UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

SUBSTANCE ABUSE TREATMENT PRACTICE GUIDELINES

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LETTER FROM DIVISON HERE

SUBSTANCE ABUSE TREATMENT PRACTICE GUIDELINES

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I.

Vision Statement

Vision Statement

The National Treatment Plan Initiative envisions a society where people with a history of alcohol or other drug problems, people in recovery, and people at risk for these problems are valued and treated with dignity and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated. We envision a society in which substance abuse and dependence are recognized as public health issues, treatable illnesses for which individuals deserve treatment. We envision a society in which high-quality services for alcohol and other drug problems are widely available and where treatment is recognized as a specialized field of expertise.

(Improving Substance Abuse Treatment: The National Treatment Plan, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment)

The Utah Department of Human Services, Division of Substance Abuse and Mental Health (DSAMH) and its Treatment Committee, which is comprised of DSAMH staff and representatives from local substance abuse treatment providers, collaborated on the development of this document containing recommended practices for the delivery of substance abuse treatment services in the State of Utah. The practice guidelines are based on the most recent scientific and clinical knowledge available from the literature as cited throughout the document. These guidelines of practice should be considered procedural guidelines for all publicly funded substance abuse treatment services in Utah. Adherence to them will not ensure a successful outcome, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment course must be made by the clinician in light of the documented clinical data presented by the patient and by the diagnostic and treatment options available.

Treatment Committee Members

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In addition, special thanks are extended to the Tennessee Department of Health, Bureau of Alcohol and Drug Abuse Services whose "Best Practice Guidelines" helped the committee develop the structure and content of this document.

Guideline Updates as of December 4, 2008:

In May 2008, the Utah Behavioral Health Care Network (UBHN) directed the Clinical Issues Sub-Committee to review and update the Mental Health and Substance Abuse Treatment Practice Guidelines on an annual basis. This updated Treatment Practice Guidelines Manual is a result of that review. The members of the review committee include:

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II.

Introduction

Introduction

Addiction to alcohol and/or other drugs is a primary, chronic, neurobiological disease, with genetic, psychosocial and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm and craving (ASAM). Like other chronic illnesses, relapses can occur and individuals may need prolonged treatment and/or multiple treatment episodes to achieve long-term recovery and restoration to full healthy functioning (NIDA).

The severity of substance-related disorders varies in intensity just like other disorders and may range from misuse to addiction. Therefore, the interventions are matched to the level of severity of the disorder, utilizing the guidelines of the current ASAM Patient Placement Criteria. Substance misuse may require a brief educational intervention, whereas a diagnosis of substance abuse or dependence may require some level of treatment: outpatient, intensive outpatient (IOP), partial hospitalization (Day Treatment), residential, and/or detoxification.

Effective addiction treatment addresses multiple factors, in preparation for long-term self-care. The maintenance phase of treatment/recovery is a life long process that may or may not require professional treatment services.

1. Cost Effectiveness of Treatment

The treatment of substance-related disorders has been shown to be as successful as treatment of other chronic illnesses/diseases such as diabetes, hypertension and asthma. Success may be measured by reduction in drug use and criminal justice involvement, reduction of homelessness, improvement in employment status, and family and community life. For additional information on treatment effectiveness as demonstrated through Utah outcomes, please see the Division of Substance Abuse and Mental Health Annual Report at www.dsamh.utah.gov.

2. Access

According to the federal Center for Substance Abuse Treatment (CSAT), between 13 and 16 million people need treatment for substance-related disorders annually and only three million receive it.

3. Outcomes

There is extensive research showing that with treatment, primary drug use is reduced by 50%. Criminal activity is reduced by 80% and medical visits associated with drug use decline by 50%. Self-sufficiency also improves.

III.

Assessment Process

Assessment Process

1. Purpose of Screening and Assessment

Screening and assessment identify the presence of substance-related disorders, as well as other areas of concern that need to be addressed in the treatment plan such as medical, employment, legal, family/social and psychiatric. They also identify strengths that may be reinforced. In addition, the assessment assists in the proper placement within the continuum of care based on individual needs. Engaging the patient or client in this process also establishes the beginning of a working relationship with the treatment provider.

A) Screening is the initial activity that identifies those who appear to have a possible substance-related disorder. Those who have been identified should be offered a complete assessment. Typically, a brief, standardized self-report questionnaire is completed, along with any collateral information about the client such as an arrest report, work record, or other reason for referral. Screening does not require extensive training and may be conducted in a variety of settings, including primary care, mental health, and criminal justice facilities. Referrals for assessment should be made to an appropriately licensed treatment professional. (Treatment Improvement Protocol (TIP) 7, CSAT)

B) Assessment: A clinical assessment should be completed when potential problem areas are identified in the screening process.

1. A comprehensive, clinical assessment builds upon the initial screening by obtaining more detailed information about the individual. Generally, the assessment process includes the completion of a standardized assessment instrument and a formal, clinical interview with an appropriately licensed treatment professional. The process of assessment should be comprehensive in scope and also sensitive to individualized needs.
The information gathered includes: current and historical alcohol and other drug use, level of readiness for change; coexisting disorders; and medical, legal, employment and family issues. Findings from the assessment determine the type of interventions that would be most effective; it drives the treatment plan and placement decisions. It also engages the patient actively in the treatment process.

2. The Utah Division of Substance Abuse and Mental Health Board requires the Addiction Severity Index (ASI) instrument or other assessment process as approved by the Utah State Board of Substance Abuse and Mental Health for an adult substance abuse assessment in any publicly funded substance abuse treatment program. It is highly recommended to all other providers as well.

3. The Utah Division of Substance Abuse and Mental Health Board requires that an assessment for adults and adolescents be completed within 72 hours for substance abuse residential admissions and within three face-to-face sessions for other substance abuse admissions, with one exception: detoxification services. The State Division of Substance and Mental Health must approve any exceptions to this requirement in writing. While the State does not require any specific assessment instrument for adolescents, assessments shall be thorough and address seven potential problem areas: medical status, employment and support, drug use, alcohol use, legal status, family/social status and psychiatric status.

4. An appropriately licensed mental health professional must meet with an individual and diagnose substance–related disorders, as well as any other mental health disorders that may be present. Other clinical staff, such as a Licensed Substance Abuse Counselor (LSAC), may assist in the screening and assessment process by collecting the information and presenting a preliminary finding to the appropriately licensed mental health professional. It is ultimately the responsibility of the licensed mental health professional to document how the individual meets diagnostic criteria for a substance use disorder, document level of care recommendations and provide the summary of assessment findings, including ASAM dimensional criteria.

