SUBSTANCE USE AND ADDICTION DISORDERS:

Part 3: Treatment And Goals Of Therapy

Introduction

In multiple substance use disorders, the treatment plan and length of the detoxification phase may vary. Previously, in this four-part series on Substance Use And Addiction Disorders it has been well established that each individual with a substance use disorder requires a personalized treatment plan according to his or her unique medical, psychiatric, and substance use history. Multiple substance users require treatment for all of the substances that they use. The treatment plan will need to consider the type of substances used, the severity of withdrawal and history of relapses, and the resources available to patients within their own family or social support network, at various levels of inpatient and outpatient treatment programs and within the community.

Due to the use of multiple substances and the frequent presence of comorbid physical and mental conditions, treatment must incorporate a number of components. The primary goals of substance use treatment are to help patients cease drug use, maintain recovery, and reach a level of productive functioning within their family and society. Multiple substance use is a complex problem that cannot be addressed by one standard treatment protocol.
Treatment Overview

In an effective treatment program, each component of the treatment program needs to address a particular aspect of the substance use condition and/or comorbid conditions. Treatment must be continuous and flexible to ensure that the patient does not resume substance use. Unfortunately, many patients do not seek or adhere to treatment. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health (NSDUH), 23.2 million persons (9.4 percent of the U.S. population) aged 12 or older needed treatment for an illicit drug or alcohol use problem in 2007. Of these individuals, 2.4 million (10.4 percent of those who needed treatment) received treatment at a specialty facility (i.e., hospital, drug or alcohol rehabilitation or mental health center). Thus, 20.8 million persons (8.4 percent of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive it. These estimates are similar to those in previous years.60

Effective treatment programs can be highly successful in helping patients cease drug use and maintain sobriety. The basis of an effective treatment program includes the following components or concepts:61

- Addiction is a complex but treatable disease that affects brain function and behavior.
- No single treatment is appropriate for everyone.
- Treatment needs to be readily available.
• Effective treatment attends to multiple needs of the individual, not just an issue of substance use.
• Remaining in treatment for an adequate period of time is critical.
• Counseling — individual and/or group — and other behavioral therapies are the most commonly used forms of substance use treatment.
• Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
• An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.
• Many individuals addicted to substances also have other mental disorders.
• Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term substance use.
• Treatment does not need to be voluntary to be effective.
• Substance use during treatment must be monitored continuously, as lapses during treatment do occur.
• Treatment programs should assess patients for the presence of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk/reduction counseling to help patients modify or change behaviors that place them at risk of contracting or spreading infectious diseases.
The specific treatment approach used will depend on the types of substances the patient is using regularly. Some substances may require extended, medically assisted detoxification, while others may benefit from medication-assisted therapy. Therefore, the clinician must work with each patient to identify the specific approach needed.

Medication and behavioral therapy are key elements in many treatment programs. The process typically begins with detoxification, followed by behavioral therapy and medication assisted treatment. A continuum of care that includes a customized treatment regimen — addressing all aspects of an individual's life, including medical and mental health services — and follow-up options (i.e., community - or family-based recovery support systems) can be crucial to a person's success in achieving and maintaining a lifestyle free of substance use.

**Medication Assisted Treatment**

Medication Assisted Treatment (MAT) is used in conjunction with counseling and behavioral therapy to treat all aspects of the substance use. Like other treatments, MAT is individualized based upon the specific needs of the patient and will only be used after the patient has received a full assessment. MAT is most commonly used to treat patients with opioid addictions. However, in some instances, it is also used to treat alcohol or other substance use disorders. MAT is also used to treat comorbid conditions, especially mental illness. The Department of Mental Health regulates the use of MAT. The following are lists of the most common medications used to treat specific substance use and addiction.

