

ASAM
**THE STANDARDS
OF CARE**

For the Addiction
Specialist Physician



ASAM The Voice of Addiction Medicine
American Society of Addiction Medicine

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ACKNOWLEDGEMENTS AND ENDORSEMENTS

The PIPMAG project was generously funded by the Substance Abuse and Mental Health Services Administration, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism. We would like to recognize all the individuals who served on the various committees and panels, especially the chairs Drs. Michael Miller, Margaret Jarvis, Corey Waller, and David Pating, and our expert consultant, Mady Chalk, PhD, who provided valuable input. We would also like to acknowledge the ASAM staff who worked on this project including Susan Awad, Beth Haynes, Alexis Geier-Horan, and Penny Mills.

This document is endorsed by the American Osteopathic Academy of Addiction Medicine (AOAAM).



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INTRODUCTION

I. Background and Purpose of Standards:

The Standards of Care for the Addiction Specialist Physician (The Standards) address the unique responsibilities borne by a physician who manages or oversees the care of a patient with addiction and related disorders. They are intended to support quality improvement activities conducted by health care provider systems, health care quality entities, medical specialty certification boards, and by individual physicians monitoring their own performance in their own practices. The Standards apply to any physician assuming the responsibility for caring for addiction and related disorders and acting in this capacity even if such a physician does not hold specialty certification in addiction medicine or addiction psychiatry. The Standards address expected physician competencies and actions with the ultimate purpose of improving patient outcomes. ASAM anticipates that The Standards will “raise the bar” of expectations and accountabilities in describing what physicians are expected to do at different points in the addiction care process. This document is a dynamic statement on quality medical care and is subject to ongoing review; it may be revised by the American Society of Addiction Medicine (ASAM) in the future based on input from ASAM leaders and consultation with other organizations that have reviewed and chosen to endorse these Standards.

It is important to note The Standards outline a minimum standard of physician performance and should not be construed as describing the extent to totality of care that a person with addiction might require. Additionally, these standards are not substance-, behavior-, or setting-specific, but apply generally to the treatment of individuals with addiction involving any addictive substance or behavior – including nicotine, alcohol, prescription or illicit drugs, and/or addictive behavior such as gambling – in any medical setting.

ASAM recognizes that, at this point in time, the epidemiology of addiction and the expert consensus on how best to treat addictive disorders is more firmly established in the case of substance use disorders than in the case of conditions involving addictive behaviors. Hence, the wording of The Standards primarily focuses on substance-related conditions and not addiction involving addictive behaviors. As scientific knowledge and clinical experience grow with respect to addiction not involving the use of substances, we expect that future statements about standards of care for addiction specialist physicians will be able to address evaluation, management, and care coordination for addiction more broadly.

The Standards were developed using a consensus process. Their development was overseen by a Steering Committee comprised of representatives of the key addiction physician specialty societies as well as academicians, researchers and clinicians experienced in standards development. The Steering Committee appointed an expert panel that was charged with developing the Standards document. The Steering Committee also appointed an expert panel to develop another document addressing the domains of performance measures for addiction specialist physicians, deriving from The Standards in the current document; members of the Expert Panel on performance measures also provided input that improved the final wording of these Standards.

Along with the expert panels, a field review panel offered additional expert feedback into the making of this document. The individuals comprising the Steering Committee, the Standards Expert Panel, the Performance Measures Expert Panel and the Field Review Panel are listed at the beginning of this document. ASAM is grateful for the generous support of SAMHSA, NIDA and NIAAA, which made this important initiative possible.

II. Addiction Specialist Physicians and Professionalism Expectations:

Addiction specialist physicians (see glossary) include addiction medicine physicians and addiction psychiatrists who hold either a board certification in addiction medicine from the American Board of Addiction Medicine (ABAM), a subspecialty board certification in addiction psychiatry from the American Board of Psychiatry and Neurology (ABPN), a subspecialty board certification in addiction medicine from the American Osteopathic Association (AOA), or certification in addiction medicine from the American Society of Addiction Medicine (ASAM).

