

## General Practice Guidelines in the County of San Diego Drug Medi-Cal Organized Delivery System (DMC-ODS)

*(from the Substance Use Disorder Provider Operations Handbook dated 3/1/19)*

The County of San Diego Behavioral Health Services (COSDBHS) recognizes that clinical care needs to be an individualized process that balances client needs, established clinical standards, and available resources. Each clinical case is unique and there are many variables that impact care; however, care guidelines can be helpful to outline generally accepted clinical standards.

The guidelines outlined below are not intended to be a comprehensive overview of all aspects of clinically appropriate substance use care. It is strongly recommended that one refer to more detailed clinical guidelines provided through SAMHSA and other respected resources for additional information. (SAMHSA publications can be found [here](#)).

### **Medical Necessity and Assessment**

Medical necessity refers to the applicable evidence-based standards applied to justify the level of services provided to a client, so the services can be deemed reasonable, necessary and/or appropriate. It refers to those SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness or injury consistent with [42 CFR 438.201\(a\)\(4\)](#) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.

It is imperative that medical necessity standards be consistently and universally applied to all clients to ensure equal and appropriate access and service delivery, and is established to demonstrate and maintain eligibility for services delivered.

Medical necessity for an adult (an individual age 18 and over) is determined using both of the following criteria:

- The individual shall have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance Related Disorders
- The individual shall meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria (i.e. meet criteria for a specific level of care).

Individuals under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, clients under the age of 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Regulations under DMC-ODS do not override any EPSDT requirements. Medical necessity for an adolescent (age 12 to 20) is determined using the following criteria:

- The adolescent shall be assessed to be at risk for developing a SUD\*
- The adolescent shall meet the ASAM adolescent treatment criteria.

\*Per DHCS, the Intergovernmental Agreement between the County of San Diego and the State allows at-risk youth (individuals under the age of 21) to be served at the ASAM Level 0.5 (Early Intervention) level of care. At-risk youth (those without a DSM-5 SUD diagnosis) would not meet medical necessity criteria for Outpatient Services (OS - also known as ASAM Level 1) or any other levels of care in the continuum.

There are various types of assessments focusing on medical necessity and clinical care, including level of care determinations. Assessments, and the corresponding documentation, serve as the foundation of high-quality care. Assessment is also an important aspect of client engagement and treatment planning and is generally performed in the initial phases of treatment, though not necessarily during the initial visit.

In the treatment of persons with SUD, ongoing assessment is an expected process and is essential in order to identify client needs and help the provider focus their services to best meet those needs.

In certain situations, brief and focused assessments may be more appropriate than more extensive assessments. However, the comprehensive treatment of addictions requires a comprehensive assessment to be conducted in the initial phases of treatment. An important competency of counselors/clinicians is to discern when a brief assessment versus a comprehensive assessment is needed. Additionally, collaborative and coordinated care is a key characteristic of quality care and is based on the ability to perform appropriately comprehensive assessments in order to determine the most suitable referral or linkage.

Staff and professionals who possess the appropriate training perform assessments within their scope of practice. Comprehensive clinical assessments are performed by appropriately trained Licensed Practitioners of the Healing Arts (LPHAs) and SUD counselors.

Clinical assessments are based on the ASAM Criteria, which includes multidimensional assessments comprised of six dimensions:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional, behavioral, or cognitive conditions and complications
4. Readiness to change
5. Relapse, continued use, or continued problem potential
6. Recovery/living environment

The multidimensional ASAM assessment provides a common language to describe holistic, biopsychosocial assessment and treatment across addiction, physical health, and mental health services. At a minimum, comprehensive assessments include the following elements:

- History of the present episode
- Substance use and addictive behavior history
- Developmental history (as appropriate)
- Family history
- Medical history
- Psychiatric history
- Social history
- Spiritual history
- Physical and mental status examinations, as needed
- Comprehensive assessment of the diagnose(s) and pertinent details of the case
- Survey of assets, vulnerabilities, and supports
- Client strengths
- Treatment recommendations

Assessments based on the ASAM Criteria ensure that necessary clinical information is obtained in order to make appropriate level of care determinations. Assessments must be appropriately documented (see the [Documentation](#) section

for specifics), reviewed, and updated on a regular basis, including at every care transition, in order to promote engagement and meet the client's needs and preferences. If during the course of assessment, the client and provider(s) determine that adequate progress toward treatment goals has been made, plans to build upon these achievements must be made, which may include transitions to other services and recovery-focused strategies. Similarly, reassessments of the diagnosis, treatment modalities/intensity/goals must be performed if progress toward agreed upon goals is not being made within a reasonable time. See [Appendix A.1](#) for ASAM Criteria Dimensions at a Glance.

Clients who prematurely exit the SUD system of care should receive case management services, with the goal of re-engagement, during the established period prior to Administrative Discharge. (See [Section D: Service Delivery](#) for additional information).

### **Drug Testing**

Drug testing is often a useful tool to monitor engagement and provide an objective measure of treatment efficacy and progress to inform treatment decisions. In general, the frequency of drug testing should be based on the client's progress in treatment, and the frequency of testing should be higher during the initial phases of treatment when continued drug use has been identified to be more common.

A punitive approach to drug testing does not facilitate a productive and therapeutic relationship with clients and should be avoided. Consequences to drug testing should be communicated in a therapeutic manner and the communication of these consequences does not need to adversely affect the therapeutic alliance. Decisions about appropriate responses to positive drug tests and relapses should consider the chronic nature of addiction, recognize that relapse is a manifestation of the condition for which people are seeking SUD treatment, and recognize instances in which medications or other factors may lead to false or appropriately positive drug test results.

Additional practice guidelines regarding drug testing can be found [here](#).

### **Evidence Based Practices (EBPs)**

Research and innovations have yielded significant progress in the development, standardization, and empirical evaluation of psychosocial treatments for SUD. This has resulted in a wide range of effective programs for SUD that differ in both theoretical orientation and treatment technique. While a number of approaches and techniques are effective depending on the clinical situation, certain treatment

approaches have a stronger evidence base and therefore must serve as the foundation of a high-quality system of SUD care.