*General Substance Use:*
• Acamprosate
• Buprenorphine
• Disulfiram
• Naltrexone
• Suboxone
• Vivitrol

**Alcohol Use:**

• Disulfiram (Antabuse)
• Naltrexone (ReVia)
• Acamprosate (Campral)

**Opiate Use:**

• Methadone
• Levo-alpha Acetyl Methadol (LAAM)
• Buprenorphine

In addition to serving as a replacement for the substance abstained from, medications have a variety of other uses in various phases of substance use treatment programs. The following table provides a thorough overview of each phase of treatment.\(^6\)

| Withdrawal | Medications offer help in suppressing withdrawal symptoms during detoxification. However, medically assisted detoxification is not in itself "treatment" — it is only the first step in the treatment process. Patients who go through medically assisted withdrawal but do not receive any further treatment show drug use patterns similar to those who were never treated. |
Medications to manage withdrawal take advantage of cross-tolerance to replace the drug being used with another and safer drug in the same class. The latter can then be gradually tapered until physiologic homeostasis is restored.

Benzodiazepines are frequently used to alleviate alcohol withdrawal symptoms, and methadone to manage opioid withdrawal, although buprenorphine and clonidine are also used. Numerous drugs such as buprenorphine and amantadine and desipramine hydrochloride have been tried with cocaine users experiencing withdrawal, but their efficacy is not established. Acute opioid intoxication with marked respiratory depression or coma can be fatal and requires prompt reversal, using naloxone. However, if a patient is physically addicted to opioids, naloxone will precipitate withdrawal symptoms.

**Discourage Substance Use**

Medications to discourage substance use precipitate an unpleasant reaction or diminish the euphoric effects of alcohol and other drugs. Disulfiram (Antabuse), the best known of these agents, inhibits the activity of the enzyme that metabolizes a major metabolite of alcohol, resulting in the accumulation of toxic levels of acetaldehyde and numerous highly unpleasant side effects such as flushing, nausea, vomiting, hypotension, and anxiety.

More recently, the narcotic antagonist, naltrexone, has also been found to be effective in reducing relapse to alcohol use, apparently by blocking the subjective effects of the first drink. Naltrexone also is used with well-motivated, drug-free opioid addicts to block the effects of usual street doses of heroin or morphine derivatives. Naltrexone keeps opioids from occupying receptor sites, thereby inhibiting their euphoric effects.

Antidipsotropic agents, such as disulfiram, and blocking agents, such as naltrexone, are only useful as an adjunct to other
<table>
<thead>
<tr>
<th><strong>Agonist Substitution Therapy</strong></th>
<th>treatment, particularly as motivators for relapse prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opioids:</strong></td>
<td>Agonist substitution therapy replaces an illicit drug with a prescribed medication.</td>
</tr>
<tr>
<td>Methadone, buprenorphine and, for some individuals, naltrexone are effective medications for the treatment of opiate addiction. Acting on the same targets in the brain as heroin and morphine, methadone and buprenorphine suppress withdrawal symptoms and relieve cravings. Naltrexone works by blocking the effects of heroin or other opioids at their receptor sites and should only be used in patients who have already been detoxified. Because of compliance issues, naltrexone is not as widely used as the other medications. All medications help patients disengage from drug seeking and related criminal behavior and become more receptive to behavioral treatments.</td>
<td></td>
</tr>
<tr>
<td><strong>Tobacco:</strong></td>
<td>A variety of formulations of nicotine replacement therapies now exist — including the patch, spray, gum, and lozenges — that are available over the counter. In addition, two prescription medications have been FDA–approved for tobacco addiction: bupropion and varenicline. They have different mechanisms of action in the brain, but both help prevent relapse in people trying to quit. Each of the above medications is recommended for use in combination with behavioral treatments, including group and individual therapies, as well as telephone quit lines.</td>
</tr>
<tr>
<td><strong>Alcohol:</strong></td>
<td>Three medications have been FDA–approved for treating an alcohol use and addiction disorder: naltrexone, acamprosate, and disulfiram. A fourth, topiramate, is showing encouraging</td>
</tr>
</tbody>
</table>
results in clinical trials. Naltrexone blocks opioid receptors that are involved in the rewarding effects of drinking and in the craving for alcohol. It reduces relapse to heavy drinking and is highly effective in some but not all patients — this is likely related to genetic differences. *Acamprosate* is thought to reduce symptoms of protracted withdrawal, such as insomnia, anxiety, restlessness, and dysphoria (an unpleasant or uncomfortable emotional state, such as depression, anxiety, or irritability). It may be more effective in patients with a severe substance use and addiction disorder.

