Public comments accepted through **Friday, Feb 2 2024** through the online survey form at https://bit.ly/adol_framework

Proposed Framework for the Adolescent and Transition Age Youth Volume of *The ASAM Criteria* – 4th Edition

Request for public comments, December 2023

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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. ASAM is currently working to develop the Adolescent and Transition Age Youth Volume of the Fourth Edition of *The ASAM Criteria* under the guidance of a new adolescent editorial team, led by Dr. Sandra Gomez-Luna, MD, FAPA, FASAM and Dr. R. Corey Waller, MD, MS, FACEP, DFASAM, and using a rigorous methodology for evidence review and formal consensus development.

In the Third Edition of *The ASAM Criteria*, standards and decision rules for adolescents were interwoven with standards for adults, making them more difficult to interpret. In addition, research on the treatment of adolescents has evolved significantly since these standards were last updated in 2013. Evolving research also demonstrates the unique developmental needs of transition age-youth. From approximately age 16 to age 25, youth are undergoing a developmental period in which social roles and responsibilities, as well as family, peer, and community supports are changing. This is also a period of significant neurodevelopment as executive functioning fully matures. As such, the second volume of the Fourth Edition of *The ASAM Criteria* will focus on the needs of adolescents and transition age youth.

ASAM's goals are to:

- Develop a comprehensive set of standards for adolescents (defined here as ages 10-18) and transition-age youth (defined here as ages 16-25) that reflects the state of the science and best clinical practice and the unique developmental needs of these populations.
- Promote integrated care for co-occurring mental health conditions.
- Promote holistic and individualized care, that is patient centered and has a family-systems orientation.
- Support delivery of a chronic care model of treatment for addiction and co-occurring conditions when appropriate.
- Promote early intervention and prevention to prevent risky substance use from causing harm and progressing to SUD.

Request for Input

This document outlines the draft framework for Adolescent and Transition Age Youth Volume of *The ASAM Criteria*, including the following:

- Principles of Care
- The Adolescent Continuum of Care
- Assessment and Treatment Planning considerations

The comment period will close at 11:59PM ET on February 2nd, 2024. We will be collecting comments through an electronic survey. For each comment you will be asked to input the page and line number (not a range, just a single number) in the appropriate boxes. Always submit your response before exiting. If you have additional comments at a later time, you can reenter the survey and submit a new response.

Please submit your comments here: https://bit.ly/adol_framework. For a preview of the survey, please click here.

Please note that your comments may be made public.

If you have questions, please email ASAMCriteria@asam.org.

ASAM's Goals

In March 2021, ASAM released a survey seeking comments from diverse stakeholders including treatment providers, system administrators, health plans, policy makers, patients, and families on what is working well in the implementation of *The ASAM Criteria*, what barriers or challenges they have faced, and what can be improved in the next edition. ASAM staff and the editorial team carefully analyzed this feedback. This input, along with their knowledge of evolving systems of care, research advances, and their own clinical experiences informed the framework proposed in this document.

The proposed changes in this document are preliminary. ASAM is seeking input from stakeholders to understand any potential unintended consequences for providers, treatment programs, state and local policy makers, health plans, families, and patients. *The ASAM Criteria* are implemented in different ways in systems across the country. No one person has insight into all these implementations. Thus, input from diverse stakeholders is needed to inform final decisions regarding these proposed changes.

Principles for Care of Adolescent and Transition Age Youth

The ASAM Criteria standards for adolescent treatment are 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 addictive disorder to progress.

- **Patients receive a multidimensional assessment that addresses the broad biological, psychological, social, and cultural factors that contribute to SUDs, addiction, and recovery.** This principle applies a whole-person and whole family approach to assessment and treatment planning, recognizing the broad range of factors that contribute to SUD prognosis and treatment and recovery support needs.
- **Treatment plans are individualized based on patient and family[1] needs and preferences**. Treatment plans are tailored to the needs of the individual and jointly developed with the patient, their family, and other relevant support systems. 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 a comprehensive evaluation of the family and other support systems.
- **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, and culturally humble manner.
- **Co-occurring mental health conditions are an expectation among patients with SUD.** This is particularly true for adolescent and young adult patients with SUD, for whom mental health conditions – such as mood, anxiety and externalizing behavioral disorders, psychosis, trauma-related conditions, autism spectrum disorder, ADHD, oppositional defiant disorder, or attachment disturbances or disruptions – are often a primary concern along with the SUD. Different funding streams and training pathways for clinical providers often leave patients with incomplete or uncoordinated care. This edition of *The ASAM Criteria* establishes the expectation that all adolescent addiction treatment programs will provide integrated treatment for co-occurring conditions. **Care should be consistent with the Systems of Care approach[2]**.
- **Patients move along the clinical continuum of care based on their progress and outcomes with a focus on transition to the least restrictive level of care as quickly as possible while maintaining safety and effectiveness.** Length of stay should be individualized, based on the severity of the patient's illness, their

Systems of Care

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

[1] Family is defined as the patient's primary support system. Family is not limited to biological family and includes others with which the patient is living and/or has deep emotional attachments.

