

Level of Care	Level 3.1	Level 3.3	Level 3.5	Level 3.7
Dimension 2 Medical conditions and 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	Individual in significant risk of serious damage to physical health or concomitant biomedical conditions
Dimension 3 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	Individual must be admitted into co-occurring capable or co-occurring enhanced program, depending on level of function or degree of impairment.
Dimension 4 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 3.3 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)	Does not accept or relate the addictive disorder to severity of existing problems; need intensive motivating strategies; need 24-hour monitoring to assure follow through with treatment plan

Level of Care	Level 3.1	Level 3.3	Level 3.5	Level 3.7
Dimension 5 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 3.3 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	Experiencing acute psychiatric/substance use disorder marked by intensification of
Dimension 6 Recovery/living environment	Environment is dangerous, but recovery achievable if Level 3.1 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	Environment is dangerous and patient lacks skills to cope outside of highly structured 24-hour setting

PROCEDURE:

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 diagnosis will be confirmed by the provider's assessment process.~~
- Individualized determination of need.
- ASAM Criteria is used 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 ASAM Criteria below:
 - 7) Withdrawal potential.
 - 8) Medical conditions and complications.
 - 9) Emotional, behavioral, or cognitive conditions and complications.
 - 10) Readiness to change – as determined by the Stages of Change Model.
 - 11) Relapse, continued use or continued problem potential.
 - 12) Recovery/living environment.

Treatment must be individualized based on a biopsychosocial assessment, diagnosis, 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 LOC, and discharge must be based on the ASAM Criteria. 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, continuing care, and recovery planning must occur prior to a move to another LOC for continued treatment.

Service Requirements

The following chart details the required amount of services that have been established for residential treatment in the three levels of care. Documentation of all core 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.

Level of Care	Minimum Weekly Core Services	Minimum Weekly Life Skills/Self Care
ASAM 3.1 Clients with lower impairment or lower complexity of needs	At least 5 hours of clinical services per week	At least 5 hours per week
ASAM 3.3 Clients with moderate to high impairment or moderate to high complexity of needs	Not less than 13 hours per week	Not less than 13 hours per week
ASAM 3.5 Clients with a significant level of impairment or very complex needs	Not less than 20 hours per week	Not less than 20 hours per week
ASAM 3.7 Clients with significant level of impairment or very complex needs	Not less than 20 hours per week	Not less than 20 hours per week

Covered Services

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

Type	Residential Services Description
Basic Care	Room, board, supervision, self-administration of medications monitoring, toxicology screening, transportation facilitating to and from treatment; and treatment environment is structured, safe, and recovery-oriented.
Treatment Basics <u>Core Service</u>	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'.
Therapeutic Interventions <u>Core Service</u>	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.
Interactive Education /Counseling <u>Core Service</u>	Interaction and teaching with client(s) and staff to 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. Examples: disease of addiction, mental health, and substance use disorder.
Life Skills/Self-Care (building recovery capital)	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.

Type	Residential Services Description
Milieu/Environment (building recovery capital)	Peer support; recreation/exercise; leisure activities; family visits; treatment coordination; support groups; drug/alcohol free campus.
Medical Services Core Service	Physician monitoring, nursing care, and observation available. Medical specialty consultation, psychological, laboratory and toxicology services available. Psychiatric services available on-site.

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 continuum, it is expected that the provider, as part of treatment planning, begins to prepare 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 LOC, 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 LOC, 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 there would be a benefit to 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 arrange for any needed assistance to ensure a seamless transfer to the next LOC.

Continuing Stay Criteria

Re-authorization or continued treatment should be based on ASAM Continued Service Criteria, medical necessity, and a reasonable expectation of benefit from continued care.

REFERENCES:

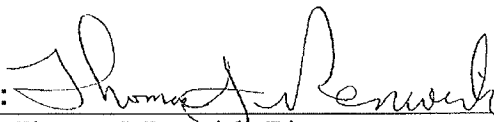
Mee-Lee, D, Shulman, GD, Fishman, M, Gastfriend, DR, and Griffith, JH, eds. (2013). *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R)*. Chevy Chase, MD: American Society of Addiction Medicine, Inc.

