

# State of Indiana Levels of Care for Addiction Treatment

Indiana Family and Social Services Administration  
Division of Mental Health and Addiction



Indiana Levels of Care for Addiction Services  
Draft January 2020

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**Introduction**

Indiana has seen the need for a clear understanding around substance use disorder/co-occurring disorder treatment Levels of Care. This will provide clarity for provider expectation and quality control to ensure a better service for Indiana’s vulnerable population. The American Society of Addiction Medicine has provided a thorough, evidence-based model to guide the level of care designation for those suffering from substance use disorder and or a co-occurring disorder.

Indiana’s levels of care are based off of ASAM criteria, however, ASAM does not speak to certain specifics which will differ across states. Indiana has identified needed expectations which will be included in the chart and explanations below. These levels of care do not imply that current state expectations will not be followed.

**Glossary**

**Addiction** - Medical terminology within the ASAM and used interchangeably with the DSM 5 substance use disorder to define/diagnose a brain disease associated with impairment from drug/alcohol use.

**Addiction Medication** - Food and Drug Administration approved medications for the treatment of SUDs and be approved by the Division of Mental Health and Addictions to offer this service. This service includes but is not limited to prescribing for opioid use disorder and tobacco use disorder. Addiction medication is also used interchangeably with the terms pharmacotherapy, pharmacology and medication assisted treatment for SUDs. These include medications such as naltrexone for cravings for alcohol use disorder and opioid use disorder. Also used for opioid use disorder are buprenorphine and methadone. For tobacco use disorder, bupropion and varenicline.

**Assessment** – Meaning an assessment for a SUD, is a biological, psychological, sociological (bio-psycho-social) comprehensive history and current picture of the consumer. This is to be completed before the person starts treatment. See pgs. 19 & 22 for more details. It is a comprehensive biological psychological and sociological (biopsychosocial) history and current picture of consumer. This is not be confused with assessment tools which are used to complement the assessment. See pg. 24 for more detail.

**Clinical Supervision** – Positive supervisor-supervisee relationship that promotes consumer welfare and professional development of the supervisee (SAMHSA TIP 52 pg. 3). Supervisors oversee clinical practice, fidelity of each evidenced based practice and ensure clinicians and or consumer contact staff are following state and federal laws per each licensure, credential and certification. This includes staff that do not have a license, credential or certification are not practicing a scope of counseling or therapy. This is conducted by a person who has completed the clinical supervision IC & RC certification. See pg. 22 for more details.

**Co-Occurring Disorder** – This is a disorder that accompanies an SUD. Most common may be a mental health disorder however

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medical conditions can and should be included in this definition.

**Counseling** – A basic therapeutic approach used for SUD treatment or intervention. This type of service can be conducted by an undergraduate level clinician such as a licensed addiction counselor. Master level clinicians can also use this type of approach (E.g. motivational interviewing, basic EBP such as 12 step DBT or 12 step facilitation).

**Evidence Based Practice** – A treatment or modality which has been shown to be superior to “treatment as usual” or another intervention. The treatment and or modality need to be verified by a university or FSSA approved entity. Results must be published for public review. SAMHSA provides a guide as well.

**Fidelity** – is showing the EPB being used is being used as designed and studied to be affective. This is done by a clinical supervisor for internal purposes but an outside organization for best practice. Without fidelity checks per the EBPs expectations or yearly, EBPs are not to fidelity.

**Group Counseling** – Similar to counseling, group counseling is a basic therapeutic approach using basic EBP practices and can be utilized by undergraduate level clinicians such as a licensed addiction counselor.

**Group Therapy** – Similar to therapy, group therapy is an advanced therapeutic approach used only by master’s level clinicians (or above) with appropriate training.

**Peer Recovery Services** – These are provided by individuals with lived experience providing structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports and maintenance of community living skills. A person in recovery from a disorder must have completed expectations designated by DMHA, including a training, test and credential for peer recovery. This service should directly support the assessment and or treatment plan. This position must not provide clinical services. Providing clinical services would be practicing out of scope and be an egregious, unethical, even harmful act.

**Psychotherapy** – Also known as therapy, is an advanced therapeutic approach used to treat SUD, Co-occurring disorders and or mental health disorders. This advanced level of treatment requires at least a master level clinician with the appropriate training, dependent on the type of therapy provided (e.g. dialectic behavioral therapy with specific training in DBT or cognitive processing therapy for post-traumatic stress disorder). It is a planned and organized service with the participant tailored off of the consumer’s assessment, treatment plan and desires.

**Substance Use Disorder** – A diagnosis based on criteria in the DSM 5 and pertains to a substance use pattern which is interfering with a person life.

**Screening** – Is defined as a verified tool which is to identify the possibility of a disorder. A SUD screening would be expected before any intake or assessment. Much of screening for co-occurring disorders would occur in a complete SUD assessment. Screening tools used must be verified by SAMHSA, the National Institute on Drug Abuse and/or approved by DMHA. All consumers should be

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screened for tobacco or tobacco related use.

**Telemedicine Services** – Are defined as the use of videoconferencing equipment to allow a medical provider to render an exam or other services to a consumer at a distant location. The Indiana Health Coverage programs covers telemedicine service, including medical exams and certain other service normally covered by Medicaid, within the parameters of specified in Indiana Administrative Code 405 IAC 5-38.

- Telemedicine is not the use of the following
  - o Telephone transmitter for trans-telephonic monitoring
  - o Telephone or another means of communication for consolation from one provider to another

**Treatment Plan** – Is a measureable consumer clinical plan that is updated with the consumer and overseeing clinician. These are to show the progress of each consumer or if there is not progress, having the discussion with the consumer on changing the plan or identifying how to assist with progress. This tool is used by clinician and consumer to participate in the treatment and show the results.

**Withdrawal management** – Pharmacological and medical insight and or oversight to assist with a person with a physical and or psychological withdrawal from a substance. This can typically be due to a SUD but is not necessarily indicative of one.

ASAM Level of Care	ASAM Brief Description	Indiana Levels of Care (In addition to ASAM)	Staff Minimums	Coverage
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OTP Opioid Treatment Program	Pharmacological and non-pharmacological treatment in an office-based setting (methadone) Physiological dependence on opioids and requires OTP to prevent withdrawals.	<ul style="list-style-type: none"> <li>➤ See OTP rule IC 12-23-18</li> </ul>		Bundled rate
0.5 - Early Intervention	Services for individuals who are at risk of developing substance-related disorders No withdrawal risk No substance use disorder Form of prevention and intervention	<ul style="list-style-type: none"> <li>➤ At risk means: meeting no more than two criteria in the DSM for a SUD and does not meet criteria for higher level of care.</li> <li>➤ Binge drinking or similar type using of other substances.</li> <li>➤ Underage drinking, tobacco or other drug use.</li> <li>➤ Best Practice Group Size max 1:20 clinician to consumer ratio not to exceed 20.</li> </ul>	<p>Employee Certification: Licensed Addiction Counselor, prevention certified person having completed the International Certification &amp; Reciprocity Consortium (IC&amp;RC) exam.</p> <p>Highly encouraged: Part Time Employee, Clinical supervisor</p> <p>Best Practice: Additional Non-clinical, peer recovery services throughout treatment for</p>	No change expected

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			non-clinical services	
1.0 - Outpatient Services	<p>Outpatient treatment (usually less than 9 hours a week for adults and less than six for adolescents), including counseling, evaluations, and interventions.</p> <p>Minimal risk of severe withdrawal.</p> <p>WM services 1</p> <p>Ability to arrange for pharmacotherapy for psychiatric or addiction medications</p>	<ul style="list-style-type: none"> <li>➤ Less than 9 hours of clinical addiction services per week but must be at least one hour monthly</li> <li>➤ Processing Group Size max: 24</li> <li>➤ Best Practice for processing group clinician to consumer ratio 1:12</li> <li>➤ Best practice is to provide Clinical Supervision for licensed and or credentialed staff which is based on 40hr week. Supervision should occur 1 hour weekly for first year of licensure/credential and Biweekly after.</li> <li>➤ Each consumer must be staffed and overseen by a medical director at least once a month.</li> <li>➤ Required to provide protocols for the continuation of MAT, including direct operational linkage or access to methadone, buprenorphine, oral/injectable naltrexone providers</li> <li>➤ 75% of services are clinical in addition medical</li> </ul>	<p>Employee Credentials: Licensed Clinical Addiction Counselor.</p> <p>PTE: clinical supervisor, medical director if necessary</p> <p>Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services</p>	No change expected
2.1 - Intensive Outpatient	9-19 hours of structured programming per week	<ul style="list-style-type: none"> <li>➤ 9-19 hours of clinical addiction services per week</li> </ul>	Employee Credentials: clinical supervisor,	Will be covered for all individuals

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Services	(Counseling and education about addiction-related and mental health programs). Minimal risk of severe withdrawal WM services 2 and lower Ability to arrange for pharmacotherapy for psychiatric	<ul style="list-style-type: none"> <li>➤ Processing Group Size max: 16</li> <li>➤ Best Practice for processing group clinician to consumer ratio 1:8</li> <li>➤ Best practice is to provide Clinical Supervision for licensed and or credentialed staff which is based of 40hr week. Supervision should occur 1 hour weekly for first year of licensure/credential and Biweekly after.</li> <li>➤ Required to provide protocols for the continuation of MAT, including direct operational linkage or access to methadone, buprenorphine, oral/injectable naltrexone providers</li> <li>➤ Able to offer level 2 and 1 withdrawal management.</li> <li>➤ 75% of services are clinical in addition medical             <ul style="list-style-type: none"> <li>○ Must provide addiction medication upon intake as medically indicated. Telehealth, contracted with dr.</li> </ul> </li> <li>➤</li> </ul>	LCAC PTE: Medical director  Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services	
2.5 - Partial Hospitalization	20 or more hours of clinically intensive	<ul style="list-style-type: none"> <li>➤ 20 or more hours of clinical addiction services per week</li> </ul>	FTE: clinical supervisor, HSPP psychologist,	No change expected



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	<p>programming per week Moderate risk of severe withdrawal Ability to arrange for pharmacotherapy for psychiatric or anti- addiction medications WM services 2 and lower</p>	<ul style="list-style-type: none"> <li>➤ Processing Group Size max: 16</li> <li>➤ Best Practice for processing group clinician to consumer ratio 1:8</li> <li>➤ Best practice is to provide Clinical Supervision for licensed and or credentialed staff which is based of 40hr week. Supervision should occur 1 hour weekly for first year of licensure/credential and Biweekly after.</li> <li>➤ Each consumer must be staffed and overseen by a medical director at least once a month.</li> <li>➤ Each consumer must meet with one of the medical staff (physician, physician assistant, or advanced practice registered nurse every 7 day.</li> <li>➤ Required to provide protocols for the continuation of MAT, including direct operational linkage or access to methadone, buprenorphine, oral/injectable naltrexone providers</li> <li>➤ Able to offer levels 1 and 2 withdrawal management.</li> <li>➤ 75% of services are clinical in addition medical</li> </ul>	<p>Nurse PTE: Medical director  Best Practice: Non- clinical, peer recovery services throughout treatment for non- clinical services</p>	
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<p>3.1 - Clinically Managed Low-Intensity Residential</p>	<p>24-hour supportive living environment; at least 5 hours of low-intensity treatment per week Minimal stable risk of withdrawal WM services 2 and lower Ability to arrange for and monitor pharmacotherapy for psychiatric medications Must offer addiction medications when clinically indicated</p>	<ul style="list-style-type: none"> <li>➤ Processing Group Size max: 16</li> <li>➤ Best Practice for processing group clinician to consumer ratio 1:8</li> <li>➤ Best practice is to provide Clinical Supervision for licensed and or credentialed staff which is based of 40hr week. Supervision should occur 1 hour weekly for first year of licensure/credential and Biweekly after.</li> <li>➤ Each consumer must be staffed and overseen by a medical director at least once a month.</li> <li>➤ Required to provide protocols for the continuation of MAT, including access to buprenorphine, oral/injectable naltrexone providers and linkage to methadone.</li> <li>➤ Able to offer levels 1 and 2 withdrawal management.</li> <li>➤ 75% of services are clinical in addition medical</li> </ul>	<p>FTE: clinical supervisor, LCAC PTE and on call: Medical director, Nurse  Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services</p>	<p>Bundled daily rate for residential treatment</p>
<p>3.3 Clinically Managed Population – Specific High Intensity</p>	<p>24 hour living environment, treatment milieu depended on impairments.</p>	<ul style="list-style-type: none"> <li>➤ 10 - 20 hours of co-occurring enhanced clinical addiction services per week</li> <li>➤ Processing Group Size max: 16</li> <li>➤ Best Practice for processing group</li> </ul>	<p>FTE: clinical supervisor, Psychologist, LCAC, PTE &amp; on call: Medical director, Nurse  Best Practice: Non-</p>	<p>Bundled daily rate for residential treatment Align authorization criteria with ASAM</p>

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<p>Residential services  (Adult only)</p>		<p>clinician to consumer ratio 1:8</p> <ul style="list-style-type: none"> <li>➤ Best practice is to provide Clinical Supervision for licensed and or credentialed staff which is based of 40hr week. Supervision should occur 1 hour weekly for first year of licensure/credential and Biweekly after.</li> <li>➤ Each consumer must be staffed and overseen by a medical director at least twice a month.</li> <li>➤ Required to provide protocols for the continuation of MAT, including access to buprenorphine, injectable naltrexone and linkage to methadone.</li> <li>➤ Able to offer levels 1 and 2 withdrawal management.</li> <li>➤ 75% of services are clinical in addition medical</li> </ul>	<p>clinical, peer recovery services throughout treatment for non-clinical services</p>	
<p>3.5 - Clinically Managed High-Intensity Residential</p>	<p>24-hour living environment, more high-intensity treatment (level 3.7 without intensive medical and nursing component) Minimal risk of severe</p>	<ul style="list-style-type: none"> <li>➤ 20 or more hours of clinical addiction services per week</li> <li>➤ Group Size max: 1:8 not to exceed 16</li> <li>➤ Best practice is to provide Clinical Supervision for licensed and or credentialed staff which is based of</li> </ul>	<p>FTE: clinical supervisor, LCAC, PTE &amp; on call: Medical director, Nurse  Best Practice: Non-clinical, peer recovery</p>	<p>Bundled daily rate for residential treatment</p>

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	<p>withdrawal WM services 3.2 and lower Ability to arrange for and monitor pharmacotherapy for psychiatric or anti-addiction medications</p>	<p>40hr week. Supervision should occur 1 hour weekly for first year of licensure/credential and Biweekly after.</p> <ul style="list-style-type: none"> <li>➤ Each consumer must be staffed and overseen by a medical director at least twice a month.</li> <li>➤ Required to provide protocols for the continuation of addiction medication, including direct operational linkage or access to methadone, buprenorphine, injectable naltrexone providers</li> <li>➤ Able to offer levels 1, 2 and 3.2 withdrawal management.</li> <li>➤ 75% of services are clinical in addition to medical</li> <li>➤ Each consumer must meet with one of the medical staff (physician, physician assistant, or advanced practice registered nurse every 7 day.</li> <li>➤ Transpiration must be provided to the next level of care if other residential services are needed or if outside services are needed.</li> </ul>	<p>services throughout treatment for non-clinical services</p>	
3.7 - Medically Monitored Intensive	<p>24-hour professionally directed evaluation, observation, medical</p>	<ul style="list-style-type: none"> <li>➤ 10 or more hours of clinical addiction services and medical educational services per week</li> </ul>	<p>FTE: Medical Director, clinical supervisor, Psychologist, Nurse,</p>	<p>Align authorization criteria with ASAM</p>

