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
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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.

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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

1 Introduction

In This Chapter...

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...

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.

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