Service Name	**DUAL DISORDER RESIDENTIAL (CO-OCCURRING DIAGNOSIS-ENHANCED) – LEVEL 3.5 ADULT SUBSTANCE USE DISORDER**
Setting	Facility based
Facility License	Licensed as required by DHHS Division of Public Health.
Basic Definition	Dual disorder residential treatment is intended for adults with a primary substance use disorder and a co-occurring mental health disorder requiring a more restrictive treatment environment. This service is highly structured, based on acuity, and provides primary, integrated treatment to further stabilize acute symptoms and engage the individual in a program of maintenance, treatment, rehabilitation and recovery.
Service Expectations basic expectations for more detail see Title 471 chapter 20	• Complete an initial diagnostic interview (IDI) if one has not been completed within the 12 months prior to admission. The IDI is to identify the need for this LOC and outline the needed services and resources for the individual. The IDI shall serve as the initial treatment plan until the comprehensive plan of care is developed. • If another provider has completed an initial assessment, and it includes a DSM (current edition) mental health diagnosis and level of care recommendation, and all information is still clinically relevant to the member's condition, it can serve as the admission assessment; otherwise, an IDI update is warranted to update the previous assessment as necessary. • A substance use disorder (SUD) assessment by a licensed clinician prior to the beginning of treatment. • If a prior SUD assessment is determined to be clinically relevant and includes a current diagnosis, level of care recommendation and a discharge plan it can serve as the admission assessment. If the prior assessment is not relevant or does not contain the necessary information than an SUD addendum would be necessary. • An initial treatment/recovery plan to guide the first seven days of treatment developed within 24 hours and the comprehensive individualized treatment/recovery plan, including discharge and relapse prevention, developed under clinical supervision with the individual within seven days of admission. • Review and update of the treatment/recovery plan under clinical supervision with the individual and other approved family/supports every 30 days or more often as needed. • A nursing assessment by a RN or LPN (under RN supervision) is to be completed within 24 hours of admission. The assessment will include recommendations for further physical examination if necessary. • Therapies/interventions should include individual, family, and group psychotherapy and/or substance use disorder counseling, educational and recreational groups of 42 hours per week. • Individual psychiatric services as clinically indicated. • Drug screenings are provided as clinically indicated.

	• Education on medication management is utilized as appropriate. • Consultation and/or referral for general medical needs. • The discharge plan is to promote successful reintegration into regular, daily activity such as work, school or family living, including the establishment of each individual's social supports to enhance recovery. • Other services should include 24 hours crisis management, family education, self-help group and support group orientation, all of which are included in the minimum of 42 hours per week. • Each staff is to be trained in recovery and trauma informed care.
Length of Service	Length of service is individualized and based on clinical criteria for admission and continuing stay.
Staffing	• Clinical director is a licensed clinician with demonstrated work experience and education/training in both mental health and addictions who is responsible for all clinical decisions (i.e. admissions, assessment, treatment/discharge planning and review) and consultation with direct care staff. The Clinical director may be a physician, physician assistant, psychiatrist, APRN, LIMHP, LMHP or a Licensed Psychologist. • The clinical director continually works to incorporate new clinical information and best practices into the program to assure program effectiveness and viability, and assure quality, organization and management of clinical records, and other program documentation. • A consulting physician or an APRN is required to be available as necessary. • RNs and/or LPNs (under the supervision of an RN) with substance use disorder/psychiatric treatment experience preferred. • Other program staff may include recreation therapists or social workers. • The clinicians are licensed, credentialed, and working within their scope of practice to provide co-occurring (MH/SUD) treatment. They are also knowledgeable about the biological and psychosocial dimensions of substance use disorder. All clinicians are to be dually licensed; however one of the licenses may be provisional. • Direct care staff holding a bachelor's degree or higher in psychology, sociology or a related human service field are preferred, but two years of coursework in a human services field and/or two years of experience/training OR two years of lived recovery experience with demonstrated skills and competencies in treatment with individuals with a behavioral health diagnoses is acceptable.
Staffing Ratio	• Clinical director to direct care staff ratio as needed to meet all responsibilities • 1:6 direct care staff to individual served during waking hours • 1:8 therapist/ licensed clinician to individuals served • One awake staff for each ten individuals during individual sleep hours (overnight) with on-call availability for emergencies, two awake staff overnight for 11 or more individuals served • On-call availability of medical and direct care staff and licensed clinicians 24/7

Hours of Operation	24/7
Desired Individual Outcome	• The individual has met their treatment plan goals and objectives. • The precipitating condition and relapse potential is stabilized such that the individual's condition can be managed without this professional level of support and intervention. • The individual has alternative support systems secured to help them maintain stability in the community.
Admission guidelines	• The individual meets the diagnostic criteria for a substance-related disorder as defined in the DSM (current version) as well as each of the six ASAM dimensional criteria for admission. Individuals may also meet the diagnostic criteria for a mental health disorder as defined in the DSM (current version), including those that are severe and persistent. • It is expected that the individual will be able to benefit from this treatment. The following six dimensions and criteria are abbreviated. Providers should refer to ASAM Criteria – 3rd Edition for complete criteria for each dimension: • Dimension 1: ACUTE INTOXICATION &/OR WITHDRAWAL POTENTIAL: At minimal risk of withdrawal, at Levels 3.3 or 3.5. If withdrawal is present, it meets Level 3.2-D criteria. • Dimension 2: BIOMEDICAL CONDITIONS & COMPLICATIONS: None or stable, or receiving concurrent medical monitoring. • Dimension 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS & COMPLICATIONS: Demonstrates repeated inability to control impulses or a personality disorder requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A Dual Diagnosis Enhanced setting is required for SPMI Severely and Persistently Mentally Ill individuals. • Dimension 4: READINESS TO CHANGE: Has marked difficulty with, or opposition to treatment, with dangerous consequences; or there is high severity in this dimension but not in others. The individual, therefore, needs a Level I motivational enhancement program. • Dimension 5: RELAPSE, CONT. USE OR CONT. PROBLEM POTENTIAL: Has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences. • Dimension 6: RECOVERY ENVIRONMENT: Environment is dangerous and individual lacks skills to cope outside of a highly structured 24-hour setting.
Continued stay guidelines	It is appropriate to retain the individual at the present level of care if: • The individual is making progress but has not yet achieved the goals articulated in the treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals;

	• The individual is not yet making progress, but has the capacity to resolve his or her problems. • The individual is actively working toward the goals in the individualized treatment plan; and/or • New problems have been identified that are appropriately treated at this level of care. • This level of care is the least intensive level of care at which the individual's new problems can be addressed effectively.