SERVICE STANDARD

INDIANA DEPARTMENT OF CHILD SERVICES

WITHDRAWAL MANAGEMENT

(FORMERLY KNOWN AS DETOXIFICATION SERVICES)

I. Service Description

A. This service standard applies to families with children involved with the Department of Child Services and/or Probation.
   1. Services may be provided for adults in need of withdrawal management services.

B. According to the Substance Abuse & Mental Health Service Administration, detoxification is:
   1. "A set of interventions aimed at managing acute intoxication and withdrawal.[1]"

C. Withdrawal is:
   1. The process of the body eliminating drugs or intoxicants, resulting in symptoms that need to be managed, to ensure the individual's well-being.

D. Providing withdrawal management services is not treatment in itself.

E. Individuals who receive withdrawal management services will need a continuum of care that corresponds to their level of need.

F. Withdrawal management should provide services that allows the individual to safely detoxify from drugs or intoxicants.

G. Services should be provided in a:
   1. Non-judgmental, supportive manner that preserves the individual's dignity.
   2. Strength based, person centered manner, to motivate the individual forward in the change process and promote ongoing treatment for the substance use/opioid use disorder and/or mental health needs.

H. Services should take into account the impact the substance use/opioid use disorder has not only on the referred individual, but also the impact on the family unit and child safety.

I. The program should seek to deliver and/or refer services that support and address the needs of the family.

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[1] Substance Abuse and Mental Health Services Administration. Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 45. HHS Publication No. (SMA) 134131. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006

J. The program must be certified and properly designated by The Division of Mental Health and Addictions (DMHA).

K. The program shall be staffed by appropriately credentialed personnel who are trained and competent to implement withdrawal management programming that is consistent with the program's DMHA certification.

II. Service Delivery

A. Providers should complete a bio-psychosocial assessment, consistent with the Substance Use Disorder Assessment service standard, on referred clients.

B. It is strongly encouraged for providers to utilize the most current American Society of Addiction Medicine Criteria (ASAM) when determining the appropriate withdrawal management level and creating a discharge/recovery plan.

C. Inpatient or ambulatory withdrawal management may be provided, dependent on the individual's needs and risk present with the withdrawal.

D. Individuals shall be accepted into the program within 5 days.

E. Providers shall give priority to pregnant women and intravenous drug abuse populations.

1. The provider shall establish and utilize a referral system if the provider has insufficient capacity to provide services to women who are pregnant.
2. The provider shall notify the Department of Mental Health and Addiction (DMHA) if immediate access to services, for a woman who is pregnant cannot be arranged.
3. Interim services, including referral for prenatal care, shall be provided to each woman who is pregnant awaiting commencement into withdrawal management services for forty-eight (48) hours or more and shall continue until such time services are fully commenced.
4. Interim services shall be provided to individuals who use intravenous drugs and wait for commencement into withdrawal management services for forty-eight (48) hours or more and shall continue to until such time services are fully commenced.

F. Upon discharge from the program, the client must have a discharge/recovery plan that provides them linkage to social support to encapsulate family, community and recovery supports and individual treatment needs.

G. Ambulatory/Outpatient Withdrawal Management Services

1. Individuals placed into ambulatory withdrawal management services will be:
   a) At no significant withdrawal risk, or be at a risk level of mild to moderate withdrawal symptomology;
   b) Have no biomedical conditions that would complicate or impact services;

c) Evaluated to have a mental status, including emotional stability and cognitive functioning, as no concern, sufficiently stable and/or currently receiving treatment for mental health concerns and compliant with said treatment;

d) Ready to change and motivated to learn harm reduction and move towards abstinence from illicit substances;

e) Able to control use with minimal support/obtain abstinence or be at risk for relapse without close monitoring;

f) Living in a supportive environment and have coping skills or

g) Living in an unsupportive environment but possess coping skills or can cope with said environment with structure and support.

2. Ambulatory services should only be provided to individuals who have a positive social support system in place and available to the individual.

3. Services under ambulatory withdrawal management should be provided at regularly scheduled sessions on a daily basis.

4. Medical and/or nursing personnel shall evaluate and confirm ambulatory withdrawal management is appropriate for the individual.

   a) The provider shall have protocols in place to access medical consultation in an emergency.

5. Individuals receiving ambulatory withdrawal management shall be engaged in substance use/opioid use disorder treatment/programming based off their level of need.

   a) It is highly encouraged providers utilize the most current version of ASAM criteria when determining the appropriate treatment level.

   b) Providers should identify determination criteria, such as ASAM, in their treatment plan.

