Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

A Treatment Improvement Protocol

TIP 47

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

INTENSIVE OUTPATIENT TREATMENT

Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

Robert F. Forman, Ph.D.
Consensus Panel Chair

Paul D. Nagy, M.S., LCAS, LPC, CCS
Consensus Panel Co-Chair

A Treatment Improvement Protocol

TIP 47

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

1 Choke Cherry Road
Rockville, MD 20857

Acknowledgments

Numerous people contributed to the development of this Treatment Improvement Protocol (TIP) (see pp. xi–xiv as well as appendixes C, D, and E). This publication was produced by JBS International, Inc. (JBS), under the Knowledge Application Program (KAP) contract numbers 270-99-7072 and 270-04-7049 with the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS). Christina Currier served as the Center for Substance Abuse Treatment (CSAT) Government Project Officer, and Andrea Kopstein, Ph.D., M.P.H., served as Deputy Government Project Officer. Lynne MacArthur, M.A., A.M.L.S., served as the JBS KAP Executive Project Co-Director. Barbara Fink, RN, M.P.H., served as the JBS KAP Managing Project Co-Director. Other KAP personnel included Dennis Burke, M.S., M.A., and Emily Schifrin, M.S., Deputy Directors for Product Development; Patricia A. Kassebaum, M.A., Senior Writer; Elliott Vanskike, Ph.D., Senior Writer/Publication Manager; Candace Baker, M.S.W., Senior Writer; Wendy Caron, Editorial Quality Assurance Manager; Frances Nebesky, M.A., Quality Assurance Editor; Leah Bogdan, Junior Editor; and Pamela Frazier, Document Production Specialist. In addition, Sandra Clunies, M.S., ICADC, served as Content Advisor. Dixie M. Butler, M.S.W., and Paddy Shannon Cook were writers.

Disclaimer

The opinions expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of CSAT, SAMHSA, or DHHS. No official support of or endorsement by CSAT, SAMHSA, or DHHS for these opinions or for particular instruments, software, or resources described in this document is intended or should be inferred. The guidelines in this document should not be considered substitutes for individualized client care and treatment decisions.

Public Domain Notice

Electronic Access and Copies of Publication

Copies may be obtained free of charge from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889; or electronically through www.ncadi.samhsa.gov.

Recommended Citation

Center for Substance Abuse Treatment. *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment.* Treatment Improvement Protocol (TIP) Series 47. DHHS Publication No. (SMA) 06-4182. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

Originating Office

Practice Improvement Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

DHHS Publication No. (SMA) 06-4182
NCADI Publication No. BKD551
Printed 2006

Contents

What Is a TIP? ..... **ix**

Consensus Panel ..... **xi**

KAP Expert Panel and Federal Government Participants ..... **xiii**

Foreword ..... **xv**

Executive Summary ..... **xvii**

Chapter 1—Introduction **1**

Forces Affecting IOT and the Contents of This TIP 2

Terminology and Definitions 3

Summary of This TIP 5

Chapter 2—Principles of Intensive Outpatient Treatment **7**

Principle 1: Make Treatment Readily Available 8

Principle 2: Ease Entry 9

Principle 3: Build on Existing Motivation 9

Principle 4: Enhance Therapeutic Alliance 10

Principle 5: Make Retention a Priority 10

Principle 6: Assess and Address Individual Treatment Needs 11

Principle 7: Provide Ongoing Care 11

Principle 8: Monitor Abstinence 12

Principle 9: Use Mutual-Help and Other Community-Based Supports 12

Principle 10: Use Medications if Indicated 13

Principle 11: Educate About Substance Use Disorders, Recovery, and Relapse 14

Principle 12: Engage Families, Employers, and Significant Others 14

Principle 13: Incorporate Evidence-Based Approaches 15

Principle 14: Improve Program Administration 15

Chapter 3—Intensive Outpatient Treatment and the Continuum of Care **17**

Overview of a Continuum of Care 17

Conceiving of a Continuum of Care 18

Key Aspects of IOT (Level II) 19

Key Aspects of Outpatient Treatment (Level I) 23
Continuing Community Care 24

Chapter 4—Services in Intensive Outpatient Treatment Programs 27

Core Services 27
Enhanced IOT Services 44
IOT Services: A Case Illustration 46
Appendix 4-A. A Case Study of Intensive Outpatient Treatment 48
Appendix 4-B. Induction Protocol for Disulfiram 56

Chapter 5—Treatment Entry and Engagement 59

Elements of Engaging the Client in IOT 60
Collect Screening Information 62
Assessing Barriers to Treatment 64
Crises and Emergencies 67
Components of the IOT Admission Process 67
Sample Treatment Plans 76
Appendix 5-A. Substance Use History Form 84
Appendix 5-B. Instruments for Determining Substance-Related and Psychiatric Diagnoses 85
Appendix 5-C. DSM-IV Criteria for Substance Dependence and Substance Abuse 87
Appendix 5-D. Supplements to the Six Assessment Domains in the ASI and Other Topics 88

Chapter 6—Family-Based Services 93

Planning for Family Involvement 94
Engaging the Family in Treatment 95
Family Services 98
Family Clinical Issues in IOT 102
Appendix 6-A. Format and Symbols for Family Genogram 107
Appendix 6-B. Family Social Network Map 109
Appendix 6-C. Resources for Family-Based Services 112

Chapter 7—Clinical Issues, Challenges, and Strategies in Intensive Outpatient Treatment 115

Client Retention 115

Relapse and Continued Substance Use 117
Substance Use by Family Members 119
Group Work Issues 120
Safety and Security 125
Client Privacy 128
Clients Who Work 130
Boundary Issues 132
Appendix 7-A. Instruments for Assessing Relapse Potential 135

Chapter 8—Intensive Outpatient Treatment Approaches 137

12-Step Facilitation Approach 138
Cognitive–Behavioral Approach 140
Motivational Approaches 141
Therapeutic Community Approach 142
The Matrix Model 146
Community Reinforcement and Contingency Management Approaches 148

Chapter 9—Adapting Intensive Outpatient Treatment for Specific Populations 153

Justice System Population 153
Women 157
Populations With Co-Occurring Psychiatric Disorders 162
Adolescents 171
Young Adults 175

Chapter 10—Addressing Diverse Populations in Intensive Outpatient Treatment 179

What It Means To Be a Culturally Competent Clinician 180
Principles in Delivering Culturally Competent IOT Services 181
Issues of Special Concern 183
Clinical Implications of Culturally Competent Treatment 188
Sketches of Diverse IOT Client Populations 189
Appendix 10-A. Cultural Competence Resources 197

Appendix A—Bibliography **205**

Appendix B—Urine Collection and Testing Procedures and Alternative Methods for Monitoring Drug Use **237**

Appendix C—Resource Panel **247**

Appendix D—Cultural Competency and Diversity Network Participants **249**

Appendix E—Field Reviewers **251**

Index **255**

CSAT TIPs and Publications Based on TIPs **265**

Exhibits

3-1 Goals, Duration, Activities, and Completion Criteria of Stage 1 21
3-2 Goals, Duration, Activities, and Completion Criteria of Stage 2 22
3-3 Goals, Duration, Activities, and Completion Criteria of Stage 3 25
3-4 Goals, Duration, Activities, and Completion Criteria of Stage 4 26
4-1 Core and Enhanced Services for IOT Programs 28
4-2 Groups Conducted in Intensive Outpatient Treatment 29
4-3 Typical Sequence of Topics Addressed in Psychoeducational Group 33
4-4 Case Management Services 39
4-5 Examples of 24-Hour Crisis Coverage Implementation 41
4-6 Alternatives to Traditional 12-Step Groups 43
4-7 Key Features of a Hospital-Based Suburban IOT Program 46
4-8 A Protocol for Ambulatory Detoxification and Disulfiram Induction 56
5-1 Effective Interviewing Techniques 63
5-2 ABC Model for Psychiatric Screening 66
5-3 The Six Dimensions of the ASAM PPC-2R for Level II.1 IOT 69
5-4 Brief Screening Instruments That Assess Motivational Stage 70
5-5 Mild Withdrawal Symptoms for Four Drug Classes That Can Be Managed in Level II.5 Ambulatory Detoxification 71

6-1 Suggestions for Engaging Family Members at Intake 96
6-2 A Treatment Calendar for Family Members 99
6-3 Social Network Grid Used in Conjunction With Network Map 111
7-1 Examples of Immediate Safety Concerns and Counselor Responses 126
8-1 Strengths and Challenges of 12-Step Approaches 139
8-2 Strengths and Challenges of Cognitive–Behavioral Approaches 141
8-3 Strengths and Challenges of Motivational Approaches 143
8-4 Strengths and Challenges of the Therapeutic Community Approach 145
8-5 Strengths and Challenges of Matrix Model Treatment 147
8-6 Strengths and Challenges of Community Reinforcement and Contingency Management Approaches 151
9-1 Core Treatment Needs and Service Elements for Women 160
9-2 SAMHSA's Service Coordination Framework for Co-Occurring Disorders 164
9-3 The Family Intervention Program 174
9-4 Characteristics and Behaviors of Adolescents and Treatment Suggestions 176
B-1 Urine Toxicology Detection Periods for Different Substances 240
B-2 Effectiveness of Drug Detection Methods That Use Different Biological Products 243

What Is a TIP?

Treatment Improvement Protocols (TIPs), developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration, within the U.S. Department of Health and Human Services, are best-practice guidelines for the treatment of substance use disorders. CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private treatment facilities to include practitioners in mental health, criminal justice, primary care, and other health care and social service settings.

CSAT's Knowledge Application Program expert panel, a distinguished group of experts on substance use disorders and professionals in such related fields as primary care, mental health, and social services, works with the State Alcohol and Drug Abuse Directors to generate topics for the TIPs. Topics are based on the field's current needs for information and guidance.

After selecting a topic, CSAT invites staff from pertinent Federal agencies and national organizations to be members of a resource panel that recommends specific areas of focus as well as resources that should be considered in developing the content for the TIP. These recommendations are communicated to a consensus panel composed of experts on the topic who have been nominated by their peers. Consensus panel members participate in a series of discussions. The information and recommendations on which they reach consensus form the foundation of the TIP. The members of each consensus panel represent substance abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A panel chair (or co-chairs) ensures that the contents of the TIP mirror the results of the group's collaboration.

A large and diverse group of experts closely reviews the draft document. Once the changes recommended by these field reviewers have been incorporated, the TIP is prepared for publication, in print and on line. TIPs can be accessed via the Internet at www.kap.samhsa.gov. The online TIPs are consistently updated and provide the field with state-of-the-art information.

Although each TIP strives to include an evidence base for the practices it recommends, CSAT recognizes that the field of substance abuse treatment is evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. For this reason, recommendations proffered in the TIP are attributed to either panelists' clinical experience or the literature. If research supports a particular approach, citations are provided.

This TIP, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment*, was written to help clinicians address the expansion of intensive outpatient treatment (IOT) represented by the development and adoption of new approaches to treat a wider variety of clients. Researchers and clinicians have begun to question the acute care model of treatment for substance use disorders; this reexamination has led to a more robust collaboration between researchers and practitioners. The resulting focus on evidence-based treatment approaches informs most of the material in this TIP. The consensus panel presents 14 guiding principles of IOT, supported by research and clinical experience. This TIP also situates IOT within the continuum of care framework established by the American Society of Addiction Medicine, including outpatient treatment and continuing community care. The volume describes the core services every program should offer, the enhanced services that should be available on site or through links with community-based services, and the process of assessment, placement, and treatment planning that helps clinicians address each client's needs. Based on research and clinical experience, the consensus panel discusses major clinical challenges of IOT and surveys the most common treatment approaches used in IOT programs, including family-based services. More specialized sections address treatment of specific groups of clients: women; adolescents and young adults; persons involved with the criminal justice system; individuals with co-occurring disorders; racial and ethnic minorities; persons with HIV/AIDS; lesbian, gay, and bisexual individuals; persons with physical or cognitive disabilities; rural populations; individuals who are homeless; and older adults.

Consensus Panel

This TIP is a consensus-based document, developed by the experts listed below. Although all panelists made significant contributions in the development of the TIP as a whole, some panelists took on the additional responsibility as writers for upfront development of particular chapters. Those chapters are listed after their names.

Chair

Robert F. Forman, Ph.D.
Clinical Scientist
Medical Affairs
Alkermes, Inc.
Cambridge, Massachusetts
Formerly
Senior Investigator
Treatment Research Institute
Assistant Professor of Psychology in Psychiatry
School of Medicine
University of Pennsylvania
Philadelphia, Pennsylvania
Writer, chapters 1 and 2

Co-Chair

Paul D. Nagy, M.S., LCAS, LPC, CCS
Program Director
Duke Addictions Program
Clinical Associate
Department of Psychiatry and Behavioral Sciences
Duke University Medical Center
Durham, North Carolina
Writer, chapters 1 and 5

Consensus Panelists

Fred Andes, D.S.W., M.P.A., LCSW
Assistant Professor of Sociology
New Jersey City University
Jersey City, New Jersey
Writer, chapters 5 and 6

Margaret K. Brooks, J.D.
Consultant
27 Warfield Street
Montclair, New Jersey
Writer, chapter 9

Frederick T. Chappelle, M.S.S.W., LCADC, CCS
Vice President and Financial Officer
Chappelle Consulting and Training Services, Inc.
Middletown, Connecticut

Gerard J. Connors, Ph.D.
Director
Research Institute on Addictions
University of Buffalo
Buffalo, New York
Writer, chapters 4 and 5

Anita L. Crawford
Chief Executive Officer
Roxbury Comprehensive Community Health Center
Roxbury, Massachusetts

Chris B. Farentinos, M.D., CADC II, NCDC II
Clinical Director
Change Point, Inc.
Portland, Oregon
Writer, chapters 4, 7, 8, and 10

Marco E. Jacome, M.A., LPC, CSADC, CEAP
Executive Director
Healthcare Alternative Systems, Inc.
Chicago, Illinois
Writer, chapter 10

George Kolodner, M.D.
Medical Director
Kolmac Clinic
Silver Spring, Maryland
Writer, chapter 4

Felicity L. LaBoy, Ph.D.
Clinical Coordinator
Dual Diagnoses Program
Substance Abuse Services
Bronx VA Medical Center
Bronx, New York
Writer, chapters 3, 4, and 9

Janice Ogden Lipscomb, M.S., ACADC
Director
Mental Health and Chemical Dependency Community Based Programs
Broadlawns Medical Center
Des Moines, Iowa
Writer, chapters 3 and 8

Mary E. McCaul, Ph.D.
Associate Professor
Psychiatry and Behavioral Sciences
Johns Hopkins University School of Medicine
Baltimore, Maryland
Writer, chapters 8 and 9

Elizabeth A. Peyton
Principal
Peyton Consulting Services
Newark, Delaware
Writer, chapters 8 and 9

Richard A. Rawson, Ph.D.
Associate Director
UCLA Integrated Substance Abuse Programs
Los Angeles, California
Writer, chapter 2

Candace M. Shelton, M.S., CSAS, CADAC, CCS
Consultant
Tucson, Arizona
Writer, chapter 10

KAP Expert Panel and Federal Government Participants

Barry S. Brown, Ph.D.
Adjunct Professor
University of North Carolina at Wilmington
Carolina Beach, North Carolina

Jacqueline Butler, M.S.W., LISW, LPCC, CCDC III, CJS
Professor of Clinical Psychiatry
College of Medicine
University of Cincinnati
Cincinnati, Ohio

Deion Cash
Executive Director
Community Treatment and Correction Center, Inc.
Canton, Ohio

Debra A. Claymore, M.Ed.Adm.
Owner/Chief Executive Officer
WC Consulting, LLC
Loveland, Colorado

Carlo C. DiClemente, Ph.D.
Chair
Department of Psychology
University of Maryland Baltimore County
Baltimore, Maryland

Catherine E. Dube, Ed.D.
Independent Consultant
Brown University
Providence, Rhode Island

Jerry P. Flanzer, D.S.W., LCSW, CAC
Chief, Services
Division of Clinical and Services Research
National Institute on Drug Abuse
Bethesda, Maryland

Michael Galer, D.B.A., M.B.A., M.F.A.
Chairman of the Graduate School of Business
University of Phoenix—Greater Boston Campus
Braintree, Massachusetts

Renata J. Henry, M.Ed.
Director
Division of Alcoholism, Drug Abuse, and Mental Health
Delaware Department of Health and Social Services
New Castle, Delaware

Joel Hochberg, M.A.
President
Asher & Partners
Los Angeles, California

Jack Hollis, Ph.D.
Associate Director
Center for Health Research
Kaiser Permanente
Portland, Oregon

Mary Beth Johnson, M.S.W.
Director
Addiction Technology Transfer Center
University of Missouri—Kansas City
Kansas City, Missouri

Eduardo Lopez, B.S.
Executive Producer
EVS Communications
Washington, D.C.

Holly A. Massett, Ph.D.
Academy for Educational Development
Washington, D.C.

Diane Miller
Chief
Scientific Communications Branch
National Institute on Alcohol Abuse and Alcoholism
Bethesda, Maryland

Harry B. Montoya, M.A.
President/Chief Executive Officer
Hands Across Cultures
Espanola, New Mexico

Richard K. Ries, M.D.
Director/Professor
Outpatient Mental Health Services
Dual Disorder Programs
Seattle, Washington

Gloria M. Rodriguez, D.S.W.
Research Scientist
Division of Addiction Services
New Jersey Department of Health and Senior Services
Trenton, New Jersey

Everett Rogers, Ph.D.
Center for Communications Programs
Johns Hopkins University
Baltimore, Maryland

Jean R. Slutsky, P.A., M.S.P.H.
Senior Health Policy Analyst
Agency for Healthcare Research and Quality
Rockville, Maryland

Nedra Klein Weinreich, M.S.
President
Weinreich Communications
Canoga Park, California

Clarissa Wittenberg
Director
Office of Communications and Public Liaison
National Institute of Mental Health
Bethesda, Maryland

Consulting Members of the KAP Expert Panel

Paul Purnell, M.A.
Social Solutions, L.L.C.
Potomac, Maryland

Scott Ratzan, M.D., M.P.A., M.A.
Academy for Educational Development
Washington, D.C.

Thomas W. Valente, Ph.D.
Director, Master of Public Health Program
Department of Preventive Medicine
School of Medicine
University of Southern California
Alhambra, California

Patricia A. Wright, Ed.D.
Independent Consultant
Baltimore, Maryland

Foreword

The Treatment Improvement Protocol (TIP) series supports SAMHSA's mission of building resilience and facilitating recovery for people with or at risk for mental or substance use disorders by providing best-practices guidance to clinicians, program administrators, and payers to improve the quality and effectiveness of service delivery and thereby promote recovery. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and client advocates debates and discusses its particular areas of expertise until it reaches a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs' panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators who serve, in the most current and effective ways, people who abuse substances. We are grateful to all who have joined with us to contribute to advances in the substance abuse treatment field.

Eric B. Broderick, D.D.S., M.P.H.
Acting Deputy Administrator
Assistant Surgeon General
Substance Abuse and Mental Health Services Administration

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

Executive Summary

This volume, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment*, and its companion text, *Substance Abuse: Administrative Issues in Outpatient Treatment*, revisit the subject matter of Treatment Improvement Protocol (TIP) 8, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse*, published in 1994 (CSAT 1994*c*). When TIP 8 was published, one volume of about 100 pages sufficed to address relevant topics in intensive outpatient treatment (IOT). Today, the same task requires two volumes, each devoted to a distinct audience, clinicians and administrators. The primary audience for this volume is clinicians working in IOT programs.

The Changing IOT Landscape

Arnold M. Washton (1997) points out that the first large expansion of IOT took place during the 1980s, when White, middle-class individuals with cocaine addiction, many of whom were business professionals, sought treatment and did not want to take time away from work or face the stigma of checking into a residential treatment facility. A second expansion of IOT was ushered in by managed care with a focus on cost containment. Throughout the 1990s, IOT grew, becoming the dominant setting for most clients with substance use disorders. This growth was spurred by the expansion of IOT's population from clients with a moderate range of problems to include clients who are homeless, adolescents, and persons with co-occurring mental disorders, all of whom formerly were considered too difficult for IOT programs to treat successfully. This expansion in clients and services means that IOT clinicians must keep abreast of a broadening array of treatment approaches and services provided beyond their programs. The current volume's focus on clinicians reflects both the increased treatment options available and the expanded range of knowledge and skills required.

Defining Substance Abuse Treatment and IOT

For most of the 20th century, substance abuse was considered an acute disorder. Viewing substance abuse more like pneumonia than like chronic diseases such as hypertension or diabetes had shaped the expectations and treatment choices of clinicians. As McLellan and colleagues (2000) point out, regarding substance abuse as a chronic disorder means realigning treatment and outcome expectations so that they resemble those for other chronic disorders. Today, many IOT programs are involved in treatment beyond the traditional 4 to 12 weeks. Increasingly, IOT programs focus on ongoing care that addresses many areas of clients' lives through case management and the involvement of other service providers and families and communities.

A parallel development has been the frequent application of research findings into practice in the field of substance abuse treatment. Research has yielded new understanding about the complexity of substance use disorders that takes into account biochemical processes, learning, spirituality, and environment. IOT programs are integral to the process of translating scientific findings into clinically effective treatments. The collaboration between research and practice has moved some treatments out of research centers and into IOT programs. Cognitive–behavioral interventions, relapse prevention training, motivational enhancement, and case management are used in community-based treatment settings as a result of the cross-fertilization of research and treatment.

One result of the convergence of research and practice is the development of evidence-based principles that shape and guide substance abuse treatment. The consensus panel recommends 14 principles for IOT programs. These principles lay a theoretical foundation for discussions of IOT services, clinical challenges, and treatment approaches and adaptations. In their focus on client engagement and retention, individualizing treatment, using the entire continuum of care, and reaching out to families, employers, and the community, the 14 principles help define the IOT program's contemporary role.

Continuum of Care and IOT Services

An IOT program is most effective at helping its clients if it is part of a continuum of care. The American Society of Addiction Medicine has established five levels of care: medically managed intensive inpatient, residential, intensive outpatient, outpatient, and early intervention. In addition, continuing community care (e.g., 12-Step support groups), which a client participates in after the conclusion of formal treatment, is another important level of service. A continuum of care ensures that clients can enter substance abuse treatment at a level appropriate to their needs and step up or down to a different intensity of treatment based on their responses. Clinicians enhance the capabilities of their programs when they are informed about and willing to refer clients to other treatment providers. Close monitoring of clients' progress toward treatment goals is key to determining when they are ready for the next appropriate level of care. Any transition in treatment increases the likelihood that a client will drop out. A step-up or stepdown in treatment intensity in the same program or a referral to a nonaffiliated provider can be disruptive for the client. Mee-Lee and Shulman (2003) recommend that a continuum of care feature seamless transfer between levels, congruence in treatment philosophy, and efficient transfer of records. Clinicians need to be thoroughly familiar with local treatment options, including support groups, so that they can orient clients as the clients transition to new treatment situations.

Services integral to all IOT programs are core services. The consensus panel believes that these core services, such as group and individual counseling, psychoeducational programming, monitoring of drug use, medication management, case management, medical and psychiatric examinations, crisis intervention coverage, and orientation to community-based support groups, are indispensable and should be available through all IOT programs. Additional services that are offered at the program site or through links with partner organizations are enhanced services. This concept is flexible, and what might be considered enhanced services for some programs may be essential services for a program with a different client population. (Clients whose first language is not English might need language classes to find work and participate in mutual-help groups, whereas a program that primarily serves native speakers would have little call for such a service.) Enhanced services include adult education classes, recreational activities, adjunctive therapies (e.g., biofeedback, acupuncture, meditation), child care, nicotine cessation treatment, housing, transportation, and food.

Entry, Engagement, and Treatment Issues

Many clients who enter substance abuse treatment drop out in the early stages (Claus and Kindleberger 2002). Entry and engagement are crucial processes; how an IOT program addresses them can influence strongly whether clients remain in treatment. Client intake and engagement can involve contradictory processes such as collecting intake information from clients while initiating a caring, empathic relationship. Balancing administrative tasks and therapeutic intervention is a challenge clinicians face during a client's first hours in an IOT program. To help clinicians achieve that balance, the consensus panel recommends assessing potential clients' readiness for change and using strategies that motivate them to enter and continue treatment. Clinicians should begin to establish a therapeutic relationship as soon as clients present themselves for treatment. Any barriers to treatment must be addressed. Based on screening and assessments, clients should be matched with the best treatment modality and setting to support their recovery. An individualized treatment plan should be developed with the cooperation of the client to address the client's needs.

Client retention is a priority throughout treatment. The consensus panel draws on research and the experience of practiced clinicians to address the issues of engagement and retention. Clients can become distracted from recovery if family members continue to use substances, boundaries between clients and staff are not established clearly, work conflicts with treatment, or they receive incompatible recommendations from different service systems. Clinicians need to know how to ensure the privacy of their clients and the safety and security of the program facility while maintaining open and productive therapeutic relationships with their clients. Clinicians also need to be familiar with common issues that can derail clients in group therapy such as intermittent attendance and other clients who are disruptive, ambivalent, or withdrawn. When clinicians understand and prepare for these problems, their clients have a better chance of being retained in and benefiting from treatment. A major factor in client retention is the quality of the relationship between client and counselor. The client is more likely to do well in treatment if a strong therapeutic alliance exists.

Treatment Approaches Used in IOT

IOT is compatible with different treatment approaches. Involving clients' families in their recovery is an effective strategy. Substance-using behavior may be rooted in part in a client's family history—whether family of origin or family of choice. Families

can play a crucial role in a client's recovery. Providers should prepare for family involvement, education, and other services so that family members can support recovery. Family involvement in treatment has been linked to positive outcomes for clients in substance abuse treatment (Rowe and Liddle 2003). For IOT providers, adopting a family systems approach means including family members in every stage of treatment: the intake interview, counseling sessions, family dinners or weekends, and graduation celebrations. If family members are to support a client's recovery, they must be disabused of unrealistic expectations and learn about relapse prevention. IOT providers should consider offering family education groups, multifamily groups, and family support groups. If family therapy (which in most States requires a licensed, master's-level clinician) is warranted and an IOT clinic cannot offer it, referral relationships can be developed with an organization that provides individual family therapy, couples therapy, and child-focused therapy.

Providers should be familiar with the strengths and challenges of different treatment approaches so they can serve their clients better by modifying and blending approaches as necessary. The 12-Step facilitation approach is common in the treatment environment. Twelve-Step-oriented treatment helps clients achieve abstinence and understand the principles of Alcoholics Anonymous and other 12-Step groups through group counseling, homework assignments, and psychoeducation. The 12-Step approach emphasizes cognitive, behavioral, spiritual, and health aspects of recovery and is effective with many different types of clients.

Cognitive–behavioral therapy focuses on teaching clients skills that will help them understand and reduce their relapse risks and maintain abstinence. Clients must be motivated and counselors must be trained extensively for cognitive–behavioral therapy to succeed.

Motivational approaches, such as motivational interviewing and motivational enhancement therapy, also rely on extensive staff training and high levels of client self-awareness. Through empathic listening, counselors explore clients' attitudes toward substance abuse and treatment, supporting past successes and encouraging problemsolving strategies. These approaches are client centered and goal driven and encourage client self-sufficiency.

Therapeutic community approaches are used most often in residential settings but have been adapted for IOT. In therapeutic community approaches, a structured community of clients and staff members is the main therapeutic agent—peers and counselors are role models, the work at the facility is used as therapy, and group sessions focus on self-awareness and behavioral change. The intensity of the treatment calls for extensive staff training and can result in high client dropout. However, therapeutic communities have proved successful with difficult clients (e.g., those with long histories of substance use and those who have served time in prison).

The Matrix model integrates a number of other treatment approaches, including mutual-help, cognitive–behavioral, and motivational interviewing. A strong therapeutic relationship between client and counselor is the centerpiece of the Matrix approach. Other features are learning about withdrawal and cravings, practicing relapse prevention and coping techniques, and submitting to drug screens.

Contingency management and community reinforcement approaches encourage clients to change behavior; these approaches reinforce abstinence by rewarding some behaviors and punishing others. Programs select a goal that is reasonable, is attainable, and contributes to overall treatment objectives and then reward small steps the client makes toward that goal. Contingency management and community reinforcement

approaches have been successful with clients who have chronic substance use disorders, when the costs for staff training and incentives can be addressed.

Treating Different Populations

Many of the approaches used in IOT programs were developed to treat substance use disorders in White, middle-class men. Adaptations to these approaches are necessary to treat a variety of clients such as those in the justice system, women, clients with co-occurring disorders, and adolescents.

Increasing numbers of people with substance use disorders are involved with the justice system. Justice agencies and treatment providers need to work closely with each other, communicating clearly and coordinating their efforts. Cooperation of a different kind must exist between clinicians and clients. Therapeutic alliance is especially important when working with clients in the justice system who may have difficulty trusting a clinician and forming meaningful relationships outside the criminal environment.

The number of treatment programs for women is increasing. These programs add enhanced services designed to address substance abuse in the context of pregnancy and parenting, self-esteem issues, and histories of physical, sexual, and emotional abuse. To treat women, clinicians often avoid confrontational techniques and focus on providing a safe and supportive environment with clearly established boundaries between client and counselor.

Many people with co-occurring mental and substance use disorders are not receiving appropriate care (Watkins et al. 2001) and find themselves shuttling between psychiatric and substance abuse treatment, caught between two systems (Drake et al. 2001). Integrated treatment attends to both disorders together, adapts standard interventions to allow for clients' cognitive limitations, and provides comprehensive services to care for both disorders. Programs that do not adopt an integrated approach are advised to coordinate services with mental health providers.

A comprehensive approach to services also is important for adolescents who are using substances. Adolescents experience incredible upheaval in their lives and often need habilitation rather than rehabilitation. Many are in treatment for the first time and need to be oriented to treatment culture. Because adolescents often are living at home, family involvement is crucial. A behavioral contract—stipulating desired behaviors and rewards—and case management—addressing medical, social, and psychological needs—are also beneficial treatment tools.

IOT programs are being called on to serve an increasingly diverse client population. Almost one-third of Americans belong to an ethnic or racial minority group, and more than 10 percent of the U.S. population was born outside the country (Schmidley 2003). Although there is widespread agreement that clinicians should be culturally competent, no consensus exists about what cultural competence means. As a starting point, clinicians should understand how to work with someone from outside their own culture and strive to understand the specific culture of the client being served. Whereas the ability to treat clients from outside one's culture is an extension of the skills of a good clinician, understanding the cultural context of individual clients is more demanding. Clinicians need to strike a balance between a broad cultural background and the specific cultural context of a client's life; an observation that is applicable to a large group may be misleading or harmful if applied to an individual.

For foreign-born clients, level of acculturation often is an issue. Most research shows that the more acculturated clients are, the more their substance use approximates U.S. norms. Programs that serve substantial numbers of foreign-born clients may consider

offering language-specific programs and linking clients to language classes, job training, and employment services. Clients from other cultures may be averse to the emphasis on self-disclosure and self-sufficiency in substance abuse treatment. Counselors must be prepared to work within the client's value system, which may be at odds with values promoted by the treatment program.

Likewise, programs should ensure that program practices and materials do not pose a barrier to clients of non-Christian faiths. Many mutual-help programs have a strong Christian element; clients from other faiths should be informed of this orientation and provided with information about secular or religion-specific mutual-help groups.

Other general guidelines for programs that treat clients from other cultures include assessing policies and practices to spot potential barriers for diverse clients, training staff members in cultural competence, providing materials at an appropriate reading level or translating materials into clients' languages, and using outreach to promote awareness of the program.

The consensus panel offers an extensive list of resources for further research as well as demographic, substance use, and treatment information on members of racial and ethnic groups; persons with physical or cognitive disabilities; persons with HIV/AIDS; persons who are lesbian, gay, or bisexual; rural populations; and homeless populations. These resources are found in appendix 10-A.

1 Introduction

In This Chapter...

Forces Affecting IOT and the Contents of This TIP

Terminology and Definitions

Summary of This TIP

The current volume addresses clinical issues and a companion volume, TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), discusses administration. Together, these TIPs break new ground as the first two-volume TIP issued by the Center for Substance Abuse Treatment (CSAT). This volume represents the most extensive discussion in a TIP of clinical issues for intensive outpatient treatment (IOT) programs.

Several developments in health care and the treatment of substance use disorders have prompted this full revision of TIP 8, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse* (CSAT 1994*c*). Since the original TIP was published, substantial changes have occurred in almost every aspect of how treatment services are conceptualized and delivered. By the late 1990s, IOT had moved from being a peripheral and relatively circumscribed clinical service, serving a small range of clients, to a robust, multidimensional treatment modality that plays a central role in the care of many individuals with substance use disorders. TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), provides a full history of IOT.

As with all TIPs sponsored by CSAT, this volume represents the thinking, experience, and work of a consensus panel. The rapidity of recent changes in the IOT field and the variety of challenges and opportunities that accompany them compelled this TIP's consensus panel to draw on its clinical experience and current research to create a TIP that is both practical and evidence based. *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* examines significant and sometimes perplexing issues facing IOT providers and offers analytical discussions and incisive opinions. In writing the TIP, the consensus panel attempted to reflect the changes of the past decade and anticipate directions that IOT may take.

Forces Affecting IOT and the Contents of This TIP

Chronic Disease Management

Recognizing that substance abuse is a chronic disorder similar to diabetes, hypertension, and asthma led the panel to question the acute care model of service delivery that has characterized substance abuse treatment for the past 50 years (McLellan et al. 2000). Panel members felt strongly that IOT providers—like providers in the rest of the health care system—should rethink the acute care approach to treating substance use disorders. Increasingly, IOT programs are involved in substance abuse treatment beyond the initial 4 to 12 weeks. Much of the discussion in this volume is devoted to continuing care and to finding ways to include case management service providers, families, communities, and mutual-help groups in the ongoing care of individuals with substance use disorders.

Practice–Research Collaboration

In the past decade, emphasis on the blending of evidence-based interventions with community-based service delivery has increased. The longstanding divide between practitioners and researchers needed to be bridged. This disparity, described in the Institute of Medicine 1998 report, *Bridging the Gap Between Practice and Research*, was a major impetus behind the creation of the National Institute on Drug Abuse's (NIDA's) Clinical Trials Network and CSAT's Addiction Technology Transfer Centers and Practice Improvement Centers. Research has resulted in new knowledge about how biochemical processes, learning, spirituality, and environment affect people who abuse substances. These advances may make it easier for clinicians, clients, family members, and the public to understand that substance use disorders are complex illnesses with important biological—as well as social, psychological, and spiritual—dimensions. IOT programs play a central role in translating scientific findings into clinically meaningful information and treatments.

The discussions of treatment and the clinical recommendations in this TIP are informed by the links between practice and research that are becoming the norm in the IOT field.

New Treatment Approaches

A growing interest in evidence-supported interventions has led practitioners to examine long-held assumptions about treatment and the recovery process. Several therapeutic approaches, previously applied primarily in university-based research centers, have begun to emerge as viable and effective interventions that can be implemented successfully in community-based treatment settings. Discussions on cognitive–behavioral interventions, relapse prevention training, motivational enhancement therapy, the use of incentives, and case management approaches have been incorporated into this TIP. Similarly, the TIP describes the benefits of integrating pharmacotherapies into IOT to help manage withdrawal and stabilize people with co-occurring disorders.

Convergence of Systems

Approximately 10 years ago, substance abuse treatment services were viewed widely as specialty services that interacted with a variety of other important stakeholders, such as the mental health, welfare, and criminal justice systems. A profound and important change affecting the delivery of IOT services is the convergence of these previously distinct systems and the substance abuse treatment system. The divisions among services have long been based on administrative convenience and funding streams, not the clinical needs of clients. Programs must be prepared to treat clients who simultaneously may be receiving public welfare, have children in

protective services, and be under criminal justice supervision. Each system may place substance abuse treatment requirements on the client, and, as a consequence, these systems can play an important role in supporting the goals of treatment. This TIP addresses the importance of simultaneously working with multiple systems.

Client and Program Diversity

IOT programs serve a greater variety of clients than they did when TIP 8 was published in 1994. The current volume makes a broader and deeper study of how individual differences affect treatment needs. Ten years ago IOT was offered primarily to privately insured clients with mild-to-moderate levels of dysfunction. Since then, IOT programs have adjusted their models to treat adolescents, clients who are homeless or economically disadvantaged, clients with mental disorders, clients involved with the criminal justice system, clients who are disabled, and those with other special needs once considered beyond the scope of IOT programs. Most programs also are responding to the needs of increasingly diverse racial and ethnic client populations. Many IOT programs now incorporate onsite ambulatory detoxification services, medication management, and infectious disease interventions.

Terminology and Definitions

IOT vs. IOP

Just as the treatment field has yet to settle on a commonly accepted name for itself (e.g., "substance abuse" versus "addiction" versus "substance use disorder" versus "chemical dependence"), there is also no agreed-on term to describe this intensive level of care. Because use of the terms "intensive outpatient treatment" and "intensive outpatient program" (IOP) varies by region, for the sake of consistency, the consensus panel agreed to use the term "intensive outpatient treatment" ("IOT") to refer to this level of care instead of the equally acceptable term "intensive outpatient program." Because of the variety of definitions applied by clinicians and researchers to "intensive outpatient treatment," IOT studies cited in this volume also include day treatment, day hospital treatment, and partial hospitalization programs, in addition to IOT programs.

> Increasingly, IOT programs are involved in substance abuse treatment beyond the initial 4 to 12 weeks.

Outpatient Care vs. Aftercare vs. Continuing Care

The term "aftercare" is avoided throughout this TIP in favor of "continuing care." Research literature occasionally uses the term "aftercare" when discussing traditional outpatient treatment that follows residential or intensive outpatient treatment. Others use the term "aftercare" when discussing clients' participation in mutual-help groups after formal treatment is completed. In this volume, the term "continuing care" designates the mutual-help groups (including 12-Step and other support groups) available in the community after formal treatment ends. Even during the continuing community care phase or treatment, many clients return to the IOT clinic for occasional followup visits, similar to regular medical checkups for other chronic diseases.

Substance Abuse Treatment vs. Mutual-Help Groups

The distinction between substance abuse treatment programs and mutual-help groups, such as 12-Step support groups, often is misunderstood by managed care organizations and the public. The American Medical

...mutual-help groups are an important component of treatment, but they cannot substitute for substance abuse treatment...

Association (1998) has adopted a policy stating that clients with substance use disorders should be treated by qualified professionals and that mutual-help groups should serve as adjuncts to a treatment plan devised within the practice guidelines of the substance abuse treatment field. Likewise, the American Psychiatric Association, American Academy of Addiction Psychiatry, and American Society of Addiction Medicine (ASAM) have issued a joint policy statement that asserts that treatment involves at least the following (American Society of Addiction Medicine 1997):

- A qualified professional is in charge of treatment.
- A thorough evaluation is performed to determine the stage and severity of illness and to screen for medical and mental disorders.
- A treatment plan is developed.
- The treatment professional or program is accountable for the treatment and for referring the client to additional services, if necessary.
- The treatment professional or program maintains contact with the client until recovery is completed.

According to the policy statement adopted by these treatment professionals' associations, mutual-help groups are an important component of treatment, but they cannot substitute for substance abuse treatment as outlined above.

What Constitutes IOT?

Although IOT traditionally has consisted of at least 9 hours of treatment per week, usually delivered in three 3-hour sessions, some programs have substantially longer hours and others provide only 6 contact hours per week. The consensus panel agrees that a program that schedules treatment daily, for 6 hours per day, should be considered a partial hospitalization program. But does such a program differ by kind or just by degree from an IOT program? At what point does an IOT service become a partial hospitalization program? Programs in which clients attend sessions 9 hours per week are clearly more intensive than once-a-week outpatient programs. But where does outpatient end and IOT begin? According to ASAM's Patient Placement Criteria, IOT programs provide 9 or more hours of structured programming per week; ASAM does not specify a minimum duration of treatment (Mee-Lee et al. 2001).

This TIP is intended to be equally useful to all IOT programs, regardless of the number of contact hours per week. But for the discussions and guidelines in this TIP to be meaningful, IOT must be delimited. The consensus panel agreed that IOT has the following features:

- **Contact hours per week:** 6 to 30
- **Stages:** Stepdown and step-up stages of care that vary in intensity and duration
- **Duration:** Minimum of 90 days followed by outpatient continuing care
- **Core features and services:**
  - Program orientation and intake
  - Comprehensive biopsychosocial assessment
  - Individual treatment planning
  - Group counseling
  - Individual counseling
  - Family counseling
  - Psychoeducational programming
  - Case management
  - Integration of clients into mutual-help and community-based support groups
  - 24-hour crisis coverage

- Medical treatment
- Substance use screening and monitoring (urine or breath tests)
- Vocational and educational services
- Psychiatric evaluation and psychotherapy
- Medication management
- Transition management and discharge planning

• **Enhanced services:**

- Adult education
- Transportation
- Housing and food
- Recreational activities
- Adjunctive therapies
- Nicotine cessation treatment
- Child care
- Parent skills training

Summary of This TIP

The following topics are covered in this volume:

Chapter 2—Principles of Intensive Outpatient Treatment presents 14 guiding principles of IOT and the research that supports them. The principles combine the findings of substance abuse research with the experiences of practiced clinicians. The principles are drawn from NIDA's *Principles of Drug Addiction Treatment* (National Institute on Drug Abuse 1999), but the chapter focuses on issues that are critical to effective delivery of IOT services.

Chapter 3—Intensive Outpatient Treatment and the Continuum of Care places IOT within a broad substance abuse treatment continuum that includes outpatient treatment and continuing community care. This chapter situates IOT within the framework of ASAM's levels of care and discusses goals, intensity and duration of treatment, treatment setting, and stages for Level I and Level II care. The chapter discusses IOT as both an entry point for substance abuse treatment and a stepdown or step-up level of care for clients and addresses the importance of transitioning clients to continuing community care.

Chapter 4—Services in Intensive Outpatient Treatment Programs describes the core services a program should provide and enhanced services that often are delivered on site or through established links with community-based providers. Core services include group counseling and therapy, individual counseling, psychoeducational programming, pharmacotherapy and medication management, monitoring substance use, case management, 24-hour crisis coverage, induction into community-based support groups, medical treatment, psychiatric screening and therapy, and vocational training and employment services. Enhanced services include adult education, transportation, adjunctive therapies, and parenting classes.

Chapter 5—Treatment Entry and Engagement addresses the complex and critical processes of screening and diagnosis, placement, assessment, and treatment planning. The desired result of these processes is the client's engagement in treatment at the appropriate level of care and the implementation of treatment that addresses his or her needs. This chapter discusses specific steps in the IOT admission process, including engaging and screening the client, assessing barriers to treatment, and attending to crises; it also illustrates them in two case studies.

Chapter 6—Family-Based Services discusses a family systems approach to IOT that acknowledges and supports the important role and influence of family members on treatment outcomes. The chapter includes goals and outcomes of family-based services and strategies for engaging families in treatment. The chapter also describes various types of family services (family education, multifamily groups, family therapy, retreats, support groups) and clinical issues that often arise when including families in treatment,

such as unrealistic expectations and sabotage of the client's recovery.

Chapter 7—Clinical Issues, Challenges, and Strategies in Intensive Outpatient Treatment looks at issues and problems that arise in clinical practice and offers solutions grounded in research and clinical experience. The chapter covers client retention, relapse and continued substance use, family members who abuse substances, group work issues, safety and security, client privacy, conflicting mandates, clients who work, and boundary issues.

Chapter 8—Intensive Outpatient Treatment Approaches provides detailed descriptions of established IOT program models and approaches. The chapter describes 12-Step facilitation, cognitive–behavioral, motivational, therapeutic community, Matrix model, and community reinforcement and contingency management approaches. The descriptions address the key aspects, research outcomes, and strengths and challenges of each approach.

Chapter 9—Adapting Intensive Outpatient Treatment for Specific Populations highlights the flexibility and adaptability of the IOT model to meet the diverse needs of specific populations: those involved with the criminal justice system, women, individuals with co-occurring disorders, and adolescents and young adults. The chapter provides a demographic overview of each group and discusses implications for IOT programming as well as clinical issues and strategies to use with each population.

Chapter 10—Addressing Diverse Populations in Intensive Outpatient Treatment examines the importance of cultural competence to substance abuse treatment. Reviewing research that supports the need for individualized treatment, the chapter describes principles for the delivery of culturally competent services and explores topics of special concern: foreign-born clients, women from other cultures, and religious considerations. Sketches of diverse populations include Hispanics/Latinos; African-Americans; Native Americans; Asian Americans and Pacific Islanders; persons with HIV/AIDS; lesbian, gay, and bisexual individuals; persons with physical or cognitive disabilities; rural populations; individuals who are homeless; and older adults. The sketches describe each group's demographic characteristics, statistics on substance use, clinical considerations, and implications for IOT. A chapter appendix contains an extensive list of resources on culturally competent treatment and on treating members of each population.

2 Principles of Intensive Outpatient Treatment

In This Chapter...

Principle 1: Make Treatment Readily Available

Principle 2: Ease Entry

Principle 3: Build on Existing Motivation

Principle 4: Enhance Therapeutic Alliance

Principle 5: Make Retention a Priority

Principle 6: Assess and Address Individual Treatment Needs

Principle 7: Provide Ongoing Care

Principle 8: Monitor Abstinence

Principle 9: Use Mutual-Help and Other Community-Based Supports

Principle 10: Use Medications if Indicated

Principle 11: Educate About Substance Use Disorders, Recovery, and Relapse

Principle 12: Engage Families, Employers, and Significant Others

Principle 13: Incorporate Evidence-Based Approaches

Principle 14: Improve Program Administration

This chapter presents 14 principles that integrate the findings of addictions research with the opinion of the consensus panel. By synthesizing research and practice, the consensus panel will assist clinicians in applying these principles to the clinical decisions they face daily. The 14 principles are expressed throughout this TIP in the form of specific recommendations. They are summarized here to provide a concise overview of effective intensive outpatient treatment (IOT) principles.

The *Principles of Drug Addiction Treatment: A Research-Based Guide* (National Institute on Drug Abuse 1999) offers a valuable starting point for the principles that are described in this chapter. The National Institute on Drug Abuse (NIDA) principles pertain to the full spectrum of addiction treatment modalities, not only to IOT. The consensus panel chose to accentuate the principles that are critical to effective IOT.

The 14 principles described in this chapter are

1. Make treatment readily available.
2. Ease entry.
3. Build on existing motivation.
4. Enhance therapeutic alliance.
5. Make retention a priority.
6. Assess and address individual treatment needs.
7. Provide ongoing care.
8. Monitor abstinence.
9. Use mutual-help and other community-based supports.
10. Use medications if indicated.
11. Educate about substance abuse, recovery, and relapse.
12. Engage families, employers, and significant others.
13. Incorporate evidence-based approaches.
14. Improve program administration.

Principle 1: Make Treatment Readily Available

Accommodate a Wide Spectrum of Clients Who Are Substance Dependent

Clinical research and practice have established that IOT is an effective and viable way for individuals with a range of substance use disorders to begin their recovery. In the 1980s, it commonly was believed that only clients who were relatively high functioning, employed, and free of significant co-occurring psychiatric disorders could benefit from IOT and that IOT was not effective with clients who were compromised by significant psychosocial stressors such as homelessness or co-occurring disorders. Today substantial research and clinical experience indicate that IOT can be effective for clients with a range of biopsychosocial problems, particularly when appropriate psychiatric, medical, case management, housing, and other support services are provided.

IOT programs have adjusted successfully to the challenges of working with many special population groups that include

- Clients who are economically disadvantaged (Gruber et al. 2000; Milby et al. 1996)
- Clients who are psychiatrically compromised (Drake et al. 1998*a*, 1998*b*; Rosenheck et al. 1998)
- Pregnant women (Eisen et al. 2000; Howell et al. 1999)
- Individuals involved with the criminal justice system and other clients coerced into treatment

IOT programs have modified their treatment models to be responsive to the needs of adolescents (Jainchill 2000) and women with children (Nardi 1998; Volpicelli et al. 2000). In addition, panel members have described the benefits of IOT programs with culturally specific components for Native American and Spanish-speaking clients and IOT services for clients at various stages of treatment readiness. The unique needs of specific client populations often can be met in IOT by adding services and creating linkages with other service providers.

Comparing Inpatient Treatment With Intensive Outpatient Treatment

Several studies comparing intensive outpatient treatment with residential treatment have found no significant differences in outcomes (Guydish et al. 1998, 1999; Schneider et al. 1996). Finney and colleagues (1996), however, in a review of 14 studies, found that the available evidence tended to favor inpatient slightly over outpatient treatment. The consensus panel has concluded that clients benefit from *both* levels of care and that comparing inpatient with outpatient treatment is potentially counterproductive because the important question is not which level of care is better but, rather, which level of care is more appropriate at a given time for each client. Matching clients with enhanced services also improves client outcomes. McLellan and colleagues (1998) found that compared with control subjects, clients with access to case managers who coordinated medical, housing, parenting, and employment services had less substance use, fewer physical and mental health problems, and better social function after 6 months. It is in the best interest of clients to have a broad continuum of treatment options available. Some clients entering IOT may be able to engage in treatment immediately, whereas others may need referral to a long-term residential program or a therapeutic community. Some clients can be detoxified successfully in an ambulatory setting, whereas others need residential services to complete detoxification successfully.

Principle 2: Ease Entry

Make Access to Treatment Straightforward and Welcoming

IOT programs need to examine policies and procedures to remove unnecessary hurdles in the admission process. From the moment a client or family member first contacts the program, efforts should be made to communicate that IOT exists to serve the client. Delays in the admission process contribute significantly to premature dropout from treatment (Festinger et al. 2002). IOT programs should strive to make the initial appointment available on demand.

Programs should address the following:

- Can the admission process be streamlined without hurting revenues?
- Are the program's hours convenient for clients?
- How can the program facilitate transportation for clients?
- How can the program accommodate clients with childcare responsibilities?
- Is the program individualizing treatment for each client?

The initial encounter with the IOT program should help the client feel like a welcomed participant who is responsible for his or her recovery. IOT programs need to develop a strong customer-focused orientation, making entry into treatment a positive and therapeutic experience.

Principle 3: Build on Existing Motivation

Employ Strategies That Enhance the Client's Motivation

One of the oldest, yet still surviving, misconceptions in the substance abuse treatment field is the notion that people have to "hit bottom" before they can be helped. Studies indicate that individuals who enter treatment for "the wrong reasons" (e.g., complying with external pressures) have outcomes that are comparable with outcomes of those who come into treatment for the "right reasons" (e.g., personal commitment to recovery) (Lawental et al. 1996).

Internal or external pressures drive people to enter treatment. Reasons include negative consequences related to substance use such as an arrest for driving under the influence, pressure from family or friends, fear that substance use is out of control, despair, job insecurity, or a trauma. An IOT program should accept that a client's presence in its office indicates some desire for treatment services.

Regardless of how well or poorly motivated clients appear at treatment entry, their motivation is likely to waver repeatedly over time. Both IOT programs and clients benefit when counselors keep clients mindful of what led them to treatment. Counselors should try to understand what clients care about and connect client concerns with addressing substance use. For example, if a client talks frequently about her daughter, the counselor might ask the client to consider how substance use affects her relationship with the child.

Because of the central importance of motivation in substance abuse treatment, strategies to enhance and maintain client motivation have been a priority in substance abuse research. Two well-researched approaches offer insights into and strategies for maximizing client motivation:

- Contingency management and related behavioral interventions use incentives to increase client retention in treatment and abstinence. Contingency management in addiction treatment has been studied for more than 30 years, but recent studies have focused on how its principles can be applied in community-based settings (Budney and Higgins 1998; Higgins and Silverman 1999; Katz et al. 2001; Kirby et

al. 1999*a;* Petry 2000). These behavioral intervention studies show that motivation is negotiable and can be increased when incentives are applied strategically and systematically. IOT programs are encouraged to find creative ways to use incentives to increase treatment adherence and enhance outcomes.

- Motivational enhancement and interviewing are techniques whereby the counselor responds to client denial and resistance by proposing thoughtful and detailed strategies that are designed to increase client readiness to change (CSAT 1999*c;* Miller and Rollnick 2002; Prochaska and DiClemente 1984). The approach is based on the theory that clients being treated for substance use disorders go through five stages of change: precontemplation, contemplation, action, relapse, and maintenance. Client resistance to treatment indicates that the counselor may be attempting to move the client to the next stage too quickly.

Principle 4: Enhance Therapeutic Alliance

Implement Strategies That Build Trust Between Counselor and Client

In treating mental and substance use disorders, research repeatedly has found one factor to be particularly important in influencing positive outcomes: therapeutic alliance (Martin et al. 2000). In fact, therapeutic alliance is one of the few aspects of treatment that consistently has been linked with increased retention in treatment and improvement in a variety of treatment outcomes. The achievement and maintenance of therapeutic alliance are high priorities in treatment.

Therapeutic alliance has four components (Gaston 1991):

- The client's capacity to work on his or her problem
- The client's emotional bond with the therapist
- The therapist's empathic understanding of the client
- The agreement between client and therapist on the goals and tasks of treatment

Therapeutic alliance tends to be enhanced when clinicians are active listeners, empathic, and nonjudgmental and approach treatment as an active collaboration (Mercer and Woody 1999).

Clinical supervisors should consider the counselors' ability to establish and maintain a therapeutic alliance when hiring and evaluating staff. Staff training and supervision should emphasize consistently that therapeutic alliance is an important element of any clinical interaction. Performance monitoring and quality improvement activities can capture and measure data on therapeutic alliance, so staff members can improve their skills at fostering this important treatment element (see CSAT 2006*f*).

Principle 5: Make Retention a Priority

Place a Premium on Retaining Clients

Early termination of treatment harms the client and staff morale. When clients drop out of treatment prematurely, they are at increased risk of relapse. Completing a prescribed treatment episode is associated with better outcomes, regardless of the length of the treatment (Gottheil et al. 1998).

Given the large number of clients who drop out in the first few weeks of treatment, programs should use strategies and approaches that ensure that clients will complete treatment, such as conducting preadmission interviews (Martino et al. 2000), delivering phone reminders and mailed reminders,

using phone orientations, and decreasing the initial call-to-appointment delay (Stasiewicz and Stalker 1999).

A major strength of IOT is that clients have the opportunity to cope with their illness and make changes in their behavior while living at home. Individual differences in how quickly clients adopt new behaviors call for clinical sophistication and flexibility on the part of counselors and the program as a whole. It can be frustrating when clients do not accept immediately the clinical approach that the IOT program is using. Clients can be frustrated when they are forced into making major lifestyle changes that do not yet make sense to them. Under such circumstances, clients may drop out. Programs need counseling approaches that help clients move toward higher levels of healthy functioning.

Principle 6: Assess and Address Individual Treatment Needs

Match Treatment Services to Clients' Needs

At intake, treatment providers gather preliminary information from clients; then, shortly after admission, programs typically complete a comprehensive biopsychosocial assessment. Many programs administer standardized assessments, such as the Addiction Severity Index (McLellan et al. 1992*a*, 1992*b*) as well as other specific and multidomain assessments. After collecting detailed information about clients' histories and future goals, programs need to use this information to tailor treatment services to clients.

When clients have unmet psychiatric, medical, legal, housing, social, family, or other personal needs, their ability to focus on recovery can be compromised. When programs match the individual treatment needs of clients to treatment services that address those needs, outcomes improve (Hser et al. 1999; McCaul et al. 2001; McLellan et al. 1998, 1999). NIDA's *Principles of Drug Addiction Treatment* notes that "matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society" (National Institute on Drug Abuse 1999, p. 3). IOT programs need to find increasingly efficient strategies for assessing treatment needs and implementing individualized care plans.

The achievement and maintenance of therapeutic alliance are high priorities in treatment.

Principle 7: Provide Ongoing Care

Employ a Chronic Care Model, Adjusting Intensity According to Clients' Needs

A substance use disorder is a complex biopsychosocial illness that is not amenable to a quick fix. In addition to their substance use disorders, clients often have significant psychiatric disorders, criminal involvement, histories of physical and sexual trauma, serious medical illnesses, or profound economic challenges or are homeless. IOT programs contribute to society when they successfully assist clients in improving their ability to function in the community, in the workplace, and in their families. The successful initiation and maintenance of this transformation require sustained and conscientious efforts by the client, his or her support system, and a clinical team.

Substance abuse is a chronic illness similar in many respects to other chronic diseases

such as asthma, diabetes, and hypertension (McLellan et al. 2000). During the early phase of treatment, intensive interventions may be required, including hospitalization. As the client's condition changes, the intensity of treatment gradually can be increased or decreased depending on the client's condition. Eventually client care may be reduced to periodic checkups that evaluate the client's status and adjust treatment accordingly. A substance use disorder often is treated as if it were an acute illness that responds to a brief, acute course of treatment. Frequently, a 6-week IOT experience is not followed by a stepped-down phase of counseling sessions. For many clients, this abrupt shift from intensive treatment to discharge is destabilizing. Because substance abuse is a chronic condition and relapse is always a possibility, IOT programs are encouraged to examine how they can provide smoother stepdown processes and continuing care services that are responsive to the chronic nature of substance use disorders.

Following their successful completion of an intensive phase of treatment, clients should be evaluated for their readiness to be transferred to less intensive levels of care. Gradually, clients should be transitioned from several therapeutic contacts per week to weekly contact to semimonthly contact and so on. The concept of graduation should be reframed to convey clearly—as it is in colleges and universities—not an ending but a commencement or a new beginning.

Principle 8: Monitor Abstinence

Recognize the Progress That Clients Make in Achieving and Maintaining Abstinence

Programs might consider requiring 30 days of abstinence before transitioning clients to a less intense level of care because extended abstinence is associated with positive long-term outcomes (McKay et al. 1999). Although it is true that not all clients readily can achieve abstinence without relapsing a few times, it also is true that outcomes are best for those clients who have stopped using drugs and have submitted a drug-free urine sample before entering treatment (Ehrman et al. 2001). To monitor abstinence, IOT programs should use urine drug screens, Breathalyzer™ tests, or other laboratory tests to confirm self-reported abstinence. Urine drug screens can be an effective adjunct in treatment and can contribute to improved treatment outcomes (National Institute on Drug Abuse 1999). Although cost considerations may limit the frequency of urine drug screens and Breathalyzer tests, the consensus panel strongly encourages the use of these objective measures of abstinence.

Principle 9: Use Mutual-Help and Other Community-Based Supports

Assist Clients in Successfully Integrating Into Mutual-Help and Other Community-Based Support Groups

Participation in mutual-help programs, such as 12-Step programs and treatment programs that facilitate 12-Step membership, is associated with better outcomes than participation in types of treatment that do not facilitate 12-Step membership (Humphreys et al. 1997; Moos et al. 1999; Project MATCH Research Group 1997; Vaillant 1983; see McCrady and Miller 1993, for a review of the Alcoholics Anonymous [AA] research literature). Clients who become involved in 12-Step programs after they step down from IOT tend to do significantly better than those who do not participate in such programs (Moos et al. 1999). IOT programs should facilitate clients' becoming integrated

successfully into healthy, community-based mutual-help groups, such as AA (www.alcoholics-anonymous.org) and Narcotics Anonymous (NA) (www.na.org), during treatment. IOT programs should assist clients directly in locating a home group and a sponsor and in becoming oriented to the culture of 12-Step programs.

It is not sufficient simply to refer clients to AA or other 12-Step groups. Just as a physician works with patients to find the right medication and dosage, counselors need to help clients identify the right type of meeting and frequency of attendance (Forman 2002). Just as patients often have unwanted side effects from medications, particularly when they first start taking them, clients who begin attending 12-Step and other mutual-help groups often experience some minor side effects. IOT programs can help clients minimize the negative side effects by providing orientation and support as clients adjust to this important treatment element. (There are many 12-Step meetings for the family, such as Al–Anon/Alateen [www.al-anon.alateen.org] and Nar-Anon [naranon.com], as well as groups for compulsive behaviors such as sex, gambling, spending, and eating.)

Many individuals who are substance dependent find abstinence through participation in faith-based organizations, and many religious groups offer support for individuals who are seeking recovery. Other individuals have benefited from support groups such as Rational Recovery (www.rational.org), Smart Recovery (www.smartrecovery.org), or Women for Sobriety (www.womenforsobriety.org) that offer an alternative to 12-Step meetings. Giving clients a choice of support groups is empowering because it enables them to make informed decisions.

Principle 10: Use Medications if Indicated

Use Appropriate Medications To Manage Co-Occurring Substance Use and Psychiatric Disorders

A substantial percentage of clients with substance use disorders also have co-occurring psychiatric conditions (Kessler et al. 1996; Marlowe et al. 1995). Psychiatric medications are critically important in the treatment of these co-occurring conditions (Carroll 1996*a*; Drake et al. 1998*b*; Minkoff 1997). Ideally, IOTs should provide psychiatric evaluation and medication management on site. If funding limitations make it impossible to offer this care on site, then efficient and functioning links with mental health providers need to be maintained.

Resistance to the use of psychiatric medications by substance abuse treatment clinicians is gradually being replaced by an appreciation for the valuable role these medications can play when used appropriately. Likewise, both NA and AA historically had been averse to medications of any kind, but both have published statements supporting the appropriate use of medications (Alcoholics Anonymous World Services 1991; Narcotics Anonymous 1998).

> Substance abuse is a chronic illness similar...to other chronic diseases such as asthma, diabetes, and hypertension.

A number of pharmacotherapies have been shown to be effective adjuncts to the treatment of substance abuse. Naltrexone has

been effective with some people who are alcohol dependent (Guardia et al. 2002). However, a multisite study by Krystal and colleagues (2001) found that naltrexone was not effective in treating men with chronic, severe alcohol dependence. Under certain conditions, naltrexone has been effective in treating individuals addicted to opioids (Cornish et al. 1997). Similarly, disulfiram (Antabuse®) has been an effective adjunct in the treatment of alcoholism (O'Farrell et al. 1998). Some IOT programs have implemented treatment tracks for clients maintained on methadone. Buprenorphine (Ling et al. 1998; O'Connor et al. 1998) and buprenorphine combined with naloxone (Fudala et al. 1998; Mendelson et al. 1999) are now available for the treatment of opioid dependence and can be prescribed at IOT programs that have medical personnel on staff.

Ideally, IOTs should provide psychiatric evaluation and medication management on site.

Principle 11: Educate About Substance Use Disorders, Recovery, and Relapse

Provide Clients and Family Members With Information About Substance Use Disorders, Recovery Skills, and Relapse Prevention

An important task in IOT is educating clients about substance use disorders and the skills they need to live comfortably in recovery. A wealth of accurate, free information about substance abuse and recovery skills is available to clinicians through Web sites and other sources mentioned throughout this volume, but a good starting place is chapter 4 of TIP 33, *Treatment for Stimulant Use Disorders* (CSAT 1999*e*). IOT programs are encouraged to develop recovery curricula for clients (or use one already developed) and to facilitate opportunities for clients to practice recovery skills while in treatment. Substance refusal training, stress management, assertiveness training, relapse prevention, and relaxation training are important behavioral techniques that can be incorporated into IOT programs (Carroll 1998; CSAT 1999*e*; Daley 2001, 2003; Marlatt and Gordon 1985; Mercer and Woody 1999). Clients should be provided with up-to-date information about the biology of substance use disorders, mutual-help programs, and appropriate use of medications.

Given the significant body of information that clients might need to support their recovery, programs are encouraged to explore the use of videotapes, written materials, and Web-based resources to help clients understand addiction and recovery. Consideration should be given to multiple approaches to educating clients, including lectures, discussions, workbook assignments, behavioral rehearsals or role plays, and daily logs or journals. Evaluation processes, such as feedback sessions, that monitor the clients' comprehension of key recovery skills are needed.

Principle 12: Engage Families, Employers, and Significant Others

Include Others Throughout the Treatment Process

The therapeutic involvement of families throughout the recovery process is associated with improved treatment outcomes (Epstein and McCrady 1998; McCrady et al. 1999; O'Farrell and Fals-Stewart 2003; Szapocznik and Williams 2000; White et al.

1998; Winters et al. 2002). Families can be a vital resource and a source of support and encouragement. Conversely, families also can influence the client adversely and undermine recovery. All clients are part of a group that functions as a "family" and as such are subject to the values, traditions, and culture of that family. IOT programs can marshal families' powerful positive influences or counter their negative influences by educating, counseling, and providing therapeutic family services. Referrals to therapists and organizations that provide family therapy should be considered when family therapy is unavailable in the IOT program.

When an individual has been referred for treatment by an employee assistance or student assistance program, representatives of the employer and school can play a potent role in supporting adherence to the treatment plan and ongoing recovery.

Principle 13: Incorporate Evidence-Based Approaches

Seek Out Evidence-Based Training Opportunities and Materials

Over the past 30 years a number of treatment approaches have been developed, tested, and demonstrated to be effective in a variety of settings (see chapter 8 for more information). These approaches include

- Cognitive–behavioral therapy (Carroll 1998)
- Motivational enhancement therapy (CSAT 1999*c*; Miller and Rollnick 2002; Prochaska and DiClemente 1984)
- Individual drug counseling (Mercer and Woody 1999)
- Relapse prevention training (Carroll et al. 1998; Daley 2001, 2003; Daley and Marlatt 1997; Daley et al. 2003)
- Contingency management and incentives (Budney and Higgins 1998; Petry 2000)
- 12-Step facilitation (Nowinski et al. 1992)
- Case management (McLellan et al. 1998, 1999)

IOT programs can adopt methods from these various treatment interventions. NIDA, the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the Center for Substance Abuse Treatment (CSAT) have published manuals about these approaches, and most of these manuals are available free of charge. A number of other evidence-based manuals are listed throughout this TIP, including documents from NIAAA Project MATCH and CSAT's Addiction Technology Transfer Centers and other CSAT publications.

Some counselors who enter the substance abuse treatment profession do not have extensive training. For them, the needed skills are learned on the job. Evidence-based manuals summarize the experience of knowledgeable clinicians and researchers, passing on effective techniques and approaches that have been refined over the years. Not all IOT programs are the same—some achieve better outcomes than others. IOT programs can improve their outcomes by successfully incorporating evidence-based approaches. The consensus panel encourages the use of evidence-based approaches as a means of improving treatment outcomes.

Principle 14: Improve Program Administration

Focus on Financial, Information, and Human Resource Management

Clinicians frequently are promoted into the role of IOT program director without any formal training in how to function as an administrator. The tasks of management differ significantly from those of a clinician, and the transition from one role to the other is not always a smooth or natural one. IOT

managers focus on the program's finances, regulatory compliance, human resource management, information management, administrative report preparation, and a host of other tasks that were not in their list of responsibilities as clinicians. TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), addresses the administrative issues that IOT managers need to master to manage programs effectively.

3 Intensive Outpatient Treatment and the Continuum of Care

In This Chapter...

Overview of a Continuum of Care

Conceiving of a Continuum of Care

Key Aspects of IOT (Level II)

Key Aspects of Outpatient Treatment (Level I)

Continuing Community Care

Overview of a Continuum of Care

"Continuum of care" refers to a treatment system in which clients enter treatment at a level appropriate to their needs and then step up to more intense treatment or down to less intense treatment as needed. As outlined by Mee-Lee and Shulman (2003), an effective continuum of care features successful transfer of the client between levels of care, similar treatment philosophy across levels of care, and efficient transfer of client records. The American Society of Addiction Medicine (ASAM) has established five main levels in a continuum of care for substance abuse treatment:

- Level 0.5: Early intervention services
- Level I: Outpatient services
- Level II: Intensive outpatient/Partial hospitalization services (Level II is subdivided into levels II.1 and II.5)
- Level III: Residential/Inpatient services (Level III is subdivided into levels III.1, III.3, III.5, and III.7)
- Level IV: Medically managed intensive inpatient services

These levels should be thought of not as discrete levels of care but rather as points in a continuum of treatment services (Mee-Lee and Shulman 2003).

From program to program, the treatment philosophy, services, settings, and client characteristics may vary for any given level of care because some aspects of treatment may be tailored to a specific population. For instance, a rural residential program primarily treating women who are alcohol dependent would be quite different from an urban residential program treating mostly men dependent on stimulants. Despite variability in the specific features of intensive outpatient treatment (IOT) or Level II care in programs across the country, the continuum of care model tries to ensure consistency throughout treatment and to ease the process of moving clients through treatment.

In addition to the levels of care described by ASAM, outpatient treatment can be broken down into four sequential stages that clients work through, regardless of the level of care at which they enter treatment:

- Stage 1—Treatment engagement
- Stage 2—Early recovery
- Stage 3—Maintenance
- Stage 4—Community support

These stages are discussed later in the chapter in the context of IOT and outpatient treatment.

Conceiving of a Continuum of Care

To reinforce the idea of a continuum of care, Mee-Lee and Shulman (2003) suggest that clinicians and administrators "envision admitting the client into the continuum *through* their program rather than admitting the client *to* their program" (p. 456). This early focus on moving the client along the continuum also prompts clinicians to look ahead to the next step in a client's treatment. This, in turn, helps clinicians engage in the treatment planning that is integral not only to the client's ongoing care but also to the transition from one level of treatment to the next.

IOT is part of a seamless continuum of levels of care.

IOT Programs and the Continuum of Care

IOT programs are diverse and flexible with respect to the spectrum, intensity, and duration of services and the settings in which services are delivered. They are, therefore, well suited to meet the varied needs of persons with substance use disorders. Conceptually, IOT is an intermediate level of ambulatory care that serves the following functions:

- **An entry point into substance abuse treatment.** The client comes to the IOT program, an assessment reveals that the client would benefit from IOT (see chapter 5 of this TIP for placement criteria), a treatment plan is developed, and services are begun.
- **A stepdown level of care.** The client is transitioned to the IOT program from an inpatient or residential facility. In this case, the client may have been stabilized in a hospital facility or residential treatment program and now needs intensive treatment services to achieve or maintain abstinence as well as address other problems.
- **A step-up level of care.** The client is referred to the IOT program if he or she has been unsuccessful in outpatient treatment or continuing community care and is assessed as needing an intensive and structured level of care to regain abstinence, work on relapse prevention skills, and address other issues.

Assisting the Client Along the Continuum

IOT is part of a seamless continuum of levels of care. Moving the client along the continuum may require the IOT provider to refer the client to another treatment organization or may be the result of an internal transfer to another component of a comprehensive IOT program.

Any change of setting, staff, or peers interjects a risk of the client's dropping out of treatment. Experience suggests that the administrative paperwork and approvals needed to transfer a client between levels of care within the same organization can be accomplished with less disruption for the client than a referral to a new provider organization. Consequently, when referrals are made to a nonaffiliated provider

organization, coordination and case management needs increase.

Key Aspects of IOT (Level II)

After considering IOT from the broad perspective of the continuum of care, it is necessary to look within Level II to understand IOT's particular goals, intensity, duration, settings, and stages.

IOT Goals

Goals of IOT programs vary based on such factors as the treatment population, program comprehensiveness, and the program's philosophy. Although programs differ, all IOT programs attempt to address the following general goals:

- To achieve abstinence
- To foster behavioral changes that support abstinence and a new lifestyle
- To facilitate active participation in community-based support systems (e.g., 12-Step fellowship)
- To assist clients in identifying and addressing a wide range of psychosocial problems (e.g., housing, employment, adherence to probation requirements)
- To assist clients in developing a positive support network
- To improve clients' problemsolving skills and coping strategies

Intensity of Treatment

Relative to traditional outpatient treatment, IOT provides an increased frequency of contact and services that respond to the chronicity and severity of substance use disorders and other problems experienced by clients. The actual number of hours and days per week that clients participate in IOT varies depending on individual client needs. State licensure bodies may require 9 treatment hours; ASAM defines IOT as 9 hours of treatment per week for adults (Mee-Lee et al. 2001). Although IOT programs generally provide structured programming for 9 hours or more per week spread over 3 to 5 days, some IOT programs provide fewer hours. The consensus panel recommends that the number of programming hours be 6 to 30 hours, based on client needs. Some clinicians find that more frequent, shorter visits are of greater benefit to the client than less frequent but longer sessions. However, some clients require longer treatment sessions, similar in intensity to partial hospitalization. More research is needed on optimal treatment intensity and factors to be considered in increasing or decreasing treatment intensity.

Duration of Treatment

The recommended minimum duration of the IOT phase often is cited as 90 days. Low-intensity outpatient treatment over a longer period may be a cost-effective means to enhance treatment outcomes because this approach is associated with less substance use and better social functioning in clients (Moos et al. 2001). Duration of treatment should be increased or decreased based on the client's clinical needs, support system, and psychiatric status, among other factors. Longer duration of care is related to better treatment outcomes (Moos and Moos 2003).

Treatment Settings

IOT can be provided in any setting that meets State licensure or certification criteria (Mee-Lee et al. 2001). Programs offering IOT only and comprehensive programs offering several levels of care may differ in structures and services provided. IOT programs that are part of a large hospital setting can provide medical detoxification services, pharmacotherapy, and treatment for other medical and psychiatric conditions. IOT programs located in prison facilities treat offenders with alcohol and drug problems and successfully link offenders with stepdown services in the community on release. Other IOT programs may be located near vocational

training sites so that welfare recipients and others easily can attend both treatment and training sessions in homeless shelters and in modified therapeutic community programs.

Stages of Treatment

Within IOT or Level II care, treatment often is delivered in sequential stages, with service intensity and structure lessening as clients progress. As IOT services taper in intensity, the client assumes increasing responsibility and is provided less structure and supervision from treatment staff. IOT programs should have the flexibility to increase the intensity of services if the client's lack of progress indicates such a need.

Sequenced IOT can motivate clients, help them succeed in reaching recovery milestones and in meeting the criteria for completing a treatment stage, and provide an incentive for clients to grow and progress. Marking the passage from one IOT stage to the next with a celebration or ceremony also motivates clients. Sequenced stages allow complex information to be broken into small units that can be modified and made appropriate for each client's cognitive and psychological functioning and stage of readiness.

IOT may be conceptualized as having two core stages, which correspond with the client's progress in treatment: stage 1—treatment engagement and stage 2—early recovery. Definitions of IOT, such as those adopted by some States or health insurers, may include additional or fewer stages or may blend similar goals and services within different stages.

Stage 1—Treatment engagement

Goals and duration. One of the most critical tasks for the counselor and clinic is encouraging the client to remain in treatment. Many clients drop out of treatment after attending only a few sessions. During this initial stage, the counselor determines the client's presenting problems with respect to substance abuse; physical, psychological, and social functioning; and social support network. Also, the counselor explains program rules and expectations and works to stabilize any crises. Exhibit 3-1 presents the goals, duration, counselor activities, and completion criteria of this stage of IOT.

Stage 2—Early recovery

Goals and duration. This stage is highly structured with educational activities, group involvement, and new behaviors to help the client develop recovery skills, address lapses, and build a substance-free lifestyle. Exhibit 3-2 presents the goals, duration, counselor activities, and completion criteria of this stage of treatment.

Transition to Outpatient Treatment

Effective treatment in a continuum of care includes ongoing, less intensive, and tapered contact with treatment systems, much as with other chronic health conditions (McLellan et al. 2000). The client and counselor must prepare for the transition to less intensive treatment, a juncture that presents a high dropout risk. This stepdown level of care sometimes is provided as part of a comprehensive IOT program by the same staff and in the same facility. In other cases, clients are transferred through formal linkages to outpatient treatment delivered by a separate community-based program, often referred to as standard, traditional, or—in this TIP—simply outpatient treatment.

Compatible models of care

The consensus panel believes that, whenever possible, the client should be referred to an outpatient treatment program with a treatment model (e.g., 12-Step, cognitive–behavioral, combined) that is compatible with that offered by the IOT program to ensure that the client is not confronted with significantly different treatment goals, approaches, and philosophies. If a client is

Exhibit 3-1

Goals, Duration, Activities, and Completion Criteria of Stage 1

Goals of the treatment engagement stage:

- Establish a treatment contract with the counselor that specifies treatment goals, client responsibilities (e.g., attend group sessions, remain abstinent, submit urine samples), and the counselor's efforts to help clients meet treatment goals and responsibilities.
- Work to resolve acute crises.
- Engage in a therapeutic alliance.
- Prepare a treatment plan with help from the counselor.

Duration of the treatment engagement stage: A few days to a few weeks

Counselor activities of the treatment engagement stage:

- Confirm diagnosis, eligibility, and appropriate placement in this level of care.
- Assess biopsychosocial problems and match services to the most pressing problems.
- Determine readiness for treatment.
- Provide feedback about assessment findings and formulate an initial treatment plan and treatment contract.
- Explain program rules, expectations, and confidentiality regulations.
- Address acute crises.
- Manage withdrawal symptoms.
- Resolve scheduling, payment, and counselor assignment issues.
- Obtain medical and psychological diagnoses and treatment, including pharmacotherapy.
- Foster therapeutic alliances between client and counselor and client and group members.
- Begin psychoeducational activities.
- Identify potential sources of social support.
- Initiate family contacts and education (with client's permission).

Completion criteria: Clinical indications that support the client's transition from the treatment engagement stage to the early recovery stage include the client's having

- Completed the assessment process
- Completed withdrawal from substance use
- Resolved immediate crises
- Completed orientation
- Established a treatment plan
- Attended scheduled sessions regularly

to be transferred to a program with a different philosophy, the client should be oriented to the differences so that the transition is not confusing and the client can benefit from the new program.

Exhibit 3-2

Goals, Duration, Activities, and Completion Criteria of Stage 2

Goals of the early recovery stage:

- Maintain abstinence.
- Demonstrate ability to sustain behavioral changes.
- Eliminate drug-using lifestyle and replace it with treatment-related routines and drug-free activities.
- Identify relapse triggers and develop relapse prevention strategies.
- Identify personal problems and begin to resolve them.
- Begin active involvement in a 12-Step or other mutual-help program.

Duration of the early recovery stage: 6 weeks to about 3 months

Counselor activities of the early recovery stage:

- Assist clients in following their individual plans to achieve and sustain abstinence.
- Assist clients in identifying relapse triggers and developing strategies to avoid or cope with triggers.
- Support evidence of positive change.
- Initiate random drug tests and provide rapid feedback of results.
- Assist clients in successfully integrating into a 12-Step fellowship or other mutual-help program.
- Help clients develop and strengthen a positive social support network.
- Encourage participation in healthful recreation and social activities.
- Continue pharmacotherapy, if appropriate, and other medical and psychiatric treatments.
- Offer education on topics such as hepatitis C and HIV infection, anger management, and parenting.
- Continue assessments for other issues requiring intervention.
- Educate clients and family members on addiction, the recovery process, and relapse.
- Provide family and multifamily counseling.
- Introduce families to 12-Step and other mutual-help programs appropriate for them; help families integrate into support groups.

Completion criteria: Clinical indications that support the client's transition from the early recovery stage of IOT to the next level of care include the client's having

- Sustained abstinence for 30 days or longer
- Completed goals as indicated in the treatment plan
- Created and implemented a relapse prevention and continuing care plan
- Participated regularly in a support group
- Maintained a sober social support network
- Obtained stable, drug-free housing
- Resolved medical, psychiatric, housing, and peer situations that may trigger relapse

Transition planning

An individual transition plan helps the client transition from one level of care to another and provides an important link between his or her current treatment provider and the next. To prepare an effective transition plan, the IOT counselor can

- Engage the client as an active participant in developing the plan early in IOT, including setting goals, establishing criteria for measuring progress, and identifying activities that will be part of ongoing treatment.
- Maintain a working knowledge of the services and resources that are available in the community.
- Develop strong working relationships with staff of key agencies (e.g., justice organizations, employers) to facilitate the transition, make special arrangements as needed, and eliminate unnecessary barriers for the client during transition.
- Obtain the client's written consent and arrange for the smooth and timely transfer of clinical information or documents to the new treatment program.

The panel recommends that the responsibility for client care be transferred clearly before a provider relinquishes clinical responsibility.

Key Aspects of Outpatient Treatment (Level I)

For clients who are stepped down from IOT, outpatient treatment offers the support they need to continue developing relapse prevention skills and resolving the personal, relationship, employment, legal, and other problems often associated with early recovery.

Outpatient Treatment Goals

The goals, strategies for treatment engagement, and recovery services of outpatient treatment are similar to those of IOT. However, the intensity and duration of the services differ from those provided in IOT.

Comparison of IOT and Outpatient Treatment

A study by McLellan and colleagues (1997) compared several components of 6 IOT programs and 10 outpatient treatment programs. Both types of programs provided group and individual abstinence counseling, relapse prevention programming, and drug and alcohol education. The IOT programs' treatment duration ranged from 30 to 90 days, and they provided 3 to 5 sessions per week. Hours per session ranged from 3 to 6. The outpatient programs' treatment duration ranged from 45 to 60 days, and they provided 1 to 2 sessions per week. Hours per session ranged from 1 to 2. Whereas the IOT programs provided more substance abuse counseling than the outpatient treatment programs, the outpatient treatment programs were more likely than IOT programs to offer medical appointments, family therapy sessions, psychotherapy, and employment counseling (McLellan et al. 1997).

Although outpatient treatment duration is typically 60 days, it is suggested strongly that clients be scheduled for periodic followup sessions on a long-term basis. The best outcomes from treatment of substance use disorders have been seen in clients who participate in continuing care, such as methadone maintenance or Alcoholics Anonymous-style support programs (McLellan et al. 2000). Because the availability of funding for followup appointments varies, outpatient treatment programs might consider strategies for establishing a service model that supports the delivery of followup sessions.

