NEW YORK STATE

Office of Addiction Services and Supports

# Clinical Pathways for Residential Redesign

**OASAS Certified Residential Programs**

# Clinical Pathways for Residential Redesign

Individuals appropriate for stabilization must meet LOC criteria for admission for mild to moderate withdrawal with the need for a stable environment, or cognitive behavioral instability, or urges and cravings to use that are unmanageable. A clinical assessment will identify the individual needs for each person. The clinical indicators for this level of care are not mutually exclusive.

There are many clinical factors that will impact the expected time in treatment including: trauma history, cognitive disability, poverty, attachment style and social factors. Clinicians should document an expected length of stay and initial discharge plan at time of 48-hour notice of admission, including all exacerbating clinical factors with clinical assessment.

An individual is recommended for the level of care through the LOCADTR based on meeting at least one of the criterion in the first column. The pathway is specific to the individual reason for admission to this level of care. They are not mutually exclusive, and an individual may receive service through one or more of the pathways as indicated in the table below.

## Stabilization Element of Care

- Medical and clinical staff are on site daily with access for emergencies 24/7.
- Medications are available and managed within the treatment setting and include addictions and psychotropic medications. Methadone is accessible through agreement with an OASAS certified OTP and no one is denied admission due to the need for methadone treatment maintenance.
- Staff are trained in trauma informed care practice and provide a safe and supportive environment with a focus of recovery.
- Individual, Group and Family counseling provided with use of evidence-based treatment approaches that have been shown to promote outcomes consistent with the goals of stabilization, including but not limited to: Motivational Interviewing, Dialectical and Behavioral Therapy, Seeking Safety, Trauma Informed Care, and Community as Method approaches such as peer mentor matching, structured community meetings and pro-community activity and bonding activities.
- Clinical tools for withdrawal, emotional distress, cognitive functioning and urges/cravings are used to assess symptoms and re-administered to measure progress to inform the clinical process.
- Treatment is individualized and based on the resident's stated goals, values and beliefs. Evidence of this will include treatment plans with the resident's own words, and use of tools to identify resident goals, interests and strengths.
- Assessment includes housing and recovery needs from the beginning of care with an initial discharge plan in place by the time of the initial treatment plan – this initial plan may change throughout time as the resident responds to treatment and additional factors for discharge needs become known.
- The program incorporates recovery principles, hopefulness and promotes recovery support between residents. Discharge planning includes goals to support recovery through natural and community supports in the next treatment or community environment.

# Clinical Pathways for Residential Redesign

## Stabilization Element

| Criteria for admission | Clinical Target for intervention | Evidence of Intervention for Target |
|---|---|---|
| **Mild to moderate withdrawal – need stable environment** | Medical/Psychiatric Assessment completed within 24 hours to identify immediate stabilization needs. Ongoing assessment will occur over time in treatment. Initial treatment and discharge plan. | Documentation of assessment and initial discharge plan to plan with 48-hour notice |
| | Substance specific taper or induction (OASAS approved ancillary withdrawal) plan. Plan will include decision points for ending the taper or extending for mild or protracted withdrawal or maintenance therapy. | Documentation of substance(s) specific withdrawal management and resident response – treatment planning. |
| | Monitoring of vital signs and symptoms of withdrawal with standardized measure (eg COWS, CIWA) medication adjustment as needed per approved protocol. Resident continually assessed per medication plan and adjustments made, for example, plan for buprenorphine taper and transition to Injectable Naltrexone is changed as resident responds to maintenance dose of buprenorphine. | Safe management of withdrawal achieved when symptoms have remitted and medication can be safely and comfortably discontinued or plan for long term management is implemented. |
| | Management of emotional aspects of withdrawal through psychosocial interventions including family engagement, if clinically appropriate. | Decease in anxiety and distress per standardized measure of anxiety, mental/emotional stress – resident and staff observation and report documented in notes |
| | Motivational interventions to increase internal motivation to connect to treatment in most appropriate level of care | Resident identifies resident expressed concern about continued use, observation by staff of change statements, commitment to change behaviors. |
| | Assessment of cravings and urges to use with medication and skills development training as clinically needed | Craving and urges to use are low based on validated measure of craving and/or resident report |

