

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**  
**Bureau of Substance Abuse and Addiction Services**

**TREATMENT TECHNICAL ADVISORY # 10**

**SUBJECT:**        Residential Treatment Continuum of Services

**ISSUED:**        September 15, 2010

**EFFECTIVE:**    October 1, 2010

**PURPOSE**

The purpose of this advisory is to establish the requirements for residential services based on the American Society of Addiction Medicine (ASAM) Level of Care (LOC) criteria, and to support individualized services that maintain cultural, age and gender appropriateness.

**SCOPE**

This advisory impacts the coordinating agency (CA) and its adult residential level of care service provider network.

**BACKGROUND**

Residential treatment includes a wide variety of covered services with the provision that these services are expected to be individualized to the needs of the client. The Administrative Rules for Substance Abuse Services, established in 1981, are very limited in indicating what activities or services must be provided to clients in a residential program. They indicate ten hours of scheduled activities, with two of those hours being formalized counseling, which must take place during each week.

At the time of their creation, these standards adequately met the needs of clients being served. In the time since the rules were promulgated, there have been many changes in the treatment field. The emergence of evidence-based best practices, the ASAM Patient Placement Criteria and the stages-of-change models that have been developed have essentially left the administrative rules obsolete in the area of recommended services. This advisory is seeking to establish residential treatment criteria that will result in services that are provided in accordance with those outlined by ASAM, and are more reflective of services that have been shown to be effective in providing care to individuals receiving residential services.

Throughout the current residential level of services, assessment, treatment planning, and recovery support preparations are required; and must be included in the authorized treatment services. Historically, residential services have been defined by length of stay, not by the needs of the client. This has resulted in essentially two descriptors for residential services:

- Short-term residential: less than 30 days in a program

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- Long-term residential: 30 days or more in a program

This view of residential treatment has contributed to the expectation that all clients will equally benefit from the services being offered and resulted in clients with varying needs being admitted into the same program. This makes it more difficult to assure and provide services that are focused on addressing the individual needs of each client.

### **Definitions**

**Toxicology Screening** – screening used for the purpose of tracking ongoing use of substances when this has been established as a part of the treatment plan or an identified part of the treatment program. (This may include onsite testing such as portable breathalyzers or non-laboratory urinalysis)

**Core Services** – Treatment Basics, Therapeutic Interventions and Interactive Education/Counseling. See the chart in the “Covered Services” section for further information.

**Counseling** – an interpersonal helping relationship that begins with the client exploring the way they think, how they feel and what they do, for the purpose of enhancing their life. The counselor helps the client to set the goals that pave the way for positive change to occur.

**Crisis Intervention** – a service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher level of care if intervention is not provided.

**Detoxification/Withdrawal Monitoring** – monitoring for the purpose of preventing/alleviating medical complications related to no longer using or decreasing the use of a substance.

**Face-to-Face** – this interaction not only includes in-person contact, it may also include real-time video and audio linkage between a client and provider, as long as this service is provided within the established confidentiality standards for substance use disorder services.

**Facilitates Transportation** – assist the client, or potential client, or referral source in arranging transportation to and from treatment.

**Family Counseling** – face-to-face intervention with the client and the significant other and/or traditional or non-traditional family members for the purpose of goal setting and achievement, as well as skill building. Note: in these situations, the identified client need not be present for the intervention.

**Family Psychotherapy** – face-to-face, insight-oriented interventions with the client and the significant other and/or traditional or non-traditional family members. Note: in these situations, the identified client need not be present for the intervention.

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**Group Counseling** – face-to-face intervention for the purpose of goal setting and achievement, as well as skill building.

**Group Psychotherapy** – face-to-face, insight-oriented interventions with three or more clients.

**Individual Assessment** – a face-to-face service for the purpose of identifying functional and treatment needs, and to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

**Individual Counseling** – face-to-face intervention for the purpose of goal setting and achievement, and skill building.

**Individual Psychotherapy** – face-to-face, insight-oriented interventions with the client.

**Individual Treatment Planning** – direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current level of care, to ensure true and realistic needs are being addressed and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each client and be specific to the diagnostic impression and assessment.

**Interactive Education** – services that are designed or intended to teach information about addiction and/or recovery skills, often referred to as didactic education.

**Interactive Education Groups** – activities that center on teaching skills to clients necessary to support recovery, including “didactic” education.

**Medical Necessity** – treatment which is reasonable, necessary and appropriate based on individualized treatment planning and evidence-based clinical standards.

**Peer Support** – individuals who have shared experiences of addiction and recovery, and offer support and guidance to one another.