In San Diego County, although other psychosocial approaches may be used, SUD providers are at a minimum expected to implement the two evidence-based psychosocial interventions of Motivational Interviewing (MI) and Relapse Prevention. Below are brief descriptions of these and other evidence-based psychosocial interventions:

- **Motivational Interviewing (MI)** - A client-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment by paying particular attention to the language of change. This approach frequently includes other problem solving or solution-focused strategies that build on clients' past successes. According to the Motivational Interviewing Network of Trainers, MI “is designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.”

- **Relapse Prevention** - According to SAMHSA’s *National Registry of Evidence-Based Programs and Practices*, relapse prevention is “a behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment. Coping skills training strategies include both cognitive and behavioral techniques. Cognitive techniques provide clients with ways to reframe the habit change process as a learning experience with errors and setbacks expected as mastery develops. Behavioral techniques include the use of lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a client's overall coping capacity.”

In addition to these two required EBPs, programs may choose to also include EBPs such as:

- **Cognitive-Behavioral Therapy (CBT)** - According to the National Institute of Drug Abuse’s *Principles of Drug Addiction Treatment: A Research-Based Guide*, “Cognitive-behavioral strategies are based on the theory that in the development of maladaptive behavioral patterns like substance abuse, learning processes play a critical role. Individuals in CBT learn to identify and correct problematic behaviors by applying a range of different skills that can be used to stop drug abuse and to address a range of other problems that often co-occur with it. A central element of

CBT is anticipating likely problems and enhancing clients' self-control by helping them develop effective coping strategies. Specific techniques include exploring the positive and negative consequences of continued drug use, self-monitoring to recognize cravings early and identify situations that might put one at risk for use and developing strategies for coping with cravings and avoiding those high-risk situations." The Matrix Model is an example of an integrated therapeutic approach that incorporates CBT techniques and has been empirically shown to be effective for the treatment of stimulant use.

- **Trauma-Informed Treatment** - According to SAMHSA's concept of a trauma-informed approach, "a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization." Seeking Safety is an example of an evidence-based trauma-informed practice.

- **Psychoeducation** - Psychoeducational interventions educate clients about substance abuse and related behaviors and consequences. The information provided may be broad but are intended to lead to specific objectives. Psychoeducation about substance abuse is designed to have a direct application to clients' lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist clients in recovery, develop an understanding of the process of recovery, and prompt people using substances to act on their own behalf.

Elements of these practices may be used in any type of service setting and must be performed by trained providers within their scope of practice. Of note, the descriptions of the evidence-based psychosocial interventions above are simply summaries and providers are encouraged to refer to other available resources and manuals for more detailed guidance as to the effective clinical application of these approaches. Implementation of Motivational Interviewing and Relapse Prevention will be a contract requirement and monitored through the contract compliance monitoring process.

### **Medication-Assisted Treatments (MAT)**

Research has shown that for the treatment of addiction, a combination of medications and behavioral therapies is more successful than either intervention alone. Subsequently, medication-assisted treatments (MAT) must be part of a

comprehensive, whole-person approach to the treatment of SUD that includes psychosocial interventions like counseling, behavioral therapies, case management, and care coordination. The use of FDA approved addiction medications as part of this comprehensive, whole-person approach to the treatment of SUD shall not be discouraged in any way. Similarly, clients shall not be denied services based solely on the fact that they are taking prescribed medication, regardless of the type of medication.

For those programs providing MAT services, required elements of service include obtaining informed consent, ordering, prescribing, administering, and monitoring of all medications for SUD. Given the biopsychosocial nature of addiction, all available clinically indicated psychosocial and pharmacological therapies must be discussed and offered as a concurrent treatment option for appropriate individuals with an alcohol and/or opioid related SUD condition at all levels of care. When MAT is part of the treatment plan, licensed prescribers operating within their scope of practice should assist the client to collaborate in clinical decision-making, assuring that the client is aware of all appropriate therapeutic alternatives. Informed consent for all pharmacotherapies must be obtained, including discussion about the advantages and disadvantages of MAT, taking into consideration the benefits, side effects, alternatives, cost, availability, and potential for diversion, among other factors.

Clients receiving MAT in OTP settings must receive a minimum of 50 minutes of counseling sessions with a therapist or counselor, not to exceed 200 minutes per calendar month, although additional services may be provided based on medical necessity. All prescribed MAT should be consistent with generally accepted standards of medical practice and best practice guidelines for the condition being treated.

There are currently several FDA-approved medications for the treatment of various types of addiction in adults:

#### Opioid Use Disorder

- Methadone
- Buprenorphine
- Naltrexone (oral and long-acting injectable formulation)

Note: In addition to the above medications for opioid use disorder treatment, Naloxone is an FDA-approved medication used to prevent opioid overdose deaths.

## Alcohol Use Disorder

- Naltrexone (oral and long-acting injectable formulation)
- Disulfiram
- Acamprosate

Details regarding the availability, pharmacology, and appropriate prescribing of FDA-approved medications for addiction are beyond the scope of this section. However, providers are encouraged to reference published prescribing guidelines and other available resources for additional information regarding medication-assisted treatments. The prescribing of MAT must be in compliance with all federal, state, and local laws and regulations.

## **Physician Consultation**

A physician consultation is a correspondence in which one physician is seeking advice, opinion, or recommendation from another physician, usually a specialist with expertise in a specific area of medicine. Based on the information provided, the consultant physician provides his/her recommendations regarding the question asked by the requesting physician. In conjunction with the consultant's expert opinion, the requesting physician utilizes his/her own professional judgment and other considerations (e.g., client preferences, family concerns, other comorbid health conditions and psychosocial factors) to provide comprehensive client treatment.

Given the shortage of medically trained addiction specialists in the SUD workforce, the physician consultation is designed to help facilitate the exchange and dissemination of addiction expertise between physician providers and within the COSD adult and youth systems of care. Under the DMC-ODS, physician consultation is a county billable service.

