Substance Abuse - Residential

Health Resources & Services Administration (HRSA) Definition: Substance Abuse Services (residential) activities are those provided for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. Activities provided under the Substance Abuse Services (residential) service category include:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication-assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Detoxification, if offered in a separate licensed residential setting (including a separately licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital).

Program Guidance: Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the HRSA Ryan White HIV/AIDS Program (RWHAP).

Acupuncture therapy may be an allowable cost under this services category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the HRSA RWHAP.

Note: HRSA RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.

Unit of Service: A unit is defined as one bed-day.

Eligibility: Clients shall meet eligibility requirements as defined in the System-Wide Standards of Care.

1.0 Agency Policies and Procedures

The Agency shall have Policies and Procedures to ensure ~~that~~ the services are accessible to all eligible clients. The Agency's policies and procedures shall ensure compliance with the following Standards:

1.0 Agency Policies and Procedures

	Standards		Measures
1.1	Comply with Florida Administrative Code Chapter 65D-30.007 and Chapter 397 of Florida Statutes.	1.1	Current licensure displayed. Staff resume, license, and certifications on file.
1.2	Providers shall maintain awake, paid staff coverage 24 hours per day, 7 days per week.	1.2	Staffing plan demonstrates the required staff coverage.
1.3	No primary counselor shall have a caseload that exceeds 15 currently participating clients.	1.3	Caseloads reflect the requirement.

2.0 Scope of Service

The agency shall comply with all of the requirements outlined in this Standard of Care unless otherwise specified in their contract.

2.0 Scope of Service

	Standards		Measures
2.1	There shall be detoxification services and three levels of residential treatment. In each level, treatment shall be structured to serve clients who need a safe and stable living environment in order to develop sufficient recovery skills for the transition to a less restrictive level of care or reintegration into the general community in accordance with placement criteria. Treatment shall also include a schedule of services provided within a positive environment that reinforces the client's recovery and clients shall be	2.1	Placement criteria reflect the required levels of residential treatment. Assessment and treatment plan reflect the appropriate level of care.

placed in a level of residential treatment that is based upon their treatment needs and circumstances. The following definitions are from Florida's State Residential Treatment for Behavioral Health Conditions: Regulation and Policy:

- **Residential Level I** services are not funded by the RWHAP Part A or Part B in the Orlando Service Area.
- **Residential Level II** programs include those that are referred to as Therapeutic Communities (TC) or some variation of TC and length of stays (LOS) are shorter in term than level I. This level is appropriate for persons characterized as having chaotic and often abusive interpersonal relationships, extensive criminal justice histories, prior treatment episodes in less restrictive levels of care, inconsistent work histories and educational experiences, and anti-social behavior. In addition to clinical services, considerable emphasis shall be placed on services that address the client's educational and vocational needs, socially dysfunctional behavior, and need for stable housing upon discharge. It shall also include services that assist the client in remaining abstinent upon returning to the community.
- **Residential Level III** programs include those that are referred to as Domiciliary Care (DC) and are generally

longer term than Level I. This level is appropriate for persons whose cognitive functioning has been severely impaired from the chronic use of substances, either temporarily or permanently. This would include persons who have varying degrees of organic brain disorder or brain injury or other problem that require extended care. The emphasis shall be on providing services that work on cognitive problems and activities of daily living, socialization, and specific skills to restore and maintain independent living. The services are typically slower paced, more concrete and repetitive. There shall be considerable emphasis on relapse prevention and reintegration into the community. This shall involve considerable use of case management and networking residents into ancillary or wrap-around services such as housing, vocational services, transportation, and self-help meetings.

- **Residential Level IV** programs include those that are referred to as Transitional Care and are generally short-term. This level is appropriate for persons who have completed other levels of residential treatment, particularly levels II and I. This includes clients who have demonstrated problems in applying recovery skills, a

	lack of personal responsibility, or a lack of connection to the world of work, education or family life. Although clinical services shall be provided, the main emphasis shall be on services that are low-intensity and typically emphasize a supportive environment. This would include services that focuses on recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual into the worlds of work, education and family life.	
2.2	• Each client shall receive services each week. The services shall include a specified number of hours of counseling as provided for below: • **Level II** - each client shall receive services in accordance with subsection 65D-30.007(4), F.A.C, including at least 10 hours of counseling; • **Level III** - each client shall receive services in accordance with subsection 65D-30.007(4), F.A.C, including at least 4 hours of counseling; and, • **Level IV**- each client shall receive services in accordance with subsection 65D-30.007(4), F.A.C, including at least 2 hours of counseling.	2.2 Documentation in client clinical record reflects the specified services in accordance with the needs of the client as identified in the Treatment Plan.