6. Treatment may include intensive outpatient treatment (defined as 3 consecutive hours 3 times a week) individual or group counseling (less than intensive outpatient treatment) and recovery coaching.

7. Please refer to the Substance Use Disorder Outpatient Treatment service standard for activities permitted under these areas.

   a) While the client is receiving ambulatory withdrawal management, a separate referral will not be provided to cover treatment services.

   b) Treatment services will be covered under the per diem rate.

8. Referred individuals should be provided with education on the dangers of withdrawal, the withdrawal process, based off a particular substance/intoxicant, and common withdrawal symptoms pertaining to the specific substance they will be detoxifying from.

   a) Providers should offer information to referred individuals on how to manage the urges to engage in substance use and how to resist said urges.

9. Connecting and introducing the individual to recovery support meetings/communities is strongly encouraged.
10. Providers should utilize interventions that are motivational in nature and encourage the client to complete withdrawal management services, engage in treatment and move towards their sobriety and recovery.
11. Recognizing the type, length and intensity of an individual's withdrawal may vary dependent on the severity of the addiction.
    a) Ambulatory withdrawal management lasting longer than 10 business days will require a justification and approval of additional referral units.

H. Inpatient Withdrawal Management

1. Inpatient withdrawal management should be delivered and consistent with the most recent version of ASAM criteria under one of the following methods:
    a) Clinically Managed
        (1) Defined by ASAM Criteria as "directed by nonphysician Addiction specialist rather than medical personnel. They are appropriate for individuals whose primary problems involve emotional, behavioral cognitive, readiness to change, relapse, or recovery environment concerns."[2]
        (2) Clinically managed services is consistent with a 3.5 ASAM Inpatient level of care.
    b) Medically Monitored
        (1) Defined by ASAM criteria as "interdisciplinary staff of nurses, counselors, social workers, addiction specialists and other health and technical personnel under the direction of a licensed physician. Medical monitoring is provided through an appropriate mix of direct patient contact, review of medical records, team meetings, 24-hour coverage by a physician, 24 hour nursing and a quality assurance program."[2]
        (2) Medically monitored services is consistent with a 3.7 ASAM inpatient level of care.
    (c) Medically Managed
        (1) Defined by ASAM criteria as "daily medical care and 24-hour nursing. An appropriately trained and licensed physician provides diagnostic and treatment services directly, manages provisions of those services, or both."[2]

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[2] Medicaid Innovation Accelerator Program "Overview of Substance Use Disorder (SUD) Care Clinical Guidelines: A Resource for States Developing SUD Delivery System Reforms April 2017." https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/asam-resource-guide.pdf

(2) Medically managed care is consistent with a 4.0 ASAM inpatient level of care.

2. Staff that deliver inpatient withdrawal management services should be knowledgeable on co-occurring disorders and how they may impact the ability of the individual to engage in services.
   a) Staff should have the ability to treat and/or refer for proper mental health treatment and in conjunction with addiction services.
   b) Individuals deemed appropriate for inpatient withdrawal management may be at a higher risk to experience the adverse effects of withdrawal due to biomedical condition and/or mental health conditions and need more intense monitoring to ensure the individual's well-being.
3. Referred individuals should be provided with education on the dangers of withdrawal, the withdrawal process, based off a particular substance/intoxicant, and common withdrawal symptoms pertaining to the specific substance they will be detoxifying from.
   a) Providers should offer information to referred individuals on how to manage the urges to engage in substance use and how to resist said urges.
   b) Connecting and introducing the individual to recovery support meetings is strongly encouraged.
   c) Providers should utilize interventions that are motivational in nature and encourage the client to complete detoxification services, engage in treatment and move towards their sobriety and recovery.
4. Recognizing the type, length and intensity of an individual's withdrawal may vary dependent on the severity of the addiction.
   a) Withdrawal management lasting longer than 10 business days will require a justification and approval of additional referral units.

I. Drug Testing

1. Drug testing shall be utilized during the course of treatment regardless of methodology.
2. The treatment provider will use best practice recommendations when considering drug testing frequency and specific time for testing.
3. All sample collection drug tests will be observed.
   a) Urine drug tests will be observed by an individual of the same gender as the client.
      (1) Gender of the client is defined as the gender listed on the client's government issued identification.
         (a) Provider staff must be aware and sensitive to the sexual and/or gender orientation of clients. If applicable, provider staff should provide

information to the client regarding changing their government issued identification, accessible at http://www.in.gov/bmv/2564.htm.

