

---

Commonwealth of Pennsylvania  
Department of Drug and Alcohol Programs

Pennsylvania's  
Client Placement  
Criteria  
for Adults

Third Edition  
2014



# Table of Contents

<b>A. INTRODUCTION</b> .....	<b>1</b>
A.1 DEVELOPMENT OF THE CRITERIA .....	1
A.1.1 <i>Initial Development of the PCPC</i> .....	1
A.1.2 <i>The 2014 Revision</i> .....	2
A.2 ACKNOWLEDGEMENTS .....	4
A.3 PRINCIPLES OF TREATMENT .....	6
<b>B. HOW TO USE THE CRITERIA</b> .....	<b>8</b>
B.1 GATHERING INFORMATION .....	8
B.2 INTERPRETING INFORMATION: THE MULTI-DIMENSIONAL APPROACH .....	8
B.3 APPLYING INFORMATION (HOW TO MAKE A LEVEL OF CARE DETERMINATION OR PLACEMENT DECISION) ....	9
B.4 ADMISSION AND CONTINUED STAY CRITERIA (DISCHARGE AND REFERRAL ONLY FOR OUTPATIENT) .....	10
B.5 WHEN TO USE CONTINUED STAY CRITERIA .....	10
B.6 USING THE CRITERIA IF AN INDIVIDUAL LEAVES AGAINST STAFF/MEDICAL ADVICE .....	11
B.7 A NOTE ON DOCUMENTATION AND CLINICAL JUSTIFICATION FOR SERVICES.....	11
B.8 PROCESS OF USING THE ADMISSION, CONTINUED STAY AND DISCHARGE CRITERIA .....	12
B.9 SPECIAL CONSIDERATIONS FOR ASSESSMENT AND PLACEMENT .....	14
B.10 MANAGING PLACEMENTS FOR INDIVIDUALS WITH CO-OCCURRING DISORDERS WITHIN THE PENNSYLVANIA SUD TREATMENT SYSTEM.....	16
<b>C. OVERVIEW OF CRITERIA</b> .....	<b>17</b>
C.1 ADMISSION CRITERIA OVERVIEW.....	17
C.2 CONTINUED STAY CRITERIA OVERVIEW .....	19
<b>D. LEVELS OF CARE AND PLACEMENT CRITERIA</b> .....	<b>21</b>
D.1 LEVEL .5 EARLY INTERVENTION .....	21
D.1.1 <i>Description of Service Level</i> .....	21
D.1.2 <i>Level .5 (Early Intervention) Admission Criteria Across 6 Dimensions</i> .....	22
D.1.3 <i>Level .5 Early Intervention Continued Stay Criteria</i> .....	22
D.2 LEVEL 1A: OUTPATIENT .....	23
D.2.1 <i>Description of Service Level</i> .....	23
D.2.2 <i>Level 1A (Outpatient) Admission Criteria Across 6 Dimensions</i> .....	24
D.2.3 <i>Level 1A (Outpatient) Continued Stay Criteria Across 6 Dimensions</i> .....	26
D.2.4 <i>Level 1A (Outpatient) Discharge Criteria Across 6 Dimensions</i> .....	28
D.2.5 <i>Level 1A (Outpatient) Do's and Don'ts</i> .....	29
D.2.6 <i>Level 1A (Outpatient) Special Populations Considerations</i> .....	31
D.3 LEVEL 1B: INTENSIVE OUTPATIENT .....	32
D.3.1 <i>Description of Service Level</i> .....	32
D.3.2 <i>Level 1B (Intensive Outpatient) Admission Criteria Across 6 Dimensions</i> .....	33
D.3.3 <i>Level 1B (Intensive Outpatient) Continued Stay Criteria Across 6 Dimensions</i> .....	35
D.3.4 <i>Level 1B (Intensive Outpatient) Do's and Don'ts</i> .....	37
D.3.5 <i>Level 1B (Intensive Outpatient) Special Populations Considerations</i> .....	39
D.4 LEVEL 2A: PARTIAL HOSPITALIZATION.....	40
D.4.1 <i>Description of Service Level</i> .....	40
D.4.2 <i>Level 2A (Partial Hospitalization) Admission Criteria Across 6 Dimensions</i> .....	42
D.4.3 <i>Level 2A (Partial Hospitalization) Continued Stay Criteria Across 6 Dimensions</i> .....	44
D.4.4 <i>Level 2A (Partial Hospitalization) Do's and Don'ts</i> .....	46

D.4.5 Level 2A (Partial Hospitalization) Special Populations Considerations .....	48
D.5 LEVEL 2B: HALFWAY HOUSE.....	49
D.5.1 Description of Service Level.....	49
D.5.2 Level 2B (Halfway House) Admission Criteria Across 6 Dimensions.....	50
D.5.3 Level 2B (Halfway House) Continued Stay Criteria Across 6 Dimensions.....	52
D.5.4 Level 2B (Halfway House) Do's and Don'ts.....	54
D.5.5 Level 2B (Halfway House) Special Populations Considerations .....	56
D.6 LEVEL 3A: MEDICALLY MONITORED INPATIENT DETOXIFICATION .....	57
D.6.1 Description of Service Level.....	57
D.6.2 Level 3A (Medically Monitored Inpatient Detox) Admission Criteria Across 6 Dimensions.....	59
D.6.3 Level 3A (Medically Monitored Inpatient Detox) Continued Stay Criteria Across 6 Dimensions .....	61
D.6.4 Level 3A (Medically Monitored Inpatient Detox) Do's and Don'ts .....	62
D.6.5 Level 3A (Medically Monitored Inpatient Detox) Special Populations Considerations .....	64
D.7 LEVEL 3B: MEDICALLY MONITORED SHORT TERM RESIDENTIAL .....	65
D.7.1 Description of Service Level.....	65
D.7.2 Level 3B (Medically Monitored Short Term Residential) Admission Criteria Across 6 Dimensions.....	67
D.7.3 Level 3B (Medically Monitored Short Term Residential) Continued Stay Criteria Across 6 Dimensions.....	69
D.7.4 Level 3B (Medically Monitored Short Term Residential) Do's and Don'ts .....	71
D.7.5 Level 3B (Medically Monitored Short Term Residential) Special Populations Considerations .....	73
D.8 LEVEL 3C: MEDICALLY MONITORED LONG TERM RESIDENTIAL .....	74
D.8.1 Description of Service Level.....	74
D.8.2 Level 3C (Medically Monitored Long Term Residential) Admission Criteria Across 6 Dimensions.....	76
D.8.3 Level 3C (Medically Monitored Long Term Residential) Continued Stay Criteria Across 6 Dimensions.....	79
D.8.4 Level 3C (Medically Monitored Long Term Residential) Do's and Don'ts .....	82
D.8.5 Level 3C (Medically Monitored Long Term Residential) Special Populations Considerations .....	84
D.9 LEVEL 4A: MEDICALLY MANAGED INPATIENT DETOXIFICATION .....	85
D.9.1 Description of Service Level.....	85
D.9.2 Level 4A (Medically Managed Inpatient Detox) Admission Criteria Across 6 Dimensions.....	87
D.9.3 Level 4A (Medically Managed Inpatient Detox) Continued Stay Criteria Across 6 Dimensions .....	90
D.9.4 Level 4A (Medically Managed Inpatient Detox) Do's and Don'ts.....	91
D.9.5 Level 4A (Medically Managed Inpatient Detox) Special Populations Considerations .....	93
D.10 LEVEL 4B: MEDICALLY MANAGED INPATIENT RESIDENTIAL .....	94
D.10.1 Description of Service Level.....	94
D.10.2 Level 4B (Medically Managed Inpatient Residential) Admission Criteria Across 6 Dimensions .....	95
D.10.3 Level 4B (Medically Managed Inpatient Residential) Continued Stay Criteria Across 6 Dimensions.....	97
D.10.4 Level 4B (Medically Managed Inpatient Residential) Do's and Don'ts.....	98
D.10.5 Level 4B (Medically Managed Inpatient Residential) Special Populations Considerations.....	100
<b>E. SPECIAL POPULATIONS AND CONSIDERATIONS .....</b>	<b>101</b>
E.1 SPECIAL POPULATION TOPIC: MEDICATION-ASSISTED TREATMENT .....	102
E.2 SPECIAL POPULATION TOPIC: CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS .....	105
E.3 SPECIAL POPULATION TOPIC: WOMEN AND WOMEN WITH CHILDREN.....	108

E.4 SPECIAL POPULATION TOPIC: CRIMINAL JUSTICE .....	111
E.5 SPECIAL POPULATION TOPIC: CULTURAL/ETHNIC.....	114
E.6 SPECIAL POPULATION TOPIC: SEXUAL ORIENTATION/GENDER IDENTITY .....	117
E.7 SPECIAL POPULATION TOPIC: CO-OCCURRING SUBSTANCE USE AND GAMBLING DISORDER .....	120
<b>APPENDIX 1: GLOSSARY OF TERMS .....</b>	<b>123</b>
<b>APPENDIX 2: PRINCIPLES OF TREATMENT NOTES AND REFERENCES .....</b>	<b>130</b>
<b>APPENDIX 3: TRAINING PRINCIPLES .....</b>	<b>134</b>
<b>APPENDIX 4: PCPC SUMMARY SHEET .....</b>	<b>136</b>
<b>APPENDIX 5: CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT FOR ALCOHOL, REVISED (CIWA-AR) .....</b>	<b>137</b>
<b>APPENDIX 6: THE CLINICAL INSTITUTE NARCOTIC ASSESSMENT (CINA) SCALE FOR WITHDRAWAL SYMPTOMS .....</b>	<b>139</b>
<b>APPENDIX 7: CLINICAL OPIATE WITHDRAWAL SCALE (COWS) .....</b>	<b>140</b>
<b>APPENDIX 8: ACT 152 OF 1988.....</b>	<b>141</b>
<b>APPENDIX 9: ACT 106 OF 1989.....</b>	<b>142</b>
<b>APPENDIX 10: REFERENCES.....</b>	<b>143</b>
<b>APPENDIX 11: ACRONYMS.....</b>	<b>151</b>
<b>APPENDIX 12: SUBCOMMITTEE ACKNOWLEDGEMENTS .....</b>	<b>152</b>

## **A. Introduction**

The Pennsylvania Client Placement Criteria for Adults (PCPC) are a set of guidelines designed to provide clinicians with a basis for determining the most appropriate care for individuals with substance use disorders (SUDs). These guidelines, which have been modified to fit Pennsylvania's specific needs and circumstances, include admission and continued stay criteria. The guidelines also give detailed guidance for special issues and populations that are important to ensuring that individuals receive optimal treatment placement. They have been formulated to promote a broad continuum of care, which places individuals in the most clinically appropriate setting, while providing the best opportunity to efficiently utilize SUD treatment, intervention, and other community resources. The PCPC plays a critical role in a Recovery Oriented System of Care (ROSC) by supporting two major ROSC elements: ensuring continuity of care and promoting access and engagement. The PCPC were developed through a comprehensive process initiated by the Pennsylvania Office of Drug and Alcohol Programs (ODAP), which was renamed the Bureau of Drug and Alcohol Programs (BDAP) in 1993 and, as of July 1, 2012, became the Department of Drug and Alcohol Programs (DDAP). It will be referred to as DDAP from here onward.

### **A.1 Development of the Criteria**

#### **A.1.1 Initial Development of the PCPC**

In 1993, DDAP began a comprehensive program to determine how to best ensure the most appropriate care for individuals experiencing problems associated with SUDs. This program, involving treatment providers, researchers, Single County Authorities, managed care organizations, and policy makers across the state of Pennsylvania, was begun in response to a series of developments in drug and alcohol legislation. In 1988, legislation was passed that required DDAP to develop criteria "governing the type, level, and length of care or treatment" of individuals with a SUD funded under Act 152. Soon after, in 1990, the Legislative Budget and Finance Committee recommended that DDAP develop "performance standards," new "case management regulations," and "a comprehensive standard assessment instrument to identify the most appropriate care." The Governor's Drug Policy Council, relating to the oversight of Health Maintenance Organizations, made similar recommendations in 1991.

DDAP began this initiative by establishing a Treatment Task Force that met for the first time in February 1993. This Task Force had four immediate objectives:

1. To recommend criteria for assessment and placement;
2. To recommend a list of acceptable assessment and placement instruments for statewide use;
3. To recommend standards and guidelines that could be used in monitoring behavioral health managed care plans; and
4. To recommend draft review criteria and procedures that could be used in analyzing, reviewing, and recommending the use of additional placement and assessment instruments.

The criteria that the Task Force sought to develop were not expected to tell professionals how to treat individuals. Rather, they were supposed to be simple, minimum standards used to inform the decision as to whether an individual with a SUD should have inpatient care, non-hospital rehabilitation, or outpatient care of some sort. It was expected that these guidelines would go a long way in promoting a broad continuum of care that placed individuals in a setting that would be the least intrusive, while providing the best opportunity to efficiently utilize health care resources.

In the 1980's, the National Association of Addiction Treatment Providers (NAATP) and the American Society of Addiction Medicine (ASAM) worked to refine the existing placement criteria. They hoped that the resulting criteria would more effectively discriminate between the needs for different types of care, enhance the guidelines for assessing the need for continued care at a given level of treatment, and improve the matching of individual needs to appropriate treatment resources. They identified and described four levels of treatment, differentiated by degrees of direct medical management, structure, and treatment intensity. The NAATP/ASAM Patient Placement Criteria were superseded in June of 1991 by the ASAM Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders. This document was used as one of the key foundations of the DDAP project, although it needed to be modified to fit the specific needs and circumstances of the state of Pennsylvania. DDAP soon received permission from ASAM to make these modifications.

Twelve focus groups were established to assist in the development of the Pennsylvania criteria: Outpatient care, Intensive Outpatient care, Partial Hospitalization, Short Term Rehabilitation (medically managed and medically monitored), Detoxification (medically managed and medically monitored), Methadone Treatment, treatment in Halfway House settings, Long Term Rehabilitation, Psychiatric Issues, Issues of Women with Children, Cultural Issues, and Alternative Lifestyle Issues. These groups were charged with the responsibility of identifying specific criteria to supplement the ASAM Patient Placement Criteria for each particular area, and developing materials specific to the characteristics which indicate that the individual is appropriate for the care modality being addressed. They assumed a full continuum of care for each individual, a previous diagnosis of Psychoactive Substance Use Disorder for the individual (as defined by the DSM), and an acceptance of the ASAM criteria on the part of each focus group for their particular level. The focus groups were expected to develop clinical assessment guidelines in such areas as the level of progression within recovery expected for an individual upon entering a particular service, identifiers which indicate the appropriateness of a specified service for an individual, and the level of functioning within recovery which is reached when it is appropriate for the individual to be transferred to the next level of service. The focus groups were also asked to isolate Admission Criteria, Continued Stay Criteria, and Discharge Criteria. After development and publication, the PCPC criteria were established and implemented through provider services across the state. A revised and updated edition (Pennsylvania's Client Placement Criteria for Adults, 2<sup>nd</sup> edition) was released in 1999.

### **A.1.2 The 2014 Revision**

DDAP convened the Clinical Standards Committee (CSC) in February 2009 to begin discussions of PCPC's revisions. The members determined that six subcommittees needed to be established based on the Special Needs and Considerations section of the PCPC 2nd edition (Medication-Assisted Treatment (MAT); Co-Occurring Disorders; Women and Women with Children; Cultural/Ethnic and Sexual Orientation/Gender Identity Considerations; Criminal Justice; Screening, Brief Intervention, Referral to Treatment [SBIRT]/Early Intervention). Three additional subcommittees were formed. The PCPC-ASAM Cross Walk subcommittee developed a comparison of the PCPC and ASAM content, levels of care (LOC) placement considerations, and length of stay (LOS). The Temperature Read subcommittee was tasked with development and dissemination of a survey to PCPC users to determine problematic areas of the current PCPC that might require revision. The Training Subcommittee assessed the PCPC training materials and techniques, and updated them according to the current needs of the Pennsylvania treatment system. The subcommittees met over a period of 5 years. The special populations subcommittees prepared scholarly papers regarding the current scientific evidence for providing optimal SUD treatment for each population, and general recommendations regarding what the major placement issues should be for each of these populations. A focus group comprised of established PCPC users and trainers convened by the Temperature Read subcommittee agreed that the PCPC were still valid, but that there were issues in praxis concerning

applying the criteria with special populations and incorrectly applying the criteria based only on the LOC available, rather than upon the individual's identified needs.

The PCPC-ASAM Crosswalk subcommittee carefully compared the PCPC to the ASAM placement criteria. Both the ASAM PPC-2R (2001) and The ASAM Criteria, Third Edition (2013) were assessed in crosswalk fashion with the PCPC to determine the similarities and differences between the placement guidelines. All of these measures emphasize the critical need for person-centered, multi-dimensional assessment. The original PCPC used the ASAM placement criteria as a foundation, and was developed with the permission of ASAM. The PCPC was then developed specifically for the Pennsylvania treatment continuum of care. It is a consensus document reflecting the expertise and input of professionals in the field from across the Commonwealth and fulfills statutory requirements. The revised PCPC provides clear guidance for placement that is directly related to the treatment options an individual may access in the Commonwealth of Pennsylvania. The ASAM placement criteria reflects treatment systems nationwide and includes services that are not widely used or available in Pennsylvania or necessarily appropriate for the population or focus of the PCPC (e.g. ASAM has extensive use of ambulatory withdrawal management). The revised PCPC is more congruent with the safety and recovery management needs of individuals in the rich continuum of Pennsylvania services.

The CSC reviewed the subcommittees' papers, focus group results and analyses, and determined that this PCPC version should reflect eight main changes:

1. Include Principles of Treatment, which were developed based on the science of SUD treatment and the whole person and community-based paradigm of recovery;
2. Introduce a new LOC: Early Intervention, for use with individuals engaging in unhealthy substance use that require a more intensive intervention than a brief intervention, but are not eligible for SUD treatment (since this level does not fall within the purview of treatment licensing, it can be provided within a general medical setting or other appropriate venue);
3. Include a DO/DON'T section on specific issues pertaining to the application of the criteria with special populations/issues in each LOC;
4. Replace the discharge/referral criteria in each LOC with overarching instructions for assessing the individual's continued fit with a given LOC, but retaining discharge criteria for the Outpatient LOC (the terminal level within the continuum);
5. Change language throughout to reflect awareness of gender, race, and ethnic concerns;
6. Change language regarding placement considerations related to co-occurring disorders to further refine the differentiation between Substance Use and Mental Health Disorders;
7. Update existing Special Populations/Considerations section and include new sections for Criminal Justice populations and Co-Occurring Substance Use and Gambling Disorder;
8. Expand upon the training considerations for the use of these criteria to ensure the PCPC is used with fidelity.

The following criteria are the work of the original PCPC focus groups that convened in the early 1990s, with changes reflecting the research, discussion and evidence-based principles of the revising CSC. They are ordered from least to most intensive modalities, and include general guidelines for: Early Intervention, Outpatient care, Intensive Outpatient care, Partial Hospitalization, treatment in Halfway House settings, Short term Rehabilitation (medically managed and medically monitored), Long term Rehabilitation, and Detoxification (medically managed and medically monitored).

## A.2 Acknowledgements

DDAP would like to thank all those individuals whose hard work has contributed to the PCPC 3<sup>rd</sup> Edition revision. Without tireless efforts and countless hours, this vitally important project would likely have never been completed.

We applaud the work of the Clinical Standards Committee, which was charged to support the implementation and further development of the PCPC, and to address additional clinical and systemic issues relevant to SUD treatment and intervention in the Commonwealth of Pennsylvania. The following are recognized for their work on this Committee:

### Chairs:

**Janice L. Pringle, PhD**  
Director  
Program Evaluation and  
Research Unit, University of  
Pittsburgh School of  
Pharmacy

**Michael Harle, MHS**  
President and Chief Executive  
Officer  
Gaudenzia, Inc.

### Members:

**Jim Aiello, MA, MEd**  
Northeast Addiction Technology  
Transfer Center

**James Bechtel, PhD,  
CCDP-D**  
Magellan Behavioral Health

**Kim Bowman, MS**  
Chester County Department of  
Human Services

**Jack Carroll, BS**  
Cumberland-Perry Drug and  
Alcohol Commission

**Sarah Davis, MSW, LSW**  
Pennsylvania Client Placement  
Criteria Trainer

**Mary Diamond, DO**  
Department of Public Welfare,  
retired

**Evan Dittman, BS**  
Cameron Elk McKean Counties  
Alcohol and Drug Abuse Services  
Inc.

**Mary A. Finck**  
Department of Corrections

**Cheryl Floyd, LSW**  
The Miracle Group

**Jeffrey Geibel, BA**  
Department of Drug and Alcohol  
Programs

**Amy Hedden**  
Department of Drug and Alcohol  
Programs

**Michael Henderson**  
Department of Drug and Alcohol  
Programs

**John Howell, EdD, LPC**  
Today, Inc.

**Doris Lugaro**  
Department of Public Welfare

**Kenneth Martz, PsyD, CAS**  
Department of Drug and Alcohol  
Programs

**Terry Matulevich**  
Department of Drug and Alcohol  
Programs

**Ted Millard, MSW**  
Good Friends, Inc.

**Bill Noonan**  
Department of Drug and Alcohol  
Programs, retired

**Richard Novak**  
Department of Public Welfare,  
retired

**Robin Rothermel**  
Department of Health

**Steven Seitchik, MA**  
Department of Drug and Alcohol  
Programs

**Mark Shirk**  
Department of Drug and Alcohol  
Programs

**Terri Somers, MA, LPC,  
CAADC**  
Department of Corrections

**William Stauffer, CADC, LSW**  
Pennsylvania Recovery  
Organizations Alliance

**Trusandra Taylor, MD**  
JEVS Human Services

**Kate Vandegrift, MA**  
Thomas Jefferson University  
(Maternal Addiction Treatment  
Education and Research)

**Cecilia Velasquez, MHS,  
CAADC, CCJP**  
Gaudenzia, Inc.

**Cheryl Williams**  
Department of Drug and Alcohol  
Programs, retired

**Technical Writer:**

**Rachel Thomas, MA**  
Program Evaluation and  
Research Unit,  
University of Pittsburgh  
School of Pharmacy

Additionally, the Committee agreed to form subcommittees addressing several issues that are relevant to the criteria such as Screening, Brief Intervention and Referral to Treatment (SBIRT), Early Intervention, PCPC User Training, and a comparison of the PCPC to the ASAM placement criteria. Special Populations subcommittees were also formed, and provided scholarly papers based on the current scientific evidence and placement considerations for topics such as: MAT, Co-Occurring Disorders, Criminal Justice, Women and Women with Children, Cultural/Ethnic and Sexual Orientation/Gender Identity Considerations. DDAP would like to thank all those who have participated on these various subcommittees for their dedication and commitment. A detailed list of these subcommittee members can be found in Appendix 12.

## A.3 Principles of Treatment

Individuals with SUDs can respond well to intervention and treatment. The concomitant provision of human services and supportive care (including participation in formal recovery support services) is often necessary for individuals receiving SUD treatment to achieve long-term recovery. Individuals with SUDs also require access to a coordinated continuum of services that are clinically appropriate in intensity, duration, and frequency. The appropriate services continuum for SUDs should be based on a formal clinical assessment conducted by properly trained professionals during which the individual's status, SUD severity and other service needs are effectively determined. The results of this assessment should be used with clinically relevant placement criteria (in Pennsylvania, the PCPC for adults and the ASAM for adolescents) to match individuals to the appropriate LOC. Research shows that SUD treatment is highly effective when provided at the appropriate LOC for the proper duration and dosage, and that SUD treatment outcomes have success rates equal to other chronic illnesses (National Institute on Drug Abuse [NIDA], 1999/2009).

Two platforms in the SUD treatment field form the foundation of the following principles: the science of SUD treatment, and the whole person and community-based paradigm of recovery. Principles derived from the platform of the science of SUD treatment aspire to implement research-based elements of effective treatment directly into practice. Principles based on the platform of recovery focus on the strengths of the person and his or her connections within a community of recovery supports.

The Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services (OMHSAS) and DDAP have collaborated with state and county agencies, treatment providers and recovery community organizations across Pennsylvania to develop and implement a Recovery-Oriented System of Care (ROSC). In a ROSC, treatment and recovery support services must be integrated into a single, seamless continuum of care that is driven by an individual's needs (Pennsylvania Drug and Alcohol Coalition [PDAC], 2010, p. 15).

The following principles should be kept in mind in providing services to those in need of SUD treatment and support.

1. Treatment is optimal when provided through individualized and coordinated treatment interventions, follow up and recovery support services that lead to each individual's long-term recovery.
2. Beyond cessation of substance use, SUD treatment should also address the individual's needs through the provision of comprehensive services (viz., mental health, medical, family, legal, basic needs, housing, transportation, etc.) provided within seamlessly linked systems of care.
3. Specific strategies and specialized programs can foster resiliency and recovery for individuals in diverse ethnic and cultural communities and in specific life situations.
4. No single treatment is appropriate for everyone.
5. Treatment should be readily available and accessible.
6. Within the continuum of treatment services, treatment placement recommendations need to be based on a comprehensive assessment that includes a review of the severity and biopsychosocial impact of the individual's substance use as well as the individual's clinical, social and recovery status (e.g., mental health status, social functioning, health status, recovery capital, family and legal status).
7. Remaining in treatment for an appropriate period of time is critical to positive outcome.

8. When combined with counseling and other behavioral therapies, medications can be an important element of treatment for some individuals.
9. An individual's treatment and services plan must be continually assessed and modified by/with the individual to meet his or her needs.
10. Many individuals have co-occurring SUD and mental health needs that must be coordinated and treated in an integrated fashion.
11. Treatment does not need to be voluntary to be effective.
12. SUD is a lifelong condition that needs ongoing monitoring.
13. Individuals with SUDs require unrestricted access to the full range of SUD and other health and human services.
14. The therapeutic alliance between the SUD treatment provider and the individual is one of the best predictors of successful engagement, retention and outcome.
15. Intervention is preventative.
16. Medically assisted detoxification is only stabilization and by itself does little to change long-term SUDs.
17. All levels of care should assess individuals for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling to help modify or change behaviors that place them at risk of contracting or spreading infectious diseases.
18. Treatment and recovery systems can and should continually evolve to serve individuals and communities appropriately.
19. Medication reconciliation, the practice of gathering information about previously prescribed medications and evaluating potential adverse consequences or interactions with new medications, should be practiced with each individual at intake.

## B. How to Use the Criteria

The Clinical Decision-Making Process: Gathering, Interpreting, and Applying Information

### B.1 Gathering Information

**A comprehensive clinical assessment is vital to the placement process, and must be conducted by a qualified professional prior to applying the PCPC for LOC determination.** Because SUDs are biopsychosocial in nature, assessments must be comprehensive and multidimensional to determine the LOC and service needs of the individual.

Assessing the individual for any **special needs** is also an important part of this process. DDAP recognizes that individuals who come from specific backgrounds, or whose lives are affected by special circumstances, may require placement in a program tailored to meet their specific needs. Each LOC includes concerns specific to that level regarding special population/consideration issues. Section E of the PCPC includes assessment considerations and narratives describing such programs for the following populations: **individuals currently engaged in MAT, individuals with co-occurring substance use and mental health disorders, individuals in the criminal justice system, women and women with children, individuals from ethnic minorities, and individuals with sexual orientation/gender identity issues (Lesbian/Bisexual/Gay/Transgender/Questioning/Intersex or LGBTQI).**

### B.2 Interpreting Information: The Multi-Dimensional Approach

Once assessment information is gathered, it can be related to each of the six dimensions specified in the PCPC. Individuals who have been diagnosed as having a SUD are very often suffering with other conditions or problems at the same time. These additional difficulties can have a significant impact on the individual's understanding and confrontation of his or her presenting problem and on the fulfillment of his or her long-term treatment goals. Information gathered during the assessment is interpreted and related to the PCPC so that a clinical determination can be made according to dimensional specifications (see the dimensional matrix under each type of service [TOS] for detailed specifications). While the dimensions are comprehensive in taking into account all of the factors involved in an individual's SUD, the goal of each dimension is to capture a particular facet of the problem and gauge the severity or degree to which that facet contributes to the overall disorder.

The PCPC guides placement determinations based on severity and level of functioning in each of the following dimensions:

**Acute Intoxication and Withdrawal** – This dimension addresses the severity of the individual's presenting SUD. The interviewer attempts to assess the severity of the individual's SUD and the degree of impairment in everyday functioning. Of particular concern is the risk of severe withdrawal syndrome. An individual who is experiencing symptoms of withdrawal (or who is at great risk of doing so) may require treatment in an intensive TOS.

**Biomedical Conditions and Complications** – This dimension investigates the individual's overall physiological condition in order to determine whether there are any medical problems or concerns. If an individual is suffering from a medical problem that is complicated by substance use, or he or she has a health problem of such severity that medical care is immediately necessary, then the inclusion of medical management in the treatment setting becomes critically important.

**Emotional/Behavioral Conditions and Complications** – This dimension addresses the individual's

mental status, in terms of the effects of any emotional or behavioral problems on the presenting SUD. The individual is evaluated in terms of his or her emotional stability, and the interviewer attempts to assess the degree to which the individual could present a danger to self or others. The goal of this dimension is to identify any mental health disorders which could complicate SUD treatment, and which may need to be treated concurrently or within the mental health treatment system. This dimension also identifies any unpredictable or self-defeating behaviors in response to emotional or environmental stressors.

**Treatment Acceptance/Resistance** – This dimension examines the individual’s attitude towards treatment. The degree to which the individual understands the nature and consequences of his or her SUD, as well as his or her motivation to engage in recovery, are vital considerations to be made when deciding upon an appropriate setting for treatment.

**Relapse Potential** – This dimension’s focus is the individual’s ability to maintain abstinence from alcohol and other drugs. It examines how the individual deals with triggers and cravings, and attempts to assess what changes in behavior are needed for him or her to maintain abstinence. Like the treatment acceptance dimension, this is a critical gauge of the degree of structure the individual needs in his or her treatment program.

**Recovery Environment** – This dimension evaluates the individual’s social and living environment in terms of how it promotes or denigrates the individual’s recovery efforts. Its main concern is whether or not the individual’s peers, family, and/or significant others are supportive of his or her recovery, either directly or indirectly. Severe conditions can require relief from the social environment in a structured setting, and information about the individual’s coping patterns can be valuable in developing his or her treatment plan.

### **B.3 Applying Information (How to Make a Level of Care Determination or Placement Decision)**

Once the individual has been properly assessed, and he or she meets each dimensional specification for a particular LOC, the PCPC provides for an overall LOC determination based on all the dimensions. This is often referred to as dimensional scoring.

Information obtained from a comprehensive assessment is interpreted according to dimensional severity (using the PCPC dimensional matrix) in order to determine the most appropriate LOC and TOS. Each LOC, from outpatient to medically managed residential, has its own dimensional specifications. For example, for a Level 1A (Outpatient) determination, the individual must meet the dimensional specifications for outpatient care in dimensions 1, 2, 3, 4, 5, and 6 (see the Overview of Criteria, pages 17-20, or the dimensional matrix, pages 24-25, for additional LOC specifications). Assessors are not to place individuals in the lowest LOC, but in the most appropriate LOC based on their need at the time of the assessment.

The PCPC includes 5 levels of care and 10 types of service:

**Level .5**

Early Intervention

**Level 1**

**A** Outpatient

**B** Intensive Outpatient

**Level 2**

- A Partial Hospitalization
- B Halfway House

**Level 3**

- A Medically Monitored Detox
- B Medically Monitored Short-Term Residential
- C Medically Monitored Long-Term Residential

**Level 4**

- A Medically Managed Inpatient Detox
- B Medically Managed Inpatient Residential

**B.4 Admission and Continued Stay Criteria (Discharge and Referral ONLY for Outpatient)**

As the full clinical picture emerges through continued evaluation, placement decisions and lengths of stay may need to be reconsidered. Admission and continued stay criteria should therefore be utilized at every TOS throughout the continuum of care. In this way, the individual receives SUD treatment services at the most appropriate LOC until he or she has developed coping strategies sufficient to be able to support a self-directed recovery program, and no longer meets the admission criteria for any LOC.

**B.5 When To Use Continued Stay Criteria**

Continued stay criteria are used to review and determine the clinical necessity of an individual's status in a particular LOC and TOS. Use of continued stay criteria ultimately determines the appropriate LOS (until admission criteria are met for another LOC or the individual is discharged from the continuum).

The following are the timeframes for continued stay review:

<b>Level of Care</b>	<b>Timeframes</b>
Outpatient	Every 60 to 180 days
Intensive Outpatient	Every 30 to 120 days
Partial Hospitalization	Every 30 to 60 days
Halfway House	Every 30 to 60 days
Medically Monitored Detox	Every 3 to 7 days
Medically Monitored Residential, Short-Term	Every 7 to 14 days
Medically Monitored Residential, Long-Term	Every 30 to 60 days
Medically Managed Inpatient Detox	Every 1 to 2 days
Medically Managed Residential	Every 7 days

Continued stay criteria should also be used when deemed clinically appropriate by the treatment provider due to a sudden change in status. For example, if an individual relapses, this could trigger review prior to the recommended timeframe.

## B.6 Using the Criteria if an Individual Leaves Against Staff/Medical Advice

In the case of an individual who leaves a particular LOC against staff advice and without giving notice, utilization of the criteria should be evidenced up to that point. As reflected in the Principles of Treatment (Section A.3), the treatment provider should reach out and attempt contact with the individual, and using motivational interviewing principles attempt to link this individual with community resources or another provider.

## B.7 A Note on Documentation and Clinical Justification for Services

The clinical record is designed to:

- Provide clinical justification for placement by matching SUD severity with appropriate LOC;
- Objectively document the need for specific interventions and support services in key biopsychosocial domains; and
- Document the effectiveness of prescribed interventions.

The record should provide a summation of an individual’s condition and progress, specifically, accurately, objectively, and in standardized clinical terms. Jargon and personal opinion have no place in a professional record. When documenting clinical justification for a prescribed LOC, it is important that individual-specific information be recorded and related with the PCPC in each of the six dimensions. Verbatim quotes from the PCPC matrix are insufficient without supporting individualized data elements.

The PCPC Summary Sheet (page 136) is designed to provide brief supporting documentation about an individual’s status or progress to justify the recommended LOC and TOS. Documentation and communication must comply with 4 Pa. Code § 255.5(b) regarding release of client-specific information when communicating restricted entities (e.g. third-party payers, probation and parole, judges). Items that may be disclosed under 4 Pa. Code § 255.5(b) include:

1. Whether or not the individual is in treatment
2. Prognosis
3. Nature of the project
4. Brief statement of progress
5. Brief statement regarding relapse and frequency of relapse

Consider the examples below regarding the differences in acceptable documentation in the clinical record and on the PCPC Summary Sheet:

1. In Dimension 2, Level 4A, Item G, the PCPC reads:  
*Previously diagnosed medical conditions being gravely complicated or exacerbated by drug use.*

Clinical Record	PCPC Summary Sheet
Individual’s daily alcohol use exacerbates liver inflammation due to known hepatitis C infection, which places individual at risk of developing cirrhosis	Individual has continued use despite serious medical complications

2. In Dimension 4, Level 3B, the PCPC reads:

*Despite serious consequences and/or effects of the SUD on the individual's life (e.g. health, family, work, or social problems), the individual does not accept or relate to the severity of these problems. The individual is in need of intensive motivating strategies, activities, and processes only available within a 24-hr program.*

Clinical Record	PCPC Summary Sheet
Despite individual's awareness of his high-risk status for developing cirrhosis of the liver, along with continued daily health problems, the individual does not connect the serious role of alcohol use to his health problems.	Despite serious medical complications related to addiction, the individual does not recognize the role of substance use in his health problems.

Examples 1 and 2 provide clear and specific reasons for recommending a LOC, within the framework provided by the PCPC Matrix Item in the first example. Every relevant clinical presentation can be documented in a similar way, providing core information, stated succinctly, which can then be used in both treatment planning and clinical application. All interactions with an individual should be documented in an objective, professional manner, including those situations in which an individual refuses a recommended service. Mitigating circumstances compelling an individual to make choices which conflict with clinical recommendations should be included in the chart narrative. In summary, an individual chart is a written record of the history of a professional relationship. Good clinical documentation is an integral part of providing quality service.

## **B.8 Process of Using the Admission, Continued Stay and Discharge Criteria**

The following process illustrates the use of admission, continued stay, and discharge (outpatient only) criteria:

### **STEP ONE: LEVEL OF CARE ASSESSMENT**

The individual is assessed by a SUD professional trained in the use of the PCPC. A LOC assessment is defined as a face-to-face interview with the individual to ascertain treatment needs based on the degree and severity of alcohol and other drug use through the development of a comprehensive confidential personal history, including significant medical, social, occupational, educational, and family information. The PCPC admission criteria are used to guide the assessor in placing the individual in an appropriate LOC and TOS. Every assessor using the PCPC criteria should carefully consider the DOs/DON'Ts and Special Population Consideration sections under each LOC, which describe ways the PCPC criteria would need to be applied for determining placement and continued stay for special populations and issues. The assessor forwards the PCPC Summary Sheet to the authorizing agency and admitting provider (if applicable).

### **STEP TWO: CONTINUED STAY REVIEW**

Continued stay criteria are utilized to determine whether the individual should stay in the current LOC and TOS. The PCPC Summary Sheet should be forwarded to the authorizing agency/payer. If the individual does not meet continued stay criteria, proceed to Step Three.

### **STEP THREE: REFERRAL**

If the individual no longer meets the criteria for his/her current LOC, a PCPC is completed by the clinician for determination of the appropriate LOC for which the individual meets admission criteria. This LOC determination should take into account issues such as the individual's history, treatment plan, progress in treatment, and special considerations. A referral is made to the subsequent provider and the admission PCPC is forwarded to the provider and the authorizing agency/payer. In all cases referral from one LOC to the next must occur via a direct connection with the individual and admitting

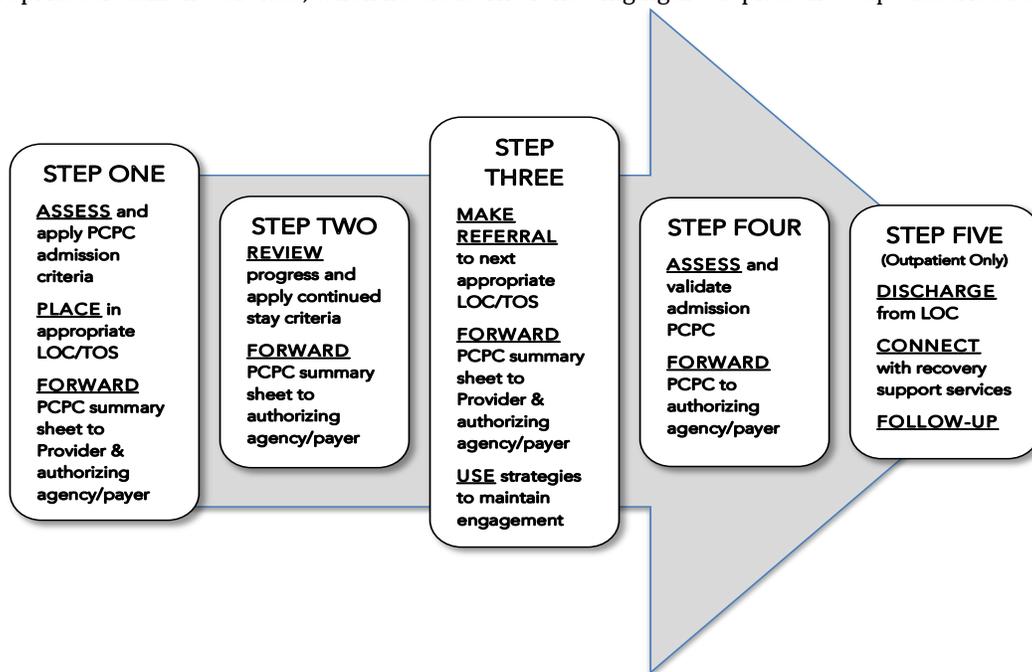
provider, often referred to as a “warm handoff,” and the referring provider should follow up to determine that the individual actually got to the new provider as planned. Where appropriate, the use of recovery support, case managers, and peer mentors to facilitate transitions and maintain individual engagement are strongly encouraged.

**STEP FOUR: ADMISSION TO SUBSEQUENT LEVEL OF CARE**

The admitting provider proceeds with the biopsychosocial assessment and validates the admission PCPC completed by the referring provider. If the admitting provider concurs with the admission PCPC, documentation of this review and validation must be noted in the clinical record. The validated PCPC is then forwarded to the authorizing agency/payer (proper consent is required to re-disclose client-identifying information). If the admitting provider determines that the LOC indicated on the admission PCPC is not valid, a new admission PCPC must be completed and the individual should be referred to the clinically appropriate LOC.