Stepdown Treatment

Clients who have completed stages 1 and 2 of their treatment at the IOT level of care can step down to outpatient treatment programs and enter stage 3—maintenance, having demonstrated a commitment to change, been stabilized, become abstinent, and developed relapse prevention skills.

Stage 3—Maintenance

Goals and duration. Stage 3—maintenance helps the client build on gains made during stages 1 and 2. The goals, duration, counselor activities, and completion criteria of this stage of treatment are presented in exhibit 3-3.

Transfer to Continuing Community Care

Having completed stage 3 of their treatment, clients are discharged from formal treatment to continuing community care. Clients who remain within a system of ongoing care relevant to their needs are more likely to maintain their gains in abstinence and overall lifestyle changes. Participation in continuing community care is related to an increase in positive outcomes (Miller et al. 1997; Ritsher et al. 2002). Continuing care planning is therefore a central task for IOT program staff whose clients remain in stepdown care within the program. IOT programs that refer clients to separate programs for a stepdown level of care must ensure, through their referral agreements and procedures, that the outpatient treatment program agrees to engage in continuing care planning.

Continuing community care in the form of 12-Step support groups, faith fellowship, or other community-based organizations is sometimes neglected by treatment providers because of the difficulties of remaining engaged with clients after formal treatment is completed. Still, the benefits of carefully planning for transferring clients into community support groups are such that added attention should be given to these tasks. To ensure client access to a full continuum of care, treatment programs need to be aware of support groups and other community resources and introduce this information to clients early in the treatment process. Other key responsibilities for providers include ensuring transition of case management responsibilities, supporting clients' early engagement in continuing community care, contributing to the expansion of community services, and encouraging clients who drop out to reengage with treatment.

Continuing Community Care

Continuing community care following IOT and stepdown care is essential for all IOT clients, especially for those who may have other long-term psychiatric, social, or medical issues. The process of rebuilding a healthy, productive, and stable life takes years, and maintaining gains made over time may require continuous support for some individuals.

Once the client maintains abstinence and has begun to address other serious problems that could threaten recovery, the client can be discharged into continuing community care. Stage 4—community support consists of the client's participating in 12-Step or other mutual-help groups and meeting with psychologists, case managers, or staff from community-based agencies, with limited support and involvement from the treatment program.

Services in Continuing Community Care

As part of continuing care services, programs can sponsor alumni meetings and provide booster or checkup counseling sessions at the IOT or outpatient treatment facility. Periodic telephone contact also may be valuable (McKay et al. 2005). Other aspects of continuing care include involvement with selected community resources as needed, such as vocational training, recreational therapy, family therapy, or medical care.

Stage 4—Community support

Goals and duration. This stage is based on a detailed and individualized discharge plan for continuing recovery in the community using available resources. Exhibit 3-4 presents the goals, duration, counselor activities, and completion criteria of this stage.

Exhibit 3-3

Goals, Duration, Activities, and Completion Criteria of Stage 3

Goals of the maintenance stage:

- Solidify abstinence.
- Practice relapse prevention skills.
- Improve emotional functioning.
- Broaden sober social networks.
- Address other problem areas.

Duration of the maintenance stage: About 2 months to 1 year

Counselor activities of the maintenance stage:

- Continue teaching and helping clients practice relapse prevention skills and refine plans to address relapse triggers.
- Help clients acknowledge and quickly contain "slips" to keep them from becoming full-blown relapses.
- Support clients as they work through painful feelings (e.g., sadness, anxiety, loneliness, shyness, shame, guilt).
- Teach clients new coping and problemsolving skills that increase self-esteem and improve interpersonal relationships, including better communication skills, anger management skills, and making amends.
- Help clients identify vocational or educational needs, improve work-related functioning, resolve family conflicts, and initiate new recreational activities.
- Facilitate client linkages with community resources that foster clients' interests and offer needed services for accomplishing life goals.
- Assist clients in making and sustaining positive lifestyle changes.
- Encourage continuing participation in support groups and ongoing work with a sponsor.
- Emphasize the importance of spirituality or altruistic values that help clients see beyond themselves and work for community goals.
- Continue monitoring random drug test results and providing feedback on results.
- Continue pharmacotherapy, as needed, and other medical or psychiatric assistance.
- Avoid complacency.

Completion criteria: Clinical indications that support the client's transition from the maintenance stage to continuing care include the client's having

- Sustained abstinence (30 days or longer)
- Improved relationships with family, friends, and significant others
- Improved coping and problemsolving skills
- Obtained drug-free, stable housing
- Continued participation in a support group
- Obtained ongoing assistance with other problems, if necessary

Exhibit 3-4

Goals, Duration, Activities, and Completion Criteria of Stage 4

Goals of the community support stage:

- Maintain abstinence.
- Maintain a healthy lifestyle.
- Develop independence from the treatment program.
- Maintain social network connections.
- Establish strong connection with support groups and pursue healthy community activities.
- Establish recreational activities and develop new interests.

Duration of the community support stage: Years, ongoing

Counselor activities of the community support stage:

- Assist clients in developing a realistic, comprehensive, and individualized plan for continuing recovery.
- Acquaint clients with local resources that allow them to
  - Sustain abstinence
  - Continue participating in 12-Step or other mutual-help groups
  - Obtain medical or psychotherapeutic assistance as needed
  - Continue pharmacotherapy as needed
  - Start or continue vocational or educational training or other courses
  - Seek and obtain employment
  - Strengthen social support networks
  - Manage stress
  - Prevent or respond to relapse
  - Enjoy abstinence
- Provide information about and encourage attendance at alumni or booster sessions at the IOT or outpatient treatment program to review recovery status.
- Provide a biannual checkup during which a comprehensive assessment is conducted of clients' recovery and status.

Completion criteria: Clients may need community support for the rest of their lives to remain abstinent or recover from relapses.

Intensity and Duration of Continuing Community Care

The duration of continuing community care varies for each individual. The chronic relapsing nature of substance use disorders often means that individuals may remain in this level of care for many months or years, relapse, return to outpatient treatment or IOT care, regain abstinence, and return to continuing community care.

4 Services in Intensive Outpatient Treatment Programs

In This Chapter...

Core Services

Enhanced IOT Services

IOT Services: A Case Illustration

A set of core services is essential to all intensive outpatient treatment (IOT) efforts and should be a standard part of the treatment package for every client. Enhanced services often are added and delivered either on site or through functional and formal linkages with community-based agencies or individual providers.

This distinction between core and enhanced services is somewhat flexible. What would be considered enhanced services for the general treatment population may be core services for a particular client group. For example, a program that serves primarily working mothers of young children may view providing child care and arranging transportation as core program elements. These same services are unlikely to be needed by most clients in an IOT program that treats mostly employed single men who do not have children living with them.

This chapter describes many of the core and enhanced elements of IOT. Each description includes the purpose and the key aspects of the service. Exhibit 4-1 lists core and enhanced services for IOT programs. Some core services are discussed in other chapters, as noted in exhibit 4-1.

Core Services

Group Counseling and Therapy

Groups form the crux of most IOT programs. Several recent studies confirm that, for delivering relapse prevention training, a group approach is at least as effective as a one-on-one format (McKay et al. 1997; Schmitz et al. 1997). Group counseling allows programs to balance the cost of more expensive individual counseling services. A group approach supports IOT clients by

Exhibit 4-1

Core and Enhanced Services for IOT Programs

Core IOT Services Provided On Site

- Group counseling and therapy
- Individual counseling
- Psychoeducational programming
- Pharmacotherapy and medication management
- Monitoring alcohol and drug use
- Case management
- 24-hour crisis coverage
- Community-based support groups
- Medical treatment
- Psychiatric examinations and psychotherapy
- Vocational training and employment services
- Family involvement and counseling*
- Comprehensive biopsychosocial screening and assessment†
- Program orientation and intake/admission†
- Individual treatment planning and review†
- Transition management and discharge planning‡

*Discussed in chapter 6. †Discussed in chapter 5. ‡Discussed in chapter 3.

Enhanced IOT Services Delivered On Site or Via Functional Linkages

- Adult education
- Transportation services
- Housing and food
- Recreational activities
- Adjunctive therapies
- Nicotine cessation treatment
- Licensed child care
- Parent skills training

- Providing opportunities for clients to develop communication skills and participate in socialization experiences; this is particularly useful for individuals whose socializing has revolved around using drugs or alcohol
- Establishing an environment in which clients help, support, and, when necessary, confront one another
- Introducing structure and discipline into the often chaotic lives of clients
- Providing norms that reinforce healthful ways of interacting and a safe and supportive therapeutic milieu that is crucial for recovery
- Advancing individual recovery; group members who are further along in recovery can help other members
- Providing a venue for group leaders to transmit new information, teach new skills, and guide clients as they practice new behaviors

Types of groups

Most IOT programs place clients in several different types of groups during the course of treatment. Broadly speaking, these include psychoeducational, skills-development, support, and interpersonal process groups. These classifications are far from rigid; each type of group borrows ideas and techniques from others. Some IOT programs also add specialized groups and clubs for job-seeking or recreational activities. TIP 41, *Substance*

Abuse Treatment: Group Therapy (CSAT 2005*f*), contains specific guidance on how to organize and conduct different types of groups in the context of a treatment program. Exhibit 4-2 highlights groups commonly conducted in IOT.

Exhibit 4-2

Groups Conducted in Intensive Outpatient Treatment

Psychoeducational groups

These groups provide a supportive environment in which clients learn about substance dependence and its consequences. These time-limited groups may be initiated at the beginning of treatment. They feature

- Low-key rather than emotionally intense environment.
- Rational problemsolving mechanisms to alter dysfunctional beliefs and thinking patterns.
- Various forms of relapse prevention and skills training. Didactic components often are supplemented by videos or slides to accommodate different learning styles.

Skills-development groups

These groups offer clients the opportunity to practice specific behaviors in the safety of the treatment setting. Common types of skills training include

- **Drug or alcohol refusal training.** Clients act out scenarios in which they are invited to use substances and role play their responses.
- **Relapse prevention techniques.** Using relapse prevention materials, clients analyze one another's personal triggers and high-risk situations for substance use and determine ways to manage or avoid them.
- **Assertiveness training.** Clients learn the differences among assertive, aggressive, and passive behaviors and practice being assertive in different situations.
- **Stress management.** Clients identify situations that cause stress and learn a variety of techniques to respond to stress.

Support groups (e.g., process-oriented recovery groups)

These groups include clients in the same recovery stage—usually a middle to late phase of treatment—who are working on similar problems. Members focus on immediate issues and on

- Pragmatic ways to change negative thinking, emotions, and behavior
- Learning and trying new ways of relating to others
- Tolerating or resolving conflict without resorting to violence or substance use
- Looking at how members' actions affect others and the function of the group

(continued)

Exhibit 4-2 (continued)

Groups Conducted in Intensive Outpatient Treatment

Interpersonal process groups

- **Single-interest groups.** These groups—usually organized at a later stage of treatment—focus on an issue of particular significance to and sensitivity for group members. The issues include gender issues, sexual orientation, criminal offense, and histories of physical and sexual abuse.
- **Family or couples groups.** These groups assist clients' relatives and other significant individuals in learning about the detrimental effects of substance use on relationships and how these effects can be ameliorated or resolved. Additional information on family services is presented in chapter 6 and TIP 39, *Substance Abuse Treatment and Family Therapy* (CSAT 2004*c*).

Key aspects of groups

Organization of groups. IOT programs often use open-ended heterogeneous groups that provide clinicians the flexibility of assigning new clients to ongoing groups. With the client census often difficult to predict from week to week, this flexibility permits immediate responsiveness to client needs. Members of open-ended heterogeneous groups have varying degrees of recognition and acceptance of their problems, and those on the road to recovery offer hope to those just beginning.

Although it may seem desirable to keep clients in the same group as they progress through the treatment process, the experience of the consensus panel has been that this is seldom possible because individuals have different responses to treatment and progress toward recovery at different rates. Hence, the composition of the group to which a client is initially assigned at admission is unlikely to remain constant throughout the treatment episode. Some clients progress rapidly to the next stage, whereas others need to cycle back to an earlier treatment intensity if they relapse or encounter other problems.

IOT programs can organize homogeneous groups based on a therapeutically relevant issue for a subset of clients or based on demographic commonalities among clients. Therapeutically relevant issues that might call for single-issue groups include single parenting, HIV/AIDS, gender issues, drug of choice, or histories of physical violence and sexual abuse. Special groups based on demographic similarities include those for women, men, elderly persons, members of minority populations, clients with common socioeconomic or legal statuses, or clients who have particular professions or are unemployed. Clients in these homogeneous groups can use their common perspective as a basis for working together. Additional information associated with programming for diverse populations is presented in chapters 9 and 10.

Client-specific adaptations. Clients with temporary or permanent cognitive impairments, literacy deficits, or language problems need special attention or assignment to special groups. IOT programs should assess whether their treatment orientation and relapse prevention materials are appropriate for clients with cognitive impairments or learning disabilities. Chapter 10 provides additional information.

Clients not yet ready to pursue abstinence (those uninterested in change—precontemplators—or those thinking about a change in the near future—contemplators) often come to the program after being mandated to treatment by another agency. These clients could be assigned to a separate, pretreatment group in which counselors raise the clients' awareness about substance use disorders through education and motivating interviews (Washton 2000).

Clients who should not participate in certain groups. Some clients should never be assigned to the same groups. Perpetrators and victims of domestic violence must be in separate groups. Neighbors, relatives, spouses, or significant others also should not be assigned to the same group (with the exception of family therapy).

Clients who violate the principles of group therapy by failing to honor group agreements or dropping out continually and clients who cannot control their impulses might respond better to individual therapy.

Some socially anxious or very introverted clients cannot tolerate groups. These clients should be offered individual counseling until they are comfortable participating in group sessions (Hoffman et al. 2000) or lower intensity group sessions that focus on coping skills training (Avants et al. 1998). Some clients with severe psychiatric disorders, such as schizophrenia or antisocial personality disorder, may be unable to participate in groups and may be able to attend individual therapy only.

Duration and frequency of group sessions. IOT group counseling sessions often are scheduled for 90 minutes, although shorter and longer timeframes also are used. Psychoeducational group sessions often are only half that long (e.g., a 30-minute lecture followed by 15 minutes for questions) because they focus on instruction instead of interaction.

The American Society of Addiction Medicine's (ASAM's) definition of IOT requires participants to have a minimum of 9 hours of therapeutic contact per week—at least in the initial treatment stage (Mee-Lee et al. 2001). A typical IOT program schedules 3 hours of treatment on 3 days or evenings each week. This might entail 2 evenings of back-to-back 90-minute groups (one for members in the same recovery stage to share day-to-day concerns and the other to study a psychoeducational topic). A third evening might include 30 minutes of individual counseling, a 90-minute family session, and an hour-long skills training group. Some IOT programs meet 5 days or evenings per week.

IOT programs vary considerably in the anticipated length of stay or expected duration of active treatment. Many courses of treatment span 12 to 16 weeks before clients step down to a less intensive (maintenance) stage. Clients may remain in the maintenance phase for 6 months or more.

Group size and format. The optimal size of a group in most IOT programs is between 8 and 15 members. Process-oriented groups may function more effectively if membership is limited to 6 to 8 members, whereas psychoeducational groups with considerable didactic content can be somewhat larger.

Most counseling guidelines suggest structuring group time (Mercer 2000; Owen 2000). Some groups use a "rule of thirds" wherein the first third of the session is used to solicit each member's current issues or experiences, the second third is used to discuss a particular issue or skill, and the final third is used to sum up the meeting and assign an exercise (Kadden et al. 1995). Another approach uses a standard problemsolving process in which an issue of concern to the group is identified, a variety of solutions is offered, each option is explored, a decision is made about the course to follow, an action plan is developed, and affected group members agree to pursue this path and report the outcomes (Gorski 2000).

Many recovery groups have traditional opening and closing rituals that are meant

to increase members' commitments to one another and to the group as a whole.

Group leaders' roles and qualifications. IOT programs usually specify the roles, responsibilities, qualifications, and personal characteristics of counselors who lead groups. Chapter 2 of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), discusses these issues in detail.

Individual Counseling

In IOT programs, individual counseling is an important, supportive adjunct to group sessions but not the primary form of treatment. Whereas concurrent psychiatric interventions and addiction counseling are appropriate for clients with co-occurring substance use and mental disorders (CSAT 1994*b*, 2005*e*; Daley and Thase 2002), most individual counseling in IOT programs addresses the immediate problems stemming from clients' substance use disorders and their current efforts to achieve and maintain abstinence. Counseling typically does not address the client's underlying, longstanding conscious and subconscious conflicts that may have contributed to substance use. Many of the readily available counseling manuals for substance abuse treatment have enhanced components for individuals or orient the entire approach to individual counseling (Kadden et al. 1995; Mercer and Woody 1999; Nowinski et al. 1992).

A 30- to 50-minute individual counseling session is typically a scheduled part of the IOT program and occurs at least weekly during the initial treatment stage. A client is assigned a primary counselor who strives to establish a close, collaborative therapeutic alliance.

An individual counseling session frequently follows a standard format. A counselor may ask the client about reactions to the recent group meeting, explore how the client spent time since the last session, ask how the client is feeling, inquire about drug and alcohol use, and ask whether there are any urgent issues. The counselor helps the client review reactions to recent group topics, reviews treatment plans and coping strategies, addresses fears and anxieties related to the change process, provides personalized feedback on urine toxicology and Breathalyzer™ results, and probes into sensitive issues that are difficult to discuss in the group. Counselors also help clients access services they need that are outside the treatment program's capabilities and plan the transition to another level of care or discharge. A counseling session usually ends with a summary of the client's plans and a schedule for the next few days (Carroll 1998; Gorski 2000; Mercer 2000).

Psychoeducational Programming

Psychoeducational groups are more didactic than process-oriented recovery groups and involve a straightforward transmission of facts. The counselors who deliver these services need to be knowledgeable about the subject matter. They also need to know where and how to obtain additional information to support their presentations and give members of the group other references and resources. These sessions, like recovery groups, stimulate discussion that helps participants relate the topic to personal experience and foster emotional and behavioral change (Washton 2000).

Exhibit 4-3 lists typical topics that are covered in psychoeducational groups and the treatment stage at which they are introduced.

Pharmacotherapy and Medication Management

Pharmacotherapy and medication management are critical adjuncts to effective substance abuse treatment that should not be ignored or separated from other therapies, psychosocial supports, and behavioral contingencies. Medications target only specific and

Exhibit 4-3

Typical Sequence of Topics Addressed in Psychoeducational Group

Treatment engagement	• Understanding motivation and committing to treatment • Counteracting ambivalence and denial • Determining the seriousness of the drug or alcohol problem • Conducting self-assessment, setting goals, and self-monitoring progress • Overcoming common barriers to treatment
Early recovery	• Learning about biopsychosocial disease and recovery processes • Understanding the effect of specific drugs and alcohol on the brain and body • Placing symptoms of substance use disorders in the context of other behavioral health problems • Learning about early and protracted withdrawal symptoms for specific drugs and alcohol • Knowing the stages of recovery and the client's place in the continuum of care • Learning strategies for quitting and finding the motivation to stop • Minimizing risks of HIV/AIDS, hepatitis C, and sexually transmitted diseases (STDs) • Identifying high-risk situations that are cues or triggers to substance use: people, places, and things • Identifying peer pressures and compulsive sexual behavior as triggers • Understanding cravings and urges, learning to extinguish thoughts about substance use, and coping with cravings • Structuring personal time • Coping with high-risk situations • Understanding abstinence and the use of prescription and over-the-counter medications • Understanding the goals and practices of various 12-Step or other mutual-help groups • Identifying and using positive support networks

(continued)

limited aspects of substance use disorders. Pharmacotherapy, by itself, does not change lifestyles or restore the damaged functioning that accompanies most drug dependence.

IOT programs that require attendance 3 to 5 days per week are ideal settings for identifying clients in need of medication, initiating medication regimens, and monitoring clients' compliance. IOT programs should give serious consideration to providing pharmacotherapy and medication management services

- To provide ambulatory detoxification and relief of withdrawal symptoms for some clients

Exhibit 4-3 (continued)

Typical Sequence of Topics Addressed in Psychoeducational Group

Maintenance and continuing care	• Understanding the relapse process and common warning signs • Identifying tools to prevent relapse • Developing personal relapse plans • Counteracting euphoria and the desire to test control • Improving coping and stress management skills • Learning anger management and relaxation techniques • Enhancing self-efficacy for handling risky situations • Responding safely to slips and avoiding escalation • Finding recovery resources • Structuring leisure time and finding recreational activities • Knowing the importance of personal health: diet, exercise, hygiene, and checkups • Taking a personal inventory • Handling shame, guilt, depression, and anxiety • Understanding family dynamics: enabling and sabotaging behaviors • Rebuilding personal relationships • Understanding sexual dysfunction and healthy sexual behavior • Developing educational and vocational skills • Learning daily living skills: money management, housing, and legal assistance • Embracing spirituality and recovery and finding meaning in life • Recognizing grief and loss and the relationship to substance use • Learning about parenting: basic needs of children and their developmental stages and developmental tasks • Maintaining balance in life

- To prevent relapse by reducing craving, by potentially precipitating an aversive reaction, or by blocking the reinforcing effects of drugs
- To reduce the medical and public health risks from use or injection of illicit drugs with medical maintenance
- To ameliorate the underlying psychopathology that may contribute to substance use disorders
- To monitor treatment of some medical conditions associated with substance use disorders

Ambulatory detoxification

ASAM criteria (Mee-Lee et al. 2001) include provisions for ambulatory detoxification when specific program and environmental supports are in place for persons who are at low risk for severe withdrawal. IOT programs should have written medical protocols or guidelines for specific detoxification procedures, as well as formal affiliations with appropriate general medical and psychiatric treatment facilities and laboratory testing and toxicology services. (This TIP is not intended to provide detailed information about detoxification and the medical management of detoxification. For more

information on detoxification see appendixes 4-A and 4-B and chapter 5 of this volume and TIP 45, *Detoxification and Substance Abuse Treatment* [CSAT 2006*e*]).

IOT programs can institute ambulatory detoxification safely for appropriate clients if they

- Make arrangements for immediate and continuous supervision or consultation by a qualified physician, with provisions for hospitalization or alternative detoxification, if necessary.
- Have medically trained staff (e.g., registered nurses, nurse practitioners, licensed practical nurses, physician's assistants) on site to conduct initial physical examinations, obtain medical histories, inform clients about medication effects, adjust dosages, and monitor clients for several hours or longer each service day.

The consensus panel recommends that family members be involved in monitoring and reporting adverse events for the client undergoing detoxification.

Using the CIWA-Ar scale. The Clinical Institute Withdrawal Assessment–Alcohol, Revised (CIWA-Ar) scale commonly is used to determine which clients who are alcohol dependent can receive ambulatory detoxification and which should be referred for inpatient care. The CIWA-Ar can be administered reliably in a few minutes by a staff member with a minimum of 3 hours of training (for more information about the CIWA-Ar, see chapter 5).

Some disagreement exists among physicians about the cutoff points on the CIWA-Ar for conducting ambulatory detoxification or referring a client for inpatient care. Many physicians seem to concur that clients with scores of 20 or higher should be treated in an inpatient medical facility. Other experienced addiction specialists find that clients with scores up to the low 20s can be managed safely in an outpatient setting with proper monitoring, supervision of medications, and other supports (see the case illustration and appendix 4-A). Medical staff members in IOT programs must use their best judgment or rely on the program's written procedures.

The CIWA-Ar also is used to monitor the client's response to administered medications at 30- to 60-minute intervals. Symptom-triggered doses are given only when trained staff members observe withdrawal signs of a specified intensity. Appropriate use of the CIWA-Ar has been shown to reduce both the numbers of clients receiving withdrawal medications and the amount of medication administered (Reoux and Miller 2000; Wiseman et al. 1998). The instrument has been adapted for monitoring benzodiazepine withdrawal (Busto et al. 1989) and for assessing opioid withdrawal (Bradley et al. 1987). (See chapter 5 for information about other screening instruments.)

Detailed guidelines and resources regarding ambulatory detoxification are available in TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT 1997*a*), and TIP 45, *Detoxification and Substance Abuse Treatment* (CSAT 2006*e*). Internet resources include articles from the *American Family Physician* (www.aafp.org), ASAM materials such as *Principles of Addiction Medicine* (www.asam.org), and *Detoxification Clinical Practice Guidelines* developed by the New South Wales Health Department (www.druginfo.nsw.gov.au/home).

Pharmacotherapies for addiction

Research supports the effectiveness of medication-assisted treatment for alcohol and opioid addiction. Despite promising leads, extensive laboratory research, and many clinical trials, no compelling evidence exists of effective medications for treating dependence on cocaine and other stimulants, marijuana, inhalants, or hallucinogens.

Preventing relapse to alcohol. Disulfiram (Antabuse®) and naltrexone (ReVia®) have been used successfully to assist clients who are alcohol dependent with avoiding relapse. An IOT program is an ideal setting to initiate disulfiram treatment because doses are effective for 3 days. Clients can receive their doses during a session, with double doses or take-home doses provided for the weekends.

Early research studies suggested that naltrexone did not reduce the frequency of alcohol use relapses but appeared to shorten the duration of relapse and to lessen the amount of alcohol drunk during a relapse episode (O'Malley et al. 1992; Volpicelli et al. 1992). However, recent data suggest that naltrexone might be ineffective in limiting drinking for men with chronic, severe alcohol dependence (Krystal et al. 2001). Clinicians who are interested in naltrexone for clients who use alcohol are referred to TIP 28, *Naltrexone and Alcoholism Treatment* (CSAT 1998*c*).

Whenever medication is used to support abstinence, clients need to be educated about the drug prescribed.

Acamprosate (Campral®) was approved by the U.S. Food and Drug Administration in 2004 for postwithdrawal maintenance of alcohol abstinence. In nearly two decades of use in Europe, acamprosate has been found to be safe and effective for treating alcohol dependence (Mann et al. 2004; Tempesta et al. 2000). Treatment with acamprosate has been shown to decrease the amount, frequency, and duration of alcohol consumption in clients who relapse to alcohol use (Chick et al. 2003; Tempesta et al. 2000) and to reduce cravings, even in clients who resume drinking (CSAT 2005*a*).

Medication maintenance for opioid dependence. Clients dependent on opioids, who frequently do not respond to other forms of substance abuse treatment, can be maintained effectively on certain longer acting opioid medications that enable them to function productively. These opioid medications include methadone, buprenorphine, and levo-alpha acetyl methadol (LAAM). (Although LAAM is still approved by the U.S. Food and Drug Administration for treatment of certain clients dependent on opioids, the U.S. manufacturer of LAAM ceased producing it in 2005.)

Treatment with methadone and LAAM currently must take place in specially approved and licensed programs or, under special circumstances, in a physician's office. Because new clients must attend these programs a minimum of 5 days a week, methadone maintenance programs are ideal settings for introducing many components of IOT programming.

Buprenorphine alone and a buprenorphine-naloxone combination are alternative medications for maintenance of individuals dependent on opioids. Buprenorphine was approved by the U.S. Food and Drug Administration in 2002 for the treatment of opioid dependence and is scheduled as a Class III narcotic. Buprenorphine can be dispensed or prescribed by physicians in office-based practices or in health care facilities that are not specially licensed, provided they obtain a waiver from the Substance Abuse and Mental Health Services Administration. IOT programs with a physician on staff or readily available are eligible to dispense or prescribe buprenorphine. Buprenorphine is safer for treating opioid dependence than methadone or LAAM because it is more difficult to overdose (Jaffe and O'Keefe 2003; Johnson et al. 2003) and, in combination with naloxone, reduces the risk of diversion (Johnson and McCagh 2000; Mendelson and Jones 2003). TIP 40, *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction* (CSAT 2004*a*), provides more information. Information about Web-based and onsite training about buprenorphine

can be obtained by clicking on Medication Assisted Treatment on the CSAT Web site (buprenorphine.samhsa.gov/training_main.html). TIP 43, *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* (CSAT 2005*b*), offers guidance about methadone, LAAM, and opioid pharmacotherapy.

Co-occurring disorders. Many clients who enter substance abuse treatment have co-occurring mental disorders. ASAM patient placement criteria recommend that individuals with moderate-severity disorders be treated in IOT programs that are designed primarily for clients who abuse substances; the placement criteria also recommend that IOT programs be capable of coordination and collaboration with mental health services. These programs can provide psychopharmacologic monitoring, psychological assessment and consultation, and treatment of substance use disorders to clients with moderate-severity mental disorders. Clients with symptomatic, high-severity psychiatric diagnoses should be treated in programs that treat co-occurring disorders by integrating mental health and substance use treatment and that have cross-trained staff (Drake et al. 1998*b*; Ries et al. 2000). (Moderate-severity co-occurring mental disorders include stable mood or anxiety disorders. High-severity disorders include schizophrenia, mood disorders with psychotic features, and borderline personality [Mee-Lee et al. 2001].) Chapter 9 provides additional information on treating individuals with co-occurring disorders. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*e*), also addresses this issue.

Clinical strategies and approach. Whenever medication is used to support abstinence, clients need to be educated about the drug prescribed. It is important for clients to understand

- Expected effects of the drug prescribed, interactions with other licit and illicit drugs, and adverse reactions that should be reported at once to the medical staff
- Side effects and how they can be ameliorated (e.g., laxatives for the commonly experienced constipation produced by methadone)
- Cross-tolerance and synergistic or other interactive effects when mixed with other drugs, especially drugs for such chronic conditions as high blood pressure, diabetes, high cholesterol, and asthma
- The time usually needed for the full effect of medications, such as antidepressants, to be felt

The way in which a medication is introduced and explained can affect clients' willingness to comply with the dosing schedule and their chances of receiving its full benefits. When clients begin a medication regimen, it may be useful to hold educational groups for clients and their family members. Accurate information can be imparted, and the questions of both clients and their families can be answered. If clients are given take-home doses, the inclusion of family members in such educational groups may be helpful for encouraging compliance with the medication protocol.

Medication-assisted IOT programs must build time into the treatment schedule for administering medications, monitoring the effects, and providing appropriate education about medications. The program can schedule the administration of medications to minimize the effect of withdrawal symptoms on the client's participation in psychosocial treatment and to maximize treatment attendance and retention.

Infectious diseases. Of paramount concern is encouraging client compliance with medication regimens to treat, control, or cure infectious diseases. Several TIPs address this issue, including TIP 6, *Screening for Infectious Diseases Among Substance Abusers* (CSAT 1993*b*); TIP 18, *The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers* (CSAT 1995*c*); and TIP 37, *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT 2000*c*).

Monitoring Alcohol and Drug Use

Routine monitoring of clients' illicit drug and alcohol consumption to determine whether the selected therapy is having the desired effect is a standard part of all IOT programs. Some programs rely on clients' self-reports. However, most programs use objective tests of biological specimens—usually urine samples, but also breath, saliva, sweat, blood, or hair samples. The results of these scientifically established procedures help program staff members reliably and accurately monitor a client's treatment course, recognize clients' success in remaining abstinent, and increase the accuracy of clients' self-reporting. Monitoring drug and alcohol use helps clinicians determine the need for treatment plan modifications, helps families reestablish trust, helps clients avoid slips or lapses, and discourages them from substituting a different drug or alcohol for their primary drug of choice.

Testing in the IOT program is designed to deter clients from using substances, not to punish or induce shame and guilt. Programs might use drug-free urine test results as a contingency for receiving specified rewards, *reinforcing* desired behaviors rather than *punishing* continued drug use (see Budney and Higgins 1998).

When programs are asked to report urine test results to the criminal justice system, an employer, or a children's protection agency, it is important to consider the negative effect reporting can have on treatment. Knowing that a positive test result may lead to punishment can inhibit a client's forthrightness in self-disclosure and encourage treatment dropout. Clients need to be informed fully that their test results will be disclosed and that testing positive may trigger serious consequences (CSAT 2004*b*).

Procedures for collecting and testing urine and a chart showing cutoff times for detecting various drugs are provided in appendix B (page 237). (Note: Alcohol is hard to test for because it may be eliminated from the client's system rapidly.) Appendix B lists methods and screening tests for detecting alcohol and illicit drugs, using a number of tests in addition to urinalysis.

Case Management

Individuals who abuse substances are likely to have significant and interrelated problems in addition to their use of psychoactive substances. Services to address these needs often are fragmented across many agencies. Services may be difficult to access without the assistance of a case manager who is knowledgeable about service providers and can help clients access these services (exhibit

Qualifications and Roles of Case Managers

- Many IOT programs hire professionally trained case managers, such as social workers or counselors whose sole function is case management. Other IOT programs may expect treatment counselors to assume case management responsibilities as well as counseling duties. In some programs, peer counselors or indigenous workers augment the work of professional staff members.
- Case managers in IOT programs develop and maintain an accurate list of local and regional services that clients may need.
- Case managers facilitate transfers to other treatment services as dictated by the clients' needs.
- Case managers in IOT programs participate in developing written memorandums of understanding and interagency agreements to ensure that these documents specify services offered, staff qualifications, number of available slots, costs, lines of authority, and referral procedures.

4-4). Case managers help clients identify and prioritize needs that cannot be met by the IOT program and access and participate in additional services to meet those needs.

Examples of client populations that might be aided by case management services include pregnant women, people who are homeless, clients with HIV/AIDS and other serious medical conditions, people with severe mental disorders, long-term welfare enrollees, people with physical disabilities, and people involved in the criminal justice system.

IOT programs—particularly those serving publicly funded clients—need to have detailed, up-to-date resource directories or formal arrangements with the following types of local services:

- Social service and child welfare agencies
- Vocational rehabilitation
- Training and employment assistance programs
- Preventive health care; inpatient, outpatient, and community health care services (e.g., visiting nurses; home health aides; physicians; specialty programs for HIV/AIDS, hepatitis C, STDs, or tuberculosis [TB]; and prenatal and pediatric care)
- Inpatient and outpatient psychiatric treatment and mental health services
- Recovery support groups

Exhibit 4-4

Case Management Services

Functions

- Provide a core set of social services that includes assessment, planning, linkage, monitoring, and advocacy.
- Provide the client with a single contact person who is responsible for finding and mobilizing needed resources, negotiating formal systems, and bartering informally with other service providers to gain access to appropriate services.
- Respond to client's needs, tailoring resources to the individual rather than fitting the client into existing services.
- Intervene with many systems and providers on behalf of the client.
- Operate in the community and transcend facility boundaries.
- Focus on pragmatic, immediate ways to meet needs (e.g., clothing, shelter).
- React sensitively and competently to clients' ethnic, gender, and cultural differences.

Models

- **Single agency model.** Case managers personally establish relationships with counterparts in other agencies to find and access services for individual clients.
- **Informal partnership model.** Staff members from several agencies link into collaborative teams or networks that consult about individual cases and share services.
- **Formal consortium model.** Case managers and service providers are joined through written agreements or contracts that define roles, responsibilities, shared services, and costs. This model usually is organized by a lead agency that has primary responsibility and receives most or all of the funding.

- Faith-based institutions appropriate for the client population
- Food banks and clothing distribution centers
- Recreational facilities and programs of many types
- Adult education programs, including instruction in adult literacy and English as a second language
- Child care
- Parent training programs
- Volunteer transportation services
- Family therapy and couples counseling
- Housing resources, including U.S. Department of Housing and Urban Development Section 8 housing, shelters for homeless persons and battered women, and recovery houses
- Legal assistance

Providers of heavily used services should be visited by IOT staff members to maintain close working relations.

Research outcomes and findings

Several studies suggest that case management services increase client retention, improve clients' occupational and social functioning, and ameliorate their psychiatric symptoms (Siegal et al. 1996, 2002). Case management services have been found to be a low-cost enhancement that improve client retention in some publicly funded, mixed-gender substance abuse treatment programs (Schwartz et al. 1997). A study by McLellan and colleagues (1998) provides support for adding case management services to IOT programs. This study evaluated the effectiveness of case-managed social services added to public-sector substance abuse treatment programs that served inner-city clients who were severely impaired. Case management consisted of coordinating and expediting clients' use of medical screening, employment counseling, drug-free housing, parenting classes, and recreational and educational services. Clients who received enhanced services had significantly better treatment outcomes than clients in traditional outpatient treatment. The investigators concluded that both addiction-focused services and supplemental social supports are necessary for effective, long-term rehabilitation.

In another study, case management for pregnant women enrolled in specialized women's outpatient substance abuse treatment included regular phone calls and home visits, written referrals to social service agencies, staff advocacy for clients' with social service agencies, and free transportation to and from treatment. Case management and transportation services were significant predictors of retention in drug treatment (Laken and Ager 1996). In a followup study, treatment retention was associated with decreased drug use and increased infant birth weight (Laken et al. 1997). TIP 27, *Comprehensive Case Management for Substance Abuse Treatment*, provides detailed information (CSAT 1998*a*).

24-Hour Crisis Coverage

Many clients in IOT programs develop problems that require immediate attention outside working hours. Arrangements are needed for 24-hour, 7-day-a-week coverage by trained personnel (exhibit 4-5). The benefits of this coverage include reducing unnecessary hospitalizations and providing fail-safe options for clients and families to head off crises.

IOT programs should ensure that clients are aware of the afterhours coverage and that the coverage is listed in published materials. Clients need clear, written instructions regarding emergencies—whether to go immediately to a hospital or to call 911.

Community-Based Support Groups

IOT programs should foster active participation in community-based 12-Step and other mutual-help groups as part of the treatment process. This effort is extremely important

Exhibit 4-5

Examples of 24-Hour Crisis Coverage Implementation

- **Hotline services.** In some programs, afterhours calls are forwarded to a hotline or other crisis intervention service. This service can provide advice and referrals or, if indicated, can contact an IOT program staff member.
- **Oncall clinicians.** A few large IOT programs that serve a particularly troubled population (e.g., persons with severe co-occurring mental disorders) may have rotating, oncall clinicians who answer and screen inquiries.
- **Agreement with 24-hour professional service providers.** In some areas, afterhours calls to the IOT program are transferred to a detoxification or inpatient rehabilitation unit that is staffed 24 hours a day.

for clients because formal substance abuse treatment is a relatively brief step in the long journey to recovery. In addition, clients need to develop a support network of positive role models and friends who can help guide their continuing recovery. Support groups serve as an important adjunct to structured therapy. At a minimum, clients need to be introduced to the basic tenets of a 12-Step or similar mutual-help group. Most IOT programs encourage participation in group meetings and give clients options about the type of community-based group they can attend.

Key aspects of community support groups

An IOT program often can facilitate voluntary attendance in support groups by helping clients understand more about local support groups through group discussion and individual counseling. At a minimum, IOT programs should give clients a thorough introduction to mutual-help programs, help clients overcome any resistance by encouraging their attendance with other group members or program alumni, and leave the decision about joining a group to the clients. Programs also can invite support groups to hold open meetings on site; these meetings allow clients to become familiar with the format of Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA), or other groups.

Counselors should be familiar with the differences between various support groups in the community and help their clients select an appropriate group meeting to attend. Counselors should match clients with groups attended by persons who have similar social, ethnic, economic, and cultural backgrounds and experiences. The substances clients abuse, as well as other factors, also may affect the match (Forman 2002).

The 12-Step fellowship

Twelve-Step fellowships are the most commonly recognized and widely attended groups for continuing recovery support. Involvement in 12-Step groups such as AA, NA, or CA is correlated positively with both retention in treatment and abstinence (Fiorentine 1999). Twelve-Step groups include a spiritual focus, espouse principles of conduct, and provide ongoing support for as long as an individual wishes to participate.

Twelve-Step groups are available throughout the country. There are different types of meetings (e.g., open speaker meetings,

Step meetings, open and closed discussion meetings). Basic AA texts include *Alcoholics Anonymous* (the "Big Book"), *Twelve Steps and Twelve Traditions*, and *Living Sober*. Basic texts of NA include *Narcotics Anonymous* and *It Works: How and Why*. Information about AA and fellowship meetings is available from the General Services Offices of Alcoholics Anonymous (www.gso.org) and from World Services, Inc. (www.alcoholics-anonymous.org). Information on AA meetings can be obtained from the central offices in each State and the District of Columbia. A list of contacts in the central offices can be found at www.aa.org/en_find_meeting.cfm. The Narcotics Anonymous Meeting Search function at www.na.org helps people locate an NA meeting throughout the United States and its territories. The CA Web site provides contact information for meetings throughout the United States, Canada, and Europe (www.ca.org/phones.html). Nowinski and colleagues (1992) and Daley and colleagues (1999) also offer guidance on conducting 12-Step-oriented counseling.

Some clients may be more comfortable in 12-Step groups that have been adapted to meet participants' needs. Depending on the geographic location, there may be gay- and lesbian-identified groups, women's groups, groups for people who are hearing impaired, men's meetings, Spanish-language meetings, meetings for agnostics, young people's meetings, and beginners' meetings.

Special 12-Step groups have been organized by people with both substance use and psychiatric disorders (see chapter 9). These groups have been shown to reduce substance use and increase compliance in clients taking prescribed medications (Laudet et al. 2000*a*).

Alternatives to community-based 12-Step groups

Community support groups exist for clients who may be uncomfortable with traditional 12-Step groups (see exhibit 4-6).

Medical Treatment

Many IOT clients enter treatment with undiagnosed or untreated medical conditions that require immediate and continuing care by a physician. All IOT programs need to have preplanned arrangements with a community health center or a local hospital that can handle any overdose or withdrawal-related emergencies. Relationships need to be in place with medical providers that will test for and treat infectious diseases, including STDs, HIV infection, TB, hepatitis B and C, and other health conditions. Programs serving women who are pregnant or of childbearing age need to have arrangements in place for obstetric and gynecological care.

Psychiatric Examinations and Psychotherapy

IOT programs need to evaluate clients' mental and psychiatric status and to refer those with signs and symptoms indicating that a thorough evaluation is warranted. Chapter 5 provides guidance on conducting psychological evaluations. Chapter 9 discusses the needs of persons in IOT with co-occurring psychiatric disorders; additional information is provided in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*e*). Ideally, IOT programs have relationships with mental health centers and with individual psychiatrists for consultation and referral.

Vocational Training and Employment Services

Unemployment or underemployment is often a problem for individuals in early recovery. Clients entering IOT programs often have issues that impede their ability to be employed fully, such as limited formal education, poor work readiness, and skill deficits. Few IOT programs are prepared to address these barriers to employment; hence, specialized vocational and employment counseling and related services on site or through case-managed referral are an optimal part of an IOT program.

Exhibit 4-6

Alternatives to Traditional 12-Step Groups

- Self-Management and Recovery Training (www.smartrecovery.org) groups were developed during the 1980s as alternatives to the 12-Step model. These groups address recovery within a cognitive–behavioral framework. Preliminary studies suggest this approach can be a viable alternative for individuals who are reluctant to attend 12-Step meetings, although further study is needed (Connors and Dermen 1996; Godlaski et al. 1997). Atheists and agnostics are less likely than clients who describe themselves as spiritual or religious to initiate and sustain AA attendance. However, clients who identify themselves as atheist and agnostic and who persist in AA attendance show no difference in days abstinent or drinking intensity when compared with clients who identify themselves as spiritual or religious (Tonigan et al. 2002; Winzelberg and Humphreys 1999).
- Secular Organizations for Sobriety (www.secularhumanism.org) and Save Our Selves (www.secularsobriety.org) promote individual empowerment, self-determination, and self-affirmation and offer groups for women and members of minority groups in addition to open groups.
- A variety of support groups can be accessed through national organizations such as Women for Sobriety, Inc. (www.womenforsobriety.org), the Women's Action Alliance, the Institute on Black Chemical Abuse (www.aafs.net/ibca/ibca.htm), the National Black Alcoholism and Addictions Council (www.nbacinc.org), the Hispanic Health and Human Services Organization, the Hispanic Health Council (www.hispanichealth.com), and the National Association of Native American Children of Alcoholics.
- Clients who are former inmates may respond positively to community-based support services that address their special needs. Programs such as the Fortune Society (www.fortunesociety.org) and the Safer Foundation, which provide assistance to former inmates, are located in several large cities.
- Religious institutions are frequently a significant community-based support system for many recovering individuals, particularly within African-American communities (CSAT 1999*b*). Many IOT programs encourage interested clients to become involved with community religious groups. For example, JACS (Jewish Alcoholics, Chemically Dependent Persons, and Significant Others) helps members reconnect with one another and explore resources within Judaism that enhance recovery.
- Some IOT programs run support groups for former clients on an indefinite basis. Generally, participation in these alumni groups does not require payment to the IOT program. The groups often are supported at minimal cost by the program as part of a continuum of care for clients who successfully complete treatment. Typical support provided by the IOT program for alumni groups includes meeting space, refreshments, and promotion of the group to clients. Some clients attend both 12-Step meetings and other support groups.

IOT programs need to stay abreast of local vocational training and employment resources and to develop relationships with these agencies and with individual counselors at these agencies. Many communities offer specific vocational resources for persons with disabilities, veterans, women, criminal justice clients, and other

groups. TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT 2000*a*), presents more information.

Enhanced IOT Services

Adult Education

Clients who have educational deficits need encouragement to enroll in local adult education classes, literacy programs, or general equivalency diploma programs. Those who do not speak English well should be encouraged to attend English-as-a-second-language courses. If a sufficient number of clients do not have high school diplomas or use a language other than English at home, an IOT program might recruit volunteers to conduct classes on site.

Transportation Services

The transportation needs of clients may be met in several ways, including providing public transportation tokens or passes. This simple accommodation should be considered by all programs that serve low-income clients as a way to encourage retention in treatment. Alternatives that are likely to involve insurance liability include using staff or volunteers to drive vans.

Housing and Food

Housing programs in many cities provide room and board for recovering persons. These recovery homes usually are not licensed treatment facilities but rather are financially self-sustaining organizations that offer housing for a limited time. The homes often are established or staffed by recovering individuals and are available for a nominal weekly or monthly rent.

The ground rules for residence are abstinence, regular rent payments, and appropriate conduct. Some recovery houses require attendance at house meetings and community-based 12-Step meetings. Some recovery houses actively encourage ongoing substance abuse treatment and employment by the end of the first 30 days of residence.

Other group-living houses are available to special populations, such as persons infected with HIV or individuals with psychiatric diagnoses, and professional staff members usually are in residence or readily available.

Many temporary shelters for homeless persons offer recovery support or more formal and staged substance abuse treatment. The Salvation Army, for example, operates halfway houses or supportive living residences for recovering persons. Some shelters for homeless people also incorporate short-term recovery support. Homeless populations and other low-income clients in IOT programs may need the assistance of food banks or access to surplus food that may be supplied by local merchants or other community agencies.

Recreational Activities

Organized recreational activities can be a valuable part of treatment, helping clients find healthful, substance-free interests to replace a former focus on substance use. Scheduled exercise (including walking, sports, weight training, and aerobics) has been shown to be an important aspect of substance abuse treatment (Kremer et al. 1995). Exercise can relieve underlying depression and anxiety (Paluska and Schwenk 2000). Organized sports, games, arts and crafts, and walks can have therapeutic benefits.

Adjunctive Therapies

Groups in which clients use various nonverbal, creative media (e.g., music, dance, drama, crafts, and arts such as painting, drawing, sculpture, and collage) can be therapeutic and helpful to recovery. Other alternative therapies that might help clients include acupuncture and stress reduction by means of biofeedback therapy (Richard et al. 1995).

Various forms of meditation (mindfulness, visualization, breath meditation, and transcendental meditation) have been used to treat diseases such as cancer and AIDS (Marlatt and Kristeller 1999). As an adjunct to substance abuse treatment, meditation can be used with the goal of reducing the

frequency and intensity of cravings and improving clients' emotional and psychological function (CSAT 1994*a*). Meditation is consonant with the philosophy of AA and other 12-Step support groups (CSAT 1999*c*).

Nicotine Cessation Treatment

Clinical experience indicates that the majority of people who are drug or alcohol dependent also smoke cigarettes. More people in this group die from tobacco-related causes than from their alcoholism or drug dependence (Hurt et al. 1996). Despite the health risks associated with smoking, substance abuse treatment staff members persistently believe that smoking cessation may be detrimental to clients' abstinence from other drugs. However, believing that the best time to quit smoking would be during treatment was the main factor in clients' accepting nicotine cessation treatment at admission to substance abuse treatment (Seidner et al. 1996). In one study, fewer than 10 percent of clients objected to a clinic's smoking ban when nicotine replacement therapy was available along with substance abuse treatment (Zullino et al. 2003).

The relapse rate for smokers in the general population who are trying to quit is high. Frank and colleagues (1991) found that fewer than 4 percent of smokers who succeed in quitting did so with the help of a physician. Smokers who are trying to quit achieve the highest success rates when they participate in behavioral therapy in combination with nicotine replacement therapy (Glover et al. 2003). These findings suggest that IOT programs are good settings for smoking cessation efforts because they offer a structured environment in which clients' efforts to quit smoking can be supported by behavioral and medication-assisted interventions and other clients. Strong associations have been shown between reductions in cigarette smoking and reductions in other substance abuse during treatment (Kohn et al. 2003; Shoptaw et al. 2002).

Nicotine replacement is available in prescription (inhaler, spray) and nonprescription (gum, patch) forms. Clients may need to try several different products of the same type (e.g., different brands or dosages of gum) or try different delivery mechanisms before they find a product that works for them. Researchers have found that inhalers, sprays, gum, and patches are more effective than placebo in helping clients quit smoking (Schmitz et al. 1998). The antidepressant medications bupropion and nortriptyline have shown promise in diminishing cravings for nicotine and improving quit rates, probably because they help alleviate depression—a major cause of relapse (da Costa et al. 2002; Richmond and Zwar 2003).

Licensed Child Care

IOT programs that serve women who have young children should have appropriate childcare facilities on site or nearby to facilitate the mothers' participation in treatment. For liability and therapeutic reasons, childcare arrangements should be provided by licensed childcare professionals, not by untrained counselors or volunteers. IOT programs should check with their county government or Single State Authority about local regulations.

Parent Skills Training

Many clients need to learn parenting skills, children's developmental stages, and appropriate disciplinary strategies for each stage. Parents also may benefit from practical information about obtaining vaccinations, diets for youngsters, listening skills, and attention-increasing activities that prepare toddlers for school. Training in parenting skills is essential for parents who have survived emotional, physical, and sexual abuse in their own childhoods. Without intervention, these clients may perpetuate this type of harmful behavior with their own children.

IOT programs can help enroll clients' young children in Head Start programs (where available) and facilitate their attendance (visit the Web site of the National Head

Start Association, www.nhsa.org). Focus on Families, a training program for parents in opioid treatment programs, has involved parents successfully in treatment, decreased their use of illicit substances, and reduced the risk factors and enhanced the protective factors for future drug use among their children; however, few significant changes have been seen in children's behavior at 1-year followup (Catalano et al. 1997, 1999). Information about Strengthening American Families and other age-specific model parent and family training programs evaluated by the Office of Juvenile Justice and Delinquency Prevention can be found at www.strengtheningfamilies.org. Information about programs, such as the National Center on Substance Abuse and Child Welfare and Starting Early, Starting Smart, that focus on children and families in the context of substance abuse prevention and treatment can be found at www.samhsa.gov/Matrix/programs_children.aspx.

IOT Services: A Case Illustration

Exhibit 4-7 describes a suburban, hospital-based IOT program, and appendix 4-A (starting on page 48) presents a case study illustrating the treatment course for one of its clients. This IOT program offers comprehensive services for diverse groups of clients. The treatment philosophy integrates the disease concept of chemical dependence with cognitive–behavioral approaches, motivational counseling, and the principles of 12-Step fellowship programs and similar mutual-help community support groups.

The facility is located within a hospital but has a separate entrance. It is close to public transportation and has ample parking. The reception room feels welcoming, and rooms for group sessions are furnished with upholstered couches and chairs, soft lighting, and pleasant artwork. Several group rooms double as offices for the counselors and onsite medical staff. This IOT program serves clients who are dependent on a variety of substances. Many clients have both substance use and mental disorders. The programming and schedules are sufficiently flexible to serve the needs of professionals, blue-collar workers, students, single-parent families, stay-at-home parents, and retirees.

Exhibit 4-7

Key Features of a Hospital-Based Suburban IOT Program

- Qualified medical staff members make the initial assessment of applicants' withdrawal potential; these medical staff members prescribe and dispense medications for symptomatic relief and monitor clients' reactions for up to 10 hours.
- Medications can be administered on site.
- Staff members provide continuing assessment of other potential psychiatric problems that may contribute to clients' substance use disorders; a psychiatrist in the hospital's psychiatric unit is available for medication evaluation and monitoring when needed.
- Whenever possible, family members (with the consent of the client) are involved in the initial assessment, treatment planning, and psychoeducational activities.

(continued)

Exhibit 4-7 (continued)

Key Features of a Hospital-Based Suburban IOT Program

- Randomized, monitored urine testing is used as a clinical tool for deterring clients' use of mood-altering substances.
- Clients are expected but not required to participate in 12-Step fellowships or other mutual-help groups early in treatment.
- Clients attend groups for both therapeutic and educational purposes. Most therapy groups are co-led by two counselors. Group members examine the ways in which their thoughts, emotions, and behaviors contribute to, or detract from, a satisfying lifestyle or recovery. The clinician is responsible for ensuring a psychologically and physically safe environment that provides support and maintains therapeutic pressure for positive change. Counselors are flexible in setting limits; they maintain order while allowing spontaneity and growth. The emphasis is on giving all group members an opportunity to participate as equals.
- Three 3-hour IOT sessions are organized into sequential groups. Issues identified during the first highly structured group are explored in depth during the second, less structured group therapy session. The third, didactic group session can be tailored to particular issues identified during the therapeutic discussions or to the basic interests of the group. These sessions, which use lectures and videos as well as written materials, address an array of topics, including basic information about alcohol and drugs, the 12 Steps of AA or NA fellowships and other support groups, and a cognitive–behavioral relapse prevention approach.
- The client's transition from the rehabilitation (early recovery) to the continuing care (maintenance) phase of treatment is carefully planned so that the client continues with the rehabilitation group while "trying out" the continuing care group. The client usually knows several members of the new group and, sometimes, a co-leader of the new group. The group meets in the facility in which earlier treatment was conducted and the structure of the sessions is similar to that of the primary treatment phase. Step-up care is used flexibly so that clients who have relapsed move to a more structured schedule until they are restabilized.
- Programming is structured to respond to individual client needs, including a variable, rather than a fixed, length of stay.
- Three levels of IOT services are offered in overlapping phases to reduce attrition and facilitate long-term recovery:
  - Partial hospitalization (ASAM Level II.5) for up to 10 hours per day for medically monitored ambulatory detoxification.
  - Intensive outpatient (ASAM Level II.1) for 3 hours per day for rehabilitation. Clients initially are seen 5 days per week. The frequency gradually is tapered to once weekly for a total of 10 to 30 sessions, depending on clinical need. Separate individual and family sessions also are scheduled.
  - Nonintensive outpatient (ASAM Level I) once weekly for 2 hours for continuing care for up to 2 years.

Appendix 4-A. A Case Study of Intensive Outpatient Treatment

Case Presentation	Commentary
Initial Contact	
Tom, a 45-year-old African-American accountant, has been referred to the program by his supervisor through his company's employee assistance program (EAP) because of repeated Monday-morning tardiness and complaints by co-workers that his work is increasingly "sloppy" and he often smells of alcohol.	Because the referral was initiated by an EAP, it is important for staff members to stay in close contact with the EAP representative.
An EAP representative telephoned and made an appointment for Tom for 9 a.m. the next day. Tom has health insurance, has not had previous treatment, and is married with a family. Tom was asked to invite his wife to come with him.	A trained intake worker screens all applicants to ascertain their eligibility and whether there is any psychiatric or medical emergency that cannot wait for a regularly scheduled appointment.
Stage 1: Treatment Engagement	
During the intake interview, Tom reports that he has been drinking "about a six pack" of beer daily for the past 5 years, with "maybe 10 or 15 beers" on weekend days. He denies other drug use and any major problems, although he was charged with driving while intoxicated (DWI) 2 years ago, at which time his blood alcohol level (BAL) was .22 mg/dl. He says he was "put out" that the judge sent him to alcohol education classes and AA meetings, even though he "wasn't really drunk or unable to drive." His doctor told him at his last checkup about a year ago that his liver function tests were slightly elevated and he should stop drinking.	Family members are invited to participate in intake interviews. Many treatment applicants initially minimize the extent or intensity of substance use and associated problems. However, Tom clearly has a substance use disorder that is affecting his functioning. After confidentiality regulations are explained, Tom consents to the program's requesting a transcript of the records of his DWI charge and his involvement with the alcohol education classes. His claim of not really being drunk despite a .22 mg/dl BAL suggests a high tolerance. He also agrees that his internist can be asked to forward medical records and conduct additional tests or examinations, if they are indicated.
Tom says he stopped drinking for a while but started again and hasn't been back to see the doctor since then. When asked about this period of abstinence, Tom says it probably lasted 4 months and that he felt	Tom's history indicates that his drinking may be complicated possibly by underlying depression, even though he blames others for his return to alcohol and does not, apparently, yet see his drinking as a problem.

Case Presentation	Commentary
depressed during that time. "It's hard having a teenage daughter," he offers as an excuse for drinking again. He says it was pretty easy to stop drinking then and would be now. He claims he has no withdrawal symptoms and is "healthy as a horse."	He agrees, however, to participate in the program because his job is in jeopardy.
When asked about Tom's drinking, his wife, Gloria, reports that he actually consumes 1½ to 2 six-packs a day and 20 or more beers per day on weekends. She's certain of this because she "picks up after him every night" after he falls asleep in his chair. She's been complaining and worrying about Tom's drinking for years and begged him to get help. She reports that his teenage daughter complains of how "mean" he gets when drinking. There has been no violence, but he shouts at the girl a lot. Gloria observes that Tom has "terrible shakes" in the morning until he has a beer. She recalls that he was pretty blue and unhappy when he stopped drinking and "couldn't sleep, either." She has begged him to go back to the doctor and says Tom never mentioned his "liver problems" to her before.	Gloria provides a more accurate description of Tom's drinking pattern and confirms both his physiological dependence and the possibility of underlying depression. She appears to be supportive of her husband although distressed by his continued drinking and its effects on the family.
Ambulatory Detoxification	
Asked to stretch out his arms, Tom has slight but visible tremors in his hands and fingers. A Breathalyzer test at 9 a.m. yields a reading of .10 mg%, indicating his BAL last night at 9 p.m. when he drank his last beer was an estimated .34 mg%.	The estimated BAL for last night is consistent with the DWI report and documents a high tolerance.
Tom is asked to submit an observed urine sample.	All newly admitted clients provide a urine sample.
He is assigned a counselor who performs a thorough assessment. Over the next few weeks, the counselor and Tom develop a treatment plan.	
The counselor administers the CIWA-Ar, and a physician's assistant conducts a brief exam and draws blood for new liver function tests. The counselor discusses the results of the assessments with Tom and Gloria and clearly explains Tom's assessed need for	Staff members determine that Tom can be detoxified safely on an outpatient basis. He agrees to remain on site during the day for monitoring, and he has a responsible wife who can drive him home and monitor him.

Case Presentation	Commentary
supported detoxification and the program's ambulatory detoxification process. The counselor also discusses the program's policy of encouraging all clients to begin taking disulfiram as soon as possible. The counselor ascertains that no contraindications exist for Tom, explains the mechanism by which disulfiram works, and provides Tom and Gloria with written information. Tom agrees to begin taking disulfiram once the medication is approved by his physician.	
Tom is given 50 mg of chlordiazepoxide (Librium®) that will be repeated every hour until he appears mildly sedated. He takes 3 doses on the first morning.	Clients with CIWA-Ar scores in the low 20s have been detoxified successfully with this protocol in this setting.
Tom attends his first group meeting in the morning. In the afternoon when there are no group meetings, Tom watches TV, reads, or sleeps in a lounge chair in a quiet room where he can be observed by the medical staff.	Immediate introduction to group treatment on the day of admission circumvents resistance to treatment beyond detoxification. It also allows group members to see the client at his worst so he cannot deny the severity of his withdrawal reactions once he is sober.
At 2 p.m., when his regularly monitored BAL reaches 0, Tom is given 125 mg of disulfiram. (For this program's protocol, see appendix 4-B.)	
By 4 p.m., Tom is feeling very anxious again and is given another 50 mg of chlordiazepoxide, which relieves his symptoms. He is asked to sit through another 3-hour evening group session and have his wife pick him up at 8:30 p.m. when the program closes.	
As he leaves for home, Tom is given three 50 mg doses of chlordiazepoxide to be taken hourly at bedtime until he falls asleep. He and Gloria are reminded that he has disulfiram in his system and should not drink.	Clients are given 50 mg doses of take-home chlordiazepoxide for up to 3 nights, but the medication is under the control of a responsible family member. The number of pills supplied should be monitored carefully. If the client has a history of dependence on sedatives, such medications are not appropriate for unmonitored administration.
The next morning, Tom reports that he needed only two doses of chlordiazepoxide to sleep, and he returns the extra dose. He is given another 125 mg of disulfiram. He is not given chlordiazepoxide during the second	

Case Presentation	Commentary
day but is given two more 50 mg doses for the second night. He needs only one and returns the other. On the third night, Tom takes home one dose of chlordiazepoxide but returns it the next day.	
Stage 2: Early Recovery	
On the third day, Tom returns to his full-time job. Because Tom works days, he is scheduled for the evening program, which he will attend on the next 5 weekdays for 3 hours each session. He will be scheduled for one individual session with his primary counselor each week. In addition to providing treatment planning and individual counseling, his counselor will provide ongoing case management. The hospital's social workers are available to assist the counselor with Tom's case management needs if necessary.	Clients who work days attend evening sessions. The 3-hour psychoeducational group sessions have a standard format: the first hour consists of a structured group during which each of the 6 to 14 members is asked individually to report significant emotional or behavioral events since the last meeting (e.g., moods, sleep patterns, activities, AA attendance, stress, cravings); a second hour is devoted to a modified form of group therapy that focuses on issues of particular relevance to members and encourages their interactions; and a third hour consists of didactic instruction on such relevant topics as medical aspects of addiction and relapse prevention techniques. All nondidactic groups are co-led by trained staff.
On the third day, a staff member gives Tom a prescription for 250 mg daily of disulfiram to fill at the hospital pharmacy. He will self-administer disulfiram at the start of each evening's group session. He will receive a double dose on Fridays to last through the weekend.	All clients who abuse alcohol are encouraged to take disulfiram throughout the rehabilitation phase. It has been found to be a useful adjunct for helping all clients who drink—whatever other drugs they use—to achieve and maintain abstinence.
When told that his initial urine came back positive for marijuana, Tom acknowledges that he smoked a joint with friends last weekend. To deter further use of illicit substances, he must now submit observed urine samples frequently and randomly. His counselor also informs Tom that his liver function test results are back and that his levels are elevated. The counselor schedules an appointment for Tom to meet with a physician to discuss the implications of these results.	The reasons and circumstances for Tom's use of marijuana—as well as alcohol—will be explored in the group. The program has a policy of total abstinence from all mood-altering drugs, and clients are expected to report any use of prescription or other substances before they are discovered by urine toxicology studies.
After five sessions, Tom's schedule is tapered to 4 evenings a week because he seems to be responding well to the group and is participating actively. He got through 1 weekend	

Case Presentation	Commentary
without too much difficulty and reports sleeping well and attending two AA meetings per week with a buddy from work. At the end of the second week, Tom reports that both his wife and daughter are proud of him—everything seems rosy.	
During the third week of treatment, however, Tom begins feeling depressed—with early morning wakening and loss of appetite. When a score of 25 on the Beck Depression Inventory reveals that he is moderately depressed, Tom's counselor meets with him and assures him that it is not unusual for people in early recovery to feel depressed and to have trouble sleeping. They discuss some things Tom can do to manage his depression, such as starting a moderate exercise program. The counselor gives Tom a relaxation tape that he can use at night to help him fall asleep easier and encourages him to report any new symptoms or worsening of his depression immediately.	Although it is not uncommon for psychiatric symptoms to emerge within the first few weeks of abstinence, clients may experience protracted abstinence withdrawal, which can cause similar symptoms. This program's policy is to manage mild-to-moderate symptoms nonmedically at first and to monitor the client carefully. Depending on the severity of the symptoms, an immediate referral for medication management of depression or for an appointment with a psychiatrist could be appropriate.
Tom also reports having some "really good" family times at baseball games over the weekends. He's pleasantly surprised at what a nice kid his daughter can be, although he's had a few arguments with her about the TV shows she prefers and the boy she has been dating. Gloria has been coming regularly to the relatives' support group and attended an Al-Anon meeting last week.	Tom's wife and daughter are encouraged to attend a weekly support group for relatives and significant others. This relatives' support group meets separately for 2 hours, and then participants join the clients for the third hour of didactic substance abuse education. No additional charges are incurred for family members' attendance at support groups. Relatives also are encouraged to attend Al-Anon or Alateen meetings.
Nevertheless, at 5 weeks into treatment Tom reveals to his counselor that he and his wife are increasingly in conflict, but he's uncomfortable discussing his marital problems in group. With Tom's permission, the counselor schedules several sessions with Tom and his wife to discuss these issues and assess the need for referral for marriage counseling.	During individual sessions, the counselor continues to assess clients' personal problems, helping them sort out issues related to their clients' (and their families') early adjustment to a recovery lifestyle. The counselor may need to address a client's issues of shame, guilt, sexual functioning, or childhood trauma if these issues appear to be interfering with the client's recovery.
Tom reports increasing feelings of sadness, irritability, and lack of energy. He says he has tried to exercise more, with some success, but often is "too tired." He has used the relaxation tape every night and says that it	The counselor continues to assess and monitor other medical or psychiatric conditions that may require more a detailed evaluation, counseling, or referral to outside resources.

Case Presentation	Commentary
helps "sometimes" but that he still is having significant problems sleeping. He has missed two group sessions in the last 2 weeks and is participating less in the group sessions he does attend. Tom's counselor schedules an appointment for Tom with the program's psychiatrist for further evaluation.	
The psychiatrist meets with Tom and decides that Tom's current level of depression should be managed medically. He prescribes antidepressant medication and discusses with Tom possible side effects and when he can expect to begin feeling the effects of the medication. The psychiatrist schedules followup appointments with Tom.	The program's consulting psychiatrist is readily available to meet with Tom and assess his need for medication. The psychiatrist meets regularly with Tom to monitor his medication and answer any questions he may have.
Tom continues to attend group sessions 4 days a week for another 4 weeks. By 3 weeks after starting the antidepressant he is participating actively, reports feeling much better, and is positive about his recovery. He attends AA three times a week and has a sponsor. He reports that he has not used marijuana, and urinalysis supports his self-report.	
At this point, program staff members assess that Tom is progressing well enough to step down his group treatment to two times per week and individual counseling to every other week.	
Stage 3: Maintenance	
In week 11, while participating in the rehabilitation phase, Tom begins attending a 2-hour continuing care group that meets in the same facility once a week in place of one of his rehabilitation phase groups. He is assigned to a group of mostly other professional people. Tom already knows a few of the members who transitioned earlier from the rehabilitation group; his counselor is a co-leader of the new group. The meeting format is familiar, consisting of group therapy but no more didactic presentations. The break between the two parts of the meeting becomes a time for group members to talk	A 2-week overlap between early recovery and maintenance groups eases the transition to the longer term, stepdown treatment phase at the same site. If possible, clients are placed in more homogeneous groups whose members have similar interests and values. Bonding and trust among group members become important in this phase as participants give one another constructive feedback and model techniques of daily living that prevent relapse. At the point of transition to the maintenance phase, Tom has been abstinent for more

Case Presentation	Commentary
frankly and share perspectives about the therapeutic process. After 2 weeks of overlap, Tom steps down to attending only the once-per-week maintenance group. At this point, Tom is given his disulfiram prescription to take on his own at home.	than 10 weeks, has started a regimen of antidepressant medications, has attended AA meetings regularly, has learned a great deal about alcoholism and substance abuse, and has begun to identify and understand the emotional triggers for his drinking and the negative influence that a circle of friends at work has on him. He is trying to implement several important lifestyle changes and has taken on more responsibility for his own recovery.
Tom adjusts well to his continuing care group and attends regularly for about 2 months. When he catches a bad cold, however, he calls in sick—just before the Christmas holidays. After Tom misses another session without reporting in—and his wife also stops coming to the relatives' support group—Tom's counselor telephones him at home.	
Tom acknowledges that he has "slipped" and has been drinking on a daily basis for 7 days. He stopped taking disulfiram about a month after he joined the continuing care group, thinking he could "handle it." He has drifted away from AA meetings. Now, Tom says, he has missed the last 2 days of work and is afraid his supervisor suspects the reason. Tom promises to return to the program the next day with his wife to discuss what to do. After Tom acknowledges that he has "messed up" because of overconfidence and the stress of the holidays, he is returned to the rehabilitation phase, attending 4 evenings a week and taking disulfiram again at the start of each session. He is expected to continue attending his weekly continuing care group, resume attending AA meetings, and reconnect with his sponsor.	It is not unusual for clients to relapse, at least briefly, after they are comfortable, think they no longer need treatment, and stop believing recovery is a lifelong process. This is a predictable event, especially among people who are in treatment for the first time. It can be difficult for them to accept that a substance use disorder is a chronic condition, requiring lifelong care. The intensity and duration of the response to a slip or relapse—a return or step-up to the rehabilitation phase—depend on a client's reactions. Each client must understand how and why the relapse occurred and not blame others. Clients should be acknowledged for interrupting their relapse quickly and returning to treatment voluntarily. This can mark a turning point in clients' understanding of their condition and recovery needs.
After Tom attends 11 of the 3-hour rehabilitation sessions over a period of 3 weeks, program staff members agree that Tom is "back on track" with an increased appreciation for the long road of recovery. He returns to his regular schedule of weekly continuing care group and AA meetings.	The program covers the costs of this more intensive relapse intervention as part of its regular charges.
Stage 4: Discharge to Continuing Community Care Planning for discharge begins early in the continuing care process. After 3 months in	Although treatment may continue at the program for as long as 1½ to 2 years, only a

Case Presentation	Commentary
the continuing care group, Tom's primary counselor refers him to a local psychiatrist for continued medication management. Tom is asked to prepare a plan for maintaining his recovery following discharge from treatment. He reports the following plans for ongoing community care to members of his group for their approval: • Continue to attend AA meetings four to five times weekly and maintain regular contact with his sponsor. • Encourage Gloria to continue attending Al-Anon meetings. • Join an AA club's bowling league team as a substitute for occasional "nights out" with rowdy drinking buddies at work who also smoke pot. • Continue to attend the church that he and Gloria have joined and continue to participate in a couples group that is part of their pastoral counseling services—with the understanding that referral to a private therapist may be indicated. • Continue his antidepressant medication and meet regularly with his psychiatrist for medication management. • Consider courses he might take that would qualify him for a promotion to a supervisory position at work. After 6 months of continuing care, Tom is discharged from active treatment. He will receive support calls every 6 months for 3 years.	minority of clients actually stay that long. Other clients leave earlier—on average, after about 25 weeks of continuing care. They are, however, encouraged to announce their plans in advance and receive clinician and group member endorsement. The goal is for them to leave with a realistic plan for ongoing recovery.

Appendix 4-B. Induction Protocol for Disulfiram

After detoxification, some IOT clients benefit from receiving drugs that help them remain abstinent and resist relapse. Disulfiram is appropriate for clients who are alcohol dependent, including clients whose alcohol dependence is combined with cocaine use and methadone clients who have alcohol problems.

Disulfiram interferes with the normal metabolism of acetaldehyde, an intermediary product in the oxidation of alcohol, and precipitates an unpleasant physical reaction if alcohol is consumed within 12 hours to 7 days (depending on dose) after taking the drug. Within several minutes of a person's drinking alcohol, the disulfiram reaction begins, with facial flushing followed by throbbing headache, tachycardia, increased respirations, and sweating. Nausea and vomiting usually occur within 30 to 60 minutes, sometimes accompanied by hypotension, dizziness, fainting, and collapse. The whole reaction can last for 1 to 3 hours and is sufficiently unpleasant to discourage most clients from drinking while taking disulfiram.

Some physicians recommend waiting 4 to 5 days after a client is alcohol free before initiating disulfiram treatment (CSAT 1997*a*). The *Physicians' Desk Reference* (2003) instructs physicians not to administer disulfiram until 12 hours after the last drink. The IOT consensus panel finds that careful monitoring of clients' BALs achieves the same effect—assurance that no alcohol exists in the system. Exhibit 4-8 outlines the protocol for ambulatory detoxification and disulfiram induction. Low doses (125 mg) of disulfiram can be administered as soon as a client's BAL reaches zero—usually on the day of admission. The consensus panel recommends that clients who are alcohol dependent receive disulfiram as soon as they are detoxified rather than jeopardize their abstinence by waiting for a liver function test to be conducted. If needed, testing for liver

Exhibit 4-8

A Protocol for Ambulatory Detoxification and Disulfiram Induction

First day:	Chlordiazepoxide 50 mg hourly until anxiety is relieved—50 mg to 300 mg
When BAL = 0:	Disulfiram 125 mg*
First night:	Chlordiazepoxide 50 mg at bedtime;† repeat hourly x 2 until asleep (3 doses provided)
Second day:	No medication
Second night:	Chlordiazepoxide 50 mg at bedtime; repeat in 1 hour if not asleep (2 doses provided)
Third night:	Chlordiazepoxide 50 mg at bedtime; repeat in 1 hour if not asleep (2 doses provided)

*Disulfiram is dispensed only at the clinic.
†All unused chlordiazepoxide doses must be returned to the clinic the following morning.

Source: G. Kolodner, M.D., personal communication, 2003.

impairment can be done during the 2 to 3 weeks after starting disulfiram.

Dosage Levels

Some experienced clinicians prefer to prescribe low doses of disulfiram (125 mg) for most clients because at this dose the reaction to drinking is not as potent or potentially dangerous as it would be at a higher dose. Other physicians use an initial dose of 250 to 500 mg of disulfiram. Lower doses are appropriate for persons who have some liver impairment, small women, and elderly persons. Although no studies exist regarding the optimal length of disulfiram treatment, some clients have taken the drug for as long as 16 years (CSAT 1997*a*). Compliance beyond the active treatment phase, however, is a major problem.

Episodic use of disulfiram is an effective strategy for clients who want to guard against drinking in situations that carry a high risk for alcohol consumption. These situations might be special events or celebrations where most people are consuming alcohol or meetings with friends who are former drinking buddies.

Contraindications and Cautions

Disulfiram is contraindicated for clients with acute hepatitis, severe myocardial disease or coronary occlusion, chronic lung disease or asthma, psychoses, or sensitivity to disulfiram or its derivatives used in pesticides and rubber vulcanization. Disulfiram is not prescribed for pregnant women or clients who have had a previous allergic reaction. Women of childbearing age are warned to use contraception while taking disulfiram because the medication might endanger a fetus.

Clients who take phenytoin (Dilantin®), isoniazid, or warfarin (Coumadin®) should be warned that disulfiram might intensify the effects of those medications, requiring a reduction in the disulfiram dose. Clients taking disulfiram should not take metronidazole (Flagyl®). They should avoid inadvertent exposure to the alcohol contained in many cough medicines and mouthwashes or emitted by alcohol-based solvents in a closed area. Consumption of food that contains liquor or wine usually does not cause a problem if the alcohol has been evaporated during the cooking process. Clients should report any allergic reaction in the form of an itchy rash, which usually can be controlled by lowering the dosage or administering an antihistamine.

Monitoring Procedures

Clients taking disulfiram should be monitored a minimum of every 4 months to ascertain whether any allergic hepatitis requires immediate discontinuation of the drug. Other potentially adverse effects include optic neuritis, peripheral neuritis, polyneuritis, and peripheral neuropathy. Mild reactions to the initiation of disulfiram, such as headaches and drowsiness, usually are transient and dissipate spontaneously within a few weeks.

5 Treatment Entry and Engagement

In This Chapter...

Elements of Engaging the Client in IOT

Collect Screening Information

Assessing Barriers to Treatment

Crises and Emergencies

Components of the IOT Admission Process

Sample Treatment Plans

Entry into intensive outpatient treatment (IOT) for a substance use disorder is a complex and critical process for both the client and the program. Clients' motivations to change range from outright resistance to eager anticipation. An IOT program's intake process, from initial contacts through ongoing assessments and treatment planning, strongly influences whether clients complete admission procedures, select appropriate interventions, and engage in treatment.

Early attrition of clients is a pervasive problem in substance abuse treatment (Claus and Kindleberger 2002). To address this problem, the consensus panel recommends the following in the admission process:

- Assessing a person's readiness for change and applying appropriate strategies to motivate the client to enter and participate in treatment
- Establishing a collaborative relationship between the clinician and client from the start
- Identifying and overcoming barriers that discourage the client from engaging in treatment
- Matching clients to the least intensive and restrictive treatment setting that can support recovery effectively
- Developing individualized interventions of variable intensity and duration that meet each client's needs, rather than fitting the person into a predefined program

More is being learned about the complicated interrelationships among substance abuse and many other biopsychosocial factors, including mental disorders, child abuse and neglect, domestic violence, issues related to physical and cognitive functioning, history of trauma, poverty, criminal activities, skill deficiencies, and infectious diseases. Many screening and assessment instruments are available to ascertain the presence of these factors.

A major challenge of the admission process is to balance a rapid and empathic response to a client's request for treatment with the need to obtain information about many aspects of the client's life that can affect the treatment response. The need for detailed assessment information must not impinge on the main admission activities: to engage the individual in treatment, ameliorate immediate crises, and remove barriers to treatment. Attention needs to be given to clinicians' interviewing styles and the program's intake procedures, as well as to the content and sequence of the screenings or assessments conducted.

> Abruptness or rudeness on the part of staff...can result in no-shows or early dropout.

Elements of Engaging the Client in IOT

The acknowledgment that the provider shares responsibility with the client for the client's motivation to change and commitment to treatment marks a fundamental shift in substance abuse treatment. Treatment engagement can be fostered by

- Providing a positive, welcoming environment
- Adopting effective initial response procedures
- Preparing for and conducting supportive, productive intake interviews

Program Surroundings

The physical layout and ambience of the IOT program can influence a person's commitment to the treatment process (Grosenick and Hatmaker 2000).

Create a welcoming environment

Programs should do everything possible to make the waiting area welcoming and comfortable. Staff members or others can provide current magazines and recovery literature. A television set can show instructive videos. Toys (games, paper and crayons) can be provided for small children who accompany potential clients. A bathroom, public telephone, and source of water should be accessible and clean. A vending machine is desirable if people spend much time in this space.

The Americans with Disabilities Act guarantees equal access to treatment for clients with disabilities. All program staff members should anticipate clients' needs, be mindful of physical barriers that limit access to or use of the program's facilities, and be prepared to make accommodations. Stairs, cluttered areas, narrow hallways, doorknobs, and even deep pile carpet may restrict the movements of clients who use crutches or wheelchairs. Clients with disabilities may require assistance in arranging transportation and may require more time to get from place to place when they are at the treatment facility.

Ensure availability

The facility where new clients are admitted should be accessible by public transportation and be open during hours that are convenient for them. Information about the program should be available by telephone. An answering service can provide an ongoing message about the program's location, access by public transportation, parking availability, hours of operation, and when a staff member is available to answer questions. This information also can be listed on a program Web site and posted on the clinic's front door.

Communicate cultural competence

Often the first thing potential clients notice is whether the program seems receptive to their ethnic, cultural, or gender identity. Posters and pictures of populations served by the program, reading materials in various languages, posted announcements of workshops and community activities that address topics of interest, and staff members who can communicate in the potential clients' languages as well as empathize with different cultural attitudes are some accommodations that IOT programs can provide. Chapters 9 and 10 discuss other aspects of serving diverse populations; chapter 4 of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), discusses how administrators can prepare programs for cultural diversity; and the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT forthcoming *a*) addresses this issue as well.

Reinforce privacy and confidentiality

All staff members need to be mindful of clients' privacy. Clients should never be greeted by name in public areas. All interviews need to be conducted in a private room. To ensure privacy, the intake worker provides the client with any forms that need to be completed and walks with the individual to a private area where the client can fill out the forms. It may be necessary to arrange for an interpreter to translate conversations and forms. Extensive telephone interviews should be conducted from a private or soundproof office so that those in the waiting room do not overhear conversations.

Initial Response Procedures

An IOT program should review its initial response procedures to make sure that it receives potential clients in a welcoming way.

Ensure a rapid response

A review of initial response procedures should include an examination of how quickly potential clients are engaged by program staff and how long the intake procedure lasts. Once they have made up their minds to seek treatment, some potential clients may become apprehensive or afraid if their first steps toward recovery are not met with support by the program staff. It is important for staff members to greet walk-in clients and those who telephone promptly and to respond knowledgeably to their questions. Individuals who leave messages inquiring about treatment should be called back as soon as possible.

The initial contact should be limited to an hour, with additional time for questions and an introduction to the treatment process. Detailed assessment usually can be delayed until a subsequent session. If intake cannot be completed during the initial contact, preliminary information should be collected and another appointment should be scheduled at the earliest mutually convenient time—preferably within 24 hours.