4. Minimum of substances tested should include:
   a) Alcohol
   b) Amphetamines
   c) Barbiturates
   d) Benzodiazepines
   e) Cocaine
   f) Cannabis
   g) Opiates
   h) Methadone
   i) Oxycodone
   j) Tramadol
   k) Buprenorphine
   l) Synthetic Marijuana
   m) Fentanyl
   n) Methamphetamine
   o) Other substances not listed that the client may report a history of using may also be tested.
5. The agency will be expected to provide reports to the referral source that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.
6. Assurance must be given for accurate results, even if the confirmation process is the only means to ensure accurate results due to the testing process providing inaccurate results.
   a) Any presumptive positive test must go through the confirmation process.
7. A laboratory participating in DCS/Probation drug testing must comply with all applicable Federal Department of Health and Human Service.
   a) Under these federal requirements, laboratories are subsumed Substance Abuse and Mental Health Services Administration (SAMHSA), or College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

8. The referring agency will be notified of positive results within 72 hours of the lab receipt of the sample specimen.

9. The referring agency will be notified of negative results within 24 hours of the lab receipt of the sample specimen.

J. Discharge/Recovery Plan

1. The provider will develop a discharge/recovery plan with the referred individual regardless of withdrawal management methodology.
2. All attempts should be made by the provider to ensure a smooth transition to subsequent level of care.
3. The written discharge/recovery plan will be completed for every client and provided to the referral source within 7 business day after client's discharge from treatment.
4. In order to ensure follow up, the discharge recommendations have to be shared verbally with the referral source, within a minimum of 3 business days, prior to client's discharge from the program.
5. The recovery plan should include the following domains:
   a) Any applicable diagnosis(s);
   b) Level of care provided during withdrawal management episode;
   c) Recommended level of care upon discharge;
   d) Prescribed medication and dosage instructions, at time of discharge;
   e) Supports in place for referred individual (social, familial, communal, relapse prevention, sponsor etc.);
   f) Strengths and limitations of referred individual;
   g) Referral recommendations, to include, but not limited to: psychological testing, psychiatrist consultation, medication evaluation, recovery support meetings, life skills etc.;
   h) Discharge/termination reason and
   i) Discharge/termination date.
6. Providers are not required to provide DCS with a monthly report.
7. Best practice will have the referred individual transition to the next level on the continuum of care when it is immediately available.
   a) If services for the next level of care are not immediately available, and there is a gap between discharge and continuing services, the provider will develop an interim plan to encourage and support the client's recovery process.

III. Target Population

A. Service must be restricted to the following eligibility categories:

1. Adult parents/caregivers who have substantiated cases of child abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status.
2. Adult parents/caregivers that have an active Informal Adjustment or whose children have the status of CHINS or JD/JS.
3. Foster/Kinship adult caregivers with whom children with the status of CHINS or JD/JS are placed.

IV. Goals and Outcomes

A. Vendors will have internal quality monitoring systems and procedures in place to track the quality and effectiveness of programming and service delivery.
   1. Indiana Department of Child Services may elect to conduct quality audits of contracted providers to ensure compliance with best practice and service standards.

B. For the Withdrawal Management Service Standard, DCS will use the following measures to monitor quality:
   1. Goal #1: Maintain timely intervention with the family and regular and timely communication with referring worker.
      a) Outcome Measure 1: 90% of services will be initiated within 5 days of the referral.
      b) Outcome Measure 2: 100% of discharge/recovery plans will be submitted to the referral source within 7 days of discharge.
      c) Outcome Measure 3: 100% of cases will include a verbal consultation with the referral source, a minimum of 3 days prior to discharge, to discuss recommended level of continued care.
   2. Goal #2: Treatment provided to referred individual will be consistent with the client's level of need. Client will be referred to a continuum of care that is appropriate for their level of need and be linked to said care upon discharge.

a) Outcome Measure 1: 100% of clients will receive an assessment prior to admission of withdrawal management services and referred to the level of care that is appropriate to their level of need.

b) Outcome Measure 2: 100% of clients will be referred to treatment for their substance use/opioid use disorder and/or mental health needs, appropriate for their level of need, upon discharge/termination.

c) Outcome Measure 3: 80% of clients will be enrolled in treatment for their substance use/opioid use disorder and/or mental health needs, at the appropriate level of need, upon discharge/termination.