**STEP FIVE: DISCHARGE FROM AN EPISODE OF CARE (OUTPATIENT ONLY)**

Individuals who no longer meet criteria for continued stay within outpatient care (only) and do not meet criteria for any other level of treatment, should be discharged from the episode of care with direct connections to community and recovery supports that will be necessary to ensure their continued recovery. These supports may take the form of self-help groups (e.g., AA, NA, etc.), recovery support peers, or case managers. The outpatient program should follow up with the individual periodically to ensure he or she is connected to the appropriate community supports and linked to appropriate treatment services, when needed. The following figure depicts the steps described above:



## B.9 Special Considerations for Assessment and Placement

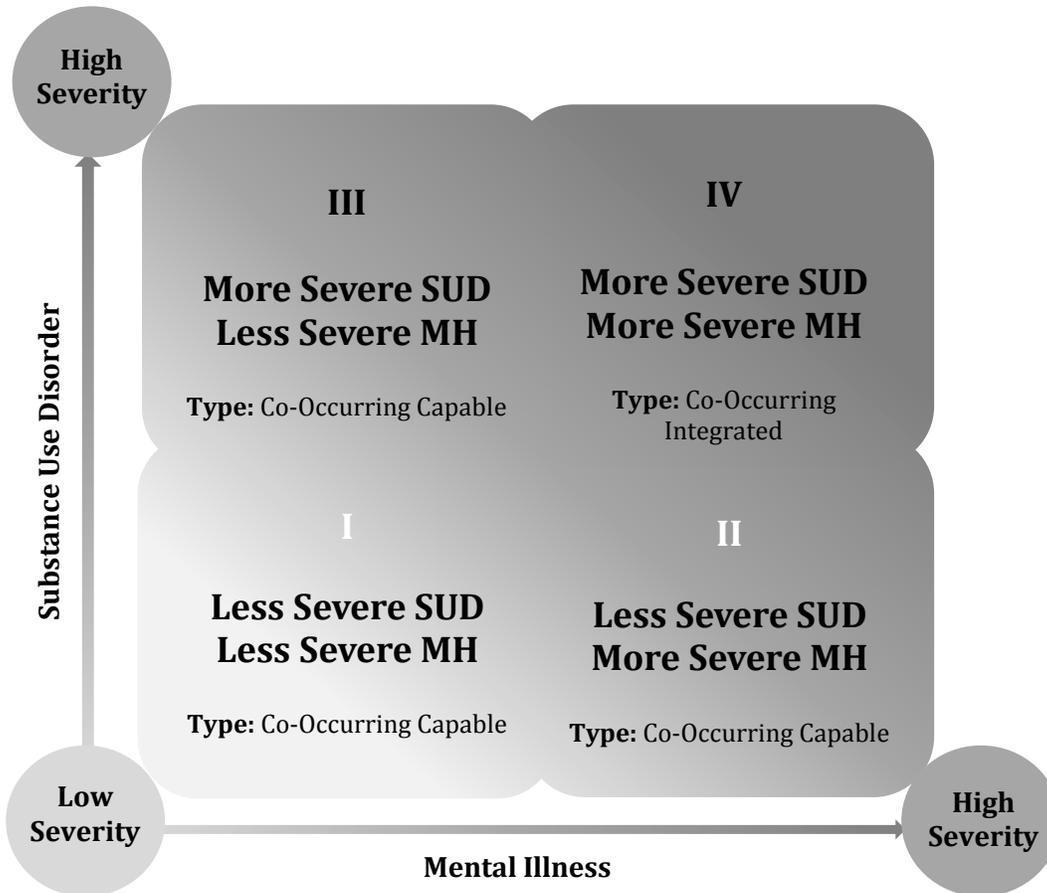
Please consider the following every time you apply any activity involving the PCPC with any given individual:

Consideration	Do	Don't
<b>LOC or Specialty Service Not Available</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure individual's safety and continuing engagement.</li> <li>• <b>Do</b> know community resources and match individuals to most appropriate service(s) available, include accommodations where needed/available (e.g. interpreter, case management).</li> <li>• <b>Do</b> give first consideration to placing the individual in the next highest LOC if assessed LOC is not available.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> deny services or ignore special needs.</li> <li>• <b>Don't</b> disregard initial LOC determination and needs.</li> </ul>
<b>Individual Declines Assessed LOC</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> document assessed LOC, reasons why individual declined the LOC and risks associated with not providing LOC.</li> <li>• <b>Do</b> work with individual to engage in most appropriate services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> change assessed LOC recommendation as indicated by PCPC.</li> </ul>
<b>Individual Not Responding/ Progressing in Assessed LOC</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> reassess appropriateness of LOC (using PCPC), the individual's treatment plan, the program and facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> terminate treatment abruptly; consider all treatment factors.</li> </ul>
<b>Recovery Resources</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that individuals have been appropriately connected to community recovery support and social services throughout treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge individuals without appropriate connection to effective community and recovery resources.</li> </ul>
<b>LOC Assessment Sufficiency</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure assessors are appropriately trained and experienced in drug and alcohol assessment and multi-dimensional protocol.</li> <li>• <b>Do</b> assess individuals face-to-face.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> employ or use assessors that do not have appropriate training and experience.</li> </ul>
<b>Seamless Continuum</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> provide facilitated handoff between services whenever possible.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge without facilitated handoff.</li> </ul>
<b>Role of Funding Availability in Placement and Continued Stay Recommendations</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure placement and continued stay recommendations are consistent with criteria.</li> <li>• <b>Do</b> document placement changes due to funding limitations.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> revise PCPC-based recommendations in response to funding availability.</li> </ul>

Consideration	Do	Don't
<b>Role of Individual Motivation</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> use Dimension 4 – Treatment Acceptance/Resistance Criteria.</li> <li>• <b>Do</b> use assessment as engagement opportunity.</li> <li>• <b>Do</b> ensure assessment staff is knowledgeable about motivational interviewing principles.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use perceived lack of motivation as basis for denial of care.</li> <li>• <b>Don't</b> use fail first mechanisms of any type.</li> </ul>
<b>Individuals in Controlled Environment</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> review status and functioning prior to admission to controlled environment; this is an essential part of PCPC LOC determination.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use lack of substance use in controlled environment as evidence of behavior change or modification of relapse risk.</li> </ul>
<b>Knowledge of Resources</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> understand resources available, including characteristics of programs within the same LOC, to ensure optimal matching.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> make uninformed placement decisions.</li> </ul>
<b>Role of Prior Treatment in LOC Determinations</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> know prior treatment history, what worked or didn't work from individual's perspective, and collateral information.</li> <li>• <b>Do</b> utilize information for optimal matching to program/facility.</li> <li>• <b>Do</b> utilize contingency and other motivational strategies as appropriate.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> have blanket policies or practices that determine service/LOC eligibility based on prior treatment history.</li> </ul>
<b>Special Populations</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> refer to appropriate Special Population Paper to determine placement and coordination of care considerations important to this population.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Co-Occurring SUD and MH Disorder</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> consider SUD and MH severity to determine whether the individual should be placed in co-occurring capable, co-occurring integrated, or MH facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Comorbidity</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that all individuals have been screened for medical and mental health co-morbidity needs and that these needs have been met via appropriate linkages to medical and mental health services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> forget the individual's medical and pain management needs when providing assessment and linkages to needed concurrent services.</li> </ul>
<b>When this LOC is Integrated Within a General Medical Setting</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> follow all confidentiality regulations (including HIPAA and other state and federal regulations) in the sharing of information.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> share clinical information in ways that might violate state or federal confidentiality regulations, or jeopardize continued care or the individual's willingness to continue with either general medical care or this LOC.</li> </ul>

## B.10 Managing Placements for Individuals with Co-Occurring Disorders within the Pennsylvania SUD Treatment System

Please consider the following quadrant diagram when making placement decisions for individuals with co-occurring disorders. The model helps to frame the systems of care serving this population in terms of symptom severity, not diagnosis. The framework defines symptom severity and level of service system coordination on a continuum from less severe to more severe disorders, and from collaboration to integration. Individuals at various stages of recovery from SUD and mental health disorders may move among these quadrants during the course of their illnesses. Note that clinical severity as indicated below is defined by the degree to which the mental health or SUDs are clinically assessed to adversely affect the individual's ability to function independently. In all cases, it is assumed that the individual meets clinical diagnostic criteria (such as DSM-5) for both mental health and SUD.



## C. Overview of Criteria

### C.1 Admission Criteria Overview

Dimensions	Level .5- Early Intervention	Level 1A - Outpatient	Level 1B - Intensive Outpatient	Level 2A - Partial Hospitalization	Level 2B - Halfway House
<b>Acute Intoxication or Withdrawal</b>	Minimal to no risk of severe withdrawal	Minimal to no risk of severe withdrawal	Minimal to no risk of severe withdrawal	Minimal to no risk of severe withdrawal	Minimal to no risk of severe withdrawal
<b>Biomedical Conditions and Complications</b>	None or very stable	Stable enough to permit participation	Not severe enough to warrant inpatient, but may distract from recovery efforts	Not severe enough to warrant twenty-four-hour observation; relapse could severely exacerbate conditions	Conditions do not interfere with treatment and do not require monitoring outside of this level; OR relapse would severely aggravate existing condition
<b>Emotional/ Behavioral Conditions and Complications</b>	None or very stable	Non-serious, transient emotional disturbances; mental status allows full participation	Able to maintain behavioral stability between contacts, symptoms do not obstruct participation	Inability to maintain behavioral stability over seventy-two-hour period; OR mild risk of dangerous behavior; OR history of dangerous behavior	Conditions do not interfere with treatment and disorders may be treated concurrently; at least one serious emotional/behavioral problem is present
<b>Treatment Acceptance/ Resistance</b>	Willing to explore how current substance use may affect personal medical/psychological/ social goals	Willing and cooperative; requires only monitoring and motivation rather than structure	Willing and cooperative; requires only monitoring and motivation rather than structure	Structured milieu required due to denial or resistance, but not so severe as to require residential setting	Cooperative and accepts need for twenty-four-hour structured setting
<b>Relapse Potential</b>	Needs an understanding of his or her current substance use patterns; capable of continuing alcohol use at nonhazardous risk levels	Able to maintain abstinence with support and counseling	Needs support and counseling; difficulty postponing immediate gratification	Likely to continue use without monitoring and intensive support; OR difficulty maintaining abstinence despite engagement in treatment	Unaware of relapse triggers, impulsivity, would likely relapse without structured setting
<b>Recovery Environment</b>	Individual's social support system increases the risk of personal conflict about alcohol or drug use	Supportive living environment or environment in which stressors can be managed so that abstinence can be maintained	Not optimal, but has supportive living environment or motivation to establish one; available supports willing to help facilitate recovery	Exposure to usual daily activities makes recovery unlikely; OR inappropriate support for recovery from significant others; OR estrangement from potential support in living environment	Lack of supportive persons in living environment; significant stressors; OR logistic barriers to treatment at less intensive LOC

## Admission Criteria

<b>Dimensions</b>	<b>Level 3A – Medically Monitored Inpatient Detox</b>	<b>Level 3B – Medically Monitored Short Term Residential</b>	<b>Level 3C – Medically Monitored Long Term Residential</b>	<b>Level 4A – Medically Managed Inpatient Detox</b>	<b>Level 4B – Medically Managed Inpatient Residential</b>
<b>Acute Intoxication or Withdrawal</b>	High risk of severe withdrawal, daily use with physical dependence but without psychiatric or medical disorder requiring medical management	Minimal to no risk of severe withdrawal	Minimal to no risk of severe withdrawal	Risk of severe withdrawal, with co-occurring mental health or medical disorder requiring medical management; OR overdose requiring medical management; OR only available setting that meets individual's management needs	Minimal to no risk of severe withdrawal
<b>Biomedical Conditions and Complications</b>	Medical condition severely endangered by continued use, requires close medical monitoring but not intensive care	Continued AOD use places individual in possible danger of serious damage to physical health	Continued AOD use places individual in danger of serious damage to physical health	Complications of SUD require daily medical management; OR medical problem require diagnosis and treatment; OR recurrent seizures	Imminent danger of serious physical health problems requiring intensive medical management
<b>Emotional/ Behavioral Conditions and Complications</b>	Psychiatric symptoms interfere with recovery, moderate risk of dangerous behaviors, impairment requires twenty-four-hour setting; self-destructive behavior related to intoxication	Psychiatric symptoms interfere with recovery; moderate risk of dangerous behaviors; impairment requires twenty-four-hour setting; self-destructive behaviors related to intoxication	Two of: disordered living skills, disordered social adaptation, disordered self-adaptiveness, disordered psychological status	Emotional/behavioral complications of SUD require daily medical management; OR risk of dangerous behavior; OR substance use would have severe mental health consequences	Two of: psychiatric complications of SUD; concurrent psychiatric illness; dangerous behaviors; mental confusion or other impairment of thought process
<b>Treatment Acceptance/ Resistance</b>	N/A	Twenty-four-hour intensive program needed to help individual understand consequences and severity of SUD	Twenty-four-hour intensive program needed to help individual understand consequences and severity of SUD	N/A	N/A
<b>Relapse Potential</b>	N/A	Inability to establish recovery despite previous treatment in less intensive settings; unable to control use in face of available substances in environment	Inability to establish recovery despite previous treatment in less intensive settings; unable to control use in face of available substances in environment	N/A	N/A
<b>Recovery Environment</b>	N/A	Social elements unsupportive or highly stressful; coping skills inappropriate to conditions	Social elements unsupportive or highly stressful; coping skills inappropriate to conditions; OR anti-social lifestyle	N/A	N/A
<p>Note: This chart is intended to serve as a general overview ONLY; for accurate application of the criteria, one must use the detailed dimensional and scoring specifications found in the descriptive narratives for each level</p>					

## C.2 Continued Stay Criteria Overview

<b>Dimensions</b>	<b>Level 1A – Outpatient</b>	<b>Level 1B – Intensive Outpatient</b>	<b>Level 2A – Partial Hospitalization</b>	<b>Level 2B – Halfway House</b>	<b>Level 3A – Medically Monitored Inpatient Detox</b>
<b>Acute Intoxication or Withdrawal</b>	Post-acute withdrawal symptoms, occasional limited lapses may occur	Post-acute withdrawal symptoms, occasional limited lapses may occur	Post-acute withdrawal symptoms, occasional limited lapses may occur	Post-acute withdrawal symptoms, occasional limited lapses may occur	Persistent withdrawal symptoms or cognitive impairment; this LOC is needed to achieve stability
<b>Biomedical Conditions and Complications</b>	Any medical conditions do not prevent progress in treatment	Any medical conditions do not prevent progress in treatment	Medical conditions may potentially distract from recovery efforts and may require monitoring which can be provided at this level	Individual making progress and medical status can be managed at this LOC by community resources	Any medical problems can be appropriately managed at this level
<b>Emotional/ Behavioral Conditions and Complications</b>	Ongoing emotional disturbances not so severe as to prevent progress	Emotional problems may be distracting, but there are indications that individual is responding to treatment	Emotional problems may be distracting, but there are indications that individual is responding to treatment	Improving behavioral stability, stress adaptation, decision-making, and social functioning which requires reinforcement provided by this TOS	Emotional/behavioral status improving, but continuing treatment in this TOS is required
<b>Treatment Acceptance/ Resistance</b>	Understanding of SUD insufficient to maintain self-directed plan of recovery	Beginning to recognize responsibility for illness, but requires intense motivation	Beginning to accept responsibility for recovery, but needs intensive motivation and support to maintain progress	Recognizes severity of problem, but has not assumed responsibility for behavioral change	Recognizes severity of problem but has little understanding of personal role in its development
<b>Relapse Potential</b>	Continuing mental preoccupation with use, and need to enhance recovery skills	Beginning to recognize relapse potential, but has not fully developed or consistently applied behavioral changes	Recognizes relapse potential, but has not yet fully developed or applied behavioral changes; requires structured program to do so	Recognizes relapse triggers and dysfunctional behavior w/o skill needed to arrest this behavior and apply appropriate coping skills to maintain abstinence	N/A
<b>Recovery Environment</b>	Sufficient skills to cope with any non-supportive elements in living environment, but not yet able to maintain self-directed plan of recovery	Individual making progress in learning to cope with environmental obstacles to recovery	Has not yet developed sufficient coping or socialization skills to establish stability in living environment without this level of intense support and treatment	Has not developed appropriate coping skills, socialization skills, or social support to deal with living environment without this TOS	Living environment makes abstinence unlikely

## Continued Stay Criteria

<b>Dimensions</b>	<b>Level 3B – Medically Monitored Short Term Residential</b>	<b>Level 3C – Medically Monitored Long Term Residential</b>	<b>Level 4A – Medically Managed Inpatient Detox</b>	<b>Level 4B – Medically Managed Inpatient Residential</b>
<b>Acute Intoxication or Withdrawal</b>	Protracted withdrawal symptoms present obstacles to recovery but do not interfere with treatment at this level; OR limited lapses may have occurred	Protracted withdrawal symptoms present obstacles to recovery but do not interfere with treatment at this level; OR limited lapses may occur more prominently and persistently than those cited for 3B	Persistence of acute withdrawal	Significant post-withdrawal symptoms persist which may be obstacles to engagement
<b>Biomedical Conditions and Complications</b>	Medical problems are not resolved but individual making progress in recognition of impact of use on medical condition	Medical problems are not resolved but individual is making progress in recognition of impact of AOD use on medical condition	Biomedical status not sufficiently altered to allow management in less intensive setting	Improvement in medical status not sufficient to allow management at less intensive TOS
<b>Emotional/ Behavioral Conditions and Complications</b>	Emotional/behavioral problems are improving but require treatment in this TOS	Demonstrating signs of progress in addressing disordered living skills, social adaptation, self-adaptation, and psychological status, but needs continued structure to maintain progress	Emotional/behavioral status not sufficiently altered to allow management in less intensive setting; OR waiting transfer to acute psychiatric care	Improvement in mental status not sufficient to allow management at less intensive TOS
<b>Treatment Acceptance/ Resistance</b>	Beginning to recognize severity of problem and understand personal role in its existence	Beginning to recognize severity of problem and understand personal role in its existence, or recognizes and understands problems but has not taken responsibility for recovery	N/A	N/A
<b>Relapse Potential</b>	Does not demonstrate skills necessary to arrest dysfunctional behaviors but shows progress	Does not demonstrate skills necessary to arrest dysfunctional behaviors, but shows progress despite minimal understanding of personal role in relapse	N/A	N/A
<b>Recovery Environment</b>	Living environment still poses a danger and coping skills have not improved sufficiently to manage dangers or stressors in the environment	Living environment still poses a danger and coping skills have not improved sufficiently to manage dangers or stressors in the environment OR anti-social lifestyle	N/A	N/A

Note: This chart is intended to serve as a general overview **ONLY**; for accurate application of the criteria, one must use the detailed dimensional and scoring specifications found in the descriptive narratives for each level

## D. Levels of Care and Placement Criteria

### D.1 Level .5 Early Intervention

#### D.1.1 Description of Service Level

- The introduction of Early Intervention into the PCPC as a defined LOC is borne out of a recognition that educational and motivational approaches serve as viable methods to address the needs of individuals exhibiting problematic patterns of substance use that do not meet the criteria of SUD at the time of assessment.
- Early Intervention is defined as an organized screening and Psycho-educational service designed to help individuals identify and reduce risky substance use behaviors.
- Early Interventions focus on providing an individual who is engaging in risky behaviors related to substance use and is in need of education to develop the skills necessary to reduce his or her substance use risk factors and increase protective factors. Services may be offered in non-specialty settings, such as hospital emergency departments or community clinics. Examples of Early Intervention may include impaired driving programs or SBIRT screenings.
- The goal of this form of Early Intervention service is to encourage the individual to examine his or her own patterns of substance use through psychoeducational sessions.
- The screening process must follow prevailing HIPAA regulations.

#### Access to Early Intervention can occur via two paths:

- Direct access for those seeking drug and alcohol education. These individuals may never have contact with a SUD professional (e.g., judge refers an individual to educational sessions)
- Referral following an assessment that does not result in a diagnosis of SUD, but in which problematic substance use is identified

#### Required Services and Support Systems include:

- Psychoeducational sessions, including group and individual sessions, as appropriate
- Ongoing monitoring of LOC needs, with referral to treatment services as identified
- Follow-up contact within three months

#### Recommended Services and Support Systems include:

- Optional Couples psychoeducational sessions (as appropriate)
- Optional Family psychoeducational sessions (as appropriate)
- Referral to non-SUD services as needed (i.e., housing, medical, legal, educational, faith-based)

The Required Staff providing Early Intervention Services must be trained personnel who are knowledgeable about the medical, emotional and psychological dimensions of SUDs, alcohol and other drug education, motivational intervention, and the consequences of inappropriate substance use.

### D.1.2 Level .5 (Early Intervention) Admission Criteria Across 6 Dimensions

**Dimensional Scoring Specifications**

Individual must meet, at a minimum, at least one of the specifications in Dimensions 4, 5, or 6, and no criteria higher than Level .5 for the remaining dimensions.

1. <b>Acute Intoxication or Withdrawal</b>	Individual is not at risk for withdrawal.
2. <b>Biomedical Conditions and Complications</b>	None or very stable.
3. <b>Emotional/ Behavioral Conditions and Complications</b>	None or very stable.
4. <b>Readiness to Change</b>	The individual is willing to explore how current alcohol or drug use may currently or in the future affect personal medical/psychological/social goals.
5. <b>Relapse Potential</b>	The individual needs an understanding of, or skills to change, his or her current alcohol and drug use patterns.
6. <b>Recovery Environment</b>	The individual's social support system, including significant others, increases the risk of ongoing personal conflict about alcohol or drug use.

### D.1.3 Level .5 Early Intervention Continued Stay Criteria

Continued Stay Criteria does not apply to Level .5 Early Intervention.

## D.2 Level 1A: Outpatient

### D.2.1 Description of Service Level

- Outpatient treatment is an organized, non-residential treatment service providing psychotherapy in which the individual resides outside the facility. These services are usually provided in regularly scheduled treatment sessions for, at most, 5 hours per week.
- Outpatient treatment may be conducted at any DDAP-licensed drug and alcohol facility as stipulated in 28 PA Code.
- All employees and contracted professionals providing clinical services within the facility must comply with the DDAP staffing requirements. The Individual:FTE Counselor ratio is not to exceed 35:1.

#### Required Services and Support Systems include:

- Biopsychosocial Assessment
- Specialized professional medical consultation, and tests such as a physical examination, psychiatric evaluation, HIV and TB testing, and other laboratory work, as needed
- Individualized treatment planning, with reviews at least every 60 days
- Psychotherapy, including individual, group, and family (per clinical evaluation)
- Aftercare planning and follow-up

#### Recommended Services and Support Systems include:

- Occupational and vocational counseling
- Case management and social services that allow the staff to assist with attendance monitoring, child care, transportation to treatment services, and the provision of shelter and other basic needs
- Structured positive social activities available within non-program hours, including evenings and weekends
- Access to more intensive LOC as clinically indicated
- Collaboration between the treatment team and various agencies for the coordinated provision of services

The Required Staff at an outpatient care facility include a director and counselor(s), and a clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and profile, a single person may hold one or more of the above positions. The Staff who may be Recommended may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. SUD counselors or other certified SUD clinicians) who may more effectively serve the facility's population.

## D.2.2 Level 1A (Outpatient) Admission Criteria Across 6 Dimensions

### **Dimensional Scoring Specifications**

Individuals must meet Level 1A criteria for all six dimensions.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Individuals must meet all of the following:</p> <p>A. The individual is assessed as being at minimal to no risk of severe withdrawal syndrome, as evidenced by:</p> <ol style="list-style-type: none"> <li>1. CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) of less than 10 following 8 hours of abstinence from alcohol, with no medication; OR</li> <li>2. Blood alcohol 0.0gm% and no withdrawal signs or symptoms present which require medication; OR</li> <li>3. Sub-acute symptoms of protracted withdrawal that, if present, can be managed safely without daily monitored medical intervention; AND</li> </ol> <p>B. For individuals with withdrawal symptoms no more severe than those noted in Section A, the individual has, and responds positively to, emotional support and comfort as evidenced by:</p> <ol style="list-style-type: none"> <li>1. Decreased emotional symptoms by the end of the initial interview session, AND</li> <li>2. Home environment able to provide appropriate support.</li> </ol>
<p><b>2. Biomedical Conditions and Complications</b></p>	<p>Any of the individual's biomedical conditions, if present, are (or continue to be) sufficiently stable to permit participation in outpatient treatment.</p>
<p><b>3. Emotional/ Behavioral Conditions and Complications</b></p>	<p>Individuals must meet all of the following:</p> <p>A. The individual's anxiety, guilt, and/or depression, if present, appear to be related to drug dependency problems rather than a coexisting psychiatric/emotional/behavioral condition. If they are related to such a condition, appropriate additional psychiatric services are provided concurrently.</p> <p>B. The mental status of the individual does not preclude his/her ability to:</p> <ol style="list-style-type: none"> <li>1. Comprehend and understand the materials presented,</li> <li>2. Participate in the treatment process, and</li> <li>3. The individual is assessed as not being at risk of harming self or others.</li> </ol>
<p><b>4. Treatment Acceptance/ Resistance</b></p>	<p>Individuals must meet all of the following:</p> <p>A. The individual expresses willingness to cooperate and attend all scheduled activities, and;</p> <p>B. The individual may also admit that he/she has an alcohol/drug problem but requires monitoring and motivating strategies. However, the individual does not need a structured milieu program.</p>
<p><b>5. Relapse Potential</b></p>	<p>The individual is assessed as being able to maintain abstinence and recovery goals only with support and scheduled therapeutic contact to help to deal with issues such as, but not limited to, mental preoccupation with alcohol/drug use, craving, peer pressures, lifestyle, and attitudinal changes.</p>

<b>6. Recovery Environment</b>	<p>Individuals must meet ONE of the following:</p> <p>A. A sufficiently supportive psychosocial environment makes outpatient treatment feasible (e.g. significant others who are in agreement with recovery efforts, supportive work or legal coercion, appropriate transportation to the program, and support meeting locations and non-alcohol/drug centered work that are accessible and close to home environment);</p> <p>B. The individual has demonstrated motivation and a willingness to obtain an ideal primary or social support system to assist with immediate sobriety, even though he/she does not presently have such a support system;</p> <p>C. Family/significant others are supportive, but individual requires professional interventions to improve chances of treatment success and recovery (e.g. assistance in limit-setting and communication skills, and a decrease in rescuing behaviors, etc.).</p>
--------------------------------	--

### D.2.3 Level 1A (Outpatient) Continued Stay Criteria Across 6 Dimensions

#### **Dimensional Scoring Specifications**

Individuals must meet, at a minimum, ONE of the Level 1A criteria for Dimensions 3, 4, 5, or 6, and meet criteria no higher than Level 1A for the remaining dimensions.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Acute symptoms of intoxication/withdrawal are absent in the individual;</p> <p>B. Individual presents symptoms of post-acute withdrawal (e.g. increased irritability, mood swings, obsessive thoughts of substance use, high levels of anxiety), which present obstacles to engaging in recovery and normal life functioning;</p> <p>C. The individual reports a limited lapse of sobriety that can be addressed constructively.</p>
<p><b>2. Biomedical Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Any biomedical conditions, if present, continue to be sufficiently stable to permit continued participation in outpatient treatment;</p> <p>B. An intervening biomedical condition or event was serious enough to interrupt treatment but the individual is again progressing in treatment.</p>
<p><b>3. Emotional/ Behavioral Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. The individual is making progress in reducing anxiety, guilt, and/or depression, if present, yet these symptoms have not been resolved sufficiently for discharge;</p> <p>B. An intervening emotional/behavioral event or problem was serious enough to interrupt treatment, but with stabilization the individual is again progressing in treatment.</p>
<p><b>4. Treatment Acceptance/ Resistance</b></p>	<p>The individual is continuing to work on treatment goals and objectives, yet he/she does not understand or accept his/her SUD sufficiently to maintain, as yet, a self-directed recovery plan.</p>
<p><b>5. Relapse Potential</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. The individual, while physically abstinent from alcohol/drug use, remains mentally preoccupied with such use to the extent that he/she is unable to appropriately address primary relationships or social or work tasks. There are indications, however, that with continued treatment the individual will effectively address these issues;</p> <p>B. The individual, while physically abstinent from alcohol/drugs, and experiencing minimal craving for them, requires continued work on the development of an alternative lifestyle, thought patterns, and emotional responses. The individual is making progress on these things.</p>

<b>6. Recovery Environment</b>	Individuals must meet ONE of the following:  A. The social environment remains non-supportive or has deteriorated, but the individual is making sufficient progress in learning social and other related coping skills to contend with the environment;  B. The social system is supportive of recovery, but the individual is not yet able to adhere to a self-directed recovery plan without substantial risk of reactivating substance use.
--------------------------------	--

## D.2.4 Level 1A (Outpatient) Discharge Criteria Across 6 Dimensions

### **Dimensional Scoring Specifications**

Individuals must meet Level 1A criteria for all dimensions.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Individuals must meet all of the following:</p> <ul style="list-style-type: none"> <li>A. The individual is assessed as not being in intoxication or withdrawal;</li> <li>B. The individual does not manifest symptoms of protracted withdrawal syndrome; AND</li> <li>C. The individual does not meet any of the Level 1A Continued Stay Criteria OR Admission Criteria for any other TOS.</li> </ul>
<p><b>2. Biomedical Conditions and Complications</b></p>	<p>The individual's biomedical problems, if any, have diminished or stabilized to the extent that they can be managed through outpatient appointments at his/her discretion, and he/she does not meet any of the Level 1A Continued Stay Criteria OR Admission Criteria for any other TOS.</p>
<p><b>3. Emotional/ Behavioral Conditions and Complications</b></p>	<p>The individual's emotional or behavioral problems have diminished or stabilized to the extent that they can be managed through outpatient appointments at his/her discretion, and the individual does not meet any of the Level 1A Continued Stay Criteria OR Admission Criteria for any other TOS.</p>
<p><b>4. Treatment Acceptance/ Resistance</b></p>	<p>The individual's awareness and acceptance of a SUD problem and commitment to recovery is sufficient to expect maintenance of a self-directed recovery plan as evidenced by:</p> <ul style="list-style-type: none"> <li>1. Recognition of the severity of his/her alcohol/drug use, AND</li> <li>2. An understanding of his/her self-defeating relationship with alcohol/drugs, AND</li> <li>3. Application of the essential skills necessary to maintain sobriety in a mutual/self-help fellowship and/or with post-treatment supportive care, AND</li> <li>4. The individual does not meet any of the Level 1A Continued Stay Criteria OR Admission Criteria for any other TOS.</li> </ul>
<p><b>5. Relapse Potential</b></p>	<p>The individual's therapeutic gains, which address craving and relapse issues, have been integrated and internalized, and the individual does not meet any of the Level 1A Continued Stay Criteria OR Admission Criteria for any other TOS.</p>
<p><b>6. Recovery Environment</b></p>	<p>Individuals must meet ONE of the following:</p> <ul style="list-style-type: none"> <li>A. The individual's social system and significant others are supportive of recovery to the extent that the individual can adhere to a self-directed recovery plan without substantial risk of relapse, and he/she does not meet any of the Level 1A Continued Stay Criteria OR Admission Criteria for any other TOS;</li> <li>B. The individual is functioning appropriately in assessed deficiencies in the life task areas of work, social functioning, or primary relationships, and the individual does not meet any of the Level 1A Continued Stay Criteria OR Admission Criteria for any other TOS.</li> </ul>

## D.2.5 Level 1A (Outpatient) Do's and Don'ts

Consideration	Do	Don't
LOC or Specialty Service Not Available	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure individual's safety and continuing engagement.</li> <li>• <b>Do</b> know community resources and match individuals to most appropriate service(s) available, include accommodations where needed/available (e.g. interpreter, case management).</li> <li>• <b>Do</b> give first consideration to placing the individual in the next highest LOC if assessed LOC is not available.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> deny services or ignore special needs.</li> <li>• <b>Don't</b> disregard initial LOC determination and needs.</li> </ul>
Individual Declines Assessed LOC	<ul style="list-style-type: none"> <li>• <b>Do</b> document assessed LOC, reasons why individual declined the LOC and risks associated with not providing LOC.</li> <li>• <b>Do</b> work with individual to engage in most appropriate services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> change assessed LOC recommendation as indicated by PCPC.</li> </ul>
Individual Not Responding/Progressing in Assessed LOC	<ul style="list-style-type: none"> <li>• <b>Do</b> reassess appropriateness of LOC (using PCPC), the individual's treatment plan, the program and facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> terminate treatment abruptly; consider all treatment factors.</li> </ul>
Recovery Resources	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that individuals have been appropriately connected to community recovery support and social services at discharge from this level (and episode) of care.</li> <li>• <b>Do</b> begin plans for what services the individual may access post-discharge immediately when the individual is admitted to this LOC.</li> <li>• <b>Do</b> follow up with each discharged individual to ensure that he/she has connected with these services and does not need additional treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge individuals from this terminal LOC without appropriate connection to effective community and recovery resources.</li> </ul>
LOC Assessment Sufficiency	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure assessors are appropriately trained and experienced in drug and alcohol assessment and multi-dimensional protocol.</li> <li>• <b>Do</b> assess individuals face-to-face.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> employ or use assessors that do not have appropriate training and experience.</li> </ul>
Seamless Continuum	<ul style="list-style-type: none"> <li>• <b>Do</b> provide facilitated handoff between services whenever possible.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge without facilitated handoff.</li> </ul>

Consideration	Do	Don't
<b>Role of Funding Availability in Placement and Stay Recommendations</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure that placement and continued stay recommendations are consistent with criteria.</li> <li>• <b>Do</b> document placement changes due to funding limitations.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> revise PCPC-based recommendations in response to funding availability.</li> </ul>
<b>Role of Individual Motivation</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> use Dimension 4 – Treatment Acceptance/Resistance Criteria.</li> <li>• <b>Do</b> use assessment as engagement opportunity.</li> <li>• <b>Do</b> ensure assessment staff is knowledgeable about motivational interviewing principles.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use perceived lack of motivation as basis for denial of care.</li> <li>• <b>Don't</b> use fail first mechanisms of any type.</li> </ul>
<b>Individuals in Controlled Environment</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> review status and functioning prior to admission to controlled environment; this is an essential part of PCPC LOC determination.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use lack of substance use in controlled environment as evidence of behavior change or modification of relapse risk.</li> </ul>
<b>Knowledge of Resources</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> understand resources available, including characteristics of programs within the same LOC, to ensure optimal matching.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> make uninformed placement decisions.</li> </ul>
<b>Special Population</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> refer to Special Population Paper to determine placement and coordination of care considerations important to this population.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Co-Occurring SUD and MH Disorder</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> consider SUD and MH severity to determine whether the individual should be placed in co-occurring capable, co-occurring integrated, or MH facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Comorbidity</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that all individuals have been screened for medical and mental health co-morbidity needs and that these needs have been met via appropriate linkages to medical and mental health services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> forget the individual's medical and pain management needs when providing assessment and linkages to needed concurrent services.</li> </ul>
<b>When this LOC is Integrated Within a General Medical Setting</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> follow all confidentiality regulations (including HIPAA and other state and federal regulations) in the sharing of information.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> share clinical information in ways that might violate state or federal confidentiality regulations, or jeopardize continued care or the individual's willingness to continue with either general medical care or this LOC.</li> </ul>

## D.2.6 Level 1A (Outpatient) Special Populations Considerations

Population	Consideration
<b>Medication-Assisted Treatment</b>	Individuals receiving MAT should have access to this LOC, provided they will receive appropriate medical monitoring throughout their treatment. Services should be provided that ensure coordination of care with other treatment providers (See Special Population Paper 1 contained in Section E).
<b>Co-Occurring</b>	Individuals with co-occurring mental health and SUD should receive the appropriate treatment concurrent with their participation in this LOC (See Special Population Paper 2 contained in Section E).
<b>Women and Women with Children</b>	Women with or without children who participate in this LOC should be provided the transportation and childcare services they need to ensure their participation. The hours provided by the program should also be adjusted to better accommodate the needs of this population. Further, the program should assess the woman's needs for appropriate supportive services outside of the program, and ensure that she is appropriately linked (via a "warm handoff") to these services. Finally, any services provided to this population must be sensitive to its specific perspectives and needs (See Special Population Paper 3 contained in Section E).
<b>Criminal Justice</b>	Ensure that this LOC is not being provided as a way of addressing the individual's gap in substance use evident while he/she was incarcerated. The extent and effects of prisonization (See Glossary) on an individual must be considered for placement in an appropriate LOC. Individuals who are leaving a jail or prison should be assessed using a biopsychosocial applied during the period just prior to their incarceration. If the individual who has been part of the criminal justice system is deemed appropriate for this LOC, services should be provided that are sensitive to his/her specific perspectives and needs (See Special Population Paper 4 contained in Section E).
<b>Cultural/Ethnic</b>	Services should be provided that are sensitive to each individual's cultural/ethnic perspectives and needs (See Special Population Paper 5 contained in Section E).
<b>Sexual Orientation/Gender Identity</b>	Services should be provided that are sensitive to each individual's sexual orientation/gender identity perspectives and needs (See Special Population Paper 6 contained in Section E).
<b>Co-Occurring Substance Use and Gambling Disorder</b>	Individuals with co-occurring SUD and gambling disorders should receive the appropriate treatment concurrent with their participation in this LOC. Specific areas of concern may be medication, risk of domestic violence and risk of suicide. Program referral should include staff with the proper education and experience to address these issues. Programs should include education on the risk of cross-addiction to gambling disorder as a part of relapse prevention planning (See Special Population Paper 7 contained in Section E).

## D.3 Level 1B: Intensive Outpatient

### D.3.1 Description of Service Level

- Intensive Outpatient treatment is an organized, non-residential treatment service in which the individual resides outside the facility. It provides structured psychotherapy and stability through increased periods of staff intervention. These services are provided according to a planned regimen consisting of regularly scheduled treatment sessions at least 3 days per week for at least 5 hours (but less than 10).
- Intensive outpatient treatment may be provided at any DDAP-licensed drug and alcohol facility, as stipulated in 28 PA Code under the Outpatient regulations.
- All employees and contracted professionals providing clinical services within the facility must comply with the DDAP staffing requirements. The Individual:FTE Counselor ratio is not to exceed 35:1; due to the intensity of the services provided, it is recommended that the individual:staff ratio not exceed 15:1.

#### Required Services and Support Systems include:

- Biopsychosocial Assessment
- Specialized professional medical consultation, and tests such as a physical examination, psychiatric evaluation, HIV and TB testing, and other laboratory work, as needed
- Individualized treatment planning, with reviews at least every 60 days (recommended: every 30 days)
- Psychotherapy, including individual, group, and family (per clinical evaluation)
- Aftercare planning and follow-up
- Development of discharge plan and plan for referral into continuum of care

#### Recommended Services and Support Systems include:

- Psychoeducational seminars
- Structured positive social activities available within non-program hours, including evenings and weekends
- Access to more intensive LOC, as clinically indicated
- Emergency telephone line available when program is not in session
- Collaboration between the treatment team and various agencies for the coordinated provision of services
- Occupational and vocational counseling
- Case management and social services that allow the staff to assist with attendance monitoring, child care, transportation to treatment services, and the provision of stable shelter and other basic care needs

The Required Staff at an intensive outpatient care facility include a director and counselor(s), and a clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and profile, a single person may hold one or more of the above positions. The Staff who may be Recommended may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. SUD counselors or other certified SUD clinicians) who may more effectively serve the facility's population.