2.3	Substance Abuse residential services shall include the following: • Biopsychosocial Assessments; • Treatment plan development; • Treatment Plan/ Review; • Urine Drug Screening; • Psychotherapeutic Treatment to include: individual sessions, group sessions, and case consultations; • crisis intervention; • referral for Psychiatric Evaluation and Treatment; and • Other services as deemed clinically appropriate. With the exception of counseling, it is not intended that all services listed below be provided. However, services shall be provided in accordance with the needs of the client as identified in the treatment plan as follows: • Individual counseling; • Group counseling; • Counseling with families; • Substance abuse education, such as strategies for avoiding substance abuse or relapse, health problems related to substance abuse, and motivational enhancement and strategies for achieving a substance-free lifestyle; • Life skills training such as anger management, communication skills, employability skills, problem solving, relapse prevention, recovery training, decision-making,	2.3 Documentation in client clinical record.

	relationship skills and symptom management; • Non-verbal therapies such as recreation therapy, art therapy, music therapy, or dance (movement) therapy to provide the client with alternative means of self-expression and problem resolution; • Training or advising in health and medical issues; employment and educational support services to assist client in becoming financially independent; and •Mental health services for the purpose of: Managing client with disorders who are stabilized; Evaluating client's needs for in-depth mental health assessment; Training client to manage symptoms; and Timely referral to an appropriate provider for mental health crises or the emergence of a primary mental health disorder when the provider is not staffed to address primary mental health problems.	
2.4	Biopsychosocial assessment shall be completed within two visits, but no longer than 30 days. Biopsychosocial assessment will include at a minimum: • Presenting problem • History of the presenting illness or problem • Psychiatric history; • Trauma history;	2.4 Complete assessment, signed and dated by the licensed professional in client's clinical record. If assessment is not completed in 30 days, reason for delay to be documented in progress note.

	• Medication history; • Alcohol and other drug use history; • Relevant personal and family, medical history; • Mental health status exam; • Cultural influences; • Educational and employment history; • Legal history; • General and HIV related medical history; • Medication adherence; • HIV risk behavior and harm reduction; • Summary of findings; • Diagnostic formulation; • Current risk of danger to self and others; • Social support and functioning, including client strengths/weaknesses, coping mechanisms and self-help strategies; • Domestic violence/abuse history; and, • Treatment recommendations or plan.	
2.5	A Biopsychosocial update is ongoing and driven by client's needs, when client's status has changed significantly or when client has left and re-entered treatment. A Biopsychosocial update is required to be completed at a minimum of every six month	2.5 Progress notes or new assessment demonstrating update in client's clinical record.

2.6	Assessments and updated assessment completed by unlicensed providers shall be co-signed by licensed clinical supervisor. •	2.6 2.6	Co-signature on file in client's clinical record.
2.7	An Individualized Treatment Plan shall be developed with the participation of the client within thirty (30) days of identifying the needs, and shall be client-centered and consistent with the client's identified strengths, abilities, needs and preferences.	2.7	The Treatment Plan in client's clinical record reflects specified time frames and requirements. If the Treatment Plan is not completed within thirty days of identifying the needs, reason for delay must be documented in progress note.
2.8	The Treatment Plan shall contain all of the following components: •The client's diagnosis code (s) consistent with assessment(s) •Individualized, strength-based goals, and appropriate to the client's diagnosis, age, culture, strengths, abilities, preferences, and needs, and expressed by the client •The Treatment modality (group or individual) •Measurable objectives with target completion dates that are identified for each goal •The Start date of services, recommended number of sessions, frequency, and duration of each service for the six-month duration of the Treatment Plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to use "as needed", "p.r.n" or to state that the client will receive a service "x to y times per week".	2.8	The Treatment Plan in the client's clinical record reflects all required components.

	•The Date of re-assessment •Projected treatment end date	
2.9	Treatment Plan is signed by a licensed professional	2.9 Treatment Plan in client's clinical record is signed and dated by a licensed professional.
2.10	A formal review of the Treatment Plan with the client shall be conducted at least every six months. The Treatment Plan shall be reviewed more often when significant changes occur.	2.10 Documentation of the formal Treatment Plan review with the client shall be in the client's clinical record within the specified time frame.
2.11	Activities, notations of discussions, findings, conclusions, and recommendations shall be documented during the Treatment Plan review. Any modifications or additions to the Treatment Plan must be documented based on the results of the review. The Treatment Plan review shall contain the following components: •Current diagnosis code(s) and justification for any changes in diagnosis •Client's progress toward meeting individualized goals and objectives •Client's progress towards meeting individualized discharge criteria •Updates to after care plan •Findings •Recommendations •Dated signature of the client •Dated signature of the client's parent, guardian or legal guardian/custodian (If client is under 18 years of age)	2.11 Written documentation must be included in the client's clinical record upon completion of the Treatment Plan review activities.

