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Framework for the Behavioral Addictions Volume of *The ASAM Criteria* – 4th Edition

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Background

The ASAM Criteria, first published in 1991, provides national standards for conducting a comprehensive multidimensional assessment and determining the appropriate level of addiction treatment for a given patient. In addition, these standards offer a model for organizing the addiction treatment system, including the types and intensities of treatment that should be available across the care continuum.

In recent years, the United States has seen substantial growth in the number of individuals exhibiting addiction-like patterns of engagement in certain behaviors, including impaired control, compulsive engagement, and continued use despite negative consequences.[1,2] Problem gambling, gaming, and social media use, and other behavioral addictions are increasingly prevalent and under-recognized public health concerns.

While most engagement in activities such as gambling, gaming, and social media use remains non-problematic, rapid technological advances, increased accessibility, and the commercialization of digital platforms have contributed to increasing risks. Of significant concern, adolescents are increasingly exposed to gambling behaviors through features such as loot boxes and gacha-style randomized-reward monetization mechanics in video games and sports betting apps that allow non-monetary bets. These behaviors are likely to impact the same brain circuits that underly addiction and may prime young brains for future disorders.

The Third Edition of *The ASAM Criteria* included a chapter focused on gambling disorder. However, it did not include a complete framework for addressing behavioral addictions or determining an appropriate level of care for patients with these disorders. As such, the fourth volume of *The ASAM Criteria* Fourth Edition will focus on the needs of individuals with behavioral addictions. ASAM's goals are to:

- Promote screening and early intervention for behavioral addictions
- Define the continuum of care for treating behavioral addictions
- Develop a comprehensive set of standards for addiction treatment programs that provide care for behavioral addictions that reflects current research and best clinical practice
- Promote integrated care for co-occurring behavioral addictions, substance use disorders (SUD), and mental health conditions
- Promote holistic, individualized, and patient centered care
- Support delivery of a chronic care model of treatment for behavioral addictions

Defining Behavioral Addictions

Under the DSM-5, behavioral addictions are classified within substance-related and addictive disorders; however, *gambling disorder* remains the only formally recognized condition, while other conditions such as *internet gaming disorder* are included for further study. ICD-11 also includes *gambling disorder*, *gaming disorder*, and *other specific disorder due to addictive behaviors*, which may include behaviors such as compulsive pornography use, shopping, or social media use. ICD-11 also includes a classification for impulse-control disorders including *compulsive sexual behavior disorder (CSBD)*. The term *addiction* is widely used by the general public in reference to a wide range of behaviors that people have trouble controlling. There is debate in the field on the specific thresholds for delineation between toxicity related to excessive engagement in specific behaviors (eg, social media use, AI use, overeating) and related disorders or addictions. The same behaviors (eg, eating, exercising, sex, gambling, gaming, social media use) may be healthy or non-problematic for many people or in some contexts but problematic or unhealthy for others. The World Health Organization (WHO) notes that defining what constitutes a behavioral addiction is, "based on similarities in symptomatology, epidemiology and neurobiology."[3]

For the purpose of this volume of *The ASAM Criteria*, we propose defining behavioral addiction as *a persistent and recurrent pattern of behavior characterized by preoccupation, impaired control, continuation despite negative consequences, and prioritization of the behavior over other life interests or daily responsibilities*. As technology and related human behaviors evolve more behaviors may have the potential to lead to related-addictions. For example, there is some evidence that individuals are developing problematic compulsive patterns of artificial intelligence (AI) use. As such, this volume will seek to be agnostic to the specific behaviors that may contribute to behavioral addiction. However, we will focus on review of the evidence related to:

- Gambling disorder
- Gaming disorder
- Problem social media use
- Compulsive sexual behavior
- Problem pornography use
- Compulsive overeating
- Binge eating disorder/compulsive overeating

While the science is not yet settled on the characterization of all of these as addictive disorders it is necessary for us to define the initial boundaries for the sake of building a framework. We expect it to evolve over time as available research and clinical understanding evolves.

Diagnostic Criteria for Behavioral Addictions

For The ASAM Criteria to be applied, it will be important to have well defined diagnostic criteria for behavioral addictions. As with the definition proposed above, we are proposing the following behavior agnostic diagnostic criteria for behavioral addictions:

- A continuous or episodic and recurrent pattern of behavior manifested over an extended period of time (eg, 12 months) associated with two or more of the following, and not better accounted for by another physical or mental health condition:
    - Frequent preoccupation with the behavior
    - Impaired control over behavior (eg, onset, frequency, intensity, duration, termination, context)
    - Increasing prioritization of the behavior over other important responsibilities and interests
    - Mood dysregulation (eg, anger, anxiety, irritability) that is disproportional to the situation (ie, significantly greater intensity or duration) when the patient is unable to engage in the behavior
    - Continuation or escalation of the behavior despite negative consequences (eg, family conflict, poor school or work performance, negative impact on health) without compensatory or proportional benefits
    - The patient's engagement in the behavior causes significant distress or functional impairment in social functioning, life skills, or daily responsibilities
        - The distress or impairment is not due to moral judgements or disapproval unrelated to negative impacts on the patient

This set of criteria was informed by behavioral addiction related diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), International Classification of Diseases 11th Revision (ICD-11), as well as Griffiths 1996 and Goodman 1990. [4,5] In alignment with ICD-11, tolerance is intentionally excluded as it is more variable in the context of behavioral addictions, compared with substance use disorders.

It is important to note that many individuals regularly engage in these behaviors in non-problematic ways. Clinicians should not assume that frequent engagement necessarily reflects disordered behavior as they may reflect a passionate hobby that is enriching or neutral rather than harmful. An Olympic athlete may be preoccupied with their sport and prioritize practice over other important responsibilities, and the balance of benefits and harms may be subjective. There are national competitions for poker and other forms of gambling, as well as for gaming. Some select individuals may be able to make a living from these activities. As such, it is important to carefully consider the holistic risks and benefits for the individual, while recognizing that some individuals with addictions can be very convincing on why a behavior is benefitting them.