[2] 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.

level of function, and their response to treatment. Admission, as well as transition decisions, are 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. However, intensive treatment and out of home care can be disruptive to an adolescent's social and educational development. A primary goal is to help the adolescent patient to acquire the SUD and mental health recovery skills and supports needed to return home as quickly as possible, while maintaining the safety and effectiveness of care. High intensity care can be delivered in home and community-based settings, if appropriate infrastructure is in place to support it. Similarly, clinicians should seek to provide the least restrictive care necessary while maintaining the level of service intensity needed to support safety and effectiveness, to minimize interference with school, home, and community life. Many patients will have continuing SUD and mental health challenges that will require ongoing integrated care, and should transition to the care setting (or settings) that can best accommodate their co-occurring needs. Patients who achieve sustained remission of SUD but continue to have mental health concerns should transition to an appropriate mental health treatment setting.

- **Adolescents should provide assent to treatment and be central participants in shared decision-making**. Treatment engagement and outcomes are enhanced by patient collaboration and shared decision-making. The patient and their family and/or support persons should be made aware of the proposed modalities of treatment, the risks and benefits of such treatment, appropriate alternative treatment modalities, and the risks of treatment versus no treatment. The updated Dimension 6 in this edition of *The ASAM Criteria* emphasizes the importance of understanding patient and family preferences and individual barriers to care to support person-centered and shared decision-making.
- **Early intervention is critical for prevention of disease progression and warrants specialty care**. Addiction is a brain disease that most often begins with substance use during adolescence, a time in which the brain is actively developing. Early intervention can prevent risky substance use from progressing to SUD or SUD from intensifying and progressing to the chronic disease of addiction. Given the risks of this developmental stage, early intervention and prevention services for adolescents and transition age youth should typically be delivered by behavioral health clinicians. Pediatricians and primary care providers have an important role to play in identifying risky substance use and providing or coordinating appropriate follow up, including interventions for risky substance use, assessment for SUD, and/or SUD treatment. Behavioral health clinicians, including adolescent psychiatrists, are an important sources of specialty consultation to primary care providers during early intervention.
- **Adolescent treatment should be family-driven 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 substance use. Some families may benefit from interventions to help them learn to provide appropriate support. 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; efforts to engage the family should not delay initiation of treatment for the adolescent patient. A therapeutic foster home or residential treatment setting may be recommended for patients who do not have a sufficiently safe and supportive home environment. Efforts to identify and develop an appropriate environment and support system for recovery should be made concurrently 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.[1] Community support should be heavily integrated into adolescent patient treatment plans consistent with the Systems of Care Approach.
- **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. Sufficient staff supervision is important for preventing inappropriate interactions between patients.

The Adolescent Continuum of Care

As discussed above, adolescents with addiction have unique needs and thus *The ASAM Criteria*: Adolescent and Transition Age Youth Volume will propose a continuum of care that is tailored to meet these as needed.

Integration of mental health and SUD treatment. A primary focus of the updated continuum of care is integration with the adolescent mental health treatment system. As noted above, **for adolescent patients, mental health conditions are very often a primary condition along with the SUD**. Therefore, a higher intensity of mental health care is needed in standard adolescent addiction treatment programs. This edition of *The ASAM Criteria* will set the expectation that all adolescent SUD treatment programs will be able to provide integrated care for mental health conditions.

The ASAM criteria are designed to identify an appropriate level of care within the SUD treatment system, not the mental health treatment system. However, given the importance of integration of mental health and SUD treatment for adolescents (regardless of whether they are treated in a mental health treatment program or a SUD treatment program), ASAM plans to align the adolescent continuum of care with the adolescent mental health treatment system standards. We worked with the American Academy of Child and Adolescent Psychiatry, including developers of The Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII), which defines standards for determining the intensity of services needed for children and adolescents from ages 6-18 years with mental health conditions. See Appendix A for an overview of how the proposed levels of care align with the CALOCUS-CASII levels of care. See Appendix B for an overview of how *The ASAM Criteria* dimensions and subdimensions align

with the CALOCUS-CASII dimensions. ASAM and AACAP plan to develop guidance for the field on when it is appropriate for adolescents with both SUD and mental health conditions to be referred to mental health programs (using the CALOCUS-CASII to determine level of care) or to SUD programs (using *The ASAM Criteria* for determining level of care).

Developmental and neurocognitive concerns should be considered in treatment planning. Cognitive and neurodevelopmental disorders such as attention deficit hyperactivity disorder (ADHD), fetal alcohol spectrum disorders, and autism spectrum disorder, among others, can contribute to the development of SUD and complicate its management. Adolescent patients should be screened for intellectual and developmental disabilities (IDDs). Patients who screen positive should be offered a neuropsychological evaluation and findings should guide development of the treatment plan the patient has the supports needed to effectively engage in addiction treatment.