The addiction specialist physician upholds the ethics policies of his/her addiction specialty organization. The addiction specialist physician also upholds the professional expectations of all physicians but has some unique professional expectations including the following:

1. Keeping abreast of changes in laws regarding illegal substances, the prescribing of controlled substances, criminalization of behaviors associated with substance use, clinical alternatives to criminal prosecution and incarceration, and interfaces between the health care system and the criminal justice system, including community corrections;
2. Understanding and complying with all applicable federal, state, and local regulations related to patient confidentiality;
3. Obtaining informed consent and ensuring that patients understand the extent and limits of privacy protections.

Addiction specialist physicians should maintain their licensure to practice medicine and their certification as addiction specialists. This includes remaining current regarding clinical advances, participating in regular self-assessment and demonstrating that, through participation in a plan of lifelong learning and practice improvement, they are actively engaged in the maintenance of their specialized clinical knowledge and competencies commensurate with a complex and ever-changing field.

The addiction specialist physician should be able to deal with substance use disorders as well as concurrent problems that exacerbate or arise from the patient's addiction. The addiction specialist physician should also have a good understanding of local cultures and subcultures and what local resources are available to support the patient's recovery. Ultimately, a patient's care should be oriented toward overall functioning and well-being while mitigating risk factors for substance related harm or relapse. The Standards identify what addiction specialist physicians do as they perform their clinical and administrative roles, not simply what knowledge, skills, or competencies they possess.

III. Addiction Specialist Physician Leadership:

The Standards presented in this document are statements of what physicians should do in their clinical practices and as the physician manifests leadership within health care teams and broader systems of care. Addiction is a complex disease that impacts many aspects of a person's life and requires long-term, coordinated care by a team of providers who can address the myriad physical, mental, social, economic, and legal ramifications of the disease. As a leader of this care team, the addiction specialist physician is well-poised to coordinate and provide the treatment required by persons with addiction due to his or her advanced and unique understanding of the dynamics of addiction and the dynamics of recovery, and how addiction manifests in varied medical, social, economic, and legal ways.

III. Addiction Specialist Physician Leadership: (cont.)

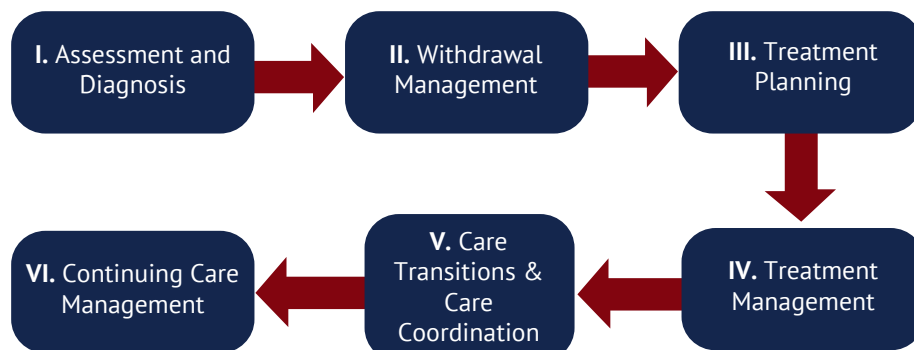
An addiction specialist physician functions at different levels of leadership or influence and as a part of formal and informal teams. As of this writing, we recognize that addiction treatment is not well integrated into most health systems and the addiction specialist physician workforce is inadequate to address individually the number of patients with addiction. As a result, collaborative management is necessary and the addiction specialist physician has a responsibility to be the leader within health care systems and/or their communities when addiction is present as part of the patient’s overall clinical situation.

Part of this responsibility is to help other providers and health care administrators understand how addiction affects the evaluation and management of other illnesses so that appropriate treatment is provided. This responsibility will also require that addiction specialist physicians be directly involved in quality assurance and evaluation, safety management, and professional development regarding treatment of patients with addiction within the relevant systems of care where they practice. Addiction specialist physician leadership will also require that s/he teach new generations of clinicians in their practice settings and/or through involvement in their professional societies.