- **The editorial team is particularly interested in feedback on the proposed diagnostic criteria and the threshold for diagnosis (ie, meeting 2 vs. 3 criteria). There is limited research to guide this determination. However, it is important that the diagnostic criteria can identify mild forms of behavioral addiction to support early intervention. The editorial team also discussed the possibility of classifying each criteria as minor or major and setting a threshold of at least 3 minor criteria or 2 or more criteria including at least one major criteria.**

Principles of Treatment for Behavioral Addictions

The ASAM Criteria standards for behavioral addiction treatment will be developed around a core set of principles, including:

- **Admission into treatment is based on patient needs rather than arbitrary prerequisites.** *The ASAM Criteria* are designed to help match patients to the least intensive/restrictive level of care where they can be safely and effectively treated. Another key element of this principle is that "treatment failure" should not be used as a prerequisite for admission to more intensive levels of care. A "treatment failure" approach potentially puts the patient at risk because it delays a more appropriate level of treatment, potentially allowing the addiction to progress.
- **Patients receive a multidimensional assessment that addresses the broad biological, psychological, social, environmental, and cultural factors that contribute to behavioral addictions and recovery.** Environmental factors include technological factors such as access, micro-betting, micro-rewards, multi-line betting, loot-boxes, infinite scrolling, targeted promotions and other features of the platforms used by the individual. This principle applies a whole-person approach to assessment and treatment planning, recognizing the broad range of factors that contribute to the prognosis, treatment, and recovery support needs for behavioral addictions. For adolescent patients and transition aged youth, this principle further addresses developmental factors and applies a whole family approach to care.

  Family is defined as the patient's primary support system. Family is not limited to biological family and includes other caregivers including those with which the patient is living and/or has deep emotional attachments.
- **Treatment plans are individualized based on patient needs and preferences and focused on the holistic success and wellbeing of the patient**. Treatment plans are tailored to the needs of the individual and jointly developed with the patient and other relevant support persons, as appropriate. Collaborative, patient-centered treatment planning can foster a therapeutic alliance and therefore improve treatment outcomes. The individualized plan should be based on a comprehensive biopsychosocial assessment of the patient and consideration of their individual risks and needs. For adolescent patients and transition aged youth, assessment should also include comprehensive evaluation of the family and other support systems and treatment plans should be family-driven and youth-guided.
- **Care is interdisciplinary, evidence-based, patient-centered, and delivered from a place of empathy.** The 4th Edition of *The ASAM Criteria* builds on the previous edition's efforts to promote the integration of addiction care with biomedical and mental health care. Addiction care is built around services involving interdisciplinary teams of professionals. Interdisciplinary care should

be delivered using a well-coordinated and team-based approach. Across all levels of care, treatment should be delivered in a non-judgmental, trauma sensitive manner with respect for the background and personal experiences of each patient.

- **Co-occurring substance-related and mental health conditions are an expectation among patients with behavioral addictions.** Among both adults and adolescents with behavioral addictions, co-occurring substance-related problems and mental health conditions are highly prevalent. However, different funding streams and training pathways for clinical providers often leave patients with incomplete or uncoordinated care. The Fourth Edition of *The ASAM Criteria* established the expectation that all addiction treatment programs will be, at minimum, co-occurring capable.
- **Patients move along the continuum of care based on their progress and outcomes rather than predetermined lengths of stay.** Duration of treatment in a given level of care should be individualized based on the severity of the patient's illness, their level of function, and their response to treatment. Admission, as well as transition decisions, should be based on a careful assessment of the patient and application of *The ASAM Criteria* Dimensional Admission Criteria which aim to identify the least intensive/restrictive level of care where the patient can be safely and effectively treated. For adolescent patients, intensive treatment and out of home care can be disruptive to social and educational development. A primary goal in more intensive levels of care is to help the adolescent patient to acquire the skills and supports needed to return to home and school as quickly as possible, while maintaining the safety and effectiveness of care.
- **Informed consent and shared decision-making accompany treatment decisions.** Treatment engagement and outcomes are enhanced by patient collaboration and shared decision-making. The patient (and their family and/or support persons, when applicable) should be made aware of the proposed modalities of treatment, the limitations of the evidence base supporting treatment recommendations, the risks and benefits of recommended treatments, appropriate alternative treatment modalities, and the risks of treatment versus no treatment.
- **Screening and early intervention are important for prevention of disease progression**. Early intervention can prevent mild behavioral addictions from progressing to more severe and chronic forms of these disorders. SUD and mental health treatment programs should regularly screen patients with substance-related and mental health conditions for problematic behaviors, assess for behavioral addictions, and offer integrated or coordinated care when indicated. Ideally, primary care providers would also screen patients for these risks and make appropriate referrals for care when needed.

For adolescents and transition aged youth, the following additional principles apply:

- **For adolescent patients, care should be consistent with the Systems of Care approach**[*]. The Systems of Care approach emphasizes the importance of coordination across the diverse systems that may support a patient's treatment and recovery support needs, including schools,

[*] See American Academy of Child and Adolescent Psychiatry (AACAP). Clinical Update: Child and Adolescent Behavioral Health Care in Community Systems of Care. J Am Acad Child Adolesc Psychiatry. 2023 Apr;62(4):367-384. doi: 10.1016/j.jaac.2022.06.001. Epub 2022 Jun 8. PMID: 35690302.

healthcare providers, juvenile carceral/legal systems, child protective service and foster care systems, and systems providing services to youth with intellectual or developmental disabilities. **Adolescent patients' needs across these diverse areas should be coordinated in a team-based, family-driven, youth-guided approach across agencies**.

- **Adolescent treatment should be family-driven (when appropriate) and youth-guided.** Adolescent patients will typically be living with at least one parent or guardian who is in a position to provide support and implement developmentally appropriate boundaries and monitoring. Family and community factors may also contribute to the adolescent's behavioral addiction. Effective treatment and recovery often requires building or rebuilding communication and conflict resolution skills and trust between the adolescent patient and their families and other support systems. Engagement in the treatment process can also help families and others learn how to more effectively support the adolescent throughout the treatment and recovery process. Some adolescent patients may not have supportive families to engage in this process; when possible, efforts to engage the family should not delay initiation of treatment for the adolescent patient. Efforts to identify and develop an appropriate environment and support system for recovery should be made concurrent with treatment.
- **Treatment interventions may take place within the patient's home, school, and community as appropriate – with a team-based approach to care coordination.** Teams supporting care coordination should follow Systems of Care values and principles, including use of wraparound service planning.[6] Community support should be heavily integrated into adolescent patient treatment plans consistent with the Systems of Care Approach.k
- **Interventions should be developmentally appropriate; adolescent patients and transition age youth should be treated in peer-specific groups, separate from adults.** Adolescent and young adult patients have unique developmental needs and are more likely to relate to others in their peer group, providing essential social support. In residential settings, patients should be roomed together by ages, separating younger adolescents from older adolescents. To the extent possible, patients in adolescent treatment programs should be treated in cohorts with others of their developmental age. When it is not possible to cohort by developmental age a qualified clinician should determine what services an individual patient can safely participate in and how to manage risks. Sufficient staff supervision is important for preventing inappropriate interactions between patients.
- **For adolescent patients, clinicians should seek to obtain assent/consent using a shared decision making framework to support participation in treatment**. While regulations regarding adolescent assent and consent for treatment vary by state and across health conditions (ie, consent requirements for medical or mental health treatment may differ from those for addiction treatment), seeking to obtain patient assent/consent for treatment is a best practice. The updated Dimension 6 in this edition of *The ASAM Criteria* emphasizes the importance of understanding patient (and family, when applicable) preferences and individual barriers to care to support person-centered and shared decision-making. Motivational techniques can be used to support patient engagement in treatment as appropriate.
- **Secondary prevention and early intervention are critical for avoiding disease progression and may warrant specialty SUD care.** Addiction is a brain disease that often begins during adolescence, when the brain is actively developing. While research is limited, some evidence