2. Diagnosis

A face to face client diagnostic interview must be conducted by an appropriately licensed mental health professional. The interview must be documented and thorough enough to provide for a full 5 axis diagnosis.

3. Patient Placement Criteria

DSAMH has mandated the utilization of the current ASAM Patient Placement Criteria for all publicly funded substance abuse programs and it is recommended in all other substance abuse treatment facilities.

In order to ensure individualized substance abuse treatment, an assessment process is used to recommend an optimal level of care. The placement recommendation should be for the least restrictive level of care available that provides sufficient services to meet the individual's needs. The ASAM Placement assessment and recommendation shall, at a minimum, include a risk assessment, client specific comments/justification to support the recommended ASAM level and a recommended ASAM level for each ASAM dimension. The ASAM shall also include a recommended ASAM level, an actual ASAM Placement level and a justification for any difference between the recommended and actual levels.

The screening and assessment process, as described above, provides a solid foundation for the development of an individualized treatment plan.

4. DUI Screening and Assessment

Specific guidelines apply for screening and assessing DUI offenders see The DUI Best Sentencing Practices Guidebook, Utah Sentencing Commission.

IV.

Treatment Process

Treatment Process

1. Purpose of Intervention/Treatment

The primary goal of addiction treatment is to meet the treatment needs of the client. These needs are biological, psychological, and social in nature.

Accordingly, the effectiveness of treatment can be measured in terms of the overall biopsychosocial health of clients, including such dimensions as:

- decreased substance use,
- improvements in medical and physical health,
- improvements in psychosocial functioning,
- greater employment stability,
- decreases in criminal justice system involvement,
- reduction of homelessness, and
- relapse prevention preparedness.

2. Levels of Care/Continuum of Care

It is the intent of the DSAMH that every person admitted to treatment has access to a complete continuum of treatment services (*see ASAM LEVELS OF SERVICE table in Appendix A).* It is understood that funding and logistical issues may preclude a complete treatment continuum for all populations statewide. It is the policy of the Division that, at an absolute minimum, Outpatient (Level I), Intensive Outpatient (Level II) and Residential (Level III) treatment will be provided directly or by sub-contract. Providers should continue to implement creative interventions and develop strategic partnerships in order to offer as complete a continuum as possible.

3. General Issues Related to Treatment

A) Length of Treatment and Retention in Treatment

- As with other disease processes, length of service is linked directly to the client's response to treatment (e.g., attainment of the treatment objectives and degree of resolution regarding the identified clinical problems.)

(American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised, ASAM PPC-2R, 2001.)

- Perhaps the most robust and pervasive indicator of favorable post-treatment outcome in all forms of substance abuse rehabilitation has been length of stay in treatment at the appropriate level of care.
- While length of stay in treatment is a significant indicator of positive outcomes, there should be a consideration of those clients on waiting lists who are not receiving any form of treatment.
- Many people who enter treatment drop out before receiving all the benefits that treatment can provide. Successful outcomes may require more than one treatment experience. Many addicted individuals have multiple episodes of treatment, often with a cumulative impact.
- Since successful outcomes often depend upon retaining the person long enough to gain the full benefits of treatment, strategies for keeping the individual in the program are

critical.

- Whether a person stays in treatment depends on factors associated with both the individual and the program.
- Individual factors related to engagement and retention include:
  - motivation to change drug-using behavior;
  - degree of support from family and friends; and
  - whether there is pressure to stay in treatment from the criminal justice system, child protection services, employers or the family.
- Programmatic factors would include:
  - whether or not the counselors are able to establish a positive, therapeutic relationship with the client;
  - whether or not the counselor ensures that a treatment plan is established and followed so that the individual knows what to expect during treatment; and
  - whether or not appropriate medical, psychiatric and social services are available.

B) Discharge

- The health care professional's decision to prescribe a type of service, and subsequent discharge of a client from a level of care, should be based upon how that treatment and its duration will not only influence the resolution of the dysfunction, but also positively alter the prognosis for long-term outcome of that individual client

(American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised, ASAM PPC-2R, 2001)

- The discharging service provider is responsible for transition planning to the next needed service and making every reasonable effort to ensure that the client makes that transition successfully. Every effort should be made to obtain appropriate authorization for release of information from the client in order to coordinate the transfer of the client from one agency/provider to another. This coordination should include the delivery of the Assessment and Discharge Summary to the receiving provider.

C) Changing Levels of Service

- As the client moves through treatment in any level of service, his or her progress in all ASAM dimensions should be continually assessed. Such multidimensional assessment ensures comprehensive treatment.
- As the client's response to treatment is assessed, his or her progress is compared with criteria for continued service and discharge to help identify the appropriate level of service.
- The resolution of the problems and/or priorities that justified admission to a level of care determines when a patient can be treated at a different level of care or discharged.

(American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised, ASAM PPC-2R, 2001)

- Because addiction is a dynamic process, the obvious signs and symptoms of the disorder will rise and fall over the course of time. Treatment and recovery are likewise dynamic processes. As a result, when clients participate in addiction treatment, their treatment needs will change.

(Overview of Addiction Treatment Effectiveness, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, February 1997, page 39.)

- As the client changes level of service, whether within an agency or between agencies, the initial service provider should be responsible for transition planning to the next needed service and making every reasonable effort to ensure that the client makes that transition successfully.

D) Unsuccessful Treatment

- Individual treatment decisions should be based upon an assessment of each client.
- Therefore, requirements that a person fail one or more times in outpatient treatment before he or she can be considered for inpatient treatment are no more rational than treating all substance abusers in an inpatient program or using a fixed length of stay for all inpatients.
- In addition, failure or lack of treatment progress does not automatically indicate an admission criterion for a more intensive level of care.
- It does indicate the need to identify what strategy or intervention was less effective than planned, and what can be improved in the treatment plan.

(American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised, ASAM PPC-2R, 2001)

E) Client Choice

- Treatment for substance-related disorders always acknowledges that the client must be the driving force in treatment decisions for those who are not court referred or court mandated.
- Clients have the right to request that treatment take place in a less restrictive or lower level of care, than recommended by ASAM criteria in order to accommodate other responsibilities they might have. If a treatment client believes he or she should be in a more restrictive or higher level of care, a treating professional will discuss this with the client and determine if additional information has been made available that may change the level of treatment recommendation. Documentation should reflect this discussion with the client.