IV. Implications and Next Steps:

Addiction treatment is in the process of evolving from a largely non-medical, isolated field into a more integrated part of mainstream medical care. As this occurs, new working relationships, treatment protocols, and reimbursement mechanisms will need to be negotiated, and some growing pains will be inevitable. For example, current commercial and regulatory requirements for physicians sometimes ask them to authenticate care for patients they have never seen. This threatens high quality care and can undermine physicians’ decision-making. In the midst of changes and pressures both old and new, The Standards set forth here (and on the diagram below) outline what we can and should expect from addiction specialist physicians in the treatment of individuals with substance use and substance-related disorders, and they can serve as a benchmark for physicians, payers, policymakers and patients alike as they seek to provide, pay for, regulate, and receive the highest quality care.

Given the evolution of the health care environment and the role of addiction treatment and addiction specialist physicians, it is expected that The Standards will be reviewed periodically and updated to reflect scientific and clinical advances in treatment and changes in the health care delivery system. ASAM invites other addiction specialty physician organizations to endorse these standards so that they will apply to as broad a physician audience as possible. The next step in this process will involve the Steering Committee overseeing the work of an expert panel as it develops a set of performance measures based on The Standards.



STANDARDS



Assessment of a patient with a substance use disorder is an ongoing process. A complete assessment is a critical aspect of patient engagement and treatment planning and should be conducted during the initial phase of treatment. However, it is important to note that it does not necessarily need to be conducted at the initial visit. In certain practice situations, but especially in emergency situations, brief, focused assessments may be appropriate, but comprehensive treatment of addiction requires comprehensive assessment at some point in time; one of the competencies of an addiction specialist physician is to discern when a brief assessment versus a comprehensive assessment is needed. The addiction specialist physician is the professional most able to determine the appropriateness of medications used for addiction, and data collection and analysis must be done with the indications for pharmacological therapy and various psychosocial therapies in mind. Appropriate assessment includes data from clinical interviews, physical examination, and diagnostic procedures, to assure optimal clinical outcomes, patient safety, treatment adherence, and the appropriate stewardship of health care resources.

STANDARD I.1: Comprehensive Assessment

The addiction specialist physician assures that an initial comprehensive, multi-component assessment is performed for each patient, either by performing it her/himself or by assuring it is conducted in full or in part by another qualified professional within the system in which she/he is working. The addiction specialist physician assures that, for every patient under his or her care, the assessment is reviewed and updated on a regular basis, including at every care transition, to promote treatment engagement and meet the patient's needs and preferences. A comprehensive assessment for a person with addiction includes the following components:

- A physical exam
- A mental status exam
- Medical and psychiatric history
- A detailed past and present substance use history, including assessment of withdrawal potential
- A history of the pathological pursuit of reward or relief through engagement in addictive behaviors, such as gambling or exercise

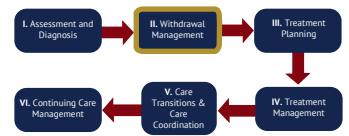
- Substance use disorder and addictive disorder treatment history and response to previous treatment, including history of use of pharmacotherapies and response to such interventions
- Family medical, psychiatric, substance use, addictive behavior and addiction treatment history
- Allergies
- Current medications
- Social history
- Consultation with appropriate collateral sources of information
- A summary of the patient's readiness to engage in treatment, potential to continue unhealthy use or return to unhealthy engagement in substance use or addictive behaviors, and the recovery environment that can support or impede recovery
- Diagnostic formulation(s)
- Identification of facilitators and barriers to treatment engagement including patient motivational level and recovery environment

STANDARD I.2: Monitoring Diagnostic Procedures

The addiction specialist physician collects appropriate data from diagnostic procedures such as structured rating scales and relevant laboratory and imaging studies at baseline, and then periodically monitors these indicators as clinically appropriate.

STANDARD I.3: Making the Diagnosis

Having assimilated data from interview/examination of the patient and other sources, the addiction specialist physician makes the diagnosis that guides the care of the patient, including any necessary withdrawal management services.



II. Withdrawal Management

Withdrawal management, when indicated, is a critical part of substance use disorder treatment. However, it is important to note that withdrawal management alone does not constitute adequate treatment for addictive disease and should be linked with ongoing treatment for substance use disorders. The addiction specialist physician assesses the extent to which withdrawal management is needed for specific classes of drugs. Additionally, medical decision-making by the addiction specialist physician includes determining whether, for a patient in acute withdrawal, the indicated intervention is acute management of the withdrawal syndrome or induction into agonist, partial agonist, or antagonist maintenance therapy. Thus, if the patient is to be placed on ongoing treatment with an agonist or partial agonist, then he or she should not be placed on a withdrawal regimen for that class of drugs, though other withdrawal management interventions may be indicated for other classes of drugs.

