Public comments accepted through Monday April 15th through the online survey form at https://bit.ly/correctional_framework

Proposed Framework for *The ASAM Criteria*, Fourth Edition Volume 3: Correctional Settings & Community Reentry

A White Paper

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Introduction

The ASAM Criteria, first published in 1991 by the American Society of Addiction Medicine (ASAM), defines national standards for organizing addiction treatment systems—including the levels of care in the care continuum, the services that should be available at each level of care, and clinical criteria for matching individuals with addiction to an appropriate level of care. These standards help the diverse stakeholders involved in supporting the delivery of quality addiction care—ranging from clinicians, payers, administrators, recovery support service (RSS) providers, and policymakers—to "speak the same language" and provide a foundation for improving the quality of addiction care.

More than half of the people involved in the criminal justice system in the US meet the criteria for substance use disorder (SUD).[1] In addition, people who have co-occurring psychiatric disorders—such as bipolar disorder, major depressive disorder, schizophrenia, and anxiety disorders, including post-traumatic stress disorder (PTSD)—are disproportionately represented in the criminal justice system.[2-5] However, no standards currently exist for organizing addiction treatment within jails and prisons. To address this gap, ASAM plans to develop and release a separate volume of *The ASAM Criteria* dedicated to the needs of justice-involved individuals. In particular, the future volume will address addiction treatment within correctional settings and upon community reentry, including:

- rapid screening for intoxication- and withdrawal-related risks,
- screening for SUDs,
- assessment and treatment planning considerations,
- levels of care in jails and prisons, and
- how to determine the appropriate level of care in jails and prisons and upon reentry.

To develop this proposed framework, ASAM convened an expert committee of seven healthcare professionals who provide addiction treatment to patients in correctional settings across the US. The expert committee reviewed published literature and drew upon their expertise in addiction treatment and clinical experiences caring for patients in carceral settings to develop a proposed framework for *The ASAM Criteria*, Fourth Edition, Volume 3: Correctional Settings & Community Reentry. The goals of this volume are to:

- lay a foundation for the standardization of addiction care in correctional settings, aligning with the standards of addiction treatment in the community;
- support the adoption of service standards that will reduce addiction-related morbidity and mortality for individuals involved with the criminal justice system; and
- promote the delivery of addiction treatment in correctional settings and upon reentry to the community to decrease recidivism.

This proposed framework aims to initiate thoughtful discussion and promote collaboration among stakeholders in the addiction treatment and criminal justice systems as ASAM prepares to develop *The ASAM Criteria*, Fourth Edition, Volume 3: Correctional Settings & Community Reentry. The proposed changes in this document are preliminary. ASAM is seeking input from stakeholders to better understand any potential unintended consequences as well as feasibility challenges. Health care is delivered in different ways in correctional settings across the country. No one person has insight into all these implementations. Thus, input from diverse stakeholders is needed to inform decisions regarding these proposed changes.

Providing Addiction Treatment in Correctional Facilities

It is estimated that over half of people in prison and two thirds of people sentenced to jail meet the DSM criteria for SUD.[1,2] Another 20% percent did not meet the official criteria for an SUD, but were under the influence of drugs or alcohol at the time of the offense for which they were currently incarcerated.[6] Mortality from drug or alcohol intoxication and withdrawal in both jails and prisons has increased precipitously over the last two decades.[7,8]

In addition to the legal obligations to provide adequate care for SUD and co-occurring mental health conditions,[*,9] jails and prisons have a unique opportunity to:

- prevent intoxication- and withdrawal-related deaths in correctional facilities,
- reduce drug overdose deaths in both the confined environment and upon reentry, and
- help people who are suffering from SUD and interrupt the cycle of incarceration.

Treating addiction and co-occurring mental health conditions has numerous benefits and aligns with the core criminal justice goals of habilitation or rehabilitation and corresponding reduction in recidivism.[10,11] Lack of resources and funding are among the most significant barriers limiting the implementation of evidence-based addiction treatment, including medications for addiction treatment (MAT), in custody settings.[12] However, treatment with MAT—particularly, medications for opioid use disorder (MOUD) such as naltrexone, buprenorphine, and methadone—during incarceration has been shown to dramatically reduce overdose deaths post-incarceration.[13,14] Psychosocial treatment without MOUD has been found to offer no protection against fatal overdose.[15] MAT has also been shown to be effective at reducing risk of recidivism.[10]

[*] The Civil Rights Act of 1871 and the Civil Rights of Institutionalized Persons Act (CRIPA) of 1980 require the provision of adequate medical care, including for mental health and substance-related concerns. The Americans with Disabilities Act of 1990 (ADA) prohibits discrimination against people with disabilities, including those with opioid use disorder (OUD) who require MAT, specifically MOUD.

The Criminal Justice System and *The ASAM Criteria*

Correctional settings in the US are being called upon to provide frontline mental health and addiction treatment with increasing frequency and urgency. However, ASAM recognizes that most jails and prisons are not typically designed to deliver specialized health care and, as such, may require considerable training, technical assistance, and funding to adapt their highly regulated operations to support such care.[12,16] Further complicating the issue is the often chaotic environment of these settings—especially jails, where individuals rapidly cycle in and out with unpredictable lengths of stay.[12]

ASAM also understands that each jail and prison face unique challenges. Considerable variability exists among jails and prisons in terms of physical size, geographic location, housing capacity, and access to resources. Smaller facilities or those with fewer internal resources are expected to meet the same foundational standards of care as larger, better-resourced institutions, but how they achieve this will differ. For example, jails and prisons are expected to screen all individuals for their risk of substance withdrawal shortly after they arrive at the facility. A larger, well-resourced jail or prison may fulfill this expectation by having healthcare staff perform screening. A smaller jail or prison with fewer resources may fulfill this expectation by having custody and/or other facility staff receive training and supervision to perform this screening or by having healthcare professionals conduct screening remotely via telemedicine.

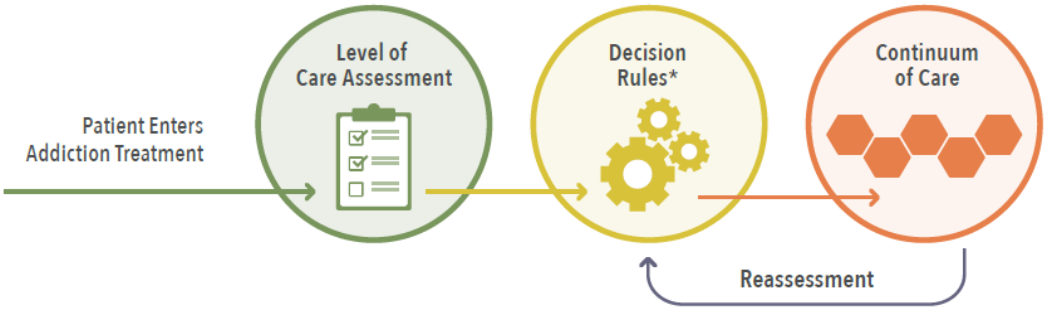
The ASAM Criteria Framework

Addiction is a chronic relapsing disease that is best managed by ensuring continuity of care from initial entry into treatment through long-term remission monitoring. *The ASAM Criteria* envisions a treatment system where, regardless of where or how a patient enters addiction treatment, they receive a standardized multidimensional assessment to determine the least intensive but safe and effective level of care based on their individual treatment needs.[17] As the patient's needs change, they transition to the next appropriate level of care.[17]

The ASAM Criteria incorporates multiple sets of interacting standards that provide a framework for organizing addiction treatment and making level of care recommendations, including:

- assessment standards for identifying an individual's clinical needs;
- Dimensional Admission Criteria for determining an appropriate level of care based on an individual's clinical needs; and
- standards for the continuum of care, including which levels of care should be available and the types and intensity of services that should be available in each level.