F) Medical Necessity

- Central to judgments concerning appropriateness of care is the concept of "medical necessity."
- Because substance-related disorders are biopsychosocial in etiology and expression, assessment and treatment are most effective if they, too, are biopsychosocial.
- The six primary problem areas identified in the ASAM PPC-2R encompass all pertinent biopsychosocial aspects of addiction that determine the severity of the client's illness.
- Medical necessity pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the client.

(American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised, ASAM PPC-2R, 2001)

G) Informed Consent

Health care requires informed consent in compliance with HIPAA, 42 CFR and 45 CFR, indicating that the client has been made aware of:

- the proposed modalities of treatment,
- the risks and benefits of such treatment,
- appropriate alternative treatment modalities, and
- the risks of treatment versus no treatment.

(American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised, ASAM PPC-2R, 2001)

- Parental consent is required for a minor to receive substance abuse treatment unless that minor is married or pregnant.

H) Supportive or Ancillary Services

The continuum of care should include access to other supportive or ancillary services in order to assist and encourage the client to participate in treatment, benefit from treatment, and have the opportunity for a successful transition to the community following treatment. Treatment providers should link clients with any needed ancillary services that are not provided by their agency.

Examples of important ancillary services include:

- child care services;
- vocational services;
- educational services;
- AIDS/HIV services;
- legal services;
- financial services;
- housing/transportation services; and
- family services.

(Principles of Drug Addiction Treatment: A Research-Based Guide, National Institute on Drug Abuse, National Institutes of Health, NIH Publication No. 99-4180, October 1999, page 14).

- Support and ancillary services should also include access to informal support groups to sustain or promote abstinence, such as those provided by community-based and faith-based organizations.

4. Treatment Techniques, Approaches, and Components

The Utah Department of Human Services, Division of Substance Abuse and Mental Health endorses the use of evidence-based treatment in all State licensed substance abuse treatment agencies.
A variety of treatment techniques, approaches, strategies and components are available for the treatment of substance abuse problems

A) Treatment Techniques

Addiction treatment is not a single, homogeneous, or uniform technique. Rather, addiction treatment includes numerous interventions, methods, strategies, and techniques with differences in philosophies, goals, and to some degree, type of clients treated.

B) Treatment Approaches

Addiction treatment can be described in terms of *treatment approach* - a treatment intervention based on a specific, evidence based philosophical approach. Some of the significant approaches are:

- Opioid Maintenance Therapy: OMT entails the substitution of heroin or other opioids with a medically safe, long-acting medication (Methadone) of known purity, potency, and quantity, usually taken orally once daily. Long Acting Methadone is taken less often. "The National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism have concluded that methadone is the most effective method available for treating heroin addiction."
  General Accounting Office, 1990
- Therapeutic Community treatment: The therapeutic community approach generally entails participation in a long-term, residential, intensive program that focuses on the holistic rehabilitation and habilitation of the addicted person.
- Outpatient Drug-Free (Non-methadone) Treatment: Represented by evidence-based program models that typically emphasize individual and group counseling, social skills training, case management, and relapse prevention training.

C) Treatment Components

The phrase "treatment components' refers to specific clinical intervention, strategies, and procedures that are provided to achieve specific treatment goals and objectives. These components include:

- Motivational Enhancement Therapy and Motivational Interviewing,
- Behavioral Relationship Therapy,
- Behavioral Contracting,
- Brief Intervention Treatment,
- Life Skills Training,
- Stress Management,
- Case Management,
- Relapse Prevention,
- 12-Step Facilitation,
- Cognitive Behavioral Therapy, and
- Parenting Classes.

D) The National Registry of Evidence Based Practices, sponsored by SAMHSA, is a searchable database of interventions for treatment and prevention and is found on the world wide web at: http://www.nrepp.samhsa.gov/

E) Priority and Interim Services

Programs must give admission priority to clients in the following order:

- Pregnant injecting drug users,
- Pregnant substance abusers,
- Injecting drug users,
- HIV positive drug users, and
- all other substance abusers.

When a program does not have capacity to admit an injecting or pregnant drug user, the program shall make every effort to place the individual in another treatment facility or provide access to interim services. Interim services shall:

- Be offered with in 48 hours,

- Continue until the individual is admitted, and
- Include strategies to reduce the adverse health effect of injecting drug use and to reduce the risk of transmission of disease.

For pregnant clients, interim services will need to provide information and education regarding the effects of alcohol and other drug use on the fetus and referrals for prenatal care. The program will need to maintain documentation of interim services provided. Even when interim services are provided, an individual requesting treatment for injecting drug use shall be admitted to an appropriate program within 120 days.

5. Medication Assisted Therapy

Pharmacologic treatments are beneficial for selected clients with substance use disorders. The categories of pharmacologic treatments are:

- medications to treat intoxication and withdrawal states,
- medications to decrease the reinforcing effects of abused substances,
- medications that discourage the use of substances by inducing unpleasant consequences through a drug-drug interaction,
- agonist substitution therapy, and
- medications to treat co-morbid psychiatric conditions.
- Methadone treatment is the treatment choice for those individuals who are repeatedly unsuccessful at remaining abstinent from heroin.
- Methadone treatment is the treatment of choice for opiate addicted pregnant women.
- Buprenorphine may be helpful with opiate dependent clients.

The effectiveness of specific pharmacotherapies for various addictions is not well established; however, evidence based on current research can provide guidance.

- Naltrexone may attenuate some of the reinforcing effects of alcohol, but there are limited data regarding the long-term efficacy for clients with alcohol use disorders.
- Disulfiram is an effective adjunct to a comprehensive treatment program in reliable, motivated clients whose drinking may be triggered by events that suddenly increase alcohol craving.
- Pregnant clients and clients with impulsive behavior, psychotic symptoms, or suicidal thoughts are poor candidates for disulfiram treatment.