3. Goal #3: Referral source and referred individuals will report satisfaction with services rendered through a quality assurance measure developed by the vendor.

a) 90% of the families who have participated in withdrawal management services will rate the service as "satisfactory" or above on a satisfaction survey (or like tool) developed by the provider.

(1) Providers are to solicit feedback from a minimum of 12 clients or 20% of their caseload (whichever results in a larger number).

(2) Feedback should be collected in a random manner and be solicited from each county served.

b) Referral source satisfaction will be rated as "satisfactory" or above on a satisfaction survey (or like tool) developed by the provider.

V. Minimum Qualifications

A. Detoxification/Withdrawal Management services must be provided under the supervision of a physician or clinical nurse specialist licensed to practice in Indiana in compliance with 440 IAC 4.4-2-1.

B. The program administrators will maintain their certification and credentialing by DMHA and will ensure the direct service staff is appropriately credentialed at all times, as necessary to remain compliant with all ongoing certification requirements.

C. The vendor shall notify DMHA regarding changes to credentialed staff, as required by DMHA.

1. Notification to DCS regarding any changes to the program's DMHA certification status or adverse action taken against vendor certification shall be sent to ChildWelfarePlan@dcs.IN.gov within 2 business days of the change.

VI. Billable Units

A. Medicaid

1. Providers will bill Medicaid or private insurance when appropriate.
2. For information on coverage of detoxification/withdrawal management services and specific Medicaid Programs, please refer to the Indiana Health Coverage Programs (IHCP) Provider Manual located at www.indianamedicaid.gov.
    a) It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any preauthorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid.
3. After receiving prior authorization from Medicaid, the provider must invoice Medicaid for the stay.
    a) If Medicaid denies the claim and the provider agency invoices DCS, the Medicaid denial must be attached to the submitted invoice.
    b) Failure to attach the denial may result in DCs denying the invoice.
    c) Denials due to improper/incorrect billing to Medicaid will not be accepted as a valid reason to invoice DCS.
4. CMHCs and agencies that are qualified providers will utilize the Medicaid Eligibility Inquiry for patients with no health care coverage.

B. DCS Funding

1. Detoxification Services (Inpatient)
    a) For those services not deemed appropriate to bill Medicaid, a Per Diem rate will be paid for services, as defined in this service standard.
    b) Detoxification Services will not be paid for services not deemed medically necessary.
    c) For invoices submitted to DCS with the statement “client is not Medicaid eligible,” the qualified provider must attach the eligibility screen to the submitted DCS invoice.

d) If Medicaid denies the claim and the provider agency invoices DCS, the Medicaid denial must be attached to the submitted invoice.

(1) Failure to attach the Medicaid denial or eligibility screen, where applicable, may result in DCS denying the service.

(2) Denials due to improper/incorrect billing to Medicaid will not be accepted as a valid reason to invoice DCS.

2. Detoxification Services (Ambulatory)

a) For those services not deemed appropriate to bill Medicaid, a Per Diem rate will be paid for services, as defined in this service standard.

b) Detoxification Services will not be paid for service not deemed medically necessary.

c) Programming for outpatient treatment services is included in the per diem rate.

(1) Vendors shall not invoice DCS for outpatient treatment services when invoicing for detoxification services.

d) For invoices submitted to DCS with the statement "client is not Medicaid eligible," the qualified provider must attach the eligibility test to the submitted DCS invoice.

(1) If Medicaid denies the claim and the provider agency invoices DCS, the Medicaid denial must be attached to the submitted invoice.

(2) Failure to attach the Medicaid denial or eligibility test to be submitted to DCS invoice.

C. Interpretation, Translation, and Sign Language Services

1. The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider.

2. If the service is needed in the delivery of services referred, DCS will reimburse the Provider for the cost of the Interpretation, Translation, or Sign Language service at the actual cost of the service to the provider.

3. The referral from DCS must include the request for Interpretation services and the agencies' invoice for this service must be provided when billing DCS for the service.

4. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required.

5. The Service Provider Agency is free to use an agency or persons of their choosing as long as the service is provided in an accurate and competent manner and billed at a fair market rate.

6. If the agency utilizes their own staff to provide interpretation, they can only bill for the interpretation services. The agency cannot bill for performing two services at one time.

D. Court

1. The provider of this service may be requested to testify in court.
2. A Court Appearance is defined as appearing for a court hearing after receiving a written or email request or subpoena from DCS to appear in court, and can be billed per appearance.
3. If the provider appeared in court two different days, they could bill for 2 court appearances.
   a) Maximum of 1 court appearance per day.
4. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

E. Reports

1. If the services provided are not funded by DCS, the 'Reports' hourly rate will be paid
2. A referral for 'Reports' must be issued by DCS in order to bill
3. For the purpose of this service standard, 'reports' is defined as the discharge/recovery plan.