Convey respect

An important aspect of treatment engagement is making certain that all program staff members greet new clients in a respectful, friendly, and supportive manner that reflects sensitivity to their situations. If a caller has to be put on hold, this should be communicated in a pleasant voice. Abruptness or rudeness on the part of staff, no matter how busy the program or what emergency occurs, can result in no-shows or early dropout. (See chapter 3 of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* [CSAT 2006*f*], for a discussion of training staff in customer service skills.)

Intake Interviews

Intake interviews may require a variety of approaches to ensure that potential clients feel connected to the treatment program.

These interviews should be used to collect screening information and lay the groundwork for treatment. Intake interviews should be conducted by counselors or staff members trained in intake procedures.

Use informal approaches for initial interviews

Potential clients who spend their first hours in an IOT program answering a series of structured questions in a formal interview are unlikely to reveal their personal problems or to become engaged in the process (Miller and Rollnick 2002). Research and anecdotal evidence suggest that other, less formal approaches are important for building rapport between the counselor and client and documenting important information. One such approach is the sandwich technique, in which a standard screening and assessment are "sandwiched" between two less formal discussions that focus on finding out the individual's views, gaining cooperation, and defusing potential resentments or hostilities.

During the first 15 to 30 minutes of the interview, a counselor

- Solicits the client's perceptions of problems that brought him or her to treatment
- Explores what the client expects from treatment
- Supports the client's commitment to change
- Offers hope that change is possible
- Informally assesses the client's readiness to change

At this point, the counselor switches from a casual and conversational tone to a more directive tone as formal screening and assessment are conducted.

The counselor can offer an explanation such as, "We started talking rather informally about what brought you to treatment. Now, we need to shift gears and complete some forms to gather more detailed information. When we are finished, we can go back to discussing questions you still may have about treatment and this program."

When summarizing findings and beginning to plan treatment, the counselor needs to use strategies that are appropriate to the client's change stage. For the final portion of the intake, the counselor can focus on the individual's expectations for treatment.

A less structured interview method uses a genogram for gathering information about the individual and his or her familial relationships (CSAT 2004*c*). A more detailed explanation of the family genogram, along with a sample, is included in chapter 6 of this TIP.

Adjust interviewing styles

Much attention has been given to the critical role that motivational interviewing plays in treatment engagement and retention (CSAT 1999*c*). Appropriately solicitous approaches increase the likelihood that intake interviews elicit accurate information from potential clients. Such approaches also foster a productive working alliance between the counselor and the potential client that can enhance the client's impetus to change and engage in treatment. Exhibit 5-1 presents effective interviewing styles based on TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*c*), and input from the consensus panel.

Collect Screening Information

During the initial contact, sufficient information needs to be collected from the client to determine whether to continue the admission process or make an immediate referral to a more appropriate facility. No one seeking treatment should be turned away from the program without a referral to a specific person at another service facility.

Exhibit 5-1

Effective Interviewing Techniques

- Begin with a brief overview of the topics to be covered, the expected duration of the interview, and confidentiality requirements.
- Ask the least threatening questions first.
- Listen attentively and reflectively. Restate what the individual said to determine the level of understanding. Provide enough time for the individual to express himself or herself.
- Support self-efficacy by communicating that the individual can change, make autonomous decisions, and act in his or her best interests.
- Affirm the strengths, and compliment the positive values of the client.
- Explain everything that is happening or planned in treatment, and allow time for questions.
- Ask open-ended questions that cannot be answered with a one-word response to encourage the individual to talk, describe feelings, and express opinions.
- Convey empathy through voice tone, facial expression, and body language as well as with direct expressions of caring.
- Observe the client for nonverbal expressions of feelings that may either be inconsistent with or confirm what the individual is saying.
- Avoid argument, remain nonjudgmental, and adjust to any resistance.
- Probe gently to clear up discrepancies and inconsistencies.
- Be completely candid and honest.
- Help the client move beyond anger, resentment, frustration, or defensiveness; even if the individual does not return, this single contact can be a constructive, positive influence.

Record Basic Information

The following information often is documented on an intake form:

- Name, age, and gender to establish identity and determine whether other special arrangements or interventions are needed (e.g., if the person is a minor). Some programs require a valid identification such as a driver's license, birth certificate, or passport.
- The referral source, if any, and supporting documentation of the need for treatment. It is important to note whether treatment is sought voluntarily or mandated formally by an organization that expects periodic reports and whether the potential client has consented formally to this arrangement. (For information on the importance of obtaining signed consent agreements before any reports are made, see *The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule* [CSAT 2004*b*].)
- The individual's perspective on why treatment is needed and any crises that may require immediate attention.
- Pertinent medical conditions.
- Any suicidal or other violent thoughts.
- The person's usual residence to determine whether the individual lives in a designated catchment area, if required, as well as the stability of living arrangements, proximity to the program, and how this might affect attendance or transportation.

- The substance use disorder and its severity, including types and amounts of substances consumed, presenting signs and symptoms, and potential for withdrawal. Appendix 5-A (page 84) has a sample form that can be used to document the current substance use pattern and can be completed during a subsequent interview. More detailed information can be collected later.
- Elapsed time since the most recent substance abuse treatment episode; what type of treatment or level of care was used and why it ended, especially if there are restrictions on readmission.
- Other information that may be germane to treatment, scheduling, and special arrangements such as
  - Employment hours and work location
  - Next of kin or person to contact, with advance consent, to locate the client
  - Number and ages of dependent children living with the client
  - Date of the individual's most recent physical examination and name of the primary care physician who can, with legal permission, release medical information
  - Primary language spoken, understanding of English, and literacy level

Use Short Screening Instruments To Document a Substance Use Disorder

Several short screening instruments are available and may be used to document the presence of a substance use disorder that later may be confirmed with a diagnostic interview.

Not all screening instruments perform equally well for specific populations. A study comparing the effectiveness of eight frequently used screening instruments for ascertaining substance use disorders used the Structured Clinical Interview for Diagnosis of DSM-IV, Version 2, Substance Abuse Disorders module (Peters et al. 2000), a well-accepted, comprehensive diagnostic criterion for measuring substance-related disorders. The study found that only three instruments had high rates of accuracy, positive predictive value, and sensitivity, in addition to the capacity to distinguish between substance abuse and dependence disorders. These three instruments are

- The Center for Substance Abuse Treatment's Simple Screening Instrument (reproduced in TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* [CSAT 1994*f*])
- A combination of the Alcohol Dependence Scale and the Addiction Severity Index (ASI)-Drug Use Subscale (see appendix 5-B for more information)
- Texas Christian University Drug Screen (see appendix 5-B for more information)

Other widely used simple screening instruments are the CAGE Questionnaire, the Short Michigan Alcoholism Screening Test, the Offender Profile Index, and the Substance Abuse Screening Instrument. Each instrument is in the public domain, and there is no cost for reproduction and use. TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (CSAT 1994*f*), provides information on these and other screening instruments. Additional resources for screening tools include *Assessing Alcohol Problems: A Guide for Clinicians and Researchers* (Allen and Columbus 1995), *Assessing Drug Abuse Among Adolescents and Adults: Standardized Instruments* (National Institute on Drug Abuse 1994), and *Diagnostic Source Book on Drug Abuse Research and Treatment* (Rounsaville et al. 1993).

Assessing Barriers to Treatment

During an initial contact, the counselor should be alert to any barriers the individual may face when entering treatment.

Intoxication or Withdrawal

Although some individuals stop consuming all abused substances a few hours or days before coming to the facility, others arrive at the IOT program shortly after ingesting a "last" dose of a substance. Intake staff must be able to recognize and know how to handle persons who are severely intoxicated, are manifesting signs of withdrawal from physical dependence on alcohol or drugs, or are at risk of developing such symptoms. Staff members need training and a protocol for determining when the intake process needs to be suspended until (1) such symptoms can be alleviated or allowed to remit spontaneously and (2) the individual can cooperate productively or return safely to the community. A severely intoxicated individual may be unable to provide accurate responses to intake questions, and the person's symptoms may mask a serious medical condition.

Staff members should note the potential client's behavioral and physical signs of intoxication and evaluate them against the individual's report of recent substance use. If discrepancies exist between the reported consumption patterns and signs of incoherence, drowsiness, or stupor, staff members should consider that a physical symptom could be the result of head injury, infections, diabetes, overdose, or some other cause. At a minimum, the program should be able to conduct a brief physical examination, assess vital signs, and document evidence of acute intoxication or potentially serious withdrawal symptoms. Persons whose level of consciousness is decreasing require urgent medical evaluation in a medical setting.

Each IOT program needs guidelines that indicate whether sick or intoxicated persons can be observed and assisted at the facility, should be transferred immediately to a more intensive level of care (e.g., detoxification facility, hospital emergency room), or are ready to return home. IOT program medical staff members must make the decision about who can be admitted safely. If medically trained staff members are unavailable on site to assess clients and to make these decisions, the IOT program should have access to immediate medical consultation or emergency treatment. Direct affiliations must be in place with other levels of care in the local alcohol and drug treatment system and with mental health facilities. If clients are too sick or intoxicated to transport themselves, the IOT program must arrange safe transportation home or to another treatment facility.

Acute or Chronic Medical Conditions

During intake, all individuals need to be screened for potential medical emergencies. Those with unexplained acute symptoms (e.g., pain, altered consciousness, disorientation, delirium) need to be referred for medical evaluation. All applicants need to be asked about diagnosed medical conditions, onset of serious symptoms, previous head injury, recent hospitalizations for major medical problems, and medications they are taking.

Psychiatric Stability

Individuals with mental disorders are at high risk for self-destructive and violent behaviors. Because use of alcohol and drugs can be associated with psychiatric symptoms and disorders, interrelationships between the substance use and the psychiatric symptoms should be considered in the screening process (Brems et al. 2002; Carey and Correia 1998; Scott et al. 1998). The IOT clinician needs to be alert to any evidence of bizarre or acutely paranoid thinking, threats to harm oneself or others, disorganized thoughts, or delusions and auditory hallucinations. Individuals with such symptoms should be asked about any history of violent

During intake, all individuals need to be screened for potential medical emergencies.

or suicidal behavior, previous psychiatric hospitalization, current treatment of mental disorders, prescribed psychotropic medications, and whether these medications are being taken at recommended doses and times.

A simple ABC model that can help intake personnel detect overt signs of psychiatric disorders is shown in exhibit 5-2.

Physical Disabilities or Cognitive Limitations

The consensus panel recommends that IOT programs conduct early screening for physical, sensory, and cognitive disabilities because these conditions may affect clients' ability to participate in treatment. Modifications in the treatment regimen or environment can help these clients function well in treatment.

A brief examination of cognitive functioning is recommended for individuals who appear, for unexplained reasons, to be disoriented with respect to time, place, or person or to have memory problems or language disturbances. Many clinicians use the Mini-Mental State Examination (MMSE) (Folstein et al. 1975) for this purpose. The MMSE can be ordered at www.minimental.com. Cognitive impairment can limit the utility and accuracy of such frequently used assessment instruments as the ASI. Additional screening instruments for use with individuals with physical and cognitive disabilities are identified in TIP 29, *Substance Use Disorder*

Exhibit 5-2

ABC Model for Psychiatric Screening

- Appearance, Alertness, Affect, and Anxiety
  - Appearance: How are general hygiene and dress?
  - Alertness: What is the level of consciousness? Confusion?
  - Affect: Are there signs of elation, anger, or depression in gestures, facial expression, and speech?
  - Anxiety: Is the person nervous, phobic, or panicky?
- Behavior
  - Movements: Is the person hyperactive, hypoactive/subdued, abrupt, agitated, or calm?
  - Organization: Is the person coherent and goal oriented?
  - Purpose: Is behavior bizarre, dangerous, impulsive, belligerent, or uncooperative?
  - Speech: What are the rate, coherence, organization, content, and sound level?
- Cognition
  - Orientation: To person, place, time, and condition
  - Calculation: Memory and capability to perform simple tasks
  - Reasoning: Insight, judgment, and problemsolving abilities
  - Coherence: Delusions, hallucinations, and incoherent thoughts

Adapted from CSAT 1994*b*, p. 16.

Treatment for People With Physical and Cognitive Disabilities (CSAT 1998*e*), and TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT 1999*d*).

Crises and Emergencies

Counselors need to be alert to any crises that threaten clients' safety or the safety of those around them.

Potential for Violence or Suicide

A brief psychiatric evaluation should be completed to determine the potential risk of violence or suicide or the presence of psychosis. A full psychiatric evaluation should proceed only after withdrawal and lingering withdrawal effects have passed. TIP 43, *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* (CSAT 2005*b*), discusses risk factors for violence and suicide and recommends measures treatment programs can take.

Immediate Threats to the Client's Safety

IOT program staff members need to be alert to any immediate threats of violence to staff or clients. The close association between domestic violence and substance abuse has become clearer and better documented in recent years (CSAT 1997*b*). It is now recognized that individuals' unexplained, evasively acknowledged, or untreated injuries—especially to the face, head, neck, abdomen, or breasts—may indicate battering. Chronic headaches, depression, recurrent vaginal infections, abdominal or joint pain, sexual dysfunction, or sleep and eating disturbances also may indicate domestic violence (Naumann et al. 1999). Reports of child abuse by a spouse or significant other should raise concerns about related abuse of the concerned parent.

Suspicions of immediate danger should be investigated at the initial contact by asking questions such as, Do you feel safe at home? Do you feel safe in your current relationship? Is someone threatening you now or making you feel unsafe? The program should have arrangements with appropriate shelters, domestic violence counselors, and experts in forensic evidence who can be consulted about appropriate protection and safety plans (CSAT 1997*b*). TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT 1997*b*), provides additional information.

Components of the IOT Admission Process

Admitting a potential client to substance abuse treatment entails

- Establishing the individual's eligibility, which involves validating the suitability of the program's services for the individual and assessing the individual's readiness to change
- Initiating treatment, which may involve detoxification, providing an orientation to the program, and addressing immediate barriers to treatment
- Conducting a comprehensive biopsychosocial assessment
- Conducting a multidimensional assessment
- Summarizing assessment findings
- Developing an initial individualized treatment plan

Although treatment entry can be a straightforward procedure, treatment staff members should be understanding and willing to adapt the intake procedure for clients who have complicated problems and living situations. Treatment evolves with the results of ongoing assessments that both monitor the client's progress and identify new or reemerging problems.

Eligibility

After screening individuals for substance-related disorders and problems that could affect treatment, IOT staff verifies whether the IOT program offers a suitable treatment intensity and environment to meet clients' needs. IOT programs should be prepared to justify the need for the specific services and support at admission and as clients progress through treatment.

Apply patient placement criteria

Criteria for matching clients to appropriate settings and services for specific problems are available. Attempts to specify placement criteria are designed to individualize substance abuse treatment and ensure its effectiveness.

The American Society of Addiction Medicine (ASAM) developed *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders* (PPC) (Hoffman et al. 1991). The criteria in this document are used widely by providers and a few payers, including Medicaid in some States. Research shows that the criteria described in ASAM PPC are reliable and have predictive validity (Gastfriend 1999).

The most current version, the ASAM PPC-2R (Second Edition, Revised) (Mee-Lee et al. 2001), separates IOT into two different degrees of treatment participation. Level II.1: Intensive outpatient treatment requires a minimum of 9 contact hours a week, whereas Level II.5: Partial hospitalization (daycare) involves at least 20 hours weekly of structured programming. Exhibit 5-3 provides an overview of the functional deficits and problem severity that indicate a client should be placed in Level II.1. The criteria for partial hospitalization are listed in ASAM PPC-2R. ASAM PPC-2R can be ordered from the ASAM Publications Distribution Center (Box 101, Annapolis Junction, MD 20701-0101; (800) 844-8948; www.asam.org).

Admission to either of the Level II IOT options requires the following:

- A diagnosis of a substance-related disorder based on the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) (American Psychiatric Association 1994), or similar criteria (see appendix 5-C)
- Identification of at least one criterion in ASAM PPC-2R dimensions 4, 5, or 6
- Meeting the requirements of dimensions 2 and 3 if biomedical, emotional, behavioral, or cognitive conditions or problems exist

The diagnosis of a substance use-related disorder is based on findings of the comprehensive assessment, a physical examination, and laboratory tests. A diagnosis also may be derived from administering specific instruments, such as those described in appendix 5-B (page 85).

Assess readiness for change

Persons with substance use disorders who are not motivated to change may not benefit from or participate in intensive treatment interventions unless their motivation improves. These precontemplators (i.e., those who have not yet considered change) and contemplators (i.e., those thinking about a change in the near future) may require special preparatory counseling that is directed at raising their awareness about the negative consequences of substance use and generating a commitment to change (Connors et al. 2001*a*; CSAT 1999*c*). Dimension 4 of ASAM PPC-2R assesses individuals' readiness to change. Programs should consider ascertaining individuals' readiness to change before conducting full-scale assessments and developing comprehensive treatment plans. Several brief instruments are available to help staff members rapidly determine a client's readiness to change or motivational stage (see exhibit 5-4).

Exhibit 5-3

The Six Dimensions of the ASAM PPC-2R for Level II.1 IOT

Dimension 1: Acute intoxication or withdrawal potential. Clients who are not experiencing or at risk of acute withdrawal (e.g., experiencing only sleep disturbances) can be managed in Level II.1 IOT, provided that their mild intoxication or withdrawal does not interfere with treatment. To be managed successfully in Level II.1 IOT, clients should be able to tolerate mild withdrawal, make a commitment to follow treatment recommendations, and make use of external supports (e.g., family).

Dimension 2: Biomedical conditions or complications. Clients with serious or chronic medical conditions can be managed in IOT as long as the clients are stable and the problems do not distract from the substance abuse treatment.

Dimension 3: Emotional, behavioral, or cognitive conditions or complications. Dimension 3 problems are not a prerequisite for admission to IOT. But if any of these problems are present, clients need to be treated in an enhanced IOT program that has staff members who are trained in the assessment and treatment of both substance use and mental disorders. IOT is appropriate for clients with co-occurring disorders who abuse family members or significant others, may be a danger to themselves or others, or are at serious risk of victimization by others. IOT also is indicated if mental disorders of mild-to-moderate severity have the potential to distract clients from recovery without ongoing monitoring.

Dimension 4: Readiness to change. The structured milieu of IOT is appropriate for clients who agree to participate in but are ambivalent about or engaged tenuously in treatment. These clients may be unable to make or sustain behavioral changes without repeated motivational reinforcement and support several times a week.

Dimension 5: Relapse, continued use, or continued problem potential. Despite prior involvement in less intensive care, the client's substance-related problems are intensifying and level of functioning deteriorating. Appendix C of ASAM PPC-2R (Mee-Lee et al. 2001) discusses this dimension in detail and suggests instruments and questions for assessing four constructs involved in relapse and continuing use potential: (1) chronicity of problem use or periods of abstinence, (2) positive and negative pharmacological response to substances, (3) reactivity to external stimuli, including triggers and chronic stress, and (4) cognitive–behavioral measures of self-efficacy, coping, impulsivity, and assumption of responsibility or assignment of blame.

Dimension 6: Recovery environment. IOT supervision is needed for clients whose recovery environment is not supportive and who have limited contacts with non-substance-abusing peers and family members. These clients have some potential for making new friends and seeking appropriate help and can cope with a passively negative home environment if offered some relief several times a week.

Source: Mee-Lee et al. 2001.

Exhibit 5-4

Brief Screening Instruments That Assess Motivational Stage

- Readiness Ruler is a simple approach that asks respondents to gauge their readiness and willingness to commit to change on a scale of 1 to 10.*
- University of Rhode Island Change Assessment Scale is a self-administered questionnaire with 32 items that requires about 5 to 10 minutes to complete. Respondents rate statements about their substance use from "Strongly Disagree" to "Strongly Agree." Summed items give scores that correspond to the four stages of change (DiClemente and Hughes 1990; Willoughby and Edens 1996).*
- The Stages of Change Readiness and Treatment Eagerness Scale is a 40-question, written test that requires about 5 minutes to complete and has 5 separately scored scales of 8 items apiece that are summed to derive the scale score (Miller and Tonigan 1996; Miller et al. 1990).*
- Readiness to Change Questionnaire—Treatment Version has 30 alcohol-related questions that can be self-rated on a 5-point Likert scale. A shorter 12-item version addresses only the precontemplation, contemplation, and action stages for hazardous drinkers (Heather et al. 1993, 1999).*
- Circumstances, Motivation, Readiness, and Suitability Scales-Revised (CMRS) is a factor-derived, 18-item instrument that a respondent at a third-grade reading level can self-administer in 5 to 10 minutes (De Leon and Jainchill 1986; De Leon et al. 1994). The revised, copyrighted CMRS is applicable to both residential and outpatient modalities.

More information about the psychometric properties, target populations, scoring, utility, ordering, and other references for these instruments can be found at www.niaaa.nih.gov by typing "Alcoholism Treatment Assessment Instruments" and clicking on Search.

* Described in detail and reproduced for unrestricted use in appendix B of TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*c*).

Beginning Treatment

Once the individual is determined eligible for IOT, detoxification is the first priority. When the individual is ready to be admitted to the IOT program, a staff member explains the treatment program so that the potential client can make an informed decision about enrollment.

Provide for detoxification

Detoxification, if necessary, should be accomplished before a client is admitted into the full IOT program. Clients experiencing symptoms of mild withdrawal from alcohol, sedative-hypnotics, opioids, or stimulants can undergo ambulatory detoxification in a Level II.5: Partial hospitalization or day treatment program (see exhibit 5-5). To undertake ambulatory detoxification of these clients, IOT programs should offer 20 hours of clinical programming per week and have direct access to medical services.

Program staff must determine whether detoxification can be accomplished safely on an ambulatory basis in an IOT program that offers fewer than 10 hours of client contact per week and has limited access to medical services. In general, referral to a more

Exhibit 5-5

Mild Withdrawal Symptoms for Four Drug Classes That Can Be Managed in Level II.5 Ambulatory Detoxification

Alcohol	Mild withdrawal without need for treatment with sedative-hypnotics; no hyperdynamic state; CIWA-Ar score of 8; no significant history of morning drinking.
Sedative-hypnotics	Mild withdrawal with history of almost daily sedative-hypnotic use; no hyperdynamic state; no need for treatment with sedative-hypnotics; no complicating exacerbation of affective disturbance; no dependence on other substances.
Opioids	Mild withdrawal in context of almost daily opioid use but no need for substitute agonist therapy; withdrawal symptoms respond well to symptomatic treatment; comfortable by the end of the day's monitoring.
Stimulants	Mild withdrawal involving lethargy, agitation, or depression; the client has sufficient impulse control, coping skills, or support to engage in treatment and to prevent immediate continued use.

Source: Mee-Lee et al. 2001.

intensive level of 24-hour care should be considered for clients who have been heavy and consistent alcohol drinkers or consumers of benzodiazepines or sedative-hypnotics or any combination of these substances for a period of weeks to months and who

- Have a slow response (more than 2 hours) or allergic reactions to the medications used for detoxification
- Have unstable vital signs, confusion, or delirium
- Have serious and unstabilized medical disorders (e.g., heart, lung, liver disease; seizure disorders; HIV infection)
- Are older adults or adolescents
- Have a history of serious psychiatric disorders and complications
- Have a history of seizures, delirium, or psychosis during previous withdrawals
- Have a history of drug overdoses
- Abuse alcohol, sedatives, barbiturates, and anxiolytics in combination
- Have an unstable, unsupportive, or unsafe home environment without supportive friends or relatives to monitor medication use

Withdrawal from alcohol and sedative-hypnotics can be life threatening. ASAM and other professional groups recommend using the Addiction Research Foundation's Clinical Institute Withdrawal Assessment-Alcohol, Revised (CIWA-Ar), to assess and monitor the severity of alcohol withdrawal. The CIWA-Ar uses a scale of 10 quantifiable signs and symptoms; has documented reliability, reproducibility, and validity (Sullivan et al. 1989); can be administered in 5 minutes by staff members who have undergone a 3-hour training; and helps in making the decision whether to hospitalize the client or treat the client as an outpatient

(Fuller and Gordis 1994). The CIWA-Ar is not copyrighted and is available from the ASAM's Web site (www.asam.org) by typing "Addiction Medicine Essentials" and clicking on Search. Appendix 4-B of this TIP provides additional resources for the clinician regarding ambulatory detoxification. TIP 45, *Detoxification and Substance Abuse Treatment* (CSAT 2006*e*), provides additional information on detoxification.

Program staff should work with clients to plan a treatment schedule around available transportation.

Conduct informal orientation

A preliminary, informal orientation consists of a description of program rules and requirements, client's rights and responsibilities, and confidentiality protections. The staff member answers specific questions about the anticipated duration of treatment, the frequency and length of sessions, and the program's scheduled hours. Many individuals at admission are too distracted by the process, nervous about the commitment, or focused on their feelings to comprehend important details. All important points should be communicated again in a more formal orientation session or, at a minimum, described in brochures or handouts.

Conduct formal orientation

A formal orientation offers an opportunity for staff members, including the program director, to introduce themselves and welcome new clients, reinforce clients' motivations to remain in treatment, and induct clients into appropriate roles. New clients need to hear—and believe—that they are respected as individuals and will be involved in planning their treatment. Although the primary treatment objective is to assist clients in achieving and maintaining abstinence, clients also need to know that the program will help them accomplish other positive and realistic goals (e.g., getting off probation, regaining child custody, enrolling in a vocational school). An orientation also should help clients allay any fears they may have about treatment. Ample time needs to be left in orientation sessions to answer questions. Topics for program orientation include

- **The general program philosophy, policies, and services offered.** Clients should be informed of the program's treatment philosophy, approach (e.g., individual and group counseling, psychoeducation, treatment phases), and policies (e.g., family involvement, drug testing, discharge criteria). Clients also need to understand how the program handles domestic violence, intoxication and driving, and the reporting of child abuse and neglect and infectious diseases.
- **The program's responsibilities to clients.** Confidentiality safeguards, procedures for issuing warnings to clients, process available to clients for appealing termination or other decisions, client access to staff members, 24-hour crisis assistance, referrals to outside agencies and services, availability of childcare services, and assistance with transportation should be discussed with clients. New clients are required to receive a written summary of Federal alcohol and drug confidentiality regulations. Programs subject to Health Insurance Portability and Accountability Act rules must provide additional information about client rights and how to exercise them (CSAT 2004*b*).
- **Clients' responsibilities to the program.** Clients need to understand their role in treatment plans and contracts and appreciate the importance of regular attendance, compliance with program and group rules, submission of drug-testing specimens, timely fee payments, participation in support groups or other community activities, and completion of homework assignments.

Address immediate barriers to treatment entry

Barriers to treatment entry that clients reveal during the intake interviews require the attention of IOT program staff. In addition to the medical and mental health conditions discussed above, these barriers may include the lack of childcare assistance, transportation, shelter, or food.

For some individuals, lack of affordable childcare assistance and reliable transportation are immediate barriers to treatment engagement. If the IOT program does not provide onsite childcare services, it should maintain a list of community-based childcare groups to which it can refer clients. Some programs offer vouchers for clients who are unable to afford this care, and some provide vouchers for public transportation. Program staff should work with clients to plan a treatment schedule around available transportation.

A client who is struggling to meet shelter and food needs is unlikely to engage in IOT. The IOT counselor, through the program's collaborations with community services, needs to connect the client to appropriate resources. After obtaining the client's consent, the counselor can arrange with community food banks for emergency food allocations, contact emergency shelters or recovery housing groups, and contact the local social service agency to start the process of obtaining temporary financial relief. A case manager is helpful in these circumstances.

Comprehensive Biopsychosocial Assessment

To develop a tailored therapeutic regimen, the counselor gathers detailed information on substance use patterns and other problems. This broad investigation of multiple dimensions of functioning should continue throughout treatment. However, the most detailed assessment occurs during the comprehensive biopsychosocial assessment.

Understand purposes of assessment

The comprehensive biopsychosocial assessment is the foundation for treatment planning, establishes a baseline for measuring a client's progress during treatment, ascertains the relative severity of a client's current problems, and helps set priorities for treatment interventions. The comprehensive assessment also identifies the client's strengths that can foster recovery. Repeated assessments are important for monitoring the client's progress and adjusting care if needed.

Develop assessment methods and protocols

IOT clinicians gather evidence about each client's problems through

- Clinical observations
- Structured and informal interviews
- Standardized tests and instruments
- Physical examinations
- Laboratory drug tests
- Medical records from previous treatment episodes (with the client's permission)
- Records and reports from referring sources (with the client's permission)
- Interviews with spouse, family members, friends, and co-workers (with the client's permission)

Most aspects of an individual's functioning can be explored adequately by a few well-chosen questions and observations. Brief screening questionnaires help direct more detailed assessments. Because this comprehensive biopsychosocial assessment serves a variety of purposes for both the client and the program, IOT programs need to consider the assessment tools, content, and staff training required to administer the instruments competently, as well as the cost of purchasing them. To guide the selection of appropriate assessments each IOT program is encouraged to consider

- The problems most commonly found in the population being served (e.g., language barriers) and the exigencies of assessing the population.
- The financial resources that can be devoted to intake and detailed assessments.
- The availability of qualified staff members to conduct interviews, administer and score standardized instruments, or perform physical examinations.
- The information needed to identify acute problems, enroll a new client, document admission, complete required State or insurance forms, and provide baseline findings for program performance evaluation.
- The scientific accuracy, utility, and psychometric properties of selected instruments and the availability of normative data or cutoff scores for the population being served.
- The availability of translated materials and the ease of use of these materials.
- The willingness of referring sources and treatment providers to forward requested records on a timely basis. The report that accompanies a referral (e.g., by a private physician, an employee assistance program, children's protective services, the criminal justice system) may contain critical information about how the applicant's substance use disorder was discovered and what consequences may ensue if progress in treatment is not demonstrated.

Multidimensional Assessment

Client records, which are a crucial part of multidimensional assessment, may include notes from the intake interview, toxicology results, reports from the referring agency or previous treatment providers, findings from other clinicians, self-administered screening tests, and specially ordered diagnostic consultations. To round out the assessment, some IOT programs design intake screening and comprehensive assessment forms, and others use standardized, multidimensional assessment instruments as the basic admission document. The ASI is a commonly used, multidimensional assessment instrument that can serve as a basic assessment document. Together, these clinical impressions and assessment instruments provide the foundation for initial treatment plans.

Using the Addiction Severity Index

The ASI generates a profile of a respondent's problem severity in six functional domains: medical status, employment and support status, alcohol and drug use, legal status, family and social relationships, and psychiatric status. The 161-item ASI is useful for measuring changes or improvements in functional and treatment outcomes. Chapter 6 of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), presents a discussion of how the ASI can be used for program performance evaluation.

At the completion of each section in the ASI, the respondent is asked to rate from "Not at All" to "Extremely" the extent to which he or she is troubled by the problem and feels a need for counseling or treatment in that area. The interviewer rates the severity of each problem area on a 10-point scale and indicates his or her confidence about whether questions were understood and answered truthfully. The instrument has demonstrated high reliability and concurrent predictive validity (Leonhard et al. 2000; McLellan et al. 1992*a*; Schottenfeld and Pantalon 1999).

Appendix 5-D (page 88) lists areas for further exploration within the six domains of the ASI and discusses ways to explore other topics that are not included in the six domains of the ASI.

Summary of Assessment Findings

The process of compiling the assessment findings into a report and presenting the report to the client leads to the development of an individualized treatment plan.

Compile the summary report

The summary report includes an overview of the clinical findings with references to admission documents, archival reports, findings from screening and assessment instruments, laboratory test results, and the physical examination. Many IOT programs format this summary according to the assessment dimensions of ASAM PPC-2R, the six domains of the ASI, or other special problem areas (e.g., housing for the homeless, parenting skills for single parents). Regardless of the format, the report should facilitate a quick review of related problems and aid clinicians and clients in setting priorities.

Present assessment findings to the client

The assessment summary is best presented in a straightforward manner in language that the client understands, with a clear interpretation of the significance of the findings. It is a good idea to introduce information in a motivational style, asking for responses and considering the client's verbal or nonverbal reactions without being judgmental or confrontational. For example, the counselor might say, "It seems that this information is distressing you" or "Is this what you expected to hear?" The counselor should avoid labeling the behavior in a negative way or interjecting opinions.

The counselor notes which findings seem most disturbing to the client. The counselor tries to elicit the client's reactions to the effects of substance abuse on his or her health, relationships, and legal and employment statuses. These reactions direct the clinician to the problems the client is most interested in solving. They also point out discrepancies between the client's values or goals and the adverse effects of substance abuse. These concerns can be highlighted in the treatment process to enhance motivation for change.

The Treatment Plan

Formulating a treatment plan is necessary to ensure clients' engagement and initial progress.

Prepare the treatment plan

Once the assessment findings have been summarized and discussed, the client—and significant others, if appropriate—collaborates with the clinician in developing a comprehensive treatment plan. This plan identifies the client's primary problem, individualized goals, and clinical interventions designed to achieve these goals (Connors et al. 2001*a*). The order and manner in which problems are addressed is tailored to each client's needs. It is not appropriate for substance abuse treatment programs to construct one-size-fits-all treatment plans for all clients, prescribing interventions to achieve goals that reflect the program's philosophy, not necessarily the client's needs. Although the treatment plan may focus on abstinence in the early stages of treatment, it addresses all noted problems, even though some problems may not be solved until long after the client leaves the IOT program.

An Emphasis on the Client's Prioritizing Problems

One research study of IOT programs found that longer retention and better treatment outcomes were associated with an early focus on the problems that clients considered most important to them (e.g., family relationships, housing, medical conditions). Although these results could be interpreted as confirming the observation that clients who do well tend to remain in treatment, they show the importance of addressing problems that clients identify (Weinstein et al. 1997).

Some variation of three general goals usually is incorporated in individualized plans for substance abuse treatment (American Psychiatric Association 1995; Schuckit 1994):

- Achieving a substance-free lifestyle
- Improving life functioning
- Preventing relapse or reducing the frequency and severity of relapses

Most treatment plans also incorporate the following elements:

- **A few clearly stated, unambiguous goals that do not compete with one another.** These should be realistically attainable by the client.
- **Specific actions for addressing each goal.** The clinician should ensure that the client understands the actions to be taken and how they will help the client achieve the goals.
- **Objective, easily measurable criteria for monitoring whether actions are completed and goals are accomplished.** Examples include (1) attending a specified number of Alcoholics Anonymous (AA) meetings each week and (2) maintaining abstinence for 3 months as monitored by three times per week Breathalyzer™ tests, self-reports, and daily ingestion of disulfiram (Antabuse®).
- **The sequence in which goals are addressed and activities undertaken.** Acute problems need to be addressed first. Until the client is stabilized and testing is completed, it may not be possible to finalize the sequence of treatment services.
- **A specified timeline or target date for goals.** The plan identifies goals that are likely to be met during IOT, those that will be worked on during continuing care, and those that need input from other agencies or community groups.
- **The resources, responsible persons, or activities required.** The means for achieving each goal are listed in detail.
- **Specific dates for reviewing the treatment plan and modifying it to reflect problems addressed or emerging issues to be assessed.**
- **A signature line for the client to indicate participation in development of the treatment plan and agreement with its specifications.** The client receives a copy as a reminder of both his or her responsibilities and role as a partner who works with the clinician to achieve treatment goals.

Plan for continuing community care

Comprehensive planning and ongoing review of the treatment plan during IOT lay the groundwork for ongoing recovery support following a client's discharge. Beginning early in treatment, the client is encouraged to help design the continuing care plan to develop a sense of ownership and involvement in implementing it. The consensus panel believes that allowing the client to choose continuing care goals and types of engagement can increase satisfaction, compliance, and positive outcomes, because the client is given some authority over the treatment plan. The earlier this process is initiated, the more time is available to address concerns, ambivalence, or other issues. Chapter 3 provides a more detailed discussion of continuing care.

Sample Treatment Plans

The following two case histories illustrate different ways problem summaries and treatment plans can be developed and documented. The first case summarizes problems that often are discovered by using the ASI as the basic assessment instrument, with supplemental followup questions by the interviewer. The treatment plan indicates goals, objectives, actions to be taken, target dates for accomplishment, and responsible persons involved. The problems in the second case are summarized according to the six dimensions of the ASAM PPC; the treatment plan specifies objectives, interventions, responsible persons, and dates for completion or service delivery.

Sample Case 1

Clinical summary

Alice is a 23-year-old, Caucasian, single mother of two daughters who are fathered by the same man, Lewis. Lewis introduced Alice to alcohol and marijuana while she was in high school. At age 15, Alice discovered she was pregnant and dropped out of school to live with Lewis. She has alternated between staying with him and staying with her mother ever since. Her drinking increased steadily over the years. Shortly after the birth of her second daughter 4 years ago, Alice and Lewis were introduced to crack cocaine. Alice's use of crack rapidly escalated. She also continued to drink to "come down." She lost several fast-food jobs because of unexplained absences. Because of her children she was eligible for Temporary Assistance for Needy Families and has depended on this assistance. To support her drug habit, Alice turned to prostitution, theft, and trading sex for crack. Before admission, she smoked crack almost daily and drank excessively. She also has injected a cocaine/heroin mix twice, at Lewis's urging.

Born in a rural community, Alice moved to a large city with her mother and five older siblings when she was 10, leaving behind an unemployed and abusive father, who was dependent on alcohol and who died of liver cirrhosis 5 years ago. Alice's relationship with her mother always has been strained, partly because her mother struggled long hours as a cleaning woman to support her children and partly because she had numerous boyfriends whom Alice resented. It seems to the counselor that Alice has spent most of her life searching for approval and love from anyone who pays attention to her.

Lewis has been incarcerated for a drug charge for the past year; he will be in prison for at least the next 5 years and will be unable to provide support for his children or for Alice. Alice had moved back with her mother when Lewis began his incarceration, but her mother threw Alice out of her house after Alice stole money from her mother's purse. Alice has been living with anyone who will take her in for the last 9 months.

The immediate events that precipitated Alice's seeking treatment are a pending criminal charge for shoplifting (she was placed on probation for a previous shoplifting charge) and the recent removal of her children from her custody and their placement in foster care. An anonymous caller to the child welfare agency complained that Alice left her children unattended for long periods and that the older daughter was truant from school most days.

Alice has a history of criminal justice system involvement, mostly for prostitution. Her current probation officer has told her if she does not seek treatment, she will be violating her probation. Alice has entered treatment twice before but dropped out both times after only a few sessions. She is now shocked at the loss of her children and terrified that she could do some long jail time. She believes she is ready to change her life and appears motivated for treatment. Although her mother is angry at Alice and appalled at the placement of her grandchildren into foster care, she has agreed to let Alice move back as long as she gets into and stays in treatment. Her mother stresses, however, that this cannot be a long-term living situation for Alice. The probation officer referred Alice to a local IOT program, where she was evaluated and admitted.

> ...allowing the client to choose continuing care goals and types of engagement can increase satisfaction, compliance, and positive outcomes...

Although she has engaged in many risky sexual behaviors and has injected drugs twice, Alice did not report any medical problems

but has not seen a physician since her younger daughter was born. At that time, she had no prenatal care, was abstinent briefly, and did not reveal her substance abuse during the 1-day hospital stay. Alice has never been tested for HIV or other sexually transmitted diseases (STDs) and does not remember the last time she went to a dentist. She has never had psychiatric evaluation or treatment, although one of her sisters committed suicide and several brothers also use substances. Alice reported that she has difficulty sleeping, feels "devastated" about the loss of her children, and cries frequently.

Alice has never been employed regularly and has no skills, but she was a good student, is articulate, and appears to be bright.

Alice stated that she wants to change her life, primarily to regain custody of her children. She says she is "done with Lewis" because she does not think he will ever change. She realizes that she needs to cease illegal activities; give up drugs; stop getting drunk; find safe, permanent housing; and obtain training and a job. She is optimistic that these goals are achievable, but she has an unrealistic view of the difficulties she faces and the time it will take to reach her goals. She does not appear to have any close friends who do not use drugs. Alice does not attend church and has no recreational interests.

Master problem list

- Children, ages 8 and 4, removed from custody and placed in foster care
- Crack cocaine and alcohol dependence
- Ongoing illegal activities and a pending criminal charge
- No permanent residence
- No apparent job skills or work history
- Lack of positive support system
- Strained relationship with mother and family members
- No recent physical or dental examination; at high risk for HIV, STDs, and hepatitis
- History of dropping out of substance abuse treatment
- Possible depression, but never evaluated (family history of substance use disorders and suicide)

The IOT program assigns case managers and counselors to clients who have numerous problems that require extensive coordination with various community agencies. After conferring with Alice about her priorities and preferences, treatment staff developed the following treatment plan. This client has multiple pressing needs, and her treatment plan includes more goals than are required for clients with fewer challenges.

Short-term goals

1. **Address cocaine and alcohol dependence**
   Objective: Help client understand the importance of abstaining from all psychoactive drugs
   Action: Enroll client in appropriate psychoeducation and early recovery groups in the IOT program; encourage her to attend mutual-help groups in the community (AA and Cocaine Anonymous [CA]); regularly monitor urine and breath drug tests
   Target date: Immediately
   Responsible persons: Client, counselor

2. **Engage client's mother in treatment**
   Objective: Increase emotional support for client's recovery
   Action: Explore mother's interest in attending family education group and participating in family therapy
   Target date: Contact mother immediately, with client's consent; if mother is willing, begin family education immediately
   Responsible persons: Mother, client, primary counselor, family counselor

3. **Establish communication with child welfare services and client's children**
   Objective: Begin process of family reunification; facilitate reasonable visitation schedule

Action: Obtain client consent to contact child welfare representative to ascertain conditions for return of child custody and negotiate an action plan (This plan may include regular reports about the client's treatment progress, having the client attend parenting classes, and having the client participate in regular, observed visits with her children.)
Target date: Within 2 weeks
Responsible persons: Client, case manager, child welfare representative

4. **Establish communication with criminal justice system**
Objective: Avoid client's probation violation; seek leniency for client's shoplifting charge
Action: Obtain client consent to contact probation officer; get officer's perspective on client and what conditions may be negotiated (e.g., regular reports to probation officer about treatment attendance and compliance, community service for shoplifting conviction)
Target date: Within 2 weeks
Responsible persons: Case manager, client, probation officer

5. **Obtain medical and dental evaluation**
Objective: Assess client's health; prevent client's potential transmission of infectious diseases
Action: Refer client for medical and dental evaluations, including testing for HIV infection and other drug-related diseases; enroll client in health education group with counseling about HIV testing; encourage the client to stop high-risk behaviors, consent to testing, and follow through on needed medical care
Target date: Within 2 weeks
Responsible persons: Client, case manager, health care coordinator, medical staff

6. **Evaluate psychological functioning**
Objective: Evaluate client's mental health; assess her suicide risk; treat her depression if necessary
Action: Observe signs of continuing depression after client is stabilized; refer her for psychological evaluation, if indicated
Target date: Within 30 days; ongoing
Responsible persons: Client, primary counselor, clinical supervisor, consulting psychologist or psychiatrist, medical director

Intermediate goals

1. **Sustain abstinence from cocaine and alcohol**
Objective: Reinforce treatment progress; assist client in meeting other goals by sustaining abstinence
Action: Help client identify cues for drug use; teach client relapse prevention techniques; monitor drug test results; encourage continuing participation in AA or CA groups in the community
Target date: Ongoing
Responsible persons: Client, case manager, medical staff, group counselor

2. **Obtain transitional housing**
Objective: Move client into safe, stable housing that supports continuing recovery
Action: Obtain client consent to contact local transitional housing program to arrange for placement and daily transportation to IOT program
Target date: Initiate within 60 days; ongoing
Responsible persons: Client, case manager, case aide, transitional housing admission staff

3. **Undergo vocational testing; begin working toward a general equivalency diploma (GED)**
Objective: Enhance client's employability and self-esteem
Action: Refer client to an educational specialist for testing; have client attend GED classes

Target date: Initiate activities within 90 days; ongoing
Responsible persons: Client, educational specialist, GED or adult education coordinator

4. **Obtain employment**
Objective: Help client become economically self-sufficient
Action: Refer client to a vocational counselor to test client and determine an appropriate career goal; ensure attendance in life skills group and job club; encourage participation in volunteer activities that enhance employment-related skills and enhance the client's résumé
Target date: Initiate activities within 90 days; obtain at least part-time employment within 6 months
Responsible persons: Client, vocational counselor, job club and life skills group leaders, case manager

5. **Cultivate a positive support group; participate in healthy leisure activities**
Objective: Encourage client to develop friendships with those who support a new abstinent way of life; encourage client to participate in appropriate recreational activities that she and her children enjoy
Action: Ensure that client continues to attend AA or CA meetings; enroll client in recreational group and parent training classes to meet other mothers; help client explore other community activities
Target date: Ongoing
Responsible persons: Client, case manager

Long-term goals

1. **Sustain abstinence from cocaine and alcohol**
Objective: Assist client in meeting life goals by remaining abstinent
Action: Encourage ongoing participation in AA or CA groups in the community
Target date: Ongoing
Responsible persons: Client

2. **Obtain full-time employment**
Objective: Help client become economically self-sufficient
Action: Support client in job search activities; refer client for search assistance if necessary
Target date: 1 year
Responsible persons: Client, vocational counselor, job club and life skills group leaders, case manager

3. **Obtain permanent housing**
Objective: Move client into safe, stable, permanent housing
Action: Assist client in finding housing in the community; assist client in negotiating lease agreement
Target date: Within 1 year
Responsible persons: Client, case manager, case aide, transitional housing staff

4. **Regain child custody**
Objective: Reunite client with children
Action: Help client meet the requirements of the child welfare services for regaining custody of her children
Target date: 2 years
Responsible persons: Client, caseworker, social worker from child welfare

Sample Case 2

Clinical summary

Joe is a 24-year-old, unmarried, African-American man who lives in a poor neighborhood of a large city and works as a dock loader for a large trucking company. He has been a heavy drinker and marijuana smoker since his teens but only recently started snorting cocaine. Joe lives with an aunt and uncle, paying a small monthly rent for a basement room, and he hangs out with his street buddies most of the time, "boozing and drugging" at dance clubs and pool halls.

Joe never knew his father and was raised by his grandparents. His alcoholic mother left Joe and two younger brothers in his

grandparents' care when she ran off with a man—only to die in an accident about a year later when Joe was 8 years old. His beloved, very religious grandfather died of complications from diabetes when Joe was in high school. Although his grandmother is alive still, Joe seldom sees her. None of the family members are close.

Now Joe is in serious trouble: a street brawl that he got into after a dance ended with the shooting death of one of his friends. Joe is one of those charged, though he swears he was not involved. He was, however, so drunk and high that he does not remember what happened. Because Joe has a history of fighting while drunk and a series of previous assault charges, the court has mandated treatment because of the alcohol and cocaine found in Joe's urine after his latest arrest. He feels lucky to have been released and sent to an IOT program rather than to jail or a residential facility.

Joe is overweight but otherwise reports no physical complaints or serious medical problems.

The one bright spot in Joe's life is the 2-year-old son, Charles, he fathered with a "nice" girl (Brianna) he has known since high school. Brianna says that she loves Joe and would like them to be a family. However, she is very concerned about Joe's alcohol and drug use and is thinking about ending the relationship. Although Brianna knows that Joe thinks Charles is special, she is reluctant to let the father and son go anywhere together—fearing that Joe is not responsible. Brianna is a stabilizing influence on Joe, with a strong spiritual side that reminds Joe of his grandfather. However, to impress Brianna and Charles, Joe has acquired a lot of bills that he sees no way to pay off. Creditors are hounding him. Moreover, Joe knows that his job is in jeopardy if he does not show up for work more regularly. He has been skipping work after attending wild parties. As a high school dropout, Joe does not have many opportunities to increase his income and has no aspirations for a better job. Also, it seems as though the more worried he is, the more money he spends on drugs and his son and girlfriend.

When asked, Joe says he wants to clean up his act and become a man like his grandfather. However, he does not see a way out, especially if he is convicted of manslaughter. The thought of spending time in prison terrifies him.

Integrated problems list

Withdrawal potential. Although he drinks daily, it does not appear that Joe will have more than minimal withdrawal symptoms when he stops consuming alcohol. These can be managed, if needed, by the IOT program as can any rebound depression he may experience from quitting cocaine.

Biomedical condition or complications. Joe definitely needs to see a physician for a thorough physical examination. His weight needs to be evaluated, along with his eating habits.

Emotional/behavioral/cognitive status. Joe's legal and financial problems are causing a great deal of stress. His repeated fighting while under the influence may mask other psychological problems. It is not clear whether Joe ever fully has expressed his grief about losing his mother and grandfather. His isolation from family members and his job situation need to be explored.

Readiness to change. Joe does not seem to appreciate fully how much his drinking and drug use have complicated his life, but he regrets the fight in which his friend was killed. He genuinely is conflicted between his love for his son and admiration of his girlfriend's values and his desire to remain one of the gang.

Relapse or continued use potential. All Joe's buddies, except for his girlfriend, abuse substances seriously and encourage his continued drinking and drug use. He has not abstained spontaneously for any period and seems to be using more drugs, more frequently.

Recovery environment. Most family members show no support for Joe's recovery. His mother was addicted to alcohol; there may be

a more extensive history of substance abuse in the family. It is unclear how far Brianna is willing to encourage Joe's recovery; it also is unclear how attached Joe is to his son and how willing he is to be a supportive father.

Joe has applied for treatment at an IOT program that has an evening schedule for employed clients and a variety of medical, psychological, and case management capabilities. After reviewing his problem list, Joe and the intake counselor developed the following plan for his initial treatment. It will be reviewed and revised again after 4 to 6 weeks, when the need for continuing IOT may have diminished.

Initial Treatment Plan

Specific Objectives	Interventions	Responsible Persons	Timing
Achieve 2 weeks of continuous abstinence	Monitor for potential withdrawal and needed medication on days 1 through 3; enroll in substance abuse education and early recovery groups 3 times per week; screen for drug and alcohol use 2 times per week; attend individual counseling 1 time per week	Client, medical staff, primary counselor, group leaders	9 hours per week in evening treatment program over first 4 to 6 weeks
Determine health status and control weight and diet	Obtain full medical history, physical examination, lab work; participate in health education group 1 time per week	Client, medical staff	As soon as possible
Relieve stress from unpaid debts and collectors	Consolidate debts and develop repayment plan; enroll in money management skills group after completing health education; refer client to Debtors Anonymous	Client, case manager, group leader, consultation with credit agency	Begin as soon as client is stable—2 to 3 weeks
Clarify legal status and explore options	Contact court about trial date, reporting requirements, potential for plea bargain, or alternative sentencing	Client, program's legal consultant, client's lawyer, primary counselor, court representative	As soon as client is stable

(continued)

Initial Treatment Plan (continued)

Specific Objectives	Interventions	Responsible Persons	Timing
Stabilize employment	Give health excuse for missing work, if needed, for first 3 days of treatment; monitor pay stubs to see whether Joe is working regularly	Client, medical staff, primary counselor	Ongoing
Strengthen treatment commitment and motivation for recovery	Explore discrepancies between client's religious values and commitment to son and girlfriend and his continuing substance abuse and lack of direction	Client, primary counselor, clinical supervisor	Begin individual counseling sessions as soon as client is stable
Identify drug-free support network	Require attendance at a mutual-help group or community alternative at least 5 times per week and participation in structured sports or leisure group 1 time per week	Client, primary counselor	Begin mutual-help group attendance immediately; begin recreational activities within 30 days
Obtain Brianna's support for Joe's recovery and explore their relationship	Encourage Brianna to attend family education 1 time per week and couples counseling 1 time per week	Client, girlfriend, primary counselor, family therapist	Begin family education immediately; begin couples counseling within 1 month
Explore grief and isolation from family	Observe reactions to group discussions of family relationships; refer client for grief counseling if needed	Client, group leaders, primary counselor, clinical supervisor	Defer referral to next phase

Appendix 5-A. Substance Use History Form

Client's Name: Date: Interviewer:

Drug Type	Street Name	Ever Used	Year of First Use	Current Use*	Date/Time Last Use	Usual Amount of Daily Use	Frequency/ Duration of Extended Use	Route/Mode	Observed Signs†
Alcohol									
Cocaine									
Methamphetamine									
Stimulant									
Anxiolytic									
Heroin									
Methadone									
Other Opioid									
Sedative-Hypnotic									
Hallucinogen									
PCP									
Cannabis									
Inhalant									
Nicotine									
Other									

* Note if just released from controlled environment.

† Circle observed signs, if any, of currently used drugs:

Needle track marks	Agitation	Burns on inside of lips	Tremors	Smell of alcohol, marijuana, or methamphetamine (production)
Burns or stains on fingers	Flushed face	Incoherence	Nodding	Unusual speech pattern (slurred, rapid, incoherent)
Dilated or constricted pupils	Scratching	Swollen hands or feet	Sores/abscesses	Unsteady gait

Sources: CSAT 1994*a*, 1994*f*.

Appendix 5-B. Instruments for Determining Substance-Related and Psychiatric Diagnoses

- **Addiction Severity Index**—Several versions of the ASI (including Spanish and clinical training versions) are available at no cost from www.tresearch.org. This Web site includes a variety of ASI manuals and related materials, all free of charge. The ASI Helpline ([800] 238-2433) provides assistance with research applications and answers training questions. Training materials for the ASI, known as the Technology Transfer Package, developed by National Institute on Drug Abuse, are available from the National Technical Information Service ([800] 553-6847) for approximately $150. The package includes forms, training videotapes, a handbook for program administrators, a training facilitator's manual, and a resource manual.
- **Alcohol Dependence Scale (ADS)**—This instrument consists of 25 items designed to provide a quantitative measure of alcohol dependence. The test can be administered in 5 minutes and covers alcohol withdrawal symptoms, impaired control with respect to alcohol, awareness of compulsion to drink, increased tolerance to alcohol, and drink-seeking behavior. A computerized version of the ADS is available. This instrument is copyrighted; user's guide and questionnaires must be purchased. (Order from Marketing Services, Addiction Research Foundation, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1; [800] 661-1111.)
- **Composite International Diagnostic Interview (CIDI)—Core Version 2.1, Alcohol and Drug Modules** (World Health Organization 1997)—This instrument covers the diagnostic criteria for both DSM-IV and *International Classification of Diseases*, 10th Edition (ICD-10) (World Health Organization 1992), for substance abuse, harmful use, and dependence disorders as well as onset of some symptoms, withdrawal, and consequences of substance use and other psychiatric diagnoses. Clinician interview and computerized, self-administered versions are available and require about 70 minutes to complete. Twelve-month and lifetime versions are available in English, Spanish, French, and Dutch. (Visit www.who.int/msa/cidi/index.html.)
- **Diagnostic Interview Schedule, Version 4**—This instrument elicits information about the presence of syndromes meeting DSM-IV diagnostic criteria in the past year, the course of these disorders, functional impairment, treatment utilization, perceived need for treatment, links between psychiatric and physical causes, and dating of most recent symptoms and risk factors. The latest version requires 90 to 120 minutes to administer and has explicit instructions for close-ended and precoded questions that are scored by a computer. (Order from Department of Psychiatry, Washington University School of Medicine, St. Louis, MO 63108; [314] 286-2267; mccrarysl@epi.wustl.edu.)
- **MINI International Neuropsychiatric Interview (M.I.N.I.)**—This instrument is an abbreviated psychiatric interview tool that screens for major Axis I psychiatric disorders using DSM-IV and ICD-10 criteria (Sheehan et al. 1998). The M.I.N.I. has high validity and reliability, can be administered in approximately 15 minutes, and has been translated into 20 languages. A computerized version can be self-administered. A more detailed M.I.N.I. Plus also is available that addresses all 24 major Axis I diagnostic categories in the DSM-IV, 1 Axis II disorder, and suicidality and requires approximately 30 to 45 minutes to administer. (Download various versions of the M.I.N.I. in English and Spanish from www.medical-outcomes.com.)
- **Psychiatric Research Interview for Substance and Mental Disorders (PRISM)**—This instrument produces reliable DSM-IV diagnoses for substance-

related and primary psychiatric disorders (Hasin et al. 1996). PRISM includes procedures for differentiating primary disorders, substance-induced disorders, and effects of intoxication and withdrawal. PRISM takes between 1 and 3 hours to administer, depending on the respondent's history, and can be useful for focusing treatment. PRISM is not copyrighted, but interviewer training is required and scoring is computerized. (Order from New York State Psychiatric Institute, Columbia Presbyterian Medical Center, Department of Research, Assessment and Training, [212] 923-8862; www.nyspi.cpmc.columbia.edu.)

- **The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I), Clinical Version**—The SCIDI-I uses the comprehensive "gold standard" for psychiatric diagnoses of not only substance-related disorders but other psychiatric disorders (First et al. 1997). A skilled mental health professional needs 1 hour or more to administer the complete and detailed version, but because the instrument is modular, only 10 minutes is required for a substance abuse or dependence diagnosis.
- **The Substance Dependence Severity Scale (SDSS)**—The SDSS is a semistructured interview that provides current (last 30 days) diagnoses of DSM-IV substance abuse or dependence (Miele et al. 2000). In addition, the SDSS assesses current severity level of dependence and has items that can yield diagnoses using the ICD-10 classification system. The instrument was designed specifically to measure changes in diagnostic severity over time. It measures quantity and frequency of recent drug use and is thereby sensitive to variation in client clinical status. The SDSS requires 30 to 45 minutes to administer. Training typically requires 2 to 3 days but may take longer if staff members have little or no background in clinical diagnosis and assessment. Computerized data entry and scoring programs are available. There are no licensing fees. (Order from New York State Psychiatric Institute, Columbia Presbyterian Medical Center, Department of Research, Assessment and Training, [212] 960-5508; www.nyspi.cpmc.columbia.edu.)
- **Texas Christian University Drug Screen (TCUDS)**—This instrument consists of 25 questions and can be administered and scored in less than 5 minutes. TCUDS often is used with incarcerated persons but is appropriate for the general population. TCUDS quickly identifies individuals who report heavy drug use or dependence (based on the CIDI—see above). TCUDS is available free of charge. (Order from Institute of Behavioral Research, Texas Christian University, TCU Box 298740, Fort Worth, TX 76129; [817] 257-7226; visit www.ibr.tcu.edu.)

Appendix 5-C. DSM-IV Criteria for Substance Dependence and Substance Abuse*

DSM-IV Diagnostic Criteria for Substance Dependence

The individual has a maladaptive pattern of substance use with clinically significant impairment or distress manifested by three or more of the following criteria, occurring at any time in the same 12-month period:

1. *Tolerance* is defined by either of the following:
   - A need for markedly increased amounts of the substance to achieve intoxication or the desired effect
   - Markedly diminished effect with continued use of the same amount of the substance.
2. *Withdrawal* is manifested by either of the following:
   - The characteristic withdrawal syndrome for the substance
   - Use of the same (or a closely related) substance to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire or there are unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain, use, or recover from the effects of the substance.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. Use of the substance is continued despite knowledge that a persistent or recurrent physical or psychological problem is likely to have been caused or exacerbated by the substance.

Specify:

- *With physiological dependence* if evidence of either tolerance or withdrawal is present or
- *Without physiological dependence* if no evidence of either tolerance or withdrawal is present.

DSM-IV Diagnostic Criteria for Substance Abuse

A. The individual has a maladaptive pattern of substance use with clinically significant impairment or distress manifested by one or more of the following criteria, occurring within a 12-month period:
   1. Recurrent substance use resulting in a failure to fulfill major obligations at work, school, or home
   2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile, operating a machine when impaired by substance use)
   3. Recurrent substance-related legal problems
   4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about the consequences of intoxication)

B. Symptoms have never met the criteria for substance dependence for this class of substance (i.e., a diagnosis of substance dependence preempts a diagnosis of substance abuse).

*Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Copyright 2000. American Psychiatric Association (2000).

Appendix 5-D. Supplements to the Six Assessment Domains in the ASI and Other Topics

Six Assessment Domains

Medical status

Information collected in this area determines the level of physician or medical involvement, laboratory tests, and health education needed. The program may want to explore

- Client's current complaints or symptoms of physical illness and infectious diseases
- Client's availability of health insurance and a personal physician
- Client's medical history including injuries, operations, hospitalizations, chronic diseases, vaccinations, and allergies
- Client's current medical treatment and prescribed medications
- Client's diet, exercise and activity level, and perception of health status
- Client's attitude toward traditional medical treatment and alternative or folk medicine
- Screening client for infectious diseases (CSAT 1994*e*, 1994*f*, 2000*c*) and administering the Risk Assessment Battery, a self-administered HIV-risk assessment instrument

Employment or support status

Clients' economic status is an indicator of their recovery potential and need for additional training or vocational counseling. Inquiries focus on

- Sources of income, number of dependents, perception of socioeconomic status, and financial solvency or indebtedness
- Eligibility for or receipt of benefits such as Medicaid or Medicare or employer health benefits
- Work history, marketable skills, access to transportation, job qualifications, and satisfaction with job and pay
- History of job terminations, previous referrals to an employment assistance program, and outcomes
- Education, including highest grade completed and educational accomplishments or difficulties
- Attitude toward money and ability to manage money

Patterns of alcohol and drug use

Patterns of substance use provide information about the severity and duration of the client's current substance use and previous treatment episodes. Questions can review

- Reasons for seeking treatment
- Quantity, frequency, route of administration, and cost of substances currently used; how long the use pattern has persisted; and primary and secondary drugs that are causing problems
- History of periods of abstinence, including efforts to control or cut back use
- Desired effects of current use, context of substance use, and usual physical and emotional consequences
- Experience with substances other than the ones currently being abused
- Triggers and circumstances for relapse
- Prior treatment, including duration and dates, types of treatment, voluntary or coerced entry, response to treatment, reason for discharge, and length of time before and reasons for relapse

Criminal history and legal status

A client's current legal status and history of criminal involvement may have implications for treatment. Topics to explore in this area include

- History of juvenile offenses or adult arrests or convictions, including types of crimes
- Time spent incarcerated and nature of the crimes
- Episodes of substance abuse treatment while in the criminal justice system
- Status and relevant dates of pending drug court appearances, pretrial release hearings, meetings with probation or parole officers, or trials
- Determination of a criminal justice system mandate for treatment
- Unresolved legal issues

Family and social relationships

The client's relationships and living arrangements have a powerful influence on the recovery process. Social networks involving or encouraging alcohol or drug use have a negative effect on treatment outcome (Longabaugh et al. 1998). A social network supportive of drinking is associated with less involvement in AA (Connors et al. 2001*b*). Topics to explore are

- Marital or primary relationship status, duration, and satisfaction; the involvement of significant others with substances; and their attitudes toward recovery
- Current living arrangements, household composition, satisfaction level with household members, residential stability and reasons for any changes in the last year, and contribution to the household
- Children (including stepchildren) and their ages, living and custody arrangements, and any charges or reports of neglect or abuse and related outcomes
- Friendships, including the numbers, perceived closeness, and activities undertaken together
- Living relatives and perceived closeness or alienation and relatives' current and previous involvement with substances
- Conflicts with relatives or friends in the last 30 days and the nature of these encounters

Domestic violence. In many States, providers have a duty to inform law enforcement of evidence of abuse. Providers need to be familiar with applicable laws in their State. Programs also should be prepared to recommend alternative housing for clients who are living with domestic violence.

TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT 1997*b*), discusses the complicated interconnections between substance abuse and battering or victimization, stressing the importance of identifying people in destructive, exploitative relationships and helping them openly address issues that are otherwise likely to sabotage recovery. TIP 25 contains the Danger Assessment (Campbell 1995) and the Psychological Maltreatment of Women Inventory (available at www-personal.umich.edu/~rtolman/pmwimas.htm) (Tolman 1989), which are not yet validated as clinical tools but which contain questions that can be used in interviews or as suggestions for promoting discussion.

Childhood history. Childhood history can have a dramatic, often unrecognized, influence on current functioning. Questions in this area focus on

- Perceived closeness of family members while growing up and currently
- Primary caregivers during childhood and memories of their expressed interest, affection, and disciplinary practices
- Quality and number of close childhood friendships and recollections of childhood problems or traumatic events
- Significant childhood illnesses, accidents, or diagnoses and treatment
- Childhood experience of emotional, physical, or sexual abuse, including frequency and duration of episodes, age at victimization, and the perpetrator's identity; family knowledge of or reactions to these events; whether and how social services or children's protective services were involved; and subsequent counseling or treatment and responses

TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000*b*), includes information about assessing adults for childhood abuse and neglect. It includes symptoms and effects, direct questioning techniques, and screening and assessment instruments. Appropriately trained and supervised staff members should screen and assess clients with respect to traumatic events.

The parent–child relationship. TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000*b*), contains information for assessing the parent–child relationship. These tools include the Parental Acceptance and Rejection Questionnaire and the Parent–Child Relationship Inventory. Requirements for reporting child abuse or neglect and strategies for working with children's protective services and child welfare systems are reviewed.

Current child abuse or neglect. Parents with substance use disorders are at increased risk for abusing or neglecting their children. In many States, providers have a duty to inform law enforcement of evidence of child abuse. Providers need to be familiar with applicable State laws. Although caution is advised about potential misinterpretation of socioeconomic and cultural differences in parenting styles, observable signs of potential child neglect or abuse by a client include, but are not limited to the following:

- Verbal abuse or belittling of children or wrongly blaming them for the client's mistakes or frustrations
- Taking inadequate safety precautions (e.g., leaving young children alone at home or with underage babysitters, letting them roam by themselves in unsafe places)
- Child's indiscriminate attachment to persons other than the parent or the child's flinching or cowering unnecessarily when the parent is present
- Expressing unrealistic, age-inappropriate behavioral expectations
- Describing children in sexual terms
- Reports of inappropriate punishment of children by oneself or a partner
- Children's consistently unkempt appearance, obvious underweight condition or hunger, or unexplained bruises or other injuries

Psychiatric status

Many people with substance-related diagnoses have co-occurring psychiatric disorders. The existence of a psychiatric disorder and the need for a referral to a mental health provider may be indicated if (Schottenfeld and Pantalon 1999)

- The onset of psychiatric symptoms preceded initial substance use.
- Symptoms persisted during previous periods of abstinence.
- Symptoms continue 2 to 4 weeks after all substance use ceases.
- A family history of the suspected mental disorder exists.
- Symptoms of the suspected mental disorder are atypical for the substance being used or the dosage being consumed.

Questions about the mental health status of clients should determine

- Current or unaddressed symptoms of psychiatric disorders (last 6 months)
- Previous diagnoses of a psychiatric disorder or central nervous system impairment
- Current or prior psychiatric treatment and currently prescribed medications for psychiatric disorders, dosage, and orders for administration

Other Topics

Sexuality

A person's feeling about sexuality may affect substance abuse treatment. Although sexuality is a sensitive topic, questions can explore

- The client's sexual orientation and personal/familial/social reactions if he or she identifies as other than heterosexual
- Whether the client is sexually active and, if so, the number of partners in the last 6 to 12 months
- Satisfaction with sexual functioning
- Any association of sexual activity with substance use/violence/control, feelings of victimization, and any current charges of sexual abuse or rape

Self-concept

The clinician can observe or ask about

- Level of positive self-regard, self-efficacy, and determination or persistence
- Coping skills, facility for communication, and problemsolving abilities
- Personal pride in accomplishments and realistic sense of strengths

Recreation and leisure activities

Non-substance-related recreation and leisure activities are important components of sustained recovery. They can remove the client from social pressures to use alcohol and drugs and provide a healthy outlet for new energies. If the client does not have any active recreational interests—and has spent most leisure time in substance-related pursuits—maintaining abstinence may be difficult without assistance in finding appealing alternatives. The counselor can ask the client about

- Recreational activities and whether these involved alcohol and drug use
- Potential leisure time pursuits, including why these are appealing and how realistic they are to pursue

Spirituality and personal values

Spirituality and personal values can sustain clients and supplement treatment efforts. Acceptance of a higher power is a fundamental element of mutual-help groups such as AA and Narcotics Anonymous. Other personal values and affiliations can contribute to stability and sobriety. The counselor can explore

- Religious affiliation and its current and prior importance
- Racial/ethnic/cultural identity and its relative importance, including immigrant status and acculturation issues, if applicable
- Community activities, political interests, and current involvement

6 Family-Based Services

In This Chapter...

Planning for Family Involvement

Engaging the Family in Treatment

Family Services

Family Clinical Issues in IOT

Substance use disorders exist within several social contexts, one of which is the family. Family members, whether they are from the family of origin or family of choice, are important forces in a client's life. Each client has a family, a family history, and a family story that play important roles in recovery. Many clients come from substance-using families and have been raised with alcohol abuse or drug use as part of their lives. Addressing this legacy is part of their recovery. In addition, a client's family members often have significant substance use and other psychiatric problems of their own. Intensive outpatient treatment (IOT) programs that take a comprehensive approach to evaluating the family are likely to identify other individuals who would benefit from being admitted to a substance abuse or mental health treatment program. Some family members may be in treatment already. For these reasons, many IOT programs incorporate a family systems approach. Family education, family therapy, and other services are necessary in an IOT program's process so that the contributions and influence of family members support recovery.

A complete discussion of family therapy for substance use disorders in IOT programs is not within the scope of this TIP. This chapter introduces features of family involvement in IOT programs and briefly discusses family therapy as an enhanced service that IOT programs may offer or, more frequently, to which they may refer clients and their families. The Center for Substance Abuse Treatment has developed TIP 39, *Substance Abuse Treatment and Family Therapy* (CSAT 2004*c*), that addresses how a substance use disorder affects the family, how family therapy works to change the interactions among family members, and the integration of family therapy into substance abuse treatment.

Families of people who abuse substances live in a world shaped by substance use. This world may include inconsistent behaviors and few or very rigid rules. Family members may have difficulty expressing their emotions, achieving intimacy, and solving problems. They frequently may experience but may not express anger, shame, guilt,

sadness, and hopelessness. To function, families often subscribe to the following: don't trust, don't feel, and don't talk. The result can be an unhealthy environment in which individuals may be isolated, engage in destructive alliances, be overly involved with other family members, or develop significant medical and stress-related problems.

> ...family members... are critical to the strength and duration of the client's recovery.

Increasingly, treatment professionals view substance use disorders from a family systems perspective (Crnkovic and DelCampo 1998). Research findings document a relationship between family involvement in treatment and positive outcomes and attest to the need for family-based services (Rowe and Liddle 2003). Family involvement in treatment seems to work equally well for adults and adolescents (Stanton and Shadish 1997). When the family is ready and able to shift from old, negative behaviors to new, healthier ones, family members become collaborators in the treatment process (Edwards and Steinglass 1995). Most IOT programs do not offer couples- or family-based therapies (Fals-Stewart and Birchler 2001). However, potential benefits of family therapy are such that IOT programs should have well-established links with organizations that provide these services.

No matter how alienated family members may be, they are critical to the strength and duration of the client's recovery. Family members are the individuals who were part of the client's life before treatment and will be part of his or her life after treatment. Family-based services that are part of IOT help ensure that family functioning adjusts to and positively influences the recovery of the client.

Planning for Family Involvement

IOT planning for family-based services involves defining the client's family in broad and flexible terms, setting essential goals, and determining the desired outcomes.

Defining the Family

In recent years, the concept and definition of family have broadened significantly to include people who are important to the client. These people can include a spouse, a boyfriend or girlfriend, a same-sex partner, parents, siblings, children, extended family members, friends, co-workers, employers, members of the clergy, and others. The term "family of origin" commonly is used to describe individuals related by blood, such as parents, grandparents, and siblings. The term "family of choice" is used to describe a family created by marriage, partnership, or friendships and other associations.

When determining the client's concept of family, the key is to identify who will be supportive of recovery and who might seek to undermine it. The treatment provider can begin this process by creating a genogram (see appendix 6-A, page 107) to assess the family of origin or choice. Similarly, a social network map (see appendix 6-B, page 109) can help the counselor identify and understand the family of origin and family of choice.

- **Creating a family genogram.** This technique renders the client's family relationships schematically and helps the counselor identify trends or patterns in the family history and understand the client's current situation. As treatment progresses, the genogram is revised to reflect new knowledge and changes in the family (CSAT 2004*c*).
- **Assessing the client's social supports with a social network map.** A social network map displays the links among individuals who have a common bond, shared social status, similar or shared functions,

or geographic or cultural connection. Highly flexible, social networks form and disband on an ad hoc basis depending on specific need and interest. A social network assessment is used in social service arenas, including substance abuse treatment. When the assessment is used in IOT, individuals are identified who can support the client or participate in the treatment process (Barker 1999).

Goals and Outcomes of Family Services

One main goal of involving families in treatment is to increase family members' understanding of the client's substance use disorder as a chronic disease with related psychosocial components. Edwards (1990) states that family-based services can have the following effects:

- **Increase family support for the client's recovery.** Family sessions can increase a client's motivation for recovery, especially as the family realizes that the client's substance use disorder is intertwined with problems in the family.
- **Identify and support change of family patterns that work against recovery.** Relationship patterns among family members can work against recovery by supporting the client's substance use, family conflicts, and inappropriate coalitions.
- **Prepare family members for what to expect in early recovery.** Family members unrealistically may expect all problems to dissipate quickly, increasing the likelihood of disappointment and decreasing the likelihood of helpful support for the client's recovery.
- **Educate the family about relapse warning signs.** Family members who understand warning signs can help prevent the client's relapses.
- **Help family members understand the causes and effects of substance use disorders from a family perspective.** Most family members do not understand how substance use disorders develop or that patterns of behavior and interaction have developed in response to the substance-related behavior of the family member who is in treatment. It is valuable for individuals in the family to gain insight into how they may be maintaining the family's dysfunction. Counselors should help family members address feelings of anger, shame, and guilt and resolve issues relating to trust and intimacy.
- **Take advantage of family strengths.** Family members who demonstrate positive attitudes and supportive behaviors encourage the client's recovery. It is important to identify and build on strengths to support positive change.
- **Encourage family members to obtain long-term support.** As the client begins to recover, family members need to take responsibility for their own emotional, physical, and spiritual recovery.

A comprehensive IOT program views the client as part of a family system. When the family is involved in treatment, the following treatment outcomes are possible:

- The client is encouraged to enter treatment.
- The client is motivated to remain in treatment.
- Relapses are minimized.
- A supportive and healthy environment for recovery is provided.
- Other family members who may need treatment or other services are identified and treated.
- Changes in the family's longstanding dysfunctional patterns of communication, behavior, and emotional expression may protect other family members from abusing substances.

Engaging the Family in Treatment

Difficulties with engaging the family in treatment often are cited as reasons for not using

a family systems approach and, in many cases, substantial obstacles exist. Family members may be resistant, or the client may be ambivalent or object to the family's involvement in treatment. But given the potential benefits associated with taking a family approach to service delivery, engaging the family in treatment is worthwhile.

Strategies To Engage the Family

The following approaches have proved helpful in encouraging families to engage in the treatment of a family member:

- **Include family members in the intake session.** The counselor can involve family members in the treatment process from the beginning. If a family member makes the initial call to the program, the counselor can ask that person to come with the client. If the client calls, the client can be asked to bring a family member. If the client is reluctant at this point, the counselor can gently encourage the client to include family members but should not make it a condition of the person's entry into treatment. In another approach, the counselor can ask, "Who close to you is concerned about your substance use and might be willing to serve as a support to you during your recovery?" The client then might be asked to invite these supportive people to come to the initial intake interview. During the intake interview, family members can be asked to complete a brief written family assessment. A more comprehensive family systems approach can involve multiple private and family interviews. These interviews and other early meetings with the family develop support from a family that is empowered to address systemic issues. Similarly, the initial meeting helps family members learn about substance use disorders, their influence on a family, and the services the program can offer to the family (see exhibit 6-1).
- **Use client-initiated engagement efforts.** The counselor and client collaborate on a plan to engage family members in treatment. The client can be given the opportunity to invite chosen family members to participate in the program. If this effort is unsuccessful, then, with the client's written permission, the counselor telephones, visits, or sends a personal note to the identified family members. Federal confidentiality rules require that client permission be documented (CSAT 2004*b*).
- **Offer a written invitation.** The IOT provider can give the client written invitations, with the clinic's contact information, to deliver to family members. Giving the client

Exhibit 6-1

Suggestions for Engaging Family Members at Intake

- Emphasize the need to gather information from family members.
- State the program's policy about family members' participation in treatment.
- Indicate the program's desire to hear family members' concerns about the client's substance abuse.
- Acknowledge family members' influence over the client and their desire to help.
- Make clear that family members' participation will help the client on the road to recovery.
- Emphasize how the program can help family members maintain a relationship with the client and manage their own feelings (anger, frustration, depression, and hopelessness).

the invitations allows the provider to determine whether the client is willing to involve family members in treatment and which family members the client wants to involve in the process. The invitation briefly describes the treatment program and identifies activities family members will be asked to participate in. For example, a family member may be asked to attend family education sessions, complete an assessment questionnaire, remove all substances from the home (if applicable), participate in family counseling sessions, or attend a celebration of the completion of a treatment phase.

- **Offer incentives.** Incentives may help address recruitment problems. Family members can be provided with coupons (e.g., for pizza, movies) for attending sessions or completing assignments. Refreshments also help family members feel welcome. In addition, providers can facilitate transportation (e.g., arrange carpools) and childcare services and remove other obstacles to family members' participation.
- **Plan picnics or dinners for families.** Multifamily picnics and dinners are a part of some IOT programs and can be scheduled for holidays or weekends. These events can be held on the program's grounds or in nearby parks or community centers and provide a supportive and nonthreatening environment where individuals can have fun and learn about substance use disorders, recovery, and the IOT program. The client and family members are asked to bring a dish, but all are welcome. Immediately after the meal, a counselor conducts an hour-long educational session covering topics such as recovery support groups, family-oriented services, and characteristics of substance use disorders. Participants are told of the educational nature of the sessions when invited.
- **Use community reinforcement training (CRT) interventions.** CRT interventions have improved the retention of family members in treatment and induced people who abuse substances to enter treatment (Meyers et al. 1998, 2002). Among other strategies, the CRT approach teaches family members that substance abuse is not a moral failing but a disease and that they are not the cause of and cannot be the cure of their loved one's substance use disorder. They also learn to identify and pursue their own interests, communicate in nonjudgmental ways, encourage drinking of nonalcoholic beverages during social occasions, manage dangerous situations, and discuss treatment entry with the family member who abuses substances when the consequences of abuse are severe (Kirby et al. 1999*b*).
- **Use the resources of the program.** To create a family-friendly environment, IOT staff at all program levels need to work together toward the goal of engaging families. For example, flexible program hours and large offices or meeting rooms may be needed to accommodate family schedules and large families. Safe toys should be made available for children so that they are less likely to disrupt a session. Front office staff should be trained to encourage and reinforce the efforts of family members who call or come in with the client for the initial visit. Programs can organize their client record systems and procedures so that staff members have easier access to family-related information for each client.
- **Provide a safe, welcoming environment.** Family members may be anxious or reluctant to participate in the treatment process. A welcoming environment encourages them to participate despite their concerns. A safe, clean, and cheerful meeting space is important. Good lighting, a well-marked and well-maintained exterior, culturally appropriate décor, comfortable furniture, and amusements for children convey the message that family members are welcome, valued by the treatment team, and essential to the recovery of the client. Ice-breaking activities, simple games, and role-play activities can make the group meeting inviting and encourage family involvement.

Overcoming Barriers to Engaging Family Members in Treatment

Not all family members participate in the treatment process. Sometimes individuals are reluctant to become involved with treatment, even though they care about the client. Women are more likely to be involved in their male partners' treatment; men are less likely to participate in their female partners' treatment (Laudet et al. 1999). Also, the client may not want family members to be involved because of threats of domestic violence or past abuse by a family member, guilt about the substance abuse, fear that family secrets may be revealed, concern about adding to the family burden, or other reasons. All family members who *do* participate must feel free to raise pertinent issues, even if another family member objects. Because of the risk of domestic abuse that comes with raising difficult issues, providers must assess carefully the potential for violence within the family (CSAT 2004*c*).

Despite these barriers, the IOT provider is encouraged to take every possible action to engage families of clients in the treatment process. Better client retention, fewer relapses, improved family functioning, and family healing are all possible outcomes (O'Farrell and Fals-Stewart 2001).

Supportive supervision of the counselors providing these family services

- Gives staff members confidence that they are providing appropriate levels of service while addressing clinical issues that inevitably arise
- Ensures that counselors and staff members understand their limitations in working with family members
- Guards against counselors and staff members attempting to provide therapy for which they have not been trained

When working with families, programs can make use of existing partnerships with agencies and groups that provide enhanced family services, individual counseling for other family members, health care, and financial and legal services to support clients' families.

Family Services

Family members

- May need guidance on how to address many issues that can arise during early recovery
- May have questions or misconceptions about substance use disorders
- May need to find healthy ways to handle their justifiable feelings of anger, frustration, shame, helplessness, guilt, and sadness that stem from attempts to fix the client's substance use disorder
- May need the counselor's intervention to understand and avoid behaviors that contribute to the client's continued use of alcohol and drugs

The types of services described in this section can support the efforts of family members as the client moves through the course of treatment. Although every family is different, and the pace of recovery varies from family to family, a sample treatment calendar is provided in exhibit 6-2. IOT services can assist family members in accomplishing the tasks described in the calendar.