The Clinician Consultation Center Substance Use Management team at UCSF provides free peer-to-peer consultation from physicians, clinical pharmacists, and nurses with special experts in substance use evaluation and management. Advice on all aspects of substance use management is provided, including:

- Assessment and treatment of opioid, alcohol, and other substance use disorders
- Approaches to suspected misuse, abuse, or diversion of prescribed opioids
- Methods to simplify opioid-based pain regimens to reduce risk of misuse and toxicity
- Urine toxicology testing – when to use it and what it means



- Use of buprenorphine and the role of methadone maintenance
- Withdrawal management for opioids, alcohol, and other CNS depressants
- Harm reduction strategies and overdose prevention
- Managing substance use in special populations (pregnancy, HIV, hepatitis)
- Productive ways of discussing known or suspected addiction with clients

This service does not occur in real-time, so is not appropriate for emergent and/or urgent consultation needs. Cases may be submitted for consultation via internet at the [UCSF Clinical Consultation Center website](http://nccc.ucsf.edu/clinician-consultation/substance-use-management/) <http://nccc.ucsf.edu/clinician-consultation/substance-use-management/> or by calling Monday-Friday, 9 a.m. – 8 p.m. EST at 855-300-3595. Physician Consultation requests are intended for DMC physicians within COSD’s network of providers only and should not be initiated by non-physicians or clients. COSD will continue to explore opportunities to expand this service, according to community need.

Referring Physicians – physicians who are based at provider sites and seeking consultation – are responsible for initiating the consultation by either submitting a case electronically via the link above, or by calling 855-300-3595. All consultation requests must include a clear explanation as to the reason for the consultation and include any relevant history and clinical details that help to inform and provide context for the concern/question.

Physician consultation services are strictly limited to routine consultation requests. Emergent and urgent consultation needs should be directed to more appropriate resources (e.g., emergency department, psychiatric emergency services, etc.).

All local, state, and federal confidentiality requirements involving HIPAA and [42 CFR Part 2](#) will be followed during the Physician Consultation process.

As the County is utilizing this free resource for physician consultation, the service is not billable to Drug Medi-Cal. Providers may be reimbursed for calls made by Physicians to UCSF for physician consultations. Physician consultations are a County billable service; providers will need to use the County-billable cost center on its monthly invoice to claim this cost.

### **Recovery Services**

Recovery Services are aftercare support services designed to help individuals become and stay engaged in the recovery process and reduce the likelihood of relapse. Recovery Services emphasize the client’s central role in managing their

health and recovery and promotes the use of effective self-management and coping strategies, as well as internal and community resources to support ongoing self-management. Medical necessity is considered established for any individual transitioning directly into Recovery Services from treatment. If there is a lapse between treatment discharge and receipt of Recovery Services, or if Recovery Services are discontinued, a screening needs to occur to determine if Recovery Services are still an appropriate service level (see [Section D: Service Delivery](#) for more details on Recovery Services.)

Recovery Services are available for all clients who have completed treatment or left treatment with satisfactory progress and are in recovery. The last treatment provider of care will serve as the default provider of Recovery services, unless necessary services are not offered, or the client prefers a change in provider. These services can be delivered by either a SUD counselor or LPHA and will be offered after completion of a treatment episode.

### **Culturally Appropriate Services**

Culturally competent care is critical in providing high quality SUD services. Research indicates that lack of cultural competency in the design and delivery of services can result in poor outcomes in areas such as access, engagement, receptivity to treatment, help-seeking behaviors, treatment goals, and family response.

Core practices that address cultural competency include:

- Attitudes, beliefs, values, and skills at the provider level.
- Policies and procedures that clearly state and outline the requirements for the quality and consistency of care.
- Readiness and availability of administrative structures and procedures to support such commitments.

Providers are required to adhere to CLAS standards and are responsible for providing services that are developmentally, culturally, and linguistically appropriate, and must ensure that their policies, procedures, and practices are consistent with this requirement. Providers must also ensure that these principles are embedded in the organizational structure of their agency, as well as being upheld in day-to-day operations.

The COSD will promote cultural competency by coordinating trainings designed to educate providers and administrators about various aspects of cultural sensitivity, with the goal of better engaging clients of diverse backgrounds and needs.

### **Case Management and Care Coordination**

Case management and care coordination are collaborative and coordinated approaches to the delivery of health and social services, linking clients with appropriate services to address specific needs and achieve treatment goals. Case management and care coordination are intended to complement and integrate with existing systems and community resources while avoiding duplication or replacement of existing services and supports. Case management and care coordination services are available to all clients who enter the County's DMC-ODS treatment system, are available throughout the treatment episode, and may be continued during recovery services as allowed by COSD.

Care coordination is meant to provide seamless transitions of care for clients within the DMC-ODS, to ensure that clients successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient, etc.) without disruption to services. This includes access to recovery services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.

In the DMC-ODS, care coordination is also meant to ensure that each client has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the client. The client shall be provided information on how to contact their designated person or entity (for more information, see the Care Coordination portion of SUDPOH Section D: Service Delivery).

The primary role of the staff providing care coordination or case management services is to coordinate client services:

- Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.
- With the services the beneficiary receives from any other managed care organization.
- With the services the beneficiary receives in FFS Medicaid.
- With the services the beneficiary receives from community and social support providers.

Additionally, staff providing care coordination or case management services shall make a best effort to conduct an initial screening of each beneficiary's needs, within 90 calendar days of the effective date of enrollment for all new beneficiaries, including subsequent attempts if the initial attempt to contact the beneficiary is unsuccessful (see Substance Use Disorder Uniform Record Manual, also known as the SUDURM, Initial Level of Care assessment forms and instructions for additional information.)

Successful care coordination requires documentation to be maintained and shared, as appropriate. The County DMC-ODS has created the SUDURM which details the requirements for maintaining a client health record in accordance with DMC-ODS and other professional standards. Written records, and the sharing of written and other types of communications, must be done in a way that maintains client confidentiality and privacy; thus, programs are to ensure that in the process of coordinating care, each client's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E and 42 CFR Part 2, to the extent that they are applicable.