**Psychotherapy** – an advanced clinical practice that includes the assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio-psychosocial problems and may include the involvement of the intrapsychic, intrapersonal, or psychosocial dynamics of individuals (from Social Work Administrative Rules).

**Recovery** – a process of change through which an individual achieves abstinence and improved health, wellness and quality of life. The experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to

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such problems, and develop a healthy, productive, and meaningful life. (White, Journal of Substance Abuse Treatment, 2007).

**Recovery Planning** – process that highlight's and organize a person's goals, strengths and capacities and to determine what barriers need to be removed or problems resolved to help people achieve their goals. This should include an asset and strength based assessment of the client.

**Recovery Support and Preparation** – services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

**Referral/Linking/Coordination of Services** – office-based service activity performed by a primary clinician or other assigned staff to address needs identified through the assessment, and/or of ensuring follow through with access to outside services, and/or to establish the client with another substance use disorder provider.

**Substance Use Disorder** – a term inclusive of substance abuse and dependence that also encompasses problematic use of substances.

### **RECOMMENDATIONS**

The residential levels of care from ASAM are established based on the needs of the client. As part of the purpose of this document, the short- and long-term descriptors will no longer be used to describe residential services. Coordinating agencies will need to have the capacity to provide a residential continuum that will meet the needs of clients at ASAM levels III.1, III.3, and III.5. ASAM level III.7 is not a requirement, but was included for those regions that have this service available. The frequency and duration of residential treatment services are expected to be guided by the ASAM levels of care, and are described as follows:

#### **ASAM Level III.1 – Clinically Managed Low-Intensity Residential Services**

These services are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual in the worlds of work, education and family life. Treatment services are similar to low-intensity outpatient services focused on improving the individual's functioning and coping skills in Dimension 5 and 6.

The functional deficits found in this population may include problems in applying recovery skills to their everyday lives, lack of personal responsibility or lack of connection to employment, education or family life. This setting allows clients the opportunity to develop and practice skills while reintegrating into the community.

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### **ASAM Level III.3 – Clinically Managed Medium-Intensity Residential Services**

These programs provide a structured recovery environment in combination with medium-intensity clinical services to support recovery. Services may be provided in a deliberately repetitive fashion to address the special needs of individuals who are often elderly, cognitively impaired or developmentally delayed. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning.

The deficits for clients at this level are primarily cognitive, either temporary or permanent. The clients in this LOC have more intensive needs and therefore, to effectively benefit from services, they must be provided at a slower pace and over a longer period of time. The client's level of impairment is more severe at this level, requiring services be provided differently in order for any benefit to be received.

### **ASAM Level III.5 – Clinically Managed High-Intensity Residential Services**

These programs are designed to treat clients who have significant social and psychological problems. Treatment is directed toward diminishing client deficits through targeted interventions. Effective treatment approaches are primarily habilitative in focus, addressing the client's educational and vocational deficits, as well as his or her socially dysfunctional behavior. Clients at this level may have extensive treatment or criminal justice histories, limited work and educational experiences, and antisocial value systems.

The services offered to clients in this modality tend to be of the longest duration among the four levels of care. As impairment is considered to be significant at this level, services must be provided over a longer time frame in order for any benefit to be received. Very often, the level of impairment will limit the services that can actually be provided to the client resulting in the primary focus of treatment at this level being centered on habilitation and development, or re-development of life skills.

### **ASAM Level III.7 – Medically Monitored Intensive Inpatient Treatment**

These programs provide 24-hour medical monitoring, evaluation, observation and addiction treatment in an inpatient setting. "They are appropriate for patients whose sub-acute biomedical and emotional, behavioral or cognitive problems are so severe that they require inpatient treatment, but who do not need the full resources of an acute care general hospital or a medically managed inpatient treatment," (Mee-Lee, Shulman, Fishman, Gastfriend & Griffith, 2001). Treatment is provided by an interdisciplinary staff of appropriately credentialed treatment professionals, and is specific to substance use disorders. The treatment team can also accommodate clients with detoxification, medical, emotional, behavioral and cognitive conditions. Clients at this level will have functional deficits in Dimensions 1, 2 and/or 3.

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The length of service will vary, based on the severity of a client's illness and their response to treatment. In addition, clients with a high severity of illness in Dimension 1, 2 or 3 require more intensive support services, as well as staff monitoring the program.