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<p>Inpatient Services</p>	<p>monitoring, and addiction treatment in a hospital setting High risk Inpatient of severe withdrawal WM services 3.7 or lower Ability to arrange for and administer pharmacotherapy for psychiatric or anti-addiction medications</p>	<ul style="list-style-type: none"> <li>➤ Group Size max: 1:8 not to exceed 16</li> <li>➤ Best practice is to provide Clinical Supervision for licensed and or credentialed staff which is based of 40hr week. Supervision should occur 1 hour weekly for first year of licensure/credential and Biweekly after.</li> <li>➤ Each consumer must be staffed and overseen by a medical director at least twice a month.</li> <li>➤ Required to provide protocols for the continuation of MAT, including access to buprenorphine, oral/injectable naltrexone providers Able to offer levels 1, 2, 3.2 and 3.7 withdrawal management.</li> <li>➤ 50% of services are medical in addition to clinical interventions</li> <li>➤ Each consumer must meet with one of the medical staff (physician, physician assistant, or advanced practice registered nurse every day.</li> <li>➤ Transpiration must be provided to the next level of care if other residential services are needed or if outside services are needed.</li> </ul>	<p>LCAC</p> <p>Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services</p>	
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<p>4.0 - Medically Managed Intensive Inpatient</p>	<p>24-hour hospital setting treatment requiring the full resources of an acute care or psychiatric hospital High risk of severe withdrawal WM services 4 and lower Ability to prescribe and administer pharmacotherapy for psychiatric or anti-addiction medications</p>	<ul style="list-style-type: none"> <li>➤ 10 or more hours of clinical addiction services and medical educational services per week</li> <li>➤ Group Size max: 1:8 not to exceed 12</li> <li>➤ Best practice is to provide Clinical Supervision for licensed and or credentialed staff which is based of 40hr week. Supervision should occur 1 hour weekly for first year of licensure/credential and Biweekly after</li> <li>➤ Each consumer must be staffed and overseen by a medical director or MD/Psychiatrist that has the medical director's approval to oversee at least three times a month.</li> <li>➤ Able to offer levels 1, 2, 3.2, 3.7 and 4 withdrawal management.</li> <li>➤ 75% of services are medical in addition to clinical interventions</li> <li>➤ Each consumer must meet with one of the medical staff (physician, physician assistant, or advanced practice registered nurse every day.</li> <li>➤ Transpiration must be provided to the next level of care if other residential services are needed or if outside services are needed.</li> </ul>	<p>FTE, Medical Director, Psychiatrist, clinical supervisor, Nurse, LCAC</p> <p>Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services</p>	<p>Align authorization criteria with ASAM</p>
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1-WM - Ambulatory Withdrawal management	Outpatient setting with 24 hr. access to emergency medical consultation. Ability to arrange for and monitor pharmacotherapy for psychiatric or anti-addiction medications	<ul style="list-style-type: none"> <li>➤ Assessed and connected to appropriate level of behavioral treatment.</li> <li>➤ Required to provide protocols for the continuation of MAT, including access to buprenorphine, oral/injectable naltrexone providers Medical milieu</li> </ul>	FTE, clinical supervisor, LCAC PTE & On call: Clinical Director, Nurse Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services	Align authorization criteria with ASAM
2-WM - Ambulatory Withdrawal management	Outpatient setting with 24 hr. access to emergency medical consultation and access to psychological and psychiatric consultation Ability to arrange for and monitor pharmacotherapy for psychiatric or anti-addiction medications	<ul style="list-style-type: none"> <li>➤ Assessed and connected to appropriate level of behavioral treatment.</li> <li>➤ Clinical Supervision occurs based of 40hr week, occurs weekly for first year of licensure. Biweekly after At least one 1:1 hour of supervision per month.</li> <li>➤ Required to provide protocols for the continuation of MAT, including access to buprenorphine, oral/injectable naltrexone providers Medical milieu</li> </ul>	FTE: clinical supervisor, LCAC PTE/On call: Clinical Director, Nurse Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services	Align authorization criteria with ASAM

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<p>3.2-WM - Clinically Managed Withdrawal management</p>	<p>Residential setting with 24 hr. access to emergency medical consultation and access to psychological and psychiatric consultation Ability to arrange for and monitor pharmacotherapy for psychiatric or anti- addiction medications</p>	<ul style="list-style-type: none"> <li>➤ Assessed and connected to appropriate level of behavioral treatment.</li> <li>➤ Transpiration must be provided to the next level of care if other residential services are needed or if outside services are needed.</li> <li>➤ Clinical Supervision occurs based of 40hr week, occurs weekly for first year of licensure. Biweekly after.</li> <li>➤ At least one 1:1 hour of supervision per month.</li> <li>➤ Required to provide protocols for the continuation of MAT, including access to buprenorphine, oral/injectable naltrexone providers Medical milieu</li> </ul>	<p>FTE, clinical supervisor, LCAC PTE &amp; on call: Clinical Director, Nurse  Best Practice: Non- clinical, peer recovery services throughout treatment for non- clinical services</p>	<p>Align authorization criteria with ASAM</p>
<p>3.7-WM - Medically Monitored Inpatient Withdrawal management</p>	<p>Hospital setting with nursing care observation. Ability to arrange for and administer pharmacotherapy for psychiatric or anti- addiction medications</p>	<ul style="list-style-type: none"> <li>➤ Assessed and connected to appropriate level of behavioral treatment, taking into account consumer abilities.</li> <li>➤ Transpiration must be provided to the next level of care if other residential services are needed or if outside services are needed.</li> <li>➤ Clinical Supervision occurs based of 40hr week, occurs weekly for first</li> </ul>	<p>FTE: Medical Director, clinical supervisor, Nurse, LCAC  Best Practice: Non- clinical, peer recovery services throughout treatment for non- clinical services</p>	<p>Align authorization criteria with ASAM</p>



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		<p>year of licensure. Biweekly after At least one 1:1 hour of supervision per month.</p> <ul style="list-style-type: none"> <li>➤ Required to provide protocols for the continuation of MAT, including direct operational linkage or access to methadone, buprenorphine, injectable naltrexone providers</li> <li>➤ Medical milieu</li> </ul>		
4-WM - Medically Monitored Intensive Inpatient Withdrawal management	Hospital setting with full medical acute care Ability to prescribe and administer pharmacotherapy for psychiatric or anti-addiction medications	<ul style="list-style-type: none"> <li>➤ Assessed and connected to appropriate level of behavioral treatment, taking into account consumer abilities.</li> <li>➤ Clinical Supervision occurs based off 40hr week, occurs weekly for first year of licensure. Biweekly after At least one 1:1 hour of supervision per month.</li> <li>➤ Transpiration must be provided to the next level of care if other residential services are needed or if outside services are needed.</li> <li>➤ Required to provide protocols for the continuation of MAT, including access to buprenorphine, oral/injectable naltrexone providers Medical milieu</li> </ul>	FTE, Medical Director who is a Psychiatrist or Nurse, LCAC  Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services	Align authorization criteria with ASAM

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<p>Sub- Support Addiction Recovery Management Services (Recovery Residence)</p>		<p>➤ Services to help people overcome personal and environmental obstacles to recovery, assist the newly recovering person into the recovering community. Some clinical addictions services which are approved and overseen by DMHA.</p>	<p>Staff depended upon level and can be identified through <a href="http://inarr.org">inarr.org</a>.  Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services</p>	<p>Covered for all individuals</p>
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## Quality of Care

SAMHSA has clear, ethical and practical ways of creating and implementing quality and to fidelity co-occurring substance use disorder services. SAMHSA continually updates relevant research and identifies best practices. The TIP, TAP and various evidence based approaches are a great resource when developing or changing addiction services. The Evidence-Based Resource Center<sup>1</sup> can guide quality practice coupled with the Assertive Community Treatment Evidence-Based Practices KIT<sup>2</sup> will guide a program to a sound practice of substance use disorder treatment.

SAMHSA resources need to be used as baseline. This will provide a basic expectation of treatment. If there are any concerns about publications or future publications, the Division of Mental Health and Addiction has the ability to speak to any disagreements. However, fidelity, best practice and what will offer the vulnerable, the person suffering from substance use disorder and or co-occurring disorder will be ethically considered and more than likely favored in any decision making.

Comprehensive care needs to be at the forefront of assessing, treating and referring individuals seeking, being treated or referred to addiction services. The National Institute on Drug Abuse gives a clear example of what this would look like<sup>3</sup>. SAMHSA also supports an integrated approach.<sup>4</sup>

American Society of Addiction Medicine is a nation leader in addiction services. They are a medical society representing over 6,000 professions ranging from physicians to associate professionals. ASAM has been dedicated to increasing access to treatment, improving the quality of treatment, education, research and prevention. Since 1954, ASAM has advocated and led in promotion of the appropriate treatment regime for the person with a substance use disorder.

ASAM has developed criteria which identifies the level of care needed for the individual needing addiction services. It also identifies what each level of care is. This is criteria offers a succinct and universal approach to identifying the level of care needed which can work for an entire system of care.

Trauma Informed, Recovery Oriented Systems of Care are needed throughout the treatment process. Identifying trauma is evident in everyone's life and how the person is coping but most importantly, what is the staff's approach to working with those with trauma. Some advanced cases of trauma, such as PTSD, would require specialized therapist training in trauma therapeutic interventions and approaches to treat the person as a whole. While Recovery Oriented Systems of Care focus on the consumer receiving recovery support, terminology and long term focus of

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<sup>1</sup> <https://www.samhsa.gov/ebp-resource-center>

<sup>2</sup> <https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/sma08-4345>

<sup>3</sup> <https://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iii/4-components-comprehensive-drug-addiction-treatm>

<sup>4</sup> <https://www.integration.samhsa.gov/about-us/esolutions-newsletter/integrating-substance-abuse-and-primary-care-services>

recovery as a part of treatment.<sup>5</sup>

### **Co-occurring disorders**

Addressing co-occurring disorders is a necessary and integral part of any addiction service. Co-occurring can mean medical or mental health disorders to accompany a substance use disorder. Having trained master level clinicians, psychologist or psychiatrist to assess mental health beyond substance use disorder is imperative. The use of a psychologist would be best practice when assessing for co-occurring behavioral disorders. This would include a detailed diagnostic impression to be based off the current DSM and any other higher level testing needed. This could include higher level psychologist testing to verify or rule out other disorder(s).

Understanding the severity of mental health and the differing needs to assess and address, needs to be common knowledge amongst addiction services. If the addiction service is less intensive outpatient service or a less intensive residential service, there are still going to be a number of persons with severe mental health issues that are stable or could become unstable that would need the appropriate treatment to address. At the very least, a robust screening and referral process to insure the whole person is being treated. Mental health needs and addiction needs have to be met and one severity does not necessarily increase the other. A person with a severe unstable mental health condition does not meet inpatient or residential addiction service criteria without that level of care needed for addiction services.

All co-occurring needs to be considered when treating a whole person. Serious mental health and medical complications need to be closely monitored, assessed and documented. This entails an appropriate level of training and education to assess the severity of the condition. Depending upon the complexity and need of the individual, the professional needs education and experience to appropriately, ethically and efficiently address the need of the individual in need of services. This would include co-occurring curriculum which SAMHSA provides guidance with their TIP 42.<sup>6</sup> Co-occurring disorder treatments will be required to have the appropriate licensure deemed by IPLA to treat addiction disorders and other mental health disorders. This type of treatment is distinctly different to address the interwoven complexities of the multiple disorders and treating the person as whole.

Safety plans are necessary for most if not all individual seeking addiction services. This would be a detailed plan created with the individual and counselor on how to best address any complications. For instance, suicide is more than just asking about if a person has thoughts of hurting themselves. It's directly asking if there have been thoughts of taking their own life, digging into their history, identifying risk factors such as co-occurring disorders, past attempts and lethality of past attempts or even ideation. A basic suicide assessment can be found on

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<sup>5</sup> [https://www.in.gov/fssa/dmha/files/TI\\_ROSC\\_Toolkit\\_FINAL.PDF](https://www.in.gov/fssa/dmha/files/TI_ROSC_Toolkit_FINAL.PDF)

<sup>6</sup> <https://store.samhsa.gov/system/files/sma13-3992.pdf>

SAMHSA's website.<sup>7</sup> For suicide screening training, DMHA can provide Question Persuade Refer (QPR) training upon request. Having suicide prevention and intervention training is imperative and is required for all clinical staff. Organizational protocols and trainings to normalize this process are needed to build a safe intervention, observational and referral processes.

Safety plans should have a detailed plan to indicate that the individual is aware of how to best address any documented co-occurring disorder. This would also allow staff to be aware of how to best treat the individual in addiction services if a co-occurring condition were become problematic. This would include a crisis intervention plan which can be identified on SAMHSA's website<sup>8</sup>. More information about crisis intervention can be found on SAMHSA's website such as "Effectiveness, Cost-Effectiveness and Funding Strategies for Behavioral Health Crisis Services."<sup>9</sup>

### **All populations**

Those in need of addiction services represent the entire population and range of individuals throughout the life time spectrum. Needing to address each person's needs may be difficult but must be considered. Having culturally competent employees, curriculum and approaches are necessary. Some populations such as our older generation, LBGTQ, those seeking refuge in America, English as a second language may need different approaches, more care, different care but the approaches should be that which doesn't demean the person receiving the services.

Ensuring your organization has the capability to identify, treat and work with the consumer in a person centered, humble, empathetic approach is necessary. Specific, continued education is necessary to best treat all Hoosiers.

### **Documentation**

There is an imperative need for appropriate and accurate documentation for all levels of care. Progress notes must be made to reflect all individual sessions, group session, organizational compliance and progress for every individual receiving services chart.

There must be the following for individual documentation: Screening to show why individual is at the current level of care prior to admission, a biopsychosocial assessment with a treatment plan which is comprehensive and multidimensional within three days of admission, and this must include all co-occurring disorders. Best practice is to complete the biopsychosocial assessment prior to admission. Specific current ASAM, DSM and other evidence based diagnostic tools and diagnosis's need to be included. The person assessing and signing off on this legal documentation must have the appropriate licensure based on the level of care and services being offered.

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<sup>7</sup> <https://store.samhsa.gov/system/files/sma09-4432.pdf>

<sup>8</sup> <https://store.samhsa.gov/product/Crisis-Intervention-Team-CIT-Methods-for-Using-Data-to-Inform-Practice-/sma18-5065>

<sup>9</sup> <https://store.samhsa.gov/system/files/sma14-4848.pdf>

Progress notes are to include documentation on all disorders, medical, referrals and collaboration with referrals. This would be progress in treatment or that the treatment is ineffective to then include other interventions to address the ineffective treatment. All notes should be reflective of the consumers diagnose(s). It is the organizations responsibility to ensure all there staff are documenting appropriately based on their level of expertise. Ensuring clinicians, making clinical notes with other observational or referral notes. Medical can make medical notes with other observational or referral clinical. Non clinical making non clinical or non-medical notes, just observational or credential based such as a peer. Based upon the person's expertise, licensure(s) and practice will determine what notation is ethically appropriate.

There are three different types of progress notes. Their basic overview would be:

1. Non clinical
  - a. This would include non-clinical staff such as non-licensed or non DMHA certified to practice addiction counseling services. Individuals such as degreed or non-degreed staff that are support staff, not involved in group counseling/therapy, individual counseling/therapy or completing assessments. This group of people should only be documenting on observation, basic screening such as drug screening and compliance related topics.
2. Clinical
  - a. This is all staff with a clinical degree, license and or DMHA approved credential or working toward their license or credential. This group of professionals should be conducting the group counseling/therapy, individual counseling/therapy and completing assessments.
3. Medical
  - a. This is all staff who have a medical based degree such as a nurse, physician or psychiatrist. These notes should be pertaining to medical impressions, procedures, progress and diagnosis.

If the treatment is ineffective, assessment and documentation of alternative routes needs to be clear and concise. The relationship between all disorders needs documentation and approaches to treat the complexity of the diagnoses. This will assist with treating each consumer as a whole.

Each diagnosis needs to be signed off by an appropriate entity based on Indiana's current code. All doctors involved with signing off of diagnoses must also sign off on the awareness of the other diagnosis's which the indivial has, is being treated for, coupled with the approaches being used. These approaches are to include any pharmacotherapy, counseling and medical treatments. This is to prevent multiple doctors singing off on differing observations and even different pharmacotherapy approaches. Overall, to collaborate with all providers to ensure all providers are working toward the same goals.

### **Clinical Supervision and Medical Director**

Addiction is a medical condition and substance use disorder that is a treatable. Having appropriate clinical and medical supervision is imperative to quality care. There are basic expertise needs for quality of care which would include the clinical supervision and medical oversight.

### **Clinical Supervisor**

A clinical supervisor for addiction services needs to have at least a master level counseling degree incorporated with addiction and supervision education. SAMHSA continues to update and print reputable and usable instruction for clinical supervisors. For instance, TAP 21-A specifies what an addiction supervisor competencies should entail<sup>10</sup> while TIP 52 specifies the professional development of those the clinical supervisor is overseeing. This education and approach is expected when providing clinical supervision. It's the clinical supervisor's role to ensure sustainable clinician to counselor ratio for caseloads and group size based on the severity and chronicity of the current consumer population.

### **Medical Director**

Due to the complexities of SUD and co-occurring disorders, medical oversight is needed for most levels of care. At least a part time medical director to oversee the individual's medical and psychological needs will suffice in programs which are less intensive or not large in size to justify a full time medical director.

A medical director should be reviewing monthly: diagnostics, co-occurring disorders and progress of each individual in services. This person will need addiction specific training, credentialing, ASAM certification, approved by DMHA. This could also be the trained person to prescribe buprenorphine and other addiction medications.

### **Transferring Levels of Care**

Transferring levels of care needs to be considered a continuum of care and needs to be a part of services provided. Providing one level of care without documentation of what is needed next is unethical and could be considered malpractice. Ensure that the person being treated is at the appropriate level of care and to increase or decrease the level of care based upon regular assessment.

Transfer of care is to be considered part of the treatment process and the organizations responsibility to ensure or to the best of their ability assist with the actual transfer. With regular assessments occurring the individual receiving addiction services will be identified as needing the same level of care, increase or decrease level of care. The transfer to a different level of care will require different levels of involvement from providers. All privacy expectations are still to take place during a transfer, including a release of information. This ROI needs be too signed and dated to transfer the amount of information needed to complete the next level of care and will expire after a year or the time which is less than year designated on the ROI.

The transfer from inpatient (or any other type of non-emergency hospitalization) to residential or to a residential to inpatient (or any other type of non-emergency hospitalization) of care should include a transportation by current provider or referral provider. This transfer should be including a discussion with consumer, referring clinical staff and referral clinical staff prior to

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<sup>10</sup> <https://store.samhsa.gov/system/files/sma14-4435.pdf>

transfer.

Recovery residences are a separate type of service but can be included into a person's recovery process after or during treatment. Recovery residences provide a safe living environment with a focus on peer support and connection to other recovery services and community. There are four levels with different criteria. Recovery residences are overseen by Indiana Affiliation of Recovery Residences, contracted by DMHA.

### **Assessment**

Individuals seeking substance use treatment for all ASAM levels of care, including, intervention, outpatient, residential, withdrawal management and inpatient, will be required to undergo a biopsychosocial assessment that will be used for the completion of a plan of treatment. As part of the assessment, providers will be required to address all six dimensions of multidimensional assessment, including the following:

- Dimension 1: Acute intoxication and/or withdrawal potential
- Dimension 2: conditions and complications
- Dimension 3: Emotional, behavioral, or cognitive conditions and complications
- Dimension 4: Readiness to change
- Dimension 5: Relapse, continued use, or continued problem potential
- Dimension 6: Recovery/living environment

Each of the six dimensions plays a critical role in assigning an individual to the most appropriate level of care. These dimensions are predominantly current reasons for current level of care for treatment. The following should also be included in a complete biopsychosocial assessment:

1. Background—family, trauma history, history of domestic violence (either as a batterer or as a battered person), marital status, legal involvement and financial situation, health, education, housing status, strengths and resources, and employment
2. Substance use—age of first use, primary drugs used (including alcohol, patterns of drug use, and treatment episodes), and family history of substance use problems
3. Mental health problems—family history of mental health problems, consumer history of mental health problems including diagnosis, hospitalization and other treatment, current symptoms and mental status, medications, and medication adherence

This assessment is paramount when working with the consumer on creating a treatment plan and assessment tools can be used to compliment, verify diagnosis's, refer and develop a treatment plan.

Regular biopsychosocial assessments are a need and should occur before admission but no less than three days after admission. Medical and adverse circumstances will be taken into account. If



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there is a medical reason such as (individual was not tracking conversation due to acute alcohol withdrawals), then appropriate documentation and proof of the individuals inability to participate is needed.

Level of care need should be assessed weekly to monthly depending upon the level of care and need of consumer. ASAM levels 3.5-4 (high intensity residential and inpatient) should have no less than weekly level of care updates. While level 1-2 (outpatient) should receive no less than monthly level of care assessments. Every updated assessment should be based off the six dimensions in ASAM criteria. This should complement the treatment plan and consumers inclusion of discharge planning.

Co-occurring disorders should be included throughout the assessment process. This would include medical and other mental health disorders. A co-occurring disorder is not indicative to increase the level of addiction treatment, rather, the addiction treatment should be indicative of the assessment. The co-occurring disorder should be treated simultaneously but specifically with a treatment modality to match the disorder(s). Just a higher level of addiction treatment would not necessarily treat the co-occurring disorder. Reiterating the importance and need to have treatment specificity for each disorder. For instance, SAMHSA's specific publication on co-occurring disorders.<sup>11</sup> At the very least, treating the SUD and mental health during the same treatment episode but separate EBP.

Recovery needs to be a considering factor within the discharge planning. The consumers discharge plan needs to be completed with the consumer prior to discharge. This will include any needed treatment, medical and psychological treatments. A social support is to be identified and all needed appointments set up by the consumer or if consumer is unable with assistance from a staff member to ensure connection to services. The discharge summary should include: the biopsychosocial assessment, treatments offered, progress on treatments, goals set and documentation on goals.

Peer supports are a large benefit which can assist in the transfer of care and discharge into a consumer driven recovery. Ensuring the consumer is set up for long term recovery plan is just as important as the initial treatment and needs to be considered high priority.

### **Technology Based Services**

FSSA/DMHA recognizes the advancement in technology, unforeseen technology and the use of it to treat substance use disorders and co-occurring disorders. Under this premise, DMHA would recognize clinically approached and well documented use of why traditional in person treatment

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<sup>11</sup> <https://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA13-3992>

is not being used. At this point in the advancement of technology, extreme caution needs to be taken to ensure 42 CFR Part 2 and Health Insurance Portability and Accountability Act are upheld, the technology has been thoroughly assessed as appropriate for the level of care. Treatments that would not be considered appropriate for Telehealth/remote/non in person services would be a residential, inpatient and persons with risks with withdrawal management or co-occurring disorders.

The use of ECHO has been a large training benefactor for professionals in need of training. An example would be these types of tracks could be used for an educational interactive series for treatment. Ensuring the professional requirements are being met for all levels of care. This is beneficial for non-local professionals which are offered

With the complexity of substance use disorder and co-occurring disorders, technology based treatment for the primary service should be considered last resort to treat. However, Indiana being a rural state, the need for technically based services is acknowledged.

Telehealth is one of routes being used which if used ethically and appropriately can be effective. These types of services need clear documentation of why they are being used and only used when necessary. Until more research is done to show the effectiveness of technology based services, it should not be considered interchangeable with in person treatment. A clear implementation, tracking and following of 42 CFR will be expected. See SAMHSA's guide for more instruction.<sup>12</sup>

## Levels of Care Details

### Adult Levels of Care

#### Level of Care: 0.5 (Early Intervention)

**Definition:** A level of clinical education which addresses the current behavior which is causing interference in a person's life. These services are not differentiated by the number of hours received during a week. The amount and type of services provided are based on individual needs including consideration of both the consumer's motivation to change and other risk factors that may be present. This level of care is typically mandated through an impaired driving program or underage drinking that requires completion before reinstating driving privileges or reconciliation of infraction. Prior to admission, a diagnostic assessment should be performed in conjunction with a comprehensive multidimensional assessment to determine whether the person meets the admission criteria for Level 0.5, which requires that the person does not meet the requirements for a substance use disorder. If new information, through the reassessment process indicates substance use

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<sup>12</sup> [https://www.integration.samhsa.gov/hit/telehealthguide\\_final\\_0.pdf](https://www.integration.samhsa.gov/hit/telehealthguide_final_0.pdf)

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disorder, and the person needs treatment, there are two options:

1. Transfer individual to a clinically appropriate level of care
2. Facilitate treatment at required 0.5 Level of care.

Length of service at this level depends on an individual's ability to comprehend the information they are provided and use the information to make behavior changes, if the person acquires new problems and needs additional treatment, or regulatory mandated service.

**Staff**

1. At least one full time licensed addictions counselor to provide appropriate clinical oversight with educational standards to best deliver services. This will ensure the assessment and education of the individual will be suffice to provide level 0.5 service, coupled with the knowledge of how to assess and refer to a higher level of care. This could be one of the most important assessments in a person's life which could prevent or slow the escalation the disease of addiction.

**Approaches:**

1. Education on the disease of addiction which could include:
  - a) progression, increased risk of a use disorder due to biological, sociological and psychological factors,
  - b) warning signs a use disorder may be starting,
  - c) co-occurring disorders
2. Speakers, such as someone who started in the current stage of life but may have been in denial and progressed into addiction,
3. Additional services such as: Screening, Brief Intervention and Referral to Treatment (SBIRT) can be used

**Other appropriate staff:**

1. Peer Recovery staff with DMHA approved certification
2. Other addiction credentials to provide services would be considered DMHA approved certification. Proof of education and working knowledge of: Addiction education, biopsychosocial multidimensional assessment, mental health screening and identification, consultation and referral.

**Necessary supports:**

1. Direct affiliations or close coordination through referral to other services, such as IOP, vocational services, literacy training and adult education.
2. Social supports to assist in a healthy lifestyle

**Level of Care: 1.0 (Outpatient Services)**

**Definition:** This level of care offers less than nine hours per week but must be at least one hour monthly. Also could be considered "aftercare" when a higher level of treatment has been

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completed. This addiction service can be delivered in a wide variety of settings which will provide a regular biopsychosocial assessment with recovery and disease management throughout treatment. Most importantly, a mental health screening to determine if there are other mental health needs to treat co-occurring disorders together. With a behavioral treatment approach not to exceed eight contact hours. Level 1.0 services are to be individually tailored based on their stage of change, needs, collaborative goal setting and co-occurring disorder(s). Mental health disorders at this level of care should be stable or a co-occurring specific group that focuses heavily on mental health needs to be incorporated. If new information, through the reassessment process indicates substance use disorder, and the person needs treatment, there are two options:

1. Increase the level of care that is clinically appropriate
2. Facilitate treatment at required level of care

Length of service will be determined by the severity of the individuals SUD(s), mental health disorder(s) and their response to treatment.

**Staff**

1. Should include at least one full time licensed clinical addictions counselor to provide appropriate clinical oversight with educational standards to best deliver services. This will ensure the education of the individual will be suffice to provide level 1 service, clinical supervision if more employees coupled with the knowledge of how to assess and refer to a higher level of care. Other counseling staff could include licensed addiction counselors.
2. A part time medical director may be necessary if there are severe mental health disorders, unstable mental health disorders or medical conditions.
3. Other addiction credentials approved by DMHA to provide addiction counseling would be considered with a master's degree in a counseling type specialty.

**Therapies and Addiction Services offered by the facility (can be contracted)**

1. Can be considered (after care) and not just used for those who have not progressed in their use disorder.
2. "Skills development" – services designed to improve the consumer's ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance and punctuality.
3. Addiction pharmacotherapy
4. Random drug screening
5. Motivational enhancement or engagement strategies
6. Counseling and clinical monitoring to support successful involvement in regular, productive activity
7. Education to include but not limited to:
  - a) Co-occurring disorders

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- b) Cross addiction
  - c) Balancing life
    - i) Health
    - ii) Diet
    - iii) Physical
    - iv) Emotional
    - v) Health Care
  - d) Pharmacotherapy specific to needs
8. Regular monitoring of consumer's medication adherence
  9. Speakers, such as someone who started in the current level of care but may have been in denial and progressed into addiction,
  10. Recovery support services
  11. Services for consumer's family and significant others, as appropriate
  12. Opportunities for consumer to be introduced to the potential benefits of addiction pharmacotherapies as a tool to manage his or her addiction.

**Other appropriate staff:**

1. Licensed Addiction counselors.
2. Peer Recovery staff with DMHA approved certification
3. Allied health professionals, such as peer recovery coaches, peer recovery coaches, peer recovery coaches, counselor aides and group living workers who are available on-site 24 hours a day or as required by licensing regulations.
4. Clinical staff who are knowledgeable about biological and psychosocial dimensions of substance use disorders and their treatment and are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation.
5. A team comprised of appropriately trained and credentialed medical, addiction and mental health professionals.
6. An addiction physician should review admission decisions to confirm clinical necessity of services.

**Necessary supports:**

1. Telephone or in –person consultation with physician and emergency services, available 24 hours a day, seven days a week.
2. Direct affiliations or close coordination through referral to other services, such as IOP, vocational services, literacy training and adult education.
3. Ability to schedule needed procedures (labs ad toxicology tests) as appropriate
4. Ability to arrange for pharmacotherapy for psychiatric and anti-addiction medication.

## **Level of Care: 2.1 (Intensive Outpatient Services)**

**Definition:**

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This level of care is between 9-19 hours of addiction services per week. Assessing for co-occurring disorders and addressing each added disorder with appropriately related evidence based programming. Determining if there are other mental or physical health needs and collaborating on how to treat co-occurring disorders together is imperative. Level 2.1 service are to be individually tailored based on their stage of change, needs, collaborative goal setting and co-occurring disorder(s). Mental health disorders at this level of care should be stable or a co-occurring specific group that focuses heavily on mental health needs to be incorporated. If new information, through the reassessment process indicates substance use disorder, and the person needs treatment, there are two options:

1. Increase or decrease the level of care that is clinically appropriate
2. Facilitate treatment at required level of care

Length of service will be determined by the severity of the individuals SUD(s), mental health disorder(s) and their response to treatment.

**Therapies and Addiction Services offered by the facility (can be contracted)**

1. “Skills development” – services designed to improve the consumer’s ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance, and punctuality.
2. Addiction pharmacotherapy
3. Random drug screening
4. Motivational enhancement or engagement strategies such as:
  - a) Motivational Interviewing
  - b) Stages of change
  - c) Dialectic Behavioral Therapy
6. Counseling and clinical monitoring to support successful involvement in regular, productive activity
7. Education to include but not limited to:
  - a) Co-occurring disorders
  - b) Cross addiction
  - c) Balancing life
    - i) Health
    - ii) Diet
    - iii) Physical
    - iv) Emotional
    - v) Health Care
  - d) Pharmacotherapy specific to needs
8. Regular monitoring of consumer’s medication adherence
9. Speakers, such as someone who started in the current level of care but may have been in denial and progressed into addiction,
10. Services for consumer’s family and significant others, as appropriate

11. Opportunities for consumer to be introduced to the potential benefits of addiction pharmacotherapies as a tool to manage his or her addiction.

**Staffed by**

- 1) Staff: Should include at least one full time licensed clinical addictions counselor to provide appropriate clinical oversight with educational standards to best deliver services. A clinical supervisor who could be the LCAC to oversee all clinical practices. Part time staff/contracted to be considered and recommended is a medical director (physician) with addiction certification/training to provide medical oversight. This would be to assist with severe mental health disorders, unstable mental health disorders and or medical conditions.

**Other appropriate staff:**

1. Licensed addiction counselors.
2. Allied health professionals, such as peer recovery coaches, peer recovery coaches, peer recovery coaches, counselor aides and group living workers who are available on-site 24 hours a day or as required by licensing regulations.
3. Clinical staff who are knowledgeable about biological and psychosocial dimensions of substance use disorders and their treatment and are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation such as master level clinicians with and addictions certification.
4. A team comprised of appropriately trained and credentialed medical, addiction and mental health professionals.

**Necessary supports:**

1. Telephone or in –person consultation with physician and emergency services, available 24 hours a day, seven days a week.
2. Direct affiliations or close coordination through referral to other services, such as IOP, vocational services, literacy training and adult education.
3. Ability to schedule needed procedures (labs ad toxicology tests) as appropriate
4. Ability to arrange for pharmacotherapy for psychiatric and anti-addiction medication.

Level of care: 2.5 (Partial Hospitalization)

**Definition:**

This level of care is between 20 or more hours of addiction services per week. This level is specific to co-occurring disorders which need direct access to psychiatric, medical and laboratory services. Assessing for co-occurring disorders and addressing each added disorder with appropriately related evidence based programing. Level 2.5 service are to be individually tailored based on their stage of change, needs, collaborative goal setting and co-occurring disorder(s). Mental health

disorders at this level of care do not have to be stable but a co-occurring specific group that focuses heavily on mental health needs to be incorporated. If new information, through the reassessment process indicates substance use disorder, and the person needs treatment, there are two options:

1. Increase or decrease the level of care that is clinically appropriate
2. Facilitate treatment at required level of care

Length of service will be determined by the severity of the individuals SUD(s), mental health disorder(s) and their response to treatment

**Therapies and Addiction Services offered by the facility (can be contracted)**

1. Specific co-occurring milieu which reflects the persons diagnostics
2. At least 1 hour per week of individual therapy with a master level appropriately designated therapist.
3. “Skills development” – services designed to improve the consumer’s ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance, and punctuality.
4. Addiction pharmacotherapy
5. Random drug screening
6. Motivational enhancement or engagement strategies
7. Counseling and clinical monitoring to support successful involvement in regular, productive activity
8. Education to include but not limited to:
  - a) Co-occurring disorders
  - b) Cross addiction
  - c) Balancing life
    - i) Health
    - ii) Diet
    - iii) Physical
    - iv) Emotional
    - v) Health Care
  - d) Pharmacotherapy specific to needs
9. Speakers, such as someone who started in the current level of care but may have been in denial and progressed into addiction,
10. Regular monitoring and possibly management of consumer’s medication adherence
11. Recovery support services
12. Services for consumer’s family and significant others, as appropriate
13. Opportunities for consumer to be introduced to the potential benefits of addiction pharmacotherapies as a tool to manage his or her addiction.

**Staffed by:**

1. Staffing minimums: Should include at least one full time licensed psychologist HSPP to



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provide appropriate clinical oversight with educational standards to best deliver services. A clinical supervisor who could be the LCAC to oversee all clinical practices. Part time staff/contracted a medical director (physician) with addiction certification/training to provide medical oversight. This would be to assist with severe mental health disorders, unstable mental health disorders and or medical conditions.

**Other appropriate staff:**

1. Licensed addiction counselors.
2. Allied health professionals, such as peer recovery coaches, peer recovery coaches, peer recovery coaches, counselor aides and group living workers who are available on-site 24 hours a day or as required by licensing regulations.
3. Clinical staff who are knowledgeable about biological and psychosocial dimensions of substance use disorders, their treatment, are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation such as master level clinicians with and addictions certification deemed appropriate by the Division of Mental Health and Addiction.
4. A team comprised of appropriately trained and credentialed medical, addiction and mental health professionals

**Necessary supports:**

1. Telephone or in person consultation with physician and emergency services, available 24 hours a day, seven days a week.
2. Direct affiliations or close coordination through referral to other services, such as IOP, vocational services, literacy training and adult education.
3. Ability to schedule needed procedures (labs and toxicology tests) as appropriate
4. Ability to arrange for pharmacotherapy for psychiatric and anti-addiction medication.

Level of care: 3.1 (Clinically Managed Low-Intensity Residential)

Individuals admitted to this level of care should have been seen in level 1 or 2 in the past or clear documentation why this level of care is needed.

**Definition:** Provides ongoing therapeutic environment for the treatment of substance-related disorders with treatment specifically focused on applying recovery skills, relapse prevention, improvement of emotional functioning, promoting personal responsibility and reintegration of the individual into work, education and family life. Programs must offer a minimum of five hours per week of low-intensity services onsite or by contractual arrangement. Individuals may be in an early stage of change which requires additional monitoring and motivational strategies to engage them in their recovery process, or suffering from long-term chronic addiction with need for establishing a network that promotes long-term recovery. The residential component of

clinically managed low-intensity residential services may be combined with low-intensity outpatient, intensive outpatient, or day treatment.

**Therapies and Addiction Services offered by the facility (can be contracted)**

1. “Skills development” – services designed to improve the consumer’s ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance, and punctuality.
2. Addiction pharmacotherapy
3. Random drug screening
4. Motivational enhancement or engagement strategies
5. Counseling and clinical monitoring to support successful involvement in regular, productive activity
6. Education to include but not limited to:
  - a) Co-occurring disorders
  - b) Cross addiction
  - c) Balancing life
    - i) Health
    - ii) Diet
    - iii) Physical
    - iv) Emotional
    - v) Health Care
  - d) Pharmacotherapy specific to needs
7. Regular monitoring of consumer’s medication adherence
8. Recovery support services
9. Services for consumer’s family and significant others, as appropriate
10. Opportunities for consumer to be introduced to the potential benefits of addiction pharmacotherapies as a tool to manage his or her addiction.

**Staffed by:**

Staffing minimums: Should include at least one full time licensed clinical addictions Counselor to provide appropriate clinical oversight with educational standards to best deliver services. A clinical supervisor who could be the LCAC to oversee all clinical practices. Part time staff/contracted a medical director (physician) with addiction certification/training to provide medical oversight. This would be to assist with severe mental health disorders, unstable mental health disorders and or medical conditions. Other counseling staff could include licensed addiction counselors.

**Other appropriate staff:**

1. Psychologist
2. Nurses
3. Licensed addiction counselors

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4. Allied health professionals, such as peer recovery coaches, peer recovery coaches, peer recovery coaches, counselor aides and group living workers who are available on-site 24 hours a day or as required by licensing regulations.
5. Clinical staff who are knowledgeable about biological and psychosocial dimensions of substance use disorders and their treatment and are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation such as master level clinicians with and addictions certification.
6. A team comprised of appropriately trained and credentialed medical, addiction and mental health professionals.

**Necessary supports:**

1. Telephone or in –person consultation with physician and emergency services, available 24 hours a day, seven days a week.
2. Direct affiliations or close coordination through referral to other services, such as IOP, vocational services, literacy training and adult education.
3. Ability to schedule needed procedures (labs ad toxicology tests) as appropriate
4. Ability to arrange for pharmacotherapy for psychiatric and anti-addiction medication.

**Level of care: 3.3 (Clinically Managed Population Specific High-Intensity Residential)**

Individuals admitted to this level of care could have been seen in level 1, 2 or 3.1 in the past or clear documentation why this level of care is needed.

**Definition** This level of care should have 10-20 hours of specialized co-occurring enhanced services. Supportive 24 hour therapeutic environment who are imminently dangerous manner upon transfer to less restrictive environment. This is for the populations which cognition, mental health and or medical health temporarily or permanently limiting their functions. Programming is focused on stabilization of dangerous addiction signs and symptoms, initiation or restoration of a recovery process, and preparation for ongoing recovery in the broad continuum of care with the goals of treatment being to promote abstinence from substance use, reduce other addictive and antisocial behaviors, and effect change in participant’s lifestyles, attitudes and values.

**Therapies and Addiction Services offered include:**

1. Planned clinical program activities to stabilize and maintain stabilization of consumer’s addiction symptoms.
2. “Skills development” – daily clinical services to improve the consumer’s ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance, and punctuality.
3. Counseling and clinical monitoring to support successful involvement in regular, productive activity
4. Random drug screening
5. A range of evidence-based cognitive, behavioral and other therapies, including addiction pharmacology

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6. Motivational enhancement or engagement strategies
7. Counseling and clinical interventions to facilitate teaching the consumer the skills necessary for productive daily activities
8. Education to include but not limited to:
  - a) Co-occurring disorders
  - b) Cross addiction
  - c) Balancing life
    - i) Health
    - ii) Diet
    - iii) Physical
    - iv) Emotional
    - v) Health Care
  - d) Pharmacotherapy specific to needs
9. Speakers, such as someone who started in the current level of care but may have been in denial and progressed into addiction,
10. Monitoring and or management of consumer's medication adherence
11. Planned clinical activities to enhance the consumer's understanding of his or her substance use and/or mental disorders
12. Daily scheduled professional services
13. Planned community reinforcement designed to foster prosocial values and milieu or community living skills.
14. Services for consumer's family and significant others.

**Staffed by:**

Staffing minimums: Should include at least one full time psychologist, licensed clinical addictions counselor to provide appropriate clinical oversight with educational standards to best deliver services. A clinical supervisor who is the psychologist is to oversee all clinical practices. Nurse to oversee the medication milieu and individuals in this level of care medical needs. Part time staff/contracted a medical director (physician) with addiction certification/training to provide medical oversight. This would be to assist with severe mental health disorders, unstable mental health disorders and or medical conditions. Part-time staff: a nurse as defined by Indiana's Professional Licensing agency. Other addiction credentials to provide addiction services would be considered with a master's degree in a counseling.

**Other appropriate staff:**

1. Clinical staff who are knowledgeable about biological and psychosocial dimensions of substance use disorders and their treatment and are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation such as

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master level clinicians with and addictions certification deemed appropriate by the Division of Mental Health and Addiction.

2. Allied health professionals, such as peer recovery coaches, peer recovery coaches, peer recovery coaches, counselor aides and group living workers who are available on-site 24 hours a day or as required by licensing regulations
3. A team comprised of appropriately trained and credentialed medical, addiction and mental health professionals
4. Clinical staff knowledgeable about biological and psychosocial dimensions of substance use and mental health disorders and their treatment. They are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation. Staff have specialized training in behavior management techniques.
5. Biomedical enhanced services are delivered by appropriately credentialed medical staff.

**Necessary supports:**

1. Telephone or in –person consultation with physician, a physician assistance or nurse practitioner and emergency services, available 24 hours a day, seven days a week.
2. Direct affiliations or close coordination through referral to other services, such as IOP, vocational services, literacy training and adult education.
3. Arranged medical, psychiatric, psychological, laboratory, and toxicology services, as appropriate to the severity and urgency of the consumer’s condition.
4. Have infrastructure for withdrawal management up to 3.2 or access to. This is not including ability for emergency withdrawal services.

Level of care: 3.5 (Clinically Managed High-Intensity Residential)

**Definition** Individuals admitted to this level of care could have been seen in level 1, 2 or 3.1 in the past or clear documentation why this level of care is needed. This level of care is to provide at least 20 hours of addiction services. Supportive 24 hour therapeutic environment to initiate or continue a recovery process for individuals that are at risk of relapse or will continue to use in an imminently dangerous manner upon transfer to less restrictive environment. Programming is focused on stabilization of dangerous addiction signs and symptoms, initiation or restoration of a recovery process, and preparation for ongoing recovery in the broad continuum of care with the goals of treatment being to promote abstinence from substance use, reduce other addictive and antisocial behaviors and effect change in participant’s lifestyles, attitudes and values.

**Therapies and Addiction Services offered include:**

1. Planned clinical program activities to stabilize and maintain stabilization of consumer’s addiction symptoms.
2. “Skills development” – daily clinical services to improve the consumer’s ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance and punctuality.
3. Counseling and clinical monitoring to support successful involvement in regular, productive activity

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4. Random drug screening
5. A range of evidence-based cognitive, behavioral and other therapies, including addiction pharmacology
6. Motivational enhancement or engagement strategies
7. Counseling and clinical interventions to facilitate teaching the consumer the skills necessary for productive daily activities
8. Education to include but not limited to:
  - a) Co-occurring disorders
  - b) Cross addiction
  - c) Balancing life
    - i) Health
    - ii) Diet
    - iii) Physical
    - iv) Emotional
    - v) Health Care
  - d) Pharmacotherapy specific to needs
9. Speakers, such as someone who started in the current level of care but may have been in denial and progressed into addiction,
10. Monitoring of consumer's medication adherence
11. Planned clinical activities to enhance the consumer's understanding of his or her substance use and/or mental disorders
12. Daily scheduled professional services
13. Planned community reinforcement designed to foster prosocial values and milieu or community living skills.
14. Services for consumer's family and significant others.

**Staffed by:**

Staffing minimums: Should include at least one full time licensed clinical addictions counselor to provide appropriate clinical oversight with educational standards to best deliver services. A clinical supervisor who could be the LCAC to oversee all clinical practices. Part-time staff/contracted a medical director (physician) with addiction certification/training to provide medical oversight. This would be to assist with severe mental health disorders, unstable mental health disorders and or medical conditions. Part-time staff: a nurse as defined by Indiana's Professional Licensing agency. Other addiction credentials to provide addiction services would be considered with a master's degree in a counseling.

**Other appropriate staff:**

6. Clinical staff who are knowledgeable about biological and psychosocial dimensions of substance use disorders and their treatment and are able to identify the signs and

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symptoms of acute psychiatric conditions, including psychiatric decompensation such as master level clinicians with and addictions certification deemed appropriate by the Division of Mental Health and Addiction.

7. Allied health professionals, such as peer recovery coaches, peer recovery coaches, peer recovery coaches, counselor aides and group living workers who are available on-site 24 hours a day or as required by licensing regulations
8. A team comprised of appropriately trained and credentialed medical, addiction and mental health professionals
9. Clinical staff knowledgeable about biological and psychosocial dimensions of substance use and mental health disorders and their treatment. They are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation. Staff have specialized training in behavior management techniques.
10. Biomedical enhanced services are delivered by appropriately credentialed medical staff.

**Necessary supports:**

5. Telephone or in –person consultation with physician, a physician assistance or nurse practitioner and emergency services, available 24 hours a day, seven days a week.
6. Direct affiliations or close coordination through referral to other services, such as IOP, vocational services, literacy training and adult education.
7. Arranged medical, psychiatric, psychological, laboratory and toxicology services, as appropriate to the severity and urgency of the consumer’s condition.
8. Have infrastructure for withdrawal management up to 3.2 or access to. This is not including ability for emergency withdrawal services.

Level of care: 3.7 Medically Monitored Intensive Inpatient

**Definition:** Medically monitored is a step below medical management which this level would provide planned, structure and medical regimen for 24 hour care to provide addiction treatment. This would could be considered an appropriate step down from level 4 to provide less medical oversight as the person is progress through their treatment.

**Staffed by:**

Staffing minimums: Should include at least one full time licensed clinical addictions counselor to provide appropriate clinical oversight with educational standards to beast deliver services. A clinical supervisor who could be the LCAC to oversee all clinical practices. Part-time staff/contracted a medical director (physician) with addiction certification/training to provide medical oversight. This would be to assist with severe mental health disorders, unstable mental health disorders and or medical conditions. Part-time staff: a nurse as defined by Indiana’s Professional Licensing agency. Other addiction credentials to provide addiction services would be considered with a master’s degree in a counseling.

**Other appropriate staff:**

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1. Clinical staff who are knowledgeable about biological and psychosocial dimensions of substance use disorders and their treatment and are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation such as master level clinicians with and addictions certification deemed appropriate by the Division of Mental Health and Addiction.
2. Allied health professionals, such as peer recovery coaches, peer recovery coaches, peer recovery coaches, counselor aides and group living workers who are available on-site 24 hours a day or as required by licensing regulations
3. A team comprised of appropriately trained and credentialed medical, addiction and mental health professionals
4. Clinical staff knowledgeable about biological and psychosocial dimensions of substance use and mental health disorders and their treatment. They are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation. Staff have specialized training in behavior management techniques.
5. Biomedical enhanced services are delivered by appropriately credentialed medical staff.

**Therapies and Addiction Services offered include:**

1. Planned clinical program activities to stabilize and maintain stabilization of consumer's addiction symptoms.
2. "Skills development" – daily clinical services to improve the consumer's ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance and punctuality.
3. Counseling and clinical monitoring to support successful involvement in regular, productive activity
4. Random drug screening
5. A range of evidence-based cognitive, behavioral and other therapies, including addiction pharmacology
6. Motivational enhancement or engagement strategies
7. Counseling and clinical interventions to facilitate teaching the consumer the skills necessary for productive daily activities
8. Education to include but not limited to:
  - a) Co-occurring disorders
  - b) Cross addiction
  - c) Balancing life
    - i) Health
    - ii) Diet
    - iii) Physical
    - iv) Emotional
    - v) Health Care
  - d) Pharmacotherapy specific to needs



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9. Speakers, such as someone who started in the current level of care but may have been in denial and progressed into addiction,
10. Monitoring of consumer's medication adherence
11. Planned clinical activities to enhance the consumer's understanding of his or her substance use and/or mental disorders
12. Daily scheduled professional services
13. Planned community reinforcement designed to foster prosocial values and milieu or community living skills.
14. Services for consumer's family and significant others.

**Necessary supports:**

1. Telephone or in-person consultation with physician, a physician assistance or nurse practitioner and emergency services, available 24 hours a day, 7 days a week.
2. Direct affiliations or close coordination through referral to other services, such as IOP, vocational services, literacy training and adult education.
3. Arranged medical, psychiatric, psychological, laboratory, and toxicology services, as appropriate to the severity and urgency of the consumer's condition.
4. Have infrastructure for withdrawal management up to 3.2 or access to. This is not including ability for emergency withdrawal services.

**Level of care: 4.0 (Medically Managed Intensive Inpatient)**

**Definition:** Medically managed is an acute hospital setting to treat severe complications within the substance use disorder spectrum. This would be for individuals with acute biomedical, emotional, behavioral and cognitive problems that the severity require primary medical and nursing care. This would include a regimen of medically directed care, evaluation and treatment services.

**Staffing minimums:**

1. Should include at least one full time: medical director, psychologist and licensed clinical addictions counselor to provide appropriate clinical oversight with educational standards to best deliver services. A clinical supervisor should have a LCAC or psychologist to oversee all clinical practices, medical director (physician, preferably addictions psychiatrist) with addiction certification/training to provide medical oversight. This would be to assist with severe mental health disorders, unstable mental health disorders and or medical conditions. A nurse to provide medical practices and 24 hour medical oversight. These roles are as defined by Indiana's Professional Licensing agency.
  - a. Other addiction credentials approved by DMHA to provide addiction counseling would be considered with a master's degree in a counseling type specialty

**Other appropriate staff:**

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1. Allied health professionals, such as peer recovery coaches, peer recovery coaches, peer recovery coaches, counselor aides and group living workers who are available on-site 24 hours a day or as required by licensing regulations.
2. Clinical staff who are knowledgeable about biological and psychosocial dimensions of substance use disorders and their treatment and are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation such as master level clinicians with and addictions certification deemed appropriate by the Division of Mental Health and Addiction.
3. A team comprised of appropriately trained and credentialed medical, addiction and mental health professionals
4. Allied health professionals, such as peer recovery coaches, peer recovery coaches, peer recovery coaches, counselor aides and group living workers. One or more clinicians with competence in the treatment of substance use disorders are available on-site or by telephone 24 hours a day.
5. Biomedical enhanced services are delivered by appropriately credentialed medical staff.

## Adolescence Levels of Care

Adolescent addiction services needs a different approach than adults. The staff need specific training on human development, disorder manifestation amongst an undeveloped brain, best practice treatment and appropriate clinical approaches. All those working with adolescent need to have continued education to adolescence and the populations they are working with.

When treating the adolescent population, it may be better to treat at a less intensive addiction services on an individual bases. If group is deemed appropriate, understanding the need for appropriate group counseling culture and that there will be a different, more delicate approach to setting up and running a group. Insuring the group is at or close to the same motivation or stage of change which would need to be a higher level such as action and above.

### **ASAM Level 0.5: Early Intervention – Adolescent**

**Definition:** These services are not differentiated by the number of hours received during a week. The amount and type of services provided are based on individual needs including consideration of both the consumer’s motivation to change and other risk factors that may be present. This level of care is typically mandated through an impaired driving program or underage drinking that requires completion before reinstating driving privileges or reconciliation of infraction. Prior to admission, a diagnostic assessment should be performed in conjunction with a comprehensive multidimensional assessment to determine whether the person meets the admission criteria for Level 0.5, which requires that the person does not meet the requirements for a substance use disorder. If new information, through the reassessment process indicates substance use disorder, and the person needs treatment, there are two options:

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1. Transfer individual to a clinically appropriate level of care
2. Facilitate treatment at required 0.5 Level of care.

Length of service at this level depends on an individual's ability to comprehend the information they are provided and use the information to make behavior changes, if the person acquires new problems and needs additional treatment, or regulatory mandated service.

**Staff**

Staffing minimums: At least one full time clinical licensed addictions counselor to provide appropriate clinical oversight with educational standards to best deliver services. This will ensure the assessment and education of the individual will be suffice to provide level 0.5 service, coupled with the knowledge of how to assess and refer to a higher level of care. This could be one of the most important assessments in a person's life which could prevent or slow the escalation the disease of addiction. It would be best practice to have access to a child psychologist and or child psychiatrist.

**Approaches:**

1. Education on the disease of addiction which could include:
  - a) progression, increased risk of a use disorder due to biological, sociological and psychological factors,
  - b) warning sings a use disorder may be starting,
  - c) co-occurring disorders
2. Speakers, such as someone who started in the current stage of life but may have been in denial and progressed into addiction,
3. Additional services such as: screening, brief intervention and referral to treatment can be used

**Other appropriate staff:**

1. Peer Recovery staff with DMHA approved certification
2. Other addiction credentials to provide services would be considered DMHA approved certification. Proof of education and working knowledge of: Addiction education, biopsychosocial multidimensional assessment, mental health screening and identification, consultation, and referral.

**Necessary supports:**

1. Direct affiliations or close coordination through referral to other services, such as IOP, vocational services, literacy training and adult education.
2. Social supports to assist in a healthy lifestyle

**ASAM Level 1.0: Outpatient – Adolescent**

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**Definition:** This level of care provides less than six hours per week of ongoing therapeutic environment for the treatment of substance-related disorders with treatment specifically focused on applying recovery skills, relapse prevention, improvement of emotional functioning, promoting personal responsibility and reintegration of the individual into school, education and family life.

Adolescent outpatient is designed for the adolescent requiring low level but long term treatment to sustain and further therapeutic gains made at a more intensive level of care because of the consumer's functional deficits such as developmental immaturity, greater than average susceptibility to peer influence, or lack of impulse control.

**Therapies and Addiction Services offered include:**

1. “Skills development” – services designed to improve the consumer’s ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance and punctuality.
2. Addiction pharmacotherapy
3. Random drug screening
4. Motivational enhancement or engagement strategies
5. Counseling and clinical monitoring to support successful involvement in regular, productive activity
6. Health education
7. Regular monitoring of consumer’s medication adherence
8. Recovery support services
9. Services for consumer’s family and significant others, as appropriate
10. Opportunities for consumer to be introduced to the potential benefits of addiction pharmacotherapies as a tool to manage his or her addiction.

**Staffed by**

Staffing minimums: Should include at least one full time licensed clinical addictions counselor to provide appropriate clinical oversight with educational standards to best deliver services. A clinical supervisor who could be the LCAC to oversee all clinical practices. Medical director (physician) with addiction certification/training and adolescent training to provide medical oversight. This would be to assist with severe mental health disorders, unstable mental health disorders and or medical conditions. Part-time staff: a nurse as defined by Indiana’s Professional Licensing agency.

**Other appropriate staff**

1. Allied health professionals, such as peer recovery coaches, peer recovery coaches, peer recovery coaches, counselor aides and group living workers who are available on-site 24 hours a day or as required by licensing regulations.
2. Staff must be knowledgeable about adolescent development with experience in engaging and working with adolescents.

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3. Clinical staff who are knowledgeable about biological and psychosocial dimensions of substance use disorders in adolescents and their treatment and are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation, in adolescents.
4. A team comprised of appropriately trained and credentialed medical, addiction and mental health professionals.
5. An addiction physician should review admission decisions to confirm clinical necessity of services.

**Necessary Supports**

1. Telephone or in-person consultation with physician and emergency services, available 24 hours a day, 7 days a week.
2. Direct affiliations or close coordination through referral to other services, such as IOP, vocational services, literacy training and continued education.
3. Ability to schedule needed procedures (labs and toxicology tests) as appropriate
4. Ability to arrange for pharmacotherapy for psychiatric and anti-addiction medication.

**ASAM Level 2.1: Intensive Outpatient – Adolescent**

Individuals admitted to this level of care should have been seen in level 1 or 2 in the past or clear documentation why this level of care is needed.

**Definition:** Provides ongoing therapeutic environment for the treatment of substance-related disorders with treatment specifically focused on applying recovery skills, relapse prevention, improvement of emotional functioning, promoting personal responsibility and reintegration of the individual into work, education and family life. Programs must offer a minimum of five hours per week of low-intensity services onsite or by contractual arrangement. Clinically managed low-intensity residential services is designed for the adolescent requiring extended treatment to sustain and further therapeutic gains made at a more intensive level of care because of the consumer's functional deficits such as developmental immaturity, greater than average susceptibility to peer influence, or lack of impulse control. This level is also sometimes warranted as a substitute for or supplement to the deficits in the adolescent's recovery environment such as chaotic home situation, drug-using caretakers or siblings, or a lack of daily structured activities such as school. The residential component of clinically managed low-intensity residential services may be combined with low-intensity outpatient, intensive outpatient, or day treatment.

**Therapies and Addiction Services offered include:**

1. Offers at least five hours of professionally directed treatment of substance-related disorders
2. “Skills development” – services designed to improve the consumer’s ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance and punctuality.

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3. Addiction pharmacotherapy
4. Random drug screening
5. Motivational enhancement or engagement strategies
6. Counseling and clinical monitoring to support successful involvement in regular, productive activity
7. Health education
8. Regular monitoring of consumer's medication adherence
9. Recovery support services
10. Services for consumer's family and significant others, as appropriate
11. Opportunities for consumer to be introduced to the potential benefits of addiction pharmacotherapies as a tool to manage his or her addiction.

**Staffed by**

Staffing minimums: Should include at least one full time licensed clinical addictions counselor to provide appropriate clinical oversight with educational standards to best deliver services. A clinical supervisor who could be the LCAC to oversee all clinical practices. Medical director (physician) with addiction certification/training and adolescent training to provide medical oversight. This would be to assist with severe mental health disorders, unstable mental health disorders and or medical conditions. Part-time staff: a nurse as defined by Indiana's Professional Licensing agency.

**Other appropriate staff**

1. Allied health professionals, such as peer recovery coaches, peer recovery coaches, peer recovery coaches, counselor aides and group living workers who are available on-site 24 hours a day or as required by licensing regulations.
2. Staff must be knowledgeable about adolescent development with experience in engaging and working with adolescents.
3. Clinical staff who are knowledgeable about biological and psychosocial dimensions of substance use disorders in adolescents and their treatment and are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation, in adolescents.
4. A team comprised of appropriately trained and credentialed medical, addiction and mental health professionals.
5. An addiction physician should review admission decisions to confirm clinical necessity of services.

**Necessary Supports**

1. Telephone or in –person consultation with physician and emergency services, available 24 hours a day, 7 days a week.
2. Direct affiliations or close coordination through referral to other services, such as IOP, vocational services, literacy training and continued education.

3. Ability to schedule needed procedures (labs and toxicology tests) as appropriate
4. Ability to arrange for pharmacotherapy for psychiatric and anti-addiction medication.

**ASAM Level 2.5: Partial Hospitalization – Adolescent**

Individuals admitted to this level of care should have been seen in level 1 or 2 in the past or clear documentation why this level of care is needed.

**Definition:** Provides ongoing therapeutic environment for the treatment of substance-related disorders with treatment specifically focused on applying recovery skills, relapse prevention, improvement of emotional functioning, promoting personal responsibility and reintegration of the individual into work, education and family life. Programs must offer a minimum of five hours per week of low-intensity services onsite or by contractual arrangement. Clinically managed low-intensity residential services is designed for the adolescent requiring extended treatment to sustain and further therapeutic gains made at a more intensive level of care because of the consumer's functional deficits such as developmental immaturity, greater than average susceptibility to peer influence, or lack of impulse control. This level is also sometimes warranted as a substitute for or supplement to the deficits in the adolescent's recovery environment such as chaotic home situation, drug-using caretakers or siblings, or a lack of daily structured activities such as school. The residential component of clinically managed low-intensity residential services may be combined with low-intensity outpatient, intensive outpatient, or day treatment.

**Therapies and Addiction Services offered include:**

1. Required to include education or ensure consumer continues to progress in their scholastic path.
2. “Skills development” – daily clinical services to improve the consumer’s ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance and punctuality.
3. Counseling and clinical monitoring to support successful involvement in regular, productive activity
4. Random drug screening
5. Adolescent specific evidence based curriculum
6. A range of evidence-based cognitive, behavioral and other therapies, including addiction pharmacology
7. Motivational enhancement or engagement strategies
8. Counseling and clinical interventions to facilitate teaching the consumer the skills necessary for productive daily activities
9. Education to include but not limited to:
  - a) Co-occurring disorders
  - b) Cross addiction
  - c) Balancing life

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- i) Health
  - ii) Diet
  - iii) Physical
  - iv) Emotional
  - v) Health Care
- d) Pharmacotherapy specific to needs
10. Speakers, such as someone who started in the current level of care but may have been in denial and progressed into addiction,
  11. Monitoring of consumer's medication adherence
  12. Planned clinical activities to enhance the consumer's understanding of his or her substance use and/or mental disorders
  13. Daily scheduled professional services
  14. Planned community reinforcement designed to foster prosocial values and milieu or community living skills.
  15. Services for consumer's family and significant others.

**Staffed by**

Staffing minimums: Should include at least one full time licensed clinical addictions counselor to provide appropriate clinical oversight with educational standards to best deliver services. A clinical supervisor who could be the LCAC to oversee all clinical practices. Medical director (physician) with addiction certification/training and adolescent training to provide medical oversight. This would be to assist with severe mental health disorders, unstable mental health disorders and or medical conditions. Part-time staff: a nurse as defined by Indiana's Professional Licensing agency.

**Other appropriate staff**

1. Allied health professionals, such as peer recovery coaches, peer recovery coaches, peer recovery coaches, counselor aides and group living workers who are available on-site 24 hours a day or as required by licensing regulations.
2. Staff must be knowledgeable about adolescent development with experience in engaging and working with adolescents.
3. Clinical staff who are knowledgeable about biological and psychosocial dimensions of substance use disorders in adolescents and their treatment and are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation, in adolescents.
4. A team comprised of appropriately trained and credentialed medical, addiction and mental health professionals.
5. An addiction physician should review admission decisions to confirm clinical necessity of services.

**Necessary Supports**



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1. Telephone or in-person consultation with physician and emergency services, available 24 hours a day, 7 days a week.
2. Direct affiliations or close coordination through referral to other services, such as IOP, vocational services, literacy training and continued education.
3. Ability to schedule needed procedures (labs and toxicology tests) as appropriate
4. Ability to arrange for pharmacotherapy for psychiatric and anti-addiction medication.

**ASAM Level 3.1: Clinical Managed Low-Intensity Residential Services – Adolescent**

**Definition:** Programs must offer a minimum of five hours per week of low-intensity services onsite. Individuals admitted to this level of care should have been seen in level 1 or 2 in the past or clear documentation why this level of care is needed. Provides ongoing therapeutic environment for the treatment of substance-related disorders with treatment specifically focused on applying recovery skills, relapse prevention, improvement of emotional functioning, promoting personal responsibility and reintegration of the individual into work, education and family life. Clinically managed low-intensity residential services is designed for the adolescent requiring extended treatment to sustain and further therapeutic gains made at a more intensive level of care because of the consumer's functional deficits such as developmental immaturity, greater than average susceptibility to peer influence, or lack of impulse control. This level is also sometimes warranted as a substitute for or supplement to the deficits in the adolescent's recovery environment such as chaotic home situation, drug-using caretakers or siblings, or a lack of daily structured activities such as school. The residential component of clinically managed low-intensity residential services may be combined with low-intensity outpatient, intensive outpatient, or day treatment.

**Therapies and Addiction Services offered include:**

1. Required to provide education or supervised transportation to obtain needed education. Best practice would be for a recovery school or provide education in services. This is to ensure consumer continues to progress in their scholastic path. At no time should the consumer be supervised in a public school setting to which counter therapeutic environments would arise. Such as making it known to a public school by supervision or punitive observation.
2. “Skills development” – daily clinical services to improve the consumer’s ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance, and punctuality.
3. Counseling and clinical monitoring to support successful involvement in regular, productive activity
4. Random drug screening
5. Adolescent specific evidence based curriculum
6. A range of evidence-based cognitive, behavioral and other therapies, including addiction pharmacology
7. Motivational enhancement or engagement strategies

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8. Counseling and clinical interventions to facilitate teaching the consumer the skills necessary for productive daily activities
9. Education to include but not limited to:
  - a) Co-occurring disorders
  - b) Cross addiction
  - c) Balancing life
    - i) Health
    - ii) Diet
    - iii) Physical
    - iv) Emotional
    - v) Health Care
  - d) Pharmacotherapy specific to needs
10. Speakers, such as someone who started in the current level of care but may have been in denial and progressed into addiction,
11. Monitoring of consumer's medication adherence
12. Planned clinical activities to enhance the consumer's understanding of his or her substance use and/or mental disorders
13. Daily scheduled professional services
14. Planned community reinforcement designed to foster prosocial values and milieu or community living skills.
15. Services for consumer's family and significant others.

**Staffed by:**

Staffing minimums: Should include at least one full time licensed clinical addictions counselor to provide appropriate clinical oversight with educational standards to best deliver services. A clinical supervisor who could be the LCAC to oversee all clinical practices. Medical director (physician) with addiction certification/training and adolescent training to provide medical oversight. This would be to assist with severe mental health disorders, unstable mental health disorders and or medical conditions. Part-time staff: a nurse as defined by Indiana's Professional Licensing agency.

**Other appropriate staff:**

1. Allied health professionals, such as peer recovery coaches, peer recovery coaches, peer recovery coaches, counselor aides and group living workers who are available on-site 24 hours a day or as required by licensing regulations.
2. Staff must be knowledgeable about adolescent development with experience in engaging and working with adolescents.
3. Clinical staff who are knowledgeable about biological and psychosocial dimensions of substance use disorders in adolescents and their treatment and are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation, in adolescents.

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4. A team comprised of appropriately trained and credentialed medical, addiction and mental health professionals.
5. An addiction physician should review admission decisions to confirm clinical necessity of services.

**Necessary Supports**

1. Telephone or in-person consultation with physician and emergency services, available 24 hours a day, 7 days a week.
2. Direct affiliations or close coordination through referral to other services, such as IOP, vocational services, literacy training and continued education.
3. Ability to schedule needed procedures (labs and toxicology tests) as appropriate
4. Ability to arrange for pharmacotherapy for psychiatric and anti-addiction medication.

**ASAM Level 3.5: Clinical Managed Medium-Intensity Residential Services – Adolescent**

**Definition** Individuals admitted to this level of care should have been seen in level 1 or 2 in the past or clear documentation why this level of care is needed. This level of care would include at least 20 hours per week of addiction services. Supportive 24-hour therapeutic environment to initiate or continue a recovery process for individuals that are at risk of relapse or will continue to use in an imminently dangerous manner upon transfer to less restrictive environment.

Environment must be safe and supportive to allow for teaching and practicing of prosocial behaviors and to facilitate healthy reintegration into the community. Programming is focused on stabilization of dangerous addiction signs and symptoms, initiation or restoration of a recovery process, and preparation for ongoing recovery in the broad continuum of care with the goals of treatment including overcoming oppositionality through a combination of confrontation, motivational enhancement, and supportive limit settings; anger management and acquisition of conflict resolution skills; values clarification and moral habilitation; character modeling and education; development of effective behavioral contingency strategies, establishment of a reliable response to external structure and the internalization of structure through self-regulation skills.

**Therapies and Addiction Services offered include:**

1. Required to provide education or supervised transportation to obtain needed education. Best practice would be for a recovery school or provide education in services. This is to ensure consumer continues to progress in their scholastic path. At no time should the consumer be supervised in a public school setting to which counter therapeutic environments would arise. Such as making it known to a public school by supervision or punitive observation.
2. “Skills development” – daily clinical services to improve the consumer’s ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance, and punctuality.

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3. Counseling and clinical monitoring to support successful involvement in regular, productive activity
4. Random drug screening
5. Adolescent specific evidence based curriculum
6. A range of evidence-based cognitive, behavioral and other therapies, including addiction pharmacology
7. Motivational enhancement or engagement strategies
8. Counseling and clinical interventions to facilitate teaching the consumer the skills necessary for productive daily activities
9. Education to include but not limited to:
  - a) Co-occurring disorders
  - b) Cross addiction
  - c) Balancing life
    - i) Health
    - ii) Diet
    - iii) Physical
    - iv) Emotional
    - v) Health Care
  - d) Pharmacotherapy specific to needs
10. Speakers, such as someone who started in the current level of care but may have been in denial and progressed into addiction,
11. Monitoring of consumer's medication adherence
12. Planned clinical activities to enhance the consumer's understanding of his or her substance use and/or mental disorders
13. Daily scheduled professional services
14. Planned community reinforcement designed to foster prosocial values and milieu or community living skills.
15. Services for consumer's family and significant others.

**Staffed by:**

Staffing minimums: Should include at least one full time licensed clinical addictions counselor to provide appropriate clinical oversight with educational standards to best deliver services. A clinical supervisor who could be the LCAC to oversee all clinical practices. Medical director (physician) with addiction certification/training and adolescent training to provide medical oversight. This would be to assist with severe mental health disorders, unstable mental health disorders and or medical conditions. Part-time staff: a nurse as defined by Indiana's Professional Licensing agency.

**Other appropriate staff:**

1. IPLA Licensed counselors and other addiction credentials approved by DMHA to

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provide addiction counseling would be considered with a master's degree in a counseling type specialty.

2. Allied health professionals, such as peer recovery coaches, peer recovery coaches, peer recovery coaches, counselor aides and group living workers who are available on-site 24 hours a day or as required by licensing regulations.
  3. Staff must be knowledgeable about adolescent development with experience in engaging and working with adolescents.
  4. Clinical staff who are knowledgeable about biological and psychosocial dimensions of substance use disorders in adolescents and their treatment and are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation, in adolescents.
  5. A team comprised of appropriately trained and credentialed medical, addiction and mental health professionals.
  6. An addiction physician should review admission decisions to confirm clinical necessity of services.
  7. Licensed or credentialed clinical staff such as addiction counselors, social workers, and licensed professional counselors with knowledge of adolescent development and experience with engaging and working with adolescents.
  8. Allied health professionals, such as peer recovery coaches, peer recovery coaches, peer recovery coaches, counselor aides and group living workers. One or more clinicians with competence in the treatment of adolescent substance use disorders are available on-site or by telephone 24 hours a day.
  9. Clinical staff knowledgeable about biological and psychosocial dimensions of adolescent substance use and mental health disorders and their treatment. They are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation. Staff have specialized training in adolescent behavior management techniques.
  10. Biomedical enhanced services are delivered by appropriately credentialed medical staff.
- Adolescent 3.5 Withdrawal Management programs must include the following supports:
1. Clinicians who are able to obtain and interpret information regarding the signs and symptoms of intoxication and withdrawal, as well as the appropriate monitoring and treatment of those conditions and how to facilitate entry into ongoing care.
  2. Appropriately trained staff who are competent to implement physician approved protocols for consumer observation, supervision, treatment, determination of the appropriate level of care, and facilitation of the consumer's transition to continuing care.
  3. Access to medical evaluation and consultation 24 hours a day to monitor the safety and outcome of withdrawal management in this setting in accordance with treatment/transfer practice guidelines.

### **Necessary Supports**

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1. Availability of emergency consultation with a physician by telephone or in person and access to emergency services
2. Arranged appropriate medical procedures, including indicated laboratory and toxicology testing.
3. Arranged appropriate medical and psychiatric treatment through consultation, referral to a contracted entity, or transfer to another level of care.
4. Direct affiliation with other levels of care (we could require MOU with another LOC).
5. Have infrastructure for withdrawal management up to 3.1 or access to. This is not including ability for emergency withdrawal services.
6. Adolescent 3.5 Withdrawal Management programs must include the following supports:
  - a) Availability of specialized clinical consultation and supervision for biomedical and emotional/behavioral problems related to intoxication and withdrawal management.
  - b) Protocols used to determine the nature of the medical monitoring and other interventions required are developed and supported by a physician knowledgeable in addiction medicine.

**ASAM Level 3.7: Medical Monitored Inpatient Services – Adolescent**

**Definition:** Individuals admitted to this level of care should have been seen in level 1 or 2 in the past or clear documentation why this level of care is needed. This level of care needs to have at least 10 hours per week of individual psychotherapy provided by a master level licensed therapist. Provides ongoing therapeutic environment for the treatment of substance-related disorders with treatment specifically focused on applying recovery skills, relapse prevention, improvement of emotional functioning, promoting personal responsibility and reintegration of the individual into work, education and family life. Programs must offer a minimum of five hours per week of low-intensity services onsite or by contractual arrangement. Clinically managed low-intensity residential services is designed for the adolescent requiring extended treatment to sustain and further therapeutic gains made at a more intensive level of care because of the consumer's functional deficits such as developmental immaturity, greater than average susceptibility to peer influence, or lack of impulse control. This level is also sometimes warranted as a substitute for or supplement to the deficits in the adolescent's recovery environment such as chaotic home situation, drug-using caretakers or siblings, or a lack of daily structured activities such as school. The residential component of clinically managed low-intensity residential services may be combined with low-intensity outpatient, intensive outpatient, or day treatment.

**Therapies and Addiction Services offered include:**

1. Required to provide education or supervised transportation to obtain needed education acceptable to Indiana's Department of Education standards. Best practice would be for a recovery school or provide education in services. This is to ensure consumer continues to

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progress in their scholastic path. At no time should the consumer be supervised in a public school setting to which counter therapeutic environments would arise. Such as making it known to a public school by supervision or punitive observation.

2. “Skills development” – daily clinical services to improve the consumer’s ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance, and punctuality.
3. Counseling and clinical monitoring to support successful involvement in regular, productive activity
4. Random drug screening
5. Adolescent specific evidence based curriculum
6. A range of evidence-based cognitive, behavioral and other therapies, including addiction pharmacology
7. Motivational enhancement or engagement strategies
8. Counseling and clinical interventions to facilitate teaching the consumer the skills necessary for productive daily activities
9. Education to include but not limited to:
  - a) Co-occurring disorders
  - b) Cross addiction
  - c) Balancing life
    - i) Health
    - ii) Diet
    - iii) Physical
    - iv) Emotional
    - v) Health Care
  - d) Pharmacotherapy specific to needs
10. Speakers, such as someone who started in the current level of care but may have been in denial and progressed into addiction,
11. Monitoring of consumer’s medication adherence
12. Planned clinical activities to enhance the consumer’s understanding of his or her substance use and/or mental disorders
13. Daily scheduled professional services
14. Planned community reinforcement designed to foster prosocial values and milieu or community living skills.
15. Services for consumer’s family and significant others.

**Staffed by**

Staffing minimums: Should include at least one full time licensed clinical addictions counselor to provide appropriate clinical oversight with educational standards to best deliver services. A clinical supervisor who could be the LCAC to oversee all clinical practices. Medical director (physician) with addiction certification/training and adolescent training to provide medical

oversight. This would be to assist with severe mental health disorders, unstable mental health disorders and or medical conditions. Part time staff: a nurse as defined by Indiana’s Professional Licensing agency.

### **Other appropriate staff**

1. IPLA Licensed Counselors and other addiction credentials approved by DMHA to provide addiction counseling would be considered with a master’s degree in a counseling type specialty.
2. Allied health professionals, such as peer recovery coaches, peer recovery coaches, peer recovery coaches, counselor aides and group living workers who are available on-site 24 hours a day or as required by licensing regulations.
3. Staff must be knowledgeable about adolescent development with experience in engaging and working with adolescents.
4. Clinical staff who are knowledgeable about biological and psychosocial dimensions of substance use disorders in adolescents and their treatment and are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation, in adolescents.
5. A team comprised of appropriately trained and credentialed medical, addiction and mental health professionals.
6. An addiction physician should review admission decisions to confirm clinical necessity of services.

### **Necessary Supports**

1. Telephone or in –person consultation with physician and emergency services, available 24 hours a day, 7 days a week.
2. Direct affiliations or close coordination through referral to other services, such as IOP, vocational services, literacy training and continued education.
3. Ability to schedule needed procedures (labs ad toxicology tests) as appropriate
4. Ability to arrange for pharmacotherapy for psychiatric and anti-addiction medication.

### **ASAM Level 4.0: Medically Managed Services – Adolescent**

**Definition:** Individuals admitted to this level of care should have been seen in level 1 or 2 in the past or clear documentation why this level of care is needed. This level of care needs to have at least 10 hours per week of individual psychotherapy provided by a master level licensed therapist. Provides ongoing therapeutic environment for the treatment of substance-related disorders with treatment specifically focused on applying recovery skills, relapse prevention, improvement of emotional functioning, promoting personal responsibility and reintegration of the individual into work, education and family life. Programs must offer a minimum of five hours per week of low-intensity services onsite or by contractual arrangement. Clinically managed low-intensity residential services is designed for the adolescent requiring extended



treatment to sustain and further therapeutic gains made at a more intensive level of care because of the consumer's functional deficits such as developmental immaturity, greater than average susceptibility to peer influence, or lack of impulse control. This level is also sometimes warranted as a substitute for or supplement to the deficits in the adolescent's recovery environment such as chaotic home situation, drug-using caretakers or siblings, or a lack of daily structured activities such as school. The residential component of clinically managed low-intensity residential services may be combined with low-intensity outpatient, intensive outpatient, or day treatment.

**Therapies and Addiction Services offered include:**

1. Required to provide education or supervised transportation to obtain needed education acceptable to Indiana's Department of Education standards. Best practice would be for a recovery school or provide education in services. This is to ensure consumer continues to progress in their scholastic path. At no time should the consumer be supervised in a public school setting to which counter therapeutic environments would arise. Such as making it known to a public school by supervision or punitive observation.
  - a) Education will need to be medically and clinically considered depending up on the consumer's ability to participate due to intensity of this level of care.
2. "Skills development" – daily clinical services to improve the consumer's ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance, and punctuality.
3. Counseling and clinical monitoring to support successful involvement in regular, productive activity
4. Random drug screening
5. Adolescent specific evidence based curriculum
6. A range of evidence-based cognitive, behavioral and other therapies, including addiction pharmacology
7. Motivational enhancement or engagement strategies
8. Counseling and clinical interventions to facilitate teaching the consumer the skills necessary for productive daily activities
9. Education to include but not limited to:
  - a) Co-occurring disorders
  - b) Cross addiction
  - c) Balancing life
    - i) Health
    - ii) Diet
    - iii) Physical
    - iv) Emotional
    - v) Health Care
  - d) Pharmacotherapy specific to needs

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10. Speakers, such as someone who started in the current level of care but may have been in denial and progressed into addiction,
11. Monitoring of consumer's medication adherence
12. Planned clinical activities to enhance the consumer's understanding of his or her substance use and/or mental disorders
13. Daily scheduled professional services
14. Planned community reinforcement designed to foster prosocial values and milieu or community living skills.
15. Services for consumer's family and significant others.

**Staffed by**

Staffing minimums: Should include at least one full time medical director with adolescent and addiction specialties, psychologist, licensed clinical addictions, clinical supervisor who could be the psychologist to oversee all clinical practices. Medical director (physician) with addiction certification/training and adolescent training to provide medical oversight. This would be to assist with severe mental health disorders, unstable mental health disorders and or medical conditions. Part-time staff: a nurse as defined by Indiana's Professional Licensing agency.

**Other appropriate staff**

1. IPLA Licensed Counselors and other addiction credentials approved by DMHA to provide addiction counseling would be considered with a master's degree in a counseling type specialty.
2. Allied health professionals, such as peer recovery coaches, peer recovery coaches, peer recovery coaches, counselor aides and group living workers who are available on-site 24 hours-a-day or as required by licensing regulations.
3. Staff must be knowledgeable about adolescent development with experience in engaging and working with adolescents.
4. Clinical staff who are knowledgeable about biological and psychosocial dimensions of substance use disorders in adolescents and their treatment and are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation, in adolescents.
5. A team comprised of appropriately trained and credentialed medical, addiction and mental health professionals.
6. An addiction physician should review admission decisions to confirm clinical necessity of services.

**Necessary Supports**

1. Telephone or in-person consultation with physician and emergency services, available 24 hours a day, 7 days a week.
2. Direct affiliations or close coordination through referral to other services, such as IOP, vocational services, literacy training and continued education.
3. Ability to schedule needed procedures (labs ad toxicology tests) as appropriate

4. Ability to arrange for pharmacotherapy for psychiatric and anti-addiction medication.

## Withdrawal Management Services

Withdrawal management that is medically monitored and managed but that does not require admission to an inpatient, medically or clinically monitored, or managed 24-hour treatment setting. All programs are expected to be able to perform the level withdrawal management directly below the level of addiction treatment provided. A provider needs the ability to treat use upon a population which use is common and part of the disorder. There must be protocols in place to admit and person under the influence for acuity level of 2.5 and higher.

Working relationships and plans with hospitals or withdrawal management programs for those with more advanced stages of a substance use disorder who have complications with withdrawal or continuous use. There needs to be direct assistance, to a higher level of care if needed due to the program not having the medical oversight to appropriately treat the level of withdrawal.

**Medically Monitored Treatment-**Services that are provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialist, and other health care professionals and technical personnel, under the direction of a licensed physician. Medical monitoring is provided through an appropriate mix of direct consumer contact, review of records, team meetings, 24-hour coverage by a physician, and quality assurance programs.

**Medically Managed Treatment-**Services that involve daily medical care, where diagnostic and treatment services are directly provided and/or managed by an appropriately trained and licensed physician. Such services are provided in an acute care hospital or psychiatric hospital or treatment unit.

**Ambulatory Withdrawal Management-** Withdrawal management that is medically and possibly clinically monitored and medically and possibly managed but that does not require admission to an inpatient or a 24-hour treatment setting.

### **Documentation Standards (in addition to non-withdrawal management):**

1. Documentation includes progress notes in the consumer record that clearly reflect implementation of the treatment plan and the consumer's response to treatment as well as subsequent amendments to the plan.
2. Withdrawal rating scale tables and flow sheets (which include tabulation of vital signs) are used as needed.

**Level 1-WM: Ambulatory Withdrawal Management Without Extended On-Site Monitoring**

**Is an organized outpatient service which may be delivered in:**

1. An office setting,
2. A health care or addiction treatment facility, OR
3. In a consumer's home

**By trained clinicians who provide:**

1. Medically supervised evaluation,
2. Withdrawal management, AND
3. Referral services according to a predetermined schedule.

**Level 1-WM Services are provided:**

1. In regularly scheduled sessions AND
2. Under a defined set of policies and procedures or medical protocols.

**Level 1-WM Support Systems feature the following:**

1. Availability of specialized psychological and psychiatric consultation and supervision for biomedical, emotional, behavioral, and cognitive problems as indicated.
2. Ability to obtain a comprehensive medical history and physical examination of the consumer at admission.
3. Affiliation with other levels of care, including other levels of specialty addiction treatment, for additional problems identified through a comprehensive biopsychosocial assessment.
4. Ability to conduct and/or arrange for appropriate laboratory and toxicology tests, which can be point-of-care testing.
5. 24-hour access to emergency medical consultation services, should such services become indicated.
6. Ability to provide or assist in accessing transportation services for consumers who lack safe transportation.

**Staff:**

1. Physicians and nurses with training and experience in assessing and managing intoxication and withdrawal states. (They do not have to be certified as addiction specialist physicians or nurses).
2. Physicians and nurses do not have to be present at all times, however they must be readily available to evaluate and confirm that withdrawal management in this less supervised setting is relatively safe.
3. Counselors, psychologists, and social workers may provide additional services through the withdrawal management service or accessed thru affiliation with other entities providing Level 1 services.
4. All clinicians who assess and treat consumers are able to obtain and interpret information regarding the needs of these persons and are knowledgeable about the biopsychosocial

dimensions of alcohol, tobacco, and other substance use disorders. (Including signs and symptoms of alcohol and other drug intoxication and withdrawal, appropriate treatment and monitoring of those conditions and how to facilitate the individual's entry into ongoing care).

**Level 1-WM Therapies provided:**

1. Individual assessment,
2. Medication or non-medication methods of withdrawal management,
3. Consumer education,
4. Non-pharmacological clinical support,
5. Involvement of family members or significant others in the withdrawal management process,
6. Discharge or transfer planning (includes referral for counseling and involvement in community recovery support groups), AND
7. Physician and/or nurse monitoring, assessment and management of signs and symptoms of intoxication and withdrawal.

**Additional services that may be provided in conjunction with Level 1-WM care by the agency or by an outside entity:**

1. 1 Outpatient Treatment-Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies.
2. 2.1 Intensive Outpatient Treatment-9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability.

**Level 1-WM Assessment/Treatment Plan Review consists of:**

1. An addiction-focused history, obtained as part of the initial assessment and conducted by or reviewed by a physician during the admission process.
2. A physical examination by a physician, physician assistant, or nurse practitioner, performed within a reasonable time frame as part of the initial assessment.
3. Sufficient biopsychosocial screening assessments to determine the level of care in which the person should be placed and for the individualized care plan to address treatment priorities identified in Dimensions 2 through 6\*\*\* of ASAM Criteria.
4. An individualized treatment plan, including problem identification in Dimensions 2 through 6\*\*\* and development of treatment plan goals and measurable treatment objectives, as well as activities designed to meet those objectives as they apply to the management of the withdrawal syndrome.
5. Daily assessment of progress during withdrawal management and any treatment changes (or less frequent, if the severity of withdrawal is sufficiently mild or stable).
6. Transfer/discharge planning, beginning at the point of admission to Level 1-WM services.
7. Referral and linking arrangements for counseling, medical, psychiatric, and continuing care.

**Level 1-WM Length of Service/Continued Service and Discharge Criteria:**

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1. Withdrawal signs and symptoms are sufficiently resolved that the consumer can participate in self-directed recovery or ongoing treatment without the need for further medical or nursing withdrawal management monitoring, OR
2. The consumer's signs and symptoms of withdrawal have failed to respond to treatment, and have intensified such that transfer to a more intensive level of withdrawal management service is indicated, OR
3. The consumer is unable to complete withdrawal management at Level 1-WM, despite an adequate trial. For example, she/he is experiencing intense craving and evidences insufficient coping skills to prevent continued alcohol, tobacco, and/or other drug use concurrent with the withdrawal management medication, indicating a need for more intensive services (such as addition of a supportive living environment).

**Level 1-WM Ambulatory Withdrawal Management Service should be comprised of:**

1. An interdisciplinary staff of clinicians trained in different professions, disciplines, or service areas, who function interactively and interdependently in conducting a consumer's biopsychosocial assessment, treatment plan and treatment services.
2. This interdisciplinary staff may include:
  - a) Physicians,
  - b) Nurses,
  - c) Counselors,
  - d) Psychologists,
  - e) Licensed and/or certified addiction counselors,
  - f) Social workers, and/or
  - g) Other health care professionals and technical personnel.
3. An appropriately trained licensed physician who is able to directly provide and/or manage:
  - a) Daily medical care,
  - b) Diagnostic services, and
  - c) Treatment services to support Medically Managed Treatment.

**Level 1-WM Ambulatory Withdrawal Management Service Medical Monitoring is provided through a mix of:**

1. Direct consumer contact,
2. Review of records,
3. Team meetings,
4. 24-hour overage by a physician, and
5. Quality assurance programs.
  - a) by interdisciplinary staff and with oversight by the appropriately trained licensed physician

**A quick guide for Level 1-WM:**

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1. Ambulatory withdrawal management without extended on-site monitoring
2. Physician's office, home health care setting
3. Staffed mainly by physicians and nurses
4. Involved in additional outpatient treatment services
5. Therapies may include medication or non-medication methods, consumer education

**Level 2-WM: Ambulatory Withdrawal Management With Extended On-Site Monitoring**

**Is an organized outpatient service which may be delivered in:**

1. An office setting,
2. A health care or addiction treatment facility, OR
3. In a consumer's home.

**By trained clinicians who provide:**

1. Medically supervised evaluation,
2. Withdrawal management, AND
3. Referral services according to a predetermined schedule.

**Level 2-WM Services are provided:**

1. In regularly scheduled sessions, AND
2. Under a defined set of policies and procedures or medical protocols.

**Level 2-WM Support Systems feature the following:**

1. Availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral, and cognitive problems.
2. Ability to obtain a comprehensive medical history and physical examination of the consumer at admission.
3. Access to psychological and psychiatric consultation.
4. Affiliation with other levels of care, including other levels of specialty addiction treatment, as well as general and psychiatric services for additional problems identified through a comprehensive biopsychosocial assessment.
5. Ability to conduct and/or arrange for appropriate laboratory and toxicology tests, which can be point-of-care testing.
6. 24-hour access to emergency medical consultation services, should such services become indicated.
7. Ability to provide or assist in accessing transportation services for consumers who lack safe transportation.

**Level 2-WM Clinicians Consist of:**

1. Physicians and nurses with training and experience in assessing and managing intoxication and withdrawal states. (They do not have to be certified as addiction specialist physicians or nurses).

2. Physicians and nurses do not have to be present at all times, however they must be readily available to evaluate and confirm that withdrawal management in this less supervised setting is relatively safe.
3. Counselors, psychologists, and social workers may provide additional services through the withdrawal management service or accessed thru affiliation with other entities providing Level 2 services.
4. All clinicians who assess and treat consumers are able to obtain and interpret information regarding the needs of these persons and are knowledgeable about the biopsychosocial dimensions of alcohol and other drug addiction. (Including signs and symptoms of alcohol and other drug intoxication and withdrawal, appropriate treatment and monitoring of those conditions and how to facilitate the individual's entry into ongoing care).

**Level 2-WM Therapies provided:**

1. Individual assessment,
2. Medication or non-medication methods of withdrawal management,
3. Consumer education,
4. Non-pharmacological clinical support,
5. Involvement of family members or significant others in the withdrawal management process,
6. Discharge or transfer planning (includes referral for counseling and involvement in community recovery support groups), AND
7. Physician and/or nurse monitoring, assessment and management of signs and symptoms of intoxication and withdrawal.

**Additional services that may be provided in conjunction with Level 2-WM care by the agency or an outside entity:**

1. 2.1 Intensive Outpatient Treatment-9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability, **and/or**
2. 2.5 Partial Hospitalization-20 or more hours of service/week for multidimensional instability not requiring 24 hour care.

**Level 2-WM Assessment/Treatment Plan Review consists of:**

1. An addiction-focused history, obtained as part of the initial assessment and conducted by or reviewed by a physician during the admission process.
2. A physical examination by a physician, physician assistant, or nurse practitioner, performed within a reasonable time frame as part of the initial assessment.
3. Sufficient biopsychosocial screening assessments to determine the level of care in which the person should be placed and for the individualized care plan to address treatment priorities identified in Dimensions 2 through 6\*\*\* of ASAM Criteria.
4. An individualized treatment plan, including problem identification in Dimensions 2 through 6\*\*\* and development of treatment plan goals and measurable treatment objectives, as well as activities designed to meet those objectives as they apply to the management of the withdrawal syndrome.



5. Daily assessment of progress during withdrawal management and any treatment changes (or less frequent, if the severity of withdrawal is sufficiently mild or stable).
6. Transfer/discharge planning, beginning at the point of admission to Level 1-WM services.
7. Referral and linking arrangements for counseling, medical, psychiatric, and continuing care.
8. Serial medical assessments, using appropriate measures of withdrawal.

**Length of Service/Continued Service and Discharge Criteria-The consumer continues in Level 2-WM withdrawal management services until:**

1. Withdrawal signs and symptoms are sufficiently resolved that the consumer can be safely managed at a less intensive level of care, OR
2. The consumer's signs and symptoms of withdrawal have failed to respond to treatment, and have intensified (as confirmed by higher score on the CIWA-Ar or other comparable standardized scoring system), such that transfer to a more intensive level of withdrawal management service is indicated, OR
3. The consumer is unable to complete withdrawal management at Level 2-WM, despite an adequate trial. For example, s/he is experiencing intense craving and has insufficient coping skills to prevent continued alcohol, tobacco, and/or other drug use, indicating a need for more intensive services.

**Level 2-WM Ambulatory Withdrawal Management Service should be comprised of:**

1. An interdisciplinary staff of clinicians trained in different professions, disciplines, or service areas, who function interactively and interdependently in conducting a consumer's biopsychosocial assessment, treatment plan, and treatment services.
2. This interdisciplinary staff may include:
  - a) Physicians,
  - b) Nurses,
  - c) Counselors,
  - d) Psychologists,
  - e) Licensed and/or certified addiction counselors,
  - f) Social workers, and/or
  - g) Other health care professionals and technical personnel.
3. An appropriately trained licensed physician who is able to directly provide and/or manage:
  - a) Daily medical care,
  - b) Diagnostic services, AND
  - c) Treatment services to support Medically Managed Treatment.

**Level 2-WM Ambulatory Withdrawal Management Service Medical Monitoring is provided through a mix of:**

1. Direct consumer contact,
2. Review of records,

3. Team meetings,
4. 24-hour coverage by a physician, and
5. Quality assurance programs.
  - a) by interdisciplinary staff and with oversight by the appropriately trained licensed physician

**A quick guide for Level 2-WM:**

1. Ambulatory withdrawal management with extended on-site monitoring
2. Day hospital services
3. Similar therapies as level 1

**Level 3.2-WM: Residential/Inpatient Withdrawal Management (Social Withdrawal Management)**

**Is an organized withdrawal management which is provided in a social setting for consumers are intoxicated or are experiencing moderate withdrawal which requires 24-hour structure and support to complete withdrawal management and increase the likelihood of continuing treatment or recovery. The emphasis is on peer and social support.**

**Level 3.2-WM Support Systems feature the following:**

1. Availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral, and cognitive problems.
2. Since this level is managed by clinicians, not medical or nursing staff, protocols are in place should a consumer's condition deteriorate and appear to need medical or nursing interventions.
  - a) These protocols are used to determine the nature of the medical or nursing interventions that may be required.
  - b) Protocols include under what conditions nursing and physician care is warranted and/or when transfer to a medically monitored facility or an acute care hospital is necessary.
  - c) The protocols are developed and supported by a physician knowledgeable in addiction medicine.
3. Affiliation with other levels of care.
4. Ability to arrange for appropriate laboratory and toxicology tests.

**Level 3.2-WM Clinicians consist of:**

1. Appropriately credentialed personnel who are trained and competent to implement physician-approved protocols for consumer observation and supervision, determination of appropriate level of care, and facilitation of the consumer's transition to continuing care.
2. Clinicians able to safely assist consumers thru withdrawal without the need for ready on-site access to medical and nursing personnel.

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3. Staff available to provide medical evaluation and consultation 24 hours a day, in accordance with treatment/transfer practice protocols and guidelines.
4. All clinicians who assess and treat consumers are able to obtain and interpret information regarding the needs of these persons and are knowledgeable about the signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as appropriate treatment and monitoring of those conditions and how to facilitate the individual's entry into ongoing care.
5. *For facilities that supervise self-administered medications:* Appropriately licensed or credentialed staff and policies/procedures in accordance with state and federal laws.
6. *For facilities that supervise self-administered medications:* Staff are qualified to assure that consumers are taking medications according to physician prescription and legal requirements.

**Level 3.2-WM Therapies provided:**

1. Daily clinical services to assess and address the needs of each consumer, which may include appropriate medical services, individual and group therapies, and withdrawal support,
2. A range of cognitive, behavioral, medical, mental health, and other therapies (individual or group), designed to:
  - a) Enhance the consumer's understanding of addiction,
  - b) Aid the completion of the withdrawal management process, and
  - c) Provide referral to an appropriate level of care for continuing treatment.
3. Interdisciplinary individualized assessment and treatment,
4. Health education services, AND
5. Services to family members or significant others.

**Additional services that may be provided in conjunction with Level 3.2-WM care by the agency or by an outside entity:**

1. 2.1 Intensive Outpatient Treatment-9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability.
2. Another type of treatment, as indicated by the ASAM Criteria for adults/adolescents.

**Level 3.2-WM Assessment/Treatment Plan Review consists of:**

1. An addiction-focused history, obtained as part of the initial assessment and reviewed with a physician during the admission process,
2. A physical examination by a physician, physician assistant, or nurse practitioner, as a part of the initial assessment, if self-administered withdrawal management medications are to be used,
3. Sufficient biopsychosocial screening assessments to determine the level of care in which the person should be placed and for the individualized care plan to address treatment priorities identified in Dimensions 2 through 6\*\*\* of ASAM Criteria,

4. An individualized treatment plan, including problem identification in Dimensions 2 through 6\*\*\* and development of treatment goals and measurable treatment objectives and activities designed to meet those objectives,
5. Daily assessment of progress thru withdrawal management and any treatment changes,
6. Transfer/discharge planning, beginning at the point of admission, AND
7. Referral arrangements, made as needed.

**Level 3.2-WM Length of Service/Continued Service and Discharge Criteria:**

1. Withdrawal signs and symptoms are sufficiently resolved that the consumer can be safely managed at a less intensive level of care, OR
2. The consumer's signs and symptoms of withdrawal have failed to respond to treatment, and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system), such that transfer to a more intensive level of withdrawal management service is indicated, OR
3. The consumer is unable to complete withdrawal management at Level 3.2-WM, despite an adequate trial. For example, s/he is experiencing increasing depression and suicidal impulses complicating cocaine withdrawal and indicating a need for a transfer to a more intensive level of care or the addition of other clinical services (such as intensive counseling).

**The Level 3.2-WM Medically Monitored Inpatient Withdrawal Management should be comprised of:**

1. An interdisciplinary staff of clinicians trained in different professions, disciplines, or service areas, who function interactively and interdependently in conducting a consumer's biopsychosocial assessment, treatment plan, and treatment services.
2. This interdisciplinary staff may include:
  - a) Physicians,
  - b) Nurses,
  - c) Counselors,
  - d) Psychologists,
  - e) Licensed and/or certified addiction counselors,
  - f) Social workers, and/or
  - g) Other health care professionals and technical personnel.
3. An appropriately trained licensed physician who is able to directly provide and/or manage:
  - a) Daily medical care,
  - b) Diagnostic services, AND
  - c) Treatment services,
4. in order to support Medically Managed Treatment.

**The Medical Monitoring for Level 3.2-WM Medically Monitored Inpatient Withdrawal Management is provided through a mix of:**

1. Direct consumer contact,
2. Review of records,
3. Team meetings,
4. 24-hour coverage by a physician, and
5. Quality assurance programs, by interdisciplinary staff and with oversight by the appropriately trained licensed physician.

**A quick guide for Level 3.2-WM:**

1. Social setting withdrawal management
2. Staffed mainly by peer and social supports
3. Physicians and nurses available as needed
4. Involved in additional outpatient treatment services
5. Therapies may include medication or non-medication methods, consumer education, referrals

**Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management**

**Is an organized service delivered by medical and nursing professionals, which provides for 24-hour evaluation and withdrawal management in a permanent facility with inpatient beds.**

**Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols.**

**Level 3.7-WM care is provided to consumers who are:**

1. Experiencing withdrawal signs and symptoms, severe enough to require 24-hour inpatient nursing care and physician visits as necessary, and
2. Unlikely to complete withdrawal management without medical, nursing monitoring.

**Level 3.7 is sometimes provided by overlapping with Level 4-WM services (as a “step-down” service):**

1. In a specialty unit of an acute care general or psychiatric hospital, with available 24-hour observation, monitoring, and treatment available, AND
2. When the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary.

**Level 3.7-WM Support systems feature the following:**

1. Availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral, and cognitive problems.
2. Availability of medical nursing care and observation as warranted, based on clinical judgement,
3. Direct affiliation with other levels of care, and
4. Ability to conduct or arrange for appropriate laboratory and toxicology tests.

**Level 3.7-WM Clinicians consist of:**

1. A physician who is available:
  - i) Twenty-four hours a day by telephone, *(In states where physician assistants or nurse practitioners are licensed as physic extenders, they may perform the duties designated for a physician under collaborative agreements or other requirements of the medical practice act in the given jurisdiction.)*
  - ii) To assess the consumer within 24 hours of admission (or earlier, if medically necessary), AND
  - iii) To provide on-site monitoring of care and further evaluation on a daily basis.
2. A registered nurse or other licensed and credentialed nurse, available to conduct a nursing assessment on admission.
3. A nurse responsible for overseeing the monitoring of the consumer's progress and medication administration on an hourly basis, if needed.
4. Appropriately licensed and credentialed staff available to administer medications in accordance with physician orders. (The level of nursing care is appropriate to the severity of consumer needs).
5. Licensed, certified, or registered clinicians who provide A planned regimen of 24-hour, professionally directed evaluation, care, and treatment services for consumers and their families.
6. An interdisciplinary team of appropriately trained clinicians available to assess and treat the consumer and to obtain and interpret information regarding the consumer's needs. The number and disciplines of team members are appropriate to the range and severity of the consumer's problems and may include:
  - a) Physicians,
  - b) Nurses,
  - c) Counselors,
  - d) Psychologists, and
  - e) Social workers.

**Level 3.7-WM Therapies provided:**

1. Daily clinical services to assess and address the needs of each consumer, which may include appropriate medical services, individual and group therapies, and withdrawal support,
2. Hourly nurse monitoring of the consumer's progress and medication administration are available, if needed,
3. A range of cognitive, behavioral, medical, mental health, and other therapies (individual or group), designed to:
  - i) Enhance the consumer's understanding of addiction,
  - ii) Aid the completion of the withdrawal management process, and
  - iii) Provide referral to an appropriate level of care for continuing treatment.
4. Multidisciplinary individualized assessment and treatment,

5. Health education services, AND
6. Services to family members and significant others.

**Additional services that may be provided in conjunction with Level 3.7-WM care by the agency or by an outside entity:**

1. 2.1 Intensive Outpatient Treatment=9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability.
2. Another type of treatment, as indicated by the ASAM Criteria for adults/adolescents.

**Level 3.7-WM Assessment/Treatment Plan Review consists of:**

1. An addiction-focused history, obtained as part of the initial assessment and reviewed with a physician during the admission process,
2. A physical examination by a physician, physician assistant, or nurse practitioner, within 24 hours of admission and appropriate laboratory and toxicology tests.
3. *If Level 3.7-WM withdrawal management services are step-down services from Level 4-WM, records of a physical examination within the preceding 7 days are evaluated by a physician within 24 hours of admission.*
4. Sufficient biopsychosocial screening assessments to determine the level of care in which the person should be placed and for the individualized care plan to address treatment priorities identified in Dimensions 2 through 6\*\*\* of ASAM Criteria,
5. An individualized treatment plan, including problem identification in Dimensions 2 through 6\*\*\* and development of treatment goals and measurable treatment objectives and activities designed to meet those objectives,
6. Daily assessment of consumer progress through withdrawal management and any treatment changes,
7. Transfer/discharge planning, beginning at the point of admission, AND

**Level 3.7-WM Length of Service/Continued Service and Discharge Criteria:**

1. Withdrawal signs and symptoms are sufficiently resolved that the consumer can be safely managed at a less intensive level of care, OR
2. The consumer's signs and symptoms of withdrawal have failed to respond to treatment, and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system), such that transfer to a Level 4-WM intensive level of withdrawal management service is indicated.

**The Level 3.7-WM Medically Monitored Inpatient Withdrawal Management should be comprised of:**

1. An interdisciplinary staff of clinicians trained in different professions, disciplines, or service areas, who function interactively and interdependently in conducting a consumer's biopsychosocial assessment, treatment plan, and treatment services.
2. This interdisciplinary staff may include:
  - a) Physicians,
  - b) Nurses,

- c) Counselors,
  - d) Psychologists,
  - e) Licensed and/or certified addiction counselors,
  - f) Social workers, and/or
  - g) Other health care professionals and technical personnel.
3. An appropriately trained licensed physician who is able to directly provide and/or manage:
    - a) Daily medical care,
    - b) Diagnostic services, AND
    - c) Treatment services,
  4. in order to support Medically Monitored Inpatient Treatment.

**The Medical Monitoring for Level 3.7-WM Medically Monitored Inpatient Withdrawal Management is provided through a mix of:**

1. Direct consumer contact,
2. Review of records,
3. Team meetings,
4. 24-hour coverage by a physician, and
5. Quality assurance programs by interdisciplinary staff and with oversight by the appropriately trained licensed physician.

**A quick guide for Level 3.7-WM:**

1. Inpatient withdrawal management and monitoring
2. Staffed mainly by physicians, nurses, and multidisciplinary clinicians
3. Involved in additional inpatient treatment services
4. Therapies may include medication or non-medication methods, consumer education, referrals

**Level 4-WM: Medically Managed Intensive Inpatient Withdrawal Management**

**Is an organized service delivered by medical and nursing professionals, which provides for 24-hour medically directed evaluation and withdrawal management in an acute care inpatient setting.**

**Level 4-WM Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols.**

**Level 4-WM care is provided to consumers who are:**

1. Experiencing withdrawal signs and symptoms, severe enough to require primary medical and nursing care services, including:
  - a) Twenty-four hour observation, monitoring, and treatment, and
  - b) Daily physician visits to modify withdrawal management regimen and manage medical instability.



**Level 4-WM Support Systems feature the following:**

1. Availability of specialized medical consultation,
2. Full medical acute care services, and
3. Intensive care, as needed.

**Level 4-WM Clinicians consist of:**

1. Physicians who are available:
  - i) Twenty-four hours a day as active members of an interdisciplinary team of appropriately trained professionals, and who medically manage the care of the consumer (*In states where physician assistants or nurse practitioners are licensed as physio extenders, they may perform the duties designated for a physician under collaborative agreements or other requirements of the medical practice act in the given jurisdiction.*),
2. A registered nurse or other licensed and credentialed nurse, available for primary nursing care and observation 24 hours per day,
3. Facility-approved addiction counselors or licensed, certified, or registered addiction clinicians, available eight hours per day to administer planned interventions according to the assessed needs of the consumer,
4. An interdisciplinary team of appropriately trained clinicians available to assess and treat the consumer with a substance use disorder, or an addicted consumer, with a concomitant acute biomedical, emotional, or behavioral disorder. The number and disciplines of team members are appropriate to the range and severity of the consumer's problems and may include:
  - i) Physicians,
  - ii) Nurses,
  - iii) Counselors,
  - iv) Psychologists, and
  - v) Social workers.

**Level 4-WM Therapies provided:**

1. Highly individualized biomedical, emotional, behavioral and addiction treatment, which may include management of all concomitant conditions in the context of addiction treatment,
2. Hourly nurse monitoring of the consumer's progress and medication administration are available, if needed,
3. A range of cognitive, behavioral, medical, mental health, and other therapies (individual or group), designed to:
  - i) Enhance the consumer's understanding of addiction,
  - ii) Aid the completion of the withdrawal management process, and
  - iii) Provide referral to an appropriate level of care for continuing treatment.
  - iv) *For the consumer with a severe comorbid psychiatric disorder, psychiatric interventions are provided which complement addiction treatment.*

- v) *For the consumer with a severe comorbid biomedical disorder, biomedical interventions are provided which complement addiction treatment.*
4. Health education services, AND
  5. Services to family members and significant others.

**Additional services that may be provided in conjunction with Level 4-WM care by the agency or by an outside entity:**

1. 2.1 Intensive Outpatient Treatment-9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability.
2. Another type of treatment, as indicated by the ASAM Criteria for adults/adolescents.

**Level 4-WM Assessment/Treatment Plan Review consists of:**

1. A comprehensive nursing assessment, performed at admission,
2. Approval of the admission by a physician,
3. A comprehensive history and physical examination performed within 12 hours of admission, accompanied by appropriate laboratory and toxicology tests.
4. An addiction-focused history, obtained as a part of the initial assessment and reviewed by a physician during the admission process,
5. Sufficient biopsychosocial screening assessments to determine placement and for the individualized care plan to address treatment priorities identified in Dimensions 2 through 6\*\*\* of ASAM Criteria,
6. Discharge/transfer planning, beginning at admission,
7. Referral arrangements, made as needed,
8. An individualized treatment plan, including problem identification in Dimensions 2 through 6\*\*\* and development of treatment goals and measurable treatment objectives and activities designed to meet those objectives, AND
9. Daily assessment of consumer progress through withdrawal management and any treatment changes.

**Level 4-WM Length of Service/Continued Service and Discharge Criteria:**

Withdrawal signs and symptoms are sufficiently resolved that the consumer can be safely managed at a less intensive level of care.

**Level 4-WM Medically Managed Intensive Inpatient Withdrawal Management should be comprised of:**

An interdisciplinary staff of clinicians trained in different professions, disciplines, or service areas, who function interactively and interdependently in conducting a consumer's biopsychosocial assessment, treatment plan, and treatment services.

- This interdisciplinary staff may include:
  - Physicians,
  - Nurses,
  - Counselors,
  - Psychologists,
  - Licensed and/or certified addiction counselors,

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- Social workers, and/or
  - Other health care professionals and technical personnel.
  - An appropriately trained licensed physician who is able to directly provide and/or manage:
    - Daily medical care,
    - Diagnostic services, AND
    - Treatment services,
- in order to support Medically Managed Intensive Inpatient Treatment.

**Medical Monitoring for Level 4-WM Medically Managed Intensive Inpatient Withdrawal Management is provided through a mix of:**

1. Direct consumer contact,
2. Review of records,
3. Team meetings,
4. 24-hour coverage by a physician, and
5. Quality assurance programs, by interdisciplinary staff and with oversight by the appropriately trained licensed physician

**A quick guide for Level 4-WM:**

1. Intensive withdrawal management
2. Inpatient acute care setting
3. Staffed by physicians and nurses and other multidisciplinary clinicians
4. Involved in additional inpatient treatment services
5. Therapies likely include medication methods, consumer education, referrals

## REFERENCES

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<sup>4</sup> <https://www.integration.samhsa.gov/about-us/esolutions-newsletter/integrating-substance-abuse-and-primary-care-services>

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