### D.3.2 Level 1B (Intensive Outpatient) Admission Criteria Across 6 Dimensions

#### **Dimensional Scoring Specifications**

Individuals must meet, at a minimum, Level 1B criteria in Dimensions 3, 4, and 5, and no criteria higher than Level 1B in the remaining dimensions.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Individuals must meet all of the following:</p> <p>A. The individual is assessed as being at minimal to no risk of severe withdrawal syndrome, as evidenced by:</p> <ol style="list-style-type: none"> <li>1. CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) of less than 10 following 8 hours of abstinence from alcohol with no medication; OR</li> <li>2. Blood alcohol 0.0gm% and no withdrawal signs or symptoms present which require medication; OR</li> <li>3. Sub-acute symptoms of protracted withdrawal that, if present, can be managed safely without daily monitored medical intervention.</li> </ol> <p>B. For individuals with withdrawal symptoms no more severe than those noted above, the individual has, and responds positively to, emotional support and comfort as evidenced by:</p> <ol style="list-style-type: none"> <li>1. Decreased emotional symptoms by the end of the initial interview session, AND</li> <li>2. Home environment able to provide appropriate support.</li> </ol>
<p><b>2. Biomedical Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. The individual’s biomedical conditions and problems, if any, are not severe enough to interfere with treatment;</p> <p>B. The individual’s biomedical conditions and problems are not severe enough to warrant inpatient treatment, but are sufficient to distract from recovery efforts. Such problems require medical monitoring and/or medical management (at least 3 days per week with between 5 and 10 contact hours per week), which can be provided by the intensive outpatient program or through concurrent arrangement with another treatment provider.</p>
<p><b>3. Emotional/ Behavioral Conditions and Complications</b></p>	<p>Individuals must meet all of the following:</p> <p>A. The individual may exhibit emotional distress, but he or she is able to maintain behavioral stability over a period of time between treatment contacts (2-4 days).</p> <p>B. The individual’s problems may be secondary to the SUD or may reflect an independent psychopathology, but they can be stabilized with ancillary treatment or medication, and do not present an obstruction to the patient’s participation in treatment or to the therapeutic milieu.</p> <p>C. The mental status of the individual does not preclude his/her ability to:</p> <ol style="list-style-type: none"> <li>1. Comprehend and understand the materials presented, and</li> <li>2. Participate in the treatment process.</li> </ol> <p>D. The individual is assessed as being at no more than a mild risk of endangering self or others (e.g. suicidal or homicidal thoughts with no active plan).</p>

<p><b>4. Treatment Acceptance/Resistance</b></p>	<p>Individuals must meet all of the following:</p> <ul style="list-style-type: none"> <li>A. The individual may acknowledge the presence of a problem, but minimizes the impact of the SUD on his/her life, and displays limited insight into the problem.</li> <li>B. The individual displays limited understanding of the process of recovery.</li> <li>C. The individual is willing to participate in the LOC.</li> </ul>
<p><b>5. Relapse Potential</b></p>	<p>The individual is assessed as being able to maintain abstinence and recovery goals only with support and scheduled therapeutic contact to help to deal with such issues as, but not limited to, mental preoccupation with alcohol/drug use, limited insight regarding relapse triggers, craving, peer pressures, lifestyle, attitudinal changes, and difficulty postponing gratification.</p>
<p><b>6. Recovery Environment</b></p>	<p>Individuals must meet ONE of the following:</p> <ul style="list-style-type: none"> <li>A. A sufficiently supportive psychosocial environment that makes outpatient treatment feasible (e.g. significant others who are in agreement with recovery efforts, supportive work or legal coercion, appropriate transportation to the program, and support meetings and non-alcohol/drug centered work that are accessible and near the home);</li> <li>B. Individual has demonstrated motivation and willingness to obtain an ideal primary or social support system to assist with immediate sobriety, even though he/she does not presently have such a support system;</li> <li>C. Family/significant others are supportive, but the individual requires professional interventions to improve chances of treatment success and recovery (e.g. assistance in limit-setting, communication skills, and a decrease in rescuing behaviors, etc.).</li> </ul>

### D.3.3 Level 1B (Intensive Outpatient) Continued Stay Criteria Across 6 Dimensions

#### **Dimensional Scoring Specifications**

Individuals must meet, at a minimum, Level 1B criteria in Dimensions 3, 4, and 5, and no criteria higher than Level 1B in the remaining dimensions.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Acute symptoms of intoxication/withdrawal are absent in the individual;</p> <p>B. Individual exhibits symptoms of post-acute withdrawal (e.g. increased irritability, mood swings, obsessive thoughts of substance use, high levels of anxiety, etc.) which present obstacles to engaging in recovery and normal life functioning;</p> <p>C. Individual reports a limited lapse of sobriety that can be addressed constructively.</p>
<p><b>2. Biomedical Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Any biomedical conditions, if present, continue to be sufficiently stable to permit continued participation in outpatient treatment;</p> <p>B. An intervening biomedical condition or event was serious enough to interrupt treatment, but the individual is again progressing in treatment.</p>
<p><b>3. Emotional/ Behavioral Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. The individual continues to be unable to maintain behavioral stability over a 3-5 day period, but the behavioral stability problem is actively being addressed in treatment, and there are indications that the individual is responding to treatment interventions;</p> <p>B. The individual's emotional/behavioral disorder, which is being concurrently managed, continues to distract the individual from treatment, but the individual is responding to treatment and it is anticipated that with further interventions, he/she will be able to achieve treatment objectives;</p> <p>C. The individual continues to manifest mild risk behaviors endangering self or others (e.g. diminishing suicidal or homicidal thoughts), but the condition is improving.</p>
<p><b>4. Treatment Acceptance/ Resistance</b></p>	<p>The individual is beginning to recognize that he/she is responsible for addressing his/her illness, but still requires the level of intensity of motivating strategies to sustain personal responsibility in treatment.</p>
<p><b>5. Relapse Potential</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Individual recognizes relapse potential but has not yet identified sufficient relapse triggers, or has not yet consistently developed and applied behavioral changes to interrupt or postpone gratification or to change the related inappropriate impulse control necessary to maintain abstinence;</p> <p>B. Individual continues to require multiple structured contacts per week to sustain abstinence.</p>

<b>6. Recovery Environment</b>	<p>Individuals must meet ONE of the following:</p> <p>A. The social support environment remains non-supportive or has deteriorated, but the individual is making sufficient progress in learning social and related coping skills to contend with the environment;</p> <p>B. The social system is supportive of recovery, but the individual is not yet able to adhere to a self-directed recovery plan without substantial risk of reactivating substance use.</p>
--------------------------------	---

### D.3.4 Level 1B (Intensive Outpatient) Do's and Don'ts

Consideration	Do	Don't
LOC or Specialty Service Not Available	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure individual's safety and continuing engagement.</li> <li>• <b>Do</b> know community resources and match individuals to most appropriate service(s) available, include accommodations where needed/available (e.g. interpreter, case management).</li> <li>• <b>Do</b> give first consideration to placing the individual in the next highest LOC if assessed LOC is not available.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> deny services or ignore special needs.</li> <li>• <b>Don't</b> disregard initial LOC determination and needs.</li> </ul>
Individual Declines Assessed LOC	<ul style="list-style-type: none"> <li>• <b>Do</b> document assessed LOC, reasons why individual declined the LOC and risks associated with not providing LOC.</li> <li>• <b>Do</b> work with individual to engage in most appropriate services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> change assessed LOC recommendation as indicated by PCPC.</li> </ul>
Individual Not Responding/Progressing in Assessed LOC	<ul style="list-style-type: none"> <li>• <b>Do</b> reassess appropriateness of LOC (using PCPC), the individual's treatment plan, the program and facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> terminate treatment abruptly; consider all treatment factors.</li> </ul>
Recovery Resources	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that individuals have been appropriately connected to community recovery support and social services at discharge from this level (and episode) of care.</li> <li>• <b>Do</b> begin plans for what services the individual may access post-discharge immediately when the individual is admitted to this LOC.</li> <li>• <b>Do</b> follow up with each discharged individual to ensure that he/she has connected with these services and does not need additional treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge individuals from this LOC without appropriate connection to effective community and recovery resources.</li> </ul>
LOC Assessment Sufficiency	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure assessors are appropriately trained and experienced in drug and alcohol assessment and multi-dimensional protocol.</li> <li>• <b>Do</b> assess individuals face-to-face.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> employ or use assessors that do not have appropriate training and experience.</li> </ul>
Seamless Continuum	<ul style="list-style-type: none"> <li>• <b>Do</b> provide facilitated handoff between services whenever possible.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge without facilitated handoff.</li> </ul>

Consideration	Do	Don't
<b>Role of Funding Availability in Placement and Stay Recommendations</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure that placement and continued stay recommendations are consistent with criteria.</li> <li>• <b>Do</b> document placement changes due to funding limitations.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> revise PCPC-based recommendations in response to funding availability.</li> </ul>
<b>Role of Individual Motivation</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> use Dimension 4 – Treatment Acceptance/Resistance Criteria.</li> <li>• <b>Do</b> use assessment as engagement opportunity.</li> <li>• <b>Do</b> ensure assessment staff is knowledgeable about motivational interviewing principles.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use perceived lack of motivation as basis for denial of care.</li> <li>• <b>Don't</b> use fail first mechanisms of any type.</li> </ul>
<b>Individuals in Controlled Environment</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> review status and functioning prior to admission to controlled environment; this is an essential part of PCPC LOC determination.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use lack of substance use in controlled environment as evidence of behavior change or modification of relapse risk.</li> </ul>
<b>Knowledge of Resources</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> understand resources available, including characteristics of programs within the same LOC, to ensure optimal matching.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> make uninformed placement decisions.</li> </ul>
<b>Special Population</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> refer to Special Population Paper to determine placement and coordination of care considerations important to this population.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Co-Occurring SUD and MH Disorder</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> consider SUD and MH severity to determine whether the individual should be placed in co-occurring capable, co-occurring integrated, or MH facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Comorbidity</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that all individuals have been screened for medical and mental health co-morbidity needs and that these needs have been met via appropriate linkages to medical and mental health services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> forget the individual's medical and pain management needs when providing assessment and linkages to needed concurrent services.</li> </ul>
<b>When this LOC is Integrated Within a General Medical Setting</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> follow all confidentiality regulations (including HIPAA and other state and federal regulations) in the sharing of information.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> share clinical information in ways that might violate state or federal confidentiality regulations, or jeopardize continued care or the individual's willingness to continue with either general medical care or this LOC.</li> </ul>

### D.3.5 Level 1B (Intensive Outpatient) Special Populations Considerations

Population	Consideration
<b>Medication-Assisted Treatment</b>	Individuals receiving MAT should have access to this LOC, provided they will receive appropriate medical monitoring throughout their treatment. Services should be provided that ensure coordination of care with other treatment providers (See Special Population Paper 1 contained in Section E).
<b>Co-Occurring</b>	Individuals with co-occurring mental health and SUD should receive the appropriate treatment concurrent with their participation in this LOC (See Special Population Paper 2 contained in Section E).
<b>Women and Women with Children</b>	Women with or without children who participate in this LOC should be provided the transportation and childcare services they need to ensure their participation. The hours provided by the program should also be adjusted to better accommodate the needs of this population. Further, the program should assess the woman's needs for appropriate supportive services outside of the program, and ensure that she is appropriately linked (via a "warm handoff") to these services. Finally, any services provided to this population must be sensitive to its specific perspectives and needs (See Special Population Paper 3 contained in Section E).
<b>Criminal Justice</b>	Ensure that this LOC is not being provided as a way of addressing the individual's gap in substance use evident while he/she was incarcerated. The extent and effects of prisonization (See Glossary) on an individual must be considered for placement in an appropriate LOC. Individuals who are leaving a jail or prison should be assessed using a biopsychosocial applied during the period just prior to their incarceration. If the individual who has been part of the criminal justice system is deemed appropriate for this LOC, services should be provided that are sensitive to his/her specific perspectives and needs (See Special Population Paper 4 contained in Section E).
<b>Cultural/Ethnic</b>	Services should be provided that are sensitive to each individual's cultural/ethnic perspectives and needs (See Special Population Paper 5 contained in Section E).
<b>Sexual Orientation/Gender Identity</b>	Services should be provided that are sensitive to each individual's sexual orientation/gender identity perspectives and needs (See Special Population Paper 6 contained in Section E).
<b>Co-Occurring Substance Use and Gambling Disorder</b>	Individuals with co-occurring SUD and gambling disorders should receive the appropriate treatment concurrent with their participation in this LOC. Specific areas of concern may be medication, risk of domestic violence and risk of suicide. Program referral should include staff with the proper education and experience to address these issues. Programs should include education on the risk of cross-addiction to gambling disorder as a part of relapse prevention planning (See Special Population Paper 7 contained in Section E).

## D.4 Level 2A: Partial Hospitalization

### D.4.1 Description of Service Level

- Partial Hospitalization treatment consists of the provision of psychiatric, psychological, and other types of therapies on a planned and regularly scheduled basis in which the individual resides outside of the facility. This service is designed for those individuals who do not require 24-hour residential care, but who would nonetheless benefit from more intensive treatments than are offered in outpatient treatment programs. The environment provides multi-modal strategies and multi-disciplinary psychotherapy along with other ancillary services. Partial hospitalization services consist of regularly scheduled treatment sessions at least 3 days per week, with a minimum of 10 hours per week.
- These services may be conducted at any DDAP-licensed drug and alcohol facility, as stipulated in 28 PA Code.
- All employees and contracted professionals providing clinical services within the facility must comply with DDAP staffing requirements. The Individual:FTE Counselor ratio is not to exceed 10:1.

#### Required Services and Support Systems include:

- Biopsychosocial Assessment
- Specialized professional/medical consultation, and tests such as a physical examination, psychiatric evaluation, HIV and TB testing, and other laboratory work, as needed
- Individualized treatment planning, with review at least every 30 days
- Individual therapy 2 times per week
- Group therapy 2 times per week (recommended group size: no more than 12)
- Couples therapy (if appropriate)
- Family therapy (if appropriate)
- Development of discharge plan and plan for referral into continuum of care
- Access to services for: vocational assessment, job readiness and job placement, GED preparation and testing, literacy and basic education tutoring, legal, medical and dental care, general health education (esp. AIDS awareness and support), budgeting, credit restoration, housing assistance, income support, and recreational/social activities (e.g. fitness, games, peer interaction)

#### Recommended Services and Support Systems include:

- Psychoeducational seminars
- Case management and social services that allow the staff to assist with attendance monitoring, child care, transportation to treatment services, and the provision of stable shelter and other basic needs
- Structured positive social activities available within non-program hours, including evenings and weekends
- Access to more intensive levels of medical or psychiatric care, as clinically indicated
- Emergency telephone line available when program is not in session
- Supportive/cooperative work programs
- Collaboration between the treatment team and various agencies for the coordinated provision of services

The Required Staff at a Partial Hospitalization care facility include a director and counselor(s), and a clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and profile, a single person may hold one or more of the above positions. The Staff who may be Recommended may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. SUD counselors or other certified SUD clinicians) who may more effectively serve the facility's population.

## D.4.2 Level 2A (Partial Hospitalization) Admission Criteria Across 6 Dimensions

### **Dimensional Scoring Specifications**

Individuals must meet, at a minimum, Level 2A criteria in Dimensions 3 and 5, and no criteria higher than Level 2A for the remaining dimensions.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Individuals must meet all of the following:</p> <p>A. The individual is assessed as being at minimal to no risk of severe withdrawal syndrome, as evidenced by:</p> <ol style="list-style-type: none"> <li>1. CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) of less than 10 following 8 hours of abstinence from alcohol without medication; OR</li> <li>2. Blood alcohol 0.0gm% and no withdrawal signs or symptoms present which require medication; OR</li> <li>3. Sub-acute symptoms of protracted withdrawal that, if present, can be managed safely without daily monitored medical intervention.</li> </ol> <p>B. For individuals with withdrawal symptoms no more severe than those noted above, the individual has, and responds positively to, emotional support and comfort as evidenced by:</p> <ol style="list-style-type: none"> <li>1. Decreased emotional symptoms by the end of the initial treatment session, and</li> <li>2. Home environment capable of providing appropriate reality, reassurance, and respect.</li> </ol>
<p><b>2. Biomedical Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. The individual’s biomedical conditions and problems, if any, are not severe enough to interfere with treatment;</p> <p>B. The individual exhibits a medical problem not severe enough to warrant 24-hour observation, but sufficiently distracting from recovery efforts as to require more frequent attention (at least 3 days per week with a minimum of 10 hours per week);</p> <p>C. The presence of a medical problem which would be severely exacerbated by a relapse.</p>
<p><b>3. Emotional/ Behavioral Conditions and Complications</b></p>	<p>Individuals must meet at least 2 of the following:</p> <p>A. Current inability to maintain behavioral stability over 72-hour period (e.g. distractibility, negative emotions, generalized anxiety, etc.);</p> <p>B. Diagnosed but stable major emotional/behavioral disorder which requires monitoring and/or management due to a history indicating its high potential of distracting the individual from recovery and/or treatment (e.g. borderline personality disorder);</p> <p>C. The individual has some mental impairments that present minor problems in his/her ability to:</p> <ol style="list-style-type: none"> <li>1. Comprehend and understand the materials presented, and</li> <li>2. Participate in treatment;</li> </ol> <p>D. Mild risk of behaviors endangering self or others (e.g. suicidal or homicidal ideation with no active plan);</p> <p>E. SUD-related abuse or neglect of spouse, children, or significant others, requiring partial treatment to reduce the risk of further deterioration.</p>

<p><b>4. Treatment Acceptance/Resistance</b></p>	<p>Individual requires structured therapy and programmatic milieu to promote treatment progress and recovery, because he/she attributes alcohol/drug problems to other persons or external events, and not his/her personal SUD. This inhibits his/her ability to make behavioral changes without clinically directed and repeated motivating interventions. The individual's resistance, however, is not so high as to render the treatment ineffective.</p>
<p><b>5. Relapse Potential</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Despite active participation in treatment, the individual is experiencing an intensification of SUD symptoms (e.g. difficulty postponing immediate gratification and related drug-seeking behavior), and the individual is deteriorating in his/her level of functioning despite revisions in the treatment plan;</p> <p>B. High likelihood of drinking or drug use without close monitoring and structured support as indicated by, for example, lack of awareness of relapse triggers, difficulty postponing immediate gratification, and/or ambivalence or resistance to treatment.</p>
<p><b>6. Recovery Environment</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Family members and/or significant others living with the individual are non-supportive of recovery goals and/or passively opposed to his/her treatment. Individual requires relief from home environment during the day or evening to stay focused on recovery, but may return home because there is no active opposition or sabotaging of recovery efforts;</p> <p>B. Lack of social contacts jeopardizes recovery (e.g. individual lives alone and has few friends or peers who don't use alcohol/drugs).</p>

### D.4.3 Level 2A (Partial Hospitalization) Continued Stay Criteria Across 6 Dimensions

#### **Dimensional Scoring Specifications**

Individuals must meet, at a minimum, Level 2A criteria in Dimensions 4, 5, and 6, and no criteria higher than Level 2A for the remaining dimensions.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Acute symptoms of intoxication/withdrawal are absent in the individual;</p> <p>B. Individual exhibits symptoms of post-acute withdrawal (e.g. increased irritability, mood swings, obsessive thoughts of substance use, high levels of anxiety) which present obstacles to engaging in recovery and normal life functioning;</p> <p>C. The individual reports a limited lapse of sobriety that can be addressed constructively at this LOC.</p>
<p><b>2. Biomedical Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. The biomedical conditions and problems, if any, continue to be present, yet are not severe enough to interfere with treatment;</p> <p>B. The individual is responding to treatment, and biomedical conditions and problems continue not to be severe enough to warrant inpatient treatment, but they are sufficient to distract from recovery efforts. Such problems require medical monitoring which can be provided at Level 2A.</p>
<p><b>3. Emotional/ Behavioral Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. The individual continues to be unable to maintain behavioral stability over a 3-5 day period, but the behavioral instability problem is actively being addressed in treatment, and there are indications that the individual is responding to treatment interventions;</p> <p>B. The individual's emotional/behavioral disorder, which is being concurrently managed, continues to distract the individual from treatment, but the individual is responding to treatment, and it is anticipated that with further interventions, he/she will be able to achieve treatment objectives;</p> <p>C. The individual continues to manifest mild risk behaviors endangering self or others (e.g. diminishing suicidal or homicidal thoughts), but the condition is improving.</p>
<p><b>4. Treatment Acceptance/ Resistance</b></p>	<p>The individual is beginning to demonstrate personal responsibility for addressing his/her substance use and recovery, but continues to require intensive structured treatment, motivating strategies, and/or consistent peer support in order to sustain and internalize recovery efforts.</p>
<p><b>5. Relapse Potential</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. The individual recognizes relapse potential, but has not yet sufficiently identified relapse triggers or consistently developed and applied behavioral changes to interrupt or postpone gratification or to change the related inappropriate impulse control necessary to maintain abstinence;</p> <p>B. The individual continues to be dependent on the program structure for sustaining abstinence.</p>

<b>6. Recovery Environment</b>	Individuals must meet ONE of the following:  A. The individual has not yet developed sufficient coping skills to withstand stressors presented by non-supportive family, work, or neighborhood environment, but has recognized the need to do so;  B. The individual has not yet integrated the socialization skills necessary to establish a supportive social network.
--------------------------------	--

#### D.4.4 Level 2A (Partial Hospitalization) Do's and Don'ts

Consideration	Do	Don't
LOC or Specialty Service Not Available	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure individual's safety and continuing engagement.</li> <li>• <b>Do</b> know community resources and match individuals to most appropriate service(s) available, include accommodations where needed/available (e.g. interpreter, case management).</li> <li>• <b>Do</b> give first consideration to placing the individual in the next highest LOC if assessed LOC is not available.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> deny services or ignore special needs.</li> <li>• <b>Don't</b> disregard initial LOC determination and needs.</li> </ul>
Individual Declines Assessed LOC	<ul style="list-style-type: none"> <li>• <b>Do</b> document assessed LOC, reasons why individual declined the LOC and risks associated with not providing LOC.</li> <li>• <b>Do</b> work with individual to engage in most appropriate services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> change assessed LOC recommendation as indicated by PCPC.</li> </ul>
Individual Not Responding/Progressing in Assessed LOC	<ul style="list-style-type: none"> <li>• <b>Do</b> reassess appropriateness of LOC (using PCPC), the individual's treatment plan, the program and facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> terminate treatment abruptly; consider all treatment factors.</li> </ul>
Recovery Resources	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that individuals have been appropriately connected to community recovery support and social services throughout treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge individuals without appropriate connection to effective community and recovery resources.</li> </ul>
LOC Assessment Sufficiency	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure assessors are appropriately trained and experienced in drug and alcohol assessment and multi-dimensional protocol.</li> <li>• <b>Do</b> assess individuals face-to-face.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> employ or use assessors that do not have appropriate training and experience.</li> </ul>
Seamless Continuum	<ul style="list-style-type: none"> <li>• <b>Do</b> provide facilitated handoff between services whenever possible.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge without facilitated handoff.</li> </ul>
Role of Funding Availability in Placement and Stay Recommendations	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure that placement and continued stay recommendations are consistent with criteria.</li> <li>• <b>Do</b> document placement changes due to funding limitations.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> revise PCPC-based recommendations in response to funding availability.</li> </ul>
Role of Individual Motivation	<ul style="list-style-type: none"> <li>• <b>Do</b> use Dimension 4 – Treatment Acceptance/Resistance Criteria.</li> <li>• <b>Do</b> use assessment as engagement opportunity.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use perceived lack of motivation as basis for denial of care.</li> <li>• <b>Don't</b> use fail first mechanisms of any type.</li> </ul>

Consideration	Do	Don't
	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure assessment staff is knowledgeable about motivational interviewing principles.</li> </ul>	
<b>Individuals in Controlled Environment</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> review status and functioning prior to admission to controlled environment; this is an essential part of PCPC LOC determination.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use lack of substance use in controlled environment as evidence of behavior change or modification of relapse risk.</li> </ul>
<b>Knowledge of Resources</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> understand resources available, including characteristics of programs within the same LOC, to ensure optimal matching</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> make uninformed placement decisions.</li> </ul>
<b>Special Population</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> refer to Special Population Paper to determine placement and coordination of care considerations important to this population.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Co-Occurring SUD and MH Disorder</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> consider SUD and MH severity to determine whether the individual should be placed in co-occurring capable, co-occurring integrated, or MH facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Comorbidity</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that all individuals have been screened for medical and mental health co-morbidity needs and that these needs have been met via appropriate linkages to medical and mental health services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> forget the individual's medical and pain management needs when providing assessment and linkages to needed concurrent services.</li> </ul>
<b>When this LOC is Integrated Within a General Medical Setting</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> follow all confidentiality regulations (including HIPAA and other state and federal regulations) in the sharing of information.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> share clinical information in ways that might violate state or federal confidentiality regulations, or jeopardize continued care or the individual's willingness to continue with either general medical care or this LOC.</li> </ul>

#### D.4.5 Level 2A (Partial Hospitalization) Special Populations Considerations

Population	Consideration
<b>Medication-Assisted Treatment</b>	Individuals receiving MAT should have access to this LOC, provided they will receive appropriate medical monitoring throughout their treatment. Services should be provided that ensure coordination of care with other treatment providers (See Special Population Paper 1 contained in Section E).
<b>Co-Occurring</b>	Individuals with co-occurring mental health and SUD should receive the appropriate treatment concurrent with their participation in this LOC. If the individual is in a co-occurring capable or integrated program mental health services should be provide as indicated in the program’s licensing requirements (See Special Population Paper 2 contained in Section E).
<b>Women and Women with Children</b>	Women with children may find it difficult to participate in this LOC unless they receive linkages to appropriate placement for their children. Since women often operate from the perspective of relational issues, women without children sometimes have difficulty participating in this LOC if they do not receive appropriate support for relational issues (e.g. being away from their significant others). Further, the program should assess the woman’s needs for appropriate supportive services inside and outside of the program, and ensure that she is appropriately linked (via a “warm handoff”) to these services. Finally, any services provided to this population must be sensitive to its specific perspectives and needs (See Special Population Paper 3 contained in Section E).
<b>Criminal Justice</b>	The extent and effects of prisonization (See Glossary) on an individual must be considered for placement in an appropriate LOC. Individuals who are leaving a jail or prison should be assessed using a biopsychosocial applied during the period just prior to their incarceration. If the individual who has been part of the criminal justice system is deemed appropriate for this LOC, services should be provided that are sensitive to his/her specific perspectives and needs (See Special Population Paper 4 contained in Section E).
<b>Cultural/Ethnic</b>	Services should be provided that are sensitive to each individual’s cultural/ethnic perspectives and needs (See Special Population Paper 5 contained in Section E).
<b>Sexual Orientation/Gender Identity</b>	Services should be provided that are sensitive to each individual’s sexual orientation/gender identity perspectives and needs (See Special Population Paper 6 contained in Section E).
<b>Co-Occurring Substance Use and Gambling Disorder</b>	Individuals with co-occurring SUD and gambling disorders should receive the appropriate treatment concurrent with their participation in this LOC. Specific areas of concern may be medication, risk of domestic violence and risk of suicide. Program referral should include staff with the proper education and experience to address these issues. Programs should include education on the risk of cross-addiction to gambling disorder as a part of relapse prevention planning (See Special Population Paper 7 contained in Section E).

## D.5 Level 2B: Halfway House

### D.5.1 Description of Service Level

- A Halfway House is a treatment facility located in the community that is state licensed, regulated, and professionally staffed. Programs focus on developing self-sufficiency through counseling, employment and other services. Some of these programs staff medical and psychiatric personnel on site to assist individuals with their medical and/or co-occurring needs. This is a live in/work out environment.
- This treatment must be conducted in a DDAP-licensed drug and alcohol non-hospital facility, as stipulated in 28 PA Code. The setting is usually an independent physical structure containing no more than 25 beds. This type of facility is meant to provide a “home-like” atmosphere within the local community, be accessible to public transportation, and give no indication of being an institutional setting. Normal housekeeping and food preparation are done on the premises by the residents.
- All employees and contracted professionals providing clinical services within the facility must comply with DDAP staffing requirements. The Individual:FTE Counselor ratio must not exceed 8:1, although halfway houses may petition DDAP for exceptions to these Individual:staff ratios.

#### Required Services and Support Systems include:

- Physical exam
- Regularly scheduled psychotherapy
- Biopsychosocial Assessment
- Specialized professional/medical consultation, and tests such as a psychiatric evaluation, HIV and TB testing, and other laboratory work, as needed
- Individualized treatment planning, with reviews at least every 30 days
- Development of a discharge plan and a plan for referral into continuum of care
- Access to services for: vocational assessment, job readiness and job placement, GED preparation and testing, literacy and basic education tutoring, legal, medical and dental care, general health education (esp. AIDS awareness and support), budgeting, credit restoration, housing assistance, income support, and recreational/social activities (e.g. fitness, games, peer interaction).

#### Recommended Services and Support Systems include:

- Group therapy once per week for at least 1.5 hours per session (group size: no more than 12)
- Individual therapy at least twice a month for at least one hour per session
- Peer group meetings four times/week for at least 45 minutes/session, to focus on daily living
- Family therapy, if indicated by the individual’s treatment plan
- Educational or instructional groups, once per month

The Required Staff in a halfway house include a director and counselor(s), and a clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and profile, a single person may hold one or more of the above positions. The Staff who may be Recommended may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. SUD counselors or other certified SUD clinicians) who may more effectively serve the facility’s population.

## D.5.2 Level 2B (Halfway House) Admission Criteria Across 6 Dimensions

### **Dimensional Scoring Specifications**

Individuals must meet, at a minimum, Level 2B criteria for Dimension 3, and Level 2B criteria from two of either Dimensions 4, 5, or 6. Individuals must not meet criteria that are higher than Level 2B in Dimensions 1 or 2.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Individuals must meet all of the following:</p> <p>A. The individual is assessed as being at minimal to no risk of severe withdrawal syndrome, as evidenced by:</p> <ol style="list-style-type: none"> <li>1. CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) of less than 10 following 8 hours of abstinence from alcohol without medication; OR</li> <li>2. Blood alcohol 0.0gm% and no withdrawal signs or symptoms present which require medication; OR</li> <li>3. Sub-acute symptoms of protracted withdrawal that, if present, can be managed safely without daily monitored medical intervention.</li> </ol> <p>B. For individuals with withdrawal symptoms no more severe than those noted above, the individual has, and responds positively to, emotional support and comfort as evidenced by decreased emotional symptoms by the end of the initial treatment session.</p>
<p><b>2. Biomedical Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. The individual’s biomedical conditions and problems, if any, are not severe enough to interfere with treatment;</p> <p>B. The individual’s biomedical conditions and problems are not severe enough to warrant Level 3 or Level 4 treatment, but are sufficient to distract from recovery efforts. Such problems require medical monitoring and/or medical management which can be provided by the Level 2B program, or through a concurrent arrangement with another treatment provider;</p> <p>C. The individual needs help with referral to educational resources for management of his or her own health care needs;</p> <p>D. Abstinence is essential if overall health is to return.</p>
<p><b>3. Emotional/ Behavioral Conditions and Complications</b></p>	<p>Individuals must meet at least 2 of the following:</p> <p>A. Inability to maintain behavioral stability (e.g. lacks impulse control);</p> <p>B. Mental status of individual does not preclude his or her ability to comprehend and understand the materials presented or to participate in the treatment process;</p> <p>C. The individual is manifesting stress behaviors related to recent or threatened losses in the work, family, or social arena to the extent that activities of daily living are significantly impaired;</p> <p>D. Mild risk of behaviors endangering self or others (e.g. suicidal or homicidal thoughts with no active plan);</p> <p>E. The individual needs reinforcement to improve cognitive skills and gain basic social functions;</p> <p>F. Low self-esteem and limited ability to make decisions;</p> <p>G. Coexisting emotional/behavioral/psychiatric conditions can be treated through referral agreements.</p>

<p><b>4. Treatment Acceptance/Resistance</b></p>	<p>Individuals must meet all of the following:</p> <ul style="list-style-type: none"> <li>A. The individual expresses willingness to cooperate and attend all scheduled activities, and</li> <li>B. The individual admits that he or she has an alcohol and/or other drug problem, and accepts the need for monitoring and motivating strategies in a 24-hr structured living environment.</li> </ul>
<p><b>5. Relapse Potential</b></p>	<p>Individuals must meet ONE of the following:</p> <ul style="list-style-type: none"> <li>A. Likelihood of drinking or other drug use without a 24-hr structured living environment (inability to integrate treatment/recovery process);</li> <li>B. Individual lacks awareness of relapse triggers and has difficulty postponing immediate gratification.</li> </ul>
<p><b>6. Recovery Environment</b></p>	<p>Individuals must meet ONE of the following:</p> <ul style="list-style-type: none"> <li>A. Family members and/or significant others living with the individual are non-supportive of recovery goals and/or passively opposed to his/her treatment. Individual requires 24-hr relief from home environment to stay focused on recovery;</li> <li>B. Lack of social contacts which jeopardizes recovery (e.g. individual lives alone, has few friends or peers who don't use alcohol/drugs);</li> <li>C. Logistic impediments (e.g. distance from treatment facility, mobility limitations, lack of drivers license, etc.) preclude participation in treatment services at a less intensive level;</li> <li>D. There is a danger of physical, sexual, and/or severe emotional attack or victimization in the individual's current environment that will make recovery unlikely without removing the individual from this environment.</li> </ul>

### D.5.3 Level 2B (Halfway House) Continued Stay Criteria Across 6 Dimensions

**Dimensional Scoring Specifications**

Individuals must meet, at a minimum, Level 2B criteria in Dimensions 3, 5, and 6, and no criteria higher than Level 2B in the remaining dimensions.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Acute symptoms of intoxication/withdrawal are absent in the individual;</p> <p>B. Individual presents symptoms of post-acute withdrawal (e.g. increased irritability, mood swings, obsessive thoughts of substance use, high levels of anxiety) which present obstacles to engaging in recovery and normal life functioning;</p> <p>C. Individual reports a limited lapse of sobriety, but this can be addressed constructively.</p>
<p><b>2. Biomedical Conditions and Complications</b></p>	<p>The individual is responding to treatment, and biomedical conditions and problems continue not to be severe enough to warrant a higher LOC, but they are sufficient to distract from recovery efforts. Such problems require medical monitoring which the individual learns to access by using community resources.</p>
<p><b>3. Emotional/ Behavioral Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Individual continues to demonstrate unstable behavior (e.g. impulse control) but shows improvement;</p> <p>B. Stress factors continue to threaten treatment process in daily living arrangements, but there is evidence of improvement;</p> <p>C. Risk of endangering self or others continues or is diminishing;</p> <p>D. Individual demonstrates improvement in cognitive skills and basic social functions but continues to need reinforcement;</p> <p>E. Decision-making and self-esteem improving but still need reinforcement.</p>
<p><b>4. Treatment Acceptance/ Resistance</b></p>	<p>The individual recognizes the severity of his or her alcohol/drug problems and manifests understanding of his/her personal relationship with psychoactive substances, yet does not demonstrate that he/she has assumed the responsibility necessary to cope with the problem.</p>
<p><b>5. Relapse Potential</b></p>	<p>Individual recognizes the severity of his/her relapse triggers and dysfunctional behaviors which undermine sobriety, and manifests an understanding of these dysfunctional behaviors, yet does not demonstrate the skills necessary to interrupt these behaviors and apply alternative coping skills necessary to maintain ongoing abstinence.</p>

<b>6. Recovery Environment</b>	Individuals must meet ONE of the following:  A. Individual has not integrated sufficient coping skills to withstand stressors in the work environment or has not developed vocational alternatives;  B. Individual has not yet developed sufficient coping skills to deal with the non-supportive family/social environment;  C. Individual has not yet integrated the socialization skills necessary to establish a supportive social network.
--------------------------------	---

### D.5.4 Level 2B (Halfway House) Do's and Don'ts

Consideration	Do	Don't
LOC or Specialty Service Not Available	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure individual's safety and continuing engagement.</li> <li>• <b>Do</b> know community resources and match individuals to most appropriate service(s) available, include accommodations where needed/available (e.g. interpreter, case management).</li> <li>• <b>Do</b> give first consideration to placing the individual in the next highest LOC if assessed LOC is not available.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> deny services or ignore special needs.</li> <li>• <b>Don't</b> disregard initial LOC determination and needs.</li> </ul>
Individual Declines Assessed LOC	<ul style="list-style-type: none"> <li>• <b>Do</b> document assessed LOC, reasons why individual declined the LOC and risks associated with not providing LOC.</li> <li>• <b>Do</b> work with individual to engage in most appropriate services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> change assessed LOC recommendation as indicated by PCPC.</li> </ul>
Individual Not Responding/Progressing in Assessed LOC	<ul style="list-style-type: none"> <li>• <b>Do</b> reassess appropriateness of LOC (using PCPC), the individual's treatment plan, the program and facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> terminate treatment abruptly; consider all treatment factors.</li> </ul>
Recovery Resources	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that individuals have been appropriately connected to community recovery support and social services throughout treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge individuals without appropriate connection to effective community and recovery resources.</li> </ul>
LOC Assessment Sufficiency	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure assessors are appropriately trained and experienced in drug and alcohol assessment and multi-dimensional protocol.</li> <li>• <b>Do</b> assess individuals face-to-face.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> employ or use assessors that do not have appropriate training and experience.</li> </ul>
Seamless Continuum	<ul style="list-style-type: none"> <li>• <b>Do</b> provide facilitated handoff between services whenever possible.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge without facilitated handoff.</li> </ul>
Role of Funding Availability in Placement and Stay Recommendations	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure that placement and continued stay recommendations are consistent with criteria.</li> <li>• <b>Do</b> document placement changes due to funding limitations.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> revise PCPC-based recommendations in response to funding availability.</li> </ul>
Role of Individual Motivation	<ul style="list-style-type: none"> <li>• <b>Do</b> use Dimension 4 – Treatment Acceptance/Resistance Criteria.</li> <li>• <b>Do</b> use assessment as engagement opportunity.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use perceived lack of motivation as basis for denial of care.</li> <li>• <b>Don't</b> use fail first mechanisms of any type.</li> </ul>

Consideration	Do	Don't
	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure assessment staff is knowledgeable about motivational interviewing principles.</li> </ul>	
<b>Individuals in Controlled Environment</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> review status and functioning prior to admission to controlled environment; this is an essential part of PCPC LOC determination.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use lack of substance use in controlled environment as evidence of behavior change or modification of relapse risk.</li> </ul>
<b>Knowledge of Resources</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> understand resources available, including characteristics of programs within the same LOC, to ensure optimal matching.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> make uninformed placement decisions.</li> </ul>
<b>Special Population</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> refer to Special Population Paper to determine placement and coordination of care considerations important to this population.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Co-Occurring SUD and MH Disorder</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> consider SUD and MH severity to determine whether the individual should be placed in co-occurring capable, co-occurring integrated, or MH facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Comorbidity</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that all individuals have been screened for medical and mental health co-morbidity needs and that these needs have been met via appropriate linkages to medical and mental health services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> forget the individual's medical and pain management needs when providing assessment and linkages to needed concurrent services.</li> </ul>
<b>When this LOC is Integrated Within a General Medical Setting</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> follow all confidentiality regulations (including HIPAA and other state and federal regulations) in the sharing of information.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> share clinical information in ways that might violate state or federal confidentiality regulations, or jeopardize continued care or the individual's willingness to continue with either general medical care or this LOC.</li> </ul>

### D.5.5 Level 2B (Halfway House) Special Populations Considerations

Population	Consideration
<b>Medication-Assisted Treatment</b>	Individuals receiving MAT should have access to this LOC, provided they will receive appropriate medical monitoring throughout their treatment. Services should be provided that ensure coordination of care with other treatment providers (See Special Population Paper 1 contained in Section E).
<b>Co-Occurring</b>	Individuals with co-occurring mental health and SUD should receive the appropriate treatment concurrent with their participation in this LOC. If the individual is in a co-occurring capable or integrated program mental health services should be provide as indicated in the program’s licensing requirements (See Special Population Paper 2 contained in Section E).
<b>Women and Women with Children</b>	Women with children may find it difficult to participate in this LOC unless they receive linkages to appropriate placement for their children. Since women often operate from the perspective of relational issues, women without children sometimes have difficulty participating in this LOC if they do not receive appropriate support for relational issues (e.g. being away from their significant others). Further, the program should assess the woman’s needs for appropriate supportive services inside and outside of the program, and ensure that she is appropriately linked (via a “warm handoff”) to these services. Finally, any services provided to this population must be sensitive to its specific perspectives and needs (See Special Population Paper 3 contained in Section E).
<b>Criminal Justice</b>	The extent and effects of prisonization (See Glossary) on an individual must be considered for placement in an appropriate LOC. Individuals who are leaving a jail or prison should be assessed using a biopsychosocial applied during the period just prior to their incarceration. If the individual who has been part of the criminal justice system is deemed appropriate for this LOC, services should be provided that are sensitive to his/her specific perspectives and needs (See Special Population Paper 4 contained in Section E).
<b>Cultural/Ethnic</b>	Services should be provided that are sensitive to each individual’s cultural/ethnic perspectives and needs (See Special Population Paper 5 contained in Section E).
<b>Sexual Orientation/Gender Identity</b>	Services should be provided that are sensitive to each individual’s sexual orientation/gender identity perspectives and needs (See Special Population Paper 6 contained in Section E).
<b>Co-Occurring Substance Use and Gambling Disorder</b>	Individuals with co-occurring SUD and gambling disorders should receive the appropriate treatment concurrent with their participation in this LOC. Specific areas of concern may be medication, risk of domestic violence and risk of suicide. Program referral should include staff with the proper education and experience to address these issues. Programs should include education on the risk of cross-addiction to gambling disorder as a part of relapse prevention planning (See Special Population Paper 7 contained in Section E).

