NEW YORK STATE

Office of Addiction Services and Supports

Clinical Standards for OASAS Certified Providers

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Welcoming
Connected to Continuum of Care
Engaging
Person Centered
Continuous evaluation and improvement
Effective
Integrated

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I. Introduction:

OASAS has been working collaboratively with the provider network to establish Standards of Care that cut across all levels of treatment. This document elaborates on the key elements needed for effective care and the clinical manifestation of those elements in practice. Providers are encouraged to read through these Standards and take stock of where your current treatment practices meet these Standards as well as areas for improvement

If in reading this document you have any questions or comments please send them to the PICM Mailbox at PICM@oasas.ny.gov

II. Welcoming:

People should be welcomed to care and provided expectation of hope and acceptance.

STANDARDS OF CARE	CLINICAL EXPECTATION
Premises support a welcoming message	• Décor, posters, art, waiting room literature, toys, etc., are reflective of community and the Community • Physical space is clean, at a comfortable temperature • Wait time is reasonable • Written material is positive, informative and uses neutral language about substance use disorder (SUD) •
Efforts are made to keep the treatment environment calm	• Minimize stimulation such as clutter, lighting, overcrowding that can have a disruptive effect on the individual • Peers and/or clinical staff meet with the individual expeditiously to provide information on expectations for the intake process and program • Security Staff, when present are welcoming and interact professional with clients and staff
Individuals and families are included in developing and maintaining the environment	• Programs collect feedback and recommendations from individuals and their family members regarding their experience of the program • Feedback is considered within the Program's Quality Assurance Plan
Additional Standards for Inpatient and Residential Programs	

The Program's entranceway provides for safety and support of individuals and their family/visitors	• Upon entrance all residents and visitors are warmly greeted and welcomed to the facility
	• Information is provided regarding
	  ○ Confidentiality
	  ○ Allowable items that can be brought into the program

	○ Sign In/Sign Out procedures ○ Support or Resources that are available to them. • First time residents are immediately provided with information regarding their orientation to the facility
Living space is responsive to the individual and communal needs	• Individual's medical/mental health, physical status, gender identification, etc., can be reasonably accommodated within the facility space • Staff respectfully and reasonably discuss with individuals any specific needs or concerns they may have regarding room assignments or common areas • The facility is well maintained and provides an environment conducive to recovery
Additional Standards for Crisis Programs	
Physical environment considers special needs of those withdrawing from substances	• Comfortable spaces with low stimulations are provided for individuals experiencing physical discomfort to rest • Medical staff urgently provide triage to identify and respond to life threatening emergencies, assess and treat significant discomfort

III. Engaging:

A. Connection/Collaboration: The Program actively works to connect with individual's at their level of need.

STANDARDS OF CARE	CLINICAL EXPECTATION
The Program identifies a person's preferences, strengths, resources, and needs in determining further course of action	• Appropriate Assessment Tools and/or individual interviews to identify: ○ The Individual's expressed area(s) of concern ○ Contextual areas such as culture, beliefs, individual as well as family and community values, that are important to the individual

	○ Self within their culture, identity, gender, family, social group, spiritual, religion and community • Assessment and action are “right sized” and based on the level, frequency, and intensity that the individual feels most comfortable • Individuals are recommended to the appropriate level of care based on the LOCADTR 3.0 and individual report • For individuals with Limited English Proficiency (LEP) the program: ○ Uses language translation services as needed and as required by law ○ Wherever possible, provides correspondence, information, other written documents to the individual in their preferred language
The Program utilizes information specific to the individual in developing a plan of action	• Individuals and staff work together in developing a plan of action which includes: ○ Identification of the concern(s) to be addressed ○ Indicators that the concerns are improving ○ Modalities used during the process to bring about improvement, e.g. medication assisted treatment (MAT), individual counseling, group counseling, etc. ○ On-going support options outside of the treatment setting • Goals are stated in the individual’s own voice and are clearly understood by both the person and staff • Individual services are strength-based, trauma-informed, holistic, and wellness and recovery oriented
The Program respects and allows for the Individuals right to choose what plan of action is right for them	• Individuals are able to access services such as counseling, peer, or Medication Assisted Treatment without being admitted • Individuals admitted to treatment in collaboration with staff choose the services they wish to receive, e.g. counseling only, medication assisted treatment only, or both • Individuals, when able and in collaboration with staff decide when the current episode or care or treatment is completed

