New York State
Office of Alcoholism & Substance Abuse Services
Addiction Services for Prevention, Treatment, Recovery

Clinical Guidance
October, 2012

This document is a resource for providers to support quality clinical practice consistent with the part 822 regulations. It was developed collaboratively with input from the Administrative Relief Group, Clinical Advisory Panel, many other individual providers and OASAS staff.

OASAS supports a broad range of philosophies and approaches to Substance Use Disorder treatment. Treatment approaches should be patient-centered and based on the best evidence available. OASAS recognizes that many treatment approaches, based on very different philosophies, have been shown to be effective in helping patients to recover. Ideally, patients should have choice in the approach taken, and access to alternative approaches should one fail to produce the desired outcome. Treatment should support a wide range of patient goals and preferences, as well as, ways that honor cultural and community values and norms.

Regardless of approach, the goal is to provide care that will engage and support patients throughout the process and stages of their recovery. OASAS is interested in reducing adverse discharges particularly adverse discharges together with programs reviewing their thresholds for continued care. OASAS actively supports the use of practice- based evidence that monitors for improved patient outcomes, better quality of life, patient perception of care, and outcomes in all functional areas.

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Introduction

Regulations are intended to identify minimum standards by which programs must operate. They lay a foundation for the provision of adequate care for patients. They are based on principles of quality care, but do not offer guidance on how programs should interpret them clinically. The following document was prepared by OASAS and a group of outpatient providers to establish clinical standards of care, to support excellence in clinical care, and to further clarify the intent of regulations. This clinical guidance document is based on the principles of patient-centered, recovery oriented care which includes a continuum of self-directed approaches that 1) respect the role of personal choice and commitment in the pursuit of wellness; 2) recognize the critical role of family and other relationships; and 3) demonstrate commitment to evidenced-based and culturally competent care.

Engagement

The opportunity to engage the patient begins with the initial request for services. In most cases, the patient will call the program requesting an appointment. The receptionist or clinician that answers the phone performs a critical function for the agency as first impressions count. Friendly, non-judgmental and welcoming staff sends a message that your program wants to help. They also increase the likelihood that prospective patients will show for their assessment appointment. OASAS has developed a Walkthrough tool-kit to help providers understand the patient perspective on what it is like to access services at your program. This patient simulation exercise includes processes such as calling your facility for an appointment, finding your facility, and entering your waiting room. The tool-kit may be accessed at:

http://www.oasas.ny.gov/hps/cos/WSCwalkthrough.cfm#toolkit

In addition, OASAS recommends that patients be scheduled for their initial appointment as soon as possible. The research indicates that there is a greater likelihood that a patient will attend their initial appointment if it is within 48 hours of the initial phone call (Festinger, et al. 2002). Given most patients' ambivalence about treatment, it is critical to capitalize on their motivation for treatment. Longer delays increase the risk that motivation will decrease. If a program cannot schedule the initial assessment visit within 48 hours, a reminder phone call to the prospective patient is recommended. It is important to recognize that patients in early recovery may have cognitive deficits that may impact their ability to keep appointments.

Admission Assessment and Initial Services

The goal of the admission assessment is to make the patient feel welcome and to engage her/him through an exploration of the referral circumstances and the problem as she/he understands it. The assessment is focused on gathering information necessary to inform an admission and level of care decision.

The admission assessment should focus on gathering information necessary to make a diagnosis of Substance Use Disorder and to determine the likelihood that the patient will benefit from outpatient Substance Use Disorder treatment and identify the most appropriate level of care. Patients who present at an outpatient clinic in need of a higher level of care should be engaged in the treatment process throughout the referral and program staff should follow-up to ensure that linkage has occurred. In most cases, the client will return to the outpatient clinic after detox, inpatient or residential services.

When the patient is determined appropriate for admission, the initial assessment should lead to an initial service plan focused on the patient's most urgent needs, barriers to recovery, medical and mental health needs and/or other emergent needs. The initial service plan should focus on the Substance Use Disorder, the presenting patient problem, and any other priority areas identified in the initial assessment.

The goal of the initial stage is to engage the patient in treatment, identify barriers to treatment engagement, build motivation for positive change, and develop a therapeutic alliance. The assessment information should include an analysis of priorities, what supports are necessary to accomplish these priorities, motivating factors, and barriers. The alliance is built around a good therapeutic relationship, mutually agreed upon client centered goals, and a realistic means to achieve those goals. Recovery oriented goals should involve *real life outcomes* in social, educational, vocational, housing, health etc. areas rather than system-oriented outcomes. Life areas addressed on the plan should follow from the needs and barriers discovered through the assessment process.

The initial period of treatment should lay the foundation for continuing Substance Use Disorder treatment. The work done with the patient during the initial treatment period of 45 days involves:

- Communicating hope that the patient can achieve goals and improve the quality of his/her life.
- Engaging the patient in the treatment process;
- Retaining the patient in the crucial initial treatment phase;
- Increasing patient intrinsic motivation for change;

- Establishing goals and a road map for action based on the patient's view of the problem and his/her strengths;
- Establishing a strong therapeutic alliance between the patient, service providers and, when appropriate, group members;
- Addressing issues in early recovery including initial health and mental health needs
- Identify resources, including people in the patient's life, who can support recovery efforts

A presenting problem is what the patient reports as the reason(s) for presenting to treatment (or evaluation) and the circumstances surrounding them. The patient may have a different perception of the problem than the counselor expects and this can lead to conflict, confrontation and patient defensiveness. Guiding the interview toward a deeper understanding of the problem can decrease the likelihood of these breaks in the therapeutic alliance. Clinical methods such as motivational interviewing (Miller and Rollnick, 2002) are useful in helping the patient and counselor work collaboratively during the assessment.

An exploration of the patient's ambivalence about treatment and change may be critical to establishing a therapeutic alliance and facilitating progress. Ambivalence about change is often present with substance use disorders and reflects the reasons substances have been used despite the negative consequences. This empathic approach can strengthen the therapeutic alliance, lead to alternative strategies for addressing problems that contribute to ongoing substance misuse and help the patient move from pre-contemplation to action. Exploration of ambivalence supports a therapeutic alliance and can be done through clinical interviewing techniques (Tatarsky & Kellogg, 2010) or methods for doing this "cost-benefit analysis" such at the Decisional Balance (Janis & Mann, 1977).

Recovery Oriented Health and Wellness

Health and wellness is best achieved and sustained through individualized, person-centered care. Personal responsibility should be fostered by encouraging partnerships with appropriate health services and by adopting prevention, early intervention and ongoing health promotion activities. All patients should be guided to initiate and maintain behaviors that enhance health and wellness, including appropriate nutrition, physical activities, sleep-pattern regulation, and stress management. It is also important to include family members or other individuals who may play a role in supporting the patient's recovery in helping to establish an orientation to long-term health and wellness.

Importance of Practicing Cultural Competence

In 2001, The *Surgeon General Supplemental Report on Culture, Race and Ethnicity in Mental Health* reported that ethnic and racial minorities: 1) have less access to and are less likely to receive needed mental health services; 2) often receive poorer quality of care; 3) are underrepresented in research; and 4) experience a greater burden of disability (1). SAMSHA recognizes that in chemical dependency settings, "culture plays a significant role in determining the adult's view of the problem, treatment, and how cultural factors influence the adult's request for help" (2).

Defining Cultural Competence

Cultural competence is the ongoing practice of integrating knowledge, information, and data from and about individuals, families and communities. This information is transformed into specific clinical standards and practices, skills, service approaches, policies, and outreach strategies that match the service population and increase the quality and appropriateness of care.