## D.6 Level 3A: Medically Monitored Inpatient Detoxification

### D.6.1 Description of Service Level

- Medically Monitored Inpatient Detoxification is a treatment conducted in a residential facility that provides a 24-hour professionally directed evaluation and detoxification of addicted individuals. Detoxification is the process whereby a drug- or alcohol-intoxicated or dependent individual is assisted through the period of time required to eliminate the presence of the intoxicating substance (by metabolic or other means) and any other dependency factors while keeping the physiological and psychological risk to the individual at a minimum. This process should also include efforts to motivate and support the individual to seek formal treatment after the detoxification process. This type of care utilizes multi-disciplinary personnel for individuals whose withdrawal problems (with or without biomedical and/or emotional problems) are severe enough to require inpatient services, 24-hour observation, monitoring, and, usually, medication. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment system are not necessary. The multi-disciplinary team and the availability of support services allows detoxification and a level of treatment consistent with the individual's mental state and required LOS, as well as the conjoint treatment of any coexisting sub-acute biomedical or emotional conditions which could jeopardize recovery.
- Treatment is conducted in a DDAP-licensed drug and alcohol non-hospital detoxification service, located in a freestanding or health care-specific environment.
- All employees and contracted professionals providing clinical services within the facility must comply with DDAP staffing requirements. The Individual:FTE Counselor (or Primary Care Staff Person) ratio must not exceed 7:1 during primary care hours.

#### Required Services and Support Systems include:

- 24-hour observation, monitoring, and treatment
- Emergency medical services available
- Referral to medically managed detox, if clinically appropriate
- Specialized professional/medical consultation, and tests such as HIV and TB testing, and other laboratory work, as needed
- Biopsychosocial Assessment
- Monitoring of medication, as needed
- Development of discharge plan, and plan for referral into continuum of care
- Medications ordered by a licensed physician and administered in accordance with the substance-specific withdrawal syndrome(s), other biomedical or psychiatric conditions, and recognized detoxification procedures
- Physical examination by a physician within 24 hours following admission, or a physical examination which was conducted within 7 days prior to admission, and was evaluated by the facility physician within 24 hours following admission
- Specific assessments performed on an individualized basis, with consideration of risk guiding the evaluation (because population frequently suffers from communicable, infectious, or transmittable diseases). Furthermore, the facility must have appropriate policies and procedures for identification, treatment, and referral of individuals found to have such illnesses, so as to protect other individuals and staff from acquiring these diseases.
- Access to services for: vocational assessment, job readiness and job placement, GED preparation and testing, literacy and basic education tutoring, legal, medical and dental care,

general health education (esp. AIDS awareness and support), budgeting, credit restoration, housing assistance, income support, and recreational/social activities (e.g. fitness, games, peer interaction)

Recommended Services and Support Systems include:

- Ability to conduct and/or arrange for appropriate laboratory and toxicology tests
- 24-hour physician available by telephone
- Face-to-face assessment by a physician within 24 hours after admission, with further assessments thereafter as medically needed (but not less than 3 times per week)
- Alcohol- or drug-focused nursing assessment by a registered nurse upon admission
- Oversight and monitoring of the individual's progress and medication administration by licensed medical staff under the physician's direction
- Professional counseling services available 12 hours a day, provided by appropriately qualified staff
- Health education services
- Clinical program activities designed to enhance the individual's understanding of his/her SUD
- Family/significant other services, as appropriate

The Required Staff at a medically monitored inpatient detox facility include a director and counselor(s), and a clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and profile, a single person may hold one or more of the above positions. The Staff who may be Recommended may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. SUD counselors or other certified SUD clinicians) who may more effectively serve the facility's population.

## D.6.2 Level 3A (Medically Monitored Inpatient Detox) Admission Criteria Across 6 Dimensions

### **Dimensional Scoring Specifications**

Individuals must meet, at a minimum, Level 3A criteria for Dimension 1, and no criteria higher than Level 3A for Dimensions 2 and 3.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. The risk of a severe withdrawal syndrome is present but manageable in this setting, as evidenced by:</p> <ol style="list-style-type: none"> <li>1. Individual is withdrawing from alcohol and CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) equals 10-19; OR</li> <li>2. Daily ingestion of sedative hypnotics or opioids for over six months, plus daily use of another mind-altering drug known to have its own withdrawal syndrome (close hourly monitoring is available, if needed), with no accompanying chronic mental/physical disorder; OR</li> <li>3. Daily ingestion of sedative hypnotics or opioids above the recommended therapeutic dosage level for at least 4 weeks (close hourly monitoring is available, if needed), with no accompanying chronic mental/physical disorder; OR</li> <li>4. The individual uses high dose/oral/nasal stimulants, or smokes or injects stimulants at least once a day in a cyclic pattern of “runs,” and is currently within 7 days of such drug use; OR</li> <li>5. The individual has marked lethargy, hypersomnolence, or high levels of agitation associated with expressed high degrees of drug craving.</li> </ol> <p>B. The individual is either not showing signs of intoxication with a blood alcohol of .15gm% or greater, or has a blood alcohol level of 0.2gm%.</p>
<p><b>2. Biomedical Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Continued alcohol/drug use places the individual in imminent danger of serious damage to physical health for concomitant biomedical conditions;</p> <p>B. Biomedical complications of SUD or a concurrent biomedical illness require medical monitoring, but not intensive care.</p>

<b>3. Emotional/ Behavioral Conditions and Complications</b>	<p>Individuals must meet ONE of the following:</p> <p>A. Depression and/or other emotional/behavioral symptoms (e.g. compulsive behavior) are sufficiently interfering with abstinence, recovery, and stability to the degree that there is a need for a structured 24-hour environment to address recovery efforts;</p> <p>B. Moderate risk of behaviors endangering self or others (e.g. current suicidal or homicidal thoughts with no active plan, but with a history of suicidal/homicidal gestures or threats);</p> <p>C. Manifesting high stress behaviors related to recent or threatened losses in the work, family, or social arena, to the extent that activities of daily living are significantly impaired. A 24-hr structured setting is needed to place the individual in a secure environment to address his or her SUD;</p> <p>D. History or presence of violent or disruptive behavior during intoxication with imminent danger to self or others, or boundary-setting difficulties;</p> <p>E. Concomitant personality disorder (e.g. antisocial personality disorder with verbal aggressive behavior requiring constant limit-setting) is of such severity that the accompanying dysfunctional behaviors require continuous monitoring.</p>
<b>4. Treatment Acceptance/ Resistance</b>	<p>N/A</p>
<b>5. Relapse Potential</b>	<p>N/A</p>
<b>6. Recovery Environment</b>	<p>N/A</p>

### D.6.3 Level 3A (Medically Monitored Inpatient Detox) Continued Stay Criteria Across 6 Dimensions

**Dimensional Scoring Specifications**

Individuals must meet, at a minimum, Level 3A criteria for Dimension 1, and Level 3A criteria from one of Dimensions 3, 4, or 6. Individuals cannot meet criteria higher than Level 3A for the remaining dimensions.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Persistence of withdrawal symptomatology, and/or withdrawal protocol, requires continued medical and/or nursing monitoring on a 24-hr basis;</p> <p>B. Post-withdrawal organicity (e.g. poor immediate and recent memory recall) inhibits cognitive functioning and the individual's ability to effectively achieve treatment objectives, but the individual's cognition is clearing and he/she is expected to respond to treatment.</p>
<p><b>2. Biomedical Conditions and Complications</b></p>	<p>Continuation of any biomedical problem which prohibits transfer to another LOC.</p>
<p><b>3. Emotional/ Behavioral Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. The individual is making progress toward resolution of an emotional or behavioral problem, but he/she has not sufficiently resolved the problem(s) to permit transfer to another LOC;</p> <p>B. The individual is being held pending transfer (within 48 hours) to a more intensive inpatient service.</p>
<p><b>4. Treatment Acceptance/ Resistance</b></p>	<p>The individual recognizes the severity of the alcohol/drug problems, but demonstrates minimal understanding of his/her self-defeating use of alcohol or drugs.</p>
<p><b>5. Relapse Potential</b></p>	<p>N/A</p>
<p><b>6. Recovery Environment</b></p>	<p>Continuing danger of physical, sexual, and/or severe emotional attack or victimization in the individual's outside environment will make recovery unlikely without removing the individual from this environment.</p>

### D.6.4 Level 3A (Medically Monitored Inpatient Detox) Do's and Don'ts

Consideration	Do	Don't
LOC or Specialty Service Not Available	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure individual's safety and continuing engagement.</li> <li>• <b>Do</b> know community resources and match individuals to most appropriate service(s) available, include accommodations where needed/available (e.g. interpreter, case management).</li> <li>• <b>Do</b> give first consideration to placing the individual in the next highest LOC if assessed LOC is not available.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> deny services or ignore special needs.</li> <li>• <b>Don't</b> disregard initial LOC determination and needs.</li> </ul>
Individual Declines Assessed LOC	<ul style="list-style-type: none"> <li>• <b>Do</b> document assessed LOC, reasons why individual declined the LOC and risks associated with not providing LOC.</li> <li>• <b>Do</b> work with individual to engage in most appropriate services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> change assessed LOC recommendation as indicated by PCPC.</li> </ul>
Individual Not Responding/Progressing in Assessed LOC	<ul style="list-style-type: none"> <li>• <b>Do</b> reassess appropriateness of LOC (using PCPC), the individual's treatment plan, the program and facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> terminate treatment abruptly; consider all treatment factors.</li> </ul>
Recovery Resources	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that individuals have been appropriately connected to community recovery support and social services throughout treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge individuals without appropriate connection to effective community and recovery resources.</li> </ul>
LOC Assessment Sufficiency	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure assessors are appropriately trained and experienced in drug and alcohol assessment and multi-dimensional protocol.</li> <li>• <b>Do</b> assess individuals face-to-face.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> employ or use assessors that do not have appropriate training and experience.</li> </ul>
Seamless Continuum	<ul style="list-style-type: none"> <li>• <b>Do</b> provide facilitated handoff between services whenever possible.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge without facilitated handoff.</li> </ul>
Role of Funding Availability in Placement and Stay Recommendations	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure that placement and continued stay recommendations are consistent with criteria.</li> <li>• <b>Do</b> document placement changes due to funding limitations.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> revise PCPC-based recommendations in response to funding availability.</li> </ul>
Role of Individual Motivation	<ul style="list-style-type: none"> <li>• <b>Do</b> use Dimension 4 – Treatment Acceptance/Resistance Criteria.</li> <li>• <b>Do</b> use assessment as engagement opportunity.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use perceived lack of motivation as basis for denial of care.</li> <li>• <b>Don't</b> use fail first mechanisms of any type.</li> </ul>

Consideration	Do	Don't
	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure assessment staff is knowledgeable about motivational interviewing principles.</li> </ul>	
<b>Individuals in Controlled Environment</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> review status and functioning prior to admission to controlled environment; this is an essential part of PCPC LOC determination.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use lack of substance use in controlled environment as evidence of behavior change or modification of relapse risk.</li> </ul>
<b>Knowledge of Resources</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> understand resources available, including characteristics of programs within the same LOC, to ensure optimal matching.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> make uninformed placement decisions.</li> </ul>
<b>Special Population</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> refer to Special Population Paper to determine placement and coordination of care considerations important to this population.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Co-Occurring SUD and MH Disorder</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> consider SUD and MH severity to determine whether the individual should be placed in co-occurring capable, co-occurring integrated, or MH facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Comorbidity</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that all individuals have been screened for medical and mental health co-morbidity needs and that these needs have been met via appropriate linkages to medical and mental health services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> forget the individual's medical and pain management needs when providing assessment and linkages to needed concurrent services.</li> </ul>
<b>When this LOC is Integrated Within a General Medical Setting</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> follow all confidentiality regulations (including HIPAA and other state and federal regulations) in the sharing of information.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> share clinical information in ways that might violate state or federal confidentiality regulations, or jeopardize continued care or the individual's willingness to continue with either general medical care or this LOC.</li> </ul>

### D.6.5 Level 3A (Medically Monitored Inpatient Detox) Special Populations Considerations

Population	Consideration
<b>Medication-Assisted Treatment</b>	Individuals receiving MAT should have access to this LOC, provided they will receive appropriate medical monitoring throughout their treatment. Services should be provided that ensure coordination of care with other treatment providers (See Special Population Paper 1 contained in Section E).
<b>Co-Occurring</b>	Individuals with co-occurring mental health and SUD should receive the appropriate treatment concurrent with their participation in this LOC. If the individual is in a co-occurring capable or integrated program mental health services should be provide as indicated in the program’s licensing requirements (See Special Population Paper 2 contained in Section E).
<b>Women and Women with Children</b>	Women with children may find it difficult to participate in this LOC unless they receive linkages to appropriate placement for their children. Since women often operate from the perspective of relational issues, women without children sometimes have difficulty participating in this LOC if they do not receive appropriate support for relational issues (e.g. being away from their significant others). Further, the program should assess the woman’s needs for appropriate supportive services inside and outside of the program, and ensure that she is appropriately linked (via a “warm handoff”) to these services. Finally, any services provided to this population must be sensitive to its specific perspectives and needs (See Special Population Paper 3 contained in Section E).
<b>Criminal Justice</b>	The extent and effects of prisonization (See Glossary) on an individual must be considered for placement in an appropriate LOC. Individuals who are leaving a jail or prison should be assessed using a biopsychosocial applied during the period just prior to their incarceration. If the individual who has been part of the criminal justice system is deemed appropriate for this LOC, services should be provided that are sensitive to his/her specific perspectives and needs (See Special Population Paper 4 contained in Section E).
<b>Cultural/Ethnic</b>	Services should be provided that are sensitive to each individual’s cultural/ethnic perspectives and needs (See Special Population Paper 5 contained in Section E).
<b>Sexual Orientation/Gender Identity</b>	Services should be provided that are sensitive to each individual’s sexual orientation/gender identity perspectives and needs (See Special Population Paper 6 contained in Section E).
<b>Co-Occurring Substance Use and Gambling Disorder</b>	Individuals with co-occurring SUD and gambling disorders should receive the appropriate treatment concurrent with their participation in this LOC. Specific areas of concern may be medication, risk of domestic violence and risk of suicide. Program referral should include staff with the proper education and experience to address these issues. Programs should include education on the risk of cross-addiction to gambling disorder as a part of relapse prevention planning (See Special Population Paper 7 contained in Section E).

## D.7 Level 3B: Medically Monitored Short Term Residential

### D.7.1 Description of Service Level

- Medically Monitored Short Term Residential treatment is a TOS that includes 24-hour professionally directed evaluation, care, and treatment for addicted individuals in acute distress. These individuals' SUD symptomatology is demonstrated by moderate impairment of social, occupational, or school functioning. Rehabilitation is a key treatment goal.
- This treatment is conducted at a DDAP-licensed drug and alcohol residential non-hospital treatment and rehabilitation facility located in a freestanding or a health care-specific environment.
- All employees and contracted professionals providing clinical services within the facility must comply with DDAP staffing requirements. The Individual:FTE Counselor ratio is not to exceed 8:1 during primary care hours.

#### Required Services and Support Systems include:

- 24-hour observation, monitoring, and treatment
- Emergency medical services available
- Referral to detoxification, if clinically needed
- Specialized professional/medical consultation, and tests such as HIV and TB testing, and other laboratory work, as needed
- Biopsychosocial Assessment
- Individualized treatment planning, with reviews at least every 30 days (where treatment is less than 30 days, review shall occur every 15 days)
- Individual therapy
- Group therapy (group size: no more than 12 members)
- Couples therapy (if appropriate)
- Family therapy (if appropriate)
- Access to occupational and vocational counseling
- Monitoring of medication, if necessary
- Physical exam
- Development of discharge plan and plan for referral into continuum of care
- Access to services for: vocational assessment, job readiness and job placement, GED preparation and testing, literacy and basic education tutoring, legal, medical and dental care, general health education (esp. AIDS awareness and support), budgeting, credit restoration, housing assistance, income support, and recreational/social activities (e.g. fitness, games, peer interaction)

#### Recommended Services and Support Systems include:

- Case management and social services that allow the staff to assist with attendance monitoring, child care, transportation to treatment services, and the provision of stable shelter and other basic care needs
- Availability of conjoint treatment
- Collaboration between the treatment team and various agencies for the coordinated provision of services

The Required Staff in Medically Monitored Short Term Residential treatment include a director and counselor(s), and a clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and profile, a single person may hold one or more of the above positions. The Staff who may be Recommended may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. SUD counselors or other certified SUD clinicians) who may more effectively serve the facility's population.

## D.7.2 Level 3B (Medically Monitored Short Term Residential) Admission Criteria Across 6 Dimensions

### **Dimensional Scoring Specifications**

Individuals must meet, at a minimum, Level 3B criteria for Dimension 3, and Level 3B criteria from one of Dimensions 4, 5, and 6. Individuals cannot meet criteria in Dimension 1 higher than Level 3B. If the individual exceeds Level 3B Dimension 1 criteria, the evaluator is directed to refer to Level 3A and 4A detoxification criteria.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Individuals must meet all of the following:</p> <p>A. The individual is assessed as being at minimal to no risk of severe withdrawal syndrome, as evidenced by:</p> <ol style="list-style-type: none"> <li>1. CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) of less than 10 following 8 hours of abstinence from alcohol without medication; OR</li> <li>2. Blood alcohol 0.0gm% and no withdrawal signs or symptoms present which require medication; OR</li> <li>3. Sub-acute symptoms of protracted withdrawal that, if present, can be managed safely without daily medically managed intervention.</li> </ol> <p>B. For individuals with withdrawal symptoms no more severe than those noted in Section A, the individual has, and responds positively to, emotional support and comfort as evidenced by decreased emotional symptoms by the end of the initial interview session.</p>
<p><b>2. Biomedical Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Continued alcohol/drug use places individual in possible danger of serious damage to physical health for any concomitant biomedical conditions (e.g. continued use of alcohol despite diagnosis and/or history of diabetes, cirrhosis of the liver, pancreatitis or seizures during withdrawal, continued cocaine use despite history of seizures associated with such use, high blood pressure or cardiovascular or cardiac problems, or continued alcohol/drug use within a self-destructive lifestyle while HIV-positive or AIDS-symptomatic);</p> <p>B. Biomedical complications of SUD or concurrent biomedical illness require medical monitoring but not intensive care (e.g. AIDS-symptomatic);</p> <p>C. If individual is pregnant, continued or recurring alcohol/drug use would place the fetus in imminent danger of temporary or permanent disability;</p> <p>D. The individual's biomedical complications are not severe enough for Levels 3 or 4, but are sufficient to distract from recovery efforts. Such conditions, which require medical monitoring, could be treated by a concurrent arrangement with another treatment provider.</p>

<p><b>3. Emotional/ Behavioral Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Depression and/or other emotional/behavioral symptoms (e.g. compulsive behaviors) are sufficiently interfering with abstinence, recovery, and stability to the degree that a structured 24-hr environment is need to address recovery efforts;</p> <p>B. There is a moderate risk (usually manifested by highly dysfunctional behavior in the recent past) of behaviors endangering self or others (e.g. suicidal or homicidal thoughts with no active plan, but a history of suicidal gestures or homicidal threats);</p> <p>C. The individual is manifesting stress behaviors related to recent or threatened losses in the work, family, or social arenas, to the extent that activities of daily living are significantly impaired. A 24-hr structured secure environment is needed to help the individual address his/her SUD;</p> <p>D. There is a history or presence of violent or disruptive behavior during intoxication, with imminent danger to self or others;</p> <p>E. Concomitant personality disorders (e.g. antisocial personality disorder with verbal aggressive behavior requiring constant limit-setting) are of such severity that the accompanying dysfunctional behaviors require continuous boundary-setting interventions.</p>
<p><b>4. Treatment Acceptance/ Resistance</b></p>	<p>Despite serious consequences and/or effects of the SUD on the individual's life (e.g. health, family, work, or social problems), the individual does not accept or relate to the severity of these problems. The individual is in need of intensive motivating strategies, activities, and processes only available within a 24-hr program.</p>
<p><b>5. Relapse Potential</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Despite a history of treatment episodes at a less intensive LOC, the individual is experiencing an acute crisis with a concomitant intensification of SUD symptoms (e.g. difficulty postponing gratification and related drug-seeking behavior);</p> <p>B. The individual is assessed to be in danger of drinking or drugging with attendant severe consequences, and is in need of 24-hr short-term professionally directed clinical interventions;</p> <p>C. The individual recognizes that alcohol and/or drug use is excessive and has attempted to reduce or control it, but has been unable to do so as long as alcohol and/or drugs are present in his/her immediate environment.</p>
<p><b>6. Recovery Environment</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. The individual lives in an environment (e.g. social or interpersonal network) in which treatment is unlikely to succeed (e.g. family full of interpersonal conflict which undermines individual's efforts to change, family members or significant others living with the individual who manifest current SUD problems and are likely to undermine the individual's recovery);</p> <p>B. Logistic impediments (e.g. distance from treatment facility, mobility limitations, lack of driver's license, etc.) preclude participation in treatment services at a less intensive level;</p> <p>C. There is a danger of physical, sexual, and/or severe emotional attack or victimization in the individual's current environment which will make recovery unlikely without removing the individual from this environment;</p> <p>D. The individual is engaged in an ongoing activity (e.g. criminal activity to support habit) or occupation where continued alcohol and/or drug use on the part of the individual constitutes substantial imminent risk to public or personal safety (e.g. individual is airline pilot, bus driver, police officer, member of clergy, doctor, nurse, construction worker, etc.).</p>

### D.7.3 Level 3B (Medically Monitored Short Term Residential) Continued Stay Criteria Across 6 Dimensions

**Dimensional Scoring Specifications**

Individuals must meet, at a minimum, Level 3B criteria for Dimension 3, and Level 3B criteria for one of Dimensions 4, 5, or 6. Individuals cannot meet criteria higher than Level 3B for the remaining dimensions.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Acute symptoms of intoxication/withdrawal are absent in the individual;</p> <p>B. The individual exhibits symptoms of protracted withdrawal syndrome that are manageable without medical intervention and are not severe enough to interfere with participation in treatment;</p> <p>C. The individual presents symptoms of post-acute withdrawal (e.g. increased irritability, mood swings, obsessive thoughts of substance use, high levels of anxiety) which present obstacles to engaging in recovery and normal life functioning;</p> <p>D. The individual reports a limited lapse of sobriety that can be addressed constructively.</p>
<p><b>2. Biomedical Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Concomitant biomedical problems exacerbated by individual’s drug use problems continue to diminish but are not sufficiently resolved to allow transfer to another LOC;</p> <p>B. The individual has begun to absorb education specific to the negative interaction of substance use and his/her medical condition, but still needs frequent reinforcement, and is moving towards improved care of physical self (if pregnant, physical selves of individual and fetus), but still has occasional lapses.</p>
<p><b>3. Emotional/ Behavioral Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. The individual is making progress toward resolution of an emotional/behavioral problem (e.g. stress, violent behaviors, or verbal aggressive behaviors which require constant limit-setting), but he/she has not sufficiently resolved problems to allow transfer or discharge to a more appropriate LOC;</p> <p>B. The individual is being held pending transfer (within 48 hours) to a more intensive inpatient service.</p>
<p><b>4. Treatment Acceptance/ Resistance</b></p>	<p>The individual recognizes the severity of the alcohol and/or drug problems, but demonstrates minimal understanding of his/her self-defeating use of alcohol/drugs; the individual is, nonetheless, progressing in treatment.</p>

<p><b>5. Relapse Potential</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. The individual continues to exhibit intensive SUD symptomatology (e.g. persistent drug or alcohol craving);</p> <p>B. The individual recognizes the severity of his or her relapse triggers and dysfunctional behaviors, yet does not demonstrate the skills necessary to interrupt these behaviors and apply alternative coping skills needed to maintain abstinence; the individual is, nonetheless, progressing in treatment.</p>
<p><b>6. Recovery Environment</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Problem aspects of the individual's social and interpersonal life are responding to treatment, but are not sufficiently supportive of recovery to allow discharge or transfer to a less intensive LOC;</p> <p>B. The social and interpersonal life of the individual have not changed or have deteriorated, and the individual needs additional treatment to learn to cope with the current situation or take steps to secure an adaptive environment;</p> <p>C. The environment from which the individual came still poses a danger to him/her for physical, sexual, and/or severe emotional attack or victimization.</p>

### D.7.4 Level 3B (Medically Monitored Short Term Residential) Do's and Don'ts

Consideration	Do	Don't
LOC or Specialty Service Not Available	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure individual's safety and continuing engagement.</li> <li>• <b>Do</b> know community resources and match individuals to most appropriate service(s) available, include accommodations where needed/available (e.g. interpreter, case management).</li> <li>• <b>Do</b> give first consideration to placing the individual in the next highest LOC if assessed LOC is not available.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> deny services or ignore special needs.</li> <li>• <b>Don't</b> disregard initial LOC determination and needs.</li> </ul>
Individual Declines Assessed LOC	<ul style="list-style-type: none"> <li>• <b>Do</b> document assessed LOC, reasons why individual declined the LOC and risks associated with not providing LOC.</li> <li>• <b>Do</b> work with individual to engage in most appropriate services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> change assessed LOC recommendation as indicated by PCPC.</li> </ul>
Individual Not Responding/Progressing in Assessed LOC	<ul style="list-style-type: none"> <li>• <b>Do</b> reassess appropriateness of LOC (using PCPC), the individual's treatment plan, the program and facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> terminate treatment abruptly; consider all treatment factors.</li> </ul>
Recovery Resources	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that individuals have been appropriately connected to community recovery support and social services throughout treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge individuals without appropriate connection to effective community and recovery resources.</li> </ul>
LOC Assessment Sufficiency	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure assessors are appropriately trained and experienced in drug and alcohol assessment and multi-dimensional protocol.</li> <li>• <b>Do</b> assess individuals face-to-face.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> employ or use assessors that do not have appropriate training and experience.</li> </ul>
Seamless Continuum	<ul style="list-style-type: none"> <li>• <b>Do</b> provide facilitated handoff between services whenever possible.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge without facilitated handoff.</li> </ul>
Role of Funding Availability in Placement and Stay Recommendations	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure that placement and continued stay recommendations are consistent with criteria.</li> <li>• <b>Do</b> document placement changes due to funding limitations.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> revise PCPC-based recommendations in response to funding availability.</li> </ul>
Role of Individual Motivation	<ul style="list-style-type: none"> <li>• <b>Do</b> use Dimension 4 – Treatment Acceptance/Resistance Criteria.</li> <li>• <b>Do</b> use assessment as engagement opportunity.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use perceived lack of motivation as basis for denial of care.</li> <li>• <b>Don't</b> use fail first mechanisms of any type.</li> </ul>

Consideration	Do	Don't
	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure assessment staff is knowledgeable about motivational interviewing principles.</li> </ul>	
<b>Individuals in Controlled Environment</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> review status and functioning prior to admission to controlled environment; this is an essential part of PCPC LOC determination.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use lack of substance use in controlled environment as evidence of behavior change or modification of relapse risk.</li> </ul>
<b>Knowledge of Resources</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> understand resources available, including characteristics of programs within the same LOC, to ensure optimal matching.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> make uninformed placement decisions.</li> </ul>
<b>Special Population</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> refer to Special Population Paper to determine placement and coordination of care considerations important to this population.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Co-Occurring SUD and MH Disorder</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> consider SUD and MH severity to determine whether the individual should be placed in co-occurring capable, co-occurring integrated, or MH facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Comorbidity</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that all individuals have been screened for medical and mental health co-morbidity needs and that these needs have been met via appropriate linkages to medical and mental health services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> forget the individual's medical and pain management needs when providing assessment and linkages to needed concurrent services.</li> </ul>
<b>When this LOC is Integrated Within a General Medical Setting</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> follow all confidentiality regulations (including HIPAA and other state and federal regulations) in the sharing of information.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> share clinical information in ways that might violate state or federal confidentiality regulations, or jeopardize continued care or the individual's willingness to continue with either general medical care or this LOC.</li> </ul>

### D.7.5 Level 3B (Medically Monitored Short Term Residential) Special Populations Considerations

Population	Consideration
<b>Medication-Assisted Treatment</b>	Individuals receiving MAT should have access to this LOC, provided they will receive appropriate medical monitoring throughout their treatment. Services should be provided that ensure coordination of care with other treatment providers (See Special Population Paper 1 contained in Section E).
<b>Co-Occurring</b>	Individuals with co-occurring mental health and SUD should receive the appropriate treatment concurrent with their participation in this LOC. If the individual is in a co-occurring capable or integrated program mental health services should be provide as indicated in the program’s licensing requirements (See Special Population Paper 2 contained in Section E).
<b>Women and Women with Children</b>	Women with children may find it difficult to participate in this LOC unless they receive linkages to appropriate placement for their children. Since women often operate from the perspective of relational issues, women without children sometimes have difficulty participating in this LOC if they do not receive appropriate support for relational issues (e.g. being away from their significant others). Further, the program should assess the woman’s needs for appropriate supportive services inside and outside of the program, and ensure that she is appropriately linked (via a “warm handoff”) to these services. Finally, any services provided to this population must be sensitive to its specific perspectives and needs (See Special Population Paper 3 contained in Section E).
<b>Criminal Justice</b>	The extent and effects of prisonization (See Glossary) on an individual must be considered for placement in an appropriate LOC. Individuals who are leaving a jail or prison should be assessed using a biopsychosocial applied during the period just prior to their incarceration. If the individual who has been part of the criminal justice system is deemed appropriate for this LOC, services should be provided that are sensitive to his/her specific perspectives and needs (See Special Population Paper 4 contained in Section E).
<b>Cultural/Ethnic</b>	Services should be provided that are sensitive to each individual’s cultural/ethnic perspectives and needs (See Special Population Paper 5 contained in Section E).
<b>Sexual Orientation/Gender Identity</b>	Services should be provided that are sensitive to each individual’s sexual orientation/gender identity perspectives and needs (See Special Population Paper 6 contained in Section E).
<b>Co-Occurring Substance Use and Gambling Disorder</b>	Individuals with co-occurring SUD and gambling disorders should receive the appropriate treatment concurrent with their participation in this LOC. Specific areas of concern may be medication, risk of domestic violence and risk of suicide. Program referral should include staff with the proper education and experience to address these issues. Programs should include education on the risk of cross-addiction to gambling disorder as a part of relapse prevention planning (See Special Population Paper 7 contained in Section E).

## D.8 Level 3C: Medically Monitored Long Term Residential

### D.8.1 Description of Service Level

- Medically Monitored Long Term Residential treatment is a TOS that includes 24-hour professionally directed evaluation, care, and treatment for addicted individuals in chronic distress, whose SUD symptomatology is demonstrated by severe impairment of social, occupational, or school functioning. Habilitation is the treatment goal. These programs serve individuals with chronic deficits in social, educational, and economic skills, impaired personality and interpersonal skills, and significant drug-abusing histories that often include criminal lifestyles and subcultures. These individuals need a model more accurately described as habilitation, as opposed to the rehabilitation model. This service often requires global changes in lifestyle, such as abstinence from mood-altering drugs (other than those needed to treat illnesses), elimination of antisocial activity, a new outlook regarding employment, and the development, display, and integration of positive social attitudes and values.
- This treatment is conducted in a DDAP-licensed drug and alcohol residential non-hospital treatment and rehabilitation facility located in a freestanding or health care-specific environment.
- All employees and contracted professionals providing clinical services within the facility must comply with DDAP staffing requirements. The Individual:FTE Counselor ratio must not exceed 8:1 during primary care hours.

#### Required Services and Support Systems include:

- Regular, scheduled psychotherapy
- Biopsychosocial Assessment
- Specialized professional/medical consultation, and testing such as a psychiatric evaluation, HIV and TB tests, and other laboratory work, as needed
- Individualized treatment planning, with reviews at least every 30 days
- Access to services for: vocational assessment, job readiness and job placement, GED preparation and testing, literacy and basic education tutoring, medical and dental care, general health education (especially AIDS awareness and support), budgeting, credit restoration, housing assistance, income support, and recreational and social activities (e.g. fitness, games, peer interaction)
- Monitoring of medication, as needed
- 24-hour observation, monitoring, and treatment
- Emergency medical services available
- Referral to detoxification, if clinically necessary
- Individual therapy
- Couples therapy (if appropriate)
- Family therapy (if appropriate)
- Physical exam (within 48 hours expected, but no later than 7 days)
- Development of discharge plan and plan for referral into continuum of care

#### Recommended Services and Support Systems include:

- Group therapy 3 times per week for at least 1.5 hours per session (group size: no more than 12)

- Individual therapy 2 times per month, for at least 1 hour per session
- Peer groups 4 times per week, for at least 45 minutes per session, to focus on daily living
- Educational/instructional groups 1 time per month

The Required Staff in Medically Monitored Long Term Residential treatment include a director and counselor(s), and a clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and profile, a single person may hold one or more of the above positions. The Staff who may be Recommended may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. SUD counselors or other certified SUD clinicians) who may more effectively serve the facility's population.

## D.8.2 Level 3C (Medically Monitored Long Term Residential) Admission Criteria Across 6 Dimensions

### **Dimensional Scoring Specifications**

Individuals must meet, at a minimum, Level 3C criteria for Dimension 3, and must not meet criteria higher than Level 3C for the remaining dimensions. If the individual exceeds Level 3C's Dimension 1 criteria, the evaluator is directed to refer to Level 3A and 4A detoxification criteria.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Individuals must meet all of the following:</p> <p>A. The individual is assessed as being at minimal or no risk of severe withdrawal syndrome as evidenced by:</p> <ol style="list-style-type: none"> <li>1. CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) of less than 10 following 8 hours of abstinence from alcohol without medication; OR</li> <li>2. Blood alcohol 0.0gm% and no withdrawal signs or symptoms present which require medication; OR</li> <li>3. Sub-acute symptoms of protracted withdrawal that, if present, can be managed safely without daily medically managed intervention.</li> </ol> <p>B. For individuals with withdrawal symptoms no more severe than those noted in Section A, the individual has, and responds positively to, emotional support and comfort as evidenced by decreased emotional symptoms by the end of the initial treatment session, and ONE of the following:</p> <ol style="list-style-type: none"> <li>1. Some psychological or emotional/behavioral craving symptoms which require continued counseling and/or monitoring on a 24-hr basis, without requiring detox;</li> <li>2. Minimal withdrawal risk which is manageable at this level because of the extended time frame of treatment;</li> <li>3. Need for management of significant, severe post-acute withdrawal symptomatology (e.g. high behavioral and social urges to use, obsessions and compulsions characteristic of those coming off excessive IV drug, cocaine, or amphetamine use);</li> <li>4. Post-withdrawal organicity (e.g. poor immediate and/or recent memory recall) inhibits cognitive functioning, but individual's history indicates that cognition should clear sufficiently to allow individual to respond to long-term treatment.</li> </ol>
<p><b>2. Biomedical Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Continued alcohol/drug use places the individual in danger of serious damage to physical health for any concomitant biomedical conditions (e.g. continued use of alcohol despite diagnosis and/or history of diabetes, cirrhosis of the liver, pancreatitis, or seizures during withdrawal, or history of cocaine use despite history of seizures with use of cocaine, high blood pressure, or cardiovascular or cardiac problems, or continued use of alcohol/drugs within a self-destructive lifestyle while HIV-positive or AIDS-symptomatic);</p> <p>B. Biomedical complications of SUD or a concurrent biomedical illness requires medical monitoring but not intensive care (e.g. AIDS-symptomatic);</p> <p>C. If individual is pregnant, continued or resumed alcohol/drug use would place the fetus in imminent danger of temporary or permanent disability;</p> <p>D. The individual's biomedical complications are not severe enough for Level 3A or 3B or Level 4, but are sufficient to distract from recovery efforts. Such conditions, which require medical monitoring, could be provided by a concurrent arrangement with another treatment provider.</p>

<p><b>3. Emotional/ Behavioral Conditions and Complications</b></p>	<p>Individuals must meet at least 2 of the following:</p> <p>A. Disordered Living Skills:</p> <ol style="list-style-type: none"> <li>1. Lacking socially acceptable norms and/or coping skills on an interpersonal, vocational, educational, or financial management level; OR</li> <li>2. A history of inability or unwillingness to internalize a sense of social responsibility; OR</li> <li>3. A history of significant consistent substance use prior to early adolescence which has continued into adulthood and has led to emotional immaturity as evidenced by magical thinking, impulsive behavior, and severe emotional sensitivity.</li> </ol> <p>B. Disordered Social Adaptiveness:</p> <ol style="list-style-type: none"> <li>1. A history of repetitive antisocial behavior patterns or various criminal charges or behavior that has or could have led to incarceration or probation; OR</li> <li>2. A history of rebellion and/or denigration of acceptable parental and/or societal values leading to a disregard of authority and basic rules which make it unlikely that a less structured LOC is appropriate.</li> </ol> <p>C. Disordered Self Adaptiveness:</p> <ol style="list-style-type: none"> <li>1. Persecutory fear, or a poor sense of self-worth as evidenced by feelings of chronic rejection, loneliness, or alienation; OR</li> <li>2. Having a history of a deeply ingrained sense of personal unworthiness or self-hatred evidenced by defeating and denigrating behaviors; OR</li> <li>3. A history of chronic external focus and/or seeking external stimuli to the exclusion of developing internal supports, as possibly evidenced by multiple SUDs; OR</li> <li>4. Inability to form supportive relationships, difficulty or unwillingness to disclose feelings; OR</li> <li>5. Pronounced external locus of control as evidenced by blaming others for personal circumstances, and unwillingness or inability to make decisions and choices to effect positive changes in the circumstances that the individual regards as undesirable.</li> </ol> <p>D. Disordered Psychological Status:</p> <ol style="list-style-type: none"> <li>1. A history of early onset (e.g. pre-adolescence) of emotional blunting or impairment, or developmental disorders as exemplified by: lack of geographical roots, lack of healthy role-modeling opportunities, little or no opportunity for parental bonding or guidance, a pervasive history of parental enabling, gang membership, dysfunctional parental modeling (such as long-term criminal behavior or other antisocial lifestyles) OR</li> <li>2. A history of significant impulsivity without due regard for potential negative consequences.</li> </ol>
<p><b>4. Treatment Acceptance/ Resistance</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Despite serious consequences and/or effects of SUD on individual's life (e.g. health, family, work, or social problems), he/she does not accept or relate to the severity of these problems. Therefore, the individual is in need of intensive motivating strategies, activities, and processes only available in a 24-hr structured environment;</p> <p>B. A high resistance to treatment despite negative consequences based on lack of living skills, education, self-discipline, or therapeutic resolution of psychological or psychosocial trauma.</p>

<p><b>5. Relapse Potential</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. A history of one or more treatment episodes at a less intensive LOC. Individual is experiencing an acute crisis with a concomitant intensification of SUD symptoms (e.g. difficulty postponing immediate gratification or related drug-seeking behavior);</p> <p>B. Individual is assessed to be in danger of drinking or drugging with attendant severe consequences, and is in need of 24-hr professionally directed clinical interventions;</p> <p>C. Individual recognizes that alcohol/drug use is excessive and has attempted to reduce or control it, but has been unable to do so as long as alcohol/drugs are present in his/her immediate environment.</p>
<p><b>6. Recovery Environment</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Individual lives in an environment (social and interpersonal network) in which treatment is unlikely to succeed (e.g. family full of interpersonal conflict which undermines individual's efforts to change, or family members and/or significant others living with individual who currently manifest SUDs and are likely to undermine the individual's recovery);</p> <p>B. Logistic impediments (e.g. distance from the treatment facility, limited mobility, lack of driver's license) preclude participation in treatment services at a less intensive level;</p> <p>C. There is a danger of physical, sexual, and/or severe emotional attack or victimization in the individual's current environment which will make recovery unlikely without removing the individual from this environment;</p> <p>D. Individual is engaged in ongoing activity (e.g. criminal activity to support habit) or occupation where continued drug/alcohol use constitutes substantial imminent risk to public or personal safety (e.g. individual is airline pilot, bus driver, police officer, clergy member, doctor, construction worker, etc.).</p>

