Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

A Treatment Improvement Protocol

TIP 47

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

Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

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

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

A Treatment Improvement Protocol

TIP 47

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

1 Choke Cherry Road
Rockville, MD 20857

Acknowledgments

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

Disclaimer

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

Public Domain Notice

Electronic Access and Copies of Publication

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

Recommended Citation

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

Originating Office

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

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

3 Intensive Outpatient Treatment and the Continuum of Care

In This Chapter...

Overview of a Continuum of Care

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

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

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

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

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

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

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

Conceiving of a Continuum of Care

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

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

IOT Programs and the Continuum of Care

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

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

Assisting the Client Along the Continuum

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

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

organization, coordination and case management needs increase.

Key Aspects of IOT (Level II)

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

IOT Goals

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

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

Intensity of Treatment

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

Duration of Treatment

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

Treatment Settings

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

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

Stages of Treatment

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

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

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

Stage 1—Treatment engagement

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

Stage 2—Early recovery

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

Transition to Outpatient Treatment

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

Compatible models of care

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

Exhibit 3-1

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

Goals of the treatment engagement stage:

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

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

Counselor activities of the treatment engagement stage:

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

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

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

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

Exhibit 3-2

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

Goals of the early recovery stage:

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

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

Counselor activities of the early recovery stage:

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

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

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

Transition planning

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

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

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

Key Aspects of Outpatient Treatment (Level I)

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

Outpatient Treatment Goals

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

Comparison of IOT and Outpatient Treatment

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

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

Stepdown Treatment

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

Stage 3—Maintenance

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

Transfer to Continuing Community Care

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

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

Continuing Community Care

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

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

Services in Continuing Community Care

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

Stage 4—Community support

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

Exhibit 3-3

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

Goals of the maintenance stage:

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

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

Counselor activities of the maintenance stage:

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

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

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

Exhibit 3-4

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

Goals of the community support stage:

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

Duration of the community support stage: Years, ongoing

Counselor activities of the community support stage:

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

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

Intensity and Duration of Continuing Community Care

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

4 Services in Intensive Outpatient Treatment Programs

In This Chapter...

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

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

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

Core Services

Group Counseling and Therapy

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

Exhibit 4-1

Core and Enhanced Services for IOT Programs

Core IOT Services Provided On Site

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

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

Enhanced IOT Services Delivered On Site or Via Functional Linkages

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

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

Types of groups

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

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

Exhibit 4-2

Groups Conducted in Intensive Outpatient Treatment

Psychoeducational groups

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

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

Skills-development groups

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

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

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

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

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

(continued)

Exhibit 4-2 (continued)

Groups Conducted in Intensive Outpatient Treatment

Interpersonal process groups

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

Key aspects of groups

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Individual Counseling

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

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

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

Psychoeducational Programming

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

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

Pharmacotherapy and Medication Management

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

Exhibit 4-3

Typical Sequence of Topics Addressed in Psychoeducational Group

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

(continued)

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

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

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

Exhibit 4-3 (continued)

Typical Sequence of Topics Addressed in Psychoeducational Group

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

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

Ambulatory detoxification

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

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

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

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

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

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

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

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

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

Pharmacotherapies for addiction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Monitoring Alcohol and Drug Use

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

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

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

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

Case Management

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

Qualifications and Roles of Case Managers

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

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

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

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

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

Exhibit 4-4

Case Management Services

Functions

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

Models

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

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

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

Research outcomes and findings

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

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

24-Hour Crisis Coverage

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

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

Community-Based Support Groups

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

Exhibit 4-5

Examples of 24-Hour Crisis Coverage Implementation

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

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

Key aspects of community support groups

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

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

The 12-Step fellowship

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

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

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

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

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

Alternatives to community-based 12-Step groups

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

Medical Treatment

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

Psychiatric Examinations and Psychotherapy

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

Vocational Training and Employment Services

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

Exhibit 4-6

Alternatives to Traditional 12-Step Groups

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

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

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

Enhanced IOT Services

Adult Education

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

Transportation Services

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

Housing and Food

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

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

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

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

Recreational Activities

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

Adjunctive Therapies

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

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

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

Nicotine Cessation Treatment

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

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

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

Licensed Child Care

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

Parent Skills Training

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

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

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

IOT Services: A Case Illustration

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

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

Exhibit 4-7

Key Features of a Hospital-Based Suburban IOT Program

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

(continued)

Exhibit 4-7 (continued)

Key Features of a Hospital-Based Suburban IOT Program

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

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

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

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

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

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

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

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

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

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

Appendix 4-B. Induction Protocol for Disulfiram

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

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

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

Exhibit 4-8

A Protocol for Ambulatory Detoxification and Disulfiram Induction

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

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

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

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

Dosage Levels

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

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

Contraindications and Cautions

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

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

Monitoring Procedures

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

Appendix A—Bibliography

Addington, J., and el-Guebaly, N. Group treatment for substance abuse in schizophrenia. *Canadian Journal of Psychiatry* 43(8):843–845, 1998.

Alcoholics Anonymous World Services. *The A.A. Member—Medications and Other Drugs*. New York: Alcoholics Anonymous World Services, 1991.