6. Services for Individuals with Co-Occurring Disorders

The following definition of co-occurring disorders was developed by the consensus panel convened to draft SAMHSA’s Treatment Improvement Protocol (TIP), *Substance Abuse Treatment for Persons with Co-occurring Disorders*: People with co-occurring substance abuse and mental disorders are “…individuals who have at least one psychiatric disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person (e.g., an episode of depression may trigger a relapse into alcohol abuse, or cocaine use may exacerbate schizophrenic symptoms) at least one disorder of each type can be diagnosed independently of the other.” (See Appendix B for Co-Occurring Treatment Spectrum.)

Treatment programs continue to see increasing numbers of individuals who present for treatment with co-occurring Axis I substance-related disorders and Axis I/Axis II mental disorders. Individuals with such co-occurring disorders (often referred to as “Dual Diagnoses”) can be conceptualized as belonging to one of two general categories:

- Moderate Severity Disorder: Such persons present with stable mood or anxiety disorders of moderate severity (including resolving bipolar disorder), or with personality disorders of moderate severity, or with signs and symptoms of a mental health disorder that are not so severe as to meet the diagnostic threshold. These individual are appropriately treated in programs designed to treat primary substance use disorders.
- High Severity Disorders: Such persons present with schizophrenia-spectrum disorders, severe mood disorders with psychotic features, severe anxiety disorders, or severe personality disorders (such as fragile borderline conditions). These individuals are best managed in dual diagnosis specialty programs that can offer integrated mental health and addiction treatment approaches.

Treatment programs are described as generally of two types - Dual Diagnosis Capable or Dual Diagnosis Enhanced - to reflect their ability to address co-occurring substance-related and mental disorders.

- Dual Diagnosis Capable programs have a primary focus on the treatment of substance-related disorders, but are also capable of treating patients who have relatively stable diagnostic or sub-diagnostic co-occurring mental health problems related to an emotional, behavioral or cognitive disorder.
- Dual Diagnosis Enhanced programs, by contrast, are designed to treat patients who have more unstable or disabling co-occurring mental disorders in addition to their substance-related disorders.
- Addiction-Only programs, either by choice or for lack of resources, cannot accommodate clients who have psychiatric illness that requires ongoing treatment, however stable the illness and however well-functioning the client. Individuals who need psychotropic medication generally are not accepted by such programs.

The Utah Division of Substance Abuse and Mental Health supports the following:

- All individuals, programs and health systems that provide treatment for addictive disorders should be prepared to serve the needs of dual diagnosis patients, at least to the extent described here as Dual Diagnosis Capable.
- All health care delivery systems should be able to deliver the services needed by clients with co-occurring mental and substance-related disorders.

Essential Elements

Certain elements must be in place in any treatment program that accepts clients with co-occurring mental and substance-related disorders:

- Mental Health Therapist level staff skilled in the diagnosis of psychopathology.
- A majority of staff are cross-trained to deal with both mental and substance-related disorders.
- Psychoeducational components of treatment address both mental and substance-related disorders, regardless of the funding source.
- Medication management is integrated into the treatment plan.
- Counselors are trained to monitor and promote compliance with pharmacotherapies.

7. Developmental Issues

Issues regarding the developmental stage of the client must be considered when making treatment decisions about level of care, and in planning and delivering treatment. Developmental issues arise for the elderly, for children and adolescents, and for those with developmental disabilities.

A) The Elderly

Researchers are only beginning to realize the pervasiveness of substance abuse among people age 60 and older. Until relatively recently, alcohol and prescription drug misuse, which affects as many as 17 percent of older adults, was not discussed in either the substance abuse or the gerontological literature. Reasons for this silence are varied:

- Health care providers tend to overlook substance abuse and misuse among older people, mistaking the symptoms for those of dementia, depression, or other problems common to older adults;
- Older adults are more likely to hide their substance abuse and less likely to seek professional help; and
- Many relatives of older individuals with substance use disorders, particularly their adult children, excuse the problem and choose not to address it.

Many substance abuse issues are unique to this population:

- Alcohol Abuse - Physiological changes, as well as changes in the kinds of responsibilities and activities pursued by older adults, make established criteria for classifying alcohol problems often inadequate for this population;
- Abuse of Prescription Drugs - People 65 and older consume more prescribed and over-the-counter medication than any other age group in the United States. Prescription drug misuse and abuse is prevalent among older adults not only because more drugs are prescribed for them but also because, as with alcohol, aging makes the body more vulnerable to drugs' effects; and
- Screening and Assessment - Every person aged 60 years and older should be screened for alcohol and prescription drug abuse as part of his or her regular physical examination. Treatment should be provided in the least intensive level possible and should address detoxification, age specific settings, coping with depression, loneliness and loss, and should be adapted treatment as needed in response to the client's gender.

B) Adolescents

In treatment, adolescents must be approached differently than adults because of their unique developmental issues, differences in their values and belief systems, and environmental considerations (e.g., strong peer influences). Their alcohol and other drug use often stems from different causes, and they have even more trouble projecting the consequences of their use into the future.

The treatment process must address the nuances of each adolescent's experience, including cognitive, emotional, physical, social, and moral development.

Characteristics of Good Adolescent Treatment Services

- **Assessment and Treatment Matching** - Programs should conduct comprehensive assessments that cover psychiatric, psychological and medical problems, learning disabilities, family functioning and other aspects of the adolescent's life.

- **Comprehensive, Integrated Treatment Approach -** Program services should address all aspects of an adolescent's life.

- **Family Involvement in Treatment** - Research shows that involving parents in the adolescent's drug treatment produces better outcomes.

- **Developmentally Appropriate Program** - Activities and materials should reflect the developmental differences between adults and adolescents.

- **Engaging and Retaining Teens in Treatment** - Treatment programs should build a climate of trust between the adolescent and the therapist.

- **Qualified Staff** - Staff should be trained in adolescent development, co-occurring mental disorders, substance abuse and addiction.

- **Gender and Cultural Competence** - Programs should address the distinct needs of adolescent boys and girls as well as cultural differences among minorities.

- **Continuing Care** - Programs should include relapse prevention training, aftercare plans, referrals to community resources and follow-up.

- **Treatment Outcomes** - Rigorous evaluation is required to measure success, target resources and improve treatment services.

"The Quality of Highly Regarded Adolescent Substance Abuse Treatment Programs: Results of an In-Depth National Survey." Rosalind Branningan, MPH; Bruce R. Schackman, PhD; Mathea Falco, JD; Roberts Millman, MD. (Reprinted) Arch Pediatric Adolescent Med/Volume 158, September 2004. www.archpediatrics.com

C) Developmental Disabilities

The developmental status of adults and adolescents should be determined during assessment and taken into account when determining level of care and treatment planning.