Adolescent patients less frequently experience severe withdrawal or biomedical sequalae that require a medically managed level of care. Historically significant withdrawal and biomedical comorbidities have been rare among adolescent patients. Anecdotal evidence suggests that with the increasing prevalence of high potency synthetic opioids (eg, fentanyl) in the drug supply the need for medical management may be increasing among adolescents. However, most areas of the country currently have insufficient demand for adolescent specific programs that deliver withdrawal management and biomedical care. As a result, most adolescents receiving these services do so in facilities that also serve adult patients. Therefore, the Adolescent and Transition Age Youth Volume will not include standards for separate adolescent medically managed levels of care but will instead discuss how the medically managed programs described in *The ASAM Criteria: Adult Volume* should adapt services to better serve adolescent and young adult patients when needed. Adult programs that provide services to adolescents should have clear policies and procedures that protect adolescent and transition age patients and ensure their unique developmental needs are considered and addressed. Adolescent patients should be treated in separate spaces from adult patients. 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.

Access to addiction and psychiatric medication. Adolescent and young adult patients may benefit from addiction and psychiatric medications. The Fourth Edition will recommend that all programs have systems in place to support medication access, including the ability to continue (without lapse) current medications that are necessary for ongoing mental health and SUD symptom management. All patients should have a medical examination within a reasonable timeframe (specific timeframes will be defined for each level of care) that assesses the patient's need for addiction and psychiatric medications. These exams should be conducted by providers with training and experience in the provision of addiction and psychiatric medications for adolescent patients. Patients who require more than weekly medical management for initiation or titration of medication would be recommended a medically managed level of care (as defined in Adult Volume of *The ASAM Criteria)*. For patients who require less than weekly medical management for initiation, titration, or continuation of medication, access can be supported by any level of care through coordinated referrals with affiliated providers.

1 **Incorporation of intensive home and community-based services.** As discussed above, family and
2 community have a profound effect on adolescent SUD and recovery. Home and community-based
3 services can allow for the delivery of more intensive care in a less restrictive environment. Level 2.1Y and
4 2.5Y programs should be able to provide home- and community- based services, with the specific
5 services delivered individualized to the patient's needs. While there may be challenges with the
6 availability of these services in some states, they are critical for effective care of adolescent patients with
7 significant SUD and co-occurring conditions. These services often exist for the treatment of adolescent
8 mental health conditions and may be expanded to provide integrated care for SUD. Integration of
9 treatment services in home and community settings can also increase access and reduce the burden on
10 families. For example, some Level 2.1Y treatment services may be integrated into school, reducing the
11 number of sessions where the family needs to travel to a treatment setting. For patients in residential
12 care, community-based treatment teams should be formed early in the treatment process, prior to the
13 transition to outpatient care.

14 **Medical monitoring in intensive levels of care**. Given the high rates of co-occurring conditions among
15 adolescent patients with SUD and the inherent complexity of treating adolescent patients with co-
16 occurring conditions, the Adolescent and Transition Age Youth Volume of the Fourth Edition is proposing
17 that all intensive levels of care (Levels 2.1Y and above) have a medical director who can provide ongoing
18 medical monitoring and management of psychiatric and addiction medication needs.

19 In alignment with this principle, the Adolescent and Transition Age Youth Volume only includes one
20 residential level of care (Level 3.5Y), in which care is overseen by a medical director. This Level aligns with
21 the CALOCUS-CASII Level 5. However, one major difference is that the CALOCUS-CASII Level 5 can be
22 delivered in a therapeutic foster home or another home setting with sufficient intensity of home and
23 community-based support. *The ASAM Criteria* Level 3.5Y will be a residential level of care, however, the
24 Dimensional Admission Criteria may separately recommend intensive or high intensity outpatient care
25 (Level 2.1Y or 2.5Y) plus a therapeutic foster home. The need for residential care will be differentiated
26 from the need for a therapeutic foster home based on Dimension 4 and 5, including risks related to
27 substance use and SUD-related behaviors and level of afterhours support needed.

28 **Accommodation for missed school.** As discussed above, residential treatment can be disruptive to
29 adolescent educational development. Treatment programs should consider how to mitigate these
30 disruptive effects. While educational services may not be appropriate during episodes of acute care, as
31 the patient transitions to less restrictive levels of care the clinicians should coordinate with the patient's
32 school to determine what interventions are needed to help the patient make up missed work. If patients
33 are expected to be away from school for a significant amount of time (eg, more than 2 weeks)
34 educational programming should be arranged by the treatment program; this may include coordination
35 of remote learning with appropriate support services. Minimizing educational disruption is one reason
36 why *The ASAM Criteria* is focused on supporting patients to transition to the least restrictive level of care
37 as quickly as possible while maintaining safety and effectiveness.

38 **Early Intervention and Prevention.** For adult patients, early intervention and prevention services are not
39 typically provided by the specialty healthcare system. However, it may be appropriate to provide
40 specialty care for adolescent patients who are using substances in risky ways to prevent escalation to a

SUD. Early intervention and prevention services, including prevention as treatment will be incorporated into adolescent Level 1.5Y. In other words, for adolescents and transition age youth who are using substances in risky ways but do not currently meet the DSM criteria for a SUD, *The ASAM Criteria* Dimensional Admission Criteria may recommend Level 1.5Y where the patient can receive treatment services to prevent the escalation to a SUD. While this change will require workforce development and updated payment models, a full assessment for potential underlying mental health concerns and substance use disorder by a master's level clinician (at minimum) and early intervention services are critical for this patient population.