	• When appropriate, staff may utilize motivational interviewing to raise the individuals awareness of need for further and or more intense action, however the final decision remains with the individual
Additional Standards for Inpatient and Residential Programs	
Treatment is individualized and allows for flexibility based on the person identified needs	• While there may be core activities for all residents, additional group and community participation should be individualized according to the person's needs • Individual preference is considered in assigning a primary clinician • Primary clinician assignment is based on clinician's strengths, special training or focus • Team member groupings should also consider the strengths, training, and experience when providing services
Additional Standards for Crisis Programs	

The post crisis plan of action begins development at the time of admission	• Beginning at admission Crisis Programs provide immediate services, as well as discharge planning which considers the individual's:
	  ○ Values
	  ○ Preferences
	  ○ Family responsibilities
	  ○ Employment/Education responsibilities
	  ○ Living situation
	  ○ Recovery resources

B. Safety: The Program provides an environment that promotes safety.

STANDARDS OF CARE	CLINICAL EXPECTATION

The Program provides services with an awareness of the Individual's unique life experience(s)	• Programs support the individual's increased emotional safety through:
	  ○ Validation of the individual's experience
	  ○ Education regarding trauma, triggers, and trauma responses
	  ○ Providing choices within the environment to facilitate empowerment
	  ○ Skill building for trauma recovery which assists with:
	  ▪ Modulating affect
	  ▪ Dealing with intrusive thoughts
	  ▪ Self-soothing, self-care as they approach difficult memories or emotions
	• Programs provide services such as group and individual counseling that specifically speak to Trauma and/or trauma related issues
	• Clinicians are aware of the affect that individual's trauma experience may have on group dynamics, and are able to effectively intervene
	• Gender and age differences are considered when formulating group membership
	• Staff are trained in:
	  ○ De-escalation and therapeutic communication
	  ○ Effective interventions in trauma informed care

The Program has policies in place in support of individual safety	• Policies which outline confidentiality requirements and expectations such as:
	  ○ Treatment information can be shared only with the signed consent of the individual
	  ○ Information shared individual or family sessions to members of a group or other supports without agreement of the individual
	• Process for the reduce the potential for abuse and/or neglect by staff which includes but is not limited to:

	○ Comprehensive hiring practices ○ Regular Supervision ○ Staff Training regarding boundaries and ethics • Availability of Naloxone, and Naloxone training for staff, clients, and family members
Additional Standards for Inpatient and Residential Programs	
Programs provide physical safety within their facility	• Exterior doors and windows are secured during sleep and other hours • Use of door alarms and surveillance cameras in common areas as appropriate • Contraband policies and procedures that utilize the community to address behaviors that threaten safety

IV. Effective

A. Medical Direction

STANDARDS OF CARE	CLINICAL EXPECTATION
Medical Direction is provided by a physician who is an addiction expert	• The Medical Director: ○ Provides leadership, along with other professionals in establishing a philosophy of treatment and standards of care ○ Provides direction, consultation and direct medical services to clients ○ Oversees the prescribing and/or approval of medications for self-administration of individuals within the facility ○ Ensures that standards and philosophy for prescribing are consistent with the up to date best practices ○ Evaluates need for prescriber coverage and provides coverage for access to prescription services as needed

	○ Develops toxicology testing policy, procedures and protocols ○ Provides guidance for all medical related aspects of treatment
Additional Standards for Inpatient and Residential Programs	
Medical Direction is provided within the residential program	• The Medical Director: ○ Participates in relevant committees (i.e. safety, incident review, CQI) ○ Assist in utilization review when communication with Managed Care Organizations are needed ○ Implements medical orders regarding treatment of medical conditions and reporting of communicable diseases in accordance with law ○ Ensures the provision of routine medical procedures and referrals to other health professionals as needed

Additional Standards for Crisis Programs	
Medical Direction is provided within the Crisis program	• The Medical Director ○ Establishes a medication plan with the patient and treatment team which promotes: ▪ Long term recovery ▪ Addiction Medication Induction as appropriate ▪ Linkage to long term medication management as needed ○ Identifies medical issues requiring follow-up and is an active participant in discharge planning