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| Criteria for admission | Clinical Target for intervention | Evidence of Intervention for Target |
|---|---|---|
| **Cognitive and or behavioral instability** | Medical and psychiatric assessment including assessment of cognitive functioning Initial treatment and discharge plan | Documentation of assessment and initial discharge plan to plan with 48-hour notice |
| | Medication Management and psychosocial interventions | Medication follow-up for psychiatric and addiction symptom management per treatment plan |
| | Coping and self-management skills development – ex. DBT, CBT, Seeking Safety | Documentation of improvement through validated measures of functioning and or staff observation and resident report of application of skills within residential setting to manage emotions, calm self, employ learned strategies to reduce distress or conflict with others. |
| | Connection to peer(s) within community. Interventions to support cognitive healing with nutrition and rehabilitative activities such as meditation, yoga, puzzles etc. | Evidence of improvement in cognitive/executive functioning through validated measures or staff observation |
| | Use of community to increase commitment to recovery and subjective feeling of safety | Improvement in feelings of distress based on validated measures, staff observation and resident self-report |
| **Strong Urges or Cravings that are unmanageable** | Substance use history, including periods of abstinence and relapse within 72 hours. Initial treatment and discharge plan | Documentation in notes |
| | Medication management, if indicated, and psycho-social interventions to reduce urges and cravings | Medication assessment and treatment for cravings and urges or for psychiatric symptoms including depression, anxiety, intrusive thoughts that may lead to urges to return to use |
| | Regular monitoring of cravings through a validated tool for assessment and clinical purposes | Monitoring of cravings to assess treatment response |
| | Skills development including skills to recognize urges and cravings and employ strategies to increase coping | Skills development to build awareness and skills to manage cravings within safety of residential setting. Development of a relapse prevention plan |
| | Connection to peer(s) to increase social support for recovery | Staff observation and self-report of increasing connection to peers |

## Rehabilitation Element of Care

- Clinical staff are on site daily. Medical Director and prescribing professional staff are on-site at least weekly and available for consultation. Nursing staff is on-site daily.
- Medications are available and managed within the treatment setting and include addictions and psychotropic medications. Methadone is accessible through agreement with an OASAS-certified OTP and no one is denied admission due to the need for methadone treatment maintenance.
- Staff are trained in trauma-informed care practice and provide a safe and supportive environment.
- Individual, Group and Family counseling provided with use of evidence based treatment approaches that have been shown to promote outcomes consistent with the goals of rehabilitation including but not limited to: Cognitive Behavioral Therapies, Social Learning, Dialectical and Behavioral Therapy, Seeking Safety, Trauma Informed Care, and Community as Method approaches such as pro-community activity, accountability to others, and job assignments to meet treatment goals.
- Clinical tools for social, community, empathy, mood, anxiety, behavioral control and anger management, for example, are used to assess symptoms and re-administered to measure progress to inform the clinical process.
- Treatment is individualized and based on the resident's stated goals, values and beliefs. Evidence of this will include treatment plans with the resident's own words, and use of tools to identify resident goals, interests and strengths.
- Assessment includes housing and recovery needs from the beginning of care with an initial discharge plan in place by the time of the initial treatment plan – this initial plan may change throughout time as the resident responds to treatment and additional factors for discharge needs become known.
- The program incorporates recovery principles, hopefulness and promotes recovery support between residents. Discharge planning includes goals to support recovery through natural and community supports in the next treatment or community environment.
- Identify and mobilize residents, strength, resources and resilience to increase coping behaviors and reduce maladaptive behaviors.