Levels of Care

As with previous editions of *The ASAM Criteria*, the proposed continuum of care for adolescents includes 4 broad treatment levels of care (Figure 1). Within these four broad levels of care, decimal numbers express further gradations of intensity and types of care provided. The adolescent specific clinically managed levels of care include the following. The proposed standards will set the expectation that all adolescent specific levels of care provide co-occurring capable treatment services with psychiatric oversight. See Table 1 for an overview of core service characteristics proposed for these levels of care.

- Level 3.5 Y – Youth Residential Treatment
- Level 2.5 Y – High Intensity Home and Community Based Treatment
- Level 2.1 Y – Intensive Home and Community Based Treatment
- Level 1.5 Y – Youth and Family Outpatient
- Level 1.0 Y – Long Term Remission Monitoring

The Adolescent Continuum of Care also includes medically managed levels of care that typically serve both adults and adolescents. In other words, *The ASAM Criteria* Dimensional Admission Criteria may recommend an adolescent specific clinically managed level of care or a medically managed level of care which typically serve both adult and adolescent patients. The core standards for these levels of care are defined in the Adult Volume of *The ASAM Criteria*. The medically managed levels of care include:

- Level 4 - Inpatient, including:
    - Level 4 – Medically Managed Inpatient
    - Level 4 Psychiatric – Medically Managed Inpatient Psychiatric
- Level 3.7 – Medically Managed Residential, including:
    - Level 3.7 Co-occurring Enhanced (COE)
    - Level 3.7 Biomedically Enhanced (BIO)[3]
- Level 2.7 – Medically Managed Intensive Outpatient, including:
    - Level 2.7 Co-occurring Enhanced (COE)
- Level 1.7 – Medically Managed Outpatient, including:
    - Level 1.7 Co-occurring Enhanced (COE)

[3] In the adult ASAM Criteria continuum of care Level 3.7 BIO programs have enhanced biomedical capabilities including the capacity to provide intravenous fluids and medications, and vacuum assisted wound care.

In the adult ASAM Criteria continuum of care, all programs are expected to be co-occurring capable at minimum. Co-occurring capability for adult programs includes:

1. Welcoming patients with co- occurring conditions.
2. Screening, identifying, and documenting the presence of any co-occurring mental health concerns, regardless of whether related psychiatric diagnoses have been formally made.
3. Collaborating with any existing mental health treatment providers, including obtaining any existing mental health assessment and treatment information when available and maintaining collaborative care coordination throughout treatment.
4. Arranging additional mental health or psychiatric assessments, including diagnostic assessments, as needed.
5. Engaging patients with integrated treatment teams that are coordinated in their efforts to support progress with both SUD and mental health concerns.
6. Identifying the stage of change that patients are in regarding their mental health conditions and providing stage-matched interventions.
7. Helping patients learn about their mental health concerns and the types of interventions that may help them manage these concerns effectively.
8. Helping patients learn basic skills for managing their mental health symptoms during addiction treatment, including how to utilize SUD and/or mental health peer support.
9. Helping patients develop skills for working effectively with prescribers to initiate or adjust any needed medications and take medications as prescribed.
10. Incorporating routine discussion of cooccurring mental health concerns into programming.
11. Developing a culture supportive of cooccurring recovery.
12. Ensuring that transition planning addresses continuing co- occurring mental health needs.

The adult continuum of care also defines standards for co-occurring enhanced (COE) levels of care. COE are addiction treatment program that have enhanced resources to routinely serve patients who have more serious co-occurring mental health or cognitive conditions—that is, conditions that are more acute or associated with more serious disabilities—but who are still able to successfully participate in addiction and mental health treatment services if provided with appropriate symptom management assistance and functional supports. Patients treated in COE programs may present with:

- severe mood disorders, including those with psychotic features, and more intense bipolar spectrum disorders;
- schizophrenia spectrum disorders associated with continuing significant symptomatology and/or disability at baseline;
- severe trauma-r elated or anxiety disorders with a high risk for severe flashbacks or overwhelming emotional instability;
- significant dissociative disorders; or
- severe personality disorders (eg, borderline personality disorder [BPD]).

