Public comments accepted until **November 15th, 2024** through the online form at https://bit.ly/adolescent_criteria

Proposed Updates to The ASAM Criteria, Fourth Edition, Adolescent Volume

Request for public comments, October - November 2024

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Background

The ASAM Criteria, first published in 1991, provides national standards for conducting a 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.

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 illustrates the unique developmental needs of transition age-youth. From approximately age 16 to age 25, youth have social roles and responsibilities, and family, peer, and community supports are changing. This is also a period of significant neurodevelopment as executive functioning fully matures. As such, the next 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 youth under 18 years of age) 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, which 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 ASAM Criteria standards for Adolescent levels of care, including the standards for:

- Assessment and Treatment Planning
- The ASAM Criteria Youth Continuum of Care
- Service Characteristics for each Level of Care

We are requesting feedback on the appropriateness of these standards for the care of adolescents and transition age youth as well as the feasibility of implementing them in diverse healthcare systems. The full text will be professionally copyedited prior to publication.

The full narrative text will not be released for public comment. See the draft Table of Contents in Appendix A for an outline of the topics that will be covered.

The Adult Volume of The ASAM Criteria, Fourth Edition was released in December 2023. For more information on the framework from that volume, see our website.

Planned future separate volumes include:

- Correctional Settings and Reentry
- Behavioral Addictions.

The comment period will close at **11:59PM ET on November 15, 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. 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.

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Summary of Major Changes

The adolescent editorial team is proposing major changes in the Adolescent and Transition-Aged Volume of The ASAM Criteria, Fourth Edition to facilitate dissemination and implementation and to address known gaps in the quality of adolescent addiction treatment. The core principles remain the same, though have been updated to reflect the needs of adolescent and transition-aged youth:

- Admission into treatment is based on patient needs rather than arbitrary prerequisites.
- Patients receive a multidimensional assessment that addresses the broad biological, psychological, social, cultural, and developmental factors that contribute to SUDs, addiction, and recovery.
- Treatment plans are individualized based on patient and family needs and preferences.
- Care is interdisciplinary, evidence-based, patient-centered, and delivered from a place of empathy.
- Co-occurring mental health conditions are an expectation among patients with SUD.
- 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.
- Clinicians should seek to obtain assent/consent from adolescent patients using a shared decision-making framework to support participation in treatment.
- Early intervention is critical for prevention of disease progression and warrants specialty care.
- Adolescent treatment should be family-driven and youth-guided.
- Treatment interventions may take place within the patient's home, school, and community as appropriate – with a team-based approach to care coordination.
- Interventions should be developmentally appropriate; adolescent patients and transition-age youth should be treated in peer-specific groups, separate from adults.

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.

These central principles of *The ASAM Criteria* reflect the biopsychosocial nature of addiction. The standards in *The ASAM Criteria* promote a holistic view of patients, acknowledging the role that physical and mental health, stage of development, life circumstances (eg, education, employment, social support, housing, trauma history, criminal legal involvement, etc.), and individual needs, strengths, and goals play in the development and maintenance of SUD and addiction. All these factors are assessed to develop an individualized treatment plan. *The ASAM Criteria* emphasizes the importance of treatment plans tailored to the needs of individual patients and families and regular reassessment and modification of treatment plans that reflect both response to treatment and the evolving needs of the patient and family as life circumstances change.

To reflect the evolving needs of the field, the Adolescent Editorial Team is proposing updates to *The ASAM Criteria* to:

- Update the continuum of care, including the expectation for:
  - Fully integrated mental health and SUD treatment
  - Availability of intensive home and community-based services
  - Medical monitoring in intensive levels of care
- Support access to specialty early intervention and prevention services for youth who are using substances and at high risk for SUD
- Update the ASAM Criteria Assessment and Treatment Planning standards
- Increase access to addiction and psychiatric medication
- Address challenges with adolescent access to medically managed care
- Consider adolescent patients' educational needs during treatment

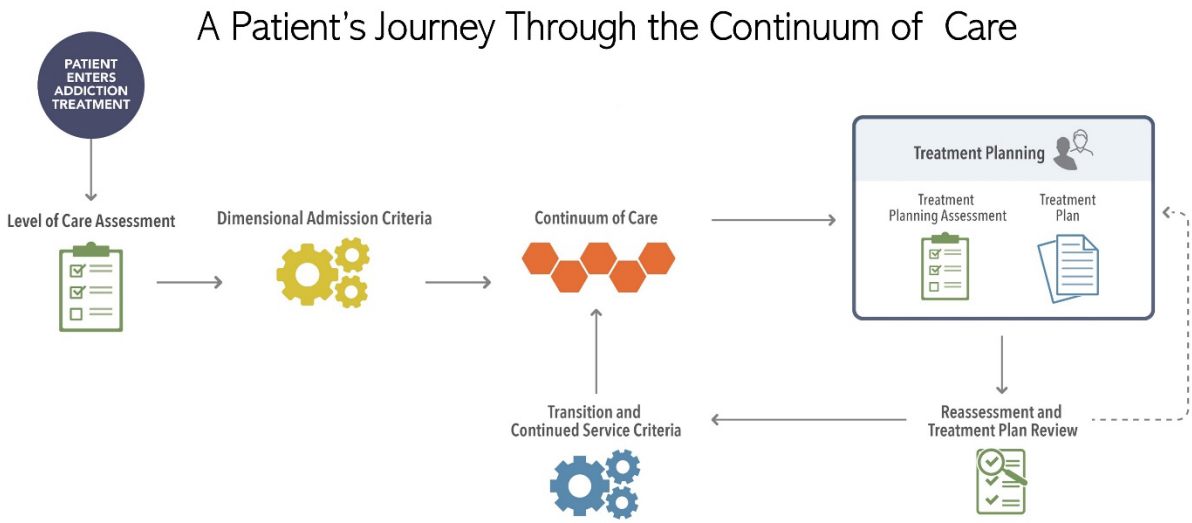
The following sections provide a comprehensive overview of the proposed changes and present the draft standards.

Core ASAM Criteria Standards

The ASAM Criteria includes standards and decision rules including:

1. Multidimensional assessment standards for:
   a. Level of Care Assessment
   b. Treatment Planning Assessment
   c. Reassessment and Treatment Plan Review
2. Treatment planning standards
3. Dimensional Admission Criteria
4. Transition and Continued Service Criteria
5. Continuum of care standards including the levels of care that should be available and service characteristic standards at each level of care

Figure 1. Patient's Journey Through the Continuum of Care



When a patient enters treatment a Level of Care Assessment is administered and the Dimensional Admission Criteria are used to make recommendations for the least intensive/restrictive level of care where the patient can be safely and effectively treated (see Figure 1). Once the patient has been admitted to a level of care in the care continuum a Treatment Planning Assessment is administered and used to develop an individualized treatment plan. Patients are regularly reassessed and treatment plans are updated based on patient progress and challenges. The Transition and Continued Service Criteria are used to determine when a patient should transition to a more or less intensive level of care or continue in the same level of care.

Note that the Dimensional Admission Criteria and Transition and Continued Service Criteria are not released for public comment. These decision rules undergo validation testing in parallel with the public comment period.

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 an individualized treatment plan. A full biopsychosocial assessment is not necessary for making a level of care recommendation, but it is the foundation for a comprehensive treatment plan.

In these standards, we discuss three types of assessments:

1. Level of Care Assessment, in which clinicians gather specific information to recommend an appropriate level of care and support initiation of treatment for immediate needs;
2. Treatment Planning Assessment, in which clinicians conduct a comprehensive biopsychosocial assessment to gather more detailed information for longer-term treatment planning; and
3. Treatment Plan Reviews, in which clinicians conduct repeated assessments to support treatment plan updates and measurement-based care and inform level of care transitions.

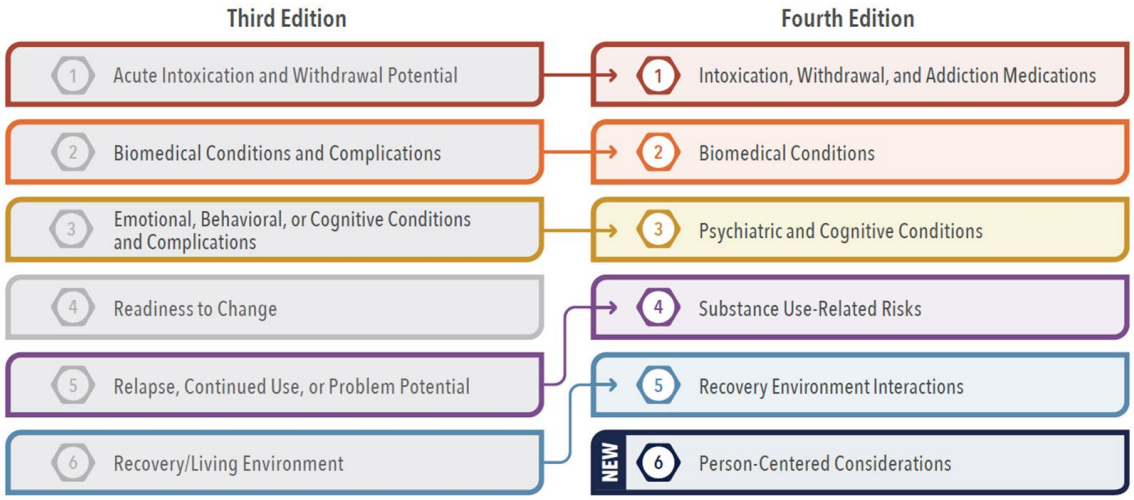
The Six Dimensions

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

- Updating the names of the dimensions for conciseness and to reflect current terminology.
- Explicit consideration of addiction medication needs in Dimension 1.
- The Third Edition's Dimension 4: Readiness to Change does not contribute independently to the recommended level of care; rather, readiness and motivation for change impact clinical judgments related to risks in other dimensions and influences the services that should be delivered at any level of care.

- With the removal of the readiness to change as a distinct dimension, the previous Dimensions 5 and 6 have now shifted to Dimension 4 (Substance Use Related Risks) and Dimension 5 (Recovery Environment interactions).
- A new Dimension 6 was added, Person-centered considerations, which considers barriers to care, patient and family preferences, and need for motivational enhancement services.

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



Subdimensions

The Fourth Edition describes subdimensions that should be assessed within each dimension. These 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 **bolded blue** are considered when determining an appropriate level of care recommendation. All subdimensions are considered during treatment planning.

Dimensions and Subdimensions – Adolescent

The editors propose the following subdimensions for the Adolescent Volume of *The ASAM Criteria*. The changes in relation to the adult volume are indicated below.

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 Concerns

Dimension 3 – Psychiatric and Cognitive Conditions

- Active Psychiatric Concerns
- **Intellectual and Developmental Concerns** [replaces the persistent disability subdimension]
- Trauma Exposure and Related Needs [updated to include exposure]
- 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 Effectively in Current Environment
- Safety in Current Environment
- Support in Current Environment
- Cultural Perceptions of Substance Use and Addiction
- Educational Needs [added to address adolescent specific needs]

Dimension 6 – Person-Centered Considerations

- Patient Needs and Preferences [updated to include needs]
- Family and Support System Preferences [added to reflect the importance of family in adolescent care]
- Barriers to Care
- Need for Motivational Enhancement

Assessment Standards

General Adolescent Assessment Policies and Procedures

- Clinicians should seek to obtain consent (and/or assent based on local regulations) from adolescents for assessment and treatment, and engage them as central participants in shared decision-making.
    - If the program is legally required to disclose any information regarding a minor patient's health status (eg, infectious disease, pregnancy status), the patient should be informed at the onset of the assessment.
- A Level of Care Assessment should be conducted prior to admission to recommend the least intensive and restrictive level of care where the patient can be safely and effectively treated.
- Treatment programs should have the ability to assess vital signs and refer for timely medical assessment as needed.

- After the patient is admitted to a level of care, a comprehensive multidimensional Treatment Planning Assessment should be conducted.
    - If the patient requires immediate treatment for acute biomedical or psychiatric symptoms, the Treatment Planning Assessment should occur once the patient is stabilized, coherent, and able to participate comfortably.
- Reassessment and Treatment Plan Reviews should be conducted:
    - Periodically, within the timeframes specified in the level of care specific standards.
    - In response to significant events or changes in the patient's condition or patient or family circumstances that may influence the treatment plan or the patient's recovery process.
- Reassessment should focus on:
    - Progress towards addressing the patient's Dimensional Drivers (dimensional factors that underly the recommendation for a certain level of care).
    - Progress towards the goals in the patient's individualized treatment plan
    - Any changes to the patient's signs, symptoms, or level of function across dimensions and subdimensions
- Reassessments should incorporate both patient and family-reported information and clinician observation.
    - Clinicians should seek to engage with both parents, if applicable and separate from the patient, when collecting the patient's history.

Considerations for Transition Age Youth

For patients who are 16 years and older:

- The Treatment Planning Assessment should assess the patient's developmental stage including the skills necessary to support a successful transition to the adult care system. The assessment should clearly document:
    - acquired healthcare management skills (eg, scheduling healthcare appointments, knowing what your medications are [including dosing], calling the pharmacy to arrange prescription pick-ups), and
    - health care management skills the patient needs to continue to develop.
- The patient's treatment plan should incorporate services to help patients build the skills necessary to support a successful transition to the adult care system.

Dimension 1: Intoxication, Withdrawal, and Addiction Medications

D1 Level of Care Assessment

General Considerations

- When assessing Dimension 1, the clinician should determine whether the patient is at risk for or is currently experiencing intoxication or withdrawal, including taking a history of recent substance use.

- If intoxication or withdrawal is apparent at the time of the assessment, a clinician should examine the patient for significant disturbances in vital signs, including blood pressure, heart rate, oxygen saturation, and temperature.
- The clinician should also note whether the patient is oriented to person, place, time, and situation and displays or reports any problems with balance, gait, sensation, and/or behavioral disturbances (e.g., agitation, disinhibition).
- When the history and exam are inconclusive as to substance(s) used, toxicology screens (that include drugs commonly used by population locally) can be considered.

Family Assessment Considerations

- If the patient is at risk for or is currently experiencing intoxication or withdrawal the clinician should seek to collect collateral information from family members (if available), including:
    - Is there any indication that the patient's recent substance use may be more concerning than reported by the patient (ie, higher quantity consumed)?
    - Does the patient have a history of overdose and/or severe or complicated withdrawal?
    - Does the patient have biomedical or psychiatric comorbidities that might complicate treatment of intoxication or withdrawal?
    - Has the patient previously received intoxication or withdrawal management services? If so, what was the outcome? Did the patient experience any adverse events?
    - Does the family indicate that they are able to monitor the patient's symptoms and help the patient adhere to the treatment plan, including medications and follow up appointments?

Intoxication and Associated Risks [LOC Assessment]

- Is the patient intoxicated?
    - If YES:
        - Are they medically stable? [if NO, transfer to the emergency department]
        - What is the peak anticipated severity of intoxication signs and symptoms (ie, based on substances ingested, potency, quantity, time frame)?*
        - Is medical management required?
            - If YES:
                - Is afterhours medical management required?
                - What level of nurse monitoring does the patient need (ie, extended nurse monitoring during the day, afterhours nurse monitoring)?
                - Is the patient expected to need IV fluids, IV medications, or services that are only available in an acute care hospital (eg, frequent lab testing, mechanical ventilation, etc.)
        - Are they behaviorally stable? Is behavioral intervention required?
        - Are they displaying altered mental status? If so, what level of observation is needed?

This determination should be made following program policies, procedures, and protocols approved by a physician or by a qualified medical professional.

Family Assessment – Intoxication and Associated Risks

- Can the family or other collateral sources provide additional information about the patient's recent substance use and/or medical history to help inform assessment of intoxication-related risks and treatment needs?

Withdrawal and Associated Risks [LOC Assessment]

- Is the patient currently in withdrawal or expected to enter withdrawal soon?
  - If YES:
    - Are they medically stable? [if NO, transfer to the emergency department]
    - What is the peak anticipated severity of withdrawal signs and symptoms (ie, based on substances ingested, potency, quantity, time frame)?*
    - Is medical management required?
      - If YES: Is afterhours medical management required?
      - What level of nurse monitoring does the patient need (ie, extended nurse monitoring during the day, afterhours nurse monitoring)?
      - Is the patient expected to need IV fluids, IV medications, or services that are only available in an acute care hospital (eg, frequent lab testing, mechanical ventilation, etc.)?
    - Are they behaviorally stable? Is behavioral intervention required?
    - Are biomedical or psychiatric comorbidities expected to complicate withdrawal management?
    - Does the patient have sufficient home support to enable effective outpatient withdrawal management, if medically indicated?

This determination should be made following program policies, procedures, and protocols approved by a physician or by a qualified medical professional.

Family Assessment – Withdrawal and Associated Risks

- Can the family provide additional information about the patient's potential withdrawal related risks, based on their observations of recent use and/or the patient's medical history?

Addiction Medication Needs [LOC Assessment]

- Does the patient need to be assessed by a medical professional for **addiction medications, including MOUD**? If yes,

- Is the patient expected to need to initiate or titrate addiction medications, including MOUD?
    - If YES:
        - Are complications/challenges anticipated (eg, due to prior history of difficulty with MOUD initiation; anticipated issues with medication adherence)?
        - Do biomedical or psychiatric comorbidities— such as pregnancy or chronic pain—necessitate closer medical monitoring of initiation or titration of addiction medications?

Family Assessment – Addiction Medication Needs

- Can the family provide additional information about the patient's addiction medication needs, based on their observations and/or the patient's medical history? For example:
    - Has the patient had difficulty achieving recovery with clinically managed care alone (eg, without medical management, including addiction medications)?
    - If the patient has previously taken addiction medication, did they have difficulty initiating, titrating, or adhering to the medication? Did they have serious or bothersome side effects?

D1 Treatment Planning Assessment

Intoxication and Withdrawal [TP Assessment]

- The patient should be monitored over the course of treatment for any new intoxication or withdrawal risks, and results of any drug testing should be reviewed with them and with the family (with appropriate assent/consent). However, if the patient is intoxicated or there is concern for new withdrawal risk, the appropriateness of the current level of care should be reassessed.

Addiction Medication Needs [TP Assessment]

- The Treatment Planning Assessment should evaluate the patient's addiction medication needs.
    - This part of the assessment should be conducted by a physician or advanced practice provider with experience treating addiction. In a clinically managed level of care, this assessment should occur during the initial physical examination or psychiatric assessment or sooner.
- The clinician should determine the following:
    - If the patient has an SUD for which medications are available (ie, FDA-approved medications for OUD, AUD, and TUD; off-label medications for other SUDs, including StUD and CUD; and medications to manage post-acute withdrawal symptoms), <u>are they currently prescribed addiction medications</u>?
        - If NO:
            - Has the patient been evaluated by a medical provider for addiction medication needs?
            - Does the patient/family need education on available treatment options?
        - If YES:

- Does the patient consistently take the medications as prescribed?
- Are the patient's cravings and post-acute withdrawal symptoms well-controlled with current treatment?
- When was the patient's last medical visit for their addiction medication needs? Document the date of, reason for, and outcome of the visit.
- Does the patient need a new appointment to address their addiction medication needs?

Family Assessment – Addiction Medication Needs

- If addiction medications are recommended, does the patient or family have concerns about initiating medication? If so, does the patient or family need education or psychosocial interventions (eg, motivational interviewing) to address these concerns?
- If there are concerns about medication adherence or diversion, is the family able to support the patient in taking addiction medications as directed? If not, does the family need education or psychosocial interventions (eg, motivational interviewing) to assist them in monitoring the patient's medication adherence?

Other Systems of Care Considerations – Addiction Medication Needs

- Will the patient require administration of their addiction medication(s) while in their school setting?
- Will the school need to be made aware of the addiction medication(s) prescribed to the patient (eg, to respond appropriately to potential side effects)?
- Is the patient involved with any other systems that need to be made aware of the addiction medication(s) prescribed (eg, juvenile legal system, child welfare)?

Dimension 2: Biomedical Conditions

D2 Level of Care Assessment

Physical health concerns [LOC Assessment]

- Is the patient experiencing physical health problems (per self-report, collateral report, or practitioner determination)? If so, and as per protocol reviewed by a qualified medical professional:
  - Are they medically stable? [If NO, transfer to an emergency department]
  - What is the current severity of the patient's physical health problem(s)?
  - Is integrated medical management required?
    - If YES, what level of medical management and/or monitoring does the patient require for their physical health problem(s)?
      - Is afterhours medical management required?
      - What level of nurse monitoring does the patient need (ie, extended nurse monitoring during the day, afterhours nurse monitoring)?

- Is the patient expected to need IV fluids, IV medications, or services that are only available in an acute care hospital (eg, frequent lab testing, mechanical ventilation, etc.)
  - Does the patient have adequate monitoring and support at home to effectively manage their physical health problems, including accessing and adhering to treatment?

Family Assessment – Physical health concerns

- (if applicable) Does the family have any concerns about the patient's health? Are these concerns currently being addressed by a medical provider?
- (if applicable) Does the family have any additional information about the patient's medical history that might support level of care decision making?
- (if applicable) Is the family able to monitor the patient's symptoms and help the patient adhere to the treatment plan, including medications and follow up appointments?

Pregnancy-related concerns [LOC Assessment]

- Is the patient currently pregnant? If so, and as per protocol reviewed by a qualified medical professional:
  - What is the status of the pregnancy?
  - Is the patient receiving adequate pregnancy-related services?
  - What level of medical management and/or monitoring is required?

Family Assessment - Pregnancy-related concerns

- (if applicable) Does the family have any concerns about the patient's health related to their pregnancy? Can they provide any additional information from their observations or the patient's medical history that might support level of care decision making?
- (if applicable) Is the family able to monitor the patient's symptoms and help the patient adhere to the treatment plan, including medications and follow up appointments?

D2 Treatment Planning Assessment

- All patients admitted to a medically managed level of care should have a medical evaluation, including complete medical history and physical, in accordance with the standards for the level of care at which they have been placed.
- While a medical professional should complete a full medical history, clinical (ie, nonmedical) staff (eg, psychologists, clinical social workers, SUD and mental health counselors) can collect a partial history.
- Patients admitted to a clinically managed level of care should either have a physical examination or a psychiatric assessment, which includes an evaluation of the need for a physical examination and coordinated referral for a physical examination when needed.

Physical Health Concerns [TP Assessment]

- Are there ongoing physical health concerns— including any pain— that require medical treatment or referral?

- If YES: Is the patient currently receiving treatment from an external provider for their physical health concern(s)?
  - If YES, determine:
    - if each condition is controlled with current treatment;
    - does the condition or its treatment impact the patient's SUD treatment (eg, interfere with treatment participation or limit the medications that may be used);
    - when the last medical visit was for each issue, documenting visit date(s), reason(s), and outcome(s);
    - if additional or different treatment or medical evaluation is needed, and if so, does the patient need a referral? How urgently?; and
    - if care coordination is needed.
  - If NO, document plan for referring the patient to external medical treatment (if the patient's physical health concerns do NOT require active or integrated medical management).
    - If the patient's physical health concerns require medically managed care, and the patient is in a clinically managed level of care that is unable to coordinate sufficient medical services, reassess the patient's level of care recommendation.

Does the patient's continued use of substances, including nicotine/tobacco, exacerbate any current physical health concerns (eg, asthma, diabetes, dental disease)?

- Are the patient's physical health concerns impacted by substance use discontinuation?
  - Does the patient have significant sleep concerns associated with the cessation of substance(s)?
  - Have the patient's biomedical conditions become more difficult to treat since the cessation of substance(s)?
  - For serious health problems, does the patient have sufficient caregiver and/or home support if they are receiving addiction treatment in an outpatient level of care (ie, Levels 1 and 2)?
    - What services does the patient require (eg, daily nursing, rehabilitation) to manage their chronic physical health symptoms and maintain function?
    - Does the patient require accommodation for any chronic physical health problems (eg, mobility assistance for a physical disability)?
    - Does the patient need educational interventions to prevent biomedical issues from arising or worsening?

Family Assessment – Physical health concerns

- (if applicable) Does the family need additional resources or support to effectively care for the patient? If so, what additional resources or support do they need?
- (if applicable) Does the family need education to help monitor and ensure appropriate care for the patient's physical health concerns?

Pregnancy-Related Concerns [TP Assessment]

For patients with child-bearing potential, determine if the patient:

- is currently on medications or has received other medical interventions for contraception,
- desires medications or interventions for contraception, and/or
- is currently pregnant or planning to become pregnant.
    - If YES, determine:
        - What, if any, decisions have the patient and family made regarding the pregnancy (ie, raising the baby, adoption, termination)?
        - Does the patient need psychoeducational interventions related to pregnancy (eg, preparing for parenthood, potential involvement of child welfare services)?
        - Is coordination with child welfare agency needed?
        - If there are any current pregnancy-related concerns?
            - If YES: The patient should be referred to an obstetrics provider.
        - If the patient is receiving appropriate prenatal care)
        - The patient's pregnancy history, including history of any complications.
- If the patient is currently pregnant and taking addiction medication, does the patient need to be assessed for the need to titrate the medication?

Family Assessment – Pregnancy-related concerns

- If applicable and the patient has consented to sharing information about their pregnancy with their family:
    - Does the family have the resources and ability to provide appropriate support for the patient's pregnancy-related concerns? If not, what additional resources or support do they need to do so?
    - Does the family need additional education or support to effectively care for the patient's pregnancy concerns and/or prepare for the birth of the baby?

Other Systems of Care Considerations – Pregnancy-related concerns

- (if applicable) Do the patient's pregnancy-related concerns require coordination of care across their primary environments (eg, school)?

Sleep Concerns [TP Assessment]

- Are there sleep concerns (eg, insomnia, sleep deprivation, sleep inversion, sleep latency, daytime sleepiness) warranting a medical evaluation?
- Does the patient need psychosocial services to help address sleep concerns (eg, behavioral interventions, psychoeducation on sleep hygiene)?
- Are Dimension 3 concerns—such as PTSD— interfering with sleep? If so, do the patient's sleep concerns require specific treatments or referral to a qualified external provider?

Dimension 3: Psychiatric and Cognitive Conditions

- Adolescent patients should be screened for active psychiatric symptoms as well as intellectual and developmental concerns.
    - Patients who screen positive for intellectual or developmental concerns should be offered or referred for a neuropsychological evaluation as appropriate and findings should guide development of the treatment plan, ascertaining if the patient has the supports needed to effectively engage in addiction treatment.*

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* Referral for neuropsychological evaluation should not delay initiation of SUD treatment.

D3 Level of Care Assessment

Active psychiatric concerns [LOC Assessment]

- Does the patient have active co-occurring mental health symptoms?
    - If so, does the patient require medical management for these concerns?
        - If YES, determine:
            - If the patient is at risk of harm to self or others;
                - If so, what is the acuity of risk?
            - The level of medical management required;
            - The need for specialty psychiatric management within the addiction program or if transfer to an acute psychiatric setting is needed; and
            - The need for a higher staff-to-patient ratio in addition to medical management.
        - If NO, determine:
            - The level of support, supervision, and monitoring needed to manage the patient's active co-occurring psychiatric concerns, including need for higher staff-to-patient ratio; and
            - The need for integrated skilled mental health interventions.

Family Assessment – Active psychiatric concerns

- Is the patient's family able to provide the monitoring and support necessary to help the patient safely manage their current mental health needs?

Intellectual and Developmental Concerns [LOC Assessment]

- Does the patient have intellectual or developmental concerns? Does the patient require more individualized support (eg, a higher staff-to-patient ratio) to support effective participation in addiction treatment?
    - If YES:
        - What level of additional support does the patient need to participate in addiction treatment?

- Specific areas of questioning to determine need for more individualized support may include:
    - Is the patient able to participate in basic activities of daily living?
    - Are there concerns about aggression or behavioral dysregulation that may cause harm to self or others?
    - Are there concerns about neurodiversity-related symptoms that may interfere with the patient's ability to participate in addiction treatment without individualized support (e.g., sensory processing disorders)?
    - If the patient is in school, do they have an active IEP or 504 plan?
        - If YES, have they been receiving accommodations? How well have those been working? What other supports might the adolescent need in the treatment setting?
        - If NO, determine:
            - Was the patient previously assessed for their learning needs and is a report available?
            - Has an IEP assessment been recommended?
            - Are there signs they might need to be assessed for an IDD?

Family Assessment – Intellectual and developmental concerns

- Does the family have any concerns about the patient's development?
- What support does the family provide to help the patient manage any intellectual or developmental concerns?
- Are other family members affected by intellectual or developmental disorders?
- Is the family able to provide sufficient stability and support to enable effective participation in addiction treatment? If not, what additional services or support might the patient and/or family need?

D3 Treatment Planning Assessment

- If significant mental health concerns were identified during the Level of Care Assessment, the patient should be assessed by a clinician with the appropriate training, experience, and scope of practice to conduct an adolescent mental health assessment.
- If undiagnosed intellectual or developmental concerns are noted, referral for neuropsychological evaluation should be coordinated.

Active Psychiatric Concerns [TP Assessment]

- Does the patient have ongoing mental health conditions that require treatment?
    - If YES: Is the patient currently receiving treatment from an external provider for their mental health problems? If YES, determine:
        - If diagnostic clarification is needed;
        - If each condition is effectively managed with current treatment
            - What is the duration of treatment?
            - What is the patient's level of treatment adherence?

    - When the last medical visit was for each issue, documenting visit date(s), reason(s), and outcome(s);
    - If additional or different treatment or referrals are needed; and
    - If care coordination is needed.
  - If NO:
    - What mental health interventions are needed to address the patient's mental health conditions?
    - Does the patient need a referral for any mental health services that cannot be provided by the program?
    - If the patient is at risk of harm to self or others, what interventions are needed to support safety?
- Does the patient have new challenges involving emotional regulation?
- How do substance use, withdrawal, and SUD impact the patient's mental health condition?
  - Does the patient's continued use of substances, including nicotine/tobacco, exacerbate any current mental health concerns (eg, anxiety, suicidality)?
  - How is acute substance withdrawal expected to impact the patient's mental health symptoms? How are the patient's mental health symptoms impacted during post-acute withdrawal?
  - Have the patient's mental health concerns become more difficult to treat since the cessation of the substance(s)? For example, does the patient have new challenges with exerting emotional control since the cessation of the substance(s)?
  - (if applicable) Have addiction and/or psychiatric medications provided sufficient symptom relief from any withdrawal-related mental health concerns? If not, does the patient need prompt evaluation for addiction and psychiatric medication needs?
- Does the patient have any Dimension 2 concerns (eg, physical health concerns, pain, pregnancy) that could impact their mental health?
  - If YES:
    - Has the patient received treatment for these physical health concerns?
      - If YES: Have any of these interventions helped alleviate the physical health concerns? How do the patient's mental health symptoms change with treatment for their physical health problems?
      - If NO: Does the patient need referral to an external medical provider?
  - If the patient's mental health continues to be impacted beyond resolution of the physical health concerns, what kind of treatment does the patient need to address ongoing mental health symptoms?
- What other factors influence the patient's mental health condition (eg, family interaction, school, etc.)

Family Assessment – Active psychiatric concerns

- In what ways has the family observed the patient's substance use affecting their mental health, and vice versa?
- Does the family adequately understand their role in supporting the patient to manage their mental health concerns? Do they need education or other resources (eg, referrals for individual therapy or support groups) to better support the patient?

- Do other family members have current mental health concerns? If so, how might these mental health concerns affect their ability to support the patient during treatment and recovery?

Other Systems of Care Considerations – Active psychiatric concerns

- Is care coordination needed with other systems (eg, school, juvenile legal, child welfare, etc.) to help support monitoring of the patient's active psychiatric concerns?

Intellectual and Development Concerns [TP Assessment]

- Does the patient have any intellectual or developmental concerns that may require accommodations or more individualized staff support to enable effective participation in addiction treatment?
    - If YES: Is the patient currently receiving sufficient support within the addiction treatment program to enable effective participation?
    - If NO: What additional supports does the patient need?
- Does the patient have any intellectual or developmental concerns that may require screening, evaluation, and/or referral to external treatment services?
    - If intellectual functioning impairments are suspected (eg, due to developmental delay) and have not been assessed, the patient should be referred for neuropsychological evaluation.
        - For instance, if concerns such as autism spectrum disorder (ASD) or fetal alcohol syndrome (FAS) are suspected, refer for full evaluation.
- If intellectual or developmental functioning impairments are present, is the patient currently receiving treatment from an external provider for their impairments?
    - If YES, determine:
        - If each condition is effectively managed with current treatment;
        - When the last medical visit was for each issue, documenting visit date(s), reason(s), and outcome(s);
        - If additional or different treatment is needed; and
        - If care coordination is needed.
    - If NO, provide or refer the patient to appropriate services.

Family Assessment – Intellectual and developmental concerns

- What de-escalation techniques or types of support are helpful in situations when the patient is stressed/dysregulated? (eg, quiet space; access to music or art supplies)
- Does the family have a full understanding of their role in supporting the patient to manage their intellectual and developmental concerns? If not, do they need education to better support the patient?

Other Systems of Care Considerations – Intellectual and developmental concerns

- Is care coordination/navigation needed with other systems (eg, school, Individuals with Disabilities Education Act (IDEA) Services, etc.) to obtain necessary supports (eg, home- and community-based services) for the patient's intellectual and developmental concerns?

Trauma Exposure and Related Needs

- Has the patient been exposed to physical, sexual, and/or emotional abuse and/or neglect? Have they been exposed to sex trafficking and/or substance use coercion? Has the patient been exposed to other trauma (e.g., witnessing domestic violence)?
    - If YES, how has the patient been impacted by the trauma they have experienced?
        - The clinician should also assess need for child welfare intervention and trauma-related mental health services.
- Has the patient experienced recent grief (eg, loss of a loved one, relationship loss, family separation, loss of home)? How has it affected their mental health?

Family Assessment – Trauma exposure and related needs

- Does the family have additional information about the patient's experiences with trauma? About potential ongoing sources of trauma in the home, family, or in other areas of the patient's life?
- Does the family have a full understanding of the impact of patient's experience with trauma and their role in helping the patient manage their trauma symptoms? Do they need additional resources (eg, education, referral to individual therapy or support group) to better support the patient?

Psychiatric and Cognitive History

- Does the patient have any current or past psychiatric and/or cognitive diagnoses? If YES:
    - Determine symptomatology present before and after substance use;
    - Conduct an intensive review of prior psychiatric diagnoses;
        - 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 conditions.
        - Consider how other adverse childhood experiences (ACEs) may contribute to current problems and treatment/recovery support needs.
    - Determine history of medications—specifying medication name(s), dose(s), route(s), frequency, duration, purpose(s), dose adherence, and effectiveness—and psychotherapies (eg, cognitive behavioral therapy [CBT], dialectical behavioral therapy [DBT]) for psychiatric and cognitive conditions—specifying modalities, duration, adherence, and effectiveness; and
    - Document response to treatment interventions, including any medication allergies and adverse events.

Family Assessment – Psychiatric and cognitive history

- Can the family provide any additional information about the patient's psychiatric and cognitive history?
- Is there any other family psychiatric or cognitive history of which the clinician should be aware?

Dimension 4: Substance Use-Related Risks

D4 Level of Care Assessment

Likelihood of Engaging in Risky Substance Use [LOC Assessment]

- How likely is the patient to engage in substance use in their current environment without appropriate treatment?
- What is the level of risk associated with the patient's substance use? Both current and historical risk should be considered.
- If the patient were to continue or return to use:
    - Would they be at risk for serious harm such as:
        - overdose or toxicity (based on their use patterns and previous overdose history)?
        - serious medical consequences from substance use (eg, physical trauma; HIV; hepatitis C; abscesses; STIs; exacerbation of chronic conditions like asthma or diabetes; GI issues, mental health crises, etc.)?
        - victimization or exploitation—such as human trafficking, intimate partner violence (IPV), or other types of violence (based on history)?
    - Would they be at risk for **destabilizing loss, such as** expulsion from school, displacement from home, serious legal consequences, loss of important relationships [including peer and family relationships], loss of home or housing?
    - What other **negative** consequences might the patient experience (eg, poor school performance, truancy, relationship difficulties, disassociation with extra-curricular activities)? What secondary consequence are likely to occur as a result of these negative consequences (eg, expulsion from school, displacement from home, loss of scholarship)? Could these lead to destabilizing losses? If so, in what timeframe?
- What level of structure, supervision, and support does the patient need to prevent **harmful and destabilizing** consequences of substance use?
- What level of structure, supervision, and support does the patient need to learn the skills and gain the insights necessary for recovery?

Family Assessment – Likelihood of engaging in risky substance use

- Is there any indication that the patient's substance use history may be more concerning than reported by the patient (ie, higher quantity, frequency, duration)?
- How aware are the parents/guardians of the patient's substance use patterns?
- In what ways does the family contribute to risk or protective factors for the patient's risky substance use? For example:
    - Are the parents/guardians able to provide sufficient supervision and structure outside of school hours to help the patient avoid risky use? Are there other trusted adults who are able to provide needed supervision and support?
    - Is there substance use in the home?

- Does the family support or encourage substance use? Does the patient use substances with family members?
- Does the family support pro-recovery behaviors, such as helping the patient remember to take medications, helping the patient make appointments, providing transportation to appointments, etc.?
- What are the parents'/guardians' attitudes toward the patient's substance use, and how might these attitudes impact the patient's recovery?

Likelihood of Engaging in Risky SUD-Related Behaviors [LOC Assessment]

- How likely is the patient to engage in risky SUD-related behaviors in their current environment without appropriate treatment? The assessor should inquire about:
  - Risky behaviors to acquire drugs (eg, drug dealing/conveyance, trading sex for drugs [including risk of trafficking], theft/robbery; gang involvement);
  - Risky behaviors while intoxicated (eg, problem gambling [eg, sports betting]; driving while impaired or being passenger with impaired driver; unprotected sex/risk of victimization due to impairment; interpersonal violence – victim or perpetrator; problem social media or internet use; problem gaming)
- If the patient engages in risky SUD-related behaviors, what is the likelihood that they will experience:
  - **serious harm** (eg, medical or psychiatric complications)
  - **destabilizing loss** (eg, expulsion from school, displacement from home, loss of important relationships)?
- What other **negative** consequences might the patient experience (eg, poor school performance, truancy, relationship difficulties, disassociation with extra-curricular activities)? What secondary consequence are likely to occur as a result of these negative consequences (eg, expulsion from school, displacement from home, loss of scholarship)? Could these lead to destabilizing losses? If so, in what timeframe?
- What level of structure, supervision, and support does the patient need to prevent **harmful and destabilizing** consequences of risky SUD-related behaviors?
- What level of structure, supervision, and support does the patient need to learn the skills and gain the insights necessary to prevent risky SUD-related behaviors?

Family Assessment - Likelihood of engaging in risky SUD-related behaviors

- Is there any indication that the patient's SUD-related behaviors may be more concerning than reported by the patient?
- How aware are the parents/guardians of the patient's risky SUD-related behaviors (if applicable)?
- In what ways does the family contribute to risk or protective factors for the patient's risky SUD-related behaviors (if applicable)? For example:
  - Are the parents/guardians able to provide sufficient supervision and structure outside of school hours to help the patient avoid risky SUD-related behaviors (if applicable)? Are there other trusted adults who are able to provide needed supervision and support?
  - Are there risky SUD-related behaviors by others in the home?

D4 Treatment Planning Assessment

Likelihood of Engaging in Risky Substance Use [TP Assessment]

- The patient's **substance use history**—self-reported or otherwise documented—should include:
    - age of use onset for each problem substance;
    - pattern of use for each problem substance, including nicotine/tobacco products, detailing:
        - set and setting;
        - amount;
        - frequency [episodic, weekend, binge, daily]);
        - chronicity;
        - route(s) of administration; and
    - date(s) of last use for each problem substance;
    - longest period of time without substance use;
    - significant consequences of substance use (eg, physical and mental health, legal, family/other important relationships, educational, social isolation);
    - addiction treatment history, including treatment for TUD;
    - history of unintentional overdose*, patient and family concerns regarding unintentional overdose risk, and need for overdose reversal training and medication;
    - triggers for use, including:
        - identifying which triggers have most often resulted in substance use in the past month (eg, substance-using peer groups; mental health symptoms);
        - determining how the patient responds to these triggers, and
        - determining if the patient requires interventions to improve their insight into triggers and/or strengthen their ability to respond to triggers; and
    - supports for avoiding use, including:
        - identifying what helps the patient engage in alternatives to substance use (eg, family support, healthy peer group support)
        - identifying what additional supports they need from family, school, etc., and
        - determining if the patient requires interventions to strengthen their ability to develop and maintain supports for engaging in alternatives to substance use
- The substance use history should also:
    - document if the patient takes prescription or OTC medication(s); also consider performance-enhancing drugs for athletics and/or academics; caffeine intake; use of inhalants; use of dextromethorphan or other OTC cold medicine, diphenhydramine; etc.
    - ascertain the risks posed by the patient's continued substance use (eg, overdose, infectious disease transmission, skin infections, exacerbation of physical health conditions [eg, asthma, diabetes], expulsion from school, family disintegration, loss of significant relationships, fire safety due to use of combustible tobacco or cannabis).

- Standardized tools—such as the BAM for risk and protective scores and the VAS for craving—should be administered as needed to establish baseline addiction symptom severity, inform interventions, and support MBC.
- The Treatment Planning Assessment should evaluate the patient and family's access to overdose reversal medication (eg, naloxone) and need for overdose prevention and reversal training.

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* intentional overdoses should be considered in Dimension 3

Family Assessment: Likelihood of Engaging in Risky Substance Use

- Does the patient's family need additional resources or support (eg, education, referral for mental health or SUD treatment, referral to support groups) to help minimize risk factors associated with substance use/maximize protective factors and support the patient to prevent substance use and related risks?

Other Systems of Care Considerations: Likelihood of Engaging in Risky Substance Use

- Is care coordination needed with other systems (eg, school, juvenile legal, child welfare) to help decrease the patient's likelihood of engaging in substance use, and/or mitigate negative consequences associated with substance use?

Likelihood of Engaging in Risky SUD-Related Behaviors [TP Assessment]

- What is the longest period of time that the patient has gone without engaging in risky SUD-related behaviors (eg, risky sexual behaviors, DWI/DUI, violence, behaviors that increase vulnerability to victimization such as running away from home; spending time with substance using adults; engaging in illegal activities)?
    - When did the current period of risky SUD-related behaviors begin?
    - What are the patient's triggers for risky SUD-related behaviors?
        - Which triggers have most often resulted in risky SUD-related behaviors in the past month?
        - How does the patient respond to these triggers?
        - Does the patient require interventions to improve their insight into triggers and/or to strengthen their ability to respond to triggers/make less risky choices?

Family Assessment: Likelihood of Engaging in Risky SUD-Related Behaviors

- Will the patient's family need additional resources or support (eg, education, referral for mental health or SUD treatment, referral to support group) to help minimize risk factors associated with risky SUD-related behaviors/maximize protective factors to help the patient prevent these behaviors?

Other Systems of Care Considerations: Likelihood of Engaging in Risky SUD-Related Behaviors

- Is care coordination needed with other systems (eg, school, juvenile legal, child welfare) to help decrease the patient's likelihood of engaging in risky SUD-related behaviors, and/or mitigate the consequences associated with these behaviors?

Dimension 5: Recovery Environment Interactions

D5 Level of Care Assessment

Ability to function in current environment [LOC Assessment]

- How able is the patient to function effectively in their current home and school environments (ie, able to maintain hygiene/basic self-care; accomplish daily tasks like adhere to daily schedule, attend and engage in school; interact with family and peer groups in a healthy way)?
    - Does the patient need services to learn prosocial skills and/or developmentally appropriate living skills?
        - If YES: What level of services is needed?
            - Does the patient need external support to learn and/or practice basic interpersonal skills and developmentally appropriate living skills? If so, what level of support is needed (ie, residential therapeutic milieu, daily therapeutic milieu, low intensity therapeutic milieu, peer support)
            - Do the patient and/or family need clinical services to better support the patient's functioning in their current environment? If so, what intensity of clinical services is required to provide these skills?
- Specific areas to explore when assessing daily life functioning may include:
    - Capacity for self-care
    - Daily routine
    - School attendance, engagement, and progress
    - Involvement in family activities
    - Family attachment
    - Involvement in extracurricular/community activities
    - Peer attachment and support (and the health of these relationships)
    - History of employment
    - Juvenile legal involvement

Family Assessment – Ability to function effectively in current environment:

- What are the family's observations about the patient's daily functioning (eg, social; fulfilling obligations such as school, chores, work, etc.)? Have there been any recent changes?
    - If functioning has worsened, how different is it from the patient's prior baseline level of functioning?
- Is the family able to provide daily support for the patient's functioning, if needed?

Safety in current environment [LOC Assessment]

- What is the patient's current living situation?

- Is the patient's current environment safe?
    - Does the patient's current environment pose a threat to their safety or well-being, such as housing or food insecurity, neglect, and/or exposure to physical, sexual, emotional, economic, or any other type of harm or abuse, including substance use coercion and sex trafficking?
    - Is there adequate supervision in the patient's current environment? Are parents/caregivers present and able to safely supervise the patient?
        - If the home environment is safe, but other environments (eg, school, social) that the patient is regularly exposed to are not safe, is there enough parental/caregiver supervision to help protect the patient?
- Is the patient at risk of running away from home?
    - If yes, where are they likely to go? What threats are they likely to be exposed to?

Family Assessment: Safety in current environment

- Does the family currently have a place to live?
- Do they have any concerns about the safety of the patient's home environment? Is there any potential abuse or neglect in the home or other environments that the patient is exposed to?
- Does the adolescent have people in the family they feel safe sharing private information with? Would they be likely to share concerns about their safety (eg, suicidality, bullying, etc.)?

Support in current environment [LOC Assessment]

- How supportive are the patient's current environments (home, social, school)?
    - How much support do the patient's current environments provide to help them cope with cravings and other recovery threats, and strengthen refusal skills?
    - To what extent do the patient's current environments expose them to substance use and/or substance use triggers?
    - If there is substance use, to what extent can environment(s) be modified to support the patient's treatment goals?
    - Are the treatment goals of the parent(s) or guardian(s) sufficiently aligned with those of the patient such that they will provide a supportive home environment?
- What are possible effects (both positive and negative) of removal from current environments?
    - What are the risks and benefits of the patient remaining in their current home environment?
    - What are the risks and benefits of the patient remaining in their current school setting?
        - In their current school environment, do they have access to substances? A healthy peer group? Are there other supports available in the school (eg, trusted recovery supportive adults, extracurricular activities)? Are there other risks present in the school that may make continued participation in the school unhealthy (eg, unhealthy relationships with adults, exposure to triggers)?

Family Assessment: Support in current environment

- Can the patient's caregivers provide enough support in their home environment to enable the patient to prevent substance use and learn the skills necessary for recovery?
    - If NO:
        - Is additional family support available? If so, will it be sufficient to enable the patient to safely remain in the home during addiction treatment? OR
        - Are there alternative options to the current home environment available that can better serve the patient's needs (eg, living with another family member)?

D5 Treatment Planning Assessment

Ability to function in current environment [TP Assessment]

- What are the patient and family's goals for increasing social, emotional, and physical well-being and improving functioning in their current environments?
    - What types of support and/or services, including cultural and spiritual resources, does the patient need to achieve these goals?
- Does the patient require services and/or support to:
    - build a daily routine or structure (eg, home, school, work) that is supportive of recovery,
    - develop social and recreational activities supportive of recovery?
- Is the patient able to interact with others in an age-appropriate prosocial manner (eg, engaging in safe leisure activities; establishing healthy boundaries with peers; conflict resolution skills)?

Family Assessment – Ability to function in current environment

- Can the family provide insight into the patient's functional well-being beyond what the patient can provide (eg, due to functional impairments and/or discomfort discussing functional impairments)?
- Is the family able to help the patient access community resources to address functional impairments (eg, social services, medical care, peer support) as needed?

Other Systems of Care Considerations – Ability to function in current environment

- Is care coordination needed with other systems (eg, school, Individuals with Disabilities Education Act [IDEA] services) to help support the patient's level of functioning?

Safety in Current Environment [TP Assessment]

- What services or supports do the patient and family need to address any safety threats in their current environment (eg, housing services, domestic violence services, etc.)? How can the treatment program help the patient and family access services available in their community?
- If in a residential treatment setting, what services or supports (if any) are needed to address any safety concerns in the patient's home environment or to identify an alternative environment where they can stay when they transition to outpatient treatment?

- How will the patient's current environment—or the environment to which they will return following transition from residential treatment—affect their ability to engage in treatment and recovery?
    - What is the patient's perspective on how safe their environment is?
        - (If the patient does not feel that their current environment is safe) What, from the patient's perspective, is needed for the recovery environment to feel safe?

Family Assessment - Safety

- Does the family feel that the patient's current environments are safe?
    - (If NO) What do they think is needed to improve the safety of the patient's current environments? Do they need additional resources or support to help improve the safety of the patient's current environments, or to help the patient access safer environments?
- Does the patient's use of substances pose safety risks for other children in the environment)? What can be done to mitigate those risks?

Support in Current Environment [TP Assessment]

- Is the patient being exposed to substance use in their living environment? (eg, if parent drinks, are they drinking in front of the adolescent?)
- Does the patient have a network of individuals (eg, family, significant others, friends, community) who are supportive of recovery? If not, how can the patient and family build recovery support?
    - Are the patient's peers supportive of their recovery?
    - Which social activities are high-risk? What alternative activities might they put in place? How can they identify peers that will support them?
    - Is social media use or gaming a trigger? Is there appropriate social media or gaming monitoring available?
- Does the patient have a supportive daily structure? How can they plan for unstructured periods (boredom)?
- Is the patient being exposed to substances and/or triggers in school?
    - (if applicable) How would an alternative educational setting (e.g., virtual school; different school; recovery school) affect the patient's ability to recovery and achieve educational goals?
- Is spirituality (and/or religion) an important component of treatment for the patient? Is it a point of conflict between the adolescent and their family?
    - If spirituality is important to the patient, do they have access to spiritual support as part of their recovery?
    - Aside from spirituality, are there other protective personal values/practices (eg, community service, sports, yoga) or sources of support the adolescent can draw upon to support recovery?

Family Assessment - Support

- Is the family currently restricting access to substances? If not, are they willing and able to limit patient access to substances in the home?
- Is spirituality/religion important to the family? Does the family find that spirituality/religion works to support the adolescent or is there conflict in this area?

Cultural Perception of Substance Use and Addiction

- Does the patient identify any cultural factors that promote or inhibit their use of substances?
- Does the patient identify any cultural factors that promote or inhibit their participation in addiction or mental health treatment or require modification of the treatment plan?

Family Assessment - Cultural Perception of Substance Use and Addiction

- Are there any familial cultural factors or aspects of the patient's culture of origin that may impact treatment or recovery? How can any risks be mitigated? How can any protective factors be maximized?
- Does the family strongly identify with a specific recovery ideology (eg, 12-step)?

Academic Educational Considerations

- Will treatment interfere with the patient's education?
    - If YES: How can educational disruption be minimized?
- Will the patient be able to meet their educational requirements/goals at the current level of care?
    - If YES: How will the patient meet educational requirements/goals while receiving treatment?
    - If NO: Are additional supports available to help the patient?
- Does the program need to coordinate access to IEP or 504 plan supports?
- Does the patient have the appropriate support to meet their educational requirements when considering physical and mental health needs, as well intellectual and developmental disabilities?
    - If YES, what services will the program provide to help the patient to meet their educational goals?
    - If NO, a professional with the appropriate scope of practice should determine what accommodations are needed for the patient to meet their educational goals.
- If a patient is unable to be schooled in their typical environment during any point of treatment:
    - what coordination is needed with the school while the patient is out of school?
    - what coordination and supports (considering all dimensional needs) will be needed for a seamless transition back to their school setting?
- Is the patient's typical educational setting supportive of recovery or does it increase the patient's vulnerability? What can be done to mitigate these risks?

Dimension 6: Person-Centered Considerations

D6 Level of Care Assessment

Patient Needs and Preferences [LOC Assessment]

- Assuming the patient and family have sufficient resources and that services are available, is the patient willing to attend the recommended level of care?
- If NO:
    - What treatment and/or harm reduction services are acceptable to the patient?
    - If the patient's preferred treatment setting is deemed unsafe or unlikely to be effective, what can be done to increase the patient's willingness to attend treatment at the recommended level of care (eg, motivational interviewing)?

Family and Support System Needs and Preferences [LOC Assessment]

- Is the patient's family willing and able to support them in attending the recommended level of care?
    - If NO:
        - What treatment and/or harm reduction services are acceptable to the patient's family?
        - If the family's preferred treatment setting is deemed unsafe or unlikely to be effective, what can be done to increase the family's willingness to support the patient at the recommended level of care (eg, family counseling)?

Barriers to Care [LOC Assessment]

- Is the patient able to attend the recommended level of care?
    - Does the patient and/or their family need any services, support, and/or resources (eg, transportation, childcare, financial) to enable participation in the recommended level of care?
    - Are sufficient services, support, and/or resources available to the patient and/or their family to enable participation in the recommended level of care?
        - If NO: What addiction treatment services can the patient access?
- Does the patient have any limitations on where they can receive treatment (eg, due to school schedules, custody agreements, transportation access, program age limitations)?
- Does the level of care need to be adjusted due to the patient's educational needs?
- Is the patient compelled to follow clinical recommendations from an external source (eg, juvenile legal system mandates)?
    - If YES: What are the requirements?

D6 Treatment Planning Assessment

Patient Needs and Preferences [TP Assessment]

- Is the patient willing to participate in the services recommended by the treatment program? Why or why not?

    - Are there specific recommended services that the patient is not willing to participate in (eg, concurrent treatment for nicotine/tobacco use)?
        - If YES: Why is the patient not willing to participate in the specific recommended service?
- Would the patient prefer that treatment services be provided in a different way (eg, different modalities, clinicians, or setting)?
    - What does the patient believe needs to be addressed or improved with treatment (eg, substance use, mental health, physical health)?
    - What adjustments can be made to the recommended treatment services given clinical indications and local availability?
    - If the patient's preferences can be accommodated, are the resulting service changes likely to have any effect—positive or negative—on treatment and recovery outcomes?
- Has the patient experienced discrimination (eg, racism, ableism, homophobia, ageism) that may impact their experience in treatment?

Family and Support System Preferences [TP Assessment]

- Is the family willing to support the patient in participating in the recommended treatment services? Why or why not?
    - Are there specific recommended services in which the family is not willing to participate?
- Would the family prefer that treatment services be provided in a different way?
    - What does the family believe needs to be addressed or improved with treatment?
    - If the family's preferences can be accommodated, are the resulting service changes likely to have an impact on treatment and recovery outcomes?
- Has the family experienced discrimination (eg, racism, ableism, homophobia, ageism) that may impact their preferences for the treatment of the patient?
- Are there discrepancies between the patient's and their family's goals for the patient's treatment?
    - If YES,
        - How can the treatment plan balance the needs of the patient and their family while remaining patient-centered and empowering?
        - Would the patient and their family benefit from family therapy to improve consensus between their goals?

Barriers to Care [TP Assessment]

- Does the patient or family have ongoing needs related to SDOH that impact their ability to fully participate in treatment? Considerations may include:
    - transportation and/or mobility challenges;
    - food or housing security;
    - childcare responsibilities;
    - family income and financial insecurity;
    - educational or employment needs/concerns;
    - lack of or limited healthcare coverage;

  - lack of appropriate social and community supports, including potential community stigma related to addiction and/or mental health treatment; and
  - language and/or literacy barriers.
- Are the support services that the patient and family needs available in the community?
  - If YES: How long will the patient and family need to wait to receive these services?
- What care coordination or recovery support services (RSS) do the patient and family need to maximize their chances of success?
  - Are the patient's cultural needs being met at the current level of care?
  - Does the patient have access to needed or requested culturally specific providers, peer networks, and/or behavioral health services?
    - If NO:
      - Does this present a barrier to treatment for the patient?
- How can any identified barriers be addressed through treatment planning?
- What sources of strength does the patient feel that they already have to support their recovery?
  - How can these strengths be built upon?

Need for Motivational Enhancement [TP Assessment]

- How ready does the patient feel to address the identified issues? How ready is the patient's family to support them in addressing the identified issues? Are motivational enhancement services needed to support engagement in recommended care?
- Does the patient/family have concerns or fears that make it difficult for them to attend or remain in treatment?
- What external pressures are motivating the patient to enter and complete treatment? Do these include legal mandates (ie, from juvenile drug treatment court)?
  - What external factors are negatively impacting the patient's motivation for treatment?
- What factors—based on clinician judgment—need to be addressed to improve the patient and/or family's motivation for change?
  - What services and/or interventions are needed to improve the patient's/family's motivation for change?

Adolescent Treatment Planning Standards

- Treatment planning should focus on addressing:
  - the Dimensional Drivers that have led the patient to require treatment at a given level of care.
  - any anticipated barriers to the patient's transition to a less intensive level of care
  - patient and family priorities
- All patients, whether mandated to treatment or pursuing treatment voluntarily, should participate in shared decision-making to develop a treatment plan following the Treatment Planning Assessment. The patient's family should also be included as appropriate. Treatment planning should be an interdisciplinary process led by the patient's primary clinician (with appropriate supervision).

- If the patient has concerns in Dimensions 1 or 2 that require medical care, the relevant part of the treatment plan should be led by medical staff in medically managed levels of care or in coordination with appropriate external medical professionals.
- If the patient has concerns in Dimension 3 that require psychiatric services, the relevant part of the treatment plan should be developed by or in coordination with an appropriately qualified mental health professional.
- In programs that do not have medical staff, the treatment plan may include care coordination, including supporting the patient to follow through with medical appointments and other elements of their medical treatment plan (eg, taking medications as directed, performing physical therapy exercises, adopting nutritional changes, monitoring glucose).
- The patient's primary clinician in the addiction treatment program should build a therapeutic alliance with the patient by establishing shared meaning with understanding and empathy. The patient should participate fully and actively in a shared decision-making process to develop an individualized treatment plan.

Problem Statements and Goals

- The treatment plan should:
    - reflect the patient and family's goals;
    - be tailored to the patient's developmental age and cognitive abilities (ie, in language they can understand);
    - incorporate the patient and family's inherent strengths and supports;
    - be informed by the patient's cultural identities, practices, and preferences; and
    - consider potential vulnerabilities resulting from the patient's trauma history.
- An individualized treatment plan includes the following components:
- Problem statements should identify concerns to be addressed in the current level of care. At minimum, the problem statements should address the Dimensional Drivers of admission to the patient's current level of care.
    - Example problem statement: Continued cannabis use despite negative impacts on [patient's] school performance.
- Goals should be clear and focused on what the patient and family wants to achieve in this phase of treatment. Goal statements should be written in the patient's own words.
    - Example goal: I want to cut down on my drinking so that I can do better at school.
- Objectives should identify short-term aims that will help the patient and family move toward their goals. Objective statements should be Specific, Measurable, Attainable, Realistic, and Timebound (SMART) and written in the patient's own words.
    - Example objective: In the next month, will learn to identify at least three triggers for heavy alcohol use and three healthy coping skills to manage triggers, urges, or cravings.
- Action steps should identify:
    - the steps that the patient will take to meet an objective;
    - the steps that the family will take to support the patient in meeting their objectives;
    - the services that the addiction treatment program will provide to help the patient meet an objective, including any:
        - medical services,

        - psychotherapeutic services,
        - psychoeducational services,
        - recovery support services,
        - referrals, and
        - coordination with external providers
- Individualized treatment plans should also include:
    - Transition plans that address:
        - continuity of care for SUDs and comorbid biomedical and psychiatric conditions, and
        - Dimension 5 and 6 concerns (eg, need for recovery- supportive housing, transportation) that may impact the transition to a less intensive level of care.
    - Contingency plans that address:
        - how the program will respond should an instability arise in resources, family dynamic, or home or community environment (eg, transition to a more intensive level of care, recommend an alternative recovery supportive home, etc.).
    - Safety plans
    - For patients in outpatient treatment programs (ie, Levels 1 and 2), the treatment plan should include or reference a safety plan that addresses how the patient and family should seek help in the event of urgent or emergent issues that arise after-hours.
        - The safety planning should consider safety in all environments to which the patient is regularly exposed (eg, home, school, etc.).

Transition Planning

- Transition plans should address:
    - addiction treatment service needs;
    - physical health service needs;
    - mental health service needs—when possible, patients with co-occurring mental health disorders should be transitioned to a setting that can provide integrated care for their continuing SUD and mental health needs;
    - Family support needs to facilitate a smooth transition;
    - Recovery support services (RSS) needs, including those related to SDOH;
    - continued access to medications, including addiction medications; and
    - overdose prevention and harm reduction, including access to overdose reversal medication.
    - educational needs, for adolescents who have been receiving alternative instruction while in addiction treatment, to ensure a smooth transition back into the school system.

Safety Planning

- In outpatient settings, the treatment planning process should include the creation of a safety plan. Safety plans should clearly identify the steps that the patient and/or family should take in the event of an emergency outside of treatment hours and include resources that are accessible in the patient's geographic location.
- Safety plans may also be included in residential or inpatient settings when needed, such as when a patient is at risk for self-harm or violent behavior.

Treatment Plan Reviews

- Treatment planning should be a continuous process, with updates incorporated as needed when new information is learned or the patient's circumstances evolve. Treatment Plan Reviews should be conducted at regular intervals (as specified in the level of care standards) to capture the patient's progress toward their goals and make appropriate adjustments to their treatment plan.
- Treatment Plan Reviews should ideally involve representation from all members of the patient's interdisciplinary treatment team, including their primary clinician, medical providers, nurses, social workers, peer support specialists and recovery coaches, and housing managers and staff as applicable.
- All treatment team members should understand and agree upon adjustments to the plan.
- The patient's primary clinician is responsible for reviewing, documenting, and keeping records of all updated treatment plans.

The ASAM Continuum of Care – Adolescent

Adolescents with SUD 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.

The adult volume of the ASAM Criteria included a few key changes to simplify the continuum and align with the types and intensities of care that are available in communities across the country:

- Expanding Levels of Care within Level 1 to differentiate between medically managed outpatient care and outpatient therapy and to add a new level (Level 1.0) for long term remission monitoring.
- Updating the Level 3.7 standards to reflect care in residential settings
- Better integration of biomedical care and withdrawal management into the continuum
- Better integration of co-occurring capability along the continuum
- Encouraging better continuity of care during transitions between levels of care.

The proposed continuum for the Adolescent and Transition Aged Volume builds on these changes to propose a continuum appropriate for Adolescents and Transition Aged Youth (see Figure 3). These changes include:

- Fully integrating mental health and SUD treatment
- Addressing challenges with adolescent access to medically managed care
- Facilitating access to addiction and psychiatric medication
- Incorporating intensive home and community-based services
- Incorporating medical monitoring in intensive levels of care
  Support access to specialty early intervention and prevention services for youth who are using substances and at high risk for SUD

Integrating 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.

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 co-occurring enhanced (COE) care (with the level determined by the patient's multidimensional needs). All Level 3.5Y programs will be expected to be able to provide COE care. This is recommended because Level 3.5Y programs serve some of the most seriously ill patients, who often have severe and/or complex co-occurring conditions who will commonly require more flexible, individualized care.

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 aligned the proposed youth 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 B for an overview of how the proposed levels of care align with the CALOCUS-CASII levels of care. See Appendix C for an overview of how *The ASAM Criteria* dimensions and subdimensions align with the CALOCUS-CASII dimensions.

Addressing challenges with adolescent access to medically managed care

Historically significant withdrawal and biomedical comorbidities have been rare among adolescent patients, and most areas of the country have had insufficient demand for adolescent specific programs that deliver withdrawal management and biomedical care. However, 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. Currently, many adolescents receiving these services do so in hospitals or facilities that also serve adult patients.

The Adolescent and Transition Age Youth Volume will include standards for youth medically managed levels of care. Because these programs are currently rare across the country, significant work will be needed to support access to these levels of care. We anticipate youth medically managed programs to be organized within existing settings, such as:

- Adolescent-focused units within programs that also provides adult medically managed levels of care
- Medically managed units within adolescent SUD treatment programs. For example:
    - A Level 2.5Y program that has a unit with the capacity to provide daily medical management and extended nurse monitoring during the day (eg, Level 2.7Y services)
    - A Level 3.5Y program that has a unit with the capacity to provide daily medical management and 24/7 nursing care (eg, Level 3.7Y services)
- Medically managed SUD treatment unit within adolescent mental health treatment programs. For example, a residential mental health treatment program that has a unit with the capacity to provide daily medical management and 24/7 nursing care for withdrawal, addiction medication initiation, and biomedical comorbidities (eg, Level 3.7Y services).

The standards will address how adult programs could adapt services to serve adolescent and young adult patients. 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 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.

Access to addiction and psychiatric medication

Adolescent and young adult patients may benefit from addiction and psychiatric medications. This Fourth Edition recommends 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 be evaluated by a qualified physician or advanced practice provider for need for addiction and psychiatric medications within a reasonable timeframe (specific timeframes will be defined for each level of care). These exams should be conducted by providers with training and experience in the provision of addiction and psychiatric medications for adolescent patients. Level 2.5Y and 3.5Y programs will be expected to initiate and titrate addiction and psychiatric medications when needed. Patients with more complex needs related to medication initiation may be recommended a medically managed level of care.

Incorporating intensive home and community-based services

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

Medical monitoring in intensive levels of care

Given the high rates of co-occurring conditions among adolescent patients with SUD and the inherent complexity of treating adolescent patients with co-occurring conditions, all high intensity levels of care (Levels 2.5Y and above) have a medical director who can provide ongoing medical monitoring and management of psychiatric and addiction medication needs. Level 2.1Y has (at minimum) a formal affiliation with a physician or advanced practice provider who can provide medical services when needed.

Accommodation for missed school

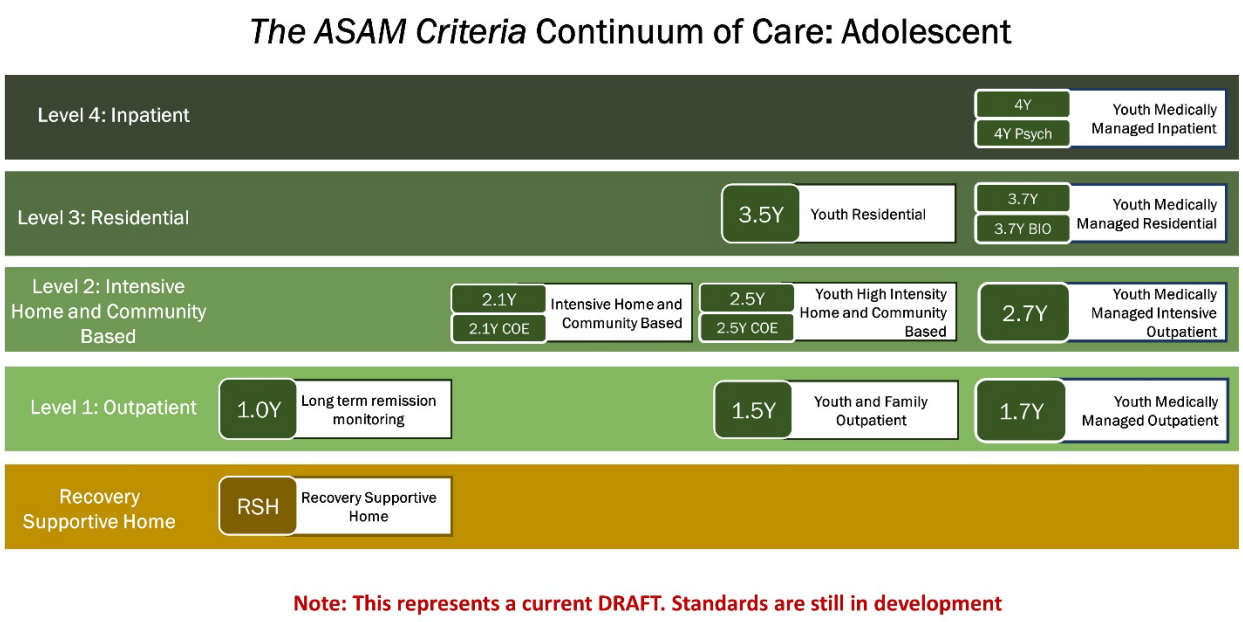
Residential treatment can be disruptive to adolescent educational development. Treatment programs should consider how to mitigate these disruptive effects. While educational services may not be appropriate during episodes of acute care, as the patient transitions to less restrictive levels of care the clinicians (in coordination with the family as appropriate) should coordinate with the patient's school to determine what interventions are needed to help the patient make up missed work. If patients are expected to be away from school for a significant amount of time (eg, more than 2 weeks) educational programming should be arranged by the treatment program; this may

include coordination of remote learning with appropriate support services. Minimizing educational disruption is one reason *The ASAM Criteria* is focused on supporting patients to transition to the least restrictive level of care as quickly as possible while maintaining safety and effectiveness.

Incorporating early intervention and prevention

It may be appropriate to provide specialty care for adolescent patients who are using substances and have a high risk of escalation to a SUD. Early intervention and prevention services, including treatment as prevention, will be incorporated into adolescent Levels 1.5Y and 2.1Y. In other words, for adolescents and transition age youth who are using substances and have a high risk for SUD, but do not currently meet the DSM criteria for a SUD, *The ASAM Criteria* Dimensional Admission Criteria may recommend Level 1.5Y or 2.1Y specialty care 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 appropriately trained clinicians (eg, a master's level clinician) and early intervention services are critical for this patient population.

Figure 3. *The ASAM Criteria* Continuum of Care: Adolescent



1 Level of Care Service Characteristic Standards

2 Overview of Service Characteristic Standards

3 Tables 1a and 1b represent an overview of the core standards in the levels of care in the Youth
4 Continuum.

5 Table 1a. Summary of Service Characteristics for the Adolescent Clinically Focused 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	Variable	Not typical	Variable	Yes	Yes
Physicians and Advanced Practice Providers	Established relationship	Encouraged to have formal affiliation	Formal affiliation	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 24/7*	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	Established relationship to support coordinated access to nursing services‡ when needed	Available as needed. Formal affiliation to support coordinated access to nursing services‡ when needed	Yes. Nursing services should be available 24/7

	1.0Y	1.5Y	2.1Y	2.5Y	3.5Y
Program Director	Variable*	Yes	Yes	Yes	Yes
Clinical Staff	Available during program hours	Available during program hours	Available during program hours and on call 24/7	Available during program hours and on call 24/7	Onsite 24/7
Mental Health Trained Clinical Staff	Able to refer for MH services	Yes	Yes	Yes	Yes
Allied Health Staff	Variable	Variable	Yes*	Yes	Yes
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 7 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 one month of treatment initiation if no recent physical exam	Within reasonable timeframe determined by psychiatric assessment	Within reasonable timeframe determined by psychiatric assessment	Within reasonable timeframe determined by psychiatric assessment
Nursing Assessment	Not typical	Not typical	As needed*	As needed*	Within 24 hours
Treatment Plan	Recovery management plan developed in the first session	Within the first 3 sessions	Within 7 days of admission	Within 72 hours of admission	Within 72 hours of admission
Formal Reassessment	Quarterly Recovery management checkups	At least quarterly	At least monthly	At least monthly	At least monthly
Clinical Services	Recovery/remission management services	Direct psychosocial services (for SUD and MH)	Direct psychosocial services (for SUD and MH);	Direct psychosocial services (for SUD and MH);	Direct psychosocial services (for SUD and MH); high-intensity

	1.0Y	1.5Y	2.1Y	2.5Y	3.5Y
		Family services‡ Able to coordinate psychiatric services as needed Treatment as prevention	therapeutic milieu Family services‡ Direct psychiatric services Treatment as prevention	therapeutic milieu Family services‡ Direct psychiatric services	therapeutic milieu Family services‡ Direct psychiatric services
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)	Yes, including recovery management checkups	Yes*	Yes*	Yes*	Yes*

*directly or through formal affiliation;
**Yes, if clinically managed
*** Psychiatric specialty expertise includes psychiatrists and advanced practice providers with specialty psychiatric certification. Addiction specialty expertise includes physicians who are board certified in addiction medicine or addiction psychiatry
‡ nursing services should be provided by a professional with the scope of practice to collect vitals and inject medications
ł family services include parent skills training, family therapy, and informal family-oriented recovery support (eg, family resource centers, peer and mutual support for family, faith-based support services, etc.)

Table 1b. Summary of Service Characteristics for the Adolescent Medically Managed Levels of Care

	Level 1.7Y	Level 2.7Y	Level 3.7Y	Level 4Y
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 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	<9 h/wk	≥20 h/wk	≥20 h/wk	Variable
Recovery Support Services (RSS)	Yes*	Yes*	Yes*	Yes*
* Directly or through formal affiliation				

Universal Standards

Overdose Reversal Medication

All programs across all levels of care should have overdose reversal medication (eg, naloxone) available

on-site.

Trauma and Culture

All programs across all levels of care should adopt trauma-sensitive practices (TSP) in all aspects of program operations; that is, performing assessment and treatment planning and providing services in a way that is designed to prevent re-traumatization and delivered with gender sensitivity and cultural humility.

Universal Setting Standards

The setting should be comfortable and responsive to the needs of adolescent patients

Universal Staff Standards

All staff should be trained in the administration of overdose reversal medication (eg, naloxone).

All programs should have sufficient staff with the training, experience, and scope of practice to assess, diagnose, and treat SUD and co-occurring mental health conditions available during program hours of operation.

All clinical and allied health staff should have competency to care for individuals who have SUD and active co-occurring mental health conditions.

Staffing Levels

Programs should have sufficient staff on-site or on-call during their hours of operation (ie, 24/7 in residential and inpatient programs) to maintain integrity of care for the range and severity of problems that may be addressed at the level(s) of care that they provide. Programs should identify the positions that are critical for running the program and the level of staffing needed to safely operate the program.

In clinically managed levels of care this should include:

- supervisory staff with at least 2 years of adolescent treatment experience available to respond to urgent situations;
- sufficient clinical staff to meet patient psychosocial treatment needs for SUD and co-occurring mental health conditions; and
- staff trained in de-escalation.

In medically managed levels of care this should include:

- sufficient nursing staff to provide coverage during program hours of operation (ie, 24/7 in residential and inpatient programs) with a sufficient staff-to-patient ratio to safely manage the program's patient population†; and
- physicians and/or advanced practice providers available on-site, on-call, or via telemedicine to provide medical management

Independently licensed clinical staff with competency to supervise co-occurring mental health treatment should be on- site or on- call during program hours of operation (ie, 24/7 in residential and inpatient programs).

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† Does not apply to Level 1.7Y programs that may not have nursing staff.

Medical Staff

In all levels of care except Level 1, psychiatrists and/or advanced practice providers with specialty certification in psychiatry (eg, psychiatric nurse practitioners [NPs]) should be available in person or via telemedicine to:

- provide psychiatric assessments as needed within a time frame appropriate to the severity and urgency of the mental health signs and/or symptoms;
- assess medication needs within 24 hours when needed;
- initiate psychiatric medications;
- provide regular (eg, weekly) titration of medication;
- coordinate access to psychiatric medications and laboratory testing, and manage medications and side effects; and
- review admission decisions as needed (eg, if a patient presents with Dimension 3 concerns that may require medical evaluation).

In all levels of care except Level 1, a psychiatrist and/or advanced practice provider with specialty certification in psychiatry (eg, psychiatric NPs) should regularly review and approve the program's policies, procedures, and protocols for making admission decisions related to Dimension 3 concerns.

Level 1 programs should have established relationships with physicians and/or advanced practice providers who have experience in addiction treatment and co-occurring mental health conditions to coordinate access to psychiatric medications and laboratory testing, and manage medications and side effects.

In clinically managed levels of care, the medical director or a formally affiliated physician and/or advanced practice providers with specialty certification in psychiatry (eg, psychiatric NP) should regularly review and approve the program's policies, procedures, and protocols for making admission decisions regarding assessment of Dimension 3 concerns and related admission policies, including when medical clearance is needed prior to admission.

Clinical Staff

Competency in both adolescent mental health and SUD treatment should be represented on the program's clinical staff.

Clinical staff with competency to manage mental health-related crises should be on-site or on-call during program hours of operation (ie, 24/7 in residential and inpatient programs).

In all levels of care, the program director (or an independent clinician in a Level 1.5Y or 1.7 level of care) should have competency in addiction, mental health, and family systems interventions.

In all levels of care, clinical staff with the appropriate training and scopes of practice should:

- deliver planned regimens of professionally directed psychosocial services, including counseling, psychoeducation, and psychotherapy;
- assess and treat SUD, other addictive disorders, and co-occurring mental health conditions;
- support coordinated treatment planning;
- support care coordination*; and
- coordinate the delivery of recovery support services (RSS).

Mental health trained and SUD trained treatment providers should be equal partners on the interdisciplinary team, supporting one another to deliver effective, integrated co-occurring capable care.

Programs should have clinical staff on the interdisciplinary team with:

- mental health training and experience who provide integrated skilled mental health interventions during program hours of operation.
- the scopes of practice to assess and treat common co-occurring mental health conditions who are available on-site or via telemedicine

Clinical staff involved in the assessment and treatment of patients should be:

- knowledgeable about the biopsychosocial dimensions of addiction, mental health, and other behavioral health disorders;
- trained to conduct and interpret multidimensional developmentally appropriate assessments according to The ASAM Criteria Dimensional Admission Criteria, particularly if they are involved with making level of care recommendations;
- trained to administer and interpret standardized screening tools and multidimensional assessments to determine individual patient needs;
- trained to engage families into the care process;
- trained to communicate in a developmentally responsive manner, including adjusting assessments, educational content, and program curriculum to be developmentally appropriate; and
- trained in de-escalation, trauma-informed approaches, and other behavior management strategies to care for patients who are experiencing mental health signs or symptoms including agitation, aggression, and risk of self-harm.

Clinical staff should also have specialized training in behavior management techniques and psychosocial evidence-based interventions (EBIs) aligned with their scopes of practice.

All programs should have clinical staff with the training and competency to:

- Triage of mental health concerns

- Provide family services for co-occurring mental health concerns
- Providing mental health care in a trauma informed, culturally humble, and developmentally appropriate context

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* The staff member responsible for care coordination for a given patient should be clearly documented.

Program Director

The program director (in applicable levels of care) is responsible for:

- leading development of program policies and procedures,
- providing administrative oversight,
- providing clinical supervision and oversight, and
- overseeing implementation of the therapeutic milieu.

Care Manager

All programs except Level 1 should have appropriately qualified staff tasked with providing care management services (eg, services to help patient's access and coordinate healthcare, social service, and educational needs). Level 1 programs are encouraged to provide these services.

Allied Health Staff

In all levels of care, allied health staff—such as certified peer support specialists, patient and family navigators, health educators, counselor aides, certified recovery coaches, and group living workers—may serve a variety of roles, including helping patients and families:

- get oriented to the program's therapeutic milieu (if applicable),
- engage in the program,
- attend mutual support group and/or mutual aid meetings,
- access benefits and social support services (eg, health insurance, transportation assistance, nutrition benefits),
- access academic coordinators and engage with the education system,
- support referrals and transitions in care, and
- coordinate with social service agencies.

Allied health staff may also support the delivery of RSS, including:

- peer support services for patients and families;
- health education and harm reduction services, such as prevention of infectious diseases (eg, HIV, hepatitis C virus [HCV]), safe sex practices, and overdose prevention and reversal training;
- coordinating access to parenting skills training;
- patient navigation services; and
- level of care transition support.

Allied heath staff, when available, should be part of the interdisciplinary team and the services they provide should be coordinated with clinical staff.

Universal Assessment and Treatment Planning Standards

Assessment and treatment planning should be conducted in a developmentally responsive manner.

Mental health trained clinical staff should be involved in assessment and treatment planning for patients' Dimension 3 needs and should coordinate with the psychiatric care provider as needed.

Assessment

A Level of Care Assessment should be conducted or reviewed prior to admission to determine the recommended level of care.

All programs should support access to routine psychiatric assessment and consultation, when needed.

All programs should be able to coordinate access to an assessment for intellectual and developmental disabilities (IDD).

A treatment planning assessment should be conducted within a reasonable timeframe to guide development of the treatment plan.

Physical Examinations

All levels of care should either directly provide or coordinate referral for a medical history and physical examination as needed. The medical history and physical examination should include an assessment for:

- addiction medication needs[1]
- need for psychiatric assessment or medications
- need for management of symptoms of post-acute withdrawal
- common sequelae of SUDs (eg, skin infections)
- common co-morbid conditions (eg, eating disorders)
- infectious disease screening and treatment or referral needs
- vaccination needs
- screening for traumatic brain injury and treatment or referral needs
- developmental concerns

Reassessment

Families should be updated routinely on treatment plan progress.

[1] Including all FDA-approved medications for OUD (including methadone, unless unavailable locally), AUD, and TUD; off-label medications for other SUDs, including StUD and CUD; and medications to manage post-acute withdrawal symptoms.

Universal Support System Standards

To support patient engagement in ongoing addiction treatment, all adolescent programs should have established relationships with adult programs to support care coordination and effective adolescent–adult care transitions.

Biomedical Support Systems

All clinically managed programs should have formal affiliations* with physicians and/or advanced practice providers who have experience in addiction treatment and controlled substance prescribing authority† to coordinate access to:

- physical examinations;
- medical assessments, including assessment of SUD or mental health related medical needs as well as general health needs (eg, wellness exams, strep throat);
- addiction medications‡;
- psychiatric medications;
- contraceptive medication;
- prescribed medications, including those that are obtained from a specialty pharmacy;
- medication management services;
- laboratory testing; and
- drug testing and toxicology services.§

In clinically managed levels of care, the medical director (or a formally affiliated* physician and/or advanced practice provider in a program without a medical director) should regularly review and approve the program's policies, procedures, and protocols for making admission decisions regarding assessment of Dimension 1, 2, and 3 concerns and related admission policies, including when medical clearance is needed prior to admission.

All programs should be able to provide coordinated referrals, as needed, to:

- primary care providers (eg, pediatricians), and
- dental care providers.

All programs should advocate with external medical providers and services as needed to ensure that significant patient health concerns are addressed in a timely manner.

When medical services are required concurrent with treatment in a clinically managed program, care should be coordinated. In programs without medical staff, care coordination may include supporting patients and their families to follow through with medical appointments and other elements of their medical treatment plan (eg, taking medications as directed, performing physical therapy exercises, adopting nutritional changes, monitoring glucose).

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* In Level 1 programs, these may be established relationships.
† Including authorization to prescribe buprenorphine.

‡ Including all FDA-approved medications for opioid use disorder (OUD; including methadone, unless unavailable locally), alcohol use disorder (AUD), and tobacco use disorder (TUD); off-label medications for other SUDs, including stimulant use disorder (StUD) and cannabis use disorder (CUD); and medications to manage post-acute withdrawal symptoms.
§ Please see ASAM's Appropriate Use of Drug Testing in Clinical Addiction Medicine consensus statement for guidance.

Psychiatric and Cognitive Support Systems

In all programs, except Level 1, psychiatrists and/or advanced practice providers with specialty certification in psychiatry (eg, psychiatric nurse practitioners [NPs]) should be available in person or via telemedicine to provide psychiatric assessments as needed within a time frame appropriate to the severity and urgency of the mental health signs and/or symptoms.

All programs should have established relationships with mental health treatment programs and service providers to support transitions in care and access to crisis services, including:

- intensive case management services,
- psychosocial rehabilitation programs,
- mental health group residential settings, and
- mental health treatment centers.

All programs should have an established relationship with the behavioral health crisis system, if locally available, to respond to urgent mental health needs.

All programs should have established relationships with clinicians with the competency and scopes of practice to provide:

- Learning disorder assessment and management
- Eating disorder assessment and treatment
- Neurodevelopmental disorder (eg, autism) assessment and treatment

All programs should be able to coordinate access to an assessment for eating disorders and intellectual and developmental concerns as needed, and:

- Coordinate care as needed
- Implement accommodations necessary for patient participation in treatment
- Integrate occupational therapy (OT) as needed

Relationships With Other Levels of Care

To support patient engagement in ongoing addiction treatment, all programs should have established relationships with other levels of addiction treatment—both more and less intensive—to support care coordination and effective transitions in care.

Emergencies

Programs should have established policies and procedures for responding to urgent and emergent medical and psychiatric needs during program hours of operation, including when to engage the on-call physician or advanced practice provider (where applicable) and when to call 911 or 988.

Community and Social Service Support Systems

Programs should have established relationships with community social service providers and other community support systems including:

- School systems to support coordination of school based clinical services, management of patient educational needs, and transitions back to school.
- Therapeutic schools and recovery high schools and colleges when available.

All programs should have established relationships with local systems of care that serve adolescents, including:

- Juvenile legal/correctional agencies
- Child welfare
- Foster care
- School systems
- Housing and homeless services
- Vocational training programs

Universal Services Standards

All services should be provided in a developmentally responsive manner.

In all levels of care except Level 1, case management services should be provided.

- The staff person with responsibility for providing case management services for a given patient should be clearly documented.

Translation and/or interpreter services should be available to make services – including medical, psychotherapeutic, and psychoeducational content – available in the patient or family's preferred language.

Psychosocial Services

Psychosocial services should be designed with the expectation that most patients will have co-occurring mental health conditions. Individual and group interventions should address concerns related to both SUD and mental health. Psychosocial services should be sensitive and responsive to trauma, designed to prevent re-traumatization, and delivered with gender sensitivity and cultural humility.

Psychotherapy, counseling, and psychoeducation should be provided by appropriately trained and supervised professionals acting within their state-regulated scopes of practice for the given service or, when appropriate, via evidence-based digital therapeutics.

Psychosocial services should:

- be evidence-based or evidence-informed,
- be provided in a developmentally responsive manner and with accommodation for learning disabilities, as needed.

Addiction treatment programs should provide individual and group therapy directly or through formally affiliated providers and programs, with individual and group therapy actively addressing and monitoring:

- SUD
- the sequalae of SUD,
- co-occurring mental health concerns,
- the interaction between SUD and mental health symptoms,
- management of mental health symptoms and trauma without using substances, and
- relapse prevention.

Appropriately trained and supervised professionals should deliver motivational interviewing and other evidence-based motivational enhancement interventions that are appropriate to patient and family's stage of readiness to change and designed to:

- facilitate understanding of the relationship between the patient's substance use, mental health conditions, and attendant life challenges;
- encourage family members to understand their role in creating a healthier environment to support recovery; and
- increase the patient and family's readiness for change.

Programs should also provide occupational and recreational therapies (eg, sports, art, music) adapted to the patient's developmental stage, level of comprehension and understanding, and physical abilities.

Programs should provide interventions directly or through formally affiliated providers and programs that are designed to:

- stabilize and maintain the stability of the patient's SUD and co-occurring mental health symptoms;
- enhance patients and families' understanding of substance use, and addiction;
- enhance patients and families' understanding of co-occurring mental health concerns and how they interact with addiction, including:
    - the patient's triggers for substance use;
    - mental health related drivers of substance use;
    - how to discuss mental health disorders, symptoms, and treatments appropriately in the context of recovery programs and mutual support groups; and
    - how to appropriately ask for help for mental health concerns from family, peers, and/or professionals when needed;
    - the importance of adherence to medications prescribed for psychiatric disorders, including:
        - how to work honestly and effectively with prescribers, and
        - why it is important to take medications as prescribed;
- help the patient gain insight into their risk factors for substance use;

- help the family gain insight into the patient's risk factors for substance use and SUD (including how substance use affects the developing brain and the neurobiology of SUD);
- educate patients and families on:
    - what to expect over the course of treatment,
    - the importance of remaining engaged in the continuum of care as they progress through treatment,
    - signs of SUD recurrence, and
    - the patient's risk for transition to use of other substances;
- educate patients and families on the role of addiction and psychiatric medications, the potential consequences of non-adherence, and the role of the family in supporting adherence;
- enhance patients and families' understanding of co-occurring mental health concerns and how they interact with substance use and addiction, including:
    - how to discuss mental health disorders, symptoms, and treatments appropriately in the context of recovery programs and mutual support groups; and
    - how to appropriately ask for help for mental health concerns from family, peers, and/or professionals when needed;
- support adherence to medications prescribed for addiction and psychiatric disorders, including:
    - how to work honestly and effectively with prescribers, and
    - why it is important to take medications as prescribed;
- improve the patient and family's ability to structure and organize tasks of daily living and recovery;
- support successful initial involvement or reinvolvement in regular, productive daily activity (eg, school, extracurricular activities, work) and reintegration into family living, as indicated;
- support patients to develop and apply skills to support long-term remission through:
    - substance use or relapse prevention;
    - exploration of interpersonal choices;
    - development of social networks supportive of recovery;
    - educational and skill building groups;
    - vocational and jobs training for adolescents;
    - occupational and recreational therapies;
    - art, music, and/or movement therapies;
    - mindfulness interventions; and
    - physical therapy;
- encourage patients and families' motivation to address their SUD and co-occurring conditions; and
- support integrated treatment for TUD, including:
    - benefits of treating TUD at the same time as other SUDs,
    - EBIs for TUD (eg, medications, counseling),
    - relative risks of nicotine/tobacco products, and
    - motivational and harm reduction strategies for patients who are ambivalent about stopping use of nicotine/tobacco.

The following psychosocial services should be available directly or through established relationships with providers and programs as needed:

- recovery support group facilitation,
- contingency management (CM),
- community reinforcement and family training (CRAFT),
- family therapy,
- cognitive behavioral therapy (CBT),
- eye movement desensitization and reprocessing (EMDR),
- solution-focused therapy (SFT),
- multisystemic therapy (MST)
- dialectical behavioral therapy (DBT), and
- other EBIs.

All programs should have educational materials routinely available (from reputable sources) that address addiction and common comorbid physical and mental health conditions, including trauma.

All programs should be able to provide health education for patients and families regarding:

- the causes of addiction and mental health disorders;
- the impact of substance use on the developing brain;
- factors that influence the progression of addiction and mental health disorders;
- understanding the risks associated with substance use prior to brain maturation;
- interactions between substance use and mental health symptoms (eg, psychosis, mania, etc.);
- the importance of taking care of physical and mental health;
- medications for addiction and psychiatric disorders;
- understanding the health risks associated with substance use (eg, infectious disease transmission, cannabis hyperemesis syndrome, victimization, etc.);
- understanding how substance use can increase risks for victimization;
- harm reduction strategies, including overdose recognition and response training (eg, naloxone training);
- health-related risk factors associated with SUD (eg, HIV, HCV, STIs, skin and soft tissue infections, unintended pregnancies); and
- the importance of taking care of physical and mental health.

All programs that provide medications should provide psychoeducation to help patients understand medication changes and report medication effects and side effects.

In addition to other evidence-based psychoeducation for patients, programs should support psychoeducational services for patients' families and significant others (with appropriate patient consent), including:

- what to expect during treatment,

- how to support loved ones during treatment, including:
  - effective communication
  - providing effective monitoring
  - setting appropriate boundaries (eg, access to money, devices, etc.)
- why self-care is important for caregivers,
- the role of medications in the management of addiction and psychiatric conditions,
- safe storage of medication, including both the patient's and any controlled medications in the home.
- the importance of ongoing engagement in the continuum of care,
- harm reduction education and training (how to use naloxone, drug checking [eg, fentanyl test strips], etc.),
- how to recognize overdose, and
- how to respond to overdose.

Family Services

The following family psychosocial services should be available directly or through established relationships with providers and programs as needed:

- Family assessment[2]
- Parental guidance counseling, including skills training related to:
  - parenting skills
  - building healthy family routines
  - self-care while caring for an adolescent with SUD or mental health concerns
  - effectively advocating for your adolescent's health care needs
- Family mutual support groups[3]
- Social services navigation
- Individual or group psychoeducation

Therapeutic Milieu

Much of addiction care is provided in a group format that invariably produces group dynamics. Thus, creating and managing a healthy therapeutic milieu is a central aspect of addiction and co-occurring mental health treatment in The ASAM Criteria Levels 2.1Y, 2.5Y, and 3.5Y. A therapeutic milieu is conscious, planned, psychotherapeutically based, and subtly modified for each patient based upon their needs. In a youth treatment program, the milieu should be adjusted to the developmental age of the patient and careful thought should be given to the range of developmental ages that are included in a given group.

The therapeutic milieu—which should be clinically managed—is more nuanced and powerful than the rules-based milieu found in recovery residences. Gentle social pressure within the treatment environment, group therapy, and meetings of the entire community are used to affect change. Efficacy is proportional to the number of hours in the day that patients are together and the level of

[2] https://www.jaacap.org/article/S0890-8567(09)62183-3/pdf
[3] May be in person or virtual

social intimacy; thus, a Level 3.5Y milieu is inherently more potent than a Level 2.1Y milieu when properly constructed and managed. An effective therapeutic milieu:

- contains the patient during periods of ambivalence about SUD or mental health remission or recovery in a caring environment, moving them along the change continuum;
- allows the patient to see themselves in others and, in doing so, moves them along the change continuum;
- encourages medication adherence;
- engenders bonding in a way that helps the patient realize they are not alone;
- holds the patient in a safe environment where they learn and practice pro-remission/recovery and behaviors modeled after patients who are further along;
- helps heal patient's negative emotions regarding SUD- and mental health related behaviors through open sharing of each other's past breaches of moral and ethical values—compassion for others in the milieu increases self-compassion;
- encourages the patient to recognize the negative aspects of addiction in others, which opens a window to reject such aspects in their own addictions;
- provides a gentle mirror that reflects thoughts, behaviors, and emotional states that either promote remission or recurrence;
- acknowledges and supports the patient as they grieve aspects of their planned future that are impacted by their SUD, mental health conditions, and/or recovery (eg, expected experiences in college or on their 21st birthday);
- furnishes a safe therapeutic environment that encourages the exploration of thoughts, behaviors, and emotional states;
- defines behaviors that promote disease remission through community rules;
- identifies unconscious and semiconscious substance- and mental health-related thinking and provides a staff-supervised path to remove or repair them; and
- practices self-driven supportive behaviors, accompanied by therapeutic iterative improvement.

Care Management

All levels of care except Level 1, should provide care management services (eg, services to help patient's access and coordinate healthcare, social service, and educational needs).

Level 1 programs are encouraged to provide care management services.

Recovery Support Services

In all levels except Level 1, peer support specialist services should be available for both adolescents and their families.

All programs should provide the following RSS, either directly or through formal affiliations* with external service providers (eg, recovery community organizations [RCOs], recovery high schools [RHSs], collegiate recovery programs [CRPs]), tailored to the needs of each individual and considering their developmental age and stage as determined based on The ASAM Criteria assessment and treatment planning standards† and appropriate to the stage of treatment:

- assessment of patient and family recovery capital and RSS needs;
- development of individualized recovery plans for patients and families;
- certified peer support specialist services, including:
    - strengths-based support and coaching,
    - recovery plan development,
    - recovery resource navigation (ie, supporting connection with other recovery resources), and
    - ally advocacy (ie, advocating for the patient and family as needed with social service organizations and professional services to address SDOH-related needs);
- support developing and practicing skills of daily living, including:
    - transportation skills,
    - health and healthcare navigation (eg, navigating changes to insurance), and
    - self-care (ie, healthy living and other activities to promote personal well-being);
- support internalizing and practicing relapse prevention skills, including:
    - learning how to navigate their environments (eg, home, school) that contain substances (or other triggers) without returning to substance use,
    - learning how to interact socially with people outside of the recovery community in a safe and healthy way, and
    - identifying and engaging in prosocial activities outside of the recovery community,
- support utilizing harm reduction strategies and services;
- support accessing services to further develop and practice core life skills (eg, educational, parenting, financial management, nutrition);
- patient navigation services** for patients who require concurrent treatment with external providers; and
- transition planning, including warm handoffs.

All programs should also provide care coordination and support accessing external RSS in the community, including support with:

- identifying and/or accessing mutual help programs (eg, assistance finding appropriate programs, identifying transportation options);
- accessing services for domestic violence, intimate partner violence (IPV)[‡], or victim services;
- accessing social services (eg, housing, nutritional assistance, health insurance), with ally advocacy recommended when feasible;
- identifying and/or accessing other community activities supportive of recovery (eg, recovery high schools and collegiate recovery programs [CRPs], recovery community centers [RCCs])[§];
- accessing transportation to necessary services (eg, community rides to mutual help meetings, help identifying public transit options and obtaining passes);
- coordinating with social service agencies (eg, children, youth, and family services; juvenile justice agencies; IPV agencies; foster care; housing and homeless services);

- identifying and obtaining community services and supports to address potential impediments to recovery (eg, legal services, educational services, housing, childcare services, vocational training, parenting education, financial training); and
- identifying and accessing harm reduction services.

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* Formal affiliation is encouraged but not a requirement for Level 1.5Y programs.
** Patient navigation is individualized support to help patients and families overcome barriers to accessing healthcare services, including help communicating with health care providers.
† Please see Chapter 8: Assessment, Reassessment, and Measurement-Based Care and Chapter 9: Treatment Planning.
‡ Programs should have established relationships with IPV service providers.
§ This is not applicable in Level 3.7Y or 4Y programs where patients do not leave the facility for nonmedical reasons.

Co-Occurring Capability

All programs should offer services that are designed to provide a welcoming environment for individuals with co-occurring mental health conditions, where patients feel safe addressing their mental health concerns and experiences.

All services should be designed with the expectation that many, if not most patients will have co-occurring mental health conditions; for example, individual and group interventions should encourage patients and families to address both SUD- and mental health-related concerns. Programs should provide assessment and treatment services for co-occurring mental health conditions. Patient mental health and SUD related concerns should be treated concurrently. Care should be coordinated with any external mental health treatment providers.

Patient mental health concerns should be treated concurrently by the addiction treatment program and/or through coordination with external providers.

All programs should provide integrated skilled mental health treatment interventions to address co- occurring mental health conditions in person or via telemedicine.

Admission criteria for addiction treatment programs should not exclude patients based on current or past mental health diagnoses alone; the appropriateness of admission should be determined by the severity and acuity of the patient's psychiatric signs and symptoms as outlined in The ASAM Criteria Dimensional Admission Criteria decision rules.*

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*Please see Chapter 10: Dimensional Admission Criteria and Algorithm.

Biomedical Capabilities

All clinically managed programs should have access to the following biomedical capabilities on-site:

- basic first aid,
- overdose reversal medication (eg, naloxone), and

- point-of-care pregnancy testing.*

Clinically managed programs are also encouraged to have an automated external defibrillator (AED) on-site.

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* This is encouraged but not a requirement for Level 1.0Y and 1.5Y programs.

Care Coordination

All programs should support care coordination to manage engagement and track progress when a patient is receiving concurrent services from an external treatment or service provider or program, including:

- data sharing as needed to support effective coordination of care, and
- monitoring of the patient's adherence in taking prescribed medications and permitted over the counter (OTC) medications or supplements.

The staff member responsible for care coordination for a given patient should be clearly documented. In clinically managed levels of care, data sharing should occur monthly, at minimum, to support formal reassessment.

Programs should coordinate patient referrals and transitions to other levels of care, including warm handoffs, as needed.

All programs should coordinate care with:

- any external mental health providers involved in the patient's care (with appropriate patient consent) at admission to and transition from the clinically managed program; at minimum, monthly (when applicable); and as needed to support effective care coordination for the individual patient;
- prescribers of addiction and psychiatric medications, including to support rapid referrals for addiction or psychiatric medications as needed;
- medical providers concurrently treating issues that may impact the patient's prognosis or recovery;
- Social service providers, including schools; and
- The patient's pediatrician or other primary care provider.

Universal Documentation Standards

Level of Care and Treatment Planning Assessments

Program documentation of the assessment process, which encompasses The ASAM Criteria Level of Care and Treatment Planning Assessments,* should include:

- the level of care at which the patient is currently receiving treatment, as well as any levels of care from which the patient has received treatment over the past 12 months;
- a summary of the results from the patient's Level of Care and Treatment Planning Assessments, including:

    - an overview and analysis of problems within each of the six dimensions of The ASAM Criteria, including:
        - ■ prioritization of the problems identified, including Dimensional Drivers,
        - ■ the relationship between the problems identified and substance-related and addictive disorders, and
        - ■ the patient's current level of functioning (eg, skills of daily living);
    - the level of care recommendation(s); and
    - the final disposition and reason(s) for any discrepancies (if applicable; eg, barriers to care, patient and/or family preferences);
- the date of the patient's most recent physical examination;
- dated standardized mental health screening and assessment results with comparison to past results (if applicable);
- alcohol, nicotine/tobacco, and other drug use status, including:
    - duration,
    - frequency,
    - intensity (eg, pack years,† binge use),
    - route(s) of administration, and
    - type(s) of products used (eg, prescription medication, high-potency substances, oral tobacco); and
- problematic behaviors and behavioral addictions;
- review of the patient's admission decision;
- the patient's care team and their contact information, including:
    - formal supports, such as healthcare providers and criminal justice officials; and
    - informal supports identified by the patient, such as family, chosen family, and community-based supports.

In all medically managed programs, documentation of the assessment process should additionally include:

- results from the nursing assessment, physical examination, and medical assessment;
- laboratory and toxicology order sets and results, including documentation on how the treatment plan was modified based on results (if applicable); and
- scoring for withdrawal rating scale tables and flow sheets, which may include tabulation of vital signs.

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* Please see Chapter X: Assessment, Reassessment, and Measurement-Based Care.
† That is, the number of packs of cigarettes smoked per day multiplied by the number of years the person has smoked.

Treatment Planning

Programs should document the following details regarding each patient's individualized treatment plan for both SUD and mental health concerns (or remission management plan for Level 1.0Y programs):

- patient diagnoses, including severity of SUD(s);
- problem statements and treatment goals;
- current state of readiness to change for each major concern;
- measurable treatment objectives;
- barriers to care;
- action steps to address identified problems and meet stated objectives;
- case management services (if applicable);
- medications and medication management plan (if applicable); and
- safety plans for after-hours medical advice and emergencies (if applicable).
- services and/or support to address concerns to be provided by external providers, as well as documentation of care coordination as necessary;
- patient and family strengths that support effective management of SUD and mental health symptoms without using substances; and
- the continuing care plan following transition from the program.

Treatment plans for patients with comorbid biomedical conditions should have specific documentation of:

- patient biomedical concerns (eg, sleep, pain, asthma, diabetes, eating disorder, tobacco use/vaping);
- screening and assessment results (if applicable);
- relevant patient and family goals;
- services and/or support, including symptom management strategies (eg, for pain), to address biomedical concerns to be provided by the program;
- services and/or support to address biomedical concerns to be provided by external providers, as well as documentation of care coordination as necessary; and
- the continuing care plan for comorbid biomedical conditions following transition from the addiction program.

Treatment plans for patients with co- occurring psychiatric conditions should have specific documentation of:

- patient mental health symptoms and diagnoses;
- risk of harm to self or others;
- services and/or support to address mental health concerns to be provided by the program;
- services and/or support to address mental health concerns to be provided by external providers, as well as documentation of care coordination as necessary;
- individual strengths that support effective management of mental health symptoms without using substances; and
- the continuing care plan for co- occurring psychiatric conditions following transition from the addiction program.

Treatment plans for patients with co-occurring IDD should have specific documentation of:

- patient intellectual or developmental concerns and diagnoses;

- services and/or support to address IDD concerns to be provided by the program;
- services and/or support to address IDD concerns to be provided by external providers, as well as documentation of care coordination as necessary; and
- the continuing care plan for IDD following transition from the addiction program.

Treatment plans for patients with social service involvement should have specific documentation of:

- patient social service needs identified from their biopsychosocial assessment;
- local agencies that can address social service needs, as well as documentation of care coordination as necessary; and
- the continuing care plan for social service needs following transition from the addiction treatment program.

Reassessment

Programs should document individualized progress notes in the patient's health record that clearly reflect implementation of the treatment plan. These progress notes should capture:

- the patient's response to therapeutic interventions for all disorders treated;
- laboratory and toxicology order sets and results, including documentation on how the treatment plan was modified based on results (if applicable);
- patient and family adherence to the treatment plan;
- significant events that may alter the course of treatment or recovery;
- changes in frequency and/or types of services;
- changes in level of care;
- subsequent amendments to the treatment plan;
- the dated signature of the patient's primary clinician; and
- the dated signature of a supervisor if the clinician is a trainee.

Care Coordination and Consent

Programs should provide a copy of the treatment plan to the patient and family upon initiation of the plan and subsequently whenever the plan gets updated. Programs should document the patient's assent/consent—or decline of assent/consent— to involve family members or other support persons. Documentation should also include patient and family assent/consent—or decline of assent/consent—for care coordination and information sharing with external providers and programs.

Program documentation should allow each clinician involved in a patient's care to access relevant medical and psychosocial information for that patient. Documentation of referral to external service providers should include:

- recommendations for care;
- reason(s) for departures from clinical recommendations (if applicable);

- incorporation of externally provided or recommended treatment and/or services in the patient's treatment plan;
- care coordination; and
- follow-up plans with external providers to ensure ongoing engagement in care, with documentation of each follow-up.

In addition, programs should maintain documentation of any memorandums of understanding (MOUs), business associate agreements (BAAs), and qualified service organization agreements with their formally affiliated providers and programs, where applicable.

Transition Planning

Program documentation of transition plans (including adolescent–adult care transition plans) should include:

- a review of the patient's six dimensions of The ASAM Criteria;
- recommendations for follow-up care;
- reason(s) for any departures from recommendations (if applicable);
- the service(s) and level(s) of care to which the patient will be transitioning;
- required medications and how the patient will maintain access to medications during the transition;
- access to overdose reversal medication and patient and family training in its use; and
- the patient/family follow-up plan to facilitate ongoing engagement in care, with documentation of each follow-up that includes dated signatures as appropriate.

Transition plans for patients transitioning from adolescent to adult care should also identify trusted, recovery supportive adults who can support the patient in the community, including their contact information with documentation of appropriate release(s) of information;

Patients or families sometimes choose to discontinue treatment against the clinical recommendations of their providers. In the event of unplanned discharge, programs should document:

- the patient's status at discharge;
- reason(s) for discharge;
- care recommendations provided to the patient and family;
- access to medications after discharge (eg, transfer of prescriptions, bridging prescription), including:
    - access to overdose reversal medication and training in its use,
    - safe discontinuation of psychoactive medication if the patient/family decline continuation of any current medications;
- notifications made, with dated signatures as appropriate to:
    - The referring provider
    - The receiving provider, and
    - The patient's primary care provider; and

- who (eg, the referring provider, the care coordinator with the adult program where the patient was supposed to transition) will follow up with the patient and/or family to re-engage them in care;
- follow up attempts, when applicable.

Staffing

Programs should maintain documentation on safe staffing levels that consider:

- in medically managed levels of care, the number of physicians and advanced practice providers that the medical director can safely manage;
- in programs with a program director, the number of clinical staff and allied health staff that the program director can safely manage; and
- maximum staff-to-patient ratios for each staff type and role.
    - When determining the actual number of patients that an individual staff member can safely manage, responsibilities beyond direct patient care (eg, administration, education) should be considered.

Medical Services

Programs that provide integrated* nursing services should carefully document how the appropriate level of nursing care for the severity of patient needs was determined. This encompasses care provided by registered nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), paramedics, and medical technicians under the supervision of an RN.

If applicable, documentation should include appropriately maintained records of the program's inventory of essential medicines based on current standards of clinical practice. Programs are responsible for ensuring that these medications are stocked and stored securely and readily accessible as needed, with accompanying careful documentation of dispensing of these medications.

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*Here, integrated refers to medical services provided within the context of addiction treatment.

Program Policies and Procedures

In all levels of care, it is important to consider how program policies and procedures align with the principles of The ASAM Criteria and support delivery of high-quality, evidence-based care (EBC) for SUD and co-occurring mental health conditions. Programs should also consider how their policies and procedures help reduce substance-related harms: How can policies and procedures better meet patients and families where they are, promote ongoing engagement in the continuum of care, recognize different pathway to recovery and remission, restore healthy development, and, ultimately, save lives?

All programs should have policies and procedures that address:

- admission, transition, and continued service criteria, in alignment with The ASAM Criteria Dimensional Admission Criteria*;
- coordination of referrals to alternative levels of care, including preparation of contingencies in the event that a patient requires a more intensive level of care that is not available;
- coordination of care with external providers and programs;
- coordination with social services (eg, school, juvenile justice, child protective services), including:
    - clear identification of the responsible staff member;
    - required competencies and training;
- adolescent–adult care transitions that includes coordination with the adolescent's support network (eg, family or chosen family, community supports);
- harm reduction, including:
    - access to overdose reversal medication on-site;
    - access to overdose reversal medication when patients are off-site;
    - overdose reversal training for staff, patients, families, and support persons; and
    - patient and family or support person access to over-dose reversal medication; and
- confidentiality related to treatment for SUD, mental health conditions, and other relevant conditions commonly experienced by the patient population (eg, sexually transmitted infections, reproductive health), including:
    - informed patient assent or consent,
    - parent or guardian consent,
    - access to health records,
    - storage of health records,
    - patient rights,
    - family/guardian rights, and
    - mandated reporting and communication with juvenile justice entities.
- safety of patients and staff, including:
    - background checks for all staff and contractors
    - regular monitoring of the sex registry database
    - mechanism to report staff concerns regarding patient care without fear of retaliation

Programs should also have policies and procedures regarding the behavior of patients and family/support system, when on-site, formalized in writing with a code of conduct. Patients and families should be presented with the code of conduct at admission and, following their review, asked to sign and date it to indicate that they understand and accept the program's expectations for safe participation in treatment. The patient code of conduct should clearly outline how the program will respond to conduct that presents risk for harm to self or others.

Policies and procedures regarding program staffing should address:

- staff competency expectations;
- supervision and monitoring of staff competencies;
- training of medical and clinical staff, as appropriate to the level of services rendered at the program's level of care;

- supervision of peer support specialists and other allied health staff;
- mental health training and competencies; and
- determination of appropriate staff-to-patient ratios.

Programs that employ peer support specialist should have policies and procedures regarding:

- the minimum duration of recovery required before an individual is eligible to be a peer;
- monitoring the individual's risk for relapse; and
- provision of support for peer staff to process their experiences providing peer support.

Considerations for program policies regarding safe staffing levels include strategies for addressing staff shortages and procedures in the event that the program is unable to fill critical positions. This may include designating interim appointments, hiring temporary staff, and/or transitioning patients to other programs if the program cannot provide safe and effective care. Program policies and procedures should ensure that staff know how to:

- have clear criteria and training regarding when to consult and how to contact a supervisor, including clear identification of the chain of command when urgent and emergent situations arise;
- respond to urgent questions that arise after-hours;
- file and handle formal grievance procedures;
- respond to requests from patients or families to change treating clinicians; and
- manage violent and threatening behaviors, including when to consider and use restraint and provision of related training.

Medically managed (ie, Levels 1.7Y, 2.7Y, 3.7Y, and 4Y) and residential (ie, Level 3.5Y) programs should have policies and procedures on medication reconciliation that address:

- responsibility for conducting a complete medication reconciliation;
- oversight of controlled substance prescriptions;
- verification against the prescription drug management program (PDMP) for each patient upon admission and at appropriate intervals;
- use of cannabis and cannabinoids for medical purposes;
- requirements for patients to authorize release of information to coordinate care with external prescribers; and
- coordination of care with external prescribers upon admission, as needed throughout treatment, and upon transition from the program.

Outpatient programs (ie, Levels 1.0Y, 1.5Y, 1.7Y, 2.1Y, 2.5Y, and 2.7Y) should have policies and procedures on:

- managing access to controlled prescriptions while patients are on-site;
- educating patients and families on safe storage of medications;
- collaborating with the family on strategies for securing medications and monitoring medication adherence.

All addiction treatment programs should maintain policies and procedures concerning the treatment of TUD, including:

- screening patients for nicotine/tobacco use;
- providing barrier-free access to EBIs for TUD, including medications and behavioral therapy;
- supporting integrated treatment for TUD;
- restricting staff, patient, family and visitor use of nicotine/tobacco products and nonmedical nicotine products (eg, combustible cigarettes, smokeless tobacco, e-cigarettes) while on-site, including program and facility smoke-free policies; and
- providing organizational support for staff to access treatment for TUD.

Programs across all levels of care should have policies and procedures that clearly outline program response to public health alerts and emergency preparedness, including:

- planning for emergency evacuation, including considerations for:
  - relocating patients in residential and inpatient programs,
  - transitioning patients during both pre- and post-disaster evacuation. and
  - communicating with family members during an emergency;
- ensuring continued access to critical medications;
- identifying staff leads and emergency points of contact;
- communicating and coordinating in an emergency; and
- utilizing backup communication strategies (eg, cell, radio, internet) if telephone and/or electrical power become inoperable.

In addition, programs should have established procedures for training staff and educating patients and families on the program's response in the event of a public health alert or emergency. Program policies should also include standards on reporting patient safety events, as well as how the program will access local, state, and/or federal services and support before, during, and after a disaster.

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* Please see Chapter X: Dimensional Admission Criteria and Algorithm.

Residential Programs

Residential programs should have policies and procedures that address:

- activities to be performed during the night shift (eg, hourly monitoring and documentation of patient whereabouts, coordinating response to urgent patient issues);
- the safety of patients and staff, including searches of patients and their belongings that are conducted in a trauma-sensitive manner and preserve privacy and dignity;
- the handling of items brought into the program (eg, addictive substances, nicotine/tobacco products, prescription medications, OTC products, weapons, paraphernalia related to addiction, pornography); and
- medication reconciliation, including when to assume management of all controlled substance prescriptions.

Residential programs that house multiple levels of care should consider delineating which beds may be filled by patients at Level 3.7Y to ensure that staffing is sufficient to meet the needs of patients placed at this level of care. If beds are used flexibly, the program must be able to expand staffing to meet the needs of all patients admitted to Level 3.7Y. Competency-based training should be provided for all staff directly involved in patient care as appropriate to their disciplines and scopes of practice.

Residential programs should have policies and procedures that address screening, control, and mitigation of infectious disease (eg, HIV, HCV, tuberculosis [TB], COVID-19), including identification of an infection control officer and the responsibilities of this role.

Dimension 1 and 2 Considerations

Policies and procedures related to Dimensions 1 and 2 concerns should be reviewed and approved by the medical director or, for programs without a medical director, physicians or advanced practice providers with demonstrated competency in specialty addiction treatment. Program policies and procedures include:

- admission, transition, and continued service criteria related to intoxication, withdrawal, and biomedical concerns and in alignment with The ASAM Criteria Dimensional Admission Criteria;
- determination of when medical evaluations are needed for intoxication, withdrawal, and other biomedical concerns;
- response to medical emergencies, including those that occur on-site;
- drug testing and toxicology services,† including:
    - when to use point-of-care tests,
    - when to use confirmatory tests,
    - when to conduct alcohol testing,
    - which staff have the scopes of practice to order and interpret test results,
    - timely communication of drug test results to patients and families (with appropriate patient assent/consent), and
    - how to address unanticipated drug test results;
- access to all addiction medications‡;
- management of patients with chronic biomedical comorbidities (eg, diabetes, asthma, seizures); and
- management of patients with co-morbid pain, including:
    - recognizing when to refer patients to a pain specialist or a pain psychologist,
    - understanding how to modify the current treatment regimen to accommodate pain as a significant trigger for recurrence, and
    - related staff training.

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† Please see ASAM's Appropriate Use of Drug Testing in Clinical Addiction Medicine consensus statement for guidance.

‡ Including all FDA-approved medications for OUD (including methadone, unless unavailable locally), AUD, and TUD; off-label medications for other SUDs, including StUD and CUD; and medications to manage post-acute withdrawal symptoms.

Dimension 3 Considerations

Policies and procedures related to Dimension 3 concerns should be reviewed and approved by a psychiatrist, psychiatric specialist advanced practice provider, or qualified master's level mental health professional as appropriate for their scope of practice. In all levels of care except Level 1, policies and procedures related to management of risk of harm to self or others should be approved by a psychiatrist. Program policies and procedures include:

- screening for mental health, developmental, and trauma concerns;
- admission, transition, and continued service criteria related to psychiatric and cognitive concerns and in alignment with The ASAM Criteria Dimensional Admission Criteria;
- determination of when mental health assessments are needed for psychiatric, intellectual or developmental concerns, including ascertaining the level of assessment needed (eg, by a master's level clinical staff versus a psychiatrist or psychiatric NP);
- accommodations for patients affected by changes in mental health or cognitive status that interfere with their treatment participation, including:
    - educating patients and families on how to ask for accommodation when needed, and
    - providing accommodations appropriate to the given level of care in a way that is transparent and fair for all patients
    - facilitating transfer to appropriate level of care when needed accommodations cannot be provided in the current level of care;
- access to medications for psychiatric disorders, including oversight and monitoring of controlled medications; and
- management of mental health advanced directives.

Secondary Prevention and Early Intervention Standards

Staff Competencies

- All staff who provide secondary prevention services should have competency in:
    - Applying the principles of secondary and tertiary prevention
    - Assessing a patient's risks associated with substance use and their risk for developing SUD
    - Motivational interviewing
    - How to support the patient to make developmentally appropriate behavioral changes
    - How to communicate effectively with adolescents and their families regarding substance use and prevention of SUD
    - How to effectively engage adolescent patients, including through use of technology
    - State and federal requirements related to adolescent confidentiality and consent
- All clinical staff should understand:

- The unique vulnerabilities of the adolescent brain to substance exposure
- The disease model of addiction and how substance use progresses to SUD
- The importance of early intervention to prevent escalation from substance use to SUD
- The importance of avoiding normalization of substance use
- The importance of avoiding stigmatizing language

Support systems

- All programs should establish relationships with the schools that are serving their adolescent patients, with appropriate assent/consent
- Level 1.5Y programs should have an established relationship with more intensive levels of care that serve adolescent patients to facilitate referral when needed.
- All programs should maintain a list of community resources to address common ancillary needs, for example:
  - Mutual support groups for families (eg, Alanon, NAMI)
  - Recovery schools, when available
  - Supportive housing options
  - Individuals with Disabilities Education Act (IDEA) support services
  - Mentoring programs
- All programs should have established relationships with local crisis services

Assessment and treatment planning

- The Treatment Planning Assessment for patients who are using substances but do not currently meet criteria for an SUD should:
  - Assess both risk and protective factors, including:
    - Home environment
    - Parental or primary caregiver support and attachment
    - Relationships with other recovery supportive trusted adults
    - Parental health, including substance use and mental health conditions
    - Adverse childhood experiences
    - Developmental concerns, including unmet milestones
    - Behavioral concerns including impulsivity, aggression, criminal justice involvement, risky behaviors, behavioral addictions
    - Academic or occupational successes, challenges, supports and aspirations
    - Community connections
    - Peer affiliations
    - Emotional regulation/coping skills
    - Family and community norms and perceptions related to substance use, addiction, and mental health
  - Assess all dimensions and subdimensions of The ASAM Criteria
  - Assess the patient's strengths (developmentally appropriate social skills, communication skills, resilience, empathy, goals and aspirations)
  - Motivation for behavior change

- Treatment plans for patients who are using substances but do not currently meet criteria for an SUD should be:
    - Tailored to the patient's needs and strengths.
    - Focused on preventing escalation to SUD through strengthening the patient's protective factors and mitigating their risk factors.
- Patients who do not currently meet the criteria for SUD but are receiving specialty care (as recommended per the Dimensional Admission Criteria) should be reassessed at least monthly for SUD.

Services

- Level 1.5Y and 2.1Y programs should provide secondary prevention services for patients who do not currently meet the criteria for SUD but are recommended specialty care per the Dimensional Admission Criteria.
- All levels of care should provide family therapy services directly or through formally affiliated providers
- Level 2.1Y programs should provide family focused recovery support services (eg, parent/family peer support) to support prevention of the escalation of risky substance use to SUD
- Level 1.5Y programs are encouraged to provide family focused recovery support services

Documentation

- Level 1.5Y and 2.1Y programs should have policies and procedures that address:
    - Admission criteria for patients who are using substances but do not currently meet criteria for SUD, in alignment with the Dimensional Admission Criteria
    - Provision of secondary prevention services
    - Monitoring patients who do not currently meet criteria for SUD for escalation to SUD

Co-occurring Enhanced (COE) Standards

Universal expectations

- Direct psychiatric management of patients
    - A psychiatrist or psychiatric advanced practice provider is the medical director or co-director
    - Nurse availability for medications (except at Level 1)
- Increased staff to patient ratio to manage instability and disability

Setting

- All COE programs should provide a welcoming and supportive environment for individuals with serious mental health conditions, including those who may experience significant active or unstable symptoms and/or significant functional impairment and/or disability.
- Level 1 COE programs should seek to provide a calm therapeutic environment.
- Level 2 and above COE programs should provide a quiet space for de-escalation.

- Level 2 and above COE programs should provide a sensory supportive therapeutic space.

Staff

- All clinical and allied health staff in COE programs should have competency to care for individuals who have active co-occurring psychiatric symptoms and/or related functional deficits.
- COE programs should generally have a higher staff-to-patient ratio than standard (ie, cooccurring capable) programs to provide additional flexibility and support.
- Medically managed COE programs should have a psychiatrist or psychiatric NP available on-site or on-call during program hours of operation (ie, 24/7 in residential and inpatient programs).

Support Systems

- The universal standards include established relationships with clinicians with the scopes of practice to provide IDD assessment and management, eating disorder assessment and management
- The universal standards include established relationships with school systems, therapeutic school and recovery schools, as available.

Assessment and Treatment Planning

- All COE programs should admit individuals with any type of co-occurring mental health disorder, diagnosis, or symptoms provided they meet program admission criteria based on their level of acuity or disability per The ASAM Criteria Dimensional Admission Criteria.
- An integrated Treatment Planning Assessment should be conducted that addresses:
    - response to prior treatment,
    - baseline acuity of psychiatric conditions and related disabilities based on history and current presentation,
    - intellectual and developmental concerns,
    - symptom management and disability support needs,
    - family services involvement and needs,
    - other youth-service systems of care considerations (eg, juvenile justice, child protective service mandates, etc.),
    - educational needs,
    - medical management of psychiatric conditions,
    - adherence to mental health treatment, including medications, and
    - psychosocial treatment services for psychiatric conditions and IDD.

Clinical Services

- All COE programs should provide skilled mental health treatment interventions to address co- occurring mental health conditions and have the flexibility to provide individual support to patients who require:
    - de-escalation or reduction of stimulation (eg, due to panic attacks or feeling overwhelmed) during program hours of operation, and

    - additional assistance due to IDD or other functional impairment.
- COE programs should also have educational materials available that address common serious mental health concerns that are youth specific/developmentally appropriate.
- COE programs should provide psychoeducation to help patients report symptoms and disabilities.
- Compared to standard (ie, co- occurring capable) programs, COE programs should provide more guidance for managing significant acute symptoms (eg, panic attacks, psychosis), IDD, cognitive impairment, and functional disabilities. Educational content should:
    - provide guidance on the identification and management of severe mental health symptoms (eg, psychosis, developmental trauma);
    - be accessible for individuals with severe cognitive impairment due to IDD or psychiatric disabilities; and
    - address how to discuss severe mental health disorders, symptoms, and treatments appropriately in the context of mutual support and other RSS.
- In COE programs, any group programming offered should:
    - be flexibly designed to accommodate those who have symptoms, functional impairment, and/or disabilities that preclude full attendance and participation,
    - be able to accommodate smaller group sizes compared to groups in standard (ie, co- occurring capable) programs, and
    - deliver content in a format appropriate for individuals who experience challenges due to IDD or psychiatric disabilities.
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Level 1.0Y Standards

Level 1.0Y Description

Level 1.0Y programs provide remission monitoring and early reintervention services for patients who are in sustained remission.

Level 1.0Y Setting

Level 1.0Y services may be offered in any appropriate outpatient or telemedicine- based treatment setting that meets state licensure or certification criteria.

Level 1.0Y Staff

Level 1.0Y programs are staffed by appropriately trained addiction and mental health treatment professionals acting within their state-regulated scopes of practice.*

Level 1.0Y programs may also be staffed by allied health staff, such as certified peer support specialists, patient and family navigators**, health educators, certified recovery coaches, and counselor aides who support ongoing engagement in addiction treatment, deliver recovery support services (RSS), and provide warm handoffs to more intensive levels of care when needed.

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* Please see Appendix D for additional information on recommended staff competencies.
** A patient and family navigator is a person who helps the patient and/or their family navigate healthcare and social service systems. They help patients and families identify and access appropriate resources in the community and communicate effectively with service providers.

Medical Staff

Level 1.0Y programs might not provide medical services and, therefore, might not have a medical director, physicians and advanced practice providers, addiction specialist physicians, nor nursing and medical support staff.

Clinical Staff

If the Level 1.0Y program is clinically managed, it should have a program director (or responsible clinician in an independent practice) who, at minimum, has a master's degree in a field related to clinical behavioral health.

Level 1.0Y Support Systems

If Level 1.0Y programs do not provide psychotherapeutic services (eg, counseling, therapy) directly, they should be made available through coordinated referral.

Level 1.0Y programs should have, at minimum, established relationships with psychiatric and addiction specialists.

Level 1.0Y Assessment and Treatment Planning

Assessment

Level of Care Assessment

The initial assessment should include an up-to-date addiction and mental health focused history (if the program does not already have this information documented).

Treatment Planning Assessment

The Treatment Planning Assessment in Level 1.0Y programs involves:

- a recovery management checkup (RMC), which should include sufficient recovery- and remission- focused biopsychosocial screening and assessments to identify:
    - any current or emerging SUD-related treatment needs;
    - any biomedical health needs that may impact the patient's recovery;
    - any mental health needs that may impact the patient's recovery, using validated tools when available (eg, Patient Health Questionnaire- 9 [PHQ- 9], Generalized Anxiety Disorder- 7 [GAD- 7], Columbia- Suicide Severity Rating Scale [C- SSRS]); and
    - any RSS needs; and
- verification that the patient has had a physical examination conducted by a physician or advanced practice provider within the past year, with the program either:
    - referring the patient for a physical examination if they have not had one in the past year, or

- identifying any care coordination needs based on the most recent physical exam.

Psychiatric Assessment

Level 1.0Y programs should be able to provide referral for a psychiatric assessment as needed.

Treatment Planning

In Level 1.0Y programs, treatment plans should be individualized recovery management plans developed at initiation of treatment that include:

- identification of any concerns that may impact the patient's recovery,
- problem identification in each applicable dimension,
- defined recovery goals and measurable recovery objectives, and
- activities designed to meet those objectives (eg, adherence to addiction or psychiatric medications, participation in mutual support, mental health counseling).

The recovery management plan should be developed in collaboration with the patient and family, reflect the patient and family's goals, and incorporate the patient and family's strengths.*

The recovery management plan should include a plan for the patient and family to contact the program between appointments if new concerns emerge that may compromise the patient's recovery.

Reassessment

Level 1.0Y programs should conduct RMCs, including recovery capital assessments, at least quarterly. Check-ins should occur more frequently in response to life events that could lead to instability (eg, end of a relationship, loss of a loved one).

Formal reassessment of the recovery management plan should occur at least yearly, with remission and recovery management plan updates incorporated as needed.

Level 1.0Y Services

Medical Services

Level 1.0Y programs that do not directly provide medical services should have established relationships with physicians and/or advanced practice providers to coordinate access to:

- medication management services,
- medication adherence monitoring,
- infectious disease screening and referral for care as needed, and
- drug testing and toxicology services.*

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* Please see ASAM's Appropriate Use of Drug Testing in Clinical Addiction Medicine consensus statement for guidance.

Clinical Services

Level 1.0Y programs should provide:

- RMCs, including recovery capital assessments, either in-person or via telemedicine;
- mental health screening; and
- patient and family healthcare navigation services, including the ability to:
    - rapidly reengage the patient in the appropriate level of addiction or mental health treatment as needed, including providing warm handoffs; and
    - rapidly refer the patient for assessment for addiction or psychiatric medications* if not directly provided by the program.

Level 1.0Y programs should provide regular follow- ups until the patient is engaged in treatment. The frequency of follow- ups should be determined by the acuity of individual patient needs.

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* Including all FDA- approved medications for opioid use disorder (OUD; including methadone, unless unavailable locally), alcohol use disorder (AUD), and tobacco use disorder (TUD); off- label medications for other SUDs, including stimulant use disorder (StUD) and cannabis use disorder (CUD); and medications to manage post- acute withdrawal symptoms.

Psychosocial Services

Level 1.0Y programs should provide psychosocial services either directly or through formally affiliated providers and programs to address emerging concerns that may undermine the patient's recovery.

Level 1.0Y programs should provide patient and family education, including education on when to seek a reassessment prior to the next scheduled RMC.

Level 1.0Y programs that do not directly provide psychosocial services should have formal affiliations with external providers to coordinate access to:

- psychosocial services, including motivational interviewing and solution-focused therapy (SFT) to support reengagement in treatment as needed;
- health education for medical concerns associated with the course of SUD and other potential health- related risk factors as appropriate (eg, HIV, hepatitis C virus [HCV], STIs, unintended pregnancies, risk of exacerbating other conditions); and

Recovery Support Services

Level 1.0Y programs should provide the following RSS either directly or through formal affiliations with external service providers (eg, recovery community organizations [RCOs]):

- assessment of RSS needs, and
- development of individualized recovery and remission management plans.

Level 1.0Y Documentation

Core documentation in Level 1.0Y includes:

- results from RMCs, and
- individualized remission management plans.

Level 1.5Y Standards

Level 1.5Y Description

Level 1.5Y programs provide outpatient psychosocial services for patients with SUD. These programs provide less than 6 hours (typically 1-2 hours) of structured clinical services per week consisting primarily of psychotherapy, counseling, and psychoeducation to address addiction and co-occurring mental health conditions.

Level 1.5Y Setting

Level 1.5Y services may be offered in any appropriate outpatient setting where psychosocial services are provided that meets state licensure or certification criteria, such as:

- office-based practices,
- health clinics,
- outpatient addiction programs, and
- behavioral health clinics.

Level 1.5Y services may also be provided in home and community settings including schools, community-based organizations, social service settings, group homes or shelters, and via telemedicine.

Level 1.5Y Staff

Level 1.5Y programs are staffed by appropriately trained addiction treatment professionals acting within their state-regulated scopes of practice, including:

- A program director (who may be the responsible clinician in an independent practice), and
- Clinical staff, such as psychologists, clinical social workers, SUD and mental health counselors, and others trained to assess and treat SUD and/or co-occurring mental health conditions with the necessary scopes of practice to support the delivery of services provided in Level 1.5Y.*

Level 1.5Y programs may be supported by allied health staff, such as certified peer support specialists, patient and family navigators**, health educators, and certified recovery coaches, counselor aides who support ongoing engagement in addiction treatment, deliver RSS, and provide warm handoffs to other levels of care.

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* Please see Appendix D for additional information on recommended staff competencies.

** A patient and family navigator is a person who helps the patient and/or their family navigate healthcare and social service systems. They help patients and families identify and access appropriate resources in the community and communicate effectively with service providers.

Medical Staff

Level 1.5Y programs do not typically provide medical services and, therefore, do not typically have a medical director, physicians and advanced practice providers, nursing or medical support staff. However, programs are encouraged to have, at minimum, formal affiliations with physicians or advanced practice providers to support access to physical examinations, medical assessments, and addiction and psychiatric medications.

Program policies and procedures should define when and how to consult with and refer to psychiatric and addiction specialist physicians as needed.

Clinical Staff

Level 1.5Y programs should have a program director (who may be the responsible clinician in an independent practice) who has, at minimum, a master's degree in a field related to clinical behavioral health and at least one year of experience working with adolescents.

Level 1.5Y Support Systems

Level 1.5Y programs should ideally have formal affiliations, but at minimum established relationships, with addiction medication providers (eg, methadone treatment providers, physicians and advanced practice providers with controlled substance prescribing authority†) to support access to addiction medications.‡

Level 1.5Y programs should have established relationships with mental health treatment providers and programs to support access to routine psychiatric consultation, and facilitate access to more intensive mental health treatment as needed.

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‡ Including all FDA-approved medications for OUD (including methadone, unless unavailable locally), AUD, and TUD; off-label medications for other SUDs, including StUD and CUD; and medications to manage post-acute withdrawal symptoms.
† Including authorization to prescribe buprenorphine.

Level 1.5Y Assessment and Treatment Planning

Assessment

Physical Examination

In Level 1.5Y programs, the patient should be referred to a physician or advanced practice provider for a physical examination, which should ideally be conducted within one months of admission – or sooner based on the patient's medical presentation – if they have not had a recent physical examination.*

The physical examination should include assessment for addiction and psychiatric medication needs.

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*Per program protocol – which should be regularly reviewed and approved by a qualified physician or advanced practice provider – and in coordination with the patient's personal physician whenever possible

Treatment Planning

In Level 1.5Y programs, a comprehensive individualized treatment plan should be developed within 3 visits.

The patient- and family-facing treatment plan should include a plan for accessing emergency care 24/7, including when to call 911 or 988.

Reassessment

Formal reassessment and treatment plan updates [with signatures from key clinical staff] should occur at least quarterly and include determination of whether the patient is progressing appropriately and if treatment at a different level of care may be needed.

Level 1.5Y Services

Clinical Services

Level 1.5Y programs provide less than 6 hours of structures clinical services per week.

Services should be provided in an amount, frequency, and intensity appropriate to individual patient and family needs and level of function as determined by The ASAM Criteria multidimensional assessment.

Level 1.5Y services may be provided via telehealth when appropriate for the patient as determined by the treating clinician.

Psychiatric Services

Level 1.5Y programs should have an established relationship at minimum with a psychiatrist or advanced practice provider with specialty certification in psychiatry (eg, psychiatric NP).

Level 1.5Y programs should be able to refer for a psychiatric assessment as needed. The physical exam should assess need for a psychiatric assessment.

Care Coordination

Level 1.5Y programs should coordinate care with prescribers of addiction and psychiatric medications, and support rapid referrals for addiction or psychiatric medications as needed.

Level 2.1Y Standards

Level 2.1Y Description

Level 2.1Y programs provide intensive outpatient services for patients with SUDs and their families. These programs provide 6 to 19 hours of structured clinical services per week consisting primarily of counseling, psychoeducation, and psychotherapy to address addiction and co-occurring mental health conditions. Level 2.1Y programs also provide a clinically planned and managed therapeutic

milieu facilitated by trained clinical staff that imparts peer support, builds pro-recovery attitudes, and improves coping strategies and behaviors.

Level 2.1Y Setting

Level 2.1Y services may be offered in any appropriate outpatient setting where psychosocial services are provided that meets state licensure or certification criteria, such as:

- outpatient treatment programs
- behavioral health clinics

Level 2.1Y services may also be provided in home (eg, intensive in-home services) and community settings including schools, community-based organizations, social service settings, informal supports, and via telemedicine.

Level 2.1Y Staff

Level 2.1Y programs are staffed by an interdisciplinary team of appropriately trained and supervised addiction treatment professionals acting within their state-regulated scopes of practice*, including:

- A medical director
- A program director
- Clinical staff, such as psychologists, clinical social workers, SUD and mental health counselors, and others trained to assess and treat SUD and/or co-occurring mental health conditions with the necessary scopes of practice to support the delivery of services provided in Level 2.1Y.
- Allied health staff, such as certified peer support specialists, patient and family navigators**, health educators, certified recovery coaches, and counselor aides who support ongoing engagement in addiction treatment, deliver recovery support services (RSS), and provide warm handoffs to other levels of care.ǂ

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* Please see Appendix D for additional information on recommended staff competencies.
** A patient and family navigator is a person who helps the patient and/or their family navigate healthcare and social service systems. They help patients and families identify and access appropriate resources in the community and communicate effectively with service providers.
ǂ In low resources areas these services may be provided by clinical staff or through established relationships with external organizations.

Medical Staff

Physicians and Advanced Practice Providers

Level 2.1Y programs should have at minimum a formal affiliation with a physician or advanced practice provider who has competency in adolescent psychiatry and/or addiction medicine with at least 2 years of documented experience treating adolescents.

A physician or advanced practice provider with the experience noted above should regularly review the program's policies, procedures, and protocols for making admission decisions.

A qualified physician or advanced practice provider should be available to review admission decisions as needed (eg, when a patient presents with concerns in Dimensions 1, 2, or 3 that may require medical evaluation or management).

Specialty Physicians

In Level 2.1Y programs, the medical director does not need to be a psychiatrist or addiction specialist physician. However, programs should have formal affiliations with psychiatric and addiction specialist(s) with adolescent treatment experience and the program's policies and procedures should define when and how to consult with and refer to them when needed.

Nursing, and Medical Support Staff

Level 2.1Y programs should have established relationships with registered nurses, other appropriately licensed and credentialed nurses (eg, LPNs), or other medical support staff with the scope of practice to collect vitals, administer medications (including injectable medications), and provide medical monitoring as needed.

Clinical Staff

Level 2.1Y programs should have appropriately trained clinical staff available during program hours of operation and on-call 24/7.

Level 2.1Y programs should have a program director who has, at minimum, a master's degree in a field related to clinical behavioral health, and at least 5 years of documented experience in addiction and/or mental health treatment with at least 2 years of experience treating adolescents.*

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* If a program is unable to identify a program director who meets these qualifications after reasonable efforts, a clinician with at least five years of documented clinical and supervisory experience in addiction treatment who meets the competencies described in Appendix D may serve as the program director. In these instances, this program director should have an established mentor and a written plan to obtain a terminal degree within five years.

Allied Health Staff

In Level 2.1Y programs, allied health staff, either directly or through formal affiliation, should be available to provide RSS during program hours.ł

ł In low resources areas RSS may be provided by clinical staff or through established relationships with external organizations.

Level 2.1Y Support Systems

Level 2.1Y programs a should also have formal affiliations with addiction medication providers (eg, methadone treatment providers, physicians and advanced practice providers with controlled substance prescribing authority†) to support access to addiction medications.‡

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‡ Including all FDA-approved medications for OUD (including methadone, unless unavailable locally), AUD, and TUD; off-label medications for other SUDs, including StUD and CUD; and medications to manage post-acute withdrawal symptoms.
† Including authorization to prescribe buprenorphine.

Level 2.1Y Assessment and Treatment Planning

Assessment

Psychiatric Assessment

In Level 2.1Y programs, a psychiatric assessment should occur within 14 calendar days.

The psychiatric assessment should:

- Assess the patient's need for addiction and psychiatric medications.†
- Determine the patient's need for a physical examination based on the timing of their most recent wellness exam and medical presentation.*

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† Including all FDA-approved medications for OUD (including methadone, unless unavailable locally), AUD, and TUD; off-label medications for other SUDs, including StUD and CUD; and medications to manage post-acute withdrawal symptoms.
* Per program protocol – which should be regularly reviewed and approved by a qualified physician or advanced practice provider – and in coordination with the patient's primary care provider whenever possible

Physical Examination

In Level 2.1Y programs, when needed, a physical examination should be conducted or reviewed by a physician or advanced practice provider within a reasonable timeframe.

- The timeframe for completing the physical exam, if needed, should be determined by a physician or advanced practice provider based on findings during:
    - The Level of Care Assessment*, and/or
    - The psychiatric assessment

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* During the Level of Care Assessment, the Dimensional Admission Criteria may flag the need for a "prompt evaluation" or "prompt medical management". A patient who needs "prompt medical management" should have a medical evaluation as soon as possible, within 24 hours at most. A patient who needs a "prompt evaluation" should have a medical evaluation within 72 hours.

Treatment Planning

In Level 2.1Y programs:

- an initial individualized treatment plan should be developed at the time of admission.
- a comprehensive individualized treatment plan should be developed within 5 business days of admission.

The patient- and family-facing treatment plan should include a plan for accessing emergency care 24/7, including when to call 911 or 988.

Reassessment

The interdisciplinary treatment team in Level 2.1Y programs should meet at least weekly to discuss patient progress and adjust the treatment plan as needed. All treatment team members do not need to be present at each meeting; the patient's primary clinician is responsible for obtaining relevant information from others who provide treatment services to the patient. A weekly progress note should be added to the clinical record that outlines progress, concerns, and any planned changes to clinical care.

Formal reassessment and treatment plan updates [with signatures from key clinical staff] should occur at least monthly and include determination of whether the patient is progressing appropriately and if treatment at a different level of care may be needed.

Level 2.1Y Services

Medical Services

A nursing assessment should be conducted as needed that includes:

- Vitals, including pulse oximetry;
- History of present illness;
- Assessment of withdrawal signs and symptoms;
- Medical history, including assessment of current biomedical, psychiatric, and cognitive concerns and medication review;
- psychiatric needs assessment; and
- Weight and BMI.

Psychiatric Services

Level 2.1Y programs provide psychiatric services, directly or through formal affiliation.

Clinical Services

Level 2.1Y programs provide 6 to 19 hours per week of structured clinical services.

Structured services selected by master's level clinical staff should be provided at least two days per week.

Services should be provided in an amount, frequency, and intensity appropriate to the individual patient and family's needs and level of function as determined by The ASAM Criteria multidimensional assessment.

Clinical services provided by formally affiliated external addiction treatment providers and programs (eg, OTPs) may count toward the total hours of weekly clinical services if care and billing are coordinated and documented.

Level 2.1Y services may be provided via telehealth when appropriate for the patient as determined by the treating clinician.

Recovery Support Services

Level 2.1Y programs should directly provide a therapeutic milieu that includes consistency in support and structure

Level 2.5Y Standards

Level 2.5Y Description

Level 2.5Y programs (previously referred to as partial hospitalization programs [PHPs] in the Third Edition) provide high-intensity outpatient services for patients with SUDs and their families. These programs provide at least 20 hours of structured clinical services per week consisting primarily of psychotherapy, counseling, and psychoeducation to address addiction and co-occurring mental health conditions. Level 2.5Y programs also provide a clinically planned and managed therapeutic milieu facilitated by trained clinical staff that imparts peer support, builds pro-recovery attitudes, and improves coping strategies and behaviors.

Level 2.5Y Setting

Level 2.5Y services may be offered in any appropriate outpatient setting where psychosocial services are provided that meets state licensure or certification criteria, such as:

- outpatient day treatment programs,
- behavioral health clinics, and
- PHPs.

Level 2.5Y services may also be provided in home (eg, intensive in-home services) and community settings including schools, community-based organizations, social service settings, informal supports, and, via telemedicine.

Level 2.5Y Staff

Level 2.5Y programs are staffed by an interdisciplinary team of appropriately trained and supervised addiction treatment professionals acting within their state-regulated scopes of practice*, including:

- A medical director,

- A program director,
- Clinical staff, such as psychologists, clinical social workers, SUD and mental health counselors, and others trained to assess and treat SUD and/or co-occurring mental health conditions with the necessary scopes of practice to support the delivery of services provided in Level 2.5Y, and
- Allied health staff, such as certified peer support specialists, patient and family navigators**, health educators, certified recovery coaches, and counselor aides who support ongoing engagement in addiction treatment, deliver RSS for patients and families, and provide warm handoffs to other levels of care. ł

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* Please see Appendix D for additional information on recommended staff competencies.
** A patient and family navigator is a person who helps the patient and/or their family navigate healthcare and social service systems. They help patients and families identify and access appropriate resources in the community and communicate effectively with service providers.
ł In low resources areas these services may be provided by clinical staff or through established relationships with external organizations.

Medical Staff

Medical Director

Level 2.5Y programs should have a medical director who has competency in adolescent psychiatry and/or addiction medicine.

- Competency in both adolescent psychiatry and addiction medicine should be represented on the program's medical team, which may include both staff and formally affiliated providers.
- The medical director should be board certified or board eligible in adolescent psychiatry, addiction psychiatry, or addiction medicine with at least 2 years of documented experience working with adolescents.

The medical director in Level 2.5Y programs should regularly review and approve the program's policies, procedures, and protocols for making admission decisions.

The medical director, or another qualified physician or advanced practice provider, should be available to review admission decisions as needed (eg, when a patient presents with concerns in Dimensions 1, 2, or 3 that may require medical evaluation or management).

Specialty Physicians

In Level 2.5Y, program leadership should include both psychiatric and addiction specialty expertise.

- Psychiatric specialty expertise includes psychiatrists and advanced practice providers with specialty psychiatric certification (eg, psychiatric NP).
- Addiction specialty expertise includes physicians who are board certified or board eligible in addiction medicine or addiction psychiatry.

In Level 2.5Y programs, a psychiatrist or advanced practice provider with specialty certification in psychiatry (eg, psychiatric nurse practitioner [NP]) should be available on-site or via telemedicine daily during program days of operation to assess patients and make medication adjustments as needed.

Physicians and Advanced Practice Providers

In Level 2.5Y programs, physicians and advanced practice providers with controlled substance prescribing authority† should be active members of the care team.

A physician or advanced practice provider should be available in-person or via telemedicine during program hours of operation to initiate or adjust medications as needed.

- Medications may be provided by medical support staff based on a patient-specific verbal order from the physician or advanced practice provider.*
- In Level 2.5Y programs, a physician or advanced practice provider should be on-call 24/7 directly or through formal affiliation.

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* Per program protocol, which should be developed, approved, and regularly reviewed by the medical director.
† Including authorization to prescribe buprenorphine.

Nursing, and Medical Support Staff

Level 2.5Y programs should have formal affiliations with registered nurses (RNs), other appropriately licensed and credentialed nurses (eg, LPNs), or other medical support staff with the scope of practice to collect vitals, administer medications (including injectable medications), and provide medical monitoring as needed.

Clinical Staff

Level 2.5Y programs should have appropriately trained clinical staff available during program hours of operation and on-call 24/7.

Level 2.5Y programs should have a program director who has, at minimum, a master's degree in a field related to clinical behavioral health and at least 5 years of documented experience in addiction and/or mental health treatment with at least 2 years of experience treating adolescents.*

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* If a program is unable to identify a program director who meets these qualifications after reasonable efforts, a clinician with at least five years of documented clinical and supervisory experience in addiction treatment who meets the competencies described in Appendix D may serve as the program director. In these instances, this program director should have an established mentor and a written plan to obtain a terminal degree within five years.

Allied Health Staff

Level 2.5Y programs should have allied health staff available during program hours of operation.

Level 2.5Y Assessment and Treatment Planning

Assessment

Psychiatric Assessment

In Level 2.5Y programs, a psychiatric assessment should occur within 5 calendar days.

Level 2.5Y programs should be able to provide a psychiatric assessment within 24 hours, when needed (as determined during the Level of Care Assessment).

- The psychiatric assessment should:
  - Assess the patient's need for addiction and psychiatric medications. †
  - Determine the patient's need for a physical examination based on the timing of their most recent wellness exam and medical presentation.*

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† Including all FDA-approved medications for OUD (including methadone, unless unavailable locally), AUD, and TUD; off-label medications for other SUDs, including StUD and CUD; and medications to manage post-acute withdrawal symptoms.
*Per program protocol – which should be regularly reviewed and approved by a qualified physician or advanced practice provider – and in coordination with the patient's primary care provider whenever possible

Physical Examination

In Level 2.5Y programs, when needed, a physical examination should be conducted or reviewed by a physician or advanced practice provider within a reasonable timeframe.

- The timeframe for completing the physical exam, if needed, should be determined by a physician or advanced practice provider based on findings during:
  - The Level of Care Assessment*, and/or
  - The psychiatric assessment

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* During the Level of Care Assessment, the Dimensional Admission Criteria may flag the need for a "prompt evaluation" or "prompt medical management". A patient who needs "prompt medical management" should have a medical evaluation as soon as possible, within 24 hours at most. A patient who needs a "prompt evaluation" should have a medical evaluation within 72 hours.
*Per program protocol – which should be regularly reviewed and approved by a qualified physician or advanced practice provider – and in coordination with the patient's primary care provider whenever possible
† Including all FDA-approved medications for OUD (including methadone, unless unavailable locally), AUD, and TUD; off-label medications for other SUDs, including StUD and CUD; and medications to manage post-acute withdrawal symptoms.

Treatment Planning

In Level 2.5Y programs, an initial individualized treatment plan should be developed at the time of admission.

In Level 2.5Y programs, a comprehensive individualized treatment plan should be developed within 5 business days of admission.

The patient- and family-facing treatment plan should include a plan for accessing emergency care 24/7, including when to call 911 or 988.

Reassessment

The interdisciplinary treatment team in Level 2.5Y programs should meet at least weekly to discuss patient progress and adjust the treatment plan as needed. All treatment team members do not need to be present at each meeting; the patient's primary clinician is responsible for obtaining relevant information from others who provide treatment services to the patient. A weekly progress note should be added to the clinical record that outlines progress, concerns, and any planned changes to clinical care.

Formal reassessment and treatment plan updates [with signatures from key clinical staff] should occur at least monthly and include determination of whether the patient is progressing appropriately and if treatment at a different level of care may be needed.

Level 2.5Y Services

Medical Services

Level 2.5Y programs should be able to provide nursing assessments as needed, that include:

- Vitals, including pulse oximetry;
- History of present illness;
- Assessment of withdrawal signs and symptoms;
- Medical history, including assessment of current biomedical, psychiatric, and cognitive concerns and medication review;
- psychiatric needs assessment; and
- Weight and BMI.

Level 2.5Y programs should be able to initiate and titrate addiction and psychiatric medications and provide medication management, including regular monitoring of the patient's adherence to prescribed medications.

Level 2.5Y programs should be able to provide medical monitoring and management of common low complexity biomedical conditions when needed, including:

- basic management of hyperglycemia and hypoglycemia;
- basic wound care;
- infectious disease management, including:
    - screening and assessment for STIs and bloodborne infections (eg, HIV, hepatitis B virus [HBV], HCV);
    - initiation of treatment and/or coordinated referral to treatment with coordination of care with infectious disease specialists as needed; and

    - initiation of treatment and/or coordinated referral for preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) and provision of patient education regarding PrEP and PEP*;
- coordination of care for pregnancy and postpartum needs;
- coordination of care for biomedical conditions, including pain, for which the patient is receiving treatment from an external provider;
- direct management or coordination of controlled medications;
- supporting pharmacy access.

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* Please see the US Public Health Service's Preexposure Prophylaxis for the Prevention of HIV Infection in the United States— 2021 Update: A Clinical Practice Guideline for guidance.
** Per program protocol, which should be developed, approved, and regularly reviewed by the medical director

Biomedical Capabilities

Level 2.5Y programs should have access to the following biomedical capabilities on-site:

- vitals measurement and monitoring, including pulse oximetry and blood pressure;
- glucose monitoring;
- basic first aid;
- an AED;
- ECG with a 3-lead rhythm strip at minimum*;
- basic wound care;
- injectable epinephrine;
- overdose reversal medication (eg, naloxone,);
- point- of- care pregnancy testing; and
- drug testing and toxicology services.

Level 2.5Y program should have established relationships to coordinate access to laboratory and phlebotomy services.

Level 2.5Y programs should provide coordinated access to vaccines (eg, hepatitis A and B viruses, influenza, COVID- 19) either on-site or through facilitated access to a community partner. †

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* The rationale for ECG capacity is to determine the level of risk and need for Level 4Y care, *not* for diagnosis or disease management. It is also important for monitoring for QTc prolongation in patients on methadone.
† Vaccines may be provided through established relationships with external partners.

Psychiatric Services

Level 2.5Y programs directly provide psychiatric services.

Clinical Services

Level 2.5Y programs provide at least 20 hours of structured clinical services per week. Structured services selected by master's level staff should be available 5 days per week.

Services should be provided in an amount, frequency, and intensity appropriate to individual patient and family's needs and level of function as determined by *The ASAM Criteria* multidimensional assessment.

Clinical services provided by formally affiliated external addiction treatment providers and programs (eg, OTPs) may count toward the total hours of weekly clinical services if care and billing are coordinated and documented.

Clinically Managed Withdrawal Management

Level 2.5Y programs should be able to provide clinical monitoring of intoxication and withdrawal symptoms, including:

- Supervision, observation, and support during program hours of operations for patients who are intoxicated or experiencing withdrawal but do not require medically monitored or managed care as determined by medical evaluation;
- Support for adherence to medications for withdrawal management in accordance with a prescription from a physician or advanced practice provider;
- Clinical monitoring of intoxication and withdrawal, including use of physician-established protocols to monitor for changes in status that may require medical consultation and/or transition to a medically managed level of care; and
- Psychosocial services designed to support completion of the withdrawal management process.

Recovery Support Services

Level 2.5Y programs should directly provide a therapeutic milieu that includes consistency in support and structure.

Level 3.5Y Standards

Level 3.5Y Description

Level 3.5Y programs provide clinically managed high-intensity residential services for youth with SUD who require a safe and stable living environment to develop and practice their recovery skills to avoid experiencing immediate recurrence or continuing to use in a manner that poses significant risk for serious harm or destabilizing loss. These programs provide at least 20 hours of structured clinical services per week consisting primarily of psychotherapy, counseling, psychoeducation, and family services to address youth addiction and co-occurring mental health conditions. Level 3.5Y programs also provide a high-intensity clinically planned and managed therapeutic milieu that encourages development and internalization of prosocial attitudes and behaviors using community support to reinforce recovery skills.

Level 3.5Y aligns with the adolescent mental health treatment system's CALOCUS-CASII Level 5. However, one major difference is that the CALOCUS-CASII Level 5 can be delivered in a therapeutic foster home or another home setting with sufficient intensity of home and community-based support. *The ASAM Criteria* Level 3.5Y will be a residential level of care, however, the Dimensional

Admission Criteria may separately recommend intensive or high intensity outpatient care (Level 2.1Y or 2.5Y) plus an alternative recovery supportive home (eg, respite, therapeutic foster home). The need for residential care will be differentiated from the need for a recovery supportive home based on Dimension 4 and 5, including risks related to substance use and SUD-related behaviors and level of afterhours support needed.

Level 3.5Y Setting

Services may be offered in any appropriate residential treatment setting with 24-hour staff and integrated clinical services that meets state licensure or certification criteria. The facility should incorporate space for:

- Individual and family counseling services,
- Group counseling and psychoeducation services,
- Other clinical activities,
- Academic activities,
- Recreational and group activities (eg, sports, music, art),
- Patient rest and privacy,
- Visiting space
- Meals, and
- Hygiene.

The layout of the facility should enable adequate supervision and management of patients at all times, ensuring that staff can respond to instability in a safe and timely manner. Patients should be able to alert staff to an issue immediately, and staff should be able to respond immediately (ie, within minutes) to assess patients' needs.

The living space should be within reasonable proximity of the space for clinical services, allowing staff to maintain adequate supervision of patients to rapidly address emerging clinical issues.

If the facility also admits adult patients, it should be designed such that adolescent patients can maintain separation from adult patients and any interactions can be closely monitored.

Living Environment

The facility should maintain a supportive living environment that provides:

- The needs of daily living;
- Safety from substances, paraphernalia, and weapons, with any searches of patients, visitors, and their belongings using trauma-sensitive practices (TSP), focused on preserving the dignity and privacy of the individual whose person or belongings are being searched; and
- Privacy and a secure place to store personal belongings

Patient Supervision

Level 3.5Y should provide 24-hour supervision of patients. Staff should verify and document the whereabouts and wellness of each patient who is on-site at least once every hour. Note that this is

separate from clinical monitoring, the frequency of which should be determined based on the individual clinical needs of each patient.

At the start of treatment in Level 3.5Y, patients should not leave program premises except under limited circumstances, such as for specialty medical or diagnostic appointments or medical or psychiatric emergencies.

- Program staff (or staff of external providers or programs delivering services to the patient) should provide continuous supervision of patients when they are off-site to prevent risky behaviors and address any instability or other issues that may arise in a safe and timely manner.
- Programs should have policies and procedures in place for providing direct supervision when patients are off-site.

As the patient progresses clinically in treatment at Level 3.5Y (as determined by a supervisory clinician), they may be given opportunities to visit family and/or to practice skills for community reintegration in preparation for transition to a less intensive level of care.

- Patients may leave program premises with appropriate staff supervision to participate in appropriate services in the community, such as mutual support meetings or school reintegration services.
    - The degree of staff supervision provided should be determined based on established policies and procedures, and documented in the patient's record.
    - The degree of supervision when patients participate in services in the community may vary from continuous observation then they are off-site to a lesser amount of staff supervision (eg, one staff member supervising a group of patients at an off-site mutual support meeting, school-based supervision for a patient preparing for school reintegration) based on the patients' readiness and progress in treatment as determined by a supervisory clinician.
- Patients may leave program premises with appropriate parent/guardian supervision for family visits, with supervisory staff approval.
    - Programs should have policies and procedures in place that govern family visits, that addresses:
        - family assessment and preparation,
        - the process for approval by supervisory staff,
        - documentation requirements, and
        - patient searches and drug testing upon return to the facility.
    - A family assessment should be conducted to determine that the patient can be safely and effectively supervised during the visit, and documented in the patient record.
    - Program clinicians should prepare the family to provide appropriate oversight and safety.

Level 3.5Y Staff

Level 3.5Y programs are staffed by an interdisciplinary team of appropriately trained and supervised addiction treatment professionals acting within their state-regulated scopes of practice, including:

- A medical director;
- A program director;
- Clinical staff, such as psychologists, clinical social workers, SUD and mental health counselors, and other trained to assess and treat SUD and/or co-occurring mental health conditions with the necessary scopes of practice to support the delivery of services provided in Level 3.5Y; and
- Allied health staff, such as certified peer support specialists, patient and family navigators*, health educators, counselor aides, certified recovery coaches, and group living workers who support ongoing engagement in SUD treatment, deliver RSS, and provide warm handoffs to other levels of care.

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* A patient and family navigator is a person who helps the patient and/or their family navigate healthcare and social service systems. They help patients and families identify and access appropriate resources in the community and communicate effectively with service providers.

Medical Staff

Medical Director

- Level 3.5Y programs should have a medical director who:
  - is board certified or board eligible in adolescent psychiatry, addiction psychiatry or addiction medicine, and
  - has at least 2 years of documented experience working with adolescents.
- Competency in both adolescent psychiatry and addiction medicine should be represented on the leadership team, which may include both staff and formally affiliated providers.
- The medical director in Level 3.5Y programs should develop (in partnership with other program staff), approve, and regularly review the program's policies, procedures, and protocols for making admission decisions.
- The medical director, or another qualified physician should be available to review admission decisions within 24 hours as needed (eg, when a patient presents with concerns in Dimension 1, 2, or 3 that may require medical evaluation or management).

Physicians and Advanced Practice Providers

- In Level 3.5Y programs, physicians and/or advanced practice providers with controlled substance prescribing authority† should be available daily on-site or via telemedicine as active members of the care team.

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† Including authorization to prescribe buprenorphine.

Specialty Physicians

- In Level 3.5Y, program leadership should include both psychiatric and addiction specialty expertise.
  - Psychiatric specialty expertise includes psychiatrists and advanced practice providers with specialty psychiatric certification.
  - Addiction specialty expertise includes physicians who are board certified or board eligible in addiction medicine or addiction psychiatry.
- A psychiatrist or advanced practice provider with specialty certification in psychiatry (eg, psychiatric nurse practitioner [NP]) should be available on site or via telemedicine 24/7 to assess patients and make medication adjustments as needed.

Nursing, and Medical Support Staff

- Registered nurses (RNs), other appropriately licensed and credentialed nurses (eg, LPNs) with the scope of practice to conduct nursing assessments should be available as needed.
- Medical support staff with the scope of practice to take vitals, administer medications (including injectable medications), and provide medical monitoring should be available on-site 24/7.
- A nursing supervisor should be available 24/7 to respond to urgent situations.

Clinical Staff

Level 3.5Y programs should have appropriately trained clinical staff available on-site 24/7.

- Level 3.5Y programs should have a program director who has, at minimum, a master's degree in a field related to clinical behavioral health and at least 5 years of documented experience in adolescent addiction and/or mental health treatment with at least 2 years of experience treating adolescents.*

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* If a program is unable to identify a program director who meets these qualifications after reasonable efforts, a clinician with at least five years of documented clinical and supervisory experience in addiction treatment who meets the competencies described in Appendix D may serve as the program director. In these instances, this program director should have an established mentor and a written plan to obtain a terminal degree within five years.

Allied Health Staff

Level 3.5Y programs should have allied health staff who are on-site and alert 24/7.

Level 3.5Y programs should have policies and procedures that define activities to be performed during the night shift (eg, hourly monitoring and documentation of patient whereabouts, response coordination to urgent patient issues).

Level 3.5Y Support Systems

- Level 3.5Y programs should have a physician or advanced practice provider available on-call 24/7 to respond to urgent situations, including determining if this level of care is appropriate for management of patients who are intoxicated or experiencing mild withdrawal.

- Level 3.5Y programs are encouraged to establish relationships (eg, memorandum of understanding [MOU] or less formal connection) with nearby hospitals, local urgent care providers, and emergency departments to support coordination of biomedical care as needed.
- Level 3.5Y programs should have established policies and procedures for responding to urgent medical and psychiatric needs 24/7, including:
    - When to engage the on-call physician or advanced practice provider,
    - When to call 911, and
    - When to call 988.

Level 3.5Y Assessment and Treatment Planning

Assessment

Psychiatric Assessment

- In Level 3.5Y programs, a psychiatric assessment should occur within 48-72 hours. The assessment should generally occur within 48 hours, but may occur within 72 hours to accommodate for weekends.
    - The psychiatric assessment should:
        - Assess the patient's need for addiction and psychiatric medications.
        - Determine the patient's need for a physical examination.
- Level 3.5Y programs should be able to provide a psychiatric assessment within 24 hours, when needed.

Physical Examination

- In Level 3.5Y programs, a physical examination should be conducted or reviewed by a physician or advanced practice provider within a reasonable timeframe, as determined during the psychiatric assessment based on the timing of their most recent wellness exam and medical presentation.*

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* Per program protocol – which should be regularly reviewed and approved by a qualified physician or advanced practice provider – and in coordination with the patient's primary care provider whenever possible

Treatment Planning

- In Level 3.5Y programs, an initial individualized treatment plan should be developed at the time of admission.
- A comprehensive individualized treatment plan should be developed within 72 hours of admission.

Reassessment

- The interdisciplinary treatment team in Level 3.5Y programs should meet at least weekly to discuss patient progress and adjust the treatment plan as needed. All treatment team members do not need to be present at each meeting; the patient's primary clinician is responsible for obtaining relevant information from others who provide treatment services

to the patient. A weekly progress note should be added to the clinical record that outlines progress, concerns, and any planned changes to clinical care.

- Formal reassessment and treatment plan updates [with signatures from key clinical staff] should occur at least monthly and include determination of whether the patient is progressing appropriately and if treatment at a different level of care may be needed.

Level 3.5Y Services

Medical Services

- A nursing assessment should be conducted at admission that includes:
  - Vitals, including pulse oximetry;
  - History of present illness;
  - Evaluation of withdrawal risks;
  - Medical history, including assessment of current biomedical, psychiatric, and cognitive concerns and medication review;
  - psychiatric needs assessment; and
  - Weight and BMI.
- Level 3.5Y programs should be able to initiate and titrate addiction and psychiatric medications and provide medication management, including regular monitoring of the patient's adherence to prescribed medications.
- A physician or advanced practice provider should be available in-person or via telemedicine daily to initiate or adjust medications.
- Medications may be provided based on a patient-specific verbal order from the physician or advanced practice provider.*
- Level 3.5Y programs should be able to provide medical monitoring and management of common low complexity biomedical conditions, including:
  - basic management of hyperglycemia and hypoglycemia;
  - basic wound care;
  - infectious disease management, including:
    - screening and assessment for STIs and bloodborne infections (eg, HIV, hepatitis B virus [HBV], HCV);
    - initiation of treatment and/or coordinated referral to treatment with coordination of care with infectious disease specialists as needed; and
    - initiation of treatment and/or coordinated referral for preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) and provision of patient education regarding PrEP and PEP**;
  - coordination of care for pregnancy and postpartum needs;
  - coordination of care for biomedical conditions, including pain, for which the patient is receiving treatment from an external provider;
  - direct management or coordination of controlled medications;
  - supporting pharmacy access.

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* Per program protocol, which should be developed, approved, and regularly reviewed by the medical director

** Please see the US Public Health Service's Preexposure Prophylaxis for the Prevention of HIV Infection in the United States— 2021 Update: A Clinical Practice Guideline for guidance.

Biomedical Capabilities

Level 3.5Y programs should have access to the following biomedical capabilities on-site:

- Vitals measurement and monitoring, including pulse oximetry and blood pressure;
- Glucose monitoring;
- Basic first aid;
- An automated external defibrillator (AED);
- Basic wound care;
- Injectable epinephrine;
- Overdose reversal medication (eg, naloxone,);
- Point-of-care pregnancy testing; and
- Drug testing and toxicology services.

Level 3.5Y program should have established relationships to coordinate access to laboratory and phlebotomy services.

Level 3.5Y programs should provide coordinated access to vaccines (eg, hepatitis A and B viruses, influenza, COVID- 19) either on-site or through facilitated access to a community partner.

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* The rationale for ECG capacity is to determine the level of risk and need for Level 4Y care, *not* for diagnosis or disease management. It is also important for monitoring for QTc prolongation in patients on methadone.
† Vaccines may be provided through established relationships with external partners.

Psychiatric Services

- Level 3.5Y programs directly provide psychiatric services.

Clinical Services

- Level 3.5Y programs provide ≥20 hours of structured clinical services per week, including family systems therapy when possible.
- Structured services selected by master's level clinical staff should be available 7 days per week.
    - These services should be designed to support recovery from SUD and co-occurring conditions and include daily activities that allow patients to learn and practice healthy social behaviors.
    - Services should be provided in an amount, frequency, and intensity appropriate to individual patient and family's needs and level of function as determined by *The ASAM Criteria* multidimensional assessment.
- Clinical services provided by formally affiliated external addiction treatment providers and programs (eg, OTPs) may count toward the total hours of weekly clinical services if care and billing are coordinated and documented.

Clinically Managed Withdrawal Management

- Level 3.5Y programs should be able to provide clinically managed residential intoxication and withdrawal management, including:
    - Twenty-four-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal but do not require medically monitored or managed care as determined by medical evaluation;
    - Dispensing of medications for withdrawal management in accordance with a prescription from a physician or advanced practice provider;
    - Clinical monitoring of intoxication and withdrawal, including use of physician-established protocols to monitor for changes in status that may require medical consultation and/or transition to a medically managed level of care; and
    - Psychosocial services designed to support completion of the withdrawal management process.

Recovery Support Services

- Level 3.5Y programs should directly provide:
    - Planned community reinforcement designed to foster healthy social values and community living skills; and
    - A therapeutic milieu that includes consistency in support and structure.

Universal MM Standards

These standards apply to all specialty medically managed settings, including Levels 1.7Y, 2.7Y, 3.7Y, and Level 4Y specialty addiction units.

Universal MM Setting

The layout of the facility should enable adequate supervision and management of patients during program hours of operation (ie, 24/7 in residential and inpatient programs), ensuring that staff can respond to instability in a safe and timely manner. Patients should be able to alert staff to an issue immediately, and staff should be able to respond immediately (ie, within minutes) to assess patients' needs.

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 and should primarily occur when patients are transitioning between spaces or waiting for appointments/sessions to begin.
- Staff should be able to see and hear any interactions between adult and adolescent patients at all times.

When applicable, the nursing station should be in close proximity to the patient area to allow nursing staff to respond to medical needs and instability in a safe and timely manner.

Universal MM Staff

Medical Staff

Medical Director

The medical director is ultimately responsible for the care delivered. The medical director:

- develops,[4] approves, and regularly reviews the program's admission and discharge criteria and medical policies, procedures, and protocols;
- directs patient care;
- ensures the adequacy of individual treatment plans;
- ensures daily medical coverage to meet patient needs;
- determines the credentials required of other physicians and advanced practice providers who serve the program;
- monitors the care delivered by other physicians and advanced practice providers who serve the program; and
- oversees the quality of treatment delivered by the program.

Written protocols related to the treatment of intoxication; withdrawal; SUD; co-occurring biomedical, psychiatric, and cognitive conditions; and addiction medications should be reviewed and approved by the medical director and a physician with adolescent treatment expertise.

Physicians and Advanced Practice Providers

In medically managed youth programs, there should be a physician leader who has at least 2 years of experience in adolescent treatment who provides oversight of the adolescent unit.

Physicians and/or advanced practice providers should be readily available to:

- review admission decisions within 24 hours of admission to confirm the appropriateness of the patient's level of care recommendation, including that withdrawal management in this setting is safe;
- perform medical histories and physical examinations;
- assess and treat substance withdrawal and active comorbid biomedical conditions;
- manage medications and other treatment modalities for acute withdrawal management and other biomedical needs;
- monitor patient response to treatment;
- coordinating parent or guardian, educating on medical care options and needs, including medications, and obtaining consent for treatment when needed; and
- provide clinical consultation and supervision for co-occurring biomedical, psychiatric, and cognitive conditions.

Physicians and advanced practice providers are responsible for managing medical care and assuring quality of care, which includes:

[4] In partnership with other program staff

- diagnosis, treatment, and treatment plan decisions[5] for acute intoxication, withdrawal, SUD, and co-occurring biomedical, psychiatric, and cognitive conditions;
- determination of if and when to admit the patient;
- determination of if and when a patient should be transitioned to a more intensive level of care;
- determination of when to transition the patient to a less intensive level of care;
- coordination with families and other trusted adults in the patient's life to support effective care; and
- coordination of care with prescribers of controlled substances.

Physicians, other than the medical director when applicable, do not need to be certified as addiction specialist physicians, but training and experience in assessing and managing intoxication and withdrawal syndromes and using addiction medications in adolescents are necessary. Advanced practice providers should have ready access to physician(s) with expertise in addiction medicine and adolescent treatment at all times.

Nursing and Medical Support Staff

When nurses are on staff, they should meet the core competencies outlined in *Addiction Nursing Competencies: A Comprehensive Toolkit for the Addictions Nurse*. Nurses do not need to be certified as addiction nurses, but training and experience in assessing and managing intoxication and withdrawal syndromes are necessary.

The level of nursing care provided (when applicable) should be appropriate to the severity of patient needs. Registered nurses (RNs) or other appropriately licensed and credentialed nurses (eg, licensed practical nurses [LPNs]) should be available during program hours of operation to:

- conduct nursing assessments on admission;
- provide primary nursing care and observation;
- monitor patient progress;
- provide medication management services;
- administer medications and nonpharmacological interventions in accordance with physician and advanced practice provider orders;
- administer standardized withdrawal severity assessments;
- conduct routine daily nursing assessments of withdrawal and co-occurring biomedical, psychiatric, and cognitive conditions; and
- provide patient and family education.

Clinical Staff

Medically managed levels of care should have appropriately trained clinical staff (eg, SUD and mental health counselors, psychologists, social workers) available directly or through formally

[5] In collaboration with the patient

affiliated providers or programs. Clinical staff should have appropriate training and scopes of practice to treat adolescent patients and should:

- deliver planned regimens of professionally directed psychosocial services, including counseling, psychoeducation, and psychotherapy;
- assess and treat substance use and other addictive disorders;
- assess and treat co-occurring mental health conditions;
- provide family services;
- support care coordination and coordinated treatment planning; and
- coordinate the delivery of recovery support services (RSS).

In medically managed youth programs, a clinical staff member who has at least 2 years of experience in adolescent treatment should provide oversight of youth treatment plans.

Allied Health Staff

Medically managed levels of care may have allied health staff (eg, certified peer support specialists, patient navigators, health educators, counselor aides, group living workers) who support the delivery of RSS, including:

- peer support services for patients and families;
- health education services, such as prevention of infectious diseases (eg, HIV, HCV), safe sex practices, and overdose prevention and reversal training;
- healthcare and social service navigation services for patients and families; and
- transition support.

Universal MM Support Systems

Medically managed programs should have formal relationships with a psychiatric specialist with training and experience treating adolescent patients.

Medically managed programs are encouraged to establish relationships with nearby hospitals, local urgent care providers, and emergency departments to support effective coordination of care. All medically managed programs should have the ability to:

- coordinate care with methadone treatment providers (eg, OTPs), unless methadone access is not locally available;
- refer for specialized clinical consultation for biomedical, psychiatric, and cognitive problems as needed, including:
    - establishing relationships with infectious disease specialists,
    - establishing relationships with obstetricians to support coordination of care for patients who are pregnant and postpartum, and
    - considering local and treatment community needs when determining the need for other relationships[6];

[6] For example, if renal failure is common in the program's patient population, consider establishing a relationship with a nearby dialysis center to support effective coordination of care.

- support access to prescribed medications, including those that are obtained from a specialty pharmacy;
- provide or refer for primary care services;
- conduct or refer for appropriate laboratory testing services (eg, infectious disease screening) as needed; and
- conduct or refer for appropriate drug testing and toxicology services as needed.[7]

Universal MM Assessment and Treatment Planning

Assessment

The Level of Care and Treatment Planning Assessments in all medically managed programs involve:

- a comprehensive nursing assessment performed at admission[8];
- a history and physical examination conducted by a physician or advanced practice provider;
- review and approval of the admission by a physician or advanced practice provider (if the history was conducted by other medical staff);
- appropriate laboratory, drug testing, and toxicology services as needed[§]; and
- sufficient biopsychosocial screening and assessments conducted to determine the appropriate level of care and develop individualized care and transition plans that address treatment priorities identified in each dimension.

Program policies and procedures should define when a physician or advanced practice provider needs to be consulted prior to admission (eg, medically complex cases).

Treatment Planning

In medically managed levels of care, a preliminary treatment plan should be developed within 24 hours of admission.

The treatment plan should reflect coordination of addiction treatment, biomedical health care, mental health care, and RSS needs to address problems identified through the comprehensive biopsychosocial assessment as needed and reflect coordination of care with external biomedical and psychiatric providers.

The treatment plan should also reflect coordination with the family, including the family's role in supporting the treatment plan.

Reassessment

Programs should perform regular reassessments at a frequency appropriate to the patient's level of stability and severity of illness to determine if the patient is progressing appropriately. Medical staff should assess patients and review patient progress daily, at minimum; in Level 3.7Y, a

[7] Please see ASAM's Appropriate Use of Drug Testing in Clinical Addiction Medicine consensus statement for guidance.
[8] This does not apply in Level 1.7Y programs, which may not have nursing staff.

physician or advanced practice provider should conduct the assessment. Daily assessments may occur in-person or, when appropriate, via video-based telemedicine check-ins during the acute phase of withdrawal management and biomedical treatment. Telephone check-ins may be appropriate alternatives to in-person or video-based telemedicine check-ins depending on the acuity of the patient's signs and symptoms and concerns regarding adherence to prescribed medications. Progress notes and treatment changes should be recorded in the patient's health record.

Serial medical assessments, including appropriate measures of withdrawal, should be conducted as needed.

Universal MM Services

Withdrawal Management

Medically managed programs provide intoxication and withdrawal management services, including:

- medical monitoring and management of signs and symptoms of intoxication and withdrawal;
- assessment with standardized scales (eg, Clinical Institute Withdrawal Assessment for Alcohol, revised [CIWA-Ar], Clinical Opiate Withdrawal Scale [COWS]) to determine the severity of withdrawal as appropriate;
- pharmacological methods of withdrawal management that are appropriate for the severity of withdrawal or anticipated withdrawal syndrome[9]*; and
- nonpharmacological clinical support, including but not limited to:
    - informing patients and families of what to expect over the course of treatment;
    - offering reassurance;
    - providing a quiet environment;
    - educating patients and families on the importance of adequate hydration and nutrition; and
    - for patients treated in outpatient settings (ie, Levels 1.7 and 2.7), educating family members, caregivers, and other support persons (with patient assent or consent as appropriate) on how to support the patient during withdrawal management, including:
        - monitoring for withdrawal signs and symptoms,
        - what situations require urgent or emergent medical or clinical services (ie, when to call the program, 911, or 988),
        - supporting medication adherence,
        - supporting adequate hydration and nutrition,
        - creating a low stimulation environment, and
        - offering encouragement and reassurance.

[9] Please see The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management for guidance

Addiction Medications

Medically managed programs should be able to support initiation, titration, and continuation of addiction medications[10] in alignment with current best practices, such as those established in:

- The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update,
- The APA Practice Guideline for the Pharmacological Treatment of Patients With Alcohol Use Disorder,
- The ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorder, and
- ASAM's Integrating Tobacco Use Disorder Interventions in Addiction Treatment: A Guide for Addiction Treatment Clinicians and Programs.

Injectable medications may be provided through an appropriate provider of injection medication services but should be available on-site.

Patient and family education should be provided regarding available addiction medications, including those currently available to treat opioid use disorder (OUD), alcohol use disorder (AUD), and tobacco use disorder (TUD).

Management of Co-occurring Biomedical and Psychiatric Conditions

All medically managed programs should provide medical monitoring and management of biomedical and psychiatric conditions, including:

- basic management of hyperglycemia and hypoglycemia;
- basic wound care;
- infectious disease management, including:
    - screening and assessment for STIs and bloodborne infections (eg, HIV, hepatitis B virus [HBV], HCV);
    - initiation of treatment and/or coordinated referral to treatment with coordination of care with infectious disease specialists as needed; and
    - initiation of treatment and/or coordinated referral for preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) and provision of patient education regarding PrEP and PEP*[11];
- coordination of care for pregnancy and postpartum needs;
- coordination of care for biomedical conditions, including pain, for which the patient is receiving treatment from an external provider;

[10] Including all FDA-approved medications for OUD (including methadone, unless unavailable locally), AUD, and TUD (some of which are approved for use in adolescents); off-label medications for other SUDs, including stimulant use disorder (StUD) and cannabis use disorder (CUD); and medications to manage post-acute withdrawal symptoms.

[11] Please see the US Public Health Service's Preexposure Prophylaxis for the Prevention of HIV Infection in the United States—2021 Update: A Clinical Practice Guideline for guidance

- psychiatric medication initiation or titration and management of common, low-moderate complexity psychiatric conditions;
- direct management or coordination of controlled medications; and
- prescription services with essential medications on-site.[12]†

Toxicology Services

Medically managed programs should provide drug testing to support the patient's individual treatment plan as needed, following standards such as those defined in ASAM's current guideline on the use of drug testing in clinical addiction medicine.

Drug testing should be conducted based on patient- specific orders from their responsible physician or advanced practice provider. Drug testing and toxicology results should be reviewed and interpreted by a physician or advanced practice provider for whom interpretation of drug testing and toxicology results is in their scope of practice.

Programs should have written policies that outline how to respond to unexpected drug test and toxicology results, including modification of the treatment plan.

Level 1.7Y Standards

Level 1.7Y Description

Level 1.7Y programs provide medically managed outpatient services for patients with SUD who can be treated safely and effectively with low-intensity outpatient services. These programs also provide outpatient psychosocial services consisting primarily of psychotherapy, counseling, and psychoeducation to address addiction and co-occurring mental health conditions.

Level 1.7Y programs should provide all the services of Level 1.5Y programs either directly or through formal affiliations with other providers or programs.

Level 1.7Y Setting

Level 1.7Y services may be offered in any appropriate outpatient treatment setting with physician oversight that meets state licensure or certification criteria, such as:

- physicians' offices,
- health clinics,
- behavioral health clinics,
- primary care settings,
- outpatient addiction programs,
- OTPs,
- office-based addiction treatment programs,

[12] This is encouraged but not required in Level 1.7Y.

- mobile addiction treatment programs (eg, street medicine), and
- school-based health clinics.

Level 1.7Y Staff

Level 1.7Y programs are staffed by appropriately trained addiction treatment professionals acting within their state-regulated scopes of practice,* including physicians with controlled substance prescribing authority.†

Level 1.7Y programs may also be staffed by:

- advanced practice providers with controlled substance prescribing authority† who collaborate with program physicians, and
- nurses with the necessary scope of practice to support the delivery of services provided in Level 1.7Y.

Level 1.7Y programs are also staffed, directly or through formally affiliated providers or programs, by clinical staff, such as psychologists, clinical social workers, SUD and mental health counselors, and others trained to assess and treat SUD and/or co- occurring mental health conditions with the necessary scopes of practice to support the delivery of psychosocial services provided in Level 1.7Y.

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* Please see Appendix D for additional information on recommended staff competencies.
† Including authorization to prescribe buprenorphine.

Medical Staff

Medical Director

Level 1.7Y programs should have a medical director (or responsible physician in an independent practice) who is a physician with at least two years of documented experience delivering specialty addiction treatment. The medical director may be supported by advanced practice providers and nursing staff.

Physicians and Advanced Practice Providers

In Level 1.7Y programs, physicians and advanced practice providers with controlled substance prescribing authority* should be active members of the care team during program hours of operation. Physicians and advanced practice providers should have consistent, direct interactions— either in-person or via video-based telemedicine— with patients in the acute phase of withdrawal.

In Level 1.7Y programs, the medical director or another physician in the program should have at least 2 years of experience in adolescent SUD treatment. This physician should provide supervision of patient treatment plans.

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* Including authorization to prescribe buprenorphine.

Addiction/Psychiatric Specialist Physicians

Level 1.7Y programs may not have addiction specialist physicians on staff. However, programs should have policies and procedures that define when and how to consult with or refer to addiction specialist physicians as needed.

Level 1.7Y programs should have established relationships with psychiatrists or advanced practice providers with specialty certification in psychiatry (eg, psychiatric NP) and experience treating adolescent patients to support effective referrals when needed.

Clinical Staff

Level 1.7Y programs should have appropriately trained clinical staff available on-site or via telemedicine during program hours of operation, directly or through formally affiliated providers or programs. At this level of care, treatment planning should be led by medical staff.

Level 1.7Y programs may have a program director.

Level 1.7Y Support Systems

Level 1.7Y programs are encouraged to provide afterhours telephonic availability through direct connection to on-call services, such as nurse triage lines. At intake, programs should educate patients and families on what to do if urgent or emergent issues arise after- hours (eg, community resources, help lines, 911, 988).

Level 1.7Y Assessment and Treatment Planning

A physical examination should be conducted by a physician or advanced practice provider within a reasonable time frame of treatment initiation.

In Level 1.7Y programs, the patient-facing treatment plan should include a plan for accessing emergency care 24/7, including when to call 911 or 988.

A psychiatric assessment should be coordinated within 7 days when needed.

A Treatment Planning Assessment should be conducted or reviewed within the first three visits.

Level 1.7Y Services

Medical Services

Level 1.7Y programs provide outpatient medical management of acute withdrawal and biomedical and psychiatric conditions including:

- a medical or nursing assessment upon admission that includes:
    - vitals, including pulse oximetry;
    - history of present illness;
    - baseline evaluation of withdrawal severity and risks; and
    - medical history, including assessment of current

- biomedical, psychiatric, and cognitive concerns and medication review;
- a physical examination or psychiatric assessment, typically at initial visit.
    - If a psychiatric assessment is conducted the provider should determine whether a physical examination is needed and, if so, provide a coordinated referral in a timeframe appropriate to the need; and
- medication initiation and management for common low complexity psychiatric conditions.

Programs should consider providing daily walk-in slots to ensure availability of services.

Level 1.7Y programs should support outpatient medical monitoring and management of common comorbid biomedical and psychiatric conditions.

Note that the draft standards require programs to be capable of conducting a hands-on assessment (eg, collection of vital signs). This may limit the ability of telehealth only programs from meeting the standards for Level 1.7Y. When assessing Dimension 1 and 2 needs and providing related medical care, in-person assessments are a best practice. However, this may present access issues in some areas of the country. We are seeking public comment on whether to leave the standards as written or to add flexibility in the standards such that the medical director may determine the appropriateness of virtual assessment for a given patient.

Biomedical Capabilities

Level 1.7Y programs should have access to the following biomedical capabilities on-site:

- vitals measurement and monitoring, including pulse oximetry and blood pressure;
- glucose monitoring;
- basic first aid;
- an automated external defibrillator (AED);
- basic wound care;
- injectable epinephrine;
- overdose reversal medication (eg, naloxone);
- point-of-care pregnancy testing;
- laboratory services; and
- drug testing and toxicology services.

Clinical Services

Level 1.7Y programs provide clinical services in an amount, frequency, and intensity appropriate to individual patient and family needs and level of function as determined by *The ASAM Criteria* multidimensional assessment.

Psychosocial Services

The psychosocial services delivered should be individualized based on the patient and family's assessment. Patients should be excused from participating in psychosocial services and RSS if acute withdrawal or biomedical, psychiatric, or cognitive conditions prevent effective participation.

If psychosocial services are provided through formally affiliated providers and programs, regular check-ins should occur regarding the care of each patient.

Level 2.7Y Standards

Level 2.7Y Description

Level 2.7Y programs provide medically managed intensive outpatient services for patients who require access to medical management with extended nurse monitoring but not 24-hour nursing support, overnight medical monitoring, nor residential structure and support.

These programs provide coordinated management of withdrawal and biomedical and psychiatric comorbidities delivered by medical and clinical staff in an intensive outpatient setting. They provide at least 20 hours of clinical services per week comprised of medical care and psychosocial services to address addiction and cooccurring mental health conditions.

Level 2.7Y programs should provide all the services of Level 2.5Y programs either directly or through formal affiliations with other providers or programs.

Level 2.7Y Setting

Level 2.7Y services may be offered in any appropriate outpatient treatment setting with physician oversight that meets state licensure or certification criteria, such as:

- IOP program settings,
- partial hospitalization program (PHP) settings,
- OTPs, and
- office- based specialty addiction treatment practices.

Level 2.7Y Staff

Level 2.7Y programs are staffed by an interdisciplinary team of appropriately trained and supervised addiction treatment professionals acting within their state-regulated scopes of practice,* including:

- a medical director;
- physicians and advanced practice providers with controlled substance prescribing authority†; and
- nurses with the necessary scope of practice to support the delivery of services provided in Level 2.7Y.

Level 2.7Y programs are also staffed, directly or through formally affiliated providers or programs, by:

- a program director; and
- clinical staff, such as psychologists, clinical social workers, SUD and mental health counselors, and others trained to assess and treat SUD and/or co- occurring mental health

conditions with the necessary scopes of practice to support the delivery of services provided in Level 2.7Y.

Level 2.7Y programs are typically supported by allied health staff, such as certified peer support specialists, patient navigators, health educators, and counselor aides who support ongoing engagement in addiction treatment, deliver RSS, and provide warm handoffs to other levels of care.

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* Please see Appendix D for additional information on recommended staff competencies
† Including authorization to prescribe buprenorphine.

Medical Staff

Medical Director

Level 2.7Y programs should have a medical director who is an addiction specialist physician or a physician with at least five years of documented experience in specialty addiction treatment.*

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* If a program is unable to identify a medical director who meets these qualifications after reasonable efforts, a physician with at least two years of documented experience in specialty addiction treatment who meets the competencies described in Appendix D may serve as the medical director. In these instances, this medical director should have an established mentor who is board certified in addiction medicine or addiction psychiatry.

Physicians and Advanced Practice Providers

In Level 2.7Y programs, physicians and advanced practice providers with controlled substance prescribing authority* should be available on- site or via telemedicine as active members of the care team during program hours of operation. Medical staff should be on call 24 hours a day to address urgent issues that arise after- hours, though qualified clinical staff may serve as first- line triage.

Level 2.7Y programs should be supported by physicians with at least 2 years of experience in adolescent SUD treatment, either on staff or through formal affiliations, who provide supervision of treatment plans.

Physicians and advanced practice providers should have consistent, direct interactions— either in-person or via video- based telemedicine— with patients in the acute phase of withdrawal.

Advanced practice providers should have ready access to the medical director or another equivalently qualified physician at all times.

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* Including authorization to prescribe buprenorphine.

Addiction/Psychiatric Specialist Physicians

In Level 2.7Y programs, an addiction specialist physician should ideally serve as the medical director. However, if addiction specialist physicians are not on staff, programs should have policies and procedures that define when and how to consult with or refer to addiction specialist physicians as needed.

Level 2.7Y programs should have formal affiliations with psychiatrists or advanced practice providers with specialty certification in psychiatry (eg, psychiatric NPs) and experience treating adolescent patients who are available on-site or via telemedicine within 24 hours. [Note: In acute situations where more rapid psychiatric services are needed, the patient should be transitioned to a more intensive level or care or crisis services should be engaged.]

Nursing and Medical Support Staff

RNs or other appropriately licensed and credentialed nurses (eg, LPNs) should be available during program hours of operation.

Clinical Staff

Level 2.7Y programs should have appropriately trained clinical staff available on-site or via telemedicine during program hours of operation, directly or through formally affiliated providers or programs. At this level of care, treatment planning should be led by medical staff.

The program director in a Level 2.7Y program (or formally affiliated program that provides psychosocial services) should, at minimum, have a master's degree in a field related to adolescent clinical behavioral health and at least five years of documented experience in addiction treatment.*

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* If a program is unable to identify a program director who meets these qualifications after reasonable efforts, a clinician with at least five years of documented clinical and supervisory experience in addiction treatment who meets the competencies described in Appendix D may serve as the program director. In these instances, this program director should have an established mentor and a written plan to obtain a terminal degree within five years.

Level 2.7Y Support Systems

Level 2.7Y programs are encouraged to provide afterhours telephonic availability through direct connection to on- call services, such as nurse triage lines. At intake, programs should educate patients and families on what to do if urgent or emergent issues arise after- hours (eg, community resources, help lines, 911, 988).

Level 2.7Y Assessment and Treatment Planning

Within 24 to 48 hours of admission, a physician or advanced practice provider should conduct a history and physical examination on-site and review and approve the admission decision.*

In Level 2.7Y programs, the patient-facing treatment plan should include a plan for contacting the program afterhours and accessing emergency care 24/7, including when to call 911 or 988.

A psychiatric assessment should be conducted within 72 hours of admission.

A Treatment Planning Assessment should be conducted or reviewed within 48 hours of admission or initial stabilization.

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* The physical exam and review and approval of admission should typically be completed within 24 hours of admission, but flexibility is included to account for programs that operate six days per week.

Level 2.7Y Services

Medical Services

Level 2.7Y programs provide intensive outpatient medical management and extended nurse monitoring for stabilization of acute withdrawal and biomedical and psychiatric conditions including:

- a comprehensive medical history and physical examination;
    - collateral information should be obtained from family members, if available.
- a nursing assessment upon admission that includes:
    - vitals, including pulse oximetry;
    - history of present illness;
    - baseline evaluation of withdrawal severity and risks; and
    - medical history, including assessment of current biomedical, psychiatric, and cognitive concerns and medication review;
- nurse monitoring;
- medication management, including regular monitoring of the patient's adherence to prescribed medications; and
- prescription services with essential medications on-site.

A physician or advanced practice provider should be available in-person or via telemedicine during program hours of operation to initiate or adjust medications based on the results of nursing assessments. Medications may be provided based on a patient-specific verbal order from the physician or advanced practice provider.*

Withdrawal management and medication initiation services should be available within 1 hour of initial assessment. Programs should consider providing daily walk-in slots to ensure availability of services.

Level 2.7Y programs provide outpatient medical monitoring and management of common comorbid biomedical and psychiatric conditions.

Programs should have policies and procedures that define essential medicines based on current standards of clinical practice. Programs are responsible for ensuring that these medications are stocked and stored securely.

In Level 2.7Y programs, a psychiatrist or advanced practice provider with specialty certification in psychiatry (eg, psychiatric NP) and experience treating adolescent patients should be available on-site or via telemedicine within 24 hours to provide medical management of psychiatric conditions and titrate psychiatric medications when needed.

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* Per program protocol, which should be developed, approved, and regularly reviewed by the medical director.

Biomedical Capabilities

Level 2.7Y programs should have access to the following biomedical capabilities on-site:

- vitals measurement and monitoring, including pulse oximetry and blood pressure;
- glucose monitoring;
- basic first aid;
- an AED;
- ECG with a 3- lead rhythm strip at minimum*;
- basic wound care;
- injectable epinephrine;
- overdose reversal medication (eg, naloxone);
- vaccine administration† (eg, hepatitis A and B viruses, influenza, COVID- 19, HPV);
- point- of- care pregnancy testing;
- laboratory and phlebotomy services; and
- drug testing and toxicology services.

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* The rationale for ECG capacity is to determine the level of risk and need for Level 4Y care, not for diagnosis or disease management. It is also important for monitoring for QTc prolongation in patients on methadone.
† Vaccines should be available on-site in Level 2.7Y programs but may be provided through established relationships with external partners.

Clinical Services

Level 2.7Y programs provide at least 20 hours of clinical services per week comprised of both medical and psychosocial services.

Services should be provided in an amount, frequency, and intensity appropriate to individual patient and family needs and level of function as determined by *The ASAM Criteria* multidimensional assessment.

Psychosocial Services

The psychosocial services delivered should be individualized based on the patient and family's assessment. Structured psychosocial services selected by master's level clinical staff should be available at least five days per week either directly or through formal affiliation.

Patients should be excused from participating in psychoeducation, psychotherapy, and RSS if acute withdrawal or biomedical, psychiatric, or cognitive conditions prevent effective participation.

If psychosocial services are provided through formally affiliated providers and programs, frequent (ie, daily or near-daily) check-ins should occur regarding the care of each patient.

Level 3.7Y Standards

Level 3.7Y Description

Level 3.7Y programs provide medically managed residential services for patients who require 24-hour observation, monitoring, and treatment but not the full resources of a hospital. These programs provide coordinated management of withdrawal and biomedical and psychiatric comorbidities delivered by medical and clinical staff in a permanent residential facility. They provide at least 20 hours of clinical services per week comprised of medical care and psychosocial services to address addiction and co-occurring mental health conditions.

Level 3.7Y programs should provide all the services of Level 3.5Y programs either directly or through formal affiliations with other providers or programs.

Level 3.7Y Setting

Level 3.7Y services may be offered in any appropriate residential treatment setting with 24-hour nursing staff and physician oversight that meets state licensure or certification criteria. The facility should incorporate space for:

- medical and nursing services, and
- all services and activities outlined in the Universal Residential Setting Standards (p x).

Patient Supervision

Level 3.7Y programs should provide 24-hour supervision of patients. Staff should verify and document the whereabouts and wellness of each patient who is on-site at least once every hour. Note that this is separate from clinical monitoring, the frequency of which should be determined based on the individual clinical needs of each patient.

At this level of care, patients should not leave program premises except under limited circumstances, such as for specialty medical or diagnostic appointments or medical or psychiatric emergencies.

Program staff (or staff of external providers or programs providing services to the patient) should provide continuous supervision of patients when they are off-site to prevent risky behaviors and address any instability or other issues that may arise in a safe and timely manner.

Programs should have policies and procedures in place for providing continuous supervision when patients are off-site.

Level 3.7Y Staff

Level 3.7Y programs are staffed by an interdisciplinary team of appropriately trained and supervised addiction treatment professionals acting within their state-regulated scopes of practice,* including:

- a medical director,
- physicians and advanced practice providers with controlled substance prescribing authority,† and
- nurses with the necessary scope of practice to support the delivery of services provided in Level 3.7Y.

Level 3.7Y programs are also staffed, directly or through formally affiliated providers or programs, by:

- a program director;
- clinical staff, such as psychologists, clinical social workers, SUD and mental health counselors, and others trained to assess and treat SUD and/or co- occurring mental health conditions with the necessary scopes of practice to support the delivery of services provided in Level 3.7Y; and
- allied health staff, such as certified peer support specialists, patient navigators, health educators, counselor aides, and group living workers who support ongoing engagement in addiction treatment, deliver RSS, and support warm handoffs to other levels of care.

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* Please see Appendix D for additional information on recommended staff competencies.
† Including authorization to prescribe buprenorphine.

Medical Staff

Medical Director

Level 3.7Y programs should have a medical director who is an addiction specialist physician with board certification in addiction medicine or addiction psychiatry.*

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*If a program is unable to identify a medical director who meets these qualifications after reasonable efforts, a physician with at least five years of documented experience in specialty addiction treatment who meets the competencies described in Appendix D may serve as the medical director. In these instances, this medical director should have an established mentor who is board certified in addiction medicine or addiction psychiatry.

Physicians and Advanced Practice Providers

In Level 3.7Y programs, physicians and advanced practice providers with adolescent treatment experience and controlled substance prescribing authority* should be available on- site or via telemedicine as active members of the care team 24 hours a day.

Level 3.7Y programs should have access to physicians with 2 or more years of experience in adolescent SUD treatment, either on staff or through formal affiliations, who provide supervision of treatment plans.

Physicians and advanced practice providers should have consistent, direct interactions— either in-person or via video-based telemedicine— with patients in the acute phase of withdrawal.

Physicians and advanced practice providers should generally assume management of all controlled substance prescriptions from external prescribers and make final determinations regarding the medication treatment plan, including when to taper or discontinue medications prescribed prior to admission.

Advanced practice providers should have ready access to the medical director or another equivalently qualified physician at all times.

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* Including authorization to prescribe buprenorphine.

Addiction/Psychiatric Specialist Physicians

In Level 3.7Y programs, the medical director should be an addiction specialist physician except under limited circumstances. Other physicians and advanced practice providers can support and extend the capabilities of addiction specialist physicians; however, they should not replace the role of the addiction specialist physician in direct patient care.

In the limited instances where addiction specialist physicians are not on staff, programs should have policies and procedures that define when and how to consult with or refer to addiction specialist physicians as needed.

Level 3.7Y programs should have formal affiliations with psychiatrists or advanced practice providers with specialty certification in psychiatry (eg, psychiatric NPs) experienced in adolescent treatment who are available onsite or via telemedicine within 24 hours. [Note: In acute situations where more rapid psychiatric services are needed the patient should be transitioned to a more intensive level or care or crisis services should be engaged.]

Nursing and Medical Support Staff

RNs or other appropriately licensed and credentialed nurses (eg, LPNs) should be available 24 hours a day. A nursing supervisor should be available 24/7 to respond to urgent situations.

Clinical Staff

Level 3.7Y programs should have appropriately trained clinical staff available on-site or on-call 24 hours a day, directly or through formally affiliated providers or programs.

At this level of care, treatment planning should be led by medical staff.

Mental health treatment providers with adolescent treatment experience should be part of the interdisciplinary team. Clinical staff members on the interdisciplinary team who have more training

and experience with mental health care should support their team members to deliver effective, integrated* co-occurring capable care.

The program director in a Level 3.7Y program (or formally affiliated program that provides psychosocial services) should, at minimum, have a master's degree in a field related to adolescent clinical behavioral health and at least five years of documented experience in addiction treatment.†

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*Here, integrated refers to mental health services provided within the context of addiction treatment.
† If a program is unable to identify a program director who meets these qualifications after reasonable efforts, a clinician with at least five years of documented clinical and supervisory experience in addiction treatment who meets the competencies described in Appendix D may serve as the program director. In these instances, this program director should have an established mentor and a written plan to obtain a terminal degree within five years.

Level 3.7Y Assessment and Treatment Planning

Within 24 hours of admission, a physician or advanced practice provider should conduct a history and physical examination on-site and review and approve the admission. When Level 3.7Y is a step- down service from Level 4, records of physical examination within the preceding seven days should be reviewed by a physician or advanced practice provider within 24 hours of admission.

A psychiatric assessment should be conducted within 72 hours of admission.

A Treatment Planning Assessment should be conducted or reviewed within 48 hours of admission or initial stabilization.

Level 3.7Y Services

Medical Services

Level 3.7Y programs provide residential medical management and 24-hour nurse monitoring for stabilization of acute withdrawal and biomedical and psychiatric conditions including:

- a comprehensive medical history and physical examination performed within 24 hours of admission;
- a nursing assessment conducted at admission that includes:
    - vitals, including pulse oximetry;
    - history of present illness;
    - baseline evaluation of withdrawal severity and risks; and
    - medical history, including assessment of current biomedical, psychiatric, and cognitive concerns and medication review;
- hourly nurse monitoring of the patient's progress and medication administration as needed;
- medication management, including regular monitoring of the patient's adherence to prescribed medications, which may include self- administered injections or infusions; and
- prescription services with essential medications on- site.

A physician or advanced practice provider should be available in-person or via telemedicine 24/7 to initiate or adjust medications based on the results of nursing assessments. Medications may be provided based on a patient-specific verbal order from the physician or advanced practice provider.*

Level 3.7Y programs should provide residential medical monitoring and management of common comorbid biomedical and psychiatric conditions.

Level 3.7Y programs are encouraged to provide at least 3.5 hours of nursing care per patient per day, encompassing care provided by RNs, LPNs, CNAs, paramedics, and medical technicians under the supervision of an RN.

Programs should have policies and procedures that define essential medicines based on current standards of clinical practice. Programs are responsible for ensuring that these medications are stocked and stored securely.

In Level 3.7Y programs, a psychiatrist or advanced practice provider with specialty certification in psychiatry (eg, psychiatric NP) and adolescent treatment experience should be available on- site or via telemedicine within 24 hours to provide medical management of psychiatric conditions, respond to psychiatric emergencies, and titrate psychiatric medications as needed.

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* Per program protocol, which should be developed, approved, and regularly reviewed by the medical director.

Biomedical Capabilities

Level 3.7Y programs should have access to the following biomedical capabilities on- site:

- vitals measurement and monitoring, including pulse oximetry and blood pressure;
- glucose monitoring;
- basic first aid;
- bottle oxygen;
- an AED;
- ECG with a 3- lead rhythm strip at minimum*;
- basic wound care;
- mobility assistance;
- injectable epinephrine;
- overdose reversal medication (eg, naloxone);
- injectable medications (eg, injectable buprenorphine, extended- release naltrexone);
- vaccine administration† (eg, hepatitis A and B viruses, influenza, COVID- 19, HPV);
- point-of-care pregnancy testing;
- laboratory and phlebotomy services, including:
    - access to laboratory services five days per week, and
    - access to blood culture services; and
    - drug testing and toxicology services.‡

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*The rationale for ECG capacity is to determine the level of risk and need for Level 4Y care, not for diagnosis or disease management. It is also important for monitoring for QTc prolongation in patients on methadone.
† Vaccines should be available on- site in Level 3.7Y programs but may be provided through established relationships with external partners.
‡ Please see ASAM's Appropriate Use of Drug Testing in Clinical Addiction Medicine consensus statement for guidance.

Clinical Services

Level 3.7Y programs provide at least 20 hours of clinical services per week comprised of both medical and psychosocial services. Structured psychosocial services selected by master's level clinical staff should be available seven days per week either directly or through formal affiliation.

Services should be provided in an amount, frequency, and intensity appropriate to individual patient and family needs and level of function as determined by The ASAM Criteria multidimensional assessment. Level 3.7Y programs should be able to provide transportation as needed for clinical services (eg, specialty healthcare services) that are not available on-site.

Psychosocial Services

The psychosocial and family services delivered should be individualized based on the patient and family's assessment. Patients should be excused from participating in psychoeducation, psychotherapy, and RSS if acute withdrawal or biomedical, psychiatric, or cognitive conditions prevent effective participation.

If psychosocial services are provided through formally affiliated providers and programs, daily check-ins should occur regarding the care of each patient.

Level 4Y Standards

Level 4Y Description

Level 4Y programs provide medically managed inpatient services for patients whose acute intoxication; withdrawal; and biomedical, psychiatric, and/or cognitive conditions are so severe that they require 24-hour medically directed evaluation and treatment in an acute care hospital. Because Level 4Y programs provide the most intensive services in the continuum of care, its principal focus is stabilization of the patient and preparation for their transition to a less intensive setting for continuing care.

Level 4Y Setting

Level 4Y services may be offered in any appropriate acute care treatment setting with 24-hour nursing staff and physician oversight that meets state licensure or certification criteria. Level 4Y treatment typically occurs in two types of settings:

- acute care general hospitals (Level 4Y General Hospital), or
- addiction treatment units within acute care general hospitals with critical care services available on premises (Level 4Y Addiction Specialty Unit).

Level 4Y General Hospital

Level 4Y Staff

Level 4Y General Hospitals are staffed by an interdisciplinary team of appropriately trained and supervised professionals acting within their state-regulated scopes of practice,* including:

- physicians with controlled substance prescribing authority†;
- nurses with the necessary scope of practice to support the delivery of services provided in Level 4Y General Hospitals; and
- clinical staff, such as psychologists, clinical social workers, SUD and mental health counselors, and others trained to assess and treat SUD and/or co-occurring mental health conditions with the necessary scopes of practice to support the delivery of services provided in Level 4Y General Hospitals.

Level 4Y General Hospitals are encouraged to employ allied health staff, such as certified peer support specialists, patient navigators, health educators, and counselor aides who support ongoing engagement in addiction treatment, deliver RSS, and provide warm handoffs to less intensive levels of care.

Advanced practice providers may collaborate with physicians at this level of care. At least one prescriber authorized to prescribe buprenorphine should be available on-site or via telemedicine 24 hours a day.

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* Please see Appendix D for additional information on recommended staff competencies.
† Including authorization to prescribe buprenorphine.

Medical Staff

Physicians and Advanced Practice Providers

In Level 4Y General Hospitals, physicians and advanced practice providers with controlled substance prescribing authority† should be available on- site or via telemedicine as active members of the care team 24 hours a day.

Physicians and advanced practice providers should determine if and when a patient should be transitioned to an intensive care unit (ICU) or relevant specialty unit.

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† Including authorization to prescribe buprenorphine.

Addiction Specialist Physicians

Level 4Y General Hospitals are encouraged to establish evidence- based addiction medicine consultation teams that have expertise in addiction medicine to address complex addiction treatment needs and facilitate appropriate referrals when transitioning patients from hospital care.

Written protocols related to the treatment of intoxication, withdrawal, and SUD should be reviewed by a physician who is board certified in addiction medicine or addiction psychiatry and has at least 2 years of experience treating adolescent patients.

Nursing and Medical Support Staff

RNs or other appropriately licensed and credentialed nurses (eg, LPNs) should be available 24 hours a day. A nursing supervisor should be available 24/7 to respond to urgent situations.

Clinical Staff

Level 4Y General Hospitals should have appropriately trained clinical staff available daily. Clinical staff with the appropriate training and scopes of practice should provide case management services according to the assessed needs of the patient and family.

Level 4Y General Hospitals do not typically have a program director.

Allied Health Staff

Level 4Y General Hospitals may have allied health staff and are encouraged to provide the following services for patients and families:

- peer support services;
- health education services, such as overdose prevention and reversal training;
- family education services;
- patient navigation services; and
- transition support.

Level 4Y Support Systems

Support systems in Level 4Y General Hospitals include a full range of acute care services, specialty consultation, and ICU services. Support system requirements are established by hospital accreditation organizations and typically include the following of relevance to the management of SUD and co-occurring conditions:

- psychiatric assessment available within a time frame appropriate to the severity and urgency of the need;
- laboratory and phlebotomy services available on- site; and
- drug testing and toxicology services,* including the ability to conduct:
    - laboratory-based immunoassay testing for common substances and substance metabolites available onsite, and
    - confirmatory testing for specialty metabolites available on-site or through established relationship with an external laboratory.

To support patient engagement in ongoing addiction treatment, Level 4Y General Hospitals are encouraged to have established relationships with less intensive levels of adolescent addiction and psychiatric treatment to support care coordination and effective transitions in care. Important examples include but are not limited to:

- addiction medication providers (eg, methadone treatment programs, physicians and advanced practice providers with controlled substance prescribing authority†) to confirm doses and support effective engagement in ongoing addiction treatment upon transition from the Level 4Y program,
- Level 3.7Y programs to support step-down to medically managed residential treatment, and
- Level 2.5Y and 3.5Y programs to support step- down to clinically managed high-intensity addiction treatment.
- CALOCUS-CASII Levels 4 (Medically Monitored Community Based Services) and 5 (Medically Monitored Intensive Integrated Services to support step- down to clinically managed high-intensity mental health treatment.

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* Please see ASAM's Appropriate Use of Drug Testing in Clinical Addiction Medicine consensus statement for guidance.
† Including authorization to prescribe buprenorphine.

Level 4Y Assessment and Treatment Planning

The Treatment Planning Assessment in Level 4Y General Hospitals involves a history and physical examination performed within 24 hours of admission.

Although Level 4Y is specifically designed for acute issues in Dimensions 1, 2, and 3, it is also important to assess any treatment priorities in Dimensions 4 through 6. The results of all biopsychosocial screening and assessments should be clearly communicated to the patient's next level of care, ideally through a direct conversation between clinicians and written documentation of assessment results and treatment plans (with appropriate patient and family assent/consent as required).

In Level 4Y General Hospitals, the treatment plan should reflect:

- case management conducted by on- site staff;
- coordination with the family; and
- coordination of addiction treatment, biomedical care (eg, obstetrics and gynecology, infectious diseases), and mental health care.

Level 4Y Services

Medical Services

Level 4Y General Hospitals should have the following medical services available:

- full medical acute care services, including:
  - medical histories and physical examinations,
  - prescribing and medication management, and
  - diagnostic assessments;
- ICU services as needed;
- psychiatric services;

- nursing assessments conducted at admission and regular intervals throughout the episode of care; and hourly or more frequent nurse monitoring of patient progress and medication administration as needed; and
- laboratory, drug testing, and toxicology services, with medical staff with the training and experience to appropriately interpret the results.

Level 4Y General Hospitals should be able to support initiation, titration, and continuation of addiction medications* in alignment with current best practices.

Level 4Y pharmacy services should include all FDA approved treatments for SUDs on their formularies, including methadone, buprenorphine, and naltrexone, as well as medications for AUD and TUD. Programs should have protocols that address care coordination with prescribers in the community.

Level 4Y General Hospitals should deliver individualized management of all acute biomedical, psychiatric, and cognitive conditions with an interdisciplinary treatment team.

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* Including all FDA- approved medications for OUD (including methadone, unless unavailable locally), AUD, and TUD; off-label medications for other SUDs, including StUD and CUD; and medications to manage post- acute withdrawal symptoms.

Biomedical Capabilities

Level 4Y General Hospitals should have access to the full biomedical capabilities available in an acute care hospital setting.

Clinical Services

Level 4Y General Hospitals directly provide:

- daily clinical services delivered by an interdisciplinary treatment team to assess and address each patient's individual needs, including:
  - nursing services;
  - medical services, including access to critical care services as needed;
  - psychiatric services; and
  - social work and/or case management services;
- integrated care delivery, including:
  - coordination between relevant specialty units within the hospital, and
  - care coordination with external providers involved in the patient's care; and
- management of transition to other levels of care.

Care Coordination

Level 4Y General Hospitals should ideally coordinate care with any external addiction or mental health care providers involved in the patient's care (with appropriate patient and family assent/consent) at admission to and transition from the Level 4Y General Hospital and as needed to support effective care coordination for the individual patient.

For patients with severe comorbid biomedical and/ or psychiatric disorders, biomedical and/or psychiatric interventions, respectively, should ideally be coordinated with intoxication, withdrawal, and/or addiction treatment services.

Level 4Y General Hospitals should coordinate patient referrals and transitions to other levels of care, including warm handoffs, through care coordination and data sharing as appropriate.

Psychosocial Services

Level 4Y General Hospitals should provide basic psychosocial services including:

- interventions designed to enhance the patient and family's understanding of addiction and co-occurring mental health concerns, completion of treatment at Level 4Y, and engagement in appropriate levels of care for continuing treatment; and
- patient and family education on withdrawal management, harm reduction (eg, opioid overdose reversal training), and addiction treatment.

Recovery Support Services

Level 4Y General Hospitals should ideally provide peer support services for patients and families to facilitate engagement in ongoing care including:

- support for engagement in a less intensive level of care;
- transition planning, including warm handoffs;
- harm reduction (eg, naloxone training and access);
- connection to appropriate community resources; and
- support accessing services for domestic violence or (DV) intimate partner violence (IPV) through established relationships with DV and IPV violence service providers.

Level 4Y Documentation

Core documentation in Level 4Y General Hospitals should include:

- scoring for withdrawal rating scale tables and flow sheets (which may include tabulation of vital signs) as needed;
- standardized addiction screening and assessment results;
- standardized mental health screening and assessment results; and
- a transition plan that ideally addresses:
    - a review of the six dimensions of The ASAM Criteria,
    - recommendations for follow-up care,
    - reason(s) for departures from recommendations (if applicable),
    - program and level of care that the patient will transition to,
    - required medications and how patients will maintain access to medications during the transition, and
    - a follow-up plan to support ongoing engagement in care and documentation of follow- ups.

Level 4Y Addiction Specialty Unit

Level 4Y Specialty Staff

Level 4Y Addiction Specialty Unit programs are staffed by an interdisciplinary team of appropriately trained and supervised professionals acting within their state-regulated scopes of practice,* including:

- a medical director;
- physicians with controlled substance prescribing authority†;
- nurses with the necessary scope of practice to support the delivery of services provided in Level 4Y Addiction Specialty Unit programs;
- clinical staff, such as psychologists, clinical social workers, SUD and mental health counselors, and others trained to assess and treat adolescent SUD and/or co-occurring mental health conditions with the necessary scopes of practice to support the delivery of services provided in Level 4Y Addiction Specialty Unit programs; and
- allied health staff, such as certified peer support specialists, patient navigators, health educators, counselor aides, and group living workers who support ongoing engagement in addiction treatment, deliver RSS, and provide warm handoffs to less intensive levels of care.

Advanced practice providers may support physicians at this level of care. At least one prescriber authorized to prescribe buprenorphine should be available on-site or via telemedicine 24 hours a day.

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* Please see Appendix D for additional information on recommended staff competencies.
† Including authorization to prescribe buprenorphine.

Level 4Y Specialty Support Systems

Support systems in Level 4Y Addiction Specialty Unit programs include a full range of acute care services, specialty consultation, and ICU services. Support system requirements are established by hospital accreditation organizations and typically include the following of relevance to the management of SUD and co- occurring conditions:

- psychiatric assessment available within a time frame appropriate to the severity and urgency of the need;
- laboratory and phlebotomy services available on-site; and
- drug testing and toxicology services,* including the ability to conduct:
    - laboratory-based immunoassay testing for common substances and substance metabolites available onsite, and
    - confirmatory testing for specialty metabolites available on-site or through established relationship with an external laboratory.

To support patient engagement in ongoing addiction treatment, Level 4Y Addiction Specialty Unit programs should have formal affiliations with less intensive levels of addiction treatment to support care coordination and effective transitions in care. Important examples include but are not limited to:

- addiction medication providers (eg, methadone treatment programs, physicians and advanced practice providers with controlled substance prescribing authority†) to confirm doses and support effective engagement in ongoing addiction treatment upon transition from the Level 4Y program,
- Level 3.7Y and 3.7 BIO programs to support step-down to medically managed residential treatment, and
- Level 2.5Y and 3.5Y programs to support step-down to clinically managed high-intensity addiction treatment.
- CALOCUS-CASII Levels 4 (Medically Monitored Community Based Services) and 5 (Medically Monitored Intensive Integrated Services to support step- down to clinically managed high-intensity mental health treatment.

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* Please see ASAM's Appropriate Use of Drug Testing in Clinical Addiction Medicine consensus statement for guidance.
† Including authorization to prescribe buprenorphine.

Level 4Y Specialty Assessment and Treatment Planning

The Treatment Planning Assessment in Level 4Y Addiction Specialty Unit programs involves a history and physical examination performed within 24 hours of admission.

Although Level 4Y is specifically designed for acute issues in Dimensions 1, 2, and 3, it is also important to assess any treatment priorities identified in Dimensions 4 through 6. The results of all biopsychosocial screening and assessments should be clearly communicated to the patient's next level of care, ideally through a direct conversation between clinicians and written documentation of assessment results and treatment plans (with appropriate patient consent as required).

In Level 4Y Addiction Specialty Unit programs, individualized treatment plans should include:

- problem identification in each applicable dimension,
- defined treatment goals and measurable treatment objectives related to the Dimensional Drivers of admission to Level 4Y Addiction Specialty Unit care, and
- activities designed to meet those objectives.

The treatment plan should be developed in collaboration with the patient and their family, reflect the patient and family goals, and incorporate the patient and family's strengths. The treatment plan should also:

- reflect case management conducted by on-site staff;

- reflect coordination of addiction treatment, biomedical care (eg, obstetrics and gynecology, infectious diseases), psychiatric care, and RSS needs to address problems identified through the comprehensive biopsychosocial assessment as needed;
- reflect coordination of care with external treatment and service providers;
- incorporate family services;
- reflect coordination with the family; and
- address any mental health treatment needs identified, including:
    - services delivered by the program's treatment team, and
    - services delivered by external providers.

For patients who are from another region or state, transitions should be coordinated to appropriate care in their local communities.

Level 4Y Specialty Services

Medical Services

Level 4Y Addiction Specialty Unit programs should have the following medical and nursing services available:

- full medical acute care services, including:
    - medical histories and physical examinations,
    - prescribing and medication management, and
    - diagnostic assessments;
- ICU services as needed;
- psychiatric services;
- nursing assessments conducted at admission and regular intervals throughout the episode of care; and
- hourly or more frequent nurse monitoring of patient progress and medication administration as needed.

Level 4Y Addiction Specialty Unit programs should be able to support initiation, titration, and continuation of addiction and psychiatric medications* in alignment with current best practices.

Level 4Y pharmacy services should include all FDA-approved treatments for SUDs on their formularies, including methadone, buprenorphine, and naltrexone, as well as medications for AUD and TUD. Programs should have protocols that address care coordination with prescribers in the community.

Level 4Y Addiction Specialty Unit programs should deliver individualized management of all acute biomedical, psychiatric, and cognitive conditions with an interdisciplinary treatment team.

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* Including all FDA-approved medications for OUD (including methadone, unless unavailable locally), AUD, and TUD; off-label medications for other SUDs, including StUD and CUD; and medications to manage post-acute withdrawal symptoms.

Biomedical Capabilities

Level 4Y Addiction Specialty Unit programs should have access to the full biomedical capabilities available in an acute care hospital setting.

Clinical Services

Level 4Y Addiction Specialty Unit programs directly provide:

- daily clinical services delivered by an interdisciplinary treatment team to assess and address each patient and family's needs, including:
  - nursing services;
  - medical services, including access to critical care services as needed;
  - psychiatric services;
  - social work and/or case management services;
  - psychosocial services, including family services;
  - health education; and
  - services integrating family and significant others;
- integrated care delivery, including:
  - coordination between relevant specialty units within the hospital, and
  - care coordination with external providers involved in the patient's care; and
- management of transition to other levels of care.

Care Coordination

Level 4Y Addiction Specialty Unit programs should coordinate care with any external mental health care providers and any other external providers involved in the patient's care (with appropriate patient and family assent/consent) at admission to and transition from the Level 4Y Addiction Specialty Unit program and as needed to support effective care coordination for the individual patient.

For patients with severe comorbid biomedical and/ or psychiatric disorders, biomedical and/or psychiatric interventions, respectively, should be coordinated with intoxication, withdrawal, and/or addiction treatment services.

Programs should coordinate patient referrals and transitions to other levels of care, including warm handoffs, through care coordination and data sharing as appropriate.

Psychosocial Services

Level 4Y Addiction Specialty Unit programs should have psychosocial services available at least 8 hours per day, with services including:

- interventions designed to enhance the patient and family's understanding of addiction, completion of treatment at Level 4Y, and engagement in appropriate levels of care for continuing treatment;
- patient and family education on withdrawal management, addiction treatment, and the role of family-systems in adolescent recovery; and
- coordination of engagement in psychosocial and recovery support services.

Many patients in Level 4Y programs may not be ready to fully engage in psychosocial support services while acute problems in Dimensions 1, 2, or 3 are being stabilized. However, once stabilized, patients should be engaged in psychosocial treatment services.

Level 4Y Psychiatric

Level 4Y Psych Setting

The program's services should be designed to provide a welcoming environment for individuals with mental health disorders co- occurring SUDs, where patients feel safe addressing their SUD-related concerns and experiences along with their mental health-related concerns.

Level 4Y Psych Staff

All clinical and allied health staff in Level 4Y Psychiatric programs should be trained to support individuals with SUDs and their families. At least one clinical staff member who is qualified by training and licensure to assess and treat SUDs should be available on-site or via telemedicine.

Level 4Y Psychiatric programs should also have physicians or advanced practice providers with controlled substance prescribing authority.*

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* Including authorization to prescribe buprenorphine.

Level 4Y Psych Support Systems

Level 4Y Psychiatric programs should have established relationships with more and less intensive levels of care, including both COE and standard (ie, co-occurring capable) addiction treatment providers and programs, to:

- support access to specialty addiction assessment and consultation, and
- facilitate coordinated transitions in care.

Programs should also have established relationships with community physicians and/or advanced practice providers who prescribe addiction medications* and have controlled substance prescribing authority.†

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* Including all FDA- approved medications for OUD (including methadone, unless unavailable locally), AUD, and TUD; off-label medications for other SUDs, including StUD and CUD; and medications to manage post- acute withdrawal symptoms.
† Including authorization to prescribe buprenorphine.

Level 4Y Psych Assessment and Treatment Planning

Initial assessment in Level 4Y Psychiatric programs includes:

- an integrated mental health and addiction history conducted or reviewed by a physician or advanced practice provider,
- a nursing assessment screening for and assessing intoxication and withdrawal risks and addiction treatment needs, and
- a physical examination conducted by a physician or advanced practice provider within 24 hours of admission.

Treatment plans should address any addiction treatment needs identified, including:

- services delivered by the program's treatment team, and
- services delivered by external providers.

Transition plans should address continuity of care for both SUDs and co- occurring mental health conditions.

Level 4Y Psych Services

Medical Services

Level 4Y Psychiatric programs should be able to provide the equivalent of Level 3.7Y intoxication, withdrawal management, and addiction treatment services, including:

- nursing and medical monitoring for stabilization of acute withdrawal and biomedical and psychiatric conditions;
- psychosocial services for patients and families to encourage engagement in ongoing treatment;
- hourly nurse monitoring of the patient's progress and medication administration;
- medical monitoring and management of signs and symptoms of intoxication and withdrawal;
- assessment with standardized scales (eg, CIWA-Ar, COWS, Richmond Agitation- Sedation Scale [RASS]) to determine the severity of withdrawal when appropriate;
- pharmacological methods of withdrawal management that are appropriate for the severity of withdrawal or anticipated withdrawal;
- nonpharmacological methods of withdrawal management when indicated, including but not limited to:
    - informing patients and families of what to expect over the course of treatment,
    - offering reassurance,
    - providing a quiet environment, and
    - educating patients and families on the importance of adequate hydration and nutrition; and
- biomedical capabilities equivalent to a Level 3.7Y program.

Level 4 Psychiatric programs should be able to support initiation, titration, and continuation of addiction medications* in alignment with current best practices.

Patient education should be provided regarding available FDA- approved medications, including those currently available to treat OUD, AUD, and TUD.

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* Including all FDA- approved medications for OUD (including methadone, unless unavailable locally), AUD, and TUD; off-label medications for other SUDs, including StUD and CUD; and medications to manage post- acute withdrawal symptoms.

Clinical Services

Level 4Y Psychiatric services should be designed with the expectation that many patients will have co-occurring substance use- related problems; individual and group interventions should encourage patients and families to address both mental health- related concerns and SUD- related concerns. Programs should support patients and families with the management of SUD- related symptoms, and patients' SUDs should be addressed concurrently by the program or through coordination with external providers as needed.

Programs should coordinate care with any external addiction and mental health care providers involved in the patient's care (with appropriate patient and family assent/ consent) at admission, discharge, and as needed to support effective care coordination for the individual patient and family.

The clinical services provided by Level 4Y Psychiatric programs should include individual and group interventions for SUD and mental health and family therapy, with interventions designed to address:

- how to manage mental health symptoms and trauma without using substances;
- how to discuss SUD, SUD symptoms, and addiction treatments— including medications— appropriately in the context of mental health treatment and RSS;
- motivation for change related to mental health and SUD concerns; and
- how to discuss improve interpersonal communications related to SUD and mental health concerns and ask for support when needed.

Patients should be excused from participating in psychotherapy, psychoeducation, and RSS if acute psychiatric, withdrawal, or biomedical conditions prevent effective participation.

Level 4Y Psychiatric programs should be able to admit individuals currently receiving opioid agonist medications for OUD (eg, methadone, buprenorphine) who require psychiatric inpatient care.

Appendix A. Adolescent and Transition Aged Youth Volume Draft Outline

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Section I: Introduction

1. Introduction
2. Methodology
3. How to Use The ASAM Criteria

Section II: Continuum of Care

4. Continuum Overview Chapter
5. Outpatient
6. Residential
7. Medically Managed Care

Section III: Assessment and Treatment Planning

8. Assessment
9. Treatment Planning
10. Dimensional Admission Criteria and Algorithm

Section IV: Implementation Considerations and Comprehensive Care

11. Prevention and Early Intervention
12. Co-Occurring Care
13. Coordination Across Systems of Care
14. Utilization Management
15. Recovery Support Services
16. Trauma/Culture/SDOH

Section V: Population Considerations

17. Transition-aged Youth
18. Pregnancy & Parenting

Appendices

Back Matter

Appendix B. 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	Treatment as prevention is now incorporated into *The ASAM Criteria* Level 1.5Y and 2.1Y.
Level 1.0Y Long term remission monitoring	Level 1: Recovery Maintenance and Health Management	*The ASAM Criteria* Level 1.0Y 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 1.5Y: Outpatient	Level 2: Low Intensity Community-based services	Less than 6 hours per week of clinical services
Level 2.1Y: Intensive Outpatient and Home-based	Level 3: High Intensity Community-based services	Clinical services at least 3 days per week
Level 2.5Y: 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 3.5Y: 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 4Y Psych: 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.

Appendix C. ASAM Criteria/CALOCUS-CASII Assessment Dimensions 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
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
Educational Needs	CALOCUS-CASII Dimension 2 – Functional Status CALOCUS-CASII Dimension 4 – Recovery Environment (environmental stress sub-scale)
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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Appendix D. Recommended Staff Competencies

The following represent recommended staff competencies to support delivery of care in alignment with *The ASAM Criteria* standards. In developing these competencies, the Editorial Team sought to align with the following existing national competencies:

- American Board of Psychiatry and Neurology Child and Adolescent Psychiatry Core Competencies Outline. American Board of Psychiatry and Neurology Child and Adolescent Psychiatry, 2011. Accessed September 4, 2024. https://www.abpn.org/wp-content/uploads/2015/02/2011_core_CAP_MREE.pdf
- Mental Health Competencies for Pediatric Practice. American Academy of Pediatrics. 2019. Accessed September 4, 2024. *Pediatrics* (2019) 144 (5): e20192757.
- American Board of Addiction Medicine. Core Competencies for Addiction Medicine, Version 2. The American Board of Addiction Medicine Foundation, Inc; 2012. Accessed April 22, 2023. https://acaam.memberclicks.net/assets/docs/Core-Competencies-for-Addiction-Medicine.pdf
- Center for Substance Abuse Treatment. Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice. Technical Assistance Publication (TAP) Series 21. HHS Publication No. (SMA) 15-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2006. Accessed January 27, 2021. https://store.samhsa.gov/sites/default/files/d7/priv/sma12-4171.pdf
- Hoge MA, Morris JA, Laraia M, Pomerantz A, Farley T. Core Competencies for Integrated Behavioral Health and Primary Care. Washington, DC: SAMHSA-HRSA Center for Integrated Health Solutions; 2014. Accessed January 27, 2021. http://womenshealthcouncil.org/wp-content/uploads/2016/11/WF-Core-Competencies-for-Integrated-Behavioral-Health-and-Primary-Care.pdf
- Substance Abuse and Mental Health Services Administration. Core Competencies for Peer Workers in Behavioral Health Services. Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2015. Accessed January 27, 2021. https://www.samhsa.gov/sites/default/files/programs_campaigns /brss_tacs/core-competencies_508_12_13_18.pdf
- Wason, K, Potter, A, Alves, J, et al. Addiction Nursing Competencies: A Comprehensive Toolkit for the Addictions Nurse. J Nurs Adm. 2021;51(9):424-429. doi:10.1097/NNA.0000000000001041

These recommendations are not meant to replace existing competency frameworks but to highlight areas of importance for implementing The ASAM Criteria standards.

Professional and Allied Health Staff

All professional (ie, medical and clinical staff) and allied health staff should have a basic understanding of *The ASAM Criteria*, including:

- Multidimensional factors that contribute to *The ASAM Criteria* level of care recommendations and treatment needs
- The continuum of care
- Principles of The ASAM Criteria

All professional and allied health staff should also have a basic understanding of addiction, SUD, and related health conditions in adolescents and transition age youth that includes:

- The prevalence and demography of SUD in these populations
- The genetic and biological basis of addiction
- The principles of early intervention and prevention
- Developmental considerations that interact with adolescent substance use
- Signs and symptoms of intoxication, withdrawal, and SUDs
- Common biomedical and psychiatric comorbidities in these populations
- Addiction treatment options and their efficacies in adolescents and transition age youth, including:
    - Addiction medications, including medications* for opioid use disorder (OUD), alcohol use disorder (AUD), and tobacco use disorder (TUD); off-label medications for other SUDs, including stimulant use disorder (StUD) and cannabis use disorder (CUD); medications to manage post-acute withdrawal symptoms
    - Psychosocial interventions
- Evidence supporting concurrent treatment for TUD and other SUDs
- The importance of recovery support services (RSS)
- The importance of diverse systems of care, including educational and other social service systems that can help support full wraparound services for adolescents
- Harm reduction approaches

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* Including FDA-approved medications and off-label use of evidence-based medications that have not been FDA-approved for use in adolescents and competency discussing boxed label warnings.

All professional and allied health staff should have the competency to:

- Provide patient-centered, whole-person care

- Facilitate shared decision-making with the patient and family
- Listen to and communicate effectively with adolescents and transition age youth
- Incorporate developmental considerations in the care provided to adolescents and transition-aged youth
- Engage the patient's family in their treatment, including providing family with education on addiction, SUD, and evidence-based treatments
- Communicate in a developmentally appropriate manner with patients and their families and support persons (with appropriate patient consent), as well as other professionals and staff with empathy, respect, compassion, and understanding, including awareness of stigmatizing language
- Be aware of available treatment and RSS resources for the patient and family
- Collaborate effectively with multidisciplinary and interdisciplinary care teams
- Advocate for patient and family needs across diverse systems of care as appropriate to scope of practice
- Apply behavior management techniques appropriately, including de-escalation and conflict resolution
- Manage violent and threatening behaviors
- Respond to urgent biomedical and psychiatric situations, including those that occur on-site
- Administer overdose medications (eg, naloxone) and basic life support (BLS), including CPR
- Recognize when to consult the chain of command and know how to contact supervisors
- Respond to requests from patients or families to change treating providers
- Document services provided consistent with clinical and regulatory standards, relevant medical necessity requirements, and awareness of utilization management (UM) needs
- Use electronic health records (EHRs) and other health technologies used by the program
- Understand and follow state and federal privacy and confidentiality laws and regulations
- Be aware of ethical considerations for providing addiction treatment and related services

As part of the provision of patient-centered, whole-person care, all professional and allied health staff should be able to:

- Contribute to a welcoming, respectful, and nonjudgmental culture in all aspects of their work
- Recognize developmental considerations specific to adolescence and transition age youth, including understanding of the signs and symptoms of neurocognitive and neurodevelopmental disorders and when to refer for a neurocognitive assessment

- Recognize the social, economic, and cultural contexts within which addiction exists, including:
    - SDOH
    - The effects of stigma and discrimination
    - The effects of racism, including structural issues at the intersection of racism, substance use, and addiction
    - Risk and resiliency factors of individuals, families, and groups
- Provide services appropriate to each patient's and family's personal and cultural identities, including:
    - Delivering services with trauma-sensitive practices (TSP)
    - Demonstrating cultural humility and openness to understand and respond to patient and family needs related to their individual culture, including race and ethnicity, sex and gender, sexual orientation, socioeconomic status, and religion and spirituality, among others
    - Understanding the core concepts of gender-sensitive and gender-responsive care, including how gender can influence addiction and mental health treatment needs and preferences
    - Working effectively with a translator as needed
- Understand the principles of harm reduction, including but not limited to:
    - The importance of educating patients and their families and support persons about harm reduction techniques
    - Overdose prevention and reversal
- Understand the unique needs and barriers faced by people experiencing dating violence, domestic violence, interpersonal violence, and intimate partner violence (IPV), including substance use coercion, and sex trafficking
- Identify resources in the community that can support common patient and family needs (eg, housing, food, transportation, parenting programs, recovery support services, legal services.)
- Understand the role of different systems of care that may impact adolescent and family service needs (eg, schools, healthcare, child welfare, juvenile legal, housing and other social services)

Professional Staff

All professional staff who provide care to adolescents should understand the following within the limits of and at a level appropriate to their scope of practice:

- Human development including neurodevelopment, typical developmental trajectories, and developmental disorders
- Family systems and dynamics

- The importance of attachment in healthy development
- Risk and protective factors for SUD and other mental health disorders
- Signs and symptoms associated with substance toxicity and withdrawal
- The continuum of care for adolescents for both addiction and mental health
- How to access specialty care for common comorbidities (eg, eating disorders)
- The impact of adverse childhood experiences (ACEs) on SUD and mental health
- The impact of neurodiversity on adolescent treatment needs
- Biological and psychological effects of commonly used substances
- Biological and psychological effects of chronic substance use and SUDs

All professional staff who provide care to adolescents should have competency in:

- Effectively communicating considerations related to privacy and confidentiality, including when protected health information may be disclosed and when reporting may be required
- Building therapeutic alliances with patients and family members
- Conveying information at a developmentally appropriate level and tailored communication to the patient and family's level of comprehension
- Conducting assessments of adolescents in alignment with their scope of practice, including:
    - Administering standardized screening and assessment tools
    - Collecting information from collateral sources (with appropriate consent or assent) including family members, teachers, coaches, other systems of care
    - Applying knowledge of risk and protective factors to identify patients at risk for SUD
    - Interpreting nonverbal communication of adolescents
- Delivering treatment services to adolescents, including:
    - Tailoring therapies to the patient's developmental age and stage
    - Adjusting treatment plans based on patient and family progress as well as the adolescent's development
- Monitoring treatment progress and challenges
- Working collaboratively with other systems of care (eg, schools, child welfare, juvenile justice) to develop a comprehensive, integrated, and individualized treatment plan, including coordinating treatment plan objectives in alignment with objectives of patient individualized education programs (IEPs) and 504 plans
- Communicating effectively across disciplines
- Assisting patients and families in overcoming barriers to care

- Making effective referrals and supporting effective transitions in care (including providing warm handoffs) as needed
- Managing the family's involvement in care, including:
    - Assessing family dynamics and their impact on the patient's SUD and mental health concerns
    - Reconciling conflicting information from patient, family, and collateral sources
    - Managing and using motivational enhancement strategies to address family ambivalence and other barriers to engagement
    - Negotiating confidentiality concerns between patients and their family members
    - Setting and managing appropriate boundaries with patients and their family members
    - Handling conflict between the patients and their family members
    - Ensuring that both the adolescent and family members are heard and given adequate time to express themselves in sessions
    - Appropriately balancing the needs and preferences of patients and their family members
    - Determining when it is or is not appropriate and beneficial to include family members
    - Building collaborative relationships with family members
    - Encouraging collaboration between patients and their family members
    - Providing psychoeducational services to families, including educating family members on how they can:
        - Modify risk and protective factors
        - Manage common stressors and fluctuations in SUD- and mental health-related signs and symptoms
    - Determining family members' need for services and referrals, including parenting programs
    - Helping family members access services to address their own SUD and mental health treatment needs

Medical Staff

Medical staff include physicians, advanced practice providers, nurses, and other medical support staff.

Physicians and Advanced Practice Providers

All physicians and advanced practice providers should have an advanced understanding of *The ASAM Criteria* that includes:

- Level of Care and Treatment Planning Assessments

- Dimensional Admission Criteria, including Risk Ratings
- Dimensional Drivers
- Medical capabilities at each level of care

All physicians and advanced practice providers should also have an advanced understanding of the core medical knowledge about addiction, SUD, and related health conditions in adolescents, including:

- The epidemiology and etiology of addiction
- The neurobiology and genetics of addiction
- Pharmacodynamics of commonly used substances
- Developmental considerations that interact with adolescent substance use
- The pathophysiology and neuropsychological effects of chronic substance use and SUDs
- Common comorbid medical and co-occurring psychiatric conditions associated with SUDs
- Fetal and neonatal effects of commonly used substances and associated intoxication and withdrawal

Physicians and advanced practice providers should be proficient in working with and leading an interdisciplinary team comprised of both medical and nonmedical (ie, clinical and allied health) staff and have knowledge of their duty to protect and mandated reporting requirements. In support of provision of patient-centered, whole-person care, physicians and advanced practice providers should understand the importance of families and support persons in addressing addiction and communicate with them effectively as appropriate.

With respect to assessment and diagnosis, all physicians and advanced practice providers are recommended to have the competency to:

- Conduct an accurate patient history that includes substance use history, trauma history, and addiction and mental health treatment history, as well as the patient's ability to function in home, school, and social environments
- Assess the patient's development and developmental history
- Perform an appropriate physical examination and detect physical signs of acute use (ie, intoxication and withdrawal), chronic use, and complications of substance use (eg, skin infections)
- Screen for and diagnose SUDs, intoxication, withdrawal, and common comorbid medical and co-occurring psychiatric conditions
- Formulate a reasonable differential diagnosis based on:

    - Signs and symptoms of acute substance use (ie, intoxication, withdrawal) and chronic substance use
    - Standard diagnostic criteria for addictive disorders
    - Common biomedical (including obstetrical) and psychiatric comorbidities of substance use
- Explain the patient's diagnosis and rationale for their treatment to them and their family and support persons (with appropriate patient consent) in developmentally and cognitively appropriate language
- Order appropriate diagnostic tests (eg, routine laboratory tests, drug tests and toxicology, diagnostic imaging) and be able to:
    - Interpret laboratory findings
    - Understand the appropriate use of drug testing and toxicology
    - Understand the benefits and limitations of drug testing
    - Collect, interpret, and monitor drug testing and toxicology data for patient treatment needs
    - Understand how drug testing and toxicology can support monitoring of adherence to medications
    - Use, interpret, and respond to drug testing results
- Determine the adolescent's need for a neurocognitive assessment
- Use and evaluate ECG rhythm strips to rule out malignant arrhythmias, such as prolonged QTc, previously undiagnosed atrial fibrillation, and sinus bradycardia and tachycardia
- Use, interpret, and respond to prescription drug monitoring program (PDMP) reports
- Understand the role of PDMPs and the benefits and limitations of the data in local PDMPs

With respect to treatment and treatment planning, all physicians and advanced practice providers are recommended to have the competency to:

- Direct the pharmacological management of intoxication, withdrawal, SUDs, and common psychiatric comorbidities tailored to adolescent patients with consideration of:
    - Adolescent appropriate dosing
    - Potential impacts on the developing brain
    - Potential impacts on developmental trajectories
    - Differential effectiveness in adults versus adolescents
- Direct the medical management of acute withdrawal and intoxication, SUDs, and common medical and psychiatric comorbidities

- Understand the psychosocial interventions that are available to treat SUD and mental health concerns in adolescents
- Provide medical management for common, low-complexity psychiatric conditions using appropriate assessment instruments to guide treat-to-target decision-making
- Provide brief intervention, secure and appropriate consultations, and referral for specialty treatment of addiction and other medical and psychiatric conditions
- Design a management plan to address nonadherence and treatment disengagement
- Determine the primary driver of the patient's risks for biomedical and psychiatric issues
- Determine when biomedical and psychiatric issues necessitate transfer or referral to other specialty systems
- Understand the unique clinical considerations related to:
    - IV drug use
    - Pre- and post-operative care
    - Nicotine/tobacco use
    - Co-occurring pain
    - Co-occurring cognitive impairment
    - Justice involvement
    - Child welfare involvement
    - Foster care involvement
    - Youth homelessness
    - Pregnancy, perinatal, and postpartum care (ie, parent-infant dyad)

With respect to care coordination, all physicians and advanced practice providers are recommended to have the competency to:

- Lead interdisciplinary treatment teams in medically managed treatment programs
- Consult with other treatment resources as appropriate
- Coordinate care with specialty biomedical and psychiatric treatment providers to support an integrated treatment plan

All physicians and advanced practice providers should have knowledge of the neurobiology of pain and the ability to manage pain in patients with addiction, which includes the ability to:

- Conduct a pain-focused history and physical examination
- Use reliable standardized tools for measuring function in patients with pain
- Determine the difference between malignant and nonmalignant pain
- Determine whether pain significantly hinders participation in addiction treatment and SUD recovery

- Design a treatment plan for patients with pain with attention to patient- and family-centered goals
- Prescribe medications for patients with pain and SUDs, with management of initial dosing, titrating, and maintaining medications as needed according to patient health status and risk factors
- Prescribe nonpharmacological therapies to help manage pain
- Coordinate with other healthcare professionals, including when recommended treatment options may pose risk for harms and alternative interventions may be needed
- Coordinate care with a pain specialist
- Know when to refer to an interventional pain specialist

Addiction Specialist Physicians

In addition to the competencies for physicians and advanced practice providers, addiction specialist physicians are recommended to have the competency to:

- Supervise and teach other health care professionals
- Direct the medical management of:
    - Addiction at any level and intensity of treatment
    - Substance use-related psychiatric and biomedical emergencies.

Psychiatric Specialist Physicians and Advanced Practice Providers

In addition to the competencies for physicians and advanced practice providers, psychiatric specialist physicians and advanced practice providers are recommended to have the competency to:

- Supervise and teach other health care professionals
- Direct the medical management of psychiatric conditions at any level and intensity of treatment
- Determine when a patient needs a physical examination and the urgency of the need
- Conduct a comprehensive assessment of the risk for harm to self or others
- Diagnose and treat sever and complicated adolescent psychiatric and developmental disorders
- Formulate a multimodal treatment plan

Nursing and Medical Support Staff

Nursing and medical support staff—such as registered nurses (RNs), licensed practical nurses (LPNs), and medical assistants (MAs)—should have a basic understanding of the core medical knowledge about addiction, SUD, and related health conditions in adolescents that includes:

- The epidemiology of addiction
- The neurobiology and genetics of addiction
- The pathophysiological and neuropsychological effects of chronic substance use and SUDs
- Common comorbid medical and co-occurring psychiatric conditions associated with SUDs
- Fetal and neonatal effects of commonly used substances and associated intoxication and withdrawal

With respect to the assessment process, nursing and medical support staff are recommended to have the competency to:

- Conduct an accurate patient history that includes substance use history, trauma history, and addiction and mental health treatment history
- Perform an appropriate physical assessment and detect physical signs of acute use (ie, intoxication and withdrawal), including:
    - Assessing for serious harm due to patient impairment from substance use
    - Identifying overdose risks, treatment, and follow-up
    - Using standardized tools for assessing withdrawal severity (eg, Clinical Opioid Withdrawal Scale [COWS], Clinical Institute Withdrawal Assessment for Alcohol, revised [CIWA-Ar])
- Screen and assess patients for depression and anxiety and apply program protocols for management of patients in need of urgent psychiatric support

Nursing and medical support staff should be trained in behavior management techniques and psychotherapeutic and psychoeducational evidence-based interventions (EBIs) aligned with their scopes of practice. Recommended competencies with respect to treatment include the ability to:

- Implement physician-approved protocols for clinical management of intoxication and withdrawal including:
    - Observation and supervision
    - Determination of appropriate level of care
    - Facilitation of the patient's transition to continuing care
- Identify indications for addiction medications and dose adjustments, and address recurrent use
- Outline addiction medications and available formulations
- Implement recommended storage, handling, and administration of intramuscular and subcutaneous medications for SUD

- Comprehend the importance of nursing standing orders for laboratory assessment, medication refills, and interventions
- Understand the benefits and limitations of drug testing and toxicology, including how it can support monitoring of adherence to medications
- Outline safety interventions required as a mandatory reporter if a patient is at risk for harm to self or others
- Employ chart review and tools in health records to effectively document and monitor patients engaged in addiction care
- Understand approaches to certain populations with addiction—such as patients with chronic pain, patients who are pregnant, and homeless youth, among others—and outline appropriate pain management strategies for patients with opioid use disorder

With respect to care coordination, nursing and medical support staff are recommended to have the competency to:

- Coordinate care between local treatment levels (eg, transfer to acute treatment services, transition to outpatient treatment programs)
- Identify local resources for RSS

Clinical Staff

Clinical staff include psychologists, clinical social workers, SUD and mental health counselors, and others who assess and treat SUD and/or co-occurring mental health conditions. Clinical staff should have a basic understanding of the core medical knowledge about addiction, SUD, and related health conditions that includes:

- The epidemiology of addiction
- The neurobiology and genetics of addiction
- Developmental considerations that interact with adolescent substance use
- Common comorbid medical and co-occurring psychiatric conditions associated with SUDs
- Familiarity with the efficacy and benefits of addiction and psychiatric medications, including off-label use of evidence-based medications that have not been FDA-approved for use in adolescents
- Crisis stabilization interventions tailored to adolescents
- Harm reduction approaches

With respect to the assessment process, clinical staff are recommended to have the competency to:

- Conduct an accurate patient history that includes substance use history, trauma history, and addiction and mental health treatment history, as well as the patient's ability to function in home, school, and social environments
- Assess developmental age and stage and identify developmental delays
- Assess the patient's educational needs and coordinate with education systems to support implementation of IEPs and 504 plans
- Assess safety risks and develop a safety plan in collaboration with the patient and family
- Screen, assess symptom severity, and monitor treatment progression for SUDs and co-occurring psychiatric conditions using validated instruments
- Screen for signs and symptoms of intoxication and withdrawal
- Screen for risk of harm to self or others
- Perform crisis assessments
- Recognize the potential for SUDs to mimic a variety of biomedical and psychiatric conditions

With respect to treatment and treatment planning, clinical staff should have knowledge of psychosocial EBIs and are recommended to have the competency to:

- Develop treatment plans that are tailored to the developmental age and stage of the patient
- Adjust psychosocial treatment modalities to the developmental age and stage of the patient
- Engage in shared decision-making with both the patient and family, appropriately balancing their needs and preferences to develop a family centered and youth-guided treatment plan
- Describe and implement a variety of strategies for reducing the negative effects of SUDs and addiction
- Support symptom management for patients with co-occurring mental health conditions
- Work with mental health treatment providers to deliver integrated care for patients with co-occurring psychiatric conditions
- Deliver psychoeducation related to the interaction of substance use and common biomedical and psychiatric comorbidities (eg, HIV, hepatitis C virus [HCV], depression, anxiety)
- Manage the therapeutic milieu
- Understand how ACEs impact SUDs and co-occurring psychiatric disorders
- Recognize and address experiences of dating violence, domestic violence, IPV and sex trafficking among patients, including:

    - Performing trauma-sensitive assessments of current and past experiences of dating violence, domestic violence, and IPV, including experiences of substance use coercion
    - Collaborating with patients in IPV-related treatment planning, including ongoing safety and safety planning
    - Referring to and coordinating with domestic violence agencies
- Recognize the importance of family, social networks including peers, and community systems in the treatment and recovery process
- Describe the behavioral, psychological, biomedical, and social effects of substance use to patients and their support networks

Every program should have clinical staff with the competency to:

- Triage mental health concerns
- Provide family services for co-occurring mental health concerns
- Provide mental health care in a trauma-informed, culturally humble and developmentally appropriate context

With respect to the family, clinical staff are recommended to have the competency to:

- Assess the adolescent's attachment to their caregivers;
- Assess family dynamics and the impact on the adolescent's SUD and mental health
- Assess family strengths and leverage them to support the adolescent's recovery
- Guide families in how to:
    - Effectively support the adolescent's recovery from both SUD and mental health concerns
    - Support healthy development of the adolescent
    - Manage the stress related to the adolescent's SUD, mental health, and other health concerns

With respect to care coordination, clinical staff are recommended to have the competency to:

- Coordinate care with other providers involved in a patient's care
- Be familiar with local treatment resources, including RSS and social services for SUDs and common comorbidities

Supervisory Clinical Staff

In addition to the competencies for all clinical staff, clinical staff in supervisory roles should have an advanced understanding of *The ASAM Criteria* that includes:

- Treatment modalities and placement considerations within the continuum of care
- Level of Care and Treatment Planning Assessments
- Dimensional Admission Criteria, including Risk Ratings
- Dimensional Drivers
- Medical capabilities at each level of care

Clinical staff in supervisory roles should also have the competency to:

- Understand the established diagnostic criteria for SUDs
- Understand and be able to provide psychosocial EBIs for SUDs and mental health disorders
- Be familiar with medical and medication treatments for SUDs and common comorbid biomedical and co-occurring psychiatric conditions
- Manage and supervise a clinical team
- Monitor the quality of care delivered by clinical staff

Allied Health Staff

Allied health staff include certified peer support specialists, patient and family navigators, health educators, counselor aides, certified recovery coaches, and group living workers who support ongoing engagement in addiction treatment, deliver recovery support services, and provide warm handoffs to other levels of care. All allied health staff should have competencies in:

- Building caring and collaborative relationships with adolescent patients and families
- Understanding appropriate roles and responsibilities
- Setting safe boundaries with patients and family members
- Recognizing and being aware of trauma
- Communicating with patients and their families and support persons (with appropriate patient consent)
- Advocating for the needs, desires, and legal and human rights of people with SUD and mental health conditions
- Providing information on community and other resources related to health, wellness, and recovery services and supports
- Respecting diverse pathways to recovery, including treatment with evidence-based addiction and psychiatric medications

In addition, certified peer support specialists should have further competencies in:

- Building supportive and collaborative long-term relationships
- Sharing personal recovery stories in a way that is inspiring and supportive
- Personalizing peer support services
- Supporting recovery planning
- Helping peers manage crises
- Protecting personal recovery while providing peer support services for others
- Recognizing countertransference and personal biases related to addiction and addiction treatment
- All allied health staff should have a basic understanding of the pharmacological and nonpharmacological interventions that are available to treat SUD and common mental health conditions in adolescents.