suggests secondary prevention and early intervention can prevent problematic behaviors from progressing to addictions.[7] Young people engaged in problematic behaviors at high risk for harm or rapid escalation to a behavioral addiction should receive early intervention services in specialty behavioral addiction treatment. Primary care providers (eg, pediatricians, family physicians) play an important role in identifying risky behaviors and coordinating appropriate follow-up care, including referrals to specialist clinicians when indicated.

A Behavioral Addictions Continuum of Care

Currently, there are few treatment programs across the country that provide specialized care for behavioral addictions. Most care is provided by individual practitioners in outpatient settings. *The ASAM Criteria*: Behavioral Addictions Volume proposes to align the continuum of specialty behavioral addiction treatment within the existing continua of care for SUD treatment for adults and adolescents defined in Volumes 1 and 2 respectively (see Figures 1 and 2). Appendices A and B provide an overview of core service characteristics for the adult and adolescent levels of care respectively. The Behavioral Addictions Volume will propose:

1. All addiction treatment programs meet core standards for **behavioral addictions capability**. This would be defined as having the ability to:
    a. Screen for behavioral addictions
    b. Assess patients who screen positive for risk
    c. Triage the patients risks related to behavioral addictions, determining what concerns can be managed by the program and when crisis services or a more intensive level of care are needed
    d. Provide symptom management support for patients with co-occurring behavioral addictions
    e. Refer patients to an appropriate treatment program for their behavioral addictions when they have treatment needs that cannot be addressed by the current program
    f. Coordinate care with external clinicians providing behavioral addiction treatment
2. Standards for Behavioral Addictions Enhanced (BAE) addiction treatment program. These standards will build upon the core standards for adult and adolescent SUD treatment programs (See Appendices A and B) and define additional service characteristic standards for each level of care necessary for a program to be BAE. For example, a Level 2.1 program that provides both SUD and behavioral addiction treatment and meets the additional standards that will be articulated in the final behavioral addictions volume of The ASAM Criteria would be designated Level 2.1 BAE.
3. Standards for Behavioral Addictions Specialized (BAS) treatment programs. These standards will align with the commensurate standards for SUD treatment programs but will be tailored to programs that primarily specialize in behavioral addiction treatment, not SUD treatment. These standards will include an expectation that BAS programs will be able to screen for substance use, assess SUDs, triage and refer patients to appropriate care, and coordinate care with external SUD treatment programs.

Figure 1. *The ASAM Criteria* Behavioral Addictions Continuum of Care: Adult

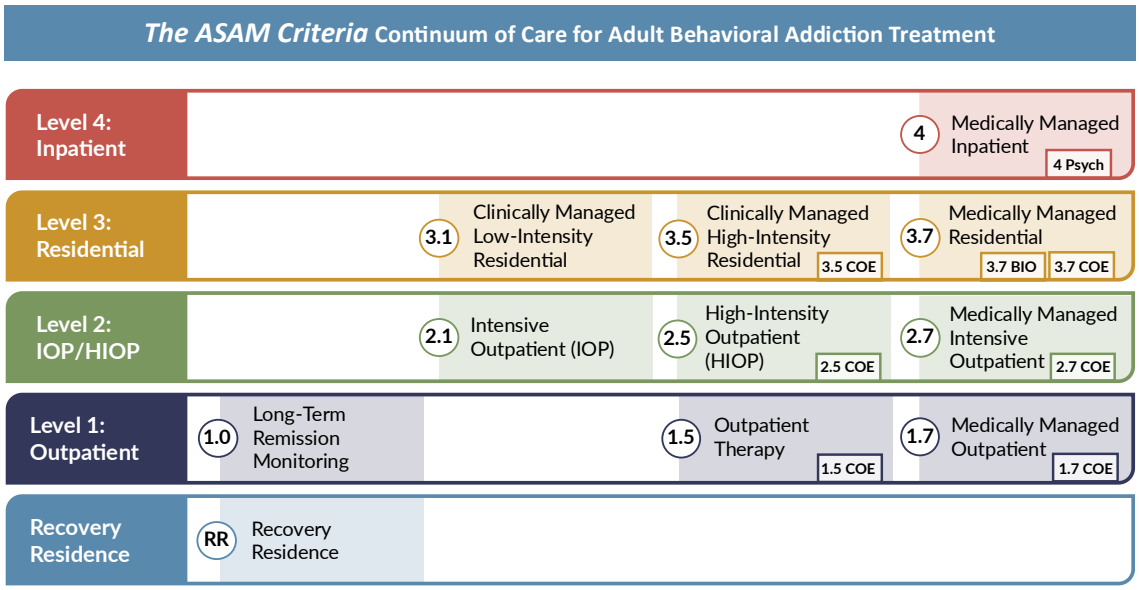
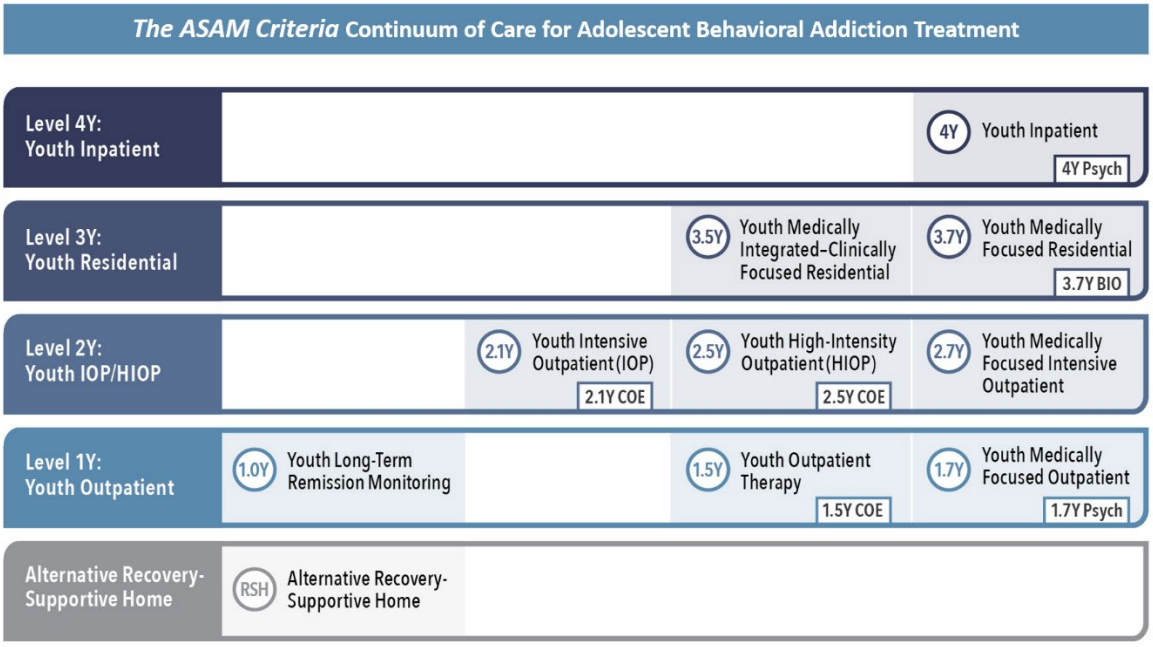


