

# **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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# **Substance Abuse: Clinical Issues in Intensive Outpatient Treatment**

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# 5 Treatment Entry and Engagement

## In This Chapter...

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

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

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

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

A major challenge of the admission process is to balance a rapid and empathic response to a client's request for treatment with the need to obtain information about many aspects of the client's life that can affect the treatment response. The need for detailed

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

assessment information must not impinge on the main admission activities: to engage the individual in treatment, ameliorate immediate crises, and remove barriers to treatment. Attention needs to be given to clinicians' inter-

viewing styles and the program's intake procedures, as well as to the content and sequence of the screenings or assessments conducted.

## Elements of Engaging the Client in IOT

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

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

## Program Surroundings

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

## Create a welcoming environment

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

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

## Ensure availability

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

## **Communicate cultural competence**

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

## **Reinforce privacy and confidentiality**

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

## **Initial Response Procedures**

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

## **Ensure a rapid response**

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

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

## **Convey respect**

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

## **Intake Interviews**

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

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

## **Use informal approaches for initial interviews**

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

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

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

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

The counselor can offer an explanation such as, “We started talking rather informally about what brought you to treatment. Now, we need to shift gears and complete some forms to gather more detailed information. When we are finished, we can go back to dis-

cussing questions you still may have about treatment and this program.”

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

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

## **Adjust interviewing styles**

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

## **Collect Screening Information**

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

**Effective Interviewing Techniques**

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

**Record Basic Information**

The following information often is documented on an intake form:

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

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

## Use Short Screening Instruments To Document a Substance Use Disorder

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

Not all screening instruments perform equally well for specific populations. A study comparing the effectiveness of eight frequently used screening instruments for ascertaining substance use disorders used the Structured Clinical Interview for Diagnosis of DSM-IV, Version 2, Substance Abuse Disorders module (Peters et al. 2000),

a well-accepted, comprehensive diagnostic criterion for measuring substance-related disorders. The study found that only three instruments had high rates of accuracy, positive predictive value, and sensitivity, in addition to the capacity to distinguish between substance abuse and dependence disorders. These three instruments are

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

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

## Assessing Barriers to Treatment

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

## Intoxication or Withdrawal

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

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

Each IOT program needs guidelines that indicate whether sick or intoxicated persons can be observed and assisted at the facility, should be transferred immediately to a more intensive level of care (e.g., detoxification facility, hospital emergency room), or are ready to return home. IOT program medical staff members must make the decision about who can be admitted safely. If medically trained staff members are unavailable on

site to assess clients and to make these decisions, the IOT program should have access to immediate medical consultation or emergency treatment. Direct affiliations must be in place with other levels of care in the local alcohol and drug treatment system and with mental health facilities. If clients are too sick or intoxicated to transport themselves, the IOT program must arrange safe transportation home or to another treatment facility.

## Acute or Chronic Medical Conditions

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

## Psychiatric Stability

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

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

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

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

## Physical Disabilities or Cognitive Limitations

The consensus panel recommends that IOT programs conduct early screening for physical, sensory, and cognitive disabilities because these conditions may affect clients' ability to participate in treatment.

Modifications in the treatment regimen or environment can help these clients function well in treatment.

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

### Exhibit 5-2

#### ABC Model for Psychiatric Screening

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

Adapted from CSAT 1994b, p. 16.

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

## Crises and Emergencies

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

### Potential for Violence or Suicide

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

### Immediate Threats to the Client's Safety

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

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

## Components of the IOT Admission Process

Admitting a potential client to substance abuse treatment entails

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

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

## Eligibility

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

## Apply patient placement criteria

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

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

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

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

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

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

## Assess readiness for change

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

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

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

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

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

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

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

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

Source: Mee-Lee et al. 2001.

**Brief Screening Instruments That Assess Motivational Stage**

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

More information about the psychometric properties, target populations, scoring, utility, ordering, and other references for these instruments can be found at [www.niaaa.nih.gov](http://www.niaaa.nih.gov) by typing “Alcoholism Treatment Assessment Instruments” and clicking on Search.

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

## **Beginning Treatment**

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

### ***Provide for detoxification***

Detoxification, if necessary, should be accomplished before a client is admitted into the full IOT program. Clients experiencing symptoms of mild withdrawal from alcohol,

sedative-hypnotics, opioids, or stimulants can undergo ambulatory detoxification in a Level II.5: Partial hospitalization or day treatment program (see exhibit 5-5). To undertake ambulatory detoxification of these clients, IOT programs should offer 20 hours of clinical programming per week and have direct access to medical services.