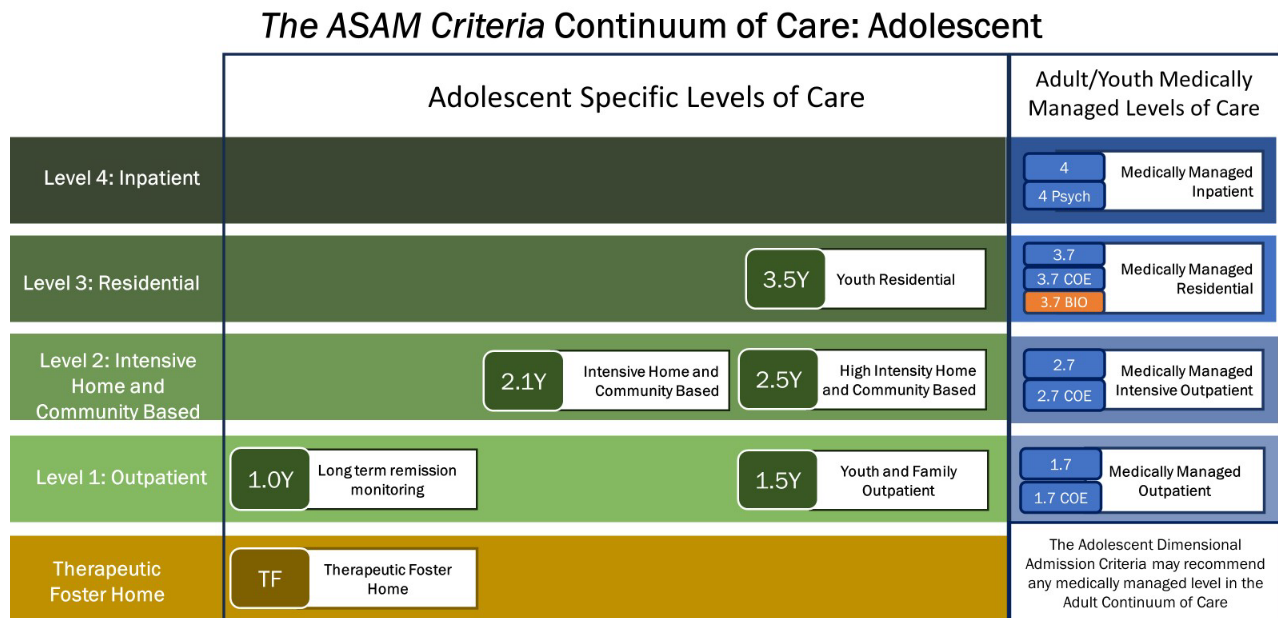
COE programs provide integrated psychiatric services and skilled mental health interventions. In addition, they have a higher staff to patient ratio to allow them to provide highly individualized

adjustment of behavioral expectations, group participation capacity, pacing of treatment progress, and titration of emotional intensity.

Because adolescent patients often have mental health conditions that are a primary concern (along with the SUD) the baseline expectations for providing integrated mental health treatment will be higher. Standard (co-occurring capable) adolescent addiction treatment programs will be expected to provide integrated psychiatric services and skilled mental health interventions. Some adolescent patients with severe psychiatric symptoms may need a higher level of individualized care than can be provided by standard adolescent addiction treatment programs. In these cases, The Adolescent and Transition Age Youth Volume of the Fourth Edition of *The ASAM Criteria* will recommend COE care (with the level determined by the patient's multidimensional needs). Patients who are recommended COE may be treated by:

- An adolescent addiction treatment program that has sufficient staffing to allow the safe and effective provision of care for the individual patient/family's acuity and complexity, or
- An adolescent mental health treatment program that provides an appropriate level of integrated services for SUD

Figure 1. *The ASAM Criteria* Continuum of Care: Adolescent



1 **Table 1. Summary of Service Characteristics for the Adolescent Levels of Care**

	1.0Y	1.5Y	2.1Y	2.5Y	3.5Y
	Long term remission monitoring	Youth and Family Outpatient	Intensive Community-Based Services	High Intensity Outpatient and Home Based	Youth Residential
Medical Director	Yes	Yes	Yes	Yes	Yes
Nursing	Not typical	Not typical	Able to coordinate access to nursing services when needed	Yes (primarily psychiatric nursing)	Yes
Program Director	Yes	Yes	Yes	Yes	Yes
Allied Health Staff (including family/support system support)	Variable	Yes	Yes	Yes	Yes
Physical exam	Verify a physical exam in the last year or refer	Within one month of treatment initiation	Within 14 days of admission	Within 7 days of admission	Within 3 days of admission
Nursing Assessment	Not typical	Not typical	As needed*	As needed*	Within 24 hours
Clinical Services	Recovery/remission management services	Direct psychosocial services Prevention as treatment Family services[ƚ] Psychiatric consultative services*	Direct psychosocial services Family services[ƚ] Able to coordinate psychiatric services as needed	Direct psychosocial services; therapeutic milieu Family services[ƚ] Direct psychiatric services Formal care coordination	Direct psychosocial services; high-intensity therapeutic milieu Family services[ƚ] Direct psychiatric services Formal care coordination
Clinical Service Hours	Quarterly services at minimum	<6 hours/week; typically, 1-2 hours per week	6-19 hours/week; structured services at least 2 days per week	≥20 hours/week; structured services at least 5 days per week	≥20 hours/week, structured services 7 days a week
Recovery Support Services (RSS)	Recovery management checkups and other RSS available	RSS available*	RSS available*	RSS available*	RSS available*

2 *directly or through formal affiliation; ƚ family services include parent skills training, family therapy, and
3 informal family-oriented recovery support (eg, family resource centers, peer and mutual support for
4 family, faith-based support services, etc.)

1 # Assessment and Treatment Planning

2 A core principle of *The ASAM Criteria* is the use of a multidimensional assessment to drive level of care
3 recommendations and the development of an individualized treatment plan. While the need for a
4 comprehensive assessment and regular reassessments is described in the book, many stakeholders have
5 requested more detailed standards to help guide effective implementation. A full biopsychosocial
6 assessment is not necessary for making a level of care recommendation, but it is the foundation for a
7 comprehensive treatment plan.