Figure 1. Core Components of *The ASAM Criteria*



* Decision rules include the Dimensional Admission Criteria and the transition and continued service criteria.

As a patient enters addiction treatment, a Level of Care Assessment is administered and the Dimensional Admission Criteria are applied to determine the recommended level of care along the care continuum. As the patient progresses through treatment, they are regularly reassessed, and transition and continued service criteria are applied to determine whether the patient needs additional time at the same level of care, needs a more intensive level of care, or is ready for a less intensive level of care. This framework guides movement along the continuum of care throughout the patient's treatment journey.

Assessment Dimensions and Subdimensions

Figure 2. *The ASAM Criteria* Assessment Dimensions and Subdimensions

Dimension 1: Intoxication, Withdrawal, and Addiction Medications
- Intoxication and Associated Risks
- Withdrawal and Associated Risks
- Addiction Medication Needs

Dimension 2: Biomedical Conditions
- Physical Health Concerns
- Pregnancy-Related Concerns
- Sleep Problems

Dimension 3: Psychiatric and Cognitive Conditions
- Active Psychiatric Symptoms
- Persistent Disability
- Cognitive Functioning
- Trauma-Related Needs
- Psychiatric and Cognitive History

Dimension 4: Substance Use-Related Risks
- Likelihood of Engaging in Risky Substance Use[1]
- Likelihood of Engaging in Risky SUD-Related Behaviors[2]

Dimension 5: Recovery Environment Interactions
- Ability to Function Effectively in Current Environment
- Safety in Current Environment
- Support in Current Environment
- Cultural Perceptions of Substance Use and Addiction

Dimension 6: Person-Centered Considerations
- Barriers to Care
- Patient Preferences
- Need for Motivational Enhancement

1. Risky substance use refers to any use with significant risk for adverse medical, emotional, social, financial, and/or legal consequences.
2. Risky SUD-related behaviors refers to any behaviors linked to substance use or SUD that cause or are anticipated to cause significant adverse medical, psychological, emotional, social, financial, and/or legal consequences.

The ASAM Criteria assessment considers six dimensions that represent the broad biopsychosocial areas that impact SUD treatment and recovery support needs. The subdimensions within each of the six dimensions reflect core actionable factors to be assessed within each dimension. While only certain subdimensions (in **bold and blue**) inform level of care recommendations, *all* subdimensions are considered for treatment planning purposes.

Continuum of Care

The ASAM Criteria continuum of care is comprised of several levels of care that represent a gradation of intensities of services.[17] Patients move along the continuum to more or less intensive levels of care depending on their evolving needs and treatment progress.[17] The continuum of care for adults in the community includes four broad treatment levels, 1 through 4. Within these four broad levels, decimal numbers express further gradations of treatment intensities and types of care provided. For a summary of the adult continuum of care see Appendix A.

As described below in the continuum of care sections specific to jails and prisons, the community continuum of care will be adapted into a simplified continuum that better reflects carceral environments and the intensity of services they can be realistically expected to support. Individuals reentering the community following release from incarceration would enter the community continuum of care for adult addiction treatment. A comprehensive discussion on reentry is beyond the scope of this proposed framework; however, reentry will be addressed in detail in the full volume of *The ASAM Criteria*, Fourth Edition for Correctional Settings & Community Reentry.

Guiding Principles of *The ASAM Criteria*

The purpose of *The ASAM Criteria* is to guide clinicians and care managers in making objective decisions about patients' evolving treatment needs related to SUD and co-occurring conditions.[17] In alignment with the Adult Volume of *The ASAM Criteria*, Fourth Edition, the following principles are proposed for the Correctional Settings & Community Reentry Volume:

- **Recommended treatment is based on the patient's clinical needs.** Addiction treatment for all individuals—regardless of the types of charges laid against them and their security classification level—should be determined by appropriately qualified healthcare professionals based on clinical presentation and treatment needs in alignment with current standards of care.
- **A multidimensional assessment is conducted to understand the broad biological, psychological, social, and cultural factors that contribute to a person's SUD(s), addiction, and recovery.** This principle applies a whole-person approach to assessment and treatment planning by recognizing the diverse factors that contribute to SUD prognosis and addiction treatment needs.

- **Treatment plans are individualized based on patient needs and preferences.** Treatment plans are responsive to the needs of each patient, developed in consultation with them, and based on a comprehensive biopsychosocial assessment that encompasses a thorough evaluation of their central support systems (eg, family, friends, significant others).
- **Care is interdisciplinary, evidence-based, patient-centered, and delivered from a place of empathy.** *The ASAM Criteria* promotes the integration of addiction care with medical and mental health care. Addiction treatment should be coordinated across treatment providers and delivered in a nonjudgmental, trauma-sensitive, and culturally humble manner. This approach offers the best chance for engaging the patient in treatment and recovery.
- **Co-occurring conditions are an expectation, not an exception, among patients with SUDs.** Patients' co-occurring mental health concerns, including trauma, should be addressed in the routine course of addiction treatment.
- **Patients move along the clinical continuum of care based on their progress and outcomes.** Treatment should be individualized, based on the severity of each patient's illness, level of function, and response to treatment. Patients move to more or less intensive levels of care depending on their evolving needs and treatment progress.
- **Informed consent and shared decision-making accompany treatment decisions.** Treatment engagement and outcomes are enhanced by collaborating with patients in shared decision-making. Individuals within the criminal justice system should be informed of their options—including relevant benefits and risks of each treatment modality, appropriate alternative treatment options, and the risks of treatment versus no treatment—and have the right to refuse treatment, with the exception of lifesaving treatment for individuals deemed at risk of suicide. This requires explanations in terms and language people can understand, which may require translation services.

Continuum of Care for Addiction Treatment in Jails

Because individuals are often only in jail for hours, days, or weeks, the proposed framework for the continuum of addiction treatment in these settings is primarily focused on meeting patients' medical needs related to SUD. All patients with SUD in jail for more than 14 days should have access to 4 or more hours of psychosocial services per week (eg, therapy, individual or group counseling,

ASAM recognizes that funding mechanisms and payment models will be needed to support the delivery of SUD treatment in jails and prisons.

psychoeducation). ASAM believes the long-term goal should be for jails to be able to provide 9 or more hours of psychosocial services per week, in alignment with community-based intensive outpatient services (IOP). However, we recognize the workforce and funding challenges associated with meeting this standard in the short term. Note that the number of hours of clinical services offered should be individualized based on each patient's needs. In addition, psychosocial service participation should never be required for an individual to receive appropriate medical care, including addiction medications. The following levels of care are recommended for jail settings:

Level of Care	Description	Notes
Level R-J Long-Term Remission Monitoring	Provides ongoing access to medications and recovery management support for individuals in sustained remission from SUD while in jail.	All jails should be able to directly provide this level of care.
Level 1-J Medically Managed Low-Intensity Treatment	Provides medical management **without** extended nurse monitoring for low complexity[†]: • withdrawal management[‡]; and • continuation, initiation, or titration of addiction medications (including buprenorphine and methadone[§]). **Plus** access to 4+ hours of psychosocial services for SUD per week (available, not required).	All jails should be able to directly provide this level of care.

