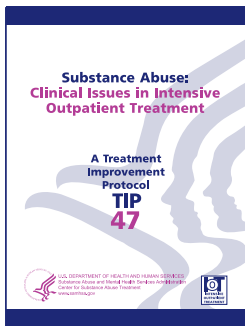


# Quick Guide

## For Clinicians

**Based on TIP 47**  
**Substance Abuse:**  
***Clinical Issues in Intensive***  
***Outpatient Treatment***



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Substance Abuse and Mental Health Services Administration  
Center for Substance Abuse Treatment  
[www.samhsa.gov](http://www.samhsa.gov)

# Contents

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Why a Quick Guide? . . . . .	2
What Is a TIP? . . . . .	3
Introduction . . . . .	5
14 Principles of IOT . . . . .	7
Intensive Outpatient Treatment and Continuing Care. . . . .	9
Services in IOT Programs . . . . .	16
Treatment Entry and Engagement. . . . .	18
Family-Based Services . . . . .	21
Clinical Issues, Challenges, and Strategies. . . . .	24
Intensive Outpatient Treatment Approaches. . . . .	35
Adapting Intensive Outpatient Treatment for Specific Populations . . . . .	43
Addressing Diverse Populations . . . . .	56

# Quick Guide

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## For Clinicians

### **Based on TIP 47**

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

This Quick Guide is based entirely on information contained in TIP 47, published in 2006. No additional research has been conducted to update this topic since publication of TIP 47.

### **WHY A QUICK GUIDE?**

This Quick Guide was developed to accompany *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment*, Number 47 in the Treatment Improvement Protocol (TIP) Series published by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA). This Quick Guide is based entirely on TIP 47 and is designed to meet the needs of the busy clinician for concise, easily accessed how-to information.

The Quick Guide is divided into 12 sections (see *Contents*) to help readers quickly locate relevant material. It will help clinicians make informed decisions when treating clients in outpatient settings.

For more information on the topics in this Quick Guide, readers are referred to TIP 47.

## WHAT IS A TIP?

The TIP series has been in production since 1991. The series provides the substance abuse treatment and related fields with consensus-based, field-reviewed guidelines on substance abuse treatment topics of vital current interest.

### *TIP 47, Substance Abuse: Clinical Issues in Intensive Outpatient Treatment—*

- Addresses the expansion of intensive outpatient treatment (IOT) represented by the development and adoption of new approaches to treat a wide range of clients
- Describes the core services every IOT program should offer, the enhanced services that should be available on site or through links with community-based services, and the processes of assessment, placement, and treatment planning that help counselors address each client's needs
- Discusses major clinical challenges of IOT and surveys the most common treatment approaches used in IOT programs
- Presents treatment strategies for specific groups including women; adolescents; criminal justice system clients; individuals with HIV/AIDS, co-occurring disorders, or physical or cognitive disabilities; racial and ethnic minorities; rural populations; people who are homeless; and older adults

## **4 Clinical Issues in Intensive Outpatient Treatment**

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- Examines the complex issues facing IOT providers and offers analytical discussions and incisive opinions.

*See the inside back cover for information on how to order TIPs and other related products.*

## INTRODUCTION

IOT is a multidimensional treatment modality that serves a variety of clients. It recognizes substance abuse as a chronic disorder requiring case management and the involvement of families, communities, and mutual-help groups in ongoing care. The blending of evidence-based interventions with community-based services has helped clinicians, clients, and family members understand that substance use disorders have complex biological, social, psychological, and spiritual dimensions. IOT has the following features:

- 6–30 contact hours per week;
- Step-up and stepdown levels of care that vary in intensity and duration;
- A minimum duration of 90 days followed by outpatient continuing care;
- Core services including—
  - Comprehensive biopsychosocial assessment
  - Group, individual, and family counseling
  - Psychoeducational programming
  - Integration into support groups
  - Relapse prevention training
  - Substance use screening and monitoring
  - Vocational and educational services; and
- Enhanced services including—
  - Ambulatory detoxification

## **6 Clinical Issues in Intensive Outpatient Treatment**

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- Child care
- Outreach.

*For more detailed information, see TIP 47, pp. 1–6.*



## **14 PRINCIPLES OF IOT**

The TIP consensus panel identified 14 principles integral to IOT:

1. Make treatment available to a wide spectrum of clients;
2. Make treatment access straightforward and welcoming;
3. Build on existing motivation by using strategies that enhance client motivation;
4. Enhance the therapeutic alliance by building trust between the counselor and client;
5. Make client retention a priority;
6. Assess the client's treatment needs and match services to the individual;
7. Provide ongoing care through a chronic care model that adjusts to the client's needs;
8. Monitor abstinence by recognizing the client's achieving and maintaining abstinence;
9. Help clients integrate into support groups;
10. If indicated, use medications to manage co-occurring substance use and mental disorders;
11. Educate clients and family members about substance use disorders and recovery skills;
12. Include families, employers, and significant others in the treatment process;

## **8 Clinical Issues in Intensive Outpatient Treatment**

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13. Seek out and use evidence-based training and materials; and
14. Improve program administration.

*For more detailed information, see TIP 47, pp. 7–16.*

## **INTENSIVE OUTPATIENT TREATMENT AND CONTINUING CARE**

The American Society of Addiction Medicine (ASAM) has established five 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 (subdivided into two levels: II.1 and II.5);
- **Level III:** Residential/inpatient services (subdivided into four levels: III.1, III.3, III.5, and III.7); and
- **Level IV:** Medically managed intensive inpatient services.

### **Key Aspects of IOT (Level II)**

The amount of time that clients participate in IOT depends on individual needs. State licensure bodies may require 9 treatment hours spread over 3 to 5 days. ASAM defines IOT as at least 9 hours of treatment per week for adults. The minimum duration of IOT often is cited as 90 days. Any setting that meets State licensure or certification criteria can provide IOT.

IOT comprises two treatment stages: treatment engagement and early recovery.