Finally, as part of care coordination, programs shall share with DHCS or other managed care organizations serving the client the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities.

### **Description of Case Management Services**

Case management services are available to clients in the DMC-ODS based on the frequency documented in the individualized treatment plan. As documented on the treatment plan, case management shall provide advocacy and care coordination to physical health and mental health, transportation, housing, vocational, educational, and transition services for reintegration into the community.

Case management is a client-centered, collaborative approach to the delivery of health and social services that focuses on reducing barriers to treatment and linking clients with necessary and appropriate services including medical, mental health, educational, social, prevocational, vocational, rehabilitative, or other community services while the client is receiving SUD treatment. The primary goal of case management services is to ensure clients in the SUD System of Care receive all the necessary support and services available to be successful at meeting their treatment goals.

Case management is effective in keeping individuals engaged in treatment and moving toward recovery and helps an individual address other problem

concurrently with substance use. Case management services are especially important among clients with chronic health problems, co-occurring disorders, or are involved with the justice system.

Case management services can often start during the intake and assessment process and continue to be provided to the client throughout SUD treatment and in recovery services (formerly known as “aftercare.”) As clients move through the system of care, case management assessments and reassessments can support different needs from initial service engagement (pre-treatment), treatment, and recovery services. Case management services may be provided face-to-face, by telephone, or by telehealth with the client and may be provided in the community as appropriate.

In order to successfully link clients with services and resources (e.g., financial, medical, or community services), case managers must have a working knowledge of the appropriate resources, both at the system and the service levels that are needed for the client to optimize care through effective and relevant networks of support. Services provided through case management are thus tailored to facilitate continuity of care across all systems of care and provide extensive assessment and documentation of the client’s progress toward self-management and autonomy.

Although an important component of case management in the SUD population is linking clients to outside systems of care, such as physical and mental health systems, case management is equally important in navigating clients through the SUD system of care. Comprehensive SUD treatment often requires that clients move to different levels of care within the SUD continuum, and case managers and care coordinators help to facilitate those transitions. See [Section D: Service Delivery](#) for more information.

### **Description of Care Coordination Services**

Care coordination is the deliberate organization of client care activities, including appropriate information sharing, between two or more services and/or providers (e.g. SUD provider, primary care physician, psychiatrist, housing resources) involved in the client’s care. The primary goal of care coordination efforts is to produce a system of integrated care with high quality referral and transition of care. Care coordination services are best delivered with a team of interdisciplinary staff who are capable of effectively advocating for the client by communicating and consulting among the network of providers across multiple disciplines. Traditionally, coordination of services is often arranged through written formal agreements (e.g. Memorandum of understanding) or protocols and provided at

separate locations; however, care coordination services may also be delivered through co-locating services where clients are being served or through alternative modalities such as telehealth.

There is not a separate billing code for care coordination services, so these types of activities are billed to “Case Management.”

Note: Both case management and care coordination services may involve handling of private and protected health information. Case management shall be consistent with and shall not violate confidentiality of alcohol or drug clients’ disclosure laws set forth in the [42 CFR Part 2](#), and California law.

The following are key care coordination service components:

- 1) Referrals and linkages: Providing high quality referrals and linkages for clients to necessary resources and services as identified on the treatment plan, which includes case management needs. High quality referrals and linkages differ from a simple referral as the case manager or care coordinator plays an active role to reduce access barriers to ensure clients have ‘actual’ access to needed services (e.g. establishing relationships and protocols with external providers to ensure clients will be served upon referral).
- 2) Navigation: Facilitating the navigation of client SUD treatment services with medical, mental health, social, legal, financial and other needed services, including helping clients set up appointment connections and transportation arrangements, and ensuring contacts with a primary care provider. Following-up with clients in service transition or notable events is also key. For example, care coordinator should follow up with client within a few days of an emergency room visit, hospital discharge, or discharge from a residential facility. Reducing barriers into care delivery by arranging for or providing clients with linkages to health, mental health, specialty care and others through co-location of services.
- 3) Monitoring client’s progress: Tracking client progress through SUD treatment services and coordinate client’s transition through the SUD provider network.
- 4) Client education and advocacy: Helping client (and their families/care-givers) understand and navigate the SUD treatment system including SUD diagnosis, availability of treatment options and services, and case management options, including coaching, educating, and mentoring clients (and caregivers) on how to

self-manage their care and access needed services; Promoting the individual's self-management and autonomy through access of community resources.

### **Case Management and Care Coordination for Populations with Special Needs**

More intensive case management and care coordination activities will be required for populations with special needs. These populations may include clients with HIV/AIDS; clients with mental illness; homeless; women perinatal; adolescents, and justice involved. Each population will require care coordination activities to help an individual effectively navigate, access, and participate in an appropriate level of care for SUD services; access health and mental health services; secure housing; and obtain other supportive services.

### **Field-Based Services**

Case management services, including care coordination activities, may be appropriate for clients served in field-based settings that may include, but are not limited to homeless encampments, runaway shelters, interim housing, permanent supportive housing, probation camps or other facilities. When services are provided in the field, providers must ensure confidentiality and document where in the community services were provided (as well as how confidentiality was maintained). See [Section D: Service Delivery](#) for more details on documentation.

### **Eligibility Criteria for Case Management Services**

Case management services are available to all clients who are enrolled in all levels of care under DMC-ODS. Reimbursement eligibility criteria for case management services are the same as DMC-ODS enrollment criteria, the beneficiary must:

- Have Medi-Cal or be Medi-Cal eligible (or EPSDT if under age 21)
- Reside within SD County
- Meet medical necessity criteria
- Be enrolled in a treatment level of care or recovery support services

### **Staffing Requirement**

Various members of the treatment team can function as the case manager, including registered/certified SUD counselors and LPHAs.

### **Housing Referrals**

Housing and an individual's living environment are oftentimes a critical component to the ability to achieve and maintain recovery from SUD. Before being admitted to treatment, all SUD clients must be assessed on all six (6) ASAM dimensions of care, including ASAM Dimension 6 – Recovery/Living

Environment. This intake assessment should reveal potential concerns regarding housing and living situations that may warrant further follow.