STANDARD II.1: Assessing Withdrawal Management Needs

The addiction specialist physician assesses the need for patient withdrawal management, the intensity of withdrawal management services needed, and the appropriate treatment environment, given the patient's severity of symptomatology. This assessment includes the number and classes of drugs from which the patient needs withdrawal management, if any, and the eventual treatment modality in which the patient will engage after the acute withdrawal syndrome has stabilized through biopsychosocial interventions.

STANDARD II.2: Providing Intoxication/Withdrawal Medical Interventions

The addiction specialist physician uses validated, objective measurements of intoxication and withdrawal (when such an instrument exists for the given substance). The addiction specialist physician also pays careful attention to potential general medical and psychiatric complications during withdrawal management of a person with a substance use disorder. The addiction specialist physician documents medical decision-making and appropriate treatment planning, including appropriate level of care, for a patient undergoing withdrawal management. When withdrawal management medications are indicated, the addiction specialist physician uses an evidence-supported approach to select a pharmacological agent, dosage, and route of administration.

STANDARD II.3: Assuring Intoxication/ Withdrawal Psychosocial Interventions

The addiction specialist physician assures that validated psychosocial interventions are instituted concurrently with medical interventions (by him/herself or other members of the treatment team) during intoxication management and withdrawal management and provides or supervises ongoing treatment for the patient's associated substance use disorder.



III. Treatment Planning

The addiction specialist physician's unique training provides an understanding of the many physical, psychological and social consequences and complications of substance use disorders and recognition that influential social networks, including families, are important to the patient's treatment. The standards in this section describe the addiction specialist physicians' role in developing the treatment plan including how they would involve other referring providers, social support networks and the documentation of clinical decisions.

STANDARD III.1: Coordinating Medical Care

The addiction specialist physician integrates and coordinates the treatment of addiction and associated problems and conditions, and negotiates with other providers the aspects of care relevant to the patient's addiction. The addiction specialist physician may be the direct provider of care, but even when he/she is only managing the direct care of other providers, the addiction specialist physician is ultimately responsible for addiction-related medical decision-making.

STANDARD III.2: Providing Therapeutic Alternatives

The addiction specialist physician discusses and offers all available clinically indicated psychosocial and pharmacological therapies to all patients, assisting the patient to collaborate in clinical decision-making, assuring that the patient is aware of therapeutic alternatives. This will include the advantages and disadvantages of medications for addiction, taking into consideration cost, availability, and potential for diversion. When pharmacotherapies are part of the treatment plan, the addiction specialist physician decides with the patient about the setting for treatment, assuring appropriate dosage and duration for the medication, monitors adherence, and assures psychosocial therapies occur throughout the treatment process.

STANDARD III.3: Evaluating Safety

The addiction specialist physician uses his or her unique expertise to evaluate safety risks associated with the patient's substance use disorder and assures that the treatment plan addresses those risks.

STANDARD III.4: Addressing Comorbidity

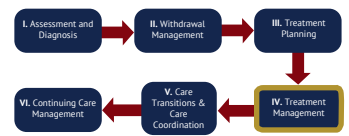
The addiction specialist physician assures that all psychiatric and medical comorbidities are addressed concurrently rather than sequentially when concurrent treatment is clinically feasible.

STANDARD III.5: Involving Social Support Networks

The addiction specialist physician assures that attempts are made to involve social networks and the people therein in the treatment process. For example, the addiction specialist physician assures that appropriate support services are made available for patients' families.

STANDARD III.6: Documenting Clinical Decisions

The addiction specialist physician assures that the reasoning behind clinical decision-making is documented within the treatment plan in the patient's health record. Documentation in the patient's health record by the addiction specialist physician or another member of the treatment team should reflect knowledge of the patient, include options discussed and patient preferences, set out a mutually agreed-upon plan of action to accommodate the individual needs of the patient, as well as delineate measurable goals of treatment.



IV. Treatment Management

Treatment management typically refers to activities by addiction specialist physicians to assure the quality of care when addiction specialist physicians are not directly providing treatment but are managing the direct care of other providers. The standards in this section, however, also include the addiction specialists' responsibilities, if they are practicing in settings where they are directly providing care.

STANDARD IV.1: Assuring Quality of Care

When the direct treatment is provided by other clinicians under his/her supervision, the addiction specialist physician remains actively engaged with the monitoring and supervision of care and in providing oversight for the quality of care of the patient. This oversight includes assuring that all clinically indicated psychosocial and pharmacological therapies are discussed with and offered to all patients. When pharmacotherapies are part of the treatment plan, the addiction specialist physician decides with the patient about the setting for treatment, assuring appropriate dosage and duration for the medication; monitors adherence; and assures psychosocial therapies occur throughout the treatment process.

- When the addiction specialist physician is managing the care rather than serving as the direct provider of care, Standards III.2-III.6 must still be followed.

STANDARD IV.2: Determining Clinical Progress

The addiction specialist physician meets with the patient or assures that other clinician (s) meet with the patient to regularly assess progress toward mutually agreed-upon, measurable goals in the treatment plan.

- If the patient and addiction specialist physician agree that progress toward these goals is adequate, then plans will be made to build upon these achievements, which may include transition to other services for recovery focused strategies.
- If the patient or the addiction specialist physician perceives that progress is not being made toward agreed-upon goals, the patient and addiction specialist physician will reassess the diagnosis, treatment modalities, treatment intensity and treatment goals in order to revise the treatment plan. Lack of treatment progress should lead to treatment plan revisions and not result in an inappropriate termination of care.

STANDARD IV.3: Assuring Support Service Referral

The addiction specialist physician assures that the treatment plan includes referral to indicated social services.



V. Care Transitions and Care Coordination

Collaborative care is a key attribute of high-quality care and it is the responsibility of the addiction specialist physician who directly provides specialty care or supervises and manages specialty care provided by other clinicians. As of the writing of this document, complying with privacy and confidentiality laws and regulations presents challenges to addiction specialty care and general medical care providers and systems who strive to attain the goals of collaboration. Challenges notwithstanding, the physician is in a unique role to advocate for collaboration that ideally includes multiple professionals, individual patients, and family members, and to assist patients as they maneuver through often-complex multi-component systems of care.

STANDARD V.1: Coordinating Treatment and Confidentiality

The addiction specialist physician takes steps to coordinate addiction care, communicates with other treatment providers and, when necessary, adjusts the treatment plan whenever patients experience a major change in physical or psychological health. This coordination is of particular importance when medications are being used to support recovery, as issues of cost, availability, potential for diversion and what to do in the event of a relapse make safe and appropriate prescription of the necessary medications challenging for those without specialized training. The addiction specialist physician also assures that proper authorizations for release of information are obtained.

- If the patient asserts their privilege to not permit sharing of confidential addiction treatment information with other providers, the addiction specialist physician educates the patient about the health and safety risks inherent in poorly coordinated care.

STANDARD V.2: Assuring Quality in Transitions

The addiction specialist physician assures that transitions between levels of care for substance use disorders are informed by a biopsychosocial evaluation, patient preferences, and the patient's history of responses to previous attempts at treatment.

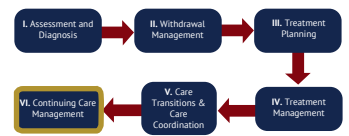
STANDARD V.3: Sharing Information and Protecting Privacy

During care transitions, the addiction specialist physician directs that information is shared with subsequent providers about the patient's health status, current treatment plan, treatment adherence and treatment progress. The addiction specialist physician assures that proper authorizations for release of information are obtained.

- If the patient asserts their privilege to not permit sharing of confidential addiction treatment information with other providers, the addiction specialist physician educates the patient about the health and safety risks inherent in poorly coordinated care.

STANDARD V.4: Providing Referral

When patients transition from a given level of care, terminate addiction treatment, or terminate with a specific addiction provider, the addiction specialist physician provides recommendations and referrals for continuing professional care and/or self-management. The addiction specialist physician assures that the community and medical resources available to the patient, including the resources available through the patient's primary care provider or medical home, have been identified in a way that maximizes the patient's sustained functional recovery and is aligned with the patient's goals.



VI. Continuing Care Management

Continuing care management is provided when the patient has achieved stable sobriety, achieved most or met all treatment goals and the patient is ready for sustainable recovery-focused self-care. Recovery check-ups by addiction specialist physicians, just as those by primary care physicians or other providers, may promote sustained recovery and prevent relapse.

STANDARD VI.1: Assuring Continuity in Addiction Care

The addiction specialist physician encourages patients to meet with him or herself or with a designated care provider who intermittently monitors and assesses the patient's maintenance of recovery. The addiction specialist physician's or other care provider's assessment for continuing care management can include the following:

- Patient and collateral interview
- Physical and/or psychological examination as appropriate
- Structured rating scales
- Review of current medications
- Laboratory studies
- Engagement in recovery activities

APPENDIX A:

GLOSSARY

As of this writing, the fields of addiction medicine and addiction psychiatry are in the midst of a change in terminology related to how substance use disorders and the disease of addiction are diagnosed and discussed.

The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, is the most commonly used manual of nosology for insurance coding and claims payment and for epidemiological research, at least in North America. The fourth edition of the *DSM (DSM-IV)*¹, described two Substance Use Disorder conditions: Substance Abuse and Substance Dependence. The fifth edition (*DSM-5*)² includes a list of Substance Use Disorders (from mild to moderate to severe) and abandons the use of the terms Substance Dependence and Substance Abuse.

The Standards defined here are intended to address substance use disorders at all levels of severity as the addiction specialist physician has a role in treating patients across the full spectrum of disease severity. Note that addiction specialist physicians are also involved with persons who manifest unhealthy substance use even when such patterns of use do not meet diagnostic criteria for a substance use disorder.

Addiction. Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, and craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Addiction Specialist Physician. Addiction specialist physicians include addiction medicine physicians and addiction psychiatrists who hold either a board certification in addiction medicine from the American Board of Addiction Medicine (ABAM), a subspecialty board certification in addiction psychiatry from the American Board of Psychiatry and Neurology (ABPN), a subspecialty board certification in addiction medicine from the American Osteopathic Association (AOA), or certification in addiction medicine from the American Society of Addiction Medicine (ASAM). (taken from the ASAM Public Policy Statement: How to Identify a Physician Recognized for Expertness in the Diagnosis and Treatment of Addiction and Substance-related Health Conditions, Adoption Date: February 1, 1986; rev. January 15, 2010.)

Biomarker. A biomarker, or biological marker, is in general a substance that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a therapeutic intervention. A biomarker can also be used to indicate exposure to various environmental substances in toxicology. In these cases, the biomarkers may be the external substance itself, e.g., alcohol or an opioid or a variant of the external substance processed by the body (a metabolite) (e.g., THC metabolites from marijuana use).

Intoxication. A clinical state marked by dysfunctional changes in physiological functioning, psychological functioning, mood state, cognitive process, or all of these, as a consequence of consumption of a psychoactive substance.

Level of Care. As used in the *ASAM Criteria*³, this term refers to a discrete intensity of clinical and environmental support services linked together and available in a variety of settings. Maintenance Treatments. Pharmacotherapy on a consistent schedule for persons with addiction, usually with an agonist or partial agonist, which militates against the pathological pursuit of reward and/or relief and allows for remission of overt addiction-related problems.

Maintenance treatments of addiction are associated with the development of a pharmacological steady-state in which receptors for addictive substances are occupied, resulting in relative or complete blockade of central nervous system receptors such that addictive substances are no longer sought for reward and/or relief. Maintenance treatments of addiction are also designed to militate against the risk of overdose. Depending on the circumstances of a given case, a care plan including maintenance treatments can be time-limited or can remain in place life-long. Integration of pharmacotherapy via maintenance treatments with psychosocial treatments generally is associated with the best clinical results. Maintenance treatments can be part of an individual's treatment plan in abstinence-based recovery activities or can be a part of harm reduction strategies.

Modality. A specific type of treatment (technique, method, or procedure) that is used to relieve symptoms and promote recovery. Modalities of addiction treatment include, for example, withdrawal management or anti-craving, agonist, and antagonist medication; motivational interviewing; cognitive-behavioral therapy; individual, family, and group therapy; social skills training, vocational counseling and self/mutual help groups.

Patient. As used in the *ASAM Criteria*, an individual receiving alcohol, tobacco, and/or other drug or addictive disorder treatment. The terms “client” and “patient” sometimes are used interchangeably, although staff in non-medical settings more commonly refer to “clients.”

Recovery. A process of sustained action that addresses the biological, psychological, social, and spiritual disturbances inherent in addiction. This effort is in the direction of a consistent pursuit of abstinence, addressing impairment in behavioral control, dealing with cravings, recognizing problems in one’s behaviors and interpersonal relationships, and dealing more effectively with emotional responses. Recovery actions lead to reversal of negative, self-defeating internal processes and behaviors, allowing healing of relationships with self and others. The concepts of humility, acceptance, and surrender are useful in this process.

Relapse. A process in which an individual who has established abstinence or sobriety experiences recurrence of signs and symptoms of active addiction, often including resumption of the pathological pursuit of reward and/or relief through the use of substances and other behaviors. When in relapse, there is often disengagement from recovery activities.

Relapse can be triggered by exposure to rewarding substances and behaviors, by exposure to environmental cues to use, and by exposure to emotional stressors that trigger heightened activity in brain stress circuits. The event of using or acting out is the latter part of the process, which can be prevented by early intervention.

Setting. A general environment in which treatment is delivered. There may be a variety of facilities that are within a general setting. Settings for addiction treatment include hospitals, residential programs, opioid treatment programs, community mental health centers, community health centers, other general medical settings, the physician’s office, the patient’s home, and correctional or other institutional settings.

Social History. An account of the personal and social details of a person’s life that serves to identify the person. Place of birth, religion, race, marital status, number of children, military status, occupational history, and place of residence are the usual components of this part of the history, but it may often include other information, such as education, current living situation and trauma history.

Social Support System. The network of relationships that surround an individual. A health social support system— involving family members, friends, employers, members of mutual support groups, and others—tends to support an individual’s recovery efforts and goals. What these individuals have in common is that their relationship with the individual is current and that the individual is comfortable contacting them in times of distress.

Substance Use Disorders. Substance use disorder is marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol, tobacco, and/or other drugs despite significant related problems. The cluster of symptoms can include tolerance; withdrawal or use of a substance in larger amounts or over a longer period of time than intended; persistent desire or unsuccessful efforts to cut down or control substance use; a great deal of time spent in activities related to obtaining or using substances or to recover from their effects; relinquishing important social, occupational or recreational activities because of substance use; and continuing alcohol, tobacco, and/or drug use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by such use; craving or strong desire to use. Specific diagnostic criteria are given in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (*DSM-5*) of the American Psychiatric Association.

A substance use disorder is the new nomenclature for what previously included substance dependence and substance abuse (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (*DSM-IV*) of the American Psychiatric Association.

Treatment. Application of planned procedures to identify and change patterns of behavior that are maladaptive, destructive, and/or injurious to health; or to restore appropriate levels of physical, psychological, and/or social functioning.

Treatment Plan. The individualized plan should be based on a comprehensive biopsychosocial assessment of the patient and, when possible, a comprehensive evaluation of the family, as well.

Withdrawal Management. This refers to services previously referred to as “Detoxification Services.” *The ASAM Criteria* describes in detail the structure and staffing of services to assist a patient’s acute withdrawal from alcohol, tobacco, stimulants, sedatives, or other drugs. As stated in the Glossary of *The ASAM Criteria*, “The liver detoxifies, but clinicians manage withdrawal.”

Withdrawal Syndrome. The onset of a predictable constellation of signs and symptoms following the abrupt discontinuation of, or rapid decrease in, dosage of a psychoactive substance.

1 American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text rev.).doi:10.1176/appi.books.9780890423349.

2 American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Washington, DC, American Psychiatric Association, 2013.

3 Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies®; 2013.

Adopted by the ASAM Board of Directors October 27, 2013 and January 29, 2014.
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