### **Stage 1—Treatment Engagement**

- **Goals—**

- Initiate a treatment contract
- Resolve acute crises
- Engage in a therapeutic alliance
- Involve clients in preparing a treatment plan.

- **Duration—**A few days to a few weeks.

- **Counselor activities—**

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

- **Completion criteria—**

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

### **Stage 2—Early Recovery**

- **Goals—**

- Maintain abstinence
- Sustain behavioral changes
- Identify relapse triggers and develop relapse prevention strategies
- Identify and begin to resolve personal problems
- Begin active involvement in a 12-Step or other mutual-help program.

- **Duration—**6 weeks to about 3 months.

- **Counselor activities—**

- Help clients follow their plans to sustain abstinence
- Assist in identifying and developing strategies for relapse triggers
- Initiate random drug tests and provide rapid feedback of results
- Help clients and families integrate into mutual-help programs

## **12 Clinical Issues in Intensive Outpatient Treatment**

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- Assist in developing and strengthening positive social support networks
- Continue appropriate pharmacotherapy, medical, and psychiatric treatments.
- **Completion criteria—**
  - Sustained abstinence for 30 days or longer
  - Completed treatment plan goals
  - Created and implemented a relapse prevention and continuing care plan
  - Participated regularly in a support group
  - Maintained a sober social support network
  - Resolved medical, psychiatric, housing, and personal situations that may trigger relapse.

### **Key Aspects of Outpatient Treatment (Level I)**

The goals of outpatient treatment are similar to those of IOT. Clients who complete stages 1 and 2 of IOT step down to stage 3, maintenance. Clients attend one or two treatment sessions per week.

### **Stage 3—Maintenance**

- **Goals—**
  - Solidify abstinence
  - Use relapse prevention skills
  - Improve emotional functioning
  - Broaden sober social networks
  - Address other problem areas.
- **Duration—**About 2 months to 1 year.

• **Counselor activities—**

- Help clients practice relapse prevention skills
- Teach new coping skills
- Help identify vocational, educational, and recreational needs
- Assist in locating community resources
- Encourage continuing work with support groups and sponsors
- Emphasize the importance of spirituality or altruistic values
- Provide feedback on random drug test results
- Continue appropriate pharmacotherapy, medical, or psychiatric assistance.

• **Completion criteria—**

- Sustained abstinence
- Improved relationships
- Improved coping and problemsolving skills
- Obtained drug-free, stable housing
- Continued participation in a support group
- Obtained assistance with other problems.

**Key Aspects of Continuing Community Care**

Individuals may remain in this level of care for the rest of their lives to remain abstinent and recover from relapses. A client's needs determine this stage's duration and intensity.

### **Stage 4—Continuing Community Care**

- **Goals—**
  - Maintain abstinence and a healthy lifestyle
  - Develop independence from the treatment program
  - Maintain social network connections
  - Establish strong connection with support groups
  - Establish recreational activities and develop new interests.
- **Duration—**Years, ongoing.
- **Counselor activities—**
  - Assist in developing a plan for continuing recovery
  - Acquaint clients with local resources
  - Encourage attendance at alumni or booster sessions
  - Provide biannual checkups.
- **Completion criteria—**Clients may need community support for the rest of their lives.

### **Transitioning Between Stages**

A transition plan helps the client move from one level of care to another. To prepare an effective transition plan, the IOT counselor—

- Engages clients in developing the plan early in IOT
- Knows about community services and resources



- Develops relationships with key agencies
- Transfers clinical information to the new treatment program.

*For more detailed information, see TIP 47, pp. 17–26.*

## SERVICES IN IOT PROGRAMS

- **Group counseling.** Common IOT groups include psychoeducational, support, and family or couples groups. They provide venues for clients to practice new behaviors. For more on group therapy, see TIP 41, *Substance Abuse Treatment: Group Therapy*.
- **Individual counseling.** Most individual counseling addresses the immediate problems stemming from substance use disorders, not underlying conflicts that may contribute to them.
- **Psychoeducational programming.** Psychoeducational groups educate clients about substances and substance use disorders.
- **Pharmacotherapy and medication management.** IOT programs that require attendance 3–5 times per week are ideal settings for identifying clients in need of pharmacotherapy and medication management.
- **Monitoring alcohol and drug use.** When asked to report drug test results to the criminal justice system, employers, or child protective services, programs should tell clients that positive test results may trigger serious consequences.
- **Case management.** Case managers provide social services and act as client advocates.

- **Community-based support groups.** IOT counselors should introduce clients to the basic tenets of support groups and encourage participation in these meetings.
- **24-hour crisis coverage.** Effective 24-hour coverage includes services that provide hotline advice or referrals and 24-hour detoxification.
- **Medical treatment and psychiatric examinations/psychotherapy.** IOT programs should partner with medical and mental health providers for consultation on and referral for medical or psychiatric disorders.
- **Vocational training and employment services.** Services on site or through case-managed referral are important for unemployed or underemployed individuals.
- **Enhanced IOT services.** These include adult education, transportation, housing and food, recreation, adjunctive therapies, nicotine treatment, child care, and parenting training.

*For more detailed information, see TIP 47, pp. 27–57.*

## **TREATMENT ENTRY AND ENGAGEMENT**

The admission process addresses early client attrition by assessing readiness for change and establishing a collaborative relationship. The counselor matches clients to the least intensive and restrictive treatment setting and develops individualized interventions of variable intensity. Treatment engagement is fostered by balancing the procedural requirements of intake with an empathic response to clients.

### **Intake**

The sandwich technique is a method of intake interviewing that helps initiate a therapeutic relationship by “sandwiching” standard assessments between two less formal discussions with clients. Before conducting a formal assessment, the counselor—

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

The following information is often documented on the intake form:

- Name, age, and gender;

- The referral source;
- The client's perspective on why treatment is needed and immediate crises;
- Pertinent medical conditions;
- Suicidal or other violent thoughts;
- The client's usual residence;
- Substance use disorder and severity; and
- Length of time since the client's last substance abuse treatment.