Figure 2. *The ASAM Criteria* Behavioral Addictions Continuum of Care: Adolescent



While we anticipate the need for medically managed care to be rare for behavioral addictions alone, patients may require a medically managed or medically focused levels of care of care for co-occurring substance-related or mental health conditions. In addition, there is some evidence for behavioral addiction associated psychosis that may require medical management. [8,9]

Because few treatment programs focused on behavioral addictions currently exist, and there is a severe shortage of clinicians with training and experience in the treatment of behavioral addictions, significant work will be needed to support access to the proposed levels of care. As with Volumes 1 and 2 of the ASAM Criteria, ASAM will continue to work closely with the American Association for Community Psychiatry (AACP) and the American Academy of Child and Adolescent Psychiatry AACAP to also support alignment with the mental health continuum of care as defined by the Level of Care Utilization System (LOCUS) and Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII). The goal is to enable existing SUD and mental health treatment programs to easily expand to provide care for behavioral addictions.

Levels of Care Service Characteristic Standards for BAE and BAS programs

Full service characteristic standards will be proposed based on input received on this framework document. They will be released for public comment and amended as needed prior to finalizing the manuscript. Examples of standards for BAE and BAS programs that will be proposed to address program capacity to provide treatment services for behavioral addictions, including but are not limited to:

- Setting:
    - The setting should be welcoming environment for individuals with behavioral addictions, where patients feel safe addressing all addictive behaviors and co-occurring mental health concerns
    - The setting should be free of imaging or objects related to the addictive behaviors treated in the program (eg, casino chips, scratch off tickets, sports betting applications, gaming devices, pornography)
        - Programs should carefully consider the population treated and individual patient needs regarding potential exposure to cues and triggers for addictive behaviors
    - Adolescent patients should be treated separately from adults.
        - Staff supervision should be provided whenever adult and adolescent patients may be in the same space.
        - Interactions between adult and adolescent patients should be minimized, primarily occurring when patients are transitioning between spaces or waiting for appointments or sessions to begin.
        - Staff should be able to see and hear any interactions between adult and adolescent patients at all times.
- Staff:
    - All BAE programs should have clinical staff with training and experience in assessment and treatment of behavioral addictions, available directly or through formal affiliation
    - All BAS programs should be staffed by clinicians with training and experience in assessment and treatment of behavioral addictions
    - All staff should be trained to understand the unique needs of patients with behavioral addiction and to be sensitive to potential triggers (eg, commenting on the appearance of a patient with compulsive sexual behavior, discussing or broadcasting sporting events) and behaviors associated with return to addictive behaviors.
- Support systems:

- All BAE and BAS programs should have established relationships with community organizations that provide recovery support services to individuals with behavioral addictions such as:
  - Mutual support (eg, gamblers anonymous, Internet and Technology Addicts Anonymous [ITAA], Sex Addicts Anonymous [SAA], Sex and Love Addicts Anonymous [SLAA], Sexaholics Anonymous [SA])
  - Financial services (eg, debt counselors)
  - Sex counselors and infectious disease specialists for programs treating patients with compulsive sexual behavior
- All BAE and BAS programs[†] should have formal affiliations, at minimum, with physicians or advanced practice providers qualified to treat behavioral addictions, including with addiction medications

- Assessment and treatment planning:
  - All patients should be screened for engagement in behaviors that may represent behavioral addictions
  - Appropriately trained clinicians should conduct a diagnostic assessment for behavioral addictions for all patients who screen positive for at-risk engagement in addictive behaviors
  - Clinicians should work with patients to develop individualized treatment plans that address behavioral addictions along with co-occurring SUDs and mental health conditions, when applicable
- Services:
  - All services should be designed with the expectation that many, if not most, patients with behavioral addictions will have co-occurring SUD and/or mental health conditions.
  - All BAE and BAS programs should provide concurrent integrated treatment for behavioral addictions, substance-related, and mental health-related concerns and coordinate care with any external mental health treatment professionals.
  - All BAE and BAS programs should provide or coordinate a medical evaluation with a physician or advanced practice provider qualified to assess patient addiction medication needs.
  - All BAE and BAS programs should provide psychosocial services (ie, psychotherapy, counseling, psychoeducation) designed to address and monitor behavioral addictions and co-occurring SUDs and mental health conditions
  - All BAE and BAS programs serving adolescents should provide family services designed to address behavioral addictions
  - Levels 1.5Y and 2.1Y BAE and BAS programs should provide *treatment as prevention* services for adolescents who do not yet meet the diagnostic criteria, but are at risk for rapid escalation to a behavioral addiction.
- Documentation:
  - Program documentation in BAE and BAS programs should capture:

[†] Except Levels 1.0, 1.0Y, 1.5, and 1.5Y

        - Findings from assessments and reassessments, including the interactions between a patient's behavioral addiction(s) and co-occurring substance-related and mental health conditions, as applicable
        - Individualized treatment plans that reflect integrated or coordinated care for the patient's behavioral addictions, substance-related and mental health conditions, as applicable
    - All programs serving patients with behavioral addictions should have policies and procedures in place to:
        - Prevent iatrogenic development of substance-related problems, including consideration of when it is or is not appropriate to mix patients with primary behavioral addictions and those with primary SUDs
        - Address safety concerns, including through deescalation, when patients have violent or aggressive reactions to devices or other materials being taken away
        - Staff use of technology, including consideration of how to preventing patient exposure to cues and triggers for addictive behaviors through staff use of personal devices while on-site

Adolescent Behavioral Addictions Continuum of Care

Adolescents and Transition Age Youth with addiction have unique needs. As such, the behavioral addictions continuum of care will align with the continuum of care for SUD in these populations as defined in The ASAM Criteria Volume 2: Adolescents and Transition Aged Youth. As articulated in that volume, all youth levels of care are expected to provide:

- **Full integration of mental health, SUD, and behavioral addictions treatment.** As noted above, **for adolescent patients, mental health conditions and SUDs are often primary conditions along with behavioral addictions**. Therefore, integrated care is needed in standard adolescent addiction treatment programs. This volume of the *Fourth Edition of the ASAM Criteria* will set the expectation that all adolescent treatment programs providing behavioral addictions treatment will be able to provide integrated treatment for SUD and mental health conditions.
- **Developmental and neurocognitive concerns should be considered in treatment planning.** Cognitive and neurodevelopmental disorders such as attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder, among others, can contribute to the development of behavioral addictions and complicate their management. [10-12] However, as with the general population, many individuals with cognitive and neurodevelopmental disorders can engage in gaming, gambling, and social media use without developing a related behavioral addiction. All patients should be screened for cognitive concerns and intellectual and developmental disabilities (IDDs). Patients who screen positive should be offered or referred for a neuropsychological evaluation and findings should guide development of the treatment plan to support the patient to effectively engage in addiction treatment.

Treatment programs that serve both adults and adolescents should have clear policies and procedures that protect adolescents and transition aged youth and ensure their unique developmental needs are considered and addressed. Adolescent patients should be treated in separate spaces from adult patients

with close staff supervision in the limited instances where adults and adolescents are in the same spaces (eg, in waiting areas). In addition, programs treating adolescents should deliver adolescent-specific content aligned with the principles articulated above. They should also have established relationships with adolescent treatment specialists to support consultation when developing adolescent treatment plans.

Co-Occurring Capable and Enhanced Care

Because individuals with behavioral addictions often have mental health conditions all behavioral addiction treatment programs will be expected to be co-occurring capable at minimum. In alignment with Volumes 1 and 2 of the ASAM Criteria Fourth Edition, co-occurring capability means:

- All programs treating adults should provide screening and assessment for mental health conditions; triage mental health needs, providing referrals as needed; provide symptom management support for mental health conditions, and coordinate care with external providers when applicable.
- All programs treating adolescents should be able to provide integrated psychiatric services and skilled mental health interventions

Some patients with severe psychiatric symptoms may need more intensive or more individualized care than can be provided by standard behavioral addiction treatment programs. In these cases, *The ASAM Criteria* will recommend co-occurring enhanced (COE) care, with the level determined by the patient's multidimensional needs. All COE programs, adolescent and adult, provide integrated psychiatric services and skilled mental health interventions. In addition, they have a higher staff to patient ratio to allow them to provide highly individualized adjustment of behavioral expectations, group participation capacity, pacing of treatment progress, and titration of emotional intensity.

	Adult Treatment Programs	Adolescent Treatment Programs
Co-occurring Capable	• Screening and assessment of mental health concerns • Triage and referral to external mental health care, when needed • Care coordination with external mental health treatment professionals • Coordinated treatment plans	• Integrated mental health-focused interventions • Psychiatric oversight[‡] • Integrated treatment plans • Care coordination with external mental health treatment professionals
Co-occurring Enhanced (COE)	• Integrated mental health-focused interventions • Psychiatric oversight[§] • Integrated treatment plans	• Integrated mental health-focused interventions • Psychiatric oversight[**] • Integrated treatment plans

[‡] Level 2Y and more intensive
[§] Level 2Y and more intensive
[**] Level 1.7Y Psych and more intensive

	• Higher staff-to-patient ratios to provide more individualized support • Greater capacity to manage more severe and complicated mental health concerns • Care coordination with external mental health treatment professionals	• Higher staff-to-patient ratios to provide more individualized support • Greater capacity to manage more severe and complicated mental health concerns • Care coordination with external mental health treatment professionals

Assessment and Treatment Planning

A core principle of *The ASAM Criteria* is the use of a multidimensional assessment to drive level of care recommendations and the development of individualized treatment plans. A full biopsychosocial assessment is not necessary for making a level of care recommendation, but it is the foundation for a comprehensive treatment plan.

The Behavioral Addictions Volume of *The ASAM Criteria* Fourth Edition will describe separate standards for the Level of Care Assessments, used to determine the recommended level of care; the Treatment Planning Assessment, used to develop an individualized treatment plan; and reassessments, used to assess patient progress, make updates to treatment plans, and guide decisions related to transitions in care. All assessments will be multidimensional and consider the patient's biological, psychological, and sociocultural context.