### **Continued Service and Discharge Criteria**

After the admission criteria for a given level of care have been met, the criteria for continued service, discharge or transfer from that level of care are as follows:

#### Continued Service Criteria:

It is appropriate to retain the client at the present level of care if:

1. The client is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals;

Or

2. The client is not yet making progress but has the capacity to address his or her problems. He or she is actively working on the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals;

and/or

3. New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the client's new problems can be addressed effectively. To document and communicate the client's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the client's existing or new problem(s), the client should continue in treatment at the present level of care. If not, refer the Discharge/Transfer Criteria, below.

#### Discharge/Transfer Criteria:

It is appropriate to transfer or discharge the client from the present level of care if he or she meets the following criteria:

1. The client has achieved the goals articulated in his or her individualized treatment plan, thus resolving the need(s) that justified admission to the current level of care;

Or

2. The client has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated;



Or

3. The client has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated;

Or

4. The client has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the client's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the client should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.

### **Coordination of Transitions in Care (Step-Up/Down within SUD System and between Health Systems)**

Coordinating transitions in client care is foundational to clients benefiting from a full SUD continuum with various levels of care to continuously meet their needs as they progress through treatment and ultimately toward recovery.

In all cases of care transitions (both when the transition occurs along the SUD care continuum and when the transition occurs between other health systems), the last treating SUD provider is responsible for and must coordinate transitions in care. Case management is a billable service that needs to be used to support these care transition responsibilities.

#### Important Components of Successful Transitions in Care

- Having established policies and procedures for standardizing the care transition process
- Ensuring sufficient training for case managers and staff who are responsible for managing transition in care to ensure understanding of the various levels of care in the DMC-ODS and other service delivery systems
- Clear and thorough treatment and discharge planning so the goals of treatment are clear, such as when transitions may be necessary and the goals of transition
- Client and family preparation and education about transitions in care (i.e. Why they are necessary, what to expect, how to seek help if the need arises, etc.)

- Warm handoffs that involve interpersonal communication and ideally physically accompanying the client during the transition, rather than solely relying on written or electronic communication
- Ensuring that the receiving provider receives necessary information to all of a smooth transition in care
- Interdisciplinary team involvement with assigned accountability for transition-related tasks and outcomes
- Follow up and tracking of referrals to ensure smooth and completed transitions in care
- Positive relationships between the sending and receiving providers
- Medication reconciliation, as needed
- Establishing a quality and process improvement process to identify and ultimately address obstacles (like transportation) to care transitions, both at individual and systemic levels.
- Maintaining client engagement throughout the transition process.

## **Special Populations**

### Prevention

San Diego County's substance use prevention strategy primarily utilizes environmental prevention, a federally approved community-change model to prevent substance use problems throughout the region. Providing a targeted focus on these issues allows the County to develop long term, strategic, cost effective and sustainable prevention plans for each initiative, provides coordination and shared resources where possible, and provides flexible prioritization in each region regarding how each initiative will be tailored to individual community needs.

### Primary Prevention

Since the inception of the San Diego County Prevention Framework in 1997, the County has initiated four regional substance use disorder prevention initiatives that are aligned with the County of San Diego's Strategic Initiatives:

- Binge and Underage Drinking initiative (1996)
- Methamphetamine Strike Force (1996)
- Marijuana Initiative (2005)
- Prescription Drug Abuse Task Force (2008).

### Adult Services

Clients who are age 18 or older with substance use and/or co-occurring disorders receive services through Adult SUD programs. These services include:

- Outpatient and Residential Treatment
- Withdrawal Management
- Case Management
- Justice Programs
- Ancillary services (i.e. TB testing)
- Opioid Treatment Programs (OTP)

### Co-Occurring Disorder Population

Co-occurring disorders (COD) are defined as the occurrence of a combination of any SUD with a mental health condition. The COD must meet the diagnostic criteria independently from the other condition and cannot simply be a cluster of symptoms resulting from a single disorder. The significant co-morbidity of SUD and mental illness (typically reported as 40% - 80% depending on study characteristics and population) and the growing body of research associating poorer outcomes with a lack of targeted treatment efforts have highlighted the importance of addressing the unique needs of this population.

Integrated treatment coordinates substance use and mental health interventions to treat the whole person more effectively. As such, integrated care broadly refers to the process of ensuring that treatment interventions for COD are combined within a primary treatment relationship or service setting. Research has generally supported that the ideal approach toward treatment for CODs is to address all conditions simultaneously, as opposed to addressing the SUD and mental health condition separately and in a silo of separate treatment approaches. When providers have staff who possess the skills and training to adequately address the needs of the COD population within their scope of practice, integrated care is best provided in-house. It is the expectation that all programs be, at a minimum, Co-Occurring Capable with the goal of becoming Co-Occurring Enhanced.

To aid in serving the needs of the COD population in San Diego County, programs are required to participate in the Comprehensive, Continuous, integrated System of Care (CCISC) CADRE.

### Perinatal Services for Women and Girls

Perinatal services (from age 15+) are gender-specific, trauma informed SUD treatment and recovery services provided to pregnant and new mothers and their dependent minor children, from birth through 17 years of age. Childcare service is provided for participants while on-site receiving services. Issues specific to

perinatal clients include substance use while pregnant, pre-natal care, parenting, and family violence.

All Perinatal Programs, regardless of funding source, are required to comply with the [Perinatal Practice Guidelines FY 2018-19 \(PPG\)](#).