Family Education Groups

Family education groups provide information about the nature of a substance use disorder; its effects on the client, the family, and others; the nature of relapse and recovery; and family dynamics. These groups often motivate families to become more involved in treatment.

The family education group typically meets weekly for 2 to 3 hours, often in the evening or on weekends, and includes between 10 and 40 individuals. The group is facilitated by a counselor and usually covers these topics:

Exhibit 6-2

A Treatment Calendar for Family Members

Beginning stage: 1–5 weeks

- Commit to treatment.
- Understand that a substance use disorder is a chronic illness.
- Support abstinence.
- Begin to identify and discontinue behaviors that support substance use.
- Learn about the family support groups:
  - Al-Anon (www.al-anon.alateen.org)
  - Nar-Anon (www.naranon.com)
  - Families Anonymous (www.familiesanonymous.org)

Middle stage: 6–20 weeks

- Assess the relationship with the client.
- Develop a realistic perspective on addiction-related behaviors so the family member remains involved with the client but establishes some protective personal distance.
- Work to eliminate behaviors that encourage the client's substance use (i.e., enabling behaviors).
- Move past behaviors that are primarily a response to the client's substance use (i.e., codependence).
- Seek new ways to enrich the family member's life.
- Begin practicing new communication methods.

Advanced stage: 21+ weeks

- Work to develop a healthy, balanced lifestyle that supports the client and addresses personal needs.
- Exercise patience with recovery.
- Evaluate and accept changes, adaptations, and limitations.

Source: Matrix Center 1989.

- Medical aspects of addiction and dependence
- Relapse and relapse prevention
- Addiction as a family disease
- Subconscious refusal to admit that the client has a substance use disorder (i.e., denial)
- Enabling behaviors
- Communication
- Reasons for testing and monitoring of the client
- Leisure time planning
- Parenting skills
- Community support groups and resources

Group members listen to lectures, discuss topics, and engage in exercises that help them become knowledgeable about substance use disorders and their effects on the family.

Multifamily Groups

Multifamily groups can be thought of as microcosms of the larger community. They offer more opportunities for learning, adaptation, and growth than do groups of one client and family members. These groups provide family members with a sense of normalcy and a support network. Individuals learn that other families face similar difficulties. This discovery may reduce the stigma and shame commonly found among families struggling with substance use disorders. Families often exhibit mutually supportive, spontaneous involvement with one another and reinforce one another's problemsolving approaches. Cross-learning—in which, for example, a man learns to understand his wife better by listening to other husbands and wives—is one of the most powerful effects of multifamily therapy. Incorporating multifamily groups into IOT has been shown to increase the length of treatment for female clients, increase completion rates for men, and improve family functioning and children's behavior (Boylin and Doucette 1997; Meezan and O'Keefe 1998). Treatment providers report that having more than one generation present in the group can help institute a family's commitment to abstinence and recovery (Conner et al. 1998).

Multifamily groups typically engage several clients and their family members in group exercises that teach them how to develop healthy communication techniques, avoid enabling behaviors, reduce codependence, and get help. Until a multifamily group coalesces, it may be helpful for members' participation to be structured (e.g., talking only about themselves, not about the person in IOT).

> Cross-learning...is one of the most powerful effects of multifamily therapy.

IOT providers should foster an atmosphere of acceptance and emotional safety so that learning occurs in a relaxed setting. Group sessions generally are scheduled weekly and last for 2 to 4 hours with group size ranging from 12 to 30 members (6 to 8 families) (Crnkovic and DelCampo 1998). Clients' recovery may be aided by the inclusion of supportive individuals from outside the family (e.g., sponsors, friends, religious leaders, co-workers). The consensus panel recommends that multifamily groups be co-led by two therapists trained in this process. Membership may change frequently, and clients and their families join the group as others graduate from the treatment program.

Family Therapy Groups

In 1997, Stanton and Shadish conducted a meta-analysis that compared the effectiveness of family education, family therapy, and other forms of family intervention for people with substance use disorders. Their results suggested family therapy is more effective than family education groups and other family services. However, family therapy can be delivered only by specially trained therapists. Forty-two States require that people practicing as family therapists be licensed. In most States, a family therapist must have a master's degree to practice independently (CSAT 2004*c*). Family therapy addresses the dynamics in the family that may encourage substance abuse and offers support for changing these dynamics. It emphasizes that the family as a dynamic system, not merely the inclusion of family members in treatment, is the hallmark of family therapy (CSAT 2004*c*). These sessions may include individual family, couples, and child-focused therapy. (Family therapy for adolescents is discussed in chapter 9.) Because not all IOT programs provide these types of therapy groups, providers should consider establishing referral agreements with other community service organizations that provide family therapy.

Individual family therapy

This type of therapy helps family members look at their interactions and identify the factors in the family that contribute to a substance use disorder. Family members are encouraged to restructure negative patterns of behavior and communication into interactions that are more conducive to recovery for everyone. Through family therapy, adults and children express to the client how behavior has affected them and how new coping skills now are affecting their lives. The client has the opportunity to use new skills learned in treatment and to receive constructive feedback from family members in a safe environment. During these sessions, families may address issues such as irresponsible behavior, indebtedness, substance use in the home by other family members, availability of alcohol on special occasions, and how to reveal treatment and recovery to others. The content of these sessions varies significantly, based on the needs and motivations of the family members. Family therapy may be scheduled monthly or more frequently.

Couples therapy

Couples counseling is useful in improving certain aspects of functioning in families with substance use disorders (O'Farrell and Fals-Stewart 2002). This therapy focuses on improving a couple's relationship and reducing problems related to substance abuse. The spouse or significant other is taught to reinforce abstinence, decrease behaviors that cue substance use, and avoid protecting the client from the adverse consequences of substance use. Both partners are taught to increase positive exchanges, improve communication, and work together to solve problems. The number of sessions can be six or more and can include sessions for one couple or groups of couples (Fals-Stewart et al. 1996).

Child-focused therapy

Play and structured recreational activities for children and parents can reduce conflict in families with substance use disorders. In groups with their children, parents are taught parenting and problemsolving skills and are given information about normal childhood development. Parents recovering from substance use disorders have a chance to experience pleasurable recreational activities with their children (e.g., volleyball, soccer) and learn to interact with them in a structured, therapeutic setting. Older children can be educated about substance use and how it can affect them and their families.

Family Retreats

Some IOT providers have found that family retreats can be effective in helping families harmed by substance use disorders, although research is unavailable on this topic. Participants can take important steps toward healing damaged relationships. Some participants have described family retreats as the most important aspect of their experience in treatment.

Most family retreats cover 2 days, usually over a weekend; participants spend nights at home. Retreats provide clients and their family members with the opportunity to work intensively with one another to address powerful emotions such as shame and guilt and to restore lost intimacy and trust. Participants take part in education sessions, exercises, and group activities. Day 1 activities can include family education on

- Communication skills
- Experiencing and working with feelings
- Developing trusting relationships within the family
- Creating healthy expectations
- Reestablishing roles

Participants receive an assignment the evening of day 1 to work on at home. Assignments may focus on developing relapse contracts, reading from journals, or sharing positive family memories. Day 2 can focus on a therapeutic event during which

- Participants discuss the assignments they completed the night before.
- Family members are encouraged to tell one another important things, which may never have been said or discussed before.
- Family sculpting exercises are conducted; this activity dramatically illustrates relationships and communication patterns that need to change. In family sculpting, each family member takes a turn positioning the other family members in relation to one another, posing them as he or she sees fit, and explaining the choices (CSAT 1999*a*).

Programs that conduct retreats find that executing a "contract for participation" with the client helps ensure that the retreats are well attended. Therapists may need to assist the client in recruiting family members to attend. Retreats should be staffed by therapists who are experienced in managing highly emotional events.

Support Groups for Families

Mutual-help groups provide the continuing emotional, educational, and interpersonal support that family members often need as clients complete their treatment. Attending support group meetings helps family members adjust to changes being made by the recovering member and begin new lives of their own. Family support groups may be sponsored on an ongoing basis by the IOT program or consist of community-based fellowships such as Al-Anon, Nar-Anon, Alateen, Adult Children of Alcoholics (www.adultchildren.org), Adult Children Anonymous (www.12stepforums.net/acoa.html), and Families Anonymous.

When a family support group is sponsored by the IOT program, it usually meets weekly. Family members can discuss problems and concerns that arise because of the client's recovery and reconnection with the family. Such groups offer continuity for family members during the difficult treatment and recovery periods. Surrounded by familiar program staff members and other family participants, family members build on the momentum of their previous experiences in treatment. Examples of the issues discussed include parenting, decisionmaking, conflicts, sexual functioning, intimacy, anger management, mood swings, reestablishing trust, adjusting roles, learning what is "normal," renegotiating relapse prevention contracts, and substance use by other family members.

Community-based 12-Step support groups such as Al-Anon, Nar-Anon, and Alateen are independent from the IOT program. Because family members may be reluctant to initiate contact with such groups, IOT providers can assist family members by providing information about meetings, such as what happens at these meetings, the rituals observed, who attends, how meetings are conducted, the purpose of the meetings, and where to find them. Members of mutual-help groups can be invited to give talks to the family members in the IOT program. Providers also should emphasize that the meetings are anonymous. By encouraging family members to attend at least three meetings before deciding whether to continue, the IOT provider increases the probability that family members have a positive experience and continue to attend. IOT staff can encourage members of multiple families from the program to attend meetings together so that they can reinforce and reassure one another.

Family Clinical Issues in IOT

Diverse questions, concerns, and behaviors are presented by family members during IOT sessions. The complexity of human relationships and interactions is revealed in treatment and can challenge both participants and counselors to use the opportunities and experiences therapeutically. Long suppressed anger, family secrets, shame, and confusion may surface. Family members may harbor feelings and thoughts that can affect the client and the family adversely and that require resolution within a therapeutic environment.

Changing Realities: Working With Clients Who Are Estranged From Their Families

In one IOT program, some clients revealed that they did not participate in family groups, family nights, and other family-oriented activities because they had no family. The clients had been ostracized by or estranged from family members for an extended period.

The counselors suggested that clients and staff rename the "family" events so that clients could feel more comfortable bringing other individuals such as co-workers or friends who made up their family of choice. Instead of Family Night, the program sponsored Support Network Night.

The results

- Participation in the events increased. More clients and their supporters attended treatment activities.
- Clients were encouraged to build an abstinent support network that included friends, co-workers, neighbors, or others as well as members of their family of origin.

Unrealistic Expectations About Treatment Outcomes

Family members often have unrealistic expectations about treatment and the client's recovery. Family members may not understand the nature of a substance use disorder or are unable to accept that it is a chronic, relapsing disease and recovery is a lifelong process. Some family members, for instance, can be so fatigued and emotionally depleted from the stress of living with the person who abuses substances that they have unrealistic hopes for treatment. Strategies and solutions to address unrealistic expectations and common fallacies about treatment and recovery include the following:

- **Informing the family early in treatment about common but unrealistic expectations.** By gently raising this issue early in treatment during individual family sessions, the IOT counselor can draw attention to and begin to dispel any fallacies. The counselor can probe for related family beliefs, answer family members' specific questions, and provide real-life examples before unrealistic expectations lead to an undermining of family and client functioning. This process also can identify specific educational needs.
- **Using a variety of formats to provide clear, understandable information about substance use disorders.** A family education group is a basic component of IOT programming that is effective in debunking many fallacies about substance use disorders. For instance, the group can be used to dispel the idea that once a client is in treatment, he or she will stop having the urge to use; that once use stops, everything will be "perfect"; or that doctors and counselors will teach how to get well. A counselor can obtain or develop written materials (fact sheets, brochures, posters) at appropriate reading levels and in relevant languages. These materials need to be available at the program facility and distributed to family members at intake and during treatment. A brief, informative video can be played during family sessions, in counselors' offices, or in the waiting room.
- **Reaching many family members.** It is important to educate as many family members as possible and to ensure that the most influential family members become knowledgeable about substance use disorders and then redirect other family members if necessary.

Family Responses to Relapse

Clients can relapse, and family members may be unwilling or unable to be compassionate or nonjudgmental about episodes of relapse. Typically, relapse is an unpopular topic with family members. If relapse occurs, counselors need to be prepared for a range of emotional responses from families, including anger, panic, blame, depression, spitefulness, and relief. Some families may abandon or withdraw from the client; others may attempt to engage the client in substance-using activities; still other families may be caught in patterns of depression and resignation or panic and fear.

The following therapeutic options may help counselors in assisting families that may experience a family member's relapse:

- **Prepare the family members as well as the client for the possibility of relapse.** Family members are likely to be the first to know when a client relapses. IOT programs focus on strengthening the client's relapse prevention skills, but families also need assistance. IOT staff members can help families
  - Understand that relapse can happen and that each family reacts in unique ways.
  - Accept that their reactions to the relapse crisis do not necessarily indicate that the family is in deep trouble.
  - Prepare a plan that identifies steps the family will take if relapse occurs.
  - Identify ways that family members can support one another.
  - Seek help if the plan fails.
- **Assist family members in engaging support services and resources.** Community-based support groups such as Al-Anon, Nar-Anon, Alateen, and Alatot (for children of parents who abuse alcohol) are available in most areas and are indispensable sources of help for many families. Family members should be encouraged to attend meetings regardless of the client's recovery status. In these groups, family members focus on their own needs, accept what they cannot change, and engage in healthy, satisfying activities. To facilitate

Living the Treatment Process

Anthony's wife and son were relieved and optimistic when he entered treatment. Soon they would be able to enjoy the husband and father they had missed during many years of substance abuse. As the weeks passed, however, Anthony's family grew more angry and disappointed. He rarely spent time with them and was always at recovery meetings. He showed little interest in their lives and was not physically or emotionally available to them. "I thought treatment would make our lives better, but it's just not true," said his wife.

Counselor's response

- Validate the feelings of family members.
- Explain that Anthony's recovery requires his full attention. For a time, he will be unable to devote much attention to the needs or expectations of others. Only as his recovery progresses and risk of relapse recedes can he become less self-focused.
- Discuss the warning signs of relapse.
- Emphasize the family members' need to focus on enhancing their own lives, independent of the addicted loved one, including involvement in support groups such as Al-Anon.

attendance, some IOT programs offer these groups space at their facility. Others sponsor their own family support groups, led by alumni of the programs, that are open to all who wish to attend for as long as they desire.

- **Seek interventions for individual family members when their responses to relapse are unhealthy.** The IOT counselor needs to be alert to the possibility that relapse by a client may require additional family interventions and referrals to other service professionals. For example, another family member also may be in recovery and may need additional assistance from a support group. Another family member may become depressed as a result of the client's relapse, or an adolescent may act out. The client and other family members may benefit from psychological or psychiatric interventions.

Sabotage by Family Members

A family can sabotage the client's progress when one or more family members behave in ways that undermine the client's abstinence or treatment. For example, family members may continue to use or leave alcohol or drugs where the client is likely to see them. They may state to the client or others that the client is likely to fail or may refuse to let the client use the family car to go to a support meeting or treatment session. Examples of successful clinical approaches to discourage sabotage and encourage positive participation are as follows:

- Schedule individual family sessions to discuss the specific behaviors that are sabotaging recovery efforts.
- Discuss alternative behaviors that support recovery, and offer support for making the behavioral changes.
- Determine whether individual therapy is needed, and support family members with a referral to a family therapist as appropriate.
- Work with family members to create a contract that specifies how their behavior is to change.
- Monitor progress.

Family Life Without Substance Abuse

As recovery begins, some family problems resolve with abstinence. Issues of trust and worries about how the family will be different are likely to emerge. Here are a few common questions and some suggested answers on how IOT counselors can help families:

1. **How do we reestablish trust?**

   - Teach family members that a lack of trust is a normal and natural reaction in early recovery but, at the same time, the recovering person may sense this lack of trust and may become angry or sad.
   - Indicate that the newly abstinent member may suffer from a "time warp" in which a week seems more like a month. Such different perceptions of time can add to conflict around the trust issue because the client may expect the family's trust after what is, in reality, only a short period of abstinence.
   - Discuss the idea that mistrust transforms into trust only as the client maintains abstinence and demonstrates positive changes in behavior. Ask the client to accept that family members may not trust him or her for a period.
   - Suggest that family members agree to extend their trust incrementally to the client. For example, an adolescent client may be given permission to use the family car for an outing if the adolescent's school attendance is satisfactory for a specific period.

2. **How do we have fun again?**

   - Suggest creating new family rituals to replace old ones that involved substance use.
   - Suggest establishing and celebrating "family" abstinence anniversaries.
   - Encourage participation in events sponsored by Al-Anon, Nar-Anon, and other family support groups.
   - Urge participation in multifamily groups sponsored by the treatment program.
   - Ask each member to identify a favorite "family fun" activity for the entire family to enjoy.
   - Ask members to consider separate couples and parent–child activities to create new relationships between family members.
   - Ask members to keep a family journal that includes ideas, feedback, and comments from family members on various activities, rituals, and other family events.

3. **What do we say to friends, neighbors, and associates about treatment and recovery?**

   - Assist family members in discussing and coming to decisions about what information they want to share with others and when. Write down this information, give it to all family members in the form of an agreement, and have each member sign the agreement.
   - Review the privacy and confidentiality provisions that govern treatment programs with family members to remind them that providers will not discuss these topics with others and that family members are in control of what others know. Use family support group sessions to discuss this issue so that members learn from the experiences and examples of other families.
   - Have family members "rehearse" situations they are likely to encounter to practice appropriate responses.

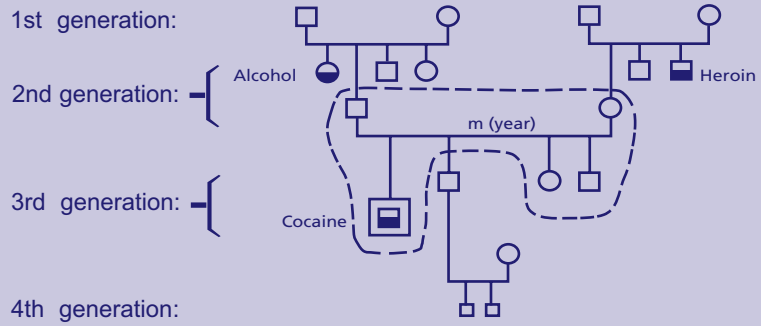
4. **First the bottle, now the meetings. Will it ever get better?**

   - Acknowledge that the spouse or significant other is disappointed and frustrated.
   - Point out that recovery is the first and most important goal during this difficult period and that people in recovery often immerse themselves in recovery activities with the same intensity with which they used substances.
   - Assist the spouse or significant other in focusing instead on his or her own recovery and in attending Al-Anon, Nar-Anon, or other support groups.

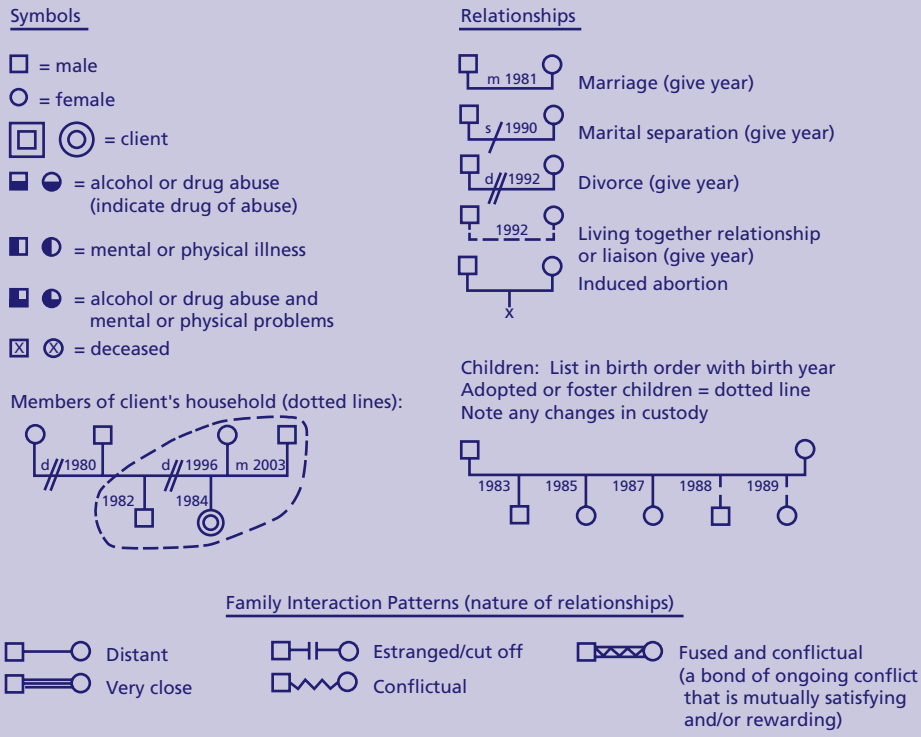
Appendix 6-A. Format and Symbols for Family Genogram*

The genogram is useful for engaging the client and significant family members in a discussion of important family relationships. Squares and circles identify parents, siblings, and other household members, and an enclosed square or circle identifies the client. Marital status is represented by unique symbols, such as diagonal lines for separation and divorce. Different types of connecting lines reflect the nature of relationships among household members. For instance, one solid line represents a distant relationship between

Format for Family Genogram

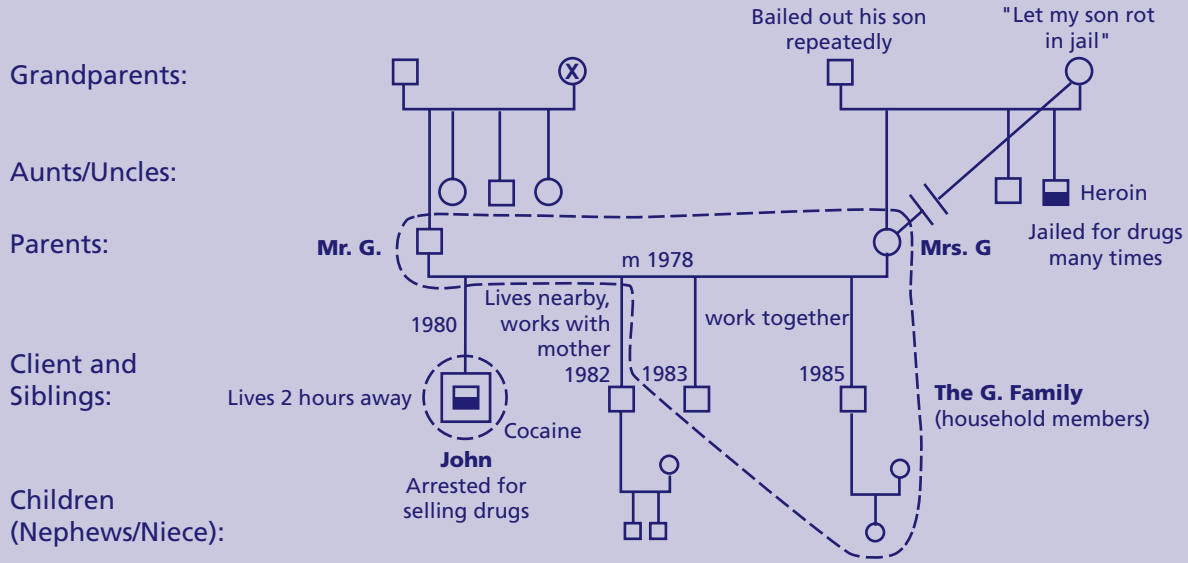


Symbols Useful for Genograms



*Source: New Jersey Division of Addiction Services, New Jersey Department of Health and Senior Services.

Client John G. and His Family



two individuals; three solid lines represent a very close relationship. Other key data, such as arrest information, are written on the genogram as appropriate.

This sample genogram depicts a family that initially was seen as a close, loving family unit. The son, John, had come under the influence of some "bad friends" and had become involved in abusing and selling substances. While expressing their willingness to help, the family denied the seriousness of the situation and minimized any problems in the nuclear or extended family.

When the discussion was extended to one of John's maternal uncles, Mrs. G. admitted that her brother had been arrested a number of times for heroin possession. Questions about the maternal grandmother's reaction to John's "problem" caused the united family front to begin to dissolve. It became apparent that Mrs. G.'s mother took an "insensitive position" regarding John's substance use disorder and there was a serious estrangement between her and her daughter. In discussing the details of the uncle's criminal activity (which was a family secret that even John and his brothers did not know), it emerged that Mrs. G. had for years agonized over her mother's pain. Now, desperately afraid of reliving her parents' experiences, Mrs. G. had stopped talking to her mother. John's brothers felt free to open up and expressed their resentment of their brother for putting the family in this position.

Mr. G., who had been most adamant in denying any family problems, now talked about the sense of betrayal and failure he felt because of John's actions. It was only through the leverage of the family's experience that the family's present conflict became evident.

Appendix 6-B. Family Social Network Map*

Designing a social network map is a practical strategy to survey various aspects of social support available to clients and their families. Mapping a client's social network is a two-stage process. First, the client uses a segmented circle to categorize people in the network (e.g., friends, neighbors). Then, a grid is used to record a client's specific responses about the supportive or non-supportive nature of relationships in the network (Tracy and Whittaker 1990). This approach allows both clinicians and clients to evaluate (1) existing informal resources, (2) potential informal resources not currently used by the client, (3) barriers to involving resources in the client's social network, and (4) whether to incorporate particular informal resources in the formal treatment plan. Mapping also can identify substance-using behaviors of individuals in the client's social network. The map takes an average of 20 minutes to complete and provides a concise but comprehensive picture of a family's social network. Practitioners report that the social network map identifies and assesses stressors, strains, and resources within a client's social environment (Tracy and Whittaker 1990). This interactive, visual tool allows clients to become actively engaged and gain new insight into how to find support within their social networks.

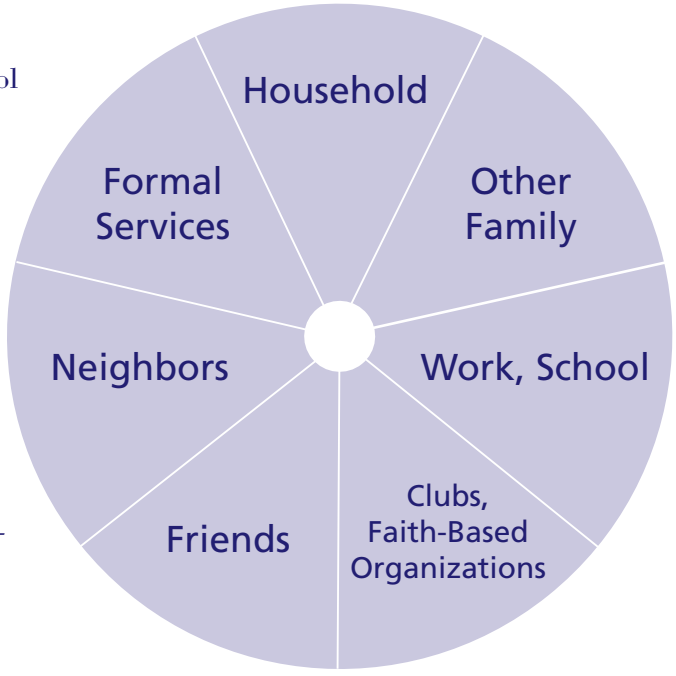
Instructions

Step one. Explain to the client that you would like to take a look at who is in the client's social network by putting together a network map. The client can use a first name or initials for each important person in his or her life; either the clinician or the client can enter the names in the appropriate segment of the circle shown at right.

Sample script. Think back over this past month, say since [date]. What people have been important to you? They may have been people you saw, talked with, or wrote letters to. This includes people who made you feel good, people who made you feel bad, and others who just played a part in your life. They may be people who had an influence on the way you made decisions during this time.

There is no right or wrong number of people to identify. Right now, just list as many people as you can think of. Do you want me to write, or do you want to do the writing? First, think of people in your household—whom does that include? Now, going around the circle, what other family members would you include in your network? How about people from work or school? (Proceed around each segment of the circle.) Finally, list professional people or people from formal agencies whom you have contact with.

Look over your network. Are these the people you would consider part of your social network this past month? (Add or delete names as needed.)



* Source: Tracy and Whittaker 1990, pp. 463–466. Reprinted with permission from *Families in Society* (www.familiesinsociety.org), published by the Alliance for Children and Families.

Step two. Number the sections of the circle 1 through 7, as shown in the Area of Life section of the grid (exhibit 6-3). If there are more than 15 names on the circle, the client selects the top 15 people to enter on the social network grid. Transfer the 15 names and the numbers that correspond to the sections of the map to the social network grid. Names of people in the network also should be put on individual slips of paper for the client to use in preparing the network grid.

Step three. After the names from the social network map have been added to the leftmost column of the social network grid, ask the client to consider the nine categories in the column headings. The client uses the 15 slips of paper with the names from the social network map to respond, sorting the slips into groups corresponding to the numerical options that accompany each category in the grid. For example, when considering how critical of the client each individual in his or her life is, the client sorts the slips into piles representing those who (1) hardly ever, (2) sometimes, or (3) almost always criticize. The name of each person and the appropriate number for his or her level of support are then entered onto the network grid in each life area. The finished grid gives an overall picture of support in the client's social network.

Sample script. Now, I'd like to learn more about the people in your network. I've put their names on this network grid with a number for the area of life. Now I'm going to ask a few questions about the ways in which they help you.

The first three questions have to do with the *types of support* people give you. Who would be available to help you out in *concrete* ways? For example, who would give you a ride if you needed one or pitch in to help you with a big chore or look after your belongings for a while if you were away? Divide your cards into three piles: those people you can hardly ever rely on for concrete help, those you can rely on sometimes, and those you'd almost always rely on for this type of help.

Now, who would be available to give you *emotional* support? For example, who would comfort you if you were upset or listen to you talk about your feelings? Again, divide your cards into three piles. (Proceed through remainder of the questions.)

Clinical Application

Mapping a client's social network provides a visual and numerical depiction of the client's significant relationships. The following aspects of social functioning are highlighted:

- Network size
- Availability of support
- Criticism client faces
- Closeness
- Reciprocity
- Direction of help
- Stability
- Frequency of contact

Exhibit 6-3. Social Network Grid Used in Conjunction With Network Map

ID _____ Respondent _____ **Name**	#	**Area of Life** 1. Household 2. Other family 3. Work/School 4. Organizations 5. Other friends 6. Neighbors 7. Formal services	**Concrete Support** 1. Hardly ever 2. Sometimes 3. Almost always	**Emotional Support** 1. Hardly ever 2. Sometimes 3. Almost always	**Infor-mation/ Advice** 1. Hardly ever 2. Sometimes 3. Almost always	**Critical of Client** 1. Hardly ever 2. Sometimes 3. Almost always	**Direction of Help** 1. Goes both ways 2. You to them 3. They to you	**Closeness** 1. Never very close 2. Sort of close 3. Very close	**How Often Seen** 0. Does not see 1. Few times/yr. 2. Monthly 3. Weekly 4. Daily/twice or more per week	**How Long Known** 1. < 1 yr. 2. 1-5 yrs. 3. > 5 yrs.
	01									
	02									
	03									
	04									
	05									
	06									
	07									
	08									
	09									
	10									
	11									
	12									
	13									
	14									
	15									

Appendix 6-C. Resources for Family-Based Services

Publications and Videos

A helpful reference is *Family Therapy: An Overview* (Goldenberg and Goldenberg 1985). This book presents a comparison of six theoretical models of family therapy, including the psychodynamic, experiential/humanistic, structural, communication, and behavioral models. Meyers and colleagues (2003) offer an overview of community reinforcement and family therapy (CRAFT) that emphasizes the approach's empirical support. Using concerned family members and friends, CRAFT works to bring those who deny they have a substance use disorder into treatment.

American Outreach Association (AOA) (www.americanoutreach.org). AOA is a private, nonprofit organization that produces pamphlets to help families cope with alcohol and substance abuse. The pamphlets can be downloaded from AOA's Web site. Topics include strategies on confronting children who use substances, effective ways for parents to communicate with their children, and ways to help someone with alcohol and drug abuse problems.

Films for the Humanities and Sciences (www.films.com). This organization offers 150 educational films on substance abuse, covering topics such as treatment issues and the effects of addiction on family members and including a series on young adults and substance abuse.

Gerald T. Rogers Productions (www.gtrvideo.com). This company produces films and videos on substance abuse for many audiences, from first graders to families with members who abuse substances.

Hazelden Foundation (www.hazeldenbookplace.org). Hazelden Bookplace is an online resource center and marketplace for products and services from Hazelden Publishing & Educational Services and provides resources to help individuals, families, and communities prevent and recover from substance use and related disorders.

Johnson Institute (johnsoninstitute.org). This organization offers books, booklets, and videos that are distributed through the Hazelden Bookplace Web site. Some family-related videotapes available are *Parenting Issues for Recovering Families*, *The Kid and Me: Parenting for Prevention*, *The Enabler*, *Intervention*, and *Intervention: How to Help Someone Who Doesn't Want Help*.

National Families in Action (NFIA) (www.nationalfamilies.org). NFIA is a national drug education, prevention, and policy center with the mission of helping families prevent substance abuse among children by promoting science-based policies. NFIA offers books, pamphlets, and afterschool programs to keep young people substance free. NFIA has collaborated with other organizations on several projects, including Allied Systems Strengthening Families Project and the Drug-Free America Foundation.

NIMCO, Inc. (www.nimcoinc.com). This organization offers videos on alcohol, tobacco, and drug education and prevention topics. Videos cover such issues as drinking and driving, steroid use, substance abuse in the workplace, and the effects of substance abuse on the mind and body.

Pyramid Media (www.pyramidmedia.com). This company offers films and videos about substance abuse that are appropriate for training, educational groups, and individual and family viewing.

Substance Abuse and Mental Health Services Administration's National Clearinghouse for Alcohol and Drug Information (NCADI) (www.ncadi.samhsa.gov). NCADI is a national resource center

funded by the Federal Government that offers a large inventory of publications and videos for treatment professionals, clients, families, and the general public, including *Alcoholism Tends To Run in Families*. This fact sheet presents important information about the influence of parental alcoholism on children and families. It considers evidence that links alcoholism to dysfunctional marital relationships, child abuse, depression, physical problems, and impaired school performances, among other undesirable effects.

Moyers on Addiction: Close to Home (www.pbs.org/wnet/closetohome). This is the online companion to the PBS show. It features real-life stories of struggles with addiction, information on treatment and prevention, and downloadable resources such as family guides, viewer's guides, teacher's guides, and health professional's guides to the PBS series.

Family Support Groups

Adult Children of Alcoholics (ACOA) (www.adultchildren.org). ACOA is a 12-Step, 12-Tradition program that offers support for grown children of parents with alcohol or drug addiction.

Al-Anon family groups (www.al-anon.org). Al-Anon is a fellowship of relatives and friends of people who have alcohol problems who share their experiences, strengths, and hopes. Members believe that alcoholism is a family illness and that changed attitudes can aid recovery. The program is based on the 12 Steps and 12 Traditions of Alcoholics Anonymous.

Families Anonymous (FA) (www.familiesanonymous.org). FA is a 12-Step, mutual-help, recovery support group for relatives and friends of those who have alcohol, drug, or behavioral problems. FA pamphlets, booklets, newsletters, and daily inspirational thought book are written by the members.

Nar-Anon family groups (www.naranon.com). Similar to Al-Anon, Nar-Anon is a fellowship of relatives and friends of people who abuse substances and offers a constructive program for members to achieve peace of mind and to gain hope for the future. Contact information is available in local telephone directories.

National Asian Pacific American Families Against Substance Abuse (www.napafasa.org). This nonprofit organization is dedicated to addressing the alcohol, tobacco, and drug issues of Asian and Pacific Islander (API) populations in the continental United States, Hawaii, and the six Pacific Island jurisdictions, as well as elsewhere. Its nationwide network consists of approximately 200 API and human service organizations, and its Web site lists resources, services for public and professional audiences, and current activities.

7 Clinical Issues, Challenges, and Strategies in Intensive Outpatient Treatment

In This Chapter...

Client Retention

Relapse and Continued Substance Use

Substance Use by Family Members

Group Work Issues

Safety and Security

Client Privacy

Clients Who Work

Boundary Issues

Once clients are engaged actively in treatment, retention becomes a priority. Many obstacles may arise during treatment. Lapses may occur. Frequently, clients are unable or unwilling to adhere to program requirements. Repeated admissions and dropouts can occur. Clients may have conflicting mandates from various service systems. Concerns about client and staff relationships, including setting appropriate boundaries, can compromise care. Intensive outpatient treatment (IOT) programs need to have clear decision-making processes and retention strategies to address these and other circumstances.

This chapter discusses common issues that IOT programs face and offers practical approaches to retaining clients in treatment. Experience has taught IOT clinicians that every problem can have many solutions and that the input and ideas of colleagues lead to creative approaches and solutions. The chapter presents specific scenarios and options from clinical practice and experience for clinicians to consider, modify, or implement.

Client Retention

Reducing client attrition during treatment must be a priority for IOT providers. Compared with clients who drop out, those who are retained in outpatient treatment tend to be White, male, and employed (McCaul et al. 2001). Client attributes associated with higher dropout rates are labeled "red flags" by White and colleagues (1998); these red flags include marginalized status (e.g., racial minorities, people who are economically disadvantaged), lack of a professional skill, recent hospitalization, and family history of substance abuse. Being aware of these red flags can help clinicians intervene early to assist clients at increased risk of dropping out. Veach and colleagues (2000) found that clients who abuse alcohol were more likely to be retained and those who abuse cocaine were less likely to be retained in outpatient treatment. Other studies have

found that the substance a client abuses is not a good predictor of retention (McCaul et al. 2001).

The following strategies improve retention of clients in treatment:

- **Form a working relationship with the client.** The counselor should foster a respectful and understanding relationship with the client. This therapeutic relationship reduces resistance and successfully engages the client in working toward mutually defined treatment goals.
- **Learn the client's treatment history.** If the client has dropped out of treatment previously, the counselor should find out why. If the client has engaged and been retained successfully in treatment before, the counselor should ask what made treatment appealing.
- **Use motivational interviewing.** The counselor should help clients work through ambivalence by supporting their efforts to change and helping them identify discrepancies between their goals and values and their substance use. Involving clients in activities, such as support groups, also is effective.
- **Provide flexible schedules.** IOT providers need to consider the client populations they serve and schedule groups accordingly. For example, morning groups can be for clients who work swing and night shifts and for women with school-age children and evening groups for those working regular business hours. It can be difficult for clients to fit many hours of treatment into their week.
- **Use the group to engage and reengage the client.** The counselor should encourage members to talk about their ambivalence, how they are overcoming it, and their experiences of dropping out of treatment, as well as the negative consequences of dropping out. The counselor can supply all group members with an updated telephone list and encourage them to talk to at least two other members daily. The counselor can ask members to call those who are absent to let them know that they were missed and are important to the group. It is important to check with clients to be sure that they are receptive to these phone calls; some may view them as intrusive and disrespectful.
- **Increase the frequency of contact during the early treatment period.** Clients often feel vulnerable or ambivalent during the first few weeks of treatment. Counselors need to contact each client frequently during this period to enhance retention. These contacts can be brief and made by telephone, e-mail, or letter. At the same time, counselors should encourage clients to contact other group members to reinforce the value of reaching out for support.
- **Use network interventions.** Counselors need to work with individuals in the community who are invested in the client's recovery to encourage the client to stay in treatment. These individuals can be

Multiple Retention Challenges

Clinical issue. A man, age 35, single, and an immigrant from El Salvador, has failed to return to treatment or contact his counselor in the last 3 days.

Approach

- The counselor writes a note to the client in Spanish, encouraging him to return to treatment.
- The counselor arranges for the client to get a ride to the next group session and for public transportation vouchers for subsequent sessions.
- The counselor schedules an individual counseling session for the client to discuss several retention problems, which include lack of transportation, language barriers, and shame over lapses to his previous drinking pattern.

probation officers, ministers, employee assistance program counselors, friends, and co-workers. If the program identifies supportive individuals early in treatment and obtains a written consent for release of information from the client, the counselor can ask these individuals to encourage the client to attend sessions or increase his or her commitment to recovery.

- **Deliver additional services throughout the treatment period.** Fishman and colleagues (1999) found that attrition was lower during the intensive "services-loaded" phase of IOT and, conversely, that attrition increased during the less rigorous program phases.
- **Never give up.** The counselor should make continual efforts to follow up with clients who have dropped out. Successful techniques include telephone calls, letters, and home visits to encourage the client to return to the program. This level of dedication can affect the client's attitude and willingness to complete treatment.

Relapse and Continued Substance Use

Lapses often happen in the difficult early months in treatment. These brief returns to substance use can be used as a therapeutic tool; the goal is to keep them from becoming full relapses with a return to substance use. IOT clients living in the community are exposed to pressures to relapse, often while struggling with cravings and their own resistance to change. Clients need to use relapse prevention strategies when they are exposed to alcohol and drugs, experience cravings, are encouraged by others to return to substance use, or are exposed to personal relapse triggers (Irvin et al. 1999). (See appendix 7-A, page 135, for descriptions of several instruments for assessing clients' relapse potential.)

General relapse prevention strategies are to

- **Educate clients and their family members about addiction and recovery.**

The Difference Between a Lapse and Relapse

Jack's experience: A lapse.

Jack comes to group distressed because he drank on the weekend. He has been abstinent for 2 months and is concerned that he has jeopardized his employment and the return of his driver's license. He discusses the episode with his counselor, and they identify treatment options. The therapeutic goal is to reinforce Jack's desire to stay abstinent, and the episode becomes an opportunity to strengthen his relapse prevention skills.

This is a lapse, that is, a brief return to substance use following a sustained period of abstinence (a month or more). The client still is committed to his recovery and has not experienced loss of control. The event is used to help the client identify relapse triggers and increase his understanding and ability to withstand pressures to use substances.

Phil's experience: A relapse.

Phil is in treatment for methamphetamine use. He has disappeared from treatment again.

When he returns, he is hyperactive, has a positive drug test, and refuses to talk about the test results or his return to drug use. He then fails again to return to the program. He is seen on the street obviously intoxicated. The compulsion to use is strong.

This is a relapse, that is, a prolonged episode of substance use during which the client is not open to therapeutic intervention or learning. Often a relapse can lead to dropout and indicates a continuing struggle by the client with his or her disease.

Clients and family members need information about the disease of addiction and its stages, cues to relapse, early signs of relapse, how addiction affects relationships, and how to find resources for support (e.g., Al-Anon). Counselors need to enlist the support of family members and significant others to keep them from sabotaging treatment. Family members need advice on how to support the client in recovery and how to cease enabling behaviors.

- **Conduct an early assessment of specific relapse triggers.** Together with the counselor, clients can conduct a functional analysis of their substance use, working to identify and understand with whom, where, when, and why they use substances. Functional analysis is a tool that identifies not only clients' high-risk circumstances for substance use but also the ways in which triggers are linked to the effects that substance use produces. TIP 33, *Treatment for Stimulant Use Disorders* (CSAT 1999*e*), and TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*c*), explain how to perform a functional analysis.
- **Develop a relapse prevention plan immediately.** A relapse prevention plan should include coping strategies developed by the counselor and client, such as going to support group meetings, avoiding places where the client used substances in the past, identifying good things about a substance-free life, and telephoning the client's sponsor regularly. TIP 33 (CSAT 1999*e*) contains information and worksheets to develop a relapse prevention plan. Technical Assistance Publication (TAP) 8, *Relapse Prevention and the Substance-Abusing Criminal Offender* (Gorski et al. 1993), and TAP 19, *Counselor's Manual for Relapse Prevention With Chemically Dependent Criminal Offenders* (Gorski and Kelley 1996), are helpful in developing a relapse prevention plan.
- **Provide intensive monitoring and support.** These activities include random drug testing (including urine samples that are collected under observation of program staff to prevent tampering), family counseling or education sessions about supporting the client during and after treatment, and the client's self-monitoring of exposure and response to substance use triggers.

A Relapse Prevention Quiz

This quiz can be a tool to support and strengthen a client's readiness to avoid relapse. Having senior members in a group answer the questions reinforces their knowledge while they educate newer members in relapse prevention skills.

- What might you say to co-workers if they ask you to have a drink or get high with them?
- Craving a drink or drug is quite natural for people who are dependent on alcohol or drugs. What three things can you do to get past the craving?
- What are three common reasons for feeling that you don't belong in a support group such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)?
- What two things can you do if someone at an AA or NA meeting annoys you?
- Why must recovery from your disease be your highest priority?
- What three qualities should you look for in a sponsor?
- Emotional discomfort takes a variety of forms. What are the three biggest problems for you? Anger, depression, self-pity, loneliness, boredom, worry, frustration, shame, guilt, or another emotion?
- What three things can you do to handle each emotional discomfort you identified?
- What are the key elements of an assertive response when offered alcohol or drugs?
- Why is it important to avoid starting romantic relationships during early recovery?

Multiple Dropouts and Readmissions

Some clients relapse or drop out of treatment and return repeatedly to treatment before they achieve a stable recovery. Providers may be reluctant to keep offering scarce treatment resources to the same individuals or to readmit individuals who drop out continually. Programs can respond to multiple dropouts and readmissions strategically by

- Conducting a comprehensive evaluation of each client to determine whether IOT is the appropriate level of care. Some clients, for example, may benefit from a brief inpatient placement to ready them for IOT (see chapter 5).
- Reviewing the client's cycle of dropouts and admissions. Several cycles may be appropriate for a client with severe, complex needs and issues. Arbitrary rules regarding the number of permitted admissions and dropouts may be too rigid to support recovery of a severely impaired individual.
- Establishing an admissions committee to review and recommend action regarding clients who seek readmission following repeated dropouts. The committee can include staff and alumni representatives.
- Developing a profile of clients likely to drop out and designing a plan for them.
- Arranging a psychiatric evaluation for the client, which may indicate that psychiatric treatment and medication are required.

- **Evaluate and review all slips and lapses.** Despite their negative consequences, lapses can be used therapeutically. The counselor and client can learn more about what constitutes high-risk situations for the client. The client needs to consider the slip or lapse a discrete, unique event that does not need to be repeated or continued. The client should remember that abstinence can be regained and that the client can renew his or her commitment to abstinence. Clients should be reminded to contact the counselor, other group members, their sponsor, or other mutual-help group members when they sense that they are verging on relapse.
- **Use the behavioral contract with clients.** A behavioral contract spells out treatment expectations and goals, the rewards when goals are met, and the consequences if the contract is broken. The counselor should involve clients in writing the contract, encouraging them to use their own words. The behavioral contract helps bind clients to their commitment to abstinence and change. TIP 35 (CSAT 1999*c*) provides more information on behavioral contracts.
- **Introduce the stages of change.** Marlatt and Gordon (1985) and Prochaska and colleagues (1994) recommend using relapse prevention interventions that are matched to the client's stage of change. Joe and colleagues (1998) and Connors and colleagues (2001*a*) argue that for clients who are ambivalent about abstinence, for example, initial interventions might focus on strengthening their resolve by analyzing the pros and cons of use, rolling with resistance, and never directly confronting clients. Subsequent interventions support abstinence by altering stimulus control and developing skills for negotiating high-risk situations. After a client experiences a period of abstinence, emphasis shifts to lifestyle modifications that promote long-term abstinence.

Substance Use by Family Members

A client may have one or more family members who also actively abuse substances. In fact, research shows that individuals with substance use disorders are more likely than others to have family histories of substance use disorders (Johnson and Leff 1999). The client may be in regular contact with

members of the extended family, a close friend, spouse, or a boyfriend or girlfriend who uses substances. Active substance use by someone living in the same place as the client or who is part of the client's social support network clearly threatens a client's recovery. The IOT counselor can consider using these options:

- **Stay alert for others using substances.** Construct and update regularly a genogram or social network assessment (see chapter 6) to identify possible substance use among family members, significant others, and friends who are likely to influence the client's recovery. Gather information from the family and client about the nature, extent, and frequency of any substance use.
- **Request that the family and client develop an agreement about substance use in the home.** It is important to enlist family members in the treatment process to help the client and any other family members who are using substances (see chapter 6). A substance use agreement, signed by family members, identifies substances that will not be kept or consumed in the home and the consequences for violating the agreement. Part of the agreement can be to report all substance use to IOT program staff for discussion during group and individual sessions.
- **Assist the client in identifying alternative housing if needed.** Recovery homes, halfway houses, and shelters, among others, may be necessary temporary alternatives for a client who needs alcohol- or drug-free housing during and after treatment. If the client's recovery is undermined continually in current housing, the counselor should consider such a housing referral.
- **Provide information about treatment to a family member who needs it.** Offer information about treatment options or referrals to a family member with a substance use disorder in a manner that ensures the privacy of the individual and does not divert attention from the client's treatment and recovery.

Group Work Issues

Group work is a core service of IOT and offers many opportunities for educating, supporting, and nurturing clients. Clients' feelings toward their peers are important factors in shaping the way clients view the treatment experience. Clients are more likely to continue with treatment when they feel accepted, supported, and "normal" and receive empathy and kindness from others in the treatment group.

Many issues can affect group work and impede the progress of clients. For example, clients may be disruptive or withdrawn, have poor English or comprehension skills, and attend sessions sporadically. TIP 41, *Substance Abuse Treatment: Group Therapy*, provides additional information on working with clients in therapeutic groups (CSAT 2005*f*).

Developing Group Cohesion

Group cohesion can be a central element in a client's recovery process. Frequent changes in group membership make it difficult to build group cohesion. Washton (1997) suggests that frequent shifting of clients among groups can result in higher dropout rates. This observation argues for limiting changes in group composition that sometimes occur in a "phased" or "stage-oriented" IOT program. Adding new clients to groups generates challenges for the counselor who must become oriented to new clients. The following approaches help create effective IOT groups and group cohesion:

- **Create group rituals.** When new clients join a group or others depart, group rituals promote a sense of acceptance, safety, and support. Current members should orient new members to group rules and speak about their group experience. A ritual can mark a client's graduation from the program and celebrate his or her success. Departure rituals may include a client's demonstration of recovery knowledge and

skills, a group discussion of the departing client's strengths and how group members can be supportive, a review of the client's relapse prevention plan and options if the plan should fail, and presentation of the program's emblem (see below).

- **Institute a program emblem.** Staff and clients can design a program emblem to build and sustain group cohesion. The emblem is a visual symbol that represents the essence of the treatment program. For example, a coin, badge, or cup might be inscribed with a recovery motto such as "Serenity and Strength Day by Day" or "Hope, Freedom, and Recovery." A logo might feature the rising sun, a stately oak, or clasped hands. These emblems can incorporate and reflect various cultural and ethnic values and designs. Some programs leave space in the emblem to inscribe each client's name and his or her program completion date. Programs that have emblems have found that clients keep them and use them as reminders of their commitment to recovery and their success in remaining abstinent. The emblem and motto should convey a message of support while maintaining the confidentiality of the client (e.g., by not including the name of the treatment program).
- **Explore the group's feelings about clients who drop out.** When a member relapses and drops out of the group, the group provides a safe environment for other members to discuss their feelings or fears about failure and relapse and their own relapse prevention strategies. Because a client's perception of his or her ability to complete the program influences the outcome, counselors need to support group members with positive statements about their potential to do well in treatment.
- **Encourage identification with the program in addition to the group.** It can be helpful if clients develop a sense of belonging to the group and the treatment program. For instance, IOT staff can share information about the overall goals of the program, use guest counselors or supervisors to co-facilitate groups, and encourage former clients to return to share their experiences. Contacts with alumni outside treatment can be valuable, too.
- **Maintain effective group size and staffing.** The ideal adult IOT group consists of 8 to 12 clients, although up to 15 clients may be on the group roster (CSAT 2005*f*). Programs may need to adjust group sizes according to staff resources, the availability of co-therapists, the experience of the counselors, and the composition of the client population (e.g., adult or adolescent, women or men, people with co-occurring mental disorders).

At least one therapist should have the required academic credentials for group therapy; a co-therapist can be an intern or trainee

Example of a Sendoff for a Treatment Program Graduate

As a client leaves treatment, he or she is invited to take a marble from a bowl of marbles. The group leader then tells the graduate: "Now that you have begun this new stage in your recovery, keep this marble with you always—perhaps in your pocket or purse. Keep it where you will see it often to remind you of how hard your addiction was on you and your family. More important, it will remind you of how firm and resolved you must be in your commitment to stay clean and work on a healthy recovery program.

"Each time you reach into your pocket or purse and touch that marble, you will be reminded of the hard times that are behind you and those that may lie ahead. If, after all this, you decide that you do not care about the hard times and suffering that your addiction has caused and may cause again, and you decide that you want to sink back down into the mess of your addiction, then take the marble and toss it as far as you can, because you will have already lost the rest of your marbles!"

who assists with managing client behaviors and observing the dynamics of the group.

Preparing Clients for Group

IOT programs should orient new clients about how group therapy is conducted and how they are to use the group counseling sessions (see chapter 4). One way to do this is with a pregroup interview that allows the counselor to assess clients' readiness for treatment, learn more about clients' circumstances, and help shape clients' expectations by answering questions and supplying information (CSAT 2005*f*). This information should include group norms and expectations and be reviewed with clients so that it is clear from the outset. Programs also should consider posting group norms on the wall of the meeting room and having clients read them aloud at the beginning of each group session.

Working With Uncommitted, Ambivalent Clients

Some clients in group treatment may not be committed to their recovery from substance use disorders. Clients who have been mandated to treatment by the justice system may feel that they do not have a problem but are only following a judge's orders. Some clients may be late habitually or talk about their continuing interest in a substance-abusing lifestyle. The counselor cannot permit the client to attend group while under the influence of drugs or alcohol because this behavior can compromise the progress of other members of the group. However, the counselor can address behaviors displayed by uncommitted clients by

- Discussing the behaviors with the client individually to identify the issues and discuss options
- Moving the client to a precontemplator or other group or terminating the client from the program
- Introducing more structure into the group to enhance its therapeutic value for all members (e.g., by combining theme-oriented information with client discussion and concentrating less on process and more on organized content)

Working With Clients Who Have Severe Mental Disorders

Individuals diagnosed with severe mental disorders often require a high level of management by trained medical and substance abuse treatment professionals. These clients may have difficulty bonding with a group and may be disruptive or unable to focus for long periods. To enhance the effectiveness of group for individuals diagnosed with severe mental disorders, IOT providers are encouraged to consider these approaches:

Treating Individuals Who Have Severe Mental Disorders

Sam increasingly was unable to control his outbursts when in group. Although he usually was able to return to a calm state, the incidents persisted. His counselor was aware that Sam experienced hallucinations and, with input from Sam's psychiatrist, determined that Sam was receiving little benefit from being in a group. His treatment plan was revised to increase his individual counseling sessions in place of group participation.

Marjorie was diagnosed with bipolar disorder and functioned well while taking prescribed medications. Her counselor noticed behavior changes in group (such as flirting with male members, hyperactivity) over several days. After Marjorie was referred to her psychiatrist, it was determined that she had stopped taking her medications. After she resumed taking her medications, her symptoms disappeared.

- Treatment should be coordinated with the client's psychiatric care provider to determine how best to respond to crises that may arise during group.
- Group treatment should be guided by clients' readiness for and ability to engage in group work (Substance Abuse and Mental Health Services Administration 2002).
- Group treatment staff members should be educated and trained about mental disorders so that they are familiar with the signs and symptoms of psychoses and crisis intervention techniques.

For more information about treating this population, see chapter 9 of this volume or TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*e*).

Working With Disruptive Clients

Clients in group express a wide range of feelings, thoughts, and behaviors. Some members may disrupt the work of the group by challenging or interrupting others, demonstrating their impatience and restlessness, or otherwise offending other group members. Some strategies to address these disruptions are to

- Ensure that all clients know the group rules; provide them in writing, if possible.
- Consistently point out group rules about disruptive behaviors and the consequences for engaging in them.
- Reassess the client's level of readiness to change, and assign the client to another group if appropriate.
- Hold individual counseling sessions to discuss specific disruptive behaviors, how they are disruptive, and why they are not allowed; then explore and identify factors that may underlie the behaviors.
- Refer the client to a mental health professional if needed.

Working With Quiet, Withdrawn Clients

Clients may be reluctant to participate in group therapy for many reasons. They may be fearful or ashamed of revealing to strangers the extent of their substance use and related behaviors. Cultural values may inhibit the sharing of personal problems with

The Angry Client in Group

Problem behaviors

- Yelling
- Foul language
- Interrupting
- Being mean or insulting to others

Key concepts for counselors

- Be in control.
- Avoid a power struggle.
- Address the behavior, not the content.
- Don't raise your voice.

What to do

Listen reflectively to validate the client's feelings and to deescalate the situation. If the client remains angry, use these approaches:

- State that you are there to protect and safeguard the members of the group.
- Identify specific behaviors that are inappropriate.
- State that these behaviors are not allowed.
- Identify the consequences if the behaviors continue (e.g., being removed from the group, not being permitted to participate in discussion for the remainder of the group session).
- Follow through with the stated consequences if the behaviors are repeated.
- Transfer the client to a different group or clinical service.

those outside the family. Language and comprehension barriers may make it difficult to follow or participate in the conversation.

Clients may refuse to take part in group discussions beyond the level of perfunctory comments because they resent being in treatment, are depressed or have some other mental disorder, find the group boring, or are uncomfortable in a group. Some clients resist treatment because they believe that they do not have a disease or do not belong in treatment.

Some strategies to assist withdrawn clients are to

- Ask clients individually why they are quiet; then explore options based on the feedback.
- Assess and diagnose language and comprehension skills, and assign clients to a group that functions at an appropriate pace and level.
- Provide individual mentoring to ensure that treatment information is conveyed and understood.
- Create a "buddy system," pairing clients to encourage a sense of acceptance and belonging among the members of the group.
- Contract with the client to increase participation in the group incrementally.
- Refer the client for psychiatric evaluation, if needed.
- Adjust the client's treatment plan to include individual rather than group counseling if that seems to be in the client's best interest.

Responding to Intermittent Attendance

It takes time for a group to become a cohesive unit, and clients who do not attend sessions regularly can impede the group process. The client who misses sessions may

Helping the Client "Speak"

A counselor noted that, time after time, a client sat quietly in group and spoke only a few words, usually when she was called on. Despite gentle, persistent encouragement from the members of the group and the counselor, the client was quiet and watchful.

After a week, the counselor suggested this reticent client write out whatever she might want to communicate. The client was instructed to take an open-ended approach to the writing, similar to writing in a journal.

The counselor also asked the client to complete the following statements:

- My health concerns are
- The most stress this week came from
- This week I'd rate my stress level as ____, with 1 being low and 10 being high.
- The best thing that happened this week was
- I'm working on my treatment goals by
- How I'm feeling about group is
- My most likely relapse trigger is
- I get support for the healthy changes I'm making from
- I participated in the following substance-free activities this week

After several days, the client returned with a sheet containing her thoughts and comments about daily events, her concerns for her children, and the statements completed. The counselor used the information to begin developing a relationship with the client that helped her feel more comfortable in the program and ultimately with the group.

feel left out of discussions and may jeopardize the development of trust among group members that is at the heart of forthright communication. Counselors may find that such clients are strongly ambivalent about being in treatment, have practical barriers that prevent them from attending regularly, or feel uncomfortable in the group.

Some strategies to assist these clients are to

- Assess their readiness to change, and assign them to a precontemplator or other group whose members are at a similar stage of readiness.
- Identify and address any barriers such as lack of reliable transportation, conflicting work hours, lack of child care, protests by the spouse or significant others to treatment, and fear of violence from a domestic partner.
- Assign these clients to a group whose members share a similar cultural orientation, age range, gender, substance used, or level of psychological functioning.
- Provide refreshments on days when attendance is high to reward desired behavior.
- Monitor attendance and seek guidance from the supervising clinician.

Safety and Security

Clients, family members, and staff members must feel comfortable and safe when coming to the IOT program. IOT programs that treat high-risk clients need to monitor these clients carefully, anticipate problems, and plan appropriate interventions. Common safety and security issues that IOT programs face are identified by examples in exhibit 7-1 along with the counselor responses.

Presence of Drug Dealers or Gang Members at the Facility

Every IOT program should post prominent signs (in multiple languages where appropriate) inside and outside its facility that prohibit loitering, drug-related activity, or unauthorized persons on the premises. One or more trained staff members promptly and firmly should ask individuals not in treatment or not participating as family members to leave. Police assistance should be requested if there is any resistance to the request or if unauthorized individuals return.

In some cases, a client may encourage the presence of drug dealers or gang members. Criminal justice-mandated clients and individuals who are ambivalent about treatment, for example, may be susceptible to the influence of individuals who use substances and are part of their social networks. If the counselor finds this to be true, the counselor should inform the client that program rules prohibit such activity and explain the consequences of the client's continued involvement with drug dealers or gang members. A client may need the encouragement of the counselor and the support of program rules and policies to end harmful associations.

Stalking, Domestic Violence, and Threats Against Clients

IOT programs must take appropriate steps to ensure the safety of clients and staff members during treatment. Safety may be threatened by stalkers, violent domestic partners, former spouses and significant others, drug-related associates, or gang members. Counselors should consider following these steps:

- Privately and in a nonjudgmental way, ask the client about restraining orders, threats, or violent incidents that have occurred or that may occur. Knowing about possible problems helps staff members and the client take needed precautions. They can be alert for evidence of any immediate danger and attempt to prevent it. Treatment staff have a duty to warn if the danger is clear and imminent, provided that confidentiality regulations are met (CSAT 2004*b*).
- Intervene early to deescalate any situation that potentially could become violent.

Exhibit 7-1

Examples of Immediate Safety Concerns and Counselor Responses

Threat of violence against another. While in group, a male client expressed strong feelings of anger toward another man involved with the client's ex-wife. The client stated that he had a gun and wanted to kill the other man.

Counselor response. The counselor removed the client from the group and engaged him in a discussion about his feelings and remarks. The counselor expressed concern about the client's well-being and assessed whether he understood the seriousness of his statements. The client's anger began to subside, and the counselor had him sign a "no violence" contract.

For several days thereafter, the counselor telephoned or spoke in person with the client to assess his feelings and thoughts. The client stated he would "never do anything like that" and had regretted his outburst.

Threat of suicide. A female client telephoned her counselor and said she was tired of struggling with her addictions and other problems and was thinking about killing herself.

Counselor response. The counselor assessed the immediacy of the threat by reviewing the case record to determine whether there had been any previous attempts at suicide and asking the client whether she had a specific plan and the means to carry out the plan. If the counselor were still concerned, he or she would have consulted immediately with the supervisor or program director to develop and document a plan to inform the police, relatives, and the client's doctor and scheduled an immediate one-on-one session. Because these criteria were not met, the counselor, with the agreement of the client, scheduled an individual therapy session. During the session the counselor and client negotiated a "no suicide" contract that included a commitment by the client to see a psychiatrist for evaluation as soon as possible.

The counselor recorded the incident in the case record and discussed it further with the supervisor.

- Place violence-related information, such as occurrences of stalking, in the client's case record. Help the client create a detailed, personal safety plan, and include it in the case record. (See TIP 25, *Substance Abuse Treatment and Domestic Violence* [CSAT 1997*b*], for a sample plan.)
- Require the client to sign a no-contact agreement that prohibits contact with a batterer during the course of treatment, with clearly delineated consequences for violations.
- Assist the client in obtaining a civil protection order that prohibits harassment, contact, communication, or physical proximity by a batterer, stalker, or other threatening individual.
- Connect the client to community services that address domestic violence, such as advocates, counselors, emergency housing, and financial assistance.

Treating Violent Clients

Occasionally, a client may display violent behaviors while in treatment, such as brandishing a weapon or threatening others. IOT staff can take these steps:

- Have all newly admitted clients sign a client code of conduct that states that threats of violence or acts of violence result in immediate termination of treatment and possible criminal prosecution. Give examples.
- Notify a law enforcement agency if a threat to safety exists or an assault or other crime occurs on the program premises; report the incident and client's name, address, and treatment status, as permitted by Federal regulations.
- If the client is mandated into treatment from the justice system, follow the steps prescribed in the program's agreement with the justice agency. Certain rule violations, for instance, may require that the IOT provider notify the justice agency. Response to other violations may fall within the discretion of the treatment program. (See TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* [CSAT 2005*d*].)
- Notify supervisors about threats.

Clients Arriving Under the Influence of Drugs or Alcohol

Clients in IOT programs are expected to attend sessions drug and alcohol free. Arriving under the influence interferes with clients' participation, their ability to recall material covered, and the ability of other group members to benefit from therapy. It also indicates that a client's substance use disorder is active and that an alternative treatment plan is indicated, at least for that day. Strategies to respond to such occurrences are as follows:

Under the Influence in Group

George arrives at group intoxicated. His speech is slurred, he staggers somewhat, and he laughs loudly and inappropriately.

Counselor response.

- Inserts an educational video, and instructs the group to continue on its own for the next 15 minutes. Alternatively, asks another staff member to sit in temporarily with the group.
- Escorts George from the group.
- Obtains a urine sample and conducts a Breathalyzer™ test to determine the substances consumed.
- Asks George in a one-on-one session how he will return home. Because George drove to the facility, the counselor tells him that he cannot drive home and that the counselor will contact police if George tries to drive. The counselor reviews with George the names of family members who can provide a ride home. The counselor follows applicable Federal, State, and local laws regarding contacts with authorities (CSAT 2004*b*).
- Allows George to use the phone to call his wife to pick him up. Note: Some programs pay for a cab.
- Expresses concern about the substance use and encourages George to return to the next session where the episode will be discussed therapeutically.

Key point. The counselor did not engage George in a discussion about his substance use, such as why it occurred and the circumstances. Instead, the counselor immediately focused on confirming George's substance use, ensuring his safety, encouraging him to return to treatment when sober, and preserving group time for the benefit of the other clients.

- **Develop clear program rules regarding use of drugs during treatment.** If a client arrives under the influence, a therapeutic response is called for. The counselor takes the client aside, reviews the rules, and helps the client arrange alternative transportation if the client drove to the program. The client is instructed to return when abstinent and is informed that the substance use will be discussed in the next session. The counselor also can write a note to or call the client to emphasize that the client is expected to return to the group—actions that are intended to normalize the event and reduce any feelings of failure and shame.
- **Assess the client's health status.** When a client arrives under the influence of drugs or alcohol, the counselor should assess the client's need for acute care or detoxification. If it is indicated, the counselor should refer the client to detoxification. In a life-threatening overdose situation, no signed release is required to arrange for emergency medical care. If indicated, emergency personnel can be called. If acute care is refused, the counselor should contact a family member or significant other to escort the client home. (Unless the situation is life threatening, the significant other can be contacted only if the client has signed a release specifying such contact is permitted.) The counselor also should provide the family member with emergency care numbers.

Client Privacy

Treatment programs often receive inquiries about clients or unsolicited information about clients. Some clients in treatment may be HIV positive but indicate they have not reported their status to their partners or a well-known leader or celebrity may enter the program. Each situation presents client privacy and ethical issues for IOT providers.

Inquiries About Clients

Federal confidentiality regulations do not permit providers to reveal, even indirectly, that someone is a client unless a signed release has been obtained from the client and is on file. IOT staff members must consult a list of client-approved individuals before they (CSAT 2004*b*)

- Acknowledge that a client is a participant in the program.
- Share any information.
- Transfer a telephone call to the client.
- Take a message for a client.

Unsolicited Information About Clients

Clients' spouses, domestic partners, or other acquaintances may leave messages with information about clients' continued substance abuse or other activities and history while they are in treatment. Sometimes these individuals share their identities but do not want them revealed to clients because they fear for their safety. The counselor can respond to unsolicited information by (1) raising the general topic with the client during individual counseling and revising the treatment plan accordingly and (2) increasing the frequency of drug testing if substance use has been reported.

Knowledge of HIV Status Withheld From Partner

Substance abuse, particularly the injection of drugs, increases risk of HIV infection (Pickens et al. 1993). During treatment the IOT counselor may learn that a client has not informed a partner of his or her HIV-positive status, exposing the partner to potential infection. The following approaches help reduce this risk while maintaining client confidentiality:

- Ensure that the client is informed fully about the connections among drug use,

The Informant

Maria calls the IOT counselor to say that her husband Juan (an IOT client) is drinking almost every night and gets really drunk every weekend. She insists that the program "has to do something about it—treatment isn't working."

Counselor response. Because Juan has signed a release that permits the counselor to speak with Maria, the counselor asks for her permission to confront Juan with this information. Maria refuses permission because she is afraid Juan will be angry with her. The counselor schedules a session with the couple to discuss problems at home.

The counselor tells Maria that, without her permission, the information will not be conveyed directly; rather, it will be used in the most therapeutic manner possible. That is, the counselor will pay increased attention to Juan's behavior and communications and will perform breath tests more frequently to obtain evidence of alcohol use.

Key points.

- The counselor avoids being drawn into keeping the wife's secrets; a couples session is scheduled to discuss openly the relationship and the husband's drinking.
- IOT staff members must have a written release to discuss Juan's behavior with anyone.
- Spouses and others who provide information about clients need to be protected from possible harm.
- Information obtained "anonymously" can be therapeutically useful.
- Clients may continue in the program, even though they may be surreptitiously using substances, if all other program criteria are met.

unprotected sex, and the transmission of HIV/AIDS.
- Acknowledge and discuss with the client any fears, feelings of embarrassment, and guilt about revealing his or her HIV status to a partner.
- Include information about HIV transmission in educational materials and presentations made to family members.
- Assist the client in finding ways to talk about the issue with the partner, offer assistance in informing the partner if the client consents, and refer the client to an HIV/AIDS counselor for assistance.
- Encourage the client to participate in a support group for HIV-positive individuals, and provide a specific program referral.
- Discuss possible referrals to community-based providers if notifying the partner results in a need for services.

(See TIP 37, *Substance Abuse Treatment for Persons With HIV/AIDS* [CSAT 2000*c*].)

Entry of a Well-Known Individual Into Treatment

Recovery from substance use disorders is the focus of treatment for all clients, regardless of their position or visibility in the community. When a well-known person, such as a political leader, sports personality, artist, member of the clergy, or media representative, enters an IOT program, a variety of issues may surface. Examples include

- **Increased risk to maintaining privacy and confidentiality.** Interest in the client may result in inquiries by media representatives, curious callers, or program visitors. Remind all staff, including administrative and support personnel, as well as clients, to adhere to the program's confidentiality procedures that protect the privacy of every client.
- **Feelings of privilege.** Well-known clients may enter treatment with a belief that they do not need to follow all the program's procedures or meet each requirement.

Counselors must assist these clients in assimilating as quickly as possible into the treatment milieu by (1) relating to the private and not the public individual, (2) communicating treatment procedures and requirements, and (3) securing a signed behavioral contract. Individuals who are well known in the community may be concerned about protecting their privacy. The IOT counselor can assist these clients by (1) acknowledging their concerns while assuring them that others in similar circumstances have completed treatment and are recovering successfully, (2) evaluating the feasibility of their being treated out of town, (3) reviewing and discussing the program's confidentiality regulations and policies, and (4) encouraging clients to attend support group meetings, which have a strong tradition of protecting the identity of participants.

- **Effect on the treatment milieu.** The presence of high-profile clients or relatives and friends of such clients may mean that the treatment environment is tense or unsettled because of media attention; group cohesion based on trust may be slow to develop. The IOT counselor might consider these approaches: (1) discuss interpersonal issues that a client may have with other clients in individual counseling sessions, (2) use the group process to discuss confidentiality, trust, or other concerns, and (3) place any clients who express a concern about being in a group with a high-profile client in different groups.
- **Dual relationships.** High-profile clients may offer to help the counselor or program financially, through a personal appearance, or through their influence. Acceptance of such an offer from a client introduces a "dual relationship," which is unethical. Programs should not accept gifts or favors from clients beyond the published fee schedules. Only after a client has been out of treatment for an extended period (which many programs consider to be 1 year or longer) should the person be considered a successful alumnus and eligible to support the program in these ways.

Clients Who Work

Many clients have employment-related challenges, which can include schedule conflicts, associating with co-workers who use substances, and unrealistic employer requests.

Conflicting Work and Treatment Schedules

Individuals who enter IOT may face conflicts between work responsibilities and attending IOT group sessions. Some clients may rotate shifts or be asked to work overtime or work on weekends. Work schedules may interfere with treatment sessions. This situation most likely occurs when the employer is unaware that the employee is in treatment. The following approaches may be helpful, depending on the client's situation:

- Encourage clients to make treatment and recovery their first priority; help clients understand that by doing so they are better able to meet their work obligations.
- Support clients in making treatment a high priority by being flexible with treatment schedules.
- Encourage clients to inform their employers that they have a health condition and to ask the employers to cooperate with efforts to address the health condition.

Working and Socializing With Co-Workers Who Use Substances

Clients may have used substances with co-workers and may find it difficult to renegotiate their relationships with co-workers and to avoid circumstances that can lead to relapse. Options for addressing these issues include

- Assisting the client in identifying specific work-related circumstances that may be

uncomfortable or increase the risk of relapse
- Encouraging the client to distance himself or herself from co-workers who use substances
- Using role plays and other counselor–client interactions so the client can practice responding to questions about treatment and invitations to use substances in ways that preclude uncomfortable discussions and limit risk-oriented situations
- Encouraging the client to transfer to another work environment that is more supportive of recovery, if possible

Employer Requests

If the employer referred the client to treatment, the employer may expect information from the IOT provider about whether the client can assume his or her job responsibilities. Many large employers have policies that address this question, specifying when an employee can resume driving a bus or carrying a gun and mandating regular drug testing for a specified period. Key points concerning this issue include that

- IOT providers do not have the expertise to determine whether a client can perform his or her job duties. Only the employer can determine this.
- IOT providers can inform an employer (with the client's consent) about the client's progress in treatment and the drug test results.
- IOT providers can refer the employer to resources such as professional associations and the drug-free workplace information available on the Internet from the Center for Substance Abuse Prevention Workplace Resource Center (workplace.samhsa.gov).
- IOT providers can negotiate with the employer for an additional period of continuing care for the employee; this period reinforces treatment gains and reduces the risk of relapse.

Millions of private-sector workers in the aviation, maritime, railroad, mass transit, pipeline, and motor carrier industries are governed by Federal legislation (the Omnibus Transportation Employee Testing Act of 1991) that makes workplace drug testing mandatory. If an employee of one of these industries fails a workplace drug test and is mandated to treatment, the treatment program is required to inform the employer in writing of assessment results and treatment recommendations (Macdonald and Kaplan 2003).

Helping Clients Achieve Balance

Once in treatment, clients sometimes try to make up for past harmful behavior during periods of substance abuse. Feeling guilty and remorseful, clients may take on additional work, extend their workdays, and try to become perfect employees. IOT providers should caution clients about the risk of

Conflicting Schedules

Emily decided to seek treatment for her substance use disorder. She was employed at a firm that depended on her to work on key projects. During treatment entry, the IOT counselor learned that Emily's supervisor sometimes expected her to work beyond regular hours. On these occasions she would be unable to attend IOT group sessions consistently.

Counselor response. After exploring this issue, the counselor concluded that Emily was unable to resolve her schedule conflicts with her employer without jeopardizing her position. The counselor then arranged for Emily to attend a Saturday group session and to increase the number of individual counseling sessions to compensate for the reduced number of group sessions. Emily was able to complete treatment successfully.

Co-Workers Who Use Substances

John and several co-workers went out together every Friday evening after work and drank heavily. They drank on Saturday and continued drinking during the Sunday football games they watched together. After making a decision to stop drinking and enter treatment, John wondered what he could say to his co-workers.

Counselor response. The counselor suggested that John follow these steps:

- Maintain distance from friends and co-workers who use substances.
- Avoid explaining or defending his decision to enter treatment.
- Avoid giving detailed explanations for refusing invitations to activities where substances are used.
- Practice using concrete statements to avoid situations in which substances are used, such as "I need to attend to personal problems in the family"; "Thanks, but no." Practice these statements in group sessions; role play the responses in individual counseling sessions.

The counselor also worked with John to develop a new social network and find recreational activities that would support his recovery.

compromising their recovery efforts by taking on too much responsibility too quickly. The following responses may assist a client who tries to overcompensate:

- Remind the client that recovery is the first priority.
- Encourage the client to maintain balance and perspective with respect to the type and intensity of activities that are undertaken.
- Assist the client in understanding that there will be time to address past mistakes once recovery is solidly underway.

Boundary Issues

Clients in treatment and IOT program staff members interact with one another on many levels—intellectual, emotional, and spiritual. The IOT experience is intense for all participants. Forming a therapeutic relationship with the client helps the counselor focus on the client's recovery and influence the client's behavior. At the same time, clients work together in group sessions over weeks and months on issues of profound significance to them. Furthermore, group members may attend community-based support groups together during and after IOT. In the process, they often develop trust and genuine concern and caring for one another. The intensity and environment of an IOT program can lead to behaviors and issues that challenge the boundaries between staff members and clients. The following are examples of these challenges and suggested responses.

Clients Giving Gifts to Staff

Gift giving is relatively common and may have meanings and consequences that require careful consideration by counselors. For example, the customs and traditions of some cultures encourage gift giving to show respect for someone who offers a valuable service. Recent immigrants from these cultures may continue this practice and bring a small gift or food item to the IOT counselor or other program staff members. In some cases, failure to accept the gift may be viewed as a lack of courtesy and result in the client's dropping out of treatment.

Other gifts given by clients to IOT staff members may be inappropriate and should be refused politely and tactfully. Most program rules prohibit staff members from accepting gifts if they

- Exceed a certain value (e.g., more than $20)

The Meaning of Gifts: A Cultural Perspective

A gift has meaning both to the individual who gives it and to the one who receives it. Understanding and appropriately acknowledging the true meaning of a gift always require an awareness of the giver's cultural background.

For example, many cultures place significant value on relationships rather than on individual priorities or achievement. The giving of a gift recognizes and reflects the value of the relationship and signals respect and caring. Gifts are given frequently and generally are not connected to an expectation of favor or privilege. By accepting modest and especially handmade gifts from these clients, IOT staff members acknowledge the respect, cultural values, and practices of these individuals.

- Are not the result of a religious or cultural tradition
- Are offered in anticipation of some response or benefit (e.g., special treatment or favor)
- Are obviously personal in nature
- Are likely to cause discomfort, questions, or confusion for others about the relationship between counselor and client

Other programs permit only such gifts as flowers, candy, cookies, or plants that can be shared by all staff members and clients rather than given to an individual staff member.

IOT providers should develop program rules that discourage gift giving and discuss these rules with clients. However, the rules should permit some flexibility for individual circumstances. It is recommended that programs require staff members to report all gifts to supervisory personnel and in the case record. Counselors should be familiar with the program's policies on these issues.

Socializing Among Clients

IOT programs differ in the degree of socializing expected outside group sessions. Some programs encourage clients to attend mutual-help meetings together and support one another in other aspects of their lives. Other programs discourage contact between clients except within the program. Most IOTs have rules regarding dating, sexual involvement, or other pairing of clients that could undermine treatment.

Client Relationships Involving Substance Use

Sometimes clients meet in an IOT program and decide to use drugs or alcohol together. Others may be acquainted before entering treatment and continue a relationship that includes substance use. Options for the counselor include the following:

- Reassess the readiness of clients for treatment and recovery.
- Develop a written contract for abstinence, and have clients sign it.
- Refer clients to separate treatment programs.
- Provide individual therapy for one client until the other client graduates from the program.

Socializing Between Staff and Clients

The therapeutic relationship between an IOT counselor and a client is built on caring, trust, and genuine interest in the recovery of the client. These three elements form a basic building block of the treatment alliance. To safeguard the therapeutic dyad and maintain the quality of the treatment environment, IOT programs typically prohibit staff–client activities such as socializing and doing favors. Program consequences for violations of these rules of professional conduct should be clear and applied consistently to all program staff, from administrators to support personnel. Consequences may vary,

Counselor Observes the Client Using Substances in the Community

Residents in a small, rural community occasionally enjoy dancing at the local nightspot. One evening an IOT counselor observes a client drinking at the bar.

Counselor response. The counselor leaves the establishment as soon as possible and does not acknowledge the client. Subsequently, in the treatment setting, the counselor meets with the client one on one. The counselor states the facts of the incident, expresses concern about the possible relapse, reminds the client of the agreement not to use substances, and, using motivational interviewing techniques, asks the client to determine how to handle the return to drinking.

based on the circumstances, and can include supervisory reprimand and counseling, oral or written warnings, probation, and dismissal. In some cases, the counselor who violates prohibitions must be reported to his or her licensing or certification board.

Counselors With Dual Roles

Many IOT counselors are also members of mutual-help programs and must maintain appropriate boundaries between these two roles. For example, it would not be appropriate for an IOT counselor to become a client's sponsor. A counselor also might meet an IOT program client by chance at a mutual-help meeting, particularly in a small community. Counselors should avoid attending meetings that current or former clients attend. When this is not possible, an IOT counselor should avoid sharing his or her personal issues at that meeting. If a counselor in this situation needs to talk, he or she should take someone aside after the meeting or call his or her sponsor. Some cities have "counselor only" meetings that are not listed in directories. The mutual-help program's intergroup office or other counselors are good resources for locating such meetings.

The Client Is My Neighbor

The IOT counselor recognizes a new client in the waiting room as her neighbor. The neighbor is surprised to see the counselor.

Counselor response. The counselor asks to speak privately to the neighbor in her office. The counselor acknowledges the social relationship that exists between them and states that she will not be involved in any way with the neighbor's treatment. The counselor also explains confidentiality regulations and indicates that the neighbor is in charge of how they relate to each other outside the treatment setting. The counselor also discloses the relationship to his or her supervisor to ensure that the counselor is not involved, even tangentially, in the client's case.