Challenging 1st Step

Cultural competency cannot occur without people confronting their own biases and prejudices. Historically, education and training in this area has remained in the cognitive and objective domain, preventing self-exploration (3). In order to achieve cultural competence, helping professionals must demonstrate the courage to examine themselves before they can hope to provide adequate services to a diverse population.

Patient Centered Interview

A patient-centered interview is a face-to-face meeting with the client to determine what type of services, if any, are appropriate. The clinician conducting the interview should consider race, ethnicity, language capability, religion/spirituality, gender, gender identity, sexual orientation, social role, age, physical or cognitive ability, and socio-economic status when working with a client to make this decision.

A patient-centered approach to the delivery of services also means that people are entitled to recovery services that are relevant to them. Knowledge, information, and data, from and about individuals and groups, should be transformed into clinical standards, service approaches, and marketing programs that match the communities and people living in them. Doing so increases the quality and appropriateness of health care and improves health outcomes.

The interview should include an exploration of reasons for the referral, history of use, prior attempts to resolve the chemical use problem, including attempts to cut down and self-help involvement. Although the patient may not accept that a substance use disorder exists, the determination of the need for treatment should be based on objective information gathered during the interview and from significant others and collateral contacts. The following chart highlights the differences between a patient-centered interview and an interview that is not patient -centered.

Patient – centered	**Not patient-centered**
Focused on the problem and circumstances of referral as the patient sees it	Focused on the interviewer's beliefs about the patient's problem and circumstances
Follows the patient content naturally as the story unfolds – guided by the interviewer	Follows questions on an intake form or other structure as directed by the interviewer
Interviewer believes that the patient has knowledge about the problem that will contribute to it's solution	Interviewer believes that patient is unaware of the problem and/or his/her defenses are such that he/she cannot, or will not, find solutions
Leads to treatment plan that is individualized and based on the patient understanding of the problem and it's resolution	Leads to a treatment plan influenced by the treatment offered in the program

Comprehensive Evaluation

During the first 45 days of treatment, the primary counselor and patient should continue to work together to gather history, refine an understanding of the patient's problem, and identify strengths and supports. The comprehensive evaluation provides a more thorough description of the patient and his/her environment. This evaluation should lead directly to a comprehensive, individualized recovery plan that incorporates the patient's unique strengths, supports, and problems.

(1) An update of the information addressed in the initial assessment;

The information gathered during the initial assessment should be updated as a more comprehensive understanding of the patient is developed. Initial information was focused on the presenting problem, substance use history, recent pattern of use (including tobacco), mental health screening results and other priority issues. At a minimum, the comprehensive evaluation should provide an update of the presenting issue, whether it has been revised, and the status of progress. By this point in treatment, the patient and counselor should have a more thorough understanding of the substance use problem and the patient may have made progress toward increased motivation for resolving the problem. This should be reflected in the comprehensive evaluation. In addition, how the patient has previously succeeded in sustaining recovery in the past should be included. Finally, if medical and mental health issues have been identified, the evaluation should include a description of what these problems are, how they relate to Substance use disorder and how to best address them in the context of Substance use disorder treatment.

(2) Substance Use Disorder

Over the initial phase of treatment, the patient should have the opportunity, during group and/or individual sessions, to explore the negative consequences of Substance use disorder (including tobacco) on self and others. The nature of the impact of use on the patient's life should be documented here. This creates an opportunity to assess family and significant others that may be supports for recovery. The improvement of significant relationships can be a powerful motivator for change.

Clinicians should continue to explore patient ambivalence about change, as this may change over the course of treatment and become easier to discuss as the therapeutic alliance grows stronger. As patients become more trusting of the clinician, they may feel freer to reveal sensitive mental health issues that may be reflected in ambivalence about changing. Supports for recovery should be explored.

(3) Physical and Mental Health

Medical staff (including nurses) should be involved in the patient care through the multi-disciplinary case conference and should review the patient's health history and medical records. If medical conditions are identified , they should be documented and included in the treatment plan with goals and objectives for addressing them. Through this process, a medical staff person may meet with the patient individually to further assess or treat the patient's condition. Additionally, patients presenting with alcohol or opiate dependence with a relapse history, or who report urges and cravings to use, should be seen by a prescribing professional to evaluate whether they may benefit from addiction medication. Patients who have screened positive for a mental health disorder, or who have symptoms, should be assessed by a qualified staff person or such an assessment should be arranged.

Current chronic or acute conditions, infectious diseases, and risk should be assessed as part of the comprehensive assessment. Program medical staff can directly provide services such as disease management, disease support, and health education, or they can refer the client to an outside provider and coordinate this care with that of the substance use disorder treatment program.

A brief Mental Status Exam including an assessment of current lethality (Danger to self or others)

The mental status examination (MSE) is a systematic evaluation of the individual's mental functioning conducted partly by asking questions and partly by observing and listening; its findings are directly applicable to both mental health and substance use assessment and treatment plan development. A mental status exam describes the patient's current physical appearance, and cognitive and affective functioning. The regulation requires a brief mental status exam for the purpose of better assessing the patient and planning for treatment needs. There are many MSE formats available and a brief MSE should address the following:

- Appearance
- Attitude
- Behavior
- Mood and Affect
- Speech
- Thought Process
- Thought Content
- Perceptions
- Cognitions
- Insight
- Judgment

Lethality Assessment

The clinician should ask, through screening or during the interview, if the patient has ever had thoughts of harming self or others. If there is a positive response:

- ask the patient to describe the nature of these thoughts;
- ask if the thoughts are currently present;
- ask if she/he has ever acted upon these thoughts and, if so, the history and consequences of the actions;
- if patient has attempted suicide before, determine the lethality of the attempt, as well as the level of "secrecy" of the attempt;
- ask if he/she intends to act upon the current thoughts;
- ask if he/she has a plan to act and what that plan consists of

In general – all thoughts of harming self and/or others should be taken seriously, but risk is thought about in a hierarchy. For example, a history of thoughts with no current thoughts should be identified and explored, but present less risk than thoughts that are currently present. Similarly, thoughts present without intent to act are less serious than thoughts present with intent. Finally, intent to act is always serious but presents less risk than intent with a plan to act. In addition, past suicide attempts that were not secret and less lethal present less risk than attempts that were kept secret and more lethal. Any person who has current thoughts of harm should be evaluated by a mental health professional. Anyone presenting with intent and/or a plan needs to be evaluated immediately.

(4) Vocational/Educational/ Employment

The counselor should work with the client to identify vocational/ educational, financial security, adequate housing and health insurance strengths and weaknesses. Productive work or engagement in a vocational or educational program is key to a successful recovery. All patients should be assessed for current functioning in this area.

(5) Family/Social

Family and social functioning are important to supporting recovery. The assessment should include current family relationships including any treatment involvement, current use patterns within the family, or current recovery environment and history of family conflicts and strengths. Social supports including experiences and preferences for peer support groups, faith communities and religious organizations, and sober recreational activities should be assessed to provide support for recovery.

(6) Legal

Many patients present with legal involvement; the circumstances surrounding criminal or family court involvement should be explored. The patient's attitude toward the legal system should be explored, Goals and motivation for working within legal mandates should be addressed.

(7) Gambling History

The gambling assessment should include age of first onset, duration/frequency of gambling, gambling methods, patterns, triggers (e.g., peer pressure, depression, life crisis, etc.), consequences, history of previous attempts to stop gambling, patient's perception of gambling, self-help involvement, prior treatment and/or mutual aid history, how has psychoactive chemical use been impacted by or impacts gambling behavior, and history of gambling by, and the impact of gambling on, significant others. The financial impact of gambling should also be assessed. Diagnostic Criteria for pathological gambling is classified as an Impulse Control Disorder and can be found in the latest version of the Diagnostic Statistical Manual (DSM), diagnostic code 312.31.

