To:	Midland Clinical Governance Network
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Date:	24 July 2013
Subject::	Uniform AOD Residential Placement Criteria

For approval		**For action**	✓	**For information**	✓

Purpose:

To provide Clinical Governance with a comprehensive understanding of international benchmarks applied to criteria for community and residential treatment options in the addiction sector.

Background:

A goal of this subcommittee is to establish *uniform placement criteria,* accepted by all providers in the field that can be used to accurately assess the severity of a client's problems in three areas: medical, psychological, and social.

Good, clear, and accepted criteria will lead to effective placement of clients in appropriate levels of care. Such criteria can also be used as a basis for making decisions about moving clients through the continuum of treatment services as treatment progresses or relapses occur.

Residential treatment is the most expensive and should be the most specialised treatment setting, and should not be the default position, or even the first avenue tried.
In the Midlands regions the funds available for residential addiction treatment are under-spent, and while these funds are theoretically available for other treatment, there is difficulty forecasting residential needs from one year to the next. Un-evenness in the distribution of beds being used adds to this difficulty.

And while there is an underspend, there is also sometimes lengthy waits before appropriate clients can access a residential bed. Some further work around these anomalies may well be called for.

A recent (June 2012) report by the National Centre on Addiction and Substance Abuse at Columbia University, examines the science of addiction (a complex disease that involves changes in the structure and function of the brain) and the profound gap between what we know about the disease and how to prevent and treat it versus current health and medical practice.
Addiction Medicine: Closing the Gap between Science and Practice

Because Residential Treatment is expensive, there should be an expectation that it is based on approaches shown in scientific studies to be more effective in helping people achieve and maintain addiction-free lives.

Paramount among these is Continuing Care after the residential phase. Unless this is in place, gains made in the residential phase are quickly lost. Likewise, marrying detoxification with entry to a residential bed is preferable; if this is not possible a local plan to keep the client safe, engaged, and participating in the recovery process is vital.

As McLellan and colleagues (2000) point out, regarding substance abuse as a chronic disorder means realigning treatment and outcome expectations so that they resemble those for other chronic disorders.

Increasingly the international research and clinical experience make it clear that addiction should be understood as a chronic recurring illness which frequently requires multiple episodes of treatment (NIDA, 1999), and can require long-term or even life-long treatment, including long-term relapse management (O'Brien, 2003).

Discussion Points

What is the best setting? Who is responsible for what?

Clients should be treated in the least restrictive setting that is safe and practical. Providing a safe environment must be the first consideration in all cases.

The setting (agency or service) that a client first presents to should take responsibility for initiating comprehensive and integrated care and should be the initial sole coordinating point for ongoing treatment.

> (From: *Te Ariari o te Oranga: the Assessment and Management of people with co-existing Mental Health and Substance Use Problems)*

Any Client Placement Process should be straight forward and should facilitate entry rather than pace further obstacles or roadblocks to timely and appropriate treatment placement. Residential programs are safe, structured environments in which patients are removed from stressful circumstances that promote or fuel the urge to use. Because negative influences are removed from a patient's daily experience, participants in residential treatment programs can begin to work on building life skills addiction had interfered with.

This intensive level of care makes residential treatment programs ideal for people who have unsuccessfully attempted to overcome addiction in outpatient programs. However, it may be that that the client who presents has needs so acute that they cannot be adequately met in an outpatient setting. In such cases residential treatment must still be part of a carefully planned continuum (with client input) which involves an adequate supportive environment upon discharge from the residential setting. The literature emphasises the need for individualised, assessment-driven treatment which follows a process. In New Zealand this is clearly outlined in *Te Ariari o te Oranga*.

A multidimensional or comprehensive assessment identifies and prioritises problems in the context of the client's severity of illness, factors which will interfere with treatment or recovery, and the client's level of functioning. Treatment services are matched to the client's needs over a continuum of care.

On-going assessment of progress and treatment response influence future treatment recommendations. Four broad features characterise this approach:

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

Four important objectives underlie them:

- enable clients to receive the most appropriate and highest-quality treatment services
- encourage the development of a continuum of comprehensive care
- promote effective, efficient use of care resources

- help protect access to and funding for care.

One important challenge in treatment is when a client relapses. Quite often discharge follows – as though the client is being punished for exhibiting the symptoms of the disorder. Should a client drink or use drugs during treatment, the immediate response should be to revise the treatment plan rather than automatically change the level of care or administratively discharge the client.

Of course, safety of the overall environment needs to be considered as well. This does sometimes mean standing a client down to stabilise (which should be facilitated and arranged) before re-engaging. Also, some providers might require that a client be "motivated for sobriety" as a requirement for admission to a programme. Given the characteristic symptoms of denial and lack of readiness to change in addiction disorders, the only requirement should be that the client is willing to enter treatment. Everyone who enters treatment of any sort will be ambivalent at best. Clinicians then facilitate the client's self-change process along the stages of change.

Placement Criteria

There are advantages to adopting Uniform Placement Criteria:

- A common language describing the dimensions of assessment and the components of the continuum of care can enable clinicians to consult about clients or program characteristics without confusion.
- Uniform criteria can provide a common basis for study and continual improvement, not only of the criteria themselves, but also of the services provided in response to particular criteria.
- Uniform Placement Criteria can help alleviate the high cost of under-treatment by ensuring that patients get all the treatment they need, based on continued stay criteria rather than arbitrary monetary or time limitations.
- Uniform Placement Criteria can alleviate the high cost of overtreatment by ensuring that patients get only the treatment they need, based on assessed needs and established criteria.
- Common definitions of levels of care, common standards of assessment, and common standards for continued stay and discharge can establish the same framework for public and private programs.

Both funders and providers may accept uniform client placement criteria, assuming those criteria:

- Accurately describe their levels of care
- Have validity regarding recommended placement level
- Are easy to use in clinical decision making
- Include reliable and objective tools and language
- Encourage positive treatment outcomes in the least restrictive environment.

Without uniformity, there are no common definitions of care, no common language, and no capacity to effectively perform and compare the essential research.
The Role and Current Status of Client Placement Criteria in the Treatment of Substance Use Disorders, Treatment Improvement Protocol (TIP) Series 13

Adult Client Placement Criteria

The need for clinically sound, cost-conscious patient placement criteria, led to a process, originating in 1991, which saw the American Society of Addiction Medicine (ASAM) develop the Patient Placement Criteria which have become the most widely accepted comprehensive set of guidelines for placement, continued stay and discharge of patients with addictive disorders.

Among the hopes for the ASAM Criteria are that they might lead to a common language to describe: (1) assessment of a patient's severity of illness; (2) the treatment levels of care provided; and (3) the clinical criteria that guide the most efficient placement of patients in the continuum of care.

The purpose of the ASAM criteria is:

- To assign the appropriate level of service and level of care.
- To make decisions about continued service or discharge by on-going assessment and review of progress.
- To do effective treatment planning and documentation.

The ASAM Adult Client Placement Criteria can be simplified as follows:

Adult Client Placement Criteria				
Levels of Care	**Level I Outpatient Treatment**	**Level II Intensive Outpatient Treatment**	**Level III Medically Monitored Intensive Inpatient Treatment**	**Level IV Medically Managed Intensive Inpatient Treatment**
1. *Acute Intoxication and/or Withdrawal Potential*	No withdrawal risk.	Minimal withdrawal risk.	Severe withdrawal risk but manageable in Level III.	Severe withdrawal risk.
2. *Biomedical Conditions and Complications*	None or very stable.	None or manageable and will not interfere with addiction treatment	Requires medical monitoring but not intensive treatment.	Requires 24-hour medical, nursing care.
3. *Emotional and Behavioural Conditions and Complications*	None or very stable.	Mild severity with potential to distract from recovery.	Moderate severity needing a 24-hour structured setting.	Severe problems requiring 24-hour psychiatric care with concomitant addiction treatment.
4. *Treatment Acceptance and Resistance*	Willing to cooperate but needs motivating and monitoring strategies.	Resistance high enough to require structured program, but not so high as to render Outpatient treatment ineffective.	Resistance high despite negative consequences and needs intensive motivating strategies in 24-hour structure.	Problems in this dimension do not qualify client for Level IV treatment.
5. *Relapse Potential*	Able to maintain abstinence and recovery goals with minimal support.	Intensification of addiction symptoms and high likelihood of relapse without close monitoring and support.	Unable to control use despite active participation in less intensive care and needs 24-hour structure.	Problems in this dimension do not qualify client for Level IV treatment.

6. *Recovery / Living Environment*	Supportive recovery environment and/or client has skills to cope.	Environment unsupportive but with structure or support, the client can cope.	Environment dangerous for recovery necessitating removal from the environment; logistical impediments to outpatient treatment.	Problems in this dimension do not qualify client for Level IV treatment.
Source: American Society of Addiction Medicine				

In making decisions about Client Placement, there are things to consider from the client's point of view, and these are described in the Client Placement Dimensions in the table below.