VII. Case Record Documentation

A. Case record documentation for service eligibility must include:

1. A completed, and dated DCS/ Probation referral form authorizing services
2. Discharge/Recovery Plan provided to referral source prior to client's discharge.
   a) Case documentation shall show when report is sent.
3. Copy of DCS/Probation case plan, informal adjustment documentation, or documentation requests for documents given to DCS/Probation.

VIII. Service Access

A. All services must be accessed and pre-approved through a referral form from the referring DCS staff.

B. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required.

C. Referrals are valid for a maximum of six (6) months unless otherwise specified by DCS/Probation.

D. Providers must initiate a re-authorization for services to continue beyond the approved period.

E. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to DCS Practice Model

A. Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect.

B. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

X. Interpreter, Translation, and Sign Language Services

A. All Services provided on behalf of the Department of Child Services must include Interpretation, Translation, or Sign Language for families who are non-English language speakers or who are hearing- impaired.

B. Interpretation is done by an Interpreter who is fluent in English and the non-English language and is the spoken exchange from one language to another.

C. Certification of the interpreter is not required; however, the interpreter should have passed a proficiency test in both the spoken and the written language in which they are interpreting.

D. Interpreters can assist in translating a document for a non-English speaking client on an individual basis, (i.e., An interpreter may be able to explain what a document says to the non-English speaking client).

E. Sign Language should be done in the language familiar to the family.

F. These services must be provided by a non-family member of the client, be conducted with respect for the socio- cultural values, life style choices, and complex family interactions of the clients, and be delivered in a neutral-valued culturally-competent manner.

G. The Interpreters are to be competent in both English and the non-English Language (and dialect) that is being requested and are to refrain from adding or deleting any of the information given or received during an interpretation session.

H. No side comments or conversations between the Interpreters and the clients should occur.

XI. Trauma Informed Care

A. Provider must develop a core competency in Trauma Informed Care as defined by the National Center for Trauma Informed Care—SAMHSA (http://www.samhsa.gov/nctic/):

1. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.
2. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?"
3. When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services.
4. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization

B. Trauma Specific Interventions: (modified from the SAMHSA definition)

1. The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
2. The provider must demonstrate an understanding, through the services provided, of the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
3. The provider will work in a collaborative way with child/family, extended family and friends, and other human services agencies in a manner that will empower child/family.

XII. Training

A. Service provider employees are required to complete general training competencies at various levels.

B. Levels are labeled in Modules (I-IV), and requirements for each employee are based on the employee's level of work with DCS clients.

C. Training requirements, documents, and resources are outlined at: http://www.in.gov/dcs/3493.htm

1. Review the **Resource Guide for Training Requirements** to understand Training Modules, expectations, and Agency responsibility.
2. Review **Training Competencies, Curricula, and Resources** to learn more about the training topics.
3. Review the **Training Requirement Checklist** and **Shadowing Checklist** for expectations within each module.

XIII. Cultural and Religious Competence

A. Provider must respect the culture of the children and families with which it provides services.

B. All staff persons who come in contact with the family must be aware of and sensitive to the child's cultural, ethnic, and linguistic differences.

C. All staff also must be aware of and sensitive to the sexual and/or gender orientation of the child, including lesbian, gay, bisexual, transgender or questioning children/youth.

1. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook.
2. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth.
3. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

D. Efforts must be made to employ or have access to staff and/or volunteers who are representative of the community served in order to minimize any barriers that may exist.

E. Contractor must have a plan for developing and maintaining the cultural competence of their programs, including the recruitment, development, and training of staff, volunteers, and others as appropriate to the program or service type; treatment approaches and models; and the use of appropriate community resources and informal networks that support cultural connections.

XIV. Child Safety

A. Services must be provided in accordance with the Principles of Child Welfare Services.

B. All services (even individual services) are provided through the lens of child safety.

1. As part of service provision, it is the responsibility of the service provider to understand the child safety concerns and protective factors that exist within the family.
2. Continual assessment of child safety and communication with the Local DCS Office is required. It is the responsibility of the service provider to report any safety concerns, per state statue, IC 31-33-5-1.

C. All service plans should include goals that address issues of child safety and the family's protective factors. The monthly reports must outline progress towards goals identified in the service plans.