*Disulfiram* interferes with the degradation of alcohol, resulting in the accumulation of acetaldehyde, which, in turn, produces a very unpleasant reaction that includes flushing, nausea, and palpitations if the patient drinks alcohol. Compliance can be a problem, but among patients who are highly motivated, disulfiram can be very effective.

| **Comorbid Psychiatric Conditions** |
|-----------------------------------|---|
| Medications to treat comorbid psychiatric conditions are an essential adjunct to substance use treatment for patients diagnosed with both a substance use disorder and a psychiatric disorder. Prescribing medication for these patients requires extreme caution, partly due to difficulties in making an accurate differential diagnosis and partly due to the dangers of intentional or unintentional overdose if the patient combines medications with substances being used or takes higher than prescribed doses of psychotropic medications. |
| Since there is a high prevalence of comorbid psychiatric disorders among people with a substance use disorder, pharmacotherapy directed at these conditions is often indicated (*i.e.*, lithium or other mood stabilizers for patients with confirmed bipolar disorder, neuroleptics for patients with schizophrenia, and antidepressants for patients with major or atypical depressive disorder). |
In the absence of a confirmed psychiatric diagnosis, it is unwise for primary care clinicians and other physicians in substance use treatment programs to prescribe medications for insomnia, anxiety, or depression (especially benzodiazepines with a high use and addiction potential) to patients who have alcohol or other drug disorders. Even with a confirmed psychiatric diagnosis, patients with substance use disorders should be prescribed drugs with a low potential for: (1) lethality in overdose situations, (2) exacerbation of the effects of the used substance, and (3) substance use itself.

Selective serotonin reuptake inhibitors (SSRIs) for depressive disorders and buspirone for anxiety disorders are examples of psychoactive drugs with low addiction potential. Medications with a low potential to develop into a substance use and addiction disorder should also be dispensed in limited amounts and be closely monitored. Because prescribing psychotropic medications for patients with dual diagnoses is clinically complex, a conservative and sequential three-stage approach is recommended.

For a person with both anxiety disorder and alcohol use, for example, nonpsychoactive alternatives such as exercise, biofeedback, or stress reduction techniques should be tried first. If these are not effective, nonpsychoactive drugs such as buspirone (or SSRIs for depression) should be administered. Only if these do not alleviate symptoms and complaints should psychoactive medications be provided.

Proper prescribing practices for these dually diagnosed patients encompass the following six "Ds" (adapted from Landry, et al., 1991):

1. **Diagnosis** is essential and should be confirmed by a careful history, thorough examination, and appropriate tests before prescribing psychotropic medications.
Patients with substance use disorders should be evaluated for anxiety disorders and, conversely, those with anxiety disorders evaluated for substance use or addiction rather than just treating presenting symptoms.

2. **Dosage** must be appropriate for the diagnosis and the severity of the problem, without over- or under-medicating. If high doses are needed, these should be administered daily in the office to ensure compliance with the prescribed amount.

3. **Duration** should not be longer than recommended in the package insert or the Physician's Desk Reference (PDR) so that additional use and potential for addiction can be avoided.

4. **Discontinuation** must be considered if there are complications (*i.e.*, toxicity or substance use disorder/addiction), at the expiration of the planned trial, if the original crisis abates, or when the patient learns and accepts alternative coping strategies.

5. **Dependence**, while the term ‘dependence’ is no longer recommended by DSM-5, is a 5th stage in Landry’s prescribing practices where the clinician is alerted to watch for the developing stages of an addiction disorder, such as any cravings or risky use, which must be continuously monitored. The clinician also should warn the patient of this possibility and the need to make decisions regarding whether the condition warrants toleration of risky use and signs of a substance use disorder.