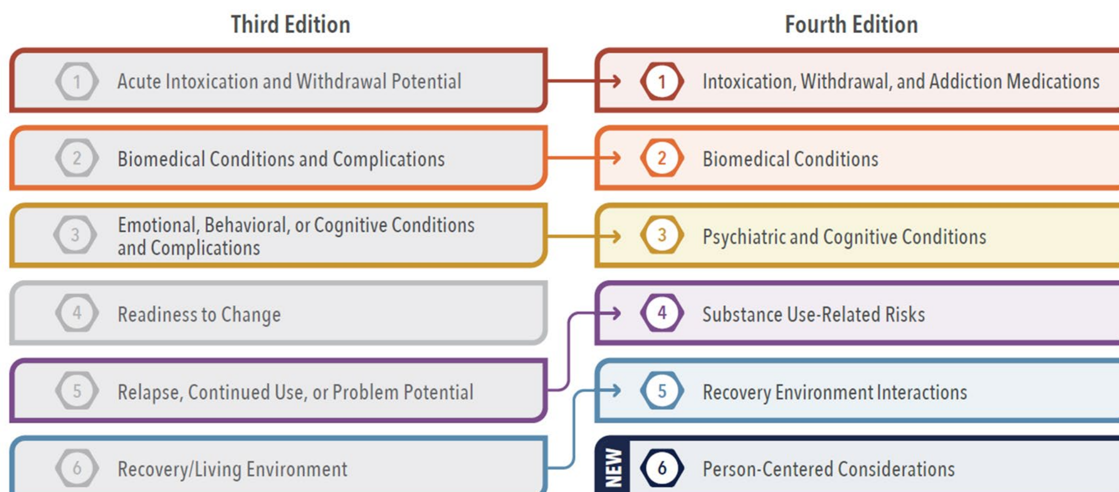
8 The Adolescent and Transition Age Youth Volume of Fourth Edition of *The ASAM Criteria* will describe
9 separate standards for the Level of Care Assessment that is used to determine the recommended level of
10 care and the Treatment Planning Assessment. Both assessments will be multidimensional and consider
11 the patient's full biological, psychological, and sociocultural context.

12 ## The Six Dimensions

13 The 4th Edition of *The ASAM Criteria*: Adult Volume updated the six assessment dimensions (Figure 2)
14 and introduced the concept of subdimensions (Figure 3). Major changes include:

15 - Updating the names of the dimensions for conciseness and to reflect current terminology.
16 - Explicit consideration of addiction medication needs in Dimension 1.
17 - The Third Edition's Dimension 4: Readiness to Change does not contribute independently to the
18 recommended level of care; rather, readiness and motivation for change impact clinical
19 judgments related to risks in other dimensions and influences the services that should be
20 delivered at any level of care and should be carefully considered in treatment planning.
21 - With the removal of the readiness to change as a distinct dimension, the previous Dimensions 5
22 and 6 have now shifted to Dimension 4 (Substance Use Related Risks) and Dimension 5
23 (Recovery Environment interactions).
24 - A new Dimension 6 was added, Person-centered considerations, which considers barriers to
25 care, patient and family preferences, and need for motivational enhancement services.

26 **Figure 2. Changes to *The ASAM Criteria* Dimensions in the Fourth Edition**



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1 ## Subdimensions
2 The Fourth Edition describes subdimensions that should be assessed within each dimension. These
3 subdimensions are the foundation for *The ASAM Criteria* Dimensional Admission Criteria. In the updated
4 framework, clinicians assign risk ratings (based on the clinical severity described in the Dimensional
5 Admission Criteria). The subdimensions in blue in Figure 3 are considered when determining an
6 appropriate level of care recommendation. All subdimensions are considered during treatment planning.

7 **Figure 3. Dimensions and Subdimensions – Adolescent Assessment**

Dimensions and Subdimensions – Adolescent Assessment

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 concerns**
- **Persistent Disability**
- Intellectual and developmental concerns
- Trauma exposure and related needs
- Psychiatric and cognitive history

Dimension 4 – Substance Use Related Risks
- **Likelihood of risky substance use**
- **Likelihood of risky SUD-related behaviors**

Dimension 5 – Recovery Environment Interactions
- **Ability to function in current environment**
- **Safety in current environment**
- **Support in current environment**
- Cultural perceptions of substance use

Dimension 6 – Person-Centered Considerations
- Patient needs and preferences
- Family and support system preferences
- Barriers to care
- Need for motivational enhancement

8

9 ## Dimension 1 – Intoxication, Withdrawal, and Addiction Medications
10 For Dimension 1, the Level of Care Assessment primarily considers the need for a medically managed
11 level of care for acute intoxication, withdrawal, or initiation or titration of addiction medications. The
12 Treatment Planning Assessment additionally considers the patient's needs for overdose prevention
13 medication, and the need for referrals for addiction medication needs that do not require active (ie,
14 more than weekly) or integrated medical management.

15 Compared with adults, it is rarer for adolescent patients to experience severe withdrawal and biomedical
16 complications; however, it is still important to screen for and address these issues and provide
17 appropriate and timely medical care when identified.