# Clinical Pathways for Residential Redesign

## Rehabilitation Element

| Criteria for admission | Clinical Target for intervention | Evidence of Intervention for Target |
|---|---|---|
| **Pattern of functional difficulty in interpersonal relationships** | Psychiatric assessment including assessment of interpersonal skills deficits. Medical assessment with medical history, current symptoms and functioning, physical exam as clinically indicated | Documentation of assessment findings. Initial plan of care developed. Medical and Psychiatric medication assessment and plan for medication management |
| | Identify pattern of behavior, expectations and beliefs surrounding interpersonal relationships | Medication follow-up for psychiatric and addiction medication management, if indicated, per treatment plan |
| | Need for Medication Management, if indicated is assessed and managed within the rehab element of care. Psychotherapy is provided with specific, individualized goals for improvement in interpersonal functioning | Documentation of improvement through validated measures of functioning and/or staff observation and resident report of application of skills within residential setting, such as improvements in verbal and nonverbal communication; listening skills; negotiation; problem solving; decision making and assertiveness. |
| | Interpersonal skills development, including but not limited to: group and individual sessions; CBT, DBT, IPT; Seeking Safety, specialized tracks (ie- Women and children, LGBT, Trauma | Documentation and evidence of improvement in interpersonal functioning through validated measures and/or staff observation and how interventions support treatment plan goals. |
| | Psychosocial Interventions that support interpersonal skills development such as; practicing newly acquired skills with role play; structured peer groups; modeling behaviors | Documented interactions within the milieu which allow for stepped change in interpersonal skills development. |
| | Purposeful use of community and community role, responsibilities to provide corrective experiences with peers to resolve differences and conflicts constructively, develop trust, and utilize peer support to meet recovery goals | Documented interactions within the milieu which allow for stepped change in interpersonal skills development. |

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| Criteria for admission | Clinical Target for intervention | Evidence of Intervention for Target |
|---|---|---|
| **Pattern of functional difficulty in expected social roles (e.g,work, parenting)** | Clinical assessment of social and role functioning through the use of a validated screening tool (ex-GAF scale) | Documentation of assessment findings.<br>Initial plan of care developed |
| | Psychological assessment for cognitive impairment and/or psychiatric disorders that may interfere with role expectations | Evidence of improvement in cognitive/emotional functioning through validated measures or staff observation of improved ability to manage community responsibilities and expectations |
| | Social role skills development, including but not limited to social skills group; Family Therapy. Development of skills to transition to educational or employment setting | Documentation of improvement through validated measures of functioning, staff observation and resident report of application of skills within residential setting that demonstrate the acquisition of skills |
| | Connection with peer(s) within milieu community to support and practice newly acquired skills through the use of modeling, corrective feedback, role play; social reinforcement | Documentation and evidence of improvement in social and role functioning through staff observation and interaction with peer(s) |
| | Purposeful use of community to expose individual to social supports and recovery oriented social activities | Documentation of exposure to social supports and engagement in recovery oriented social activities will support aftercare/relapse prevention plan |
| | Purposeful use of role assignments within the community to address individual needs and targeted behaviors that need modifying – for example assigning a role that requires listening and reporting for someone who lacks skills in that area. | Documentation of how the role assignment will meet goals of treatment plan – for example – Resident will serve in role of mentor to new residents to support ability to communicate expectations to others |

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| Criteria for admission | Clinical Target for intervention | Evidence of Intervention for Target |
|---|---|---|
| **Pattern of behavior that indicates functioning deficits that lead to difficulty following established rules and conforming to community norms** | Clinical assessment of community functioning, criminal history and functioning within institutional and community settings | Documentation of assessment findings<br>Initial plan of care developed |
| | Psychological assessment including assessment for cognitive impairment that may interfere with impulse control and judgement | Evidence of improvement in controlling impulses and executive functioning through the use of a validated tool and/or staff observation of behavior. Documentation of decreased maladaptive behaviors if indicated in treatment plan |
| | Increase conformity to conventional adult social norms through use of community to establish rules, norms, natural consequences, rewards and therapeutic use of reinforcement for prosocial behaviors | Staff observation of behaviors within community – following rules, norms, expectations, and appropriate interactions with peers during prosocial activities. |
| | Skills development, including but not limited to: group and individual sessions; CBT, DBT, specialized tracks (i.e.- Criminal Thinking; Anger Management, Trauma) | Documentation of improvement through validated measures of functioning and/or staff observation and resident report of application of skills within residential setting, such as improvements in verbal and nonverbal communication; listening skills; negotiation; problem solving; decision making and assertiveness. |
| | Purposeful use of community role assignments to increase understanding of | Functioning improved based on validated tool of prosocial behavior and/or staff observation of increased ability to display behavior appropriate to assigned role |
| | Connection with peer(s) to allow resident to practice newly acquired skills and positive social development. Interventions to support social development such as modeling, corrective feedback, role play; social reinforcement | Observation of increased positive and socially appropriate interactions with others |