Michigan Department of Health and Human Services, Office of Recovery Oriented Systems of Care. *Michigan's ROSC Glossary of Terms*. Retrieved from http://www.michigan.gov/documents/mdch/ROSC_Glossary_of_Terms_350345_7.pdf.

Michigan Department of Licensing and Regulatory Affairs, Michigan Administrative Code. (n.d.). *[Administrative Rules for] Substance Use Disorder Service Programs*. Promulgated pursuant to Michigan Public Act 368 of 1978, Section 6231(1), as amended. Retrieved from http://www7.dleg.state.mi.us/orr/Files/AdminCode/103_65_AdminCode.pdf

Michigan Department of Licensing and Regulatory Affairs, Michigan Administrative Code. (n.d.). *[Administrative Rules for] Social Work General Rules*. Promulgated pursuant to Michigan Public Act 368 of 1978, Sections 16145(3) and 18501, as amended. Retrieved from http://www7.dleg.state.mi.us/orr/Files/AdminCode/104_85_AdminCode.pdf

APPROVED BY:



Thomas J. Renwick, Director
Bureau of Community Based Services



JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

DATE: August 25, 2009
TO: All Regional Substance Abuse Coordinating Agencies
FROM: Deborah A. Hollis, Acting Director
Office of Drug Control Policy (ODCP)
SUBJECT: Treatment Policy #11: *Fetal Alcohol Spectrum Disorders*

Attached is a final copy of Treatment Policy #11: *Fetal Alcohol Spectrum Disorders* (FASD). The purpose of this treatment policy is to provide guidance to the publicly funded substance abuse system regarding the requirement for FASD prevention and the pre-screening of children for FASD. This policy establishes the standards and expectations that were identified in Treatment Technical Advisory #4: *Fetal Alcohol Spectrum Disorder*, as contract requirements for Fiscal Year 2010.

ODCP received two comments from the field in response to the draft policy. The only change made was a revision to add a recommendation for programs serving men with children, that they be given consideration to include FASD prevention education within the treatment setting. Otherwise, there have been no other changes to the content of this document; it just seeks to move it from advisory status to policy status.

Comments and/or questions can be directed to Joyce Washburn at washburnjoy@michigan.gov or by phone at (517) 335-5247.

DJH:ssb

Attachment

TREATMENT POLICY # 12

SUBJECT: Women's Treatment Services

ISSUED: September 30, 2010

EFFECTIVE: October 1, 2010

PURPOSE:

The purpose of this policy is to establish the philosophy and requirements for women's treatment services (designated women's programs and gender competent programs).

SCOPE

This policy impacts the PIHP, its designated women's programs, and gender competent service provider network.

BACKGROUND

The Substance Abuse Prevention and Treatment (SAPT) Block Grant requires states to spend a set minimum amount each year for treatment and ancillary services for eligible women. Eligible women have been defined as, "pregnant women and women with dependent children, including women who are attempting to regain custody of their children." (42 U.S.C. 96.124 [e])

Pregnant women are identified as a priority population under the SAPT Block Grant regulations. Michigan Public Act 368 of 1978, part 62, section 333.6232, identifies "a parent whose child has been removed from the home under the child protection laws of this state or is in danger of being removed from the home under the child protection laws of this state because of the parent's substance abuse," as a priority population for substance use disorder services above others with substantially similar clinical conditions.

Michigan law extends priority population status to men whose children have been removed from the home or are at danger of being removed under the child protection laws. To support their entrance into and success in treatment, men who are shown to be the primary caregivers for their children are also eligible to access ancillary services such as child care, transportation, case management, therapeutic interventions for children, and primary medical and pediatric care, as defined by 45 CFR Part 96.

In August 2008, the National Association of State Alcohol and Drug Abuse Directors and the Women's Services Network (WSN), comprised of representatives from all 50 states, produced a document for the field entitled, *Guidance to States: Treatment Standards for Women with Substance Use Disorders*. This document is based on the knowledge and experience of the WSN

members. Its purpose is to improve substance use disorder treatment services to women through the establishment of standards that build on the capabilities, strengths and creativity of state systems and provider networks.

To be able to offer services that are gender and culturally competent, it is important to understand the client and their environment, and embrace values that promote the best services possible to the population. Successful recovery for women requires that the service delivery system integrates substance use disorder treatment, mental health services, recovery supports and, frequently, treatment for past traumatic events. When it is left to the woman seeking treatment to integrate these services, an unnecessary burden is placed on her and her potential for recovery.