Allen, J.P., and Columbus, M., eds. *Assessing Alcohol Problems: A Guide for Clinicians and Researchers.* Treatment Handbook Series 4. NIH Publication No. 95–3723. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, 1995.

Amass, L., and Kamien, J.B. A tale of two cities: Financing two voucher programs for substance abusers through community donations. *Experimental and Clinical Psychopharmacology* 12(2):147–155, 2004.

American Academy of Pediatrics. Fetal alcohol syndrome and alcohol-related neurodevelopmental disorders. *Pediatrics* 106:358–361, 2000.

American Indian Development Associates. *Promising Practices and Strategies To Reduce Alcohol and Substance Abuse Among American Indians and Alaska Natives.* Washington, DC: Office of Justice Programs, 2000.

American Medical Association. Role of Self-Help in Addiction Treatment. Res. 713, A-98. 1998. www.ama-assn.org/ama1/pub/upload/mm/388/referral_treatment.pdf [accessed April 26, 2004].

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised (DSM-III-R). Washington, DC: American Psychiatric Association, 1987.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV). Washington, DC: American Psychiatric Association, 1994.

American Psychiatric Association. *Practice Guidelines for Treatment of Patients With Substance Use Disorders: Alcohol, Cocaine, Opioids.* Washington, DC: American Psychiatric Association, 1995.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR). Washington, DC: American Psychiatric Association, 2000.

American Psychological Association (APA). *APA Rural Initiative: 1999 Year in Review.* Washington, DC: APA, 1999. www.apa.org/rural/report99.html [accessed February 11, 2004].

American Society of Addiction Medicine. The effectiveness of social interventions for homeless substance abusers (special issue). *Journal of Addictive Diseases* 14(4), 1995.

American Society of Addiction Medicine. Relationship Between Treatment and Self Help: A Joint Statement of the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry, 1997. www.asam.org/ppol/aaap.htm [accessed February 11, 2004].

Armstrong, T.D., and Costello, E.J. Community studies on adolescent substance use, abuse, or dependence and psychiatric comorbidity. *Journal of Consulting and Clinical Psychology* 70:1224–1239, 2002.

Avants, S.K.; Margolin, A.; Kosten, T.R.; Rounsaville, B.J.; and Schottenfeld, R.S. When is less treatment better? The role of social anxiety in matching methadone patients to psychosocial treatments. *Journal of Consulting and Clinical Psychology* 66(6):924–931, 1998.

Barker, R.L. *The Social Work Dictionary*, Fourth Edition. Washington, DC: National Association of Social Workers, 1999.

Bartholomew, N.G.; Rowan-Szal, G.A.; Chatham, L.R.; Nucatola, D.C.; and Simpson, D.D. Sexual abuse among women entering methadone treatment. *Journal of Psychoactive Drugs* 34(4):347–354, 2002.

Bean, F.D.; Trejo, S.J.; Crapps, R.; and Tyler, M. *The Latino Middle Class: Myth, Reality, and Potential.* Los Angeles, CA: Tomás Rivera Policy Institute, 2001.

Beck, A.J., and Harrison, P.M. Prisoners in 2000. *Bureau of Justice Statistics Bulletin.* Washington, DC: Office of Justice Programs, August 2001. www.ojp.gov:80/bjs/abstract/p00.htm [accessed February 11, 2004].

Belenko, S. Research on drug courts: A critical review, 1999 update. *National Drug Court Institute Review* 2(2):1–59, 1999.

Bell, P. *Chemical Dependency and the African American: Counseling and Prevention Strategies*, Second Edition. Center City, MN: Hazelden Publishing, 2002.

Beresford, T., and Gomberg, E., eds. *Alcohol and Aging.* New York: Oxford University Press, 1995.

Bigelow, G.E., and Silverman, K. Theoretical and empirical foundations of contingency management treatments for drug abuse. In: Higgins, S.T., and Silverman, K., eds. *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions.* Washington, DC: American Psychological Association, 1999, pp. 15–31.

Bixler, J.B., and Emery, B.D. Successful programs for individuals with co-occurring mental health and substance abuse disorders: Examples from five states. *A Report of the Joint NASMHPD-NASADAD*

Task Force on Co-Occurring Mental Health and Substance Abuse Disorders. Alexandria, VA: National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors, 2000.

Bloom, F.; Owen, B.; and Covington, S. *Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders.* Washington, DC: National Institute of Corrections, June 2003. nicic.org/pubs/2003/018017.pdf [accessed February 11, 2004].

Blume, S.B. Understanding addictive disorders in women. In: Graham, A.W.; Shultz, T.K.; and Wilford, B.B., eds. *Principles of Addiction Medicine*, Second Edition. Chevy Chase, MD: American Society of Addiction Medicine, Inc., 1998, pp.1173–1190.

Bowser, B.P., and Bilal, R. Drug treatment effectiveness: African-American culture in recovery. *Journal of Psychoactive Drugs* 33(4):391–402, 2001.

Boylin, W.M., and Doucette, J. Multifamily therapy in substance abuse treatment with women. *American Journal of Family Therapy* 25(1):39–47, 1997.