### D.8.3 Level 3C (Medically Monitored Long Term Residential) Continued Stay Criteria Across 6 Dimensions

**Dimensional Scoring Specifications**

Individuals must meet, at a minimum, Level 3C criteria for Dimensions 3, 4 and 5, and no criteria higher than Level 3C for the remaining dimensions.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Acute symptoms of intoxication/withdrawal are absent in the individual;</p> <p>B. Individual exhibits symptoms of protracted withdrawal syndrome that are manageable without medical intervention, and are not severe enough to interfere with participation in treatment;</p> <p>C. Individual exhibits symptoms of post-acute withdrawal (e.g. increased irritability, mood swings, obsessive thoughts of substance use, high levels of anxiety) which present obstacles to engaging in recovery and normal life functioning;</p> <p>D. Individual continues to have some psychological/emotional/behavioral craving, but frequency of occurrence is beginning to diminish;</p> <p>E. Post-acute symptomatology (e.g. behavioral or social urges to use) or obsessions/ compulsions typical of drug-specific sequences are less intrusive but still powerful on occasion;</p> <p>F. Post-withdrawal organicity (e.g. poor immediate and/or recent memory recall) is abating but not gone.</p>
<p><b>2. Biomedical Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Concomitant biomedical problems exacerbated by individual’s drug use continue to diminish, but are not sufficiently resolved to allow transfer to another LOC;</p> <p>B. Individual has begun to absorb education specific to the negative interaction of substance use and his/her medical condition, but still needs frequent reinforcement; individual is moving toward improved care of physical self (and of fetus, if pregnant) but still has occasional lapses;</p> <p>C. Individual is responding to treatment aid, and the biomedical conditions and problems continue not to be severe enough to warrant a higher LOC.</p>
<p><b>3. Emotional/ Behavioral Conditions and Complications</b></p>	<p>Individuals must meet at least 2 of the following:</p> <p>A. Disordered Living Skills:</p> <ol style="list-style-type: none"> <li>1. Individual is in the process of unlearning old norms and integrating new ones; however, the integration is not yet intact and automatic. Occasional lapses from rehabilitative efforts still occur and keep individual at risk; OR</li> <li>2. Individual is developing a sense of constructive community integration and involvement, and has increased his/her desire to internalize these skills, but acting-out limit-setting confrontations are still necessary on occasion; OR</li> <li>3. Individual has begun to realize that SUD issues must be dealt with so that recovery can proceed. Individual continues to react with shame, rage, revenge, or isolation on occasion in his/her struggle for resolution; OR</li> <li>4. Because of early adolescent onset of substance use, individual lacks developmental maturity; individual’s skills in these areas are still in formative stage, and he/she continues to require major daily clinical guidance to reinforce these new skills.</li> </ol>

	<p>B. Disordered Social Adaptiveness:</p> <ol style="list-style-type: none"> <li>1. Individual continues to have difficulty in assimilating concepts of responsiveness to society; OR</li> <li>2. Individual has begun to understand rebellion as a dysfunctional self-defeating process, but has not yet accepted the need for compliance with rules, societal mores, or external direction. Defenses are not always identified as such, and individual continues to need intensive daily therapy to recognize these behaviors when they occur; OR</li> <li>3. Inappropriate denigration, devaluation, or dominance issues are being addressed, but individual's defenses are still partially intact. He/she has not yet grasped the concept of the healthy boundaries needed to validate his/her own sense of worth and also the worth of others; OR</li> <li>4. Individual has not yet internalized skills nor begun to implement them.</li> </ol> <p>C. Disordered Self Adaptiveness:</p> <ol style="list-style-type: none"> <li>1. Fears are beginning to diminish, and/or concepts of self and societal acceptance are not yet firm enough to avoid regression to old patterns; OR</li> <li>2. Sense of self-validation and individuation not yet secure; OR</li> <li>3. Acceptance of self-worth and raising of self-esteem have not yet been sufficiently integrated; OR</li> <li>4. Individual is demonstrating some progress in his/her ability to form supportive relationships and appropriately disclose feelings; however, he/she still cannot appropriately achieve these outcomes in a manner that could support recovery.</li> </ol> <p>D. Disordered Psychological Status:</p> <ol style="list-style-type: none"> <li>1. Individual's recognition of his/her dysfunctional past has not yet been absorbed. The relearning and trusting process needed to supplant his/her chaotic world view has not yet been integrated; OR</li> <li>2. Individual's ability to experience self-appreciation and defer gratification is still undeveloped; individual has difficulty processing cause and effect.</li> </ol>
<p><b>4. Treatment Acceptance/ Resistance</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. The individual recognizes the severity of the alcohol/drug problem, but demonstrates minimal understanding of his/her self-defeating use of alcohol/drugs; nevertheless, the individual is progressing in treatment;</p> <p>B. The individual recognizes the severity of his/her alcohol/drug problem and exhibits understanding of his/her personal relationship with psychoactive substances, yet does not demonstrate that he/she has assumed the responsibility necessary to cope with the problem.</p>
<p><b>5. Relapse Potential</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Individual continues to exhibit intensive SUD symptomatology (e.g. persistent drug/ alcohol craving);</p> <p>B. Individual recognizes specific relapse triggers or dysfunctional behaviors which have previously undermined sobriety; however, he/she demonstrates minimal understanding of their role in relapse; individual is nevertheless progressing in treatment;</p> <p>C. Individual recognizes the severity of his/her relapse triggers and dysfunctional behaviors which undermine sobriety, and manifests an understanding of these dysfunctional behaviors, yet does not demonstrate the skills necessary to interrupt these behaviors and apply alternative coping skills needed to maintain ongoing abstinence.</p>

<b>6. Recovery Environment</b>	<p>Individuals must meet ONE of the following:</p> <p>A. Problem aspects of the individual's social and interpersonal life are responding to treatment, but are not sufficiently supportive of recovery to allow discharge or transfer to a less intensive LOC;</p> <p>B. The social and interpersonal life of the individual has not changed or has deteriorated, and the individual needs additional treatment to learn to cope with the current situation or to take steps to secure an alternative environment;</p> <p>C. Individual has not yet given up emotional ties to his/her past antisocial behaviors, and is unable to commit to an acceptable, responsible, or productive way of life.</p>
--------------------------------	--

### D.8.4 Level 3C (Medically Monitored Long Term Residential) Do's and Don'ts

Consideration	Do	Don't
LOC or Specialty Service Not Available	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure individual's safety and continuing engagement.</li> <li>• <b>Do</b> know community resources and match individuals to most appropriate service(s) available, include accommodations where needed/available (e.g. interpreter, case management).</li> <li>• <b>Do</b> give first consideration to placing the individual in the next highest LOC if assessed LOC is not available.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> deny services or ignore special needs.</li> <li>• <b>Don't</b> disregard initial LOC determination and needs.</li> </ul>
Individual Declines Assessed LOC	<ul style="list-style-type: none"> <li>• <b>Do</b> document assessed LOC, reasons why individual declined the LOC and risks associated with not providing LOC.</li> <li>• <b>Do</b> work with individual to engage in most appropriate services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> change assessed LOC recommendation as indicated by PCPC.</li> </ul>
Individual Not Responding/Progressing in Assessed LOC	<ul style="list-style-type: none"> <li>• <b>Do</b> reassess appropriateness of LOC (using PCPC), the individual's treatment plan, the program and facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> terminate treatment abruptly; consider all treatment factors.</li> </ul>
Recovery Resources	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that individuals have been appropriately connected to community recovery support and social services throughout treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge individuals without appropriate connection to effective community and recovery resources.</li> </ul>
LOC Assessment Sufficiency	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure assessors are appropriately trained and experienced in drug and alcohol assessment and multi-dimensional protocol.</li> <li>• <b>Do</b> assess individuals face-to-face.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> employ or use assessors that do not have appropriate training and experience.</li> </ul>
Habilitative Services	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that individuals who require habilitative services receive the appropriate linkages to community resources, care management, and recovery supports necessary to permit them the ability to gain these vital life skills.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> forget to evaluate the individual's ability to maintain recovery without habilitative services.</li> </ul>
Seamless Continuum	<ul style="list-style-type: none"> <li>• <b>Do</b> provide facilitated handoff between services whenever possible.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge without facilitated handoff.</li> </ul>
Role of Funding Availability in Placement and Stay Recommendations	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure that placement and continued stay recommendations are consistent with criteria.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> revise PCPC-based recommendations in response to funding availability.</li> </ul>

Consideration	Do	Don't
	<ul style="list-style-type: none"> <li>• <b>Do</b> document placement changes due to funding limitations.</li> </ul>	
<b>Role of Individual Motivation</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> use Dimension 4 – Treatment Acceptance/Resistance Criteria.</li> <li>• <b>Do</b> use assessment as engagement opportunity.</li> <li>• <b>Do</b> ensure assessment staff is knowledgeable about motivational interviewing principles.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use perceived lack of motivation as basis for denial of care.</li> <li>• <b>Don't</b> use fail first mechanisms of any type.</li> </ul>
<b>Individuals in Controlled Environment</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> review status and functioning prior to admission to controlled environment; this is an essential part of PCPC LOC determination.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use lack of substance use in controlled environment as evidence of behavior change or modification of relapse risk.</li> </ul>
<b>Knowledge of Resources</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> understand resources available, including characteristics of programs within the same LOC, to ensure optimal matching.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> make uninformed placement decisions.</li> </ul>
<b>Special Population</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> refer to Special Population Paper to determine placement and coordination of care considerations important to this population.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Co-Occurring SUD and MH Disorder</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> consider SUD and MH severity to determine whether the individual should be placed in co-occurring capable, co-occurring integrated, or MH facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Comorbidity</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that all individuals have been screened for medical and mental health co-morbidity needs and that these needs have been met via appropriate linkages to medical and mental health services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> forget the individual's medical and pain management needs when providing assessment and linkages to needed concurrent services.</li> </ul>
<b>When this LOC is Integrated Within a General Medical Setting</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> follow all confidentiality regulations (including HIPAA and other state and federal regulations) in the sharing of information.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> share clinical information in ways that might violate state or federal confidentiality regulations, or jeopardize continued care or the individual's willingness to continue with either general medical care or this LOC.</li> </ul>

### D.8.5 Level 3C (Medically Monitored Long Term Residential) Special Populations Considerations

Population	Consideration
<b>Medication-Assisted Treatment</b>	Individuals receiving MAT should have access to this LOC, provided they will receive appropriate medical monitoring throughout their treatment. Services should be provided that ensure coordination of care with other treatment providers (See Special Population Paper 1 contained in Section E).
<b>Co-Occurring</b>	Individuals with co-occurring mental health and SUD should receive the appropriate treatment concurrent with their participation in this LOC. If the individual is in a co-occurring capable or integrated program mental health services should be provided as indicated in the program's licensing requirements (See Special Population Paper 2 contained in Section E).
<b>Women and Women with Children</b>	Women with children may find it difficult to participate in this LOC unless they receive linkages to appropriate placement for their children. Since women often operate from the perspective of relational issues, women without children sometimes have difficulty participating in this LOC if they do not receive appropriate support for relational issues (e.g. being away from their significant others). Further, the program should assess the woman's needs for appropriate supportive services inside and outside of the program, and ensure that she is appropriately linked (via a "warm handoff") to these services. Finally, any services provided to this population must be sensitive to its specific perspectives and needs (See Special Population Paper 3 contained in Section E).
<b>Criminal Justice</b>	The extent and effects of prisonization (See Glossary) on an individual must be considered for placement in an appropriate LOC. Individuals who are leaving a jail or prison should be assessed using a biopsychosocial applied during the period just prior to their incarceration. If the individual who has been part of the criminal justice system is deemed appropriate for this LOC, services should be provided that are sensitive to his/her specific perspectives and needs (See Special Population Paper 4 contained in Section E).
<b>Cultural/Ethnic</b>	Services should be provided that are sensitive to each individual's cultural/ethnic perspectives and needs (See Special Population Paper 5 contained in Section E).
<b>Sexual Orientation/Gender Identity</b>	Services should be provided that are sensitive to each individual's sexual orientation/gender identity perspectives and needs (See Special Population Paper 6 contained in Section E).
<b>Co-Occurring Substance Use and Gambling Disorder</b>	Individuals with co-occurring SUD and gambling disorders should receive the appropriate treatment concurrent with their participation in this LOC. Specific areas of concern may be medication, risk of domestic violence and risk of suicide. Program referral should include staff with the proper education and experience to address these issues. Programs should include education on the risk of cross-addiction to gambling disorder as a part of relapse prevention planning (See Special Population Paper 7 contained in Section E).

## D.9 Level 4A: Medically Managed Inpatient Detoxification

### D.9.1 Description of Service Level

- Medically Managed Inpatient Detoxification is a type of treatment that provides 24-hour medically directed evaluation and detoxification of individuals with SUDs in an acute care setting. Detoxification is the process whereby a drug- or alcohol-intoxicated or dependent individual is assisted through the period of time needed to eliminate (by metabolic or other means) the presence of the intoxicating substance or the dependency factors, while keeping the physiological or psychological risk to the individual at a minimum. Ideally, this process should also include efforts to motivate and support the individual to seek formal treatment after the detoxification process. The individuals who utilize this type of care have acute withdrawal problems (with or without biomedical and/or emotional/behavioral problems) that are severe enough to require primary medical and nursing care facilities. 24-hour medical service is provided, and the full resources of the hospital facility are available. Although this treatment is specific to SUD, the multi-disciplinary team and the availability of support services allows for the conjoint treatment of coexisting acute biomedical and/or emotional/behavioral conditions which could jeopardize recovery and need to be addressed.
- This type of treatment is conducted at a PA Department of Health-licensed acute care setting, with intensive biomedical and/or psychiatric services and a DDAP-licensed treatment unit. Three examples of such settings are: an acute care general hospital, an acute care psychiatric hospital or a psychiatric unit in an acute care general hospital, or an appropriately licensed drug dependency specialty hospital with an acute care medical and nursing staff and emergency and life-support equipment. Such settings must be capable of providing medically directed acute detoxification and related treatments aimed at alleviating acute emotional, behavioral, and/or biomedical stress resulting from the individual's use of alcohol or other drugs. If needed, life support care and treatment is available on-site, or through an effective arrangement, for the timely and responsive provision of such care. This may be accomplished through the transfer of the individual to another service within the facility or to another medical facility.
- All employees and contracted professionals providing clinical services within the facility must comply with DDAP staffing requirements. The Individual:FT Primary Care Staff Person (e.g. Physician's Assistant, RN, LPN, clinical staff) ratio is not to exceed 5:1 during primary care hours.

#### Required Services and Support Systems include:

- Assessment and treatment of adults with SUDs or addicted individuals with concomitant acute biomedical and/or emotional/behavioral disorders. Clinicians in this setting must be knowledgeable about the biopsychosocial dimensions of SUDs, biomedical problems, and emotional/behavioral disorders.
- 24-hour physician availability
- 24-hour primary nursing care and observation
- Professional therapeutic services
- Referral agreements among different LOC
- Biopsychosocial Assessment
- Monitoring of medication, as needed
- Health care education services
- Services for families and significant others

- Medication administered in accordance with the substance-specific withdrawal syndrome(s), other biomedical or psychiatric conditions, and recognized detoxification procedures
- Comprehensive nursing exam upon admission
- Physician-approved admission
- Physician who is responsible for a comprehensive history (including drug and alcohol) and a physical examination within 24 hours following admission
- Specific assessments performed on an individualized basis, with consideration of risk guiding the evaluation (because this population frequently suffers from communicable, infectious, or transmittable diseases). Furthermore, the facility must have appropriate policies and procedures for identification, treatment, and referral of individuals found to have such illnesses, so as to protect other individuals and staff from acquiring these diseases.

The Required Staff in a Medically Managed Inpatient Detox facility is chosen according to the Joint Commission on the Accreditation of Hospital Organization's (JCAHO's) standard hospital practices. In addition, they must comply with DDAP staffing requirements. The Staff who may be Recommended may include trained clinicians, SUD counselors, or registered, certified SUD clinicians able to administer planned interventions according to the assessed SUD needs of the individual.

## D.9.2 Level 4A (Medically Managed Inpatient Detox) Admission Criteria Across 6 Dimensions

### **Dimensional Scoring Specifications**

Individuals must meet, at a minimum, Dimension 1 criteria for Level 4A, or Dimension 1 criteria for 3A if Dimension 2 or 3 are at Level 4A.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Individuals must meet one of the following:</p> <p>A. Individual is assessed as being at risk of severe withdrawal syndrome as evidenced by:</p> <ol style="list-style-type: none"> <li>1. CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) greater than or equal to 20; OR</li> <li>2. Blood alcohol greater than 0.1gm% with withdrawal signs present; or blood alcohol greater than 0.2gm%; OR</li> <li>3. Pulse greater than 110 or blood pressure higher than 160/110 and a CIWA-Ar score greater than 10; OR</li> <li>4. History of seizures, hallucinations, myoclonic contractions, or delirium tremens when withdrawing from similar amounts of alcohol or other sedative hypnotic drugs; OR</li> <li>5. Seizures, delirium tremens, hallucinations, myoclonic contractions, or hyperprexia (elevated temperature); OR</li> <li>6. Daily ingestion of sedative hypnotics for over six months plus daily alcohol use, or regular use of another mind-altering drug, known to have its own withdrawal syndrome, with a coexisting chronic mental/physical disorder; OR</li> <li>7. Daily ingestion of sedative hypnotics above the recommended therapeutic dosage level for at least 4 weeks, with a coexisting chronic mental/physical disorder; OR</li> <li>8. Antagonist medication used in withdrawal (e.g. pharmacological induction of opiate withdrawal and subsequent management); OR</li> <li>9. Recent (&lt;12 hrs) serious head trauma or loss of consciousness resulting in need to observe intoxicated individual more closely; OR</li> <li>10. Individual with history of opioid use who exhibits opioid withdrawal (e.g. muscular twitching, myalgia, arthralgia, abdominal pain, rapid breathing, fever, anorexia, nausea, vomiting, diarrhea, extremes of vital signs, dehydration, “curled-up position,” etc.) requiring acute nursing care for management; OR</li> <li>11. Drug overdose compromising mental status, cardiac functioning, or other vital signs; OR</li> <li>12. Individual with history of daily opioid use for at least 2 weeks prior to admission; past attempts to stop at similar dosages have resulted in one or more signs or symptoms of withdrawal (e.g. muscular twitching, myalgia, arthralgia, abdominal pain, rapid breathing, fever, anorexia, nausea, vomiting, diarrhea); OR</li> <li>13. Clinical state requiring close medical observation (e.g. intoxication with acute agitation or stuporous state, without reliable medical history or with history of use of substance of unknown origin, or intoxication with multiple drug combinations with unpredictable, complicated withdrawal).</li> </ol> <p>B. There is a strong likelihood that the individual will not complete detoxification or enter into continuing treatment as evidenced by current use of medication or presence of a medical condition known to interfere with ability to complete detox (e.g. MAO Inhibitors in association with alprazolam, or Xanax).</p> <p>C. This is the only available LOC which can provide the needed medical support and comfort for the individual, as evidenced by:</p> <ol style="list-style-type: none"> <li>1. Detoxification regimen or individual’s response to the regimen requires monitoring at least every 2 hrs (e.g. clonidine detoxification with opiates, or high dose benzodiazepine withdrawal); OR</li> <li>2. Individual requires detoxification while pregnant.</li> </ol>
---	--

<p><b>2. Biomedical Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <ul style="list-style-type: none"> <li>A. Biomedical complications of SUD requiring medical management and skilled nursing care;</li> <li>B. Concurrent biomedical illness or pregnancy needing stabilization and daily medical management with daily primary nursing interventions (e.g. severe anemia, poorly controlled or complicated diabetes mellitus);</li> <li>C. Presence of biomedical problems requiring inpatient diagnosis and treatment (e.g. liver disease resulting in hepatic decompensation, acute pancreatitis requiring parenteral treatment, active gastrointestinal bleeding, cardiovascular disorders requiring monitoring, multiple current biomedical problems);</li> <li>D. Recurrent or multiple seizures;</li> <li>E. Disulfiram (Antabuse)-alcohol reaction;</li> <li>F. Life-threatening symptomatology related to excessive use of alcohol/drugs (e.g. stupor, convulsions, etc.);</li> <li>G. Previously diagnosed medical conditions being gravely complicated or exacerbated by drug use;</li> <li>H. Changes in individual's medical status, such as a severe worsening of medical condition, make abstinence imperative;</li> <li>I. Individual demonstrates other biomedical problems requiring 24-hr observation and evaluation.</li> </ul>
<p><b>3. Emotional/ Behavioral Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <ul style="list-style-type: none"> <li>A. Emotional/behavioral complications of SUD require medical management and skilled nursing care;</li> <li>B. Concurrent emotional/behavioral illness needs stabilization, daily medical management, and primary nursing interventions;</li> <li>C. Uncontrollable behavior endangering self or others (e.g. suicidal, impulsive, aggressive, unstable, threatening, etc.);</li> <li>D. Mental confusion or fluctuating orientation;</li> <li>E. Coexisting serious emotional/behavioral disorders which complicate the treatment of drug dependency and require differential diagnosis and treatment;</li> <li>F. Extreme depression;</li> <li>G. Impairment of thought processes and abstract thinking, limitations in conceptual ability impair individual's daily living activities;</li> <li>H. Previously diagnosed psychiatric/emotional/behavioral condition being gravely complicated or exacerbated by alcohol/drug use;</li> <li>I. Altered mental status, with or without delirium, as manifested by disorientation to self, alcoholic hallucinosis, or toxic psychosis.</li> </ul>

<b>4. Treatment Acceptance/ Resistance</b>	N/A
<b>5. Relapse Potential</b>	N/A
<b>6. Recovery Environment</b>	N/A

### D.9.3 Level 4A (Medically Managed Inpatient Detox) Continued Stay Criteria Across 6 Dimensions

**Dimensional Scoring Specifications**

Individuals must meet, at a minimum, Level 4A criteria for Dimensions 1 and 2, and no criteria higher than Level 4A for the remaining dimensions.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Persistence of acute withdrawal symptomatology, or detoxification protocol requires continued medical and/or nursing management on a 24-hr basis.</p>
<p><b>2. Biomedical Conditions and Complications</b></p>	<p>A biomedical condition that was initially interfering with treatment is improving, but the individual still requires 24-hr continued medical management for this condition along with SUD treatment.</p>
<p><b>3. Emotional/ Behavioral Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. The individual is making progress toward resolution of a concomitant emotional/behavioral problem, but continued medical and nursing managed interventions are needed before transfer can be made to a less intensive LOC;</p> <p>B. The individual is being held pending transfer (within 48 hrs) to an acute psychiatric inpatient service;</p> <p>C. The individual is assessed as having a co-occurring psychiatric condition or disorder that, in combination with alcohol/drug use, continues to present a major mental health risk, and is actively being treated (e.g. medication stabilization).</p>
<p><b>4. Treatment Acceptance/ Resistance</b></p>	<p>N/A</p>
<p><b>5. Relapse Potential</b></p>	<p>N/A</p>
<p><b>6. Recovery Environment</b></p>	<p>N/A</p>

#### D.9.4 Level 4A (Medically Managed Inpatient Detox) Do's and Don'ts

Consideration	Do	Don't
<b>LOC or Specialty Service Not Available</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure individual's safety and continuing engagement.</li> <li>• <b>Do</b> know community resources and match individuals to most appropriate service(s) available, include accommodations where needed/available (e.g. interpreter, case management).</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> deny services or ignore special needs.</li> <li>• <b>Don't</b> disregard initial LOC determination and needs.</li> </ul>
<b>Individual Declines Assessed LOC</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> document assessed LOC, reasons why individual declined the LOC and risks associated with not providing LOC.</li> <li>• <b>Do</b> work with individual to engage in most appropriate services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> change assessed LOC recommendation as indicated by PCPC.</li> </ul>
<b>Individual Not Responding/Progressing in Assessed LOC</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> reassess appropriateness of LOC (using PCPC), the individual's treatment plan, the program and facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> terminate treatment abruptly; consider all treatment factors.</li> </ul>
<b>Recovery Resources</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that individuals have been appropriately connected to community recovery support and social services throughout treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge individuals without appropriate connection to effective community and recovery resources.</li> </ul>
<b>LOC Assessment Sufficiency</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure assessors are appropriately trained and experienced in drug and alcohol assessment and multi-dimensional protocol.</li> <li>• <b>Do</b> assess individuals face-to-face.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> employ or use assessors that do not have appropriate training and experience.</li> </ul>
<b>Seamless Continuum</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> provide facilitated handoff between services whenever possible.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge without facilitated handoff.</li> </ul>
<b>Role of Funding Availability in Placement and Stay Recommendations</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure that placement and continued stay recommendations are consistent with criteria.</li> <li>• <b>Do</b> document placement changes due to funding limitations.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> revise PCPC-based recommendations in response to funding availability.</li> </ul>
<b>Role of Individual Motivation</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> use Dimension 4 – Treatment Acceptance/Resistance Criteria.</li> <li>• <b>Do</b> use assessment as engagement opportunity.</li> <li>• <b>Do</b> ensure assessment staff is knowledgeable about motivational interviewing principles.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use perceived lack of motivation as basis for denial of care.</li> <li>• <b>Don't</b> use fail first mechanisms of any type.</li> </ul>

Consideration	Do	Don't
<b>Individuals in Controlled Environment</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> review status and functioning prior to admission to controlled environment; this is an essential part of PCPC LOC determination.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use lack of substance use in controlled environment as evidence of behavior change or modification of relapse risk.</li> </ul>
<b>Knowledge of Resources</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> understand resources available, including characteristics of programs within the same LOC, to ensure optimal matching.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> make uninformed placement decisions.</li> </ul>
<b>Special Population</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> refer to Special Population Paper to determine placement and coordination of care considerations important to this population.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Co-Occurring SUD and MH Disorder</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> consider SUD and MH severity to determine whether the individual should be placed in co-occurring capable, co-occurring integrated, or MH facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Comorbidity</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that all individuals have been screened for medical and mental health co-morbidity needs and that these needs have been met via appropriate linkages to medical and mental health services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> forget the individual's medical and pain management needs when providing assessment and linkages to needed concurrent services.</li> </ul>
<b>When this LOC is Integrated Within a General Medical Setting</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> follow all confidentiality regulations (including HIPAA and other state and federal regulations) in the sharing of information.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> share clinical information in ways that might violate state or federal confidentiality regulations, or jeopardize continued care or the individual's willingness to continue with either general medical care or this LOC.</li> </ul>

### D.9.5 Level 4A (Medically Managed Inpatient Detox) Special Populations Considerations

Population	Consideration
<b>Medication-Assisted Treatment</b>	Individuals receiving MAT should have access to this LOC, provided they will receive appropriate medical monitoring throughout their treatment. Services should be provided that ensure coordination of care with other treatment providers (See Special Population Paper 1 contained in Section E).
<b>Co-Occurring</b>	Individuals with co-occurring mental health and SUD should receive the appropriate treatment concurrent with their participation in this LOC. If the individual is in a co-occurring capable or integrated program mental health services should be provide as indicated in the program's licensing requirements (See Special Population Paper 2 contained in Section E).
<b>Women and Women with Children</b>	Women with children may find it difficult to participate in this LOC unless they receive linkages to appropriate placement for their children. Since women often operate from the perspective of relational issues, women without children sometimes have difficulty participating in this LOC if they do not receive appropriate support for relational issues (e.g. being away from their significant others). Further, the program should assess the woman's needs for appropriate supportive services inside and outside of the program, and ensure that she is appropriately linked (via a "warm handoff") to these services. Finally, any services provided to this population must be sensitive to its specific perspectives and needs (See Special Population Paper 3 contained in Section E).
<b>Criminal Justice</b>	The extent and effects of prisonization (See Glossary) on an individual must be considered for placement in an appropriate LOC. Individuals who are leaving a jail or prison should be assessed using a biopsychosocial applied during the period just prior to their incarceration. If the individual who has been part of the criminal justice system is deemed appropriate for this LOC, services should be provided that are sensitive to his/her specific perspectives and needs (See Special Population Paper 4 contained in Section E).
<b>Cultural/Ethnic</b>	Services should be provided that are sensitive to each individual's cultural/ethnic perspectives and needs (See Special Population Paper 5 contained in Section E).
<b>Sexual Orientation/Gender Identity</b>	Services should be provided that are sensitive to each individual's sexual orientation/gender identity perspectives and needs (See Special Population Paper 6 contained in Section E).
<b>Co-Occurring Substance Use and Gambling Disorder</b>	Individuals with co-occurring SUD and gambling disorders should receive the appropriate treatment concurrent with their participation in this LOC. Specific areas of concern may be medication, risk of domestic violence and risk of suicide. Program referral should include staff with the proper education and experience to address these issues. Programs should include education on the risk of cross-addiction to gambling disorder as a part of relapse prevention planning (See Special Population Paper 7 contained in Section E).

## D.10 Level 4B: Medically Managed Inpatient Residential

### D.10.1 Description of Service Level

- Medically Managed Inpatient Residential treatment provides 24-hour medically directed evaluation, care, and treatment for addicted individuals with coexisting biomedical, psychiatric, and/or behavioral conditions that require frequent care. Facilities for such services need to have, at a minimum, 24-hour nursing care, 24-hour access to specialized medical care and intensive medical care, and 24-hour access to physician care.
- The setting for this type of care is a PA Department of Health-licensed acute care facility, with an intensive biomedical and/or psychiatric service contained in a DDAP-licensed treatment unit.
- All employees and contracted professionals providing clinical services within the facility must comply with DDAP staffing requirements. The Individual:FT Primary Care Staff Person (e.g. Physician's Assistant, RN, LPN, clinical staff) ratio is not to exceed 7:1 during primary care hours. Individuals who have more severe illnesses in the biomedical or emotional/behavioral dimensions will require more intensive staffing patterns and support services, such as those found in an intensive component in a hospital.

#### Required Services and Support Systems include:

- 24-hour observation, monitoring, and treatment
- Full resources of an acute care general or psychiatric hospital, or a medically managed intensive inpatient treatment service
- Treatment for SUD and for coexisting medical and/or psychiatric disorders
- Access to detoxification or other more intensive medical/psychiatric services for related emotional/behavioral problems or family conditions which could jeopardize recovery
- Assistance in accessing support services
- Emergency medical services available
- Referral to detox, if clinically necessary
- Specialized professional/medical consultation, and testing such as HIV and TB tests, and other laboratory work if needed
- Biopsychosocial Assessment
- Individualized treatment planning, with review at least every 30 days (where treatment is less than 30 days, the review shall occur every 15 days)
- Individual therapy
- Group therapy (group size: no larger than 12)
- Couples therapy and/or family therapy (if appropriate)
- Occupational and vocational counseling
- Monitoring of medication, as needed
- Physical exam
- Development of discharge plan and plan for referral into continuum of care

The Required Staff in a Medically Managed Inpatient Residential facility are appointed according to the Joint Commission on the Accreditation of Hospital Organization's (JCAHO's) standard hospital practices. In addition, they must comply with DDAP staffing requirements. The Staff who may be Recommended may include SUD counselors or registered, certified SUD clinicians able to administer planned interventions according to the assessed needs of the individual.

## D.10.2 Level 4B (Medically Managed Inpatient Residential) Admission Criteria Across 6 Dimensions

### **Dimensional Scoring Specifications**

Individuals must meet Level 4B criteria in all six dimensions. If the individual exceeds Level 3B criteria in Dimension 1, the evaluator is directed to refer to Level 3A and 4A detoxification criteria.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Individuals must meet all of the following:</p> <p>A. The individual is assessed as being at minimal to no risk of severe withdrawal syndrome, as evidenced by:</p> <ol style="list-style-type: none"> <li>1. CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) of less than 10 following 8 hours of abstinence from alcohol without medication; OR</li> <li>2. Blood alcohol 0.0gm% and no withdrawal signs or symptoms present which require medication; OR</li> <li>3. Sub-acute symptoms of protracted withdrawal that, if present, can be managed safely without daily monitored medical intervention.</li> </ol> <p>B. For individuals with withdrawal symptoms no more severe than those noted in Section A, the individual has, and responds positively to, emotional support and comfort, as evidenced by decreased emotional symptoms by the end of the initial treatment session.</p>
<p><b>2. Biomedical Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Continued alcohol/drug use places the individual in imminent danger of serious damage to physical health for concomitant biomedical conditions;</p> <p>B. Biomedical complications of SUD require medical monitoring, or a concurrent biomedical illness needs medical management, but not intensive care;</p> <p>C. Biomedical complications of SUD requiring intensive medical management and skilled nursing care;</p> <p>D. Concurrent biomedical illness or pregnancy needing stabilization, medical management, and treatment with primary nursing interventions at least once every 8 hours;</p> <p>E. Presence of biomedical problems requiring inpatient diagnosis, such as liver disease resulting in hepatic decompensation, acute pancreatitis requiring parenteral treatment, active gastrointestinal bleeding, cardiovascular disorders impairing daily activity and requiring medical adjustment, chronic obstructive pulmonary disease requiring continuous oxygen, recent cerebrovascular accident with neurological deficits, active infectious disease (e.g. HIV) requiring IV antibiotics and continuous monitoring, or multiple current biomedical problems requiring intensive medical management or treatment;</p> <p>F. History of recurrent or multiple seizures;</p> <p>G. Severe disulfiram (Antabuse)-alcohol reaction;</p> <p>H. Life-threatening symptomatology related to excessive use of alcohol/drugs (e.g. stupor, convulsions, etc.) which requires intensive medical monitoring;</p> <p>I. Previously diagnosed medical conditions, which require intensive medical monitoring, are being gravely complicated or exacerbated by drug use;</p> <p>J. Changes in individual’s medical status, such as a severe worsening of medical condition which makes abstinence imperative, or daily improvement in a previously unstable medical condition</p>

	<p>which allows the individual to respond to drug dependency problem which requires excessive monitoring;</p> <p>K. Individual demonstrates other biomedical problems requiring 24-hr observation and evaluation.</p>
<b>3. Emotional/ Behavioral Conditions and Complications</b>	<p>Individuals must meet at least 2 of the following:</p> <p>A. Emotional/behavioral complications of SUD require medical management and nursing care;</p> <p>B. Concurrent emotional/behavioral illness needs stabilization, daily medical management, and primary nursing interventions;</p> <p>C. Recent history of severe uncontrolled behavior endangering self or others;</p> <p>D. Severe mental confusion or fluctuating orientation;</p> <p>E. Coexisting serious emotional/behavioral disorder which complicates the treatment of drug dependency and requires differential diagnosis and intensive treatment;</p> <p>F. Extreme depression or mania requiring intensive treatment;</p> <p>G. Impairment in thought processes and abstract thinking, limitations in conceptual ability which impair individual's daily living activities;</p> <p>H. Previously diagnosed psychiatric/emotional/behavioral condition gravely complicated or exacerbated by alcohol/drug use;</p> <p>I. Altered mental status, with or without delirium, as evidenced by:</p> <ol style="list-style-type: none"> <li>1. Disorientation to self, or</li> <li>2. Alcoholic hallucinosis, or</li> <li>3. Toxic psychosis.</li> </ol>
<b>4. Treatment Acceptance/ Resistance</b>	N/A
<b>5. Relapse Potential</b>	N/A
<b>6. Recovery Environment</b>	N/A

### D.10.3 Level 4B (Medically Managed Inpatient Residential) Continued Stay Criteria Across 6 Dimensions

**Dimensional Scoring Specifications**

Individuals must meet Level 4B criteria for all six dimensions.

<p><b>1. Acute Intoxication or Withdrawal</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Acute symptoms of intoxication/withdrawal are absent in the individual;</p> <p>B. Individual exhibits symptoms of protracted withdrawal syndrome that are manageable without medical intervention and are not severe enough to interfere with participation in treatment;</p> <p>C. Individual exhibits symptoms of post-acute withdrawal (e.g. increased irritability, mood swings, obsessive thoughts of substance use, high levels of anxiety) which present obstacles to engaging in recovery and normal life functioning;</p> <p>D. Individual reports a limited lapse of sobriety that can be addressed constructively.</p>
<p><b>2. Biomedical Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. A continued biomedical problem or intervening medical event was serious enough to interrupt treatment, but the individual is again progressing in treatment;</p> <p>B. A biomedical condition that was initially interfering with treatment is improving, yet the individual still requires 24-hr continuous medical management for this condition, along with treatment for his/her SUD.</p>
<p><b>3. Emotional/ Behavioral Conditions and Complications</b></p>	<p>Individuals must meet ONE of the following:</p> <p>A. Individual is making progress toward resolution of a concomitant emotional/behavioral problem, but continued medically managed and nursing interventions are needed before a transfer can be made to a less intensive LOC;</p> <p>B. The individual is being held pending transfer (within 48 hours) to an acute psychiatric inpatient service;</p> <p>C. The individual is assessed as having a co-occurring psychiatric condition or disorder that, in combination with alcohol/drug use, continues to present a major mental health risk, and is actively being treated (e.g. medication stabilization).</p>
<p><b>4. Treatment Acceptance/ Resistance</b></p>	<p>N/A</p>
<p><b>5. Relapse Potential</b></p>	<p>N/A</p>
<p><b>6. Recovery Environment</b></p>	<p>N/A</p>

### D.10.4 Level 4B (Medically Managed Inpatient Residential) Do's and Don'ts

Consideration	Do	Don't
<b>LOC or Specialty Service Not Available</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure individual's safety and continuing engagement.</li> <li>• <b>Do</b> know community resources and match individuals to most appropriate service(s) available, include accommodations where needed/available (e.g. interpreter, case management).</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> deny services or ignore special needs.</li> <li>• <b>Don't</b> disregard initial LOC determination and needs.</li> </ul>
<b>Individual Declines Assessed LOC</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> document assessed LOC, reasons why individual declined the LOC and risks associated with not providing LOC.</li> <li>• <b>Do</b> work with individual to engage in most appropriate services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> change assessed LOC recommendation as indicated by PCPC.</li> </ul>
<b>Individual Not Responding/Progressing in Assessed LOC</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> reassess appropriateness of LOC (using PCPC), the individual's treatment plan, the program and facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> terminate treatment abruptly; consider all treatment factors.</li> </ul>
<b>Recovery Resources</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that individuals have been appropriately connected to community recovery support and social services throughout treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge individuals without appropriate connection to effective community and recovery resources.</li> </ul>
<b>LOC Assessment Sufficiency</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure assessors are appropriately trained and experienced in drug and alcohol assessment and multi-dimensional protocol.</li> <li>• <b>Do</b> assess individuals face-to-face.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> employ or use assessors that do not have appropriate training and experience.</li> </ul>
<b>Seamless Continuum</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> provide facilitated handoff between services whenever possible.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> discharge without facilitated handoff.</li> </ul>
<b>Role of Funding Availability in Placement and Stay Recommendations</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> make sure that placement and continued stay recommendations are consistent with criteria.</li> <li>• <b>Do</b> document placement changes due to funding limitations.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> revise PCPC-based recommendations in response to funding availability.</li> </ul>
<b>Role of Individual Motivation</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> use Dimension 4 – Treatment Acceptance/Resistance Criteria.</li> <li>• <b>Do</b> use assessment as engagement opportunity.</li> <li>• <b>Do</b> ensure assessment staff is knowledgeable about motivational interviewing principles.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use perceived lack of motivation as basis for denial of care.</li> <li>• <b>Don't</b> use fail first mechanisms of any type.</li> </ul>

Consideration	Do	Don't
<b>Individuals in Controlled Environment</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> review status and functioning prior to admission to controlled environment; this is an essential part of PCPC LOC determination.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> use lack of substance use in controlled environment as evidence of behavior change or modification of relapse risk.</li> </ul>
<b>Knowledge of Resources</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> understand resources available, including characteristics of programs within the same LOC, to ensure optimal matching.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> make uninformed placement decisions.</li> </ul>
<b>Special Population</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> refer to Special Population Paper to determine placement and coordination of care considerations important to this population.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Co-Occurring SUD and MH Disorder</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> consider SUD and MH severity to determine whether the individual should be placed in co-occurring capable, co-occurring integrated, or MH facility.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> refuse treatment if optimal service unavailable.</li> </ul>
<b>Comorbidity</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> ensure that all individuals have been screened for medical and mental health co-morbidity needs and that these needs have been met via appropriate linkages to medical and mental health services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> forget the individual's medical and pain management needs when providing assessment and linkages to needed concurrent services.</li> </ul>
<b>When this LOC is Integrated Within a General Medical Setting</b>	<ul style="list-style-type: none"> <li>• <b>Do</b> follow all confidentiality regulations (including HIPAA and other state and federal regulations) in the sharing of information.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Don't</b> share clinical information in ways that might violate state or federal confidentiality regulations, or jeopardize continued care or the individual's willingness to continue with either general medical care or this LOC.</li> </ul>

### D.10.5 Level 4B (Medically Managed Inpatient Residential) Special Populations Considerations

Population	Consideration
<b>Medication-Assisted Treatment</b>	Individuals receiving MAT should have access to this LOC, provided they will receive appropriate medical monitoring throughout their treatment. Services should be provided that ensure coordination of care with other treatment providers (See Special Population Paper 1 contained in Section E).
<b>Co-Occurring</b>	Individuals with co-occurring mental health and SUD should receive the appropriate treatment concurrent with their participation in this LOC. If the individual is in a co-occurring capable or integrated program mental health services should be provide as indicated in the program’s licensing requirements (See Special Population Paper 2 contained in Section E).
<b>Women and Women with Children</b>	Women with children may find it difficult to participate in this LOC unless they receive linkages to appropriate placement for their children. Since women often operate from the perspective of relational issues, women without children sometimes have difficulty participating in this LOC if they do not receive appropriate support for relational issues (e.g. being away from their significant others). Further, the program should assess the woman’s needs for appropriate supportive services inside and outside of the program, and ensure that she is appropriately linked (via a “warm handoff”) to these services. Finally, any services provided to this population must be sensitive to its specific perspectives and needs (See Special Population Paper 3 contained in Section E).
<b>Criminal Justice</b>	The extent and effects of prisonization (See Glossary) on an individual must be considered for placement in an appropriate LOC. Individuals who are leaving a jail or prison should be assessed using a biopsychosocial applied during the period just prior to their incarceration. If the individual who has been part of the criminal justice system is deemed appropriate for this LOC, services should be provided that are sensitive to his/her specific perspectives and needs (See Special Population Paper 4 contained in Section E).
<b>Cultural/Ethnic</b>	Services should be provided that are sensitive to each individual’s cultural/ethnic perspectives and needs (See Special Population Paper 5 contained in Section E).
<b>Sexual Orientation/Gender Identity</b>	Services should be provided that are sensitive to each individual’s sexual orientation/gender identity perspectives and needs (See Special Population Paper 6 contained in Section E).
<b>Co-Occurring Substance Use and Gambling Disorder</b>	Individuals with co-occurring SUD and gambling disorders should receive the appropriate treatment concurrent with their participation in this LOC. Specific areas of concern may be medication, risk of domestic violence and risk of suicide. Program referral should include staff with the proper education and experience to address these issues. Programs should include education on the risk of cross-addiction to gambling disorder as a part of relapse prevention planning (See Special Population Paper 7 contained in Section E).