### **Screening**

Short screening instruments should be used to document a substance use disorder that later may be confirmed with a diagnostic interview. Three have shown high rates of accuracy:

- CSAT's Simple Screening Instrument (reproduced in TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases*);
- A combination of the Alcohol Dependence Scale and Addiction Severity Index-Drug Use Subscale (see appendix 5-B in TIP 47); and
- Texas Christian University Drug Screen (see appendix 5-B in TIP 47).

### **The IOT Admission Process**

Counselors must establish a client's eligibility before initiating treatment. Biopsychosocial and multidimensional assessments should be

conducted, summarized, and presented to the client. The counselor should then develop a treatment plan with the client.

### **Treatment Planning**

In planning treatment, counselors should—

- Involve the client in developing the plan
- Set unambiguous goals with criteria for accomplishment
- Set sequence and target dates for goals and for reviewing and modifying the plan
- Locate required resources, responsible persons, or activities.

*For more detailed information, see TIP 47, pp. 59–91.*

## **FAMILY-BASED SERVICES**

A family can be considered anyone important to the client. This “family of choice” can differ from the client’s close relatives or “family of origin.”

### **Engaging the Family in Treatment**

Family members may resist involvement in the client’s treatment, or the client may object to the family’s involvement. The client may not want family members to be involved because of domestic violence threats, fear of revealing family secrets, or other reasons. Methods to help engage families include using community reinforcement training interventions, involving family members in the intake session, and offering written invitations and incentives. If domestic abuse is suspected, clinicians must assess the client and family carefully for any potential for violence.

### **Family Services**

- **Family education groups** meet weekly for 2 to 3 hours, include between 10 and 40 individuals, and are facilitated by a clinician.
- **Multifamily groups** provide family members with a support network and engage clients and families in group exercises.

- **Family therapy** includes the following:
  - *Individual family therapy.* Helps family members look at their interactions and identify factors that contribute to substance use;
  - *Couples therapy.* Focuses on teaching partners to improve communication and work together in problemsolving; and
  - *Child-focused therapy.* Teaches parenting and problemsolving skills and provides information about normal childhood development.
- **Family retreats** encourage families to take part in daylong education sessions and group activities.
- **Support groups for families** meet weekly to provide support to family members as their loved ones complete their treatment.

### **Family Clinical Issues in IOT**

Long-suppressed anger and other negative feelings may surface during treatment. Families may also have unrealistic expectations. Counselors should provide clear information about substance abuse and treatment. Clients and family members must prepare for the possibility of relapse. The client's abstinence can resolve some family problems but also may raise new concerns about trust and how the family will be different. Common questions that family members ask include the following:



- **How do we reestablish trust?** The newly abstinent client may expect the trust of family members before they are willing to give it. Family members can agree to extend trust to the client incrementally, as the client remains abstinent.
- **How do we have fun again?** New rituals can replace ones that involved substance use.
- **What do we say to friends, neighbors, and associates?** Family members should practice appropriate responses to situations they are likely to encounter.
- **First the bottle, now the meetings. Will it ever get better?** People in recovery often immerse themselves in recovery activities. Family members should be patient.

*For more detailed information, see TIP 47, pp. 93–113, and TIP 39, Substance Abuse Treatment and Family Therapy.*

## CLINICAL ISSUES, CHALLENGES, AND STRATEGIES

### Client Retention

Counselors should strive to form good relationships with their clients. Methods to improve client retention include the following:

- **Learning the client's treatment history.** The counselor should understand why previous treatment was unsuccessful; if the client had been engaged and retained in treatment previously, the counselor should determine what made treatment appealing.
- **Using motivational techniques.** The counselor should help clients identify life goals and how substance abuse interferes with them.
- **Providing flexible schedules** to accommodate clients.
- **Using the group to engage the client.** The counselor can encourage members to discuss prior treatment experiences, even if they were negative, and call one another for support.
- **Increasing contact frequency during early treatment.** Even brief phone or e-mail contact can help clients through feelings of vulnerability and ambivalence common in early recovery.
- **Using network interventions.** Counselors should work with individuals who are invested in the client's recovery.

- **Delivering services throughout treatment.** Client dropout is more frequent during less rigorous program phases. Evening out the intensity of services can help retain clients.
- **Never giving up.** The counselor should follow up with clients who dropped out.

### **Relapse and Continued Substance Use**

Lapses are brief returns to substance use following a sustained period of abstinence. They often occur in early months of treatment and can be used as a therapeutic tool. Clients need relapse prevention strategies to stop lapses from becoming relapses. Counselors can—

- Educate clients and their families about addiction and recovery
- Conduct an early assessment of relapse triggers
- Develop a relapse prevention plan
- Provide intensive monitoring and support
- Evaluate and review all lapses
- Use behavioral contracts.

### **Substance Use by Family Members**

Substance use within the client's social network can threaten recovery. The counselor can—

- Stay alert for others using substances
- Have the family and client sign an agreement stating that substances that will not be kept or consumed in the home

- Assist in finding alternative housing
- Provide treatment information to family members.

### **Group Work Issues**

Clients are more likely to continue treatment when they feel supported by the group. TIP 41, *Substance Abuse Treatment: Group Therapy*, provides more information on therapeutic groups.

### **Developing Group Cohesion**

Cohesive groups can contribute to recovery. Counselors can create group cohesion by—

- Creating group rituals
- Instituting a program emblem
- Exploring the group's response to clients who drop out
- Encouraging identification with the program, not just the group
- Maintaining effective group size (8–12 clients).

### **Preparing Clients for Group**

Pregroup interviews allow the counselor to assess clients' treatment readiness and shape their expectations of group. Programs can also post group norms in meeting rooms.

### **Working With Ambivalent Clients**

Ambivalent clients can compromise the group's progress. The counselor can address ambivalence by discussing client behaviors individually,

by introducing theme-oriented information, or by focusing less on process and more on content. Some clients may need to be moved to another group or to individual therapy or be terminated from the program.