Bradley, B.P.; Gossop, M.; Phillips, G.T.; and Legarda, J.J. The development of an opiate withdrawal scale (OWS). *British Journal of the Addictions* 82:1139–1142, 1987.

Brady, K.T., and Randall, C.L. Gender differences in substance use disorders. *Psychiatric Clinics of North America* 22(2):241–252, 1999.

Brems, C.; Johnson, M.E.; and Namyniuk, L.L. Clients with substance abuse and mental health concerns: A guide for conducting intake interviews. *Journal of Behavioral Health Services Research* 29(3):327–334, 2002.

Brisbane, F.L. Introduction: Diversity among African Americans. In: Center for Substance Abuse Prevention (CSAP). *Cultural Competence for Health Care Professionals Working With African-American Communities: Theory and Practice.* CSAP Cultural Competence Series 7. DHHS Publication No. (SMA) 98–3238. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998, pp. 1–8.

Brochu, S.; Guyon, L.; and Desjardins, L. Comparative profiles of addicted adult populations in rehabilitation and correctional services. *Journal of Substance Abuse Treatment* 6(2):173–182, 1999.

Brown, T.G.; Seraganian, P.; Tremblay, J.; and Annis, H. Matching substance abuse aftercare treatments to client characteristics. *Addictive Behavior* 27:585–604, 2002.

Budney, A.J., and Higgins, S.T. *A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction.* Manual 2: Therapy Manuals for Drug Addiction Series. NIH Publication No. 98–4309. Rockville, MD: National Institute on Drug Abuse, 1998.

Bureau of Justice Assistance. *Integrating Drug Testing Into a Pretrial Services System: 1999 Update.* Washington, DC: Office of Justice Programs, July 1999. bja.ncjrs.org/publications/#1 [accessed April 8, 2004].

Bureau of Justice Statistics. *Correctional Populations in the United States, 1997.* Washington, DC: Office of Justice Programs, November 2000. www.ojp.usdoj.gov/bjs/abstract/cpus97.htm [accessed February 11, 2004].

Busto, U.E.; Sykora, K.; and Sellers, E.M. A clinical scale to assess benzodiazepine withdrawal. *Journal of Clinical Psychopharmacology* 9:412–416, 1989.

Campbell, J.C. Prediction of homicide of and by battered women. In: Campbell, J.C., ed. *Assessing Dangerousness: Violence by Sexual Offenders, Batterers, and*

Child Abusers. Thousand Oaks, CA: Sage Publications, 1995, pp. 96–113.

Carey, K.B., and Correia, C.J. Severe mental illness and addictions: Assessment considerations. *Addictive Behaviors* 23(6):735–748, 1998.

Carroll, K.M. Integrating psychotherapy and pharmacotherapy in substance abuse treatment. In: Rodgers, F.; Keller, D.S.; and Morgenstern, J., eds. *Treating Substance Abuse: Theory and Technique.* New York: Guilford Press, 1996*a*, pp. 286–318.

Carroll, K.M. Relapse prevention as a psychosocial treatment: A review of controlled clinical trials. *Experimental and Clinical Psychopharmacology* 4(1):46–54, 1996*b*.

Carroll, K.M. *A Cognitive–Behavioral Approach: Treating Cocaine Addiction.* Manual 1: Therapy Manuals for Drug Addiction Series. NIH Publication No. 94–4308. Rockville, MD: National Institute on Drug Abuse, 1998.

Carroll, K.M.; Nich, C.; Ball, S.A.; McCance, E.; and Rounsaville, B.J. Treatment of cocaine and alcohol dependence with psychotherapy and disulfiram. *Addiction* 93(5):713–727, 1998.

Catalano, R.F.; Gainey, R.R.; Fleming, C.B.; Haggerty, K.P.; and Johnson, N.O. An experimental intervention with families of substance abusers: One-year follow-up of the Focus on Families project. *Addiction* 94(2):241–254, 1999.

Catalano, R.F.; Haggerty, K.P.; Gainey, R.R.; and Hoppe, M. Reducing parental risk factors for children's substance misuses: Preliminary outcomes with opiate-addicted parents. *Substance Use & Misuse* 32(6):699–721, 1997.

Center for Substance Abuse Prevention. *Substance Abuse Resource Guide: Asian and Pacific Islander Americans.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 1996*a*. ncadi.samhsa/gov/pubs/govpubs/MS408 [accessed March 4, 2004].

Center for Substance Abuse Prevention. *Substance Abuse Resource Guide: Hispanic/Latino Americans.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 1996*b*. ncadi.samhsa.gov/govpubs/MS441 [accessed March 4, 2004].

Center for Substance Abuse Prevention. Communicating appropriately with Asian and Pacific Islander audiences. *Technical Assistance Bulletin,* June 1997. ncadi.samhsa.gov/govpubs/MS701 [accessed February 11, 2004].

Center for Substance Abuse Prevention. *Cultural Competence for Health Care Professionals Working With African-American Communities: Theory and Practice.* Cultural Competence Series 7. DHHS Publication No. (SMA) 98–3238. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*a*.