Treatment Planning

What is a Treatment Plan?

A person-centered Treatment Plan is a holistic, culturally sensitive plan that respects the role of personal choice and commitment in pursuit of recovery. It includes selected family members and/or supportive others, utilizes community recovery support services, if needed, and is facilitated by capable, knowledgeable staff. Treatment plans should be developed with the patient's full participation and based on the patient's needs, strengths, motivation and goals.

The written document:

- identifies the client's most important goals for treatment;
- describes measurable, time sensitive steps toward achieving those goals;
- provides a map for treatment as agreed upon by counselor and patient

Treatment plans should be considered living documents that provide a map for the course of care. Each visit should relate to the plan.

A checklist for treatment plans is included as an appendix and here by link:

http://www.nattc.org/aboutUs/blendingInitiative/matrs/CHECKLISTMATRS.pdf

Multi-Disciplinary Team

One of the great strengths of OASAS Certified Outpatient Clinics and Opioid Treatment Programs is the multi-disciplinary team. Substance use disorders (SUDs) and gambling related problems are often described as bio-socio-emotional-spiritual disorders. People and family members affected by these problems often present with multiple and complex needs.

The multi-disciplinary team offers expertise and skills represented from different professional training and experience to develop a more comprehensive understanding of the needs and strengths of the patient. It ensures that the treatment/ recovery plan is individually

responsive, patient-centered and best able to incorporate the identified strengths and resources in addressing the apparent needs and barriers to recovery.

Individual clinicians, regardless of training, skills and experience, cannot substitute for the combined training, experience and skill represented in the multi-disciplinary team. Therefore, the treatment plans are required to be approved, signified by dated signatures of the multi-disciplinary team members participating in the approval. Although the PART 822 regulations do not require that subsequent treatment/recovery plans reviews also be approved by a multi-disciplinary team, it is a preferred practice for the multi-disciplinary team to participate in all treatment/recovery plan reviews.

Additional valuable roles of the multi-disciplinary team include participating in decisions to maintain a person in IOS for more than the approved six week period, transfer a person into or out of outpatient rehabilitation services, change the intensity or current level of care, review the current care when individuals are failing to make expected progress in treatment, or are failing to adhere to reasonable program rules and expectations, or are being considered for discharge from outpatient care.

Progress Notes

Progress notes, in order to qualify as evidence of services delivered for reimbursement, must document a face-to face visit with an active patient. Such notes are not mere statements of fact or documentation of dialogue between the clinician/ medical and nursing staff and the patient. They are intended to document the clinician's assessment of what transpired during a counseling session, including mutually agreed upon strategies for change. Therefore, progress notes document a client's progress toward treatment plan goals. Further, progress notes should describe the client's unique course of treatment and follow a logical chronology of goal attainment.

Progress notes are recorded in the patient's file following every individual, family or group service. The purpose of the progress note is to document what occurred during that session in relation to the goals indentified in the treatment plan. The following kinds of information are included in a progress note (further guidelines reflective of goals and approaches identified in the treatment plan and examples appear below):

- counseling session duration which can be documented as start and stop times;
- medication prescription and monitoring;
- the modalities and frequencies of treatment furnished;
- results of clinical tests; and
- a summary of the following items:
    - o diagnosis;

- functional status;
- symptoms;
- prognosis; and
- progress to date

Progress notes may be structured, using the SOAP or DAP models, or unstructured.

NOTE: *For SOAP and DAP notes below: make sure they have a parallel structure (i.e., either written in the language that the clinician would use in an actual progress note, such as the S and O in SOAP below, or in the language of description, such as in the A and P in SOAP below.*

SOAP - Notes are structured as follows:

Subjective - The client reports…

Objective - Urine screen was negative for substances of abuse.

Assessment - Counselor formulates how both objective and subjective material are related to the treatment plan and implications for further treatment. The assessment should include patient response to specific interventions and any changes that will be made to the planned intervention

Plan - documents what specific interventions are planned for subsequent visits.

DAP - Notes are structured as follows:

Description – What was the focus of the session, may document a problem, issues, results of an assignment or other material discussed in the session

Response – May be woven into the description or separated. It is the response of the counselor to the patient material. Documents what the counselor did in the session to respond to the patient. The response should be related to the treatment plan and overall approach described in the plan.

Assessment – Documents the counselor understanding of the meaning of the material covered to the patient and progress toward goals.

Plan - Documents what will occur next. This may include planned focus of next session or homework assigned.

Coordination of Care Notes

While not specifically referenced in the regulations, good clinical practice includes documentation of a variety of occurrences and communications that do not occur during treatment sessions These might be referred to as “activity notes” and may include documentation of telephone or other verbal communications with the consumer, family members, their significant others, referral sources, consumers’ medical providers, other behavioral service providers, criminal justice agencies, and others. These notes might also be used to document outreach efforts for consumers who have missed appointments, and to describe

events for incident reporting purposes.

Discharge Planning

Discharge planning should begin early in treatment. The primary counselor should begin to consider what recovery and community resources will be needed to support the patient's long-term recovery. Whenever possible the patient should begin to actively engage with these supports while still in treatment so that the patient's response and effective use of the supports can be assessed and adjustments can be made, if necessary. All treatment plan dimensions should be considered when determining needed supports. The discharge plan should include resources that have been helpful to the client in the past. The discharge plan should also include any follow-up actions to be taken by the primary counselor to ensure that appropriate linkages are made. The discharge plan should be developed with the patient and should reflect the patient's unique needs, values and recovery philosophy. It should also clearly identify ongoing medical concerns and medication with specific referrals for follow-up and a plan to coordinate the referral.

Recovery Supports and Living Environment

The discharge plan should address how the patient will continue to support recovery following treatment. This should include a plan for ongoing formal support through mutual recovery groups, recovery centers, alumni associations and informal supports with which the patient has connections, including churches, social or recreational groups, family and community organizations, etc. Throughout treatment, the patient should assess his/her living environment to build strategies and supports to ensure as supportive an environment as possible. The discharge plan should include specific steps the patient will take, or will continue to take, to minimize risks in the environment and maximize supports.

Quality Improvement and Utilization Review

Examples of accepted models of Quality Improvement and Utilization Review include the Plan-Do-Study Act Model (PDSA) developed by the Institute for Healthcare Improvement and the NIATx Model developed by the University of Wisconsin.

PDSA Model: The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change by planning it, doing it, evaluating the results, and acting upon what is learned. This is the scientific method used for action-oriented learning.

For more information on the PDSA model: http://www.ihi.org

NIATx Model: The NIATx model is designed to improve access to and retention in behavioral health treatment by making process improvement part of the service culture. The NIATx model aims to reduce the wait time between a client's first request for service and the first treatment session, reduce client no-shows, increase admissions, and increase the treatment continuation rate between the first and the fourth treatment sessions. By improving these organizational processes, the NIATx model reduces barriers to treatment that, in turn, reduces duplication of effort, identifies systems that no longer work, and increases the chance that new systems are effective from the outset. These improvements reduce frustration for patients who need care as well as for administrators, clinicians, and staff striving to help these patients.

For more information about the NIATx model: https://www.niatx.net (University of Wisconsin, 2008)
Measures For Quality Improvement:

NIAAA: TYPES OF QUALITY MEASURES

From:
http://pubs.niaaa.nih.gov/publications/arh291/19-26.htm

Structural Measures

Structural measures refer to the features of a health care organization that determine its capacity to provide care, such as the existence of an electronic records system or the ratio of AOD treatment providers to clients.