### ***Working With Clients Who Have Severe Mental Disorders***

Individuals with severe mental disorders may be disruptive in groups. The counselor can coordinate treatment with the client's psychiatric care provider and use the client's readiness to engage in group work as a guide for group treatment. Staff members involved in group treatment for these clients should have appropriate training and experience.

### ***Working With Disruptive Clients***

If a group member is impatient or restless or offends other members, the counselor should review the group's rules and consequences of their violation and then reassess the disruptive client's status. If necessary, the counselor can hold an individual counseling session or refer the client to a mental health professional.

### ***Working With Quiet, Withdrawn Clients***

Clients are reluctant to participate in group sessions for many reasons, including resentment at being in treatment, depression, and denial. Counselors can—

- Ask clients individually why they are reticent and discuss options
- Assess language and comprehension skills and move a client to an appropriate group
- Pair clients to encourage acceptance and participation
- Contract with a client to increase participation step by step
- Refer a client for psychiatric evaluation.

### ***Responding to Intermittent Attendance***

Clients who miss sessions may jeopardize the group's trust. The counselor should address any barriers to attendance as well as assess each client's readiness for change. If necessary, clients can be assigned to another group with which they have more in common.

### **Safety and Security**

#### ***Drug Dealers or Gang Members at the Facility***

IOT programs should post signs prohibiting loitering, drug-related activity, and unauthorized persons on site. Some clients may be reluctant to break ties with substance-using acquaintances and may need the counselor's encouragement and program's rules to end harmful associations.

#### ***Stalking, Domestic Violence, and Threats Against Clients***

IOT programs can take the following steps to ensure client and staff safety:

- Ask clients about restraining orders or threats. Staff members have a duty to warn if danger is imminent and confidentiality regulations are met. Chapter 7 of TIP 47 provides more information;
- Intervene early to deescalate potentially violent situations;
- Place violence-related information in case records and help clients create a personal safety plan. TIP 25, *Substance Abuse Treatment and Domestic Violence*, provides a sample plan;
- Require clients to sign a no-contact agreement that forbids contact with a batterer;
- Assist clients in obtaining a civil protection order; and
- Connect clients with community services that address domestic violence.

### ***Treating Violent Clients***

IOT staff can take the following steps when treating violent clients:

- Have all new clients sign a code of conduct stating that acts of violence result in termination;
- Notify supervisors and law enforcement if a threat to safety exists or a crime is being committed; and
- For clients mandated to treatment, follow steps prescribed in the agency agreement. TIP 44, *Substance Abuse Treatment for Adults in*

*the Criminal Justice System*, provides more information.

### **Clients Arriving Under the Influence of Drugs**

Arriving under the influence indicates that a substance use disorder is active and requires an alternative treatment plan. Counselors should—

- Assess the client's need for acute care or detoxification
- Review the rules with the client
- Instruct the client to return when abstinent
- Arrange for safe transportation home
- Write or call the client to invite him or her to return to treatment
- Discuss the substance use during the next session.

### **Client Privacy**

Federal confidentiality regulations do not permit providers to reveal information about a client unless the client signs a release. IOT staff members must consult a list of client-approved individuals before they—

- Acknowledge that a client is a program participant
- Share any information
- Transfer a phone call to the client
- Take a message for the client.



Clients' spouses, partners, or acquaintances may want to anonymously inform IOT providers about continued substance use. The counselor can respond by speaking with the client during individual counseling and revising the treatment plan if necessary.

### **Knowledge of HIV Status Withheld From Partner**

During treatment a counselor may learn that a client has not informed a partner of his or her HIV-positive status. The following strategies reduce this risk and maintain client confidentiality:

- Ensure that the client is aware of how HIV/AIDS is transmitted;
- Discuss feelings of fear, embarrassment, and guilt about revealing HIV status to a partner;
- Include information about HIV transmission in educational material for family members;
- Help the client and partner discuss the issue and refer the client to HIV/AIDS counseling; and
- Encourage the client to participate in a support group and provide a referral.

### **Helping Clients Balance Work and Treatment**

Individuals who enter IOT may face conflicts with work, especially if the employer is unaware that the employee is in treatment. Counselors should encourage clients to make treatment and recovery

their first priority and should be flexible with treatment schedules.

Once in treatment, clients sometimes try to make up for past actions by taking on additional tasks. Counselors should remind the client that recovery is the first priority and encourage the client to balance the activities undertaken, suggesting that there will be time to address past mistakes when recovery is solidly underway.

### **Clients, Co-Workers, and Employers**

Clients who have used substances with co-workers may find it difficult to renegotiate these relationships. Options for addressing these issues include—

- Helping the client identify circumstances that increase the risk of relapse
- Encouraging the client to distance himself or herself from co-workers who use substances
- Using role plays to practice responding to treatment questions and substance use invitations
- Encouraging the client to transfer to another work environment.

If an employer referred the client to treatment, the employer may expect information about the client's readiness to resume work duties. IOT counselors cannot determine a client's fitness for work; only the employer can determine this. With

the client's consent, counselors can inform the employer about treatment progress. Counselors can also refer the employer to drug-free workplace information available on the Internet (**www.workplace.samhsa.gov**) and negotiate with the employer for continuing treatment.

Workplace drug testing is mandatory for some private-sector workers. If one of these employees is mandated to treatment, the counselor must inform the employer in writing of assessment results and treatment recommendations.

### **Boundary Issues**

Clients and staff members become involved on intellectual, emotional, and spiritual levels. This can lead to behaviors that challenge boundaries between and among staff and clients.

### ***Clients Giving Gifts to Staff***

IOT programs should develop rules that limit gifts to items that can be shared by staff members and clients. Inappropriate gifts should be refused politely. Most programs prohibit gifts that—

- Exceed a certain value
- Are not the result of a religious or cultural tradition
- Are offered in anticipation of special treatment
- May cause confusion about the counselor–client relationship.