B. Research based

STANDARDS OF CARE	CLINICAL EXPECTATION

Care provided is consistent with the scientific literature and is responsive to the unique needs of every individual	• In all elements of care the program uses the best and promising practices as identified by the latest scientific literature and based on the specific needs of their population or subpopulation, i.e.:
	  ○ Thinking for a Change for Criminal Justice
	  ○ Seeking Safety for high trauma populations,
	  ○ Behavioral and cognitive skill building for those having urges or cravings, etc.
	• Staff is trained in evidence-based models which include but are not limited to:
	  ○ Cognitive Behavioral Therapy
	  ○ Motivational Interviewing
	  ○ Community Reinforcement
	  ○ Functional Family Therapy
	  ○ Twelve Step Facilitation
	  ○ Matrix Model
	  ○ Seeking Safety
	  ○ HepC and HIV support
	  ○ Dialectical and Behavioral Therapy
	  ○ Trauma-informed models
	• Program documents that all staff are trained and/or certified in the particular EBP being used
	• Clinicians utilize measures to track progress and outcomes and adjust treatment as necessary for increased effectiveness
	• Clinical Interventions are individualized to address the individual's behaviors, strengths, and desired therapeutic effect

	• Medication Assisted Treatments, including all treatment options allowable within the setting for that are FDA approved for the diagnosis, are available and provided, as appropriate to the individual's needs. • Programs utilize motivational interviewing and cognitive approaches to identify and enhance internal reasons for change. • Programs employ methods for improving linkage to treatment including, but not limited to: warm hand-off, telephonic or telehealth sessions with the next level of care, peer connections to help with discharge.

C. Clinical Supervision

STANDARDS OF CARE	CLINICAL EXPECTATION

Clinical Supervision is the cornerstone for effective treatment, improved retention and successful outcomes	• Programs must have policies that prioritize and ensure the provision of clinical supervision
	• Clinical supervision should:
	  ○ Be individualized to clinical staff need
	  ○ Focus on clinical skills, personal reactions
	  ○ Offer opportunity for change to treatment approach
	  ○ Identify stuck points
	  ○ Provide opportunities for skill building and introduction to new models of treatment
	  ○ Address staff performance
	  ○ Documented
	• Clinical Supervisors:
	  ○ Have appropriate levels of training and experience
	  ○ Are strength based, and
	  ○ Trauma Informed
	• Clinical Supervision is provided regularly via:
	  ○ Individual

	○ Group ○ Direct and indirect observation
Additional Standards for Inpatient and Residential Programs	
Clinical Supervision is the cornerstone for effective treatment, improved retention and successful outcomes	• Clinical Supervision includes focus on staff and resident interaction within the community • In Part 820 Stabilization and Rehabilitation Elements, a Nurse Supervisor's duties may include but are not limited to: ○ Oversight of day to day nursing operations ○ Providing direct LPN supervision

D. Caseload

STANDARDS OF CARE	CLINICAL EXPECTATION
There is a clear policy and procedures for assignment of cases and monitoring of caseload size to ensure that all clients can expect quality treatment.	• Programs have a systematic process, and the concomitant policies and procedures to monitor, review, and track clinician caseloads by size, complexity of individuals and other factors can be demonstrated. • Program determinates for caseload include but are not limited to: ○ Intensity of treatment for individuals on clinicians roster ○ Units of services per clinical staff (81-226 per month is the current range for 85% of all outpatient clinics. 300- 833 inclusive of medication administration for OTP) ○ Staff sufficiency indicators including: ▪ On time documentation ▪ Individuals on caseload are seen regularly ▪ Rating from Perception of Care Survey ▪ Staff reports • Program has a clear policy on group size that includes the minimum and maximum members based on the type and goals of group and a mechanism for making sure that the size limits are adhered to

	• Program has a mechanism for assessing group effectiveness based on client report and some outcome measure informed by at least one measurement-based tool appropriate to the group goals
Additional Standards for Crisis Programs	
There is a clear policy and procedures for assignment of cases and monitoring of caseload size to ensure that all clients can expect quality treatment.	• Staffing is sufficient to ensure that all individuals in care meet with an individual counselor within 12 hours of admission and prior to discharge