6. **Documentation** is critical to ensure a record of the presenting complaints, the diagnosis, the course of
Medications can be used to help reestablish normal brain function and to prevent relapse and diminish cravings. Medications for opioids (heroin, morphine), tobacco (nicotine), and alcohol addiction are available and others are being developed to treat stimulant (cocaine, methamphetamine) and cannabis (marijuana) addiction. Substance users require treatment for all of the substances that they use.

Medication Assisted Treatment is especially common in the treatment of opioid addiction. Therefore, when a patient with a multiple substance use disorder discloses regular use of opioids, MAT should be considered as an element of the treatment program. Research shows that patients who utilize MAT for opioid addiction have a lower incidence of relapse and are more likely to maintain recovery. When MAT is used to treat opioid addiction, the programs require strict regulations and continuous monitoring. Therefore, federal regulations have been developed that outline the specific procedures opioid treatment facilities must follow when dispensing medication to patients. The federal regulations for opioid treatment, while not entirely aligned with the terminology of DSM-5, are necessary for clinicians to know and are outlined in the table below:

<table>
<thead>
<tr>
<th>FEDERAL OPIOID TREATMENT PROGRAM (OTP) STANDARDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid treatment programs (OTPs) must provide treatment in accordance with the standards listed here, and must comply with these standards as a condition of certification.</td>
</tr>
<tr>
<td>Administrative and organizational structure:</td>
</tr>
<tr>
<td>An OTP's organizational structure and facilities shall be adequate to ensure quality</td>
</tr>
</tbody>
</table>
patient care and to meet the requirements of all pertinent Federal, State, and local laws and regulations. At a minimum, each OTP shall formally designate a program sponsor and medical director.

The program sponsor shall agree on behalf of the OTP to adhere to all requirements set forth in this part and any regulations regarding the use of opioid agonist treatment medications in the treatment of opioid addiction, which may be promulgated in the future. The medical director shall assume responsibility for administering all medical services performed by the OTP. In addition, the medical director shall be responsible for ensuring that the OTP is in compliance with all applicable Federal, State, and local laws and regulations.

Continuous quality improvement:

(1) An OTP must maintain current quality assurance and quality control plans that include, among other things, annual reviews of program policies and procedures and ongoing assessment of patient outcomes.

(2) An OTP must maintain a current “Diversion Control Plan” or “DCP” as part of its quality assurance program that contains specific measures to reduce the possibility of diversion of controlled substances from legitimate treatment use and that assigns specific responsibility to the medical and administrative staff of the OTP for carrying out the diversion control measures and functions described in the DCP.

Staff credentials:

Each person engaged in the treatment of opioid addiction must have sufficient education, training, and experience, or any combination thereof, to enable that person to perform the assigned functions.

All physicians, nurses, and other licensed professional care providers, including addiction counselors, must comply with the credentialing requirements of their respective professions.

Patient admission criteria:

(1) Maintenance treatment:

An OTP shall maintain current procedures designed to ensure that patients
are admitted to maintenance treatment by qualified personnel who have
determined, using accepted medical criteria such as those listed in the
Diagnostic and Statistical Manual for Mental Disorders, that the person is
currently addicted to an opioid drug, and that the person became addicted
at least 1 year before admission for treatment.

In addition, a program physician shall ensure that each patient voluntarily
chooses maintenance treatment and that all relevant facts concerning the
use of the opioid drug are clearly and adequately explained to the patient,
and that each patient provides informed written consent to treatment.

(2) Maintenance treatment for persons under age 18:

A person under 18 years of age is required to have had two documented
unsuccessful attempts at short-term detoxification or drug-free treatment
within a 12-month period to be eligible for maintenance treatment.
No person under 18 years of age may be admitted to maintenance
treatment unless a parent, legal guardian, or responsible adult designated
by the relevant State authority consents in writing to such treatment.