### **Socializing Among Clients**

Some programs encourage clients to support one another outside the program; others discourage outside contact. Most IOT programs have rules regarding dating and other client pairings that could undermine treatment.

### **Socializing Between Clients and Staff**

To safeguard the therapeutic relationship, IOT programs typically prohibit staff–client relationships outside treatment. Consequences for violations include reprimand, probation, and dismissal. In some cases, the staff member must be reported to the licensing or certification board.

### **Counselors With Dual Roles**

IOT counselors who are members of mutual-help groups must maintain boundaries between their professional life and their own recovery. A counselor cannot be a client's sponsor. Counselors should avoid meetings attended by current or former clients. If this is not possible, the counselor should avoid sharing personal issues at the meeting. Large cities have “counselor only” meetings that are not listed in directories.

*For more detailed information, see TIP 47, pp. 115–136.*

## **INTENSIVE OUTPATIENT TREATMENT APPROACHES**

IOT programs modify and blend multiple treatment approaches. Resources are on pages 137 and 138 of TIP 47.

### **12-Step Facilitation Approach**

The 12-Step facilitation approach is based on the Alcoholics Anonymous (AA) concept that alcoholism is a primary, progressive disease with biological, psychological, and spiritual features. The 12-Step facilitation approach to treatment involves helping clients understand AA principles, work through the 12 Steps, achieve abstinence, and become involved in community-based 12-Step groups. Substance use is seen as a disease marked by denial and loss of control. Group work focuses on accepting the disease and taking responsibility for recovery. Emphasis is on writing journals, reading 12-Step literature, and adopting spiritual values. Staff members who are not in recovery should familiarize themselves with 12-Step literature and with the characteristics of local meetings. The strengths and challenges of 12-Step facilitation are as follows:

- **Strengths—**

- Provides meetings that are free, widely available, supportive, and specialized

- Emphasizes an array of recovery tasks in cognitive, spiritual, and health realms
- Is effective with clients from diverse backgrounds.
- **Challenges—**
  - Can be difficult to monitor clients' compliance with assigned step tasks
  - May be difficult for some clients to accept emphasis on a higher power
  - May be difficult for small communities to support 12-Step meetings or meetings for those with co-occurring disorders.

### **Cognitive Behavioral Approach**

Cognitive behavioral therapy (CBT) is based on the theory that most emotional and behavioral reactions are learned and that new reactions can be taught to help clients maintain abstinence. Clients learn to recognize substance abuse triggers and learn strategies for counteracting them. Many CBT programs also encourage 12-Step participation. The strengths and challenges of CBT are as follows:

- **Strengths—**
  - Engages clients in therapy and learning
  - Is described in numerous manuals
  - Is suitable for diverse clients with histories of substance abuse
  - Provides structured methods for understanding and preparing for relapse triggers and situations.

- **Challenges—**

- May require adjustments for clients with poor cognitive skills
- Requires counselor training
- Requires clients be motivated to complete extensive homework assignments
- Was developed as an individual counseling approach.

### **Motivational Approaches**

Motivational approaches include motivational interviewing (MI) and motivational enhancement therapy (MET). They acknowledge that substances have rewarding properties that can disguise their hazards and long-term negative effects. MI is a directive counseling strategy designed to reduce ambivalence toward treatment. It is frequently paired with problemsolving strategies that build on past successes. In MET, counselors act as coaches rather than authority figures. They provide feedback about results on standardized assessments and discuss clients' responses to this feedback. The strengths and challenges of MI and MET are as follows:

- **Strengths—**

- Are client centered and relevant to clients' interests
- Focus on realistic goals
- Encourage self-efficacy and self-sufficiency

- Emphasize positive support that does not undermine or elicit anger from clients
- Do not require that staff members achieve specific educational levels.
- **Challenges—**
  - Rely on clients' capabilities and self-awareness
  - Are incompatible with common problem-oriented assessment instruments
  - Require staff training and supervision
  - May be difficult to combine with disease- or therapeutic community-oriented approaches that expect adherence to program-imposed rules
  - Were developed as individual approaches (their effectiveness for use with groups is unproved)
  - Do not specify session content.

### **Therapeutic Community Approach**

Therapeutic communities (TCs) use the “community as method” approach, in which the whole treatment community is the therapeutic agent. The TC model considers substance use a disorder of the whole person and recovery a developmental process entailing mutual help and social learning. Treatment is organized into phases. Many clients served by TCs have histories of severe substance use disorders and criminal behavior, so TCs strive



to habilitate, rather than rehabilitate, clients. TCs focus on all aspects of the client's life, featuring a structured day and peers who confront negative behaviors in a supportive milieu. The strengths and challenges of TC approaches are as follows:

- **Strengths—**

- Are effective for people with long histories of substance dependence and antisocial behavior
- Are effective in teaching clients how to achieve goals
- Can reduce recidivism among clients who have served time in prison.

- **Challenges—**

- May be too confrontational for some clients
- Require staff training
- Can pose difficulties for clients with co-occurring disorders
- May require time to find an effective mix of clinicians and recovering staff.

### **The Matrix Model**

The Matrix model integrates several techniques (CBT, 12-Step, MET) and emphasizes group work over individual sessions. A primary therapist or counselor coordinates the client's treatment, and the client-family relationship is critical. The following structured groups are central:

- **Early recovery groups** meet during the first month of treatment and focus on teaching clients cognitive tools for managing cravings and structuring time;
- **Family education sessions** focus on the biology of addiction, conditioning and addiction, and addiction's effects on the family;
- **Relapse prevention groups** focus on cognitive and behavioral change; and
- **Social support groups** help clients pursue drug-free activities and develop friendships not focused on drug use.

The strengths and challenges of the Matrix model are as follows:

- **Strengths—**
  - Integrates a CBT approach with family involvement, psychosocial education, 12-Step support, and urine testing
  - Follows a manual that provides specific instructions and exercises
  - Has been used widely and effectively with people dependent on stimulants.
- **Challenges—**
  - May require modification of material for clients with impaired cognitive functioning
  - Requires special staff training and supervision
  - May not appeal to all clients

- May not allow for treatment of other non-drug-specific problems.

### **Community Reinforcement and Contingency Management Approaches**

Community reinforcement (CR) and contingency management (CM) interventions are based on operant conditioning. Effective CR and CM programs use incentives (e.g., vouchers for food or entertainment) to reward clients for attaining a desired goal (e.g., having a negative drug test). Rewards are tailored to clients' responses and program capacities. More frequent reinforcers, even if small, have a greater effect than larger, more remote rewards. The strengths and challenges of CR and CM are as follows:

- **Strengths—**

- Reduce drug use significantly when incentives are used
- Combine readily with other psychosocial interventions and pharmacotherapies
- Can be implemented with low-cost incentives such as donated goods or services
- Are effective in reducing drug use and increasing treatment compliance
- Have extensive scientific support in laboratory and clinical studies.

- **Challenges—**

- May be difficult to keep clients from returning to baseline drug use rates when incentives are terminated
- Can be labor intensive and require staff training and frequent client attendance
- Require sufficiently large rewards to have continuing appeal
- Have been studied using small samples that incurred large costs for incentives
- May be difficult to acquire required resources
- Do not emphasize importance of long-term supports.

*For more detailed information, see TIP 47, pp. 137–152.*

## **ADAPTING INTENSIVE OUTPATIENT TREATMENT FOR SPECIFIC POPULATIONS**

### **Justice System Population**

The justice system population is overwhelmingly male and younger than the general population. It is also more likely than the general population to have problems related to employment and finances; housing and transportation; education; co-occurring disorders; and HIV/AIDS, tuberculosis, or hepatitis C.

Offenders who are compelled to participate in treatment include the following:

- Offenders referred to treatment in lieu of incarceration;
- Offenders discharged from residential treatment who need continuing treatment;
- Offenders who need treatment and are placed under community supervision; and
- Offenders who are incarcerated.

### ***Rules for Offenders in Treatment***

Some justice system policies and sanctions may conflict with treatment principles. IOT program staff and justice system partners must agree on consequences for alcohol use or lapses in abstinence, discharge criteria, and the use of drug-testing results.

### **Communication Between Systems**

IOT programs should designate point-of-contact personnel for all justice system referrals. Clients must sign confidentiality forms stipulating information that can be shared between systems. All agreements between the IOT program and justice system need to be formalized in a memorandum of understanding that includes the following:

- Each partner's responsibilities;
- Consequences for noncompliance;
- The types, content, and schedule of reporting; and
- Definitions of critical incidents that require the IOT program to notify the justice agency.

### **Staff Training**

Staffs in both systems need cross-training that includes each system's philosophy, approach, goals, objectives, and boundaries. Treatment providers need information about the justice system's structure, operations, and security concerns. Justice system personnel need information about substance use disorders and the components of treatment.

### **Women**

Compared with men, women usually begin substance use later and enter treatment earlier. The following issues are of particular concern when treating women:

- **Violence.** Women with substance use disorders are more likely than men to have been abused as children and more likely than other women to be victims of domestic violence;
- **Mental disorders.** Women have higher rates of psychiatric comorbidity than do men;
- **Parenting issues.** Women often are children's sole caretakers and may fear losing custody;
- **Welfare issues.** In some States, failure to participate in treatment may jeopardize benefits;
- **Pregnancy.** Substance use during pregnancy can result in neurologically damaged, low-weight, and premature babies; and
- **Relationships.** A woman's substance use often is influenced by her partner.

### ***Barriers to Treatment Entry and Retention***

Barriers that affect a woman's treatment entry and retention include fear of retribution from an abusive spouse or partner, gender insensitivity in treatment programs, lack of affordable or reliable child care, and ineligibility for treatment medications if pregnant.

### ***Entry and Assessment***

A woman entering treatment may respond better if the intake counselor is a woman. Staff members need to be patient during intake, understanding that for many women it is empowering to decide when to provide information and how much to

provide. Female clients need careful assessments for psychiatric disorders and history of childhood trauma and adult victimization.

### ***Clinical Issues and Strategies***

Women-only groups may be advantageous for female clients. Other core clinical issues that should be addressed in IOT for women include the following:

- **Relationships with family and significant others.** Provide family or couples counseling;
- **Feelings of low self-esteem and self-efficacy.** Address in group and individual counseling and identify and build on the client's strengths;
- **History of physical, sexual, and emotional abuse.** Avoid using confrontational techniques and hold individual and group therapy sessions or refer for treatment;
- **Psychiatric disorders.** Refer for or provide evaluation and treatment of psychiatric disorders, medication management, and therapy;
- **Parenting, child care, and child custody.** Hold parenting classes, develop substance abuse prevention services for children, provide or arrange licensed child care (including a nursery for young children and afterschool programs for older children), and assist with Head Start enrollment;



- **Medical problems.** Refer for medical care including reproductive health; and
- **Gender discrimination and harassment.** Ensure that the program has policies against harassment.

### ***Staff Training***

Staff members should be trained about the assessment and ramifications of sexual, physical, and emotional abuse. Staff should understand and enforce sexual harassment rules.

### **Populations With Co-Occurring Psychiatric Disorders**

Treating clients with co-occurring disorders often is complicated by the presence of interacting symptoms. Coordination between mental health and substance abuse systems is crucial. Long-term approaches seem to be more effective than short-term acute care. Clients with psychotic conditions might pose insurmountable challenges for most IOT programs.

### ***Integrated Treatment***

Integrated treatment considers both disorders to be chronic, primary, biologically based mental illnesses but assumes that comprehensive, conjoint treatment can reduce symptoms of both disorders effectively. Integrated treatment usually involves intensive case management and a long treatment period. It may not be feasible for all IOT programs.

### **Core Service Elements**

- **Screening.** All clients need to be screened for co-occurring psychiatric disorders.
- **Assessment.** Assessment should be performed by a clinician trained in both areas or by clinicians from each field as soon as it is possible to distinguish substance-induced from independent conditions.