Women who are pregnant and/or parenting with substance abuse and/or co-occurring disorders receive SUD services through the Perinatal Services Network. The mothers are the clients, but their children are the motivating factor behind these services. Health and safety of both the mother and her child/children are key. The following are essential service elements:

- Trauma Informed, gender specific, and culturally competent treatment
- Residential, Outpatient and Perinatal Detox treatment
- Child Care on site
- Incredible Years Parenting curriculum and Infant Massage
- Transportation
- Registered/certified SUD counselors and Mental Health clinicians
- Therapeutic services such as behavioral and developmental therapies for children on site
- Teen perinatal SUD treatment
- Homeless Outreach Workers
- Dependency Drug Court

#### Gender Responsive Treatment

Contractor's systems and services shall recognize the importance of the histories, life circumstances, and behaviors of women and men with substance use disorders and take these into account when providing SUD treatment with the goal of producing the best possible treatment outcomes. Contractor shall ensure that the program addresses gender-specific issues in determining individual treatment needs and therapeutic approaches.

As outlined in the [SAMHSA TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women](#), core principles for gender responsive treatment include:

- Acknowledging the importance as well as the role of the socioeconomic issues and differences among women.
- Promoting cultural competence specific to women.

- Recognizing the role as well as the significance of relationships in women's lives.
- Addressing women's unique health concerns.
- Endorsing a developmental perspective.
- Attending to the relevance and influence of various caregiver roles that women often assume throughout the course of their lives.
- Recognizing that ascribed roles and gender expectations across cultures affect societal attitudes toward women who abuse substances.
- Adopting a trauma-informed perspective.
- Using a strengths-based model for women's treatment.
- Incorporating an integrated and multidisciplinary approach to women's treatment.
- Maintaining a gender responsive treatment environment across settings.
- Supporting the development of gender competency specific to women's issues.

Additionally, in [SAMHSA TIP 56: Addressing the Specific Behavioral Health Needs of Men](#), particular factors impacting men are addressed, such as barriers to engagement and ways to engage men in SUD treatment.

#### Deaf and Hard of Hearing (DHH) Clients

For persons who are deaf or hard of hearing, the principles of addiction are the same as they are for hearing people, yet these individuals are currently unable to fully access the resources available to hearing individuals. DHH individuals are at a severe disadvantage in receiving and realizing long-term benefits from treatment for substance abuse, since treatment efforts are typically not focused on culturally specific information. During treatment, the majority of the therapeutic benefit comes from being involved with the counselor on a 1:1 basis, with peers in group and the interactions that occur during non-structured periods of the day. Without the availability of communication during program hours, a deaf person does not benefit from substance abuse treatment in the same way and to the same extent as their hearing peers. Ideally, individuals who successfully complete an alcohol/drug treatment program should be able to return to the environment that they lived in prior to entering a treatment program. However, that environment must include a sober living option, family/friend support, professionals trained to work with clients on aftercare issues and accessible support group meetings. This kind of environment is unavailable for the majority of deaf and hard of hearing individuals. Currently, there are only a handful drug and alcohol recovery programs for DHH people in the United States and less who have a full continuum of treatment and

recovery options such as residential treatment and sober living homes.

While the County of San Diego explores treatment options for this special population, the following practice guidelines are recommended:

- Client records should reflect the client's hearing status, use of personal hearing assistive technology, preferred method of communication (including language and hearing assistive technology needs), preferred language for care and for written materials, presence of interpreters/communication service providers during any service delivery, preferred method(s) of contact, and communication method used to secure informed consent;
- Intake and assessment should include gathering information about cultural identification and hearing acuity, age of onset of hearing loss, etiological components, and language proficiencies;
- Treatment plans for each DHH client shall include services necessary to meet the client's needs, including interpreters, technology support, other services to ensure full linguistic access, and culturally accessible services;
- For clients whose preferred communication method is sign language, access to sign-fluent staff and/or an interpreter shall be utilized for all services.

### Adolescent Services

As documented in the State of California's Youth Treatment Guidelines (2002)<sup>1</sup>, substance abuse and dependence among youth is a complex problem, resulting from multiple factors including biological predisposition, psychological factors, adolescent development, and social factors. Adolescents have added social factors such as bullying, peer pressure, and low self-esteem that have led to gang activity, prostitution, and depression on top of their substance use. Therefore, the biopsychosocial approach will aid in understanding and treating these disorders.

In San Diego County, the drug of choice for adolescents upon admission into substance use disorder programs is marijuana. With recent legalization of marijuana for adults, this will further add to the appeal of marijuana use.

Teen Recovery Centers (TRCs) are specialty population outpatient programs for adolescents that experience many of the complex issues paired with substance use. TRCs provide substance abuse treatment for adolescents age 12-17 and their families. Outpatient services, crisis intervention, and residential treatment services are offered in our urban and rural communities. In addition to their main clinics in

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<sup>1</sup> The State Department of Health Care Services is currently in the process of updating the Youth Treatment Guidelines, so this reference is the most recent version.

the regional communities of San Diego, TRCs are also located within school sites to increase access and coordination with school personnel. The goals of BHS TRC services are as follows:

- Provide developmentally and culturally appropriate substance abuse treatment services for adolescents throughout the County
- Increase access to care by reducing access times to entering programs
- Improve capability and functioning for youth and their families
- Decrease the incidence of crime
- Support the youth in becoming self-supporting through education/employment
- Provide Family Counseling
- Provide Co-occurring disorder treatment
- Increase prosocial skills and eliminate illicit substance use

Contracted providers are to follow the [Youth Treatment Guidelines](#) in developing and implementing youth treatment programs/services.