Appendix 7-A. Instruments for Assessing Relapse Potential

Clinicians have access to several instruments that help clients identify situations that pose high risks of relapse and understand their personal relapse triggers. Most instruments are not under copyright and can be used free of charge. More information about these tools, including information on obtaining copies and links to downloadable versions, can be found at the National Institute on Alcohol Abuse and Alcoholism's Web site (www.niaaa.nih.gov) by entering "Alcoholism Treatment Assessment Instruments" into the site's search engine.

Alcohol Abstinence Self-Efficacy Scale (AASE)

AASE evaluates a client's confidence in the ability to abstain from drinking in 20 situations that present common drinking cues. The instrument comprises 40 items that gauge a client's risk of relapse on four scales: when the client is experiencing

- Negative emotions (e.g., depression, frustration)
- Feelings of well-being (e.g., celebrating, on vacation)
- Physical pain (e.g., headache, fatigue)
- Cravings (e.g., testing willpower, experimenting with one drink)

AASE is a paper-and-pencil instrument that can be administered and scored in 20 minutes. No training is required to use it. It can be used to evaluate clients admitted to an IOT program, to guide treatment, or to design individualized relapse prevention strategies. A user-friendly version of AASE can be found at adai.washington.edu/instruments/pdf/AASE.pdf.

Alcohol Effects Questionnaire (AEQ)

AEQ assesses the positive and negative effects that clients expect alcohol to have. Based on their beliefs about alcohol, clients respond "agree" or "disagree" to 40 statements. AEQ yields scores in eight different categories that describe the expected effects of alcohol: general positive feelings, social and physical pleasure, sexual enhancement, power and aggression, social expressiveness, relaxation and tension reduction, cognitive and physical impairment, and unconcern. Administration and scoring of the pencil-and-paper AEQ take 10 minutes, and no special training is required. Although AEQ has been used largely as a research instrument, it can be used therapeutically to assess the effects a client desires to achieve by drinking and to initiate discussions about alternative methods of attaining those effects. The AEQ has proved especially helpful with college students who use alcohol.

Alcohol-Specific Role Play Test (ASRPT)

ASRPT uses role playing to gauge client responses to 10 different situations that pose a threat of relapse. Clients listen to taped prompts and then act out their responses, which are videotaped for scoring purposes. Five of the situations involve clients playing out an interaction with another person (e.g., a scenario in which a business contact asks the person in recovery to complete a deal over drinks at a local bar); five require clients to act out their responses to an internal conflict (e.g., a scenario in which the person in recovery has been working in the yard all day and suddenly thinks that a cold beer sounds good). The ASRPT can be administered in 20 minutes; male and female role-play partners and a videotape technician

are necessary. Training is required to give the test, and trained judges must score it.

Situational Confidence Questionnaire (SCQ)

SCQ assesses a client's confidence in the ability to cope with eight types of high-risk drinking situations. For each of the SCQ's 39 items, clients indicate on a 6-point scale (ranging from "not at all confident" to "very confident") how they feel about their ability to resist the urge to drink. SCQ is available in paper-and-pencil and computerized versions and can be self-administered in 8 minutes. (Scoring for the paper-and-pencil version takes 5 minutes; the computerized version is scored as soon as the questionnaire is completed.) Required minimal training is available from a user's guide that can be purchased with SCQ.

8 Intensive Outpatient Treatment Approaches

In This Chapter...

12-Step Facilitation Approach

Cognitive–Behavioral Approach

Motivational Approaches

Therapeutic Community Approach

The Matrix Model

Community Reinforcement and Contingency Management Approaches

Intensive outpatient treatment (IOT) programs use a variety of theoretical approaches to treatment. No definitive research has established a best approach to treatment, and many factors (such as client characteristics and duration of treatment) influence research outcomes. However, studies have found positive associations between several treatment approaches and client outcomes.

Providers should be aware of the most commonly used approaches and their effectiveness so that they can make informed choices. This chapter contains descriptions of six commonly used and studied treatment approaches that form the core of treatment for many IOT programs:

- 12-Step facilitation
- Cognitive–behavioral
- Motivational
- Therapeutic community
- Matrix model
- Community reinforcement and contingency management

The chapter highlights each approach's distinguishing characteristics, theoretical orientation, research support, and other critical elements such as staffing requirements or funding considerations. Exhibits summarize the strengths and challenges of each approach.

These descriptions give readers only a basic overview; they are not recipes for implementing the approaches in an IOT program. Clients often have complex psychosocial needs that demand creativity on the part of providers. These approaches are a means for shaping clinical interventions, but none should be considered complete treatment on its own. Excellent information, books, and treatment manuals are available from the Hazelden Foundation (www.hazelden.org), the National Institute on Drug Abuse (NIDA) (www.nida.nih.gov), the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (www.niaaa.nih.gov), and the Substance Abuse and Mental Health Services

Administration's National Clearinghouse for Alcohol and Drug Information (www.ncadi.samhsa.gov) and Center for Substance Abuse Treatment (CSAT) (www.csat.samhsa.gov).

Although this chapter describes these six approaches as distinct, in reality IOT counselors increasingly use multiple approaches, modifying and blending them to address clients' specific needs. This type of tailoring is a hallmark of effective treatment, but combining approaches calls for the provider to recognize and adjust for conflicts that may undermine each approach's effectiveness.

12-Step Facilitation Approach

The Basics

The treatment approach of many IOT programs evolved from the Minnesota Model of treatment, so called because it was first conceptualized at Hazelden Foundation and Willmar State Hospital in Minnesota in the late 1940s (White 1998). The Minnesota Model (also known as 12-Step facilitation) is based on the concepts of 12-Step fellowships, such as Alcoholics Anonymous (AA). These programs' efforts were guided by the philosophical belief that alcoholism was a primary, progressive disease, with biological, psychological, and spiritual features.

The Minnesota Model used treatment teams of physicians, nurses, alcoholism counselors, family counselors, vocational rehabilitation counselors, and AA members in the treatment process. Basic to the process was a thorough introduction of clients to the principles of AA fellowship and the 12 Steps, education about the disease of alcoholism, and participation in AA groups inside and outside the hospital (M.M. Miller 1998).

Over time, the 12-Step approach evolved for use with people who use drugs and those with other compulsive disorders (such as eating disorders) (M.M. Miller 1998). Counselors, originally all in recovery themselves and often with little training, became more professional as training and credentialing standards were implemented (M.M. Miller 1998). Programs also were adapted to a variety of settings, including IOT. However, the basic principles and methods of the 12-Step treatment approach programs remained intact.

IOT programs that use a 12-Step approach focus on helping clients understand AA principles, start working through the 12 Steps, achieve abstinence, and become involved in community-based 12-Step groups, such as AA, Narcotics Anonymous (NA), or Cocaine Anonymous (CA). In these programs, educational efforts present alcoholism as a disease characterized by denial and loss of control. Homework assignments entail reading 12-Step literature, keeping a journal, and undertaking recovery tasks that personalize the 12 Steps. Much of the group work focuses on accepting the disease, assuming responsibility for the recovery process and one's own actions, renewing hope, establishing trust, changing behavior, practicing self-disclosure, developing insights into one's behavior, and making amends. Problems often are addressed in the context of step work. Clients are encouraged strongly to accept their addiction, develop or adopt spiritual values, and develop a sense of fellowship with others in recovery. IOT programs using a 12-Step approach usually invite AA, NA, CA, or other 12-Step groups to hold onsite meetings. Clients are encouraged strongly to attend meetings in the community and to find a sponsor and home group for ongoing peer support following completion of the formal treatment program. Ideally, 12-Step-oriented IOT programs are in touch with a network of persons in recovery who can accompany ambivalent or reluctant clients to meetings in the community and help them find compatible groups.

Exhibit 8-1 summarizes the strengths and challenges of 12-Step facilitation.

Exhibit 8-1

Strengths and Challenges of 12-Step Approaches

Strengths	Challenges
• 12-Step meetings are a free, widely available, ongoing source of support. Metropolitan areas in particular offer many meetings with a specialized focus (e.g., meetings for young people, women, newcomers to treatment, lesbians, gay men, Spanish-language speakers). • The 12-Step approach emphasizes an array of recovery tasks in cognitive, spiritual, and health realms. • The 12-Step approach is effective with clients from diverse backgrounds (Tonigan 2003).	• It can be difficult to monitor accurately clients' compliance with assigned step tasks, including meeting attendance. • 12-Step groups' emphasis on a higher power may be unacceptable to some clients. • Some communities may not be large enough to sustain 12-Step meetings or appropriate meetings for people with significant psychiatric disorders.

Other Important Aspects

Staff

Staff members who are not in recovery themselves should read AA, NA, and CA literature and consider regularly attending open meetings to ensure that they understand the beliefs, values, and mores of 12-Step fellowships. Likewise, staff members should familiarize themselves with local meetings and with the level of acceptance of clients with special needs (e.g., those with mental disorders). Familiarity with 12-Step culture and with local meetings help staff members orient departing clients to 12-Step recovery and to the available options.

Clients

Research has attempted to identify the individual characteristics that seem most predictive of affiliation with 12-Step programs, particularly AA, but results often have been contradictory for some variables (McCrady 1998). The 12-Step approach may not be appropriate for every client, but 12-Step groups clearly serve a widely diverse group of people.

Research Outcomes and Findings

The NIAAA-funded Project MATCH compared treatment outcomes for persons dependent on alcohol who were exposed to one of three different treatment approaches: 12-Step facilitation (a 12-Step approach that followed a manual), cognitive–behavioral coping skills therapy, and motivational enhancement therapy (MET). All three approaches resulted in positive outcomes regarding drinking behavior from baseline to 1 year following treatment. The study found little difference in outcomes by type of treatment, although 12-Step facilitation showed a slight advantage over the 3 years following treatment (Project MATCH 1998).

Brown and colleagues (2002) investigated matching client attributes to two types of aftercare: structured relapse prevention and 12-Step facilitation. Overall, the 12-Step

facilitation approach provided more favorable outcomes for most people who abuse substances. In particular, the study found that clients reporting high psychological distress, women, and clients reporting multiple substance use at baseline maintained abstinence for longer periods following treatment with 12-Step facilitation than with structured relapse prevention.

Cognitive–Behavioral Approach

The Basics

Cognitive–behavioral therapy (CBT) is based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.

The CBT approach focuses on teaching clients skills that help them recognize and reduce relapse risks, maintain abstinence, and enhance self-efficacy. Clients learn to identify personal "cues" or "triggers"—the people, situations, or feelings that may lead to drinking or drug use. Such triggers may be internal (such as physiological craving or stress reactions) or external (such as seeing friends with whom the client has used drugs). Clients then are taught new coping and problemsolving skills and strategies for effectively counteracting urges to drink or use drugs.

By analyzing their triggers, deciding on recovery-oriented responses and strategies, and role playing high-risk situations and responses, clients gain confidence that they can resist triggered urges to use substances. CBT approaches also are applied to other challenges in recovery, such as interpersonal relations, depression, anxiety, and anger management.

IOT programs are ideal for implementing cognitive–behavioral interventions. Clients usually continue to live and work in their normal environments, which are filled with relapse triggers. These situations provide material for problemsolving exercises, homework, and role plays during group or individual counseling and offer clients opportunities to use new coping strategies, cognitive skills, and behaviors.

The number, duration, and focus of treatment sessions vary widely in CBT-oriented programs. The CBT and 12-Step approaches are compatible, and many CBT-oriented programs encourage participation in 12-Step meetings.

Exhibit 8-2 summarizes the strengths and challenges of CBT.

Other Important Aspects

Staff

Counselors must be familiar with the theory and practice of CBT and have basic counseling skills. It is sometimes helpful to have co-therapists lead cognitive–behavioral groups, particularly those involving role plays and other interactive exercises.

Clients

CBT has been effective with a broad range of clients. However, clients with low literacy or intellectual skills or those for whom English is a second language may struggle with homework or group exercises that require reading or writing. Also, people with significant psychiatric disorders that have not been stabilized may be unable to participate sufficiently.

Research Outcomes and Findings

CBT models have been evaluated extensively, and randomized clinical trials found CBT-based relapse prevention treatment to be superior to minimal or no treatment (Carroll 1996*b*). When CBT was compared with other active therapeutic interventions,

Exhibit 8-2

Strengths and Challenges of Cognitive–Behavioral Approaches

Strengths	Challenges
• CBT actively engages clients in therapy and experiential learning. • Numerous manuals on CBT are available. • CBT is suitable for clients from diverse backgrounds and with varying histories of alcohol and drug use. • CBT provides structured methods for understanding relapse triggers and preparing for relapse situations.	• Clients with poor reading or cognitive skills may need alternatives to written assignments. • The approach requires counselor training in CBT principles and techniques. • Client motivation is critical because of the extent of homework assignments. • CBT was developed as an individual, not group, counseling approach.

results were mixed. Project MATCH found CBT to be comparable with MET and 12-Step facilitation for decreasing alcohol use and alcohol-related problems. All three therapies resulted in positive improvements in participants' outcomes that persisted for up to 3 years (Project MATCH 1998). Farabee and colleagues (2002) found that clients who received CBT reported more frequent engagement in substance-use avoidance activities 1 year after treatment than did clients who received treatment with contingency management.

Motivational Approaches

The Basics

In practice, motivational approaches include both motivational interviewing (MI) and MET. These motivational approaches can be incorporated into every stage of treatment (see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT 1999*c*], pages 31–32, for specific suggestions).

MI techniques developed by Miller and Rollnick (2002) were derived from a variety of theoretical approaches to how people recover in progressive stages from addiction and other problem behaviors (Prochaska and DiClemente 1984, 1986). MI is a client-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problemsolving or solution-focused strategies that build on clients' past successes. Motivational approaches acknowledge that drugs of abuse have rewarding properties that can disguise, at least temporarily, their hazards and negative long-term effects. Through empathic listening and skillful interviewing, the counselor encourages the client to

- Identify discrepancies between significant life goals and the consequences of substance abuse.
- Believe in his or her capabilities for change.
- Choose among available strategies and options.
- Take responsibility for initiating and sustaining healthy personal behavior.

MI requires the counselor to relate to clients in a nonjudgmental, collaborative manner. Counselors pose questions to clients in a way that solicits information while strengthening clients' motivation and commitment to positive change. The counselor acts as a coach or consultant rather than as an authority figure. Counselors using MI follow four basic principles (CSAT 1999c):

- **Express empathy.** The counselor communicates that the client always is responsible for change and respects the client's decision on this issue.
- **Identify discrepancies.** The counselor encourages the client to focus on how current behavior differs from his or her ideals and goals.
- **Roll with resistance and avoid arguing.** The counselor uses strategies to reduce resistance.
- **Support self-efficacy.** The counselor recognizes client strengths and encourages him or her to believe that change is possible.

MET uses structured instruments for assessing dimensions of substance use (e.g., consumption, biomedical and social consequences, family history, readiness for change, risk factors). (Several of these instruments are reproduced in appendix B of TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT 1999c].) Counselors provide feedback about assessment results in relation to societal norms and discuss clients' responses to this feedback.

Exhibit 8-3 summarizes the strengths and challenges of MI and MET.

Other Important Aspects

Staff

Staff members' educational levels are not critical to a motivational approach. Successful counselors may have graduate degrees and professional certification or be recovering peers. However, to become effective practitioners, counselors need special training as well as ongoing supervision to become proficient. Counselors also need to be flexible and have a high level of therapeutic empathy. Counselors are seen as collaborators or consultants rather than as experts.

Clients

MET was developed for, and has been effective with, clients exhibiting varying severities of alcohol-related problems. Court-mandated clients appear to benefit as much from MET as do self-referred clients.

Research Outcomes and Findings

A four-session version of MET was one of three 12-week approaches tested in Project MATCH. MET was found to be as effective as the other, more intensive interventions (CBT and 12-Step facilitation). Clients who rated high in anger fared better with MET, having more abstinent days (Project MATCH 1998).

Miller and Sanchez (1994) report that studies conducted in at least 14 countries indicate that relatively brief motivational interventions can have lasting, positive effects on drinking behavior that are comparable with the effects obtained with longer term treatment interventions.

Therapeutic Community Approach

The Basics

Therapeutic communities (TCs) have provided residential substance abuse treatment since the 1960s. Some programs have developed a modified, community-based IOT component either to provide treatment on an outpatient basis or to help graduates successfully transition from residential treatment into the community. Some traditional,

Exhibit 8-3

Strengths and Challenges of Motivational Approaches

Strengths	Challenges
• MI and MET are client centered and relevant to clients' personal interests. • MI and MET focus on realistic, attainable goals. • MI and MET encourage client self-efficacy and self-sufficiency. • MI and MET emphasize positive, empathic support that does not undermine or elicit anger from clients.	• MI and MET rely heavily on clients' capabilities and level of self-awareness. • Commonly used problem-oriented assessment instruments are incompatible with a motivational approach. • Although MET provides some guidance about effective interpersonal strategies for treating ambivalent clients, the approach does not specify session content. • Motivational approaches require significant staff training, reorientation, and ongoing supervision. • Motivational approaches may be difficult to combine with disease- or therapeutic community-oriented approaches that expect adherence to program-imposed goals. • MI and MET were developed as individual approaches; their effectiveness for use with groups is unproved.

community-based IOT programs serve clients who participated in TCs while the clients were incarcerated. IOT providers should understand the TC process to ensure continuity for clients.

TCs use an approach known as "community as method" (De Leon 2000). This approach sees the community as a whole—its social organization, its staff and clients, and its daily activities—as the therapeutic agent.

The TC model considers a substance use disorder as a disorder of the whole person. TC program staff members assess each participant's problems along dimensions of psychological dysfunction and social deficits (e.g., problems with authority, poor impulse control, dishonesty) as well as substance use patterns. The TC approach assumes that recovery is a developmental process entailing mutual help and social learning. The beliefs and values that are essential to a client's recovery include (De Leon 2000)

- Demonstrating truth and honesty in all situations
- Remaining in the "here and now"
- Assuming personal responsibility for one's behavior and future
- Demonstrating concern for others
- Developing a work ethic and understanding that rewards must be earned
- Understanding the distinction between external behavior and inner self
- Accepting that change is the only certainty
- Valuing the learning process

- Developing economic self-reliance
- Becoming involved in one's community
- Developing good citizenship

Because many clients served by TCs have histories of severe substance use disorders and criminal behavior, TCs typically strive to habilitate, rather than rehabilitate, clients. TCs focus on all aspects of the client's life, and all activities in the TC promote recovery and habilitation. TCs follow highly structured schedules, centering daily activities on group sessions and hierarchical job functions that teach participants specific behaviors and skills. In general, participants move from job to job in the community for different learning experiences. Peers confront negative behaviors and erroneous thinking in one another within a supportive milieu.

TCs include the following components (De Leon 1995):

- **A sense of community.** Community is created partly by a separation from other agency or institutional programs and, more important, from the drug-using environment. A TC facility contains communal space for promoting a sense of commonality during collective activities. Treatment or educational services (except individual counseling) must be delivered within the peer community.
- **Peers and staff members as role models.** TC members and staff members serve as positive role models by demonstrating expected behaviors and reflecting the values and teachings of the community. The strength of the community for social learning rests on the number and quality of its positive role models.
- **Work as therapy and education.** Consistent with the TC's self-help approach, all clients are responsible for the daily management of the facility, and work roles are designed to bring about essential educational and therapeutic effects.
- **Peer encounter groups, awareness training, and emotional growth training.** The encounter session is the main therapeutic group and heightens clients' awareness of specific attitudes or behavioral patterns that need to change. Other groups focus on helping clients identify feelings and express them appropriately and constructively.

TCs feature a structured day that includes ordered, routine activities to counter the characteristically disordered lives of clients and distract them from negative thinking and boredom. The treatment protocol is organized into phases and stages. When a client masters the objectives in one phase, he or she moves to the next phase. The length of treatment depends on the client's needs and progress in recovery. Continuing services are part of the TC approach. Clients benefit from a peer network that assists them with ongoing community-based services to sustain recovery.

De Leon (2000) describes the basic stages of a TC program as

- Admission evaluation (a preprogram stage)
- Induction (an orientation stage)
- Primary treatment
- Reentry (into the outside community)

Exhibit 8-4 summarizes the strengths and challenges of the TC approach.

Other Important Aspects

Staff

TC staff members are generally a mix of trained clinicians (certified counselors, nurses, physicians, and case managers) and TC graduates who have had at least some additional training (many become certified). All staff members are part of the community and serve as role models. Staff members typically receive considerable training in TC philosophy and methods. Management staff in particular must be well trained to work effectively in a TC.

Exhibit 8-4

Strengths and Challenges of the Therapeutic Community Approach

Strengths	Challenges
• The TC approach is effective for people with long histories of substance dependence and antisocial behavior. • The TC approach is particularly effective in teaching clients how to plan, set, and achieve goals and to be accountable. • The TC approach is effective in reducing recidivism among clients who have served time in prison.	• The approach may be too confrontational for some clients. • Effective TC treatment requires extensive staff training. • Treating clients with mental disorders can pose difficulties. • Finding an effective mix of professional clinicians and recovering staff (who may not be trained in assessment, treatment planning, and counseling) can take time.

Clients

Clients appropriate for TC treatment typically have educational and employment deficits and histories of poverty, relationship problems, criminal behavior experiences or criminal associations, housing instability, psychiatric disorders, or antisocial or other dysfunctional behavior. Many have had previous treatment episodes.

TC approaches should be modified for women, adolescents, and those with co-occurring mental disorders because the confrontational nature and strict hierarchical structure of a standard TC may not be as effective with these groups.

Training Manuals

CSAT has developed the *Therapeutic Community Curriculum* (CSAT 2006*g*, CSAT 2006*h*) to help supervisors provide TC staff members with an understanding of the essential components and methods of the TC and an appreciation that they are part of a long tradition of community as a method of treatment. The curriculum provides detailed session-by-session instructions for trainers and exercises for participants.

Special considerations

For clients in an outpatient TC, it is important to arrange for drug-free housing.

Research Outcomes and Findings

NIDA has funded treatment outcome studies that have found that TC treatment is associated with positive outcomes. For example, the Drug Abuse Treatment Outcome Study, a long-term study of treatment outcomes, found that clients who completed TC treatment had lower levels of cocaine, heroin, and alcohol use; criminal behavior; unemployment; and depression than they had before treatment (National Institute on Drug Abuse 2002).

Clinical trials of TC day treatment have found that client outcomes for residential TC and for day TC treatment are not significantly different (Guydish et al. 1999).

A study of the effectiveness of extending the TC model from prisons to community-based settings showed that inmates who participated in an institutional TC followed by a TC-oriented outpatient work-release program

had lower rates of drug use and recidivism than offenders who participated only in the institutional program (Inciardi 1996).

The Matrix Model

The Basics

The Matrix model was developed during the 1980s as an effective way to treat the increasing number of people dependent on stimulant drugs, particularly cocaine. Developers designed the Matrix model as a more intensive intervention than the then-standard weekly outpatient counseling or 28-day inpatient treatment. The Matrix model is a good fit for clients who require comprehensive care.

The Matrix model, originally known as neurobehavioral treatment, integrated several research-based techniques (including cognitive–behavioral, 12 Step, and motivational enhancement) to target clients' behavioral, emotional, cognitive, and relationship issues. More research is needed to determine optimal combinations of treatment approaches; the Matrix model is one of many programs that combine various approaches. The Matrix model has been selected for discussion because its approach is comprehensive and manual based and assessment data are available.

The Matrix approach is predicated on

- Establishing a strong therapeutic relationship between the client and counselor
- Teaching clients how to structure time and initiate an orderly and healthy lifestyle
- Imparting accurate, comprehensible information about acute and subacute withdrawal effects and cravings for substances
- Providing opportunities to learn and practice relapse prevention and coping techniques
- Involving family and significant others in the therapeutic and educational processes to gain their support for—and prevent their sabotaging of—treatment
- Encouraging clients to participate in community-based mutual-help groups
- Conducting random urinalyses or breath tests to assess treatment effectiveness

Several variations of the Matrix model have been developed. The original 12-month version began with 6 months of intensive treatment that included 56 individual counseling sessions (including conjoint sessions with the client and family members); clients attended treatment sessions 3 or 4 times a week. The individual sessions were supplemented by several types of educational, relapse prevention, family, and social support groups (Obert et al. 2000). The original cocaine-specific treatment protocol was followed by versions for people who used alcohol or opioids primarily. Because of cost constraints, a 16-week version of the Matrix model was developed that cut the number of individual sessions to three and emphasized group work.

In all versions of Matrix model treatment, a primary therapist coordinates the client's treatment experience. The relationship between the primary therapist and the client (and his or her family) is critical to treatment progress (Obert et al. 2000).

Individual sessions focus on treatment planning and evaluating progress and may include members of the client's family for at least part of the session. In addition to the individual sessions, the treatment protocol for the 16-week program includes specific structured groups (Obert et al. 2000):

- **Early recovery groups.** These groups are for those in the first month of treatment and are small to maximize the attention each client receives. Early recovery groups focus on teaching clients cognitive tools for managing cravings and emphasize time management. Clients create a daily schedule and monitor their activities with group input and support. Early recovery groups assist clients in connecting with community support services.

- **Family education sessions.** Family education is presented as a 12-week series and includes both clients and family members. These sessions include slide presentations, videos, panel presentations, and group discussions on topics such as the biology of addiction, medical effects of substances, conditioning and addiction, and effects of addiction on the family.
- **Relapse prevention groups.** These groups are the primary component of treatment. Group sessions are highly structured and focus on cognitive and behavioral change and on connecting clients to mutual-help programs. The group protocol includes 32 specific topics.
- **Social support groups.** These groups begin in the last month of treatment and focus on helping clients pursue drug-free activities and develop friendships with people who do not use substances. They are less structured than the other groups, and the content is determined by the needs of the group members.

Matrix programs orient clients to 12-Step programs and often schedule onsite 12-Step meetings. Clients are encouraged strongly to attend additional meetings in the community and to find a 12-Step sponsor.

Exhibit 8-5 summarizes the strengths and challenges of the Matrix model.

Other Important Aspects

Staff

Trained therapists are crucial to Matrix model treatment. They are expected to create nurturing, nonjudgmental relationships; maintain a supportive attitude in the face of a client's relapse; foster each client's self-esteem and dignity; and function as teachers or coaches without being either parental or confrontational. Clients with established long-term abstinence sometimes co-lead groups, serving as role models who put a human face on the recovery process.

Clients

The Matrix model has been used in many different settings (including prisons,

Exhibit 8-5

Strengths and Challenges of Matrix Model Treatment

Strengths	Challenges
• The model integrates a cognitive–behavioral approach with family involvement, psychosocial education, 12-Step support, and urine testing. • The model follows a manual, providing therapists with specific instructions and practical exercises. A version of the Matrix materials is available free from NCADI (CSAT 2006*c*, 2006*d*). • The model has been used extensively with people dependent on stimulants and has been shown to be effective.	• Some materials may need to be modified for clients whose cognitive functioning is impaired. • The program requires special staff training and supervision. • The highly structured content may not appeal to all clients. • The tight structure and schedule may not leave time for identification and stabilization of other non-drug-specific problems.

substance abuse treatment centers, and hospitals) and with a varied client population across the United States and in Mexico, Thailand, and the Middle East (Rawson 2003).

Treatment manuals

The Matrix model treatment materials contain instructions for therapists on conducting individual, group, and family education sessions (visit www.matrixinstitute.org). Handouts for clients and family members cover therapeutic session topics. Some materials have been translated into Spanish, Arabic, Thai, and other languages. CSAT has adapted the Matrix treatment manuals and made them available as a package called *Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders* (CSAT 2006*c*, 2006*d*).

Research Outcomes and Findings

Studies support the utility of Matrix model treatment. In a 1985 pilot study, individuals who selected Matrix treatment over a 28-day inpatient hospital program or participation in 12-Step groups reported significantly lower rates of cocaine use 8 months after treatment than those in either of the other groups (Rawson et al. 1986).

A controlled trial of the model found that people from lower income groups who smoke crack are more difficult to retain in Matrix treatment than those who used cocaine intranasally and had more social stability and resources (Obert et al. 2000).

Researchers conducting a CSAT-supported outcome study of Matrix model treatment (Rawson et al. 2002) interviewed a nonrandomized sample of clients who had used methamphetamine and received Matrix model treatment. They found that 2 to 5 years after completing treatment these clients had reduced their methamphetamine and other drug use substantially compared with their pretreatment levels. In addition, a substantial number of the former clients were employed and were not in the criminal justice system.

Shoptaw and colleagues (1998) developed a 48-session variation of Matrix treatment for gay and bisexual men who abuse methamphetamine. The model was found to be an important tool for preventing HIV infection because clients reduced their risky sexual behaviors concurrently with reductions in their stimulant use—without any specific focus on HIV/AIDS during treatment (Shoptaw et al. 1997, 1998).

Community Reinforcement and Contingency Management Approaches

The Basics

Community reinforcement (CR) and contingency management (CM) are treatment approaches based on operant conditioning theory. This theory maintains that future behavior is based on the positive or negative consequences of past behavior. For example, drug use is maintained by the positively reinforcing effects of the drug itself or by the negative reinforcement of relieving the pain of withdrawal. Abstinence, in and of itself, may not be sufficiently reinforcing to maintain a person's motivation to stop using drugs, particularly in early abstinence. Other rewards must be found that reinforce ongoing abstinence and lifestyle change.

CM is an approach in its own right, but its operant interventions are also the main treatment tool used in CR. In CR, the positive and negative reinforcers that characterize CM are understood to be socially mediated. CR uses aspects of the client's life—relationships with family and friends,

job, hobbies, social events—to provide the positive reinforcement that motivates the client to stop using substances. CR is successful when the client chooses the rewarding relationship and activities over substance use. (See Chapter 6 for a discussion of how CR can be used to motivate family members to support the client.) CR and CM approaches motivate clients' behavioral change and reinforce abstinence by systematically rewarding desirable behaviors and ignoring or punishing others. Reinforcers are typically positive, pleasurable, and rewarding events or objects, but some negative reinforcers also are effective. Removing a fine or restriction after a client has complied with a specified regimen is an example of negative reinforcement.

A challenge in this treatment model is to identify a reward for a desired behavior that is both practical and sufficiently powerful—over time—to replace or substitute for the potent, pleasurable, or pain-reducing effects of the drug. The reward must be available without too much cost or expenditure of staff energy. The rewards and punishments must be tailored carefully to clients' responses, as well as program capabilities. For example, vouchers worth $5 may be motivators for some clients but not others or at a particular point in treatment but not later. Most of the financial or voucher-based CM interventions use an escalating series of rewards for achievement of the target behavior, such as drug-free urine specimens. The escalating rewards provide a greater incentive for sustaining the desired behavior. On the other hand, Kirby and colleagues (1998) found greater reductions in cocaine use when a larger reward was given at the beginning of treatment, coupled with increased requirements for earning vouchers as treatment progressed.

An example of this approach is described in a NIDA treatment manual, *A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction* (Budney and Higgins 1998). In this approach, abstinence is reinforced by awarding vouchers. Drug avoidance skills and relapse prevention techniques are taught along with social and recreational counseling, relationship counseling, and social and other skills training. Clients earn points for each urine screen that is negative for cocaine. For each consecutive negative urine screen, the number of points is increased. If a client submits a urine specimen that is positive for cocaine, the point value returns to baseline. The client can earn back the points lost by submitting five consecutive negative urine specimens. The client can "redeem" points for a variety of retail items that are purchased by program staff (clients are never given cash). Staff members have veto power over clients' requests. In general, staff members approve only items that are consistent with a client's treatment goals and encourage drug-free activities. Examples of items purchased for the program's clients include socks, toaster ovens, baby clothes, camera equipment, ski lift tickets, bicycle equipment, and continuing education materials.

> Abstinence...may not be sufficiently reinforcing to maintain a person's motivation to stop using drugs...

Effective CR and CM programs select a targeted behavior that is attainable in a reasonable amount of time and has a direct effect on the desired outcome. For example, expecting clients who have never submitted a drug-free urine sample to achieve immediate abstinence may be optimistic. Abstinence from a specific substance might precede abstinence from all substances. Targeting small changes is an effective strategy. More frequent reinforcers, even if small, have a greater effect than larger, more remote rewards or punishments. It is also important that the desired behavior contribute to the treatment goals. A person's merely attending counseling sessions may not affect his or her drug use. Of course,

all rewards must be delivered as promised for the treatment to remain credible (Crowley 1999; Morral et al. 1999).

Specialized assessment and treatment planning instruments are not required for successful implementation of a CM intervention. However, CM interventions depend on detailed and precise measurements of the targeted behavior. Because of the short half-life of alcohol, using CM procedures to monitor alcohol abuse can be difficult. Self-reported drug use status is not adequate for awarding vouchers. Rather, drug use status must be determined by frequent testing of observed urine specimens (Crowley 1999). Similarly, if work activity is the target behavior, it is not enough to ask clients about their attendance or productivity. Objective, verifiable measures that demonstrate accomplishments must be used.

Activity schedules used in CR and CM programs can vary dramatically. As an example, the activity schedule of an intensive reinforcement-based day hospital program provided abstinence-contingent partial support of housing and food and access to recreational activities, social skills training, and job-finding groups (Gruber et al. 2000). The program required clients recently detoxified from heroin and cocaine to attend treatment for 6 hours a day on weekdays and 3 to 4 hours a day on weekends for the first 2 weeks, then 1-hour individual counseling sessions three times per week for the next 6 weeks, and then two sessions per week for another 4 weeks. Abstinence-based contingencies were in effect for the first month of the program. By contrast, the schedule for a 6-month CR-plus-vouchers treatment entailed 60-minute individual counseling sessions two times a week and urine monitoring three times a week during the first 12 weeks. This was followed by weekly counseling and twice weekly urine testing in weeks 13 to 24 (Budney and Higgins 1998).

Exhibit 8-6 summarizes the strengths and challenges of CR and CM.

Other Important Aspects

Staff

Designing CR and CM treatment programs requires specialized training and knowledge of operant learning principles. In practical terms, however, operant learning principles can be applied by staff members who have proper training and supervision. Some counselors may feel that the theories of operant conditioning or behavioral learning are inconsistent with the disease concept of substance use disorders (Bigelow and Silverman 1999) and are incompatible with their training and practice because behaviorists view addiction as a learned behavior rather than an illness with biological, psychological, and spiritual roots.

Clients

Intensive CM interventions have been used with treatment-resistant clients and with clients who have severe problems related to employment or housing or who have psychological and medical conditions and have been unsuccessful in achieving abstinence through traditional counseling methods. Behavioral interventions have been effective with people who use cocaine (Higgins 1999), persons who are homeless (Milby et al. 1996), pregnant women (Higgins 1999), and individuals on methadone who need to discontinue other drug abuse (Higgins 1999).

Funding

The cost-effectiveness of CR and CM is affected by the expense of incentives, additional urine screens, and the additional time demands placed on staff members. In some research projects incentives cost $1,200 or more per client. This expense has limited application of CM techniques to research studies or small-scale project demonstrations. However, alternative low-cost incentives can be used to bolster the effect of traditional treatment interventions; donated goods and services can reduce the costs of CR and CM (Amass and Kamien

Exhibit 8-6

Strengths and Challenges of Community Reinforcement and Contingency Management Approaches

Strengths	Challenges
• CR and CM have been shown to reduce drug use significantly when incentives are used. • CR and CM can be combined readily with other psychosocial interventions and pharmacotherapies. • CR and CM can be implemented with a variety of low-cost incentives such as donated goods or services. • CR and CM have proved effective for reducing drug use and increasing treatment compliance among clients with severe problems who are chronically substance dependent. • CR and CM have extensive and robust scientific support in both laboratory and clinical studies.	• Clients may return to baseline drug use rates when incentives are terminated. • CM approaches can be labor intensive, require specialized staff or training for implementation, and entail frequent client attendance. • For maximal effectiveness, rewards must be sufficiently large—and increase in value—to have continuing appeal to clients. • Many research studies demonstrating CR and CM effectiveness have used small samples and incurred large costs for incentives. • Resources required for implementing CR and CM (e.g., onsite urine-testing capabilities or alternatives to costly incentives) may be unavailable. • Lack of emphasis on long-term supports is a potential drawback.

2004). Anniversary celebrations, special books, reductions in clinic fees, and letters of support to employers and protective service workers are among the incentives that can be used. Some programs have raised funds to support incentives or solicited local merchants for donations of goods or services (Kirby et al. 1999*a*).

Research Outcomes and Findings

Studies show that the CM approach to treating substance use disorders has proved effective in motivating clients to achieve and sustain abstinence as well as increase their compliance with other treatment objectives (Bigelow and Silverman 1999; Higgins 1999; Morral et al. 1999). Generally, these studies have been conducted in outpatient settings in which delivery of incentives is coupled with traditional individual or group counseling and education services. More recently, the CM approach has been applied in intensive outpatient and day treatment settings.

The NIDA treatment manual on community reinforcement (Budney and Higgins 1998) has provided an impetus for using empirically established CM techniques for treating cocaine abuse. The manual presents findings from five controlled clinical trials that supported the superiority of CR plus vouchers over standard care. In one study, 75 percent of the clients participating in CR plus vouchers completed the program, compared with

only 11 percent of standard care clients. Two subsequent studies showed that adding redeemable vouchers was more effective than CR as a standalone treatment (Higgins et al. 1995). A literature review of similar CR approaches found positive effects on cocaine dependence in 11 of 13 studies (Higgins 1996). Higgins and colleagues (2000) found that incentives delivered contingent on cocaine-free urinalysis results significantly increased abstinence during treatment and at 1-year followup.

Another landmark CM study examined the effectiveness of housing incentives for reducing crack cocaine use among people who are homeless (Milby et al. 1996). Incentives for drug-free housing and vouchers for social and recreational activities were more effective than 12-Step-oriented treatment alone for reducing alcohol and cocaine use as well as homelessness. At the 12-month followup, however, cocaine use in both groups had returned to baseline levels, suggesting the need for more intensive aftercare in this difficult-to-treat population.

9 Adapting Intensive Outpatient Treatment for Specific Populations

In This Chapter...

Justice System Population

Women

Populations With Co-Occurring Psychiatric Disorders

Adolescents

Young Adults

Many assumptions and approaches used in intensive outpatient treatment (IOT) programming were developed for and validated with middle-class, employed, adult men. This chapter presents information about how IOT can be adapted to meet the needs of specific populations: the justice system population, women, people with co-occurring mental disorders, and adolescents and young adults. Chapter 10 presents information on treatment approaches for other special groups, including minority populations.

Justice System Population

The number of people in the justice system with a history of substance use disorders has increased dramatically over the last 20 years because of increased drug-related crime, Federal and State legislation, and mandatory sentencing guidelines; many of these people are caught in a cycle of repeated incarcerations.

Between 1990 and 1999, the number of inmates sentenced to Federal prison for drug offenses rose more than 60 percent (Beck and Harrison 2001). About three-quarters of all prisoners reported some type of involvement with alcohol or drug abuse before their offenses, and an estimated 33 percent of State prisoners and 22 percent of Federal prisoners say that they had committed their current offenses while under the influence of drugs, with marijuana/hashish and cocaine/crack used most often (Mumola 1999).

Description of the Population

Justice system populations are younger than the general population, are overwhelmingly male, and are challenged with many psychosocial, medical, and financial problems (Brochu et al. 1999).

Psychosocial issues

People involved with the justice system typically have many problems related to employment and financial support, housing, education, transportation, and unresolved legal issues. Many inmates have not completed high school or earned a general equivalence diploma. Only about 55 percent were employed full time before their incarceration (Bureau of Justice Statistics 2000).

Medical and psychiatric problems

Offenders with a substance use disorder may have co-occurring psychiatric disorders. Approximately 16 percent of State inmates, 7 percent of Federal inmates, and 16 percent of jail inmates and probationers reported having mental illnesses, and nearly 60 percent of these offenders reported that they were under the influence of alcohol or drugs at the time of their offenses (Ditton 1999). People in prison have a high incidence of HIV/AIDS (Maruschak 2002), tuberculosis, sexually transmitted diseases, and hepatitis C (National Institute of Justice 1999).

A major challenge to IOT providers is to integrate substance abuse treatment with justice system processes.

Female offenders

Between 1990 and 2000, the number of women involved with the justice system (incarcerated, on probation, or paroled) increased by 81 percent (Bloom et al. 2003). Women accounted for 15 percent of the total correctional population in 1998; 90 percent were under community supervision (Glaze 2003; Harrison and Beck 2003). Seventy-two percent of the women in Federal prisons were convicted of drug offenses or committed their crimes while under the influence of drugs or alcohol (Greenfeld and Snell 1999). Female offenders with substance use disorders experienced more health, educational, and employment problems; had lower incomes; reported more depression, suicidal behavior, and sexual and physical abuse; and had more mental and physical health problems than did male offenders with substance use disorders (Langan and Pelissier 2001). More than half the female inmates in prisons had at least one child younger than 18 (Mumola 2000). The National Institute of Corrections' *Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders* (Bloom et al. 2003) provides more information about female offenders.

Double stigma

Offenders often are affected by the stigma associated with involvement in the justice system, as well as the stigma associated with substance abuse. These two factors can impede an offender's ability to obtain appropriate employment or housing.

Implications for IOT

In response to the increase in drug-related judicial cases, several approaches for treating offenders who have a substance use disorder have been developed. IOT providers become involved in treating offenders when the offender is (1) referred to treatment in lieu of incarceration, (2) incarcerated, or (3) released.

Coercion frequently is used to compel offenders to participate in treatment. Coercion may be a sentence mandating treatment or a prison policy mandating treatment for inmates discovered to have a substance use disorder while incarcerated for a non-drug-related crime. For nonincarcerated offenders, a sanction for refusing to participate in treatment often is incarceration. Research indicates that treatment adherence and outcomes of clients legally referred to

treatment were the same as or better than those of clients entering treatment of their own volition (Farabee et al. 1998; Marlowe et al. 1996, 2003).

Working With the Judicial System

IOT programs provide treatment for the following justice system clients:

- **Offenders referred to treatment in lieu of incarceration.** IOT providers have developed effective partnerships with drug courts and Treatment Accountability for Safer Communities (TASC) programs to provide treatment (Farabee et al. 1998). Drug courts, begun in 1989, divert nonviolent offenders with substance use disorders into treatment instead of incarceration. Drug courts oversee the offender's treatment, coordinate justice and treatment systems procedures, and monitor progress. TASC, formerly known as Treatment Alternatives to Street Crime, identifies and assesses offenders involved with drugs and refers them to community treatment services.
- **Offenders discharged from residential substance abuse treatment who need continuing community-based treatment.** IOT programs provide stepdown, but structured, services and transitional services and links to other services for offenders who are discharged from residential treatment.
- **Offenders who need treatment and are placed under community supervision (pretrial, probation, or parole).** Many justice programs have been developed to support this type of treatment for people who are under the supervision of the justice system but are allowed to remain in the community.
- **Offenders reentering the community after incarceration.** Reentry management programs funded by various Federal agencies facilitate the transition and reintegration of prisoners released into the community. IOT providers, working closely with justice staff before individuals are released, engage offenders in treatment and support their continuing recovery through flexible, individualized approaches. TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT 1998*b*), provides more information on transition of prisoners to the community.
- **Offenders who participate in treatment while incarcerated.** IOT can be modified for use in prisons and jails, although this stretches the concept of outpatient treatment. Institutions that can segregate offenders in IOT from the rest of the incarcerated population provide a more effective and supportive structure (U.S. House Committee on the Judiciary 2000).

Forging a Working Partnership

A major challenge to IOT providers is to integrate substance abuse treatment with justice system processes. Partnerships are being forged effectively as justice agencies and treatment providers recognize that, although they have different perspectives, they can work together. Both parties need to be flexible and interact with clients on a case-by-case basis (Farabee et al. 1998). Justice officials and IOT providers need to agree on which clients are appropriate for treatment and establish clear screening and admission criteria.

Rules for Offenders in Treatment

Most justice system and IOT program partners agree that offenders in treatment must not commit another offense, must abstain from drug use, and must comply with treatment requirements. However, disagreements about additional rules may emerge. As a result, some policies and sanctions may work against the recovery they are designed to achieve. IOT program staff members can

help prevent or resolve such conflicts by discussing these matters with judges and other criminal justice officials. Staff members who are familiar with research on treatment outcomes are best suited to convey to others a realistic, convincing argument for treatment and to foster cooperation that leads to client recovery. Developing and agreeing on a process for resolving conflicts early in the collaboration may reconcile discordant opinions. For the collaboration to function smoothly, IOT program staff needs the discretion to make decisions about treatment, such as whether the offender needs a different level of care. The justice system staff needs to be confident that it will be informed of treatment progress or if sanctions are justified. The partners must agree on the following:

- **Consequences for lapses in abstinence and continued drug use.** When a client admits to a single episode of drug use in a treatment session, the counselor may view this as a positive development; this admission of use may indicate that the client has gone beyond denial and begun to work on treatment issues. Justice system staff, however, may disagree and consider any drug use grounds for incarceration. IOT staff members may agree to sanctions only when continued episodes of drug use indicate that the offender is not committed to treatment.
- **Consequences for use of alcohol.** The justice system considers alcohol a legal substance and is concerned only with illegal activity resulting from its use. Consequently, the justice agency may not apply sanctions for continued alcohol use. In contrast, treatment providers consider alcohol an addictive substance and usually enforce no-use-of-alcohol rules. The topic warrants extended conversation between partners to develop reasonable responses to alcohol use.
- **Discharge criteria.** Agreed-on discharge criteria that define treatment goals, conditions indicating therapeutic discharge, and behavior meriting immediate discharge are needed.
- **Uses of drug-testing results.** The justice system regards drug-screening test results as an objective measure of progress or nonadherence to treatment and can impose severe consequences for positive drug tests. Many IOT programs use drug test results therapeutically, to inform treatment plans and to deter clients from using substances. Both systems need to discuss how drug test results will be used.

Communication Between Systems

Clear communication between the two systems is essential. For all referrals from the justice system (pretrial services, probation, and parole), an IOT program should designate point-of-contact personnel. To ensure clients' privacy rights, programs need to have confidentiality release forms that specify the information to be shared and the length of time the forms are in effect; all clients must sign these forms. These forms permit the two agencies to communicate information about the offender for monitoring purposes.

IOT providers are advised to discuss and agree on the following communication issues with their justice system partners:

- The form and timing of updates on treatment progress from the treatment program to the justice agency
- Reportings of critical incidents, such as when an offender threatens to commit a crime or fails to appear for treatment
- Reportings from the criminal justice agency, such as when an offender is rearrested or incarcerated

Memorandum of Understanding

Once justice system and IOT program partners agree on rules, consequences, and elements of communication, the agreement

needs to be formalized in a written memorandum of understanding (MOU). The suggested elements of an MOU include

- Parameters of treatment, including the kinds of services
- Each partner's responsibilities (e.g., the criminal justice agency refers and monitors clients; the treatment program assesses and treats clients)
- The consequences for noncompliant behavior, recognizing that not every contingency can be foreseen
- Identification of which agency determines the consequences of noncompliant behavior
- The types, content, and timetable of communications and reportings required between the partners
- Definitions of critical incidents that require the treatment program to notify the justice agency

Clinical Issues and Services

Although working with clients involved with the criminal justice system is challenging, it can be rewarding. For example, approximately 60 percent of people involved with drug courts remained in treatment for at least a year, with a minimum 48-percent graduation rate (Belenko 1999). Clients involved with the justice system have unique stressors, including, but not limited to, their precarious legal situation. Clients may need help with transportation, educational services, family issues, financial issues such as obtaining welfare and Medicaid benefits and arranging restitution payments, housing such as arranging temporary shelter and permanent housing, and job skills and employment counseling. Case management can coordinate services for justice system clients.

TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* (CSAT 2005*d*), provides more information about treating this population.

Staff Training

Treatment is impeded when counselors have a negative attitude toward clients, believe that clients have a poor prognosis for recovery, or are reluctant to serve offenders in general. These issues should be included in staff training and cross-training.

To provide effective substance abuse treatment to criminal justice system clients, staffs in both systems need cross-training (Farabee et al. 1999). Topics include the philosophy, approach, goals, objectives, and boundaries of both systems. Treatment providers need information about the responsibilities, structure, operations, and goals of the justice system; public safety and security concerns; and how involvement with the justice system affects offenders. Criminal justice system personnel need information about the dynamics of substance use disorders, components of treatment, how treatment can reduce recidivism, confidentiality, and co-occurring psychiatric disorders.

> For all referrals from the justice system...an IOT program should designate point-of-contact personnel.

Women

In recent years, heightened awareness and new funding have encouraged the development of specialized programs to address the treatment needs of women. The number of treatment facilities offering programs for pregnant and postpartum women rose from 1,890 in 1995 to 2,761 in 2000, and more than 5,000 facilities offered special programs for women (Substance Abuse and Mental Health Services Administration 2002). The forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT forthcoming *b*), TIP 25, *Substance Abuse Treatment and Domestic Violence*

(CSAT 1997*b*), and TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000*b*), provide more information.

Description of the Population

Even though women and men who have substance use disorders have many similarities, they differ in some important ways. Women typically begin using substances later and enter treatment earlier in the course of their illnesses than do men (Brady and Randall 1999). Other differences with therapeutic implications are briefly surveyed below. Discussions of strategies for addressing women-specific treatment issues follow.

Violence

Women with substance use disorders are more likely than men with substance use disorders to have been physically or sexually abused as children (Bartholomew et al. 2002; Simpson and Miller 2002). In addition, women who have a substance use disorder are more likely to be victims of domestic violence (Chermack et al. 2001), with reported rates of women in treatment who have been victims of physical and sexual violence ranging from 75 percent (Oumiette et al. 2000) to 88 percent (B.A. Miller 1998).

Mental disorders

Compared with men, women with substance use disorders have nearly double the occurrence (30.3 percent vs. 15.7 percent) of serious mental illness and past year substance use disorders (Epstein et al. 2004). These higher rates of psychiatric comorbidity are particularly evident in mood and anxiety disorders (Zilberman et al. 2003).

Parenting issues

Women in treatment often bear the sole caretaking responsibility for their children, and this role can be a substantial obstacle to seeking and remaining in treatment. Women may have difficulty finding reliable and affordable child care. They may fear losing custody of their children because of their substance use, and this fear may deter them from entering treatment. At the same time, women (and men) who abuse substances are more likely to abuse or neglect their children (National Clearinghouse on Child Abuse and Neglect Information 2003).

Welfare issues

Some States require that individuals receiving welfare benefits be screened and treated for substance use disorders; failure to enroll in or dropping out of treatment may jeopardize benefits (Legal Action Center 1999). Such requirements can help retain a client in an IOT program, and a case manager should coordinate treatment with welfare staff.

Pregnancy

Substance use during pregnancy can mean poor prenatal care, unregistered delivery, and low-weight and premature babies (Howell et al. 1999). Heavy or binge alcohol or drug use during pregnancy can result in negative consequences for the child such as neurological damage, including fetal alcohol syndrome (American Academy of Pediatrics 2000).

Relationships

A woman's substance use disorder is often influenced by her partner. Women with male partners who use substances are retained in treatment for a shorter time than women with substance-free partners (Tuten and Jones 2003). Conversely, a woman's partner can have a positive influence on treatment through support and participation in treatment.

Implications for IOT

Effective treatment for women cannot occur in isolation from the social, health, legal, and other challenges facing female clients. Some studies suggest that gender-specific treatment may be advantageous for female

clients (Grella et al. 1999), producing higher success rates in women-only groups or programs. However, research to date on the best treatment for women is inconclusive (Blume 1998).

Barriers to treatment entry and retention

Once a woman decides to seek help, she may face a long wait because of the lack of appropriate treatment. In addition, she faces gender-specific barriers and issues that may affect entry and retention in treatment such as

- Concerns about fulfilling her responsibilities as a mother, wife, or partner
- Fears of retribution from an abusive spouse or partner
- Gender and cultural insensitivity of some treatment programs
- Threat of legal sanction, such as loss of child custody
- Lack of affordable or reliable child care
- The disproportionate societal intolerance and stigma associated with substance abuse in women compared with men
- Ineligibility for treatment medications if she is pregnant or may become pregnant
- Having few other women in treatment with her

Entry and assessment

A woman entering treatment needs to feel that the environment is safe and supportive. IOT program staff members who are understanding, respectful, optimistic, and nurturing can build a positive, therapeutic relationship. It may help if the intake counselor is a woman. The client may be fearful, confused, in withdrawal, or in denial, and staff members need to be patient and supportive, understanding that it is empowering for the client to choose when to provide information and what information to provide. Additional ways to facilitate entry include providing help with child care and extending program hours for working women.

Using a comprehensive assessment, staff members can identify the client's strengths and weaknesses and work with her to develop specific treatment goals and a treatment plan. Because of the likelihood of victimization and presence of co-occurring psychiatric disorders, female clients need careful assessments for psychiatric disorders and history of childhood trauma and adult victimization. Chapter 5 discusses intake forms that can be used or modified to gather these data. Victimization experiences may be hidden beneath shame and guilt but, as trust develops, the client can discuss these events.

A woman entering treatment needs to feel that the environment is safe and supportive.

Clinical Issues and Strategies

Some women-specific programs are based on the philosophy that supporting and empowering women improve treatment success. Some programs advocate using predominantly female staff in professional and support positions. Providing enhanced services that respond to the social service needs of women is important for effective substance abuse treatment for women with children (Marsh et al. 2000; Volpicelli et al. 2000).

Treatment components specific to women

Exhibit 9-1 identifies core clinical needs and service elements that should be addressed in IOT for women (CSAT 1994*d*).

It is important to identify issues that the client is uncomfortable discussing in a group setting. As a woman feels more comfortable, she may be able to discuss them. Relapse prevention techniques may need to be modified for women. There is some evidence that

Exhibit 9-1

Core Treatment Needs and Service Elements for Women

Core Treatment Needs	Service Elements
Relationships with family and significant others	Provide family or couples counseling
Feelings of low self-esteem and self-efficacy	Address in group and individual counseling Identify and build on the client's strengths
History of physical, sexual, and emotional abuse	Avoid using harsh confrontational techniques that could retraumatize the client Hold individual and group therapy sessions or refer for treatment
Psychiatric disorders	Refer for or provide evaluation and treatment of psychiatric disorders, medication management, and therapy
Parenting, child care, and child custody	Hold parenting classes Develop substance abuse prevention services for children Provide or arrange for licensed child care, including a nursery for infants and young children and afterschool programs for older children Assist with Head Start enrollment
Medical problems	Refer for medical care, including reproductive health, pregnancy testing, and testing for or treating of infectious diseases
Gender discrimination and harassment	Ensure that the program has policies against harassment and that they are enforced

women's relapses are related to negative mood, more so than men's (Rubin et al. 1996). Also, women may do better in women-only counseling groups (Hodgins et al. 1997).

Therapeutic styles

Women who abuse substances may benefit more from supportive therapies than from other approaches and need a treatment environment that is safe and nurturing (Cohen 2000). Safety includes appropriate boundaries between counselor and client, physical and emotional safety, and a therapeutic relationship of respect, empathy, and compassion (Covington 2002).

For women with low self-esteem and a history of abuse, harsh confrontational approaches may further diminish their self-image and retraumatize them. Less aggressive approaches based on understanding and trust are more likely to effect change (Miller and Rollnick 2002). The confrontational approach of "breaking down" a person in treatment and rebuilding her as a recovering person may be overly harsh and not conducive to treating women (Covington 1999).

Woman clients can be referred to mutual-help groups such as Women for Sobriety and 12-Step groups that are sensitive to the needs of women. Some areas have women-only Alcoholics Anonymous (AA) and Narcotics Anonymous meetings, and some groups provide onsite child care. *A Woman's Way Through the Twelve Steps* (Covington 1994) and its companion workbook can help women adapt the 12 Steps for their use (Covington 2000).

Considerations for domestic violence survivors

IOT providers need to consider the safety of the client, develop and implement a personal safety plan for her, and notify the proper authorities if she is in danger. TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT 1997*b*), provides additional information.

Treatment for pregnant women

Because of the possible harm to fetuses, it is important to provide comprehensive treatment services to pregnant women who abuse substances. IOT has produced positive results for pregnant women, and retention in treatment is facilitated by provision of support services such as child care, parenting classes, and vocational training (Howell et al. 1999). Elements of one model program for pregnant women include (CSAT 1993*a*; Howell et al. 1999)

- A family-centered approach with pregnancy and parenting education and mother–child play groups
- Interdisciplinary staff
- Counselor continuity
- Physical and mental health services
- Child care and transportation services
- Housing services that address homelessness or unstable and unsafe housing conditions

Other programs have found that being flexible and responsive to clients' needs and using nonconfrontational approaches improve the health of the women and newborns (Whiteside-Mansell et al. 1999).

Staffing and Training

Making a treatment program gender sensitive requires changes in staffing, training, and treatment approaches. Female program staff and advisory board members may be more sensitive to the needs of female clients. However, male clinicians can work effectively with female clients.

Training on issues and resources specific for women is necessary. Both female and male staff members should be trained about the ramifications for treatment of sexual, physical, and emotional abuse and partner violence. Training should overcome the tendency to blame the victim. Other training needs may include assessment techniques for violence or abuse, appropriate referrals

to mental health professionals, coordinating services with other agencies, and food programs that serve women and children. To prevent sexual harassment of female clients, program rules should be explicit and strictly enforced. Providers need to become familiar with the duty-to-warn requirement as it pertains to reporting child abuse and neglect and partner violence.

Populations With Co-Occurring Psychiatric Disorders

In the field of substance abuse treatment, people with both psychiatric and substance use disorders are said to have co-occurring mental disorders.

Description of the Population

Many clients with co-occurring disorders are in IOT. The Drug Abuse Treatment Outcome Study found that 39 percent of admissions to substance abuse treatment met *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised (DSM-III-R) (American Psychiatric Association 1987) diagnostic criteria for an antisocial personality disorder, 11.7 percent met criteria for a major depressive episode, and 3.7 percent met criteria for a general anxiety disorder (Flynn et al. 1996). Other studies support these findings (Compton et al. 2000; Merikangas et al. 1998).

Most people with co-occurring mental and substance use disorders are not receiving appropriate care.

According to the Treatment Episode Data Set, people admitted to treatment who had a co-occurring psychiatric disorder were less likely than people admitted with only substance use disorders to be in the labor force. They were more likely to be women, abuse alcohol, and be referred through alcohol or drug abuse treatment providers and other health care providers than people admitted for substance abuse only (who were more likely to be have been referred by the criminal justice system) (Office of Applied Studies 2003*a*).

Group characteristics

When a client has co-occurring disorders, both the client and IOT counselor are presented with many challenges, such as

- Interacting symptoms that complicate treatment
- Increased biopsychosocial disruptions such as increased family problems, violent victimization, financial instability, homelessness, incarceration, suicidal ideation or attempts, and medical problems

Barriers to accessing treatment

Most people with co-occurring mental and substance use disorders are not receiving appropriate care (Watkins et al. 2001). Two of the numerous barriers to treatment are limited access to treatment and poor coordination between treatment systems.

In addition, historically, substance abuse and psychiatric treatments were provided in separate settings, and it was believed that one disorder must be stabilized before the other disorder could be treated, resulting in fragmented services. Clients were caught between two systems (Drake et al. 2001). The different treatment approaches led to misunderstandings between mental health and substance abuse treatment providers. Mental health providers may use more motivational and supportive techniques and professionally trained staff, whereas substance abuse treatment programs use more confrontational approaches, which may be distressing

for clients with co-occurring disorders, and often combine peer support with professionally trained counselors (Minkoff 1994). Some substance abuse treatment providers and recovering peers still may harbor antimedication attitudes and not understand the benefit of psychotropic medications.

Implications for IOT

Although clients with co-occurring psychiatric disorders may be challenging, they benefit from treatment (Dixon et al. 1998). Treatment has produced marked reductions in suicide attempts, mental health visits, and reports of depression (Karageorge 2002). Clients with less serious mental disorders appear to do well in traditional substance abuse treatment settings (Sloan and Rowe 1998), and outpatient treatment can be an effective setting for treating substance use disorder in clients with less serious mental disorders (Flynn et al. 1996). Long-term approaches seem more effective than short-term acute care (Bixler and Emery 2000). Clients with psychotic conditions, however, might pose insurmountable challenges for most IOT programs.

Theoretical Background

Integrated treatment

For the past two decades, integrated treatment has been proposed as an effective treatment approach. Minkoff (1994) presents a theoretical framework that considers both disorders chronic, primary, biologically based mental illnesses that are likely to be lifelong, but he suggests that conjoint treatment could reduce symptoms of both disorders effectively and promote recovery. His general treatment principles follow:

- Recognize that the basic elements and processes of addiction treatment are the same for clients who have a psychiatric disorder as for those without one.
- Include education, empathic confrontation of denial, relapse prevention, and involvement with both professional- and peer-led groups.
- Modify standard substance abuse treatment by simplifying interventions, accommodating cognitive limitations if necessary, adapting step or group work, and using mutual-help groups for people with co-occurring psychiatric disorders.
- Develop interventions specific to each phase of treatment.
- Provide comprehensive services that cover treatment of both disorders.

In a review of the literature on treating substance use disorders and co-occurring schizophrenia, Drake and colleagues (1998*b*) found that integrated treatment, especially when delivered for 18 months or longer, resulted in significant reduction in substance abuse and, in some cases, in substantial rates of remission, reductions in hospitalizations, and improvements in other outcomes. Many IOT programs do not treat clients with serious mental disorders such as schizophrenia on a regular basis and do not have the advantages of the programs cited in Drake and colleagues' review (e.g., intensive case management, 18-month treatment window). Charney and colleagues had similar success treating clients with co-occurring depression over a 6-month period (2001). Treatment retention and outcome improved when psychiatric services were provided at the substance abuse treatment facility.

Integrated treatment coordinates substance use and mental disorder interventions to treat the whole client and

- Recognizes the importance of ensuring that entry into *one* system provides access to *all* needed systems
- Emphasizes the association between the treatment models for mental disorders and addiction
- Advocates the concomitant treatment of both disorders
- Follows a staged approach

- Uses treatment strategies from both the mental health and substance abuse treatment fields

Conceptual framework

The National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors, with support from the Substance Abuse and Mental Health Services Administration (SAMHSA), developed a conceptual framework of four quadrants to classify service coordination and help providers categorize treatment according to the severity of symptoms of both disorders (see exhibit 9-2) (Substance Abuse and Mental Health Services Administration 2002).

Clients in category I often are identified in primary care, educational, or community settings and may need consultation services for prevention and early intervention services. Clients in categories II and III generally present or are referred for treatment for their more severe disorder—either mental or substance use disorder—often leaving them with little or no care for the other disorder. These clients may be referred to IOT programs, and care requires collaboration between mental health and IOT providers. Clients in category IV generally need comprehensive, integrated treatment (Substance Abuse and Mental Health Services Administration 2002).

Clinical Issues and Strategies

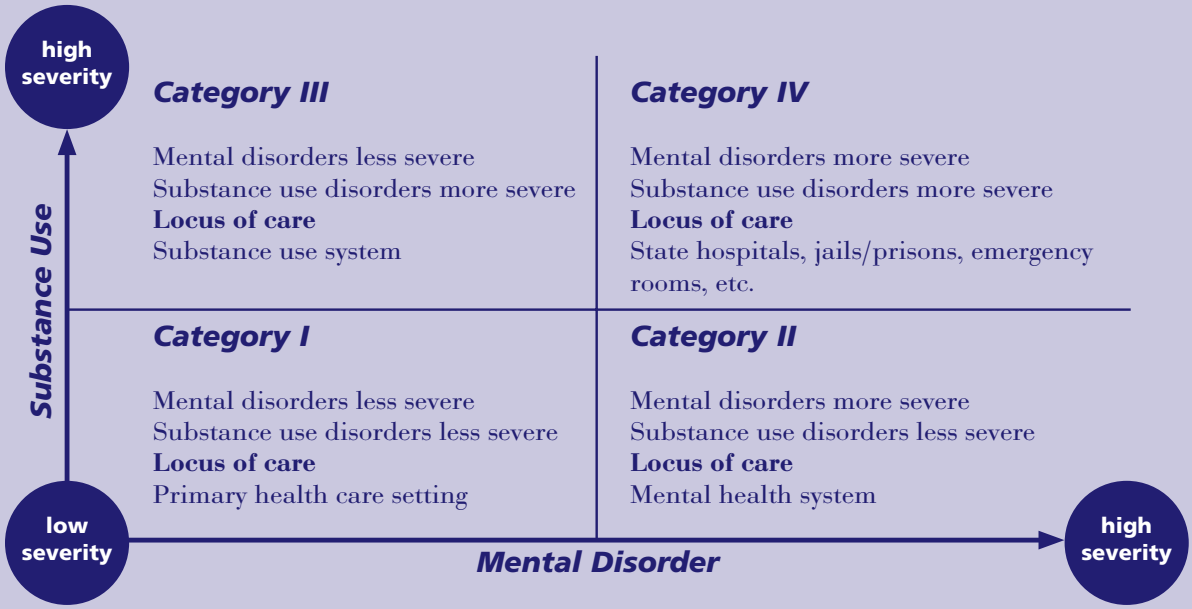
Modifications to clinical approaches and service elements to assist clients with mental disorders are essential. When financial or other limitations require the provision of care in separate settings, treatment services need to be coordinated assertively and efficiently.

Core treatment needs and service elements

Screening. All clients need to be screened for co-occurring psychiatric disorders to

Exhibit 9-2

SAMHSA's Service Coordination Framework for Co-Occurring Disorders



determine whether they have signs and symptoms warranting a comprehensive psychological assessment. These signs and symptoms may be subtle, and clients may minimize or deny symptoms because of fear of stigma.

Assessment. A thorough assessment should be performed either by a clinician trained in both areas or by clinicians from each field. On occasion, symptoms of acute or chronic alcohol and drug toxicity or withdrawal can mimic those of psychiatric disorders. The client should be observed closely for worsening conditions that warrant transfer to a more appropriate facility or to determine whether treatment for withdrawal symptoms is needed. Conversely, substance abuse can mask psychiatric symptoms, which may appear during the initial stages of abstinence. Programs should be organized around the premise that co-occurring disorders are common; assessment should proceed as soon as it is possible to distinguish the substance-induced symptoms from other independent conditions. Particular attention should be paid to the following:

- Psychiatric history of the client and family including diagnoses, previous treatment, and hospitalizations
- Current symptoms and mental status
- Medications and medication adherence
- Safety issues such as thoughts of suicide, self-harm, or harming others
- Severe psychiatric symptoms that result in the inability to function, communicate effectively, or care for oneself

This information can be augmented by objective measurement with assessment tools such as those described in the TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*e*).

Many programs have rigid guidelines for the initial mental health assessment and evaluation, including the initial psychopharmacology evaluation, such as requiring a certain length of abstinence. Programs should be flexible about assessment, removing these barriers when possible. Similarly, denial of access to evaluation or treatment for a substance use disorder because an individual is taking a prescribed psychotropic medication is inappropriate. Clients should continue taking medication for a serious mental disorder while being treated for their substance use disorders (Minkoff 2002).

Treatment engagement. Some clients with co-occurring psychiatric disorders, especially severe disorders, may have difficulty committing to and staying in treatment. Providing continuous support and outreach, assisting with immediate problems (such as housing), monitoring individual needs, and helping clients access services help develop a therapeutic treatment relationship. In the absence of such support, clients with co-occurring psychiatric disorders may be at high risk for dropping out (Drake and Mueser 2000).

Treatment planning. Factors to consider when developing a treatment plan for these clients include the client's psychiatric status, housing, social support, income, medication adherence, and symptom management. By understanding the client's strengths and goals, IOT program staff can develop a treatment plan that is consistent with the client's needs. Regular reassessments monitor the client's progress in both conditions and are the basis for adjustments to the treatment plan. Increased individual sessions and smaller group sizes also are indicated.

Referral. Clients with psychiatric disturbances that require secure inpatient treatment setting, 24-hour medical monitoring, or detoxification (such as clients who are actively suicidal or hallucinating) should be referred to a facility equipped to provide appropriate care. The American Society of Addiction Medicine provides placement criteria for clients with co-occurring psychiatric disorders (Mee-Lee et al. 2001).

Mental health care

Any IOT program that serves a significant number of clients with co-occurring psychiatric

disorders should include mental health specialists and psychiatric consultants on the treatment team.

Prescribing psychiatrist. It is ideal to have a psychiatrist with substance abuse treatment expertise on site to provide assessment and treatment services, on a full-time, part-time, or consultant basis (Charney et al. 2001). This approach overcomes problems with offsite referral such as the client's lack of transportation and the difficulty of working with another agency. However, when funding or other constraints prohibit providing mental health care services on site, other options are (1) employing a master's-level clinical specialist who can treat clients, consult with other staff members on mental disorders, and function as the liaison with psychiatric consultants or (2) establishing a working relationship with a mental health care agency to provide onsite care.

Medication provision and monitoring. Appropriate psychotropic medications are essential. Pharmacological advances over the past decade have resulted in medications with improved effectiveness and fewer side effects. Psychotropic medications stabilize clients, control their symptoms, and improve their functioning. The IOT program counselor can

- Refer the client to a psychiatrist or other mental health care provider for treatment evaluation.
- Help arrange appointments with the mental health care provider and encourage the client to keep them.
- Become familiar with common psychotropic medications, their indications, and their side effects.
- Instruct the client on the importance of complying with the medication regimen.
- Report symptoms and behavior to the prescribing psychiatrist and other staff members to assist in the determination of medication needs.
- Use peers or peer groups to monitor medication and to support the client's proper use of medication.
- Monitor side effects.

A helpful resource is *Psychotherapeutic Medications 2003: What Every Counselor Should Know* (Mid-America Addiction Technology Transfer Center 2000).

Collaboration with mental health care agencies

If circumstances prevent the provision of mental health care services in the IOT program, a collaborative relationship with a mental health agency can be established. One way to form this relationship is through an MOU that ensures that psychiatric services are adequate and comprehensive. The MOU specifies referral procedures, responsibilities of both parties, communication channels, payment requirements, emergency contacts, and other necessary procedures. TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), provides more information about setting up formal mechanisms for working with other agencies.

Case management services provide assistance with service coordination when clients with co-occurring disorders require treatment in two or more systems of care. TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998*a*), provides extensive details about case management.

Modified program structure

Treating clients with co-occurring psychiatric disorders in an IOT program often necessitates modifying the program structure or approach.

Separate treatment tracks in IOT. Separate tracks for clients with both disorders allow clients to be grouped together to address issues pertinent to them in group sessions. This arrangement particularly helps clients

with severe co-occurring psychiatric disorders. Establishing a separate track may entail organizational change as the agency modifies its scheduling, staffing, and training needs.

Staged approaches. Staged approaches provide successive interventions geared to the client's current stage of motivation and recovery and address varying levels of severity and disability of the co-occurring disorders (Drake et al. 1998*a*; Minkoff 1989). The model developed by Osher and Kofoed (1989) includes four overlapping stages—engagement, persuasion, active treatment, and relapse prevention—that integrate treatment principles from both fields. The model advocates treatment components consisting of low-intensity, highly structured programs; case management services; provision of appropriate detoxification; toxicology screening; family involvement; and participation in mutual-help groups. Other staged approaches are described in Minkoff (1989) and Prochaska and DiClemente (1992).

Working with clients with co-occurring psychiatric disorders

When mental and substance use disorders co-occur, both disorders require specific and appropriately intensive primary treatment and need to be individualized for each client according to diagnosis, phase of treatment, level of functioning, and assessment of level of care based on acuteness, severity, medical safety, motivation, and availability of recovery support (Minkoff 2002).

The treatment of clients with substance use and high-severity psychiatric disorders (schizophrenia or schizoaffective disorder) differs from the treatment of clients who have anxiety or mood disorders and a substance use disorder. Clients with severe disorders often are the most difficult to treat. Examples of approaches that attempt to integrate and modify psychiatric and substance abuse treatments to meet the needs of the client are (1) a skills-based approach, (2) dual-recovery therapy, (3) assertive community treatment, and (4) money-management therapy (Ziedonis and D'Avanzo 1998).

The treatment of clients with substance use and mood or anxiety disorders incorporates approaches such as cognitive–behavioral therapy, which addresses both disorders. Several other components, such as relaxation training, stress management, and skills training, are emphasized in the treatment of both types of disorders (Petrakis et al. 2002).

Some clients may have cognitive deficits that make it difficult for them to comprehend written material or to comply with program assignments. Materials can be adapted to express ideas and concepts simply and concretely, incorporating stepped assignments and using visual aids to reinforce information. TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998*e*), provides more information on accommodating clients with disabilities.

Pharmacological advances... have resulted in medications with improved effectiveness and fewer side effects.

The therapeutic relationship

Establishing a trusting, therapeutic relationship is essential during the engagement process and throughout treatment. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*e*), suggests the following guidelines for developing a therapeutic relationship with clients with both disorders:

- Maintain a belief that recovery is possible.
- Manage countertransference.

- Monitor psychiatric symptoms.
- Provide additional structure and support.
- Use supportive and empathic counseling.
- Use culturally appropriate methods.

The clinician's ease in establishing and maintaining a therapeutic alliance is affected by comfort with the client. IOT program clinicians may find working with some clients with psychiatric illnesses unsettling or feel threatened by them and may have difficulty forming a therapeutic alliance with them. Consultation with a supervisor is important, and with experience, training, supervision, and mentoring, the problem can be overcome.

Confrontational approaches may be ineffective for clients with co-occurring psychiatric disorders because they may be unable to tolerate stressful interpersonal challenges. When counseling clients with co-occurring psychiatric disorders, it is helpful if the counselor is empathic and firm at the same time. By setting limits on negative behaviors, counselors provide structure for clients. Another assertive intervention involves counselors' supplying feedback that consists of a straightforward and factual presentation of the client's conflicting thoughts or problem behavior. Provided in a caring manner, such feedback can be both "confrontive" and caring. The ability to do this well is often critical in maintaining the therapeutic alliance with a client who has co-occurring psychiatric disorders (see chapter 5 in TIP 42 [CSAT 2005*e*]). TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*c*, p. 41), provides more information.

Group treatment... is used widely and effectively with clients with co-occurring disorders.

Clients with co-occurring psychiatric disorders may become demoralized and despairing because of the complexity of having two disorders and the slow pace of improvement in symptoms and functioning. Inspiring hope is a necessary task of the IOT program clinician. Some suggestions include

- Demonstrating an understanding and acceptance of the client
- Helping the client clarify the nature of his or her difficulties
- Communicating to the client that the clinician will help the client help himself or herself
- Expressing empathy and a willingness to listen to the client
- Assisting the client in solving external problems immediately
- Fostering hope for positive change

Group treatment

Group treatment, a mainstay of IOT, is used widely and effectively with clients with co-occurring disorders (Weiss et al. 2000), including clients with schizophrenia (Addington and el-Guebaly 1998). Several approaches can be used: 12-Step based, educational, supportive, and social skills improvement. These group interventions have demonstrated success in increasing treatment engagement and abstinence rates and decreasing the need for hospitalization (Drake et al. 1998*a*). Some examples of groups follow:

- **Psychoeducational groups** increase clients' awareness of both problems in a safe and positive environment.
- **Psychiatric disorders groups** present topics such as signs and symptoms of mental disorders, use of medications, and the effects of mental disorders on substance use problems.
- **Medication management groups** provide a forum for clients to learn about medication and its side effects and help the counselor develop solutions to compliance problems.
- **Social skills training groups** provide opportunities to learn how to handle

common social situations by teaching clients to solicit support, develop drug and alcohol refusal skills, and develop effective strategies to cope with pressures to discontinue their prescribed psychiatric medication. Group participants role play situations and practice appropriate responses. Reinforcing the difference between substances of abuse and treatment medications is another simple but important activity of these groups.
- **Onsite support groups** are led by an IOT staff facilitator and provide an arena for discussing problems and practicing new coping skills.

Group treatment may need to be modified and augmented with individual counseling sessions for clients with both disorders. The clients' ability to participate in counseling depends on their level of functioning, stability of symptoms, response to medication, and mental status. Some clients cannot tolerate the emotional intensity of interpersonal interactions in group sessions or may have difficulty focusing or participating. Many clients with a serious mental illness (schizophrenia, schizoid and paranoid personality) have difficulty participating in groups but can be incorporated gradually into a group setting at their own pace. Clients with less severe psychiatric disorders may have little problem participating in group sessions. Some suggestions for working with groups of clients with co-occurring disorders include

- Orally communicate in a brief, simple, concrete, and repetitive manner.
- Affirm accomplishments instead of using disapproval or sanctions.
- Address negative behavior rapidly in a positive manner.
- Be sensitive and responsive to needs of the client.
- Shorten sessions.
- Organize smaller groups.
- Use more focused, but gentle directional techniques.

Mutual-help groups in the community

The consensus panel encourages the use of "double trouble" mutual-help recovery groups for people with co-occurring psychiatric disorders. Because all attendees have a co-occurring psychiatric disorder, they are less likely to be subject to the misunderstanding and conflicting messages about their psychiatric symptoms or use of psychotropic medications that sometimes occur in traditional 12-Step-oriented groups (Magura et al. 2003). These groups do not provide clinical or counseling interventions; members help one another achieve and maintain recovery and be responsible for their personal recovery.

Various dual recovery organizations have been established by people in recovery and usually are based on the AA model but adapted for people with both disorders, including

- Double Trouble in Recovery (www.doubletroubleinrecovery.org)
- Dual Disorders Anonymous
- Dual Recovery Anonymous (www.draonline.org)
- Dual Diagnosis Anonymous

The research on traditional 12-Step groups is not definitive, but attendance at such groups may be beneficial for some clients with co-occurring psychiatric disorders (Kelly et al. 2003). However, clients with severe mental disorders may have difficulty attending these groups (Jordan et al. 2002). Some people with co-occurring disorders attend both dual disorder and traditional mutual-help groups (Laudet et al. 2000*b*). In one study, most AA respondents had positive attitudes toward people with co-occurring disorders and 93 percent indicated that such individuals should continue taking their psychotropic medications (Meissen et al. 1999). AA has published *The A.A. Member—Medications and Other Drugs* (Alcoholics Anonymous World Services 1991), a helpful booklet that discusses AA members' use of

medications when prescribed by a physician knowledgeable about alcoholism (visit www.alcoholics-anonymous.org to order).

Relapse prevention

In addition to learning techniques to prevent relapse to substance abuse, clients with co-occurring psychiatric disorders may benefit from learning to recognize worsening psychiatric symptoms, manage symptoms, or seek support from a "buddy" or a mutual-help group. Some providers suggest that clients keep "mood logs" to increase their awareness of how they feel and the situational factors that trigger negative feelings or symptoms. Other techniques include affect or emotion management, including how to identify, contain, and express feelings appropriately. Several relapse prevention interventions for clients with both disorders have been developed (Evans and Sullivan 2000; Weiss et al. 2000).

Other issues

Family education and support. Clients with co-occurring disorders frequently have unsatisfactory relationships with their families. Some clients with psychiatric disorders remain dependent on their families for an extended period, creating complicated family dynamics. Other clients may be estranged from or have strained relationships with family members, partners, or children. Groups for family members can be a venue for education and support. Psychoeducation combines fundamental information, guidance, and support and allows for low-key engagement and continued assessment opportunities. Family members and significant others need to understand the implications of both disorders and the ways that one disorder, if not properly monitored and treated, can worsen the symptoms of the other.

At times more intensive family intervention may require removing clients from stressful family relationships and helping them toward independence. Some families may be in need of intensive family therapy and should be referred for appropriate care.

Peer networks. Developing supportive peer networks to replace friends who use substances is an important component of recovery and needs to be addressed in treatment. When a client's family is not supportive, other, more supportive networks can be sought.

Discharge planning and continuing care

Because people with co-occurring psychiatric disorders have two chronic conditions, they often require long-term care that supports their progress and can respond quickly to a relapse of either disorder. Some clients may need to continue intensive mental health care but can manage their substance use disorder by participation in support groups. Other clients may need minimal mental health care but require some form of continued formal substance abuse treatment. Participation in continuing care tends to improve treatment outcomes (Moggi et al. 1999).

Cross-Training

Ideally, an interdisciplinary staff that provides both substance abuse treatment and psychiatric services works as an integrated unit, and providers have training and expertise in both fields. Cross-training about the differing views of treatment and challenges helps staff members from both fields reach a common perspective and approach for treating clients with co-occurring psychiatric disorders.

A helpful training resource is the Mid-America Addiction Technology Transfer Center's *A Collaborative Response: Addressing the Needs of Consumers With Co-Occurring Substance Use and Mental Health Disorders*, an eight-session curriculum designed to promote a cross-disciplinary understanding between mental and substance use disorder clinicians (available at

www.mattc.org). SAMHSA's *Strategies for Developing Treatment Programs for People With Co-Occurring Substance Abuse and Mental Disorders* (Substance Abuse and Mental Health Services Administration 2003) provides information on starting a program for treating people with both disorders.

Adolescents

It is important to recognize that youth are not little adults, and IOT for adolescents should differ from that provided for adult populations (Deas et al. 2000). Adolescents experience many developmental changes, may require habilitation rather than rehabilitation, may be considered dependents legally, and may require parental consent for treatment.