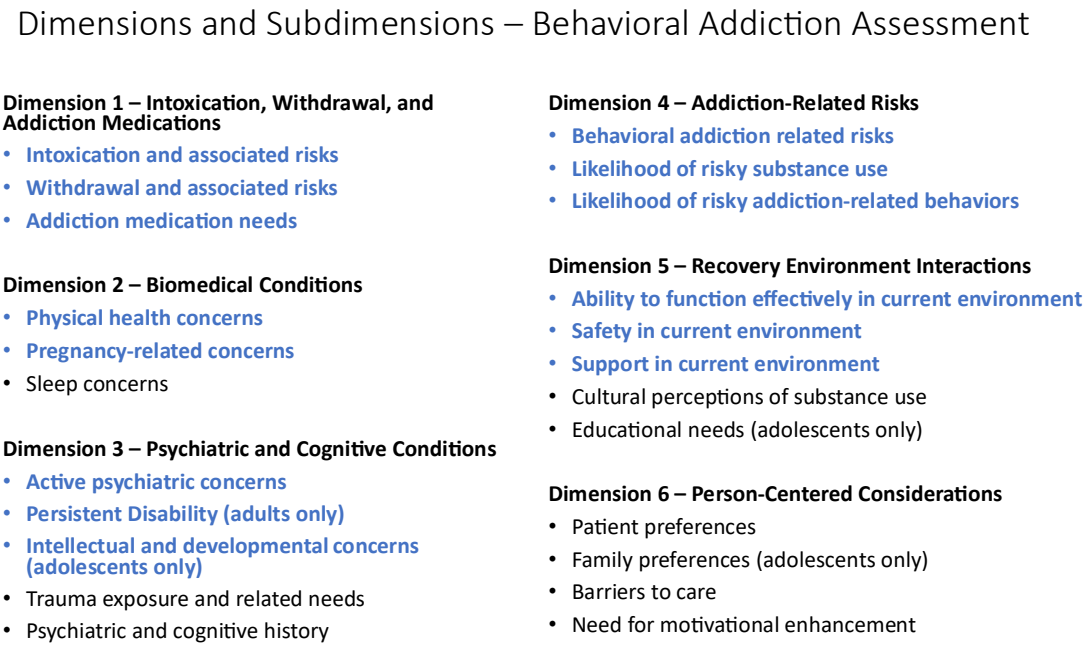
Dimensions and Subdimensions

The 4th Edition of *The ASAM Criteria*: Adult Volume updated the six assessment dimensions and introduced the concept of subdimensions (Figure 3). The subdimensions are the foundation for *The ASAM Criteria* Dimensional Admission Criteria. In the updated framework, clinicians assign risk ratings based on the clinical severity described in the Dimensional Admission Criteria. The subdimensions in blue in Figure 3 are considered when determining an appropriate level of care recommendation. All subdimensions are considered during treatment planning.

For the behavioral addictions volume, we propose expanding Dimension 4 to include behavioral addiction related risks. Dimension 4 would be titled Addiction-Related Risks and would include the following subdimensions:

- Behavioral addiction-related risks
- Likelihood of risky substance use
- Likelihood of risky addiction-related behaviors

Figure 3. *The ASAM Criteria* Dimensions and Subdimensions in the Fourth Edition



Dimension 1 – Intoxication, Withdrawal, and Addiction Medications

For Dimension 1, the Level of Care Assessment considers the patient's need for:

- medically managed care for acute intoxication or withdrawal
- initiation or titration of medications for behavioral addictions
- initiation or titration of addiction medications for co-morbid SUD

While there are currently no FDA-approved medications available to treat behavioral addictions, some medications, such as naltrexone, have evidence of efficacy and may be used off label. [13] All patients with behavioral addictions should be offered a medical evaluation that considers the appropriateness of addiction medications.

Dimension 2 – Biomedical Concerns

For Dimension 2, the Level of Care Assessment considers biomedical comorbidities and the need for medically managed care for biomedical concerns and pregnancy-related concerns. The Treatment Planning Assessment more broadly considers needs for referrals for biomedical care, including consideration of medications for conditions that contribute to behavioral addictions; sleep related needs; and health educational interventions to prevent biomedical issues from arising. Identifying and appropriate management of concerns in Dimension 2 is an important component of all addiction care.

Dimension 3 – Psychiatric and Cognitive Concerns

Suicide risk is markedly elevated among people with behavioral addictions.[14-17] For Dimension 3, the Level of Care Assessment considers active psychiatric concerns, including risk of harm to self or others, as well functional impairments related to persistent mental health and cognitive impairments – including those related to intellectual and developmental disorders – and related needs for specialty mental

health services. The Treatment Planning Assessment also considers the patient's need for psychiatric medications, including for mental health concerns that contribute to their behavioral addiction (eg, impulse control disorders) and service needs related to cognitive functioning, trauma, and psychiatric and cognitive history.

The psychiatric history should consider the history of the patient's attachments including loss, separation, disruption, and neglect and how they contribute to the patient's behavioral addictions and co-occurring substance-related and mental health concerns. It is also important to consider other adverse childhood experience (ACEs), including ongoing experiences, that may be contributing to current problems and related treatment and recovery support needs.

Dimension 4 – Addiction-Related Risks

For Dimension 4, the Level of Care Assessment considers the patient's risks related to behavioral addictions, substance use, and addiction-related behaviors. The assessment considers the likelihood that the patient will continue to engage in problematic and risky behaviors and the degree of risk posed by the patient's patterns of addictive behaviors, including risk for serious harm, destabilizing loss, or negative but not destabilizing consequences. Assessment of risk in this dimension also considers how the patient's preoccupation with the behavior, and related distraction can contribute to risk for harm (eg, distracted driving or walking). This dimension considers the level of clinical support and/or supervision the patient needs to prevent serious harm or destabilizing loss.

The Treatment Planning Assessment includes a full history of engagement in addictive behaviors and considers age of initiation, typical patterns of engagement, impacts on other risky behaviors (eg, substance use) and mental health, and response to prior treatment attempts.[18] It also considers the range of treatment and recovery support services the patient needs to address behavioral addictions, substance use (when applicable), and related risky behaviors.

For adolescents, family involvement is considered in this dimension as a component of the clinician's assessment of the likelihood of the patient continuing to use engage in problematic and risky behaviors; strong parental involvement and supervision may decrease the likelihood of patient engagement in these behaviors.

Dimension 5 – Recovery Environment Interactions

For Dimension 5, the Level of Care Assessment considers the patient's ability to effectively function and the level of clinical support the patient needs to develop the skills necessary for achieving and maintaining recovery, including prosocial skills and other skills of daily living. This dimension also considers environmental risks to patient's safety, including exposure to abuse. Based on this assessment, Dimension 5 considers whether a recovery residence (for adults) or an alternative recovery supportive home (eg, kinship care, community group home, therapeutic foster home, recovery boarding schools, respite for adolescents) is needed to protect the patient or support effective engagement in care.

In addition, this dimension considers the level of support the patient has for engaging in treatment and recovery including family, friends, and community support (including school support, when applicable). For example, clinicians consider whether the patient has support persons who are willing and able to help them attend appointments when needed or help prevent the patient's engagement in addictive behaviors (eg, access to technologies). If there are factors in the patient's home or community

environments that would prevent effective engagement in treatment or recovery, the Dimensional Admission Criteria may recommend a residential level of care, recovery residence, or alternative recovery supportive home as applicable.