Process Measures
Process measures are used to assess how well a health care service adheres to recommendations for clinical practice. These recommendations are based on research or consensus (i.e., the views of experts when the research evidence is lacking or inconclusive) regarding the probability that providing particular services will achieve the desired outcomes. Generally, process measures are expressed as rates, with the denominator defining a population that is of interest because of its demographic and clinical condition, and the numerator defining the subgroup receiving specific services.

Process measures are particularly important because they can be used to identify specific areas of care that may need improvement. For example, if clients are not returning after an initial service, outreach efforts could be mounted in an effort to retain clients in treatment. Moreover, the data to calculate process variables can often be obtained as part of an administrative data system that includes information on clients' dates and types of treatment services. Recently, researchers have developed processes by which a range of stakeholders (e.g., clinicians, specialists in measurement) can work together to select core sets of process measures for common use based on analyses of how meaningful and feasible different process measures are (Hermann et al. 2004).

Outcome Measures

Outcome measures are generally used to evaluate the state of a patient's health resulting from the interventions received. In general, outcomes can be considered both in terms of patient functioning and in terms of categories of symptom severity related to the patient's clinical problem. For AOD disorders, health outcomes include four areas:

1) sustained reductions in AOD use;
2) improvements in personal health;
3) sustained improvements in functioning (e.g., employment); and
4) sustained reductions in threats to public health and safety (McLellan et al. 2005).

Access Measures

Access measures assess the extent to which a person who needs care and services is able to receive them. This type of measure is particularly important for addictive disorders because of the large gap between those who have serious problems and those who actually use any services.

Patient Experience Measures

These measures are aggregated from patients' reports about their observations of, and participation in, AOD treatment.
Perception of Care-content for inclusion in the CAP

The 2006 Institute of Medicine (IOM) report (2006 IOM) provides recommendations for improving substance abuse and mental health services in seven strategic areas. Among its recommendations for patient-centered care is: Involve patients and their families in the design, administration, and delivery of treatment and recovery services. (p. 126) Recommendations for enhancing the quality improvement infrastructure include that providers use measures of the processes and outcomes of care to continuously improve the quality of care provided. (p. 179) Well designed and implemented perception of care surveys provide an opportunity for involving clients in improving both

the quality and effectiveness of services while being responsive to the IOM recommendations.

Obtaining client feedback is a standard in the health care field. Accreditation bodies require treatment organizations to routinely obtain input from their stakeholders, especially clients. OASAS certified programs are required to develop an annual quality improvement plan and to collect and use on a quarterly basis client satisfaction data as part of the quality improvement process. OASAS is intent on building its capacity to support providers in implementing effective perception of care surveys as part of their quality improvement processes. OASAS developed a web-based client perception of care system utilizing the federal modular survey developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) in collaboration with the Forum on Performance Measures for Behavioral Health and Related Service Systems. The tool, known as the Substance Abuse Perception of Care Survey, measures five domains: access and quality; perceived outcomes; social connectedness; readiness for change and program recommendation. It also provides three open-ended qualitative questions for clients to describe both strengths and weaknesses of the programs they are receiving services from. The survey was developed using item response theory (IRT), the state of the art for knowledge testing and attitude measurement. IRT is especially important when a survey will be used across different populations or to compare responses over time. A four-point response scale is used (disagree, somewhat agree, agree and strongly agree) instead of the typical Likert scale in order to avoid the "ceiling effect" that limits improvement measurement. The development of the survey tool, including its psychometric methods and results, are documented in a white paper available on request.

A provider using the OASAS online system will be able to collect and analyze their own client survey data in 'real-time'. Each provider will be able to set their own sample targets based upon their monthly census and then monitor their data to ensure completion of the sample size. A series of graphical indicator reports can be generated to view the data in colorful charts and results may be compared across different programs. In addition, the system offers the capability to view trends over time and improvement within a program over time. The ability to filter client data utilizing demographic data is so a feature of the system. For example, a program may desire to examine feedback from Hispanic males in a certain age group that have been in treatment less than one month. The system will facilitate the analysis of the data and provide a graphical report for further analysis. All of the reports may be printed and displayed or shared with clients thereby creating a feedback loop back to the clients. Next steps could include the development and implementation of a change team; inclusive of clients, to test strategies

to impact the perception of care findings. Re-administration of the survey will then provide comparative data to help the program determine if they are moving in the right direction. Leadership of the program should routinely analyze the client feedback and use the data for program planning, performance improvement, strategic planning, organizational advocacy, financial planning and resource planning.

Programs may access the new online system at the OASAS Applications pages. Provider administrators should complete an IRM-15 to access the system and resource guides on how to use the system.

Utilization Review

Utilization Review (UR) is a check to ensure that the agency's admission, retention and discharge policy and procedures are consistently applied and implemented. The utilization review process should be as independent as possible to ensure that the review is a separate and objective review of the original primary counselor and multidisciplinary team's decisions. The UR entity may be a contracted outside agency or internal review entity and must consist of at least one qualified health professional. If the review is completed by an internal entity, they must not review their own cases.

The review should include a check on the documented progress of the patient to justify continued treatment. The reviewer should consider whether the patient is at the appropriate level of care, still in need of the current service level, and making sufficient progress to warrant continued care at the current level of service. If the reviewer finds that the documentation found in the case record does not support continued care at the current level, the chart should be referred back to the primary counselor for additional documentation to support the current plan or the counselor must take immediate action to discharge and or refer the patient to appropriate services.

Medication-Assisted Treatment

Medication-assisted treatment is pharmacotherapy in combination with counseling, behavioral therapies and recovery support services. It provides the patient with a comprehensive and "whole-patient" approach to treatment in addressing substance use disorders. MAT is clinically driven, evidence- based, and focused on the patient as an individual with the ultimate goal of patient recovery and full social functioning.

When conducting an assessment in the clinical setting, information collected should include the frequency and intensity of alcohol and substance use disorder cravings and urges that may impact the patient's ability to succeed in treatment. Clinical staff in outpatient substance use disorder treatment programs should be knowledgeable of available addiction medications, the mechanisms of actions of those

medications and the evidence-based practices supporting their use.
Medication-assisted treatment for opioid dependence refers to the use of buprenorphine, methadone or naltrexone to treat opioid dependence. These medications are approved by the federal Food and Drug Administration (FDA) to treat opioid dependence. Research indicates that if patients leave treatment too early or do not receive simultaneous, evidence-based counseling and recovery support services to prevent recurrence, they tend to return to acute addiction. . All patients who present with an opioid use disorder should have an established relationship with a medical provider the program. Patients who do not have a primary care physician should be referred to a physician for a medical evaluation. The purpose of this evaluation is to assess general physical health, medical conditions secondary to substance use disorder (particularly intravenous use), and the potential benefit of medication- assisted treatment.

Medication-assisted treatment for alcohol dependence refers to the use of acamprosate (Campral), naltrexone (Depade, Vivitrol, ReVia), and disulfiram (Antabuse). Patients with an alcohol use disorder who either have a history of relapsing, report strong urges and cravings to use, or lack confidence in their ability to stop using, should also be considered for referral to a physician (e.g., program medical staff, primary care physician or a community medical provider) who will assess for appropriateness of medication assisted treatment.