**Treatment engagement.** Providing continuous support, assisting with immediate needs, and helping clients access services can improve client retention.

- **Treatment planning.** Psychiatric status, social support, housing, medication adherence, and symptom management must be considered when making a treatment plan.
- **Referral.** Clients with psychiatric disturbances that require secure inpatient treatment, 24-hour medical monitoring, or detoxification should be referred for appropriate care.

### **Mental Health Care**

IOT programs that serve clients with co-occurring psychiatric disorders should include mental health specialists on the treatment team. An onsite psychiatrist can overcome problems of offsite referral. Alternatively, providers can establish a working relationship with a mental health care provider. Providers can—

- Arrange appointments with a mental health care provider
- Become familiar with psychotropic medications, their indications, and side effects
- Instruct the client on the importance of complying with the medication regimen
- Report symptoms and behavior to the prescribing psychiatrist
- Use peer groups to monitor and support proper use of medication
- Monitor side effects.

### ***Modified Program Structure***

Separate treatment tracks for clients with co-occurring disorders allow clients to be grouped together to address common issues in group sessions. Using staged approaches provides successive interventions geared to the client's current stage of recovery and addresses levels of severity of the co-occurring disorders.

### ***Therapeutic Relationship***

Counselors should monitor psychiatric symptoms and assist clients in solving external problems. Because confrontational approaches may be ineffective or harmful, counselors can be assertive but remain empathic by presenting straightforwardly to the client his or her conflicting thoughts and behaviors. TIP 42, *Substance*

*Abuse Treatment for Persons With Co-Occurring Disorders*, provides more guidance.

### **Group Treatment**

Group treatment can increase abstinence rates and decrease the need for hospitalization. Groups for these clients should be small and use short sessions with focused directional techniques. Counselors should communicate in a simple, concrete, and repetitive manner and affirm accomplishments rather than use disapproval or sanctions. Examples of groups for clients with co-occurring disorders include psychoeducational groups, medication management groups, and social skills training groups.

### **Mutual-Help Groups in the Community**

Dual recovery organizations include—

- Double Trouble in Recovery (**[www.doubletroubleinrecovery.org](http://www.doubletroubleinrecovery.org)**)
- Dual Disorders Anonymous
- Dual Recovery Anonymous (**[www.draonline.org](http://www.draonline.org)**)
- Dual Diagnosis Anonymous (**[www.ddaworldwide.org](http://www.ddaworldwide.org)**).

### **Family**

Clients with co-occurring disorders often have unsatisfactory family relationships. Psychoeducational groups for family members combine information, guidance, and support.

### ***Continuing Care***

People with co-occurring disorders have two chronic conditions, often require long-term care that supports their progress, and can respond quickly to a relapse of either disorder.

### ***Cross-Training***

Cross-training helps staff members from both fields reach a common approach for treating clients with co-occurring disorders. The Mid-America Addiction Technology Transfer Center's curriculum promotes cross-disciplinary understanding. More information is at [www.mattc.org](http://www.mattc.org).

### ***Adolescents***

Adolescents experience many developmental changes and may require habilitation rather than rehabilitation. They may have short attention spans, limited future perspectives, and limited abilities to think abstractly. They may also require parental consent for treatment. Adolescents can come to IOT through parental request, school referral, or juvenile justice system mandate. Unlike adult clients, adolescents are likely to be entering treatment for the first time.

### **Assessment**

Information to gather for assessment includes—

- School records, class schedule, and school involvement
- Relationships with peers and family members
- Mental and physical health status
- History of abuse and trauma
- Involvement with the juvenile justice system.

Special attention should be paid to family assessment and should include—

- Financial and housing status
- Substance use history and treatment episodes
- Mental and physical health
- Family problems with violence
- Family involvement in the legal system
- Family strengths and resources.

Assessment for psychiatric disorders and risk of suicide is crucial. More than half of adolescents with substance use disorders also have co-occurring psychiatric disorders.

### **Family Involvement**

IOT providers treating adolescents should work with the family as much as possible. TIP 39, *Substance Abuse Treatment and Family Therapy*, provides more information. Counselors can—

- Emphasize the importance of family members in recovery

- Require that a family member accompany the adolescent to the intake interview
- Encourage family attendance at the program's family education and therapy sessions
- Have family members help develop and reinforce the behavioral contract (see below).

Family-based treatment approaches include multidimensional family therapy, multisystemic therapy, family CBT, and adolescent community reinforcement.

### ***Behavioral Contract***

The clinician works with the adolescent and the family to develop and commit to a contract that specifies treatment goals, unacceptable behaviors, and rewards and consequences. The conditions in the contract help the adolescent and the family understand the treatment process.

### ***Case Management***

When treating adolescents, case managers monitor school performance; coordinate medical health, mental health, and social services; and work with juvenile justice. Caseloads should be limited to 8 to 10 adolescents per staff member.

### ***Group Work Strategies***

Groups should consist of adolescents of the same age and gender with similar levels of motivation

for change. Structured discussions appear more successful than open-ended sessions.

### ***Clinical Considerations***

Not all adolescents who use substances are dependent. Prematurely diagnosing adolescents is counterproductive, and many adolescents respond poorly to confrontational techniques. MI, MET, and CBT models are useful. Common issues in adolescent treatment and practical suggestions for resolving them include the following:

- **Inconsistent ability for abstract thinking.** Limit abstract, future-oriented activities, use mentors, and avoid scare tactics and labels;
- **Impulsive and short attention spans.** Practice activities to teach self-control skills;
- **Vulnerability to peer influence.** Help establish positive peer groups and develop skills in resisting negative peer pressure;
- **Frequent emotional fluctuations.** Validate feelings, acknowledge pressures of adolescence, and help improve stress management skills;
- **Lack of involvement in healthy recreational activities.** Help develop daily schedules and find new recreational activities; and
- **Tendency toward pessimistic or fatalistic attitudes.** Recognize fatalist attitudes and validate anger or perceived obstacles to success but challenge clients to think positively.



