

# What's New in **The ASAM Criteria** *Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*

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## The Six Dimensions of Multidimensional Assessment

*The ASAM Criteria* structures multidimensional assessment around these six dimensions to provide a common language of holistic, biopsychosocial assessment and treatment across addiction treatment, physical health, and mental health services, which addresses as well the spiritual issues relevant in recovery.

The six assessment dimensions, briefly described here, are essentially the same as in earlier editions of ASAM's criteria, with slight modifications to apply to co-occurring mental health conditions that were initially described in PPC-2R (2001)

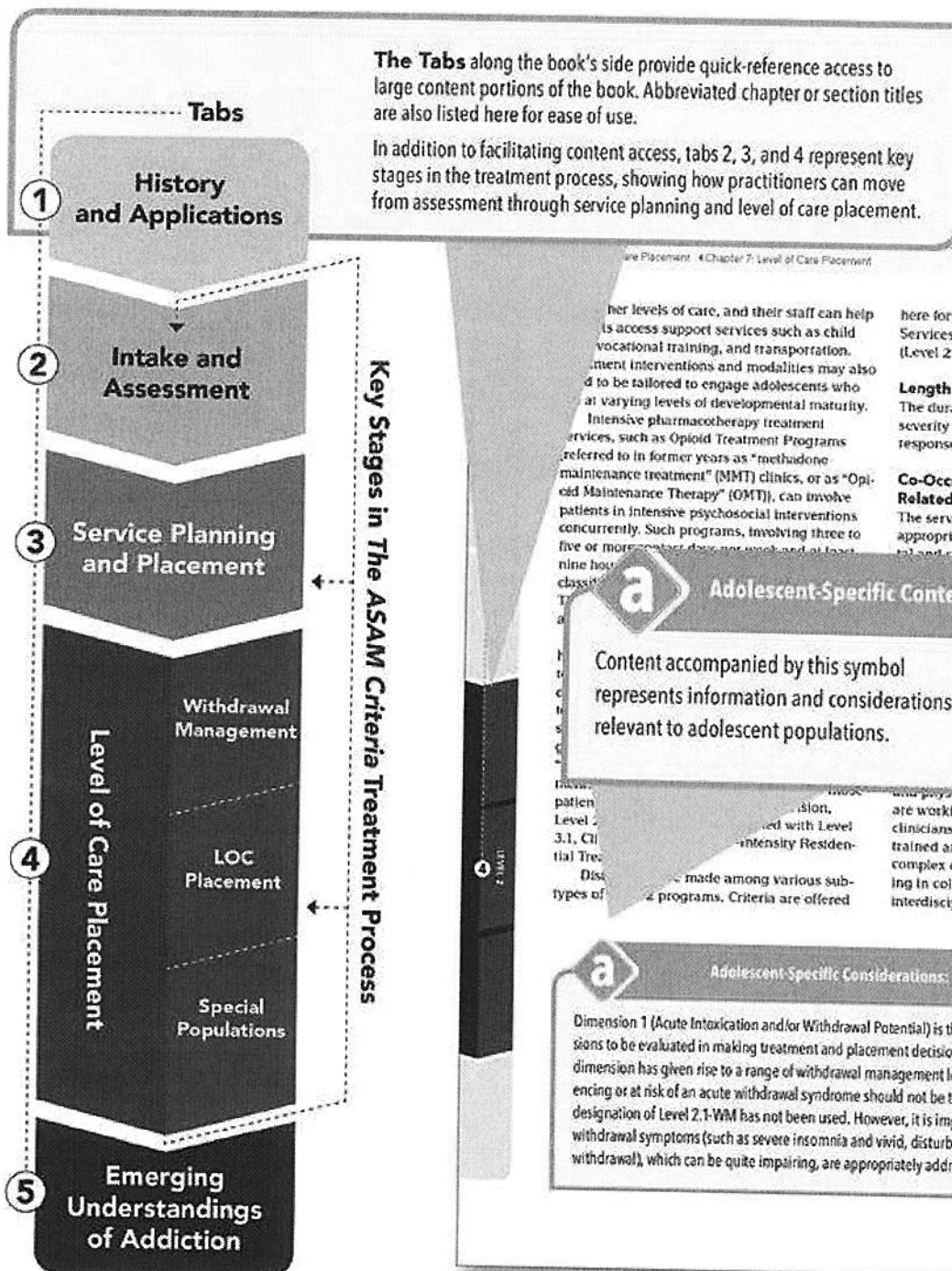
### AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT

ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:

1	<b>DIMENSION 1</b>	<b>Acute Intoxication and/or Withdrawal Potential</b> Exploring an individual's past and current experiences of substance use and withdrawal
2	<b>DIMENSION 2</b>	<b>Biomedical Conditions and Complications</b> Exploring an individual's health history and current physical condition
3	<b>DIMENSION 3</b>	<b>Emotional, Behavioral, or Cognitive Conditions and Complications</b> Exploring an individual's thoughts, emotions, and mental health issues
4	<b>DIMENSION 4</b>	<b>Readiness to Change</b> Exploring an individual's readiness and interest in changing
5	<b>DIMENSION 5</b>	<b>Relapse, Continued Use, or Continued Problem Potential</b> Exploring an individual's unique relationship with relapse or continued use or problems
6	<b>DIMENSION 6</b>	<b>Recovery/Living Environment</b> Exploring an individual's recovery or living situation, and the surrounding people, places, and things

# How to Use *The ASAM Criteria*

XIV Introduction



Each content page of *The ASAM Criteria* has been created with several tools to facilitate reader usability. Take a look at the page sample below for an example of how to navigate through this book.

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## Treatment Levels Within Level 2

### Level 2.1: Intensive Outpatient Services

Pay attention to these section break indicators. Within certain chapters, breaks between sections may represent a new criteria set or a new population focus.

is (IOPs) generally used programming hours for adolescents and mental health needs for psychiatric services are addressed in the program arrangements.

Intensive outpatient treatment requires only maintenance monitoring. (Services provided outside the primary program must be tightly coordinated with the primary program.)

There are occasions when the patient's progress in the IOP no longer requires nine hours per week of treatment for adults or six hours per week for adolescents but he or she has not yet made enough stable progress to be transferred to a Level 1 program. In such cases, less than nine hours per week for adults and six hours per week for adolescents as a transition step down in intensity should be considered as a continuation of the IOP program for one or two weeks. Such continuity allows for a smoother transition to Level 1 to avoid exacerbation and recurrence of signs and symptoms.

Intensive outpatient treatment differs from partial hospitalization (Level 2.5) programs in the intensity of clinical services that are directly available. Specifically, most intensive outpatient programs have less capacity to effectively treat

offered in any appropriate setting that meets state licensure or certification criteria.

**SUPPORT SYSTEMS**

**All Programs**

In Level 2.1 programs, necessary support systems include:

- a. Psychiatric, laboratory, and medical services
- b. Telephone 24 hours a day, 7 days a week when the treatment program is not in session.
- c. Direct affiliation with (or close coordination through referral to) more and less intensive levels of care and supportive housing services.

**Co-Occurring Enhanced Programs**

In addition to the support systems described here for co-occurring capable programs, Level 2.1 co-occurring enhanced programs offer

**Using both the book and the software**

This book and *The ASAM Criteria Software* are companion text and application. This text delineates the dimensions, levels of care, and decision rules that comprise the ASAM criteria. The software provides the approved structured interview to guide the adult assessment and calculate the complex decision tree to yield suggested levels of care. The text and the software should be used in tandem, the text to provide the background and guidance for proper use of the software, and the software to enable comprehensive, standardized evaluation. Effective, reliable treatment planning requires that both be used together. Note that services specifically tailored for adolescents are addressed throughout *The ASAM Criteria* but are not included in *The ASAM Criteria Software*.



## Guiding Principles of *The ASAM Criteria*

Beginning with the first edition of ASAM's criteria, certain foundational concepts have continued through this edition and will no doubt serve as the foundation for any future developments. Similar to its predecessors, the following guiding principles serve as the basis for all content within *The ASAM Criteria*:

- » Moving from one-dimensional to **multidimensional assessment**
- » Moving from program-driven to **clinically driven and outcomes-driven treatment**
- » Moving from fixed length of service to **variable length of service**
- » Moving from a limited number of discrete levels of care to a **broad and flexible continuum of care**
- » Identifying **adolescent-specific needs**
- » **Clarifying the goals of treatment**
- » **Moving away from using previous "treatment failure"** as an admission prerequisite
- » Moving toward an **interdisciplinary, team approach to care**
- » **Clarifying the role of the physician**
- » **Focusing on treatment outcomes**
- » Engaging with **"Informed Consent"**
- » Clarifying **"Medical Necessity"**
- » **Incorporating ASAM's definition of addiction**