Medication assisted treatment has proven to be most effective when a team of clinical staff comprised of medical, counseling and support staff offer a full range of services including medication, counseling and referral. All staff should be trained in the effective use of medication - assisted treatment. Nurses can play a critical role in the clinical aspects of medication systems supervision, coordination of care and treatment planning. Further, medical personnel should be consulted in the formulation of policies and procedures for the use and storage of medication in accordance with federal guidelines.

Medication assisted treatment, when made available to appropriate individuals and provided in the proper setting, has proven to be safe and effective. Using a holistic comprehensive treatment program model, MAT has been shown to:

- Improve survival;
- Increase retention in treatment;
- Decrease illicit drug use;
- Decrease hepatitis and HIV seroconversion;
- Decrease criminal activities;
- Increase employment; and
- Improve birth outcomes with perinatal patients.

List of Links

TAP 30 Center for Substance use disorder Treatment - Buprenorphine: A Guide for Nurses

http://buprenorphine.samhsa.gov/TAP_30_Certified.pdf

Substance use disorder and Mental Health Services Administration: Buprenorphine

http://buprenorphine.samhsa.gov/

OASAS: Addiction Medicine – Addiction Medications

http://www.oasas.ny.gov/AdMed/meds/meds.cfm

OASAS: Addiction Medicine – Physician Resources

http://www.oasas.ny.gov/AdMed/cme.cfm

TIP 40: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction: Treatment Improvement Protocol (TIP) Series

http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A72248

TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs: Treatment Improvement Protocol (TIP) Series

http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A82676

http://www.kap.samhsa.gov/products/manuals/tips/pdf/tip43_erratum_10_08.pdf

TIP 49: Incorporating Alcohol Pharmacotherapies Into Medical Practice: Treatment Improvement Protocol (TIP) Series

http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A92752

Medication-Assisted Treatment for Opioid Addiction: Facts for Families and Friends

http://kap.samhsa.gov/products/brochures/pdfs/med_assisted_tx_facts.pdf

Psychotropic Medications

Programs that provide integrated co-occurring disorder treatment should have the capacity to assess and treat co-occurring mental health disorders. This includes the ability to assess patients for the need for a psychotropic medication and when indicated, ongoing psychotropic medication management to support substance use disorder treatment and recovery. Programs that provide integrated treatment should train clinical staff in the pharmacology, indications, classes and side-effects of psychotropic medications and ensure that staff is comfortable integrating them into substance use disorder treatment.

Resource for psychotropic medications:

http://www.samhsa.gov/co-occurring/docs/Pharm_Principles_508.pdf

Clinical Supervision

To position clinical supervision, within the system of prevention, treatment, and recovery-oriented services, as integral to a continuous learning culture that encourages professional develop- ment, service improvement, and quality of care, maximizing benefits to the client.

~OASAS Clinical Supervision Vision Statement

There are many definitions of clinical supervision in the literature. Bernard and Goodyear (1998) propose the following:

Supervision is an intervention that is provided by a senior member of the profession to a junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of junior member(s), monitoring the quality of professional services offered to the clients she, he or they see, and serving as a gatekeeper of those who are to enter the particular profession.

The definition includes the purpose of the supervisory relationship as well as establishing that there is a power differential. Clinical supervision includes monitoring and evaluative functions as well as acting as a "gatekeeper" for the profession. The counselor-supervisor relationship shares some similarities with that of the counselor-patient relationship. In both relationships, one person is responsible for helping to promote growth and change in the other person. The relationships also share the difference in power between parties that requires adherence to ethical guidelines for respecting boundaries and creating a "safe" relationship in which one can explore vulnerabilities as well as to celebrate successes.

According to Bernard and Goodyear (2004), clinical supervision has two main objectives: 1) fostering the professional development of the supervisee; and 2) ensuring the welfare of patients. The supervisor works with the counselor to improve clinical skills with the goal of improving the counselor's ability to have a positive impact on patient care. They also monitor the quality of counselor/patient interactions to ensure that patients are making progress and are not harmed by the counselor.

The relationship in supervision is as important as the relationship in clinical work. The same warmth, genuineness, acceptance and nonjudgmental attitudes that are effective in gaining an alliance with a patient work to develop trust and an alliance with a supervisee. Gallon, Hausotter, and Bryan (2005) propose a list of important characteristics of a healthy supervisory relationship including:

- bi-directional trust, respect and facilitation;
- a commitment to enthusiasm and energy for the relationship;
- an adequate amount of time committed to supervision;

- sensitivity to supervisee's developmental needs;
- encouragement of autonomy;
- sense of humor;
- comfort in disclosing perceived errors;
- clarity of expectations, and regular feedback;
- a non-defensive supervisory style; and
- a clear understanding of the rights and responsibilities of both supervisor and supervisee.

David Powell has written extensively about clinical supervision as it specifically relates to addiction counselors. He advocates a developmental model of supervision that takes into account the counselor's level of experience and stage of professional development.. Powell and other proponents of a developmental model argue that counselors will move through stages as they develop and will need different approaches from their supervisor accordingly. Counselors who are early in their career will need an educational approach while those later in their career will need a more egalitarian approach as they move towards increasing autonomy.

Powell states (1993) that supervisory models have tended to promote either skill development or the emotional/interpersonal self-discovery of the worker. He uses an integrated model of clinical supervision influenced by the work of Stoltenberg and Delworth (1987). In Powell's model, the developmental stage of counselor and supervisor are considered and the focus is on both the development of clinical skills as well as emotional growth and self-awareness. The goal of supervision is to support a counselor's transition through the stages of professional development to a confident and relatively autonomous practice.
Link to TIP #52 Clinical Supervision and Professional Development of the substance use disorder counselor:
http://kap.samhsa.gov/products/manuals/tips/pdf/TIP52.pdf

Chemical Dependence Counselor Competencies

The chemical dependence counselor plays a central role in the provision of treatment to consumers in the 822 outpatient treatment setting. In order to provide the highest standard of care, the counselor must possess skills that lead to competent performance in the following areas: clinical evaluation, treatment planning, referral, care coordination, counseling, documentation, and professional ethics/responsibilities.

Reference: **SAMHSA TAP 21:** http://www.nattc.org/resPubs/tap21/TAP21.pdf

Clinical Evaluation: The clinical evaluation is used in order to assess the consumer's level of care needs and determine the initial course of treatment. Components of a complete evaluation include: intake, screening, and assessment. All counselors must follow OASAS guidelines for this process, which begins with making an initial determination, level of care determination, and an admission decision.

NYS OASAS Level of Care

Determination Form: http://www.oasas.ny.gov/treatment/health/locadtr/locadtr_home.cfm

Treatment Planning: Upon completion of the clinical evaluation, a client must be presented with an initial treatment plan. During this process, the clinician should: obtain and interpret assessment information, present and explain findings, provide patient and family members with additional information (if applicable), collaborate with client and family to examine treatment implications, confirm readiness, formulate mutual and measurable treatment goals, identify strategies, coordinate treatment activities, develop mutually acceptable plan of action, inform of confidentiality, rights, and procedures, and reassess the treatment plan at regular intervals.

Referral: Once initial treatment planning is completed and the counselor, client and family (if applicable) agree on an initial course, the counselor must be able to facilitate the entire referral process by: establishing and maintaining relationships with professionals, agencies and governmental entities; assessing and evaluating referral resources; determining the most appropriate referrals; arranging the referral, explaining in clear and specific language the need for referral and working to ensure follow through; exchanging relevant information with the place of referral; and evaluating the outcome of the referral.

Service Coordination: For those consumers who are referred to the counselor for treatment services, the counselor must be able to coordinate care, which, at a minimum, involves: treatment plan implementation, consulting with other providers and referral sources, and performing ongoing assessment and treatment

planning in accordance with 822 regulations.

Counseling: The substance use disorder counselor must be knowledgeable in a variety of counseling techniques in order to provide individual, group and family counseling as required. At a minimum, all counseling staff should be trained in motivational interviewing and be familiar with the "Stages of Change" Model.

"Motivational Interviewing in a Substance use disorder Treatment Setting" (NYS OASAS):
http://www.oasas.ny.gov/AdMed/documents/motinter06.pdf

Documentation: Documentation is a critical function of the Substance use disorder counselor. Proper documentation serves not only to summarize a consumer's journey through treatment, but demonstrates regulatory compliance, clinical intervention and rationale for ongoing treatment. In order to meet minimum standards in this area, the counselor must: know accepted principles of records management; protect client confidentiality when handling and releasing records; prepare accurate and concise reports; record treatment plans consistent with agency and OASAS regulations; record progress of clients in relation to treatment goals; prepare accurate and concise discharge summaries; and document treatment outcome using accepted methods and instruments.

Professional and Ethical Responsibilities: The substance use disorder counselor must: adhere to applicable professional codes of ethics; adhere to Federal and State laws and agency rules and policies; know and apply current research literature to practice; recognize individual differences and how they affect patient behaviors; use a range of supervisory options to process personal feelings; conduct self-evaluations of professional performance to enhance self-awareness; obtain appropriate continuing professional education; participate in ongoing supervision and consultation; and, develop and utilize strategies to maintain one's own physical and mental health.

NYS OASAS Canon of Ethical Principles:
http://www.oasas.ny.gov/sqa/credentialing/casac_canon.cfm

Co-Occurring Disorder Treatment

The Commissioners of OASAS and OMH issued a memorandum of understanding in 2008 to OASAS and OMH certified programs. The memorandum acknowledges that integrated treatment is preferred to simultaneous or sequential treatment for both disorders. It further identifies how programs can implement integrated treatment within a singly certified agency. Patients who meet the admission criteria for the program can receive treatment for a co-occurring disorder within the context of the admitting disorder. This means that a patient who is admitted for a cocaine and

alcohol dependence who also has a co-occurring mood disorder should receive screening, assessment and treatment (if qualified staff are able to provide such treatment) at the certified substance use disorder treatment program.

Treatment provided by a single program or collaborative team of practitioners working with a single integrated treatment plan is superior to independent treatment of each disorder. Programs can use a tool developed by Dartmouth the Dual Diagnosis Capability in Addiction Treatment Programs (DDCAT) (Mc Govern, Matzkin, Giard 2007) to assess their level of dual disorder capability ranging from providing addiction services only (ASO) to Dual Disorder capable (DDC) through Dual Disorder Enhanced (DDE). The instrument measures 35 benchmark areas across seven dimensions of programming including:

- Program Structure
- Program Milieu
- Assessment
- Treatment
- Continuity of Care
- Staffing
- Training

For access to this tool programs can follow the link below:
http://dms.dartmouth.edu/prc/dual/atsr/

All programs should include mental health screening in the intake process to identify potential co-occurring disorders. Three screening tools were recommended by the Co-occurring Disorder task force and OASAS has issued guidance to the field on implementing screening. Links to the screening instruments and guidance are below.

http://www.omh.ny.gov/omhweb/resources/providers/co_occurring/adult_services/screening.html

The incidence of co-occurring chemical dependency and mental health disorders has been estimated to be as high as 60% (Muessner 2001) in chemical dependence settings. All programs that provide Substance use disorder services should expect to see many patients with a co-occurring disorder and plan to address the mental health disorder in the course of treatment. Although integrated treatment is best, programs may not have the staff, psychiatrist or expertise to deliver this care directly. In this case, programs should consider collaborations with mental health providers to deliver treatment through a single treatment plan. At minimum, programs must have relationships with mental health providers to refer patients for simultaneous treatment. Programs that wish to provide integrated care should consider the DDCAT benchmarks in all seven dimensions and develop policies and procedures that are consistent with providing good quality services for both chemical dependency and mental health disorders.

At minimum programs offering integrated care should meet the following standards:

Screening/ Assessment

- Program must utilize a recommended screening and must have a policy and procedures for staff to be trained in the use of the screening instrument.
- The program must have clear policies and procedures for how the staff should respond to both positive and negative patient screens, including a policy and procedure for effectively assessing and addressing suicidal or homicidal thoughts.
- The program should have qualified staff that can assess both chemical dependency and mental health disorders. At minimum, these staff should be master's level licensed clinicians working within the scope of practice established by the licensing authority.
- The assessment should include stage of change consistent with the subsequent treatment plan.
- The mental health portion of the assessment should be integrated into the treatment plan.

Treatment

- The program should have policies and procedures on handling emergencies related to both chemical dependency and mental health issues including a plan for 24 hour response.
- The program should have policies and procedures for securing timely psychiatric assessment and treatment services and have the capacity to provide psychotropic medications when indicated.
- Stage-wise treatment should be provided that is patient-centered and responsive to the patient's assessed stage of change for both mental health and chemical dependency
- Treatment plans should reflect goals and objectives for both disorders
- The program should provide integrated chemical dependency and mental health treatment groups, recovery services and individual counseling.
- The program utilizes evidence or consensus based treatment for treating chemical dependency and mental health disorders including, where possible, peer services.

- Staff are trained in both mental health and chemical dependency and clinical supervision is provided by qualified staff
- The program has training and clinical supervision policy and procedures for all program staff in the provision of co-occurring disorder services.

Continuity of Care

- Program addresses both Substance use disorder and mental health needs in discharge planning;
- Recovery and Peer support service needs reflect both substance use disorder and mental health;
- Program philosophy includes recovery concepts and supports for co-occurring disorders; and
- Program has policy and procedures for maintaining continuity of patient's psychotropic and addiction medications.

Many programs do not meet the standards for providing truly integrated services and may not meet the standards set above. However, all programs should have a plan to screen, assess and ensure treatment for dual disorders through referrals and agreements with local mental health providers.

Link to TIP #42 Substance use disorder Treatment for Persons with Co-occurring Disorders: http://store.samhsa.gov/shin/content/SMA13-3992/SMA13-3992.pdf

Traumatic Brain Injury (TBI)

In 2010, SAMHSA issued an advisory which stated that Traumatic brain injury (TBI) is a frequent but under recognized condition co-occurring with substance abuse disorders. The frequency of TBI in OASAS programs is often underestimated due to lack of familiarity with this disability, patients' not disclosing or lack of awareness about TBI and its functional limitations. Scientific studies of people in substance abuse treatment have estimated the incidence of prior TBI from 36 percent to 63 percent [one study (Corrigan 2005) looked at people enrolled in OASAS outpatient programs and estimated the co-morbidity of brain injury in OASAS certified programs as more than 50 percent].

Just as programs providing chemical dependence treatment should expect to see many patients with mental health concerns, programs should anticipate seeing individuals who have cognitive and psychosocial support needs secondary to TBI.

Individuals with TBI often demonstrate significant difficulties with memory, abstract thinking, self-awareness, language and social skills which make traditional treatment programs challenging.

Both the individual and the clinician may experience frustrations, as TBI can pose an obstacle to successful recovery when not accommodated or understood. In many cases TBI may not be identified on intake without specific screening.