8. Female Clients

Information on the natural history, clinical presentation, physiology, and treatment of substance use disorders in women is limited. Although women are estimated to comprise 34% of all persons with substance use disorders in the United States, psychosocial and financial barriers (e.g., lack of child care) prevent many women from seeking treatment. Other explanations for women's under-use of alcohol and drug treatment services may include women's perception of greater social stigma associated with their abuse of drugs and alcohol. It is imperative that programs include services designed specifically for women, particularly pregnant women.

- Once in treatment, women have been found to have a higher prevalence of primary comorbidity.
- Many women with a substance use disorder have a history of physical and/or sexual abuse (both as children and as adults), which may also influence treatment planning, participation and outcome.
- Female clients may have more family responsibilities and may need more assistance with family-related problems.

A) Children of Women in Treatment

Those programs that admit dependent children of women in treatment provide an array of services for those children:

- age appropriate biopsychosocial assessment;
- treatment services to address issues identified in the assessment; and
- therapeutic day care or access to public education.

- Federal regulations require treatment programs receiving funding from the Substance Abuse Prevention and Treatment (SAPT) Block Grant to provide or arrange for primary pediatric care for the children including immunizations, and therapeutic interventions for children in custody of women in treatment which may address their developmental needs and their issues of sexual and physical abuse and neglect. (45 CFR 96)

B) Pregnant Substance Abusing Women

It is important that treatment programs serving pregnant, substance-using women include the following services, or support active outreach to and linkage with appropriate service resources already available in the community:

- Comprehensive residential and outpatient treatment on demand
- Comprehensive medical services
- Gender-specific services that are ethnically and culturally sensitive. These services must respond to women's needs regarding reproductive health, sexuality, relationships, and all forms of victimization. Services should be offered in a nonjudgmental manner and in a supportive environment.
- Transportation services, including cab vouchers, bus tokens, and alternatives for women who live in communities where public transportation is cumbersome, unreliable, or unsafe.
- Child care, baby-sitting, and therapeutic day care services for children
- Counseling services, including individual, group, and family therapy
- Vocational and educational services leading to training for meaningful employment, the General Equivalency Diploma (GED), and higher education
- Drug-free, safe housing
- Financial support service
- Case management service
- Pediatric follow-up and early intervention services
- Services that recognize the unique needs of pregnant women and adolescent substance-users

Issues for treatment of pregnant substance-using women:

- Continuum of care
- Medical stabilization and withdrawal
- Medical withdrawal from alcohol
- Opioid stabilization
- Cocaine withdrawal
- Sedative-hypnotic medical withdrawal
- Mental health considerations

Medical issues for pregnant substance-using women:

- Prenatal intake
- Prenatal follow-up
- Labor and delivery for women who have received prenatal care
- Labor and delivery for women with no prenatal care
- Postpartum care
- Obstetrical care for HIV-infected women
- Drug-exposed neonates
- Urine toxicology consideration
- Nutritional considerations

Substance abuse treatment programs must provide services to pregnant women and not deny these services based solely on the fact that a woman is pregnant.

State law requires that the Division of Child and Family Services (DCFS) be notified when an infant is born drug dependent or when an infant is exposed to alcohol and other drugs at the time of birth.

Utah Code Section 62A-4a-404.

When client information is involved, treatment programs must follow Federal laws and regulation concerning the confidentiality of drug and alcohol treatment records.

9. Criminal Justice Populations.

Research suggests that when Substance Abuse Treatment and Criminal Justice Personnel work closely together the outcomes for substance abusing offenders are increased more so than with treatment or supervision alone. Through this coordinated effort substance abusing offenders commit fewer crimes than their counterparts, remain drug and alcohol free longer, become employed at a higher rate and give back to their communities at a higher rate than their counterparts who do not receive these coordinated efforts. The number of criminally involved individuals seeking treatment in Utah is increasing at a significant rate and substance abuse treatment providers must be prepared to respond to these offenders in a manner that is consistent with evidence based best practices. In addition to providing substance abuse treatment services as outlined in these Practice Guidelines, the Division endorses the following:

A) Coordination of treatment planning and correctional case supervision:

   a. For individuals referred from corrections the treatment provider should make every effort to gather a release of information from the client allowing them to discuss client progress with the corrections officer overseeing the case.
   b. If allowed, the treatment provider should collaborate with corrections staff to evaluate each individual's treatment plan to ensure all of the clients needs are being met and that the client is not being held to differing requirements between corrections and treatment.
   c. All contacts with corrections and the courts should be documented in the client's clinical record.
   d. The treatment provider and corrections/courts should coordinate frequently to discuss each client and their progress, or lack of progress, towards completion of treatment goals.

B) Treatment should encompass thinking errors that support ciminal behavior:

   a. Thinking errors that support ciminal behavior is a combination of attitudes and beliefs that support a criminal lifestyle and criminal behavior. This pattern of thinking often contributes to drug use and criminal behavior.
   b. For individuals involved in the criminal justice system, the treatment provider should ensure the individual is assessed for thinking patterns. This can either be done by corrections or by the treatment provider.
   c. For individuals assessed as needing criminal thinking treatment, the provider should ensure this service is provided either through the corrections system, by the provider, or through referral. This should be coordinated with the corrections officer overseeing the case.

C) Drug use should be monitored through drug testing: Drug testing can be a key component in evaluating a client for a possible substance use disorder.

a. Purpose of Drug Testing
    i. determine the extent of a clients use at assessment
    ii. monitor a client's progress in treatment
    iii. deter patients from using drugs

b. Method and Frequency:
    i. Test frequency should decrease with proven compliance and progress in treatment.
    ii. Tests should be random and observed.
    iii. Specimen collection should occur in a secure and confidential setting.

c. Cutoff Levels: DSAMH encourages all drug test providers to use the cut off levels adopted by SAMHSA**.**

d. RELEASE OF DRUG TEST RESULTS: Release of test results to police departments, prosecutors, or other governmental authorities (e.g., child protection agencies) should occur only under court order or with the authorization of the patient, consistent with federal and state confidentiality regulations.

e. Urine Collection Procedures: All drug test providers shall develop written policy and procedures.

f. Quick Screens: Quick tests showing positive for a substance shall be sent to a lab for confirmation

g. Records and Reports: The collector shall maintain a log for all urinalysis specimens collected which indicates:
    i. Client's name and/or identifying number
    ii. Collection date
    iii. Barcode number
    iv. Whether collection was scheduled or unscheduled
    v. Any drugs or medication taken
    vi. Collector's initials
    vii. Drugs screened

h. Client records shall contain documentation of all drug tests performed as part of the treatment episode. Documentation shall include:
    i. Collection date
    ii. Collector's initials
    iii. Drugs screened
    iv. Test results
    v. Consequence if any imposed

11. Cultural Competence/Ethnicity

The Utah Department of Human Services, Division of Substance Abuse and Mental Health endorses culturally competent assessment and service delivery.