ASAM levels of care describe the need for treatment from the perspective of the level of impairment of the client; with the higher level of impairment requiring the longer duration, slower more repetitive services. The identification of these needs is intended to assist with service selection and authorization for care. The placement of the client is based on the ASAM LOC determination. Due to the unique and complex nature of each client, it is recognized that not every client will "fit" cleanly into one level over another by just looking at the level of impairment. There may be situations where a case could be made for a client to receive services in each of these levels and each would be appropriate. In these situations, documentation should be made as to the rationale for the decision. The cost of the service should not be the driving force behind the decision; the decision should be made based on what is most likely to help the client be successful in treatment.

### Admission Criteria

Admission to residential treatment is limited to the following criteria:

- Medical necessity;
- Diagnosis: The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression of a substance use disorder (also known as provisional diagnosis) – the diagnostic impression must include all five axes:
  - 1) Axis I Clinical Disorders
  - 2) Axis II Personality Disorders, Mental Impairment
  - 3) Axis III General Medical Conditions
  - 4) Axis IV Psychosocial and Environmental Problems
  - 5) Global Assessment of Functioning
- Individualized determination of need; and
- Use of ASAM Patient Placement Criteria (PPC) to determine substance use disorder treatment placement/admission and/or continued stay needs, and are based on a LOC determination using the six assessment dimensions of the current ASAM PPC below:
  - 1) Withdrawal potential.
  - 2) Medical conditions and complications.
  - 3) Emotional, behavioral or cognitive conditions and complications.
  - 4) Readiness to change – as determined by the Stages-of-change Model.
  - 5) Relapse, continued use or continued problem potential.
  - 6) Recovery/living environment.

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Treatment must be individualized based on a biopsychosocial assessment, diagnostic impression and client characteristics that include, but are not limited to age, gender, culture, and development. Authorization decisions on length of stay (including continued stay), change in level of care, and discharge, must be based on the ASAM PPC. As a client's needs change, the frequency and/or duration of services may be increased or decreased as medically necessary. Client participation in referral and continuing care planning must occur prior to a move to another level of care for continued treatment.

### Service Requirements

The following chart details the required amount of services that have been established for residential treatment in the four levels of care. Alternative forms of therapy such as art, music, etc., should be reflected in the client's treatment plan and follow the documentation requirements. Documentation of all required services, and the response to them by the client, must be found in the client's chart. In situations where the required services cannot be provided to a client in the appropriate frequency or quantity, a justification must also be documented in the client record.

<b>Level of Care</b>	<b>Minimum Daily Core Services</b>	<b>Minimum Weekly Core Services</b>	<b>Minimum Weekly Life Skills/Self Care</b>
<b>ASAM III.1</b> Clients with lower impairment or lower complexity of needs	n/a	At least 5 hours of clinical services per week.	At least 5 hours per week.
<b>ASAM III.3</b> Clients with moderate to high impairment or moderate to high complexity of needs	6 days per week; not less than 3 hours per day. 7 <sup>th</sup> Day; not less than 2 hours. Core services not under 2 hours in any day.	Not less than 20 hours per week.	Not less than 13 hours per week.
<b>ASAM III.5</b> Clients with a significant level of impairment or very complex needs	6 days per week; not less than 2 hours per day. 7 <sup>th</sup> Day; not less than 1 hour. Core services not under 1 hour in any day.	Not less than 13 hours per week.	Not less than 20 hours per week.
<b>ASAM III.7</b> High Dimension 1, 2 and 3 needs	Due to the intensive medical needs and components of the programming, we are not identifying specific service requirements for this level of care. They feature permanent facilities, including inpatient beds, and function under a defined set of policies, procedures and clinical protocols.		

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### Covered Services

The following services must be available in a residential setting regardless of the LOC and based on individual client need:

<b>Type</b>	<b>Residential Services Description</b>
<b>Basic Care</b>	Room, board, supervision, monitoring self administration of medications, toxicology screening, facilitates transportation to and from treatment, treatment environment: structured, safe, and recovery oriented.
<b>Treatment Basics</b> <b><u>Core Service</u></b>	Assessment; Episode of Care Plan (addressing treatment, recovery, discharge and transition across episode); coordination and referral; medical evaluation and attempt to link to services; connection to next provider and medical services, preparation for 'next step.'
<b>Therapeutic Interventions</b> <b><u>Core Service</u></b>	Individual, group and family psychotherapy services; appropriate for the individual's needs; and crisis intervention. Services provided by an appropriately licensed, credentialed and supervised professional working within their scope of practice.
<b>Interactive Education /Counseling</b> <b><u>Core Service</u></b>	Interaction and teaching with client(s) and staff that process skills and information adapted to the individual client needs. This includes alternative therapies, individual, group and family counseling, anger management, coping skills, recovery skills, relapse triggers, and crisis intervention. Ex: disease of addiction, mental health & substance use disorder.
<b>Life Skills/Self-Care</b>	Social activities that promote healthy community integration/reintegration, development of community supports, parenting, employment, job readiness, how to use public transportation, hygiene, nutrition, laundry, education.
<b>Milieu/Environment (building recovery capital)</b>	Peer support; recreation/exercise; leisure activities; family visits; coordination with treatment, support groups; maintaining a drug/alcohol free campus.