Center for Substance Abuse Prevention: *Substance Abuse Resource Guide: American Indians and Alaska Natives.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*b*. ncadi.samhsa.gov/govpubs/MS419 [accessed March 4, 2004].

Center for Substance Abuse Prevention. *Responding to Pacific Islanders: Culturally Competent Perspectives for Substance Abuse Prevention.* Cultural Competence Series 8. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999.

Center for Substance Abuse Prevention. *Substance Abuse Resource Guide: Lesbian, Gay, Bisexual, and Transgender Populations.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000. ncadi.samhsa.gov/

referrals/resguides.aspx?InvNum=MS489 [accessed February 11, 2004].

Center for Substance Abuse Prevention. *Health Promotion and Substance Abuse Prevention Among American Indian and Alaska Native Communities: Issues in Cultural Competence*. Cultural Competence Series 9. DHHS Publication No. (SMA) 99–3440. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001.

Centers for Disease Control and Prevention. Increasing morbidity and mortality associated with abuse of methamphetamine—United States, 1991–1994. *Morbidity and Mortality Weekly Report* 44(47):882–886, 1995.

Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report* 14:1–48, 2002.

Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report* 16:1–46, 2004.

Charney, D.A.; Paraherakis, A.M.; and Gill, K.J. Integrated treatment of comorbid depression and substance use disorders. *Journal of Clinical Psychiatry* 62(9):672–677, 2001.

Chermack, S.T.; Walton, M.A.; Fuller, B.E.; and Blow, F.C. Correlates of expressed and received violence across relationship types among men and women substance abusers. *Psychology of Addictive Behaviors* 15(2):140–151, 2001.

Chick, J.; Lehert, P.; and Landron, F. Does acamprosate improve reduction of drinking as well as aiding abstinence? *Journal of Psychopharmacology* 17(4):397–402, 2003.

Claus, R.E., and Kindleberger, L.R. Engaging substance abusers after centralized assessment: Predictors of treatment entry and dropout. *Journal of Psychoactive Drugs* 34:25–31, 2002.

Cohen, M. *Counseling Addicted Women: A Practical Guide*. Thousand Oaks, CA: Sage Publications, 2000.

Compton, W.M., III; Cottler, L.B.; Phelps, D.L.; Ben Abdallah, A.; and Spitznagel, E.L. Psychiatric disorders among drug dependent subjects: Are they primary or secondary? *American Journal on Addictions* 9(2):126–134, 2000.

Conner, K.R.; Shea, R.R.; McDermott, M.P.; Grolling, R.; Tocco, R.V.; and Baciewicz, G. The role of multifamily therapy in promoting retention in treatment of alcohol and cocaine dependence. *American Journal on Addictions* 7(1):61–73, 1998.

Connors, G.J., and Dermen, K.H. Characteristics of participants in Secular Organizations for Sobriety (SOS). *American Journal of Drug and Alcohol Abuse* 22:281–295, 1996.

Connors, G.J.; Donovan, D.M.; and DiClemente, C.C. *Substance Abuse Treatment and the Stages of Change: Selecting and Planning Interventions*. New York: Guilford Press, 2001*a*.

Connors, G.J.; Tonigan, J.S.; and Miller, W.R. A longitudinal model of intake symptomatology, AA participation, and outcome: Retrospective study of the Project MATCH outpatient and aftercare samples. *Journal of Studies on Alcohol* 62:817–825, 2001*b*.

Cornish, J.W.; Metzger, D.; Woody, G.E.; Wilson, D.; McLellan, A.T.; Vandergrift, B.; and O'Brien, C.P. Naltrexone pharmacotherapy for opioid dependent federal probationers. *Journal of Substance Abuse Treatment* 14(6):529–534, 1997.

Covington, S. *A Woman's Journey Home: Challenges for Female Offenders and Their Children*. Washington, DC: Urban Institute, 2002.

Covington, S.S. *A Woman's Way Through the Twelve Steps*. Center City, MN: Hazelden Information Education, 1994.

Covington, S.S. *Helping Women Recover: A Program for Treating Addiction.* San Francisco: Jossey-Bass, 1999.

Covington, S.S. *A Woman's Way Through the Twelve Steps Workbook.* Center City, MN: Hazelden Information Education, 2000.

Coyhis, D., and White, W.L. Addiction and recovery in Native America: Lost history, enduring lessons. *Counselor* 3(5):16–20, 2002.

Crnkovic, A.E., and DelCampo, R.L. A systems approach to the treatment of chemical addiction. *Contemporary Family Therapy* 20(1):25–36, 1998.

Crowley, T.J. Research on contingency management treatment of drug dependence: Clinical implications and future directions. In: Higgins, S.T., and Silverman, K., eds. *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions.* Washington, DC: American Psychological Association, 1999, pp. 345–370.

CSAT (Center for Substance Abuse Treatment). *Pregnant, Substance-Using Women*. Treatment Improvement Protocol (TIP) Series 2. DHHS Publication No. (SMA) 95–3056. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993*a*, reprinted 1995.