Brief Overview of TBI

Common causes of TBI include falls, motor vehicle accidents, assaults, loss of oxygen (often associated with overdose), and stroke, Veterans of the Iraqi and Afghanistan wars are susceptible to TBI due to IED explosions and TBI is considered the "signature injury" of these wars. Many individuals admitted to OASAS certified treatment programs have had multiple concussions throughout their life which can be cumulative. This means, individual concussions might not have resulted in disability, but the end result of many concussions or blows to the head lead to a TBI related disability. **Examples of this are repeated fights sports injuries, domestic violence, and war related blast injuries**. Alcohol consumption can also result in acquired brain injury, seen in Wernike's or Korsakoff's syndrome, for example.

Screening Assessment

Patients with a history of TBI can be identified in several ways. One method is to inquire about past hits to head, including car accidents, sports participation, military service, fights, gunshot wounds, attacks, falls or strokes. Individuals who know they have had incidents leading to changes in functioning, or who have been hospitalized and treated, or received rehabilitation will often talk about these incidents if directly asked. The HELPS Screen has been incorporated into the OASAS Part 822-4 Model Case Record Forms http://www.oasas.ny.gov/mis/forms/reg/822/documents/TA-05822-4.pdf

A positive score on a screen does not mean the individual has a TBI related disability, but does indicate need for further monitoring and evaluation. At minimum, observe the individual's 'ability to benefit from treatment and comprehend and recall the information provided. If you start to see they are having problems, consider offering treatment accommodations or refer out as needed.

Treatment Accommodations

Individuals with identified cognitive support needs following TBI should receive accommodations to enhance successes in recovery. Provision of accommodations involves instruction in and use of compensatory strategies. These strategies aim to assist individuals with TBI in compensating, or working around difficulties. Compensatory strategies are considered as Best Practices approach.

Suggested accommodations and strategies for clients with TBI and memory problems include: writing things down, using a date book, calendar, or cellphone to record appointments and information, To Do lists, and pillboxes for organizing and

remembering medication. Other memory strategies include using rhymes, visual images/mental pictures, and daily check-lists.

Staff may provide supports which include: reducing pace of information given by going more slowly, repetition, encouraging patients to write things down, asking them to repeat main points to check and see if they understood. Staff may use both visual & verbal presentation of information and offer daily orientation. Examples include reviewing & daily posting of the date and goals, using handouts or worksheets with written text and/or pictures and cue cards. Staff might use individual sessions to review and reinforce group concepts. Extra patience is advised. It may take longer to see changes in behavior as a result of your interventions. It is essential to understand that many individuals with TBI related disabilities have reduced self-awareness and cognitive issues that may look like denial. Increasing understanding if TBI helps the clinician see that these are not the same, and with supports, the individual can begin to succeed in their recovery process!

Treatment plans should reflect goals and objectives for disorders, substance abuse and TBI. .

As with the advisory for treating individuals with both substance use and mental health disorders, in regard to co-occurring SUD and TBI, integrated treatment is best. We recognize that most, programs may not have the staff, training, or expertise to deliver this care directly. In this case, follow the recommendations which can be carried out within your scope of practice and seek consultation, referral, and use of additional resources as indicated.

Continuing Care Planning and Options

Consistent with integrated mental health programs, providers should begin to addresses both substance abuse disorders and TBI needs in discharge planning;

- Refer to community based TBI support groups for individuals with TBI and family or caregivers
- Connect with local TBI Chapters
- Refer for evaluation for neuropsychological testing, mental health & counseling at local outpatient clinics or hospitals
- Independent Living Centers for benefits counseling and to access additional support services
- TBI Waivers: Available through both OPWDD (injured prior to age 22) and NYS DOH, these Waivers provide home and community based services and supports, skills training, and access to day programming options for individuals with TBI.

RESOURCES:

OASAS Resources

- OASAS TBI Home Page http://www.oasas.ny.gov/tbi/index.cfm
- OASAS Addiction Medicine Education Series: The Traumatic Brain Injury and Chemical Dependency Connection (1 hour) (CASAC Section II, CPP, CPS Section I) - http://www.oasas.ny.gov/admed/edseries.cfm
- HELPS Screening Instrument: http://www.oasas.ny.gov/TBI/HELPS.cfm
- R. E. Blaisdell Addiction Treatment Center (male only facility) has a TBI specific inpatient program. INTAKE: 845-680-7626 General number: 845-359-8500

Brain Injury Association of NYS
518-459-7911
1-800-228-8201 (Family Help Line)
www.bianys.org

DOH Bureau of Long Term Care
518-474-6580

SAMHSA/CSAT

- TBI: SAMHSA Advisory http://kap.samhsa.gov/products/manuals/advisory/pdfs/Advisory_TBI.pdf
- TIP 29: Substance Use Disorder Treatment for People with Cognitive and Physical Disabilities http://store.samhsa.gov/product/TIP-29-Substance-Use-Disorder-Treatment-for-People-With-Physical-and-Cognitive-Disabilities/SMA08-4078
- http://kap.samhsa.gov/products/tools/ad-guides/pdfs/QGA_29.pdf

Department of Defense and Veteran's Administration

- http://www.dvbic.org/
- http://www.polytrauma.va.gov/understanding-tbi/
- http://maketheconnection.net/conditions/traumatic-brain-injury/
- http://www.brainline.org/landing_pages/categories/substanceabuse.html

Ohio Valley Center for Brain Injury Prevention and Rehabilitation
www.ohiovalley.org

OPWDD
866-946-9733

Empirically Supported Treatments

Empirically supported treatments (ESTs) refer to psychological interventions that have been evaluated scientifically. Evidence-based practice (EBP), as defined by the American Psychological Association, is "the integration of the best available research with clinical expertise" (as cited in Beidas & Kendall, 2010).

All addictions programs should be engaged in a process of disseminating and implementing ESTs and the treatments utilized should have demonstrated efficacy with the population for which they are being provided. Dissemination refers to the deliberate distribution of relevant materials (e.g., an empirically-supported cognitive-behavioral therapy manual) to practicing clinicians; Implementation refers to the act of adopting and integrating evidence-based practices into daily patient care. These processes happen over time across many stages including: 1) exploration and adoption; 2) installation; 3) initial implementation; 4) full implementation; 5) innovation; and 6) sustainability (Fixen et al., 2005).

Additionally, a systems-contextual (SC) perspective can serve as a useful model for dissemination and implementation efforts. This model takes into account therapist, client, and organizational variables that influence training and subsequent adoption of EBPs (Beidas & Kendall, 2010). Effective dissemination occurs only when clinicians are trained properly and when the context can support the practice (Sanders & Turner, 2005). Quality training includes a workshop that uses active learning techniques (e.g., role plays, Cross et al. 2007), a manual, and ongoing clinical supervision (Sholomskas et al., 2005). Many suggest that training should focus on principles and the underlying "spirit" (Miller et al., 2004) as opposed to didactic instruction of specific manual elements (Abramowitz, 2006; Miller et al., 2004). Further, the organizational system must support ongoing supervision to ensure therapist adherence and competence (Herschell et al., 2004; Kendall & Southam-Gerow, 1996) and consequentially,fidelity to ESTs.

Treatment of Trauma in Chemical Dependency Settings

Practitioners should have an understanding of the possible meanings and functions of substance use for clients with histories of trauma. Examples include but are not limited to:

- Self-medicating, self-soothing the symptoms of trauma;
- Supporting dissociation (i.e. "fuzzing out")
- Inducing a sense of "aliveness" in the midst of emptiness
- Facilitating temporary reconnection with dissociated

aspects of the self such as grief, sexuality and anger.

Establishment of trust may occur slowly and gradually with trauma survivors. Thus, these patients may remain in the pre-contemplation and contemplation stages of change while substance use continues for a period of time.

Counselors should select modalities and interventions that match the client's stage of readiness for change. It is critical that the counselor carefully considers the timing and pace of any interventions used; failure to do so may be experienced by the patient as re-traumatizing.