## **E. Special Populations and Considerations**

A vital component of the decision-making process in placement concerns the determination of the individual's need for specialized services. Several factors should be taken into account when formulating an individual's particular treatment plan. Specifically, issues that must be considered prior to an individual's placement include (but are not limited to): MAT, Co-Occurring Substance Use and Mental Health Disorders, Women and Women with Children, Criminal Justice, Culture/Ethnicity and Sexual Orientation/Gender Identity.

Before a determination of the individual's level and type of care, assessment questions that target special needs should be utilized. Affirmative responses to these questions require consideration of "Special Issue" criteria prior to placement.

Information on specific tracks or programs can be obtained from your local Single County Authority (SCA) or DDAP.

## E.1 Special Population Topic: Medication-Assisted Treatment

<b>Major Placement Considerations</b>	<ul style="list-style-type: none"> <li>• Methadone, buprenorphine and naltrexone are approved to treat opiate addiction.</li> <li>• Methadone has been used for over 40 years to treat the symptoms of heroin addiction.</li> <li>• Various medications are available to treat alcohol addiction; medications can be orally administered or intramuscularly injected.</li> </ul>
<b>Strategies to Address Placement Considerations</b>	<ul style="list-style-type: none"> <li>• To receive methadone, individuals must be opioid dependent for one year or more and be over the age of 18.</li> <li>• There are exceptions to this rule including pregnancy, recent release from prison and minors with two recorded unsuccessful attempts at detox.</li> <li>• MAT is the preferred course of treatment for pregnant women who are opioid dependent.</li> </ul>
<b>Placement Barriers Associated</b>	<ul style="list-style-type: none"> <li>• Ensure coordination of care and medication reconciliation.</li> <li>• Organizational policies may prevent MAT.</li> </ul>

### E.1.1 Introduction

“Medication-assisted treatment” (MAT) is the nomenclature that is now recommended to represent the subject of “pharmacotherapy” as it is defined in the PCPC. For the purpose of this paper, the term “MAT” will replace the previous term “pharmacotherapy.”

MAT is the use of medications, in combination with counseling and behavioral therapies, to provide an integrated, person-centered approach to the treatment of SUD. It is a comprehensive treatment approach requiring staff with identified prerequisite competencies and relevant programmatic licensure approved by state and federal agencies such as SAMHSA, DEA and DDAP. When treating SUDs, and specifically opioid dependence, developing a comprehensive and integrated healthcare approach that combines medication and behavioral therapies achieves the greatest success and treatment outcome.

### E.1.2 Major Placement Considerations

Medications that are currently approved and available in the United States for the treatment of opioid dependence are methadone, buprenorphine and naltrexone. Methadone is a synthetic opioid that blocks the effects of heroin and other prescription drugs containing opiates and/or opioids. Used successfully for more than 40 years, methadone has been shown to eliminate withdrawal symptoms and relieve drug cravings from heroin and prescription opiate medications (Center for Substance Abuse Treatment [CSAT], 2005). Methadone can only be dispensed and administered in licensed and federally accredited Opioid Treatment Programs.

The Drug Addiction Treatment Act of 2000 (DATA 2000) expanded the clinical context of medication-assisted opioid dependence treatment by allowing qualified physicians to prescribe and/or dispense specifically approved Schedule III, IV, and V narcotic medications for the treatment of opioid dependence in treatment settings other than the traditional Opioid Treatment Programs (i.e., methadone maintenance programs). In October 2002, the Food and Drug Administration (FDA)

approved a buprenorphine monotherapy product, Subutex®, and a buprenorphine/naloxone combination product, Suboxone®, for use in treatment for opioid dependence. The combination product is designed to decrease the potential for use by injection. Subutex® and Suboxone® are currently the only Schedule III, IV, or V medications to have received FDA approval for opioid dependence in settings other than Opioid Treatment Programs. Buprenorphine can be prescribed and/or dispensed in Opioid Treatment Programs, but the individual and practitioner must adhere to the regulations for MAT of that program and as required by the Drug Enforcement Administration (DEA).

Medications approved for the treatment of alcohol dependence include:

- Disulfiram , Antabuse®
- Naltrexone, Revia® (for oral administration)
- Naltrexone, Vivitrol® (for intramuscular injection)
- Acamprosate, Campral®

These medications may be prescribed for the treatment of alcohol dependence and are not controlled substances. Unlike methadone and buprenorphine, these medications are not regulated. These medications may be prescribed to individuals in all LOC involving the PCPC.

### **E.1.3 Strategies to Address Placement Considerations**

Potential candidates for MAT with methadone must be 18 years of age or older, must be addicted to opioids for over one year (as per federal regulations) and must have current physiological dependence upon opioids. CSAT's *Medication-assisted Treatment for Opioid Addiction in Opioid Treatment Programs: Treatment Improvement Protocol (TIP) #43* outlines helpful guidelines for initial screening and assessment. Important factors to consider are any serious physical illness or infectious disease (including HIV/AIDS) that will need to be treated prior to or during placement, whether the individual has had prior adverse reactions to MAT, whether the individual is experiencing withdrawal or has a history of needing acute inpatient hospitalization for previous episodes of withdrawal, and the individual's risk for continued use or problems. The candidate should also be assessed for any health risk including co-morbid psychiatric disorders or drug use and other high risk factors such as unprotected sexual encounters, domestic abuse, poverty, and stressors such as parenting, isolation and homelessness, etc. Potential candidates for medication-assisted treatment with buprenorphine should have an objectively ascertained diagnosis of opioid addiction (compulsive use of opioids despite harm), and should meet criteria outlined in CSAT's *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction: Treatment Improvement Protocol (TIP) #40*.

CSAT allows for some exceptions to the "1-year rule" for MAT. If appropriate, a program physician can invoke an exception to the 1-year addiction history requirement for individuals released from correctional facilities (within 6 months after release), pregnant women (program physician must certify pregnancy), and previously treated individuals (up to 2 years after discharge) (Federal Opioid Treatment Standards [FOTS], 2001). A person younger than 18 must have undergone at least two documented attempts at detoxification or outpatient psychosocial treatment within 12 months to be eligible for maintenance treatment. A parent, a legal guardian, or an adult designated by a relevant state authority must consent in writing for an adolescent to participate in MAT (FOTS, 2001). Individuals that are younger than age 18 should receive age-appropriate treatments, ideally with a separate treatment track. MAT may also be warranted if the individual has a history of unsuccessful responses to other SUD treatment interventions. MAT with methadone is the preferred course of treatment for pregnant women with opioid dependence. No long term developmental effects are

directly associated with methadone exposure in utero (Kaltenbach & Finnegan, 1984). Treating pregnant women with buprenorphine is also acceptable when an individual refuses methadone, methadone is not available or benefits outweigh risks (CSAT, 2005).

#### **E.1.4 Placement Barriers**

Treatment facilities must practice coordination of care with an individual's previous providers, including doctors, hospitals, etc., to prevent medical errors and to avoid duplicate services. Additionally, providers must always practice medication reconciliation to avoid the negative and potentially dangerous side effects of prescribing multiple medications. Organizational policies that are not supported by the current standard of care may represent barriers to the acceptance and or application of MAT for certain individuals upon assessment for treatment. This type of bias can be harmful to individuals who may benefit from MAT, for whom the elimination of opioid withdrawal symptoms and establishment of abstinence can lead to successful therapeutic outcomes.

## E.2 Special Population Topic: Co-Occurring Substance Use and Mental Health Disorders

<b>Major Placement Considerations</b>	<ul style="list-style-type: none"> <li>Assessing for a co-occurring disorder should be part of the process for every individual.</li> <li>Individuals should be placed in the LOC appropriate for the severity of both their SUD and their mental illness. Mental health severity may increase the LOC recommendation.</li> <li>Where possible, treatment should be integrated or coordinated between SUD and MH providers.</li> <li>SUD and mental health medications should be coordinated.</li> </ul>
<b>Strategies to Address Placement Considerations</b>	<ul style="list-style-type: none"> <li>Because each individual's case is extremely variable, treatment needs to be person-centered and highly individualized.</li> <li>The Four-Quadrant Model provides a basis for placing individuals based on their specific needs.</li> <li>SAMSHA's Co-Occurring Center for Excellence guiding principles provide additional criteria.</li> </ul>
<b>Placement Barriers Associated</b>	<ul style="list-style-type: none"> <li>Many individuals with a co-occurring disorder receive treatment for either mental health or substance disorders, not both.</li> <li>Some individuals may require immediate stabilization for one of their co-occurring symptoms.</li> </ul>

### E.2.1 Introduction

For purposes of this paper, the term *co-occurring disorders* (COD) refers to simultaneous substance use and mental health disorders. A diagnosis of co-occurring disorders occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder (CSAT, 2005). Individuals with COD are best served through an integrated screening, assessment, and treatment planning process that addresses both substance use and mental health disorders, each in the context of the other (Co-Occurring Center for Excellence [COCE], 2007). Since each illness affects the course and severity of the other, both disorders are considered primary.

### E.2.2 Major Placement Considerations

Assessing for a co-occurring disorder should be part of the process for every individual. The assessment process to establish the presence or absence of a co-occurring disorder may include a variety of information gathering methods including the administration of standardized assessment instruments, an in-depth clinical interview, a social history, a treatment history, interviews with family and friends with signed consents, and review of medical information. At a minimum, a basic assessment process for co-occurring disorders would include the following information:

- Demographic information
- SUD history
- Psychiatric history
- Substance use and mental health treatment histories
- Physical health history

- Family history
- Potential risk of harm
- Medication information
- Strengths and supports
- Functional impairments
- Stage of change for each disorder

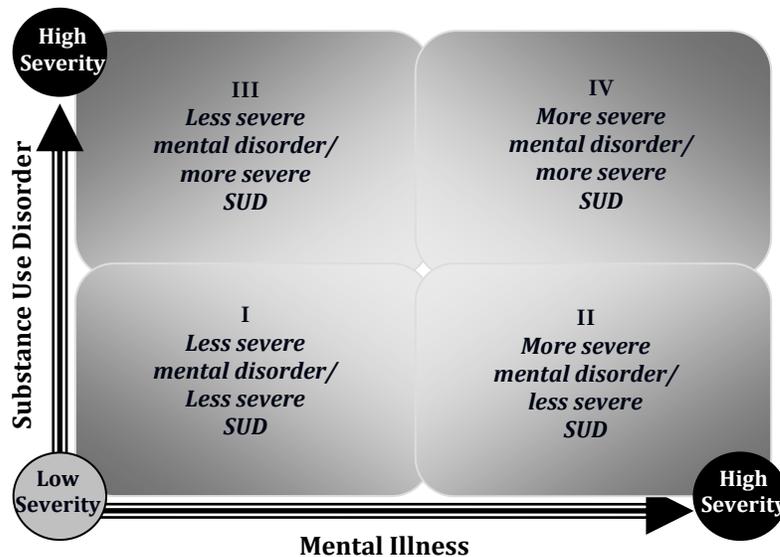
### E.2.3 Strategies to Address Placement Considerations

Co-occurring disorders vary by severity, chronicity, symptomatology, degree of impairment, and motivation to change. All of these factors impact the LOC placement, as well as the appropriate behavioral health system for treatment services. For this reason, treatment needs to be person-centered and highly individualized. Two resources are available to guide practitioners in placement: the Four-Quadrant Model and SAMHSA’s COCE guiding principles.

#### The Four-Quadrant Model:

To help conceptualize each individual’s treatment needs and improve system integration between the two disciplines, a quadrants of care model was developed in 1993 and utilized by the State of New York (Ries, 1993; CSAT, 2005). In 1998, the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) revised the conceptual framework, based on symptom multiplicity and severity, not on specific diagnoses. Since then, variations of the quadrants of care model have been developed.

The Four-Quadrant Model is illustrated as:



Source: NASMHPD and NASADAD, 1998.

#### SAMSHA’s Co-Occurring Center for Excellence Guiding Principles (COCE, 2007):

- Co-occurring disorders must be expected when evaluating any person, and clinical services should incorporate this assumption into all screening, assessment, and treatment planning.

- Within the treatment context, both co-occurring disorders are considered primary.
- Empathy, respect, and belief in the individual's capacity for recovery are fundamental provider attitudes.
- Treatment should be individualized to accommodate the specific needs, personal goals, and cultural perspectives of unique individuals in different stages of change.
- The special needs of children and adolescents must be explicitly recognized and addressed in all phases of assessment, treatment planning, and service delivery.
- The contribution of the community to the course of recovery for individuals with COD and the contribution of individuals with COD to the community must be explicitly recognized in program policy, treatment planning, and advocacy.

#### **E.2.4 Placement Barriers Associated**

Individuals with co-occurring substance use and mental health disorders have long been recognized as a population with poor outcomes and higher costs in multiple domains (Curie, 2005). Many individuals receive treatment only for their SUD *or* mental health disorder, if they receive treatment at all (Curie, 2005). In addition, some individuals may require immediate stabilization of a co-occurring related symptom(s), depending on their severity, prior to engaging in any treatment services.

### E.3 Special Population Topic: Women and Women with Children

<b>Major Placement Considerations</b>	<ul style="list-style-type: none"> <li>• The prevalence of domestic violence is high among women with SUDs; a large percentage of this population has PTSD.</li> <li>• There is a high incidence of co-morbidity among Women and Women with Children.</li> <li>• Medical and psychological conditions should be assessed in conjunction with SUDs, for women as well as their children.</li> </ul>
<b>Strategies to Address Placement Considerations</b>	<ul style="list-style-type: none"> <li>• The committee recommends specialized training for all providers, due to the complexity of women’s issues.</li> <li>• Medical, psychiatric, trauma and violence, childcare, and legal considerations must be understood to assure access and continued treatment.</li> </ul>
<b>Placement Barriers Associated</b>	<ul style="list-style-type: none"> <li>• Since women are predominantly the sole caregivers of their children, they often have difficulty accessing and staying in treatment.</li> <li>• The children of women seeking treatment may have their own medical and special needs that may present a barrier for the woman. The issues of the children must be accounted for when assessing the appropriate LOC.</li> </ul>

#### E.3.1 Introduction

Women and women with children who have SUDs present a unique and complex set of issues that can dramatically affect either a compelling motivation for treatment or, conversely, present a real and insurmountable barrier to treatment at all LOC. This special population includes all pregnant and parenting women. Many issues are associated with this population: women may or may not have custody of their children, may be experiencing co-occurring disorders, and may be receiving MAT. Additional issues include domestic violence, criminal justice, a high risk of HIV/AIDS, injection drug use and minority sexual orientations.

#### E.3.2 Major Placement Considerations

Parenting: Women work from a relational perspective, and substance use interferes with the connection between self and other. This results in a lack of trust and a reduced sense of confidence about their own parenting abilities (Pajulo, Suchman, Kalland, & Mayes, 2006).

Violence: The prevalence of interpersonal trauma is very high in this population, with literature suggesting that between 30-60% of women in SUD treatment experience abuse in the families of origin. Violence with intimate partners is also common. The National Coalition Against Domestic Violence (NCADV, 2007) reports that 1 in 4 heterosexual women will experience intimate partner violence in her lifetime. It is estimated that 1.3 million heterosexual women are victims of a physical assault at the hands of an intimate partner each year (Tjaden & Thoennes, 2000). Females between the ages of 20 to 24 are at the greatest risk for intimate partner violence (Maguire, 2010).

Between 55 to 99% of women with SUD problems report a lifetime history of physical and/or sexual abuse (Najavits, Weiss, & Shaw, 1997), with 30-59% diagnosed with PTSD, which is consistent with the current research findings (Brown & Wolfe, 1994). Studies have confirmed associations between

substance use, mental disorders, and trauma (Back, et al., 2003; Duncan, et al., 1996; El-Bassel, et al., 2003; Ouimette, et. al, 2000).

Psychiatric: There is a high incidence of co-morbidity with the combined effects of substance use, mental illnesses (depression, anxiety, self-harming behaviors, suicidality), homelessness, high-risk pregnancy, primary child-rearing responsibilities, trauma and violence (Hien, et al., 2004). All of these elements must be carefully assessed and considered when determining the appropriate LOC for this population, particularly with continued stay criteria.

Medical: In addition to any mental issues, the medical concerns of women must be critically assessed as part of determining the appropriate LOC. Sexually transmitted HIV infection is rapidly increasing among reproductive-age, non-injection substance using women. Obstetrical and gynecological issues (high risk pregnancies, unintended pregnancies, abortions, rapes), eating disorders, and smoking disorders are generally not attended to when in an active addiction. These issues require special assessment and treatment (CSAT, 1993).

Child Abuse and Parenting Issues: Many adults with SUD were abused (physically and/or sexually) or neglected during childhood. This is not a determinant of continued neglect or abuse, but does place children at an increased risk for possible abuse.

Legal/Social/Welfare: On April 22, 2010, the Pennsylvania Independent Regulatory Review Commission approved a Pennsylvania Department of Public Welfare proposed legislation that officially codified the Family Violence Option (FVO) in Pennsylvania. The FVO allowed states to access Temporary Assistance to Needy Families (TANF) for those families experiencing domestic violence. This waiver continues to provide relief for those identified victims of domestic violence who may need help and would otherwise be disqualified for benefits due to their current circumstances (Women's Law Project, 2010).

The effects of violence, poverty, homelessness, lack of education, and a paucity of marketable job skills contribute to a woman's sense of helplessness and dependence on social networks that can be exceedingly violent, dispiriting, and that can expose the woman and her children to possible harm and danger.

### **E.3.3 Strategies to Address Placement Considerations**

Due to the complexity of issues that may or may not be apparent at the time of assessment, the committee recommends intensive, mandatory training on women's issues for all providers. According to CSAT's *Pregnant, Substance-using Women: Treatment Improvement Protocol (TIP) 2*, training for this population should include an understanding of medical guidelines, treatment readiness in substance-using women, assessment instruments, women with positive toxicology screens in alcohol and other drug treatment programs, follow-up care, federal and state guidelines for alcohol and other drug treatment, confidentiality and reporting, urine toxicology screening and legal issues. In addition to these guidelines, specialized trainings are available through DDAP. It is the recommendation of this committee that specialized training is essential if the appropriate LOC is to be assessed and implemented based on the special needs, circumstances, history, and expectations for successful recovery for both mother and child(ren).

### **E.3.4 Placement Barriers Associated**

The number of women receiving SUD treatment is increasing; for example, according to SAMHSA's Office of Applied Studies, from 1992-2002 there was an increase of approximately 28% in female admissions to treatment (Brady & Ashley, 2005). However, since women are predominantly the sole caregivers for their children, they often have difficulty accessing and staying in treatment. Domestic violence, mental health disorders, homelessness, fear of losing children to child protective services, legal issues, medical issues, HIV/AIDS and pregnancy may create additional barriers to accessing treatment unless properly assessed. Also, women are less likely to enter treatment if the treatment program does not offer childcare services (Nelson-Zlupko, et al., 1996). Women should be in treatment for a sufficient length of time to appropriately address their psychosocial functioning per the PCPC domain six, Recovery Environment, which typically involves remaining in treatment between 6-12 months (CSAT, 2009). The LOS for women is often longer than that of men, and this population in particular is of vital importance since treatment often involves the entire family (CSAT, 2009; NASADAD, 2011). When a parent is diagnosed with a SUD, the repercussions extend to the entire family system, and children are at an increased risk of developmental, behavioral and emotional issues (Connors et al., 2004). Research has shown that effective treatment can have positive outcomes on both mother and child (Clark, 2001). It is important to consider the children's issues when assessing for barriers to treatment and ways to integrate these issues into the appropriate LOC.

## E.4 Special Population Topic: Criminal Justice

<b>Major Placement Considerations</b>	<ul style="list-style-type: none"> <li>• Criminology and addiction often coexist, but each can be distinct and function independently of the other.</li> <li>• Participation in prison SUD treatment can lessen the effects of prisonization (See Glossary) on an offender.</li> <li>• Many offenders are not receiving treatment voluntarily, although this does not impact the achievement of effective outcomes.</li> <li>• The majority of individuals involved in the criminal justice system are minorities.</li> <li>• Female offenders make up approximately 4.6% of the total PA state offender population.</li> <li>• Since offenders are expected to be abstinent from the use of substances while incarcerated, the evaluation should examine substance use patterns in the 6 months prior to incarceration for the purpose of assessment.</li> </ul>
<b>Strategies to Address Placement Considerations</b>	<ul style="list-style-type: none"> <li>• Treatment behind the walls followed by a community-based continuum of care leads to the best outcomes.</li> <li>• NIDA provides Principles for Drug Abuse in Criminal Justice Populations.</li> </ul>
<b>Placement Barriers Associated</b>	<ul style="list-style-type: none"> <li>• Staff should have specialized training/experience and supervision to evaluate and assist the criminal justice population.</li> <li>• Individuals with criminal justice involvement may have a higher distrust of systems and organizations.</li> </ul>

### E.4.1 Introduction

Substance-using criminal justice offenders may represent some of the most challenging cases in SUD treatment. Criminology and addiction often coexist, but each can be distinct and function independently of the other: addiction can lead to and reinforce criminal behavior, and engagement in criminal behavior can lead to and reinforce addiction. If reintegration of this population into the community is to be successful, both addiction and criminology must be effectively and simultaneously addressed. Numerous studies indicate that treatment is effective for this population. In some cases, the level of criminal activity has been shown to decline significantly from before treatment to after treatment (Gerstein et al, 1994; Ammerman et al, 1999).

### E.4.2 Major Placement Considerations

Similar to addiction, criminology exists on a continuum, and is manifested through a range of beliefs, attitudes, behaviors, values, culture, and commitment to the lifestyle. Each male or female is unique and may demonstrate some or multiple behaviors in varying degrees (Moran, 1999; Glaser & Deane, 1999; Zamble & Porporino, 1988). Prisonization, or effects of incarceration, can be evidenced in a number of maladaptive behaviors including: self-doubt, low self-esteem, over compliance, criminal self-identification, avoidance, manipulation, disrespect of general social values, reaction formation, anti-authority, opposition, resistance, adversarial relationships, prejudice, harassment, careless and cruel conduct, violence and intimidation, feelings of powerlessness, and inhibited functioning in the outside world (Moran, 1999; Zamble & Porporino, 1988). The criminal justice population presents major challenges to the community-based provider of SUD treatment services. Like many who seek

treatment, many are not there voluntarily. As an added feature, this population has members of the criminal justice system monitoring their compliance.

### **E.4.3 Strategies to Address Placement Considerations**

Research indicates that individuals involved in the criminal justice system reach the threshold of significant improvement at about a minimum of three months in treatment, and that additional treatment can produce further progress toward recovery (NIDA, 1999). Findings from CSAT, NIDA and the California Drug Abuse Treatment Assessment (CALDATA) all speak to the cost-benefit value of both crime and addiction reductions when applying long-term residential treatment (Level 3C-Medically Monitored Long Term Residential in Pennsylvania). The Therapeutic Community Model, which generally lasts between six and 12 months, has been shown to be particularly effective for criminally involved individuals, reducing both violent and nonviolent arrests by up to 40% (De Leon, 2000).

#### Principles of Drug Abuse Treatment for Criminal Justice Populations (NIDA, 1999)

1. Drug addiction is a brain disease that affects behavior.
2. Recovery from drug addiction requires effective treatment, followed by management of the problem over time.
3. Treatment must last long enough to produce stable behavioral changes.
4. Assessment is the first step in treatment.
5. Tailoring services to fit the needs of the individual is an important part of effective SUD treatment for criminal justice populations.
6. Drug use during treatment should be carefully monitored.
7. Treatment should target factors that are associated with criminal behavior.
8. Criminal justice supervision should incorporate treatment planning for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements.
9. Continuity of care is essential for drug users re-entering the community.
10. A balance of rewards and sanctions encourages pro-social behavior and treatment participation.
11. Offenders with co-occurring SUD and mental health problems often require an integrated treatment approach.
12. Medications are an important part of treatment for many drug-abusing offenders.
13. Treatment planning for drug abusing offenders who are living in or re-entering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis.

### **E.4.4 Placement Barriers**

There are four critical stakeholders in the drug and alcohol treatment process: the offender, the drug and alcohol system, the criminal justice system and the community. Effective drug and alcohol treatment must accommodate the needs of all four stakeholders. Often the treatment providers find themselves in conflict when the needs of the stakeholders appear to be in direct opposition to one another. Some potentially critical areas of conflict are confidentiality and individual accountability to both the treatment and criminal justice systems. Collaboration between the criminal justice and the drug and alcohol systems at the time of assessment can influence placement decisions and increase

public safety, prevent technical violations or new crimes, and enhance progress in treatment. As the criminal justice population may represent some of the most challenging cases in SUD treatment, staff selection, clinical supervision, and staff training are critical for achieving successful outcomes. Staff must be fully engaged and able to handle authority without dominating or abusing individuals. Regularly scheduled supervision meetings and ongoing informal supervision are necessary, and should address the complexity of treating this population as part of the professional development of clinicians. Supervisors should assist clinicians in utilizing their strengths, increasing their self-awareness, accepting peer feedback, and developing team building skills. Staff training should focus on specific aspects of knowledge building, skill development, effective treatment models, the intersection of addiction and criminality, and professional development.

## E.5 Special Population Topic: Cultural/Ethnic

<b>Major Placement Considerations</b>	<ul style="list-style-type: none"> <li>• Demographics of individuals in DDAP programs differ from the general population in several ways. For example, more individuals seeking services are male and in the 15-34 age group.</li> <li>• Healing practices, languages, values and beliefs will vary within each ethnic group.</li> <li>• Culturally and Linguistically Appropriate Services (CLAS) Standards ensure that health care organizations offer appropriate services in an individual's language and relative to his or her culture.</li> </ul>
<b>Strategies to Address Placement Considerations</b>	<ul style="list-style-type: none"> <li>• Culturally competent counselors have an advantage in that they can foster support from an individual's family and community.</li> <li>• The strengths of a culture can be used to reinforce prevention and treatment programs.</li> </ul>
<b>Placement Barriers Associated</b>	<ul style="list-style-type: none"> <li>• Some individuals may have experienced hate crimes, genocide, victimization or violence as a result of their inclusion in a minority group.</li> <li>• Certain behaviors have different meanings depending on the cultural context; failure to recognize the appropriate cultural context could result in misinformation or incorrect placement.</li> </ul>

### E.5.1 Introduction

Cultural competency is a crucial component in gaining understanding and trust within the ethnic population. Healing practices, languages, values and beliefs will vary within each ethnic group. It is important to understand these diversities and to be able to provide culturally competent treatment in order to facilitate the LOC an individual needs.

### E.5.2 Major Placement Considerations

Demographics: Individuals who are serviced by programs funded by DDAP are different from the general population in several ways. The majority (68%) of individuals are male, while the general population is 49% male. More than half of the individuals (57%) are in the combined age group of 15-34 years old. There are a higher percentage of African Americans in treatment (17%) compared to the total Pennsylvania population (11%). There are a lower percentage of Asian/Pacific Islanders in treatment (0.3%) compared to the total Pennsylvania population (2.3%). There are a higher percentage of Hispanics in treatment (6%) compared to the general population (4.5%). Nearly one in five (18%) individuals in treatment are of unknown ethnicity, so the percentage of Hispanics in treatment may actually be higher. All Pennsylvania population percentages are from the 2007 Pennsylvania State Data Center Estimates.

Legislation in Support of Culturally Competent Services: Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color and national origin for any programs receiving federal funds, including Medicaid and Medicare. It also ensures that individuals are given access to language interpreters to support the communication of healthcare information between the consumer and the provider. According to the Code of Federal Regulations, states are mandated to publish and make available bulletins that explain the rules governing eligibility and appeals, "in simple and

understandable terms.” State agencies are also required to provide services “without delay” (Availability of Program Information, 2010).

The National Standards for Culturally & Linguistically Appropriate Services (Office of Minority Affairs) provides standards primarily directed at healthcare organizations to make their services more accessible to different cultures and ethnicities. The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14).

### **E.5.3 Strategies to Address Placement Considerations**

Research indicates that although socially marginalized groups are overrepresented among drug users and drug-related emergency hospital admissions, they are less likely to seek treatment and less likely to complete treatment once begun (Rebach, 1992). One theory that accounts for the disproportionate drug use problem in minority communities states that drug and alcohol use can be seen as a response to environmental stress, experienced by greater segments of minority rather than majority individuals. These conditions may be the same for both minority and majority members, but the circumstances of minority life may create conditions for the onset of drug use for more people (Rebach, 1992). Culturally competent counselors have an advantage in treating ethnic minorities in that they can draw upon the individuals' family and community support in their treatment strategy. Service providers can enlist community leaders, both official and unofficial, to motivate community members to participate in prevention and treatment efforts. In a similar manner, religious leaders (including non-traditional faith and spiritual practices like Espiritismo, Santeria, or Voodoo) can be recruited to promote anti-drug messages. Finally, counselors can utilize the strengths of ethnic culture, beliefs regarding family and gender roles as well as music, art, and other folk expressions to reinforce prevention and treatment programs.

Criteria for Assessing Organizational Cultural Sensitivity: Organizations must also be assessed because, like individuals, they exhibit attitudes, values, policies, behaviors, and practices that can be either destructive or beneficial to minorities. The cultural sensitivity of an agency is important because "minorities will not seek services or employment in an atmosphere that disregards their culture" (Woody, 1992). Some criteria for assessing an organization for cultural sensitivity include (Gordon, 1994):

- Is it guided by the needs of individuals and communities that it serves?
- Does it reflect an integration of case management services?
- Does it acknowledge and work with the informal support systems of its individuals?
- Does it provide language accessibility at all points of contact?
- Does it recruit and employ practitioners that reflect the gender, ethnicity, race, and sexual orientation of its individuals?
- Do staff members value diversity and utilize appropriate ethnic strengths and traditions in devising treatment strategies?

### **E.5.4 Placement Barriers Associated**

For those who have had to deny, conceal or otherwise limit the expression of their unique identity and minority status due to discrimination and/or persecution, failure to inquire about and identify the specific needs of these individuals can undermine their sense of safety and wellbeing. Individuals who have experienced hate crimes, genocide, or victimization and violence as a result of their inclusion in a

minority group will need to be identified. Appropriate measures will need to be taken to ensure their personal safety and sense of wellbeing during their entire course of treatment. Some individuals may be associated with a specific minority group because of the nature of their employment or their role of authority in faith-based organizations, government or community leadership. For these individuals, additional accommodation may be needed to assure their anonymity and confidentiality as they participate in the assessment, placement and treatment process. Placing assessment and evaluation measures in an appropriate cultural context that accounts for distinct beliefs and attitudes toward health, illness, drug use, and mental health is particularly important because similar behaviors may have different meanings across cultures.

## E.6 Special Population Topic: Sexual Orientation/Gender Identity

<p><b>Major Placement Considerations</b></p>	<ul style="list-style-type: none"> <li>• Non-heterosexual individuals often experience harassment, violence, discrimination, and other forms of bias or prejudice contrary to the experiences of heterosexual individuals.</li> <li>• They may enter the treatment process with distrust or caution.</li> <li>• Not all individuals may feel safe revealing their non-heterosexual identity.</li> <li>• Assessors should have or seek familiarity with sexual identity development.</li> </ul>
<p><b>Strategies to Address Placement Considerations</b></p>	<ul style="list-style-type: none"> <li>• Many LGBTQI individuals can be served well in programs that are not directly targeted to the LGBTQI communities.</li> <li>• Some individuals, especially those who have experienced negative consequences related to their sexual orientation, might have better results in a program with targeted services.</li> <li>• Refer to SAMHSA's <i>A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals</i> (2001).</li> </ul>
<p><b>Placement Barriers Associated</b></p>	<ul style="list-style-type: none"> <li>• Individuals with non-heterosexual orientations have long been associated with a high risk of substance use challenges.</li> <li>• Individuals may need assistance in accessing resources within the community that are not associated with drug use.</li> </ul>

### E.6.1 Introduction

The PCPC strives to provide assessors with a framework from which to make sound judgments about placement. It is critical that all assessments address sexual orientation, without making assumptions and with openness to a wide range of responses (Matthews, 2007). First, everybody has a sexual orientation (Savin-Williams, 2005). Second, sexual orientation is not immediately evident. The lesbian, gay, bisexual, transgender and questioning population has been referred to as a "hidden minority" (Fassinger, 1991; Pope, 1995) because their minority status is not apparent by observation. Indeed, assumptions based on observation can often be wrong (Matthews, 2007). Furthermore, assessment of sexual orientation is more complex than determining whom one prefers as a partner.

### E.6.2 Major Placement Considerations

In conducting the assessment, it is important to create an atmosphere wherein the individual feels safe to respond honestly without fear of judgment or recrimination (Matthews, 2007). There is considerable research documenting the experiences that gay, lesbian, bisexual, transgender and questioning people have with daily hassles, harassment, violence, and discrimination in areas such as employment, custody rights, and housing (e.g., Berrill, 1992; Haddock & Zanna, 1998; Herek, 1989, 1991, 1996; Herek, Gillis, & Cogan, 1999; Herek, Gillis, Cogan, & Glunt, 1997; Swim, Johnston, & Pearson, 2009). Thus, it is not uncommon for gay, lesbian, bisexual, transgender or questioning people to enter the assessment process with some level of distrust, or at least caution.

Assessors should have some familiarity with sexual identity development. Awareness of the process of sexual identity development is important because assessors, counselors, and individuals, regardless of sexual identity, will be influenced by their own development and each other's. Hence, each person's

sexual identity will affect the therapeutic relationship (Brown, 1996; Matthews, 2007; Mohr, 2002). Assessors need to be aware of their own comfort level with diverse sexual identities to be able to assess the individual's level of development.

Another area to assess is the individual's relationship with family of origin and family of choice. Same-sex marriage is not legal in most states, yet this does not prevent non-heterosexuals from forming committed relationships and kinship networks. It is important to ask individuals whom they consider to be family and to incorporate those choices into treatment as any family would be, regardless of blood or legal ties. As in heterosexual relationships, it is important to assess for the potential of physical and/or emotional abuse. This often gets overlooked in same-sex relationships because many people have difficulty believing that men can be victims or that women can be abusive (Letellier, 1994; Pitt & Dolan-Soto, 2001; Seelau & Seelau, 2005).

Spirituality is an integral part of many treatment programs, yet it can be a delicate issue for many lesbian, gay, bisexual, transgender and questioning people (Hicks, 2000; Matthews et al., 2005). It is important to assess for lesbian, gay, bisexual, transgender and questioning individuals' experiences with faith traditions and their needs in addressing this in treatment. Matthews et al., (2005) found that developing creative ways to reestablish faith while relinquishing painful remnants of traditional religion was key to recovery for many of the participants in their study of lesbians in recovery from addiction.

### **E.6.3 Strategies to Address Placement Considerations**

Many lesbian, gay bisexual, transgender and questioning individuals can be served well in programs that do not have services specifically geared toward these populations, but that are nonetheless affirmative and informed. Other individuals, especially those who are at particular stages of identity development or who have experienced negative consequences related to their sexual orientation, might do better in a program with targeted services.

Any program calling itself specialized should be able to clearly identify the services specifically targeting non-heterosexual individuals. Ideally, the staff should be trained and committed to following the guidelines put forth in SAMHSA's *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (2001). In any event, the staff should have extensive training and experience in working with this population. The program should be stable and able to be maintained through staff turnover. Any program to which sexual minority individuals are referred should offer 1) a safe environment where lesbian, gay, bisexual, transgender and questioning individuals can feel free to be themselves without fear of harassment or harm; 2) a non-discrimination policy that includes sexual orientation and gender identity; 3) staff, regardless of sexual identity, who are knowledgeable about the unique needs of non-heterosexual individuals struggling with addiction; and 4) referral networks that have been vetted to ensure safety and affirmation for sexual minorities.

### **E.6.4 Placement Barriers Associated**

This special population has long been considered a high-risk group with respect to drug use (CSAT, 2009). As more research has been done, we have learned that the relationship of non-heterosexuals to drugs is a complex one that goes beyond what can be covered in this short discussion. Nonetheless, there are factors that warrant mention. For example, use of crystal methamphetamine is considered a serious problem among gay men (Gay and Lesbian Medical Association [GLMA], 2006). Drug use can also play a role in HIV risk, especially among gay men (GLMA, 2006; Halkitis, Parsons, & Stirratt, 2001; Mattison, Ross, Wolfson, Franklin, & HNRC Group, 2001; McDowell, 2000; Ross, Mattison, & Franklin,

2003). Thus, it is important to assess for HIV risk factors as well, especially in men reporting risky use of stimulants and other drugs in conjunction with sexual activity. Historically, the gay bar was the only place for non-heterosexuals to gather. Things are changing; however, alcohol continues to play a role in social interaction among some segments of this population and can be a point of entry into the community for some (Weinberg, 1994). Likewise, "circuit parties," which involve heavy use of a variety of drugs, especially stimulants, are popular with some gay men (McDowell, 2000). Assessing the ways in which non-heterosexual individuals are connected to the community helps to determine whether there is a need for placement in a facility that can help them to participate in the community without using substances.

## E.7 Special Population Topic: Co-Occurring Substance Use and Gambling Disorder

<b>Major Placement Considerations</b>	<ul style="list-style-type: none"> <li>Assessing for a co-occurring gambling disorder should be part of the process for every individual.</li> <li>Individuals should be placed in the LOC appropriate for the severity of both their SUD and their gambling disorder. Mental health severity may increase the LOC recommendation.</li> <li>Where possible, treatment should be integrated or coordinated between SUD and gambling providers.</li> <li>Assessment should consider characteristics specifically common to the gambling disorder population.</li> <li>Those assessing and treating gambling disorders should have specialty certification in this area of expertise, or at minimum, equivalent specialty gambling training and supervision.</li> </ul>
<b>Strategies to Address Placement Considerations</b>	<ul style="list-style-type: none"> <li>Because each individual's case is extremely variable, treatment needs to be person-centered and highly individualized.</li> <li>Certain characteristics associated with gambling disorder should be included in the complete assessment if an individual is identified as having a gambling disorder.</li> </ul>
<b>Placement Barriers Associated</b>	<ul style="list-style-type: none"> <li>Many individuals are in denial of their gambling disorder, instead identifying it as "money problem."</li> <li>Although they have been expanding, resources such as Gamblers Anonymous, outpatient treatment workforce, and residential levels of care are limited.</li> </ul>

### E.7.1 Introduction

For purposes of this paper, the term *co-occurring disorders* (COD) refers to simultaneous substance use and gambling disorders. A diagnosis of co-occurring disorders occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder (CSAT, 2005). Individuals with COD are best served through an integrated screening, assessment, and treatment planning process that addresses both substance use and mental health disorders, each in the context of the other (COCE, 2007). Since each illness affects the course and severity of the other, both disorders are considered primary. Pathological Gambling, an Impulse Control Disorder in DSM-IV has recently been moved to Gambling Disorder in the category of Substance Use and other Addictive Disorders in the DSM-5. It is known that about 9-16% of those with a primary substance use disorder have a COD of Gambling Disorder, and about 47-52% of those with Gambling Disorder have a COD of Substance Use Disorder (DeCaria et al., 1996, SAMSHA, 2013).