To meet the specific needs of women, successful programs begin with an understanding of the emotional growth of women. Current thinking describes a woman's development in terms of the range of relationships in which a woman can engage. This is very different from the theories of emotional growth, which have been the basis of substance use disorder treatment, and which apply to the psychological growth of men. The relationship theories for women suggest that the best context for stimulating emotional growth comes from an immersion in empathic, mutual relationships.

The strongest impetus for women seeking treatment is problems in their relationships, especially with their children. A woman's self-esteem is often based on her ability to nurture relationships. Her motivation and willingness to continue treatment is likely to be fueled by her desire to become a better mother, partner, daughter, etc. Programs that meet the needs of women acknowledge this desire to preserve relationships as strength to be built upon, rather than as resistance to treatment. When a program operates from this theoretical point of view, the characteristics of the clinical treatment program, and its objectives and measures of success are defined very differently from those of traditional treatment programs.

Vision

To implement a change in the practice of women's substance use disorder treatment providers and system transformation in Michigan. This will be accomplished by having a strength-based coordinated system of care, driven by a shared set of core values that is reflected and measured in the way we interact with, and deliver supports and services for families who require substance abuse, mental health, and child welfare services.

Core Values

- ◆ Family-Centered: A family centered approach means that the focus is on the family, as defined by the client themselves. Families are responsible for their children and are respected and listened to as we support them in working toward meeting their needs, reducing system barriers, and promoting changes that can be sustained over time. The goal of a family-centered team and system is to move away from the focus of a single client

represented in a system, to a focus on the functioning, safety and wellbeing of the family as a whole.

- ◆ **Family Involvement:** The family's involvement in the process is empowering and increases the likelihood of cooperation, ownership and success. Families are viewed as full and meaningful partners in all aspects of the decision-making process affecting their lives, including decisions made about their service plans. It is important to recognize that a woman defines her own family and that this definition may not be traditional.
- ◆ **Build on Natural and Community Supports:** Recognize and utilize all resources in our communities creatively and flexibly, including formal and informal supports and service systems. Every attempt should be made to include the family's relatives, neighbors, friends, faith community, co-workers or anyone the family would like to include in the team process. Ultimately families will be empowered and have developed a network of informal, natural, and community supports so that formal system involvement is reduced or not needed at all.
- ◆ **Strength-Based:** Strength-based planning builds on the family's unique qualities and identified strengths that can then be used to support strategies to meet the family's needs. Strengths should also be found in the family's environment through their informal support networks, as well as in attitudes, values, skills, abilities, preferences and aspirations. Strengths are expected to emerge, be clarified and change over time as the family's initial needs are met and new needs emerge, with strategies discussed and implemented.
- ◆ **Unconditional Care:** Means that we care for the family, not that we will care "if." It means that it is the responsibility of the service team to adapt to the needs of the family – not of the family to adapt to the needs of a program. If difficulties arise, the individualized services and supports change to meet the family's needs.
- ◆ **Collaboration Across Systems:** An interactive process in which people with diverse expertise, along with families, generate solutions to mutually defined needs and goals building on identified strengths. All systems working with the family have an understanding of each other's programs and a commitment and willingness to work together to assist the family in obtaining their goals. The substance use disorder, mental health, child welfare and other identified systems collaborate and coordinate a single system of care for families involved within their services.
- ◆ **Team Approach Across Agencies:** Planning, decision-making and strategies rely on the strengths, skills, mutual respect, and creative and flexible resources of a diversified, committed team. Team member strengths, skills, experience and resources are utilized to select strategies that will support the family in meeting their needs. Team members may include representatives from the multiple agencies a family is involved in, as well as any who offer support and resources to families. All family, formal and informal team

members share responsibility, accountability, and authority; while understanding and respecting each other's strengths, roles and limitations.