E. Addiction Medication

STANDARDS OF CARE	CLINICAL EXPECTATION
All SUD programs assess addiction medication needs and provide Medication management	• Programs have policies and procedures regarding medication assisted treatment which includes but is not limited to: o Assessment of need for MAT which includes indicators that trigger referral to an appropriate medical professional for further evaluation o Provision of medication/medication prescribing where indicated o Informing/educating individuals on addiction medication, options, risk, rewards o Addiction Medication Assessment for those who take or test positive for psychoactive medications including benzodiazepines; which includes a Risk/Benefit analysis regarding MAT for these individuals

Additional Standards for Inpatient and Residential Programs	

All SUD programs assess addiction medication needs and provide Medication management	• Additional Policies and procedures regarding:
	  ○ Ancillary Withdrawal Protocols
	  ○ Process for MAT Maintenance for those in Rehabilitation and/or Reintegration Elements of Care

Additional Standards for Crisis Programs	
All SUD programs assess addiction medication needs and provide Medication management	• Treatment is focused on the addressing withdrawal through medication • Does no taper off medication if the treatment goal is maintenance • The Treatment Team is aware of the medication plan and actively work to support the plan through to the next treatment setting.

V. Person Centered:

A. Assessment

STANDARDS OF CARE	CLINICAL EXPECTATION

Assessment includes the individual's preferences, values, beliefs, goals and voice is captured with quotes from the individual	• Assessment includes the individual's view of the problem, strengths, previous success with presenting issues as well as:
	  ○ Emergency or urgent issues which require immediate intervention, e.g. mental health crisis, housing, domestic violence, etc.
	  ○ Assessment of family, friends, natural and/or community supports
	  ○ Risks and Resources
	  ○ Obtaining and reviewing Collateral information
	  ○ History of withdrawal management, periods of remission and relapse

Additional Standards for Inpatient and Residential Programs	
Assessment includes the individual's preferences, values, beliefs, goals and voice is captured with quotes from the individual	• Assessment is specific to the element of care and the clinical reasons for admission to stabilization, rehabilitation or reintegration and the assessment is consistent with the need for the level of care.

B. Treatment Plan

STANDARDS OF CARE	CLINICAL EXPECTATION
Treatment plan includes goals, methods, modalities and techniques that reflect individual preferences, values, beliefs and recovery capital	• The Treatment plan is written in the voice of the individual and reflects assessment and clinical formulation • Provision of addiction medications if indicated, is included in the treatment plan and clinical and milieu staff support the use of medication assisted treatment through group and individual sessions • Physical and mental health needs of the individual are adequately addressed and includes care coordination as needed • Measurable and attainable steps that are realistic and specific toward the achievement of the individual 's goals are identified with target dates • Continuous measurement-based care assessments done as needed to develop and maintain an active, appropriate treatment/discharge/recovery plan to develop strategies for appropriate interventions.
Additional Standards for Inpatient and Residential Programs	
Treatment plan includes goals, methods, modalities and techniques that reflect individual preferences, values, beliefs and recovery capital	• In each Element of care (Stabilization, Rehabilitation, and Reintegration) Treatment/discharge/recovery plan goals, objectives, and services are clearly linked to the comprehensive assessment,

	measurement-based care tools and discharge criteria that are individualized and person-centered. • The treatment plan includes individualized residential experiences matched to the assessment.

C. Discharge Planning

STANDARDS OF CARE	CLINICAL EXPECTATION

Discharge plans bridge the time between a specific time of active treatment and a longer term plan for continued recovery.	• Discharge plans are developed in collaboration between the clinician and the individual in care. Depending on the individual's expressed needs the plan may include:
	  ○ Establishing/continuing care at a different level or for a different type of concern
	  ○ Engagement in community based recovery support
	  ○ Other Recovery/Wellness supports
	  ○ Referral to:
	  ▪ Primary care
	  ▪ Housing
	  ▪ Employment services, etc.
	  ○ Ongoing support for MAT when appropriate
	• In as much as possible the above supports will be initiated and/or established prior to the discharge date
	• Programs support the bridging process by providing referrals, linkages, and access to Peer Support for engagement purposes
	• Outpatient Programs offer Continuing Care Services for those who wish for a less intense/frequent support after discharge

Additional Standards for Inpatient and Residential Programs	
Discharge begins at admission and includes a chronic condition management approach to long-term recovery	• In all Elements of Care, arrangements for appropriate services (appointment dates, contact names and numbers, etc.) are discussed and made with the individual and their significant others prior to planned discharge date. • Services within the Elements of Care are "front-loaded" to enhance retention and provide hope for individual s (i.e. linkage to family counselling, housing and employment opportunities are offered in early recovery). • Recovery Oriented Supports and linkages to community services are key to this approach of long-term recovery. Alumni groups, recovery check-ups, recovery centers, continuing care strategies should be utilized to enhance outcomes.

D. Toxicology Terminology

STANDARDS OF CARE	CLINICAL EXPECTATION

Treatment is provided in a way that is accepting; language neutral terminology is used in talking about substance use disorder. Treatment includes lab work including toxicology which is used to inform treatment.	• The Program has a policy and procedure on toxicology that includes but is not limited to:
	  ○ Clinical criteria for the use of toxicology
	  ○ The Program's understanding that:
	  ▪ Toxicology is used as any other lab test would be used in health care treatment
	  ▪ Toxicology is used to inform treatment and is not used punitively
	  ▪ Toxicology screening provide valuable information on the likelihood that the patient either used or didn't use the substances screened.

	▪ Results will be used therapeutically is related to the goals of the patient and the purpose of the test ▪ Counselor language supports the chronic nature of substance use disorder, individuals should not be blamed for symptoms ○ Interactions and relationships with other systems, e.g. criminal justice, child welfare, including education around treatment and toxicology results

VI. Quality Improvement

STANDARDS OF CARE	CLINICAL EXPECTATION
Continuous Evaluation and Improvement lead to better outcomes	• Quality Improvement is linked to individual outcomes, program success, and risk mitigation (both fiscal and clinical) • Program understands and distinguishes process based and outcome based measures and incorporates necessary metrics in ongoing program development. • Program identifies and chooses metrics consistent with mission and goals. • Self-reported measures of treatment progress are utilized by the program. The tools are used clinically and may be aggregated to show clinician, program and system wide progress. • Program includes appropriate measures to ensure data collection and ensures appropriate baselines are determined and benchmarks set, and has a process to track, identify when targets are not being met and incorporates data into decision making process. • Program utilizes Plan-Do-Study ACT cycles, NIATx model or other recognized quality improvement methods as appropriate.

VII. Resources

Clinical Supervision:

Clinical Supervision Overview Module One

Clinical Supervision Module Two: The Clinical Alliance

NYS OASAS Clinical Supervision Foundations I – Online 14 hour course approved for OASAS SUD Clinical Supervisory Requirements

NYS OASAS Clinical Supervision Foundations II – Listing of training providers for the 16 hour classroom training required for OASAS SUD Clinical Supervisors

NYS OASAS Scope of Practice

NYS Office of Professions

Person-Centered Care

Person-centered Medication Treatment

Standards for Certified Programs

Certified Recovery Peer Advocate Certification

Trauma informed Care

VIII. References

Center for Substance Abuse Treatment. Substance Abuse: Clinical Issues in Intensive Outpatient Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2006. (Treatment Improvement Protocol (TIP) Series, No. 47.) Chapter 5. Treatment Entry and Engagement. Available from: http://www.ncbi.nlm.nih.gov/books/NBK64084/

Grosenick JK and Hatmaker CM (2000). Perceptions of the importance of physical setting in substance abuse treatment. Journal of Substance Abuse Treatment; 18, 29 – 39.

Loveland, David; PhD. (June 19, 2014) *Creating a Front Door to Engage and Retain Individuals with a SUD*. PowerPoint presented at the Community Care Behavioral Health Organization, Engagement Strategies Supporting Wellness and Recovery Conference, State College, PA.