## What's New in *The ASAM Criteria*



### BRAND NEW CHAPTERS IN THE ASAM CRITERIA

#### Application to Adult Special Populations

- » Older Adults
- » Parents or Prospective Parents Receiving  
Addiction Treatment Concurrently with Their  
Children
- » Persons in Safety-Sensitive Occupations
- » Persons in Criminal Justice Settings

#### Emerging Understandings of Addiction

- » Gambling Disorder
- » Tobacco Use Disorder

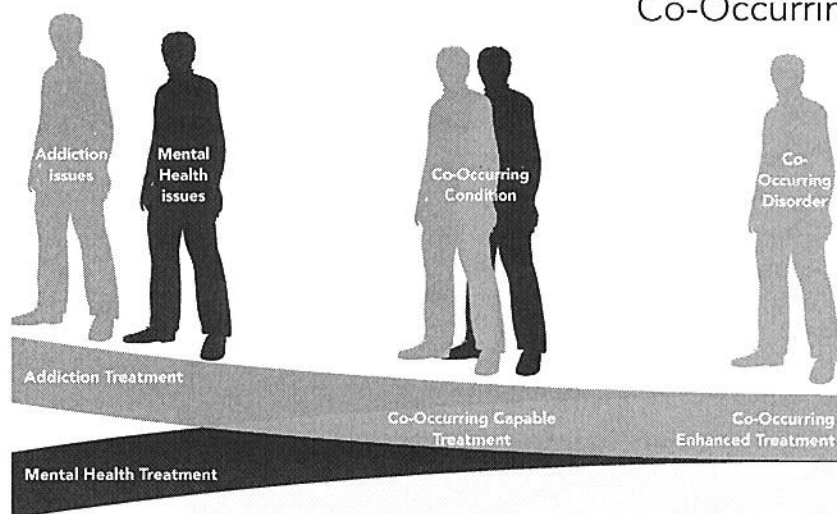


### NEW TERMINOLOGY IN THE ASAM CRITERIA

- » The individuals served in treatment are now most often referred to as "individual," "person," "participant," or "patient," and these are used interchangeably in this publication
- » Book title and concept is now *"The ASAM Criteria"*
- » Terms such as **"dual diagnosis"** and **"dual disorders"** are now described in the spectrum of **"co-occurring disorders or conditions"**
- » **"Detoxification services"** are referred to in this edition as **"withdrawal management"**
- » **"Opioid Maintenance Therapy (OMT)"** is now discussed as Opioid Treatment Programs (OTP) and Office-Based Opioid Treatment (OBOT) within **"Opioid Treatment Services (OTS)"**
- » **"Level III.3: Clinically Managed Medium-Intensity Residential Treatment"** is now **"Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Services"**

- Compatible with *The ASAM Criteria Software*
- Combining adult and adolescent treatment information
- Incorporation of the latest understanding of Co-occurring Disorders Capability
- Inclusion of the conceptual framework of ASAM's definition of Addiction and Recovery Oriented Systems of Care
- Further expansion on the role of the physician
- Updated Diagnostic Admission Criteria for the levels of care
- New chapters on gambling and tobacco use disorder
- An updated opioid treatment section
- Updates to better assess, understand and provide services for all six ASAM criteria dimensions
- Revised terminology
- Reformatted levels of care numbers
- A user-friendly format

## Co-Occurring Disorders



"Co-Occurring Conditions" and "Co-Occurring Disorders" refer to individuals.

"Co-Occurring Capable" and "Co-Occurring Enhanced" refer to types of programs.