CSAT (Center for Substance Abuse Treatment). *Screening for Infectious Diseases Among Substance Abusers.* Treatment Improvement Protocol (TIP) Series 6. DHHS Publication No. (SMA) 93–2048. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993*b*.

CSAT (Center for Substance Abuse Treatment). *Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients.* Treatment Improvement Protocol (TIP) Series 10. DHHS Publication No. (SMA) 94–3004. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*a*.

CSAT (Center for Substance Abuse Treatment). *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse.* Treatment Improvement Protocol (TIP) Series 9. DHHS Publication No. (SMA) 94–2078. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*b*.

CSAT (Center for Substance Abuse Treatment). *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse.* Treatment Improvement Protocol (TIP) Series 8. DHHS Publication No. (SMA) 94–2077. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*c*.

CSAT (Center for Substance Abuse Treatment). *Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*d*.

CSAT (Center for Substance Abuse Treatment). *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 7. DHHS Publication No. (SMA) 94–2076. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*e*.

CSAT (Center for Substance Abuse Treatment). *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases.* Treatment Improvement Protocol (TIP) Series 11. DHHS Publication No. (SMA) 94–2094. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*f*.

CSAT (Center for Substance Abuse Treatment). *Detoxification From Alcohol and Other Drugs*. Treatment

Improvement Protocol (TIP) Series 19. DHHS Publication No. (SMA) 95–3046. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*a*.

CSAT (Center for Substance Abuse Treatment). *Treating Alcohol and Other Drug Abusers in Rural and Frontier Areas: 1994 Award for Excellence Papers.* Technical Assistance Publication (TAP) Series 17. DHHS Publication No. (SMA) 95–3054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*b*.

CSAT (Center for Substance Abuse Treatment). *The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers.* Treatment Improvement Protocol (TIP) Series 18. DHHS Publication No. (SMA) 95–3047. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*c*.

CSAT (Center for Substance Abuse Treatment). *Bringing Excellence to Substance Abuse Services in Rural and Frontier America: 1996 Award for Excellence Papers.* Technical Assistance Publication (TAP) Series 20. DHHS Publication No. (SMA) 97–3134. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1996.

CSAT (Center for Substance Abuse Treatment). *A Guide to Substance Abuse Services for Primary Care Clinicians.* Treatment Improvement Protocol (TIP) Series 24. DHHS Publication No. (SMA) 97–3139. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997*a*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment and Domestic Violence.* Treatment Improvement Protocol (TIP) Series 25. DHHS Publication No. (SMA) 97–3163. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997*b*.

CSAT (Center for Substance Abuse Treatment). *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27. DHHS Publication No. (SMA) 98–3222. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*a*.

CSAT (Center for Substance Abuse Treatment). *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community.* Treatment Improvement Protocol (TIP) Series 30. DHHS Publication No. (SMA) 98–3245. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*b*.

CSAT (Center for Substance Abuse Treatment). *Naltrexone and Alcoholism Treatment.* Treatment Improvement Protocol (TIP) Series 28. DHHS Publication No. (SMA) 98–3206. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*c*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Among Older Adults.* Treatment Improvement Protocol (TIP) Series 26. DHHS Publication No. (SMA) 98–3179. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*d*.

CSAT (Center for Substance Abuse Treatment). *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities.* Treatment Improvement Protocol (TIP) Series 29. DHHS Publication No. (SMA) 98–3249. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*e*.

CSAT (Center for Substance Abuse Treatment). *Brief Interventions and Brief Therapies for Substance Abuse.* Treatment Improvement Protocol (TIP) Series 34. DHHS Publication No. (SMA) 99–3353. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*a*.

CSAT (Center for Substance Abuse Treatment). *Cultural Issues in Substance Abuse Treatment.* DHHS Publication No. (SMA) 99–3278. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*b*.

CSAT (Center for Substance Abuse Treatment). *Enhancing Motivation for Change in Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 35. DHHS Publication No. (SMA) 99–3354. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*c*.

CSAT (Center for Substance Abuse Treatment). *Screening and Assessing Adolescents for Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 31. DHHS Publication No. (SMA) 99–3282. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*d*.

CSAT (Center for Substance Abuse Treatment). *Treatment for Stimulant Use Disorders.* Treatment Improvement Protocol (TIP) Series 33. DHHS Publication No. (SMA) 99–3296. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*e*.

CSAT (Center for Substance Abuse Treatment). *Treatment of Adolescents With Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 32. DHHS Publication No. (SMA) 99–3283. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*f*.

CSAT (Center for Substance Abuse Treatment). *Integrating Substance Abuse Treatment and Vocational Services.* Treatment Improvement Protocol (TIP) Series 38. DHHS Publication No. (SMA) 00–3470. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000*a*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues.* Treatment Improvement Protocol (TIP) Series 36. DHHS Publication No. (SMA) 00–3357. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000*b*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment for Persons With HIV/AIDS.* Treatment Improvement Protocol (TIP) Series 37. DHHS Publication No. (SMA) 00–3410. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000*c*.

CSAT (Center for Substance Abuse Treatment). *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals.* DHHS Publication No. (SMA) 01–3498. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001.

CSAT (Center for Substance Abuse Treatment). *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction.* Treatment Improvement Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04–3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004*a*.