[†] Note that the terms *mild, moderate, and moderately severe* and *low, moderate, and moderately high complexity* will be defined in the Dimensional Admission Criteria that will be developed after this proposed framework is finalized. The Dimensional Admission Criteria will be released for public comment prior to publication.
[‡] Note that the standard of care for opioid withdrawal management includes treatment with buprenorphine or methadone.
[§] Unless unavailable locally.

Level of Care	Description	Notes
Level 2-J Medically Managed Moderate-Intensity Treatment	Provides medical management **with** extended monitoring by medical support staff (eg, nurses, paramedics, medical technicians) for moderate complexity[†]: • intoxication management; • withdrawal management[‡]; and • continuation, initiation, or titration of addiction medications (including buprenorphine and methadone[§]). **Plus** access to 4+ hours of psychosocial services for SUD per week (available, not required).	Lower-resourced jails that do not have the capacity to provide daily on-site medical monitoring services should transfer patients who need this level of care to an appropriate medical facility.
Level 3-J Medically Managed High-Intensity Treatment	Provides medical management **with** 24-hour on-site nurse monitoring with 24-hour medical oversight by physicians or advanced practice providers for moderately high complexity[†]: • intoxication management; • withdrawal management[‡]; and • continuation, initiation, or titration of addiction medications (including buprenorphine and methadone[§]). **Plus** access to 4+ hours of psychosocial services for SUD per week (available, not required).	Jails that do not have the capacity to provide 24-hour on-site medical monitoring and management services should transfer patients who need this level of care to an appropriate medical facility.
Level 4 Medically Managed Inpatient Treatment	Provides medical management in an acute care inpatient setting (ie, general hospital) delivered by medical professionals who provide 24-hour medically directed on-site evaluation and treatment of intoxication, withdrawal, and biomedical and psychiatric comorbidities.	All jails are expected to support transfer to an acute care hospital if Level 4 care is needed.

Levels of Care in Jails

The level of care descriptions below include terms such as mild, moderate, and high severity, and low, moderate, and moderately high complexity. **These terms will be fully defined in the Dimensional Admission Criteria that will be developed after this proposed framework is finalized. The Dimensional Admission Criteria will be released for public comment prior to publication.**

Level R-J: Long-Term Remission Monitoring

Based on the chronic care model of addiction treatment, Level R-J is intended to provide remission management services to support ongoing monitoring and early reintervention for patients in sustained remission from SUD. Services include continuation of MAT and recovery management checkups (RMCs). RMCs should include sufficient recovery- and remission-focused biopsychosocial screening and assessment to identify current or emerging addiction treatment needs, biomedical and/or mental health needs that may impact recovery, and additional recovery support service (RSS) needs.

Level 1-J: Medically Managed Low-Intensity Treatment

Level 1-J is appropriate for patients with SUD who require medical management but not nurse monitoring. This level provides evaluation and management of:

- mild** intoxication or withdrawal;
- initiation (including low-threshold initiation), titration, or continuation of MAT that is expected to be low complexity**;
- post-acute withdrawal signs or symptoms; and/or
- mild to moderate** psychiatric or biomedical concerns that interact with the individual's SUD-related needs.

Level 1-J is uniquely positioned to provide low-threshold access to MAT—especially MOUD such as buprenorphine and methadone. Low-threshold treatment is an important strategy to engage individuals in care and create trusting relationships with healthcare providers while stabilizing their symptoms and reducing their risk for overdose and death. *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder* highlights that[18]:

> Patients' psychosocial needs should be assessed, and patients should be offered or referred to psychosocial treatment based on their individual needs. However, a patient's decision to decline psychosocial treatment or the absence of available psychosocial

** Note that the terms *mild, moderate, and moderately severe* and *low, moderate, and moderately high complexity* will be defined in the Dimensional Admission Criteria that will be developed after this proposed framework is finalized. The Dimensional Admission Criteria will be released for public comment prior to publication.

treatment should not preclude or delay pharmacotherapy, with appropriate medication management.

Level 1-J is also appropriate for patients with SUD who are incarcerated for more than 2 weeks and require psychosocial services but do not require medication management or nurse monitoring. Addiction-specific psychosocial services should be available (eg, addiction psychotherapy, cognitive behavioral therapy [CBT] for addiction, psychoeducation on SUD and co-occurring disorders) in addition to general psychosocial services (eg, anger management, general psychoeducation) and the full suite of RSS, including transition and reentry planning. The intensity of psychosocial services should be individualized. Jails should provide individuals with SUD with access to 4 or more hours per week of psychosocial services. However, an individual's decision to not engage in psychosocial services should not preclude them from having access to MAT while in jail.

Level 2-J: Medically Managed Moderate-Intensity Treatment

Level 2-J is appropriate for patients with SUD who require evaluation and management for:

- more complex** intoxication or withdrawal that requires medical management and regular nurse monitoring during the day;
- initiation, titration, or continuation of addiction medications that is expected to be moderately complex,** requiring medical management and regular nurse monitoring during the day; and/or
- moderate to moderately severe** biomedical or psychiatric concerns that interact with the individual's SUD-related needs and requires frequent medical services and regular nurse monitoring during the day.

Intoxication from alcohol or other substances is a leading cause of death in the first few days of a person's entry into jail and, thus, requires extended monitoring for effective management.[19]

Recovery-Specific Cohorting

The Fourth Edition of *The ASAM Criteria* incorporated recovery residences into the adult continuum of care as an environmental supplement to community-based outpatient care. Recovery-specific cohorting for individuals receiving care in correctional settings can be thought of as the carceral equivalent to recovery residences. Recovery-specific cohorting refers to the colocation or grouping of individuals who are actively receiving treatment and working toward recovery.

Social networks in carceral environments—such as the prevalence of substance use and SUDs within housing groups and cell blocks or yard politics—can influence an individual's ability to avoid purchasing and/or using substances. When feasible, jails are encouraged to provide recovery-specific housing groups, yards, or cell blocks that can create supportive environments

of like-minded individuals, reducing social pressure and coercion around substance use. Recovery-specific cohorting provides a therapeutic milieu, which is a safe and secure treatment environment that provides structured programming and uses community dynamics to promote healing. Individuals who are willing to engage in treatment but have not yet developed relapse prevention skills would benefit most from recovery-specific cohorting.

The ASAM Criteria Dimensional Admission Criteria may recommend recovery-specific cohorting, where feasible, based on an individual's needs.

Level 3-J: Medically Managed High-Intensity Treatment

Some large, well-resourced jails may have medical units that can provide 24-hour medical management and nurse monitoring. Level 3-J is appropriate for patients with SUDs who require care delivered in a monitored clinic space with 24-hour medical monitoring within the jail to evaluate and manage:

- moderately severe intoxication or withdrawal or risk of moderately severe to severe withdrawal,** and/or
- moderately severe** biomedical or psychiatric concerns that interact with the individual's SUD-related needs requiring 24-hour medical monitoring.

