Service Standard for Residential Services for Treatment of youth with Substance Use Disorders

This service standard is an addendum to the Residential Treatment Services Provider Contract for those programs who provide treatment services for youth with Substance Use Disorders of sufficient severity that residential treatment is required.

1. Service Description

a. Services should be offered to youth with Substance Use Disorders (SUD) with a diagnosed severity of moderate to severe intensity. (meets 4 or more of 11 diagnostic criteria) that cannot therefore be treated on an outpatient basis due to the safety risk to the child and community. Child need not have a formal diagnosis of Substance Use Disorder with specified severity if agency is able to determine from history and presenting issues that criteria for the diagnosis are likely present. Services may be provided to families and children involved with the Department of Child Services, Probation, Department of Corrections, Department of Education and/or Private pay. Ages and genders of the youth served must fall within the scope of the provider's license and program description for this population.

b. In addition to meeting the basic needs of the child for safety, shelter and normalcy, this program will provide intensive evidence-based services to address any mental health needs of this population, including PTSD, depression, anxiety disorders and a wide range of symptoms associated with complex trauma.

c. Youth who are physically addicted to a substance should first receive detoxification in a medically supervised program and be medically cleared before admission to a Substance Use Disorder treatment program.

d. The residential provider will coordinate services provided by an interdisciplinary team, and the anticipated length of stay will be determined by the agency's current program description and youth's progress in treatment based on treatment planning of individual needs.

e. Development and accessing of community supports that are supportive of sobriety are an integral part of long-term success in Substance Use Disorder treatment. It is therefore important for the SUD program to build and strengthen these supports at a pace commensurate with youth progress in treatment.

d. Programs should begin identification of triggers to substance use and develop safety plans for youth at admission to mitigate the increased risk of relapse outside the program when accessing the community. Aforementioned plans should include at a minimum an identification of high-risk situations, people and emotional states, along with plans to either avoid, cope with, or escape those risks without relapse.

e. This service standard relies on the use of evidence-based practices in substance use treatment including the appropriate licensure and training of therapists providing the substance use disorders treatment.

f. Drug screens should be provided as appropriate for those children/youth in drug treatment after home visits, community outings, in compliance with probation and court requirements and anytime relapse is suspected.

2. Therapeutic Services

a. An individualized recovery plan must be developed within 10 days of admission that considers the client's age, ethnic background, cognitive development and functioning, and clinical issues. Recovery plans shall provide a framework for measuring success and progress. Recovery plans should also include goals and objectives. Goals shall be designed to address the issue(s) identified in the substance use assessment and include an achievable time frame. A recovery plan partially based on a functional assessment of each resident's daily living, socialization, and coping skills that is based on structured evaluation and observation of behavior.

b. Service providers must adopt and utilize evidence-based treatments which focus not only on the behavior associated with the substance use disorder, but also any underlying trauma which may be contributing to the disorder. The DCS approved model for treatment of trauma is TF-CBT. Programs must receive approval from DCS licensing unit before implementing a different primary Evidence Based Practice (EBP) for trauma treatment.

c. SUD programs should provide at least weekly individual, and group sessions and a minimum of twice monthly family therapy sessions as indicated in assessment and treatment planning as part of the Individual Recovery Plan.

3. Discharge and Aftercare services

a. Discharge planning begins at admission, and should become gradually more specific as youth progresses in treatment.

b. Aftercare for this population will meet the requirements of FFPSA and include, where possible, the coordination of services to support sobriety in the community, including giving youth the opportunity to meet community providers of sobriety support services in the targeted discharge community on home visits prior to discharge.

4. Qualifications

a. Therapists and- Program Supervisors

In response to an acknowledged deficit of Licensed Clinical Addiction Counselors, especially in rural areas, and in keeping with contractual requirements to meet or exceed Medicaid MRO/MCO standards for professional licensure in DCS licensed residential programs, the following requirements are hereby adopted for this service standard:
SECTION1.IC12-15-5-20 Medicaid Requirements for licensure of SUD program supervision and service provision:
(1) If the office requires a supervisor for addiction based intensive outpatient treatment under this article, the following supervisors who either have at least two (2) years of experience in addiction treatment or hold an addiction credential, as determined by the division, are eligible supervisors:

(1) Licensed clinical social workers.

(2) Licensed mental health counselors.
(3) Licensed marriage and family therapists.
(4) Licensed clinical addiction counselors.

The office may not require a direct service provider in an intensive outpatient treatment program to be a licensed addiction counselor or a licensed clinical addiction counselor. However, the HEA 1326 — Concur 2
direct service provider must, under the supervision of a clinician described in subsection (b), either:
(1) hold an addiction credential, as determined by the division; or
(2) have training and experience in addiction treatment, as determined by the division.

b. Case Managers

In addition to meeting requirements for 465 IAC 2-9-49 or 465 IAC 2-11-49, case managers should be specifically trained in the unique challenges of working with youth and families dealing with addiction issues, including but not limited to family dynamics, healthy boundaries, interdependency vs. co-dependency, child parentification, and cultural differences in beliefs about substance use. Although Case managers will not normally serve as recovery coaches, a training that encompasses topics normally covered by ACADA training for recovery coaching would be one example of beneficial training for Case Managers who will be working with youth in Aftercare to establish community supports.

c. Direct Care Staff

In addition, to meeting training requirements as described in 465 IAC 2-9-54 and/or 465 IAC 2-11-54 on-the-job competency evaluations of direct care staff should assess competency of training in issues common to youth with SUD diagnosis including but not limited to how to model healthy relationship boundaries, avoiding discussion of personal recreational substance use and general trauma-informed care.

5. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.