National Institute on Drug Abuse. principles of drug addiction treatment A research-based guide, Third Addition, NIH Publication No. 12–4180 Printed 1999; Reprinted July 2000, February 2008; Revised April 2009; December 2012

White, W., Scott, C, Dennis, M., Boyle, M; (2005), It's time to stop Kicking People out of Addiction Treatment, *Counselor Magazine* 2-12

IBID

The National Quality Forum, *A Path Forward to Measuring Continuing Care Management for Substance Use Illness: Patient-focused Episodes of Care,* (November 4, 2009), Washington, D.C.

Center for Substance Abuse Treatment. *Substance Abuse Treatment and Family Therapy*. Chapter 4 Integrated Models for Treating Family Members, Treatment Improvement Protocol (TIP) Series, No. 39. DHHS Publication No. (SMA) 05-4006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.

Substance Abuse and Mental Health Services Administration. *Improving Cultural Competence.* Treatment Improvement Protocol (TIP) Series No. 59. HHS Publication No. (SMA) 14-4849. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Center for Substance Abuse Treatment. Substance Abuse: Administrative Issues in Outpatient Treatment. Chapter 4 Preparing a Program to Treat Diverse Clients, Treatment Improvement Protocol (TIP) Series 46. DHHS Publication No. (SMA) 06-4151. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

Substance Abuse and Mental Health Services Administration. *Trauma-Informed Care in Behavioral Health Services*. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Center for Substance Abuse Treatment. *Substance Abuse Treatment and Family Therapy*. Treatment Improvement Protocol (TIP) Series, No. 39. DHHS Publication No. (SMA) 05-4006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.

Substance Abuse and Mental Health Services Administration. *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series, No. 27. HHS Publication No. (SMA) 12-4215. Rockville, MD: Author, 2012.

White, W., Scott, C, Dennis, M., Boyle, M; (2005), It's time to stop Kicking People out of Addiction Treatment, *Counselor Magazine* 2-12

Center for Substance Abuse Treatment. Clinical Supervision and Professional Development of the Substance Abuse Counselor. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2009. (Treatment Improvement Protocol (TIP) Series, No. 52.)

Center for Substance Abuse Treatment. *Technical Assistance Publication (TAP) Series 21, Addiction Counseling Competencies: The knowledge, skills, and attitudes of professional practice*. Rockville, MD: Substance Abuse and Mental Health Services Administration (DHHS Publication No. SMA 064171), 2006.

Scopes of Practice & Career Ladder for Substance Use Disorder Counseling, Expert Panel on Scopes of Practice in the Field of Substance Use Disorders, held on March 12, 2010, supported by SAMHSA

Substance Abuse and Mental Health Services Administration. *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series, No. 27. HHS Publication No. (SMA) 12-4215. Rockville, MD: Author, 2012.

National Institute on Drug Abuse. Principles of drug addiction treatment A research-based guide, Third Addition, NIH Publication No. 12–4180 Printed 1999; Reprinted July 2000, February 2008; Revised April 2009; December 2012

SAMHSA. Medication-Assisted Treatment for Substance Use Disorders, Pharmacotherapy for Substance Use Disorders. Retrieved from http://dpt.samhsa.gov/medications/medsindex.aspx.

The Addiction Technology Transfer Center Network, Introduction to Evidence-Based Practices in Addiction Treatment, (PowerPoint). Retrieved from *www.nattc.org/resPubs/bpat/docs/Presentations/intro**ebp**.ppt*

Kizer, K.W., Nishimi, R.Y., & Power, E.J. (December 2004). *Evidence-Based Treatment Practices for Substance Use Disorders*, Washington, D.C. National Quality Forum (NQF)

National Institute on Drug Abuse. Principles of Drug Addiction Treatment A research-based guide, Evidence Based Practice to Drug Addiction Treatment, Third Addition, NIH Publication No. 12–4180 Printed 1999; Reprinted July 2000, February 2008; Revised April 2009; December 2012

PsychGuides.com (http://www.psychguides.com). Crisis Management Treatment Program Options, 8 pp.

Substance Abuse and Mental Health Services Administration. *Clinical Issues in Intensive Outpatient Treatment.* Treatment Improvement Protocol (TIP) Series, No. 47. HHS Publication No. (SMA) 12-4215. Rockville, MD: Author, 2012.