Treatment for adolescents requires a comprehensive approach that addresses their social, medical, and psychological needs. The best candidates for adolescent IOT are youth who are experiencing problems as a result of recent, moderate-to-heavy use of legal or illegal substances, who have functional but ineffective coping skills, and who need a marginally structured setting, not complete removal from their living situation (CSAT 1999*f*).

TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT 1999*d*), and TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT 1999*f*), provide additional information about screening and treating adolescents for substance abuse.

Description of the Population

Developmental changes

Adolescence is a period characterized by physical, emotional, and cognitive changes. Developmental tasks include the many transformations that move adolescents from childhood to adulthood. Physical changes include rapid growth, development of secondary sex characteristics, and fluctuations in hormonal levels. Cognitively, adolescents often have shorter attention spans than adults, have limited perspectives on the future, may be inconsistent in applying abstract thinking skills, and may be impulsive. During adolescence, morals, values, and ideals continue to develop, and intellectual interests expand. During late adolescence, youth become more introspective and sensitive to the consequences of their actions (CSAT 1999*f*) and improve their capacity for setting goals.

IOT for adolescents should differ from that provided for adult populations.

Development of substance abuse in adolescents

Many factors are associated with the onset of substance use problems in adolescents including genetic background, parental substance use and troubled family relations, individual characteristics such as cognitive dysfunction, and to some extent peer influence (Weinberg et al. 1998). Risk factors for developing a substance use disorder include a history of personality problems such as aggression or an affective disorder, school failure, distant or hostile relations with parents or guardians, family disruption, or a history of victimization (Weinberg et al. 1998).

Implications for IOT

Adolescents reach IOT by a number of paths, including parental request, school referral, and juvenile justice system mandate. The IOT provider must be prepared to meet developmental, family, psychiatric, behavioral, and other treatment challenges that may resemble those of adult clients only superficially.

Adolescents need thorough biopsychosocial, medical, and psychological assessments and may need educational, medical, mental health, and social services. Unlike adult clients, adolescents are likely to be entering treatment for the first time, may have little knowledge of the treatment process, and need more orientation than adults.

The assessment process involves a comprehensive evaluation of the adolescent's risks, needs, strengths, and motivation. Psychosocial assessment instruments appropriate for adolescents should be used. Information to gather includes school records, class schedule, and school involvement; relationships with peers; sexual activity and pressures; relationship with family members; mental and physical health status; history of abuse and trauma; and involvement with the juvenile justice system.

Family assessment

The adolescent's family consists of the main caregivers (usually parents) and anyone the client considers family. Family issues to assess include family structure and functioning, financial and housing statuses, substance use history and treatment episodes, mental and physical health, the family's feelings about the adolescent, and family members' problems with violence and involvement in the legal system. The strengths and resources available to the family need to be identified as well. IOT program staff members may want to interview the adolescent in private initially and then meet with family members.

Psychiatric assessment

Every client can benefit from a thorough psychiatric assessment by a mental health professional trained in adolescent care. As many as 60 percent of adolescents with a substance use disorder also have co-occurring psychiatric disorders (Armstrong and Costello 2002), such as anxiety, mood disorders (Kandel et al. 1999), or attention deficit/hyperactivity disorder (Weinberg et al. 1998). Adolescents should be assessed for suicide risk as well.

Diagnosis

Although some adolescents may meet the diagnostic criteria for substance dependence, many are in the early stage of involvement with alcohol or drugs. The *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (American Psychiatric Association 2000) does not contain diagnostic criteria specific to adolescent substance dependence, and some adult diagnostic criteria, such as withdrawal symptoms and alcohol-related medical problems, present differently in adolescents. For these reasons, the DSM criteria have limitations when applied to adolescents (Martin and Winters 1998).

Clinical Issues and Strategies

Family involvement

Because outpatient family therapy may offer benefits superior to other outpatient treatments (Williams et al. 2000), IOT providers are encouraged to work with the family as much as possible. Chapter 6 on family therapy in this TIP and TIP 39, *Substance Abuse Treatment and Family Therapy* (CSAT 2004*c*), provide more information.

Engaging the family. The IOT counselor can engage family members by

- Emphasizing how critical family members are to the adolescent's recovery
- Requiring (whenever possible) that a family member accompany the adolescent to the initial intake interview and including time for the family assessment during that meeting
- Encouraging family attendance at the program's family education and therapy sessions

- Helping family members participate in developing and reinforcing the behavioral contract (see below)
- Supporting family members in encouraging the adolescent to attend treatment

Treatment of the family. Family-oriented interventions have long been used to treat adolescents who abuse substances. Szapocznik and colleagues (1983, 1986) helped establish the effectiveness of family therapy in treating adolescents. The premise of family therapy is that the family plays a role in creating conditions leading to adolescent drug use and that family elements help adolescents recover (Liddle et al. 2001). Evidence shows that youth who receive family therapy have less drug use at treatment completion than those who receive peer group therapy or whose families participate in parent education or a multifamily intervention (Liddle et al. 2001).

Some family-based approaches are as follows:

- Multidimensional family therapy and multisystemic therapy expand classic family therapy models to focus on promoting change in four areas: (1) the adolescent, (2) family members, (3) family interaction patterns, and (4) influences from outside the family (Liddle 1999, 2002).
- Family cognitive–behavioral therapy integrates traditional family systems theory with techniques of cognitive–behavioral therapy. This approach considers adolescent substance abuse as a conditioned behavior that is reinforced by cues and contingencies within the family (Latimer et al. 2003).
- The adolescent community reinforcement approach focuses on teaching adolescents coping skills and changing environmental influences related to continued substance use (Godley et al. 2001).
- The family support network intervention increases parental support of an adolescent's recovery through developing a support group for parents, provides home therapy sessions combined with group sessions, and can be used with any standard adolescent treatment approach (Hamilton et al. 2001).
- The family intervention program (see exhibit 9-3) addresses many problems experienced by families with an adolescent who uses substances. It includes the family and systems that affect the family, such as schools and the community.

As many as 60 percent of adolescents with a substance use disorder also have co-occurring psychiatric disorders...

The behavioral contract

Adolescents who abuse substances may behave in disruptive, destructive, or sometimes criminal ways, such as skipping school, having poor school performance, violating curfew, being argumentative with or withdrawing from family members, joining gangs, or committing crimes.

To address these behaviors, a behavioral contract can be a valuable therapeutic tool. The clinician works with the adolescent (and his or her family) to develop a contract that specifies treatment goals, acceptable and unacceptable behaviors, and the rewards or consequences associated with each.

The conditions defined in the contract help the youth and the family understand the treatment process and what is expected of them. Once the contract is completed, the client and each family member indicate their agreement by signing the contract. IOT program staff uses the contract to guide discussions during family group sessions, to monitor progress, and to minimize the undermining of treatment by family members.

Exhibit 9-3

The Family Intervention Program

This approach partners a family therapist with a community resource specialist. The specialist helps the family establish healthy community networks. Working as a team, the therapist and specialist conduct five family therapy sessions and perform the following:

1. Assess the family system; explore the family's resources, concerns, and goals; and create a treatment plan.
2. Explore relationships among family members, identify areas of difficulty and stress, and determine the effect on the family system.
3. Determine the effect of other systems, such as schools, on the family.
4. Focus on the family's concerns and goals and include others who can help resolve problems.
5. Work on how the family can resolve issues without staff help and develop a followup plan.

Source: Fishman and Andes 2001.

Case management services for adolescents

The IOT provider may need to provide extensive case management services. The case manager works with schools to monitor a youth's compliance with the behavioral contract; coordinates medical, mental health, and social services; and works with the juvenile justice system, if needed. Caseloads are best kept to about 8 to 10 adolescents per staff member.

Group work strategies for adolescents

Treating adolescents involves bringing together youth from different areas, backgrounds, and developmental levels. Many practitioners recommend, if possible, that the groups consist of adolescents of the same gender, with similar levels of motivation for change, and of similar age. Clients in middle-to-late adolescence (ages 16 to 18) usually have different life experiences, developmental levels, and concerns than do younger adolescents. There is limited evidence of the effectiveness of treating adolescents in groups, perhaps because of the complexities just mentioned. The consensus panel reports that, with this population, approaches emphasizing structured discussions around a topic introduced by the counselor are more successful than open-ended sessions. Same-gender groups can provide a safe environment in which to explore such issues as sexuality, intimacy, self-esteem, and relationships. If programs do not have enough adolescent clients to have a treatment group, a gender-specific group session can be held weekly to discuss sensitive issues.

To foster productive group work, it is helpful to enforce clear, specific, concrete rules. IOT program staff can post the rules in the session room and ask each participant to sign a copy. Rules should prohibit bullying and teasing. Groups also commonly prohibit nostalgic stories of substance use.

Group members frequently are asked to sign a confidentiality statement promising that information shared in the group will not be repeated outside group. Other suggestions for treating adolescents in groups are

- Including activities and keeping discussions short
- Varying session content, activity level, and purpose
- Including frequent breaks

CSAT's Cannabis Youth Treatment Series offers many specific ideas for use with adolescents (Godley et al. 2001; Hamilton et al. 2001; Liddle 2002; Sampl and Kadden 2001; Webb et al. 2002).

A co-counselor is helpful in running groups for adolescents because of the complexity of adolescent issues and behavior management challenges.

Clinical considerations

Providing incentives acknowledges the efforts of youth and encourages them to persevere. Incentives should be meaningful to the youth, such as gift certificates from a music store, movie theater, or clothing store.

Other key points about treating adolescents include the following:

- A cognitive–behavioral model and motivational enhancement techniques are useful.
- Not all adolescents who use substances are dependent, and prematurely diagnosing or labeling adolescents or pressuring them to accept that they have an addictive disease may not work.
- Many adolescents respond better to motivational interviewing than to confrontation.

Exhibit 9-4 lists characteristics and behaviors of adolescents in treatment and practical treatment suggestions.

Staff Training

IOT program staff members need to understand adolescent development and treatment needs. Clinicians working with youth should

- Be flexible and able to interact warmly with adolescents.
- Observe clear and appropriate personal boundaries.
- Be able to set firm behavioral limits in a nonjudgmental or nonpunitive manner.
- Know about the substances and combinations that adolescents use, the slang in use, and the physical and behavioral effects of any new drugs.
- Have substantial knowledge of the school system.
- Understand family dynamics.

Core program staff members should include a clinical coordinator who is trained in adolescent treatment. Skills development training for staff should occur regularly on topics appropriate for adolescent treatment.

Young Adults

Some caregivers may find it difficult to recognize or accept that young adults (ages 18 to 24) are no longer legal dependents. Even though a youth still may live at home or be in school, parental responsibility changes and the young adult can make his or her own choices. Counselors may find that they need to help both the young adult client and parents realize that the client can make choices and is responsible for actions. Some young adult clients may be totally on their own, with little family contact.

The use of alcohol or drugs at an early age may have delayed normal development. Although these young clients are legally adults, they may not have grown into young adult social roles.

The young adult may be ready clinically for placement in an adult treatment group or may be placed more appropriately in an adolescent program. A thorough assessment is needed to determine appropriate placement.

IOT Programming for Young Adults

To engage and retain these clients, IOT programming can incorporate techniques used in adolescent programs. To involve young adult clients in treatment, it is important to

Exhibit 9-4

Characteristics and Behaviors of Adolescents and Treatment Suggestions

Characteristics and Behaviors of Adolescents in Treatment	Suggestions for Improving the Treatment Experience for Adolescents
Inconsistent ability for abstract thinking	Limit abstract, future-oriented activities Use mentors Avoid scare tactics and labels
Impulsive, often with short attention spans	Design activities to teach self-control skills; allow practice time
Need to belong and identify with others; vulnerability to peer influence	Create opportunities for group members to bond Help clients establish positive peer groups and develop skills in resisting negative peer pressure Promote positive peer feedback in group
Frequent emotional fluctuations	Validate feelings Acknowledge the pressures and stresses of adolescence Help youth improve stress management skills
Lack of involvement in healthy recreational activities	Help clients develop daily schedules Help youth find new recreational activities not involving substance use such as games, sports, hobbies, and religious or spiritual groups
Tendency toward pessimistic or fatalistic attitudes	Recognize fatalist attitudes such as "I'm going to die soon, anyway," and "Drugs are the only way out for me" Validate clients' anger, hopelessness, or perceived obstacles to success, but challenge youth to think positively

reach out to them through family, colleges, employers, and the court system. Treatment should be relevant to young adult concerns, interests, and social activities and be flexible enough to adapt to the client's developmental deficits. The following issues are relevant:

- **Education and employment.** Educational and job skill levels need to be assessed and addressed. Some clients who have grown up in poverty have witnessed the futility of working at a low-paying job versus the financial benefits of selling illicit drugs. These clients need special attention.
- **Family roles.** Some clients may have children and family responsibilities and need assistance in obtaining child care and developing parenting skills.
- **Separating from parents.** Young adults in treatment often have parents who are unwilling to set limits, which fosters dependence and intense attachment on the part of the clients. Parents need to understand that their enabling behavior is a barrier to their young adult's recovery. Young adult clients often require life skills development. Treatment should focus on habilitation, rather than rehabilitation.
- **Peer relationships.** Some clients may need assistance in developing and maintaining healthy peer networks and family relationships.
- **Mentoring.** A positive adult role model provides a meaningful example.
- **Community service.** Young adults in treatment can contribute to society and should be encouraged to participate in and volunteer for community or faith-based events.

10 Addressing Diverse Populations in Intensive Outpatient Treatment

In This Chapter...

What It Means To Be a Culturally Competent Clinician

Principles in Delivering Culturally Competent IOT Services

Issues of Special Concern

Clinical Implications of Culturally Competent Treatment

Sketches of Diverse IOT Client Populations

Intensive outpatient treatment (IOT) programs increasingly are called on to serve individuals with diverse backgrounds. Roughly one-third of the U.S. population belongs to an ethnic or racial minority group. More than 11 percent of Americans, the highest percentage in history, are now foreign born (Schmidley 2003).

Culture is important in substance abuse treatment because clients' experiences of culture precede and influence their clinical experience. Treatment setting, coping styles, social supports, stigma attached to substance use disorders, even whether an individual seeks help—all are influenced by a client's culture. Culture needs to be understood as a broad concept that refers to a shared set of beliefs, norms, and values among any group of people, whether based on ethnicity or on a shared affiliation and identity.

In this broad sense, substance abuse treatment professionals can be said to have a shared culture, based on the Western worldview and on the scientific method, with common beliefs about the relationships among the body, mind, and environment (Jezewski and Sotnik 2001). Treating a client from outside the prevailing United States culture involves understanding the client's culture and can entail mediating among U.S. culture, treatment culture, and the client's culture.

This chapter contains

- An introduction to current research that supports the need for individualized treatment that is sensitive to the client's culture
- Principles in the delivery of culturally competent treatment services
- Topics of special concern, including foreign-born clients, women from other cultures, and religious considerations
- Clinical implications of culturally competent treatment
- Sketches of diverse client populations, including
  - Hispanics/Latinos
  - African-Americans
  - Native Americans

  - Asian Americans and Pacific Islanders
  - Persons with HIV/AIDS
  - Lesbian, gay, and bisexual (LGB) populations
  - Persons with physical and cognitive disabilities
  - Rural populations
  - Homeless populations
  - Older adults

- Resources on culturally competent treatment for various populations

What It Means To Be a Culturally Competent Clinician

It is agreed widely in the health care field that an individual's culture is a critical factor to be considered in treatment. The Surgeon General's report, *Mental Health: Culture, Race, and Ethnicity*, states, "Substantive data from consumer and family self-reports, ethnic match, and ethnic-specific services outcome studies suggest that tailoring services to the specific needs of these [ethnic] groups will improve utilization and outcomes" (U.S. Department of Health and Human Services 2001, p. 36). The *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) (American Psychiatric Association 1994) calls on clinicians to understand how their relationship with the client is affected by cultural differences and sets up a framework for reviewing the effects of culture on each client.

Mental Health: Culture, Race, and Ethnicity is the first comprehensive report on the status of mental health treatment for minority groups in the United States. This report synthesizes research data from a variety of disciplines and concludes that

- Disparities in mental health services exist for racial and ethnic minorities. These groups face many barriers to availability, accessibility, and use of high-quality care.
- The gap between research and practice is worse for racial and ethnic minorities than for the general public, with problems evident in both research and practice settings. No ethnic-specific analyses have been done in any controlled clinical trials aimed at developing treatment guidelines.
- In clinical practice settings, racial and ethnic minorities are less likely than Whites to receive the best evidence-based treatment. (It is worth noting, however, that given the requirements established by funders and managed care, clients at publicly funded facilities are perhaps *more* likely than those at many private treatment facilities to receive evidence-based care.)

Because verbal communication and the therapeutic alliance are distinguishing features of treatment for both substance use and mental disorders, the issue of culture is significant for treatment in both fields. The therapeutic alliance should be informed by the clinician's understanding of the client's cultural identity, social supports, self-esteem, and reluctance about treatment resulting from social stigma. A common theme in culturally competent care is that the treatment provider—not the person seeking treatment—is responsible for ensuring that treatment is effective for diverse clients.

Meeting the needs of diverse clients involves two components: (1) understanding how to work with persons from different cultures and (2) understanding the specific culture of the person being served (Jezewski and Sotnik 2001). In this respect, being a culturally competent clinician differs little from being a responsible, caring clinician who looks past first impressions and stereotypes, treats clients with respect, expresses genuine interest in clients as individuals, keeps an open mind, asks questions of clients and other providers, and is willing to learn.

This chapter cannot provide a thorough discussion of attributes of people from various cultures and how to attune treatment to those attributes. The information in this

chapter provides a starting point for exploring these important issues in depth. More detailed information on these groups, plus discussions of substance abuse treatment considerations, is found in the resources listed in appendix 10-A (page 197). The following resources may be especially helpful in understanding the broad concepts of cultural competence:

- *Mental Health: Culture, Race, and Ethnicity* (U.S. Department of Health and Human Services 2001) (www.mentalhealth.org/cre/default.asp). Chapter 2 discusses the ways in which culture influences mental disorders and mental health services. Subsequent chapters explain the historical and sociocultural context in which treatment occurs for four major groups—African-Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic/Latino Americans.
- Chapter 4 of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*). This chapter describes steps that an IOT administrator can take to prepare an IOT organization to treat diverse clients more competently and sensitively. Chapter 4 also lists resources not found in the appendix at the end of this chapter.
- The forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT forthcoming *a*) includes an in-service training guide.

Principles in Delivering Culturally Competent IOT Services

The Commonwealth Fund Minority Health Survey found that 23 percent of African-Americans and 15 percent of Latinos felt that they would have received better treatment if they were of another race. Only 6 percent of Whites reported the same feelings (La Veist et al. 2000). Against this backdrop, it clearly is important for providers to have a genuine understanding of their clients from other cultures, as well as an awareness of how personal or professional biases may affect treatment.

Most IOT counselors are White and come from the dominant Western culture, but nearly half of clients seeking treatment are not White (Mulvey et al. 2003). This stark fact supports the argument that clinicians consider treatment in the context of culture. Counselors often feel that their own social values are the norm—that their values are typical of all cultures. In fact, U.S. culture differs from most other cultures in a number of ways. IOT clinicians and program staff members can benefit from learning about the major areas of difference and from understanding the common ways in which clients from other cultures may differ from the dominant U.S. culture.

> ...an individual's culture is a critical factor to be considered in treatment.

Treatment Principles

Members of racial and ethnic groups are not uniform. Each group is highly heterogeneous and includes a diverse mix of immigrants, refugees, and multigenerational Americans who have vastly different histories, languages, spiritual practices, demographic patterns, and cultures (U.S. Department of Health and Human Services 2001).

For example, the cultural traits attributed to Hispanics/Latinos are at best generalizations that could lead to stereotyping and alienation of an individual client. Hispanics/Latinos are not a homogeneous group. For example, distinct Hispanic/Latino cultural groups—Cuban Americans, Puerto Rican Americans, Mexican Americans, and Central and South Americans—do not think and act

alike on every issue. How recently immigration occurred, the country of origin, current place of residence, upbringing, education, religion, and income level shape the experiences and outlook of every individual who can be described as Hispanic/Latino.

Many people also have overlapping identities, with ties to multiple cultural and social groups in addition to their racial or ethnic group. For example, a Chinese American also may be Catholic, an older adult, and a Californian. This individual may identify more closely with other Catholics than with other Chinese Americans. Treatment providers need to be careful not to make facile assumptions about clients' culture and values based on race or ethnicity.

Culture is only a starting point for exploring an individual's perceptions, values, and wishes.

To avoid stereotyping, clinicians must remember that each client is an individual. Because culture is complex and not easily reduced to a simple description or formula, generalizing about a client's culture is a paradoxical practice. An observation that is accurate and helpful when applied to a large group of people may be misleading and harmful if applied to an individual. It is hoped that the utility of offering broad descriptions of cultural groups outweighs the potential misunderstandings. When using the information in this chapter, counselors need to find a balance between understanding clients in the context of their culture and seeing clients as merely an extension of their culture. Culture is only a starting point for exploring an individual's perceptions, values, and wishes. How strongly individuals share the dominant values of their culture varies and depends on numerous factors, including their education, socioeconomic status, and level of acculturation to U.S. society.

Differences in Worldview

A first step in mediating among various cultures in treatment is to understand the Anglo-American culture of the United States. When compared with much of the rest of the world, this culture is materialistic and competitive and places great value on individual achievement and on being oriented to the future. For many people in U.S. society, life is fast paced, compartmentalized, and organized around some combination of family and work, with spirituality and community assuming less importance.

Some examples of this worldview that differ from that of other cultures include

- **Holistic worldview.** Many cultures, such as Native-American and Asian cultures, view the world in a holistic sense; that is, they see all of nature, the animal world, the spiritual world, and the heavens as an intertwined whole. Becoming healthy involves more than just the individual and his or her family; it entails reconnecting with this larger universe.
- **Spirituality.** Spiritual beliefs and ceremonies often are central to clients from some cultural groups, including Hispanics/Latinos and American Indians. This spirituality should be recognized and considered during treatment. In programs for Native Americans, for example, integrating spiritual customs and rituals may enhance the relevance and acceptability of services.
- **Community orientation.** The Anglo-American culture assumes that treatment focuses on the individual and the individual's welfare. Many other cultures instead are oriented to the collective good of the group. For example, individual identity may be tied to one's forebears and descendants, with their welfare considered in making decisions. Asian-American and Native-American clients may care more about how the substance use disorder

harms their family group than how they are affected as individuals.

- **Extended families.** The U.S. nuclear family consisting of parents and children is not what most other cultures mean by family. For many groups, family often means an extended family of relatives, including even close family friends. IOT programs need a flexible definition of family, accepting the family system as it is defined by the client.
- **Communication styles.** Cultural misunderstandings and communication problems between clients and clinicians may prevent clients from minority groups from using services and receiving appropriate care (U.S. Department of Health and Human Services 2001). Understanding manifest differences in culture, such as clothing, lifestyle, and food, is not crucial (with the exception of religious restrictions on dress and diet) to treating clients. It often is the invisible differences in expectations, values, goals, and communication styles that cause cultural differences to be misinterpreted as personal violations of trust or respect. However, one cannot know an individual's communication style or values based on that person's group affiliation (see appendix 10-A for more information and resources on cross-cultural communication).
- **Multidimensional learning styles.** The Anglo-American culture emphasizes learning through reading and teaching. This method sometimes is described as linear learning that focuses on reasoned facts. Other cultures, especially those with an oral tradition, do not believe that written information is more reliable, valid, and substantial than oral information. Instead, learning often comes through parables and stories that interweave emotion and narrative to communicate on several levels at once. The authority of the speaker may be more important than that of the message. Expressive, creative, and nonverbal interventions that are characteristic of a specific cultural group can be helpful in treatment. Cultures with this kind of rich oral tradition and learning pattern include Hispanics/Latinos, African-Americans, American Indians, and Pacific Islanders.

Common issues affecting the counselor–client relationship include the following:

- **Boundaries and authority issues.** Clients from other cultures often perceive the counselor as a person of authority. This may lead to the client's and counselor's having different ideas about how close the counselor–client relationship should be.
- **Respect and dignity.** For most cultures, particularly those that have been oppressed, being treated with respect and dignity is supremely important. The Anglo-American culture tends to be informal in how people are addressed; treating others in a friendly, informal way is considered respectful. Anglo Americans generally prefer casual, informal interactions even when newly acquainted. However, some other cultures view this informality as rudeness and disrespect. For example, some people feel disrespected at being addressed by their first names.
- **Attitudes toward help from counselors.** There are wide differences across cultures concerning whether people feel comfortable accepting help from professionals. Many cultures prefer to handle problems within the extended family. The clinician and client also may harbor different assumptions about what a clinician is supposed to do, how a client should act, and what causes illness (U.S. Department of Health and Human Services 2001).

Issues of Special Concern

The IOT consensus panel recommends that IOT programs look at the following areas of special concern:

- Whether the program is prepared to adequately serve foreign-born clients living within their catchment area

- Whether the special needs of their minority or foreign-born women clients are being addressed adequately
- Whether the program needs to make any content adjustments out of respect for the religious orientation of current or potential clients

Foreign-Born Clients

In 2002, according to the U.S. Census Bureau, about 32.5 million U.S. residents were foreign born, of whom 52 percent came from Latin America and 26 percent from Asia (Schmidley 2003). Eleven percent were born in another country and may be speaking or learning English as a second language. Migration is a stressful life event, and immigrants are at risk for substance abuse because of stress, isolation, and the lack of social support they experience in adjusting to their new country.

The reason for a person's immigration is considered an important factor in the level of stress that immigrants experience as they settle into a new life. Refugees typically have been forced to abandon their countries and former lives, leaving their belongings behind, to relocate to a different and sometimes unwelcoming new world in which language, social structures, and community resources may be totally unfamiliar (Jezewski and Sotnik 2001). This displacement can be particularly difficult for older refugees.

Clinical considerations

Having a personal history of abuse and trauma is recognized as a major factor in substance use disorders and in the inability to maintain recovery. A large percentage of Asian-American and Hispanic-American immigrants show clinical evidence of posttraumatic stress disorder (PTSD) as a result of exposure to severe trauma, such as genocide, war, torture, or extreme threat of death or serious injury (U.S. Department of Health and Human Services 2001). In some samples, up to 70 percent of refugees from Vietnam, Cambodia, and Laos met diagnostic criteria for PTSD, compared with about 4 percent with a prevalence for PTSD in the U.S. population as a whole (U.S. Department of Health and Human Services 1999). For this reason, treatment for foreign-born clients often needs to address both substance use and the client's background of abuse and violence.

Other clinical issues include the following:

- **Mistrust of authority.** Immigrants and refugees from many regions of the world feel extreme mistrust of government based on the atrocities committed in their countries of origin or fear of deportation by U.S. authorities. This mistrust can be a barrier to entering treatment and to obtaining services.
- **Extreme sense of stigma.** Clients from other cultures view mental disorders, including substance abuse, much more negatively than does the general U.S. population (U.S. Department of Health and Human Services 1999). In some Asian cultures, this stigma is so strong that a person's substance dependence is thought to reflect poorly on the family lineage, diminishing the marriage and economic prospects for the client and for other family members.
- **Level of acculturation.** Providers should take into account a client's level of acculturation in assessment and treatment. Generally speaking, foreign-born persons have rates of substance use lower than U.S.-born counterparts; the more acculturated the person is to the United States, the more that person's use approaches U.S. substance-using norms. Among Hispanics/Latinos, substance use disorders are less frequent in those who were born outside the United States (Turner and Gil 2002). For example, foreign-born Cuban Americans have lower lifetime use of alcohol and start drinking later in life than do U.S.-born Cuban Americans (Vega et al. 1993). However, being born in the United States does not mean necessarily that a

person is acculturated. In a later study, Vega and colleagues (1998) found that the highest rates of substance abuse among Hispanic/Latino adolescents were seen in those who were born in the United States but had low acculturation levels. The researchers attributed these results to the fact that these adolescents faced the language problems of foreign-born Hispanics/Latinos and the acculturation conflicts of U.S.-born Hispanics/Latinos.

Implications for IOT providers

IOT providers who want to reach out to foreign-born clients in their community and serve them better should become more knowledgeable about the history and experiences of the newcomers. One way to start is by researching and reading about these cultural groups. Providers also should get to know newcomer populations by visiting community refugee and immigrant organizations, such as their Mutual Assistance Associations. Representatives of these associations can identify the need for substance abuse treatment among their constituents, as well as provide advice and suggestions about designing culturally specific services.

Providers can consider setting up an IOT group in the immigrants' native language. For example, it has been found that linguistic Spanish-only groups are helpful for recently arrived Hispanic/Latino immigrants. One note on language: In addition to native-language treatment groups, programs should provide services in English for those clients who want them. Many immigrants understand that not knowing English can be a barrier, and they are motivated to improve their English-language skills.

Some suggestions for programs that establish language-specific groups include the following:

- A program catering to a language-specific population needs to facilitate communication in that language. All documents in the program should be adapted. The program also can have a phone message in the clients' native language, with calls returned by a counselor who speaks the language.
- The important issues that immigrants face need to be addressed as part of the treatment program. These issues include cultural differences between the dominant culture and their native culture, sense of displacement, lack of community, language problems, accessing social services, and finding employment.
- The clients' cultural attitudes and values about substance use should shape program content. Clients need to acquire an understanding of how their native cultural attitudes differ from the values of U.S. society, which involves understanding U.S. laws, social expectations, and way of life.
- Using the terminology of the treatment field becomes a challenge because many words are difficult to translate and the meanings can vary according to the culture. Often, the counselor needs to translate both a word *and* its meaning in the English language and U.S. culture. For example, in Russian the concept of denial is positive. This concept generally translates into Russian as "It is good to deny that you have a problem." Likewise, "defenses" also translates as a positive concept. The word "defense" in Russian refers to a tool for addressing rude or disrespectful behavior from another person. In translation, these words carry the connotation of "To be defended and in denial are good tools to handle one's problems."

> ...mistrust can be a barrier to entering treatment and to obtaining services.

- Immigrant clients may need many social and educational support services that may be difficult for the clients to access because of language and cultural barriers. Often clients are not familiar with the existence, range, and purpose of these needed

Cultural Issues in a Russian-Language IOT Program

The ChangePoint IOT Program for Russian immigrants in Portland, Oregon, usually has about 15 clients in treatment at a time. Clients are immigrants from all over Russia, and most are religious refugees. The newcomers generally stay in family groups that immigrate together, so these clients have close family connections.

Clients learn about the social and legal expectations regarding substance use in the United States. The group work focuses on the cultural attitudes that these Russian clients bring to their substance use and treatment. Examples of differing U.S.–Russian cultural values that the program helps clients understand include

- **Acceptable levels of alcohol use.** Alcohol use among Russian clients is higher than average for the United States. In Russia, drinking enormous quantities of alcohol is tolerated provided the person behaves appropriately.
- **Legal expectations.** Russians tend to view the law in a "black or white" context. In Russia, there is zero tolerance for any blood alcohol level (BAL) when driving. When clients hear that a BAL below 0.08 is legal in the United States, they think, "I can drink and drive as long as I'm under 0.08 or as long as I'm careful."
- **Attitudes about money and treatment.** Russian clients may assume that the program will understand if they cannot pay their bills on time. Russian people expect that they will be paid regularly, often lend money to family and friends, and feel a high level of trust that they will be paid back. This translates into an expectation that the program also will trust them to pay their bills at some time in the future.

supports, and some fear or are confused by the complexities of government procedures; their access to these services may be impeded by the documentation processes that bureaucracies often require. IOT case management can broker needed support services. One model for doing this, called culture brokering, consists of conflict resolution and problemsolving strategies designed to help two cultures communicate and cooperate. In the context of cultural competence, the two cultures are represented by clients who are foreign born or disabled and treatment providers. (See cirrie.buffalo.edu/cbrokering.html for more information.)

Women From Other Cultures

Immigrant women face the same barriers to treatment that confront many Anglo-American women—restricted availability of child care, low income, unsupportive spouses, lack of health insurance benefits, and lack of education and job skills—but have the added barrier of being outsiders to the culture.

- **View the woman's behavior and treatment goals in the context of her culture.** Treatment needs to be sensitive to the cultural mores and female roles in that woman's culture and to the client's level of acculturation. Some societies can be paternalistic and dominated by men, with women expected to play traditional roles as wives and mothers. A woman client may have values and attitudes that reflect that culture. Her substance use disorder, her attitudes about her addiction, and her perception of her recovery options occur within that cultural framework. It is therefore important to understand the client's level of comfort with what is expected in treatment. Treatment goals should depend on the woman's hopes and should conform to the cultural role she wants for herself.
- **Expect to work within complex, conflicting value systems.** Women from male-dominated cultures often are raised to be

gentle, passive, and selfless in serving their husbands and families. Some counselors may want to push such women toward independence and self-assertion but should be aware that these attributes may not be personally or culturally desirable for foreign-born female clients.

Often, treatment must be more intensive for poor immigrant women than for immigrant women with more economic resources. Treatment programs that enhance women's economic autonomy through social and employment support are effective in reducing substance use (Gregoire and Snively 2001). As with many women in treatment, foreign-born women may need transportation to their medical and legal appointments, as well as to substance abuse treatment sessions. Other services should include

- **Domestic violence intervention.** Staff members need to understand the factors in clients' home life that interfere with recovery, such as domestic violence or having a significant other who also uses substances.
- **Multidisciplinary meetings with other caregivers.** The IOT staff can organize multidisciplinary meetings for the client that involve all referring agencies. Staff from the referring agencies should be encouraged to attend and develop a plan to address any issues that may be interfering with the client's treatment.
- **Parenting classes.** Parenting classes help women meet some of the stipulations required by State departments of child and family services. In addition, some child-rearing practices in other cultures may not be acceptable in American culture, and classes offer the chance for women to learn more acceptable practices.

Religious Orientation

IOT providers need to ensure that their program is welcoming to people from all religious faiths and that no treatment practices are a barrier to those from non-Christian religions. Programs should address specifically the following issues:

- **Religious acceptance and tolerance within the program.** Local religious leaders can educate substance abuse treatment providers about traditions and practices. Providers, in turn, can educate religious leaders about services that are available. In the years immediately following the attacks of September 11, 2001, American Muslims experienced increased incidents of bias, discrimination, overt hostility, abuse, and violence. Collaborating with local imams can help treatment providers and the religious community reach out and aid people more effectively (Goodman 2002). Intolerance by other clients in treatment should not be condoned and needs to be addressed. (For a brief introduction on responding to the mental health needs of Arab Americans and American Muslims in the wake of terrorism, see Goodman [2002].)
- **Knowledge of religious customs.** Providers need to understand and accommodate the religious customs of individual clients. A culturally sensitive IOT program should ask about clients' dietary preferences, special holidays, and religious customs (e.g., daily prayers).
- **Preparing clients for mutual-help programs.** Non-Christian clients who are referred to mutual-help programs for continuing care should be informed that meetings often incorporate elements of Christianity. As an example, the Lord's Prayer, which comes from the Christian Bible, frequently is selected for closing Alcoholics Anonymous (AA) meetings. Because this is a Christian prayer, it potentially is offensive to the religious point of view of such groups as Jews, Muslims, Hindus, and Buddhists. Jewish mutual-help meetings exist in many communities. The Web site of Jewish Alcoholics, Chemically Dependent Persons and Significant Others at www.jacsweb.org provides additional information. Many areas of the country have secular mutual-help

meetings. Providers should become familiar with these meetings, so they can direct their non-Christian clients to them.
- **Support from religious leaders.** Clients whose religious faith is central to their lives should be encouraged to seek help from their religious leaders and from fellow believers.

Clinical Implications of Culturally Competent Treatment

IOT programs should take the following steps to ensure culturally competent treatment for their clients:

- Assess the program for policies and practices that might pose barriers to culturally competent treatment for diverse populations. Removing these barriers could entail something as simple as rearranging furniture to accommodate clients in wheelchairs or as involved as hiring a counselor who is from the same cultural group as the population the program serves. Chapter 4 of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), provides more information about assessing program needs.
- Ensure that all program staff receive training about the meaning and benefits of cultural competence in general and about the specific cultural beliefs and practices of client populations that the program serves.
- Incorporate family and friends into treatment to support the client. Although family involvement is often a good idea in an IOT program, it may be particularly effective given the importance of family in many cultures. Some clients left families and friends behind when they came to the United States. Helping these clients build support systems is critical.
- Provide program materials on audiotapes, in Braille, or in clients' first languages. All materials should be sympathetic to the culture of clients being served.
- Ensure that client materials are written at an appropriate reading level. People who are homeless and those for whom English is a second language may need materials written at an elementary school reading level.
- Include a strong outreach component. People who are unfamiliar with U.S. culture may be unaware that substance abuse treatment is available or how to access it.
- Hire counselors and administrators and appoint board members from the diverse populations that the program serves. Chapter 4 of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), provides more information about recruiting and hiring diverse staff members.
- Incorporate elements from the culture of the populations being served by the program (e.g., Native-American healing rituals or Talking Circles).
- Partner with agencies and groups that deliver community services to provide enhanced IOT services, such as child care, transportation, medical screening and services, parenting classes, English-as-a-second-language classes, substance-free housing, and vocational assistance. These services may be necessary for some clients to be able to stay in treatment.
- Provide meals at the program facility. This may bring some clients (e.g., those who are elderly or homeless) into treatment and induce them to stay.
- Make case management services available for clients who need them.
- Emphasize structured programming, as opposed to open-ended discussion, in group therapy settings.
- Base treatment on clients' strengths. Experienced providers report that this approach works well with clients from many cultures and is the preferred approach for clients struggling with self-esteem or empowerment.
- Use a motivational framework for treatment, which seems to work well with clients from many cultures. Basic principles

of respect and collaboration are the basis of a motivational approach, and these qualities are valued by most cultures.
- Encourage clients to participate in mutual-help programs to support their recovery. Although the mutual-help movement's roots are in White, Protestant, middle-class American culture, data show that members of minorities benefit from mutual-help programs to the same extent as do Whites (Tonigan 2003).

Sketches of Diverse IOT Client Populations

The following demographic sketches focus on diverse clients who may be part of an IOT caseload. These descriptions characterize entire groups (e.g., number of people, geographic distribution, rates of substance use) and include generalized cultural characteristics of interest to the clinician. This type of cultural overview is only a starting point for understanding an individual. To serve adequately clients from the diverse groups described here, IOT providers need to get to know their clients and educate themselves. Appendix 10-A (page 197) contains an annotated list of resources on cultural competence in general, as well as resources listed by population group. These resources include free publications available from government agencies—in particular the Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention—and describe population-specific treatment guidelines and strategies.

Hispanics/Latinos

Hispanics/Latinos include individuals from North, Central, and South America, as well as the Caribbean. Hispanic people can be of any race, with forebears who may include American Indians, Spanish-speaking Caucasians, and people from Africa. Great disparities exist among these subgroups in education, economic status, and labor force participation. In 2002, the Hispanic/Latino population totaled 37.4 million, more than 13 percent of the total U.S. population, and it is now the largest ethnic group in the Nation. Mexican Americans are the largest subgroup, representing more than two-thirds of all Hispanics/Latinos in the United States (Ramirez and de la Cruz 2003).

> All [program] materials should be sympathetic to the culture of clients being served.

Two-thirds of the Hispanic/Latino people in the United States were born here. As a group, they are the most urbanized ethnic population in the country. Although poverty rates for Hispanics/Latinos are high compared with those of Whites, by the third generation virtually no difference in income exists between Hispanic/Latino and non-Hispanic/Latino workers who have the same level of education (Bean et al. 2001).

Celebrations and religious ceremonies are an important part of the culture, and use of alcohol is expected and accepted in these celebrations and ceremonies. In the interest of family cohesion and harmony, traditional Hispanic/Latino families tend not to discuss or confront the alcohol problems of family members. Among Hispanics/Latinos with a perceived need for treatment of substance use disorders, 23 percent reported the need was unmet—nearly twice the number of Whites who reported unmet need (Wells et al. 2001). Studies show that Hispanics/Latinos with substance use disorders receive less care and often must delay treatment, relative to White Americans (Wells et al. 2001). De La Rosa and White's (2001) review of the role social support systems play in substance use found that family pride and parental involvement are more influential

among Hispanic/Latino youth than among White or African-American youth. The 2000 Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Household Survey on Drug Abuse (NHSDA) found that nearly 40 percent of Hispanics/Latinos reported alcohol use. Five percent of Hispanics reported use of illicit substances, with the highest rate occurring among Puerto Ricans and the lowest rate among Cubans (Office of Applied Studies 2001). Hispanics/Latinos accounted for 9 percent of admissions to substance abuse treatment in 2000 (Office of Applied Studies 2002).

...only 20 percent of American Indians and Alaska Natives live on reservations or trust lands...

Spanish-language treatment groups are helpful for recently arrived Hispanic/Latino immigrants. Programs in areas with a large population of foreign-born Hispanics/Latinos should consider setting up such groups, using Spanish-speaking counselors. AA has Spanish-language meetings in many parts of the country, especially in urban areas.

African-Americans

African-Americans make up 13 percent of the U.S. population and include 36 million residents who identify themselves as Black, more than half of whom live in a metropolitan area (McKinnon 2003). The African-American population is extremely diverse, coming from many different cultures in Africa, Bermuda, Canada, the Caribbean, and South America. Most African-Americans share the experience of the U.S. history of slavery, institutionalized racism, and segregation (Brisbane 1998).

Foreign-born Africans living in America have had distinctly different experiences from U.S.-born African-Americans. As one demographer points out, "Foreign-born African-Americans and native-born African-Americans are becoming as different from each other as foreign-born and native-born Whites in terms of culture, social status, aspirations and how they think of themselves" (Fears 2002, p. A8). Nearly 8 percent of African-Americans are foreign born; many have grown up in countries with majority Black populations ruled by governments consisting of mostly Black Africans.

The 2000 NHSDA found that 34 percent of African-Americans reported alcohol use, compared with 51 percent of Whites and 40 percent of Hispanics/Latinos. Only 9 percent of African-American youth reported alcohol use, compared with at least 16 percent of White, Hispanic/Latino, and Native-American youth (Office of Applied Studies 2001). Six percent of African-Americans reported use of illicit substances, compared with 6 percent of Whites and 5 percent of Hispanics/Latinos (Office of Applied Studies 2001). African-Americans accounted for 24 percent of admissions to substance abuse treatment in 2000 (Office of Applied Studies 2002). Among African-Americans with a perceived need for substance abuse treatment, 25 percent reported the need was unmet—more than twice the number of Whites who reported unmet need (Wells et al. 2001).

Native Americans

The Bureau of Indian Affairs recognizes 562 different Native-American tribal entities. (The term "Native American" as it is used here encompasses American Indians and Alaska Natives.) Each tribe has unique customs, rituals, languages, beliefs about creation, and ceremonial practices. On the 2000 census, about 2.5 million Americans listed themselves as Native Americans and 1.6 million Americans listed themselves as at least partly Native American, accounting for

4.1 million people or 1.5 percent of the U.S. population (Ogunwole 2002).

Currently only 20 percent of American Indians and Alaska Natives live on reservations or trust lands, where they have access to treatment from the Indian Health Service. More than half live in urban areas (Center for Substance Abuse Prevention 2001). The 2000 NHSDA found that 35 percent of Native Americans reported alcohol use. Thirteen percent of Native Americans reported use of illicit substances (Office of Applied Studies 2001). Among all youth ages 12 to 17, the use of illicit substances was most prevalent among Native Americans—22 percent (Office of Applied Studies 2001). Native Americans begin using substances at higher rates and at a younger age than any other group (U.S. Government Office of Technology Assessment 1994). Native Americans accounted for 3 percent of admissions to substance abuse treatment in 2000 (Office of Applied Studies 2002). More than three-quarters of all Native-American admissions for substance use are due to alcohol. Alcoholism, often intergenerational, is a serious problem among Native Americans (CSAT 1999*b*). One study found that rates for alcohol dependence among Native Americans were higher than the U.S. average (Spicer et al. 2003) but not as high as often had been reported. Thirty percent of men in culturally distinct tribes from the Northern Plains and the Southwest were alcohol dependent, compared with the national average of 20 percent of men. Among the Northern Plains community, 20 percent of women were alcohol dependent, compared with the national average of 8.5 percent. Only 8.7 percent of all women in the Southwest were found to be alcohol dependent.

Among Native Americans, there is a movement toward using Native healing traditions and healers for the treatment of substance use disorders. Spiritually based healing is unique to each tribe or cultural group and is based on that culture's traditional ceremonies and practices.

Asian Americans and Pacific Islanders

Asian Americans and Pacific Islanders are the fastest growing minority group in the United States, making up more than 4 percent of the U.S. population and totaling more than 12 million. They account for more than one-quarter of the U.S. foreign-born population. The vast majority live in metropolitan areas (Reeves and Bennett 2003); more than half live in three States: California, New York, and Hawaii (Mok et al. 2003). Nearly 9 out of 10 Asian Americans either are foreign born or have at least one foreign-born parent (U.S. Census Bureau 2003). Asian Americans represent many distinct groups and have extremely diverse cultures, histories, and religions.

Pacific Islanders are peoples indigenous to thousands of islands in the Pacific Ocean. Pacific Islanders number about 874,000 or 0.3 percent of the population. Fifty-eight percent of these individuals reside in Hawaii and California (Grieco 2001).

Grouping Asian Americans and Pacific Islanders together can mask the social, cultural, linguistic, and psychological variations that exist among the many ethnic subgroups this category represents. Very little is known about interethnic differences in mental disorders, seeking help, and use of treatment services (U.S. Department of Health and Human Services 2001).

The 2000 NHSDA found that 28 percent of Asian Americans and Pacific Islanders reported alcohol use. Only 7 percent of adolescent Asian Americans and Pacific Islanders reported alcohol use, compared with at least 16 percent of White, Hispanic/Latino, and Native-American youth (Office of Applied Studies 2001). Three percent of Asian Americans and Pacific Islanders reported use of illicit substances (Office of Applied Studies 2001). As a group Asian Americans and Pacific Islanders have the lowest rate of illicit substance use, but significant intragroup differences exist.

Koreans (7 percent) and Japanese (5 percent) use illicit substances at much greater rates than Chinese (1 percent) and Asian Indians (2 percent) (Office of Applied Studies 2001). Asian Americans and Pacific Islanders accounted for less than 1 percent of admissions to substance abuse treatment in 2000 (Office of Applied Studies 2002).

Persons With HIV/AIDS

In the United States, more than 918,000 people are reported as having AIDS (Centers for Disease Control and Prevention 2004). HIV is still largely a disease of men who have sex with men and people who inject drugs; these groups together account for nearly four-fifths of all cases of HIV/AIDS (Centers for Disease Control and Prevention 2004). Minorities have a much higher incidence of infection than does the general population. Although African-Americans make up only 13 percent of the U.S. population, they accounted for 50 percent of new HIV infections in 2004 (Centers for Disease Control and Prevention 2004). HIV is spreading most rapidly among women and adolescents. In 2000, females accounted for nearly half of new HIV cases reported among 13- to 24-year-olds. Among 13- to 19-year-olds, females accounted for more than 60 percent of new cases (Centers for Disease Control and Prevention 2002). HIV/AIDS is increasing rapidly among African-American and Hispanic/Latino women. Although they represent less than a quarter of U.S. women, these groups account for more than four-fifths of the AIDS cases reported among women; African-American women account for 64 percent of this total (Centers for Disease Control and Prevention 2004). Gay people who abuse substances also are at high risk because they are more likely to engage in risky sex after alcohol or drug use (Greenwood et al. 2001).

The development of new medications—and combinations of medications—has had a significant effect on the length and quality of life for many people who live with HIV/AIDS. However, these new treatment protocols require clients to take multiple medications on a complicated regimen. Clients with HIV often present with a cluster of problems, including poverty, indigence, homelessness, mental disorders, and other medical problems.

Lesbian, Gay, and Bisexual Clients

LGB individuals come from all cultural backgrounds, ethnicities, racial groups, and regions of the country. Cultural groups differ in how they view their LGB members. In Hispanic culture, matters of sexual orientation tend not to be discussed openly. LGB members of minority groups often find themselves targets of discrimination within their minority culture and of racism in the general culture.

Because of inconsistent research methods and instruments that do not ask about sexual orientation, no reliable information is available on the number of people who use substances among LGB individuals (CSAT 2001). Studies indicate, however, that LGB individuals are more likely to use alcohol and drugs, more likely to continue heavy drinking into later life, and less likely to abstain from using drugs than is the general population. They also are more likely to have used many drugs, including such drugs as Ecstasy, ketamine ("Special K"), amyl nitrite ("poppers"), and gamma hydroxybutyrate during raves and parties. These drugs affect judgment, which can increase risky sexual behavior and may lead to HIV/AIDS or hepatitis (Centers for Disease Control and Prevention 1995; Greenwood et al. 2001; Woody et al. 1999).

Persons With Physical and Cognitive Disabilities

Nearly one-sixth of all Americans (53 million) have a disability that limits their

functioning. More than 30 percent of those with disabilities live below the poverty line and generally spend a large proportion of their incomes to meet their disability-related needs (LaPlante et al. 1996). Most people with disabilities can and want to work. But those with skills tend to be underemployed or unemployed. The combination of depression, pain, vocational difficulties, and functional limitations places people with physical disabilities at increased risk of substance use disorders (Hubbard et al. 1996).

Those with cognitive or physical disabilities are more likely than the general population to have a substance use disorder but less likely to receive effective treatment (Moore and Li 1998). Many community-based treatment programs do not currently meet the Federal requirements of the Americans with Disabilities Act. An IOT program is likely to have clients who present with a variety of disabilities. Experienced clinicians report that an appreciable number of individuals with substance use disorders have unrecognized learning disabilities that can impede successful treatment. People who have the same disability may have differing functional capacities and limitations.

Treating substance use disorders in persons with disabilities is an emerging field of study. Culture brokering is a treatment approach that was developed to mediate between the culture of a foreign-born person and the health care culture of the United States. This model helps rehabilitation providers understand the role that culture plays in shaping the perception of disabilities and treatment (Jezewski and Sotnik 2001). Culture brokering is an extension of techniques that IOT providers already practice, including assessment and problemsolving.

Rural Populations

In 2000, nearly 20 percent of the U.S. population (55.4 million people) lived in nonmetropolitan areas; the nonmetropolitan population increased 10.2 percent from 1990 to 2000 (Perry and Mackun 2001). The economic base and ethnic diversity of these populations, not just their isolation, are critical factors. This population includes people of Anglo-European heritage in Appalachia and in farming and ranching communities of the Midwest and West, Hispanic/Latino migrant farm workers across the South, and Native Americans on reservations.

Treating substance use disorders in persons with disabilities is an emerging field of study.

Despite this diversity, rural communities from different parts of the country have commonalities: low population density, limited access to goods and services, and considerable familiarity with other community members. People living in rural situations also share broad characteristics that affect treatment. These characteristics are

- Overall higher resistance to seeking help because of pride in self-sufficiency
- Concerns about confidentiality and resistance to participating in group work because in small communities "everyone knows everyone else"
- A sense of strong individuality and privacy, sometimes coupled with difficulty in expressing emotions
- A culturally embedded suspicion of treatment for substance use and mental disorders, although this varies widely by area

Among adults older than age 25, the rate of alcohol use is lower in rural areas than in metropolitan areas. But rates of heavy alcohol use among youth ages 12 to 17 in rural areas are almost double those seen in metropolitan areas (Office of Applied Studies 2001). Women in rural areas have higher

rates of alcohol use and alcoholism than women in metropolitan areas (American Psychological Association 1999). However, in one study, urban residents received substance abuse treatment at more than double the rate of their rural counterparts (Metsch and McCoy 1999). Researchers attribute this disparity to the relative unavailability and unacceptability of substance abuse treatment in rural areas of the United States (Metsch and McCoy 1999).

Homeless Populations

Approximately 600,000 Americans are homeless on any given night. One census count of people who are homeless found about 41 percent were White, 40 percent were African-American, 11 percent were Hispanic, and 8 percent were Native American. Compared with all U.S. adults, people who are homeless are disproportionately African-American and Native American (Urban Institute et al. 1999). Homeless populations include groups of people who are

- **Transient.** These individuals may stay temporarily with others or have a living pattern that involves rotating among a group of friends, relatives, and acquaintances. These individuals are at high risk of suddenly finding themselves on the street. For some, continued living in other people's residences may be contingent on providing sex or drugs.
- **Recently displaced.** Some people may be employed but have been evicted from their homes. Their housing instability may be related to financial problems resulting from substance use.
- **Chronically homeless.** These individuals may have severe substance use and mental disorders and are difficult to attract into traditional treatment settings. Reaching these individuals requires the IOT program to bring its services to the homeless through a variety of creative outreach and programming initiatives.

Approximately two-thirds of people who are homeless report having had an alcohol, drug, or mental disorder in the previous month (Urban Institute et al. 1999). Three-quarters of people who are homeless and need substance abuse treatment do not receive it (Magura et al. 2000). For 50 percent of people who are homeless and admitted to treatment, alcohol is the primary substance of abuse, followed by opioids (18 percent) and crack cocaine (17 percent) (Office of Applied Studies 2003*b*). Twenty-three percent of people who are homeless and in treatment have co-occurring disorders, compared with 20 percent who are not homeless (Office of Applied Studies 2003*b*). People who are homeless are more than three times as likely to receive detoxification services as people who are not homeless (45 percent vs. 14 percent) (Office of Applied Studies 2003*b*).

In addition to the resources found in appendix 10-A, the following clinical guidelines will assist providers in treating people who are homeless:

- Clients who are homeless often drop out of treatment early. Meeting survival needs of clients who are homeless is integral to successful outcomes. An IOT program needs to provide safe shelter, warmth, and food, in addition to the components of effective treatment provided to other clients who use substances, including extensive continuing care (Milby et al. 1996).
- Individuals who are homeless benefit from intensive contact early in treatment. Clients who attend treatment an average of 4.1 days per week are more successful than those attending fewer days (Schumacher et al. 1995).
- The Alcohol Dependence Scale, the Alcohol Severity Index, and the personal history form have been found to be reliable and valid screening tools for this population (Joyner et al. 1996). Reliability is higher when items are factual and based on a recent time interval and when individuals are interviewed in a protected setting.

- Case management must be available to ease access to and coordinate the variety of services needed by clients who are homeless and abuse substances. Case management should arrange for stable, safe, and drug-free housing. The availability of housing is a powerful influence on recovery. Making such housing contingent on abstinence has been shown to be a useful strategy (Milby et al. 1996). Case management also should coordinate medical care, including psychiatric care, with vocational training and education to help individuals sustain a self-sufficient life.
- Providers should work with homeless shelters to provide treatment services. Strategies include (1) working with staff members at shelters and with public housing authorities to find and arrange for housing, (2) locating the IOT program within a homeless shelter or at least providing core elements of IOT at the shelter, and (3) placing a substance abuse treatment specialist at the shelter as a liaison with the IOT program.

Older Adults

The number of older adults needing treatment for substance use disorders is expected to increase from 1.7 million in 2001 to 4.4 million by 2020. This increase is the result of a projected 50-percent increase in the number of older adults as well as a 70-percent increase in the rate of treatment need among older adults (Gfroerer et al. 2003). America's aging cohort of baby boomers (people born between 1946 and 1964) is expected to place increasing demands on the substance abuse treatment system in the coming years, requiring a shift in focus to address their special needs. This older generation will be more ethnically and racially diverse and have higher substance use and dependence rates than current older adults (Korper and Council 2002).

As a group, older people tend to feel shame about substance use and are reluctant to seek out treatment. Many relatives of older individuals with substance use disorders also are ashamed of the problem and rationalize the substance use or choose not to address it. Diagnosing and treating substance use disorders are more complex in older adults than in other populations because older people have more—and more interconnected—physical and mental health problems. Barriers to effective treatment include lack of transportation, shrinking social support networks, and financial constraints.

Oslin and colleagues (2002) find that older adults had greater attendance and lower incidence of relapse than younger adults in treatment and conclude that older adults can be treated successfully in mixed-age groups, provided that they receive age-appropriate individual treatment. When treating older clients, IOT programs need to be involved actively with the local network of aging services, including home- and community-based long-term care providers. Older individuals who do not see themselves as abusers—particularly those who misuse over-the-counter or prescription drugs or do not understand the problems caused by alcohol and drug interactions—need to be reached through wellness, health promotion, social service, and other settings that serve older adults. In addition, IOT programs can broaden the multicultural resources available to them by working through the aging service network to link up with diverse language, cultural, and ethnic resources in the community.

> ...older adults ha[ve] greater attendance and lower incidence of relapse than younger adults...

IOT programs that develop geriatric expertise can provide an essential service by making consultation available to staff members at IOT programs that face similar challenges, along with inservice training, coordination of interventions, and care

conferences designed to solve problems and develop care plans for individuals. There also may be opportunities to make this expertise available to caregivers and participants in settings where older adults receive interdisciplinary care (e.g., a support group for family caregivers or a discussion group for participants at a social daycare or adult day health center).

Appendix 10-A. Cultural Competence Resources

Many resources listed below are volumes in the TIP and Technical Assistance Publication (TAP) Series published by CSAT. TIPs and TAPs are free and can be ordered from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at www.ncadi.samhsa.gov or (800) 729-6686 (TDD, [800] 487-4889). The full text of each TIP can be searched and downloaded from www.samhsa.gov/centers/csat2002/publications.html.

The Health Resources and Services Administration lists cultural competence assessment tools, resources, curricula, and Web-based trainings at www.hrsa.gov/culturalcompetence.

General

The Journal of Ethnicity in Substance Abuse—This quarterly journal (formerly *Drugs and Society*) explores culturally competent strategies in individual, group, and family treatment of substance abuse. The journal also investigates the beliefs, attitudes, and values of people who abuse substances to understand the origins of substance abuse for different populations. Visit www.haworthpress.com/web/JESA to find out more.

Cultural Issues in Substance Abuse Treatment (CSAT 1999*b*)—This booklet contains population-specific discussions of treatment for Hispanic Americans, African-Americans, Asian Americans and Pacific Islanders, and American Indians and Alaska Natives, along with general guidelines on cultural competence. Order from SAMHSA's NCADI.

Chapter 4, "Preparing a Program To Treat Diverse Clients," in TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*)—This chapter includes an introduction to cultural competence and why it matters to treatment programs, as well as information on assessing a diverse population's treatment needs and conducting outreach to attract clients and involve the community. This chapter also includes a list of resources for assessment and training, in addition to culture-specific resources.

The forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT forthcoming *a*)—This volume addresses screening, assessment, and treatment planning; case management; counseling for specific cultural groups; and engaging and retaining diverse clients in the context of cultural competence.

"Alcohol Use Among Special Populations" (National Institute on Alcohol Abuse and Alcoholism 1998)—This special issue of the journal *Alcohol Health & Research World* (now called *Alcohol Research & Health*) includes articles on alcohol use in Asian Americans and Pacific Islanders, African-Americans, Alaska Natives, Native Americans, and Hispanics/Latinos. Authors also address such topics as alcohol availability and advertising in minority communities, special populations in AA, and alcohol consumption in India, Mexico, and Nigeria. Visit pubs.niaaa.nih.gov/publications/arh22-4/toc22-4.htm to download the articles.

Mental Health: Culture, Race, and Ethnicity (U.S. Department of Health and Human Services 2001)—This publication describes the disparities in mental health services that affect minorities, presents evidence of the need to address those disparities, and documents promising strategies to eliminate them. Visit www.mentalhealth.samhsa.gov/cre/default.asp to download a copy of this publication.

Cultural Competence Works: Using Cultural Competence To Improve the Quality of Health Care for Diverse Populations and Add Value to Managed Care Arrangements (Health Resources and Services Administration 2001)—This booklet bases its recommendations for implementing cultural competence

on practices already in place in health care programs across the country. Along with its general discussions of culturally competent care, the publication includes descriptions of the programs from which the recommendations are drawn and a list of resources. Visit minority-health.pitt.edu/archive/00000278 to download a copy of this publication.

Counseling the Culturally Different: Theory and Practice, Third Edition (Sue and Sue 1999)—This book offers a conceptual framework for counseling across cultural lines and includes treatment recommendations for specific cultural groups, with individual chapters on counseling Hispanics/Latinos, African-Americans, Asian Americans, and Native Americans and special sections on women, gay and lesbian people, and persons who are elderly and disabled.

Bridges to Recovery: Addiction, Family Therapy, and Multicultural Treatment (Krestan 2000)—This volume of essays discusses substance abuse treatment for Native-American, African-American, West Indian, Asian-American, Mexican-American, and Puerto Rican families.

The Cultural Context of Health, Illness, and Medicine (Loustaunau and Sobo 1997)—This book, written by a sociologist and an anthropologist, examines the ways in which cultural and social factors shape understandings of health and medicine. Although its discussions are not specific to substance abuse, they address the effect of social structures on health, differing conceptions of wellness, and cross-cultural communication.

Pocket Guide to Cultural Health Assessment, Third Edition (D'Avanzo and Geissler 2003)—This quick reference guide has individual sections on 186 countries, each of which lists demographic information (e.g., population, ethnic and religious descriptions, languages spoken), political and social information, and health care beliefs.

American Cultural Patterns: A Cross-Cultural Perspective, Second Edition (Stewart and Bennett 1991)—This book focuses on aspects of American culture that are central to understanding how American society functions. The authors examine perceptions, thought processes, language, and nonverbal behaviors and their effect on cross-cultural communication.

Promoting Cultural Diversity: Strategies for Health Care Professionals (Kavanagh and Kennedy 1992)—This text discusses strategies for learning about diversity and techniques for communicating effectively with culturally diverse populations. Case studies are used to illustrate the practical applications of cross-cultural communication.

Hispanics/Latinos

Materials for clients

NCADI has publications and videotapes for clients, parents, and employers available in Spanish. Visit www.ncadi.samhsa.gov.

The National Institute on Drug Abuse (NIDA) offers a number of publications in Spanish. Visit www.nida.nih.gov.

Relapse prevention workbooks in Spanish can be purchased at www.tgorski.com.

The Hazelden Foundation offers a collection of Spanish fellowship books and videotapes approved by AA and Narcotics Anonymous. Visit www.hazelden.org.

Materials for counselors

CSAP Substance Abuse Resource Guide: Hispanic/Latino Americans (Center for Substance Abuse Prevention 1996*b*; www.ncadi.samhsa.gov/govpubs/MS441/)—This resource guide provides information and referrals to help prevention specialists, educators, and community leaders better meet the needs of the Hispanic/Latino community. Order from SAMHSA's NCADI.

Quality Health Services for Hispanics: The Cultural Competency Component (National

Alliance for Hispanic Health 2000)—This book includes sections on the culture, language, and history of Hispanics/Latinos in the United States, Hispanic/Latino health status, guidelines for education and outreach, recommendations for working cross-culturally, and case studies. Visit www.ask.hrsa.gov/detail.cfm?id=PC00029 to order this volume.

"Counseling Latino Alcohol and Other Substance Users/Abusers: Cultural Considerations for Counselors" (Gloria and Peregoy 1996)—This article discusses Hispanic/Latino cultural values as they relate to substance use and presents a substance abuse counseling model for use with Hispanic/Latino clients.

"Drugs and Substances: Views From a Latino Community" (Hadjicostandi and Cheurprakobkit 2002)—The researchers explore perceptions and use of licit and illicit substances in a Hispanic/Latino community. The primary concerns of the community are the increasing availability and use of substances among Hispanic/Latino youth.

"Acculturation and Latino Adolescents' Substance Use: A Research Agenda for the Future" (De La Rosa 2002)—This article reviews literature on the effects of acculturation to Western values on Hispanic/Latino adolescents' mental health and substance use, discusses the role that acculturation-related stress plays in substance use, and suggests directions for treatment and further research.

"Cultural Adaptations of Alcoholics Anonymous To Serve Hispanic Populations" (Hoffman 1994)—This article evaluates two specific adaptations to 12-Step fellowship: one adapts conceptions of machismo and the other is less confrontational.

African-Americans

Chemical Dependency and the African American: Counseling and Prevention Strategies, Second Edition (Bell 2002)—This book from the co-founder of the Institute on Black Chemical Abuse explores the dynamics of race, culture, and class in treatment and examines substance abuse and recovery in the context of racial identity.

Cultural Competence for Health Care Professionals Working With African-American Communities: Theory and Practice (Center for Substance Abuse Prevention 1998*a*)—This book provides tips for health care workers. Order from SAMHSA's NCADI or download at www.hawaii.edu/hivandaids/links.htm.

Relapse Prevention Counseling for African Americans: A Culturally Specific Model (Williams and Gorski 1997)—This book examines the way that cultural factors interact with relapse prevention efforts in African-Americans.

Relapse Prevention Workbook for African Americans: Hope and Healing for the Black Substance Abuser (Williams and Gorski 1999)—This workbook leads readers through clinical exercises designed to help them avoid relapse due to race-related issues.

"Drug Treatment Effectiveness: African-American Culture in Recovery" (Bowser and Bilal 2001)—This article endeavors to explain African-Americans' high rates of substance abuse and low rates of recovery. Culture is seen as both a problem and a solution; some African-American coping strategies act as barriers, but successful treatment programs incorporate African-American cultural elements.

Native Americans

Materials for clients

GONA (Gathering of Native Americans) is a community development and empowerment training process that uses Native-American trainers. A GONA curriculum provides structure for Native-American community gatherings and is available from SAMHSA. Visit p2001.health.org/CTI05/Cti05ttl.htm.

A significant recovery movement for Native-American people is the Red Road to Recovery developed by Gene Thin Elk, a Lakota elder. Many individuals, especially in urban areas, have achieved and maintained sobriety by following the Red Road. The Red Road to Recovery addresses the cognitive, affective, and experiential needs of Native Americans who are rebuilding their lives from substance use and mental disorders and presents a system of cultural values that promote an abstinent and balanced lifestyle. The following Web sites offer information on GONA, the Red Road to Recovery, and other Native-American recovery resources:

- www.naigso-aa.org. This Web site of the Native-American Indian General Service Office of Alcoholics Anonymous includes a link to information on Talking Circles. Talking Circles are common practice in Native-American treatment settings.
- www.whitebison.org. This Web site offers information about the Wellbriety Movement (a Native-American recovery movement that emphasizes health and abstinence), which includes information about Wellbriety for youth, children of people who abuse alcohol, and people in prison. The site also includes a Talking Circle chat room, training information and materials, and books, videotapes, and audiotapes on recovery.

Materials for counselors

Health Promotion and Substance Abuse Prevention Among American Indian and Alaska Native Communities: Issues in Cultural Competence (Center for Substance Abuse Prevention 2001)—This volume frames the development of substance abuse prevention and treatment efforts in the context of health disparities that have affected Native-American and Alaskan-Native communities in rural and urban settings, as well as on reservations. Grounded in traditional healing practices, the volume examines innovative approaches to substance abuse prevention. Order from SAMHSA's NCADI.

Substance Abuse Resource Guide: American Indians and Native Alaskans (Center for Substance Abuse Prevention 1998*b*)—A substance abuse resource guide for American Indians and Alaska Natives, including books, articles, classroom materials, posters, and Web sites. Order from SAMHSA's NCADI.

"Addiction and Recovery in Native America: Lost History, Enduring Lessons" (Coyhis and White 2002)—This journal article provides recommendations for treatment based on the history of addiction in Native-American communities.

Promising Practices and Strategies To Reduce Alcohol and Substance Abuse Among American Indians and Alaska Natives (American Indian Development Associates 2000)—This report collects descriptions of successful substance abuse prevention efforts by Native-American groups. It also includes a literature review and list of Federal resources. Visit www.ojp.usdoj.gov/americannative/promise.pdf to download the report.

"Morning Star Rising: Healing in Native American Communities" (Nebelkof et al. 2003)—This special issue of the *Journal of Psychoactive Drugs* is devoted to healing in Native-American communities, with 13 articles on various aspects of prevention and treatment. Contact Haight-Ashbury Publications at (415) 565-1904.

Walking the Same Land—This videotape presents young Indians who are returning to traditional cultural ways to strengthen their recovery from substance abuse. It includes aboriginal men from Australia and Mohawk men from New York. Order from SAMHSA's NCADI.

Asian Americans and Pacific Islanders

Asian and Pacific Islander American Health Forum (www.apiahf.org/resources/index.htm)— This site provides links to information and resources.

Asian Community Mental Health Services (www.acmhs.org)—This site provides links to information and describes a substance abuse treatment program in Oakland, California.

Substance Abuse Resource Guide: Asian and Pacific Islander Americans (Center for Substance Abuse Prevention 1996*a*; ncadi.samhsa.gov/govpubs/MS408)—This guide contains resources appropriate for use in Asian and Pacific Islander communities. It also contains facts and figures about substance use and prevention within this diverse group.

Asian American Mental Health: Assessment Theories and Methods (Kurasaki et al. 2002)—This compendium of essays highlights conceptual, theoretical, methodological, and practice issues related to Asian-American mental health assessment. This text focuses on important questions about the cultural nature of diagnostic and assessment processes.

Responding to Pacific Islanders: Culturally Competent Perspectives for Substance Abuse Prevention (Center for Substance Abuse Prevention 1999)—This book examines the culture-specific factors that affect substance abuse prevention in Pacific Islander communities. Order from SAMHSA's NCADI.

"Communicating Appropriately With Asian and Pacific Islander Audiences" (Center for Substance Abuse Prevention 1997)—This *Technical Assistance Bulletin* discusses population characteristics, lists cultural factors related to substance use in nine distinct ethnic groups, and presents guidelines on developing effective prevention materials for these populations. Visit ncadi.samhsa.gov/govpubs/MS701 to download the bulletin.

Opening Doors: Techniques for Talking With Southeast Asian Clients About Alcohol and Other Drug Issues—This program is available on videocassette in Vietnamese and Khmer with English subtitles. Order from SAMHSA's NCADI, and visit store.health.org/catalog/productDetails.aspx?ProductID=15136 to view it on the Web.

Persons With HIV/AIDS

TIP 37, *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT 2000*c*)—This TIP discusses the medical aspects of HIV/AIDS (epidemiological data, assessment, treatment, and prevention), the legal and ethical implications of treatment, the counseling of patients with HIV/AIDS, the integration of treatment and enhanced services, and funding sources for programs.

The Hawaii AIDS Education and Training Center has numerous resources available for download at www.hawaii.edu/hivandaids/links.htm.

LGB Populations

The Web site of the National Association of Lesbian and Gay Addiction Professionals is a clearinghouse for information and resources, including treatment programs and mutual-help groups, organized by State. Visit www.nalgap.org.

Substance Abuse Resource Guide: Lesbian, Gay, Bisexual, and Transgender Populations (Center for Substance Abuse Prevention 2000)—This publication lists books, fact sheets, magazines, newsletters, videos, posters, reports, Web sites, and organizations that increase understanding of issues important to lesbian, gay, bisexual, and transgender clients. Download the resource guide from ncadi.samhsa.gov/referrals/resguides.aspx?InvNum=MS489.

A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals (CSAT 2001)—This book addresses issues of interest to clinicians and administrators. It discusses treatment approaches for this population, ways to improve services to LGB clients, steps for starting LGB-sensitive programs, organizational missions, and strategies for building alliances to provide services. Order from SAMHSA's NCADI.

Counseling Lesbian, Gay, Bisexual, and Transgender Substance Abusers: Dual Identities, Second Edition (Finnegan and McNally 2002)—This guide examines different counseling approaches and provides practical treatment suggestions for LGB populations. The book includes an organization audit of attitudes and practices, plus a list of resources and other suggested readings.

*Addiction and Recovery in Gay and Lesbian Person*s (Kus 1995)—This book examines the incidence of substance use among gay and lesbian people and special concerns when treating this population, including HIV/AIDS, homophobia, gay and lesbian mutual-help groups, and special needs of rural gay and lesbian clients.

Addictions in the Gay and Lesbian Community (Guss 2000)—This volume includes personal experiences of substance use and recovery and research into the sources of and treatment for substance use disorders in gay and lesbian clients. The book also includes techniques for assessing and treating LGB clients, including adolescents.

Persons With Physical and Cognitive Disabilities

IOT programs should link with local groups that offer specialized housing, vocational training, and other supports for people who are disabled. The Centers for Independent Living (CILs) are organizations run by and for persons with disabilities to provide mutual-help and advocacy. CILs and Client Assistance Programs were developed to provide a third party to broker the interaction between clients and the service system. The Special Olympics may be able to help locate recreational activities appropriate for individual clients.

Materials for clients

For a catalog of AA literature available on audiocassettes, in Braille, and in large print, as well as a list of closed-caption videotapes, AA books in American Sign Language on videotape, and easy-to-read literature, contact Alcoholics Anonymous General Service Office, P.O. Box 459, Grand Central Station, New York, NY 10163 or orders@aa.org.

Materials for counselors

Coping With Substance Abuse After TBI—This report answers basic questions about substance use and traumatic brain injury (TBI) and includes recommendations from clients with TBI who are now abstinent. Download the publication at www.mssm.edu/tbicentral/resources/publications/tbi_consumer_reports.shtml.

TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998*e*)—This volume discusses screening, treatment planning, and counseling for clients with disabilities. The book includes a compliance guide for the Americans with Disabilities Act, a list of appropriate terms to use when referring to people with disabilities, and screening instruments for use with this population, including an Education and Health Survey and an Impairment and Functional Limitation Screen.

TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998*a*)—This TIP discusses various models of case management and provides information on linking with service providers and evaluation. Chapter 5 explores the use of case management services with special needs populations.

TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT 2000*a*)—This volume examines the role that employment plays in recovery from substance use disorders, with special attention to referral relationships and their capacity to expand the services available to clients and enhance the resources available to programs.

Substance Abuse Resources and Disability Issues Program at Wright State School

of Medicine (www.med.wright.edu/citar/sardi)—This Web site offers products for professionals and persons with disabilities, including a training manual with an introduction on substance abuse and the deaf culture, as well as a Web course on substance abuse and disability.

National Center for the Dissemination of Disability Research's Guide to Substance Abuse and Disability Resources (www.ncddr.org/du/products/saguide)—This Web site provides links to books, journal articles, newsletters, training manuals, audiotapes, and videotapes on substance abuse and individuals who are disabled.

Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals (www.mncddeaf.org)—This Web site includes links to articles on substance abuse treatment of individuals who are deaf and to manuals and videotapes for use in treatment.

Co-Occurring and Other Functional Disorders Cluster Cultural Diversity Training Guide (www.med.wright.edu/citar/sardi/publications.html)—This guide recommends topics and methods for initial staff training in cultural diversity for programs serving clients who are disabled and includes a list of references on multicultural counseling.

Ohio Valley Center for Brain Injury Prevention and Rehabilitation (www.ohiovalley.org/abuse)—This Web site includes guidelines for treating people with substance use disorders and traumatic brain injury and links to other resources.

Center for International Rehabilitation Research and Information Exchange (cirrie.buffalo.edu/mseries.html)—This Web site includes downloadable versions of cultural guides that describe the demographics and attitudes toward disability of 11 countries, including countries in Asia, Central America, and the Caribbean. The site also includes a booklet that describes culture brokering, a practice in which counselors mediate between cultures to improve service delivery.

Rural Populations

TAP 17, *Treating Alcohol and Other Drug Abusers in Rural and Frontier Areas* (CSAT 1995*b*)—The papers in this volume describe providers' experiences across a variety of treatment issues relevant to rural substance abuse treatment, including domestic violence, enhanced service delivery, building coalitions and networks, and practical measures to improve treatment.

TAP 20, *Bringing Excellence to Substance Abuse Services in Rural and Frontier America* (CSAT 1996)—The papers in this volume examine innovative strategies and policies for treating substance use disorders in rural and frontier America. Topics include rural gangs and crime, needs assessment approaches, coalitions and partnerships, and minorities and women in treatment.

Rural Substance Abuse: State of Knowledge and Issues (Robertson et al. 1997)—This NIDA Research Monograph examines rural substance abuse from many perspectives, looking at substance use among youth and at the health, economic, and social consequences of substance use. The final section of the book addresses ethnic and migrant populations, including rural Native Americans, African-Americans, and Mexican Americans. Visit www.nida.nih.gov/PDF/Monographs/Monograph168/Download168.html to download the monograph.

Homeless Populations

National Resource Center on Homelessness and Mental Illness (www.nrchmi.samhsa.gov/pdfs/bibliographies/Cultural_Competence.pdf)—This Web site has an annotated, online bibliography of journal articles, resource guides, reports, and books that address cultural competence. Many resources discuss substance use disorders.

"The Effectiveness of Social Interventions for Homeless Substance Abusers" (American Society of Addiction Medicine 1995)—This special issue of the *Journal of Addictive Diseases*

includes 11 articles that examine important aspects of treating people who are homeless, including retaining clients, residential versus nonresidential treatment, enhanced services, treating mothers who are homeless, and clients with co-occurring disorders.

The U.S. Department of Housing and Urban Development has compiled a list of local agencies by State and other resources to assist people who are homeless. Visit www.hud.gov/homeless/index.cfm.

The U.S. Department of Health and Human Services offers assistance and resources for people who are homeless. For example, the Health Care for the Homeless Program provides grants to community-based organizations in urban and rural areas for projects aimed at improving access for the homeless to primary health care, mental health care, and substance abuse treatment. Visit aspe.hhs.gov/homeless/index.shtml.

Substance Abuse Treatment: What Works for Homeless People? A Review of the Literature (Zerger 2002)—This report links research on homelessness and substance abuse with clinical practice and examines various treatment modalities, types of interventions, and methods for engaging and retaining people who are homeless. Download the report from National Health Care for the Homeless Council's Web site at www.nhchc.org/Publications/SubstanceAbuseTreatmentLitReview.pdf.

National Resource Center on Homelessness and Mental Illness (www.nrchmi.samhsa.gov)—This Web site lists trainings and workshops (such as the National Training Conference on Homelessness for People With Mental Illness and/or Substance Use Disorders), technical assistance, and fact sheets and other publications on homelessness.

Older Adults

TIP 26, *Substance Abuse Among Older Adults* (CSAT 1998*d*)—This volume discusses the relationship between aging and substance abuse and offers guidance for screening, assessing, and treating substance use disorders in older adults.

Substance Abuse Relapse Prevention for Older Adults: A Group Treatment Approach (CSAT 2005*c*)—This manual presents a relapse prevention intervention that uses a cognitive–behavioral and self-management approach in a counselor-led group setting to help older adults overcome substance use disorders. Order from SAMHSA's NCADI.

Substance Abuse by Older Adults: Estimates of the Future Impact on the Treatment System (Korper and Council 2002)—This report examines substance abuse treatment services for older adults in the context of increased demand in the future and calls for better documentation of substance abuse among older adults and prevention and treatment strategies that are tailored to subgroups of older adults, such as immigrants and racial and ethnic minorities. Download the report at www.drugabusestatistics.samhsa.gov/aging/toc.htm.

Alcohol and Aging (Beresford and Gomberg 1995)—This book for clinicians covers topics such as diagnosis and treatment, mental disorders, interactions of alcohol and prescription medications, and the biochemistry of intoxication for older adults.

Alcoholism and Aging: An Annotated Bibliography and Review (Osgood et al. 1995)—This volume surveys 30 years of research on older adults who use alcohol, providing abstracts of articles, books and book chapters, and research studies on the prevalence, effects, diagnosis, and treatment of alcohol use in older adults.

Administration on Aging (www.aoa.gov/prof/adddiv/adddiv.asp)—This Web site offers information on cultural competence, including resources on aging and ethnic minorities and the booklet, *Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans and Their Families*, which can be downloaded at www.aoa.gov/prof/adddiv/cultural/addiv_cult.asp.

Appendix A—Bibliography

Addington, J., and el-Guebaly, N. Group treatment for substance abuse in schizophrenia. *Canadian Journal of Psychiatry* 43(8):843–845, 1998.

Alcoholics Anonymous World Services. *The A.A. Member–Medications and Other Drugs*. New York: Alcoholics Anonymous World Services, 1991.

Allen, J.P., and Columbus, M., eds. *Assessing Alcohol Problems: A Guide for Clinicians and Researchers.* Treatment Handbook Series 4. NIH Publication No. 95–3723. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, 1995.

Amass, L., and Kamien, J.B. A tale of two cities: Financing two voucher programs for substance abusers through community donations. *Experimental and Clinical Psychopharmacology* 12(2):147–155, 2004.

American Academy of Pediatrics. Fetal alcohol syndrome and alcohol-related neurodevelopmental disorders. *Pediatrics* 106:358–361, 2000.

American Indian Development Associates. *Promising Practices and Strategies To Reduce Alcohol and Substance Abuse Among American Indians and Alaska Natives.* Washington, DC: Office of Justice Programs, 2000.

American Medical Association. Role of Self-Help in Addiction Treatment. Res. 713, A-98. 1998. www.ama-assn.org/ama1/pub/upload/mm/388/referral_treatment.pdf [accessed April 26, 2004].

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised (DSM-III-R). Washington, DC: American Psychiatric Association, 1987.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV). Washington, DC: American Psychiatric Association, 1994.

American Psychiatric Association. *Practice Guidelines for Treatment of Patients With Substance Use Disorders: Alcohol, Cocaine, Opioids.* Washington, DC: American Psychiatric Association, 1995.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR). Washington, DC: American Psychiatric Association, 2000.

