where the individual acknowledges a SUD problem, but needs 24-hour clinical structure to maintain sobriety and to develop life-skills/recovery maintenance skills.)

- **DIM 5:** Characterized by at least ONE of the following:
 - a) The patient demonstrates limited coping skills to address relapse triggers and urges and/or deteriorating mental functioning;
 - b) The patient understands his or her addiction, but is at risk of relapse in a less structured LOC;
 - c) The patient needs staff support to maintain engagement in his or her recovery program while transitioning to the community;
 - d) The patient is at high risk of substance use, addictive behavior, or deteriorated mental functioning, with dangerous emotional, behavioral, or cognitive consequences in the absence of 24-hour structured environment.
- **DIM 6:**
 - a) a) The patient is able to cope, for limited periods of time, outside of the 24-hour structure of a Level 3.1 program to participate in vocational, educational, and community activities, *AND*
 - b) The patient has been living in an environment that is characterized by a moderately high risk of initiation or repetition of physical, sexual, or emotional abuse, or substance use so endemic that the patient is assessed as being unable to achieve or maintain recovery at a less intensive level of care; *OR*
 - c) The patient lacks social contacts or has high-risk social contacts that jeopardize his or her recovery, or the patient's social network is characterized by significant social isolation and withdrawal; *OR*
 - d) The patient's social network involves living in an environment that is so invested in alcohol or other drug use that the patient's recovery goals are assessed unachievable; *OR*
 - e) Continued exposure to the patient's school, work, or living environment makes recovery unlikely, and the patient has insufficient resources and skills to maintain an adequate level of functioning outside of a 24-hour supportive environment; *OR*
 - f) The patient is in danger of victimization by another and requires 24-hour supervision.

The ASAM Criteria "do not purport to set medical or legal standard of care and may not encompass all the levels of service options that may be available in a changing health care field or within any particular state", (ASAM, p. ix). Additionally, the descriptions are intended to provide a more comprehensive

understanding of each LOC; and “are not intended to replace or supersede the relevant statutes, licensure, or certification requirements of any state or federal jurisdiction” (ASAM, p. 19). Therefore, training and application guidance, as it pertains to Pennsylvania’s halfway house LOC, is set forth in this document.

1. DDAP, recognizing The ASAM Criteria is a guide for placement and overall clinical care, clarifies that PA’s description of service delivery will continue to be determined by regulatory requirements outlined in the PA licensing requirements, and as defined by DDAP in its contractual agreements (Treatment Manual, Operations Manual, etc.). Additionally, DDAP clarifies the utilization of The ASAM Criteria does not change the regulatory definition or application of the term “medically necessary”, as set forth in 55 Pa. Code Chapter 1101.21.
2. In PA, the HWH LOC is licensed as a non-hospital residential facility providing, structured, regulated, professionally staffed services focused on developing self-sufficiency through counseling, employment and other services. Within The ASAM Criteria, the term halfway house is not synonymous with the term halfway house as documented in PA regulations and licensing requirements.
3. The ASAM Criteria’s Level 3 placements include a continuum of residential services, 3.1, 3.3, 3.5, and 3.7. Within Pennsylvania’s system of care, it has been determined that HWHs, because of the live-in, work-out environment, are most appropriately described by ASAM’s 3.1, with guidance for applying The ASAM Criteria to PA’s system of care and regulatory requirements.
4. Contrary to The ASAM Criteria’s indication that clinical services in this 3.1 LOC are usually provided in an outpatient setting (ASAM, p. 223), in Pennsylvania, HWH’s are licensed, clinical providers that deliver onsite substance use disorder treatment, with referrals to an appropriate off-site mental health provider unless a provider is also credentialed to provide such services within the facility.
5. As always, it is essential that assessors are aware of all the service providers to which they make referrals so that individuals being referred are appropriately matched to the provider/facility that can best meet the needs of the individual.
6. The ASAM Criteria is individually focused, rather than program-focused. It is DDAP’s expectation that clients, in any LOC, will be treated as individuals, and if a service is needed, the provider will ensure that the client’s needs are met within the program’s structure or through a referral to a specialized provider.
7. Even though there has been legislation passed to certify or license recovery residences, recovery houses are not authorized to provide clinical services. While housing may be an ancillary need that can be met while an individual is participating in one of the outpatient levels of care, the appropriate clinical service would be either ASAM’s 1.0, 2.1, or 2.5, with an ancillary referral to an approved recovery residence, but NOT an ASAM Level 3 placement. The need for housing and a safe recovery environment cannot be the sole driver for placement into HWH/residential services, rather an individual must meet the admission criteria of the other dimensions as well.
8. DDAP is providing clarification to the Level 3.1 Adult Dimensional Admission Criteria, Dimension 3, All Programs statement located on page 228:

All Programs: The patient may not have any significant problems in this dimension. However, if any of the Dimension 3 conditions are present, the patient must be admitted to a co-occurring capable or co-

occurring enhanced program (depending on his or her level of function, stability, and degree of impairment). In Pennsylvania, these admission criteria can be satisfied by an admission into a co-occurring capable, a co-occurring enhanced program, a program with a Certificate of Approval as meeting the criteria in the co-occurring disorder competent bulletin, or through a client referral to a mental health provider. As noted on ASAM's p.45: "If the emotional, behavioral or cognitive signs and symptoms are part of addiction (e.g., mood swings because the individual is using "uppers" and "downers"), then Dimension 3 needs may be safely addressed as part of addiction treatment."

9. An individual is not required to have a co-occurring issue to utilize the 3.1 LOC, nor does having a co-occurring condition negate placement in this LOC. Rather, The ASAM Criteria is inclusive of those individuals who may have co-occurring conditions in Level 3.1 (and all LOCs).

Clinically Managed Population-Specific High-Intensity Residential Services – Level 3.3 (pp. 240 – 243)

1. Some providers may have a DDAP Non-Hospital Program license and have a Mental Health license to address persons with severe co-occurring disorders (COD) and therefore are equipped to serve individuals with significant cognitive dysfunction, developmental delays and/or debilitating CODs. Currently, while such population-specific programs exist in Pennsylvania, they are mostly unavailable. Clinicians/assessors need to be mindful of available services and programming done by providers.
2. While there are some providers that are equipped with the level of specialty staff to serve individuals with severe cognitive impairments or co-occurring disorders, there are no SUD treatment programs that are licensed to serve only individuals with these specialized needs.
3. In such instances where an individual is assessed as having cognitive impairments that require services that are adapted to fit the level of impairment and staffing requirement, assessors and clinicians should make every effort to identify programs that can better deliver such services, even though the facility patient population is not limited to these specialized services or specific individuals, or concurrent referrals for specialized care should be made.
4. Where functionality is so impaired that the physical or mental health issue is primary or supersedes the SUD need, appropriate referral to a therapeutic rehabilitation program or a traumatic brain injury program is required, followed by SUD referral upon stabilization, as appropriate.

Clinically-Managed High Intensity Residential Services (Adult) High Intensity Residential Services (ST) and Highest Intensity Residential Services (LT) – Level 3.5

Note: while neither LOC will be eliminated, references to what has historically been referenced as:

3B: “Medically Monitored Short-Term Residential” and 3C: “Medically Monitored Long-Term Residential” will now be regarded as: **“High Intensity Residential Services” (Short-term) and “Highest Intensity Residential Services” (Long-term)** to more accurately reflect the ASAM principles of client-centered treatment planning:

1. While this distinction was made in the PCPC, it is not delineated within the licensing regulations. Both types of care are licensed under the Chapters 709 & 711 Standards for Licensure of Freestanding Treatment Facilities. Furthermore, although programs licensed under the 709 & 711 regulations may have medical staff or access to medical staff, since the licensing regulations do not specify the requirement for medical professionals to be employed within the LOCs formerly known as 3B or 3C, both LOCs are best defined as “Clinically Managed” Residential Services.
2. Although both types of residential service, short-term and long-term, are now identified under the 3.5 LOC, it does NOT mean that either one will be eliminated with the transition to The ASAM Criteria. When an individual meets the admission criteria for the 3.5 LOC, the additional placement considerations that follow specifically for Pennsylvania should be made in determining the distinction between “High Intensity” (Short-Term) and “Highest Intensity” (Long-term) LOCs:

Clinically Managed High-Intensity Residential Services – Level 3.5 (pp. 254 – 259)

ADULT DIMENSIONAL ADMISSION CRITERIA – Clinically Managed High-Intensity Services

*Admission is appropriate when specifications are met in **each** of the 6 dimensions:*

- **DIM 1:** Patient has no signs or symptoms of withdrawal, or withdrawal needs can be safely managed.
- **DIM 2:**
 - a) Biomedical problems, if any are stable and do not require 24-hour medical or nurse monitoring; patient is capable of self-administering medication; *OR*
 - b) Current biomedical condition is not severe enough to warrant inpatient treatment, but warrants medical monitoring, which can be provided by the program or through an established arrangement with another provider.
- **DIM 3:** Patient's status is characterized by a and one of b, c, d, or e, or f.
 - a) Patient's mental status is assessed as sufficiently stable to participate, *AND*
 - b) Patient's psychiatric condition is stabilizing; *OR*
 - c) Patient has inability to control impulses to use or engage in antisocial behavior and is in imminent danger of relapse, *OR*
 - d) Patient demonstrates antisocial behavior patterns which prevent positive change and precludes participation in a less structured environment; *OR*
 - e) Patient has significant functional deficits requiring treatment that is habilitative in nature; *OR*
 - f) Patient's concomitant personality disorders are so severe that the accompanying dysfunctional behaviors require continuous boundary setting interventions.
 - g) If significant emotional, behavioral, or cognitive conditions and impairment are present, the patient must be admitted into a co-occurring capable, a co-occurring enhanced program, a program with a Certificate of Approval as meeting the criteria in the co-occurring disorder competent bulletin, or through a client referral to a mental health provider. *see "Co-Occurring," p. 24
- **DIM 4:** At least one of the following:
 - a) The intensity and chronicity of the SUD or the patient's mental health problems are such that he or she has limited insight or little awareness of the need for treatment or continuing care;
 - b) Despite experiencing consequences of the SUD or mental health problem, the patient has marked difficulty understanding the relationship between his or her SUD, addiction, mental health or life problems and impaired coping, or blaming others for his or her addiction problem;
 - c) Patient demonstrates passive or active opposition to addressing the severity of his or her mental or addiction problem, or does not recognize the need for treatment;
 - d) Patient requires structured therapy and a 24-hour programmatic milieu to promote treatment progress and recovery because motivation interventions have not succeeded at less intensive levels of care;
 - e) Patient's perspective impairs his or her ability to make behavior changes without repeated, structured, clinically motivated interventions developed in a 24-hour milieu;

- f) Despite recognition of a SUD and understanding the relationship between his or her use, addiction, and life problems, the patient expresses little to no interest in changing;
- g) Patient attributes his or her alcohol, drug, addictive, or mental problem to other persons or external events, rather than to a substance use or addictive or mental disorder.
- **DIM 5:** At least one of the following:
 - a) Patient requires 24-hour monitoring and structured support. Patient does not recognize relapse triggers and has little awareness of the need for continuing care and is, therefore, not committed to treatment. His or her continued substance use poses an imminent danger of harm to self or others in the absence of 24-hour monitoring and structured support;
 - b) Patient's psychiatric condition is stabilizing; however, patient is unable to control his or her use of alcohol, other drugs, and/or antisocial behaviors. The patient has limited ability to interrupt the relapse process or to use peer supports when at risk for relapse;
 - c) Patient is experiencing psychiatric or addiction symptoms, insufficient ability to postpone immediate gratification and other drug-seeking behaviors. Poses an imminent danger of harm to self or others in the absence of 24-hour monitored support;
 - d) Patient is in danger of relapse or continued use, with dangerous emotional, behavioral, or cognitive consequences as a result of a crisis situation;
 - e) Despite recent, active participation in treatment at a less intensive level of care, the patient continues to use alcohol or other drugs, or to deteriorate psychiatrically, with imminent serious consequences;
 - f) Patient demonstrates a lifetime history of repeated incarceration with a pattern of relapse to substances and uninterrupted use outside of incarceration, with imminent risk of relapse to addiction or mental health problems and recidivism to criminal behavior. The patient's imminent danger of relapse is accompanied by an uninterrupted cycle of relapse-reoffending-incarceration-release-relapse without the opportunity for treatment.
- **DIM 6:**
 - a) Patient has been living in an environment that is characterized by a moderately high risk of initiation or repetition of physical, sexual, or emotional abuse or substance use so endemic that the individual is assessed as being unable to achieve or maintain recovery in a less intensive level of care; *OR*
 - b) Individual's social network includes regular users of alcohol, tobacco, and/or other drugs, such that the individual's recovery goals are assessed as unachievable; *OR*
 - c) Patient's social network is characterized by significant social isolation or withdrawal; *OR*
 - d) Patient's social network involves living with an individual who is a regular user, addicted user or dealer of alcohol and/or other drugs, or the living environment is so invested in alcohol and/or other drug use that his or her recovery goals are assessed as unachievable; *OR*
 - e) Patient is unable to cope, for even limited periods of time, outside of 24-hour care.

PA-Specific Considerations for Clinically-Managed High-Intensity Residential Services (Short-term)

- **DIM 3:** Emotional/behavioral symptoms are interfering with abstinence/recovery; or, the patient’s emotional, behavioral, or cognitive conditions require 24-hr structure; or, concomitant personality disorders are severe & require continuous boundary setting interventions. *see “Co-Occurring,” p. 24

For Clinically-Managed High-Intensity Residential Services to be appropriate, the individual *must need habilitation services, rather than rehabilitation services* (see ASAM, pp. 419 & 427 for definitions of habilitation and rehabilitation). Many persons start stabilization/treatment in High-Intensity (short term) services, but after careful monitoring and further comprehensive assessment, transition to Highest-Intensity (long term) services may be necessary.

PA Specific Considerations for Clinically-Managed Highest-Intensity Residential Services (Long-term)

- **DIM 3:** The individual must meet at least 2: Disordered Living Skills, i.e., lacking socially acceptable norms/coping skills; history of inability to internalize social responsibility; history of significant, consistent substance use prior to early adolescence. Disordered Social Adaptiveness, i.e., history of repetitive antisocial or criminal behavior with or without incarceration; history of rebellion/denigration of acceptable societal values with disregard of authority and basic rules. Disordered Self-Adaptiveness, i.e., Persecutory fear, poor sense of self-worth, self-hatred; history of chronic external focus/seeking of external stimuli to the exclusion of developing internal supports; inability to develop supportive relationships; blaming others and difficulty/unwillingness to make decisions to effect positive changes in the circumstances that the individual regards as undesirable.
- **DIM 4:** The individual has little to no recognition that his or her SUD use is a problem or is causing a problem; requires 24-hr, directed motivational interventions to gain insight into the SUD to make behavioral changes.
- **DIM 5:** The individual demonstrates a lifetime history of repeated incarceration with a pattern of relapse to substances and uninterrupted use outside of incarceration, with imminent risk of relapse to addiction or mental health problems and recidivism to criminal behavior. Imminent danger of relapse is accompanied by an uninterrupted cycle of relapse-reoffending-incarceration-release-relapse without the opportunity for treatment.
- **DIM 6:** The individual requires 24-hours monitoring to achieve and maintain abstinence.

For Clinically-Managed Highest-Intensity Residential Services to be appropriate, the individual *must need habilitation services, rather than rehabilitation services*. (see ASAM, pp. 419 & 427 for definitions of habilitation and rehabilitation). “Habilitation” as referenced and delivered within an adult SUD treatment program primarily addresses those issues identified in dimension three above and not instruction or interventions related to daily living skills such as bathing, toileting, dressing, etc.

While placement in the most appropriate LOC should be determined by clinical assessment and judgment, until which time when all referring entities understand and become accustomed to the full transition to The ASAM Criteria, there may be court-ordered appointments to the Highest Intensity Clinically Managed Residential LOC or designated specialized “Criminal Justice” placement/residential

service. Please refer to the text to more fully understand how to approach and document mandated treatment episodes. (ASAM, p. 20).

Note: For either LOC, High Intensity or Highest Intensity Clinically Managed Residential Services, when an individual has both SUD and Mental Health conditions and where there are co-occurring capable, or co-occurring enhanced services available, such would be the more appropriate type of service/referral. * see "Co-Occurring," p. 24

Additionally, for either LOC, the length of stay in treatment should be variable, and based on the continued assessment of the individual's symptom severity and level of functioning.

Medically Monitored Intensive Inpatient Services – Level 3.7 (pp. 272 - 276)

ADULT DIMENSIONAL ADMISSION CRITERIA – Medically Monitored Intensive Inpatient Services

*Admission is appropriate when specifications are met in at least **two** of the six dimensions, at least **one** of which is in dimensions 1, 2, or 3:*

- **DIM 1:** Patient needs withdrawal management protocol.
- **DIM 2:**
 - a) Interaction of the patient’s biomedical condition and continued alcohol and/or other drug use places the patient at significant risk of serious damage to physical health or concomitant biomedical conditions; *OR*
 - b) A current biomedical condition requires 24-hour nursing and medical monitoring or active treatment, but not the full resources of an acute care hospital.
- **DIM 3:** If significant emotional, behavioral, or cognitive conditions and impairment are present, the patient must be admitted into a co-occurring capable, a co-occurring enhanced program, a program with a Certificate of Approval as meeting the criteria in the co-occurring disorder competent bulletin, or through a client referral to a mental health provider. *see “Co-Occurring,” p. 24
- **DIM 4:**
 - a) Despite experiencing serious consequences or effects of the addictive disorder and/or behavioral health problem, the patient does not accept or relate the addictive disorder to the severity of the presenting problem; *OR*
 - b) Patient is in need of intensive motivating strategies, activities, and processes available only in a 24-hour structured, medically monitored setting; *OR*
 - c) Ongoing 24-hour psychiatric monitoring to assure follow through with the treatment regimen, and to deal with issues such as ambivalence about adherence to psychiatric medications and a recovery program.
- **DIM 5:**
 - a) Patient is experiencing an acute psychiatric or substance use crisis, marked by intensification of symptoms of his or her addictive or mental disorder, which poses a serious risk of harm to self or others in the absence of 24-hour monitoring and structured support; *OR*
 - b) Patient is experiencing an escalation of relapse behaviors and/or reemergence of acute symptoms, which places the patient at serious risk to self or others in the absence of the type of 24-hour monitoring and structured support found in a medically monitored setting; *OR*
 - c) The intensity or modality of treatment protocols to address relapse require that the patient receive Level 3.7 program, to safely and effectively initiate antagonist therapy, or agonist therapy.
- **DIM 6:**
 - a) Patient requires continuous medical monitoring while addressing his or her substance use and/or psychiatric symptoms because his or her current living situation is characterized by a high risk or initiation or repetition of physical, sexual, or emotional

abuse, or active substance abuse, such that the patient is assessed as being unable to achieve or maintain recovery at a less intensive level of care; *OR*

b) Family members or significant others living with the patient are not supportive of his or her recovery goals and are actively sabotaging treatment, or their behavior jeopardizes recovery efforts; *OR*

c) Patient is unable to cope, for even limited periods of time, outside of 24-hour care.

1. Because of the medical staffing requirement of this LOC, Medically Monitored Residential Providers licensed under the 710 or 711 regulations will most likely qualify to deliver 3.7 services, i.e., residential treatment provided in a healthcare facility, a hospital capable of monitoring; a psychiatric hospital.

2. However, in such instances where a program licensed under the 709 regulations that also provides withdrawal management services and is required to have primary care staffing as per Licensing Alert 3-02, would also meet the requirements to provide Medically Monitored Intensive Inpatient Services, i.e., a free-standing psychiatric hospital or a residential provider with access to medical staff.

Medically Managed Intensive Inpatient Services – Level 4.0 (pp. 286 – 287)

ADULT DIMENSIONAL ADMISSION CRITERIA – Medically Managed Intensive Inpatient Services

*Admission is appropriate when specifications are met in at least **one** of dimensions 1, 2, or 3:*

- **DIM 1:** See separate WM specifications.
- **DIM 2:**
 - a) Biomedical complications of the addictive disorder require medical management and skilled nursing care; *OR*
 - b) A concurrent biomedical illness or pregnancy requires stabilization and daily medical management with daily primary nursing interventions; *OR*
 - c) Patient has a concurrent biomedical condition(s) in which continued alcohol or other drug use presents an imminent danger to the life or severe danger to health; *OR*
 - d) Patient is experiencing recurrent or multiple seizures; *OR*
 - e) Patient is experiencing a disulfiram-alcohol reaction; *OR*
 - f) Patient has life-threatening symptoms that are related to use of alcohol, tobacco, and/or other drugs; *OR*
 - g) Patient’s alcohol, tobacco, and/or other drug use is gravely complicating or exacerbating a previously diagnosed medical condition; *OR*
 - h) Changes in the patient’s medical status, such as significant worsening of a medical condition, make abstinence imperative; *OR*
 - i) Significant improvement in a previously unstable medical condition allows the patient to respond to addiction treatment; *OR*
 - j) Patient has (an)other biomedical problem(s) that requires 24-hour observation and evaluation.
- **DIM 3:** Patient whose status is characterized by stabilized emotional, behavioral, or cognitive condition is appropriately assessed as in need of Level 4 co-occurring capable program services; *OR* if the patient’s emotional, behavioral, or cognitive conditions symptoms are so severe as to require admission to a Level 4 program, then only a co-occurring enhanced program is sufficient to meet the patient’s needs.
- **DIM 4:** Only a patient who meets criteria in Dimensions 1, 2, or 3 is appropriately placed in a Level 4 program.
- **DIM 5:** Only a patient who meets criteria in Dimensions 1, 2, or 3 is appropriately placed in a Level 4 program.
- **DIM 6:** Only a patient who meets criteria in Dimensions 1, 2, or 3 is appropriately placed in a Level 4 program.

OTHER ASSESSMENT CONSIDERATIONS / SPECIAL POPULATIONS

Pennsylvania Regulatory Requirements versus ASAM

1. Assessors and clinicians should keep in mind that while The ASAM Criteria serves as a resource and clinical guide, the Criteria does not replace legal or regulatory guidelines, certification guidelines or contractual requirements established by the state or certification authorities.
2. When considering PA's licensing regulations when applying The ASAM Criteria, assessors and clinicians should be reminded that the regulations are *minimum standards* and do not prohibit the adoption of more robust clinical expectations. For example, The ASAM Criteria's guidelines for conducting ongoing continued stay reviews (ASAM, pp. 299 - 306) more frequently than outlined in the Pennsylvania regulations is an allowable clinical activity, and in fact, will be the expectation as the transition to ASAM becomes more fully implemented.
3. The above noted clarifications support DDAP's position regarding who can administer The ASAM Criteria. Pennsylvania has clearly defined requirements for case management, assessment and clinical staff. All staff determining LOC placement should have proper training and skills and always be appropriately supervised to ensure proper application of the Criteria.
4. *Please refer to pages ix, x, xi, 19 in The ASAM Criteria, 2013 for further clarification of the items discussed above.*
5. Service descriptions/LOCs, staffing requirements, and timeline for treatment plan reviews will remain unchanged until further notice from DDAP.

Assessment Upon Re-Entry From Incarceration

1. DDAP's clinical position in applying the PCPC to persons being released from the Criminal Justice System has been that forced abstinence does not equate to recovery and therefore the individual's SUD condition should be assessed based upon the 6 months prior to incarceration. While incarceration should never be a substitution for needed treatment, in transitioning to the ASAM, assessors must do a clinical assessment based on ALL 6 dimensions.
 - a) While Dimension 1, Acute Intoxication and Withdrawal Potential may be low, accurate clinical assessment of the remaining Dimensions will be especially important.
 - b) In assessing all dimensions, clinical attention should be in Dimension 4: "Readiness to Change", as is indicated in The ASAM Criteria, the "...assessment of state of change is designated from the clinician's point of view as to what the individual needs to change and accept as a condition requiring treatment."
 - c) In assessing Dimension 5, "Relapse, Continued Use, or Continued Problem Potential": The clinician should "assess the need for relapse prevention services. If the person has not achieved a period of recovery from which to relapse (see definition of relapse and expanded constructs (ASAM, p. 52), this dimension assesses the potential for continued use for SUD, or continue problem potential..." If an individual was untreated or undertreated during incarceration, it is clinically unlikely that forced abstinence resulted in recovery. *The ASAM Criteria, 2013* glossary defines abstinence and recovery as follows:
 - Abstinence is "intentional and consistent restraint from the pathological pursuit of reward and/or relief that involves the use of substances and other behaviors." (ASAM, p. 411)

- Recovery is “a process of sustained action that addresses the biological, psychological, social, and spiritual disturbances inherent in addiction. This effort is in the direction of a consistent pursuit of abstinence, addressing impairment in behavioral control, dealing with cravings, recognizing one’s behaviors and interpersonal relationships, and dealing more effectively with emotional responses. Recovery actions lead to reversal of negative, self-defeating internal processes and behaviors, allowing healing of relationships with self and others. The concepts of humility, acceptance, and surrender are useful in this process.” (ASAM, p. 427)

2. While it is not specifically noted in The ASAM Criteria, it is implied by the information cited above, that assessors will continue to adhere to the premise that jail time should not replace the need for clinical or support services. Rather, clinical judgment must be utilized about use and difficulties experienced prior to incarceration (client history) with consideration given to clinical interventions that may or may not have been received while incarcerated and how this impacts the assessment of risk.

3. Otherwise, the ASAM includes consideration for SUD treatment for those who are currently incarcerated which can be utilized by assessors in the settings described (ASAM, pp. 350 - 356).

Co-Occurring Substance Use and Mental Health Disorders*

1. There is no *level of care* in PA that will be restricted to only individuals who have a co-occurring condition; however, there may be *providers* that specifically serve only those with a co-occurring condition. Such programs would likely be dually licensed.

2. DDAP has historically required the assessment of co-occurring needs and appropriate referral by the SUD assessor, and follow up by the case manager. Whenever possible, individuals were to have been referred to integrated services. The transition to The ASAM Criteria brings this assessment and referral requirement to the forefront. While it may be the case that individuals who have a SUD may not have a behavioral health (BH) condition, and individuals who have a BH condition may not have a SUD, co-morbidity often exists and when it does, it is important that they are treated concurrently.

3. DDAP and OMHSAS recognizes that the availability of integrated services is frequently a gap in our service-delivery system and that prior efforts in strengthening co-occurring integrated care will need to be resurrected, not only because of The ASAM Criteria transition, but to improve services overall. Until this occurs, co-occurring disorders must be considered as part of the assessment process and referrals made accordingly: when available to a provider able to offer integrated services, to a provider that can offer co-occurring capable or co-occurring enhanced services, or to a separate behavioral health provider as individual need and available services dictates.

4. While ASAM’s primary focus in DIM 3 is to assess the need for mental health services, The ASAM Criteria recognizes that thought disorders, anxiety, guilt and/or depression may be related to SUD problems, that are currently stable but may lead to relapse if not in a structured environment. “If the emotional, behavioral or cognitive signs and symptoms are part of addiction (e.g., mood swings because the individual is using “uppers” and “downers”), then Dimension 3 needs may be safely addressed as part of addiction treatment.” (ASAM, p. 45)

Parents or Prospective Parents Receiving Addiction Treatment Concurrently with Their Children

1. As per PA Act 65 of 1993 and by way of federal substance abuse block grant (SABG) requirements, Pennsylvania has a robust system of services for pregnant women and women with children, including specialized providers offering care to these individuals. While The ASAM Criteria broadens the scope to include the parenting individual, Pennsylvania has few, if any, programs that admit parenting men with their children. Nevertheless, regardless of gender, the needs of the parenting individual with an SUD should be considered at the time of assessment and recommendations/referral for treatment and appropriate supports for the individual and child should be considered, referrals made, and appropriate follow up conducted for any LOC.
2. Otherwise, the considerations outlined in The ASAM Criteria regarding parenting or pregnant women, are applicable (ASAM, pp. 318 – 339) and in such instances, the clinician should refer to these specialized services. (Note: pregnant women and individuals who use intravenous drugs/women remain a priority population to receive services as determined by the federal SABG).

Medication Assisted Treatment (MAT)

1. Historically, while Pennsylvania has had licensed Narcotic Treatment Programs (NTPs, also known as Opioid Treatment Programs/OTPs), the placement criteria (PCPC 3rd Edition) assessed referral to MAT as a special population consideration.
2. For referral to an NTP using methadone, per federal regulations (with certain exceptions), an individual must be 18+ years of age and be opioid dependent for over one year.
3. In keeping with the true intent of medication being used as an assistance to treatment, the ASAM Criteria recognizes the use of medications in all levels of care across the continuum, even if the treatment provider is not the prescriber of the medication. This ensures/encourages the coordination of care between therapeutic and pharmaceutical interventions.
4. The ASAM Criteria are guided by an individualized, person-centered approach to services rather than a program-driven, fixed length-of-stay model. It is DDAP's expectation that clients will be treated as individuals, and if medication is needed, that the provider will ensure that the clients' needs are met. It is imperative that providers licensed as "drug-free providers" understand the expectation that medications that are being used to address an individual's SUD be regarded similarly to other medication (insulin, beta blockers, etc.) that are not prescribed by them and do not preclude the admission of individuals on MAT into services.
5. Clinicians and programs are encouraged to reference SAMHSA's TIP 63, "Medications for Opioid Use Disorder" (<https://store.samhsa.gov/product/SMA18-5063FULLDOC>) as well as "The ASAM National Practice Guideline For the Use of Medication in the Treatment of Addiction Involving Opioid Use" (<https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf>)