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

## Exhibit 5-5

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

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

Source: Mee-Lee et al. 2001.

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

- Have a slow response (more than 2 hours) or allergic reactions to the medications used for detoxification
- Have unstable vital signs, confusion, or delirium
- Have serious and unstabilized medical disorders (e.g., heart, lung, liver disease; seizure disorders; HIV infection)
- Are older adults or adolescents
- Have a history of serious psychiatric disorders and complications
- Have a history of seizures, delirium, or psychosis during previous withdrawals
- Have a history of drug overdoses

- Abuse alcohol, sedatives, barbiturates, and anxiolytics in combination
- Have an unstable, unsupportive, or unsafe home environment without supportive friends or relatives to monitor medication use

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

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

*Treatment* (CSAT 2006e), provides additional information on detoxification.

### **Conduct informal orientation**

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

### **Conduct formal orientation**

A formal orientation offers an opportunity for staff members, including the program director, to introduce themselves and welcome new clients, reinforce clients' motivations to remain in treatment, and induct clients into appropriate roles. New clients need to hear—and believe—that they are respected as individuals and will be involved in planning their treatment. Although the primary treatment objective is to assist

clients in achieving and maintaining abstinence, clients also need to know that the program will help them accomplish other positive and realistic goals (e.g., getting off probation, regaining child custody, enrolling in a vocational school). An orientation also should help clients allay any fears they may have about treatment. Ample time needs to be left in orientation sessions to answer questions. Topics for program orientation include

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

## ***Address immediate barriers to treatment entry***

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

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

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

## ***Comprehensive Biopsychosocial Assessment***

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

## ***Understand purposes of assessment***

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

## ***Develop assessment methods and protocols***

IOT clinicians gather evidence about each client's problems through

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

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

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

## Multidimensional Assessment

Client records, which are a crucial part of multidimensional assessment, may include notes from the intake interview, toxicology results, reports from the referring agency or previous treatment providers, findings from other clinicians, self-administered screening tests, and specially ordered diagnostic consultations. To round out the assessment, some IOT programs design intake screening and comprehensive assessment forms, and others use standardized, multidimensional assessment instruments as the basic admis-

sion document. The ASI is a commonly used, multidimensional assessment instrument that can serve as a basic assessment document. Together, these clinical impressions and assessment instruments provide the foundation for initial treatment plans.

## Using the Addiction Severity Index

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

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

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

## Summary of Assessment Findings

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

## ***Compile the summary report***

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

## ***Present assessment findings to the client***

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

The counselor notes which findings seem most disturbing to the client. The counselor tries to elicit the client's reactions to the effects of substance abuse on his or her

health, relationships, and legal and employment statuses. These reactions direct the clinician to the problems the client is most interested in solving. They also point out discrepancies between the client's values or goals and the adverse effects of substance abuse. These concerns can be highlighted in the treatment process to enhance motivation for change.

## **The Treatment Plan**

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

### ***Prepare the treatment plan***

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

## ***An Emphasis on the Client's Prioritizing Problems***

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

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

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

Most treatment plans also incorporate the following elements:

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

**problems addressed or emerging issues to be assessed.**

- **A signature line for the client to indicate participation in development of the treatment plan and agreement with its specifications.** The client receives a copy as a reminder of both his or her responsibilities and role as a partner who works with the clinician to achieve treatment goals.

## ***Plan for continuing community care***

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

## **Sample Treatment Plans**

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

## Sample Case 1

### *Clinical summary*

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

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

Lewis has been incarcerated for a drug charge for the past year; he will be in prison for at least the next 5 years and will be unable to provide support for his children or for Alice. Alice had moved back with her mother when Lewis began his incarceration, but her mother threw Alice out of her house

after Alice stole money from her mother's purse. Alice has been living with anyone who will take her in for the last 9 months.

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

Alice has a history of criminal justice system involvement, mostly for prostitution. Her current probation officer has told her if she does not seek treatment, she will be violating her probation. Alice has entered treatment twice before but dropped out both times after only a few sessions. She is now shocked

at the loss of her children and terrified that she could do some long jail time. She believes she is ready to change her life and appears motivated for treatment. Although her mother is angry at Alice and appalled at the placement of her grandchildren into foster care, she has agreed to let Alice move back as long as she gets into and stays in treatment. Her mother stresses, however, that this cannot be a long-term living situation for Alice. The probation officer referred Alice to a local IOT program, where she was evaluated and admitted.