(3) Maintenance treatment admission exceptions:

If clinically appropriate, the program physician may waive the requirement
of a 1-year history of addiction under paragraph (e)(1) of this section, for
patients released from penal institutions (within 6 months after release),
for pregnant patients (program physician must certify pregnancy), and for
previously treated patients (up to 2 years after discharge).

(4) Detoxification treatment:

An OTP shall maintain current procedures that are designed to ensure that
patients are admitted to short- or long-term detoxification treatment by
qualified personnel, such as a program physician, who determines that
such treatment is appropriate for the specific patient by applying
established diagnostic criteria. Patients with two or more unsuccessful
detoxification episodes within a 12-month period must be assessed by
the OTP physician for other forms of treatment. A program shall not
admit a patient for more than two detoxification treatment episodes in one year.

Required services:

(1) General:
OTPs shall provide adequate medical, counseling, vocational, educational, and other assessment and treatment services. These services must be available at the primary facility, except where the program sponsor has entered into a formal, documented agreement with a private or public agency, organization, practitioner, or institution to provide these services to patients enrolled in the OTP. The program sponsor, in any event, must be able to document that these services are fully and reasonably available to patients.

(2) Initial medical examination services:
OTPs shall require each patient to undergo a complete, fully documented physical evaluation by a program physician or a primary care physician, or an authorized healthcare professional under the supervision of a program physician, before admission to the OTP. The full medical examination, including the results of serology and other tests, must be completed within 14 days following admission.

(3) Special services for pregnant patients:
OTPs must maintain current policies and procedures that reflect the special needs of patients who are pregnant. Prenatal care and other gender specific services or pregnant patients must be provided either by the OTP or by referral to appropriate healthcare providers.

(4) Initial and periodic assessment services:
Each patient accepted for treatment at an OTP shall be assessed, initially and periodically, by qualified personnel to determine the most appropriate combination of services and treatment. The initial assessment must include preparation of a treatment plan that includes the patient’s short-term goals and the tasks the patient must perform to complete the short-
term goals; the patient's requirements for education, vocational rehabilitation, and employment; and the medical, psychosocial, economic, legal, or other supportive services that a patient needs. The treatment plan also must identify the frequency with which these services are to be provided.

The plan must be reviewed and updated to reflect that patient's personal history, his or her current needs for medical, social, and psychological services, and his or her current needs for education, vocational rehabilitation, and employment services.

(5) Counseling services:

(i) OTPs must provide adequate substance abuse counseling to each patient as clinically necessary. This counseling shall be provided by a program counselor, qualified by education, training, or experience to assess the psychological and sociological background of patients, to contribute to the appropriate treatment plan and to monitor patient progress.

(ii) OTPs must provide counseling on preventing exposure to, and the transmission of, human immunodeficiency virus (HIV) disease for each patient admitted or readmitted to maintenance or detoxification treatment.

(iii) OTPs must provide directly, or through referral to adequate and reasonably accessible community resources, vocational rehabilitation, education, and employment services for patients who either request such services or who have been determined by the program staff to be in need of such services.

(6) Drug abuse testing services:

OTPs must provide adequate testing or analysis for drugs of abuse, including at least eight random drug abuse tests per year, per patient in maintenance treatment, in accordance with generally accepted clinical practice. For patients in short-term detoxification treatment, the OTP shall perform at least one initial drug abuse test. For patients receiving long-term detoxification treatment, the program shall perform initial and
monthly random tests on each patient.

**Recordkeeping and patient confidentiality:**

(1) OTPs shall establish and maintain a recordkeeping system that is adequate to document and monitor patient care. This system is required to comply with all Federal and State reporting requirements relevant to opioid drugs approved for use in treatment of opioid addiction. All records are required to be kept confidential in accordance with all applicable Federal and State requirements.

(2) OTPs shall include, as an essential part of the recordkeeping system, documentation in each patient's record that the OTP made a good faith effort to review whether or not the patient is enrolled any other OTP. A patient enrolled in an OTP shall not be permitted to obtain treatment in any other OTP except in exceptional circumstances.