"Building on the individual's cultural strengths and values is critical to the success of substance abuse treatment. Cultural competency is not a euphemism for translated materials or someone who can speak a second language. It is, however, the delivery of services that are rooted in an understanding of and respect for the consumer's needs, cultural values, and environment." Attributed to Dr. Nelba Chavez

While ethnicity alone is a smaller factor in treatment outcome, the specific characteristics describing the language, customs, attribution of meaning, cultural events and beliefs of an individual are culturally sensitive factors. Knowledge of these factors may have a significant effect on establishing rapport, building a therapeutic relationship, and in the delivery and acceptance of treatment. Cultural sensitivity should remain as a component of training for treatment professionals as a support for increasing identification with the client.

V.

Record of the Person Served

<u>Record of the Person Served</u>

Recommendations and Requirements for Individual Clinical Records

1. Intent

A complete and accurate record is developed to ensure that all appropriate individuals have access to relevant clinical and other information regarding each person served.

2. Standards

The individual record is maintained in a manner so as to protect confidentiality and comply with 42 C.F.R. (Code of Federal Regulations) Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) documentation/privacy standards. The record is organized, clear, complete, current and legible.

3. The Individual Record Includes:

<u>Admission</u>: Admission information including date of first service, consent to treatment, fee agreement, TB (required in residential programs and recommended in outpatient programs) test results, and person to contact in case of emergency. All MIS information submitted to the State Division of Substance Abuse and Mental Health shall be supported by information in the individual record.

<u>Assessment</u>: See the "Assessment Process" of this document.

<u>Diagnoses</u>: The DSM IV diagnoses are specified by a qualified licensed mental health professional. A diagnosis is a necessary, but not a sufficient determinant of treatment. The client is matched to services based on clinical severity, not placed in a set program based only on having met diagnostic criteria.

<u>ASAM Placement Assessment and Recommendations</u>: The ASAM Placement assessment and recommendation shall, at a minimum, include a risk assessment, client specific comments/justification to support the recommended ASAM level and a recommended ASAM level for each ASAM dimension. The ASAM shall also include a recommended ASAM level, an actual ASAM Placement level and a justification for any difference between the recommended and actual levels. The Appendix A grid may be used as a quick reference guide to show the requirements of the ASAM dimensions and minimum requirements for services at each level, however, it should be considered a guide only. The current version of the ASAM manual shall be referenced when documenting ASAM level of care placement by dimension.

<u>Narrative Summary</u>: A complete narrative summary that consolidates the biopsychosocial information summarizes key clinical issues, and serves to connect the assessment and the treatment plan is to be kept in the record. The narrative summary identifies diagnostic indicators for substance abuse or dependence and any indicators of other existing mental health disorders. The narrative summary includes the justification for the assessed level of care as well as justification if level of care is being substituted.

<u>Treatment Plan</u>: The treatment plan should be individualized for each client based on need identified by the assessment. The application of the American Society of Addiction Medicine (ASAM) Patient

Placement Criteria-2R is critical in guiding the development of the treatment plan. It is necessary to document the process used to select a level of care and those problems identified at the highest risk should be treated first. The ASAM dimensions shall be clearly identified in the record. The format of the Treatment Plan may be modified to be used with various electronic record systems, but as a minimum, all treatment plans should contain the following elements:

- **<u>Problem Selection/Identification</u>**: The most significant problem(s) should be selected for consideration based on the assessment. (Non-urgent problems may be set aside for follow-up or referral after treatment is complete.)

- **<u>Goals</u>**: Broad goals are established that facilitate resolution of the target problem(s). These goals are long range and need not be measurable. ~~One goal for each problem area is adequate.~~

- **<u>Objectives</u>**: Design behaviorally measurable objectives to demonstrate what the client will do to achieve the goal. Use action verbs and identifiable outcomes such as quantity and frequency. Objectives should be time specific.

- **<u>Intervention</u>**: Interventions are actions of the clinician and/or client designed to help the patient complete the objectives. Interventions should be selected on the basis of the client's needs and the provider team's full treatment repertoire.

- Evidence of the client's active participation in the development of the plan.

- Treatment plans are fluid and reviewed regularly to show client progress towards the objectives and goals established in the plan. When the client is not making sufficient progress the treatment plan reflects changes to address this.

<u>Progress Notes</u>: Progress notes should include the date, duration and type of intervention. Notes should be legible and signed by a qualified staff indicating appropriate credentials. No-shows and cancellations should be documented. Any gaps in service such as vacation, incarceration, home visits, etc., should be noted.

Individual and group notes should be specific and refer back to the objectives identified in the treatment plan. Progress or lack of progress toward treatment goals should be documented. Notes should reflect behavioral changes as well as changes in attitudes and beliefs.

Each contact must be documented. Participation in group therapy shall be documented for each contact however; individualized "group summaries" may be used. Other group activities such as substance abuse education, life skills, case management, and recreation may be summarized and dated with the date the activity occurred.

<u>Continued Stay and Treatment Plan Reviews</u>: The appropriateness of treatment intensity and treatment progress is reviewed on a regular basis. The current ASAM Patient Placement Criteria is used to determine if the client remains at the current level, transfers to another level of treatment, or is discharged. Documentation of the review of ASAM dimensions can be accomplished by use of the ASAM grid (see Appendix A) or specific notation in the review narrative. If the treatment level is changed due to treatment objectives being met or if new problems are identified, the treatment plan shall be updated. Continued Stay Reviews shall be conducted every two weeks for intensive residential

treatment; every thirty days for less intensive residential and partial hospitalization/day treatment, every sixty days for intensive outpatient, and every ninety days for outpatient treatment.

A licensed mental health therapist shall be involved in all reviews, is responsible for any clinical action, and signs each review indicating appropriate credentials.
Regardless of level of care change, at the time of the treatment plan review and continued stay review, the Treatment Plan should be updated to reflect completion of objectives, addition of new objectives and/or addition of a new treatment plan.

Discharge Summary: At the time of discharge a summary shall be prepared and includes the diagnosis, the extent to which established goals and objectives were achieved, services provided, reason for discharge or referral, and recommendations for additional service. Should a client be transferring to a new level of care, based on ASAM PPC a full ASAM dimensional justification for the new level of care should be included in the client file regardless of their discharge status.

If the client fails to complete treatment, leaves a residential program Against Medical Advice (AMA), or does not appear for scheduled appointments, the case will be closed no later than 30 days after the last contact.

Other: The following shall be in the record:

- Correspondence pertinent to the person served,
- Authorization for the release of information and notation of the date and recipient of the information,
- Documentation of internal or external referrals, and
- Documentation of all medical/laboratory testing.

Information for this section was drawn from the CARF Standards Manual-Behavioral Health July 2002, the Chemical Dependence Treatment Planner, Robert R. Perkinson and Arthur E. Jongsma, Jr., John Wiely & Sons, Inc., 1998, and other contributors.

VI.

Outcomes/Data Submission

Outcomes/Data Submission

1. Quality Improvement in Client Wellness Through Preferred Measurement System

- Outcomes Monitoring: an assessment, at different points in time, of patient status in key life areas related to substance use disorders.
- Purposes of outcomes monitoring include the following:
  a. Provide the State, treatment professionals, and policymakers with data to help determine the effectiveness of certain types of substance abuse treatment for different types of patients.
  b. Improve program performance by using outcomes data to identify weaknesses or gaps in services, and provide feedback to enhance system performance.
  c. Improve the patient assessment process by using empirical outcomes data to develop and refine treatment placement criteria that optimize the chance of successful outcomes.
- Data Collection Points:
  a. At intake
  b. During treatment
  c. At discharge or other transition points
  d. After treatment
- Utah's public substance abuse Treatment Outcomes Monitoring System:
  a. Treatment Episode Data Set (TEDS)—admission set, Addiction Severity Index (ASI)—for adults, current ASAM patient placement criteria at intake.
  b. Currently the Performance Partnership Grant (PPG) measures deal with reduction in use, involvement with the criminal justice system, employment, independent living, and any other measure deemed necessary to measure outcomes.
  c. TEDS discharge set for all clients; for adult clients, the PPG data set at discharge or transition. Data collection mechanisms for adolescents are still to be determined.
  d. After treatment data collection is still to be determined.

2. Current Requirements

On a quarterly basis all publicly funded substance abuse treatment providers are required to electronically submit to DSAMH the following data:

a. Treatment Episode Data Set (TEDS), for admission and discharge, as described in the appropriate fiscal year File Format and the TEDS Definitions Manual.
b. The National Outcome Measures data set will be submitted quarterly.
c. The Mental Health Statistical Improvement Protocol (MHSIP), and the youth (YSS) and parent or guardian of youth (YSSF) versions, 5-minute surveys regarding client and family satisfaction, must be offered to all adult clients on an annual basis at a point in time, to be determined by the Division of Substance Abuse and Mental Health.
d. A minimum of 5% return rate is currently required with an increase to 10% in fiscal year 2010.

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Appendix A

ASAM Levels of Service
Early Intervention, Outpatient, Residential and Inpatient

ASAM LEVELS OF SERVICE

EARLY INTERVENTION, OUTPATIENT, RESIDENTIAL AND INPATIENT

Dimension Criteria	**Level 0.5 Early Intervention**	**Level 1 Outpatient** Typically does not exceed 8 hrs of contract per week.	**Level 2.1 Intensive Outpatient** Typically ranging from 9 to 19 hrs per week over a minimum of three days.	**Level 2.5 Partial Hospitalization** Typically exceeding 20 hrs/week over a minimum of 3 days during the week.	**Level 3.1 Clinically-Managed Low Intensity Residential** 5 to19 hrs/week either at residential site or out patient setting.	**Level 3.3 Clinically- Managed Medium Intensity Residential** 24 hr observation.	**Level 3.5 Clinically-Managed Medium/High Intensity Residential** 24 hr observation.
Dimension 1: Alcohol Intoxication and/or Withdrawal Potential	No withdrawal Risk.	I-D, Ambulatory detoxification without extending on-site monitoring. Minimal risk of severe withdrawal.	Minimal risk of severe withdrawal.	I-D, Ambulatory detoxification without extending on-site monitoring. Moderate risk of severe withdrawal	No withdrawal risk.	3.3-D, Clinically Managed Residential Detoxification Services. No severe withdrawal risk, but moderate withdrawal manageable in 3.2-D.	Minimal risk of severe withdrawal for Level 3.5. If withdrawal is present, meets Level 3.2-D criteria.
Dimension 2: Biomedical Conditions and Complications	None or very stable.	None or very stable.	None or not a distraction from treatment and manageable in Level 2.1	None or not sufficient to distract from treatment and manageable in Level 2.5	None or stable.	None or stable.	None or stable: receiving concurrent medical monitoring.
Dimension 3: Emotional/Behavioral Conditions and Complications	None or very stable.	None or very stable.	Mild severity, with potential to distract from recovery; needs monitoring.	Mild to moderate severity, with potential to distract from recovery; needs stabilization.	None or minimal; not distracting to recovery.	Mild to moderate severity; needs structure to allow focus on recovery.	Repeated inability to control impulse; personality disorder requires high structure to shape behavior.
Dimension 4: Treatment Acceptance/Resistance	Willing to understand how current use may affect personal goals.	Willing to cooperate but needs monitoring strategies.	Resistance high enough to require structured program but not so high as to render outpatient treatment ineffective.	Resistance high enough to require structured program but not so high as to render outpatient treatment ineffective.	Open to recovery, but needs structured environment to maintain therapeutic gains.	Little awareness; patient needs interventions available only in Level 3.3 to engage and keep in treatment.	Marked difficulty with or opposition to treat-ment, with dangerous consequences if not engaged in treatment.
Dimension 5: Relapse/Continued Use Potential	Needs understanding of or skills to change current use patterns.	Able to maintain abstinence or control use and pursue recovery goals with minimal support.	Intensification of addiction symptoms despite active participation in Level 1 and high likelihood of relapse or continued use without close monitoring and support.	Intensification of addiction symptoms despite active participation in Level 1 or 2.1 and high likelihoodlikelihood of relapse or continued use without close monitoring and support.	High likelihood of use without structured support. Accepts problems but at high risk of relapse at lower level of treatment.	Does not recognize relapse triggers. No commitment to recovery.	Addiction symptoms are not responsive to lower level of treatment. Does not recognize relapse triggers. No commitment to recovery.
Dimension 6: Recovery Environment	Social support system or significant others increase risk for personal conflict about alcohol/drug use.	Supportive recovery environment and/or patient has skills to cope.	Environment unsupportive but with structure and support the patient can cope.	Environment is not supportive. Structure, support, and relief from home environment allows patient to cope.	Environment is dangerous; but recovery achievable if Level 3.1 structure is available.	Environment is dangerous; patient needs 24 hr structure to learn to cope.	Environment is dangerous; patient lacks skills to cope outside of a highly structured 24 hr setting.

American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised, ASAM PPC-2R, 2001

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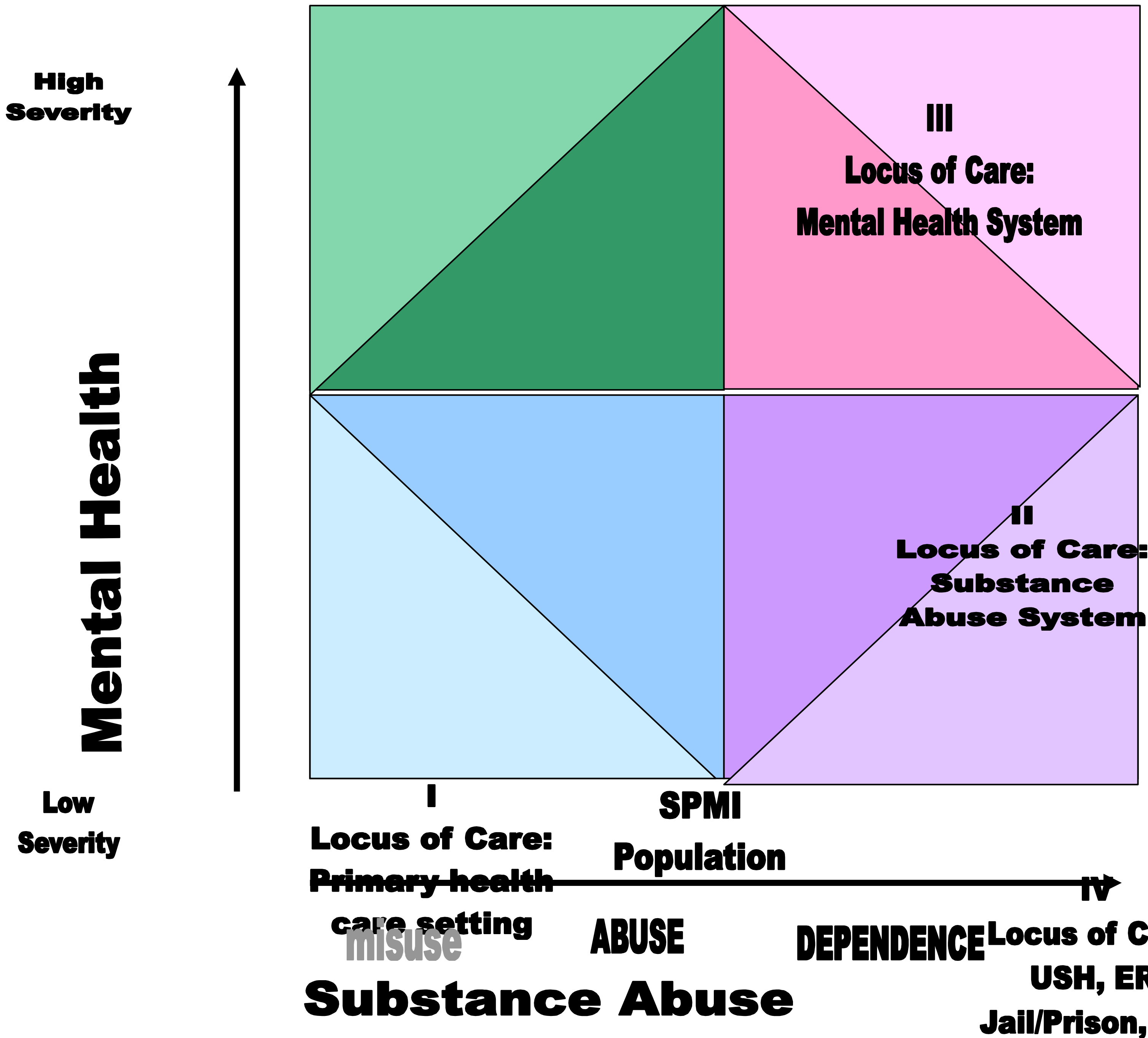
Appendix B

Co-Occurring Treatment Spectrum Diagram

The Co-Occurring Treatment Spectrum



This diagram was derived from multiple sources including: SAMHSA Report to Congress 2002 Executive Summary, Kathleen Sciacca, Ph.D. and the Utah Division of Substance Abuse and Mental Health

Appendix C

Acronyms

ACRONYMS	
ASAM	American Society of Addiction Medicine
ASI	Addiction Severity Index
AUDIT	Alcohol Use Disorders Identification Test
CARF	Commission on Accreditation of Rehabilitation Facilities
CSAT	Federal Center for Substance Abuse Treatment
DOPL	Division of Occupational and Professional Licensing, Utah Department of Commerce
DSAMH	Division of Substance Abuse and Mental Health, Utah Department of Human Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
HIPAA	Health Insurance Portability and Accountability Act of 1996
LSAC	Licensed Substance Abuse Counselor
MHSIP	Mental Health Statistical Improvement Protocol
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
PPG	Performance Partnership Grant
SAMHSA	U. S. Substance Abuse and Mental Health Services Administration
SAPT	Federal Substance Abuse Prevention and Treatment Block Grant
SASSI	Substance Abuse Subtle Screening Inventory
TEDS	Treatment Episode Data Set
TIP	Treatment Improvement Protocol
42 CFR	Code of Federal Regulations
45 CFR	Code of Federal Regulations