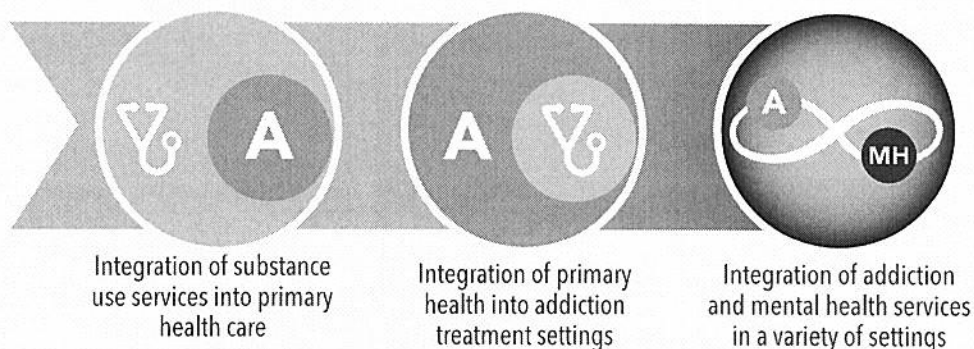
## Adolescent-Specific Criteria

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## Adolescent-Specific Considerations: Co-Occurring Disorders

It is increasingly recognized that comorbidity among adolescents with substance use disorders is the rule and not the exception. As in adults, the line between addiction treatment and mental health treatment is increasingly blurring, and the need for co-occurring enhanced, or combined behavioral health programming, is great. Although our evidence base for co-occurring treatment is limited compared to that for adults, it is growing. For example, there is mounting evidence that identifying and treating depression in substance-involved youth improves substance use outcomes, and vice versa. Another example is our growing awareness of the psychiatric sequelae of marijuana use in youth, and our growing clinical suspicions that these problems are much worse with synthetic cannabinoids ("K2," "spice," etc.). As more knowledge emerges, future editions of the criteria should incorporate it to support clinical decision making.

## RELEVANT AREAS OF INTEGRATION



A major advance during the past decade has been the growth of capacity or capability to address mental health, substance use disorder, and general health issues in "integrated" settings. This approach facilitates participant engagement and improves outcomes while using resources more efficiently. Consequently, just as addiction programs have improved co-occurring capability (and thereby improved their ability to integrate attention to co-occurring issues within addiction settings), the same thing has been happening in other areas of the health care system as well.

## Levels of Care

LEVEL OF CARE	ADOLESCENT TITLE	ADULT TITLE	DESCRIPTION
0.5	Early Intervention	Early Intervention	Assessment and education for at-risk individuals who do not meet diagnostic criteria for substance use disorder
1	Outpatient Services	Outpatient Services	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies
2.1	Intensive Outpatient	Intensive Outpatient	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability
2.5	Partial Hospitalization	Partial Hospitalization	20 or more hours of service/week for multidimensional instability not requiring 24-hour care
3.1	Clinically Managed Low-Intensity Residential	Clinically Managed Low-Intensity Residential	24-hour structure with available trained personnel; at least 5 hours of clinical service/week
3.3	<i>*This Level of Care not designated for adolescent populations</i>	Clinically Managed Population-Specific High-Intensity Residential	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
3.5	Clinically Managed Medium-Intensity Residential	Clinically Managed High-Intensity Residential	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community
3.7	Medically Monitored High Intensity Inpatient	Medically Monitored Intensive Inpatient	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. Sixteen hour/day counselor ability
4	Medically Managed Intensive Inpatient	Medically Managed Intensive Inpatient	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
OTP (LEVEL 1)	<i>*OTPs not specified here for adolescent populations, though information may be found in discussion of adult services</i>	Opioid Treatment Program (Level 1)	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder

### TOBACCO CASE STUDIES

#### CASE 6

TH is a 50-year-old addiction counselor who works at a residential addiction treatment center. The center has decided that they are going to begin treating tobacco addiction along with all other addiction. The staff is not going to be able to smoke at all at work, and will not be allowed to come to work smelling of tobacco smoke. TH is in recovery from addiction to alcohol and pain medications. He has been sober for 23 years and always felt that tobacco was not part of his disease. He feels that he has extra rapport with patients since he goes out smoking with them on breaks. TH has often advised patients who wanted to stop smoking that they should wait at least a year before they even consider stopping, because "it is too hard to quit more than one thing at a time." TH has been told by his doctor that his frequent bouts of bronchitis are directly related to his smoking, and that he needs to stop before he does permanent damage to his lungs. TH is about 40 lbs. overweight and fears that if he stops smoking, he will gain even more weight. He has never tried to quit, and is angry about his workplace forcing him to stop.