Center for Substance Abuse Treatment. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005. (Treatment

Improvement Protocol (TIP) Series, No. 43.) Chapter 4. Initial Screening, Admission Procedures, and Assessment Techniques. Available from: http://www.ncbi.nlm.nih.gov/books/NBK64165/

Clark, L., Haram, E., Johnson, K., & Molfenter, T. (2010) NIATx and the University of Wisconsin- Madison. *Getting Started with Medication-assisted Treatment,*

Substance Abuse and Mental Health Services Administration. SAMHSA Opioid Overdose Prevention Toolkit. HHS Publication No. (SMA) 13-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

Joint Commission on Accreditation of Healthcare Organizations. *Sentinel event policy and procedures.* In: JCAHO, ed. Chicago, JCAHO, 1999.

Hunter, S. B., Ober, A. J., Paddock, S. M., Hunt, P. E., & Levan, D. (2014). Continuous quality improvement (CQI) in addiction treatment settings: design and intervention protocol of a group randomized pilot study. *Addiction Science & Clinical Practice*, *9*(1), 4. doi:10.1186/1940-0640-9-4

Quanbeck, A. R., Madden, L., Edmundson, E., Ford, J. H., McConnell, K. J., McCarty, D., & Gustafson, D. H. (2012). A business case for quality improvement in addiction treatment: Evidence from the NIATx collaborative. *The Journal of Behavioral Health Services & Research*, *39*(1), 91–100. doi:10.1007/s11414-011-9259-6

National Institute on Drug Abuse. Principles of drug addiction treatment A research-based guide, Third Addition, NIH Publication No. 12–4180 Printed 1999; Reprinted July 2000, February 2008; Revised April 2009; December 2012

Treatment Improvement Protocol (TIP) 47 - Substance Abuse: Clinical Issues in Intensive Outpatient Treatment. Health and Human Services, CSAT, Rockville, Md.: SAMHSA, 2006. See Chap 2, Principle 2, “Ease Entry”.

Gustafson DH, Resar R, Johnson K and Daigle JG (2008). Don’t fumble the treatment handoff. Addiction Professional, September – October, 6 (5), 30 – 33.

Center for Substance Abuse Treatment. Substance Abuse Treatment for Persons With Co-Occurring Disorders. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005. (Treatment Improvement Protocol (TIP) Series, No. 42.) 4 Assessment. Available from: http://www.ncbi.nlm.nih.gov/books/NBK64196/

SAMHSA-HRSA Center for Integrated Health Solutions. Medication Assisted Treatment (MAT) Overview. Retrieved from http://www.integration.samhsa.gov/clinical-practice/mat/mat-overview

Treatment Improvement Protocols (TIP) No. 42, 43, 44, and 51, "Substance Abuse Treatment: Addressing the Specific Needs of Women". CSAT, Rockville, Md.: SAMHSA, see chapter sections on health areas assessment

Citation Center for Substance Abuse Treatment. Substance Abuse Treatment for Adults in the Criminal Justice System. Treatment Improvement Protocol (TIP) Series 44 Chapter 2, "Conclusions and Recommendations." HHS Publication No. (SMA) 13-4056. Rockville ,MD: Substance Abuse and Mental Health Services Administration, 2005.

Center for Substance Abuse Treatment. Substance Abuse: Clinical Issues in Intensive Outpatient Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2006. (Treatment Improvement Protocol (TIP) Series, No. 47.) Chapter 5. Treatment Entry and Engagement. Available from: http://www.ncbi.nlm.nih.gov/books/NBK64084/

Center for Substance Abuse Treatment. Substance Abuse Treatment for Persons with Co-Occurring Disorders. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005. (Treatment Improvement Protocol (TIP) Series, No. 42.) 4 Assessment. Available from: http://www.ncbi.nlm.nih.gov/books/NBK64196/

White, W., Scott, C, Dennis, M., Boyle, M; (2005), It's time to stop Kicking People out of Addiction Treatment, *Counselor Magazine* 2-12

Ashcraft, L. (2007). Eight Steps of Recovery Planning: For Service Providers, Families, and People on the Road to Recovery. Retrieved from www.t-mha.org/media/pdf/rr/8_Steps_of_Recovery.pdf

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.