American Psychological Association (APA). *APA Rural Initiative: 1999 Year in Review.* Washington, DC: APA, 1999. www.apa.org/rural/report99.html [accessed February 11, 2004].

American Society of Addiction Medicine. The effectiveness of social interventions for homeless substance abusers (special issue). *Journal of Addictive Diseases* 14(4), 1995.

American Society of Addiction Medicine. Relationship Between Treatment and Self Help: A Joint Statement of the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry, 1997. www.asam.org/ppol/aaap.htm [accessed February 11, 2004].

Armstrong, T.D., and Costello, E.J. Community studies on adolescent substance use, abuse, or dependence and psychiatric comorbidity. *Journal of Consulting and Clinical Psychology* 70:1224–1239, 2002.

Avants, S.K.; Margolin, A.; Kosten, T.R.; Rounsaville, B.J.; and Schottenfeld, R.S. When is less treatment better? The role of social anxiety in matching methadone patients to psychosocial treatments. *Journal of Consulting and Clinical Psychology* 66(6):924–931, 1998.

Barker, R.L. *The Social Work Dictionary*, Fourth Edition. Washington, DC: National Association of Social Workers, 1999.

Bartholomew, N.G.; Rowan-Szal, G.A.; Chatham, L.R.; Nucatola, D.C.; and Simpson, D.D. Sexual abuse among women entering methadone treatment. *Journal of Psychoactive Drugs* 34(4):347–354, 2002.

Bean, F.D.; Trejo, S.J.; Crapps, R.; and Tyler, M. *The Latino Middle Class: Myth, Reality, and Potential.* Los Angeles, CA: Tomás Rivera Policy Institute, 2001.

Beck, A.J., and Harrison, P.M. Prisoners in 2000. *Bureau of Justice Statistics Bulletin.* Washington, DC: Office of Justice Programs, August 2001. www.ojp.gov:80/bjs/abstract/p00.htm [accessed February 11, 2004].

Belenko, S. Research on drug courts: A critical review, 1999 update. *National Drug Court Institute Review* 2(2):1–59, 1999.

Bell, P. *Chemical Dependency and the African American: Counseling and Prevention Strategies*, Second Edition. Center City, MN: Hazelden Publishing, 2002.

Beresford, T., and Gomberg, E., eds. *Alcohol and Aging.* New York: Oxford University Press, 1995.

Bigelow, G.E., and Silverman, K. Theoretical and empirical foundations of contingency management treatments for drug abuse. In: Higgins, S.T., and Silverman, K., eds. *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions.* Washington, DC: American Psychological Association, 1999, pp. 15–31.

Bixler, J.B., and Emery, B.D. Successful programs for individuals with co-occurring mental health and substance abuse disorders: Examples from five states. *A Report of the Joint NASMHPD-NASADAD*

Task Force on Co-Occurring Mental Health and Substance Abuse Disorders. Alexandria, VA: National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors, 2000.

Bloom, F.; Owen, B.; and Covington, S. *Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders.* Washington, DC: National Institute of Corrections, June 2003. nicic.org/pubs/2003/018017.pdf [accessed February 11, 2004].

Blume, S.B. Understanding addictive disorders in women. In: Graham, A.W.; Shultz, T.K.; and Wilford, B.B., eds. *Principles of Addiction Medicine*, Second Edition. Chevy Chase, MD: American Society of Addiction Medicine, Inc., 1998, pp.1173–1190.

Bowser, B.P., and Bilal, R. Drug treatment effectiveness: African-American culture in recovery. *Journal of Psychoactive Drugs* 33(4):391–402, 2001.

Boylin, W.M., and Doucette, J. Multifamily therapy in substance abuse treatment with women. *American Journal of Family Therapy* 25(1):39–47, 1997.

Bradley, B.P.; Gossop, M.; Phillips, G.T.; and Legarda, J.J. The development of an opiate withdrawal scale (OWS). *British Journal of the Addictions* 82:1139–1142, 1987.

Brady, K.T., and Randall, C.L. Gender differences in substance use disorders. *Psychiatric Clinics of North America* 22(2):241–252, 1999.

Brems, C.; Johnson, M.E.; and Namyniuk, L.L. Clients with substance abuse and mental health concerns: A guide for conducting intake interviews. *Journal of Behavioral Health Services Research* 29(3):327–334, 2002.

Brisbane, F.L. Introduction: Diversity among African Americans. In: Center for Substance Abuse Prevention (CSAP). *Cultural Competence for Health Care Professionals Working With African-American Communities: Theory and Practice.* CSAP Cultural Competence Series 7. DHHS Publication No. (SMA) 98–3238. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998, pp. 1–8.

Brochu, S.; Guyon, L.; and Desjardins, L. Comparative profiles of addicted adult populations in rehabilitation and correctional services. *Journal of Substance Abuse Treatment* 6(2):173–182, 1999.

Brown, T.G.; Seraganian, P.; Tremblay, J.; and Annis, H. Matching substance abuse aftercare treatments to client characteristics. *Addictive Behavior* 27:585–604, 2002.

Budney, A.J., and Higgins, S.T. *A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction.* Manual 2: Therapy Manuals for Drug Addiction Series. NIH Publication No. 98–4309. Rockville, MD: National Institute on Drug Abuse, 1998.

Bureau of Justice Assistance. *Integrating Drug Testing Into a Pretrial Services System: 1999 Update.* Washington, DC: Office of Justice Programs, July 1999. bja.ncjrs.org/publications/#1 [accessed April 8, 2004].

Bureau of Justice Statistics. *Correctional Populations in the United States, 1997.* Washington, DC: Office of Justice Programs, November 2000. www.ojp.usdoj.gov/bjs/abstract/cpus97.htm [accessed February 11, 2004].

Busto, U.E.; Sykora, K.; and Sellers, E.M. A clinical scale to assess benzodiazepine withdrawal. *Journal of Clinical Psychopharmacology* 9:412–416, 1989.

Campbell, J.C. Prediction of homicide of and by battered women. In: Campbell, J.C., ed. *Assessing Dangerousness: Violence by Sexual Offenders, Batterers, and*

Child Abusers. Thousand Oaks, CA: Sage Publications, 1995, pp. 96–113.

Carey, K.B., and Correia, C.J. Severe mental illness and addictions: Assessment considerations. *Addictive Behaviors* 23(6):735–748, 1998.

Carroll, K.M. Integrating psychotherapy and pharmacotherapy in substance abuse treatment. In: Rodgers, F.; Keller, D.S.; and Morgenstern, J., eds. *Treating Substance Abuse: Theory and Technique.* New York: Guilford Press, 1996*a*, pp. 286–318.

Carroll, K.M. Relapse prevention as a psychosocial treatment: A review of controlled clinical trials. *Experimental and Clinical Psychopharmacology* 4(1):46–54, 1996*b*.

Carroll, K.M. *A Cognitive–Behavioral Approach: Treating Cocaine Addiction.* Manual 1: Therapy Manuals for Drug Addiction Series. NIH Publication No. 94–4308. Rockville, MD: National Institute on Drug Abuse, 1998.

Carroll, K.M.; Nich, C.; Ball, S.A.; McCance, E.; and Rounsaville, B.J. Treatment of cocaine and alcohol dependence with psychotherapy and disulfiram. *Addiction* 93(5):713–727, 1998.

Catalano, R.F.; Gainey, R.R.; Fleming, C.B.; Haggerty, K.P.; and Johnson, N.O. An experimental intervention with families of substance abusers: One-year follow-up of the Focus on Families project. *Addiction* 94(2):241–254, 1999.

Catalano, R.F.; Haggerty, K.P.; Gainey, R.R.; and Hoppe, M. Reducing parental risk factors for children's substance misuses: Preliminary outcomes with opiate-addicted parents. *Substance Use & Misuse* 32(6):699–721, 1997.

Center for Substance Abuse Prevention. *Substance Abuse Resource Guide: Asian and Pacific Islander Americans.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 1996*a*. ncadi.samhsa/gov/pubs/govpubs/MS408 [accessed March 4, 2004].

Center for Substance Abuse Prevention. *Substance Abuse Resource Guide: Hispanic/Latino Americans.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 1996*b*. ncadi.samhsa.gov/govpubs/MS441 [accessed March 4, 2004].

Center for Substance Abuse Prevention. Communicating appropriately with Asian and Pacific Islander audiences. *Technical Assistance Bulletin*, June 1997. ncadi.samhsa.gov/govpubs/MS701 [accessed February 11, 2004].

Center for Substance Abuse Prevention. *Cultural Competence for Health Care Professionals Working With African-American Communities: Theory and Practice.* Cultural Competence Series 7. DHHS Publication No. (SMA) 98–3238. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*a*.

Center for Substance Abuse Prevention: *Substance Abuse Resource Guide: American Indians and Alaska Natives.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*b*. ncadi.samhsa.gov/govpubs/MS419 [accessed March 4, 2004].

Center for Substance Abuse Prevention. *Responding to Pacific Islanders: Culturally Competent Perspectives for Substance Abuse Prevention.* Cultural Competence Series 8. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999.

Center for Substance Abuse Prevention. *Substance Abuse Resource Guide: Lesbian, Gay, Bisexual, and Transgender Populations.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000. ncadi.samhsa.gov/

referrals/resguides.aspx?InvNum=MS489 [accessed February 11, 2004].

Center for Substance Abuse Prevention. *Health Promotion and Substance Abuse Prevention Among American Indian and Alaska Native Communities: Issues in Cultural Competence*. Cultural Competence Series 9. DHHS Publication No. (SMA) 99–3440. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001.

Centers for Disease Control and Prevention. Increasing morbidity and mortality associated with abuse of methamphetamine—United States, 1991–1994. *Morbidity and Mortality Weekly Report* 44(47):882–886, 1995.

Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report* 14:1–48, 2002.

Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report* 16:1–46, 2004.

Charney, D.A.; Paraherakis, A.M.; and Gill, K.J. Integrated treatment of comorbid depression and substance use disorders. *Journal of Clinical Psychiatry* 62(9):672–677, 2001.

Chermack, S.T.; Walton, M.A.; Fuller, B.E.; and Blow, F.C. Correlates of expressed and received violence across relationship types among men and women substance abusers. *Psychology of Addictive Behaviors* 15(2):140–151, 2001.

Chick, J.; Lehert, P.; and Landron, F. Does acamprosate improve reduction of drinking as well as aiding abstinence? *Journal of Psychopharmacology* 17(4):397–402, 2003.

Claus, R.E., and Kindleberger, L.R. Engaging substance abusers after centralized assessment: Predictors of treatment entry and dropout. *Journal of Psychoactive Drugs* 34:25–31, 2002.

Cohen, M. *Counseling Addicted Women: A Practical Guide*. Thousand Oaks, CA: Sage Publications, 2000.

Compton, W.M., III; Cottler, L.B.; Phelps, D.L.; Ben Abdallah, A.; and Spitznagel, E.L. Psychiatric disorders among drug dependent subjects: Are they primary or secondary? *American Journal on Addictions* 9(2):126–134, 2000.

Conner, K.R.; Shea, R.R.; McDermott, M.P.; Grolling, R.; Tocco, R.V.; and Baciewicz, G. The role of multifamily therapy in promoting retention in treatment of alcohol and cocaine dependence. *American Journal on Addictions* 7(1):61–73, 1998.

Connors, G.J., and Dermen, K.H. Characteristics of participants in Secular Organizations for Sobriety (SOS). *American Journal of Drug and Alcohol Abuse* 22:281–295, 1996.

Connors, G.J.; Donovan, D.M.; and DiClemente, C.C. *Substance Abuse Treatment and the Stages of Change: Selecting and Planning Interventions*. New York: Guilford Press, 2001*a*.

Connors, G.J.; Tonigan, J.S.; and Miller, W.R. A longitudinal model of intake symptomatology, AA participation, and outcome: Retrospective study of the Project MATCH outpatient and aftercare samples. *Journal of Studies on Alcohol* 62:817–825, 2001*b*.

Cornish, J.W.; Metzger, D.; Woody, G.E.; Wilson, D.; McLellan, A.T.; Vandergrift, B.; and O'Brien, C.P. Naltrexone pharmacotherapy for opioid dependent federal probationers. *Journal of Substance Abuse Treatment* 14(6):529–534, 1997.

Covington, S. *A Woman's Journey Home: Challenges for Female Offenders and Their Children*. Washington, DC: Urban Institute, 2002.

Covington, S.S. *A Woman's Way Through the Twelve Steps*. Center City, MN: Hazelden Information Education, 1994.

Covington, S.S. *Helping Women Recover: A Program for Treating Addiction.* San Francisco: Jossey-Bass, 1999.

Covington, S.S. *A Woman's Way Through the Twelve Steps Workbook.* Center City, MN: Hazelden Information Education, 2000.

Coyhis, D., and White, W.L. Addiction and recovery in Native America: Lost history, enduring lessons. *Counselor* 3(5):16–20, 2002.

Crnkovic, A.E., and DelCampo, R.L. A systems approach to the treatment of chemical addiction. *Contemporary Family Therapy* 20(1):25–36, 1998.

Crowley, T.J. Research on contingency management treatment of drug dependence: Clinical implications and future directions. In: Higgins, S.T., and Silverman, K., eds. *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions.* Washington, DC: American Psychological Association, 1999, pp. 345–370.

CSAT (Center for Substance Abuse Treatment). *Pregnant, Substance-Using Women*. Treatment Improvement Protocol (TIP) Series 2. DHHS Publication No. (SMA) 95–3056. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993*a*, reprinted 1995.

CSAT (Center for Substance Abuse Treatment). *Screening for Infectious Diseases Among Substance Abusers.* Treatment Improvement Protocol (TIP) Series 6. DHHS Publication No. (SMA) 93–2048. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993*b*.

CSAT (Center for Substance Abuse Treatment). *Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients.* Treatment Improvement Protocol (TIP) Series 10. DHHS Publication No. (SMA) 94–3004. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*a*.

CSAT (Center for Substance Abuse Treatment). *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse.* Treatment Improvement Protocol (TIP) Series 9. DHHS Publication No. (SMA) 94–2078. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*b*.

CSAT (Center for Substance Abuse Treatment). *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse.* Treatment Improvement Protocol (TIP) Series 8. DHHS Publication No. (SMA) 94–2077. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*c*.

CSAT (Center for Substance Abuse Treatment). *Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*d*.

CSAT (Center for Substance Abuse Treatment). *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 7. DHHS Publication No. (SMA) 94–2076. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*e*.

CSAT (Center for Substance Abuse Treatment). *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases.* Treatment Improvement Protocol (TIP) Series 11. DHHS Publication No. (SMA) 94–2094. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*f*.

CSAT (Center for Substance Abuse Treatment). *Detoxification From Alcohol and Other Drugs*. Treatment

Improvement Protocol (TIP) Series 19. DHHS Publication No. (SMA) 95–3046. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*a*.

CSAT (Center for Substance Abuse Treatment). *Treating Alcohol and Other Drug Abusers in Rural and Frontier Areas: 1994 Award for Excellence Papers.* Technical Assistance Publication (TAP) Series 17. DHHS Publication No. (SMA) 95–3054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*b*.

CSAT (Center for Substance Abuse Treatment). *The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers.* Treatment Improvement Protocol (TIP) Series 18. DHHS Publication No. (SMA) 95–3047. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*c*.

CSAT (Center for Substance Abuse Treatment). *Bringing Excellence to Substance Abuse Services in Rural and Frontier America: 1996 Award for Excellence Papers.* Technical Assistance Publication (TAP) Series 20. DHHS Publication No. (SMA) 97–3134. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1996.

CSAT (Center for Substance Abuse Treatment). *A Guide to Substance Abuse Services for Primary Care Clinicians.* Treatment Improvement Protocol (TIP) Series 24. DHHS Publication No. (SMA) 97–3139. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997*a*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment and Domestic Violence.* Treatment Improvement Protocol (TIP) Series 25. DHHS Publication No. (SMA) 97–3163. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997*b*.

CSAT (Center for Substance Abuse Treatment). *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27. DHHS Publication No. (SMA) 98–3222. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*a*.

CSAT (Center for Substance Abuse Treatment). *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community.* Treatment Improvement Protocol (TIP) Series 30. DHHS Publication No. (SMA) 98–3245. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*b*.

CSAT (Center for Substance Abuse Treatment). *Naltrexone and Alcoholism Treatment.* Treatment Improvement Protocol (TIP) Series 28. DHHS Publication No. (SMA) 98–3206. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*c*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Among Older Adults.* Treatment Improvement Protocol (TIP) Series 26. DHHS Publication No. (SMA) 98–3179. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*d*.

CSAT (Center for Substance Abuse Treatment). *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities.* Treatment Improvement Protocol (TIP) Series 29. DHHS Publication No. (SMA) 98–3249. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*e*.

CSAT (Center for Substance Abuse Treatment). *Brief Interventions and Brief Therapies for Substance Abuse.* Treatment Improvement Protocol (TIP) Series 34. DHHS Publication No. (SMA) 99–3353. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*a*.

CSAT (Center for Substance Abuse Treatment). *Cultural Issues in Substance Abuse Treatment.* DHHS Publication No. (SMA) 99–3278. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*b*.

CSAT (Center for Substance Abuse Treatment). *Enhancing Motivation for Change in Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 35. DHHS Publication No. (SMA) 99–3354. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*c*.

CSAT (Center for Substance Abuse Treatment). *Screening and Assessing Adolescents for Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 31. DHHS Publication No. (SMA) 99–3282. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*d*.

CSAT (Center for Substance Abuse Treatment). *Treatment for Stimulant Use Disorders.* Treatment Improvement Protocol (TIP) Series 33. DHHS Publication No. (SMA) 99–3296. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*e*.

CSAT (Center for Substance Abuse Treatment). *Treatment of Adolescents With Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 32. DHHS Publication No. (SMA) 99–3283. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*f*.

CSAT (Center for Substance Abuse Treatment). *Integrating Substance Abuse Treatment and Vocational Services.* Treatment Improvement Protocol (TIP) Series 38. DHHS Publication No. (SMA) 00–3470. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000*a*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues.* Treatment Improvement Protocol (TIP) Series 36. DHHS Publication No. (SMA) 00–3357. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000*b*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment for Persons With HIV/AIDS.* Treatment Improvement Protocol (TIP) Series 37. DHHS Publication No. (SMA) 00–3410. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000*c*.

CSAT (Center for Substance Abuse Treatment). *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals.* DHHS Publication No. (SMA) 01–3498. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001.

CSAT (Center for Substance Abuse Treatment). *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction.* Treatment Improvement Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04–3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004*a*.

CSAT (Center for Substance Abuse Treatment). *The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule: Implications for Alcohol and Substance Abuse Programs.* DHHS Publication No.

(SMA) 04-3947. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004*b*. www.hipaa.samhsa.gov/download2/SAMHSAHIPAAComparisonClearedPDFVersion.pdf [accessed April 5, 2005].

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment and Family Therapy.* Treatment Improvement Protocol (TIP) Series 39. DHHS Publication No. (SMA) 04–3957. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004*c*.

CSAT (Center for Substance Abuse Treatment). Acamprosate: A new medication for alcohol use disorders. *Substance Abuse Treatment Advisory* 4(1), 2005*a*.

CSAT (Center for Substance Abuse Treatment). *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.* Treatment Improvement Protocol (TIP) Series 43. DHHS Publication No. (SMA) 05-4048. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005*b*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Relapse Prevention for Older Adults: A Group Treatment Approach.* DHHS Publication No. 05-4053. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005*c*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment for Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 44. DHHS Publication No. (SMA) 05–4056. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005*d*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment for Persons With Co-Occurring Disorders.* Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05–3922. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005*e*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment: Group Therapy.* Treatment Improvement Protocol (TIP) Series 41. DHHS Publication No. (SMA) 05–3991. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005*f*.

CSAT (Center for Substance Abuse Treatment). *Client's Handbook: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders.* DHHS Publication No. (SMA) 06–4154. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*a*.

CSAT (Center for Substance Abuse Treatment). *Client's Treatment Companion: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders.* DHHS Publication No. (SMA) 06–4155. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*b*.

CSAT (Center for Substance Abuse Treatment). *Counselor's Family Education Manual: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders.* DHHS Publication No. (SMA) 06–4153. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*c*.

CSAT (Center for Substance Abuse Treatment). *Counselor's Treatment Manual: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders.* DHHS Publication No. (SMA) 06–4152. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*d*.

CSAT (Center for Substance Abuse Treatment). *Detoxification and Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 45. DHHS Publication No. (SMA) 06–4131. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*e*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse: Administrative Issues in Outpatient Treatment.* Treatment Improvement Protocol (TIP) Series 46. DHHS Publication No. (SMA) 06–4151. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*f*.

CSAT (Center for Substance Abuse Treatment). *Therapeutic Community Curriculum: Participant's Manual.* DHHS Publication No. (SMA) 06-4122. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*g*.

CSAT (Center for Substance Abuse Treatment). *Therapeutic Community Curriculum: Trainer's Manual.* DHHS Publication No. (SMA) 06-4121. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*h*.

CSAT (Center for Substance Abuse Treatment). *Improving Cultural Competence in Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, forthcoming *a*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment: Addressing the Specific Needs of Women.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, forthcoming *b*.

da Costa, C.L.; Younes, R.N.; and Lourenco, M.T. Stopping smoking: A prospective, randomized, double-blind study comparing nortriptyline to placebo. *Chest* 122:403–408, 2002.

Daley, D.C. *Relapse Prevention Workbook for Recovering Alcoholics and Drug Dependent Persons*, Third Edition. Holmes Beach, FL: Learning Publications, 2001.

Daley, D.C. *Dual Disorders: Relapse Prevention Workbook*, Second Edition. Center City, MD: Hazelden Foundation, 2003.

Daley, D.C., and Marlatt, G.A. *Managing Your Drug or Alcohol Problem: Therapist Guide*. San Antonio, TX: Psychological Corporation, 1997.

Daley, D.C.; Marlatt, G.A.; and Spotts, C.E. Relapse prevention: Clinical models and specific intervention strategies. In: Graham, A.W.; Schultz, T.K.; Mayo-Smith, M.F.; Ries, R.K.; and Wilford, B.B., eds. *Principles of Addiction Medicine*, Third Edition. Chevy Chase, MD: American Society of Addiction Medicine, 2003, pp. 467–485.

Daley, D.C.; Mercer, D.; and Carpenter, G. *Drug Counseling for Cocaine Addiction: The Collaborative Cocaine Treatment Study Manual.* Manual 4: Therapy Manuals for Drug Addiction Series. NIH Publication No. 99–4380. Rockville, MD: National Institute on Drug Abuse, 1999.

Daley, D.C., and Thase, M.E. *Dual Disorders Recovery Counseling: Integrated Treatment for Substance Use and Mental Health Disorders.* Independence, MO: Independence Press, 2002.

D'Avanzo, C., and Geissler, E. *Pocket Guide to Cultural Health Assessment*, Third Edition. Mosby's Pocket Series. Philadelphia: Elsevier, 2003.

Deas, D.; Riggs, P.; Langenbucher, J.; Goldman, M.; and Brown, S. Adolescents are not adults: Developmental considerations in alcohol users. *Alcoholism*,

Clinical and Experimental Research 24:232–237, 2000.

De La Rosa, M. Acculturation and Latino adolescents' substance use: A research agenda for the future. *Substance Use & Misuse* 37(4):429–456, 2002.

De La Rosa, M.R., and White, M.S. A review of the role of social support systems in the drug use behavior of Hispanics. *Journal of Psychoactive Drugs* 33(3):233–240, 2001.

De Leon, G. Therapeutic communities for addictions: A theoretical framework. *International Journal of the Addictions* 30(12):1603–1645, 1995.

De Leon, G. *The Therapeutic Community: Theory, Model, and Method.* New York: Springer Publishing, 2000.

De Leon, G., and Jainchill, N. Circumstance, motivation, readiness, and suitability as correlates of treatment tenure. *Journal of Psychoactive Drugs* 18:203–208, 1986.

De Leon, G.; Melnick, G.; Kressel, D.; and Jainchill, N. Circumstances, motivation, readiness, and suitability (the CMRS Scales): Predicting retention in therapeutic community treatment. *American Journal of Drug and Alcohol Abuse* 20(4):495–515, 1994.

DiClemente, C.C., and Hughes, S.O. Stages of change profiles in outpatient alcoholism treatment. *Journal of Substance Abuse* 2:217–235, 1990.

Ditton, P.M. Mental health and treatment of inmates and probationers. *Bureau of Justice Statistics Special Report.* Washington, DC: Office of Justice Programs, July 1999. www.ojp.usdoj.gov/bjs/abstract/mhtip.htm [accessed February 11, 2004].

Dixon, L.; McNary, S.; and Lehman, A. Remission of substance use disorder among psychiatric inpatients with mental illness. *American Journal of Psychiatry* 155(2):239–243, 1998.

Drake, R.E.; Essock, S.M.; Shaner, A.; Carey, K.B.; Minkoff, K.; Kola, L.; Lynde, D.; Osher, F.C.; Clark, R.E.; and Rickards, L. Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services* 52:469–476, 2001.

Drake, R.E.; McHugo, G.J.; Clark, R.E.; Teague, G.B.; Xie, H.; Miles, K.; and Ackerson, T.H. Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: A clinical trial. *American Journal of Orthopsychiatry* 68(2):201–215, 1998*a*.

Drake, R.E.; Mercer-McFadden, C.; Mueser, K.T.; McHugo, G.J.; and Bond, G.R. Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin* 24(4):589–608, 1998*b*.

Drake, R.E., and Mueser, K.T. Psychosocial approaches to dual diagnosis. *Schizophrenia Bulletin* 26:105–118, 2000.

Edwards, J.T. *Treating Chemically Dependent Families: A Practical Systems Approach for Professionals.* Minneapolis, MN: Johnson Institute, 1990.

Edwards, M.D., and Steinglass, P. Family therapy treatment outcomes for alcoholism. *Journal of Marital and Family Therapy* 21(4):475–509, 1995.

Ehrman, R.N.; Robbins, S.J.; and Cornish, J.W. Results of a baseline urine test predict levels of cocaine use during treatment. *Drug and Alcohol Dependence* 62(1):1–7, 2001.

Eisen, M.; Keyser-Smith, J.; Dampeer, J.; and Sambrano, S. Evaluation of substance use outcomes in demonstration projects for pregnant and postpartum women and their infants: Findings from

a quasi-experiment. *Addictive Behaviors* 25(1):123–129, 2000.

Epstein, E.E., and McCrady, B.S. Behavioral couples treatment of alcohol and drug use disorders: Current status and innovations. *Clinical Psychology Review* 18(6):689–711, 1998.

Epstein, J.; Barker, P.; Vorburger, M.; and Murtha, C. *Serious Mental Illness and Its Co-Occurrence With Substance Use Disorders, 2002.* Analytic Series A-24. DHHS Publication No. (SMA) 04–3905. Rockville, MD: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, 2004. www.oas.samhsa.gov/CoD/Cod.htm [accessed August 17, 2004].

Evans, K., and Sullivan, J.M. *Dual Diagnosis: Counseling the Mentally Ill Substance Abuser*, Second Edition. New York: Guilford Press, 2000.

Fals-Stewart, W., and Birchler, G.R. A national survey of the use of couples therapy in substance abuse treatment. *Journal of Substance Abuse Treatment* 20:277–283, 2001.

Fals-Stewart, W.; Birchler, G.R.; and O'Farrell, T.J. Behavioral couples therapy for male substance-abusing patients: Effects on relationship adjustment and drug-using behavior. *Journal of Consulting and Clinical Psychology* 64:959–972, 1996.

Farabee, D.; Prendergast, M.; and Anglin, M.D. The effectiveness of coerced treatment for drug-abusing offenders. *Federal Probation* 62:3–10, 1998.

Farabee, D.; Prendergast, M.; Cartier, J.; Wexler, H.; Knight, K.; and Anglin, M.D. Barriers to implementing effective correctional drug treatment programs. *Prison Journal* 79:150–162, 1999.

Farabee, D.; Rawson, R.; and McCann, M. Adoption of drug avoidance activities among patients in contingency management and cognitive–behavioral treatments. *Journal of Substance Abuse Treatment* 23(4):343–350, 2002.

Fears, D. A Diverse—and Divided—Black Community. *Washington Post*, February 24, 2002, pp. A1, A8.

Festinger, D.S.; Lamb, R.J.; Marlowe, D.B.; and Kirby, K.C. From telephone to office: Intake attendance as a function of appointment delay. *Addictive Behaviors* 27(1):131–137, 2002.

Finnegan, D.G., and McNally, E.B. *Counseling Lesbian, Gay, Bisexual, and Transgender Substance Abusers: Dual Identities*, Second Edition. Binghamton, NY: Haworth Press, 2002.

Finney, J.W.; Hahn, A.C.; and Moos, R.H. The effectiveness of inpatient and outpatient treatment for alcohol abuse: The need to focus on mediators and moderators of setting effects. *Addiction* 91(12):1773–1796; discussion 1803–1820, 1996.

Fiorentine, R. After drug treatment: Are 12-Step programs effective in maintaining abstinence? *American Journal of Drug and Alcohol Abuse* 25(1):93–116, 1999.

First, M.B.; Spitzer, R.L.; Gibbon, M.; and Williams, J.B.W. *Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I), Clinician Version.* Washington, DC: American Psychiatric Association, 1997.

Fishman, H.C., and Andes, F. Enhancing family therapy: The addition of a community resource specialist. *Journal of Marital and Family Therapy* 27(1):111–116, 2001.

Fishman, J.; Reynolds, T.; and Riedel, E. A retrospective investigation of an intensive outpatient substance abuse treatment program. *American Journal of Drug and Alcohol Abuse* 25(2):185–196, 1999.

Flynn, P.M.; Craddock, S.G.; Luckey, J.W.; Hubbard, R.L.; and Dunteman, G.H. Comorbidity of antisocial personality and mood disorders among psychoactive substance-dependent treatment clients. *Journal of Personality Disorders* 10(1):56–67, 1996.

Folstein, M.F.; Folstein, S.E.; and McHugh, P.R. Mini-Mental State: A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research* 12:189–198, 1975.

Forman, R. One AA meeting doesn't fit all: Six keys to prescribing 12-Step programs. *Current Psychiatry*, October 2002, pp. 1, 10, 16–24.

Frank, E.; Winkleby, M.A.; Altman, D.G.; Rockhill, B.; and Fortmann, S.P. Predictors of physician's smoking cessation advice. *JAMA* 266:3139–3144, 1991.

Fudala, P.J.; Yu, E.; MacFadden, W.; Boardman, C.; and Chiang, C.N. Effects of buprenorphine and naloxone in morphine-stabilized opioid addicts. *Drug and Alcohol Dependence* 50:1–8, 1998.

Fuller, R.K., and Gordis, E. Refining the treatment of alcohol withdrawal: Editorial. *JAMA* 272:557–558, 1994.

Gastfriend, D.R. Placement matching: Challenges and technical progress. In: *Proceedings: Tenth Annual Meeting & Symposium, December 2–5, 1999.* Prairie Village, KS: American Academy of Addiction Psychiatry, 1999, pp. 18–19. www.aaap.org/meetings/proceedings.pdf [accessed February 11, 2004].

Gaston, L. Reliability and criterion-related validity of the California Psychotherapy Alliance Scales—patient version. *Psychological Assessment* 3:68–74, 1991.

Gfroerer, J.; Penne, M.; Pemberton, M.; and Folsom, R. Substance abuse treatment need among older adults in 2020: The impact of the aging baby-boom cohort. *Drug and Alcohol Dependence* 69(2):127–135, 2003.

Glaze, L.E. Probation and parole in the United States, 2002. *Bureau of Justice Statistics Bulletin.* Washington, DC: Office of Justice Programs, August 2003. www.ojp.usdoj.gov/bjs/pub/pdf/ppus02.pdf [accessed February 11, 2004].

Gloria, A.M., and Peregoy, J.J. Counseling Latino alcohol and other substance users/abusers: Cultural considerations for counselors. *Journal of Substance Abuse Treatment* 13:119–126, 1996.

Glover, E.D.; Glover, P.N.; and Payne, T.J. Treating nicotine dependence. *American Journal of the Medical Sciences* 326(4):183–186, 2003.

Godlaski, T.M.; Leukefeld, C.; and Cloud, R. Recovery: With and without self-help. *Substance Use & Misuse* 32(5):621–627, 1997.

Godley, S.H.; Meyers, R.J.; Smith, J.E.; Karvinen, T.; Titus, J.C.; Godley, M.D.; Dent, G.; Passetti, L.; and Kelberg, P. *The Adolescent Community Reinforcement Approach for Adolescent Cannabis Users.* Cannabis Youth Treatment Series, Volume 4. DHHS Publication No. (SMA) 01–3489. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2001.

Goldenberg, I., and Goldenberg, H. *Family Therapy: An Overview*, Second Edition. Brooks Grove, CA: Brooks/Cole Publishing Co., 1985.

Goodman, D. Arab Americans and American Muslims express mental health needs. *SAMHSA News* 10(1):2–3, 2002.

Gorski, T.T. The CENAPS® model of relapse prevention therapy (CMRPT®). In: Carroll, K.M., ed. *Approaches to Drug Abuse Counseling.* NIH Publication No. 00–4151. Rockville, MD: National

Institute on Drug Abuse, 2000, pp. 23–38.

Gorski, T.T., and Kelley, J.M. *Counselor's Manual for Relapse Prevention With Chemically Dependent Criminal Offenders.* Technical Assistance Publication (TAP) Series 19. DHHS Publication No. (SMA) 96–3115. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1996.

Gorski, T.T.; Kelley, J.M.; Havens, L.; and Peters, R.H. *Relapse Prevention and the Substance-Abusing Criminal Offender.* Technical Assistance Publication (TAP) Series 8. DHHS Publication No. (SMA) 95–3071. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1993, reprinted 1995.

Gottheil, E.; Weinstein, S.P.; Sterling, R.C.; Lundy, A.; and Serota, R.D. A randomized controlled study of the effectiveness of intensive outpatient treatment for cocaine dependence. *Psychiatric Services* 49(6):782–787, 1998.

Greenfeld, L.A., and Snell, T.L. Women offenders. *Bureau of Justice Statistics Special Report.* Washington, DC: Office of Justice Programs, December 1999, revised October 2000. www.ojp.usdoj.gov/bjs/abstract/wo.htm [accessed February 11, 2004].

Greenwood, G.L.; White, E.W.; Page-Shafer, K.; Bein, E.; Osmond, D.H.; Paul, J.; and Stall, R.D. Correlates of heavy substance use among young gay and bisexual men: The San Francisco Young Men's Health Study. *Drug and Alcohol Dependence* 61(2):105–112, 2001.

Gregoire, T.K., and Snively, C.A. The relationship of social support and economic self-sufficiency to substance abuse outcomes in a long-term recovery program for women. *Journal of Drug Education* 31(3):221–237, 2001.

Grella, C.E.; Polinsky, M.L.; Hser, Y.-I.; and Perry, S.M. Characteristics of women-only and mixed-gender drug abuse treatment programs. *Journal of Substance Abuse Treatment* 17:37–44, 1999.

Grieco, E.M. The Native Hawaiian and other Pacific Islander population: 2000. *Census 2000 Brief.* C2KBR/01-14. Washington, DC: U.S. Census Bureau, 2001.

Grosenick, J.K., and Hatmaker, C.M. Perceptions of the importance of physical setting in substance abuse treatment. *Journal of Substance Abuse Treatment* 18:29–39, 2000.

Gruber, K.; Chutuape, M.A.; and Stitzer, M.L. Reinforcement-based intensive outpatient treatment for inner city opiate abusers: A short-term evaluation. *Drug and Alcohol Dependence* 57:211–223, 2000.

Guardia, J.; Caso, C.; Arias, F.; Gual, A.; Sanahuja, J.; Ramirez, M.; Mengual, I.; Gonzalvo, B.; Segura, L.; Trujols, J.; and Casas, M. A double-blind, placebo-controlled study of naltrexone in the treatment of alcohol-dependence disorder: Results from a multicenter trial. *Alcoholism, Clinical and Experimental Research* 26(9):1381–1387, 2002.

Guss, J.R., ed. *Addictions in the Gay and Lesbian Community.* New York: Haworth Press, 2000.

Guydish, J.; Sorensen, J.L.; Chan, M.; Werdegar, D.; Bostrom, A.; and Acampora, A. A randomized trial comparing day and residential drug abuse treatment: 18-month outcomes. *Journal of Consulting and Clinical Psychology* 67(3):428–434, 1999.

Guydish, J.; Werdegar, D.; Sorensen, J.L.; Clark, W.; and Acampora, A. Drug abuse day treatment: A randomized clinical

trial comparing day and residential treatment programs. *Journal of Consulting and Clinical Psychology* 66(2):280–289, 1998.

Hadjicostandi, J., and Cheurprakobkit, S. Drugs and substances: Views from a Latino community. *American Journal of Drug and Alcohol Abuse* 28(4):693–710, 2002.

Hamilton, N.L.; Brantley, L.B.; Tims, F.M.; Angelovich, N.; and McDougall, B. *Family Support Network for Adolescent Cannabis Users.* Cannabis Youth Treatment Series, Volume 3. DHHS Publication No. (SMA) 01–3488. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2001.

Harrison, P.M., and Beck, A.J. Prisoners in 2002. *Bureau of Justice Statistics Bulletin.* Washington, DC: Office of Justice Programs, July 2003. www.ojp.usdoj.gov/bjs/pub/pdf/p02.pdf [accessed February 11, 2004].

Hasin, D.S.; Trautman, K.D.; Miele, G.M.; Samet, S.; Smith, M.; and Endicott, J. Psychiatric Research Interview for Substance and Mental Disorders (PRISM): Reliability for substance abusers. *American Journal of Psychiatry* 153:1195–1201, 1996.

Health Resources and Services Administration. *Cultural Competence Works: Using Cultural Competence To Improve the Quality of Health Care for Diverse Populations and Add Value to Managed Care Arrangements.* Washington, DC: U.S. Department of Health and Human Services, 2001.

Heather, N.; Luce, A.; Peck, D.; Dunbar, B.; and James, I. Development of a treatment version of the Readiness to Change Questionnaire. *Addiction Research* 7:63–68, 1999.

Heather, N.; Rollnick, S.; and Bell, A. Predictive validity of the Readiness to Change Questionnaire. *Addiction* 88:1667–1677, 1993.

Higgins, S.T. Some potential contributions of reinforcement and consumer-demand theory to reducing cocaine use. *Addictive Behaviors* 21(6):803–816, 1996.

Higgins, S.T. Introduction. In: Higgins, S.T., and Silverman, K., eds. *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions.* Washington, DC: American Psychological Association, 1999, pp. 3–13.

Higgins, S.T.; Budney, A.J.; Bickel, W.K.; Foerg, F.E.; Ogden, D.; and Badger, G.J. Outpatient behavioral treatment for cocaine dependence: One year outcomes. *Experimental and Clinical Psychopharmacology* 3:205–212, 1995.

Higgins, S.T., and Silverman, K., eds. *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions.* Washington, DC: American Psychological Association, 1999.

Higgins, S.T.; Wong, C.J.; Badger, G.J.; Ogden, D.E.; and Dantona, R.L. Contingent reinforcement increases cocaine abstinence during outpatient treatment and 1 year of follow-up. *Journal of Consulting and Clinical Psychology* 68(1):64–72, 2000.

Hodgins, D.C.; el-Guebaly, N.; and Addington, J. Treatment of substance abusers: Single or mixed gender programs. *Addiction* 92(7):805–812, 1997.

Hoffman, F. Cultural adaptations of Alcoholics Anonymous to serve Hispanic populations. *International Journal of Addiction* 29(4):445–460, 1994.

Hoffman, J.A.; Jones, B.; Caudill, B.D.; Mayo, D.W.; and Mack, K.A. The living in balance counseling approach. In: Carroll,

K.M., ed. *Approaches to Drug Abuse Counseling*. NIH Publication No. 00–4151. Rockville, MD: National Institute on Drug Abuse, 2000, pp. 39–60.

Hoffmann, N.G.; Halikas, J.A.; Mee-Lee, D.; and Weedman, R.D. *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders.* Chevy Chase, MD: American Society of Addiction Medicine, 1991.

Howell, E.M.; Heiser, N.; and Harrington, M. A review of recent findings on substance abuse treatment for pregnant women. *Journal of Substance Abuse Treatment* 16:195–219, 1999.

Hser, Y.I.; Polinsky, M.L.; Maglione, M.; and Anglin, M.D. Matching clients' needs with drug treatment services. *Journal of Substance Abuse Treatment* 16(4):299–305, 1999.

Hubbard, J.R.; Everett, A.S.; and Khan, M.A. Alcohol and drug abuse in patients with physical disabilities. *American Journal of Drug Abuse* 22(2):215–231, 1996.

Humphreys, K.; Moos, R.H.; and Cohen, G. Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Alcoholism Studies* 58:231–238, 1997.

Hurt, R.D.; Offord, K.P.; Croghan, I.T.; Gomez-Dahl, L.; Kottke, T.E.; Morse, M.E.; and Melton, L.J., III. Mortality following inpatient addictions treatment: Role of tobacco use in a community-based cohort. *JAMA* 275:1097–1103, 1996.

Inciardi, J.A. *A Corrections-Based Continuum of Effective Drug Abuse Treatment: Research Preview.* Washington, DC: National Institute of Justice, U.S. Department of Justice, June 1996.

Institute of Medicine. *Bridging the Gap Between Practice and Research: Forging Partnerships With Community-Based Drug and Alcohol Treatment.* Washington, DC: National Academy Press, 1998.

Irvin, J.E.; Bowers, C.A.; Dunn, M.E.; and Wang, M.C. Efficacy of relapse prevention: A meta-analytic review. *Journal of Consulting and Clinical Psychology* 67:563–570, 1999.

Jaffe, J.H., and O'Keefe, C. From morphine clinics to buprenorphine: Regulating opioid agonist treatment of addiction in the United States. *Drug and Alcohol Dependence* 70:S3–S11, 2003.

Jainchill, N. Substance dependency treatment for adolescents: Practice and research. *Substance Use & Misuse* 35(12–14):2031–2060, 2000.

Jezewski, M.A., and Sotnik, P. *Culture Brokering: Providing Culturally Competent Rehabilitation Services to Foreign-Born Persons.* Buffalo, NY: Center for International Rehabilitation Research Information and Exchange, 2001. cirrie.buffalo.edu/cbrokering.html [accessed February 11, 2004].

Joe, G.W.; Simpson, D.D.; and Broome, K.M. Effects of readiness for drug abuse treatment on client retention and assessment of process. *Addiction* 93:1177–1190, 1998.

Johnson, K.M., and Beale, C.L. The rural rebound. *Wilson Quarterly* 22(2):16–27, 1998.

Johnson, J.L., and Leff, M. Children of substance abusers: Overview of research findings. *Pediatrics* 103:1085–1099, 1999.

Johnson, R.E., and McCagh, J.C. Buprenorphine and naloxone for heroin dependence. *Current Psychiatry Reports* 2:519–526, 2000.

Johnson, R.E.; Strain, E.C.; and Amass, L. Buprenorphine: How to use it right. *Drug and Alcohol Dependence* 70:S59–S77, 2003.

Jordan, L.C.; Davidson, W.S.; Herman, S.E.; and Boots Miller, B.J. Involvement in 12-Step programs among persons with dual diagnoses. *Psychiatric Services* 53:894–896, 2002.

Joyner, L.M.; Wright, J.D.; and Devine, J.A. Reliability and validity of the Addiction Severity Index among homeless substance misusers. *Substance Use & Misuse* 31(6):729–751, 1996.

Kadden, R.; Carroll, K.M.; Donovan, D.; Cooney, N.; Monti, P.; Abrams, D.; Litt, M.; and Hester, R., eds. *Cognitive–Behavioral Coping Skills Therapy Manual: A Clinical Research Guide for Therapists Treating Individuals With Alcohol Abuse and Dependence.* Project MATCH Monograph Series, Volume 3. NIH Publication No. 94–3724. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, 1995.

Kandel, D.B.; Johnson, J.G.; Bird, H.R.; Weissman, M.M.; Goodman, S.H.; Lahey, B.B.; Regier, D.A.; and Schwab-Stone, M.E. Psychiatric comorbidity among adolescents with substance use disorders: Findings from the MECA study. *Journal of the American Academy of Child and Adolescent Psychiatry* 38:693–699, 1999.

Karageorge, K. *Mental Health Status of Male and Female Clients Before and After Substance Abuse Treatment*. NEDS Fact Sheet 135. Fairfax, VA: National Evaluation Data Services, 2002.

Katz, E.C.; Gruber, K.; Chutuape, M.A.; and Stitzer, M.L. Reinforcement-based outpatient treatment for opiate and cocaine abusers. *Journal of Substance Abuse Treatment* 20(1):93–98, January 2001.

Kavanagh, K., and Kennedy, P.H. *Promoting Cultural Diversity: Strategies for Health Care Professionals.* Thousand Oaks, CA: Sage Publications, 1992.

Kelly, J.F.; McKellar, J.D.; and Moos, R. Major depression in patients with substance use disorders: Relationship to 12-Step self-help involvement and substance use outcomes. *Addiction* 98(4):499–508, 2003.

Kelly, R.C.; Mieczkowski, T.; and Sweeney, S.A. Hair analysis for drugs of abuse. Hair color and race differentials or systematic differences in drug preferences? *Forensic Science International* 107(1–3):63–86, 2000.

Kessler, R.C.; Nelson, C.B.; McGonagle, K.A.; Edlund, M.H.; Frank, R.G.; and Leaf, P.J. The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry* 66(1):17–31, 1996.

Kirby, K.C.; Amass, L.; and McLellan, A.T. Disseminating contingency management research to drug abuse treatment practitioners. In: Higgins, S.T., and Silverman, K., eds. *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions.* Washington, DC: American Psychological Association, 1999*a*, pp. 327–344.

Kirby, K.C.; Marlowe, D.B.; Festinger, D.S.; Garvey, K.A.; and LaMonaca, V. Community reinforcement training for family and significant others of drug abusers: A unilateral intervention to increase treatment entry of drug users. *Drug and Alcohol Dependence* 56:85–96, 1999*b*.

Kirby, K.C.; Marlowe, D.B.; Festinger, D.S.; Lamb, R.J.; and Platt, J.J. Schedule of voucher delivery influences initiation of cocaine abstinence. *Journal of Consulting and Clinical Psychology* 66(5):761–767, 1998.

Kohn, C.S.; Tsoh, J.Y.; and Weisner, C.M. Changes in smoking status among substance abusers: Baseline characteristics and abstinence from alcohol and drugs at 12-month follow-up. *Drug and Alcohol Dependence* 69:61–71, 2003.

Korper, S.P., and Council, C.L., eds. *Substance Use by Older Adults: Estimates of Future Impact on the Treatment System.* Analytic Series A-21. DHHS Publication No. (SMA) 03–3763. Rockville, MD: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, 2002.

Kremer, D.; Malkin, M.J.; and Benshoff, J.J. Physical activity programs offered in substance abuse treatment facilities. *Journal of Substance Abuse Treatment* 12:327–333, 1995.

Krestan, J.-A., ed. *Bridges to Recovery: Addiction, Family Therapy, and Multicultural Treatment.* New York: Free Press, 2000.

Krystal, J.H.; Cramer, J.A.; Krol, W.F.; Kirk, G.F.; and Rosenheck, R.A. Naltrexone in the treatment of alcohol dependence. *New England Journal of Medicine* 345(24):1734–1739, 2001.

Kurasaki, K.S.; Okazaki, S.; and Sue, S., eds. *Asian American Mental Health: Assessment Theories and Methods.* New York: Plenum, 2002.

Kus, R.J., ed. *Addiction and Recovery in Gay and Lesbian Persons.* New York: Haworth Press, 1995.

Laken, M.P., and Ager, J.W. Effects of case management on retention in prenatal substance abuse treatment. *American Journal of Drug and Alcohol Abuse* 22:439–448, 1996.

Laken, M.P.; McComish, J.F.; and Ager, J. Predictors of prenatal substance use and birth weight during outpatient treatment. *Journal of Substance Abuse Treatment* 14:359–366, 1997.

Langan, N.P., and Pelissier, B.M. Gender differences among prisoners in drug treatment. *Journal of Substance Abuse* 13:291–301, 2001.

LaPlante, M.P.; Kennedy, J.; Kaye, H.S.; and Wenger, B.L. Disability and employment. *Disability Statistics Abstract.* Number 11. San Francisco: Disability Statistics Center, 1996. dsc.ucsf.edu/pdf/abstract11.pdf [accessed February 11, 2004].

Latimer, W.W.; Winters, K.C.; D'Zurilla, T.; and Nichols, M. Integrated family and cognitive–behavioral therapy for adolescent substance abusers: A stage I efficacy study. *Drug and Alcohol Dependence* 71(3):303–317, 2003.

Laudet, A.; Magura, S.; Furst, R.T.; and Kumar, N. Male partners of substance-abusing women in treatment: An exploratory study. *American Journal of Drug and Alcohol Abuse* 25(4):607–627, 1999.

Laudet, A.; Magura, S.; Vogel, H.; and Knight, E. Twelve Month Follow-up on Members of a Dual Recovery Self-help Program. Poster presented at the 128th Annual Meeting of the American Public Health Association, Boston, November 2000*a*.

Laudet, A.B.; Magura, S.; Vogel, H.S.; and Knight, E. Recovery challenges among dually diagnosed individuals. *Journal of Substance Abuse Treatment* 18(4):321–329, 2000*b*.

La Veist, T.A.; Diala, C.; and Jarrett, N.C. Social status and perceived discrimination: Who experiences discrimination in the health care system, how, and why? In: Hogue, C.J.R.; Hargraves, M.A.; and Collins, K.S., eds. *Minority Health in America.* Baltimore: Johns Hopkins University Press, 2000, pp. 194–208.

Lawental, E.; McLellan, A.T.; Grissom, G.; Brill, P.; and O'Brien, C.P. Coerced treatment for substance abuse problems detected through workplace urine surveillance: Is it effective? *Journal of Substance Abuse* 8(1):115–128, 1996.

Legal Action Center. *Steps to Success: Helping Women With Alcohol and Drug*

Problems Move From Welfare to Work. New York: Legal Action Center, 1999.

Leonhard, C.; Mulvey, K.; Gastfriend, D.R.; and Shwartz, M. The Addiction Severity Index: A field study of internal consistency and validity. *Journal of Substance Abuse Treatment* 18(2):129–135, 2000.

Liddle, H.A. Theory development in a family-based therapy for adolescent drug abuse. *Journal of Clinical Child Psychology* 28(4):521–532, 1999.

Liddle, H.A. *Multidimensional Family Therapy for Adolescent Cannabis Users.* Cannabis Youth Treatment Series, Volume 5. DHHS Publication No. (SMA) 02–3660. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2002.

Liddle, H.A.; Dakof, G.A.; Parker, K.; Diamond, G.S.; Barrett, K.; and Tejeda, M. Multidimensional family therapy for adolescent drug abuse: Results of a randomized clinical trial. *American Journal of Drug and Alcohol Abuse* 27(4):651–688, 2001.

Ling, W.; Charuvastra, C.; Collins, J.F.; Batki, S.; Brown, L.S., Jr.; Kintaudi, P.; Wesson, D.R.; McNicholas, L.; Tusel, D.J.; Malkerneker, U.; Renner, J.A., Jr.; Santos, E.; Casadonte, P.; Fye, C.; Stine, S.; Wang, R.I.; and Segal, D. Buprenorphine maintenance treatment of opiate dependence: A multicenter, randomized clinical trial. *Addiction* 93(4):475–486, 1998.

Longabaugh, R.; Wirtz, P.W.; Zweben, A.; and Stout, R.L. Network support for drinking, Alcoholics Anonymous and long-term matching effects. *Addiction* 93:1313–1333, 1998.

Loustaunau, M.O., and Sobo, E.J. *The Cultural Context of Health, Illness, and Medicine.* Westport, CT: Bergin & Garvey, 1997.

Macdonald, D.I., and Kaplan, D.J. The role of the substance abuse professional. In: Graham, A.W.; Schultz, T.K.; Mayo-Smith, M.F.; Ries, R.K.; and Wilford, B.B., eds. *Principles of Addiction Medicine*, Third Edition. Chevy Chase, MD: American Society of Addiction Medicine, 2003, pp. 987–992.

Magerl, H., and Schulz, E. Methods of Saliva Analysis and the Relationship Between Saliva and Blood Concentration. Paper presented at 13th International Conference on Alcohol, Drugs and Traffic Safety, Adelaide, Australia, August 13–18, 1995. www.druglibrary.org/schaffer/Misc/driving/s3p1.htm [accessed February 11, 2004].

Magura, S.; Laudet, A.B.; Mahmood, D.; Rosenblum, A.; Vogel, H.S.; and Knight, E.L. Role of self-help processes in achieving abstinence among dually diagnosed persons. *Addictive Behaviors* 28(3):399–413, 2003.

Magura, S.; Nwakeze, P.C.; Rosenblum, A.; and Joseph, H. Substance misuse and related infectious diseases in a soup kitchen population. *Substance Use & Misuse* 35(4):551–583, 2000.

Mann, K.; Lehert, P.; and Morgan, M.Y. The efficacy of acamprosate in the maintenance of abstinence in alcohol-dependent individuals: Results of a meta-analysis. *Alcoholism, Clinical and Experimental Research* 28(1):51–63, 2004.

Marlatt, G.A., and Gordon, J.R., eds. *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors.* New York: Guilford Press, 1985.

Marlatt, G.A., and Kristeller, J.L. Mindfulness and meditation. In: Miller, W.M., ed. *Integrating Spirituality Into Treatment: Resources for Practitioners.* Washington, DC: American Psychological Association, 1999.

Marlowe, D.B.; DeMatteo, D.S.; Lamb, R.J.; and Festinger, D.S. A sober assessment of drug courts. *Federal Sentencing Reporter* 16(2):153–157, 2003.

Marlowe, D.B.; Husband, S.D.; Lamb, R.J.; Kirby, K.C.; Iguchi, M.Y.; and Platt, J.J. Psychiatric comorbidity in cocaine dependence. *American Journal on Addictions* 4:70–81, 1995.

Marlowe, D.B.; Kirby, K.C.; Bonieskie, L.M.; Glass, D.J.; Dodds, L.D.; Husband, S.D.; Platt, J.J.; and Festinger, D.S. Assessment of coercive and noncoercive pressures to enter drug abuse treatment. *Drug and Alcohol Dependence* 42(2):77–84, 1996.

Marsh, J.C.; D'Aunno, T.A.; and Smith, B.D. Increasing access and providing social services to improve drug abuse treatment for women with children. *Addiction* 95:1237–1247, 2000.

Martin, C.S., and Winters, K.C. Diagnosis and assessment of alcohol use disorders among adolescents. *Alcohol and Youth* 22:95–105, 1998. www.niaaa.nih.gov/publications/arh22-2/95-106.pdf [accessed March 3, 2004].

Martin, D.J.; Garske, J.P.; and Davis, M.K. Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology* 68:438–450, 2000.

Martino, S.; Carroll, K.M.; O'Malley, S.S.; and Rounsaville, B.J. Motivational interviewing with psychiatrically ill substance abusing patients. *American Journal on Addictions* 9(1):88–91, 2000.

Maruschak, L.M. HIV in prisons, 2000. *Bureau of Justice Statistics Bulletin.* Washington, DC: Office of Justice Programs, October 2002, revised February 2003. www.ojp.usdoj.gov/bjs/abstract/hivp00.htm [accessed February 11, 2004].

Matrix Center. *The Matrix Model of Outpatient Chemical Dependency Treatment: Family Education Guidelines and Handouts.* Los Angeles: The Matrix Center, 1989.

McCaul, M.E.; Svikis, D.S.; and Moore, R.D. Predictors of outpatient treatment retention: Patient versus substance use characteristics. *Drug and Alcohol Dependence* 62(1):9–17, 2001.

McCrady, B.S. Recent research in twelve step programs. In: Graham, A.W.; Schultz, T.K.; and Wilford, B.B, eds. *Principles of Addiction Medicine*, Second Edition. Chevy Chase, MD: American Society of Addiction Medicine, 1998, pp. 707–717.

McCrady, B.S.; Epstein, E.E.; and Hirsch, L.S. Maintaining change after conjoint behavioral alcohol treatment for men: Outcomes at 6 months. *Addiction* 94(9):1381–1396, 1999.

McCrady, B.S., and Miller, W.R., eds. *Research on Alcoholics Anonymous: Opportunities and Alternatives.* New Brunswick, NJ: Rutgers Center of Alcohol Studies, 1993.

McKay, J.R.; Alterman, A.I.; Cacciola, J.S.; Rutherford, M.J.; O'Brien, C.P.; and Koppenhaver, J. Group counseling versus individualized relapse prevention aftercare following intensive outpatient treatment for cocaine dependence: Initial results. *Journal of Consulting and Clinical Psychology* 65(5):778–788, 1997.

McKay, J.R.; Alterman, A.I.; and Rutherford, M.J. The relationship of alcohol use to cocaine relapse in cocaine dependent patients in an aftercare study. *Journal of Studies on Alcohol* 60(2):176–180, 1999.

McKay, J.R.; Lynch, K.G.; Shepard, D.S.; and Pettinati, H.M. The effectiveness of telephone-based continuing care for alcohol and cocaine dependence: 24-month outcomes. *Archives of General Psychiatry* 62(2):199–207, 2005.

McKinnon, J. The Black population in the United States: March 2002. *Current Population Reports.* P20–541. Washington, DC: U.S. Census Bureau, 2003.

McLellan, A.T.; Cacciola, J.; Kushner, H.; Peters, R.; Smith, I.; and Pettinati, H. The fifth edition of the Addiction Severity Index: Cautions, additions and normative data. *Journal of Substance Abuse Treatment* 9:461–480, 1992*a*.

McLellan, A.T.; Hagan, T.A.; Levine, M.; Gould, F.; Meyers, K.; Bencivengo, M.; and Durell, J. Supplemental social services improve outcomes in public addiction treatment. *Addiction* 93:1489–1499, 1998.

McLellan, A.T.; Hagan, T.A.; Levine, M.; Meyers, K.; Gould, F.; Bencivengo, M.; Durell, J.; and Jaffee, J. Does clinical case management improve outpatient addiction treatment? *Drug and Alcohol Dependence* 55:91–103, 1999.

McLellan, A.T.; Hagan, T.A.; Meyers, K.; Randall, M.; and Durell, J. "Intensive" outpatient substance abuse treatment: Comparisons with "traditional" outpatient treatment. *Journal of Addictive Diseases* 16(2):57–84, 1997.

McLellan, A.T.; Kushner, H.; and Metzger, D. The fifth edition of the Addiction Severity Index. *Journal of Substance Abuse Treatment* 9:199–213, 1992*b*.

McLellan, A.T.; Lewis, D.C.; O'Brien, C.P.; and Kleber, H.D. Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *JAMA* 284(13):1689–1695, 2000.

Mee-Lee, D., and Shulman, G.D. The ASAM placement criteria and matching patients to treatment. In: Graham, A.W.; Schultz, T.K.; Mayo-Smith, M.F.; Ries, R.K.; and Wilford, B.B., eds. *Principles of Addiction Medicine*, Third Edition. Chevy Chase, MD: American Society of Addiction Medicine, 2003, pp. 453–465.

Mee-Lee, D.; Shulman, G.D.; Callahan, J.F.; Fishman, M.; Gastfriend, D.; Hartman, R.; and Hunsicker, R.J., eds. *Patient Placement Criteria for the Treatment of Substance-Related Disorders: Second Edition-Revised* (PPC-2R). Chevy Chase, MD: American Society of Addiction Medicine, 2001.

Meezan, W., and O'Keefe, M. Multifamily group therapy: Impact on family functioning and child behavior. *Families in Society* 79(1):32–44, 1998.

Meissen, G.; Powell, T.J.; Wituk, S.A.; Girrens, K.; and Arteaga, S. Attitudes of AA contact persons toward group participation by persons with a mental illness. *Psychiatric Services* 50(8):1079–1081, 1999.

Mendelson, J., and Jones, R.T. Clinical and pharmacological evaluation of buprenorphine and naloxone combinations: Why the 4:1 ratio for treatment. *Drug and Alcohol Dependence* 70:S29–S37, 2003.

Mendelson, J.; Jones, R.T.; Welm, S.; Baggott, M.; Fernandez, I.; Melby, A.K.; and Nath, R.P. Buprenorphine and naloxone combinations: The effects of three dose ratios in morphine-stabilized, opiate-dependent volunteers. *Psychopharmacology* 141:37–46, 1999.

Mercer, D. Description of an addiction counseling approach. In: Carroll, K.M., ed. *Approaches to Drug Abuse Counseling.* NIH Publication No. 00–4151. Rockville, MD: National Institute on Drug Abuse, 2000, pp. 81–90.

Mercer, D., and Woody, G.E. *An Individual Drug Counseling Approach to Treating Cocaine Addiction: The Collaborative Cocaine Treatment Study Model.* Manual 3: Therapy Manuals for Drug Addiction. NIH Publication No. 99–4380. Rockville, MD: National Institute on Drug Abuse, 1999.

Merikangas, K.R.; Mehta, R.L.; Molnar, B.E.; Walters, E.E.; Swendsen, J.D.; Aguilar-

Gaziola, S.; Bijl, R.; Borges, G.; Caraveo-Anduaga, J.J.; Dewitt, D.J.; Kolody, B.; Vega, W.A.; Wittchen, H.-U.; and Kessler, R.C. Comorbidity of substance use disorders with mood and anxiety disorders: Results of the international consortium in psychiatric epidemiology. *Addictive Behaviors* 23:893–907, 1998.

Metsch, L.R., and McCoy, C.B. Drug treatment experiences: Rural and urban comparisons. *Substance Use & Misuse* 34(4&5):763–784, 1999.

Meyers, R.J.; Miller, W.R.; Hill, D.E.; and Tonigan, J.S. Community reinforcement and family training (CRAFT): Engaging unmotivated drug users in treatment. *Journal of Substance Abuse* 10:291–308, 1998.

Meyers, R.J.; Miller, W.R.; Smith, J.E.; and Tonigan, J.S. A randomized trial of two methods for engaging treatment-refusing drug users through concerned significant others. *Journal of Consulting and Clinical Psychology* 70:1182–1185, 2002.

Meyers, R.J.; Smith, J.E.; and Lash, D.N. The community reinforcement approach. *Recent Developments in Alcoholism* 16:183–195, 2003.

Mid-America Addiction Technology Transfer Center (MATTC). *Psychotherapeutic Medications 2003: What Every Counselor Should Know*. Kansas City, MO: MATTC, 2000. 134.193.108.18/MATTC/information/mattcProds.asp [accessed February 11, 2004].

Mieczkowski, T., and Newel, R. Patterns of concordance between hair assays and urinalysis for cocaine: Longitudinal analysis of probationers in Pinellas County, Florida. In: Harrison, L., and Hughes, A., eds. *Validity of Self-Reported Drug Use: Improving the Accuracy of Survey Estimates*. NIDA Research Monograph 167. NTIS Publication No. 97–4147. Rockville, MD: National Institute on Drug Abuse, 1997, pp. 161–199.

Mieczkowski, T.; Newel, R.; and Wraight, B. Using hair analysis, urinalysis, and self-reports to estimate drug use in a sample of detained juveniles. *Substance Use & Misuse* 33(7):1547–1567, 1998.

Miele, G.M.; Carpenter, K.M.; Cockerham, M.S.; Trautman, K.D.; Blaine, J.; and Hasin, D.S. Substance Dependence Severity Scale (SDSS): Reliability and validity of a clinician-administered interview for DSM-IV substance use disorders. *Drug and Alcohol Dependence* 59:63–75, 2000.

Milby, J.B.; Schumacher, J.E.; Raczynski, J.M.; Caldwell, E.; Engle, M.; Michael, M.; and Carr, J. Sufficient conditions for effective treatment of substance abusing homeless persons. *Drug and Alcohol Dependence* 43:39–47, 1996.

Miller, B.A. Partner violence experiences and women's drug use: Exploring the connections. In: Wetherington, C.L., and Roman, A.B., eds. *Drug Addiction Research and the Health of Women*. Rockville, MD: National Institute on Drug Abuse, 1998, pp. 407–416.

Miller, M.M. Traditional approaches to the treatment of addiction. In: Graham, A.W.; Schultz, T.K.; and Wilford, B.B, eds. *Principles of Addiction Medicine*, Second Edition. Chevy Chase, MD: American Society of Addiction Medicine, 1998, pp. 315–326.

Miller, N.S.; Ninonuero, F.G.; Klamen, D.L.; Hoffmann, N.G.; and Smith, D.E. Integration of treatment and posttreatment variables in predicting results of abstinence-based outpatient treatment after one year. *Journal of Psychoactive Drugs* 29(3):239–248, 1997.

Miller, W.R., and Rollnick, S. *Motivational Interviewing: Preparing People for Change*, Second Edition. New York: Guilford Press, 2002.

Miller, W.R., and Sanchez, V.C. Motivating young adults for treatment and lifestyle

change. In: Howard, G.S., and Nathan, P.E., eds. *Alcohol Use and Misuse by Young Adults.* Notre Dame, IN: University of Notre Dame Press, 1994, pp. 55–81.

Miller, W.R., and Tonigan, J.S. Assessing drinkers' motivation to change: The States of Change Readiness and Treatment Eagerness Scale (SOCRATES). *Psychology of Addictive Behaviors* 10(2):81–89, 1996.

Miller, W.R.; Tonigan, J.S.; and Montgomery, H.A. *Assessment of Client Motivation for Change: Preliminary Validation of the SOCRATES (Rev.) Instrument.* Albuquerque, NM: University of New Mexico, 1990.

Minkoff, K. An integrated treatment model for dual diagnosis of psychosis and addiction. *Hospital and Community Psychiatry* 40(10):1031–1036, 1989.

Minkoff, K. Models for addiction treatment in psychiatric populations. *Psychiatric Annals* 24(8):412–417, 1994.

Minkoff, K. Integration of addiction and psychiatric services. In: Minkoff, K., and Pollack, D., eds. *Managed Mental Health Care in the Public Sector: A Survival Manual.* The Netherlands: Harwood Academic Publishers, 1997, pp. 233–246.

Minkoff, K. Dual Diagnosis: An Integrated Model for the Treatment of People With Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems. Presentation at Building the Bridge: The Integration of Mental Health and Substance Abuse Services, Baltimore, August 5–7, 2002.

Moggi, F.; Ouimette, P.C.; Finney, J.W.; and Moos, R.H. Effectiveness of treatment for substance abuse and dependence for dual diagnosis patients: A model of treatment factors associated with one-year outcomes. *Journal of Studies on Alcohol* 60(6):856–866, 1999.

Mok, D.; Matthews, L.; and Mendoza, J. Changing American ethnic minority families: Highlights on Asian American, African American, and Hispanic/Latino Families. *The Family Psychologist* 19(3):4–9, 2003.

Moore, D., and Li, L. Prevalence and risk factors of illicit drug use by people with disabilities. *American Journal on Addictions* 7(2):93–102, 1998.

Moos, R.; Schaefer, J.; Andrassy, J; and Moos, B. Outpatient mental health care, self-help groups, and patients' one-year treatment outcomes. *Journal of Clinical Psychology* 57:273–287, 2001.

Moos, R.H.; Finney, J.W.; Ouimette, P.C.; and Suchinsky, R.T. A comparative evaluation of substance abuse treatment: I. Treatment orientation, amount of care, and 1-year outcomes. *Alcoholism, Clinical and Experimental Research* 23(3):529–536, 1999.

Moos, R.H., and Moos, B.S. Long-term influence of duration and intensity of treatment on previously untreated individuals with alcohol use disorders. *Addiction* 98:325–337, 2003.

Morral, A.R.; Iguchi, M.Y.; and Belding, M.A. Reducing drug use by encouraging alternative behaviors. In: Higgins, S.T., and Silverman, K., eds. *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions.* Washington, DC: American Psychological Association, 1999, pp. 203–220.

Mulvey, K.P.; Hubbard, S.; and Hayashi, S. A national study of the substance abuse treatment workforce. *Journal of Substance Abuse Treatment* 24:51–57, 2003.

Mumola, C.J. Substance abuse and treatment, State and Federal prisoners, 1997. *Bureau of Justice Statistics Special Report.* Washington, DC: Office of Justice Programs, January 1999. www.ojp.usdoj.

gov/bjs/abstract/satsfp97.htm [accessed February 11, 2004].

Mumola, C.J. Incarcerated parents and their children. *Bureau of Justice Statistics Special Report.* Washington, DC: Office of Justice Programs, August 2000. www.ojp.usdoj.gov/bjs/abstract/iptc.htm [accessed February 11, 2004].

Narcotics Anonymous. In Cooperation With Therapeutic Communities Worldwide. Presentation to the World Federation of Therapeutic Communities Conference, Cartagena, Colombia, February 1998. www.na.org/prespapers/in-cooperation.htm [accessed April 15, 2004].

Nardi, D. Addiction recovery for low-income pregnant and parenting women: A process of becoming. *Archives of Psychiatric Nursing* 12(2):81–89, 1998.

National Alliance for Hispanic Health. *Quality Health Services for Hispanics: The Cultural Competency Component.* DHHS Publication No. 99–21. Washington, DC: U.S. Department of Health and Human Services, 2000.

National Clearinghouse on Child Abuse and Neglect Information. *Substance Abuse and Child Maltreatment.* Washington, DC: U.S. Department of Health and Human Services, 2003. nccanch.acf.hhs.gov/pubs/factsheets/subabuse_childmal.cfm [accessed May 25, 2006].

National Institute of Justice. *1996–1997 Update: HIV/AIDS, STDs, and TB in Correctional Facilities.* Washington, DC: U.S. Department of Justice, July 1999. www.ojp.gov/80/nij/pubs-sum/176344.htm [accessed February 11, 2004].

National Institute on Alcohol Abuse and Alcoholism. Alcohol use among special populations (special issue). *Alcohol Health & Research World* 22(4), 1998.

National Institute on Drug Abuse (NIDA). *Assessing Drug Abuse Among Adolescents and Adults: Standardized Instruments.* The Clinical Report Series. NIH Publication No. 94–3757. Rockville, MD: NIDA, 1994.

National Institute on Drug Abuse (NIDA). *Principles of Drug Addiction Treatment: A Research-Based Guide.* NIH Publication No. 99–4180. Rockville, MD: NIDA, 1999, reprinted 2000.

National Institute on Drug Abuse (NIDA). Therapeutic community. *NIDA Research Report Series.* NIH Publication No. 02–4877. Rockville, MD: NIDA, 2002.

Naumann, P.; Langford, D.; Torres, S.; Campbell, J.; and Glass, N. Women battering in primary care practice. *Family Practice* 16(4):343–352, 1999.

Nebelkopf, E.; Philips, M.; and Native American Health Center Staff. Morning star rising: Healing in Native American communities (special issue). *Journal of Psychoactive Drugs* 35(1), 2003.

Nowinski, J.; Baker, S.; and Carroll, K.M. *Twelve Step Facilitation Therapy Manual: A Clinical Research Guide for Therapists Treating Individuals With Alcohol Abuse and Dependence.* NIAAA Project MATCH Monograph Series, Volume 1. DHHS Publication No. (ADM) 92–1893. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, 1992, reprinted 1994 and 1999.

Obert, J.L.; McCann, M.J.; Marinelli-Casey, P.; Weiner, A.; Minsky, S.; Brethen, P.; and Rawson, R. The matrix model of outpatient stimulant abuse treatment: History and description. *Journal of Psychoactive Drugs* 32(2):157–164, 2000.

O'Connor, P.G.; Oliveto, A.H.; Shi, J.M.; Triffleman, E.G.; Carroll, K.M.; Kosten, T.R.; Rounsaville, B.J.; Pakes, J.A.; and Schottenfeld, R.S. A randomized trial of buprenorphine maintenance for heroin dependence in a primary care clinic for substance users versus a methadone

clinic. *American Journal of Medicine* 105:100–105, 1998.

O'Farrell, T.J.; Choquette, K.A.; and Cutter, H.S.G. Couples relapse prevention sessions after behavioral marital therapy for male alcoholics: Outcomes during the three years after starting treatment. *Journal of Studies on Alcohol* 59(4):357–370, 1998.

O'Farrell, T.J., and Fals-Stewart, W. Family-involved alcoholism treatment: An update. *Recent Developments in Alcoholism* 15:329–356, 2001.

O'Farrell, T.J., and Fals-Stewart, W. Behavioral couples therapy for alcoholism and drug abuse. *Journal of Substance Abuse Treatment* 18:51–54, 2002.

O'Farrell, T.J., and Fals-Stewart, W.A. Alcohol abuse. *Journal of Marital and Family Therapy* 29(1):121–146, 2003.

Office of Applied Studies. *Summary of Findings From the 2000 National Household Survey on Drug Abuse.* NHSDA Series H–13. DHHS Publication No. (SMA) 01–3549. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001. www.samhsa.gov/oas/NHSDA/2kNHSDA/2kNHSDA.htm [accessed February 11, 2004].

Office of Applied Studies. *Treatment Episode Data Set (TEDS): 1992–2000, National Admissions to Substance Abuse Treatment Services.* DASIS Series: S-17, DHHS Publication No. (SMA) 02–3727. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2002. wwwdasis.samhsa.gov/teds00/TEDS_2k_index.htm [accessed February 11, 2004].

Office of Applied Studies. *The DASIS Report: Admissions of Persons With Co-Occurring Disorders, 2000*. Rockville, MD: Substance Abuse and Mental Health Services Administration, April 2003*a*. www.samhsa.gov/oas/2k3/dualTX/dualTX.htm [accessed February 11, 2004].

Office of Applied Studies. *The DASIS Report: Characteristics of Homeless Admissions to Substance Abuse Treatment, 2000.* Rockville, MD: Substance Abuse and Mental Health Services Administration, August 8, 2003*b*. www.samhsa.gov/oas/2k3/homelessTX/homelessTX.htm [accessed February 11, 2004].

Ogunwole, S.U. The American Indian and Alaska Native population: 2000. *Census 2000 Brief.* C2KBR/01–15. Washington, DC: U.S. Census Bureau, 2002.

O'Malley, S.S.; Jaffe, A.J.; Chang, G.; Schottenfeld, R.S.; Meyer, R.E.; and Rounsaville, B. Naltrexone and coping skills therapy for alcohol dependence: A controlled study. *Archives of General Psychiatry* 49(11):881–887, 1992.

Osgood, N.J.; Wood, H.E.; and Parham, I.A., eds. *Alcoholism and Aging: An Annotated Bibliography and Review.* Westport, CT: Greenwood, 1995.

Osher, F.C., and Kofoed, L.L. Treatment of patients with psychiatric and psychoactive substance abuse disorders. *Hospital and Community Psychiatry* 40(10):1025–1030, 1989.

Oslin, D.W.; Pettinati, H.; and Volpicelli, J.R. Older age predicts better adherence and drinking outcomes. *American Journal of Geriatric Psychiatry* 10:740–747, 2002.

Ouimette, P.C.; Kimerling, R.; Shaw, J.; and Moos, R.H. Physical and sexual abuse among women and men with substance use disorders. *Alcoholism Treatment Quarterly* 18(3):7–17, 2000.

Owen, P. Minnesota model: Description of a counseling approach. In: Carroll, K.M., ed. *Approaches to Drug Abuse Counseling*. NIH Publication No. 00–4151. Rockville, MD: National Institute on Drug Abuse, 2000, pp. 117–125.

Paluska, S.A., and Schwenk, T.L. Physical activity and mental health: Current concepts. *Sports Medicine* 29(3):167–180, 2000.

Perry, M.J., and Mackun, P.J. Population change and distribution: 1990 to 2000. *Census 2000 Brief*. C2KBR/01-2. Washington, DC: U.S. Census Bureau, 2001.

Peters, R.H.; Greenbaun, P.E.; Steinberg, M.L.; Carter, C.R.; Ortiz, M.M.; Fry, B.C.; and Valle, S.K. Effectiveness of screening instruments in detecting substance use disorders among prisoners. *Journal of Substance Abuse Treatment* 18:349–358, 2000.

Petrakis, I.L.; Gonzalez, G.; Rosenheck, R.; and Krystal, J.H. *Comorbidity of Alcoholism and Psychiatric Disorders: An Overview*. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, November 2002. www.niaaa.nih.gov/publications/arh26-2/81-89.htm [accessed February 11, 2004].

Petry, N.M. A comprehensive guide to the application of contingency management procedures in standard clinic settings. *Drug and Alcohol Dependence* 58:9–25, 2000.

Physicians' Desk Reference (PDR), 53d Edition. Montvale, NJ: Medical Economics, 2003.

Pickens, R.W.; Battjes, R.; Svikis, D.S.; and Gupman, A.E. Substance use risk factors for HIV infection. *Psychiatric Clinics of North America* 16:119–125, 1993.

Preston, K.L.; Silverman, K.; and Cone, E.J. Monitoring cocaine use during contingency management interventions. In: Higgins, S.T., and Silverman, K., eds. *Motivating Behavior Change Among Illicit Drug Abusers*. Washington, DC: American Psychological Association, 1999, pp. 283–308.

Prochaska, J.O., and DiClemente, C.C. *The Transtheoretical Approach: Crossing Traditional Boundaries of Therapy*. Homewood, IL: Dow Jones and Irwin, 1984.

Prochaska, J.O., and DiClemente, C.C. Toward a comprehensive model of change. In: Miller, W.R., and Heather, N., eds. *Treating Addictive Behaviors: Processes of Change*. New York: Plenum Press, 1986, pp. 3–27.

Prochaska, J.O., and DiClemente, C.C. Stages of change in the modification of problem behavior. In: Hersen, M.; Eisler, R.; and Miller, P.M., eds. *Progress in Behavior Modification*. Sycamore, IL: Sycamore Publishing, 1992.

Prochaska, J.O.; Norcross, J.C.; and DiClemente, C.C. *Changing for Good*. New York: William Morrow, 1994.

Project MATCH Research Group. Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol* 58:7–29, 1997.

Project MATCH Research Group. Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. *Alcoholism, Clinical and Experimental Research* 22:1300–1311, 1998.

Ramirez, R.R., and de la Cruz, G.P. The Hispanic population in the United States: March 2002. *Current Population Reports*, P20–545. Washington, DC: U.S. Census Bureau, 2003.

Rawson, R.A. Welcome to the ISAP news. *ISAP News* 1(1):1, 2003. www.uclaisap.org/newsletter/documents/May-2003-ISAP-News.pdf [accessed February 11, 2004].

Rawson, R.A.; Huber, A.; Brethen, P.; Obert, J.; Gulati, V.; Shoptaw, S.; and Ling, W. Status of methamphetamine users 2–5

years after outpatient treatment. *Journal of Addictive Diseases* 21:107–119, 2002.

Rawson, R.A.; Obert, J.L.; McCann, M.J.; and Mann, A.J. Cocaine treatment outcome: Cocaine use following inpatient, outpatient, and no treatment. In: Harris, L.S., ed. *Problems of Drug Dependence, 1985: Proceedings of the 47th Annual Scientific Meeting, the Committee on Problems of Drug Dependence, Inc.* NIDA Research Monograph 67. Rockville, MD: National Institute on Drug Abuse, 1986, pp. 271–277.

Reeves, T., and Bennett, C. The Asian and Pacific Islander population in the United States: March 2002. *Current Population Reports*, P20–540. Washington, DC: U.S. Census Bureau, 2003.

Reoux, J.P., and Miller, K. Routine hospital alcohol detoxification practice compared to symptom triggered management with an objective withdrawal scale (CIWA-Ar). *American Journal on Addictions* 9(2):135–144, 2000.

Richard, A.J.; Montoya, I.D.; Nelson, R.; and Spence, R.T. Effectiveness of adjunct therapies in crack cocaine treatment. *Journal of Substance Abuse Treatment* 12(6):401–413, 1995.

Richmond, R., and Zwar, N. Review of bupropion for smoking cessation. *Drug and Alcohol Review* 22:203–220, 2003.

Ries, R.K.; Russo, J.; Wingerson, D.; Snowden, M.; Comtois, K.A.; Srebnik, D.; and Roy-Byrne, P. Shorter hospital stays and more rapid improvement among patients with schizophrenia and substance disorders. *Psychiatric Services* 51:210–215, 2000.

Ritsher, J.B.; Moos, R.H.; and Finney, J.W. Relationship of treatment orientation and continuing care to remission among substance abuse patients. *Psychiatric Services* 53(5):595–601, 2002.

Robertson, E.B.; Sloboda, Z.; Boyd, G.M.; Beatty, L.; and Kozel, N.J. *Rural Substance Abuse: State of Knowledge and Issues.* NIDA Research Monograph 168. NIH Publication No. 97–4177. Rockville, MD: National Institute on Drug Abuse, 1997.

Rosenheck, R.; Harkness, L.; and Johnson, B. Intensive community-focused treatment of veterans with dual diagnoses. *American Journal of Psychiatry* 155(10):1429–1433, 1998.

Rounsaville, B.J.; Tims, F.M.; Horton, A.M.; and Sowder, B.J., eds. *Diagnostic Source Book on Drug Abuse Research and Treatment.* DHHS Publication No. (ADM) 93–3508. Rockville, MD: National Institute on Drug Abuse, 1993.