Because a high percentage of individuals with substance use disorders have some history of trauma, treatment services need to be offered in a manner which accommodates the needs of trauma survivors. This includes assessing and addressing trauma-related issues and avoiding re-traumatization during the course of care. This care recognizes the effects, symptoms and healing processes involved in trauma and includes:

- screening and/or assessment for trauma;
- recognizing trauma-related disorders and symptoms;
- recognizing the special safety needs which some trauma survivors might have;
- using an empowerment approach;
- integrating trauma approaches into Substance use disorder treatment;
- using of evidence-based trauma-informed interventions as part of the treatment process, as appropriate. Examples of these can be found at the National Center for Trauma-Informed Care website at: http://samhsa.gov/nctic/

- The selection of modalities and interventions and the timing and pace of treatment should reflect the patient's participation in clinical decision-making and readiness. Failure to do so may be experienced by the patient as re-traumatizing;
- referring to practitioners with expertise in trauma, domestic violence, abuse, etc., as needed;
- developing the capacity to address concrete needs of survivors currently experiencing domestic violence and/or abuse (e.g. safety planning, alternative living arrangements, criminal prosecution assistance, etc.) whether by direct service or referral; and
- integrating trauma into staff development activities, including understanding the potential functions of substance use for patients with histories of trauma, such as self-medication & soothing, supporting dissociation, inducing arousal amidst

feelings of deadness, and facilitating temporary reconnection with dissociated aspects of the self such as grief, sexuality and aggression.

Intensive Outpatient Treatment / Day Rehabilitation Services

Some patients, who are able to live in the community but have functional deficits impacting recovery, need additional support and a structured program to attain and maintain early remission from SUD in an outpatient setting. These patients need targeted interventions to build strengths in functional areas. OASAS regulations support two levels of care for patients who meet the ASAM, LOCADTR or other LOC determination tool, Intensive Outpatient Treatment (IOT) and Day Rehabilitation Services. Both levels of care are delivered by an interdisciplinary team in a structured day setting. Each is a time-limited structured intervention for the purpose of building skills in functional areas to support recovery.

Intensive outpatient treatment should provide opportunities for group, individual and family interventions that are individualized to the patient's needs and focused on functional areas including mental and physical health, family/social functioning, community support (including safe housing supportive of recovery), vocational/educational, and legal involvement. Patients who are in intensive treatment should show signs of improvement and many will step down to outpatient treatment within 6 weeks.

Day rehabilitation offers a structured program for patients with significant functional, social or medical deficits/needs. Day rehab is provided in partial days of at least 2 hours or full days of at least 4 hours. The program may focus on specific populations including co-occurring disorders, women with children, criminal justice populations or homeless populations. Treatment should be person-centered and focused on improving functioning to enable patients to attain and maintain recovery.

Working With Mandated Patients

Criminal Justice Involved Patients

Patients may be mandated to treatment through a criminal justice entity including: probation, parole, drug court, veteran's court, or as a DWI offender through the DMV licensing requirement process. Working with criminal justice agencies and patients referred by them requires clinical staff to consider the impact of the referral on the therapeutic relationship and the specialized needs of patients.

Therapeutic Relationship

When a patient enters into treatment under mandate from a criminal justice agency the clinical staff person enters into a relationship with both the mandating agency and the patient. This can have both positive and negative influences on the therapeutic alliance. The patient can

be very motivated to work towards recovery goals due the legal mandate; thus, the clinician and patient can ally together to meet goals that are in the best interest of the patient. When this occurs, it is clear that the referent, the patient and the clinician have identified common ground and are all working towards the same goals, often for similar purposes. For example, probation is interested in helping the patient become a law-abiding successful participant in the community, the clinician is supporting the patient in attaining and maintaining recovery from substances and the patient is recognizing substance use as a problem that interferes with his life goals.

The clinician can be pulled in different directions by the mandating agency and the patient when they do not share the same goals. Often, patients are angry about the intrusion into their lives, are not convinced that they have a problem with substance use disorder and see the counselor as an extension of the criminal justice system. In these cases, the clinician needs to be aware of the conflicts. It is important to have good clinical supervision to help establish and keep clear boundaries with the referent and the patient. Treatment works best when the criminal justice entity maintains the role of supporting the court imposed mandates through both rewards and sanctions, while the treatment provider utilizes clinical interventions (e.g., enhancing motivation for change, increasing clinical, peer, case management, medication management, community supports, and changing the level of care when needed) to facilitate progress on the treatment plan.

Specialized Needs of Criminal Justice Referred Patients

Substance use disorder counseling with this population should include the use of specialized skills by a clinician to address criminogenic distortions in thinking and help criminal justice involved individuals and their families achieve their individualized treatment objectives using individual, family or small group sessions. Substance Use Disorder counselors can utilize curricula to assist criminal justice involved individuals in addressing the symptoms of SUDs and impaired functioning. Counseling generally addresses issues of motivation, skills to resist use, understanding of alcohol/drug use and the recovery process, connections to trauma or mental health issues, negative consequences, managing feelings, interpersonal relationships, self-efficacy, problem-solving abilities, alternatives to alcohol/drug use, self-esteem and identity. Substance Use Disorder counseling utilizes a relational framework that addresses the criminal justice involved individuals' unique pathways to alcohol and drug use, associated with criminal behavior and will move to develop treatment in alignment with cause and effect, consequences of use, motivations for change, treatment needs and relapse factors.

OASAS issued an LSB on working with criminal justice entities that can be found here: http://www.oasas.ny.gov/mis/bulletins/lsb2008-02.cfm

This LSB provides on guidance on the clinical responsibilities of programs working with criminal justice partners.

Clinical staff should have specific training in assessing criminal behavior including differentiating between criminal behavior associated with substance use, antisocial behavior patterns and severe personality patterns that include lack of ability to attach to others and a pattern of exploitation of others. Decisions about group composition should be informed by these assessments. Patients at the higher end of sociopathology scales should not be placed in group settings where they may subject other members to exploitation. Patients who score high in sociopathy may be better suited for coping skills groups rather than interactional therapies. (Cooney, 1991) Clinical staff treating criminal justice populations, especially those with a prison history should have training in assessment and treatment of criminal thinking and behaviors.

Child Protective Services

Patients referred to substance use disorder treatment through a child welfare referral may need to complete treatment to maintain or re-gain custody of their children. In the case where a child is in foster care, treatment programs face strict timetables for treatment progress and completion because the court will enforce timeframes for permanency planning. Clinicians and Child Protective workers will often see progress from different perspectives with child protective workers having the child's safety as the goal and the clinician seeing the parent's Substance use disorder treatment progress as the goal. This can cause conflicts between service providers that need to be anticipated. Clinicians working with this mandated population should coordinate treatment with child protective services and understand the perspective of both CPS workers and the courts in implementing permanency planning to inform and advocate for patients.

Patients will present with a wide range of emotions, motivation and co-occurring issues that need to be addressed. The threat of losing a child or having a child placed in foster care is a traumatic event for the family and individually indicated parent. The clinician's role includes engaging the patient, building a therapeutic alliance, developing mutual goals with each party and identifying and working through counter transference reactions. Treatment may also need to focus on parenting, coping with anger, stress and may need to address issues related to past physical or sexual abuse of the parent. Substance use disorder programs may not have the resources or expertise to address all of these issues, but should coordinate with

child welfare, family treatment, mental health and parenting programs to ensure holistic treatment.

TIP #36 Substance use disorder Treatment for Persons with Child Abuse and Neglect Issues

http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A63145

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