- ◆ **Ensuring Safety:** When Children's Protective Services, foster care agencies, or domestic violence shelters are involved, the team will maintain a focus on family and child safety. Consideration will be given to whether the identified threats to safety are still in effect, whether the child is being kept safe by the least intrusive means possible and whether the safety services in place are effectively controlling those threats. In situations involving domestic violence, the team will need to work with the family to develop and maintain a viable safety plan.
- ◆ **Gender/Age/Culturally Responsive Treatment:** Services reflect an understanding of the issues specific to gender, age, disability, race, ethnicity and sexual orientation, and also reflect support, acceptance, and understanding of cultural and lifestyle diversity.
- ◆ **Self-sufficiency:** Families will be supported, resources shared and team members held responsible for achieving self-sufficiency in essential life domains (including, but not limited to safety, housing, employment, financial, educational, psychological, emotional and spiritual).
- ◆ **Education and Work Focus:** Dedication to positive, immediate and consistent education, employment and or employment-related activities that result in resiliency and self-sufficiency, improved quality of life for self, family and the community.
- ◆ **Belief in Growth, Learning and Recovery:** Family improvement begins by integrating formal and informal supports that instill hope and are dedicated to interacting with individuals with compassion, dignity and respect. Team members operate from a belief that every family desires change and can take steps toward attaining a productive and self-sufficient life.
- ◆ **Outcome Oriented:** From the onset of family team meetings, levels of personal responsibility and accountability for all team members, both formal and informal supports, are discussed, agreed upon and maintained. Identified outcomes are understood and shared by all team members. Legal, education, employment, child-safety and other applicable mandates are considered in developing outcomes. Progress is monitored and each team member participates in defining success. Selected outcomes are standardized, measurable and based on the life of the family and its individual members.

DEFINITIONS

Care Management/Care Coordination: An administrative function performed at the PIHP or through the access system, allowable under Medicaid, which manages an episode of care.

Case Management: A substance use disorder program that coordinates, plans, provides, evaluates and monitors services or recovery, from a variety of resources, on behalf of, and in collaboration with a client who has a substance use disorder. A substance use disorder case management program offers these services through designated staff working in collaboration with the substance use disorder treatment team and as guided by the individualized treatment planning process.

Eligible: Pregnant women and women with dependent children, including women who are attempting to regain custody of their children.

Gender Competent: Capacity to identify where difference on the basis of gender is significant, and to provide services that appropriately address gender differences and enhance positive outcomes for the population.

Gender-Responsiveness (Designated Women's Program): Creating an environment through site selection, staff selection, program development, content, and material that reflects an understanding of the realities of the lives of women and girls, and that addresses and responds to their strengths and challenges. (Bloom and Covington, 2000)

REQUIREMENTS AND PROCEDURE

The Michigan Department of Health & Human Services (MDHHS) is dedicated to the following fundamental principles as the foundation for integrating women-specific substance use disorder treatment services and non-gender specific services, while focusing on effective and comprehensive treatment of women and their families.

Developing a Philosophy of Working with Women who have Substance Use Disorders

Program Structure:

1. Treatment revolves around the role women have in society, therefore treatment services must be gender specific.
 - ◆ Gender-responsive programs are not simply “female only” programs that were designed for males.
 - ◆ A woman’s sense of self develops differently in women-specific groups as opposed to co-ed groups.
 - ◆ Because women place so much value on their role in society and relationships, to not take this into consideration in the recovery process is to miss a large component of a woman’s identity.
 - ◆ Equality does not mean sameness; in other words, equality of service delivery is not simply about allowing women access to services traditionally reserved for men. Equality must be defined in terms of providing opportunities that are relevant to each gender so that treatment services may appear very different depending on to whom the service is being delivered.