Rowe, C.L., and Liddle, H.A. Substance abuse. *Journal of Marital and Family Therapy* 29:97–120, 2003.

Rubin, A.; Stout, R.L.; and Longabaugh, R. Gender differences in relapse situations. *Addiction* 91(Suppl):S111–S120, 1996.

Sampl, S., and Kadden, R. *Motivational Enhancement Therapy and Cognitive-Behavioral Therapy for Adolescent Cannabis Users: 5 Sessions.* Cannabis Youth Treatment Series, Volume 1. DHHS Publication No. (SMA) 01–3486. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2001.

Schmidley, D. The foreign-born population in the United States: March 2002. *Current Population Reports*, P20–539. Washington, DC: U.S. Census Bureau, 2003.

Schmitz, J.M.; Henningfield, J.E.; and Jarvik, M.E. Pharmacologic therapies for nicotine dependence. In: Graham, A.W.; Schultz, T.K.; and Wilford, B.B., eds. *Principles of Addiction Medicine*, Second Edition. Chevy Chase, MD: American

Society of Addiction Medicine, 1998, pp. 571–582.

Schmitz, J.M.; Oswald, L.M.; Jacks, S.D.; Rustin, T.; Rhoades, H.M.; and Grabowski, J. Relapse prevention treatment for cocaine dependence: Group versus individual format. *Addictive Behaviors* 22(3):405–418, 1997.

Schneider, R.; Mittelmeier, C.; and Gadish, D. Day versus inpatient treatment for cocaine dependence: An experimental comparison. *Journal of Mental Health Administration* 23(2):234–245, 1996.

Schottenfeld, R.S., and Pantalon, M.V. Assessment of the patient. In: Galanter, M., and Kleber, H.D., eds. *The American Psychiatric Press Textbook of Substance Abuse Treatment*, Second Edition. Washington, DC: American Psychiatric Press, 1999, pp. 109–119.

Schuckit, M.S. Goals of treatment. In: Galanter, M., and Kleber, H.D., eds. *The American Psychiatric Press Textbook of Substance Abuse Treatment.* Washington, DC: American Psychiatric Press, 1994, pp. 3–10.

Schumacher, J.E.; Milby, J.B.; Caldwell, E.; Raczynski, J.; Engle, M.; Michael, M.; and Carr, J. Treatment outcome as a function of treatment attendance with homeless persons abusing cocaine. *Journal of Addictive Diseases* 14(4):73–85, 1995.

Schwartz, M.; Baker, G.; Mulvey, K.P.; and Plough, A. Improving publicly funded substance abuse treatment: The value of case management. *American Journal of Public Health* 87:1659–1664, 1997.

Scott, J.; Gilvarry, E.; and Farrell, M. Managing anxiety and depression in alcohol and drug dependence. *Addictive Behaviors* 23(6):919–931, 1998.

Seidner, A.L.; Burling, T.A.; Gaither, D.E.; and Thomas, R.G. Substance-dependent inpatients who accept smoking treatment. *Journal of Substance Abuse* 8(1):33–44, 1996.

Sheehan, D.V.; Lecrubier, Y.; Harnet-Sheehan, K.; Amorim, P.; Janavs, J.; Weiller, E.; Hergueta, T.; Baker, R.; and Dunbar, G. The Mini International Neuropsychiatric Interview (M.I.N.I.): The development and validation of a structured diagnostic psychiatric interview. *Journal of Clinical Psychiatry* (Suppl. 20):22–33, 1998.

Shoptaw, S.; Frosch, D.; Rawson, R.A.; and Ling, W. Cocaine abuse counseling as HIV prevention. *AIDS Education and Prevention* 9(3):15–24, 1997.

Shoptaw, S.; Reback, C.J.; Freese, T.E.; and Rawson, R.A. *Friends Health Center: Behavioral Interventions for Methamphetamine Abusing Gay and Bisexual Men, A Treatment Manual Combining Relapse Prevention and HIV Risk-Reduction Interventions.* Los Angeles: Friends Research Institute, Inc., 1998.

Shoptaw, S.; Rotheram-Fuller, E.; Yang, X.; Frosch, D.; Nahom, D.; Jarvik, M.E.; Rawson, R.A.; and Ling, W. Smoking cessation in methadone maintenance. *Addiction* 97:1317–1328, 2002.

Siegal, H.A.; Fisher, J.A.; Rapp, R.C.; Kelliher, C.W.; Wagner, J.H.; O'Brien, W.F.; and Cole, P.A. Enhancing substance abuse treatment with case management: Its impact on employment. *Journal of Substance Abuse Treatment* 13(2):93–98, 1996.

Siegal, H.A.; Li, L.; and Rapp, R.C. Case management as a therapeutic enhancement: Impact on post-treatment criminality. *Journal of Addictive Diseases* 21:37–46, 2002.

Simpson, T.L., and Miller, W.R. Concomitance between childhood sexual and physical abuse and substance use problems: A review. *Clinical Psychological Review* 22(1):27–77, 2002.

Sloan, K.L., and Rowe, G. Substance abuse and psychiatric illness: Treatment experience. *American Journal of Drug and Alcohol Abuse* 24(4):589–601, 1998.

Spicer, P.; Beals, J.; Croy, C.D.; Mitchell, C.M.; Novins, D.K.; Moore, L.; Manson, S.M.; and the American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project Team. The prevalence of DSM-III-R alcohol dependence in two American Indian populations. *Alcoholism, Clinical and Experimental Research* 27(11):1785–1797, 2003.

Stanton, M.D., and Shadish, W.R. Outcome, attrition, and family—Couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. *Psychological Bulletin* 122(2):170–191, 1997.

Stasiewicz, P.R., and Stalker, R. A comparison of three "interventions" on pretreatment dropout rates in an outpatient substance abuse clinic. *Addictive Behaviors* 24(4):579–582, 1999.

Stewart, E.C., and Bennett, M.J. *American Cultural Patterns: A Cross-Cultural Perspective*, Second Edition. Yarmouth, ME: Intercultural Press, 1991.

Substance Abuse and Mental Health Services Administration (SAMHSA). *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders*. Rockville, MD: SAMHSA, 2002.

Substance Abuse and Mental Health Services Administration (SAMHSA). *Strategies for Developing Treatment Programs for People With Co-Occurring Substance Abuse and Mental Disorders*. SAMHSA Publication No. 3782. Rockville, MD: SAMHSA, 2003.

Sue, D.W., and Sue, D. *Counseling the Culturally Different: Theory and Practice*, Third Edition. New York: John Wiley and Sons, 1999.

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Instrument for Alcohol Scale (CIWA-Ar). *British Journal of the Addictions* 84:1353–1357, 1989.

Szapocznik, J.; Kurtines, W.M.; Foote, F.H.; Perez-Vidal, A.; and Hervis, O. Conjoint versus one-person family therapy: Some evidence for the effectiveness of conducting family therapy through one person. *Journal of Consulting and Clinical Psychology* 51:881–889, 1983.

Szapocznik, J.; Kurtines, W.M.; Foote, F.H.; Perez-Vidal, A.; and Hervis, O. Conjoint versus one-person family therapy: Further evidence for the effectiveness of conducting family therapy through one person with drug-abusing adolescents. *Journal of Consulting and Clinical Psychology* 54:395–397, 1986.

Szapocznik, J., and Williams, R.A. Brief strategic family therapy: Twenty-five years of interplay among theory, research and practice in adolescent behavior problems and drug abuse. *Clinical Child and Family Psychology Review* 3(2):117–134, 2000.

Tempesta, E.; Janiri, L.; Bignamini, A.; Chabac, S.; and Potgieter, A. Acamprosate and relapse prevention in the treatment of alcohol dependence: A placebo-controlled study. *Alcohol and Alcoholism* 35(2):202–209, 2000.

Tolman, R.M. The development of a measure of psychological maltreatment of women by their male partners. *Violence and Victims* 4:159–177, 1989.

Tonigan, J.S. Project MATCH treatment participation and outcome by self-reported ethnicity. *Alcoholism, Clinical and Experimental Research* 27(8):1340–1344, 2003.

Tonigan, J.S.; Miller, W.R.; and Schermer, C. Atheists, agnostics, and Alcoholics

Anonymous. *Journal of Studies on Alcohol* 63:534–541, 2002.

Tracy, E.M., and Whittaker, J.K. The social network map: Assessing social support in clinical practice. *Families in Society: The Journal of Contemporary Human Services* 71:461–470, 1990.

Turner, R.J., and Gil, A.G. Psychiatric substance use disorders in South Florida: Racial/ethnic and gender contrasts in a young adult cohort. *Archives of General Psychiatry* 59(1):43–50, 2002.

Tuten, M., and Jones, H.E. A partner's drug-using status impacts women's drug treatment outcome. *Drug and Alcohol Dependence* 70(3):327–330, 2003.

Urban Institute; Burt, M.R.; Aron, L.Y.; Douglas, T.; Valente, J.; Lee, E.; and Iwen, B. *Homelessness: Programs and the People They Serve–Findings of the National Survey of Homeless Assistance Providers and Clients, Technical Report.* Washington, DC: Interagency Council on the Homeless, 1999. www.huduser.org/publications/homeless/homeless_tech.html [accessed February 11, 2004].

U.S. Census Bureau. Asian Pacific American Heritage Month: May 2003. *Facts for Features.* Washington, DC: U.S. Census Bureau, April 17, 2003. www.census.gov/Press-Release/www/2003/cb03-ff05.html [accessed February 11, 2004].

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1999. www.mentalhealth.org/features/surgeongeneralreport/home.asp [accessed February 11, 2004].

U.S. Department of Health and Human Services. *Mental Health: Culture, Race, and Ethnicity–A Supplement to Mental Health: A Report of the Surgeon General.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2001. www.mentalhealth.org/cre/default.asp [accessed February 11, 2004].

U.S. Government Office of Technology Assessment. *Technologies for Understanding and Preventing Substance Abuse and Addiction.* Washington, DC: U.S. Government Printing Office, 1994.

U.S. House Committee on the Judiciary, Subcommittee on Crime. *Testimony of Bruce C. Fry, J.D., M.P.P.*, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. 104th Cong., 2d sess., October 2, 2000. www.house.gov/judiciary/fry1002.htm [accessed February 11, 2004].

Vaillant, G.E. *The Natural History of Alcoholism.* Cambridge, MA: Harvard University Press, 1983.

Veach, L.J.; Remley, T.P., Jr.; Kippers, S.M.; and Sorg, J.D. Retention predictors related to intensive outpatient programs for substance use disorders. *American Journal of Drug and Alcohol Abuse* 26(3):417–428, 2000.

Vega, W.A.; Gil, A.G.; and Wagner E. Cultural adjustment and Hispanic adolescents. In: Vega, W.A., and Gil, A.G., eds. *Drug Use and Ethnicity in Early Adolescence.* New York: Plenum, 1998, pp. 125–148.

Vega, W.A.; Gil, A.G.; and Zimmerman, R.S. Patterns of drug use among Cuban-American, African-American, and white non-Hispanic boys. *American Journal of Public Health* 83(2):257–259, 1993.

Volpicelli, J.R.; Alterman, A.I.; Hayashida, M.; and O'Brien, C.P. Naltrexone in the treatment of alcohol dependence. *Archives of General Psychiatry* 49:876–880, 1992.

Volpicelli, J.R.; Markman, I.; Monterosso, J.; Filing, J.; and O'Brien, C.P. Psychosocially enhanced treatment for cocaine-dependent mothers: Evidence of efficacy. *Journal of Substance Abuse Treatment* 18(1):41–49, 2000.

Washton, A.M. Evolution of intensive outpatient treatment (IOP) as a "legitimate" treatment modality. *Journal of Addictive Diseases* 16(2):xxi–xxvii, 1997.

Washton, A.M. A psychotherapeutic and skills-training approach to the treatment of addiction. In: Carroll, K.M., ed. *Approaches to Drug Abuse Counseling.* NIH Publication No. 00–4151. Rockville, MD: National Institute on Drug Abuse, 2000, pp. 139–148.

Watkins, K.E.; Burnam, A.; Kung, F.Y.; and Paddock, S. A national survey of care for persons with co-occurring mental and substance use disorders. *Psychiatric Services* 52(8):1062–1068, 2001.

Webb, C.; Scudder, M.; Kaminer, Y.; and Kadden, R. *The Motivational Enhancement Therapy and Cognitive–Behavioral Therapy Supplement: 7 Sessions of Cognitive–Behavioral Therapy for Adolescent Cannabis Users.* Cannabis Youth Treatment Series, Volume 2. DHHS Publication No. (SMA) 02–3659. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2002.

Weinberg, N.Z.; Rahdert, E.; Colliver, J.D.; and Glantz, M.D. Adolescent substance abuse: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry* 37:252–261, 1998.

Weinstein, S.P.; Gottheil, E.; and Sterling, R.C. Randomized comparison of intensive outpatient vs. individual therapy for cocaine abusers. *Journal of Addictive Diseases* 16(2):41–56, 1997.

Weiss, R.D.; Griffin, M.L.; Greenfield, S.F.; Najavits, L.M.; Wyner, D.; Soto, J.A.; and Hennen, J.A. Group therapy for patients with bipolar disorder and substance dependence: Results of a pilot study. *Journal of Clinical Psychiatry* 61(5):361–367, 2000.

Wells, K.; Klap, R.; Koike, A.; and Sherbourne, C. Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. *American Journal of Psychiatry* 158:2027–2032, 2001.

White, J.M.; Winn, K.I.; and Young, W. Predictors of attrition from an outpatient chemical dependency program. *Substance Abuse* 19(2):49–59, 1998.

White, W.L. *Slaying the Dragon: The History of Addiction Treatment and Recovery in America.* Bloomington, IL: Chestnut Health Systems, 1998.

Whiteside-Mansell, L. The development and evaluation of an alcohol and drug prevention and treatment program for women and children: The AR-CARES Program. *Journal of Substance Abuse Treatment* 16:265–275, 1999.

Williams, R., and Gorski, T.T. *Relapse Prevention Counseling for African Americans: A Culturally Specific Model.* Independence, MO: Herald, 1997.

Williams, R., and Gorski, T.T. *Relapse Prevention Workbook for African Americans: Hope and Healing for the Black Substance Abuser.* Independence, MO: Herald, 1999.

Williams, R.J.; Chang, S.Y.; and Addiction Centre Adolescent Research Group. A comprehensive and comparative review of adolescent substance abuse treatment outcome. *Clinical Psychology: Science and Practice* 7:138–166, 2000.

Willoughby, F.W., and Edens, J.F. Construct validity and predictive utility of the stages of change scale for alcoholics. *Journal of Substance Abuse* 8:275–291, 1996.

Winters, F.; Fals-Stewart, W.; O'Farrell, T.J.; Birchler, G.R.; and Kelley, M.L. Behavioral couple therapy for female substance-abusing patients: Effects on substance abuse and relationship adjustment. *Journal of Consulting and Clinical Psychology* 70:344–355, 2002.

Winzelberg, A., and Humphreys, K. Should patients' religiosity influence clinicians' referral to 12-step self-help groups? Evidence from a study of 3,018 male substance abuse patients. *Journal of Consulting Psychology* 67:790–794, 1999.

Wiseman, E.J.; Henderson, K.L; and Briggs, M.J. Individualized treatment for outpatients withdrawing from alcohol. *Journal of Clinical Psychiatry* 59(6):289–293, 1998.

Woody, G.E.; Donnell, D.; Seage, G.R.; Metzger, D.; Marmor, M.; Koblin, B.A.; Buchbinder, S.; Gross, M.; Stone, B.; and Judson, F.N. Non-injection substance use correlates with risky sex among men having sex with men: Data from HIVNET. *Drug and Alcohol Dependence* 53(3):197–205, 1999.

World Health Organization (WHO). *International Classification of Diseases, 10th Edition (ICD-10) Classification of Mental and Behavioral Disorders: Clinical Descriptions and Diagnostic Guidelines.* Geneva, Switzerland: WHO, 1992.

World Health Organization (WHO). *Composite International Diagnostic Interview (CIDI).* Core Version 2.1. Geneva, Switzerland: WHO, 1997.

Zerger, S. *Substance Abuse Treatment: What Works for Homeless People? A Review of the Literature.* Nashville, TN: National Health Care for the Homeless Council, 2002.

Ziedonis, D.M., and D'Avanzo, K. Schizophrenia and substance abuse. In: Kranzler, H.R., and Rounsaville, B.J., eds. *Dual Diagnosis and Treatment.* New York: Marcel Dekker, 1998, pp. 427–465.

Zilberman, M.L.; Tavares, H.; Blume, S.B.; and el-Guebaly, N. Substance use disorders: Sex differences and psychiatric comorbidities. *Canadian Journal of Psychiatry* 48(1):5–13, 2003.

Zullino, D.F.; Besson, J.; Favrat, B.; Krenz, S.; Zimmerman, G.; Schnyder, C.; and Borgeat, F. Acceptance of an intended smoking ban in an alcohol dependence clinic. *European Psychiatry* 18(5):255–257, 2003.

Appendix B—Urine Collection and Testing Procedures and Alternative Methods for Monitoring Drug Use

Urine testing is the best developed and most commonly used monitoring technique in substance abuse treatment programs. This appendix describes procedures for implementing this service and other methods for detecting clients' substance use. The Substance Abuse and Mental Health Services Administration (SAMHSA) has a number of documents about drug testing available in the Workplace Resources section of its Web site, www.samhsa.gov.

Testing Schedule

Urine specimens are collected

- As part of the intake process to confirm a newly admitted client's substance use history
- As a routine part of therapy
- To identify an intoxicated client or confirm abstinence

Each intensive outpatient treatment (IOT) program should consider establishing a schedule for urine testing that takes into account Federal and State requirements (e.g., for methadone programs) and balances the therapeutic needs of the population being served with costs to the program or payer. Clients generally need more frequent monitoring during the initial stages of treatment when they are trying to achieve abstinence but still may be using substances. Routine specimen collection after admission should take place in conjunction with regular clinic visits.

Under ideal conditions, the consensus panel believes that collection should occur not less than once a week or more frequently than every 3 days in the first weeks of treatment. It is important that the scheduled frequency of urine collection match the usual detection window for the primary drug. Too long an interval between urine tests can lead to unreliable results because most of the target drug and its metabolites will have been excreted. On the other hand, if the interval between tests is too short, a single incidence of drug use may

be detected twice in separate urine samples. Multiple positive urine test results produced by a single ingestion (carryover positives) can be discouraging for the client and misleading for the clinician (Preston et al. 1999).

Once clients are stabilized in treatment, they require less intensive monitoring of abstinence. At this point, most programs reduce the frequency of scheduled tests and randomize the collection times. Even with a decreased and randomized testing schedule, specimen collection should be scheduled on clinic days following weekends, holidays, or paychecks—the times when clients are most tempted to use.

During IOT, monthly testing is standard in most programs. Random testing can be achieved by

- Asking clients to produce specimens only on random days
- Requiring that all clients provide a specimen on every visit but analyzing only a randomly selected sample

Collection Procedures and Policies

Urine sample collection procedures need to strike a balance between trusting clients and ensuring that specimens are not contaminated or falsified. Some programs insist that a staff member of the same sex accompany a client into the bathroom to observe urine collection. Others find that monitoring through an open door and having clients leave packages and coats outside are sufficient. A sink that is separate from the toilet area also discourages attempts to dilute samples (Bureau of Justice Assistance 1999). Many programs use temperature strips to make certain that urine specimens are produced on site and are body temperature. Tests of creatinine or specific gravity can determine whether a sample has been diluted with water or the client is consuming excessive fluids to lower the concentration of drugs below detectable levels (Preston et al. 1999).

Information about how to beat the drug testing system is widely available. Web sites advertise inexpensive products that can be added to urine specimens to absorb toxins as well as herbal remedies for consumption for a few hours before testing to cleanse the urine. Concentrated, "clean" specimens can be purchased for mixing with warm water at the test site. A variety of low-cost, self-testing kits also are available to preview likely results from more formal testing procedures.

As part of their orientation to the IOT program, clients need to be informed about the urine collection and testing procedures. Clients also should be advised that informed consent is necessary for release of toxicology results to anyone other than staff (see chapter 7 of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* [CSAT 2006*f*]). Most IOT programs do not comply with workplace standards for testing or maintain an adequate chain-of-custody for specimens that would meet court challenges. If employers, representatives of the criminal justice system, or children's protection agencies feel that such reporting is necessary, they can be advised to conduct their own testing or to accept other clinical evidence of client progress in treatment.

Clients should report any substance use to their counselor before a urine sample is submitted so that the substance use can be addressed therapeutically. It may be helpful to remind clients that the clinic conducts drug monitoring to support their recovery. Because there may be some likelihood of cross-reactivity and false positive results on screening tests, clients need to keep counselors informed about any prescribed medications or over-the-counter (OTC) drugs they have used.

Appropriate attention needs to be given to handling and storing collected specimens. Collection bottles that are sent to an offsite laboratory should be clean and tamperproof. Waterproof labels attached to the bottles

should note either the client's name or identification number and be checked for accuracy by the client and the counselor or technician. Collected specimens need to be kept cool—or refrigerated—until transmitted to the laboratory and should be stored in a protected or locked room for security. Clients and staff members who touch the urine collection bottles need to be reminded to wash their hands thoroughly. Rubber gloves should be worn by technicians who perform onsite analyses.

Selection of Drug Batteries and Testing Techniques

Programs need to test for a standard battery of drugs, which may include such drug groups as amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, methadone, methaqualone, opioids, phencyclidine (PCP), propoxphene, or euphorics (Ecstasy). In programs where the majority of clients use only a few types of substances, the standard battery can be small, and only selected individual clients need be tested for other specified substances. Programs should add substances to the routine battery, temporarily or permanently, if patterns of substance use change in the target population or in the community. It is helpful to stay up to date about local drug use patterns identified by the nearest Community Epidemiology Work Group (www.nida.nih.gov/CEWG/CEWGHome.html) or the Single State Authority. For example, oxycodone (OxyContin®) has become a serious drug of abuse in particular locales. Fads come and go for abuse of a wide variety of substances (e.g., Ecstasy, PCP, pentazocine [Talwin®], propoxyphene [Darvon®]).

Detection Limits for the Substances Being Tested

The length of time during which different licit and illicit substances or their metabolites can be detected in urine samples depends on many interacting factors, including

- Chemical properties (e.g., half-life) of the selected drugs
- Metabolism rates and excretion routes
- Amount, administration route, frequency, and chronicity of the dose consumed
- Sensitivity and specificity of the assay
- Individual variations in clients' physical health, exercise, diet, weight, gender, and fluid intake that affect excretion rates

Most substances of abuse can be detected for approximately 2 to 4 days (see exhibit B-1). However, the higher the dose taken and the more frequently the substance has been used over an extended time, the more likely that it will be detected. Although substances are excreted at various rates, they accumulate in the body with continued use. Whereas a single use of cocaine may be detectable in urine for only a day or less, continued daily use is likely to be detectable for 2 to 3 days following its discontinuation (Preston et al. 1999). Chronic use of such drugs as marijuana, PCP, and benzodiazepines may be detectable for up to 30 days, whereas alcohol remains in the system for 24 hours or less. Realistically, it may be difficult to detect illicit substances in most clients who stop all use for several days before a drug screen. An accurate profile of a client's substance use over more than a few days requires both urine test results and a good retrospective history.

Selecting an Appropriate Testing Technique

A program should consider a variety of factors in selecting a method and source for drug testing. None of the methods are inexpensive, with costs ranging from less than $5 to more than $100 per assay for a particular drug. Turnaround time in receiving results is another important determinant. Whereas onsite methods can provide results in a matter of minutes, more accurate and expensive commercial laboratory analyses may take

Exhibit B-1

Urine Toxicology Detection Periods for Different Substances

Substance	Typical Urine Detection Period
Amphetamine or methamphetamine	2–4 days
Barbiturates Short-acting—Secobarbital Long-acting—Pentobarbital Phenobarbital	 1–2 days 2–4 days 10–20 days
Benzodiazepines Therapeutic dose Chronic dosing	 3–7 days Up to 30 days
Cocaine	1–3 days
Cannabinoids Casual use Daily use Chronic use	 1–3 days 5–10 days Up to 30 days
Ethanol (alcohol)	12–24 hours
Opioids (e.g., codeine, morphine)	1–3 days
Methadone	2–4 days
Propoxyphene	6–48 hours
Ecstasy/euphorics	1–5 days
PCP Acute use Chronic use	 2–7 days Up to 30 days

several days or longer. Reliability is a major consideration. However, substance abuse treatment programs that are using results for clinical purposes do not require the same accuracy (i.e., workplace standards) as agencies that make important, one-time decisions

about such issues as employment, safety, eligibility for sports competitions, or probation or parole violations. Some cities and States have assumed responsibility for selecting a single vendor for providers under their jurisdiction to use and choosing a standard battery of drugs to be tested. Providers may wish to create a buying collective to negotiate the best discounts from a local drug-testing laboratory.

Two categories of urine tests are available:

- **Screening tests.** These detect only the presumptive presence or absence of a class of drugs in the urine specimen, return results rapidly, are relatively inexpensive ($1 to $5 per assay), can be set to detect low concentrations of drugs (have high sensitivity), and are relatively simple to perform. But these screening tests—the ones most frequently used by substance abuse treatment programs—do not distinguish specific drug metabolites (only groups), provide only qualitative results (yes or no), and may mistake other chemically similar medications, OTC preparations, or substances for the target drug class (Preston et al. 1999). This potential for cross-reactivity is of more concern in detecting amphetamines, benzodiazepines, and opioids than cocaine or marijuana. More specifically, the following cross-reactive results may occur:
  - Some cough suppressors in OTC preparations may be reported as a positive result for opioids.
  - Phenylpropanolamine or ephedrine in cold remedies can cause false positives for amphetamines.
  - Ibuprofen and other anti-inflammatories may be interpreted as positives for marijuana on the enzyme-multiplied immunoassay technique (EMIT) test.
  - Amitriptyline (an antidepressant) can be mistaken for opioids.
  - Some antibiotics may cause false positives for cocaine.
  - Diazepam has been mistaken for PCP.
- **Confirmatory tests.** These provide more definitive information about the quantitative concentrations (nanograms/milliliter) of specific drugs or their metabolites in urine specimens and are more accurate than drug screens (have higher specificity and sensitivity). They are much more expensive (up to $100 per assay), technically complex, labor intensive, and time consuming—often taking days to complete. If the results of a drug test will be used as a basis for actions taken against an individual (e.g., in a justice system context), positive findings should be followed by a confirmatory test of equal or greater sensitivity and better specificity (Bureau of Justice Assistance 1999). Although results from these quantitative tests can be more useful than a simple positive or negative for monitoring intermediate changes in drug consumption patterns, the concentration in urine might be the same for a small amount of a drug administered recently as for a large amount of the drug consumed several days ago. In addition, concentrations can be affected by fluid consumption levels and may be misleading (Preston et al. 1999).

The Meaning of Test Results

Urine test results can be inaccurate. Counselors should keep this fact in mind when discussing findings with a client. Asking the client whether results are accurate and, if so, when and how much of a particular substance was used can be the beginning of a therapeutic discussion that includes the circumstances surrounding substance use and the client's triggers.

In interpreting test results, clinicians should know the following:

- Positive results show a presumptive or confirmed presence of targeted substances at a detectable level. Positive results also mean that the amount of the substance detected is above the cutoff point for labeling a specimen positive. (SAMHSA has

established Federal guidelines for cut-off levels; see workplace.samhsa.gov/DrugTesting/RegGuidance/UrineConcen.htm.) Findings cannot determine when, how much, or how a drug was administered or the degree of impairment the drug produced (Bureau of Justice Assistance 1999).

- Negative results do not guarantee that the individual did not consume the substances tested. Despite a client's use of the targeted substance, results could be negative because (1) most evidence may have been excreted or metabolized before testing took place, (2) the specimen may have been diluted or switched, (3) the client may have consumed an excessive amount of fluids to dilute the urine, or (4) the test may not have been sufficiently sensitive (Bureau of Justice Assistance 1999).
- False-positive results that mistakenly find the presence of a substance can result from laboratory errors (e.g., outdated reagents and labeling mistakes), specimen tampering, or cross-reactivity of an immunoassay test with a substance of similar chemical structure.

Urine-Testing Techniques

Most screening tests are immunoassays that take advantage of antigen-antibody interactions—using enzymes, radioisotopes, or fluorescent compounds—and compare the specimen with a calibrated quantity of the substance being tested (Bureau of Justice Assistance 1999).

- EMIT test is the least expensive, most widely used, and simplest test to conduct. It often is used on site at a cost of about $5 per screen. It also has the poorest performance record, returning up to 30 percent false positives. Although EMIT can be used to test for a wide variety of drugs and alcohol, some sources report that as many as 300 OTC preparations cause false-positive readings.
- Fluorescent polarization immunoassay TDx™ is highly sensitive and highly specific.
- Radioimmunoassay (RIA) is a more sensitive test than the EMIT and is used extensively by the military.
- Kinetic interaction of microparticles in solution is a screening test used with most substances.
- Thin-layer chromatography (TLC) involves the addition of a solvent to the specimen that causes the target drugs and metabolites to move up a porous strip, leaving colored spots at different distances that can be compared with known standards. The results are reported as positive or negative, without any quantitative information, and require skill to interpret. Because TLC returns many false positives, it is no longer used widely.

Confirmatory urine testing methods include

- Gas liquid chromatography
- High performance liquid chromatography
- Gas chromatography/mass spectrometry (GC/MS) (the gold standard for drug detection, but costly at $25 to $100 a test)

Alternative Testing Methods

Several other body products are gaining prominence in the search for simpler, less expensive, noninvasive, and more accurate techniques for detecting the recent and current use of substances. Exhibit B-2 compares the effectiveness of urine, breath, saliva, sweat, blood, and hair testing methodologies for detecting drugs.

Breath-Testing Techniques

Because alcohol is metabolized rapidly at an average rate of 15 to 25 milligrams per hour—and the detection period is hours, not days—drinking usually is not monitored by urine or blood tests. Instead, clinicians frequently rely on other observations of current use (e.g., an odor of alcohol, slurred speech)

Exhibit B-2

Effectiveness of Drug Detection Methods That Use Different Biological Products

Body Product	Drug Detection Time	Major Advantages	Major Limitations	Primary Use
Urine	2–4 days	Mature technique; established cutoffs for detecting many drugs of abuse	Detects only recent use; needs costly confirmation to be accurate	Monitors recent drug use in many populations
Breath (**alcohol**)	12–24 hours	Easy to use; readily available and well-established method	Short detection time	Confirms observed intoxication or impairment
Saliva	12–24 hours	Easy to obtain samples; good correlation with blood levels for some substances	Very short detection time; new method; oral cavity is contaminated easily	Links positive drug test to behavioral impairment and intoxication
Sweat	1–4 weeks	Cumulative measure; relatively tamper-proof collection method	High potential for contamination; new technique	Detects recent and less recent drug use
Blood	12–24 hours	Accurate results; established method	Invasive method; expensive; detects only current use or intoxication	Detects drug effects on crashes, medical emergencies
Hair	4–6 months	Measures long-term drug use; readily available samples; accurate results	New technique; costly and time-consuming; no dose-response relation established	Confirms drug use in past 4 to 6 months; prevalence studies

or an easily administered Breathalyzer™ test to confirm alcohol intoxication or drinking within the past several hours. Blood alcohol concentrations—measured in milligrams (mg) of alcohol per deciliter (dl) of blood—usually are expressed as a percentage (i.e., 100 mg/dl equals 100 mg percent or 0.1 percent) and correspond closely with measures of alcohol on the breath. One drink increases the breath alcohol level (BAL) by approximately 0.025 percent.

For most men, some impairment is observable at 0.05 percent BAL, and driving ability is appreciably affected at 0.07 percent. A woman weighing 150 pounds would reach a BAL of 0.1 percent if she consumed approximately four drinks in an hour (compared with six drinks in an hour for a 200-pound man), although individuals' metabolism of alcohol varies considerably according to gender, age, simultaneous ingestion of food, and physical condition, as well as weight and consumption rate. BALs between 0.10 percent and 0.20 percent without obvious signs of intoxication usually indicate tolerance for alcohol and regular, heavy drinking characteristic of dependence (CSAT 1997*a*).

Normally, with little or no tolerance for alcohol, the following impairment levels are observed:

- 0.40 percent = lethal
- 0.30 percent = unconscious
- 0.20 percent = decreased consciousness
- 0.10 percent = intoxication
- 0.07 percent = impaired driving ability
- 0.05 percent = detectable effect

In addition to Breathalyzer tests, several other simple-to-use but accurate techniques now exist for determining either a client's BAL or his or her approximate blood alcohol concentration. One is a relatively inexpensive, portable, and disposable unit the size of a cigarette containing crystals that turn a particular color—from yellow to blue—to signify a blood alcohol concentration of 0.02 percent, 0.08 percent, or 0.10 percent within 30 seconds after someone blows into the unit for 10 seconds.

Saliva

For alcohol, saliva is correlated closely with blood concentrations 2 hours after consumption. However, routes of drug administration that contaminate the oral cavity can change the pH levels of saliva. These changes can distort correlations of other drugs found in saliva with blood plasma levels (Magerl and Schulz 1995; Preston et al. 1999). One advantage of saliva testing is the ready availability of saliva specimens and the packaging for onsite testing. However, the short time window for detecting substances limits the effectiveness of this method to ascertaining only recent drug use (e.g., for accident investigations and for pilots or other employees about to engage in safety-sensitive activities). Most substances disappear from both blood and saliva within 12 to 24 hours of use; cannabinoids may be detectable for only 4 to 10 hours after marijuana is smoked. The U.S. Food and Drug Administration (FDA) recently approved limited use of RIA-based saliva tests. Kits that detect tetrahydrocannabinol (the active component of marijuana), opioids, and cocaine are available for about $30.

Sweat

Although a number of licit and illicit substances can be detected in perspiration (probably diffused from blood), perspiration is difficult to collect for monitoring purposes. Manufacturers have introduced a "sweat patch" with a tamper-proof adhesive that is worn for about a week. It has been used successfully to detect amphetamines, cocaine, ethanol, methadone, methamphetamine, morphine, nicotine, and PCP. The drugs are absorbed gradually into the pad, which must be applied carefully on clean skin and removed carefully for analysis. Although no rapid methods for analysis are available, and the pads must be mailed to laboratories, the FDA has approved their use for detecting

cocaine, amphetamines, and opioids. The pads are used primarily to monitor offenders on parole or probation.

Hair

Hair analysis can be used for detecting illicit substance use in the workplace and for drug treatment screening. The exact mechanism by which drug metabolites are absorbed into hair follicles remains unclear. Trace amounts of metabolites in the bloodstream enter hair follicles; these metabolites then are trapped in the core of each hair strand. It seems to take about a week after substance use for hair follicles to absorb drug residues. Because hair grows at a rate of about ½-inch per month, a 2-inch strand retains the record of a person's substance use over approximately the past 4 months—a much longer historical record than can be found through urine testing (Mieczkowski et al. 1998).

The advantages of this technique are

- The presence of larger concentrations of the substance use than in urine samples
- The ease of specimen collection; hair usually is taken from the scalp, but any body hair can be used
- The difficulties in falsification or tampering and the simplicity of storage and shipping

Certain objections to this technique have not been resolved. Few laboratories conduct the analyses. Questions exist about potential environmental contamination of hair, the relationship of dose to the concentrations of the substance in hair, and whether biophysical attributes affect outcome. However, a large random study of hair analysis found little evidence of any bias in assay results associated with hair color, race, or ethnicity (Kelly et al. 2000). Because hair grows slowly and recent drug use cannot be detected reliably, the methodology has limited application for routine monitoring of treatment compliance. It could be useful for corroborating an intake drug history and conducting prevalence research (Preston et al. 1999).

Hair testing involves dissolving about 50 strands of hair in solvents and testing the liquefied sample with GC/MS. The technique appears to be highly reliable for detecting cocaine and crack, opioids (heroin), methamphetamines, PCP, and synthetic substances such as methylenedioxyamphetamine and 3-4 methylenedioxymethamphetamine or Ecstasy. It may be less reliable for detecting marijuana (Mieczkowski and Newel 1997).

Appendix C—Resource Panel

James Callahan, D.P.A.
Executive Vice President & CEO
American Society of Addiction Medicine
Chevy Chase, Maryland

Caroline Cooper
Associate Director
Justice Programs Office
School of Public Affairs
American University
Washington, D.C.

Jennifer Edwards
Assistant to the Director
Corrections Program Office
U.S. Department of Justice
Washington, D.C.

Jerry Flanzer, D.S.W., LCSW, CAC
Social Science Analyst
Division of Clinical and Services Research
National Institute on Drug Abuse
National Institutes of Health
Bethesda, Maryland

Brenda Harding
Public Health Advisor
Division of State and Community Assistance
Center for Substance Abuse Treatment
Rockville, Maryland

Gil Hill
Director, Office of Substance Abuse
American Psychological Association
Washington, D.C.

Thomas F. Hilton, Ph.D.
Program Official for Organization and Management Sciences Research
Services Research Branch
Division of Clinical and Services Research
National Institute on Drug Abuse
National Institutes of Health
Bethesda, Maryland

Elizabeth (Beth) A. Peyton
President
Peyton Consulting
Newark, New Jersey

Barbara Ray
Public Health Analyst
Substance Abuse and Mental Health Services Administration
Rockville, Maryland

Barbara Roberts, Ph.D.
Senior Policy Analyst
Office of Demand Reduction
Office of National Drug Control Policy
Executive Office of the President
Washington, D.C.

Mickey Smith
Public Health Advisor
Division of State and Community Assistance
Center for Substance Abuse Treatment
Rockville, Maryland

Richard T. Suchinsky, M.D.
Associate Chief for Addictive Disorders and Psychiatric Rehabilitation
Mental Health and Behavioral Sciences Services
Department of Veterans Affairs
Washington, D.C.

Appendix D—Cultural Competency and Diversity Network Participants

Faye Belgrave, Ph.D.
Professor of Psychology
Virginia Commonwealth University
Richmond, Virginia

Thomas P. Beresford, M.D.
Professor of Psychiatry
University of Colorado Health Sciences
Department of Veterans Affairs Medical Center
Denver, Colorado

Deion Cash
Executive Director
Community Treatment and Correction Center, Inc.
Canton, Ohio

Marty Estrada
Case Manager
General Relief Team
East County Intake and Eligibility Center
Ventura, California

Michael T. Flaherty, Ph.D.
Executive Director
Institute for Research Education and Training in Addictions
Pittsburgh, Pennsylvania

Robin C. Halprin, Ph.D.
Licensed Psychologist
D.C. Department of Health/CSA
Washington, D.C.

Martin Hernandez
Administrative Assistant
Ventura County Board of Supervisors, Third District
Ventura, California

Alixe McNeil
Assistant Vice President
National Council on the Aging
Washington, D.C.

Rhoda Olkin, Ph.D.
Professor of Psychology
California School of Professional Psychology
Alameda, California

David W. Oslin, M.D.
Assistant Professor
Geriatric Psychiatry
University of Pennsylvania
Philadelphia, Pennsylvania

Lawrence Schonfeld, Ph.D.
Professor, Department of Aging and Mental Health
Louis de la Parte Florida Mental Health Institute
University of South Florida
Tampa, Florida

Antony P. Stephen, Ph.D., LCSW, RAS
Executive Director
Mental Health & Behavioral Sciences
New Jersey Asian American Association for Human Services, Inc.
Elizabeth, New Jersey

Ann Yabusaki, Ph.D.
Substance Abuse Director
Coalition for a Drug-Free Hawaii
Kaneohoe, Hawaii

Appendix E—Field Reviewers

Lonnetta Albright
Director
Great Lakes Addiction Technology Transfer Center
University of Illinois
Chicago, Illinois

Thomas S. Baker, D.M., LPC
Senior Consultant
Employee Assistance
Johnson & Johnson Corporate Headquarters
New Brunswick, New Jersey

Toni Barrett, M.A., CAP
Senior Vice President of Programs
Stewart-Marchman Center
Daytona Beach, Florida

Faye Belgrave, Ph.D.
Professor of Psychology
Virginia Commonwealth University
Richmond, Virginia

Thomas P. Beresford, M.D.
Professor of Psychiatry
University of Colorado Health Sciences Center
Department of Veterans Affairs Medical Center
Denver, Colorado

Allan J. Cohen, M.A., MFT
Director of Research and Development
Aegis Medical Systems, Inc.
Canoga Park, California

Stephanie Covington, Ph.D.
Consultant
La Jolla, California

Michael Cunningham, Ph.D., CDP
Clinical Supervisor
Triumph Treatment Services
Yakima, Washington

Dennis C. Daley, Ph.D.
Chief, Addiction Medicine Service
Associate Professor of Psychiatry
Western Psychiatric Institute and Clinic
Pittsburgh, Pennsylvania

Philip Diaz, M.S.W.
Chief Executive Office
Gateway Community Services
Jacksonville, Florida

John Edwards, Ph.D.
Family Therapy Trainer/Consultant
Durham, North Carolina

Marty Estrada
Case Manager
General Relief Team
East County Intake and Eligibility Center
Ventura, California

Marvin E. Fangman, M.A., LMSW, ACADC
Program Manager
First Step: Mercy Recovery Center
Mercy Medical Center
Des Moines, Iowa

Dorothy J. Farr, LSW, LADC
Clinical Director
Bucks County Drug and Alcohol Commission
Warminster, Pennsylvania

Michael T. Flaherty, Ph.D.
Executive Director
Institute for Research, Education and Training in Addictions
Pittsburgh, Pennsylvania

Cyrus V. Galyon, CAP
Clinical Manager, Non-Residential Services
Center for Drug-Free Living, Inc.
Orlando, Florida

Stephen J. Gumbley, M.A., ACDP II, LCDP
Project Director
Discovery House/Smart Management
Providence, Rhode Island

Diane E. Hague, M.S.S.W., LCSW, CADC
Director
Jefferson Alcohol and Drug Abuse Center
Louisville, Kentucky

James A. Hall, Ph.D., LISW
Associate Professor of Pediatrics
Roy J. and Lucille A. Carver College of Medicine
University of Iowa
Iowa City, Iowa

Robin C. Halprin, Ph.D.
Licensed Psychologist
D.C. Department of Mental Health/CSA
Washington, D.C.

Martin Hernandez
Administrative Assistant
Ventura County Board of Supervisors, Third District
Ventura, California

Anne M. Herron, M.S., CRC, CASAC
Director, Treatment Programming
NYS Office of Alcoholism and Substance Abuse Services
Albany, New York

Sheryl D. Hunter, M.D.
Massachusetts Mental Health Center
Boston, Massachusetts

Dick Jacobs, M.S., LMFT, CAP
Chief Operating Officer
Center for Drug-Free Living, Inc.
Orlando, Florida

Margaret M. Kotz, D.O.
Addiction Psychiatrist
Cleveland Clinic
Cleveland, Ohio

Roland C. Lamb
Manager, Provider Network Administration
Community Behavioral Health of Philadelphia's Behavioral Health System
Philadelphia, Pennsylvania

Kimberly A. Lucas, M.S., CADC
Treatment Specialist
Delaware Division of Substance Abuse and Mental Health
New Castle, Delaware

Thomas E. Lucking, M.A., Ed.S.
Consultant
Kalamazoo, Michigan

Pierluigi Mancini, Ph.D., NCAC II
Executive Director
Clinic for Education, Treatment and Prevention of Addiction, Inc.
(Hispanic Program)
Atlanta, Georgia

Michael J. McCann, M.A.
Associate Director
Matrix Institute on Addictions
Los Angeles, California

James R. McKay, Ph.D.
Scientific Director
Treatment Research Institute
Philadelphia, Pennsylvania

Cecilia McNamara, Ph.D.
Health Science Administrator
Behavioral Treatment Development Branch
National Institute on Drug Abuse
National Institutes of Health
Bethesda, Maryland

Alixe McNeil
Assistant Vice President
National Council on the Aging
Washington, D.C.

Terence McSherry, M.P.H., M.H.A.
President and Chief Executive Officer
Northeast Treatment Center
Philadelphia, Pennsylvania

Delinda Mercer, Ph.D.
Treatment Research Center
University of Pennsylvania
Philadelphia, Pennsylvania

Ethan Nebelkopf, Ph.D.
Director
Family and Child Guidance Clinic
Native American Health Center
Oakland, California

Rhoda Olkin, Ph.D.
Professor of Psychology
California School of Professional Psychology
Alameda, California

David W. Oslin, M.D.
Assistant Professor of Geriatric Psychiatry
University of Pennsylvania
Philadelphia, Pennsylvania

Deborah J. Owens, M.S., LPC, CACD, CEAP
Senior Consultant
Employee Assistance Programs
Fort Washington, Pennsylvania

Lawrence Schonfeld, Ph.D.
Professor of Aging and Mental Health
Louis de la Parte Florida Mental Health Institute
University of South Florida
Tampa, Florida

Harvey A. Siegal, Ph.D.
Professor and Director
Center for Interventions, Treatment, and Addictions Research
Wright State University School of Medicine
Dayton, Ohio

Thomas M. Slaven, Ph.D., LPC
Consulting Associate
Duke University Medical Center
Durham, North Carolina

David Smith, M.D.
Founder and Medical Director
Haight-Ashbury Free Clinics
Medical Director
California Alcohol and Drug Programs
San Francisco, California

Antony P. Stephen, Ph.D., LCSW, RAS
Executive Director
Mental Health & Behavioral Studies
New Jersey Asian American Association for Human Services, Inc.
Elizabeth, New Jersey

Mary Ann Chutuape Stephens, Ph.D.
Health Scientist Administrator
Center for the Clinical Trials Network
National Institute on Drug Abuse
National Institutes of Health
Bethesda, Maryland

Erik Stone, M.S., CAC III
Director of Compliance and Quality Improvement
Signal Behavioral Health Network
Denver, Colorado

Kathy J. Stone, M.B.A., LMSW
Associate Executive Director
Magellan Behavioral Care of Iowa
West Des Moines, Iowa

Philip Toal, Ed.D., LMHC
Clinical Manager, Non-Residential Services
Center for Drug-Free Living, Inc.
Orlando, Florida

Tim Williams, M.S.W., LCSW
Adult Services Director
Orange, Person and Chatham Area Programs
Carrboro, North Carolina

Ann Yabusaki, Ph.D.
Substance Abuse Director
Coalition for a Drug-Free Hawaii
Kaneohe, Hawaii

Index

Because the entire volume is about clinical issues in intensive outpatient treatment (IOT), the use of these terms as entry points has been minimized in this index. Commonly known acronyms are listed as main headings. Page references for information contained in exhibits appear in *italics*.

12-Step facilitation, 138–139
  strengths and challenges of, *139*
12-Step groups. *See* mutual-help groups
24-hour crisis coverage, 40, *41*

A

abstinence
  family life, 105–106
  monitoring, 12
acamprosate, 36
Addiction Severity Index, 11, 64, 74, 85
  supplements to six assessment domains, 88–91
Addiction Technology Transfer Centers, 2
adjunctive therapies, 45
admission process, 9, 59–60
  components of, 67
adolescents, 171
  Asian Americans and Pacific Islanders, 191
  behavioral contract, 173
  case management, 174
  characteristics and behaviors of, *176*
  family involvement, 172–173
  group treatment, 174
  Hispanics/Latinos, 185
  HIV, 192
ADS. *See* Alcohol Dependence Scale
adult education, 44
African Americans, 190
  resources, 199
Alcohol Abstinence Self-Efficacy Scale, 135
Alcohol Dependence Scale, 64
Alcohol Effects Questionnaire, 135
Alcohol-Specific Role Play Test, 135
ambulatory detoxification, 34–35, *56*
American Society of Addiction Medicine
  continuum of care levels, 17
  Patient Placement Criteria, 68, *69*
Americans with Disabilities Act, 60, 193
anger, 123, 126. *See also* violence
approaches to treatment
    12-Step facilitation, 138–139
  cognitive-behavioral approach, 140–141
  community reinforcement and contingency management, 148–152
  Matrix model, 146–148
  motivational approaches, 141–142
  therapeutic community approach, 142–145
ASI. *See* Addiction Severity Index
Asian Americans and Pacific Islanders, 191–192
  resources, 200–201
assessment, biopsychosocial, 73–74
attrition of clients, 59

B

barriers to treatment
  addressing, 73
  assessing, 64–66
  engaging family members in treatment, 98
  language, 185
  mistrust of authority, 184
  people with psychiatric disorders, 162
  physical, 60
  religious orientation, 187
  women, 159, 186
biopsychosocial assessment, 73–74
boundary issues, 132–134
buprenorphine, 14, 36

C

CAGE questionnaire, 64
case management, 38–40
  adolescents, 174
  clients who are homeless, 194
  psychiatric disorders, 166

qualifications and role of managers, 38
research outcomes and findings, 40
services, *39*
child care, 45
barrier to treatment, 73, 159
child-focused therapy, 101
chronic medical conditions
screening for at intake, 65
substance abuse, 12
CIDI. *See* Composite International Diagnostic Interview
Circumstances, Motivation, Readiness, and Suitability Scales–Revised, *70*
CIWA–Ar scale. *See* Clinical Institute Withdrawal Assessment–Alcohol, Revised scale
client issues
attrition, 59
boundary issues, 132–134
counselor-client trust, 10
disruptiveness, 123
education, 14
employment-related challenges, 130–132
quiet, withdrawn clients, 123–124
retention, 10–11, 115–117
socializing, 133
under the influence in group, 127–128
Clinical Institute Withdrawal Assessment–Alcohol, Revised scale, 35, 64, 71–72
Clinical Trials Network, National Institute on Drug Abuse, 2
CMRS. *See* Circumstances, Motivation, Readiness, and Suitability Scales–Revised
cognitive-behavioral approach, 140–141
strengths and challenges of, *141*
community reinforcement and contingency management approaches, 148–152
research outcomes and findings, 151–152
strengths and challenges of, *151*
training, 97
community support, 40–41
goals of, 24, *26*
key aspects of, 41
compatible models of care, 20–21
Composite International Diagnostic Interview, 85
confidentiality, 61, 63, 72, 96, 128–130
contingency management, 9–10, 148–152
continuing care, 2
definition, 3
people with psychiatric disorders, 170
continuing community care, 24, 40–41
goals of, *25*
intensity and duration of, 26
plan for, 76
continuum of care, 17–18
ASAM levels of care, 17
assisting the client through, 18–19
IOT programs, 18
core services of IOT, 27–44, *28*
counselor-client trust, 10
couples therapy, 101
cross-training, 170–171
cultural competence, 61
African Americans, 190
Asian Americans and Pacific Islanders, 191–192
clinical issues, 184, 188–189
clinician issues, 180–181
disability, clients with, 192–193
foreign-born clients, 184
Hispanics/Latinos, 189–190
HIV/AIDS, 192
homeless populations, 194–195
lesbian, gay, and bisexual clients, 192
Native Americans, 190–191
older adults, 195
religious orientation, 187
resources, 197–204
rural populations, 193
staff issues, 185–186
treatment services, 181–182
women, 186–187
worldview differences, 182–183

D

definitions
continuing care, 3
family, 94
intensive outpatient treatment, 3
detoxification
ambulatory, 34–35, *56*
providing, 70–72
withdrawal symptoms for four drug classes, *71*
Diagnostic Interview Schedule, 85
DIS. *See* Diagnostic Interview Schedule

disability
clients with, 60, 192–193
resources, 202–203
screening for, 66
disruptive clients, 123
domestic violence, 125–126, 161. *See also* violence
barrier to family engagement, 98
dropouts, multiple, 119
drug dealers at facility, 125
DSM-IV criteria for substance dependence and substance abuse, 87
duration of treatment, 19

E

education
adult, 44
client, 14
eligibility for IOT, determining, 68
employment
-related challenges, 130–132
services, 42–44
enhanced IOT services, *28*, 44–46
enhancing motivation to treatment, 9–10
entry to treatment
ease of, 9
women, 159
evidence-based approaches, 15

F

family involvement in substance abuse treatment, 14–15, 94–95, 170
abstinence, 105–106
adolescents, 172–173
definition of family, 94
engaging the family in treatment, 95–97
estrangement, 103
Family Intervention Program, *174*
genogram, 107–108
resources, 112–113
response to relapse, 104
sabotage by family members, 105
sample treatment calendar, *99*
social network, 109–110, 111
substance use by family members, 119–120
family services
clinical issues, 102
education groups, 98–99
expectations about treatment outcomes, 103
goals of, 95
multifamily groups, 100
mutual-help groups, 102
retreats, 101–102
sample treatment calendar, *99*
therapy groups, 100–101
foreign-born clients, 184
funding, of community reinforcement and contingency management approaches, 150

G

gang members at facility, 125
genogram, 94, 107–108
gifts from clients to staff, 132–133
goals
family services, 95
IOT, 19
outpatient treatment, 23
stage 1 treatment, 20, *21*
stage 2 treatment, 20, *22*
stage 3 treatment, 24, *25*
stage 4 treatment, 24, *26*
graduation from treatment program, 121
group counseling and therapy, 27
adolescents, 174
client under the influence, 127–128
developing cohesion, 120–121
difficult clients, 122–124
family therapy groups, 100–101
key aspects of, 30–32
multifamily groups, 100
psychiatric disorders, 168–169
types of groups, 28–29, *29–30*

H

Health Insurance Portability and Accountability Act (HIPAA), 72
Hispanics/Latinos, 189–190
resources, 198–199
history form, 84
HIV/AIDS, 128–129, 192
resources, 201
homeless populations, 194–195
housing programs, 44
resources, 203–204

I

individual
  counseling, 32
  family therapy, 101
infectious diseases, 37
initial response procedures, 61
inpatient treatment, versus intensive outpatient treatment, 8
instruments, 85–86
  Addiction Severity Index (ASI), 11, 64, 74, 85
  Alcohol Abstinence Self-Efficacy Scale, 135
  Alcohol Dependence Scale (ADS), 64, 85
  Alcohol Effects Questionnaire, 135
  Alcohol-Specific Role Play Test, 135
  assessing relapse potential, 135–136
  CAGE questionnaire, 64
  Circumstances, Motivation, Readiness, and Suitability Scales–Revised (CMRS), *70*
  Clinical Institute Withdrawal Assessment–Alcohol, Revised scale, 35, 64, 71–72
  Composite International Diagnostic Interview (CIDI), 85
  Diagnostic Interview Schedule (DIS), 85
  MINI International Neuropsychiatric Interview, 85
  Mini-Mental State Examination (MMSE), 66
  Offender Profile Index, 64
  Psychiatric Research Interview for Substance and Mental Disorders (PRISM), 85
  Readiness Ruler, *70*
  Readiness to Change Questionnaire–Treatment Version, *70*
  Short Michigan Alcoholism Screening Test (S-MAST), 64
  Simple Screening Instrument, 64
  Situational Confidence Questionnaire, 136
  Stages of Change Readiness and Treatment Eagerness Scale, *70*
  Structured Clinical Interview for Diagnosis of DSM-IV, Version 2, Substance Abuse Disorders module (SCID), 64
  Structured Clinical Interview for DSM-IV Axis I Disorders, 86
  Substance Abuse Screening Instrument (SASI), 64
  Substance Dependence Severity Scale, 86
  Texas Christian University Drug Screen (TCUDS), 64, 86
  University of Rhode Island Change Assessment Scale (URICA), *70*
intake interviews, 61–62
  effective techniques, *63*
  including family members, 96
intensive outpatient treatment
  case illustrations, 46–55
  core features and services, 4–5
  culturally competent services, 181
  definition, 3, 19, 31
  engaging the client, 60–61
  functions of, 18
  goals of, 19
  versus inpatient treatment, 8
  the justice system, 155
  versus outpatient treatment, 23
intoxication, symptoms at intake, 65

J

justice system
  clinical issues, 157
  communication between systems, 156
  female offenders, 154
  memorandum of understanding, 156–157
  population in, 152–154
  staff issues, 157
  stigma, 154

L

LAAM, 36
lesbian, gay, and bisexual clients, 192
  resources, 201–202

M

matching treatment services to client needs, 11
Matrix model, 146–148
  research outcomes and findings, 148
  strengths and challenges of, *147*
medical treatment, 42
medication management, 13–14, 32–34
memorandum of understanding, 156–157
methadone, 36
Mini-Mental State Examination, 66
Minnesota Model. *See* 12-Step facilitation
MMSE. *See* Mini-Mental State Examination

models, 39, *66*
Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction (NIDA treatment model), 149
compatible models of care, 20–21
monitoring
abstinence, 12
alcohol and drug use, 38
motivational approaches, 9–10, 68, 141–142
case sample, 77
screening instruments to assess, *70*
strengths and challenges of, *143*
working with uncommitted clients, 122
mutual-help groups, 12–13, 41–42, 138–139. *See also* continuing community care
alternatives to, 42, *43*
families, 102
psychiatric disorders, 169
versus substance abuse treatment, 3–4

N

naltrexone, 14, 36
Native Americans, 190–191
resources, 199–200
nicotine cessation treatment, 45

O

Offender Profile Index, 64
older adults, 195
resources, 204
Omnibus Transportation Employee Testing Act of 1991, 131
ongoing care, 11–12
orientation to program, 72
outpatient treatment
goals of, 23
versus intensive outpatient treatment, 23
transition to, 20

P

parenting issues, 90, 158, 187
parent skill training, 45–46
Patient Placement Criteria, ASAM, 68
six dimensions of, *69*
pharmacotherapy, 13–14, 32–37, 166
pregnancy, 158, 161
principles of intensive outpatient treatment, 7
principle 1: make treatment readily available, 8
principle 2: ease entry, 9
principle 3: build on existing motivation, 9–10
principle 4: enhance therapeutic alliance, 10
principle 5: make retention a priority, 10–11
principle 6: assess and address individual treatment needs, 11
principle 7: provide ongoing care, 11–12
principle 8: monitor abstinence, 12
principle 9: use mutual-help and other community-based supports, 12–13
principle 10: use medications if indicated, 13–14
principle 11: educate about substance use disorders, recovery, and relapse, 14
principle 12: engage families, employers, and significant others, 14–15
principle 13: incorporate evidence-based approaches, 15
principle 14: improve program administration, 15–16
PRISM. *See* Psychiatric Research Interview for Substance and Mental Disorders
privacy. *See* confidentiality
program administration, 15–16
psychiatric disorders, 90
ABC model for psychiatric screening, *66*
barriers to treatment, 162
clinical issues, 164
establishing a therapeutic relationship, 167–168
group treatment, 168–169
the justice system, 154
medications to treat, 13–14
mutual-help groups, 169
people with psychiatric disorders, 165
symptoms at intake, 65
theoretical background, 162–163
working with clients who have, 122–123
Psychiatric Research Interview for Substance and Mental Disorders, 85
psychoeducational counseling, 32
topics addressed in, *33–34*
psychotherapy, 42

publications
A.A. Member–Medications and Other Drugs, 169
Alcoholics Anonymous (the "Big Book"), 42
Assessing Alcohol Problems: A Guide for Clinicians and Researchers, 64
Assessing Drug Abuse Among Adolescents and Adults: Standardized Instruments, 64
Bridging the Gap Between Practice and Research (Institute of Medicine report), 2
Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule, The, 63
Counselor's Manual for Relapse Prevention With Chemically Dependent Criminal Offenders (TAP 19), 118
Diagnostic Source Book on Drug Abuse Research and Treatment, 64
Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders, 154
It Works: How and Why, 42
Living Sober, 42
Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders, 148
Mental Health: Culture, Race, and Ethnicity (Surgeon General report), 180
Narcotics Anonymous, 42
Principles of Drug Addiction Treatment: A Research-Based Guide (National Institute on Drug Abuse), 5, 7, 11
Psychotherapeutic Medications 2003: What Every Counselor Should Know, 166
Relapse Prevention and the Substance-Abusing Criminal Offender (TAP 8), 118
Strategies for Developing Treatment Programs for People With Co-Occurring Substance Abuse and Mental Disorders (SAMHSA), 171
Therapeutic Community Curriculum (CSAT manual), 145
Twelve Steps and Twelve Traditions, 42
Woman's Way Through the Twelve Steps, A, 161

Q

quiet, withdrawn clients, 123–124

R

readily available treatment, 8
readiness for change, assessing, 68
Readiness Ruler, *70*
Readiness to Change Questionnaire–Treatment Version, *70*
recreational activities, 44, 91
relapse, 14, 36
  family response, 104
  instruments, 135–136
  versus lapse, 117
  prevention quiz, 118
  prevention strategies, 117–118, 170
religious orientation, 187. *See also* spirituality
research outcomes and findings
  12-Step approaches, 139–140
  case management, 40
  cognitive-behavioral therapy, 140–141
  community reinforcement and contingency management approach, 151
  Matrix model, 148
  motivational approaches, 142
  therapeutic community approach, 145
respect for clients, 61
retention, 10–11, 115–117
round-the-clock crisis coverage, 40, *41*
rural populations, 193
  resources, 203

S

safety, 125–128, *126*. *See also* violence
SASI. *See* Substance Abuse Screening Instrument
SCID. *See* Structured Clinical Interview for Diagnosis of DSM-IV, Version 2, Substance Abuse Disorders module
screening
  ABC model for psychiatric screening, 66
  brief instruments that assess motivational stage, *70*
  chronic medical conditions, 65
  collecting information, 62–64
  psychiatric disorders, 164–165
sexuality, 90–91
Short Michigan Alcoholism Screening Test, 64
Simple Screening Instrument, 64
Situational Confidence Questionnaire, 136

S-MAST. *See* Short Michigan Alcoholism Screening Test
socializing, 133
social network, 94–95, 109–110
  social network grid, 111
spirituality, 91
staff issues
  adolescents, 175
  community reinforcement and contingency management approaches, 150
  counselor-client trust, 10
  counselors with dual roles, 134
  cross-training, 170–171
  cultural competence, 185–186
  familiarity with 12-Step culture, 139
  familiarity with cognitive-behavioral therapy, 140
  female clients, 161–162
  the justice system, 157
  the Matrix model, 147
  motivational approaches, 142
  therapeutic community approaches, 144
Stages of Change Readiness and Treatment Eagerness Scale, *70*
stepdown treatment, 23–24
stigma, in the justice system, 154
Structured Clinical Interview for Diagnosis of DSM-IV, Version 2, Substance Abuse Disorders module, 64
Structured Clinical Interview for DSM-IV Axis I Disorders, 86
substance abuse, as a chronic illness, 12
Substance Abuse Screening Instrument, 64
Substance Dependence Severity Scale, 86
suicidality, screening for at intake, 67
summary report of assessment findings, 74–75

T

TCUDS. *See* Texas Christian University Drug Screen
Temporary Assistance for Needy Families, 77
Texas Christian University Drug Screen, 64, 86
therapeutic alliance, 10
therapeutic community approach, 142–145
  research outcomes and findings, 145
  strengths and challenges of, *145*
TIPs cited
  Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction (TIP 40), 36
  Comprehensive Case Management for Substance Abuse Treatment (TIP 27), 40, 166
  Continuity of Offender Treatment for Substance Use Disorders From Institution to Community (TIP 30), 155
  Detoxification and Substance Abuse Treatment (TIP 45), 35, 72
  Enhancing Motivation for Change in Substance Abuse Treatment (TIP 35), 62, 118, 141, 142, 168
  Guide to Substance Abuse Services for Primary Care Clinicians, A (TIP 24), 35
  Improving Cultural Competence in Substance Abuse Treatment (forthcoming), 61, 181
  Integrating Substance Abuse Treatment and Vocational Services (TIP 38), 44
  Intensive Outpatient Treatment for Alcohol and Other Drug Abuse (TIP 8), 1
  Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs (TIP 43), 37, 67
  Naltrexone and Alcoholism Treatment (TIP 28), 36
  Screening and Assessing Adolescents for Substance Use Disorders (TIP 31), 67, 171
  Screening for Infectious Diseases Among Substance Abusers (TIP 6), 37
  Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases (TIP 11), 64
  Substance Abuse: Administrative Issues in Outpatient Treatment (TIP 46), 1, 16, 32, 61, 74, 166, 181, 188
  Substance Abuse Treatment: Addressing the Specific Needs of Women (forthcoming), 157
  Substance Abuse Treatment and Domestic Violence (TIP 25), 67, 89, 126, 157, 161
  Substance Abuse Treatment and Family Therapy (TIP 39), 30, 93, 172

Substance Abuse Treatment for Adults in the Criminal Justice System (TIP 44), 127, 157
Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues (TIP 36), 90, 158
Substance Abuse Treatment for Persons With Co-Occurring Disorders (TIP 42), 37, 42, 123, 165, 167
Substance Abuse Treatment for Persons With HIV/AIDS (TIP 37), 37, 129
Substance Abuse Treatment: Group Therapy (TIP 41), 29, 120
Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities (TIP 29), 66, 167
Treatment for Stimulant Use Disorders, (TIP 33), 14, 118
Treatment of Adolescents With Substance Use Disorders (TIP 32), 171
Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers, The (TIP 18), 37
transition
outpatient treatment, 20
planning, 23
transportation services, 44
treatment
duration of, 19
entry to, 9, 159
graduation from, 121
intensity of, 19
interventions, 15
matching to client needs, 11
medical, 42
plan, 75–83
settings, 19
stages of, 20
well-known person, 129–130
trust between counselor and client, 10

U

University of Rhode Island Change Assessment Scale, *70*
URICA. *See* University of Rhode Island Change Assessment Scale
urine drug tests, 12

V

violence, *126*
domestic, 67, 89, 98, 125–126, 161
screening for at intake, 67
treating violent clients, 127
women, 158
vocational training, 42–44

W

Web sites cited
Adult Children Anonymous, 102
Adult Children of Alcoholics, 102
Al-Anon/Alateen, 13, *99*
Alcohol Abstinence Self-Efficacy Scale, 135
Alcoholics Anonymous, 13, 42, 170
American Family Physician, 35
assessment instruments, *70*
Center for Substance Abuse Prevention Workplace Resource Center, 131
Center for Substance Abuse Treatment, 138
children and families, 46
Clinical Institute Withdrawal Assessment–Alcohol, Revised scale, 72
Cocaine Anonymous, 42
Detoxification Clinical Practice Guidelines, 35
domestic violence assessment, 89
Double Trouble in Recovery, 169
Dual Recovery Anonymous, 169
Families Anonymous, *99*
Fortune Society, *43*
General Services Offices of Alcoholics Anonymous, 42
Hazelden Foundation, 137
Hispanic Health Council, *43*
Institute on Black Chemical Abuse, *43*
Jewish Alcoholics, Chemically Dependent Persons and Significant Others, 187
Medication Assisted Treatment, 37
Mini-Mental State Examination, 66
Nar-Anon, 13, *99*
Narcotics Anonymous, 13, 42
National Black Alcoholism and Addictions Council, *43*
National Clearinghouse for Alcohol and Drug Information, 138
National Head Start Association, 46
National Institute on Alcohol Abuse and Alcoholism, 135, 137

Office of Juvenile Justice and Delinquency Prevention, 46
Patient Placement Criteria, ASAM, 68
Principles of Addiction Medicine, 35
Rational Recovery, 13
resources for family-based services, 112–113
Save Our Selves, *43*
Secular Organizations for Sobriety, *43*
Self-Management and Recovery Training, *43*
Smart Recovery, 13
Women for Sobriety, 13, *43*
withdrawal
symptoms at intake, 65
symptoms for four drug classes, *71*
women, 157–158
barriers to treatment, 159
clinical issues, 159–161
culturally competent services, 186–187
domestic violence, 158, 161
entry to treatment, 159
the justice system, 154
pregnancy, 158, 161

Y

young adults, 175–177

CSAT TIPs and Publications Based on TIPs

What Is a TIP?

Treatment Improvement Protocols (TIPs) are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other Federal and non-Federal experts to reach consensus on state-of-the-art treatment practices. TIPs are developed under CSAT's Knowledge Application Program to improve the treatment capabilities of the Nation's alcohol and drug abuse treatment service system.

What Is a Quick Guide?

A Quick Guide clearly and concisely presents the primary information from a TIP in a pocket-sized booklet. Each Quick Guide is divided into sections to help readers quickly locate relevant material. Some contain glossaries of terms or lists of resources. Page numbers from the original TIP are referenced so providers can refer back to the source document for more information.

What Are KAP Keys?

Also based on TIPs, KAP Keys are handy, durable tools. Keys may include assessment or screening instruments, checklists, and summaries of treatment phases. Printed on coated paper, each KAP Keys set is fastened together with a key ring and can be kept within a treatment provider's reach and consulted frequently. The Keys allow the busy clinician or program administrator to locate information easily and to use this information to enhance treatment services.

TIP 1 **State Methadone Treatment Guidelines**—Replaced by TIP 43

TIP 2* **Pregnant, Substance-Using Women**—*BKD107*

Quick Guide for Clinicians *QGCT02*

KAP Keys for Clinicians *KAPT02*

TIP 3 **Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents**—Replaced by TIP 31

TIP 4 **Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents**—Replaced by TIP 32

TIP 5 **Improving Treatment for Drug-Exposed Infants**—*BKD110*

TIP 6 **Screening for Infectious Diseases Among Substance Abusers**—*BKD131*

Quick Guide for Clinicians *QGCT06*

KAP Keys for Clinicians *KAPT06*

TIP 7 **Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System**—Replaced by TIP 44

TIP 8 **Intensive Outpatient Treatment for Alcohol and Other Drug Abuse**—Replaced by TIPs 46 and 47

TIP 9 **Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse**—Replaced by TIP 42

TIP 10 **Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients**—Replaced by TIP 43

TIP 11 **Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases**—*BKD143*

Quick Guide for Clinicians *QGCT11*

KAP Keys for Clinicians *KAPT11*

TIP 12 **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**—Replaced by TIP 44

TIP 13 **Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders**—*BKD161*

Quick Guide for Clinicians *QGCT13*

Quick Guide for Administrators *QGAT13*

KAP Keys for Clinicians *KAPT13*

TIP 14 **Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment**—*BKD162*

TIP 15 **Treatment for HIV-Infected Alcohol and Other Drug Abusers**—Replaced by TIP 37

TIP 16 **Alcohol and Other Drug Screening of Hospitalized Trauma Patients**—*BKD164*

Quick Guide for Clinicians *QGCT16*

KAP Keys for Clinicians *KAPT16*

TIP 17 **Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System**—Replaced by TIP 44

TIP 18 **The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers**—*BKD173*

Quick Guide for Clinicians *QGCT18*

KAP Keys for Clinicians *KAPT18*

TIP 19 **Detoxification From Alcohol and Other Drugs**—Replaced by TIP 45

TIP 20 **Matching Treatment to Patient Needs in Opioid Substitution Therapy**—Replaced by TIP 43

TIP 21 **Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System**—*BKD169*

Quick Guide for Clinicians and Administrators *QGCA21*

TIP 22 **LAAM in the Treatment of Opiate Addiction**—Replaced by TIP43

TIP 23 **Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing**—*BKD205*

Quick Guide for Administrators *QGAT23*

TIP 24 **A Guide to Substance Abuse Services for Primary Care Clinicians**—*BKD234*

Quick Guide for Clinicians *QGCT24*

KAP Keys for Clinicians *KAPT24*

TIP 25 **Substance Abuse Treatment and Domestic Violence**—*BKD239*

Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Treatment Providers *MS668*

Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Administrators *MS667*

Quick Guide for Clinicians *QGCT25*

KAP Keys for Clinicians *KAPT25*

**Under revision*

TIP 26 **Substance Abuse Among Older Adults**—*BKD250*

Substance Abuse Among Older Adults: A Guide for Treatment Providers *MS669*

Substance Abuse Among Older Adults: A Guide for Social Service Providers *MS670*

Substance Abuse Among Older Adults: Physician's Guide *MS671*

Good Mental Health is Ageless PHD881 (English), PHD881S (Spanish)

Aging, Medicines and Alcohol PHD882 (English), PHD882S (Spanish)

Quick Guide for Clinicians *QGCT26*

KAP Keys for Clinicians *KAPT26*

TIP 27 **Comprehensive Case Management for Substance Abuse Treatment**—*BKD251*

Case Management for Substance Abuse Treatment: A Guide for Treatment Providers *MS673*

Case Management for Substance Abuse Treatment: A Guide for Administrators *MS672*

Quick Guide for Clinicians *QGCT27*

Quick Guide for Administrators *QGAT27*

TIP 28 **Naltrexone and Alcoholism Treatment**—*BKD268*

Naltrexone and Alcoholism Treatment: Physician's Guide *MS674*

Quick Guide for Clinicians *QGCT28*

KAP Keys for Clinicians *KAPT28*

TIP 29 **Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities**—*BKD288*

Quick Guide for Clinicians *QGCT29*

Quick Guide for Administrators *QGAT29*

KAP Keys for Clinicians *KAPT29*

TIP 30 **Continuity of Offender Treatment for Substance Use Disorders From Institution to Community**—*BKD304*

Quick Guide for Clinicians *QGCT30*

KAP Keys for Clinicians *KAPT30*

TIP 31 **Screening and Assessing Adolescents for Substance Use Disorders**—*BKD306*

See companion products for TIP 32.

TIP 32 **Treatment of Adolescents With Substance Use Disorders**—*BKD307*

Quick Guide for Clinicians *QGC312*

KAP Keys for Clinicians *KAP312*

TIP 33 **Treatment for Stimulant Use Disorders**—*BKD289*

Quick Guide for Clinicians *QGCT33*

KAP Keys for Clinicians *KAPT33*

TIP 34 **Brief Interventions and Brief Therapies for Substance Abuse**—*BKD341*

Quick Guide for Clinicians *QGCT34*

KAP Keys for Clinicians *KAPT34*

TIP 35 **Enhancing Motivation for Change in Substance Abuse Treatment**—*BKD342*

Quick Guide for Clinicians *QGCT35*

KAP Keys for Clinicians *KAPT35*

Faces of Change *PHD1103*

TIP 36 **Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues**—*BKD343*

Quick Guide for Clinicians *QGCT36*

KAP Keys for Clinicians *KAPT36*

Helping Yourself Heal: A Recovering Woman's Guide–*PHD981* (English), *PHD981S* (Spanish)

Helping Yourself Heal: A Recovering Man's Guide—*PHD1059* (English), *PHD1059S* (Spanish)

TIP 37 **Substance Abuse Treatment for Persons With HIV/AIDS**—*BKD359*

HIV/AIDS: Is Your Client at Risk? *MS965*

Drugs, Alcohol and HIV/AIDS: A Consumer Guide *PHD1126* (English), *PHD1134* (Spanish)

Quick Guide for Clinicians *MS678*

KAP Keys for Clinicians *KAPT37*

TIP 38 **Integrating Substance Abuse Treatment and Vocational Services**—*BKD381*

Quick Guide for Clinicians *QGCT38*

Quick Guide for Administrators *QGAT38*

KAP Keys for Clinicians *KAPT38*

TIP 39 **Substance Abuse Treatment and Family Therapy**—*BKD504*

Quick Guide for Clinicians *QGCT39*

Quick Guide for Administrators *QGAT39*

TIP 40 **Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction**—*BKD500*

Quick Guide for Physicians *QGPT40*

KAP Keys for Physicians *KAPT40*

TIP 41 **Substance Abuse Treatment: Group Therapy**—*BKD507*

Quick Guide for Clinicians *QGCT41*

TIP 42 **Substance Abuse Treatment for Persons With Co-Occurring Disorders**—*BKD515*

Quick Guide for Clinicians *QGCT42*

Quick Guide for Administrators *QGAT42*

KAP Keys for Clinicians *KAPT42*

TIP 43 **Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs**—*BKD524*

Quick Guide for Clinicians *QGCT43*

KAP Keys for Clinicians *KAPT43*

TIP 44 **Substance Abuse Treatment for Adults in the Criminal Justice System**—*BKD526*

Quick Guide for Clinicians *QGCT44*

KAP Keys for Clinicians *KAPT44*

TIP 45 **Detoxification and Substance Abuse Treatment**—*BKD541*

TIP 46 **Substance Abuse: Administrative Issues in Outpatient Treatment**—*BKD545*

Quick Guide for Administrators *QGAT46*

TIP 47 **Substance Abuse: Clinical Issues in Intensive Outpatient Treatment**—*BKD551*

Treatment Improvement Protocols (TIPs) from the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT)

Place the quantity (up to 5) next to the publications you would like to receive and print your mailing address below.

___TIP 2* BKD107
___QG† for Clinicians QGCT02
___KK† for Clinicians KAPT02

___TIP 5 BKD110

___TIP 6 BKD131
___QG for Clinicians QGCT06
___KK for Clinicians KAPT06

___TIP 11 BKD143
___QG for Clinicians QGCT11
___KK for Clinicians KAPT11

___TIP 13 BKD161
___QG for Clinicians QGCT13
___QG for Administrators QGAT13
___KK for Clinicians KAPT13

___TIP 14 BKD162

___TIP 16 BKD164
___QG for Clinicians QGCT16
___KK for Clinicians KAPT16

___TIP 18 BKD173
___QG for Clinicians QGCT18
___KK for Clinicians KAPT18

___TIP 21 BKD169
___QG for Clinicians & Administrators QGCA21

___TIP 23 BKD205
___QG for Administrators QGAT23

___TIP 24 BKD234
___QG for Clinicians QGCT24
___KK for Clinicians KAPT24

___TIP 25 BKD239
___Guide for Treatment Providers MS668
___Guide for Administrators MS667
___QG for Clinicians QGCT25
___KK for Clinicians KAPT25

___TIP 26 BKD250
___Guide for Treatment Providers MS669
___Guide for Social Service Providers MS670
___Physician's Guide MS671
___Good Mental Health PHD881
___Good Mental Health PHD881S (Spanish)
___Aging, Medicine PHD882
___Aging, Medicine PHD882S (Spanish)
___QG for Clinicians QGCT26
___KK for Clinicians KAPT26

___TIP 27 BKD251
___Guide for Treatment Providers MS673
___Guide for Administrators MS672
___QG for Clinicians QGCT27
___QG for Administrators QGAT27

___TIP 28 BKD268
___Physician's Guide MS674
___QG for Clinicians QGCT28
___KK for Clinicians KAPT28

___TIP 29 BKD288
___QG for Clinicians QGCT29
___QG for Administrators QGAT29
___KK for Clinicians KAPT29

___TIP 30 BKD304
___QG for Clinicians QGCT30
___KK for Clinicians KAPT30

___TIP 31 BKD306
(see products under TIP 32)

___TIP 32 BKD307
___QG for Clinicians QGC312
___KK for Clinicians KAP312

___TIP 33 BKD289
___QG for Clinicians QGCT33
___KK for Clinicians KAPT33

___TIP 34 BKD341
___QG for Clinicians QGCT34
___KK for Clinicians KAPT34

___TIP 35 BKD342
___QG for Clinicians QGCT35
___KK for Clinicians KAPT35
___Faces PHD1103

___TIP 36 BKD343
___QG for Clinicians QGCT36
___KK for Clinicians KAPT36
___Brochure for Women (English) PHD981
___Brochure for Women (Spanish) PHD981S
___Brochure for Men (English) PHD1059
___Brochure for Men (Spanish) PHD1059S

___TIP 37 BKD359
___Your Client At Risk MS965
___Drugs, Alcohol & HIV/AIDS PHD1126
___Drogas, Alcohol y el VIH/SIDA PHD1134
___QG for Clinicians QGCT37
___KK for Clinicians KAPT37

___TIP 38 BKD381
___QG for Clinicians QGCT38
___QG for Administrators QGAT38
___KK for Clinicians KAPT38

___TIP 39 BKD504
___QG for Clinicians QGCT39
___QG for Administrators QGAT39

___TIP 40 BKD500
___QG for Physicians QGPT40
___KK for Physicians KAPT40

___TIP 41 BKD507
___QG for Clinicians QGCT41

___TIP 42 BKD515
___QG for Clinicians QGCT42
___QG for Administrators QGAT42
___KK for Clinicians KAPT42

___TIP 43 BKD524
___QG for Clinicians QGCT43
___KK for Clinicians KAPT43

___TIP 44 BKD526
___QG for Clinicians QGCT44
___KK for Clinicians KAPT44

___TIP 45 BKD541

___TIP 46 BKD545

___TIP 47 BKD551

**Under revision*
†QG = Quick Guide; KK = KAP Keys

Name: _____

Address: _____

City, State, Zip: _____

Phone and e-mail: _____

You can either mail this form or fax it to (240) 221-4292. Publications also can be ordered by calling SAMHSA's NCADI at (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889.

TIPs can also be accessed on line at www.kap.samhsa.gov.

FOLD

STAMP

SAMHSA's National Clearinghouse for Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 20847-2345

FOLD

Substance Abuse:
Clinical Issues in Intensive Outpatient Treatment

This TIP, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment,* addresses the practical needs of treatment providers as they design and implement intensive outpatient treatment programs. The TIP provides specific information on the principles of intensive outpatient treatment; services and treatment models; modifications for distinct population groups; culturally competent treatment; screening and patient placement criteria; counseling methods and techniques, including involvement of families; and the continuum of care. The TIP also covers such important issues as how to improve early retention, provide the appropriate length and intensity of services, provide the most promising mix of wrap-around services for positive client outcomes, and arrange ongoing care in the community.

Collateral Products
Based on TIP 47

Quick Guide for Clinicians
KAP Keys for Clinicians

DHHS Publication No. (SMA) 06-4182
NCADI Publication No. BKD551
Printed 2006

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment