

The New ASAM Criteria for the Treatment of Addictive, Substance-Related and Co-Occurring Conditions - What's New and Why?

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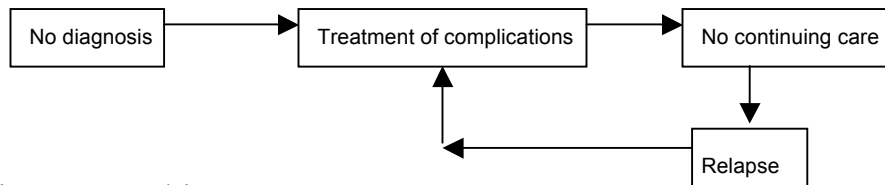
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A. Underlying Principles/Concepts of The ASAM Criteria - Generations of Clinical Care

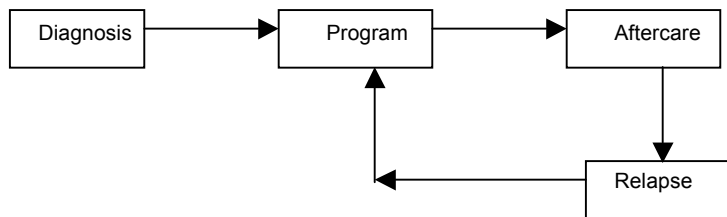
(a) Complications-driven Treatment

- ⤴ No diagnosis of Substance Use Disorder
- ⤴ Treatment of complications of addiction with no continuing care
- ⤴ Relapse triggers treatment of complications only

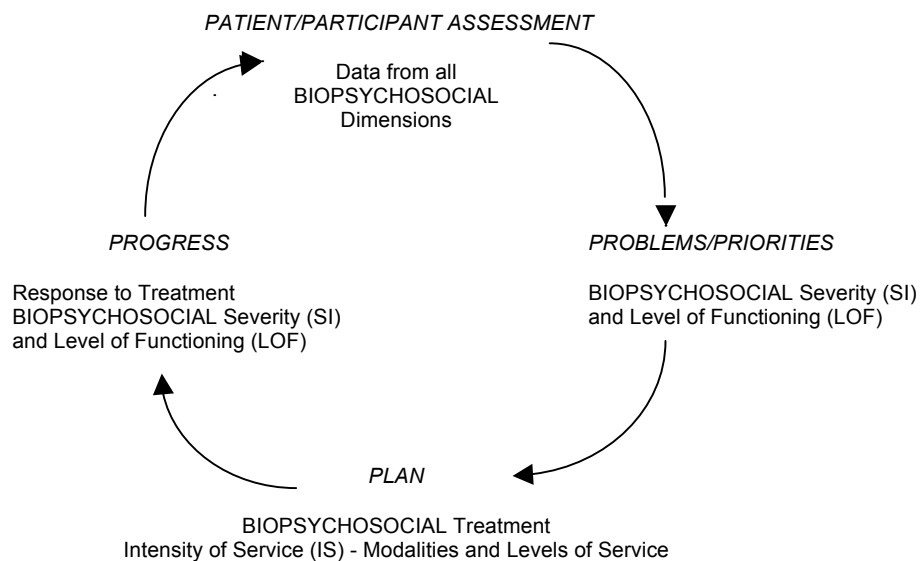


(b) Diagnosis, Program-driven Treatment

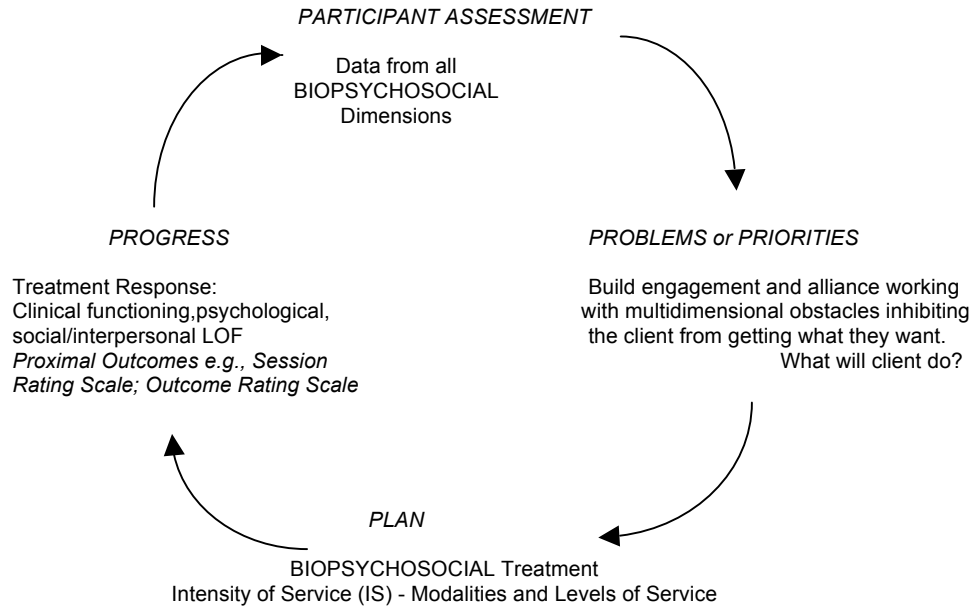
- ⤴ Diagnosis determines treatment
- ⤴ Treatment is the primary program and aftercare
- ⤴ Relapse triggers a repeat of the program