- ◆ The unique needs and issues (e.g., physical/sexual/emotional victimization, trauma, pregnancy and parenting) of women should be addressed in a safe, trusting and supportive environment.
 - ◆ Treatment and services should build on women's strengths/competencies and promote independence and self-reliance.
2. A relational model, based on the psychological growth of women shall be the foundation for recovery (e.g., the Self-in-Relation model). The recognition that, for women, the primary experience of self is relational; that is, the self is organized and developed in the context of important relationships. (Surrey, 1985)
- ◆ A model that emphasizes the importance of relationships in a woman's life, and attempts to address the strengths as well as the problems arising for women from a relational orientation.
3. A collaborative philosophy, driven by the woman and her family, shall be used.
- ◆ Utilizing cross-systems collaboration and the involvement of informal supports to promote a woman's recovery.
 - ◆ A client-centered, goal-oriented approach to accessing and coordinating services across multiple systems by:
 1. assessing needs, resources and priorities,
 2. planning for how the needs can be met,
 3. establishing linkages to enhance a woman's access to services to meet those identified needs,
 4. coordinating and monitoring service provision through active cross-system communication and coordinated treatment/service plans, and
 5. removing barriers to treatment and advocating for services.
 - ◆ A woman's needs determine the connections with agencies and systems that impact her life or her family's life, despite the number of agencies or systems involved.
 - ◆ Ideally, each woman will have a single, collaborative treatment plan or service plan used across systems. When this is not possible, coordination of as many systems as possible will lessen the confusion and stress this creates in a woman's life.
 - ◆ Care coordination and case management are the key to a woman's progress in recovery.
4. A model of empowerment is utilized in treatment and recovery planning.
- ◆ The client is shown and taught how to access services, advocate for herself and her family, and request services that are of benefit to her and her family.
 - ◆ This process is woven into recovery, and could be taught by a recovery coach or case manager.
 - ◆ The ultimate goal for the service system is to weave the woman so well into the informal support systems that the role of formal services is very small or not needed at all.
5. Employment is recommended as an important component in recovery and serves as an important therapeutic tool.

- ◆ The structure of work is a benefit to recovery, and treatment providers need to be aware of the work requirements of Temporary Assistance for Needy Families/Work First. Historically, treatment providers have been reluctant to encourage clients to return to work or engage in work related activities during the early stages of recovery. However, waiting to address employment concerns may create further challenges for the client facing Work First requirements.
6. A multi-system approach that is culturally aware shall be employed in the recovery process.
- ◆ Gender specificity and cultural competence go hand-in-hand. There are a number of gender and cultural competencies that allow people to assist others more effectively. This requires a willingness and ability to draw on community-based values, traditions and customs, and to work with knowledgeable people of and from the community.

Education/Training of Staff:

In addition to current credentialing standards, individuals working and providing direct service within a designated women's program (gender responsive) must have completed a minimum of 12 semester hours, or the equivalent, of gender specific substance use disorder training or 2080 hours of supervised gender specific substance use disorder training/work experience within a designated women's program. Those not meeting the requirements must be supervised by another individual working within the program, and be working towards meeting the requirements. Documentation is required to be kept in personnel files.

Those working and providing direct service within a gender competent program must have completed a minimum of 8 semester hours, or the equivalent, of gender specific substance use disorder training or 1040 hours of supervised gender specific substance use disorder training. Those not meeting the requirements must be supervised by another individual working within the program, and be working towards meeting the requirements. Documentation is required to be kept in personnel files. Other arrangements can be approved by the Office of Recovery Oriented Systems of Care (OROSC) Women's Treatment Coordinator.

Appropriate topics for gender specific substance use disorder training include, but are not limited to:

- ◆ Women's studies
- ◆ Trauma
- ◆ Grief
- ◆ Relationships
- ◆ Parenting
- ◆ Child Development
- ◆ Self-esteem/empowerment
- ◆ Relational treatment model
- ◆ Women in the criminal justice system
- ◆ Women and addiction

Admissions:

PIHPs and treatment providers must follow the priority population guidelines identified in the MDHHS/OROSC contract with PIHPs, listed below, for admitting women to treatment:

Population	Admission Requirement	Interim Service Requirement
<u>Pregnant Injecting Drug User</u>	1) Screened and referred within 24 hours. 2) Detoxification, methadone or residential – offer admission within 24 business hours. Other Levels of Care – offer admission within 48 business hours.	Begin within 48 hours: 1. Counseling and education on: a. HIV and TB. b. Risks of needle sharing. c. Risks of transmission to sexual partners and infants. d. Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early Intervention Clinical Services.
<u>Pregnant with Substance Use Disorder</u>	1) Screened and referred within 24 hours. 2) Detoxification, methadone or residential – offer admission within 24 business hours. Other Levels of Care – offer admission within 48 business hours.	Begin within 48 hours: 1. Counseling and education on: a. HIV and TB. b. Risks of transmission to sexual partners and infants. c. Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early Intervention Clinical Services.
<u>Injecting Drug User</u>	Screened and referred within 24 hours. Offer admission within 14 days.	Begin within 48 hours – maximum waiting time 120 days: 1. Counseling and education on: a. HIV and TB. b. Risks of needle sharing. c. Risks of transmission to sexual partners and infants. 2. Early Intervention Clinical Services.
<u>Parent at Risk of Losing Children</u>	Screened and referred within 24 hours. Offer admission within 14 days.	Begin within 48 business hours: Early Intervention Clinical Services.
<u>All Others</u>	Screened and referred within seven calendar days. Capacity to offer admission within 14 days.	Not Required.