### **Staff Training**

IOT program staff members need to practice empathy and set boundaries. Counselors should know what substances adolescents use as well as current slang and the effects of any new drugs. They should also have knowledge of the school system and understand family dynamics.

### **Young Adults**

Young adults may be ready for placement in an adult group. The following issues are relevant:

- **Education and employment.** Educational and job skill levels need to be addressed;
- **Family roles.** Some clients may have family responsibilities and need assistance with child care and parenting skills;
- **Separating from parents.** Young adults often require life skills development;
- **Peer relationships.** Some clients may need help in developing healthy peer networks;
- **Mentoring.** Positive adult role models can provide meaningful examples; and
- **Community service.** Young adults in treatment should be encouraged to participate in community or faith-based events.

*For more detailed information, see TIP 47, pp. 153–177.*

## **ADDRESSING DIVERSE POPULATIONS**

Treatment providers increasingly serve diverse populations. Treating a client from outside the prevailing U.S. culture involves understanding the client's culture and mediating among it, U.S. culture, and the treatment culture.

### **What It Means To Be Culturally Competent**

The Surgeon General's report *Mental Health: Culture, Race, and Ethnicity* concludes that the gap between research and practice is worse for minorities than for the general public. The culturally competent provider is responsible for ensuring that treatment is effective for diverse clients. Information on diverse populations can be found in the resources listed in appendix 10-A of TIP 47.

### **Delivering Culturally Competent IOT Services**

Cultural observations that may be accurate when applied to a group can be misleading and harmful when applied to an individual. Clinicians should seek a balance between understanding clients in the context of their culture and seeing clients as merely an extension of their culture.

### **Differences in Worldview**

U.S. culture tends to be more materialistic and places greater value on individual achievement

and being future oriented than other cultures. Other cultural issues include the following:

- **Holistic worldview.** Many cultures see all of nature as an intertwined whole. Becoming healthy entails reconnecting with the larger universe;
- **Spirituality.** Spiritual beliefs should be recognized;
- **Community orientation.** Many cultures are oriented to the collective good of the group;
- **Extended families.** IOT programs must employ a flexible definition of family;
- **Communication styles.** Cultural misunderstandings can be misinterpreted as personal violations of trust or respect and can prevent clients from receiving appropriate care;
- **Multidimensional learning styles.** Many cultures do not believe that written information is more reliable than oral information. The authority of the speaker may be of great importance;
- **Respect and dignity.** Treating others in an informal, friendly way—which is acceptable in the United States—may be viewed by other cultures as disrespectful; and
- **Attitudes toward help from counselors.** Many cultures prefer to handle problems within the extended family and may be reluctant to accept help from a therapist.

### ***Foreign-Born Clients***

Refugees often have experienced severe trauma before arriving in the United States. Other clinical issues include mistrust of authority, extreme stigma, and the client's level of acculturation. IOT providers can better serve foreign-born clients by visiting community refugee and immigrant organizations. Providers can also set up IOT groups in the immigrants' native language. Language-specific programs should—

- Translate or adapt program documents and contact information
- Address important issues faced by immigrants
- Use general terminology, avoiding words that are difficult to understand or translate
- Familiarize clients with the existence of social and educational services
- Make English-language services available to clients who are motivated to learn English.

### ***Women From Other Cultures***

Immigrant women face the same barriers that American women face but have the added barrier of being cultural outsiders. Women raised in male-dominated cultures are often passive and selfless. Counselors may want to push women toward independence but should be aware that this may not be personally or culturally desirable. Effective treatment programs seek to enhance women's economic autonomy. Other services

should include domestic violence intervention, multidisciplinary meetings with caregivers, and parenting classes.

### ***Religious Orientation***

IOT providers must ensure that their program welcomes people from all faiths and that no treatment practices are a barrier to those from non-Christian religions. Providers can promote religious acceptance within the program by learning religious customs and seeking support from religious leaders.

### **Clinical Implications of Culturally Competent Treatment**

To ensure culturally competent treatment, a program should—

- Assess its policies posing barriers to treating diverse populations
- Ensure that staff receive training in the cultural beliefs of client populations
- Incorporate clients' family and friends into treatment
- Provide appropriate program materials in clients' first languages
- Hire staff and board members from the diverse groups the program serves
- Incorporate elements from the culture of the populations being served

- Partner with agencies and groups that deliver community services
- Use a motivational framework for treatment.

For demographic sketches of the following populations, see pages 189–196 in TIP 47:

- Hispanics/Latinos;
- African Americans;
- Native Americans;
- Asian Americans and Pacific Islanders;
- Persons with HIV/AIDS;
- Lesbian, gay, and bisexual clients;
- Persons with physical and cognitive disabilities;
- Rural populations;
- Homeless populations; and
- Older adults.

*For more detailed information, see TIP 47, pp. 179–204.*

# Ordering Information

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## TIP 47

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

#### TIP 47-RELATED PRODUCTS

KAP Keys for Clinicians Based on TIP 47

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3. Access TIPs online at **[www.kap.samhsa.gov](http://www.kap.samhsa.gov)**.



## **Other Treatment Improvement Protocols (TIPs) that are relevant to this Quick Guide:**

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**TIP 25:** *Substance Abuse Treatment and Domestic Violence* (1997) **BKD239**

**TIP 31:** *Screening and Assessing Adolescents for Substance Use Disorders* (1999) **BKD306**

**TIP 32:** *Treatment of Adolescents With Substance Use Disorders* (1999) **BKD307**

**TIP 39:** *Substance Abuse Treatment and Family Therapy* (2004) **BKD504**

**TIP 41:** *Substance Abuse Treatment: Group Therapy* (2004) **BKD507**

**TIP 45:** *Detoxification and Substance Abuse Treatment* (2006) **BKD541**

**TIP 46:** *Substance Abuse: Administrative Issues in Outpatient Treatment* (2006) **BKD545**

See the inside back cover for ordering information for all TIPs and related products.