Substance Abuse:
Clinical Issues in Intensive Outpatient Treatment

A Treatment Improvement Protocol
TIP
47

IoT

**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

Acknowledgments

Disclaimer

Public Domain Notice

Electronic Access and Copies of Publication

Recommended Citation

Originating Office

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

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 regu-

lar 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 col-

leagues (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 other-

wise 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 genu-

ine 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)

- 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.