The key difference between Level 2-J and 3-J is the setting in which treatment is delivered. Level 3-J provides cohorted clinical space with 24-hour on-site monitoring by nurses and other medical support staff (eg, paramedics) who have 24-hour access to physicians or advanced practice providers (eg, nurse practitioners [NPs], physician assistants [PAs]). A qualified medical professional acting within their state-regulated scope of practice should determine if the jail has the capacity to manage the anticipated intoxication, withdrawal syndrome, biomedical concerns, or psychiatric concerns safely and effectively. If not, the individual should be immediately transferred to an acute care hospital.

Level 4: Medically Managed Inpatient Treatment

Level 4 is appropriate for patients with SUDs who require 24-hour medically directed evaluation and treatment of intoxication, withdrawal, and biomedical and psychiatric comorbidities in an acute care hospital or inpatient setting. When Level 4 is recommended, the individual should be transferred from the jail to a hospital. The proposed standards for jails will have a lower threshold for recommending Level 4 care than the community standards due to the greater medical complexity of individuals in jails and the complex administrative processes involved with transfers from jail to hospital.

Continuum of Care for Addiction Treatment in Prisons

Individuals entering prison are typically transferred from another correctional facility. As such, there is typically less risk for acute intoxication and withdrawal. Therefore, the proposed framework for the continuum of addiction treatment in prisons centers around access to medications for addiction treatment (MAT), psychosocial treatment services, and long-term monitoring. The following levels of care are recommended for prison settings:

Level of Care	Description	Notes
Level R-P Long-Term Remission Monitoring	Provides ongoing access to medications and recovery management support for individuals in sustained remission from SUD while in prison.	All prisons should be able to directly provide this level of care.
Level 1-P Medically Managed Low-Intensity Treatment	Provides medical management **without** extended nurse monitoring for low complexity[††]: • withdrawal management[‡‡]; and • continuation, initiation, or titration of addiction medications (including buprenorphine and methadone[§§]). **Plus** access to under 9 hours of psychosocial services for SUD per week (available, not required).	All prisons should be able to directly provide this level of care.

[††] Note that the terms *mild, moderate, and moderately severe* and *low, moderate, and moderately high complexity* will be defined in the Dimensional Admission Criteria that will be developed after this proposed framework is finalized. The Dimensional Admission Criteria will be released for public comment prior to publication.
[‡‡] Note that the standard of care for opioid withdrawal management includes treatment with buprenorphine or methadone.
[§§] Unless unavailable locally.

Level of Care	Description	Notes
Level 2-P Medically Managed Moderate-Intensity Treatment	Provides medical management **without** extended nurse monitoring for low complexity[††]: • withdrawal management[‡‡]; and • continuation, initiation, or titration of addiction medications (including buprenorphine and methadone[§§]). **Plus** access to 9+ hours of psychosocial services for SUD per week (available, not required).	All prisons should be able to directly provide this level of care.
Level 3-P Recovery Unit	Provides medical management **without** extended nurse monitoring for low complexity[††]: • withdrawal management[‡‡]; and • continuation, initiation, or titration of addiction medications (including buprenorphine and/or methadone[§§]). **Plus** access to 9+ hours of psychosocial services for SUD per week (available, not required). Care at this level is delivered in a **recovery unit** or **cohorted housing**.	ASAM is proposing that all prisons be able to directly provide this level of care. We are particularly interested in feedback on the feasibility of this for small prisons.

Level of Care	Description	Notes
Level 3.7-P High-Intensity Medical Unit	Provides medical management **with** 24-hour on-site nurse monitoring and 24-hour medical oversight by physicians or advanced practice providers for moderately high complexity[††]: • intoxication management; • withdrawal management[‡‡]; and • continuation, initiation, or titration of addiction medications (including buprenorphine and methadone[§§]). Care at this level is delivered in a **monitored clinical space** (ie, medical unit).	Prisons that do not have the capacity to provide 24-hour on-site medical monitoring and management services should transfer patients who need this level of care to an appropriate medical facility.
Level 4 Medically Managed Inpatient Treatment	Provides medical management in an acute care inpatient setting (ie, general hospital) delivered by medical professionals who provide 24-hour medically directed on-site evaluation and treatment of intoxication, withdrawal, and biomedical and psychiatric comorbidities.	All prisons are expected to support transfer to an acute care hospital if Level 4 care is needed.

Levels of Care in Prisons

The level of care descriptions below include terms such as mild, moderate, and high severity, and low, moderate, and moderately high complexity. **These terms will be fully defined in the Dimensional Admission Criteria that will be developed after this proposed framework is finalized. The Dimensional Admission Criteria will be released for public comment prior to publication.**

Level R-P: Long-Term Remission Monitoring

Based on the chronic care model of addiction treatment, Level R-P is intended to provide remission management services to support ongoing monitoring and early reintervention for patients in sustained remission from SUD. Services include continuation of MAT and recovery management checkups (RMCs). RMCs should include sufficient recovery- and remission-focused biopsychosocial screening and assessment to identify current or emerging addiction treatment needs, biomedical and/or mental health needs that may impact recovery, and additional recovery support service (RSS) needs.

Level 1-P: Medically Managed Low-Intensity Treatment

Level 1-P is appropriate for patients with SUD who require medical management but not nurse monitoring. This level provides evaluation and management of:

- mild[***] intoxication or withdrawal;
- initiation (including low-threshold initiation), titration, or continuation of MAT that is expected to be low complexity[***];
- post-acute withdrawal signs or symptoms; and/or
- mild to moderate[***] psychiatric or biomedical concerns that interact with the individual's SUD-related needs.

Level 1-P is also appropriate for patients with SUD who require low-intensity (ie, less than 9 hours per week) psychosocial services for SUD but do not require medical management. Addiction-specific psychosocial services should be available (eg, addiction psychotherapy, cognitive behavioral therapy [CBT] for addiction, recovery support groups, psychoeducation on SUD and co-occurring disorders) in addition to general psychosocial services (eg, anger management, general psychoeducation) and the full suite of RSS, including transition and reentry planning. However, an individual's decision to not engage in addiction-specific psychosocial services should not preclude them from having access to MAT while in prison.

Level 2-P: Medically Managed Moderate-Intensity Treatment

Level 2-P is appropriate for patients with SUD who require moderate-intensity (ie, 9 or more hours per week) addiction-specific psychosocial services. This treatment intensity is equivalent to that provided by a community-based intensive outpatient program (IOP).

Level 2-P also provides medical management equivalent to that provided in Level 1-P.

Level 3-P: Recovery Unit

The Fourth Edition of *The ASAM Criteria* incorporated recovery residences into the adult continuum of care as an environmental supplement to community-based outpatient care. Recovery-specific cohorting for individuals receiving care in correctional settings can be thought of as the carceral equivalent to recovery residences. Recovery-specific cohorting refers to the colocation or grouping of individuals who are actively receiving treatment and working toward recovery.

[***] Note that the terms *mild, moderate, and moderately severe* and *low, moderate, and moderately high complexity* will be defined in the Dimensional Admission Criteria that will be developed after this proposed framework is finalized. The Dimensional Admission Criteria will be released for public comment prior to publication.

Level 3-P is appropriate for patients with SUD who require recovery-specific cohorting to support safe and effective treatment and recovery. As noted above, ASAM is proposing that all prisons be able to directly provide this level of care. We are particularly interested in feedback on the feasibility of this for small prisons.

Social networks in carceral environments—such as the prevalence of substance use and SUDs within housing groups and cell blocks or yard politics—can influence an individual's ability to avoid purchasing and/or using substances. Recovery units in prisons that consist of recovery-specific housing groups, yards, or cell blocks can create supportive environments of like-minded individuals, reducing social pressure and coercion around substance use. Recovery-specific cohorting provides a therapeutic milieu, which is a safe and secure treatment environment that provides structured programming and uses community dynamics to promote healing. Individuals who are willing to engage in treatment but have not yet developed relapse prevention skills would benefit most from recovery-specific cohorting.

Level 3-P also provides medical management equivalent to that provided in Level 1-P.

Level 3.7-P: High-Intensity Medical Unit

Level 3.7-P is appropriate for patients with SUDs who require high-intensity medical care delivered in a monitored clinic space within the prison with 24-hour nurse monitoring to evaluate and manage:

- moderately severe intoxication or withdrawal or risk of moderately severe withdrawal,[***] and/or
- severe[***] biomedical or psychiatric concerns that interact with the individual's SUD-related needs requiring 24-hour medical monitoring.

Level 3.7-P provides cohorted clinical space with 24-hour on-site monitoring by nurses and other medical support staff (eg, paramedics) who have 24-hour access to physicians or advanced practice providers (eg, nurse practitioners [NPs], physician assistants [PAs]). A qualified medical professional acting within their state-regulated scope of practice should determine if the prison has the capacity to manage the anticipated intoxication, withdrawal syndrome, biomedical concerns, or psychiatric concerns safely and effectively. If not, the individual should be immediately transferred to an acute care hospital.

While acute withdrawal and intoxication are less common in prisons compared to jails, the increasing prevalence of high-potency synthetic drugs such as fentanyl has made this a more common phenomenon.

Level 4: Medically Managed Inpatient Treatment

Level 4 is appropriate for patients with SUDs who require 24-hour medically directed evaluation and treatment of intoxication, withdrawal, and biomedical and psychiatric comorbidities in an acute care hospital or inpatient setting. When Level 4 is recommended, the individual should be transferred from the prison to a hospital. The proposed standards for prisons will have a lower threshold for recommending Level 4 care than the community standards due to the greater medical complexity of individuals in prisons and the complex administrative processes involved with transfers from prison to hospital.

Assessment and Treatment Planning

Screening

As discussed above, individuals who are incarcerated have high rates of SUD. Jails and prisons should screen every person, regardless of their length of stay, for intoxication and withdrawal risk at intake. In addition, all individuals should be screened for SUD during or prior to the initial physical exam.

Assessment and Treatment Planning

There are many biological, psychological, social, and cultural factors that influence the course of a person's SUD and their treatment needs. A guiding principle of *The ASAM Criteria* is that these diverse factors should be considered when determining an individual's treatment needs. *The ASAM Criteria* assessment types proposed for jails and prisons include:

- A *Level of Care Assessment*, used to triage individuals into the appropriate level of care by identifying immediate risks and evaluating relevant risk factors.
- A *Treatment Planning Assessment*, a comprehensive biopsychosocial assessment used to develop an individualized treatment plan.
- A Treatment Plan Review, periodic reassessment to inform updates to the individual's treatment plan.
- A *Reentry Assessment*, used to identify the individual's needs to support ongoing engagement in SUD treatment and recovery upon reentry.

The ASAM Criteria includes the six dimensions described in the framework, each of which includes key subdimensions that inform level of care recommendations and treatment planning (see Figure 2).[17] The dimensions have been organized to promote a deductive approach that ensures that the dimensions with the highest potential for acute—and potentially life-threatening—medical needs are assessed first.

The same dimensions and subdimensions are proposed for the Correctional Settings & Community Reentry Volume. Important considerations for application of these dimensions and subdimensions in this volume are discussed below.

Dimension 1: Intoxication, Withdrawal, and Addiction Medications

Intoxication and Associated Risks. Individuals who use a substance immediately before entering correctional settings may not necessarily appear intoxicated at booking or intake but could decompensate over their initial hours at the facility. Individuals who are intoxicated should be referred for immediate clinical assessment. Facilities should consider monitoring any individual who screens positive for recent substance use for intoxication, even if they do not appear intoxicated or unwell at booking or intake.[19]

Withdrawal and Associated Risks. Assessment and management of withdrawal should be a priority for all correctional settings since withdrawal syndromes for alcohol, opioids, and sedative–hypnotics can be deadly if left untreated. In addition, withdrawal can exacerbate preexisting physical and mental health conditions, which can lead to potentially life-threatening sequelae such as seizures and suicidal behaviors. Assessment and management of withdrawal risks should align with the BJA's *Guidelines for Managing Substance Withdrawal in Jails*.[19]

Addiction Medication Needs. All correctional facilities should be able to initiate, titrate, and continue FDA-approved MAT, either directly or through formal affiliation.[17] The US Department of Justice has clarified that the ADA protects individuals who are taking legally prescribed addiction medications to treat OUD, which means policies—whether official or tacit—that prohibit the use of addiction medications are considered discriminatory against people with OUD and in violation of the ADA.[20]

Dimension 2: Biomedical Conditions

Physical Health Concerns. Individuals involved with the criminal justice system have disproportionately high rates of chronic physical health conditions.[7,8,21-23] A key goal of the initial assessment for Dimension 2 in criminal justice settings is to identify comorbidities that interact with or are exacerbated by substance use, such as heart disease, liver disease, and infectious diseases like HIV and viral hepatitis.[7,8,21-23]

Pregnancy-Related Concerns. Approximately 3% of women in federal prisons and 4% in state prisons reported they were pregnant at intake.[21] Correctional facilities are recommended to offer universal pregnancy testing—conducted by qualified healthcare professionals—to all individuals of childbearing potential or childbearing age at intake.[19]

Dimension 3: Psychiatric and Cognitive Conditions

Active Psychiatric Symptoms. The prevalence of mental health conditions is disproportionately high among individuals involved with the criminal justice system.[2,3,5] While jails and prisons have separate policies and procedures regarding screening for and managing mental health conditions, this area is assessed as part of *The ASAM Criteria* because it may influence the individual's SUD treatment needs and/or affect their ability to participate in treatment.

Suicide is the leading cause of death in jails and the second leading cause of death in prisons[7,8,24]; the risk of suicide is heightened during intoxication and withdrawal.[25-27] It is therefore critical that correctional institutions establish and implement policies and protocols on screening to mitigate the risk of suicide in their facilities. Structured and standardized approaches to assessment of suicide risk helps ensure the burden of decision-making is not placed on non-clinical corrections and custody staff.[28,29] Non-clinical staff can be trained to administer validated screening tools such as the Columbia–Suicide Severity Rating Scale (C-SSRS) and the Patient Health Questionnaire-9 (PHQ-9; specifically, question nine of the PHQ-9 that deals with thoughts of harm to self).[30,31] *The ASAM Criteria* decision rules for this volume may flag the need for referral for care for a co-occurring mental health condition and ongoing coordination of care.

Individuals should be assessed for signs and/or symptoms of active psychosis at intake given the considerable behavioral and safety concerns that may present, which can be challenging to manage within the confines of correctional institutions. Facilities should have a low threshold for referral to mental health services; individuals experiencing active psychosis should be transferred to an acute care setting (ie, hospital emergency department) until they have stabilized and received medical clearance for admission into the jail or prison.

It is essential that any psychiatric medications individuals are receiving at entry to a facility are continued due to the potential for rapid destabilization following discontinuation.

Persistent Disability. Individuals should be assessed for any persistent impairment related to chronic mental health or cognitive issues that affect their functioning. People with low education and literacy, intellectual or developmental disabilities, a history of head injuries, and mental health conditions—all of which can impact cognition—are overrepresented in correctional institutions.[32-36] Persistent disability should not be a reason to deny services, including addiction treatment. Instead, accommodation should be made, such as using plain language, avoiding written materials for those with low literacy, and speaking slowly and chunking information for those with cognitive impairment or intellectual disability.

Dimension 4: Substance Use-Related Risks

Likelihood of Engaging in Risky Substance Use and SUD-Related Behaviors. Many factors influence an individual's likelihood of engaging in risky substance use and SUD-related

behaviors, including recent and historical patterns of use, access to substances, current or likely exposure to use triggers in the daily environment, awareness of use triggers, and ability to cope with stressors and cravings.

Environmental factors in jails and prisons can also influence the likelihood of engaging in substance use and SUD-related behaviors. Individuals may seek out substances due to boredom and the lack of stimulation in the carceral environment. Individuals could also be coerced into substance use or risky behaviors by others whom they are incarcerated with. Social networks within carceral environments and the prevalence of substance use within an individual's housing group or cell block and yard politics can influence an individual's ability to avoid purchasing and/or using substances. Assessments should include inquiries into these factors and substance use coercion. Facilities should seek to separate recovering patients from housing groups and/or cell blocks engaged in heavy substance use and risky behaviors.

Illicit opioid use is often widespread when MAT is not available in the facility.[37] The risks associated with substance use and SUD-related behaviors may be mitigated within carceral settings by making MAT widely accessible. As such, this dimension will likely contribute more to treatment planning than level of care recommendations in criminal justice settings.

Dimension 5: Recovery Environment Interactions

For each subdimension in Dimension 5, the Treatment Planning Assessment should consider both the carceral environment as well as the environment where the individual will return upon release.

Ability to Function Effectively in Current Environment. Deficits in social and interpersonal skills and skills of daily living that prevent the individual from functioning effectively or might affect their ability to take part in or benefit from treatment programs should be assessed. For example, conflict resolution skills, ability to cooperate with others, and flexibility when confronted with challenging interpersonal situations should be evaluated. The need for any specific services and/or support to enhance interpersonal skills should also be documented.

Safety in Current Environment. Carceral institutions face considerable challenges to protect the safety of all individuals—both staff and individuals who are incarcerated—within their walls. The assessment should consider vulnerability to abuse by others during incarceration due to advanced or youthful age, mental health disorders, cognitive impairment, sexual orientation and/or gender identity, and physical and intellectual disabilities. Steps should be taken to provide physical and psychological safety for vulnerable individuals.

Support in Current Environment. Social networks within criminal justice settings are multifaceted, helping individuals in some aspects of daily life while hindering others. For example, being part of a specific social group may be an important source of safety while also

undermining recovery. A potential solution could be recovery-specific cohorting, the proposed carceral equivalent of recovery residences in the community. Recovery-specific cohorting can create supportive environments of like-minded individuals, reducing social pressure and coercion around substance use and participation in illicit activities. Individuals who are motivated to achieve recovery but have not yet developed relapse prevention skills to maintain their safety around potential triggers would benefit most from recovery-specific cohorting.

Dimension 6: Person-Centered Considerations

Though the initial level of care recommendation is based on the assessment of Dimensions 1 through 5, the assessment of Dimension 6 is crucial for determining which level of care the individual is willing and able to participate in.

Barriers to Care. Traditional patient-level barriers to care may be less of a concern within correctional institutions since factors such as transportation needs, childcare, and health insurance are not an issue for individuals during incarceration. However, individuals might face barriers related to language, health literacy, or social pressure from peers or family. Furthermore, individuals often face significant barriers to accessing care on reentry to the community following their release from jail or prison, which should be considered during treatment planning.

Patient Preferences. An individual's motivation to initiate treatment while incarcerated may be lower if they have a shorter or unknown duration of custody. Continuity of care and anticipated challenges on reentry may also influence an individual's motivation to engage in treatment while incarcerated. Past experiences with addiction treatment can also impact motivation to engage in treatment. Prior negative experiences decrease motivation to initiate new treatment. Individuals should be provided adequate information about potential treatments and services to allow them to make informed choices; their preferences should be taken into account and followed whenever possible. Each individual should be given a voice to collaborate with their clinical providers to develop a treatment plan that satisfies both the individual's preferences and the criminal justice system's mandated requirements.

Need for Motivational Enhancement. Readiness to engage in recommended treatment should be considered in the context of other challenges the individual may be facing, whether within the carceral system or upon reentry to the community. Staff should be mindful of their own potential biases and misperceptions regarding motivation during incarceration and upon reentry. Those incarcerated in jails with shorter or unpredictable lengths of stay may be less motivated to engage in treatment due to uncertainty around their ability to complete treatment or concerns about lengthening their incarceration to complete treatment. An individual may also prioritize obtaining housing and paid work over attending treatment upon reentry; however, this does not necessarily mean they lack motivation and are unwilling to engage in treatment.

An individual's readiness for change should *not* affect their ability to access or receive appropriate treatment, including MAT, at a suitable level of care.[17] Instead, the patient's readiness should be considered during treatment planning and used to explore and address potential hindrances through motivational enhancement interventions.[17]

Dimensional Admission Criteria

The ASAM Criteria Dimensional Admission Criteria represent the decision rules that help clinicians make a level of care recommendation based on the patient's clinical presentation. Comprehensive discussion of potential decision rules is beyond the scope of this proposed framework. ASAM plans on developing Dimensional Admission Criteria specific to correctional settings and community reentry; the proposed Dimensional Admission Criteria will be released for public comment prior to publication.

The decision rules for making level of care recommendations in jails and prisons are anticipated to be simpler than the rules for individuals in the community given that the proposed continuum of care for jails and prisons contains fewer distinct levels of care. The decision rules for community reentry are anticipated to be more complex, factoring in the full continuum of care for adult addiction treatment in the community combined with the complex care needs of individuals recently released from incarceration.

Service Characteristics

The ASAM Criteria describes service characteristics standards for each level of care including setting, staff, support systems, assessment and treatment planning, services, and documentation. The full set of service characteristic standards is beyond the scope of this proposed framework; they will be developed based upon the feedback obtained on the proposed framework outlined here and will be released for public comment. ASAM proposes the following universal service characteristic standards for all levels of care in all correctional facilities.

Figure 3. *The ASAM Criteria* Service Characteristic Categories

Setting

All jails and prisons should have overdose reversal medication (eg, naloxone) available on-site. All facility staff should be educated on where to find it and trained on how and when to administer it.

Staff and Support Systems

All correctional facilities should have access to medical professionals (on staff or through formal affiliation) with the scopes of practice to:

- assess individuals who are intoxicated, at risk for withdrawal, or who have addiction medication needs; and
- determine if the facility has the medical capacity to provide the necessary monitoring and care for each individual's needs.

If the jail or prison does not have the necessary medical capacity to care for a given individual, they should arrange for immediate transfer to another facility or medical setting (eg, acute care hospital) that can provide adequate monitoring and treatment.

All jails and prisons should have formal affiliations (ie, contracts or memorandums of understanding [MOUs]) with:

- Physicians and/or advanced practice providers who have experience in addiction treatment and controlled substance prescribing authority to coordinate access to physical examinations and medical assessments, addiction medications, medication management services, and laboratory and drug testing.
- Addiction medication providers (eg, methadone treatment providers, physicians and advanced practice providers with experience prescribing addiction medications) to support access to medications for addiction treatment (MAT). If the facility is not certified as an opioid treatment program (OTP), they should have a formal affiliation with an external OTP to support initiation, continuation, or titration of methadone.
- Mental health treatment providers and programs to coordinate care for mental health conditions and facilitate access to mental health care appointments on-site or via telemedicine as needed.
- Psychiatrists and/or advanced practice providers with specialty certification in psychiatry (eg, psychiatric nurse practitioners [NPs]) to provide psychiatric assessments as needed within a time frame appropriate to the severity and urgency of the mental health signs and/or symptoms.

Additionally, jails and prisons should have established relationships with external addiction treatment programs to support care coordination and effective transitions in care upon reentry

without any interruption in medication regimens. Facilities can consider telemedicine to bridge any service gaps that might result from limited local resources.

Carceral facilities should have established relationships with community medical and mental health providers (eg, federally qualified health centers, hospital clinics, community health centers, other community providers) to support the delivery of uninterrupted medical and mental health treatment as individuals re-enter the community.

Carceral facilities should also have established relationships with social service providers to support needs related to social determinants of health (SDOH) such as housing, health insurance, food, and employment.

Assessment and Treatment Planning

All jails and prisons should:

1. ***Screen*** *every* individual upon entry to the jail or prison to identify **any risks related to intoxication, withdrawal, and potential addiction medication needs**. Healthcare professionals or corrections staff should use standardized screening tools to determine whether an individual needs to be monitored for withdrawal or referred for assessment by a healthcare professional for intoxication or withdrawal risks.[†††] Any individual who appears unwell on screening should be referred for immediate clinical assessment by a qualified healthcare professional or transferred to hospital.
2. ***Screen for SUD.*** Individuals should be screened for SUD during or prior to the initial physical examination.
3. ***Conduct Level of Care Assessments*** for individuals who screen positive for intoxication, withdrawal risk, or SUD. Healthcare professionals gather just enough information from the individual to recommend an appropriate level of care and support initiation of treatment for immediate needs, including the need for initiation, continuation, or titration of MOUD.
4. ***Conduct Treatment Planning Assessments*** for individuals receiving treatment for withdrawal or SUD. Healthcare professionals perform a comprehensive multidimensional assessment to gather more detailed information from the individual for longer-term treatment planning once their immediate needs have been stabilized.
5. ***Conduct Treatment Plan Reviews*** periodically during SUD treatment. Healthcare professionals perform repeated assessments to inform treatment plan updates.
6. ***Conduct Reentry Assessments*** *in advance of each individual's release* from the jail or prison (unless not feasible due to the lack of advanced notice of release). Healthcare

[†††] In alignment with the US Department of Justice's *Guidelines for Managing Substance Withdrawal in Jails*.

professionals perform an assessment to determine the appropriate community-based level of care for the individual to continue their treatment upon reentry. Facilities should aim to conduct proper discharge planning, including linkage with services in the community, for all individuals in their custody. Transition and reentry planning should begin at intake so individuals who are released on short notice have plans to continue with the treatment services that were initiated during their incarceration. Reentry planning should consider the individual's need for:

- overdose reversal medication (ie, naloxone kits);
- connection to local harm reduction services;
- information for accessing crisis services;
- follow-up appointment(s) with community healthcare providers soon after discharge as appropriate to facilitate smooth transition of care;
- a sufficient amount of their prescription medications (eg, available prepaid at a community pharmacy, dosing with injectable medication shortly before discharge), including addiction medications (if applicable), as a bridge until they can follow up with community providers;
- housing assistance;
- transportation assistance to access community appointments; and
- insurance assistance (eg, reinitiating Medicaid).

Services

All jails and prisons should be able to provide or coordinate access to the following services:

- Intoxication and withdrawal management services, which include:
    - assessment and triage of intoxication and withdrawal risks,
    - ongoing monitoring for withdrawal signs and symptoms,
    - pharmacological management of withdrawal appropriate for the severity of the current or anticipated withdrawal syndrome, and
    - nonpharmacological clinical support (eg, hydration, nutrition, education).
- Addiction medications:
    - Jails and prisons should be able to support initiation, continuation, and titration of all FDA-approved medications for SUD, as well as medications to manage post-acute withdrawal symptoms.
    - All patients should be supported to continue addiction and psychiatric medications. Changes to patients' medication regimens should only be made for medical reasons and with the patient's informed consent following documented assessment by a licensed medical professional acting within their state-regulated scope of practice.

- Basic psychosocial services, such as therapy, counseling, and psychoeducation:
    - The psychosocial services in corrections-based addiction treatment programs should be designed with the understanding that most patients will have co-occurring mental health conditions.
    - Regardless of an individual's initial interest, addiction-specific psychosocial treatment should be readily available and easily accessible in jails and prisons. Participation in psychosocial treatment, however, should not be mandatory to receive MAT. Individuals who initially decline psychosocial services should be reassessed regularly to explore their interest in engagement. Further, individuals in prisons should be permitted to self-refer to addiction-specific psychosocial treatment at any time.
- Recovery support services (RSS):
    - RSS are the collection of services that provide emotional and practical support for continuing recovery, as well as daily structure and rewarding alternatives to substance use. RSS in correctional settings often include mutual support groups, case management, certified peer support specialist services, and patient navigation services. Consideration of RSS needs is an important component of reentry planning and should include support for:
        - identifying and/or accessing mutual help programs,
        - accessing social services (eg, housing, nutritional assistance, transportation, health insurance, personal form of identification),
        - coordinating with social service agencies (eg, Child Protective Services),
        - identifying and obtaining community services to address potential impediments to recovery (eg, legal services, educational services, recovery housing, childcare services, vocational training, parenting education, financial training), and
        - identifying and accessing harm reduction services (eg, naloxone, syringe services programs [SSPs], drug testing strips for fentanyl and xylazine, testing and treatment for infectious diseases).
- Harm reduction services:
    - Individuals in jails and prisons are at high risk for overdose death upon reentry. Jails and prisons should provide access to opioid overdose reversal medication (eg, naloxone) upon reentry as well as related educational services. In addition, individuals in these settings are at increased risk for infectious diseases, such as HIV and hepatitis C, compared to the general population. Jails and prisons should offer health education services designed to reduce these risks.[38-41]

Next Steps

ASAM looks forward to receiving feedback on the ideas presented in this proposed framework on adapting *The ASAM Criteria* to tailor the delivery of addiction treatment to individuals in correctional settings. With the publication of this proposed framework, ASAM hopes to initiate thoughtful discussion and promote collaboration among stakeholders in the addiction treatment and criminal justice systems in preparation for the development of *The ASAM Criteria*, Fourth Edition, Volume 3: Correctional Settings & Community Reentry.

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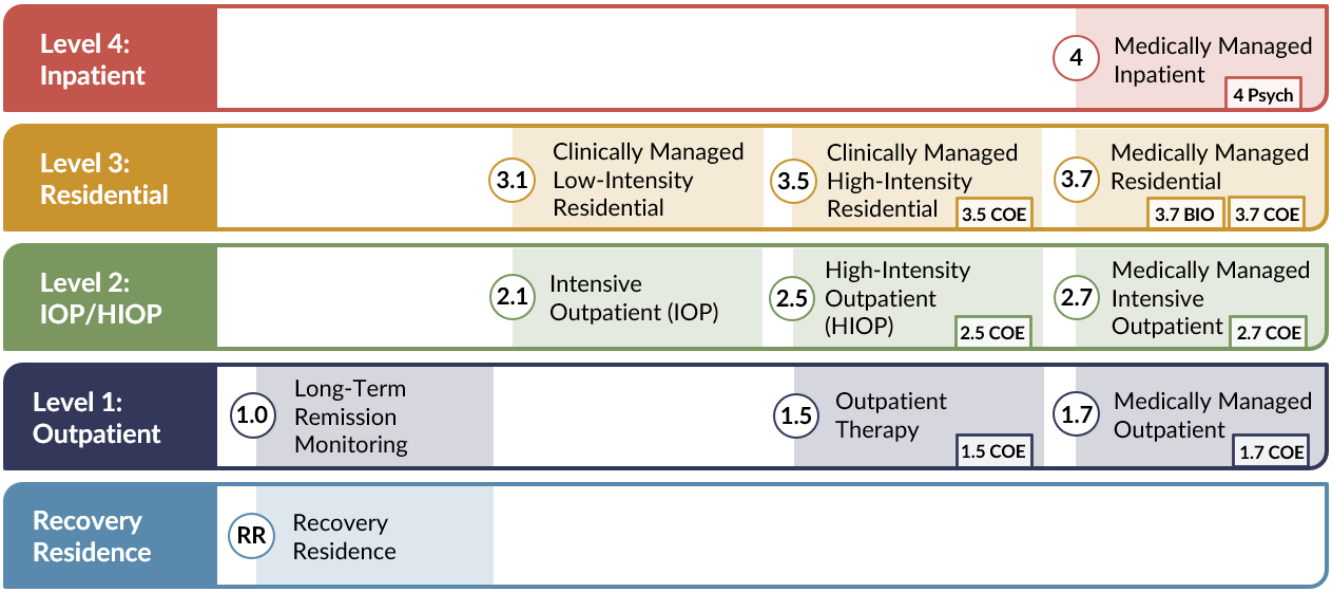
Appendices

Appendix A: *The ASAM Criteria* Continuum of Care for Adult Addiction Treatment



Outpatient Treatment	
Level 1.0 Long-Term Remission Monitoring	Level 1.0 programs provide remission monitoring and early reintervention services for patients who are in sustained remission. This level provides regular (ie, quarterly, at minimum) recovery management checkups (RMCs) and has established relationships with more intensive levels of care to facilitate rapid readmission to treatment as needed.
Level 1.5 Outpatient Therapy	Level 1.5 programs provide outpatient psychosocial services for patients with SUDs. These programs provide less than 9 hours of structured clinical services per week consisting primarily of psychotherapy, counseling, and psychoeducation to address addiction and co-occurring mental health conditions.
Level 1.7 Medically Managed Outpatient Treatment	Level 1.7 programs provide medically managed outpatient services for patients with SUDs who can be treated safely and effectively with low-intensity outpatient services. These programs also provide outpatient psychosocial services consisting primarily of psychotherapy, counseling, and psychoeducation to address addiction and co-occurring mental health conditions. Level 1.7 programs should provide all the services of Level 1.5 programs either directly or through formal affiliations with other providers or programs.
Level 2.1 Intensive Outpatient Treatment	Level 2.1 programs provide intensive outpatient services for patients with SUDs. These programs provide 9 to 19 hours of structured clinical services per week consisting primarily of counseling, psychoeducation, and psychotherapy to address addiction and co-occurring mental health conditions. Level 2.1 programs also provide a clinically planned and managed therapeutic milieu facilitated by trained clinical staff that imparts peer support, builds prorecovery attitudes, and improves coping strategies and behaviors.
Level 2.5 High-Intensity Outpatient Treatment	Level 2.5 programs provide high-intensity outpatient services for patients with SUDs. These programs provide at least 20 hours of structured clinical services per week consisting primarily of psychotherapy, counseling, and psychoeducation to address addiction and co-occurring mental health conditions. Level 2.5 programs also provide a clinically planned and managed therapeutic milieu facilitated by trained clinical staff that imparts peer support, builds prorecovery attitudes, and improves coping strategies and behaviors.
Level 2.7 Medically Managed Intensive Outpatient Treatment	Level 2.7 programs provide medically managed intensive outpatient services for patients with SUDs who require access to medical management with extended nurse monitoring but not 24-hour nursing support, overnight medical monitoring, nor residential structure and support. These programs provide coordinated management of withdrawal and biomedical and psychiatric comorbidities delivered by medical and clinical staff in an intensive outpatient setting. They provide at least 20 hours of clinical services per week comprised of medical care and psychosocial services to address addiction and co-occurring mental health conditions.

Residential Treatment	
Level 3.1 Clinically Managed Low-Intensity Residential Treatment	Level 3.1 programs provide clinically managed low-intensity residential services for patients with SUDs who require structure and support to build and practice recovery and coping skills. These programs provide 9 to 19 hours of structured clinical services per week consisting primarily of counseling, psychoeducation, and psychotherapy to address addiction and co-occurring mental health conditions. Level 3.1 programs also provide a clinically planned and managed therapeutic milieu with 24-hour structure and support facilitated by trained clinical staff that imparts peer support, builds prorecovery attitudes, and improves coping strategies and behaviors.
Level 3.5 Clinically Managed High-Intensity Residential Treatment	Level 3.5 programs provide clinically managed high-intensity residential services for patients with SUDs who require a safe and stable living environment to develop and practice their recovery skills to avoid experiencing immediate recurrence or continuing to use in a manner that poses significant risk for serious harm or destabilizing loss upon transition to a less intensive level of care. These programs provide at least 20 hours of structured clinical services per week consisting primarily of psychotherapy, counseling, and psychoeducation to address addiction and co-occurring mental health conditions. Level 3.5 programs also provide a high-intensity clinically planned and managed therapeutic milieu that encourages development and internalization of prosocial attitudes and behaviors using community support to reinforce recovery skills.
Level 3.7 Medically Managed Residential Treatment	Level 3.7 programs provide medically managed residential services for patients with SUDs who require 24-hour observation, monitoring, and treatment but not the full resources of a hospital. These programs provide coordinated management of withdrawal and biomedical and psychiatric comorbidities delivered by medical and clinical staff in a permanent residential facility. They provide at least 20 hours of clinical services per week comprised of medical care and psychosocial services to address addiction and co-occurring mental health conditions.
Inpatient Treatment	
Level 4 Medically Managed Inpatient Treatment	Level 4 programs provide medically managed inpatient services for patients with SUDs whose acute intoxication; withdrawal; and biomedical, psychiatric, and/or cognitive conditions are so severe they require 24-hour medically directed evaluation and treatment in an acute care hospital. Because Level 4 programs provide the most intensive services in the continuum of care, its principal focus is stabilization of the patient and preparation for their transition to a less intensive setting for continuing care.

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