* The full table can be found in the MDHHS/OROSC contract with PIHPs.

The admission standards listed above should be considered minimum standards. Those CAs and programs interested in providing the best possible treatment to families should be meeting a higher standard for admission and interim service provision.

Treatment:

Programs that are designed to meet women's needs tend to be more successful in retaining women clients. For a provider to be able to offer women-specific treatment, its programs shall include the following criteria:

1. Accessibility

CAs and providers must demonstrate a process to reduce barriers to treatment by ensuring that priority population requirements are met, as well as providing ancillary services or ensuring that appropriate referrals to other community agencies are made.

- ◆ There are many barriers that may critically inhibit attendance and follow-through for women with children. They may include child care, transportation, hours of operation and mental health concerns.

2. Assessment

Assessment shall be a continuous process that evaluates the client's psychosocial needs and strengths within the family context, and through which progress is measured in terms of increased stabilization/functionality of the individual/family. In addition, all assessments shall be strength-based.

- ◆ Women with children need to be assessed and treated as a unit. Women often both enter and leave treatment because of their children's needs. By assessing the family and addressing areas that need strengthening, providers give women a better chance at becoming stable in their recovery.

3. Psychological Development

Providers shall demonstrate an understanding of the specific stages of psychological development and modify therapeutic techniques according to client needs, especially to promote autonomy.

- ◆ Many of the traditional therapeutic techniques reinforce women's guilt, powerlessness and "learned helplessness," particularly as they operate in relationships with their children and significant others.

4. Abuse/Violence/Trauma

Providers must develop a process to identify and address abuse/violence/trauma issues. Services will be delivered in a trauma-informed setting and provide safety from abuse, stalking by partners, family, other participants, visitors and staff.

- ◆ A history of abuse, violence and trauma often contributes to the behavior of substance abusing and dependent women. A provider who does not take this history into consideration when treating the woman is not fully addressing the addiction or resulting behaviors.

5. Family Orientation

Providers must identify and address the needs of family members through direct service, referral or other processes. Families are a family of choice defined by the clients themselves.

Agencies will include informal supports in the treatment process when it is in the best interest of the client.

- ◆ Many women present in a family context with major family ties and responsibilities that will continue to define their sense of self. Drug and alcohol use in a family puts children at risk for physical and emotional growth and developmental problems. Early identification and intervention for the children's problems is essential.

6. Mental Health Issues

Providers must demonstrate the ability to identify concurrent mental health disorders, and develop a process to have the treatment for these disorders take place, in an integrated fashion, with substance use disorder treatment and other health care. It is important to note that treatment for both mental health issues and substance use disorders may lead to the use of medication as an adjunct to treatment.

- ◆ Women with substance abuse problems often present with concurrent mood disorders and other mental health problems.

7. Physical Health Issues

Providers shall:

- ◆ inquire about health care needs of the client and her children, including completing the Fetal Alcohol Syndrome Disorder screening as appropriate (MDHHS/OROSC Treatment Policy #11, 2009),
- ◆ make appropriate referrals, and
- ◆ document client and family health needs, referrals, and outcomes.
 - Women with a substance use disorder and their children are at high risk for significant health problems. They are at a greater risk for communicable diseases such as HIV, TB, hepatitis and sexually transmitted diseases. Prenatal care for women using/abusing substances is especially important, as their babies are at risk for serious physical, neurological and behavioral problems. Early identification and intervention for children's physical and emotional growth and development, and for other health issues in a family is essential.

8. Legal Issues

Providers shall document each client's compliance and facilitate required communication to appropriate authorities within the guidelines of federal confidentiality laws. Additionally, programs will individualize treatment in such a way as to help a client manage compliance with legal authorities.

