[NAME] of Agency
Policy and Procedure: Program Requirements: Admissions, Therapies, and Staffing for Ambulatory Care

July 1, 2025

Section 1: Policy

This outpatient program [NAME] will admit patients without regard to race, creed, color, handicap, sexual orientation, gender identity, or ethnic origin; however, certain patients are excluded from admission due to not meeting the entrance and/or diagnostic criteria of the program, an inability to participate in the program, agency not being designed to meet the needs of every type of patient, or patients who present a safety risk to other patients. Additionally, certain patients may be excluded from joining specific groups that are gender and/or diagnosis based (i.e., gender specific groups, groups tailored around specific stages of recovery, etc.)

If an individual receives medication assisted treatment (MAT) for opioid use disorder or alcohol use disorder, the program cannot discriminate against admitting such a patient. Once a patient receiving MAT is admitted, the ambulatory program must ensure that MAT continues and coordination with the prescriber or opioid treatment program (OTP) occurs.

Further, it is the policy of [NAME] to provide the following procedural plan to address all aspects of the intake and admission process including the following issues:

- Criteria for admission
- Treatment methodology
- Requirements for completion of treatment
- Involuntary discharge and termination criteria
- Disclosure to patient of criteria for admission, continued stay, and discharge
- Patient orientation to the program
- Completion of patient histories

- Consent to treatment
- Handling of protected health information (PHI), to include consent to disclose information, and situations when PHI can be shared without consent
- Physical examination and laboratory results
- Psychosocial evaluation
- Preliminary treatment and rehabilitation plan

Section 2: Procedure

Admission

[NAME] sites provide a wide variety of services including: outpatient treatment (ASAM 1 CM, ASAM 1 OP, ASAM 1 CS, ASAM 1 OTP), ambulatory withdrawal management (ASAM 1-WM), intensive outpatient (ASAM 2.1) and partial hospitalization (ASAM 2.5) services for adults and children. The services are delivered using different criteria for admission, continued stay, and discharge for each level of care and for adults versus children.

Adult Admission Criteria

1. Admission decisions pertaining to adults are made using the American Society of Addiction Medicine (ASAM) criteria. See Attachment 1. All clinical staff making admission decisions shall be trained in the ASAM criteria. To be admitted for ambulatory services, the adult must meet the following conditions:
    a. Must have a substance use diagnosis as defined in the DSM-5; and,
    b. Must meet ASAM criteria for that particular level of services found in the ASAM 3rd edition; and,
    c. Must be 18 years of age or above.

Adolescent Admission Criteria

1. Admission decisions pertaining to adolescents are made using the ASAM criteria. See Attachment 1: ASAM Ambulatory Admission Criteria. All clinical staff making admission decisions shall be trained in the ASAM criteria. To be admitted for ambulatory services, the adolescent must meet the following conditions:
    a. Must have a substance use diagnosis as defined in the DSM-5; and,
    b. Must meet ASAM criteria for that particular level of services found in the ASAM 3rd edition; and,

c. Must be younger than 18 years of age at time of admission.

Discrimination

1. Patients requesting admission will not be discriminated against on the basis of race, color, religion, creed, national origin, sexual orientation, gender identity or disability. Patients requesting admission and utilizing or wanting to utilize MAT will also not be discriminated against regardless of the medication or dosage. Whenever possible, accommodation will be made for those with disabilities. Prospective patients who cannot be accommodated will be referred to another agency better able to meet his/her needs. In certain cases, there may be reasons based on medical and/or clinical necessity that an individual may not be approved for admission and instead they would be provided with a referral elsewhere. Some examples could be:
    a. Patients who do not have a substance use diagnosis.
    b. Patients who do not meet admission criteria for this level of care.
    c. Patients with severe psychiatric condition(s) that the agency is not designed to treat and where the patient would be unable to participate in program or would present as a safety risk to other patients (i.e., actively psychotic, suicidal, homicidal, etc.). ASAM allows mild to moderate psychiatric conditions at the ambulatory levels of care only.
    d. Patients with severe physiological handicap(s) that the agency is not designed to treat and where that handicap would prohibit active participation in the program, or the handicap would present as a safety risk to other patients.
    e. Patients with severe intellectual and developmental disability (I/DD) where an individual is unable to comprehend at a basic level, the information presented in the program (i.e., moderate to severe I/DD).
    f. Adults with a history of, or convictions for, sexual crimes against minors requesting admission to an agency where adolescents are seen.
    g. SCAs and their contracted providers must provide services that are respectful of and responsive to cultural and linguistic needs, cultural health beliefs and practices, preferred languages, health literacy levels, and other communication needs.
2. Every effort will be made to refer prospective patients excluded from the program to programs where their needs can be met. Admission staff will generally make and document the referral. If the patient has already been admitted prior to discovery of

ineligibility for treatment, the appropriate nursing or counseling staff shall make arrangements for and document transfer of the patient.

Treatment Methodology

1. [NAME] offers four levels of care at this particular site: outpatient treatment (ASAM 1 CM, ASAM 1 OP, ASAM 1 CS, ASAM 1 OTP), ambulatory withdrawal management (ASAM 1-WM), intensive outpatient (ASAM 2.1) and partial hospitalization (ASAM 2.5) services for adults and children. Within those four levels of care, the following types of treatment are offered based on the multidimensional needs and preferences of the patient and/or family being served:

Service	**1-WM**	**2-WM**	**1.0**	**2.1**	**2.5**	**Adolescent**
Individual assessment	X	X	X	X	X	X
Withdrawal management supports, to include nursing and medical monitoring or treatment, use of over-the-counter medications for symptomatic relief, individual or group therapies specific to withdrawal, and withdrawal support	X	X				X
Patient education	X	X	X	X	X	X
Non-pharmacological clinical support	X	X				
Physician and/or nurse monitoring	X	X				
Involvement of family members and/or significant others in the treatment process, including family therapy	X	X	X	X	X	X

Service	1-WM	2-WM	1.0	2.1	2.5	Adolescent
Physician and/or nurse daily assessment of progress during withdrawal management and any treatment, or less frequently if severity of withdrawal is sufficiently mild or stable	X	X				X
Physician and/or nurse management of signs and symptoms of intoxication and withdrawal	X	X				X
Medical assessment and evaluation (provided by [NAME], through consultation, or direct referral to an external provider)			X	X	X	X
Laboratory and toxicology services, including point of care testing (provided by [NAME], through consultation, or referral)	X	X	X	X	X	X
Clinical services to assess and address withdrawal needs (adolescents)						X
Psychiatric assessment and evaluation (provided by [NAME], through consultation, or referral) *on-site required for ASAM 2.1 and 2.5 Co-Occurring Enhanced	X		X	X*	X*	X
Psychological assessment and evaluation (provided by [NAME], through consultation, or referral)	X		X	X	X	X
Medication management			X	X	X	X
Individual counseling			X	X	X	X
Group counseling			X	X	X	X

Service	1-WM	2-WM	1.0	2.1	2.5	Adolescent
Educational services						X
Aftercare/discharge planning	X	X	X	X	X	X
Addiction pharmacotherapy	X	X	X	X	X	X
Additional therapies as clinically indicated (e.g., occupational therapy, recreational therapy)			X	X	X	X
Provide or assist in accessing transportation services	X	X				
Intensive case management [1]for highly crisis-prone individuals *ASAM 2.5 co-occurring enhanced only			X		X*	

2. [NAME] has documentation that agonist, partial agonist, or antagonist medications used in the treatment of opioid use disorder (OUD) should be prescribed in the context of psychosocial supports and interventions to manage the patient's addiction. When medically and clinically appropriate, patients may be referred to OTP or Office-Based Opioid Treatment services while receiving outpatient levels of care. Medications used to treat alcohol use disorder and for tobacco use cessation must also be offered and provided if clinically appropriate and requested by the patient.
3. Counseling and other therapies use motivational enhancement and engagement strategies.
4. A written description and rationale of all therapies is available and includes which staff can provide the treatment.

[1] For the purposes of this document, Case Management refers to the ASAM definition and not a specific job title:
Case management is a collaborative process which assess, plans, implements, coordinates, monitors and evaluates the options and services to meet an individuals' health needs, using communication and available resources to promote quality, cost effective outcomes

5. Treatment services are individualized based on the amount, frequency, and intensity appropriate to the treatment plan. Treatment services should be adapted to meet the patient's developmental stage and comprehensive level.
    a. ASAM Level 2.1 services must include a minimum of 9 hours per week and no more than 19 hours per week of skilled treatment.
    b. ADOLESCENT ONLY – Level 2.1 services must include a minimum of 6 hours per week of skilled treatment.
    c. ASAM Level 2.5 services must include a minimum of 20 hours per week of skilled treatment.
6. Emergency services are available by telephone 24 hours a day, 7 days a week when the treatment program is not in session.
    a. ASAM 1-WM and 2-WM ONLY – [NAME] ensures there is 24-hours access to emergency medical consultation services should such services become indicated.
7. ADOLESCENT ASAM 1.0 ONLY – [NAME] has a process in place to provide ongoing active treatment to sustain therapeutic gains, for example relapse prevention, strengthening of protective factors, and on-going monitoring.
8. ASAM 2.1 ONLY – [NAME] ensures if a patient is not yet fully stable to safely transfer to an ASAM Level 1.0 program that is not associated with [NAME], the patient's treatment for Level 1 services may be continued within the current ASAM level 2.1 program.
9. ASAM 2.1 AND 2.5 CO-OCCURRING CAPABLE ONLY – [NAME] ensures therapies offered to patients with co-occurring addictive and mental disorders are able to tolerate and benefit from a planned program of therapies.