18 Access to addiction medications is often a challenge for adolescent and young adult patients. While the
19 risk benefit determination for addiction medications should be considered in the developmental context,
20 it is important that adolescent patients have access to these medications when the benefits are likely to
21 outweigh risks for the individual. Drug overdose deaths more than doubled among adolescents from
22 2019 to 2021 with 90 percent involving opioids.[2] Medications for opioid use disorder (MOUD) are an

important component of care for reducing opioid mortality risk. All patients should be assessed for addiction medication needs.

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, sleep related needs, and educational interventions to prevent biomedical issues from arising.

Adolescent patients typically present with less chronic biomedical concerns compared with adults; However, adolescents and transition age youth are susceptible to the same biomedical sequalae of addiction as adults, such as HIV, viral hepatitis, pain, and injection site injections, among others. Identifying and appropriately managing concerns in Dimension 2 is an important component of addiction care.

Dimension 3 – Psychiatric and Cognitive Concerns

For Dimension 3, the Level of Care Assessment considers active psychiatric concerns as well functional impartments related to persistent mental health and cognitive impairments – including those related to intellectual and developmental disorders – and related needs for specialty mental health services, including psychiatric and neuropsychological services. The Treatment Planning Assessment also considers the patient's service needs related to cognitive functioning, developmental concerns, trauma, and psychiatric and cognitive history.

Serious mental illnesses may first present during adolescence and young adulthood. It can be challenging to differentiate between mental illness and substance-induced psychotic disorders. It is important that a qualified mental health professional, often a psychiatrist, conduct the Dimension 3 assessment when a patient is presenting with significant mental health symptoms.

For adolescent and transition age youth, 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 substance use and co-occurring 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 – Substance Use Related Risks

For Dimension 4, the Level of Care Assessment considers the patient's risks related to substance use and SUD-related behaviors. The assessment considers the likelihood that the patient will continue to use substances or engage in risky behaviors and the degree of risk posed by the patient's patterns of substance use and related behaviors, including risk for serious harm, destabilizing loss, or negative but not destabilizing consequences. Family involvement is considered in this dimension as a component of the clinician's assessment of the likelihood of the patient continuing to use substance or engage in risky behaviors; strong parental involvement and supervision may decrease the likelihood of patient engagement in these behaviors. 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

considers the range of treatment and recovery support services the patient needs to address substance use and related risky 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, including prosocial skills and other skills of daily living, necessary for achieving and maintaining recovery. This dimension also considers environmental risks to patient's safety, including exposure to abuse, neglect, and other adverse or traumatic events at home as well as at school (eg, bullying) and whether a residential level of care or therapeutic foster home are needed to protect the patient or support effective engagement in care while continued efforts are made to engage the parents or other primary caregivers in the treatment process.

In addition, this dimension considers the level of support the patient has for engaging in treatment and recovery including family, friends, school, and community support. If there are factors in the patient's home or school environment that would prevent effective engagement in treatment or recovery, the Dimensional Admission Criteria may recommend a residential level of care or therapeutic foster home.

Parent/guardian substance use, and psychiatric history are considered in the context of both the patient's safety and available support. The Treatment Planning Assessment considers service needs, including caregiver interventions to improve safety and support for the patient. The Treatment Planning Assessment also considers cultural influences that may impact the patient's and family's perceptions of substance use, addiction, and treatment engagement.

Dimension 6 – Person-Centered Considerations

Dimension 6 considers barriers to care, patient needs and preferences, family and support system preferences, 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. The clinician determines the level of care recommendation based on assessment of Dimensions 1 through 5 and application of the Dimensional Admission Criteria and then works closely with patient and their family to determine what level of care they are able and willing to participate in. Behavioral and developmental challenges may be considered in this dimension when determining what level of care at which an individual patient can effectively participate. Care should be family driven and youth guided.

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, justice services, educational services, vocational 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 patient and family at home, in school, and in the community.

References

1. Olson JR, Benjamin PH, Azman AA, et al. Systematic Review and Meta-analysis: Effectiveness of Wraparound Care Coordination for Children and Adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2021;60(11):1353-1366. doi:10.1016/j.jaac.2021.02.022
2. Tanz LJ, Dinwiddie AT, Mattson CL, O'Donnell J, Davis NL. Drug Overdose Deaths Among Persons Aged 10–19 Years — United States, July 2019–December 2021. *MMWR Morb Mortal Wkly Rep*. 2022;71:1576–1582. doi:http://dx.doi.org/10.15585/mmwr.mm7150a2

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Appendix A – ASAM Criteria/CALOCUS-CASII Levels of Care Crosswalk