The Treatment Planning Assessment considers service needs to improve safety and support for the patient. It also considers cultural influences that may impact the patient's perceptions of addiction and treatment engagement. For adolescents and transition aged youth, caregiver behavioral addictions, SUD, and mental health history are considered in the context of both the patient's safety and available support and considers the need for family services. The Treatment Planning Assessment for adolescents also considers the patient's educational needs.

Dimension 6 – Person-Centered Considerations

Dimension 6 considers barriers to care, patient preferences, family preferences for adolescent patients[††], and the need for motivational enhancement services. This dimension does not contribute to the level of care recommendation; it is the foundation for shared decision-making with the patient, and family when appliable. The clinician determines the level of care recommendation based on assessment of Dimensions 1 through 5 and application of the ASAM Criteria Dimensional Admission Criteria and then works closely with the patient (and their family, when appropriate) to determine what level of care they are able and willing to participate in.

For adolescent patients, in alignment with the Systems of Care approach outlined above, treatment planning in this dimension should consider all of the systems that the patient and their family are engaged with or should be engaged with including child welfare, juvenile legal services, educational services, vocational services, housing services, mental and physical health care services, and developmental services, among others. Treatment planning should be coordinated across systems to develop a shared understanding of goals and align service delivery strategies to support overall better functioning of the adolescent and family at home, in school, and in the community.

Dimensional Admission Criteria

The final volume will include Dimensional Admission Criteria for both adults and adolescents that are agnostic to the specific behavior. We anticipate these criteria will align with the commensurate criteria for SUD such that more intensive levels of care will be recommended based on higher levels of risk or clinical needs. For example, Level 3.5 or 3.5Y residential treatment would be recommended for individuals:

- ❖ At imminent (ie, within hours or days) risk for serious harm or destabilizing loss
- ❖ Who are assessed as unable to progress in treatment without a high-intensity therapeutic milieu

The criteria will generally require the patient to have a diagnosis or provisional diagnosis of a behavioral addiction, with the exception of any prevention specific Dimensional Admission Criteria for adolescents.

[††] When appropriate and with patient consent when required.

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Appendix A – Core Service Characterizes for the Adult Continuum of Addiction Care

Table A1. Core Service Characteristic Standards for Adult Clinically Managed Levels of Care

	1	1.5	2.1	2.5	3.1	3.5
	Long-term Remission Monitoring	**Outpatient Therapy**	**Intensive Outpatient Treatment**	**High-intensity Outpatient Treatment**	**Clinically Managed Low-intensity Residential Treatment**	**Clinically Managed High-intensity Residential Treatment**
Medical Director	Not typical	Not typical	Not typical	Yes	Not typical	Yes
Nursing	Not typical	Not typical	Not typical	Variable†	Not typical	Variable†
Program Director	Variable*	Yes	Yes	Yes	Yes	Yes
Allied Health Staff	Variable	Variable	Typically available	Typically available	On-site and alert 24 h/d	On-site and alert 24 h/d
Physical exam	Verify a physical exam in the last year or refer	Within 1 month of treatment initiation	Within 14 days of admission§	Within 7 days of admission	Within 14 days of admission‖	Within 72 hours of admission
Nursing Assmt	Not typical	Not typical	Not typical	Not typical	Not typical	Not typical
Clinical Services	Recovery and remission management services	Direct psychosocial services	Direct psychosocial services Therapeutic milieu	Direct psychosocial services Therapeutic milieu	Direct psychosocial services Therapeutic milieu	Direct psychosocial services High-intensity therapeutic milieu 24-hour clinical supervision

	1	1.5	2.1	2.5	3.1	3.5
	Long-term Remission Monitoring	**Outpatient Therapy**	**Intensive Outpatient Treatment**	**High-intensity Outpatient Treatment**	**Clinically Managed Low-intensity Residential Treatment**	**Clinically Managed High-intensity Residential Treatment**
Clinical Service Hours	Quarterly services at minimum	<9 h/wk	9-19 h/wk	≥20 h/wk	9-19 h/wk, available 7 d/wk	≥20 h/wk, available 7 d/wk
Recovery Support Services (RSS)	Recovery management checkups Other RSS*	Yes*	Yes*	Yes*	Yes*	Yes*

* Direct or through formal affiliation.
† Some 2.5 and 3.5 programs may have nurses available to support integration of biomedical care.
‡ Or responsible clinician in an independent practice.
§ The physical exam should ideally be conducted within seven days; however, extra flexibility is included in the standards to reflect known workforce shortages.
‖ The physical exam should ideally be conducted within seven days; however, extra flexibility is included in the standards to reflect known workforce shortages

Table A2. Core Service Characteristic Standards for Adult Medically Managed Levels of Care

	1.7	2.7	3.7	4
	Medically Managed Outpatient Treatment	**Medically Managed Intensive Outpatient Treatment**	**Medically Managed Residential Treatment**	**Medically Managed Inpatient Treatment**
Medical Director	Yes‡	Yes	Yes	Yes
Physicians/ Advanced Practice Providers			Available on-site or via telehealth 24/7	Typically available on-site 24/7
Nursing	Variable	Yes	Available 24/7	Available 24/7
Program Director	Not typical	Yes	Yes	Variable
Allied Health Staff	Variable	Typically available	Typically available	Typically available

	1.7	2.7	3.7	4
	Medically Managed Outpatient Treatment	**Medically Managed Intensive Outpatient Treatment**	**Medically Managed Residential Treatment**	**Medically Managed Inpatient Treatment**
Physical exam	Typically at initial assessment	Within 24-48 hours of initial assessment	Within 24 hours of admission	Within 24 hours of admission
Nursing Assessment	Variable	At admission	At Admission	At Admission
Clinical Services	Direct withdrawal management and biomedical services Management of common psychiatric disorders Psychosocial services*	Direct withdrawal management and biomedical services, with extended nurse monitoring Management of common psychiatric disorders Psychosocial services*	Direct withdrawal management and biomedical services Management of common psychiatric disorders Psychosocial services*	Direct withdrawal management and biomedical services (ICU available) Psychiatric Services Psychosocial services*
Clinical Service Hours	<9 h/wk	≥20 h/wk‖	≥20 h/wk	Variable
Recovery Support Services (RSS)	Yes*	Yes*	Yes*	Yes*

* Direct or through formal affiliation.