Section 3: Staffing Model

1. The program is staffed by an interdisciplinary team of appropriately credentialed and/or licensed treatment professionals that can assess and treat substance-related, mental, and addictive disorders, which may include:
    a. Addiction counselors
    b. Psychologists
    c. Social workers
    d. Physicians with SUD experience
    e. Addiction specialist physician (available for consult at a minimum)
    f. Peers

    g. Care coordinators
    h. Nurses
2. Staff must receive ASAM training within 365 days of hire.
3. Staffing credentials and position titles and scope of practice are clearly defined.
4. If appropriate, the program includes staff who are sufficiently licensed, credentialed, trained, or experienced in treating specialty populations, such as:
    a. Staff who are cross trained to assess and treat members with co -occurring mental health disorders, to include understanding the signs and symptoms of mental disorders, and the uses of psychotropic medications and their interactions with substance-related disorders.
    b. Staff knowledgeable about adolescent development.
5. Staff training is conducted upon hire and at least annually, or when a new protocol or treatment is implemented. Standard training may include:
    a. Evidenced based addiction therapies
    b. Motivational and enhancement strategies
    c. Psychiatric and addiction pharmacotherapies
    d. Specialty populations
6. There is a process by which program staff can escalate complex cases to addiction specialist physicians and other specialty providers as needed.

Attachment 1: ASAM 3rd Edition Ambulatory Admission Criteria

ASAM uses six dimensions to summarize a person's needs, define severity and develop a treatment plan. The six dimensions of the ASAM criteria are:

- Dimension 1. Acute Intoxication and/or Withdrawal Potential.
- Dimension 2 Biomedical Conditions and Complications.
- Dimension 3 Emotional, Behavioral or Cognitive Conditions and Complications.
- Dimension 4 Readiness to Change.
- Dimension 5 Relapse, Continued Use or Continued Problem Potential.
- Dimension 6 Recovery Environment

Adult 0.5 Early Intervention ASAM pages 181-182
ADULT DIAGNOSTIC ADMISSION CRITERIA (ASAM 2013 p. 181) The individual who is an appropriate candidate for Level 0.5 services evidences problems and risk factors that appear to be related to substance use or addictive behavior. However, the individual may not meet the diagnostic criteria for a substance use or addictive disorder, as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria, or there is currently insufficient information to perform a diagnostic assessment. ADULT DIMENSIONAL ADMISSION CRITERIA (ASAM 2013 p. 181) The individual who is appropriately cared for at Level 0.5 meets at least one of the specifications in Dimensions 4, 5, or 6. Any identifiable problems in Dimensions 1, 2, or 3 are stable or are being addressed through appropriate outpatient medical or mental health services. DIMENSION 1 ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL: See separate withdrawal management chapter for how to approach “unbundled” withdrawal management for adults. DIMENSION 2 BIOMEDICAL CONDITIONS AND COMPLICATIONS: The individual’s biomedical conditions and problems, if any, are stable or are being actively addressed, and thus will not interfere with therapeutic interventions. DIMENSION 3 EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS AND COMPLICATIONS: The individual’s emotional, behavioral, or cognitive conditions and complications, if any, are being addressed through appropriate mental health services, and thus will not interfere with therapeutic interventions.

Adult 0.5 Early Intervention ASAM pages 181-182

DIMENSION 4 READINESS TO CHANGE: The individual expresses willingness to gain an understanding of how his or her current addictive behavior and/or use of alcohol, tobacco, and/or other drugs may be harmful or impair his or her ability to meet responsibilities and achieve personal goals. This could also include those individuals who are ambivalent about exploring how their current behavior or use of alcohol and other drugs may be harmful or impairing, or those whose motivation is to achieve some goal other than the modification of their substance use behaviors (e.g., having their driving privileges restored).

DIMENSION 5 RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL: The individual's status in Dimension 5 is characterized by (a) or (b):

a. The individual does not understand the need to alter his or her current behavior or pattern of use of alcohol, tobacco, and/or other drugs to prevent harm that may be related to such use or behavior; or
b. The individual needs to acquire specific skills needed to change his or her current pattern of use or behavior.

DIMENSION 6 LIVING ENVIRONMENT: The individual's status in Dimension 6 is characterized by at least (a) or (b) or (c) or (d):

a. The individual's social support system is composed primarily of persons whose substance use or addictive behavior patterns prevent them from meeting social, work, school, or family obligations; or
b. The individual's family member(s) currently is/are addictively using alcohol or other drugs (or has/have done so in the past), thereby heightening the individual's risk for a substance use disorder; or
c. The individual's significant other expresses values concerning addictive behavior and/or alcohol or other drug use that create serious conflict for the individual; or
d. The individual's significant other condones or encourages high-risk addictive behavior and/or use of alcohol or other drugs.

ADOLESCENT 0.5 Early Intervention ASAM pages 182-183

Adolescent DIAGNOSTIC ADMISSION CRITERIA

The adolescent who is an appropriate candidate for Level 0.5 services evidences problems and risk factors that appear to be related to substance use or addictive behavior. However, the individual may not meet the diagnostic criteria for substance use or addictive disorder, as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other

ADOLESCENT 0.5 Early Intervention ASAM pages 182-183

standardized and widely accepted criteria, or there is currently insufficient information to perform a diagnostic assessment.

ADOLESCENT DIMENSIONAL ADMISSION CRITERIA

The adolescent who is appropriately cared for at Level 0.5 meets at least one of the specifications in Dimensions 4, 5, or 6. Any identifiable problems in Dimensions 1, 2, or 3 are stable or are being addressed through appropriate outpatient medical or mental health services.

DIMENSION 1: The adolescent who is an appropriate candidate for Level 0.5 services shows no signs of acute or subacute withdrawal, or risk of acute withdrawal.

DIMENSION 2: The adolescent's biomedical conditions and problems, if any, are stable or are being actively addressed, and thus will not interfere with therapeutic interventions.

DIMENSION 3: The adolescent's emotional, behavioral, or cognitive conditions and complications, if any, are being addressed through appropriate mental health services, and thus will not interfere with therapeutic interventions.

DIMENSION 4: The adolescent expresses willingness to gain an understanding of how his or her current addictive behavior and/or use of alcohol, tobacco, and/or other drugs may be harmful or impair his or her ability to meet responsibilities and achieve personal goals. This could also include those individuals who are ambivalent about exploring how their current behavior or use of alcohol and other drugs may be harmful or impairing, or those whose motivation is to achieve some goal other than the modification of their substance use behaviors (e.g., having their driving privileges restored).

DIMENSION 5: The adolescent's status in Dimension 5 is characterized by (a) or (b)

a. The adolescent does not understand the need to alter his or her current behavior or pattern of use of alcohol, tobacco, and/or other drugs to prevent harm that may be related to such use or behavior; or
b. The adolescent needs to acquire specific skills needed to change his or her current pattern of use or behavior.

DIMENSION 6:The adolescent's status in Dimension 6 is characterized by at least (a) or (b) or (c) or (d)

a. The adolescent's social support system is composed primarily of persons whose substance use or addictive behavior patterns prevent him or her from meeting social, work, school, or family obligations; or

ADOLESCENT 0.5 Early Intervention ASAM pages 182-183

b. The adolescent's family member(s) currently is/are addictively using alcohol or other drugs (or has/have done so in the past), thereby heightening the adolescent's risk for a substance use disorder; or

c. A significant member of the adolescent's support system expresses values concerning addictive behavior and/or alcohol or other drug use that create serious conflict for the individual; or

d. A significant member of the adolescent's support system condones or encourages high-risk addictive behavior and/or use of alcohol or other drugs.

Adult 1.0 Outpatient Services ASAM pages 191-193

ADULT DIAGNOSTIC ADMISSION CRITERIA (p. 190)

The patient who is appropriately placed in a Level 1 program is assessed as meeting the diagnostic criteria for a substance use, substance-induced, and/or other addictive disorder as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the dimensional criteria for admission.

If the patient's presenting alcohol, tobacco, and/or other drug use or addictive behavior history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information appropriately submitted or obtained from collateral parties (such as family members, legal guardians, and significant others) when there is valid authorization to obtain this information.

Co-Occurring Capable Programs

At Level 1, some patients have co-occurring mental disorders that meet the stability criteria for a co-occurring capable program. Other patients have difficulties in mood, behavior, or cognition as the result of other psychiatric or substance-induced disorders, or the patient's emotional, behavioral, or cognitive symptoms are troublesome but not sufficient to meet the criteria for a diagnosed mental disorder.

Co-Occurring Enhanced Programs

In contrast to the diagnostic criteria described above for co-occurring capable programs, the patient who is identified as in need of Level 1 co-occurring enhanced program services is assessed as meeting the diagnostic criteria for a mental disorder as well as a substance use or induced disorder, as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the dimensional criteria for admission.

Adult 1.0 Outpatient Services ASAM pages 191-193

If the patient's presenting history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties (such as family members, legal guardians, and significant others).

ADULT DIMENSIONAL ADMISSION CRITERIA

All Services

The patient who is appropriately admitted to Level 1 is assessed as meeting specifications in all of the following six dimensions.

DIMENSION 1: The patient has no signs or symptoms of withdrawal, or his or her withdrawal needs can be safely managed in a Level 1 setting. See separate withdrawal management chapter for how to approach "unbundled" withdrawal management for adults.

DIMENSION 2: The patient's status in Dimension 2 is characterized by biomedical conditions and problems, if any, that are sufficiently stable to permit participation in outpatient treatment. Examples include uncomplicated pregnancy or asymptomatic HIV disease.

DIMENSION 3: The patient's status in Dimension 3 is characterized by (a) or (b); and both (c) and (d):

a. The patient has no symptoms of a co-occurring mental disorder, or any symptoms are mild, stable, fully related to a substance use or other addictive disorder, and do not interfere with the patient's ability to focus on addiction treatment issues; or
b. The patient's psychiatric symptoms (such as anxiety, guilt, or thought disorders) are mild, mostly stable, and primarily related to either a substance use or other addictive disorder, or to a co-occurring cognitive, emotional, or behavioral condition. Mental health monitoring is needed to maintain stable mood, cognition, and behavior. For example, fluctuations in mood only recently stabilized with medication, substance-induced depression that is resolving but still significant, or a patient with schizophrenic disorder recently released from the hospital; and
c. The patient's mental status does not preclude his or her ability to: (1) understand the information presented and (2) participate in treatment planning and the treatment process; and
d. The patient is assessed as not posing a risk of harm to self or others and is not vulnerable to victimization by another.

Co-Occurring Enhanced Programs

Adult 1.0 Outpatient Services ASAM pages 191-193

In addition to the above criteria, the patient's status in Dimension 3 is characterized by either (a); or all of (b) and (c) and (d):

a. The patient has a severe and chronic mental illness that impairs his or her ability to follow through consistently with mental health appointments and psychotropic medication. However, the patient has the ability to access services such as assertive community treatment and intensive case management or supportive living designed to help the patient remain engaged in treatment; or

b. The patient has a severe and chronic mental disorder or other emotional, behavioral, or cognitive problems, or substance-induced disorder; and

c. The patient's mental health functioning is such that he or she has impaired ability to: (1) understand the information presented, and (2) participate in treatment planning and the treatment process. Mental health management is required to stabilize mood, cognition, and behavior; and

d. The patient is assessed as not posing a risk of harm to self or others and is not vulnerable to victimization by another.

DIMENSION 4: The patient's status in Dimension 4 is characterized by (a); and one of (b) or (c) or (d):

a. The patient expresses willingness to participate in treatment planning and to attend all scheduled activities mutually agreed upon in the treatment plan; and

b. The patient acknowledges that he or she has a substance-related or other addictive disorder and/or mental health problem and wants help to change; or

c. The patient is ambivalent about a substance-related or other addictive disorder and/or mental health condition. He or she requires monitoring and motivating strategies, but not a structured milieu program. For example: (a) the patient has sufficient awareness and recognition of a substance use or addictive disorder and/or mental health problems to allow engagement and follow through with attendance at intermittent treatment sessions as scheduled; (b) The patient acknowledges that he or she has a substance-related and/or mental health problem but is ambivalent about change. He or she is invested in avoiding negative consequences and is in need of monitoring and motivating strategies to engage in treatment and progress through stages of change; or

d. The patient may not recognize that he or she has a substance-related or other addictive disorder and/or mental health problem. For example, he or she is more invested in avoiding a negative consequence than in the recovery effort.

Adult 1.0 Outpatient Services ASAM pages 191-193

Such a patient may require monitoring and motivating strategies to engage in treatment and to progress through stages of change.

DIMENSION 5: In Dimension 5, the patient is assessed as able to achieve or maintain abstinence and related recovery goals. Or the patient is able to achieve awareness of a substance or other addiction problem and related motivational enhancement goals, only with support and scheduled therapeutic contact. This is to assist him or her in dealing with issues that include (but are not limited to) concern or ambivalence about preoccupation with alcohol, tobacco, and/or other drug use; other addictive behavior; cravings to use or gamble; peer pressure; and lifestyle and attitude changes.

Co-Occurring Programs

In addition to the above criteria for all programs, the patient is assessed as able to achieve or maintain mental health functioning and related goals only with support and scheduled therapeutic contact to assist him or her in dealing with issues that include (but are not limited to) impulses to harm self or others and difficulty in coping with his or her affects, impulses, or cognition. While such impulses and difficulty in coping may apply to patients in both co-occurring capable and co-occurring enhanced programs, patients in need of co-occurring enhanced program services are more unstable and require the outreach and support of assertive community treatment and intensive case management to maintain their mental health function. For example, such a patient may be unable to reliably keep mental health appointments because of instability in cognition, behavior, or mood.

DIMENSION 6: The patient's status in Dimension 6 is characterized by (a) or (b) or (c):

a. The patient's psychosocial environment is sufficiently supportive that outpatient treatment is feasible (for example, significant others are in agreement with the recovery effort; there is a supportive work environment or legal coercion; adequate transportation to the program is available; and support meeting locations and non-alcohol/drug-centered work are near the home environment and accessible); or

b. The patient does not have an adequate primary or social support system, but he or she has demonstrated motivation and willingness to obtain such a support system; or

c. The patient's family, guardian, or significant others are supportive but require professional interventions to improve the patient's chance of treatment success and recovery. Such interventions may involve assistance in limit-setting, communication skills, a reduction in rescuing behaviors, and the like.

Adult 1.0 Outpatient Services ASAM pages 191-193

Co-Occurring Enhanced Programs

In addition to the above criteria, the patient's status in Dimension 6 is characterized by (a) or (b) or (c):

a. The patient does not have an adequate primary or social support system and has mild impairment in his or her ability to obtain a support system. For example, mood, cognition, and impulse control fluctuate and distract the patient from focusing on treatment tasks; or

b. The family, guardian, or significant others require active family therapy or systems interventions to improve the patient's chances of treatment success and recovery. These may include family enmeshment issues, significant guilt or anxiety, or passivity or disengaged aloofness or neglect; or

c. The patient's status in Dimension 6 is characterized by all of the following: (1) the patient has a severe and chronic mental disorder or an emotional, behavioral, or cognitive condition, and (2) the patient does not have an adequate family or social support system, and (3) the patient is chronically impaired, but not in imminent danger, and has limited ability to establish a supportive recovery environment. However, he or she does have access to intensive outreach and case management services that can provide structure and allow him or her to work toward stabilizing both the substance use or other addictive disorder and mental disorders.

Adolescent 1.0 Outpatient Services ASAM pages 194-196

ADOLESCENT DIAGNOSTIC ADMISSION CRITERIA (ASAM 2013 p. 194)

The adolescent who is appropriately placed in a Level 1 program is assessed as meeting the diagnostic criteria for a substance use, substance-induced, and/or other addictive disorder as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the dimensional criteria for admission.

If the adolescent's presenting alcohol, tobacco, and/or other drug use or addictive behavior history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information appropriately submitted or obtained from collateral parties (such as family members, legal guardians, and significant others) when there is valid authorization to obtain this information.

ADOLESCENT DIMENSIONAL ADMISSION CRITERIA

Adolescent 1.0 Outpatient Services ASAM pages 194-196

The adolescent who is appropriately admitted to Level 1 is assessed as meeting specifications in all of the following six dimensions.

DIMENSION 1: The adolescent has no signs or symptoms of withdrawal, or his or her withdrawal needs can be safely managed in a Level 1 setting.

The adolescent who is appropriately placed in a Level 1 program is not experiencing acute or subacute withdrawal from alcohol or other drugs, and is not at risk of acute withdrawal; or

If the adolescent is experiencing very mild withdrawal, the symptoms consist of no more than lingering but improving sleep disturbance.

Nicotine: Nicotine withdrawal is the exception to the previous statement, as it may be marked by more severe symptoms. However, these can be managed in a Level 1 setting. Nicotine withdrawal symptoms may require either nicotine replacement therapy or non-nicotine pharmacological agents for symptomatic treatment.

NOTE: If the adolescent is presenting for treatment after recently experiencing an episode of acute withdrawal without treatment (as opposed to stepping down from a more intensive level of care following a good response to treatment), it is safer to err on the side of greater intensity of services in making a placement. For example, a Level 2.1 setting may be indicated if the adolescent is doing poorly or if there are indicators for that level of care in other dimensions.

DIMENSION 2: The adolescent's status in Dimension 2 is characterized by biomedical conditions and problems, if any, that are sufficiently stable to permit participation in outpatient treatment. Examples include uncomplicated pregnancy or asymptomatic HIV disease.

DIMENSION 3: The adolescent's status in Dimension 3 is characterized by all of the following:

a. Dangerousness/Lethality: The adolescent is assessed as not posing a risk of harm to self or others. He or she has adequate impulse control to deal with any thoughts of harm to self or others.

b. Interference with Addiction Recovery Efforts: The adolescent's emotional concerns relate to negative consequences and effects of addiction, and he or she is able to view them as part of addiction and recovery. Emotional, behavioral, or cognitive symptoms, if present, appear to be related to substance-related problems rather than to a co-occurring psychiatric, emotional, or behavioral condition. If they are related to such a condition, appropriate additional psychiatric services are provided concurrent with the Level 1 treatment. The adolescent's mental status does not preclude his or her ability to: (1) understand the materials presented (that is, his or her

Adolescent 1.0 Outpatient Services ASAM pages 194-196

cognitive abilities are appropriate to the treatment modality and materials used); and (2) participate in the treatment process.

c. Social Functioning: Relationships or spheres of social functioning (as with family, friends, and peers at school and work) are impaired but not endangered by substance use (for example, there is no imminent break-up of family, expulsion from home, or imminent failure at school). The adolescent is able to meet personal responsibilities and to maintain stable, meaningful relationships despite the mild symptoms experienced (such as mood swings without aggression or threats of danger, or in-school suspension for lateness but no suspensions for truancy).

d. Ability for Self-Care: The adolescent has adequate resources and skills to cope with emotional, behavioral, or cognitive problems, with some assistance. He or she has the support of a stable environment and is able to manage the activities of daily living (feeding, personal hygiene, grooming, and the like).

e. Course of Illness: The adolescent has only mild signs and symptoms. Any acute problems (such as severe depression, suicidality, aggression, or dangerous delinquent behaviors) have been well stabilized, and chronic problems are not serious enough to pose a high risk of vulnerability (such as chronic and stable low-lethality self-injurious behavior, chronic depression without significant impairment or increase in severity, or chronic stable threats without risk of aggression).

DIMENSION 4: The adolescent's status in Dimension 4 is characterized by (a) and one of (b) or (c) or (d):

a. The adolescent expresses willingness to participate in treatment planning and to attend all scheduled activities mutually agreed upon in the treatment plan; and

b. The adolescent acknowledges that he or she has a substance-related or other addictive disorder and/or mental health problem and wants help to change, but is ambivalent about recovery efforts and requires monitoring and motivating strategies; or

c. The adolescent is ambivalent about a substance-related or other addictive disorder and/or mental health condition. He or she requires monitoring and motivating strategies, but not a structured milieu program. For example: (a) the adolescent has sufficient awareness and recognition of a substance use or addictive disorder and/or mental health problems to allow engagement and follow through with attendance at intermittent treatment sessions as scheduled; (b) The adolescent acknowledges that he or she has a

Adolescent 1.0 Outpatient Services ASAM pages 194-196

substance-related and/or mental health problem but is ambivalent about change. He or she is invested in avoiding negative consequences and is in need of monitoring and motivating strategies to engage in treatment and progress through stages of change; or

d. The adolescent may not recognize that he or she has a substance-related or other addictive disorder and/or mental health problem. For example, he or she is more invested in avoiding a negative consequence than in the recovery effort. Such an adolescent may require monitoring and motivating strategies to engage in treatment and to progress through the stages of change.

DIMENSION 5: In Dimension 5, the adolescent is assessed as able to achieve or maintain abstinence and related recovery goals. Or the adolescent is able to achieve awareness of a substance or other addiction problem and related motivational enhancement goals, only with support and scheduled therapeutic contact. This is to assist him or her in dealing with issues that include (but are not limited to) concern or ambivalence about preoccupation with alcohol, tobacco, and/or other drug use; other addictive behavior; cravings to use or gamble; peer pressure; and lifestyle and attitude changes.

DIMENSION 6: The adolescent's status in Dimension 6 is characterized by (a) or (b) or (c):

a. The adolescent's psychosocial environment is sufficiently supportive that outpatient treatment is feasible (for example, significant others are in agreement with the recovery effort; there is a supportive work environment or legal coercion; adequate transportation to the program is available; and support meeting locations and non-alcohol/drug-centered work are near the home environment and accessible); or

b. The adolescent does not have an adequate primary or social support system, but he or she has demonstrated motivation and willingness to obtain such a support system; or

c. The adolescent's family, guardian, or significant others are supportive but require professional interventions to improve the adolescent's chance of treatment success and recovery. Such interventions may involve assistance in limit-setting, communication skills, a reduction in rescuing behaviors, and the like.

Adult 2.1 Intensive Outpatient Services ASAM pages 201-204

ADULT DIAGNOSTIC ADMISSION CRITERIA

Adult 2.1 Intensive Outpatient Services ASAM pages 201-204

The patient who is appropriately placed in a Level 2.1 program is assessed as meeting the diagnostic criteria for a substance use and/or other addictive disorder as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the dimensional criteria for admission.

If the patient's presenting alcohol and/or other drug use and other addictive behavior history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties (such as family members, legal guardians, and significant others).

Co-Occurring Enhanced Programs

The patient in need of Level 2.1 co-occurring enhanced program services is assessed as meeting the diagnostic criteria for a mental disorder as well as a substance use disorder, as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the dimensional criteria for admission.

If the patient's presenting history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties (such as family members, legal guardians, and significant others).

ADULT DIMENSIONAL ADMISSION CRITERIA

Direct admission to a Level 2.1 program is advisable for the patient who meets specifications in Dimension 2 (if any biomedical conditions or problems exist) and in Dimension 3 (if any emotional, behavioral, or cognitive conditions or problems exist), as well as in at least one of Dimensions 4, 5, or 6.

Transfer to a Level 2.1 program is advisable for the patient who

a. has met the essential treatment objectives at a more intensive level of care and
b. requires the intensity of services provided at Level 2.1 in at least one of Dimensions 4, 5, or 6.

A patient also may be transferred to Level 2.1 from a Level 1 program when the services provided at Level 1 have proved insufficient to address the patient's needs or when Level 1 services have consisted of motivational interventions to prepare the patient for participation in a more intensive level of service, for which he or she now meets the admission criteria.

DIMENSION 1: The patient has no signs or symptoms of withdrawal, or his or her withdrawal needs can be safely managed in a Level 2.1 setting.

Adult 2.1 Intensive Outpatient Services ASAM pages 201-204

DIMENSION 2: In Dimension 2, the patient's biomedical conditions and problems, if any, are stable or are being addressed concurrently and thus will not interfere with treatment. Examples include mild pregnancy-related hypertension, asthma, hypertension, or diabetes.

DIMENSION 3: Problems in Dimension 3 are not necessary for admission to a Level 2.1 program. However, if any of the Dimension 3 conditions are present, the patient must be admitted to either a co-occurring capable or co-occurring enhanced program, depending on the patient's level of function, stability, and degree of impairment in this dimension.

Co-Occurring Capable Programs

The patient's status in Dimension 3 is characterized by (a) or (b):

a. The patient engages in abuse of family members or significant others, and requires intensive outpatient treatment to reduce the risk of further deterioration; or

b. The patient has a diagnosed emotional, behavioral, or cognitive disorder that requires intensive outpatient monitoring to minimize distractions from his or her treatment or recovery.

Co-Occurring Enhanced Programs

The patient's status in Dimension 3 is characterized by (a) or (b) or (c):

a. The patient has a diagnosed emotional, behavioral, or cognitive disorder that requires management because the patient's history suggests a high potential for distraction from treatment; such a disorder requires stabilization concurrent with addiction treatment (for example, an unstable borderline personality disorder, compulsive personality disorder, unstable anxiety, or mood disorder); or

b. The patient is assessed as at mild risk of behaviors endangering self, others, or property (for example, he or she has suicidal or homicidal thoughts but no active plan); or

c. The patient is at significant risk of victimization by another. However, the risk is not severe enough to require 24-hour supervision (for example, the patient has sufficient coping skills to maintain safety through attendance at treatment sessions at least 9 or more hours per week).

DIMENSION 4: The patient's status in Dimension 4 is characterized by (a) or (b):

a. The patient requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at

Adult 2.1 Intensive Outpatient Services ASAM pages 201-204

another level of care have failed. Such interventions are not feasible or are not likely to succeed in a Level 1 program; or

b. The patient's perspective inhibits his or her ability to make behavioral changes without repeated, structured, clinically directed motivational interventions. (For example, the patient attributes his or her alcohol or other drug and mental health problems to other persons or external events rather than to an addictive or mental disorder.) Such interventions are not feasible or are not likely to succeed in a Level 1 program. However, the patient's willingness to participate in treatment and to explore his or her level of awareness and readiness to change suggest that treatment at Level 2.1 can be effective.

Co-Occurring Enhanced Programs

The patient's status in Dimension 4 is characterized by meeting criteria for all programs and (a); and one of (b) or (c):

a. The patient is reluctant to agree to treatment and is ambivalent about his or her commitment to change a co-occurring mental health problem; and

b. The patient is assessed as requiring intensive services to improve his or her awareness of the need to change. The patient has such limited awareness of or commitment to change that he or she cannot maintain an adequate level of functioning without Level 2.1 services. For example, the patient continues to experience mild to moderate depression, anxiety, or mood swings, and is inconsistent in taking medication, keeping appointments, and completing mental health assignments; or

c. The patient's follow through in treatment is so poor or inconsistent that Level 1 services are not succeeding or are not feasible.

DIMENSION 5: The patient's status in Dimension 5 is characterized by (a) or (b):

a. Although the patient has been an active participant at a less intensive level of care, he or she is experiencing an intensification of symptoms of the substance-related disorder (such as difficulty postponing immediate gratification and related drug-seeking behavior) and his or her level of functioning is deteriorating despite modification of the treatment plan; or

b. There is a high likelihood that the patient will continue to use or relapse to use of alcohol and/or other drugs or gambling without close outpatient monitoring and structured therapeutic services, as indicated by his or her lack of awareness of relapse triggers, difficulty in coping, or in postponing immediate gratification or ambivalence toward treatment. The patient has unsuccessfully attempted treatment at a less intensive level of care, or such treatment is

Adult 2.1 Intensive Outpatient Services ASAM pages 201-204

adjudged insufficient to stabilize the patient's condition so that direct admission to Level 2.1 is indicated.

Co-Occurring Enhanced Programs

The patient's status in Dimension 5 is characterized by psychiatric symptoms that pose a moderate risk of relapse to the alcohol, other drug, or other addictive or psychiatric disorder.

Such a patient has impaired recognition or understanding of—and difficulty in managing—relapse issues, and requires Level 2.1 co-occurring enhanced program services to maintain an adequate level of functioning. For example, the patient may have chronic difficulty in controlling his or her anger, with impulses to damage property, or the patient continues to increase his or her medication dose beyond the prescribed level in an attempt to control continued symptoms of anxiety or panic.

DIMENSION 6: The patient's status in Dimension 6 is characterized by (a) or (b):

a. Continued exposure to the patient's current school, work, or living environment will render recovery unlikely. The patient lacks the resources or skills necessary to maintain an adequate level of functioning without the services of a Level 2.1 program; or

b. The patient lacks social contacts, has unsupportive social contacts that jeopardize recovery, or has few friends or peers who do not use alcohol or other drugs. He or she also lacks the resources or skills necessary to maintain an adequate level of functioning without Level 2.1 services.

Co-Occurring Enhanced Programs

The patient's status in Dimension 6 is characterized by a living, working, social, and/or community environment that is not supportive of good mental functioning. The patient has insufficient resources and skills to deal with this situation.

For example, the patient is unable to cope with continuing stresses caused by hostile family members with addiction, and he or she evidences increasing depression and anxiety. The support and structure of a Level 2.1 co-occurring enhanced program provide sufficient stability to prevent further deterioration.

Adolescent 2.1 Intensive Outpatient Services ASAM pages 205-207

ADOLESCENT DIAGNOSTIC ADMISSION CRITERIA

The adolescent who is appropriately placed in a Level 2.1 program is assessed as meeting the diagnostic criteria for a substance use and/or other addictive disorder as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of

Adolescent 2.1 Intensive Outpatient Services ASAM pages 205-207

the American Psychiatric Association or other standardized and widely accepted criteria, as well as the dimensional criteria for admission.

If the adolescent's presenting alcohol and/or other drug use and other addictive behavior history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties (such as family members, legal guardians, and significant others).

ADOLESCENT DIMENSIONAL ADMISSION CRITERIA

Direct admission to a Level 2.1 program is advisable for the adolescent who meets the stability specifications in Dimension 1 (if any withdrawal problems exist) and Dimension 2 (if any biomedical conditions or problems exist) and the severity specifications in at least one of Dimensions 3, 4, 5, and 6.

Transfer to a Level 2.1 program is appropriate for the adolescent who has met the objectives of treatment in a more intensive level of care and who requires the intensity of service provided at Level 2.1 in at least one dimension.

An adolescent also may be transferred to Level 2.1 from a Level 1 program when the services provided at that level have proven insufficient to address his or her needs or when Level 1 services have consisted of motivational interventions to prepare the adolescent for participation in a more intensive level of care for which he or she now meets criteria. (The adolescent may be transferred to the next higher intensity level of care if the indicated level is not available in the immediate geographic area.)

DIMENSION 1: The adolescent who is appropriately placed in a Level 2.1 program is not experiencing or at risk of acute withdrawal. At most, the adolescent's symptoms consist of subacute withdrawal marked by minimal symptoms that are diminishing (as during the first several weeks of abstinence following a period of more severe acute withdrawal).

ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

The adolescent is likely to attend, engage, and participate in treatment, as evidenced by his or her meeting the following criteria:

a. The adolescent is able to tolerate mild subacute withdrawal symptoms.
b. He or she has made a commitment to sustain treatment and to follow treatment recommendations.
c. The adolescent has external supports (family and/or court) that promote engagement in treatment.

NOTE: If the adolescent presents for treatment after recently experiencing an episode of acute withdrawal without treatment (as opposed to stepping down from a more intensive level of care following a good response), it is safer to err on the side of

Adolescent 2.1 Intensive Outpatient Services ASAM pages 205-207

greater intensity of services when making a placement decision. For example, a Level 2.5 setting may be indicated if the adolescent is doing poorly or if there are indications in other dimensions that he or she would benefit from that level of care.

DIMENSION 2: In Dimension 2, the adolescent's biomedical conditions and problems, if any, are stable or are being addressed concurrently and thus will not interfere with treatment. Examples include mild pregnancy-related hypertension, asthma, hypertension, or diabetes. Or

The adolescent's biomedical conditions and problems are severe enough to distract from recovery and treatment at a less intensive level of care, but will not interfere with recovery at Level 2.1. The biomedical conditions and problems are being addressed concurrently by a medical treatment provider.

DIMENSION 3: The adolescent's status in Dimension 3 is characterized by at least one of the following:

a. Dangerousness/Lethality: The adolescent is at mild risk of behaviors endangering self, others, or property (for example, he or she has suicidal or homicidal thoughts, but no active plan), and requires frequent monitoring to assure that there is a reasonable likelihood of safety between IOP sessions. However, his or her condition is not so severe as to require daily supervision.

b. Interference with Addiction Recovery Efforts: The adolescent's recovery efforts are negatively affected by an emotional, behavioral, or cognitive problem, which causes mild interference with, and requires increased intensity to support, treatment participation and/or adherence. For example, the adolescent requires frequent repetition of treatment materials because of memory impairment associated with marijuana use.

c. Social Functioning: The adolescent's symptoms are causing mild to moderate difficulty in social functioning (involving family, friends, school, or work), but not to such a degree that he or she is unable to manage the activities of daily living or to fulfill responsibilities at home, school, work, or community. For example, the adolescent's problems may involve significantly worsening school performance or in-school detentions, a circle of friends that has narrowed to predominantly drug users, or loss of interest in most activities other than drug use.

d. Ability for Self-Care: The adolescent is experiencing mild to moderate impairment in ability to manage the activities of daily living, and thus requires frequent monitoring and treatment interventions. Problems may involve poor hygiene secondary to exacerbation of a chronic mental illness, poor self-care,

Adolescent 2.1 Intensive Outpatient Services ASAM pages 205-207

or lack of independent living skills in an older adolescent who is transitioning to adulthood, or in a younger adolescent who lacks adequate family supports.

e. Course of Illness: The adolescent's history and present situation suggest that an emotional, behavioral, or cognitive condition would become unstable without frequent monitoring and maintenance. For example, he or she may require frequent prompting and monitoring of medication adherence (in an adolescent with a history of medication non-adherence) or frequent prompting and monitoring of behavioral adherence (in an adolescent with a conduct disorder or other serious pattern of delinquent behavior).

DIMENSION 4: The adolescent's status in Dimension 4 is characterized by (a) or (b):

a. The adolescent requires structured therapy and a programmatic milieu to promote progress through the stages of change, as evidenced by behaviors such as the following: (1) the adolescent is verbally compliant, but does not demonstrate consistent behaviors; (2) the adolescent is only passively involved in treatment; or (3) the adolescent demonstrates variable adherence with attendance at outpatient sessions or self or mutual help meetings or support groups. Such interventions are not feasible or are not likely to succeed in a Level 1 service; or

b. The adolescent's perspective inhibits his or her ability to make progress through the stages of change. For example, he or she has unrealistic expectations that the alcohol or other drug problem will resolve quickly and with little or no effort, or does not recognize the need for continued assistance. The adolescent thus requires structured therapy and a programmatic milieu. Such interventions are not feasible or are not likely to succeed in a Level 1 service.

DIMENSION 5: The adolescent's status in Dimension 5 is characterized by (a) or (b):

a. Although the adolescent has been an active participant at a less intensive level of care, he or she is experiencing an intensification of symptoms of the substance-related disorder (such as difficulty postponing immediate gratification and related drug-seeking behavior) and his or her level of functioning is deteriorating despite modification of the treatment plan; or

b. There is a high likelihood that the adolescent will continue to use or relapse to use of alcohol and/or other drugs or gambling without close outpatient monitoring and structured therapeutic services, as indicated by his or her lack of awareness of relapse triggers, difficulty in coping, or in postponing immediate gratification or ambivalence toward treatment. The adolescent has unsuccessfully attempted treatment at a less intensive level of care, or such

Adolescent 2.1 Intensive Outpatient Services ASAM pages 205-207

treatment is adjudged insufficient to stabilize the adolescent's condition so that direct admission to Level 2.1 is indicated.

DIMENSION 6: The adolescent's status in Dimension 6 is characterized by (a) or (b) or (c):

a. Continued exposure to the adolescent's current school, work, or living environment will render recovery unlikely. The adolescent lacks the resources or skills necessary to maintain an adequate level of functioning without the services of a Level 2.1 program; or

b. The adolescent lacks social contacts, has unsupportive social contacts that jeopardize recovery, or has few friends or peers who do not use alcohol or other drugs. He or she also lacks the resources or skills necessary to maintain an adequate level of functioning without Level 2.1 services. Or

c. In addition to the characteristics for all programs, a third option is that the adolescent's family or caretakers are supportive of recovery, but family conflicts and related family dysfunction impede the adolescent's ability to learn the skills necessary to achieve and maintain abstinence.

NOTE: The adolescent may require Level 2.1 services in addition to an out-of-home placement (for example, at Level 3.1 or the equivalent, such as a group home or a non-treatment residential setting such as a detention program). If his or her present environment is supportive of recovery but does not provide sufficient addiction-specific services to foster and sustain recovery goals, the adolescent's needs in Dimension 6 may be met through an out-of-home placement, while other dimensional criteria would indicate the need for care in a Level 2.1 program.

Adult 2.5 Partial Hospitalization Services ASAM pages 212-215

ADULT DIAGNOSTIC ADMISSION CRITERIA

The patient who is appropriately placed in a Level 2.5 program is assessed as meeting the diagnostic criteria for a substance use and/or other addictive disorder as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the dimensional criteria for admission.

If the patient's presenting substance use or gambling history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties (such as family members, legal guardians, and significant others).

Co-Occurring Enhanced Programs

Adult 2.5 Partial Hospitalization Services ASAM pages 212-215

The patient in need of Level 2.5 co-occurring enhanced program services is assessed as meeting the diagnostic criteria for a mental disorder as well as a substance use or addictive disorder, as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the dimensional criteria for admission.

If the patient's presenting history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties (such as family members, legal guardians, and significant others).

ADULT DIMENSIONAL ADMISSION CRITERIA

Direct admission to a Level 2.5 program is advisable for the patient who meets specifications in Dimension 2 (if any biomedical conditions or problems exist) and in Dimension 3 (if any emotional, behavioral, or cognitive conditions or problems exist), as well as in at least one of Dimensions 4, 5, or 6.

Transfer to a Level 2.5 program is advisable for the patient who

a. has met essential treatment objectives at a more intensive level of care and
b. requires the intensity of services provided at Level 2.5 in at least one dimension.

A patient also may be transferred to Level 2.5 from a Level 1 or Level 2.1 program when the services provided at the less intensive level have proved insufficient to address the patient's needs, or when those services have consisted of motivational interventions to prepare the patient for participation in a more intensive level of service, for which he or she now meets the admission criteria.

DIMENSION 1: The patient has no signs or symptoms of withdrawal, or his or her withdrawal needs can be safely managed in a Level 2.5 setting. See separate withdrawal management chapter for how to approach "unbundled" withdrawal management for adults.

DIMENSION 2: In Dimension 2, the patient's biomedical conditions and problems, if any, are not sufficient to interfere with treatment, but are severe enough to distract from recovery efforts. Examples include unstable hypertension or asthma requiring medication adjustment or chronic back pain that distracts from recovery efforts.

Such problems require medical monitoring and/or medical management, which can be provided by a Level 2.5 program either directly or through an arrangement with another treatment provider.

DIMENSION 3: Problems in Dimension 3 are not necessary for admission to a Level 2.5 program. However, if any of the Dimension 3 conditions are present, the patient

Adult 2.5 Partial Hospitalization Services ASAM pages 212-215

must be admitted to either a co-occurring capable or co-occurring enhanced program, depending on the patient's level of function, stability, and degree of impairment in this dimension.

The severity of the patient's problems in Dimension 3 may require partial hospitalization or a similar supportive living environment in conjunction with a Level 3.1 program. On the other hand, if the patient receives adequate support from his or her family or significant other(s), a Level 2.5 program may suffice.

Co-Occurring Capable Programs

The patient's status in Dimension 3 is characterized by a history of mild to moderate psychiatric decompensation (marked by paranoia or mild psychotic symptoms) on discontinuation of the drug use. Such decompensation may occur and requires monitoring to permit early intervention.

Co-Occurring Enhanced Programs

The patient's status in Dimension 3 is characterized by (a) or (b) or (c):

a. The patient evidences current inability to maintain behavioral stability over a 48-hour period (as evidenced by distractibility, negative emotions, or generalized anxiety that significantly affects his or her daily functioning); or

b. The patient has a history of moderate psychiatric decompensation (marked by severe, non-suicidal depression) on discontinuation of the drug of abuse. Such decompensation is currently observable; or

c. The patient is at mild to moderate risk of behaviors endangering self, others, or property, and is at imminent risk of relapse, with dangerous emotional, behavioral, or cognitive consequences, in the absence of Level 2.5 structured services. For example, the patient does not have sufficient internal coping skills to maintain safety to self, others, or property without the consistent structure achieved through attendance at treatment sessions daily, or at least 20 hours per week.

DIMENSION 4: The patient's status in Dimension 4 is characterized by (a) or (b):

a. The patient requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another level of care have failed. Such interventions are not feasible or are not likely to succeed in a Level 2.1 program; or

b. The patient's perspective and lack of impulse control inhibit his or her ability to make behavioral changes without repeated, structured, clinically directed motivational interventions. (For example, the patient has unrealistic expectations that his or her alcohol, other drug, or mental health problem will

Adult 2.5 Partial Hospitalization Services ASAM pages 212-215

resolve quickly, with little or no effort, or the patient experiences frequent impulses to harm himself or herself. He or she is willing to reach out but lacks ability to ask for help.) Such interventions are not feasible or are not likely to succeed in a Level 1 or Level 2.1 program. However, the patient's willingness to participate in treatment and to explore his or her level of awareness and readiness to change suggest that treatment at Level 2.5 can be effective.

Co-Occurring Enhanced Programs

The patient's status in Dimension 4 is characterized by (a); and one of (b) or (c):

a. The patient has little awareness of his or her co-occurring mental disorder; and

b. The patient is assessed as requiring more intensive engagement, community, or case management services than are available at Level 2.1 in order to maintain an adequate level of functioning (for example, the patient experiences frequent impulses to harm himself or herself, with poor commitment to reach out for help); or

c. The patient's follow through in treatment is so poor or inconsistent that Level 2.1 services are not succeeding or are not feasible.

DIMENSION 5: The patient's status in Dimension 5 is characterized by (a) or (b):

a. Although the patient has been an active participant at a less intensive level of care, he or she is experiencing an intensification of symptoms of the substance-related disorder (such as difficulty postponing immediate gratification and related drug-seeking behavior) and his or her level of functioning is deteriorating despite modification of the treatment plan; or

b. There is a high likelihood that the patient will continue to use or relapse to use of substances or gambling without close outpatient monitoring and structured therapeutic services, as indicated by his or her lack of awareness of relapse triggers, difficulty in coping or postponing immediate gratification, or ambivalence toward treatment. The patient has unsuccessfully attempted treatment at a less intensive level of care, or such treatment is adjudged insufficient to stabilize the patient's condition so that direct admission to Level 2.5 is indicated.

Co-Occurring Enhanced Programs

The patient's status in Dimension 5 is characterized by psychiatric symptoms that pose a high risk of relapse to the substance or psychiatric disorder.

Such a patient has impaired recognition or understanding of relapse issues, and inadequate skills in coping with and interrupting mental disorders and/or avoiding or

Adult 2.5 Partial Hospitalization Services ASAM pages 212-215

limiting relapse. Such a patient's follow through in treatment is so inadequate or inconsistent, and his or her relapse problems are escalating to such a degree, that treatment at Level 2.1 is not succeeding or not feasible.

For example, the patient may continue to inflict superficial wounds on himself or herself and have continuing suicidal ideation and impulses. However, he or she has no specific suicide plan and agrees to reach out for help if seriously suicidal. Or the patient's continuing substance-induced psychotic symptoms are resolving, but difficulties in controlling his or her substance use exacerbate the psychotic symptoms.

DIMENSION 6: The patient's status in Dimension 6 is characterized by (a) or (b):

a. Continued exposure to the patient's current school, work, or living environment will render recovery unlikely. The patient lacks the resources or skills necessary to maintain an adequate level of functioning without the services of a Level 2.5 program; or

b. Family members and/or significant other(s) who live with the patient are not supportive of his or her recovery goals, or are passively opposed to his or her treatment. The patient requires the intermittent structure of Level 2.5 treatment services and relief from the home environment in order to remain focused on recovery, but may live at home because there is no active opposition to, or sabotaging of, his or her recovery efforts.

Co-Occurring Enhanced Programs

The patient's status in Dimension 6 is characterized by a living, working, social, and/or community environment that is not supportive of good mental functioning. The patient has such limited resources and skills to deal with this situation that treatment is not succeeding or not feasible.

For example, the patient is unable to cope with continuing stresses caused by homelessness, unemployment, and isolation, and evidences increasing depression and hopelessness. The support and intermittent structure of a Level 2.5 co-occurring enhanced program provide sufficient stability to prevent further deterioration.

Adolescent 2.5 Partial Hospitalization Services ASAM pages 215-218

ADOLESCENT DIAGNOSTIC ADMISSION CRITERIA

The adolescent who is appropriately placed in a Level 2.5 program is assessed as meeting the diagnostic criteria for a substance use and/or other addictive disorder as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of

Adolescent 2.5 Partial Hospitalization Services ASAM pages 215-218

the American Psychiatric Association or other standardized and widely accepted criteria, as well as the dimensional criteria for admission.

If the adolescent's presenting substance use or gambling history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties (such as family members, legal guardians, and significant others).

ADOLESCENT DIMENSIONAL ADMISSION CRITERIA

Direct admission to a Level 2.5 program is advisable for the adolescent who meets the stability specifications in Dimension 1 (if any withdrawal problems exist) and Dimension 2 (if any biomedical conditions or problems exist) and the severity specifications in one of Dimensions 3, 4, 5, and 6.

Transfer to a Level 2.5 program is appropriate for the adolescent who has met the objectives of treatment in a more intensive level of care and who requires the intensity of service provided at Level 2.5 in at least one dimension.

An adolescent also may be transferred to Level 2.5 from a Level 1 or 2.1 program when the services provided at those levels have proven insufficient to address his or her needs or when Level 1 or 2.1 services have consisted of motivational interventions to prepare the adolescent for participation in a more intensive level of care for which he or she now meets criteria. (The adolescent may be transferred to the next higher level of care if the indicated level is not available in the immediate geographic area.)

DIMENSION 1:The adolescent who is appropriately placed in a Level 2.5 program is experiencing acute or subacute withdrawal, marked by mild symptoms that are diminishing (as during the first several weeks of abstinence following a period of more severe acute withdrawal).

Withdrawal rating scale tables and flow sheets (which may include tabulation of vital signs) are used as needed.

The adolescent is likely to attend, engage, and participate in treatment, as evidenced by meeting the following criteria:

a. The adolescent is able to tolerate mild withdrawal symptoms.
b. He or she has made a commitment to sustain treatment and to follow treatment recommendations.
c. The adolescent has external supports (as from family and/or court) that promote treatment engagement.

Drug-specific examples follow:

Adolescent 2.5 Partial Hospitalization Services ASAM pages 215-218

a. Alcohol: Mild withdrawal; no need for sedative/hypnotic substitution therapy; no hyperdynamic state; CIWA-Ar score of ≤6; no significant history of regular morning drinking; the adolescent's symptoms are stabilized and he or she is comfortable by the end of each day's active treatment or monitoring.

b. Sedative/hypnotics: Mild withdrawal; the adolescent may have a history of near-daily sedative/hypnotic use, but no cross-dependence on other substances; no disturbance of vital signs; no unstable complicating exacerbation of affective disturbance; no need for sedative/hypnotic substitution therapy; the adolescent's symptoms are stabilized, and he or she is comfortable by the end of each day's active treatment or monitoring.

c. Opiates: Mild withdrawal; the adolescent may need over-the-counter medications for symptomatic relief, but does not need prescription medications or opiate agonist substitution therapy; he or she is comfortable by the end of each day's active treatment or monitoring. The adolescent has sufficient impulse control, coping skills, and/or supports to prevent immediate continued use beyond the active treatment day.

d. Stimulants: Mild to moderate withdrawal (for example, involving depression, lethargy, or agitation), so that the adolescent is likely to need frequent contact and/or higher intensity services to tolerate symptoms, engage in treatment, and bolster external supports. The adolescent has sufficient impulse control, coping skills, and/or supports to prevent immediate continued use beyond the active treatment day.

e. Inhalants: Mild subacute intoxication (involving cognitive impairment, lethargy, agitation, and depression), such that the adolescent is likely to need frequent contact and/or higher intensity services to tolerate symptoms, engage in treatment, and bolster external supports. The adolescent has sufficient impulse control, coping skills, and/or supports to prevent immediate continued use beyond the active treatment day.

f. Marijuana: Moderate withdrawal (involving irritability, general malaise, inner agitation, and sleep disturbance) or sustained subacute intoxication (involving cognitive disorganization, memory impairment, and executive dysfunction), such that the adolescent is likely to need frequent contact and/or higher intensity services to tolerate symptoms, engage in treatment, and bolster external supports.

g. Hallucinogens: Mild chronic intoxication (involving mild perceptual distortion, mild suspiciousness, or mild affective instability). The adolescent has sufficient compensatory coping skills to support engagement in treatment.

Adolescent 2.5 Partial Hospitalization Services ASAM pages 215-218

DIMENSION 2: The adolescent's biomedical conditions and problems are severe enough to distract from recovery and treatment at a less intensive level of care, but will not interfere with recovery at Level 2.5. Examples include unstable diabetes or asthma requiring medication adjustment, or physical disabilities that distract from recovery efforts.

Such problems require medical monitoring and/or medical management, which can be provided by a Level 2.5 program either directly or through an arrangement with another treatment provider.

DIMENSION 3: The adolescent's status in Dimension 3 is characterized by at least one of the following:

a. Dangerousness/Lethality: The adolescent is at mild risk of behaviors endangering self, others, or property (for example, he or she has suicidal or homicidal thoughts, but no active plan), and requires frequent monitoring to assure that there is a reasonable likelihood of safety between PHP sessions. However, his or her condition is not so severe as to require 24-hour supervision.

b. Interference with Addiction Recovery Efforts: The adolescent's recovery efforts are negatively affected by an emotional, behavioral, or cognitive problem, which causes moderate interference with, and requires increased intensity to support, treatment participation and/or adherence. For example, cognitive impairment or significant attention deficit hyperactivity disorder prevents achievement of recovery tasks or goals.

c. Social Functioning: The adolescent's symptoms are causing mild to moderate difficulty in social functioning (involving family, friends, school, or work), but not to such a degree that the adolescent is unable to manage the activities of daily living or to fulfill responsibilities at home, school, work, or community. For example, the adolescent's problems may involve recent arrests or legal charges, or non-adherence with probation, progressive school suspensions or truancy, risk of failing the school year, regular intoxication at school or work, involvement in drug trafficking, or a pattern of intentional property damage.

   Alternatively, the adolescent may be transitioning back to the community as a step down from an institutionalized setting.

d. Ability for Self-Care: The adolescent is experiencing moderate impairment in ability to manage the activities of daily living, and thus requires near-daily monitoring and treatment interventions. Problems may involve disorganization and inability to manage the demands of daily self-scheduling, a progressive pattern of promiscuous or unprotected sexual contacts, or poor

Adolescent 2.5 Partial Hospitalization Services ASAM pages 215-218

vocational or prevocational skills that require habilitation and training provided in the program.

e. Course of Illness: The adolescent's history and present situation suggest that an emotional, behavioral, or cognitive condition would become unstable without daily or near-daily monitoring and maintenance. For example, signs of imminent relapse may indicate a need for near-daily monitoring of an adolescent with attention deficit hyperactivity disorder and a history of disorganization that becomes unmanageable in school with substance use; or an initial lapse indicates a need for near-daily monitoring in an adolescent whose conduct disorder worsens dangerously within the context of progressive use.

DIMENSION 4: The adolescent's status in Dimension 4 is characterized by (a) or (b):

a. The adolescent requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another level of care have failed. Such interventions are not feasible or are not likely to succeed in a Level 2.1 program; or

b. The adolescent's perspective and lack of impulse control inhibit his or her ability to make behavioral changes without repeated, structured, clinically directed motivational interventions. (For example, the adolescent has unrealistic expectations that his or her alcohol, other drug, or mental health problem will resolve quickly, with little or no effort, or the adolescent experiences frequent impulses to harm himself or herself. He or she is willing to reach out but lacks the ability to ask for help.) Such interventions are not feasible or are not likely to succeed in a Level 1 or Level 2.1 program. However, the adolescent's willingness to participate in treatment and to explore his or her level of awareness and readiness to change suggest that treatment at Level 2.5 can be effective.

DIMENSION 5: The adolescent's status in Dimension 5 is characterized by (a) or (b):

a. The adolescent is at high risk of relapse or continued use without almost daily outpatient monitoring and structured therapeutic services (as indicated, for example, by susceptibility to relapse triggers, a pattern of frequent or progressive lapses, inability to overcome the momentum of a pattern of habitual use, difficulty in overcoming a pattern of impulsive behaviors, or ambivalence about or disinterest in treatment). Also, treatment at a less intensive level of care has been attempted or given serious consideration and been judged insufficient to stabilize the adolescent's condition; or

b. The adolescent demonstrates impaired recognition and understanding of relapse or continued use issues. He or she has such poor skills in coping with

Adolescent 2.5 Partial Hospitalization Services ASAM pages 215-218

and interrupting substance use problems, and avoiding or limiting relapse, that the near-daily structure afforded by a Level 2.5 program is needed to prevent or arrest significant deterioration in function.

DIMENSION 6: The adolescent's status in Dimension 6 is characterized by (a) or (b) or (c):

a. Continued exposure to the adolescent's current school, work, or living environment will render recovery unlikely. The adolescent lacks the resources or skills necessary to maintain an adequate level of functioning without the services of a Level 2.5 program; or

b. Family members and/or significant other(s) who live with the adolescent are not supportive of his or her recovery goals, or are passively opposed to his or her treatment. The adolescent requires the intermittent structure of Level 2.5 treatment services and relief from the home environment in order to remain focused on recovery, but may live at home because there is no active opposition to, or sabotaging of, his or her recovery efforts; or

c. The adolescent lacks social contacts, or has high-risk social contacts that jeopardize recovery, or has few friends or peers who do not use alcohol or other drugs. He or she also has insufficient (or severely limited) resources or skills necessary to maintain an adequate level of functioning without the services of a Level 2.5 program, but is capable of maintaining an adequate level of functioning between sessions.

The adolescent may require Level 2.5 services in addition to an out-of-home placement (for example, at Level 3.1 or the equivalent, such as a group home or a non-treatment residential setting such as a detention program). If his or her present environment is supportive of recovery but does not provide sufficient addiction-specific services to foster and sustain recovery goals, the adolescent's needs in Dimension 6 may be met through an out-of-home placement, while other dimensional criteria would indicate the need for care in a Level 2.5 program.

LEVEL 1-WM AMBULATORY WITHDRAWAL MANAGEMENT WITHOUT EXTENDED ON-SITE MONITORING

DIAGNOSTIC ADMISSION CRITERIA

The same diagnostic criteria apply to all levels of withdrawal management (WM) care, with two exceptions. All patients who are appropriately placed in any level (1-WM through 4-WM) of withdrawal management meet the diagnostic criteria for substance withdrawal disorder of the current Diagnostic and Statistical Manual of Mental

LEVEL 1-WM AMBULATORY WITHDRAWAL MANAGEMENT WITHOUT EXTENDED ON-SITE MONITORING

Disorders of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the dimensional criteria for admission.

The only exceptions, however, are that in the case of Levels 1-WM and 2-WM, for patients whose presenting alcohol or other drug history is inadequate to substantiate such a diagnosis, information provided by collateral parties (such as family members or a legal guardian) can indicate a high probability of such a diagnosis, subject to confirmation by further evaluation.

Dimensional Admission Criteria Decision Rules

LEVEL 1-WM AMBULATORY WITHDRAWAL MANAGEMENT WITHOUT EXTENDED ON-SITE MONITORING

The patient is experiencing at least mild signs and symptoms of withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent. The patient is assessed as being at minimal risk of severe withdrawal syndrome and can be safely managed at this level.

ALCOHOL (p. 166)

Examples include, but are not limited to the following:

1-WM The presence of mild to moderate symptoms of withdrawal, with a CIWA-Ar score of less than 10, or the equivalent for a comparable standardized scoring system.

SEDATIVE / HYPNOTICS (p. 167)

1-WM Any recent use is confined to therapeutic levels and is not complicated by daily use of alcohol or other mind-altering drugs known to produce a significant withdrawal syndrome. There is a reliable history that the patient is withdrawing from therapeutic doses of sedative/hypnotics, but there is no evidence of other alcohol or drug dependence. Withdrawal symptoms have responded to, or are likely to respond to, substitute doses of sedative/hypnotics in the therapeutic range within 2 hours.

OPIOIDS (p. 168)

Examples include, but are not limited to the following:

1-WM For withdrawal management not using opioid agonist medication: Either the patient's use of high-potency opioids (such as injectable or smoked forms) has not been daily for more than 2 weeks preceding admission or the use of opioids is near the therapeutically recommended level.

LEVEL 1-WM AMBULATORY WITHDRAWAL MANAGEMENT WITHOUT EXTENDED ON-SITE MONITORING

For withdrawal management using opioid agonist medication, such as methadone or other appropriate opioids: Either the patient is being withdrawn gradually from opioid agonist medication or the patient is being treated for mild opioid withdrawal symptoms.

STIMULANTS (p. 169)

Examples include, but are not limited to the following:

1-WM The patient is withdrawing from stimulants and is experiencing some lethargy, agitation, paranoia, mild psychotic symptoms, or depression, but he or she has good impulse control.

NICOTINE (p. 170)

Examples include, but are not limited to the following:

1-WM The patient is withdrawing from nicotine and is experiencing withdrawal symptoms that require either nicotine replacement therapies or non-nicotine agents for symptomatic treatment.

LEVEL 1-WM (pages 171-172): The patient has withdrawal symptoms but is at minimal risk of severe withdrawal syndrome and is assessed as likely to complete needed withdrawal management and to enter into continued treatment or self-help recovery, as evidenced by meeting [1] or [2] or [3] :

[1] The patient has an adequate understanding of ambulatory withdrawal management and has expressed commitment to enter such a program; or

[2] The patient has adequate support services to ensure commitment to completion of withdrawal management and entry into ongoing treatment or recovery; or

[3] The patient is willing to accept a recommendation for treatment (for example, to begin disulfiram, naltrexone, or other medication once withdrawal has been managed, or to attend outpatient sessions or self-help groups).

LEVEL 1-WM (p. 173) For patients whose withdrawal symptoms are no more severe than those noted in the specifications shown on pages 165-170, the patient has, and responds positively to, emotional support and comfort, as evidenced by:

[1] Decreased emotional symptoms at the close of the initial treatment session; and

[2] The patient's or support person's ability to clearly understand instructions for care, and the presence of both the ability and resources to follow instructions.

LEVEL 2-WM AMBULATORY WITHDRAWAL MANAGEMENT WITH EXTENDED ON-SITE MONITORING

The patient is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent.

The patient is assessed as being at moderate risk of severe withdrawal syndrome outside the program setting; is free of severe physical and psychiatric complications; and would safely respond to several hours of monitoring, medication, and treatment.

ALCOHOL (p. 166)

Examples include, but are not limited to the following:

2-WM A CIWA-Ar score of 10 to 25, or the equivalent for a comparable standardized scoring system.

SEDATIVE / HYPNOTICS (p. 167)

2-WM There is a reliable history that the patient is withdrawing from sedative/hypnotics and withdrawal symptoms have responded to, or are likely to respond to, substitute doses of sedative/hypnotics within the observable hours of the program. The patient has ingested sedative/hypnotics in excess of therapeutic levels daily for at least 4 weeks, but the risk of seizures, hallucinations, dissociation, or severe affective disorder during unobserved periods outside the program is assessed as minimal. Close hourly monitoring is available, if needed. There is no accompanying chronic mental or physical disorder that poses a danger to the patient during withdrawal. The patient has ingested sedative/hypnotics at not more than therapeutic levels daily for at least 6 months, in combination with daily alcohol use or regular use of another mind-altering drug known to have its own dangerous withdrawal syndrome. Nonetheless, the risk of seizures, hallucinations, dissociation, or severe affective symptoms outside the program is minimal.

OPIOIDS (p. 168)

2-WM For withdrawal management not using opioid agonist medication: The abstinence syndrome—as indicated by vital signs and evidence of physical discomfort or craving—can be stabilized by the end of each day's monitoring, so that the patient can manage such symptoms at home with appropriate supervision. For withdrawal management using opioid agonist medication, such as methadone or other appropriate opioids: The withdrawal signs and symptoms are of such severity or instability that extended monitoring is required to determine the appropriate dosage.

STIMULANTS (p. 169)

LEVEL 2-WM AMBULATORY WITHDRAWAL MANAGEMENT WITH EXTENDED ON-SITE MONITORING
2-WM The patient is withdrawing from stimulants and is experiencing significant lethargy, agitation, paranoia, psychotic symptoms, or depression, and requires extended outpatient monitoring to determine impulse control and readiness for Level 1-WM ambulatory withdrawal management services or the need for Level 3.2-WM withdrawal management services. LEVEL 2-WM (pages 171-172) The patient is assessed as likely to complete withdrawal management and to enter into continued treatment or self-help recovery, as evidenced by meeting [1] and either [2] or [3] or [4] : [1] The patient or support persons clearly understand instructions for care and are able to follow instructions; and [2] The patient has an adequate understanding of ambulatory withdrawal management and has expressed commitment to enter such a program; or [3] The patient has adequate support services to ensure commitment to completion of withdrawal management and entry into ongoing treatment or recovery; or [4] The patient evidences willingness to accept a recommendation for treatment once withdrawal has been managed (for example, to attend outpatient sessions or self-help groups).

Note: There are no separate Withdrawal Management Services for Adolescents Medically Monitored Inpatient Withdrawal Management

MAT
The patient who is appropriately placed in an opioid treatment program is assessed as meeting the diagnostic criteria for severe opioid use disorder, as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) or other standardized and widely accepted criteria, aside from those exceptions listed in 42 CFR 8.12. If the patient's drug use history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by other health care professionals and programs, and collateral parties (such as family members, legal guardians, or significant others). Individuals who are admitted to treatment with methadone or buprenorphine must demonstrate specific objective and subjective signs of opioid use disorder, as defined in 42 CFR 8.12.

Attachment 2

Six Dimensions
Dimension 1 Acute Intoxication/Withdrawal Potential: Previous withdrawal episodes, outcome of said episodes, history of overdoses, seizures, or other withdrawal related complications, withdrawal medications used in the past, and responses to said medications, substances used leading up to current treatment episode, amounts of substances being used, route of administration. Withdrawal scores (COWS, CIWA, etc.) if available.
Dimension 2 Biomedical Conditions and Complications: Current and past medical diagnoses, treatment, response to treatments, recent hospitalizations and surgeries, and current medications.
Dimension 3 Emotional, Behavioral or Cognitive Conditions and Complications: Current or past mental health diagnoses or symptoms. Current and past treatments for mental health diagnoses or symptoms including medications prescribed, response to medications, length of time medication was taken. Psychiatric hospitalizations, dates, lengths, outcomes, and locations of hospitalizations. Dates, circumstances, and outcomes of any suicide attempts. History of self harm, eating disorder, sleeping disorders, violence, and traumas. Military or first responder status. Relevant information about family of origin, developmental history, family or caregiver social history and childhood.
Dimension 4 Readiness for Change: Reasons for presenting for treatment, previous attempts at recovery and treatment and outcomes, self help group/recovery/spiritual group past engagement, awareness and insight into substance use and other problems, ability to verbalize reasons for wanting to change behavior, motivation for following through with treatment recommendations.
Dimension 5 Relapse, Continued Use or Continued Problem Potential: History of attempts at recovery and outcomes, situations/events preceding return to use, history of adherence to medications for SUD or mental health, stage of readiness for change, severity of cravings, ability to identify high risk situations and people, and ability to verbalize an action plan to respond to high risk situations or avoid them.

Six Dimensions
Dimension 6 Recovery/Living Environment: Peer and family relationships and friendships are supportive/not supportive of recovery, housing status, legal status, education history, employment status, parenting status, access to affordable childcare, access to transportation, access to recovery support/spiritual/self help groups, leisure and recreational interests. • If the counselor conducting the assessment identifies that any information gathered is outside of the scope of practice or expertise, the interdisciplinary team should be consulted while interpreting data and information while formulating the assessment. • Summary of the patient's strengths and needs in each of the six dimensions. • Treatment and LOC recommendations. • Documentation of the patient's abilities, goals, and preferences throughout the assessment.