TH is in the precontemplation stage of change. He needs education about nicotine addiction and motivation for tobacco cessation. If TH will accept treatment, he may benefit from combination pharmacotherapy, taking into account his concern about weight gain. Outpatient counseling (Level 1) is the most appropriate place to begin, with additional online resources and quitline assistance. TH may find Nicotine Anonymous helpful, since he will be able to use the same philosophy and skills to quit tobacco that he used to enable recovery from alcohol and pain medications in the past. Group support at work will help motivate TH and enable his tobacco cessation attempts to be successful. TH's primary care physician should monitor his tobacco cessation and weight, and give positive feedback about improvements in his bronchitis and lung function.

### LEVEL OF WITHDRAWAL MANAGEMENT FOR ADULTS

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

3.2-WM

Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery

Medically Monitored Inpatient Withdrawal Management

3.7-WM

Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring

Medically Managed Intensive Inpatient Withdrawal Management

4-WM

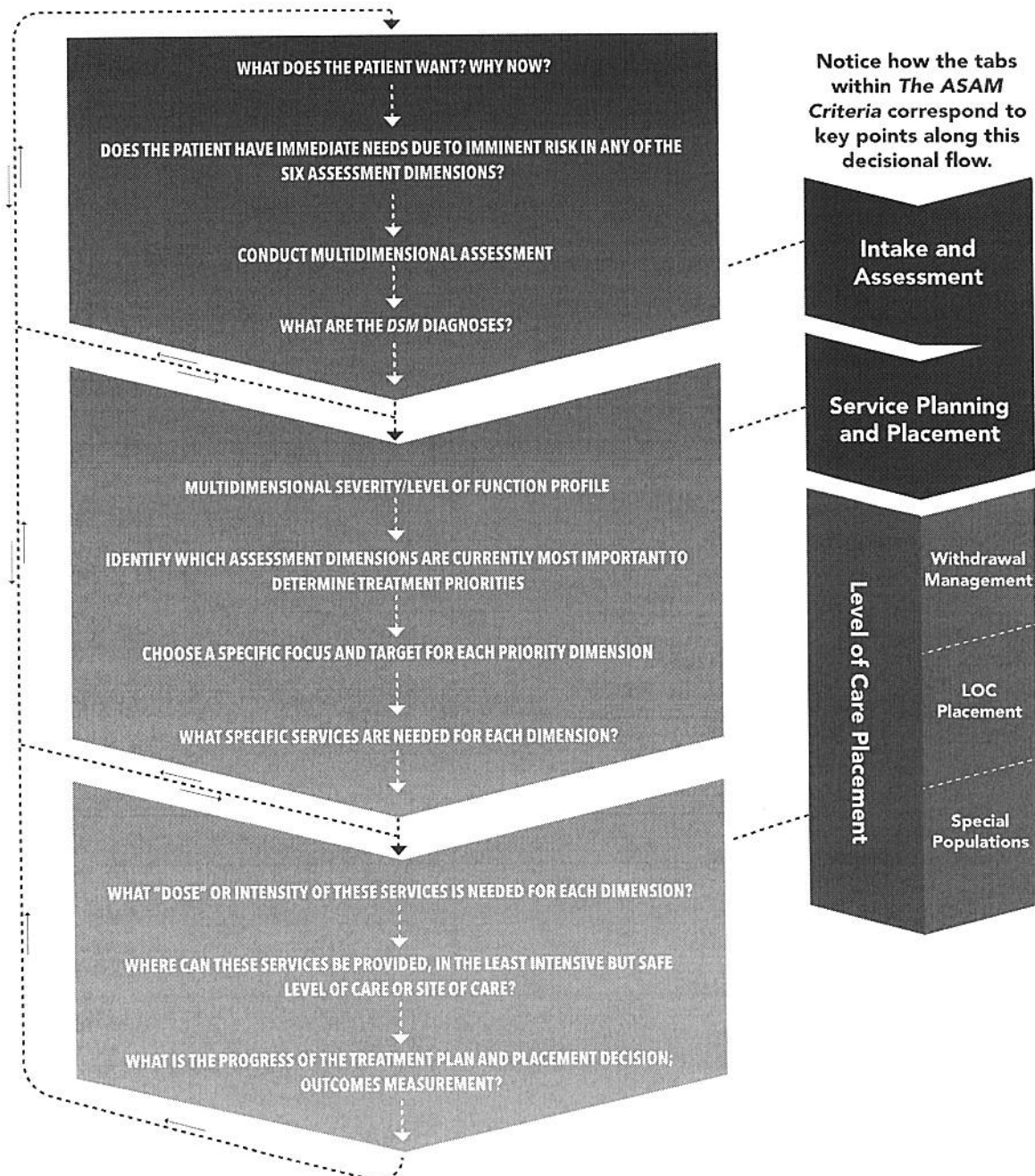
Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability

NOTE: There are no unbundled withdrawal management services for adolescents.



# Decisional Flow to Match Assessment and Treatment/Placement Assignment

To guide clinical evaluation and discussion, sequentially move through the following decisional flow to match assessment and treatment/placement assignment. If disagreement occurs with another member of the treatment team or a care manager or utilization reviewer, work through this flow to identify which steps there is clinical agreement on and which steps are in question.



## Five challenges and special considerations with criminal justice populations

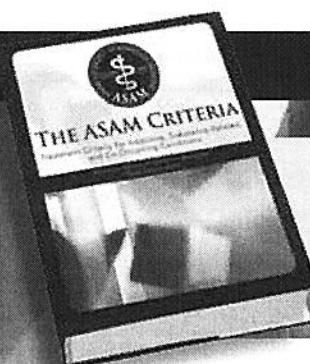
1. The ASAM criteria assesses Dimension 4 (Readiness to Change) and applies individualized treatment using evidence-based practices (EBPs), which assess stages of change and apply motivational enhancement strategies with flexible lengths of stay (LOS). However, frequently there is an expectation in criminal justice systems that the individual should be in the action stage in order to manifest healthy, prosocial behaviors and remain in compliance with court orders. In addition, this is often mistakenly thought to be attainable in addiction treatment programs in criminal justice systems by designing a fixed length of stay and non-individualized program completion/graduation targets. The criminal justice system may have unrealistic assumptions about how soon a person can reach the action stage, and correctional services may involve a mandated length of stay in clinical care that is too brief to achieve reasonable clinical outcome goals, including goals for motivational enhancement interventions.

Judges, other court officials, and probation and parole officers often mandate specific levels of care (eg, residential treatment) and lengths of stay (eg, 1 year) versus focusing on mandating comprehensive assessment and ongoing treatment adherence. It is understood that judges, other court officials, and probation and parole officers often do what they do because they perceive it as being required of them, as is the case in the context of sentencing and supervision guidelines given to those in the criminal justice system by a legislature or an executive branch authority. It is the treatment community's role, and challenge, to assist the criminal justice system in interpreting the guidelines in a manner that offers the best match to the treatment options for this population.

2. Due to limited resources, community and institutional corrections most often make treatment and placement decisions based not on "offenders' needs" but on "what resources are available."
3. Criminal justice's emphasis on criminogenic risk, need, and responsivity (RNR) may place the need for addressing substance use disorders or co-occurring disorders

as a secondary or tertiary focus, versus addressing these disorders concurrently. While recognizing substance use disorders as a criminogenic need, criminal justice may place higher priority and resource focus on other high-risk criminogenic factors such as antisocial values, criminal associates, and antisocial personality traits. The challenging question for the treatment community in linking the ASAM criteria to this population may be as follows: Is the behavioral health care provider adequately trained or equipped to address the RNR for the offender population? And if not, what should be done to improve this capability? However, the treatment of the other non-criminogenic disorders, while not the priority, are necessary for recovery and reducing criminogenic factors.

4. The individual's responsivity to a formal course of treatment and other recommended interventions at times may be in conflict with the criminal justice system's expectations of the participant. It is critical to involve all parties (eg, judges, probation and parole officers, other court officials) as well as the justice-involved individual in the decision-making process. It is also important to create learning opportunities for criminal justice personnel to understand more about substance-related and addictive disorders, and also co-occurring mental health conditions.
5. Most treatment programs in prisons and jails, drawing from clinical traditions employed in therapeutic communities, emphasize the group and community as primary change agents in contrast to individual, one-on-one counseling. Individual sessions are provided, but are secondary to the group structure and milieu interventions. This approach may be followed because of high caseloads and budgetary considerations, but it may also be based on the belief that criminogenic risks and needs are best addressed in a group context, and thus take priority over individual counseling and individualized treatment planning. This is not to say that individualized treatment does not occur for this special population; it does, but it needs to be contextualized to the limitations of the specific criminal justice setting.



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