#### Children, Youth, and Family Services

These services focus on a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

- *Relapse Prevention.* Relapse Prevention education and activities shall be available to help the client maintain sobriety over time. Example activities include:
  - Use relapse prevention workbooks and journals
  - Develop skills to reinforce sobriety and relapse prevention
  - Organize physical activities (individuals or teams) on site or off-site
  - Conduct meditation and relaxation activities
  - Cooking classes, food preparation, and nutrition education
  - Music appreciation sessions and/or learning to play a musical instrument
  - Organize outings to demonstrate drug free lifestyle changes
  - Communication building sessions/activities
  - Parent training on relapse prevention
  - Youth Leadership Group development/activities

- *Recovery Planning Groups.* Recovery planning groups shall be available and provide strategies to achieve abstinence, physical and mental health, financial, employment, educational, and spiritual goals. Example activities include:
  - Recovery services workbook exercises
  - Journaling
  - Conduct meditation and relaxation activities
  - Invite Guest Speakers in recovery (community leaders, parents or motivational speakers)
  - Jobs and career development activities with presentation from groups like Workforce Partnerships or Jobing.com
  - Host financial literacy and credit building sessions with groups like Money Management International
  - Aftercare recovery groups
  
- *Community-based Self-Help Group Participation.* Clients shall be referred to one community peer group per week. Example activities include:
  - Educate and introduce the concept of self-help and its strategy in maintaining sobriety and recovery.
  - Coordinate client attendance at women- or youth-oriented self-help group meeting off-site
  - Invite guest speakers to promote the benefits from self-help processed that support recovery
  - Host a woman- or youth-oriented self-group meeting on site

### Clients Involved with the Justice System

The justice system includes accused or adjudicated clients who require various SUD services. Parole and probation status is not a barrier to SUD treatment services provided that the parolees and probationers meet the DMC eligibility verification and medical necessity criteria. For many people in need of alcohol and drug treatment, contact with the justice system is their first opportunity for treatment. Services can be provided through courts, probation or parole agencies, community-based or institutional settings, or in sex offender programs. In each of these situations, the individual is accountable to comply with a criminal justice sanction. Legal incentives to enter SUD treatment at times motivate individuals to pursue recovery, whereas for other offenders, arrest and incarceration are part of a recurring cycle of drug abuse and crime.

Ingrained patterns of maladaptive coping skills, criminal values and beliefs, and a lack of job skills may require a more intensive treatment approach for the justice



population, particularly among offenders with a prolonged history of substance abuse and crime. However, strong empirical evidence over the past several decades has consistently shown that the justice population can be effectively treated, and that SUD treatment can reduce crime.

Best practice is that staff working with justice populations receive specific training in working with criminogenic risk, need, and responsivity (RNR), as well as SUD and CODs. Staff also must be capable of integrating identified treatment goals with the goals of the involved agencies. As a result, it is critical for treatment providers to have a strong working relationship with probation and parole officers, judges, the court, and other legal entities involved in the client's care.

The first step in providing SUD treatment to people under justice supervision is to identify offenders in need of treatment. Comprehensive assessments incorporate issues relevant to justice involved individuals, such as assessment of criminogenic RNR, anger management, impulse control, values and behaviors, family structure and functioning, criminal lifestyle, and antisocial peer relationships. Assessments also pay particular attention to CODs, developmental and cognitive disorders, and traumatic brain injury.

In general, clinical approaches and the use of medication-assisted treatments must parallel those used with individuals who are not involved with the justice system, and a qualified counselor/clinician should determine the appropriate level of placement and interventions rather than court/probation requirements. Treatment interventions must be based on a multidimensional assessment and individualized needs. However, working with the justice population does have unique requirements that necessitate modified treatment approaches in order to meet their specific needs. Additionally, it is essential to collaborate with correctional staff to ensure that the treatment goals align with correctional and supervision case planning and/or release conditions (particularly involving the prescription of certain MAT).

Clinical strategies for working with justice clients may include interventions to address criminal thinking and provide basic problem-solving skills. Providers must be capable of using evidence-based practices designed to address SUD, mental health, and criminogenic needs. For example, motivational interviewing, cognitive behavioral therapy that focuses on both substance use and antisocial behaviors that lead to recidivism, trauma-informed care, and contingency management therapies.

Due to court mandates, classification policies and procedures, various security issues, and differences in available programming, one of the challenges of working with the justice population is determining when the ASAM Criteria can be meaningfully applied. The ideal scenario is for the level of care setting to match the severity of illness and functional impairment, similar to the general population. However, there are instances in working with offenders that necessitate close collaboration with correctional staff to provide services that are clinically appropriate and that also align with correctional and supervision case planning and/or release conditions. When skillfully applied, the ASAM Criteria can be used to access the full continuum of care in a clinically appropriate manner for the justice population.

Similar to other groups, treatment of offenders needs to be regarded as a dynamic, longitudinal process that is consistent with the chronic disease model of addiction. As such, effective treatment is expected to continue even after the legal issues for justice clients are resolved.

### Homeless Population

There is wide recognition that substance use in the homeless population cannot be treated apart from addressing the needs of the whole person in the context of his or her environment. A continuum of comprehensive services is needed to address the various safety, health, social and material needs of homeless clients. Common examples include assistance with accessing food, clothing, shelter/housing, identification papers, financial assistance and entitlements, legal aid, medical and mental health care, dental care, job training, and employment services. These services may be provided within the SUD program itself or through linkages with existing community resources. Proactive outreach, addressing needs in a non-judgmental and non-threatening environment, and addressing the various identified needs early in treatment may help to better engage this population.

On the whole, research demonstrates that effective programs for homeless clients address their substance use as well as their tangible needs (e.g., housing, employment, food, clothing, finances); are flexible and non-demanding; target the specific needs of subpopulations, such as gender, age, or diagnoses (e.g., COD/TAY/older adult populations); and provide longer-term, continuous interventions. As a result of these diverse needs, effective treatment for homeless clients must involve various disciplines and collaboration across agencies and organizations.

Stable housing is often critical to attaining treatment goals and is an important component of necessary services. Services that link clients to secure housing early in treatment tend to produce better outcomes, emphasizing the importance of case management in order to meet the varied needs of homeless clients.

Psychosocial interventions and MAT for homeless clients must mirror the approaches that are successfully used in other populations, with modifications to meet the unique needs of this population. Mobile outreach services are ideal, along with motivational enhancement interventions, in order to encourage continued treatment engagement. As a whole, the homeless population tends to be less responsive to confrontational approaches to treatment. Counselors and clinicians also must be mindful of the physical and mental health needs of this population, given high rates of co-morbidity for many homeless individuals. Medications should be used when clinically indicated, with prescribing practices that take into consideration the environment in which these medications will be used and stored (for example, care is to be taken to ensure that medications that require refrigeration are not prescribed when the client has no way to store such medications). Integrated interventions that concurrently address the multitude of medical, psychiatric, substance use, and psychosocial needs of homeless persons tend to produce improved outcomes compared to interventions that are provided sequentially or in parallel with other services.