CSAT (Center for Substance Abuse Treatment). *The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule: Implications for Alcohol and Substance Abuse Programs.* DHHS Publication No.

(SMA) 04-3947. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004*b*. www.hipaa.samhsa.gov/download2/SAMHSAHIPAAComparisonClearedPDFVersion.pdf [accessed April 5, 2005].

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment and Family Therapy.* Treatment Improvement Protocol (TIP) Series 39. DHHS Publication No. (SMA) 04–3957. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004*c*.

CSAT (Center for Substance Abuse Treatment). Acamprosate: A new medication for alcohol use disorders. *Substance Abuse Treatment Advisory* 4(1), 2005*a*.

CSAT (Center for Substance Abuse Treatment). *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.* Treatment Improvement Protocol (TIP) Series 43. DHHS Publication No. (SMA) 05-4048. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005*b*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Relapse Prevention for Older Adults: A Group Treatment Approach.* DHHS Publication No. 05-4053. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005*c*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment for Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 44. DHHS Publication No. (SMA) 05–4056. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005*d*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment for Persons With Co-Occurring Disorders.* Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05–3922. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005*e*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment: Group Therapy.* Treatment Improvement Protocol (TIP) Series 41. DHHS Publication No. (SMA) 05–3991. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005*f*.

CSAT (Center for Substance Abuse Treatment). *Client's Handbook: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders.* DHHS Publication No. (SMA) 06–4154. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*a*.

CSAT (Center for Substance Abuse Treatment). *Client's Treatment Companion: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders.* DHHS Publication No. (SMA) 06–4155. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*b*.

CSAT (Center for Substance Abuse Treatment). *Counselor's Family Education Manual: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders.* DHHS Publication No. (SMA) 06–4153. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*c*.

CSAT (Center for Substance Abuse Treatment). *Counselor's Treatment Manual: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders.* DHHS Publication No. (SMA) 06–4152. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*d*.

CSAT (Center for Substance Abuse Treatment). *Detoxification and Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 45. DHHS Publication No. (SMA) 06–4131. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*e*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse: Administrative Issues in Outpatient Treatment.* Treatment Improvement Protocol (TIP) Series 46. DHHS Publication No. (SMA) 06–4151. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*f*.

CSAT (Center for Substance Abuse Treatment). *Therapeutic Community Curriculum: Participant's Manual.* DHHS Publication No. (SMA) 06-4122. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*g*.

CSAT (Center for Substance Abuse Treatment). *Therapeutic Community Curriculum: Trainer's Manual.* DHHS Publication No. (SMA) 06-4121. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*h*.

CSAT (Center for Substance Abuse Treatment). *Improving Cultural Competence in Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, forthcoming *a*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment: Addressing the Specific Needs of Women.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, forthcoming *b*.

da Costa, C.L.; Younes, R.N.; and Lourenco, M.T. Stopping smoking: A prospective, randomized, double-blind study comparing nortriptyline to placebo. *Chest* 122:403–408, 2002.

Daley, D.C. *Relapse Prevention Workbook for Recovering Alcoholics and Drug Dependent Persons*, Third Edition. Holmes Beach, FL: Learning Publications, 2001.

Daley, D.C. *Dual Disorders: Relapse Prevention Workbook*, Second Edition. Center City, MD: Hazelden Foundation, 2003.

Daley, D.C., and Marlatt, G.A. *Managing Your Drug or Alcohol Problem: Therapist Guide*. San Antonio, TX: Psychological Corporation, 1997.

Daley, D.C.; Marlatt, G.A.; and Spotts, C.E. Relapse prevention: Clinical models and specific intervention strategies. In: Graham, A.W.; Schultz, T.K.; Mayo-Smith, M.F.; Ries, R.K.; and Wilford, B.B., eds. *Principles of Addiction Medicine*, Third Edition. Chevy Chase, MD: American Society of Addiction Medicine, 2003, pp. 467–485.

Daley, D.C.; Mercer, D.; and Carpenter, G. *Drug Counseling for Cocaine Addiction: The Collaborative Cocaine Treatment Study Manual.* Manual 4: Therapy Manuals for Drug Addiction Series. NIH Publication No. 99–4380. Rockville, MD: National Institute on Drug Abuse, 1999.

Daley, D.C., and Thase, M.E. *Dual Disorders Recovery Counseling: Integrated Treatment for Substance Use and Mental Health Disorders.* Independence, MO: Independence Press, 2002.

D'Avanzo, C., and Geissler, E. *Pocket Guide to Cultural Health Assessment*, Third Edition. Mosby's Pocket Series. Philadelphia: Elsevier, 2003.

Deas, D.; Riggs, P.; Langenbucher, J.; Goldman, M.; and Brown, S. Adolescents are not adults: Developmental considerations in alcohol users. *Alcoholism,*

Clinical and Experimental Research 24:232–237, 2000.

De La Rosa, M. Acculturation and Latino adolescents' substance use: A research agenda for the future. *Substance Use & Misuse* 37(4):429–456, 2002.