- ◆ Women entering treatment may be experiencing legal problems including custody issues, civil actions, criminal charges, probation and parole. This adds another facet to the treatment and recovery planning process and reinforces the need for case management associated with women's services. By helping a woman identify her legal issues, steps that need to be taken, and how to incorporate this information into goals for her individualized treatment plan, a provider can greatly reduce stress on the client and make this type of challenge seem more manageable.

9. Sexuality/Intimacy/Exploitation

Providers shall:

- ◆ conduct an assessment that is sensitive to sexual abuse issues,
- ◆ demonstrate competence to address these issues,
- ◆ make appropriate referrals,
- ◆ acknowledge and incorporate these issues in the recovery plan, and
- ◆ assure that the client will not be exposed to exploitive situations that continue abuse patterns within the treatment process (co-ed groups are not recommended early in treatment, physical separation of sexes is recommended in residential treatment settings).
 - A high rate of treatment non-compliance among females with substance use disorders, with a history of sexual abuse, has been documented. The frequent incidence of sexual abuse among women with substance use disorders necessitates the inclusion of questions specifically related to the topic during the initial evaluation (assessment) process. Lack of recognition of a sexual abuse history or improper management of disclosure can contribute to a high rate of non-compliance in this population.

10. Survival Skills

Providers must identify and address the client's needs in the following areas, including but not limited to:

- ◆ Education and literacy.
- ◆ Job readiness and job search.
- ◆ Parenting skills.
- ◆ Family planning.
- ◆ Housing.
- ◆ Language and cultural concerns.
- ◆ Basic living skills/selfcare.

The provider shall refer the client to appropriate services and document both the referrals and outcomes.

- ◆ Women's treatment is often complicated by a variety of problems that must be addressed and integrated into the therapeutic process. Many of these problems may be addressed in the community, utilizing community resources, which will in turn help the client build a supportive relationship with the community.

11. Continuing Care/Recovery Support

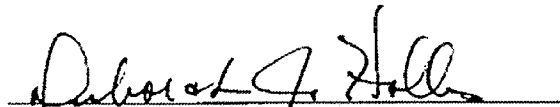
Providers shall:

- ◆ develop a recovery/continuing care plan with the client to address and plan for the client's continuing care needs,
- ◆ make and document appropriate referrals as part of the continuing care/recovery plan, and
- ◆ remain available to the client as a resource for support and encouragement for at least one year following discharge.
 - In order for a woman to maintain recovery after treatment, she needs to be able to retain a connection to treatment staff or case managers, and receive support from appropriate services in the community.

REFERENCES

- Bloom, B., & Covington, S. (2000, November). *Gendered justice: programming for women in correctional settings*. Paper presented to the American Society of Criminology, San Francisco, CA, p. 11.
- Covington, S. & Surrey J. (2000). *The relational model of women's psychological development: implications for substance abuse*. (Work in Progress, no. 91). Wellesley, MA: Stone Center, Working Paper Series.
- Mandell, K. & Werner, D. (2008). *Guidance to states: treatment standards for women with substance use disorders*. National Association of State Alcohol and Drug Abuse Directors.
- Mee-Lee D., Shulman G.D., Fishman M., Gastfriend D.R., & Griffith J.H., eds. (2001). *ASAM patient placement criteria for the treatment of substance-related disorders*. (Second Edition-Revised) (ASAM PPC-2R). Chevy Chase, MD: American Society for Addiction Medicine, Inc.
- Michigan Department of Health & Human Services, Office of Recovery Oriented Systems of Care (MDHHS/OROSC). (2009). *Substance Abuse Treatment Policy #11: Fetal Alcohol Spectrum Disorders*. Retrieved from http://www.michigan.gov/mdhhs/0,1607,7-132-2941_4871_4877-133156--00.html.
- State of Michigan, State Office of Administrative Hearings and Rules. (1981). *Michigan administrative code, substance use disorder service programs*. Retrieved from http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&Admin_Num=32514101&Dpt=CH&RngHigh=.
- Surrey, J. (1985). *Self in relation: a theory of women's development*. Retrieved November 20, 2009 from www.wcwoonline.org.

APPROVED BY:


Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services