### E.7.2 Major Placement Considerations

Assessing for a co-occurring gambling disorder should be part of the process for every individual. In addition to the standard biopsychosocial assessment process, there are three screening tools commonly used to examine the risk of gambling disorder and whether further assessment is needed. The simplest screenings are only 2-3 questions long and can be easily incorporated into a standard assessment. The Lie-Bet Screen is based on 2 questions: 1) Have you ever felt the need to bet more and more money? 2) Have you ever had to lie to people important to you about how much you gambled? Similarly, the National Opinion Research Center (NORC) Diagnostic Screen for Gambling

Disorders (NODS-CLiP) has three questions reflecting Control, Lying and Preoccupation including 1) Have you ever tried to stop, cut down, or control your gambling? 2) Have you ever lied to family members, friends or others about how much you gamble or how much money you lost on gambling? 3) Have there been periods lasting two weeks or longer when you spent a lot of time thinking about your gambling experiences, or planning out future gambling ventures or bets? Additionally, a more extensive screening which is commonly used is the South Oaks Gambling Screening, consisting of 16 questions, including a broader review of gambling-related issues that is similar to a drug and alcohol assessment, with items such as type of gambling, frequency of gambling, and amount of money spent. If an individual is diagnosed with gambling disorder without an associated SUD, the Gambling Patient Placement Criteria (GPPC), published by the Reno Problem Gambling Center, is designed to specifically examine LOC placement for primary gambling disorders. For individuals with this severity of gambling disorder, best practice would be that the assessment, placement and treatment be implemented by providers with specialty certification and training in gambling disorder.

### E.7.3 Strategies to Address Placement Considerations

In considering placement of an individual with a gambling disorder, the following are areas of special consideration for an individual with gambling disorder.

- **Acute Intoxication and Withdrawal:** While a withdrawal syndrome of irritability, agitation nausea, vomiting and headaches is common among individuals with severe gambling disorders (SAMHSA, 2013), it typically does not reach the need of life-threatening withdrawal. In the context of assessing the severity of the progression of the gambling disorder, it is valuable to consider the individual's location on the classic Chart of Compulsive Gambling and Recovery by Robert Custer. This chart reviews progression into the disease from the "winning phase," to the "losing phase" and "desperation phase" as well as recovery process from the "critical phase" through the "rebuilding phase" and "growth phase." For those screening positive for gambling disorder, a more thorough assessment of gambling behaviors is required.
- **Biomedical Conditions and Complications:** In terms of biomedical conditions, gamblers should be assessed for dopamine related medication issues commonly prescribed for Parkinson's disease and Restless Leg Syndrome. Individuals should also be assessed for stress related physical conditions associated with gambling such as Carpal Tunnel Syndrome, heart attack, stroke, ulcers, headaches and stomach distress.
- **Emotional/Behavioral Conditions and Complications:** Individuals with gambling disorders should be specifically assessed for common comorbid emotional disorders such as major depression, bipolar disorder, ADHD and other mood disorders such as persistent depressive disorder and anxiety disorders. Personality disorders such as narcissistic personality disorder, dependent personality disorder and antisocial personality disorder should also be considered. Antisocial personality disorder should be considered with care as many antisocial behaviors developed as a result of the gambling disorder rather than as a personality disorder. Cognitive assessment should consider the distorted beliefs and thinking patterns associated with the gambling patterns, as well as a consideration of impulse control. Readiness to change should be assessed in relation to the gambling disorder, and Motivational Interviewing can be used to enhance treatment engagement.
- **Treatment Acceptance/Resistance:** Individuals with a gambling disorder should be assessed for their stage of change and associated motivational enhancement therapy techniques should be used to address challenges in treatment engagement. Specific issues include denial in the form of the belief that they "have it under control" or that they have a "money problem rather than a gambling problem." Similarly, gamblers often see the gambling as the only solution to the money problem, creating resistance to a change in gambling behaviors. Treatment engagement is particularly

important in this population since there is no objective drug test to determine relapse in gambling behaviors.

- **Relapse/Continued Problem Potential:** Risk assessment should consider gambling patterns such as continuous gambling versus binge patterns, presence or absence of a history of any period of long term abstinence, and risk of crossover addiction to other substance or behaviorally related process addictions such as shopping, sex addiction or workaholism. Other relapse risks may be continued employment in a gaming establishment, proximity to gaming establishments (e.g. working next door to the casino), binge drinking, and continued financial stress.
- **Recovery Environment:** Assessment should review the relationship with significant family members. Often well-intentioned family members will pay off gambling debts. This is known as a “bail out” and in some circumstances can be harmful to the recovery process. Examples of a supportive environment may include living with a sober/recovery-oriented roommate or living with a supportive family member who understands gambling addiction. Examples of a less supportive environment for gambling disorder include living alone, living with a hostile spouse/partner, living with someone who is in active addiction, and living with a codependent/enabling family member. Engagement in family therapy when possible can facilitate the recovery environment by reducing conflict in the relationship and improving the support available in the relationship.
- **Other Placement Considerations:** Individuals with gambling disorders have high rates of attempted suicide, including 15% of men and 50% of women (Ciarrocchi, 2001). Safety issues must also be assessed to determine if there is risk of harm associated with illegal debts. Individuals often are in need of intensive support services for legal counsel for bankruptcy issues, divorce, and embezzlement/other gambling-related crimes. There is also often a need for referral for financial counseling to address budgeting and debt related issues since individuals with a gambling disorder often have debts of 2-3 times their annual salary. This service is sometimes provided through credit counseling services or through a “Pressure Relief Group” through Gamblers Anonymous.

#### **E.7.4 Placement Barriers Associated**

Placement barriers exist in the public level, client level, and the provider level. From the public perspective, there is limited awareness of the risks associated with gambling disorder. Education campaigns are often focused on risks of substance use, but have limited focus on risks associated with gambling disorder or awareness of the disease process as similar to SUD. From the individual’s perspective, there is substantial stigma attached, as well as issues of denial. For example, individuals will often deny having a gambling problem, instead perceiving it as a money problem.

From a provider level, there are very few Gamblers Anonymous meetings as compared to other 12-Step support availability. Although it is growing rapidly, there is a limited workforce of treatment providers with specialty training in gambling disorder to address this issue. Related to this workforce concern, there is limited availability of a continuum of care to provide the intensity of treatment as needed for those with a more severe gambling disorder. Similarly, the available trainings in this specialty field are primarily geared toward outpatient treatment services, rather than specialty skills needed for an intensive treatment setting. Best practice would suggest that individuals providing assessment and placement of gambling disorder hold specialty certification in gambling, or at minimum specialty training and supervision. Experience as a SUD counselor alone is not sufficient qualification to address the specialty needs of individuals with gambling disorders, and these clients should be referred to counselors with the appropriate qualifications (SAMHSA, 2013). These challenges are consistent across the country and not limited to Pennsylvania.

For more information about accessing gambling services, visit [www.paproblemgambling.com](http://www.paproblemgambling.com) or call the PA Problem Gambling Hotline at 1-877-565-2112.

## Appendix 1: Glossary of Terms

**Abstinence:** Refraining from the use of alcohol and other drugs (PDAC, 2010, p. 21).

**Addiction:** Addiction is a primary disease, although it is often co-occurring with other disorders. It is caused by a combination of genetic, biological and environmental factors. Addiction is characterized by drug-seeking and drug-taking behavior despite adverse health, social or legal consequences due to continued use. The disease is often progressive and fatal if untreated.

**Admission:** The point in an individual's relationship with an organized treatment service when the intake process has been completed and the individual is entitled to receive the services of the treatment program.

**Admission Criteria:** The PCPC admission criteria are used to guide the assessor in placing the individual in the necessary Level of Care (LOC) and Type of Service (TOS).

**Aftercare Plan:** A plan for individuals to follow after they leave formal treatment. This is the individual's tailored plan for the future, and includes an identification of his or her personal goals and objectives.

**Ancillary Services (or Wraparound Services):** Services individuals receive outside of the drug and alcohol treatment program itself. Most of these services are offered through other local agencies. Examples of ancillary services include health care, transportation, education, vocational training, stable and secure living environments, and support networks.

**Appeal:** A request for a reversal of a denial of authorization for a prescribed or recommended service that was made by an appropriately qualified practitioner.

**Assessment:** The process of gathering information to ascertain the degree and severity of alcohol and other drug (AOD) use, the social, physical, and psychological effects of that use, and the strengths and needs of the individual.

**Assessor:** An individual who has knowledge, training, and experience in SUDs.

**Behavioral Health Managed Care:** Any of a variety of strategies employed to control behavioral health (e.g. mental health and substance use) costs, while ensuring quality care and appropriate utilization. Cost-containment and quality assurance methods include the formation of preferred provider networks, gate keeping (or pre-certification), case management, relapse prevention, retrospective review, claims payment, etc.

**Care Management (a.k.a. Service Management):** The activities of screening, assessment (medical necessity determination), placement, authorization, continued stay/concurrent review, and utilization review.

**Case Management:** An organized system of coordinated activities developed to ensure individual continuity of service, efficient and effective utilization of available resources, and appropriateness of service to meet the needs of each individual.

**Clinical Institute Narcotic Assessment (CINA):** This scale measures 11 signs and symptoms commonly seen in individuals experiencing withdrawal from narcotics. This tool can help to gauge the severity of symptoms and changes in clinical status over time.

**Clinical Opiate Withdrawal Scale (COWS):** A clinician-administered instrument tool used to measure opiate withdrawal by measuring 11 common signs and symptoms. The tool determines the level of opiate withdrawal and also helps to determine the appropriate treatment.

**Comorbidity:** The occurrence of more than one disorder in the same individual.

**Concurrent Review:** A routine review of the medical necessity for continued treatment, by an internal or external utilization reviewer, during the course of an individual's treatment.

**Continued Stay Criteria:** Continued stay criteria are utilized to determine if an individual's current level of service is appropriate for his or her needs.

**Continued Stay Review:** The process of reviewing the appropriateness of continued stay at a LOC and/or referral to a more appropriate LOC.

**Co-occurring Disorders:** A diagnosis of co-occurring disorders occurs when at least one substance use disorder and one mental health disorder can be established independent of the other.

**Co-occurring Capable:** In these programs, SUD and mental health services are coordinated in all aspects of the treatment process. Program staff receive specialty training in identifying and addressing the interactions between substance use and mental health disorders, the individual's readiness to change, and relapse and recovery environment. These facilities also can provide medication monitoring and addiction and psychological assessment and consultation, either on or off-site. If these programs take place in a SUD facility their primary focus is SUD treatment. Conversely, if these programs take place in a mental health facility, their primary focus is mental health treatment.

**Co-occurring Integrated:** Individuals in these programs have unstable co-occurring substance use and mental health disorders. As within Co-Occurring Capable programs, in these programs SUD and mental health services are coordinated in all aspects of the treatment process. Addiction treatment and mental health symptom management services, including physician monitoring and integrated medication services, are incorporated in these programs, as well as motivational enhancement therapies, crisis services, case management services, and continuing care.

**Counselor:** An individual who meets the education and experience requirements listed in Chapter 704, and who provides a wide variety of treatment services which may include performing diagnostic assessments for drug dependency, developing treatment plans, providing individual and group counseling and other treatments.

**Cultural Perspective:** Respect for the point of view of the constituency/constituencies served and for the dynamics of difference relative to their empowerment.

**Culturally Competent:** Sensitive to the integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, gender, or social group, as demonstrated by a set of behaviors, attitudes, and policies that come together at all levels of a system, agency, or among professionals, and enable that system to work effectively in cross-cultural situations.

**Detoxification:** The process whereby a drug or alcohol-intoxicated or dependent individual is assisted through the period of time necessary to eliminate (by metabolic or other means) the presence of the intoxicating substance or dependency factors, while keeping the physiological or psychological risks to the individual at a minimum. This process should also include efforts to motivate and support the individual to seek formal treatment after the detoxification process.

**Discharge:** The point at which an individual's active involvement with a treatment service is terminated, and he or she no longer is carried on the service's records as a patient.

**Discharge Criteria:** Benchmarks that are utilized to determine when an individual no longer meets criteria for the Outpatient LOC and is ready to be discharged from the treatment continuum.

**Drug:** A substance:

- 1) Recognized in the official United States Pharmacopoeia or official National Formulary, or the supplements to either.
- 2) Intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals.
- 3) Other than food which is intended to affect the structure or function of the body of man or other animals.
- 4) Intended for use as a component of any article specified in subparagraph 1, 2, or 3, but not including devices or their components, parts, or accessories.

**Drug-Free Approach:** The provision of guidance, advice, and psychological treatment as a means to deal with the individual's emotional structure and concurrent problems, without the use of a maintenance substance. Temporary medication, for treatment of physiological conditions or as an adjunct to psychosocial treatment may be utilized in this approach.

**Early Intervention:** Early intervention is an organized screening, and Psycho-educational service designed to help individuals identify and reduce risky substance use behaviors.

**Episode of Care:** The combined services provided to an individual during a period of treatment.

**Halfway House:** A treatment facility located in the community that is state licensed, regulated, and professionally staffed. Programs focus on developing self-sufficiency through counseling, employment and other services. Some of these programs staff medical and psychiatric personnel on site to assist individuals with their medical and/or co-occurring needs. This is a live in/work out environment.

**Harm Reduction:** Refers to policies, programs and practices that aim to reduce the harms associated with the use of psychoactive drugs. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs. Harm reduction approaches are sometimes offered as alternatives, not in place of the clinically recommended treatment, but as an effort to keep an individual safe while attempts are made to engage him or her in active treatment. Needle exchanges are an example of harm reduction.

**Inpatient Hospital Activity:** The provision of medically managed detoxification, treatment, and/or rehabilitation services, on a 24-hour basis, in a hospital. The hospital shall be licensed by the PA Department of Health as an acute care or general hospital, or be approved by the Department of Public Welfare as a psychiatric hospital.

**Inpatient Non-hospital Activity:** The provision of medically monitored residential treatment in a freestanding or health care-specific environment, which provides one of the following drug and alcohol services:

- Residential treatment and rehabilitation services
- Short-term detoxification
- Halfway House care

**Instrument:** A measurement tool, usually a questionnaire, that is used for gathering information about an individual to aid screening, assessment, diagnosis, and/or clinical decisions.

**Intensive Outpatient:** An organized non-residential treatment service in which the individual resides outside the facility. It provides structured psychotherapy and individual stability through increased periods of staff intervention. Services are provided according to a planned regimen consisting of regularly scheduled treatment sessions at least 3 days per week, for a total time between 5 and 10 hours per week.

**Intervention:** A process utilized with an individual to assist in understanding the risks associated with substance use. This can be in the form of an educational presentation, a formalized and planned discussion that includes the individuals and significant others, etc.

**Length of Stay (LOS):** The number of days and/or sessions attended in the course of primary treatment.

**Level of Care (LOC):** One of the four care settings, primarily differentiated by the intensity of service provided and the degree of monitoring provided. Each level is subdivided into Types of Services.

**Maintenance (as in Medication-assisted Treatment):** The prolonged scheduled administration of methadone or other pharmacological substances intended as a substitute or antagonist to opiate substances, in accordance with federal and state regulations.

**Managed Care Organization:** Those companies, organizations, states, counties, and EAPs that are charged with approving the treatment facility, the type(s) of treatment provided, and the amount spent on those treatments.

**Medical Necessity:** The determination that a specific health care service is medically appropriate, based on the biopsychosocial severity of the individual's situation and determined by a multidimensional assessment of the individual.

**Medically Managed Inpatient Detoxification:** An inpatient health care facility that provides a 24-hour medically directed evaluation and detoxification of individuals with a substance use disorder in an acute care setting.

**Medically Managed Inpatient Residential:** An inpatient health care facility that provides 24-hour medically directed evaluation, care, and treatment for addicted individuals with coexisting biomedical and/or psychiatric/behavioral conditions that require frequent medical management. Such a service needs to have 24-hour nursing care, 24-hour access to intensive and specialized medical care, and 24-hour access to physician care.

**Medically Monitored Inpatient Detoxification:** A residential facility that provides a 24-hour professionally directed evaluation and detoxification of addicted individuals.

**Medically Monitored Long Term Residential:** A residential facility that provides 24-hour professionally directed evaluation, care, and treatment for addicted individuals in chronic distress, whose SUD symptomatology is demonstrated by severe impairment of social, occupational, or school functioning. Habilitation is a treatment goal.

**Medically Monitored Short Term Residential:** A residential facility that provides 24-hour professionally directed evaluation, care, and treatment for addicted individuals in acute distress, whose SUD symptomatology is demonstrated by moderate impairment of social, occupational, or school functioning. Rehabilitation is a treatment goal.

**Medication-Assisted Treatment (MAT):** A therapeutic option that includes the use of prescribed medications to ameliorate the symptoms and/or cravings of SUD. Common MAT medications are methadone, buprenorphine and naltrexone. In order to maximize the effectiveness of these medications, it is recommended that they be used in combination with counseling interventions.

**Opioid:** The term “opiate” refers to opium and derivatives of opium, a naturally occurring substance, whose effects are similar to those of morphine. Heroin, codeine, and morphine are examples of opiates. The term “opioid” refers to all substances, both those derived from opium and those synthetically produced, which have effects similar to morphine. Examples of opioids include heroin and codeine, which are natural derivatives of opium, and Demerol or Percodan, which are synthetics. Methadone can be used in opioid MAT.

**Outpatient:** An organized, non-residential treatment service providing psychotherapy in which the individual resides outside the facility. Services are usually provided in regularly scheduled treatment sessions for, at most, 5 contact hours per week.

**Partial Hospitalization:** The provision of psychiatric, psychological, or other therapies on a planned and regularly scheduled basis in which the individual resides outside the facility. Partial hospitalization is designed for those individuals who would benefit from more intensive services than are offered in outpatient treatment projects, but who do not require 24-hour residential care. This environment provides multi-modal and multi-disciplinary psychotherapy. Services consist of regularly scheduled treatment sessions at least 3 days per week, for a total time of at least 10 hours per week.

**Peer Group Sessions:** Self-conducted group sessions monitored by a staff member of a halfway house, focusing primarily on daily living and coping skills.

**Pennsylvania Client Placement Criteria (PCPC):** Pennsylvania’s standards of clinical necessity, or guidelines for, alcohol and other drug (AOD) treatment that describe specific conditions under which adults should be admitted to a particular LOC (Admission criteria), conditions under which they should continue to remain in that LOC (Continued Stay criteria), and conditions under which they should be discharged from the continuum (Discharge criteria).

**Prisonization:** The process of being normalized into the everyday conditions and culture of prison life. Prisonization can be evidenced in a number of maladaptive behaviors including: self-doubt, low self-esteem, over compliance, criminal self-identification, avoidance, manipulation, disrespect of general social values, reaction formation, anti-authority, opposition, resistance, adversarial

relationships, prejudice, harassment, careless and cruel conduct, violence and intimidation, feelings of powerlessness, and inhibited functioning in the outside world (Moran, 1999; Zamble & Porporino, 1988.) Also known as institutionalization.

**Physician:** An individual licensed under the statutes of the Commonwealth of PA to engage in the practice of medicine and surgery in its branches, or to practice osteopathy or osteopathic surgery as defined in 1 PA C.S. 1991 (relating to definitions).

**Placement:** The process of matching the assessed service and treatment needs of an individual with the appropriate LOC and TOS.

**Recovery:** A highly individualized journey that requires abstinence from all mood and mind-altering substances that may be supported through the use of medication that is appropriately prescribed and taken. This journey is a voluntarily maintained lifestyle that includes the pursuit of spiritual, emotional, mental and physical well-being that is often supported by others.

**Recovery Support:** Individual, program and system-level approaches to recovery that foster resilience and health. Recovery support can include providing assistance with permanent housing, employment, education, and reducing barriers to social inclusion.

**Recovery Oriented Systems of Care (ROSC):** An integrated approach to recovery that presents SUD treatment as a continuum of care. Treatment approaches are person-centered and self-directed. By recognizing the various life phases of recovery, this collaborative approach builds on individual strengths and resilience so that individuals, families and communities may take responsibility for their sustained health and abstain from drugs and alcohol.

**Referral:** A formal process linking an individual to an appropriate provider to address the individual's identified needs.

**SBIRT (Screening, Brief Intervention, and Referral to Treatment):** A comprehensive, integrated public health model designed to provide universal screening, secondary prevention (detecting risky or hazardous substance use before the onset of abuse or dependence), early intervention, and timely referral and treatment for people who have SUDs.

**Screening:** The first step in identifying the presence or absence of alcohol or other drug (AOD) use, whereby data is collected on an individual in order to make an initial determination if an alcohol or other drug problem exists and/or to determine if emergency services are warranted.

**Single County Authority (SCA):** The agency designated by the local authorities in a county or joinder to plan, fund, and administer drug and alcohol treatment activities. These are the agencies that DDAP uses as its primary contractor for this purpose.

**Sub-acute Protracted Withdrawal:** Withdrawal that is less severe than acute, but not yet chronic. It is a drawn-out withdrawal, with such signs as sleeplessness, anxiety, or confusion.

**Suboxone® (buprenorphine):** This FDA-approved treatment for opiate addiction is available in 2- or 8- mg sublingual tablets. A partial antagonist at the mu opioid receptor and an antagonist at the kappa receptor, Suboxone® is an attractive treatment option for individuals as well as medical professionals because it is safer and has less potential for abuse than methadone.

**Substance Use Disorder (SUD):** A maladaptive pattern of substance use leading to clinically significant impairment or distress.

**Treatment:** Application of planned procedures to identify and change patterns of behavior that are mal-adaptive, destructive, and/or injurious to health; or to restore appropriate levels of physical, psychological, and/or social functioning (ASAM, 2013).

**Type of Service (TOS):** Services provided within the different LOC. There are currently ten TOS.

**Vivitrol® (28-day Injectable Naltrexone):** This injectable treatment for opioid or alcohol dependence can be administered once a month, as opposed to methadone, buprenorphine or oral naltrexone, which must be administered daily. Vivitrol® is not a controlled substance, and can be administered by any healthcare provider who is licensed to prescribe medications. Individuals must be abstinent from opioids for a minimum of 7-10 days before being administered Vivitrol®.

**Warm handoff:** A referral process that involves direct introduction to a service provider by another provider, instead of simply informing an individual of who to contact or passive referral to service.

**Xanax (Benzodiazepine):** Anti-anxiety agent in the Valium family.

## Appendix 2: Principles of Treatment Notes and References

- 1. Treatment is optimal when provided through individualized and coordinated treatment interventions, follow up and recovery support services that lead to each individual's long-term recovery.** Services should optimally be provided in flexible, unbundled packages that evolve over time to meet each individual's changing needs. Individuals should also be able to access a comprehensive array of services that are fully coordinated to effectively provide support throughout their unique journeys to sustained recovery (SAMHSA, 2010, p. 2).
- 2. Beyond cessation of substance use, SUD treatment should also address the individual's needs through the provision of comprehensive services (viz., mental health, medical, family, legal, basic needs, housing, transportation, etc.) provided within seamlessly linked systems of care.** Individuals who suffer from SUD possess a broad range of service needs in various life domains. Effective SUD treatment should include comprehensive services: i.e., provision or linkages to wraparound or supportive services to meet individuals' multiple and complex needs. In turn, comprehensive services are associated with improvements in individual retention and treatment outcomes (Ducharme, et al., 2007).
- 3. Specific strategies and specialized programs can foster resiliency and recovery for individuals in diverse ethnic and cultural communities and in specific life situations.** Tailoring treatment settings, interventions, services, and recovery supports to an individual's unique history, as well as his or her personal strengths, is critical to his or her ultimate success in returning to productive functioning within the family, workplace, and society (Straussner, 2012; SAMHSA, 2010).
- 4. No single treatment is appropriate for everyone.** SUDs are complex disorders with varying etiologies and expressions, and individuals who suffer from SUD require individualized interventions. Thus, treatment services must be adaptable and dynamic enough to meet the diverse needs of those suffering from SUDs (NIDA, 1999/2009, p. 2).
- 5. Treatment should be readily available and accessible.** Because individuals with SUDs may be uncertain about entering treatment, making appropriate treatment services available and accessible immediately when the individual is ready for treatment is critical. As with other chronic diseases, the earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes (NIDA, 1999/2009, p. 2).
- 6. Within the continuum of treatment services, treatment placement recommendations need to be based on a comprehensive assessment that includes a review of the severity and biopsychosocial impact of the individual's substance use as well as the individual's clinical, social and recovery status (e.g., mental health status, social functioning, health status, recovery capital, family and legal status).** SUDs are not isolated disorders; they are a response to a complex web of factors in an individual's life. Treatment placement should consider and continue to review how the SUD relates to the individual's personal identity, beliefs, relationships, education, work, legal and financial concerns, as well as the individual's clinical status. It is also important that treatment placement be appropriate for the individual's age, gender, ethnicity, and general culture (NIDA, 1999/2009).
- 7. Remaining in treatment for an appropriate period of time is critical to positive outcome.** The appropriate treatment duration for an individual depends on the type and degree of his or her problems and needs. Research indicates that most individuals with SUDs need at least 3 months in treatment to significantly reduce or stop their substance use and that the best outcomes occur with longer treatment durations. Recovery from a SUD is a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses can occur and could signal a need for treatment to be reinstated or

- adjusted. Because individuals often leave treatment prematurely, programs should include strategies to engage and keep individuals in treatment (NIDA, 1999/2009, p. 2-3).
8. **When combined with counseling and other behavioral therapies, medications can be an important element of treatment for some individuals.** For example, methadone and buprenorphine are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opioid-addicted individuals and some individuals with alcohol dependence. Other medications for alcohol dependence include acamprosate, disulfiram, and topiramate. For individuals addicted to nicotine, a nicotine replacement product (such as patches, gum, or lozenges) or an oral medication (such as bupropion or varenicline) can be an effective component of treatment when part of a comprehensive behavioral treatment program (NIDA, 1999/2009, p. 3).
  9. **An individual's treatment and services plan must be continually assessed and modified by/with the individual to meet his or her individual needs.** An individual may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, an individual may require medication, medical services, mental health services, family therapy, parenting instruction, vocational rehabilitation, and/or social and legal services, as well as recovery support services. Substance use during treatment must be monitored continuously, as lapses during treatment do occur. For many individuals, a continuing care approach provides the best results, with the treatment intensity varying according to a person's changing needs (NIDA, 1999/2009, p. 4).
  10. **Many individuals have co-occurring SUDs and mental health disorders that must be coordinated and treated in an integrated fashion.** Individuals diagnosed with a co-occurring disorder have one or more substance-related disorders as well as one or more psychiatric disorders. A co-occurring disorder exists "when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from a single disorder" (CSAT, 2005). Co-occurring issues and conditions are an expectation, not an exception. This expectation must be included in every aspect of system planning, program design, clinical policy and procedure, and clinical competency, as well as incorporated in a welcoming manner in every clinical contact, to promote access to care and accurate screening and identification of individuals and families with multiple co-occurring issues (Minkoff & Cline, 2004, 2005). When co-occurring issues and conditions co-exist, each issue or condition is considered to be primary. The best practice intervention is integrated dual or multiple primary treatment approaches, in which each condition or issue receives appropriately matched intervention at the same time (Minkoff & Cline, 2004, 2005).
  11. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of SUD treatment interventions (NIDA, 1999/2009, p. 5).
  12. **SUD is a lifelong condition that needs ongoing monitoring.** The etiology of SUDs is highly complex, but we know that substances alter the brain's structure and function, resulting in changes that can persist long after substance use has ceased. This may be one factor that explains why individuals with SUDs are at risk for relapse even after long periods of abstinence and despite the potentially devastating consequences (NIDA, 1999/2009, p. 2). Thus, treatment shouldn't end once an individual has achieved abstinence. The full array of treatment services should continue to be made available to individuals as they move through the recovery process (Lash, et al., 2011). Continuing care includes services that are accessed post discharge from treatment and at a lower intensity. Continuing care provides sustained

- access to treatment and recovery services and continued abstinence and recovery. Effective continuity of care contributes to improved treatment outcomes (SAMHSA, 2010, p. 25).
- 13. Individuals with SUDs require unrestricted access to the full range of SUD and other health and human services.** Sometimes services are not accessible to individuals for various reasons: insurance or reimbursement restrictions; stigma based on gender, class, race, or disability, or other forms of discrimination; or unavailability of services. Stigma particularly limits the options of individuals needing comprehensive services. Stigmatizing social policies place severe restrictions on individuals, making it extremely difficult for them to succeed in recovery goals (van Olphen, Eliason, Freudenberg & Barnes, 2009). Individuals who suffer from SUD deserve the best that is available, and when a lack of treatment and other needed human resources is detected for whatever reason, providers should alert authorities to promote improvement of the treatment system.
  - 14. The therapeutic alliance between the SUD treatment provider and the individual is one of the best predictors of successful individual engagement, retention and outcome.** Stronger collaborative relationships between individuals and their therapists, called the therapeutic alliance, predict whether the individual will remain engaged in SUD treatment and experience better clinical outcomes (Bethea, et al., 2008; Urbanoski, 2012).
  - 15. Intervention is preventative.** Brief intervention following early intervention screening is provided as a single encounter that focuses on increasing insight and awareness regarding substance use risk and motivation toward behavioral change (Gryczynski et al., 2011).
  - 16. Medically assisted detoxification is only stabilization and by itself does little to change long-term SUDs.** Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal and, for some, can pave the way for effective long-term SUD treatment, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, individuals should be encouraged to continue SUD treatment following detoxification. Motivational enhancement and incentive strategies, begun at initial detoxification service individual intake, can improve treatment engagement (NIDA, 1999/2009).
  - 17. All levels of care should assess individuals for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling to help individuals modify or change behaviors that place them at risk of contracting or spreading infectious diseases.** SUD treatment should address some of the substance-related behaviors that put people at risk of infectious diseases. Conversely, targeted counseling specifically focused on reducing infectious disease risk can help individuals further reduce or avoid substance-related and other high-risk behaviors. Counseling can also help those who are already infected to effectively manage their illness. Individuals may be reluctant to accept screening for HIV (and other infectious diseases); therefore, it is incumbent upon treatment providers to appropriately encourage and support HIV screening and inform individuals that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among populations with SUDs (NIDA, 1999/2009, p. 4).
  - 18. Treatment and recovery systems can and should continually evolve to serve individuals and communities appropriately.** The implementation of effective treatment and recovery support services is complex. It requires system-wide education, training, monitoring, and feedback. SUD treatment needs to be research-based and outcomes driven, and needs to be appropriately and flexibly financed (SAMHSA, 2009, p. 2). Without the cooperation of these different facets in the treatment system, the individual's needs may not be met. System managers and providers must take an active role in assessing the needs and capabilities of both treatment and recovery support programs through implementing effective quality assurance processes. It is crucial to identify and communicate gaps and

challenges in order to ensure consistently high levels of effective treatment and recovery support services for all individuals being served (Pating, et al., 2012).

- 19. Medication reconciliation, the practice of gathering information about previously prescribed medications and evaluating potential adverse consequences or interactions with new medications, should be practiced with each individual at intake.** Medication reconciliation is intended to identify and resolve any discrepancies with newly prescribed medications, in order to avoid adverse consequences or drug interactions. According to the Joint Commission, elements of medication reconciliation should include obtaining a list of current medications, defining medication information, comparing this information to the list of prescriptions an individual is currently taking, providing the individual with written information on the medications he/she should be taking, and explaining the importance of medication management to the individual (Joint Commission, 2013).

## Appendix 3: Training Principles

These principles represent guidelines for the PCPC training, for becoming trained, and for having knowledge about the PCPC. This document outlines training principles for trainees who will administer the PCPC as well as for those who will not administer the PCPC but wish to understand the instrument.

The PCPC Principles of Training are:

1. Minimum Participant Status. Those who register for PCPC training must have a profile within DDAP's training website. Anyone who wishes to learn about the PCPC can participate in the training; however, a certificate of attendance alone does not qualify a participant to administer the PCPC independently. Criteria for the ability to administer the PCPC independently are delineated below. Completing the basic PCPC training is a prerequisite for attending the Practical Applications of PCPC course. The effectiveness and application of the PCPC is enhanced by prior participation in basic addictions training such as Addictions 101, Screening and Assessment, Confidentiality, and Ethics; therefore participation in these trainings is highly recommended.
2. Class Size. The optimum number of participants in a PCPC training class is 25. To increase class capacity, the requestor must contact DDAP's Training Section for approval.
3. Course Objectives. By the end of the PCPC training participants will:
  - a. Review the purpose and use of the PCPC;
  - b. Identify the levels of care, types of service and dimensional specifications of the PCPC;
  - c. Increase knowledge of Admission, Continued Stay, and Discharge criteria of the PCPC;
  - d. Demonstrate understanding by applying the PCPC to case studies;
  - e. Increase competency of placement considerations for special populations.
4. Skill Targets. For participants intending to administer the PCPC, the following skills are targeted. Participants must demonstrate the ability to:
  - a. Integrate the assessment results to determine placement recommendations;
  - b. Ensure that the PCPC recommendation is culturally responsive and addresses individual treatment needs and special considerations;
  - c. Reliably and validly recommend placement of an individual in an appropriate LOC and TOS.
5. Course Format. The PCPC training course is a six-hour course that is both didactic and highly experiential. Participants are expected to be fully engaged in all aspects of the training.
6. Participant Certificate. Upon successful completion of the course, participants will receive the DDAP certificate of completion. Successful completion includes:
  - a. Attendance for the entire course. Participants may not miss more than 30 cumulative minutes of class time for any reason. Should a participant miss more than 30 minutes, he/she will be marked as incomplete and will not receive a certificate or partial credits for the course;

- b. Online submission of the PCPC training evaluation through the DDAP training website.
  
- 7. Administrative Approval. Upon successful completion of the six hour PCPC course, the participant may administer the PCPC, but must obtain supervisory signature for all placement recommendations until the requirements below are met.
  - a. Completion of the following courses:
    - i. Addictions 101;
    - ii. Screening and Assessment;
    - iii. Case Management Overview (*\*applies to Case Management staff only*);
    - iv. Confidentiality;
    - v. Practical Applications of PCPC;
    - vi. Practical Applications of Confidentiality;

Note: Course completion documented by Supervisory signature.
  - b. The Supervisor must document in the employee's personnel record that the competency requirements have been fulfilled and attest that the employee may independently administer the PCPC.
    - i. Supervisor must have completed Practical Applications of PCPC and Practical Applications of Confidentiality and be a supervisor employed in an SCA or a licensed drug and alcohol treatment facility.
    - ii. Completion of Addictions 101, Screening and Assessment, and Case Management Overview may be waived at the discretion of the SCA Administrator, upon request by the facility director, provided that comparable training and educational requirements have been met.
  
- 8. PCPC Trainer Requirements. PCPC Trainers must successfully complete Training of Trainers (TOT) or provide documentation of expertise and proficiency in teaching the PCPC course. All DDAP PCPC trainers must be approved by DDAP and comply with all procedures and requirements put forth by the DDAP Training Section.
  
- 9. Training Evaluation. DDAP-monitored trainings will be evaluated for quality and fidelity to the PCPC and the PCPC training curriculum. PCPC trainings will be evaluated:
  - a. Through participant feedback, which will be elicited via a training evaluation form obtained after the training is completed, or via comments on the DDAP website;
  - b. By having random unannounced site visits by DDAP Training Section staff who will provide feedback to the trainer;
  - c. By randomly having participants complete pre- and post- tests to determine effectiveness of the training.
  
- 10. Communicating PCPC Trainings and PCPC-Related Information. Available PCPC trainings will be communicated to the field through DDAP's training website, Communicator, List-serve, etc. Training announcements and other PCPC-relevant information (such as clarifications in PCPC application, etc.) will also be communicated through the DDAP website. DDAP will ensure the appropriate number of qualified PCPC trainers and training sessions are occurring to meet provider needs, as identified through needs assessment. DDAP will also publish yearly the results of the PCPC training efforts.



# PCPC Summary Sheet

(Required fields are in **BOLD**)

Provider Location: \_\_\_\_\_

Provider Name: \_\_\_\_\_

DDAP License #: \_\_\_\_\_

UCN: \_\_\_\_\_ Date: \_\_\_\_\_

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_

Assessor: \_\_\_\_\_ Phone # & Ext.: \_\_\_\_\_

Type (Check One):  Admission  Continued Stay  Discharge (OP only)

	<u>Level of Care</u>	<u>Criteria Included</u>
D1. Intoxication/Withdrawal:	_____ (Please Select)	_____
D2. Biomedical Conditions:	_____ (Please Select)	_____
D3. Emotional/Behavioral:	_____ (Please Select)	_____
D4. Treatment Accept/Resistance:	_____ (Please Select)	_____
D5. Relapse Potential:	_____ (Please Select)	_____
D6. Recovery Environment:	_____ (Please Select)	_____

A brief comment about the individual's progress or status is required in each dimension.

Dimension 1: \_\_\_\_\_

Dimension 2: \_\_\_\_\_

Dimension 3: \_\_\_\_\_

Dimension 4: \_\_\_\_\_

Dimension 5: \_\_\_\_\_

Dimension 6: \_\_\_\_\_

Indicate the level of care recommended: \_\_\_\_\_  
(Please Select)

Indicate the level of care received: \_\_\_\_\_  
(Please Select)

If recommended level of care is different from received, why? \_\_\_\_\_  
(Please Select)

Indicate the program or facility referred to: \_\_\_\_\_

**Supervisor signature is only required until the assessor has met the training and competency requirements.**

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For completion by the provider receiving the referred PCPC Summary Sheet:**

If referred from another provider, has the receiving provider validated this PCPC as the clinically appropriate Level of Care?  
 Yes  No (If "no", a new PCPC Summary Sheet needs to be complete.)