In general, treatment for homeless clients with SUD is challenging, but successful outcomes can be achieved by prioritizing access to appropriate housing and providing comprehensive, well-integrated, client-centered services with uniquely qualified staff.

For these reasons, designated Recovery Centers and Perinatal programs throughout the county will provide Homeless Outreach Worker (HOW) services to assist with outreach and engagement in the community. Potential clients will be screened and then provided short-term case management and referral services as needed.

#### Lesbian, Gay, Bisexual, Transgender, Questioning Population

Lesbian, gay, bisexual, transgender, questioning (LGBTQ) populations tend to experience higher rates of substance use than the general population. The stigma and discrimination of being a member of a marginalized community such as the LGBTQ community causes some individuals to cope with these additional stressors by using substances. Furthermore, research has also shown that once LGBTQ clients do meet the criteria for a diagnosable SUD, they are less likely to seek help. These findings may be due to the various barriers the LGBTQ

population faces in seeking treatment, and unique needs LGBTQ clients have that may not be addressed by SUD programs.

In many ways, psychosocial and pharmacologic interventions (medication-assisted treatment) geared toward LGBTQ clients are similar to those for other groups. An integrated biopsychosocial approach considers the various individualized needs of the client, including the societal effects on the client and his/her substance use. Unless SUD providers carefully explore each client's individual situation and experiences, they may miss important aspects of the client's life that may affect recovery (e.g., social scenes that may contribute to substance use, prior experiences being discriminated against, a history of antigay violence and hate crimes such as verbal and physical attacks, etc.).

As with any client, substance use providers must screen for physical and mental health conditions in LGBTQ persons due to the risk of co-morbid health conditions. As a result of previously discussed challenges confronted by the LGBTQ community, members of this group do have higher rates of certain mental health conditions and are also at greater risk for certain medical conditions. Comprehensive screening and assessments can assist LGBTQ clients in accessing appropriate care for their physical and mental health concerns.

The methods of best practice outlined in counseling competency literature apply to all populations, particularly in working with LGBTQ clients. From this perspective, a counselor respects the client's frame of reference; recognizes the importance of cooperation and collaboration with the client; maintains professional objectivity; recognizes the need for flexibility; is willing to adjust strategies in accordance with client characteristics; appreciates the role and power of a counselor; appreciates the appropriate use of content and process therapeutic interventions; and is non-judgmental, respectfully accepting of the client's cultural, behavioral, and value differences.

There are also some unique aspects of treating LGBTQ clients that providers must be aware of. For example, while group therapies should be as inclusive as possible and should encourage each member to discuss relevant treatment issues or concerns, some group members may have negative attitudes toward LGBTQ clients. Staff members must ensure that LGBTQ clients are treated in a therapeutic manner and group rules should make clear that homophobia is not to be tolerated. The LGBTQ client (and not the other group members) is solely responsible for deciding whether to discuss issues relating to his/her sexual orientation and/or gender identity in mixed groups. Although providing individual services decreases

the likelihood that heterosexism/homophobia/transphobia will become an issue in the group setting, there is also an opportunity for powerful healing experiences in the group setting when LGBTQ clients experience acceptance and support from non- LGBTQ peers.

Elements of treatment that promote successful treatment experiences for the LGBTQ client include cultural sensitivity, an awareness of the impact of cultural victimization, and addressing issues of internalized shame and negative self-acceptance. Cognitive-behavioral therapies challenge internalized negative beliefs and promote emotional regulation, which can be helpful for relapse prevention. Motivational enhancement techniques may also encourage treatment engagement in this population.

### Veterans

Although veterans share commonalities, their experiences are as varied and unique as their needs. Some veterans may have experienced combat in one or more wars, while others may have served in non-combat roles. Likewise, some veterans may have experienced injury, including traumatic brain injuries (TBI), loss of limb, or other physical injury, while others may have emotional scars. In particular, gender may also influence veteran experiences, as reports of women veterans who have experienced sexual harassment and/or physical and sexual trauma are becoming more common. As a result of the cumulative effects of these events and experiences, veterans and family members may develop SUD and present to treatment with a unique set of needs and circumstances that must be addressed.

Under certain circumstances, veterans may be ineligible for Veteran's Administration (VA) benefits due to a dishonorable discharge or discharge "under other than honorable conditions," among other circumstances. Additionally, some veterans and family members may attempt to secure services from SUD treatment programs due to the long wait times at the VA. Regardless of the situation, SUD treatment providers should work to ensure that the services provided address the varied and unique needs of individuals.

While substances of abuse vary, veterans may abuse sedating substances such as prescription drugs in efforts to address untreated/under-treated anxiety or other mental health conditions. Additionally, co-occurring physical health conditions and injury may increase rates of prescription drug and opioid abuse, including the use of heroin, and thus certain veterans may be at higher risk for fatal overdoses and may be appropriate candidates for medication-assisted treatments.

Given the higher likelihood of trauma, physical and behavioral health complications of the veteran population, SUD providers perform thorough assessments that encompass the full range of complications that may be present. For example, assessments may include questions concerning trauma, combat or war experiences, or injuries that may impact the client's participation in SUD treatment. If the client reports (or it is determined that) injuries exist that may impact treatment, the SUD treatment provider should work with other providers (e.g., medical, mental health) to coordinate care, which is often particularly critical in this population.

Veterans may also have different reasons for their substance use, such as untreated/under-treated physical injury or mental health issue. Stigma is often an additional complicating issue. Although stigma exists around substance use, within the military stigma often also exists for seeking help for any health condition. Anger or personality disorders may also be present, further making treatment engagement difficult. In these instances, effectively engaging veterans and utilizing evidence-based techniques, such as motivational interviewing, will be critical to treatment success.

In summary, treatment providers may need additional training to fully understand the nuances of the veteran population and how their experiences impact their behaviors in order to adequately treat veterans and their families.