‖ Clinical service hours can include medical services, including nurse monitoring, as well as psychosocial services. Patients who are too acutely ill to participate in psychosocial services should be excused from participation. Nurse monitoring may include passive monitoring with structured check-ins at least once per hour performed by appropriately licensed medical professionals using validated instruments. Check-ins may be telephonic when appropriate.

Appendix B – Core Service Characterizes for the Adolescent Continuum of Addiction Care

Table B1. Core Service Characteristic Standards for *The ASAM Criteria* Adolescent Clinically Focused and Medically Integrated–Clinically Focused Levels of Care

	Level 1.0Y	**Level 1.5Y**	**Level 2.1Y**	**Level 2.5Y**	**Level 3.5Y**
	Long-Term Remission Monitoring	**Outpatient Therapy**	**Intensive Home- and Community-Based Treatment**	**High-Intensity Home- and Community-Based Treatment**	**Medically Integrated–Clinically Focused Residential Treatment**
Medical Director	Variable	Not typical	Variable	Yes*	Yes*
Physicians and Advanced Practice Providers	Established relationship	At minimum established relationship	Formal affiliation to support referral for medical services	Yes† On-call 24/7	Yes† On-call 24/7
Psychiatric and Addiction Expertise‡	At minimum, established relationship(s) with psychiatric and addiction specialist(s)	At minimum, established relationship(s) with psychiatric and addiction specialist(s)	At minimum, formal affiliation(s) with psychiatric and addiction specialist(s)	Program leadership should include both psychiatric and addiction specialty expertise Psychiatric specialist should be available during program hours†	Program leadership should include both psychiatric and addiction specialty expertise Psychiatric specialist should be available on-site or via telemedicine 24/7
Nursing Services	Not typical	Not typical	Not typical	Not typical	Medical support staff available to support medication administration 24/7
Program Director	Variable†	Yes§	Yes	Yes	Yes

	Level 1.0Y	Level 1.5Y	Level 2.1Y	Level 2.5Y	Level 3.5Y
	Long-Term Remission Monitoring	**Outpatient Therapy**	**Intensive Home- and Community-Based Treatment**	**High-Intensity Home- and Community-Based Treatment**	**Medically Integrated–Clinically Focused Residential Treatment**
Clinical Staff	Available during program hours	Available during program hours	Available during program hours On-call 24/7	Available during program hours On-call 24/7	On-site 24/7
Mental Health-Trained Clinical Staff	Able to refer for mental health services	Yes	Yes	Yes	Yes
Allied Health Staff	Variable	Variable	Yes[†]	Yes	On-site 24/7
Psychiatric Assessment	Able to refer as needed	Able to refer as needed Physical exam should assess the need for a psychiatric assessment	Within 14 days	Within 5 days Able to provide within 24 hours when needed	Generally, within 48 hours, but not more than 72 hours Able to provide within 24 hours when needed
Physical Exam	Verify a physical exam in the last year or refer	Within 1 month if no recent physical exam	Within a reasonable time frame (determined by psych assmt**)	Within a reasonable time frame (determined by psych assmt**)	Within a reasonable time frame (determined by psych assmt**)
Nursing Assessment	Not typical	Not typical	Not typical	Not typical	Variable[††]
Treatment Plan	Recovery management plan developed at the first session	Within the first 3 sessions	Within 5 business days of admission	Within 5 treatment days of admission	Within 72 hours of admission
Formal Reassessment	At least quarterly recovery management	At least quarterly	At least monthly	At least monthly	At least monthly

	Level 1.0Y	Level 1.5Y	Level 2.1Y	Level 2.5Y	Level 3.5Y
	Long-Term Remission Monitoring	**Outpatient Therapy**	**Intensive Home- and Community-Based Treatment**	**High-Intensity Home- and Community-Based Treatment**	**Medically Integrated–Clinically Focused Residential Treatment**
	checkups (RMCs)				
Clinical Services	Recovery and remission management services	Direct psychosocial services for SUD and mental health Family services‡‡ Able to coordinate psychiatric services as needed Treatment as prevention	Direct psychosocial services for SUD and mental health Family services‡‡ Coordinated psychiatric services Therapeutic milieu Treatment as prevention	Direct psychosocial services for SUD and mental health Family services‡‡ Direct psychiatric services Therapeutic milieu	Direct psychosocial services for SUD and mental health Family services‡‡ Direct psychiatric services High-intensity therapeutic milieu
Clinical Service Hours	Quarterly services at minimum	<6 hours per week; Typically 1–2 hours per week	6–19 hours per week Structured services at least 2 days per week§§	≥20 hours per week Structured services at least 5 days per week§§	≥20 hours per week Structured services 7 days a week§§
Recovery Support Services (RSS)	Yes, including RMCs	Variable†	Yes†	Yes†	Yes

Table B2. Core Service Characteristic Standards for *The ASAM Criteria* Adolescent Medically Focused Levels of Care

	Level 1.7Y	Level 2.7Y	Level 3.7Y	Level 4Y
	Medically Focused Outpatient Treatment	**Medically Focused Intensive Outpatient Treatment**	**Medically Focused Residential Treatment**	**Inpatient Treatment**
Medical Director	Yes*	Yes	Yes	Yes
Physicians and Advanced Practice Providers	Yes	Available on-site or via telemedicine during program hours of operation	Available on-site or via telemedicine 24/7	Typically available on-site 24/7
Nursing	Variable	Yes (extended nurse monitoring)	Yes (24/7)	Yes (24/7)
Program Director	Variable	Yes†	Yes†	Variable
Allied Health Staff	Variable	Typically available	Yes†	Yes
Physical Exam	Typically at initial assessment	Within 24–48 hours of initial assessment	Within 24 hours of admission	Within 24 hours of admission
Nursing Assessment	Variable	At admission	At admission	At admission
Clinical Services	Direct withdrawal management and biomedical services Management of common psychiatric disorders Psychosocial services†	Direct withdrawal management and biomedical services with extended nurse monitoring Management of common psychiatric disorders Psychosocial services†	Direct withdrawal management and biomedical services with 24/7 nurse monitoring Management of common psychiatric disorders Psychosocial services†	Direct withdrawal management and biomedical services (ICU available) Management of common psychiatric disorders Psychosocial services†
Clinical Service Hours	<6 hours per week	≥20 hours per week‡	≥20 hours per week‡	Variable
Recovery Support Services (RSS)	Yes†	Yes†	Yes†	Yes†