ASAM Level of Care	CALOCUS-CASII	Comments
Prevention Services, previous ASAM Criteria Level 0.5.	Level 0: Basic Services: Prevention and Health Maintenance	Prevention as treatment is now incorporated into *The ASAM Criteria* Level 1.5.
Level 1.0 Long term remission monitoring	Level 1: Recovery Maintenance and Health Management	*The ASAM Criteria* Level 1.0 is a new level that was introduced in the Fourth Edition; includes a minimum of quarterly recovery management check-ups to support rapid reengagement in care when needed.
Level 1.5: Outpatient	Level 2: Low Intensity Community-based services	Less than 6 hours per week of clinical services
Level 2.1: Intensive Outpatient and Home-based	Level 3: High Intensity Community-based services	Clinical services at least 3 days per week
Level 2.5: Intensive Outpatient and Home-based	Level 4: Medically Monitored Community Based Services: Intensive Integrated Services without 24 hr Psychiatric Monitoring	Daily or near daily clinical services.
Level 3: Residential	Level 5: Medically Monitored Intensive Integrated Services: Non-secure, 24-hour service with psychiatric monitoring	CALOCUS-CASII Level 5 does not need to be delivered in a residential setting. It provides 24-hour services, including mobile crisis response. *The ASAM Criteria* Level 3 is a residential level of care.
Level 4: Inpatient Psychiatric	Level 6: Medically Managed Secure, Integrated Intensive Services: Secure, 24-hour Services with Psychiatric Management	Psychiatric hospital or secure psychiatric unit within a general hospital.

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1 ## Appendix B – ASAM Criteria/CALOCUS-CASII Assessment Dimensions
2 ## Crosswalk

***The ASAM Criteria* Dimensions and Subdimensions**	**CALOCUS-CASII Dimensions**
ASAM Criteria Dimension 1 - Intoxication, Withdrawal, and Addiction Medications	
Intoxication and related risks	CALOCUS-CASII Dimension 3 – Co-occurrence of Conditions
Withdrawal and related risks	CALOCUS-CASII Dimension 3 – Co-occurrence of Conditions
Addiction medication needs	CALOCUS-CASII Dimension 3 – Co-occurrence of Conditions
ASAM Criteria Dimension 2 - Biomedical Conditions	
Physical health concerns	CALOCUS-CASII Dimension 3 – Co-occurrence of Conditions
Pregnancy-related concerns	CALOCUS-CASII Dimension 3 – Co-occurrence of Conditions
Sleep problems	CALOCUS-CASII Dimension 3 – Co-occurrence of Conditions
***The ASAM Criteria* Dimension 3 - Psychiatric and Cognitive Conditions**	
Active psychiatric symptoms	CALOCUS-CASII Dimension 1 – Risk of Harm CALOCUS-CASII Dimension 3 – Co-occurrence of Conditions
Persistent disability	CALOCUS-CASII Dimension 2 - Functional Status CALOCUS-CASII Dimension 3 – Co-occurrence of Conditions
Cognitive functioning	CALOCUS-CASII Dimension 2 - Functional Status
Intellectual and Developmental Concerns	CALOCUS-CASII Dimension 2 - Functional Status CALOCUS-CASII Dimension 3 – Co-occurrence of Conditions
Trauma-related needs	CALOCUS-CASII Dimension 1 – Risk of Harm CALOCUS-CASII Dimension 3 – Co-occurrence of Conditions CALOCUS-CASII Dimension 4 – Recovery Environment (environmental stress sub-scale)
Psychiatric and Cognitive History	CALOCUS-CASII Dimension 5 – Resiliency and Response to Services
***The ASAM Criteria* Dimension 4 - Substance-Use Related Risks**	
Likelihood of engaging in risky substance use	CALOCUS-CASII Dimension 1 – Risk of Harm CALOCUS-CASII Dimension 5 – Resiliency and Response to Services
Likelihood of engaging in risky SUD-related behaviors	CALOCUS-CASII Dimension 1 – Risk of Harm CALOCUS-CASII Dimension 5 – Resiliency and Response to Services
***The ASAM Criteria* Dimension 5 - Recovery Environment Interactions**	

Ability to function effectively in current environment	CALOCUS-CASII Dimension 2 – Functional Status CALOCUS-CASII Dimension 5 – Resiliency and Response to Services
Safety in current environment	CALOCUS-CASII Dimension 1 – Risk of Harm CALOCUS-CASII Dimension 4 – Recovery Environment (environmental stress sub-scale)
Support in current environment	CALOCUS-CASII Dimension 4 – Recovery Environment (environmental support sub-scale) CALOCUS-CASII Dimension 6 – Engagement in Services (parental engagement)
Cultural perceptions of substance use and addiction	CALOCUS-CASII Dimension 4 – Recovery Environment CALOCUS-CASII Dimension 6 – Engagement in Services
***The ASAM Criteria* Dimension 6 - Person-Centered Considerations**	
Barriers to care	CALOCUS-CASII Dimension 6 – Engagement in Services (Child or Adolescent Engagement and Parental and/or Primary Caretaker Engagement sub-scales)
Patient needs and preferences	CALOCUS-CASII Dimension 6 – Engagement in Services (Child or Adolescent Engagement and Parental and/or Primary Caretaker Engagement sub-scales)
Family and support system preferences	CALOCUS-CASII Dimension 6 – Engagement in Services (Child or Adolescent Engagement and Parental and/or Primary Caretaker Engagement sub-scales)
Need for motivational enhancement services	CALOCUS-CASII Dimension 6 – Engagement in Services (Child or Adolescent Engagement and Parental and/or Primary Caretaker Engagement sub-scales)

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