	•Signatures of the treatment team members who participated in review of the plan Treatment Plan review completed by unlicensed providers shall be co-signed by a licensed clinical supervisor. If the Treatment Plan review process indicates that the goals and objectives have not been met, documentation shall reflect the treatment team's re-assessment of services and justification if no changes are made.	
2.12	A periodic re-evaluation of the Treatment Plan shall be completed at least monthly and is amended based on life changes or client's circumstances.	2.12 Documentation in client's clinical record reflects re-evaluation in a monthly basis.
213	All client must have had a physical exam within the past 6 months. If they have not, one must be provided or coordinated for them.	2.13 Documentation in client clinical record of a physical exam
2.14	Each provider shall arrange for or provide transportation services to client who are involved in activities or in need of services that are provided at other facilities.	2.14 Documentation of transportation in client clinical record.
2.15	**Detoxification** – Detoxification is a process involving acute or subacute care that is provided on a non-hospital inpatient to assist individuals who meet the placement criteria for this component to	2.15 Documentation in client's clinical record of the need for detoxification.

withdraw from the physiological and psychological effects of substance use. The following standards apply for inpatient detoxification.

- **(a) Services:**
  - 1. Stabilization services shall be provided as an initial phase of detoxification.
  - 2. Supportive Counseling. Each individual shall participate in supportive counseling on a daily basis unless the individual is not sufficiently stable. Supportive counseling sessions shall be of sufficient duration to enable staff to make reasonable decisions regarding the individual's need for other services. Services shall be directed toward ensuring that the individual's most immediate needs are addressed and encouraging the individual to remain engaged in treatment and to follow up on referrals after discharge.
  - 3. Daily Activities. The provider shall develop a schedule of daily activities that will be provided based on the detoxification protocols as defined in subsection 65D-30.002(27), F.A.C. This shall include recreational and educational activities, and participation shall be documented in the clinical record.
  - 4. Involuntary Assessment and Disposition. Individuals who are involuntarily admitted into a detoxification unit

Documentation in client's clinical record of services provided.

Client's clinical record shall document the instability of the client if supportive counseling is not provided.

Documentation of daily activities provided in client's clinical record.

Observation of space layout

Observation of posted information.

under protective custody, emergency admission or involuntary assessment and stabilization pursuant to section 397.6772, 397.6797, or 397.6811, F.S., shall be assessed and referred as in subsection 65D-30.005(9), F.A.C.	Appropriate staffing documented.
• (b) **Observation of Individuals**. Individuals requiring close medical observation, as determined and documented by medical staff, shall be visible and readily accessible to nursing staff. Individuals who do not require close medical observation shall be in a bed area that allows for general nursing observation.	
• **(c) Staff Coverage.** Each facility shall have a physician on call at all times to address medical problems and to provide emergency medical services. The physician's name, telephone number, and schedule for this arrangement shall remain current and clearly posted at the nurse's station. An R.N. shall be the supervisor of all nursing services and shall be on-call 24 hours per day, 7 days per week. An L.P.N. or R.N. shall be on-site 24 hours per day, 7 days per week. All staff shall have immediate access to a nurse supervisor or physician for consultation.	
• **(d) Staffing Requirement and**	

Bed Capacity. The minimum staffing requirements for nurses and nursing support personnel must be in alignment with Florida Statute 65E-12.105.	

3.0 Discharge

Client who are no longer engaged in Substance Abuse Services (residential) or have achieved self-sufficiency shall have their cases closed based on the criteria and protocol outlined in the client Treatment Plan and the Agency's Policies and Procedures Manual.

3.0 Discharge

Standards		Measures	
3.1	Upon termination of services, client's case shall be closed and a discharge summary completed within 30 days of last contact. For face-to-face discharge, clients shall receive a discharge plan which has been approved by a clinical supervisor.	3.1	Documentation of discharge summary in client's clinical record. For face to face discharge, document is signed by the client and the clinical supervisor.
3.2	Discharge plan should include the following: reason for closure, outline available resources and follow up instructions, and signed by the provider and the clinical supervisor.	3.2	Written documentation included in client's clinical record including required components upon completion.
3.3	Cases may be closed when the client: • Has achieved all goals listed on the Treatment Plan; • Has become ineligible for services;	3.3	Documentation of reasons for case closure in client's clinical record.

	• Is deceased; • No longer needs the service • Decide to discontinue the service; • The Service provider is unable to contact the client thirty (30) days after expired eligibility; or • Is found to be improperly utilizing the service or is asked to leave the program.		
	All discharged client shall be offered an exit interview via one of the following: • face-to-face visit; • telephone call; or • written communication **Note: When the treating provider is not able to conduct an exit interview, reason must be documented in the record**	3.4	
3.4	All attempts to contact the client and notification about case closure shall be communicated to the referral source Medical Case Manager/Supervisor.	3.5	Documentation that an exit interview was offered shall be recorded in client's clinical record. If an exit interview was not completed the reason must be stated. Documentation of attempts to contact clients and communication about case closure with the MCM/ Supervisor.