De La Rosa, M.R., and White, M.S. A review of the role of social support systems in the drug use behavior of Hispanics. *Journal of Psychoactive Drugs* 33(3):233–240, 2001.

De Leon, G. Therapeutic communities for addictions: A theoretical framework. *International Journal of the Addictions* 30(12):1603–1645, 1995.

De Leon, G. *The Therapeutic Community: Theory, Model, and Method.* New York: Springer Publishing, 2000.

De Leon, G., and Jainchill, N. Circumstance, motivation, readiness, and suitability as correlates of treatment tenure. *Journal of Psychoactive Drugs* 18:203–208, 1986.

De Leon, G.; Melnick, G.; Kressel, D.; and Jainchill, N. Circumstances, motivation, readiness, and suitability (the CMRS Scales): Predicting retention in therapeutic community treatment. *American Journal of Drug and Alcohol Abuse* 20(4):495–515, 1994.

DiClemente, C.C., and Hughes, S.O. Stages of change profiles in outpatient alcoholism treatment. *Journal of Substance Abuse* 2:217–235, 1990.

Ditton, P.M. Mental health and treatment of inmates and probationers. *Bureau of Justice Statistics Special Report.* Washington, DC: Office of Justice Programs, July 1999. www.ojp.usdoj.gov/bjs/abstract/mhtip.htm [accessed February 11, 2004].

Dixon, L.; McNary, S.; and Lehman, A. Remission of substance use disorder among psychiatric inpatients with mental illness. *American Journal of Psychiatry* 155(2):239–243, 1998.

Drake, R.E.; Essock, S.M.; Shaner, A.; Carey, K.B.; Minkoff, K.; Kola, L.; Lynde, D.; Osher, F.C.; Clark, R.E.; and Rickards, L. Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services* 52:469–476, 2001.

Drake, R.E.; McHugo, G.J.; Clark, R.E.; Teague, G.B.; Xie, H.; Miles, K.; and Ackerson, T.H. Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: A clinical trial. *American Journal of Orthopsychiatry* 68(2):201–215, 1998*a*.

Drake, R.E.; Mercer-McFadden, C.; Mueser, K.T.; McHugo, G.J.; and Bond, G.R. Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin* 24(4):589–608, 1998*b*.

Drake, R.E., and Mueser, K.T. Psychosocial approaches to dual diagnosis. *Schizophrenia Bulletin* 26:105–118, 2000.

Edwards, J.T. *Treating Chemically Dependent Families: A Practical Systems Approach for Professionals.* Minneapolis, MN: Johnson Institute, 1990.

Edwards, M.D., and Steinglass, P. Family therapy treatment outcomes for alcoholism. *Journal of Marital and Family Therapy* 21(4):475–509, 1995.

Ehrman, R.N.; Robbins, S.J.; and Cornish, J.W. Results of a baseline urine test predict levels of cocaine use during treatment. *Drug and Alcohol Dependence* 62(1):1–7, 2001.

Eisen, M.; Keyser-Smith, J.; Dampeer, J.; and Sambrano, S. Evaluation of substance use outcomes in demonstration projects for pregnant and postpartum women and their infants: Findings from

a quasi-experiment. *Addictive Behaviors* 25(1):123–129, 2000.

Epstein, E.E., and McCrady, B.S. Behavioral couples treatment of alcohol and drug use disorders: Current status and innovations. *Clinical Psychology Review* 18(6):689–711, 1998.

Epstein, J.; Barker, P.; Vorburger, M.; and Murtha, C. *Serious Mental Illness and Its Co-Occurrence With Substance Use Disorders, 2002.* Analytic Series A-24. DHHS Publication No. (SMA) 04–3905. Rockville, MD: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, 2004. www.oas.samhsa.gov/CoD/Cod.htm [accessed August 17, 2004].

Evans, K., and Sullivan, J.M. *Dual Diagnosis: Counseling the Mentally Ill Substance Abuser*, Second Edition. New York: Guilford Press, 2000.

Fals-Stewart, W., and Birchler, G.R. A national survey of the use of couples therapy in substance abuse treatment. *Journal of Substance Abuse Treatment* 20:277–283, 2001.

Fals-Stewart, W.; Birchler, G.R.; and O'Farrell, T.J. Behavioral couples therapy for male substance-abusing patients: Effects on relationship adjustment and drug-using behavior. *Journal of Consulting and Clinical Psychology* 64:959–972, 1996.

Farabee, D.; Prendergast, M.; and Anglin, M.D. The effectiveness of coerced treatment for drug-abusing offenders. *Federal Probation* 62:3–10, 1998.

Farabee, D.; Prendergast, M.; Cartier, J.; Wexler, H.; Knight, K.; and Anglin, M.D. Barriers to implementing effective correctional drug treatment programs. *Prison Journal* 79:150–162, 1999.

Farabee, D.; Rawson, R.; and McCann, M. Adoption of drug avoidance activities among patients in contingency management and cognitive–behavioral treatments. *Journal of Substance Abuse Treatment* 23(4):343–350, 2002.

Fears, D. A Diverse—and Divided—Black Community. *Washington Post*, February 24, 2002, pp. A1, A8.