Validated By: \_\_\_\_\_ Validation Date: \_\_\_\_\_

**Supervisor signature is only required until the validator has met the training and competency requirements.**

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix 5: Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-Ar)

Name:		Pulse or heart rate, taken for 1 minute:	
Date:	Time:	Blood pressure:	
<p><b>NAUSEA AND VOMITING:</b> Ask, "Do you feel sick to your stomach? Have you vomited?"</p> <p>Observation:</p>		<p><b>TACTILE DISTURBANCES:</b> Ask, "Have you any itching, pins-and-needles sensations, any burning, any numbness, or do you feel bugs crawling under your skin?"</p> <p>Observation:</p>	
0	No nausea and no vomiting	0	None
1	Mild nausea with no vomiting	1	Very mild itching, pins and needles, burning, or numbness
2		2	Mild itching, pins and needles, burning, or numbness
3		3	Moderate itching, pins and needles, burning, or numbness
4	Intermittent nausea with dry heaves	4	Moderately severe hallucinations
5		5	Severe hallucinations
6		6	Extremely severe hallucinations
7	Constant nausea, frequent dry heaves and vomiting	7	Continuous hallucinations
<p><b>TREMOR:</b> Arms extended and fingers spread apart. Observation:</p>		<p><b>AUDITORY DISTURBANCES:</b> Ask, "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?"</p> <p>Observation:</p>	
0	No tremor	0	Not present
1	Not visible but can be felt fingertip to	1	Very mild harshness or ability to frighten
2	fingertip	2	Mild harshness or ability to frighten
3		3	Moderate harshness or ability to frighten
4	Moderate, when individual's arms are	4	Moderately severe hallucinations
5	extended	5	Severe hallucinations
6		6	Extremely severe hallucinations
7	Severe, even with arms not extended	7	Continuous hallucinations

<p>PAROXYSMAL SWEATS: Observation:</p> <p>0 No sweat visible</p> <p>1</p> <p>2</p> <p>3</p> <p>4 Beads of sweat obvious on forehead</p> <p>5</p> <p>6</p> <p>7 Drenching sweat</p>	<p>VISUAL DISTURBANCES: Ask, "Does the light appear to be too bright? Is the color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation:</p> <p>0 Not present</p> <p>1 Very mild sensitivity</p> <p>2 Mild sensitivity</p> <p>3 Moderate sensitivity</p> <p>4 Moderately severe hallucinations</p> <p>5 Severe hallucinations</p> <p>6 Extremely severe hallucinations</p> <p>7 Continuous hallucinations</p>
<p>ANXIETY: Ask, "Do you feel nervous?" Observation:</p> <p>0 No anxiety</p> <p>1 Mildly anxious</p> <p>2</p> <p>3</p> <p>4 Moderately anxious, or guarded, so anxiety is inferred</p> <p>5</p> <p>6</p> <p>7 Equivalent to acute panic states, as seen in severe delirium or acute schizophrenic reactions</p>	<p>HEADACHE, FULLNESS IN HEAD: Ask, "Does your head feel different? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness. Otherwise, rate severity.</p> <p>0 Not present</p> <p>1 Very mild</p> <p>2 Mild</p> <p>3 Moderate</p> <p>4 Moderately severe</p> <p>5 Severe</p> <p>6 Very severe</p> <p>7 Extremely severe</p>
<p>AGITATION: Observation:</p> <p>0 Normal activity</p> <p>1 Somewhat more than normal activity</p> <p>2</p> <p>3</p> <p>4 Moderately fidgety and restless</p> <p>5</p> <p>6</p> <p>7 Paces back and forth during most of the interview, or constantly thrashes about</p>	<p>ORIENTATION AND CLOUDING OF SENSORIUM: Ask, "What day is this? Where are you? Who am I?" Observation:</p> <p>0 Oriented and can do serial additions</p> <p>1 Cannot do serial additions or is uncertain about date</p> <p>2 Disoriented for date by no more than 2 calendar days</p> <p>3 Disoriented for date by more than 2 calendar days</p> <p>4 Disoriented for place and/or person</p>
<p>SCORE: _____ (maximum possible score=67)</p>	<p>Note: Source: Sullivan et al., 1989. This scale is not copyrighted and may be used freely.</p>

## Appendix 6: The Clinical Institute Narcotic Assessment (CINA) Scale for Withdrawal Symptoms

PARAMETERS	FINDINGS	POINTS
<b>Parameters based on Questions and Observation:</b>		
(1) Abdominal changes: Do you have any pains in your abdomen?	No abdominal complaints; normal bowel sounds Reports waves of crampy abdominal pain Crampy abdominal pain; diarrhea; active bowel sounds	0 1 2
(2) Changes in temperature: Do you feel hot or cold?	None reported Reports feeling cold; hands cold and clammy to touch Uncontrolled shivering	0 1 2
(3) Nausea and vomiting: Do you feel sick in your stomach? Have you vomited?	No nausea or vomiting Mild nausea; no retching or vomiting Intermittent nausea with dry heaves Constant nausea; frequent dry heaves and/or vomiting	0 2 4 6
(4) Muscle aches: Do you have any muscle cramps?	No muscle aching reported; arm and neck muscles soft at rest Mild muscle pains Reports severe muscle pains; muscles in legs arms or neck in constant state of contraction	0 1 3
<b>Parameters based on Observation Alone:</b>		
(5) Goose flesh	None visible Occasional goose flesh but not elicited by touch; not permanent Prominent goose flesh in waves and elicited by touch Constant goose flesh over face and arms	0 1 2 3
(6) Nasal congestion	No nasal congestion or sniffing Frequent sniffing Constant sniffing watery discharge	0 1 2
(7) Restlessness	Normal activity Somewhat more than normal activity; moves legs up and down; shifts position occasionally Moderately fidgety and restless; shifting position frequently Gross movement most of the time or constantly thrashes about	0 1 2 3
(8) Tremor	None Not visible but can be felt fingertip to fingertip Moderate with patient's arm extended Severe even if arms not extended	0 1 2 3
(9) Lacrimation	None Eyes watering; tears at corners of eyes Profuse tearing from eyes over face	0 1 2
(10) Sweating	No sweat visible Barely perceptible sweating; palms moist Beads of sweat obvious on forehead Drenching sweats over face and chest	0 1 2 3
(11) Yawning	None Frequent yawning Constant uncontrolled yawning	0 1 2
<b>TOTAL SCORE</b>	[Sum of points for all 11 parameters]	
Minimum score=0, Maximum score=31. The higher the score, the more severe the withdrawal syndrome. Percent of maximal withdrawal symptoms= $((\text{total score})/31) \times 100\%$ . Source: Peachey & Lei, 1988. Reprinted with permission from Blackwell Publishing, Ltd.		

## Appendix 7: Clinical Opiate Withdrawal Scale (COWS)

For each item, circle the number that best describes the patient's signs or symptoms. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.

<b>Patient's Name:</b> _____		<b>Date and Time</b> ___/___/___ :_____	
<b>Reason for this assessment:</b> _____			
<b>Resting Pulse Rate:</b> _____ beats/minute <i>Measured after patient is sitting or lying for one minute</i> 0 Pulse rate 80 or below 1 Pulse rate 81-100 2 Pulse rate 101-120 4 Pulse rate greater than 120		<b>GI Upset: over last ½ hour</b> 0 no GI symptoms 1 Stomach cramps 2 Nausea or loose stool 3 Vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting	
<b>Sweating: over past ½ hour not accounted for by room temperature or patient activity.</b> 0 No report of chills or flushing 1 Subjective report of chills or flushing 2 Flushed or observable moistness on face 3 Beads of sweat on brow or face 4 Sweat streaming off face		<b>Tremor observation of outstretched hands</b> 0 No tremor 1 Tremor can be felt, but not observed 2 Slight tremor observable 4 Gross tremor or muscle twitching	
<b>Restlessness Observation during assessment</b> 0 Able to sit still 1 Reports difficulty sitting still, but is able to do so 3 Frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds		<b>Yawning Observation during assessment</b> 0 No yawning 1 Yawning once or twice during assessment 2 Yawning three or more times during assessment 4 Yawning several times/minute	
<b>Pupil size</b> 0 Pupils pinned or normal size for room light 1 Pupils possibly larger than normal for room light 2 Pupils moderately dilated 5 Pupils so dilated that only the rim of the iris is visible		<b>Anxiety or Irritability</b> 0 None 1 Patient reports increasing irritability or anxiousness 2 Patient obviously irritable anxious 4 Patient so irritable or anxious that participation in the assessment is difficult	
<b>Bone or Joint aches</b> <i>If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</i> 0 Not present 1 Mild diffuse discomfort 2 Patient reports severe diffuse aching of joints/ muscles 4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort		<b>Gooseflesh skin</b> 0 Skin is smooth 3 Piloerection of skin can be felt or hairs standing up on arms 5 Prominent piloerection	
<b>Runny nose or tearing</b> <i>Not accounted for by cold symptoms or allergies</i> 0 Not present 1 Nasal stuffiness or unusually moist eyes 2 Nose running or tearing 4 Nose constantly running or tears streaming down cheeks		<p style="text-align: right;">Total Score _____</p> <p style="text-align: center;">The total score is the sum of all 11 items</p> Initials of person completing Assessment: _____ <p style="text-align: right;">Source: Wesson &amp; Ling, 2003</p>	

**Score: 5-12 = Mild      25-36 = Moderately severe      13-24 = Moderate      More than 36 = Severe withdrawal**

## Appendix 8: Act 152 of 1988

- Prior to Act 152 (P.L. 1988-152, No. 1239), Medicaid covered only limited outpatient and limited hospital services for SUD treatment.
- Act 152 expands prior coverage to provide a continuum of alcohol and drug detoxification and rehabilitation to persons eligible for medical assistance. Treatment settings added include:
  - Non-hospital Residential Detoxification;
  - Non-hospital Residential Rehabilitation;
  - Halfway House.
- Requires use of criteria developed by DDAP for governing the type, level and length of care or treatment, including hospital detoxification, as a basis for the development of standards for services.
  - DDAP developed the PCPC for use with the adult population.
  - DDAP approved the use of ASAM for use with the adolescent population.
- All services must be licensed by DDAP, Division of Drug and Alcohol Program Licensure.
- The Act also required an independent evaluation to study the impact of Act 152 implementation.
  - This study was conducted by Villanova University in 1994, *“Evaluation of the Implementation of Act 152: The Quantitative Findings.”*
  - Found that the provision of residential services was highly correlated with reductions in crime and improvement in employment.

### Act 152 of 1988 states:

“It is the general purpose of this section to provide for a continuum of alcohol and drug detoxification and rehabilitation services to persons eligible for medical assistance. Facilities serving as appropriate treatment settings include ... hospital and nonhospital alcohol detoxification and rehabilitation facilities and outpatient services licensed by the Office of Drug and Alcohol Programs [now DDAP]... The Department of Public Welfare shall ... Use criteria developed by the Office of Drug and Alcohol Programs for governing the type, level and length of care or treatment, including hospital detoxification.”

## Appendix 9: Act 106 of 1989

Act 106 (P.L. 1989-106, No. 755) requires all commercial group health plans, HMOs, and the Children's Health Insurance Program (CHIP) to provide comprehensive treatment for alcohol and other drug addictions. State law, such as Act 106, does not apply to federal health plans such as Medicare or veterans benefits.

### **Minimum benefits:**

- All services must be in facilities licensed by DDAP.
- Inpatient Detoxification:
  - Hospital or non-hospital facility, licensed by DDAP;
  - Minimum 7 days per admission;
  - Minimum 4 admissions per lifetime.
- Non-Hospital Residential:
  - Facility must be licensed by DDAP;
  - Minimum 30 days per year;
  - Minimum 90 days per lifetime.
- Outpatient:
  - Facility must be licensed by DDAP;
  - Minimum 30 full-session visits or equivalent partial visits per year;
  - Minimum 120 full-session visits or equivalent partial visits per lifetime.
- Additional treatment:
  - An additional 30 sessions of Outpatient or Partial Hospitalization are provided per year may be exchanged on a 2:1 basis to secure up to 15 additional non-hospital residential treatment days.
- Family counseling and intervention services within facilities licensed by DDAP.
- Reasonable deductible or copayment plans, or both, may be applied to benefits.

### ***Per the PA Insurance Department, Drug and Alcohol Use and Dependency Coverage, Notice 2003-06***

“Under the act, the only lawful prerequisite before an insured obtains nonhospital residential and outpatient coverage for alcohol and drug dependency treatment is a certification and referral from a licensed physician or licensed psychologist. It is the Department's determination that the same prerequisite applies for inpatient detoxification coverage. The certification and referral in all instances controls both the nature and duration of treatment.”

- This notice was upheld by the Pennsylvania Supreme Court May 27, 2009.

### **Act 106 of 1989 states:**

“All group health or sickness or accident insurance policies ...shall include within the coverage ...benefits for alcohol or other drug abuse and dependency...Inpatient detoxification... of four admissions for detoxification and reimbursement or admission may be limited to seven(7) days of treatment...Non-hospital residential...for a minimum of thirty(30) days per year for residential care. Outpatient...for a minimum of thirty outpatient, full-session visits...subject to a lifetime limit, for any covered individual, of one hundred and twenty outpatient, full-session visits.”

## Appendix 10: References

- American Society of Addiction Medicine. (2013). *The ASAM criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions*. Mee-Lee, D., Shulman, G.D., Fishman, M.J., Gastfriend, D.R., Miller, M.M. (Eds.). Carson City: The Change Companies.
- Ammerman, R.T., Ott, P.J., & Tarter, R.E. (1999). *Prevention and societal impact of drug and alcohol abuse*. Mahwah: Lawrence Erlbaum Associates.
- Availability of Program Information. (2010). Code of Federal Regulations. Title 42. Chapter IV. Subchapter C. Part 435. Subpart J. Section 435.905.
- Back, S., Sonne S., Killeen, T., Dansky, B., & Brady, K. (2003). Comparative profiles of women with PTSD and comorbid cocaine dependence or alcohol dependence. *American Journal of Drug and Alcohol Abuse, 29*, 169-189.
- Beauvais, F., & Trimble, J.E. (1992). The role of the researcher in evaluating American-Indian alcohol and other drug abuse prevention programs. In Orlandi, M., Weston, R. & Epstein, L. (Eds.), *Cultural competence for evaluators: A guide for alcohol prevention practitioners working with ethnic/racial communities*. Rockville, MD: Office for Substance Abuse Prevention.
- Berrill, K. T. (1992). Anti-gay violence and victimization in the United States: An overview. In G. M. Herek & K. T. Berrill (Eds.), *Hate crimes: Confronting violence against lesbians and gay men*. Newbury Park, CA: Sage.
- Bethea, A., Acosta, M. & Haller, D. (2008). Patient versus therapist alliance: Whose perception matters? *Journal of Substance Abuse Treatment 32 (2)*, 174-183.
- Brady, T.M., & Ashley, O.S. (Eds.) (2005). *Women in substance abuse treatment: Results from the alcohol and drug services study (ADSS)*. DHHS Publication No. SMA 04-3968, Analytic Series A-26. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Studies.
- Brown, L. S. (1996). Ethical concerns with sexual minority patients. In R. P. Cabaj (Ed.), *Textbook of homosexuality and mental health*. Washington, DC: American Psychiatric Press.
- Brown, P.J., & Wolfe, J. (1994). Substance abuse and post-traumatic stress disorder comorbidity. *Drug and Alcohol Dependence, 35*, 51-59.
- Casas, J.M. (1992). A culturally sensitive model for evaluating alcohol and other drug abuse prevention programs: A Hispanic perspective. In Orlandi, M., Weston, R. & Epstein, L. (Eds.), *Cultural competence for evaluators: A guide for alcohol prevention practitioners working with ethnic/racial communities*. Rockville, MD: Office for Substance Abuse Prevention.
- Center for Substance Abuse Treatment (CSAT). (2009). *Assessing the specific needs of women (TIP) 51*. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA).

- Center for Substance Abuse Treatment (CSAT). (2009). *A provider's introduction to substance abuse treatment for lesbian, gay, bisexual, and transgender individuals*. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA).
- Center for Substance Abuse Treatment (CSAT). (2004). *Clinical guidelines for the use of Buprenorphine in the treatment of opioid addiction: Treatment Improvement Protocol (TIP) 40*. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA).
- Center for Substance Abuse Treatment (CSAT). (1999). *Cultural Sensitivity: An overview and selected bibliographies*. National Evaluation Data and Technical Assistance Center. Retrieved from: <http://www.icpsr.umich.edu/SAMHDA/NTIES/NTIES-PDF/BIBLIOS/sens99.pdf>.
- Center for Substance Abuse Treatment (CSAT). (2007). *Definitions and terms relating to co-occurring disorders*. COCE overview paper 1. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services (SAMHSA).
- Center for Substance Abuse Treatment (CSAT). (2005.) *Medication-assisted treatment for opioid addiction in opioid treatment programs: Treatment Improvement Protocol (TIP) 43*. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA).
- Center for Substance Abuse Treatment (CSAT). (1993). *Pregnant, substance-using women: Treatment Improvement Protocol (TIP) 2*. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA).
- Center for Substance Abuse Treatment (CSAT). (2007). *Overarching principles to address the needs of persons with co-occurring disorders*. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA).
- Center for Substance Abuse Treatment (CSAT). (2007). *Screening, assessment, and treatment planning for persons with co-occurring disorders, COCE overview paper 2*. Rockville, MD: Substance Abuse and Mental Health Administration, and Center for Mental Health Services (SAMHSA).
- Center for Substance Abuse Treatment (CSAT). (2005). *Substance abuse treatment for persons with co-occurring disorders: Treatment Improvement Protocol (TIP) 42*. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA).
- Ciarrocchi, J. (2001). *Counseling problem gamblers: A self-regulation manual for individual and family therapy*. Academic Press, St. Louis, MO.
- Civil Rights Act of 1964. Pub. L. 88-352, title 6, Sec. 601, 78 Stat. 252. Enacted July 2, 1964.
- Clark, H. W. (2001). Residential substance abuse treatment for pregnant and postpartum women and their children: Treatment and policy implications. *Child Welfare, 80*, 179-198.
- Connors, N.A, Bokony, P., Whiteside-Mansell, L., Bradley, Robert H., Liu, J. 2004. Addressing the treatment needs of children affected by maternal addiction: Challenges and solutions. *Evaluation and Program Planning 27 (2)*, 241-247.

- Curie, C., Minkoff, K., Hutchings, G., and Cline, C. (2004). Strategic implementation of system change for individuals with mental health and substance abuse disorders. *Journal of Dual Diagnosis*, 75, 76-85.
- DeCaria, C., Hollander, E., Grossman, R. Wong, C. Mosovich, S., Cherkaskey, S. (1996). Diagnosis, neurobiology and treatment of pathological gambling. *Journal of Clinical Psychiatry*, (57) 80-84.
- De Leon, G. (2000). *The therapeutic community: Theory, model, and method*. Springer Publishing Company, New York, NY.
- Drug Addition Treatment Act. (2000). Code of Federal Regulations, Title 21, section 823.
- Ducharme, L., Mello, H., Roman, P.M., Knudsen, H.K., & Johnson, J.A. (2007). Service delivery in substance abuse treatment: Reexamining 'comprehensive care.' *Journal of Behavioral Health Services & Research* 34 (2), 121-136.
- Duncan, R., Saunders, B., Kilpatrick, D., Hanson, R., & Resnick, H. (1996). Childhood physical assault as a risk factor for PTSD, depression, and substance abuse: Findings from a national survey. *American Journal of Orthopsychiatry*, 66, 437-448.
- El-Bassel, N., Gilbert, L., Witte, S., Wu, E., Gaeta, T., Schilling, R., & Wada, T. (2003). Intimate partner violence and substance abuse among minority women receiving care from an inner-city emergency department. *Women's Health Issues*, 13, 16-22.
- Fassinger, R. E. (1991). The hidden minority: Issues and challenges in working with lesbian women and gay men. *The Counseling Psychologist*, 19, 157-176.
- Federal Opioid Treatment Standards. (2001). Code of Federal Regulations, Title 42, Section 8.12.
- Fultz, J. & Senay, E. (1975). Guidelines for the management of hospitalized narcotics addicts. *Annals of Internal Medicine* 82 (6), 815-818.
- Gay and Lesbian Medical Association. (2006). *Breaking the grip: Treating crystal methamphetamine addiction among gay and bisexual men*. Retrieved from: [http://www.glma.org/\\_data/n\\_0001/resources/live/BreakingtheGrip.pdf](http://www.glma.org/_data/n_0001/resources/live/BreakingtheGrip.pdf)
- Gerstein, D.R., Johnson, R.A., Harwood, H., Fountain, D., Suter, N. and Mallory, K. (1994). *Evaluating recovery services: The California drug and alcohol treatment assessment (CALDATA)*. Nation Opinion Research Center at the University of Chicago and Lewin-VHI, Inc., Fairfax, VA.
- Glaser, W. & Deane, K. (1999). Normalization in an abnormal World: A study of prisoners with an intellectual disability. *International Journal of Offender Therapy and Comparative Criminology*, 43, 338-356.
- Gordon, J.U. (Ed.). (1994). *Managing multiculturalism in substance abuse services*. Thousand Oaks, CA: Sage.

- Greenfield, L., Burgdorf, K., Chen, X., Porowski, A., Roberts, T., & Herrell, J. (2004). Effectiveness of long-term residential substance abuse treatment for women: Findings from three national studies. *American Journal of Drug and Alcohol Abuse, 30* (3), 537-550.
- Gryczynski, J., Gwin Mitchell, S., Peterson, T., Gonzales, A., Moseley, A. & Schwartz, R. (2011). The relationship between services delivered and substance use outcomes in New Mexico's screening, brief intervention, referral and treatment (SBIRT) initiative. *Drug and Alcohol Dependence, 118* (2-3), 152-157.
- Haddock, G., & Zanna, M. P. (1998). Authoritarianism, values, and the favorability and structure of anti-gay attitudes. In G. M. Herek (Ed.), *Psychological perspectives on lesbian and gay issues: Vol. 4. Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals*. Thousand Oaks, CA; Sage.
- Halkitis, P. N., Parsons, J. T., & Stirratt, M. J. (2001). A double epidemic: Crystal methamphetamine drug use in relation to HIV transmission among gay men. *Journal of Homosexuality, 41* (2), 17-35.
- Hien, D.A., Cohen, L.R. Miele, G.M., Litt L.C. & Capstick, C. (2004). Promising treatments for women with comorbid PTSD and substance use disorders. *American Journal of Psychiatry, 161*, 1426-1432.
- Herek, G. M. (1989). Hate crimes against lesbians and gay men: Issues for research and policy. *American Psychologist, 44*, 948-955.
- Herek, G. M. (1991). Stigma, prejudice, and violence against lesbians and gay men. In J. C. Gonsiorek & J. D. Weinrich (Eds.), *Homosexuality: Research implications for public policy*. Newbury Park, CA: Sage.
- Herek, G. M. (1996). Heterosexism and homophobia. In R. J. Cabaj & T. S. Stein (Eds.), *Textbook of homosexuality and mental health*. Washington, DC: American Psychiatric Press.
- Herek, G. M., Gillis, J. R., & Cogan, J. C. (1999). Psychological sequelae of hate-crime victimization among lesbian, gay, and bisexual adults. *Journal of Consulting and Clinical Psychology, 67*, 945-951.
- Herek, G. M., Gillis, J. R., Cogan, J. C., & Glunt, E. K. (1997). Hate crime victimization among lesbian, gay, and bisexual adults: Prevalence, psychological correlates, and methodological issues. *Journal of Interpersonal Violence 12*, 195-215.
- Hicks, D. (2000). The importance of specialized treatment programs for lesbian and gay patients. In J. R. Guss & J. Drescher (Eds.), *Addictions in the gay and lesbian community*. New York: Haworth Medical Press.
- Kaltenbach, K., Finnegan, L.P. (1984). Developmental outcome of children born to methadone maintained women: A review of longitudinal studies. *Neurobehavioral Toxicology & Teratology, 6* (4), 271-275.

- Lash, S., Timko, C., Curran, G., McKay, J. & Burden, J. (2011). Implementation of evidence-based substance use disorder continuing care interventions. *Psychology of Addictive Behaviors* 25 (2), 238-251.
- Letellier, P. (1994). Gay and bisexual male domestic violence victimization: Challenges to feminist theory and responses to violence. *Violence and Victims*, 9, 95-106.
- Maguire, C. (2010). *Exploring the relationship between intimate partner violence and internalized heterosexism among lesbian women*. (Unpublished doctoral dissertation). Drexel University, Philadelphia.
- Matthews, C. R. (2007). Affirmative lesbian, gay, and bisexual counseling with all individuals. In K. J. Bieschke, R. M. Perez, & K. A DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender individuals*, 2<sup>nd</sup> ed. Washington, DC: American Psychological Association.
- Matthews, C. R., Lorah, P., & Fenton, J. (2005). Toward a grounded theory of lesbians' recovery from addiction. *Journal of Lesbian Studies*, 9, 57-68. (concurrently published in the book, *Making lesbians visible in the substance abuse field*, E. Ettorre, (Ed.), Binghamton, NY: Harrington Park Press).
- Mattison, A. M., Ross, M. W., Wolfson, T., Franklin, D., & HNRC Group. (2001). Circuit party attendance, club drug use, and unsafe sex in gay men. *Journal of Substance Abuse*, 13, 119-126.
- McDowell, D. (2000). Gay men, lesbians and substances of abuse and the "club and circuit party scene:" What clinicians should know. In J.R. Guss & J. Drescher (Eds.), *Addictions in the gay and lesbian community*. New York: Haworth Medical Press.
- Minkoff, K. & Cline, C.A. (2004). Changing the world: The design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. *Psychiatric Clinics of North America*, 27 (4), 727-743.
- Mohr, J. J. (2002). Heterosexual identity and the heterosexual therapist: An identity perspective on sexual orientation dynamics in psychotherapy. *The Counseling Psychologist*, 30, 532-566.
- Moran P. (1999). The epidemiology of antisocial personality disorder. *Social Psychiatry and Psychiatric Epidemiology*, 34, 231-242.
- Najavits, L.M., Weiss R.D., & Shaw, S.R. (1997). The link between substance abuse and post-traumatic stress disorder stress in women: A research review. *American Journal on Addictions*, 6 (4), 273-283.
- National Association of State Alcohol and Drug Abuse Directors (NASADAD). 2011. *Therapeutic services for children whose parents receive substance use disorder treatment*. Washington, D.C.: Substance Abuse and Mental Health Services Administration (SAMHSA).
- National Association of State Mental Health Program Directors & National Association of State Alcohol and Drug Use Directors. (1999). *National dialogue on co-occurring mental health and substance abuse disorders*. Retrieved from: <http://www.nasadad.org/index.php?baseid=100>

- National Coalition Against Domestic Violence. (2007). *Domestic violence facts*. Retrieved from: [http://www.ncadv.org/files/DomesticViolenceFactSheet\(National\).pdf](http://www.ncadv.org/files/DomesticViolenceFactSheet(National).pdf)
- National Institute on Drug Abuse. (1999). *Principles of drug addiction treatment: A research-based guide*. NIH Publication No. 12-4180. Washington, D.C.: United States Department of Health and Human Services.
- National Institute of Drug Abuse. (2009). *Principles of drug addiction treatment: A research-based guide, 2<sup>nd</sup> edition*. Rockville, MD: NIH Publication No. 09-4180, Revised April 2009.
- National Standards for Culturally and Linguistically Appropriate Services in Health Care. (2001). *Executive Summary*. Washington, D. C.: U.S. Department of Health and Human Services.
- Nelson-Zlupko, L., Dore, M.M. Kauffman, E., & Kaltenbach, K. (1996). Women in recovery: Their perceptions of treatment effectiveness. *Journal of Substance Abuse Treatment, 13*, 51-59.
- Ouimette, P., Kimerling, R., Shaw, J., & Moos, R. (2000). Physical and sexual abuse among women and men with substance use disorders. *Alcoholism Treatment Quarterly, 18*, 7-17.
- Pajulo, M. Suchman, N., Kalland, M., & Mayes, L. (2006). Enhancing the effectiveness of residential treatment for substance abusing pregnant and parenting women: Focus on maternal reflective functioning and mother-child relationship. *Infant Mental Health Journal, 27* (5), 448-465.
- Pating, D.R., Miller, M.M., Goplerund, E., Martin, J. & Ziedonis, D.M. (2012). New systems of care for substance use disorders: Treatment, finance, and technology under health care reform. *Psychiatric Clinics of North America 35*, 327-356.
- Peachey, J.E., and Lei, H. (1988). Assessment of opioid dependence with naloxone. *British Journal of Addiction 83*(2),193-201.
- Pennsylvania Drug and Alcohol Coalition. (2010). *White paper: Recovery-oriented system of care: A recovery community perspective*. Retrieved from: [http://www.facesandvoicesofrecovery.org/pdf/White/rosc\\_community\\_perspective\\_2010.pdf](http://www.facesandvoicesofrecovery.org/pdf/White/rosc_community_perspective_2010.pdf)
- Pitt, E., & Dolan-Soto, D. (2001). Clinical considerations in working with victims of same-sex domestic violence. *Journal of the Gay and Lesbian Medical Association, 5* (4), 163-169.
- Pope, M. (1995). The "salad bowl" is big enough for us all: An argument for the inclusion of lesbians and gay men in any definition of multiculturalism. *Journal of Counseling and Development, 73*, 301-304.
- Rebach, H.M. (1992). *Substance abuse among ethnic minorities in America: A critical annotated bibliography*. New York: Garland Pub.
- Ries, R.K., and Miller, N.S. (1993). Dual diagnosis: Concept, diagnosis, and treatment. In Dunner, D., (Ed.). *Current Psychiatric Therapy*. Philadelphia: W.B. Saunders Company.
- Ross, M. W., Mattison, A. M., & Franklin, D. R., Jr. (2003). Club drugs and sex on drugs are associated with different motivations for gay circuit party attendance in men. *Substance Use and Misuse, 38*, 1173-1183.

- Savin-Williams, R. C. (2005). *The new gay teenager*. Cambridge, MA: Harvard University Press.
- Seelau, S. M., & Seelau, E. P. (2005). Gender-role stereotypes and perceptions of heterosexual, gay, and lesbian domestic violence. *Journal of Family Violence, 20*, 363-371.
- Straussner, S. (2012). *Ethnocultural factors in substance abuse treatment*. New York: The Guilford Press.
- Swim, J. K., Johnston, K., & Pearson, N. K. (2009). Daily experiences with heterosexism: Relations between heterosexist hassles and psychological well-being. *Journal of Social and Clinical Psychology 28*, 597-629.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2010). *Results from the 2009 national survey on drug use and health: Volume I. Summary of national findings*. Office of Applied Studies: Rockville, MD.
- Sullivan, J. T., Sykora, K., Schneiderman, J., Naranjo, C. A. & Sellers, E.M. (1989). Assessment of alcohol withdrawal: the revised clinical institute withdrawal assessment for alcohol scale (CIWA-Ar). *British Journal of Addiction, 84*(11), 1353-1357.
- The Joint Commission. (2013). National patient safety goals effective January 1, 2013. Retrieved from: [http://www.jointcommission.org/assets/1/18/NPSG\\_Chapter\\_Jan2013\\_HAP.pdf](http://www.jointcommission.org/assets/1/18/NPSG_Chapter_Jan2013_HAP.pdf).
- Tjaden, P., & Thoennes, N. (2000). Prevalence and consequences of male-to-female and female-to-male intimate partner violence as measured by the National Violence against Women Survey. *Violence Against Women, 6*, 142-161.
- Urbanoski, K., Kelly, F., Hoepfner, B. & Slaymaker, V. (2012). The role of therapeutic alliance in substance use disorder treatment for young adults. *Journal of Substance Abuse Treatment, 43* (3), 344-51.
- U.S. Census Bureau. (2013). *State and county QuickFacts, Philadelphia County, Pennsylvania*. Last revised: June 27, 2013. Retrieved from: <http://quickfacts.census.gov/qfd/states/42/42101.html>
- van Olphen, J., Eliason, M., Freudenberg, N., & Barnes, M. (2009). Nowhere to go: How stigma limits the options of female drug users after release from jail. *Substance Abuse Treatment, Prevention, and Policy 4*, 10.
- Weinberg, M. S., Williams, C. J., & Pryor, D. W. (1994). *Dual attractions: Understanding bisexuality*. New York: Oxford.
- Wesson, D.R. & Ling, W. (2003). The clinical opiate withdrawal scale (COWS). *Journal of Psychoactive Drugs 35*(2), 253-259.
- Women's Law Project. (2010). *Approval of DPW regulations secures critical protection for domestic violence victims*. Retrieved from [http://www.womenslawproject.org/NewPages/wkVAW\\_policy.html](http://www.womenslawproject.org/NewPages/wkVAW_policy.html)

Woody, D.L. (1992). *Recruitment and retention of minority workers in mental health programs*.  
Rockville, MD: National Institute of Mental Health.

Zamble, E. & Porporino, F. J. (1988). *Coping, behavior, and adaptation in prison inmates (Research in criminology)*. New York: Springer-Verlag.

## Appendix 11: Acronyms

<b>ASAM</b>	American Society of Addiction Medicine
<b>CSAT</b>	Center for Substance Abuse Treatment
<b>CSC</b>	Clinical Standards Committee
<b>DDAP</b>	Department of Drug and Alcohol Programs
<b>DOC</b>	Department of Corrections
<b>LGBTQI</b>	Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex
<b>LOC</b>	Level of Care
<b>LOS</b>	Length of Stay
<b>MAT</b>	Medication-Assisted Treatment
<b>PCPC</b>	Pennsylvania Client Placement Criteria
<b>PRO-A</b>	Pennsylvania Recovery Organizations Alliance
<b>ROSC</b>	Recovery Oriented System of Care
<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration
<b>SBIRT</b>	Screening, Brief Intervention and Referral to Treatment
<b>SUD</b>	Substance Use Disorder
<b>TOS</b>	Type of Service

## Appendix 12: Subcommittee Acknowledgements

The following are recognized for their contributions of time, effort and expertise to the various subcommittees of the PCPC 3<sup>rd</sup> edition revision.

### M.1 SBIRT

**Chair:**

**Janice L. Pringle, PhD**  
Program Evaluation and  
Research Unit, University of  
Pittsburgh School of  
Pharmacy

**Members:**

**James Allen, MEd**  
Allegheny County Bureau of  
Drug and Alcohol Services

**Marleen Bruce, BS, CAC**  
UPMC Mercy Family Medicine

**Melinda Campopiano, MD**  
UPMC Mercy Hospital

**Stacey Conway**  
Bucks County Council on  
Alcoholism & Drug Dependence,  
Inc.

**Mary Diamond, DO, MA, MPA**  
Department of Public Welfare

**Vincent Giannetti, PhD**  
School of Pharmacy  
Duquesne University

**Jeff Geibel**  
Department of Drug and Alcohol  
Programs

**Adam Gordon, MD**  
University of Pittsburgh School  
of Medicine

**Frank Gould**  
City of Philadelphia  
Department of Behavioral  
Health &  
Mental Retardation Services

**Margaret Hanna**  
Bucks County Drug and Alcohol  
Commission, Inc

**Amy Hedden**  
Department of Drug and Alcohol  
Programs

**Cynthia Holland, MPH**  
University of Pittsburgh  
School of Pharmacy, PERU

**Leanne Huey**  
Clearfield-Jefferson Community  
Mental Health Center

**Bethany Kyper**  
Mainstream Counseling

**Terry Matulevich**  
Department of Drug and Alcohol  
Programs

**Jill Pecht**  
Clear Concepts Counseling

**Shauna Spencer**  
Pittsburgh Regional Health  
Initiative

**Kelly Turner**  
Clearfield-Jefferson Drug and  
Alcohol Commission

### M.2 Early Intervention Subcommittee:

**Chair:**

**John Howell, EdD, LPC**  
Today, Inc.

**Members:**

**Craig Adamson, PhD**  
CSF & Buxmont Academy

**James Bechtel, PhD,**  
**CCDP-D**  
Magellan Behavioral Health

**Maureen Cleaver**  
Department of Drug and Alcohol  
Programs

**Sherry Clouser**  
Dauphin County Department of  
Drug and Alcohol Services

**Mary A. Finck**  
Department of Corrections

**Beverly Haberle**  
The Council of Southeast  
Pennsylvania

**Amy Hedden**  
Department of Drug and Alcohol  
Programs

**Doris Lugaro**  
Department of Public Welfare

**Kate Vandegrift, MA**  
Thomas Jefferson University  
(Maternal Addiction Treatment  
Education and Research)

**M.3 Training Subcommittee:**

**Co-Chairs:**

**Cecilia Velasquez, MHS,**  
**CAADC, CCJP**  
Gaudenzia, Inc.

**Nancy Milliron, MS, ICADC,**  
**LPC, CCMS, CCPG**  
PCPC Trainer & Consultant

**Members:**

**Debra Browning**  
Department of Drug and Alcohol  
Programs

**Sarah Davis, MSW, LSW**  
PCPC Trainer

**Evan Dittman**  
Cameron Elk McKean Counties  
Alcohol and Drug Abuse  
Services Inc.

**Mary Finck**  
Department of Corrections

**Jeff Geibel**  
Department of Drug and Alcohol  
Programs

**Amy Hedden**  
Department of Drug and Alcohol  
Programs

**Kenneth Martz, Psy.D., CAS**  
Department of Drug and Alcohol  
Programs

**Julia B. Monaco, PhD, MSPH,**  
**MS**  
Gaudenzia, Inc.

**Stephen Paesani, MA, MTS**  
The Behavioral Health Training  
& Education Network

**Missy Repsher, BA, CADC, CCJP**  
Pennsylvania Board of  
Probation and Parole

**Terri Somers, MA, LPC, CAADC**  
Department of Corrections

**June Steiner**  
CRC Health Group

**Paul Toth, PhD, LPC, CAADC,**  
**CCDP-D**  
Eagleville Hospital

#### **M.4 PCPC/ASAM Crosswalk Subcommittee:**

**Chair:**

**Kim Bowman, MS**  
Chester County Department of  
Human Services

**Co-Chair:**

**James Bechtel, PhD,**  
**CCDP-D**  
Magellan Behavioral Health

**Members:**

**Andrew Burkins, MD**  
Magellan Behavioral Health

**Mike Donahue**  
Luzerne-Wyoming Counties  
Drug and Alcohol Program

**Amy Hedden**  
Department of Drug and Alcohol  
Programs

#### **M.4 Temperature Read/PCPC Survey Subcommittee:**

**Co-Chairs:**

**Janice L. Pringle, PhD**  
Program Evaluation and  
Research Unit, University of  
Pittsburgh School of  
Pharmacy

**Jim Aiello, MA, MEd**  
Northeast ATTC

#### **M.5 Medication-Assisted Treatment Subcommittee:**

**Chair:**

**Trusandra Taylor, MD,**  
**FASAM, MPH**  
ACT1-JEVS Human Services

**Co-Chair:**

**Kate Vandegrift, MA**  
Thomas Jefferson University  
(Maternal Addiction  
Treatment Education and  
Research)

**Members:**

**Bill Noonan**

Department of Drug and Alcohol Programs, retired

**Mary Diamond**

Department of Public Welfare, retired

**Adam J. Gordon, MD MPH, FACP, FASAM**

University of Pittsburgh School of Medicine

**Stephen Weinstein, MD**

Thomas Jefferson University

**M.6 Co-Occurring Disorders Subcommittee:**

**Chair:**

**Ted Millard, MSW**

Good Friends, Inc.

**Co-Chair:**

**Kim Bowman, MS**

Chester County Department of Human Services

**Members:**

**Dorothy J. Farr, LSW, LADC, CCDP-D, ICCDPD**

Bucks County Behavioral Health System/Drug and Alcohol Commission, Inc.

**John Howell, EdD, LPC Today, Inc.**

**Rosemary Madl-Young, PhD, RN, CCPD-D, CAC**

Gaudenzia, Inc.

**Julia B. Monaco, PhD, MSPH, MS**

Gaudenzia, Inc.

**David F. Moran, CAC, CCPD-D, LCSW, CP, PAT**

Crozer Chester Medical Center

**Richard Novak**

Department of Public Welfare, retired

**Lisa Olander, MEd, LPC, CAC, CCJP, CCBT**

Bowling Green, Brandywine

**Jean Rush**

Department of Public Welfare

**James Schuster, MD, MBA**

Community Care Behavioral Health Organization

**Mark Shirk**

Department of Drug and Alcohol Programs

**M.7 Women and Women with Children Subcommittee:**

**Chair:**

**Kate Vandegrift, MA**

Thomas Jefferson University  
(Maternal Addiction Treatment Education and Research)

**Co-Chair:**

**Florence Paige, MHS**  
Gaudenzia, Inc.

**Members:**

**Christine Abdur-Rahim**  
Gaudenzia, Inc.

**Mary Bair, LPN**  
Gaudenzia, Inc.

**Heather Bowser**  
Family Links

**Celeste Wansley-Carpenter,  
MA, LPC, NCP, CCDP-D**  
Libertae, Inc.

**Kathleen Curtin, BA**  
Libertae, Inc.

**Deb Filanowski**  
Gaudenzia, Inc.

**Mary Gomez**  
Gaudenzia, Inc.

**Paula Kiernan, MS, CAC, CCDP**  
Gaudenzia, Inc.

**Shirley Laffey**  
POWER, Inc.

**Gretchen Luchs**  
Family Links

**Colleen Maguire, PhD, PA-C**  
Family Center, Thomas Jefferson  
University

**Nancy Milliron, MS, CPC**  
Another Way, Inc.

**Latrice Parr, MHS**  
Gaudenzia, Inc.

**Laura Rostolsky**  
Department of Drug and Alcohol  
Programs

**Evelyn Savido**  
POWER, Inc. (Retired)

**Marilyn Shearn**  
Gaudenzia, Inc.

**Leslie Ziegler**  
Gaudenzia, Inc.

**M.8 Criminal Justice Subcommittee:**

**Chair:**

**Cecilia Velasquez, MHS,  
CAADC, CCJP**  
Gaudenzia, Inc.

**Members:**

**Karen Bornstein**  
Pennsylvania Board of  
Probation and Parole

**Robert Csandl, MHS, LPC**  
Treatment Trends, Inc

**Harry Davis**  
Commonwealth of Pennsylvania,  
retired

**Mary A. Finck**  
Department of Corrections

**Charles Folks, LCSW**  
Eagleville Hospital

**Harris Gubernick**  
Director of Corrections at Bucks  
County

**Sheree Hargrove-Eley**  
Gaudenzia, Inc.

**Dan Klarsch**  
Department of Drug and Alcohol  
Programs

**Kenneth Martz, Psy.D., CAS**  
Department of Drug and Alcohol  
Programs

**Tracy Smith**  
Department of Corrections

**Heather Yates**  
Formerly Department of  
Corrections

**M.9 Cultural/Ethnic and Sexual Orientation/Gender Identity  
Considerations Subcommittee:**

**Chair:**

**Cecilia Velasquez, MHS,**  
**CAADC, CCJP**  
Gaudenzia, Inc.

**Co-Chair:**

**Mary Diamond, DO**  
Department of Public Welfare,  
retired

**Members:**

**Sherree Hargrove-Eley**  
Gaudenzia, Inc.

**Connie Matthews**  
New Perspectives, LLC

**Kathy Jo Stence**  
Department of Drug and Alcohol  
Programs

**Cheryl Williams**  
Department of Drug and Alcohol  
Programs, retired