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What’s New in DSM-5 and The New ASAM Criteria?  
Implications in an Era of Healthcare Reform

A new edition of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine (ASAM) was unveiled October 24, 2013 in Arlington, Virginia. The new title is The ASAM Criteria – Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. As the most comprehensive set of guidelines for assessment, service planning, placement, continued stay and transfer/discharge of individuals with addiction and co-occurring conditions, ASAM’s criteria are required in over 30 states and in Department of Defense addiction programs around the world. Many payers also manage care using the criteria that are the most intensively researched set of addiction placement criteria in the USA and Europe.

The other significant publication in behavioral health care published in May 2013 was the new fifth edition of the Diagnostic and Statistical Manual of the American Psychiatric Association – DSM-5. Another important publication just released in September, 2013 is the National Survey on Drug Use and Health (NSDUH) from SAMHSA, the Substance Abuse and Mental Health Services Administration. The results for 2012 reinforce what previous years’ data show – that millions of Americans needing addiction treatment are not identified; do not try to access services; and only about 10% actually get into specialty addiction services.

The new edition of The ASAM Criteria, DSM-5, and the NSDUH data are all significant given the current climate of healthcare reform. Consider the following data: The Affordable Care Act (ACA) is fully enacted in 2014, with potentially 30 million people now uninsured who could access health insurance. Not all will enroll and/or live in States that will not expand Medicaid to allow them to get health insurance. But there will still be millions more who have health insurance, even if it is just a fifth of those who eligible to be covered.

Secondly, in the latest data from the 2012 National Survey on Drug Use and Health (NSDUH):

- 23.1 million people 12 years and older needed treatment for an illicit drug or alcohol use problem.

- But 20.6 million of those needing treatment did not receive treatment in a specialty addiction agency in the past year.
94.6% of those 20.6 million people did not perceive a need for treatment, so made no effort to seek treatment.

3.7% of those 20.6 million people felt they needed treatment but did not make an effort to seek treatment; and only 1.7% felt they needed treatment and made an effort to get treatment. A picture is worth a thousand words, so take a look:

Past Year Perceived Need for and Effort Made to Receive Specialty Treatment among Persons Aged 12 or Older Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use: 2012

So what to make of these data? Here is a challenge to ponder:

If there are millions more people who in 2014 can now be covered by health insurance with access to addiction treatment, how will addiction treatment agencies increase access to care when we already have waiting lists and can’t even meet treatment-on-demand now, for the 2.5 million people who did eventually receive specialty addiction treatment?

What’s New in The ASAM Criteria and DSM-5 and How They Can Help

Perhaps you noticed that in this new third edition of ASAM’s criteria, the title is The ASAM Criteria – no “patient placement” in the title. That does not diminish the importance that the new edition still places on defining levels of care and admission criteria for placement in the broad continuum of care. But this edition ties in with
ASAM’s definition of addiction that sees addiction as “a primary, chronic disease of brain reward, motivation, memory and related circuitry.” Thus the new edition is as much about guidelines for chronic disease management as it is placing people in programs.

In the context of healthcare reform and the data from the NSDUH and other such data, the new edition of *The ASAM Criteria* with related notes on DSM-5:

- Expands on Level 0.5, Early Intervention services to include Screening, Brief Intervention, Referral and Treatment (SBIRT) to emphasize the importance of reaching out to the 20.6 million people who aren’t even thinking about addiction treatment. DSM-5’s new chapter on Substance-Related and Addictive Disorders defines 11 criteria in one new category Substance Use Disorder (SUD). If a person does not meet at least two of these 11 criteria, Level 0.5 is the service level needed. If two or more SUD criteria are met then the patient requires at least Level 1 services.

- Broadens perspectives that Level 1, Outpatient Treatment isn’t just a gateway into addiction treatment or “aftercare,” but should also be seen as ongoing disease management of addiction for maintenance chronic disease care—from which some people will never “graduate” just as people don’t graduate or complete diabetes, hypertension, and asthma treatment. Patients who are at least moderate (4-5 of the 11 SUD criteria) or severe SUD (6 or more criteria) will likely need ongoing chronic disease management.

- Preserves the importance of admission criteria for each level of care placement, but highlights that *The ASAM Criteria* are helpful beyond just defining specialty addiction treatment criteria. The multidimensional assessment of six dimensions provides a common language of assessment for general healthcare and mental health as well. Accountable Care Organizations (ACOs) will increasingly need to address those with addiction, as these patients increase the ACO’s healthcare costs and hospital readmission rates. DSM-5 provides the diagnostic criteria to the Diagnostic Admission Criteria for each level of care; and *The ASAM Criteria* provides the guidelines on how to assess addiction and access a broad continuum of care.

- Expands on the importance of integrated co-occurring substance-related and mental health conditions to reach out to the many patients who revolve through...
acute psychiatric units with substance-induced psychosis and mood disorders. DSM-5 continues the criteria for Substance-Induced Disorders that is so important for clinicians to consider in the differential diagnosis. Too many people using “uppers” and “downers” are being diagnosed as having Bipolar Disorder and prescribed a mood stabilizer medication when it is really a Substance Induced Bipolar Disorder needing addiction treatment.

- Builds on ASAM’s definition of addiction that reflects the “individual pathologically pursuing reward and/or relief by substance use and other behaviors.” Thus The ASAM Criteria has a new section on Gambling Disorder consistent with DSM-5’s new chapter on Substance-Related and Addictive Disorders and Internet Gaming Disorder in Section III, Conditions for Further Study.

New Terminology in The ASAM Criteria and DSM-5

While the specific admission criteria and levels of care have not essentially changed in The ASAM Criteria, there are some changes in how we designate the levels of care. Instead of Roman numerals for the levels, regular Arabic numerals are used. So what was once Level I or II services become Level 1 or 2 services, and so on. DSM-5 also switched away from Roman numerals as in DSM-IV, in part so DSM could become a “living document” with changes and enhancements accessible through a subscription web-based version. Perhaps we will soon see version DSM-5.1 or DSM-5.2. The ASAM Criteria also has a web-enhanced subscription version for similar reasons.

Another significant change in terminology in The ASAM Criteria is to re-name “detoxification.” Since the liver detoxifies substances, but clinicians manage the withdrawal, the new edition changed “detox services” to “withdrawal management services.” Often patients are placed in the most intensive and expensive level of withdrawal management—a hospital Level 4 service for three or four days—to ensure they do not have withdrawal seizures. Then upon discharge or soon after, the person uses substances again and is confronted about using when they were already “detoxed.”

Actually, the patient was treated just long enough to prevent seizures and then discharged, but begins to use again because his or her withdrawal was not managed. The change to “withdrawal management” emphasizes the importance of using a continuum of withdrawal management services to support a person through both the physiological and psychological signs and symptoms of withdrawal. This may require a couple of weeks for
some, not just a few days in hospital. Such withdrawal management can be done using the same or even fewer resources than are spent on a few days in Level 4 hospital, which often has rates of up to a $1,000/day.

Here are a few more terminology changes in DSM-5 that clinicians will need to get used to:

- No more multiaxial system (Axes I, II, III, IV and V) to document diagnoses, functioning, and psychosocial factors – just a diagnoses list to reflect the whole person, not separating mental disorders from physical and general medical conditions.
- No more “Substance Abuse and Dependence.” Now use “Substance Use Disorder” with severities of mild, moderate, and severe.
- No more “Not otherwise specified” (NOS). Now use “other specified disorder” to document the specific reason the client presentation does not quite fit a diagnostic category. Or, use “unspecified disorder” if the clinician chooses not to document the reason criteria for a disorder are not met.

**Working Effectively with Managed Care and Health Care Reform** *(The ASAM Criteria 2013, pp 119 - 126)*

Much time and resources are spent by clinicians and managed care organizations communicating back and forth in the treatment payment approval process. One of the goals of the new edition is to have *The ASAM Criteria* enhance assessment, placement, and the care management processes for providers and payers. With an unsustainable trajectory of healthcare costs, we should all be managing care to use resources efficiently and increase access to care. When focused on assessing all six assessment dimensions of *The ASAM Criteria* and planning an individualized collaborative plan, clinicians are in fact managing care if the treatment level selected is the least intensive but safest level of care for the person.

This isn’t about placing a person in the least intensive level until they “fail” that level. This is about making sure we give people all the care they need, but not in a more intensive level than is clinically safe, as that is wasteful of scarce resources. But also take care to not place them in lower level of care that does not matches their severity and level of function. If patients go to a less intensive level than is needed, and end up getting worse—the patient, his or her family, and budgets suffer.
The following decision flow outlines how to move from engagement of the client (“What do you want?”), to assessment of immediate and multidimensional needs; diagnosis, then to service planning and level of care decision. The DSM diagnoses are necessary, but not sufficient to determine treatment needs and level of care. It is the multidimensional severity and function that is pivotal in placement criteria. This is the process in both care delivery and care management.

**INSERT FIGURE 1 HERE**

*The ASAM Criteria Software*, now in demonstration pilot testing phase, is slated to be released in the fall of 2014. The software will work hand in hand with the Criteria book to make the utilization review and care management process much more efficient for everyone involved – providers, payers and care managers.

So now you have a bird’s eye view of the new *The ASAM Criteria* and DSM-5. If you’d like to see more about *The ASAM Criteria*, visit www.ASAMcriteria.org for additional information on how to buy the criteria book; subscribe to a web-enhanced version, get Continuing Education credits in three eTraining modules; and download free articles on *The ASAM Criteria*. You can even download some PowerPoint slides on what’s new.

**References**


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**Bio**
David Mee-Lee, M.D. is a board-certified psychiatrist and is certified by the American Board of Addiction Medicine (ABAM). Based in Davis, California, he trains and consults nationally and internationally. Dr. Mee-Lee has led the development of the ASAM Criteria since the late 1980's. He co-authored the first and second editions and is Chief Editor of ASAM PPC-2R (2001) and the new edition of The ASAM Criteria (2013). He is also Senior Vice President of The Change Companies.
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Figure 1 - From Engagement, Assessment, Service Planning to Level of Care

What Does the Client Want? Why Now?

Does client have immediate needs due to imminent risk in any of the six assessment dimensions?

Conduct multidimensional assessment

What are the DSM* diagnoses?

Multidimensional Severity /LOF* Profile

Identify which assessment dimensions are currently most important to determine treatment priorities

Choose a specific focus and target for each priority dimension

What specific services are needed for each dimension?

What “dose” or intensity of these services is needed for each dimension?

Where can these services be provided, in the least intensive, but safe level of care or site of care?

What is the progress of the treatment plan and placement decision; outcomes measurement?

(The ASAM Criteria 2013, p 124)

* DSM = Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association
* LOF = Level of Function