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

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

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

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

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

### **Master problem list**

- Children, ages 8 and 4, removed from custody and placed in foster care
- Crack cocaine and alcohol dependence
- Ongoing illegal activities and a pending criminal charge
- No permanent residence
- No apparent job skills or work history
- Lack of positive support system
- Strained relationship with mother and family members
- No recent physical or dental examination; at high risk for HIV, STDs, and hepatitis
- History of dropping out of substance abuse treatment

- Possible depression, but never evaluated (family history of substance use disorders and suicide)

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

### **Short-term goals**

#### **1. Address cocaine and alcohol dependence**

*Objective:* Help client understand the importance of abstaining from all psychoactive drugs

*Action:* Enroll client in appropriate psychoeducation and early recovery groups in the IOT program; encourage her to attend mutual-help groups in the community (AA and Cocaine Anonymous [CA]); regularly monitor urine and breath drug tests

*Target date:* Immediately

*Responsible persons:* Client, counselor

#### **2. Engage client’s mother in treatment**

*Objective:* Increase emotional support for client’s recovery

*Action:* Explore mother’s interest in attending family education group and participating in family therapy

*Target date:* Contact mother immediately, with client’s consent; if mother is willing, begin family education immediately

*Responsible persons:* Mother, client, primary counselor, family counselor

#### **3. Establish communication with child welfare services and client’s children**

*Objective:* Begin process of family reunification; facilitate reasonable visitation schedule

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

*Target date:* Within 2 weeks

*Responsible persons:* Client, case manager, child welfare representative

**4. Establish communication with criminal justice system**

*Objective:* Avoid client's probation violation; seek leniency for client's shoplifting charge

*Action:* Obtain client consent to contact probation officer; get officer's perspective on client and what conditions may be negotiated (e.g., regular reports to probation officer about treatment attendance and compliance, community service for shoplifting conviction)

*Target date:* Within 2 weeks

*Responsible persons:* Case manager, client, probation officer

**5. Obtain medical and dental evaluation**

*Objective:* Assess client's health; prevent client's potential transmission of infectious diseases

*Action:* Refer client for medical and dental evaluations, including testing for HIV infection and other drug-related diseases; enroll client in health education group with counseling about HIV testing; encourage the client to stop high-risk behaviors, consent to testing, and follow through on needed medical care

*Target date:* Within 2 weeks

*Responsible persons:* Client, case manager, health care coordinator, medical staff

**6. Evaluate psychological functioning**

*Objective:* Evaluate client's mental health; assess her suicide risk; treat her depression if necessary

*Action:* Observe signs of continuing depression after client is stabilized; refer her for psychological evaluation, if indicated

*Target date:* Within 30 days; ongoing

*Responsible persons:* Client, primary counselor, clinical supervisor, consulting psychologist or psychiatrist, medical director

## **Intermediate goals**

**1. Sustain abstinence from cocaine and alcohol**

*Objective:* Reinforce treatment progress; assist client in meeting other goals by sustaining abstinence

*Action:* Help client identify cues for drug use; teach client relapse prevention techniques; monitor drug test results; encourage continuing participation in AA or CA groups in the community

*Target date:* Ongoing

*Responsible persons:* Client, case manager, medical staff, group counselor

**2. Obtain transitional housing**

*Objective:* Move client into safe, stable housing that supports continuing recovery

*Action:* Obtain client consent to contact local transitional housing program to arrange for placement and daily transportation to IOT program

*Target date:* Initiate within 60 days; ongoing

*Responsible persons:* Client, case manager, case aide, transitional housing admission staff

**3. Undergo vocational testing; begin working toward a general equivalency diploma (GED)**

*Objective:* Enhance client's employability and self-esteem

*Action:* Refer client to an educational specialist for testing; have client attend GED classes

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

**4. Obtain employment**

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

**5. Cultivate a positive support group; participate in healthy leisure activities**

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

## **Long-term goals**

**1. Sustain abstinence from cocaine and alcohol**

*Objective:* Assist client in meeting life goals by remaining abstinent  
*Action:* Encourage ongoing participation in AA or CA groups in the community  
*Target date:* Ongoing  
*Responsible persons:* Client

**2. Obtain full-time employment**

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

**3. Obtain permanent housing**

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

**4. Regain child custody**

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

## **Sample Case 2**

### **Clinical summary**

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

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

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

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

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

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

worried he is, the more money he spends on drugs and his son and girlfriend.

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

### ***Integrated problems list***

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

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

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

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

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

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

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

Joe has applied for treatment at an IOT program that has an evening schedule for

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

### **Initial Treatment Plan**

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

**(continued)**

### ***Initial Treatment Plan (continued)***

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

# Appendix 5-A. Substance Use History Form

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

\* Note if just released from controlled environment.