Festinger, D.S.; Lamb, R.J.; Marlowe, D.B.; and Kirby, K.C. From telephone to office: Intake attendance as a function of appointment delay. *Addictive Behaviors* 27(1):131–137, 2002.

Finnegan, D.G., and McNally, E.B. *Counseling Lesbian, Gay, Bisexual, and Transgender Substance Abusers: Dual Identities*, Second Edition. Binghamton, NY: Haworth Press, 2002.

Finney, J.W.; Hahn, A.C.; and Moos, R.H. The effectiveness of inpatient and outpatient treatment for alcohol abuse: The need to focus on mediators and moderators of setting effects. *Addiction* 91(12):1773–1796; discussion 1803–1820, 1996.

Fiorentine, R. After drug treatment: Are 12-Step programs effective in maintaining abstinence? *American Journal of Drug and Alcohol Abuse* 25(1):93–116, 1999.

First, M.B.; Spitzer, R.L.; Gibbon, M.; and Williams, J.B.W. *Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I), Clinician Version.* Washington, DC: American Psychiatric Association, 1997.

Fishman, H.C., and Andes, F. Enhancing family therapy: The addition of a community resource specialist. *Journal of Marital and Family Therapy* 27(1):111–116, 2001.

Fishman, J.; Reynolds, T.; and Riedel, E. A retrospective investigation of an intensive outpatient substance abuse treatment program. *American Journal of Drug and Alcohol Abuse* 25(2):185–196, 1999.

Flynn, P.M.; Craddock, S.G.; Luckey, J.W.; Hubbard, R.L.; and Dunteman, G.H. Comorbidity of antisocial personality and mood disorders among psychoactive substance-dependent treatment clients. *Journal of Personality Disorders* 10(1):56–67, 1996.

Folstein, M.F.; Folstein, S.E.; and McHugh, P.R. Mini-Mental State: A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research* 12:189–198, 1975.

Forman, R. One AA meeting doesn't fit all: Six keys to prescribing 12-Step programs. *Current Psychiatry*, October 2002, pp. 1, 10, 16–24.

Frank, E.; Winkleby, M.A.; Altman, D.G.; Rockhill, B.; and Fortmann, S.P. Predictors of physician's smoking cessation advice. *JAMA* 266:3139–3144, 1991.

Fudala, P.J.; Yu, E.; MacFadden, W.; Boardman, C.; and Chiang, C.N. Effects of buprenorphine and naloxone in morphine-stabilized opioid addicts. *Drug and Alcohol Dependence* 50:1–8, 1998.

Fuller, R.K., and Gordis, E. Refining the treatment of alcohol withdrawal: Editorial. *JAMA* 272:557–558, 1994.

Gastfriend, D.R. Placement matching: Challenges and technical progress. In: *Proceedings: Tenth Annual Meeting & Symposium, December 2–5, 1999*. Prairie Village, KS: American Academy of Addiction Psychiatry, 1999, pp. 18–19. www.aaap.org/meetings/proceedings.pdf [accessed February 11, 2004].

Gaston, L. Reliability and criterion-related validity of the California Psychotherapy Alliance Scales—patient version. *Psychological Assessment* 3:68–74, 1991.

Gfroerer, J.; Penne, M.; Pemberton, M.; and Folsom, R. Substance abuse treatment need among older adults in 2020: The impact of the aging baby-boom cohort. *Drug and Alcohol Dependence* 69(2):127–135, 2003.

Glaze, L.E. Probation and parole in the United States, 2002. *Bureau of Justice Statistics Bulletin*. Washington, DC: Office of Justice Programs, August 2003. www.ojp.usdoj.gov/bjs/pub/pdf/ppus02.pdf [accessed February 11, 2004].

Gloria, A.M., and Peregoy, J.J. Counseling Latino alcohol and other substance users/abusers: Cultural considerations for counselors. *Journal of Substance Abuse Treatment* 13:119–126, 1996.

Glover, E.D.; Glover, P.N.; and Payne, T.J. Treating nicotine dependence. *American Journal of the Medical Sciences* 326(4):183–186, 2003.

Godlaski, T.M.; Leukefeld, C.; and Cloud, R. Recovery: With and without self-help. *Substance Use & Misuse* 32(5):621–627, 1997.

Godley, S.H.; Meyers, R.J.; Smith, J.E.; Karvinen, T.; Titus, J.C.; Godley, M.D.; Dent, G.; Passetti, L.; and Kelberg, P. *The Adolescent Community Reinforcement Approach for Adolescent Cannabis Users*. Cannabis Youth Treatment Series, Volume 4. DHHS Publication No. (SMA) 01–3489. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2001.

Goldenberg, I., and Goldenberg, H. *Family Therapy: An Overview*, Second Edition. Brooks Grove, CA: Brooks/Cole Publishing Co., 1985.

Goodman, D. Arab Americans and American Muslims express mental health needs. *SAMHSA News* 10(1):2–3, 2002.

Gorski, T.T. The CENAPS® model of relapse prevention therapy (CMRPT®). In: Carroll, K.M., ed. *Approaches to Drug Abuse Counseling*. NIH Publication No. 00–4151. Rockville, MD: National