There are also factors to consider in determining what type of and service what level / intensity of service can and should be provide. These are described in the Service Characteristics in the table below.

Client Placement Dimensions

1. Clients wishes (evidence indicates this is a predictor of successful completion)
2. Age, gender, ethnic, and cultural background
3. Severity and course of illness, experiences with previous treatment
4. Relapse potential
5. Need for medical or addiction treatment or pharmacological, psychiatric, familial and social, employment, or legal services
6. Attitude toward entering and continuing treatment
7. Effects of environmental and social influences, such as living situation, family support, support for recovery, and susceptibility to abuse or neglect.

Service Characteristics

Intensity of services –what level, where, and for how long. (For example, it may mean that some clients require 4 or 6 weeks, others 8, and some others 12 weeks - all of which flows out of the treatment and management plans)

Intensity of environmental support

Availability of medical services

Variety of professional disciplines involved

Availability of services specific to cultural background, age, sex, or disabilities

Program elements

Discharge planning

Client-to-staff ratio.

Individualised Treatment Plan

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

The treatment plan should list:

- problems prioritised by obstacles to treatment and risks and arranged according to severity – such as obstacles to recovery, knowledge or skill deficits, dysfunction or loss
- strengths – such as readiness to change, a positive social support system and a strong connection to a

source of spiritual support
- goals – a statement to guide realistic, achievable, short-term resolution or reduction of the problems
- methods or strategies – treatment services to be provided, site of those services, staff responsible for delivering treatment
- a timetable for follow-through with the treatment plan, which promotes accountability.

The plan should be written to facilitate measurement of progress.

Referrals should be clear and adhere to the principles above.

When a client leaves one treatment facility to which they have been referred, there should be formal referral back to the Agency the client first approached so that continuing care may be facilitated.

Recommendations:

1. Residential treatment should be available for those clients with complex presentations and high needs for whom previous attempts at recovery in less intensive environments have not been able to be sustained.

2. Residential Treatment Facilities will have staff that is trained and competent to provide treatment for clients with high and complex needs. The Facility will thus be expected to meet all of the criteria in ASAM Level III.

3. It is expected that as a matter of course the Treatment Facility will provide Trauma informed treatment. It is also expected that there will be a clear knowledge of and competency in handling the interaction of addiction and head injury (including alcohol and other drug induced brain injury), anxiety and social anxiety, PTSD (especially disassociation, hyper vigilance etc), Bi-polar disorder, Schizophrenia, and other co-existing problems.

   There should be the ability to provide treatment for people who are maintained on medication, whether this is Opioid Substitution, psychiatric medication, medication for anxiety etc.

4. All referrals to Residential Treatment will be initiated by a Registered Practitioner. This referral will include a Comprehensive Assessment (based on *Te Ariari o te Oranga*), a management plan, and a clear statement why residential treatment is sought as part of the management plan.

5. The Management Plan will present a Residential Treatment placement as one part of a planned journey of recovery. It will include:
   - The client's efforts to achieve recovery locally
   - Detoxification as required
   - Residential Treatment
   - Post Discharge Plans
   - Continuing care Plans

6. The management plan will address all of the problems and diagnoses identified in the Comprehensive Assessment.

7. See Appendix 1 - Referral Flow Chart which indicates the clinical pathway.

8. A simple form which follows the process through can be developed for use within the Midlands area.

   This may be as simple as a completed Comprehensive assessment, and a statement (based on the above information) as to why the desired treatment option is best for this client, and the timeframe within which this treatment place should best be met, and what alternatives are in place to keep the client stable at this point.

   At present there are different approaches in each DHB with regards to Needs Assessment, and the grounds that those Assessments are "granted" or "denied".

   It is considered to be very important for client care that the referral to a Residential Treatment facility and the

acceptance of that referral be as simple as possible for the client, and does not have an un-productive and discouraging wait-time caused by a clumsy, unwieldy "vetting" process. Recommendation 3 above indicates the way through this.

Hopefully a common process, based on standardised assessment approaches, with a uniform approach to assessment reports, treatment plans, and using clear and uniform placement criteria, will give an easy way to make decisions and reach referrals.

9. **Clinical Governance to determine next steps**

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Appendix 1 – Referral Flow Chart