(c) Individualized, Clinically-driven Treatment



(d) Client-Directed, Outcome-Informed Treatment



2. Assessment of Biopsychosocial Severity and Function (*The ASAM Criteria* 2013, pp 43-53)

The common language of six ASAM Criteria dimensions determine needs/strengths in behavioral health:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral/cognitive conditions and complications
4. Readiness to Change
5. Relapse/Continued Use/Continued Problem potential
6. Recovery environment

Assessment Dimensions	Assessment and Treatment Planning Focus
1. Acute Intoxication and/or Withdrawal Potential	Assessment for intoxication and/or withdrawal management. Withdrawal management in a variety of levels of care and preparation for continued addiction services
2. Biomedical Conditions and Complications	Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services
3. Emotional, Behavioral or Cognitive Conditions and Complications	Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services
4. Readiness to Change	Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change
5. Relapse, Continued Use or Continued Problem Potential	Assess readiness for relapse prevention services and teach where appropriate. If still at early stages of change, focus on raising consciousness of consequences of continued use or problems with motivational strategies.
6. Recovery Environment	Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services

3. Biopsychosocial Treatment - Overview: 5 M's

- * Motivate - Dimension 4 issues; engagement and alliance building
- * Manage - the family, significant others, work/school, legal
- * Medication - detox; HIV/AIDS; anti-craving anti-addiction meds; disulfiram, methadone; buprenorphine, naltrexone, acamprosate, psychotropic medication
- * Meetings - AA, NA, Al-Anon; Smart Recovery, Dual Recovery Anonymous, etc.
- * Monitor - continuity of care; relapse prevention; family and significant others

4. Treatment Levels of Service *(The ASAM Criteria 2013, pp 106-107)*

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	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 WM support and supervision; at night, has supportive family or living situation; likely to complete WM.
Clinically-Managed Residential Withdrawal Management	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	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 Inpatient Withdrawal Management	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify WM regimen and manage medical instability
ASAM Criteria Levels of Care	Level	Same Levels of Care for Adolescents except Level 3.3
Early Intervention	0.5	Assessment and education for at risk individuals who do not meet diagnostic criteria for Substance-Related Disorder
Outpatient Services	1	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/ strategies
Intensive Outpatient	2.1	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability
Partial Hospitalization	2.5	20 or more hours of service/week for multidimensional instability not requiring 24 hour care
Clinically-Managed Low-Intensity Residential	3.1	24 hour structure with available trained personnel; at least 5 hours of clinical service/week
Clinically Managed Population-Specific High-Intensity Residential Services (Adult criteria only)	3.3	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
Clinically-Managed High-Intensity Residential	3.5	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
Medically-Monitored Intensive Inpatient	3.7	24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. Sixteen hour/day counselor ability
Medically-Managed Intensive Inpatient	4	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
Opioid Treatment Services	OTS	Opioid Treatment Program (OTP) – agonist meds: methadone, buprenorphine; Office Based Opioid Treatment (OBOT); antagonist medication - naltrexone

B. Guiding Principles of *The ASAM Criteria 2013* (*The ASAM Criteria 2013*, pp 3-11)

- Moving from one-dimensional to multidimensional assessment
The ASAM Criteria continues to encourage moving away from treatment based on diagnosis alone (i.e., seeing a diagnosis as a sufficient justification for entering a certain modality or intensity of treatment) toward treatment that is holistic and able to address multiple needs. A diversity of clinical offerings and intensities reflect the diversity of patients who may have needs in a number of clinical and functional dimensions. ASAM's six assessment dimensions were created in order to address this guiding principle.
- Moving from program-driven to clinically driven and outcomes-driven treatment
Rather than focusing on "placement" in a program, often with a fixed length of stay, *The ASAM Criteria* supports individualized, person-centered treatment that is responsive to specific needs and the patient's progress in treatment.
- Moving from fixed length of service to variable length of service
Outcomes research in addiction treatment has not provided a scientific basis for determining precise lengths of stay for optimum results. Thus, addiction treatment professionals recognize that length of stay must be individualized, based on the severity and level of function of the patient's illness, as well as based on their response to treatment, progress, and outcomes. At the same time, research does show a positive correlation between longer treatment in the continuum of care and better outcomes. While length of service is still presented as variable, based on patients' complex needs and outcomes in the current edition, both sides of this discussion (fixed versus variable lengths) are raised within these criteria in order to increase awareness of length of stay issues.
- Moving from a limited number of discrete levels of care to a broad and flexible continuum of care
Treatment is delivered across a continuum of services that reflect the varying severity of illnesses treated and the intensity of services required. Referral to a specific level of care must be based on a careful assessment of the patient with an alcohol, tobacco and/or other substance use disorder; and/or a gambling disorder. A primary goal underlying the criteria presented here is for the patient to be placed in the most appropriate level of care. For both clinical and financial reasons, the preferable level of care is that which is the least intensive while still meeting treatment objectives and providing safety and security for the patient. Moreover, while the levels of care are presented as discrete ranks, in reality they represent benchmarks or points along a continuum of treatment services that could be harnessed in a variety of ways, depending on a patient's needs and responses. A patient may begin at a required level and move to a more or less intensive level of care, depending on his or her individual needs.
- Identifying adolescent-specific needs
Adolescents who use alcohol, tobacco and/or other drugs differ from adults in significant ways. While substance use disorders in adolescents and adults may have common biopsychosocial elements of etiology, they are different in many aspects of their expression and treatment. Adolescence affords a unique opportunity to modify risk factors that are still active and not yet complete in their influence on development. Adolescents must be approached differently from adults because of differences in their stages of emotional, cognitive, physical, social and moral development. Examples of these fundamental developmental issues include the extremely potent influences of the adolescent's interactions with family and peers, the expected immaturity of most adolescents' independent living skills, and the fact that some amount of testing limits is a normative developmental task of adolescence.

The ASAM Criteria distinguishes and highlights adult and adolescent treatment information, where appropriate.

- Clarifying the goals of treatment
Treatment that is tailored to the needs of the individual and guided by an individualized treatment plan, developed in consultation with the patient, is helpful in establishing a therapeutic alliance and therefore contributing significantly to treatment outcomes. The individualized plan should be based on a comprehensive biopsychosocial assessment of the patient and, when possible, a comprehensive evaluation of the family as well.

Patient-centered care includes documentation showing where and how the treatment plan:

- Identifies problems or priorities, such as obstacles to recovery, knowledge or skill deficits that inhibit achievement of the patient's overall reason for seeking treatment.
- Includes strengths, skills and resources, such as coping strategies to deal with negative affects and stressors, successful exercise routines, medications that have been effective, positive social supports, and a strong connection to a source of spiritual support.
- States goals that guide realistic, measurable, achievable, and short-term resolution of priorities or reduction of the symptoms or problems.
- Lists methods or strategies that identify the personal actions of the patient and the treatment services to be provided by staff, the site of those services, staff responsible for delivering treatment, and a timetable for follow-through with the treatment plan that promotes accountability.
- Is written so as to facilitate measurement of progress. As with other disease processes, length of service should be linked directly to the patient's response to treatment (for example, attainment of the treatment goals and degree of resolution regarding the identified clinical problems or priorities).

The goals of intervention and treatment (including safe and comfortable withdrawal management, motivational enhancement to identify the need for recovery, the attainment of skills to maintain abstinence, etc.) determine the methods, intensity, frequency and types of services provided. The clinician's decision to prescribe a type of service, and subsequent discharge or transfer of a patient from a level of care, needs to be based on how that treatment and its duration will not only influence the resolution of the dysfunction, but also positively alter the prognosis for long-term recovery and outcome for that individual patient.

- Moving away from using "treatment failure" as an admission prerequisite
Another concern that guided the development of this publication is the concept of "treatment failure." This term has been used by some reimbursement or managed care organizations as a prerequisite for approving admission to a more intensive level of care (for example, "failure" in outpatient treatment as a prerequisite for admission to inpatient treatment). In fact, the requirement that a person "fail" in outpatient treatment before inpatient treatment is approved is no more rational than treating every patient in an inpatient program or using a fixed length of stay for all. It also does not recognize the obvious parallels between addictive disorders and other chronic diseases such as diabetes or hypertension. For example, failure of outpatient treatment is not a prerequisite for acute inpatient admission for diabetic ketoacidosis or hypertensive crisis.
- Moving toward an interdisciplinary, team approach to care
The ASAM Criteria maintains and builds on ASAM's previous efforts to respond to ongoing changes and needs within the special field of addiction treatment. It also recognizes that with health reform, more services to persons with addiction will be delivered outside of a separate (and separately funded) specialty treatment system for addiction and will be delivered inside of general medical and general behavioral health settings. Addiction care has always been built around services involving interdisciplinary teams of professionals, including and sometimes led by physicians. With health reform, addiction care as well as mental health care will increasingly be delivered by clinicians working in interdisciplinary teams of not only "addiction professionals" but also general medical care professionals.

The expansion of the Patient Centered Health Care Home model for delivering comprehensive, integrated care for patients and families—including “behavioral healthcare” (mental health and substance related disorders care)—will mean that persons making decisions about how and where to offer treatment to persons with addiction and related conditions will need to envision new treatment models and settings. Such models and settings will be unfamiliar to many clinicians who have been practicing in, and who likely received their clinical training in, specialty settings for addiction care. They will need to incorporate new skills of greater collaboration with other non-addiction treatment professionals; and inclusion of peers and peer supports.

The current edition of *The ASAM Criteria* recognizes that a broad trend in healthcare is for addiction and related disorders to be increasingly recognized and embraced by physicians—both general medical providers and physicians in a wide range of medical and surgical specialties, and an expanding number of physicians trained and certified (e.g., by the American Board of Addiction Medicine and the American Board of Psychiatry and Neurology) as specialists in addiction care.

- Clarifying the role of the physician

Due to their prevalence, substance use and addictive disorders are health conditions that have significant impact on public health. Physicians are an essential part of the healthcare delivery system for addiction, as well as for all acute and chronic medical and surgical conditions. Increasingly, teams of professionals are working in a coordinated fashion to deliver healthcare. While mental health care has been offered through interdisciplinary teams for decades, especially in public sector settings, general medical care is only recently developing models to involve a range of health, social services, rehabilitation, and other professionals to manage chronic diseases. The Patient Centered Health Care Home model is a prominent example of this.

There are many patients with substance use and other addictive disorders, and many more with high-risk substance use and addictive behaviors, who could benefit from the care interventions described as Level 0.5, Early Intervention Services, in *The ASAM Criteria*. Such interventions include Screening, Brief Intervention, Referral and Treatment (SBIRT), risk advice and education. Because so few physicians have had special addiction training, this approach cannot be universally applied.

- Focusing on treatment outcomes

Increasingly, funding for practitioners and programs will be based not on the service provided, but on the outcomes achieved. Treatment services and reimbursement based on patient engagement and outcome is consistent with trends in disease and illness management, especially when conducted in real-time during the treatment experience, as with the management of hypertension or diabetes. With these chronic illnesses, changes to the treatment plan are based on treatment outcomes and tracked by real-time measurement at every visit (e.g., blood pressure or blood sugar levels are monitored to determine the success of the current treatment regimen). While there has been increased attention on Evidence-Based Practices (EBP), more focus on patient engagement and outcomes-driven services is still needed.

While EBPs contribute to positive outcomes in treatment, the quality of the therapeutic alliance and the degree to which hope for recovery is conveyed to the patient contribute even more to the outcome. (Wampold, Mondin, Moody, Stich, Benson, & Ahn, 1997; Orlinsky, Grawe, & Parks, 1994; Bachelor & Horvath, 1999; Duncan et al., 2004; Wampold, 2001; Mee-Lee, McLellan, Miller, 2010).

- Engaging with “Informed Consent”

Treatment adherence and outcomes are enhanced by patient collaboration and shared decision-making. To engage people in treatment and recovery, person-centered services encompass clear information to patients. Certain sections of *The ASAM Criteria* mention directly or draw upon the concept of “informed consent.” Healthcare requires informed consent, indicating that the adult, adolescent, legal guardian, and/or family member has been made aware of the proposed modalities of treatment, the risks and benefits of such treatment, appropriate alternative treatment modalities and the risks of treatment versus no treatment.

- Clarifying “Medical Necessity”
Other sections may mention or draw upon the term of “medical necessity.” This concept is central to judgments for third-party payers and managed care organizations to determine appropriateness of care. Because substance use, addictive and mental disorders are biopsychosocial in etiology and expression, treatment and care management are most effective if they, too, are biopsychosocial. The six assessment dimensions identified in *The ASAM Criteria* encompass all pertinent biopsychosocial aspects of addiction and mental health that determine the severity of the patient’s illness and level of function.

For these reasons, *The ASAM Criteria* asserts that “medical necessity” should pertain to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. It should not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs as in Dimension 2; or Dimension 3 psychiatric issues (such as imminent suicidality). Rather, “medical necessity” encompasses all six assessment dimensions so that a more holistic concept would be “Necessity of Care,” or “clinical appropriateness.”

- Harnessing ASAM’s Definition of Addiction
When it was first published in 1991, ASAM’s *Patient Placement Criteria* was considered a guide for linking severity of illness to intensity of service, specifically for when the health condition was a “Psychoactive Substance Use Disorder.” This first edition was published only two years after ASAM adopted its current name as a national medical specialty society, the American Society of Addiction Medicine. At the time, bringing together physicians interested in treating alcoholism with physicians interested in treating opioid and other drug addictions, along with physicians interested in treating nicotine addiction, was revolutionary in its own way.

But still, the focus of this new society was on the prevention and treatment of, and medical education and research about, specific forms of “chemical dependency.” Conditions such as “pathological gambling” were well known, but over the years ASAM repeatedly declined to redefine itself as an organization that would address “non-substance-related addiction” in its policies, education, or advocacy activities. ASAM chose not to identify its mission as including “behavioral addictions.”

There is a “short version” definition of addiction (shown below), as well as a “long version” definition (available at <http://www.asam.org/for-the-public/definition-of-addiction>), which serves as more of a description of the condition. In April of 2011, these two versions were unanimously adopted as official ASAM statements.

ASAM Definition of Addiction – “Short Version”
Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.
Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Notice how this “short version” definition uses the singular term “addiction” to describe a condition that is “primary” and “chronic.” So although this definition explains how compulsive, impulsive, or out-of-control substance use can be present, addiction can also involve impaired control over behaviors (such as gambling) that do not involve psychoactive substance use.

C. **What's New in *The ASAM Criteria*** (*The ASAM Criteria* 2013, pp 11-14)

- *The ASAM Criteria* now expands on prior understanding and applications to serve a wider and more diverse population.

Application to Adult Special Populations (*The ASAM Criteria* 2013, pp 307 -356)

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

Other key highlights of this new edition include, but are not limited to:

- Synchronization with *The ASAM Criteria Software*, such that the definitions and specifications in this text for the dimensions, levels of care and admissions decision rules serve as the reference manual for *The ASAM Criteria Software*, released by SAMHSA.
- Incorporation of the latest understanding of Co-occurring Disorders Capability (formerly termed Dual Diagnosis Capability), and what might better be termed “complexity capability,” to acknowledge the range of service needs beyond just addiction and mental health treatment. The need for persons with substance use disorders to be assessed and treated for co-occurring infectious diseases is but one clear example of this concept. Programs and practitioners increasingly understand the need for trauma informed care and primary health/behavioral health integration, as core features of all addiction treatment programs.

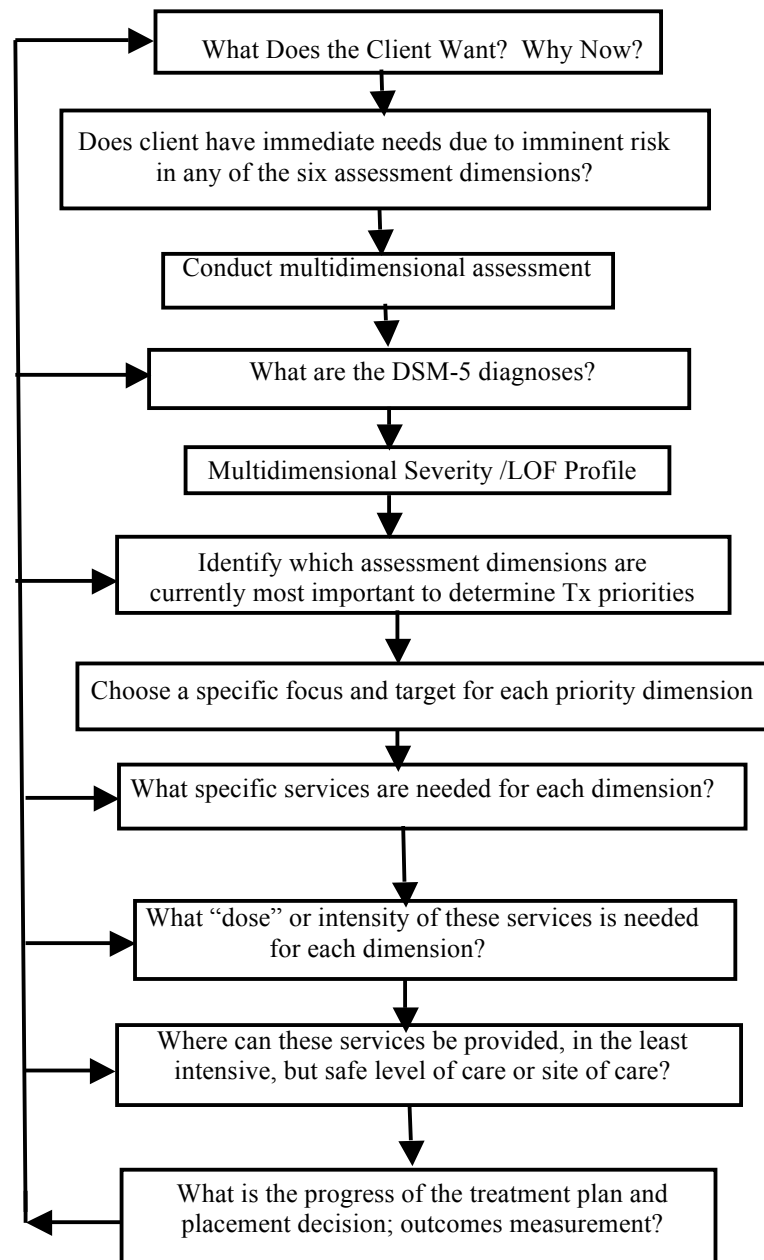
As the treatment field has learned more about the complexities of the people we serve, it increasingly is becoming more trauma-informed and responsive to the needs of people with co-occurring mental and substance use disorders. Services that are “co-occurring capable or enhanced” and “complexity capable” are described.

- Inclusion of the conceptual framework of Recovery Oriented Systems of Care to facilitate understanding of addiction treatment services within a recovery-oriented “chronic disease management” continuum, rather than as repeated, disconnected “acute episodes of treatment” for the acute complications of addiction; and/or repeated and disconnected readmissions to addiction or mental health programs that employ rigid lengths of stay in which patients are “placed.”
- Updated Diagnostic Admission Criteria for the levels of care to be consistent with the American Psychiatric Association’s 2013 publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).
- A new chapter on Gambling Disorder that is consistent with ASAM’s definition of addiction, asserting that the pathological pursuit of reward or relief can involve not just the use of psychoactive substances, but also the engagement in certain behaviors. The inclusion of a Gambling Disorder section also reflects shifts in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which includes Gambling Disorder in the Substance Use and Addictive Disorders chapter.
- A new chapter on Tobacco Use Disorder reflects a decision to address the treatment field’s inconsistencies in, and even ambivalence about, viewing this addiction as similar to alcohol and other substance use disorders.
- An updated opioid treatment section to incorporate new advances, named Opioid Treatment Services (addressing opioid antagonist pharmacotherapy in addition to opioid agonist pharmacotherapy). Previous editions and supplements of ASAM’s criteria have described care offered in what this edition is naming Opioid Treatment Programs (utilizing methadone to treat opioid use disorder in

Level 1 and previously called Opioid Maintenance Therapy, OMT.) *The ASAM Criteria*, Third Edition, is the first to address the growing use of office-based opioid treatment, utilizing buprenorphine products to treat opioid addiction.

- Updates to better assess, understand and provide services for all six ASAM criteria dimensions to reflect current science and research. This can be seen in sections such as “Addressing Withdrawal Management” and Appendix B, “Special Considerations for Dimension 5 Criteria.” Relapse, Continued Use, Continued Problem Potential - Dimension 5 (*The ASAM Criteria* 2013, pp 401-410)

D. Working Effectively with Managed Care (*The ASAM Criteria* 2013, pp 119 -126)



(*The ASAM Criteria* 2013, p 124)

LITERATURE REFERENCES

Mee-Lee D, Shulman GD, Fishman MJ, and Gastfriend DR, Miller MM eds. (2013). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. Third Edition. Carson City, NV: The Change Companies.

For more information on the new edition: www.ASAMcriteria.org

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