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

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

Sources: CSAT 1994a, 1994f.

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

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

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

- **The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I), Clinical Version**—The SCIDI-I uses the comprehensive “gold standard” for psychiatric diagnoses of not only substance-related disorders but other psychiatric disorders (First et al. 1997). A skilled mental health professional needs 1 hour or more to administer the complete and detailed version, but because the instrument is modular, only 10 minutes is required for a substance abuse or dependence diagnosis.
- **The Substance Dependence Severity Scale (SDSS)**—The SDSS is a semistructured interview that provides current (last 30 days) diagnoses of DSM-IV substance abuse or dependence (Miele et al. 2000). In addition, the SDSS assesses current severity

level of dependence and has items that can yield diagnoses using the ICD-10 classification system. The instrument was designed specifically to measure changes in diagnostic severity over time. It measures quantity and frequency of recent drug use and is thereby sensitive to variation in client clinical status. The SDSS requires 30 to 45 minutes to administer. Training typically requires 2 to 3 days but may take longer if staff members have little or no background in clinical diagnosis and assessment. Computerized data entry and scoring programs are available. There are no licensing fees. (Order from New York State Psychiatric Institute, Columbia Presbyterian Medical Center, Department of Research, Assessment and Training, [212] 960-5508; [www.nyspi.cpmc.columbia.edu](http://www.nyspi.cpmc.columbia.edu).)

- **Texas Christian University Drug Screen (TCUDS)**—This instrument consists of 25 questions and can be administered and scored in less than 5 minutes. TCUDS often is used with incarcerated persons but is appropriate for the general population. TCUDS quickly identifies individuals who report heavy drug use or dependence (based on the CIDI—see above). TCUDS is available free of charge. (Order from Institute of Behavioral Research, Texas Christian University, TCU Box 298740, Fort Worth, TX 76129; [817] 257-7226; visit [www.ibr.tcu.edu](http://www.ibr.tcu.edu).)

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

### DSM-IV Diagnostic Criteria for Substance Dependence

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

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

Specify:

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

### DSM-IV Diagnostic Criteria for Substance Abuse

- A. The individual has a maladaptive pattern of substance use with clinically significant impairment or distress manifested by one or more of the following criteria, occurring within a 12-month period:
  1. Recurrent substance use resulting in a failure to fulfill major obligations at work, school, or home
  2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile, operating a machine when impaired by substance use)
  3. Recurrent substance-related legal problems
  4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about the consequences of intoxication)
- B. Symptoms have never met the criteria for substance dependence for this class of substance (i.e., a diagnosis of substance dependence preempts a diagnosis of substance abuse).

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

## Six Assessment Domains

### ***Medical status***

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

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

### ***Employment or support status***

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

- Sources of income, number of dependents, perception of socioeconomic status, and financial solvency or indebtedness
- Eligibility for or receipt of benefits such as Medicaid or Medicare or employer health benefits
- Work history, marketable skills, access to transportation, job qualifications, and satisfaction with job and pay

- History of job terminations, previous referrals to an employment assistance program, and outcomes
- Education, including highest grade completed and educational accomplishments or difficulties
- Attitude toward money and ability to manage money

### ***Patterns of alcohol and drug use***

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

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

### ***Criminal history and legal status***

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

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

### **Family and social relationships**

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

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

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

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

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

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

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

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

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

- Verbal abuse or belittling of children or wrongly blaming them for the client’s mistakes or frustrations
- Taking inadequate safety precautions (e.g., leaving young children alone at home or with underage babysitters, letting them roam by themselves in unsafe places)
- Child’s indiscriminate attachment to persons other than the parent or the child’s flinching or cowering unnecessarily when the parent is present
- Expressing unrealistic, age-inappropriate behavioral expectations

- Describing children in sexual terms
- Reports of inappropriate punishment of children by oneself or a partner
- Children’s consistently unkempt appearance, obvious underweight condition or hunger, or unexplained bruises or other injuries

## **Psychiatric status**

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

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

Questions about the mental health status of clients should determine

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

## **Other Topics**

### **Sexuality**

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

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

### ***Self-concept***

The clinician can observe or ask about

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

### ***Recreation and leisure activities***

Non-substance-related recreation and leisure activities are important components of sustained recovery. They can remove the client from social pressures to use alcohol and drugs and provide a healthy outlet for new energies. If the client does not have

any active recreational interests—and has spent most leisure time in substance-related pursuits—maintaining abstinence may be difficult without assistance in finding appealing alternatives. The counselor can ask the client about

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

### ***Spirituality and personal values***

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

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

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