### Treatment Planning/Recovery Planning

Clients entering any level of residential care will have recovery and functional needs that will continue to require intervention once residential services are no longer appropriate. Therefore, residential care should be viewed as a part of an episode of care within a continuum of services that will contribute toward recovery for the client. Residential care should not be presented to clients as being a complete episode of care. To facilitate the client moving along the treatment

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continuum, it is expected that the provider, as part of treatment planning, begin the process of preparing the client for the next stage of the recovery process as soon after admission as possible. This will help to facilitate a smooth transition to the next service, as appropriate, and make sure that the client is aware that services will continue once the residential stay is over.

To make the transition to the next level of care, the residential care provider may assist the client in: choosing an appropriate service based on needs and location, scheduling appointments, arranging for a meeting with the new service provider, arranging transportation, and ensuring all required paperwork is completed and forwarded to the new service provider in a timely manner. These activities are provided as examples of activities that could take place if it were determined that doing so would benefit the client. There could potentially be many other activities or arrangements that may be needed or the client may require very little assistance. To the best of their ability, it is expected that the residential provider provide any needed assistance to ensure a seamless transfer to the next level of care.

### Continuing Stay Criteria

Re-authorization or continued treatment should be based on ASAM PPC continued service criteria, medical necessity, and when there is a reasonable expectation of benefit from continued care.

Continuing stay can be denied in situations where the client has decided not to participate in his/her treatment. This is evidenced by continued non-compliance with treatment activities, other behavior that is deemed to violate the rules and regulations of the program providing the services, or a demonstrated lack of benefit from treatment received, after documented attempts to meet the needs of the client, by adjusting the services, were made. Progress notes must support lack of benefit, and that other appropriate services have been offered, before a client can be terminated from a treatment episode.

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The ASAM Assessment Dimensions must be used to assist in the determination of the level of care needed by a client:

<b>Level of Care</b>	<b>Level III.1</b>	<b>Level III.3</b>	<b>Level III.5</b>
<b>Dimension 1</b> Withdrawal Potential	No withdrawal risk, or minimal/stable withdrawal; Concurrently receiving Level I-D or Level II-D	Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level III.2-D	At minimal risk of severe withdrawal at Levels III.3 or III.5. If withdrawal is present, it meets Level III.2-D criteria
<b>Dimension 2</b> Medical conditions & complications	None or very stable, or receiving concurrent medical monitoring	None or stable or receiving concurrent medical monitoring	None or stable or receiving concurrent medical monitoring
<b>Dimension 3</b> Emotional, behavioral, or cognitive conditions and complications	None or minimal; not distracting to recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required	Mild to moderate severity; needs structure to focus on recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required. Treatment should be designed to respond to any cognitive deficits	Demonstrates repeated inability to control impulses, or a personality disorder that requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A dual diagnosis enhanced setting is required for the seriously mentally ill client
<b>Dimension 4</b> Readiness to change	Open to recovery but needs a structured environment to maintain therapeutic gains	Has little awareness and needs interventions available only at Level III.3 to engage and stay in treatment; or there is high severity in this dimension but not in others. The client needs a Level I motivational enhancement program (Early Intervention)	Has marked difficulty engaging in treatment, with dangerous consequences; or there is high severity in this dimension but not in others. The client needs a Level I motivational enhancement program (Early Intervention)
<b>Dimension 5</b> Relapse, continued use or continued problem potential	Understands relapse but needs structure to maintain therapeutic gains	Has little awareness and needs intervention only available at Level III.3 to prevent continued use, with imminent dangerous consequences because of cognitive deficits or comparable dysfunction	Has no recognition of skills needed to prevent continued use, with imminently dangerous consequences
<b>Dimension 6</b> Recovery/living environment	Environment is dangerous, but recovery achievable if Level III.1 24-hour structure is available	Environment is dangerous and client needs 24-hour structure to cope	Environment is dangerous and client lacks skills to cope outside of a highly structured 24-hour setting

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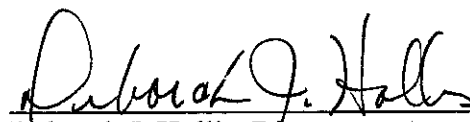
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