If the medical director or program physician of the OTP in which the patient is enrolled determines that such exceptional circumstances exist, the patient may be granted permission to seek treatment at another OTP, provided the justification for finding exceptional circumstances is noted in the patient's record both at the OTP in which the patient is enrolled and at the OTP that will provide the treatment.

**Medication administration, dispensing, and use:**

1) OTPs must ensure that opioid agonist treatment medications are administered or dispensed only by a practitioner licensed under the appropriate State law and registered under the appropriate State and Federal laws to administer or dispense opioid drugs, or by an agent of such a practitioner, supervised by and under the order of the licensed practitioner. This agent is required to be a pharmacist, registered nurse, or licensed practical nurse, or any other healthcare professional authorized by Federal and State law to administer or dispense opioid drugs.
2) OTPs shall use only those opioid agonist treatment medications that are approved by the Food and Drug Administration under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) for use in the treatment of opioid addiction. In addition, OTPs who are fully compliant with the protocol of an investigational use of a drug and other conditions set forth in the application may administer a drug that has been authorized by the Food and Drug Administration (FDA) under an investigational new drug application under section 505(i) of the Federal Food, Drug, and Cosmetic Act for investigational use in the treatment of opioid addiction. Currently the following opioid agonist treatment medications will be considered to be approved by the FDA for use in the treatment of opioid addiction:

(i) Methadone;
(ii) Levomethadyl acetate (LAAM); and
(iii) Buprenorphine and buprenorphine combination products that have been approved for use in the treatment of opioid addiction.

3) OTPs shall maintain current procedures that are adequate to ensure that the following dosage form and initial dosing requirements are met:

(i) Methadone shall be administered or dispensed only in oral form and shall be formulated in such a way as to reduce its potential for parenteral abuse.

(ii) For each new patient enrolled in a program, the initial dose of methadone shall not exceed 30 milligrams and the total dose for the first day shall not exceed 40 milligrams, unless the program physician documents in the patient's record that 40 milligrams did not suppress opiate abstinence symptoms.

4) OTPs shall maintain current procedures adequate to ensure that each opioid agonist treatment medication used by the program is administered and dispensed in accordance with its approved product labeling. Dosing and administration decisions shall be made by a program physician familiar with the most up-to-date product labeling. These procedures must ensure that any significant deviations from the approved labeling, including deviations with regard to dose, frequency, or the conditions of use
described in the approved labeling, are specifically documented in the patient's record.

(i) Unsupervised or “take-home” use. To limit the potential for diversion of opioid agonist treatment medications to the illicit market, opioid agonist treatment medications dispensed to patients for unsupervised use shall be subject to the following requirements.

(1) Any patient in comprehensive maintenance treatment may receive a single take-home dose for a day that the clinic is closed for business, including Sundays and State and Federal holidays.

(2) Treatment program decisions on dispensing opioid treatment medications to patients for unsupervised use beyond that set forth in paragraph (i)(1) of this section, shall be determined by the medical director.

In determining which patients may be permitted unsupervised use, the medical director shall consider the following take-home criteria in determining whether a patient is responsible in handling opioid drugs for unsupervised use.

i) Absence of recent abuse of drugs (opioid or nonnarcotic), including alcohol;

ii) Regularity of clinic attendance;

iii) Absence of serious behavioral problems at the clinic;

iv) Absence of known recent criminal activity, e.g., drug dealing;

v) Stability of the patient's home environment and social relationships;

vi) Length of time in comprehensive maintenance treatment;

vii) Assurance that take-home medication can be safely stored within the patient's home; and

viii) Whether the rehabilitative benefit the patient derived from decreasing the frequency of clinic attendance
outweighs the potential risks of diversion.

(3) Such determinations and the basis for such determinations consistent with the criteria outlined in paragraph (i)(2) of this section shall be documented in the patient's medical record. If it is determined that a patient is responsible in handling opioid drugs, the following restrictions apply:

i) During the first 90 days of treatment, the take-home supply (beyond that of paragraph (i)(1) of this section) is limited to a single dose each week and the patient shall ingest all other doses under appropriate supervision as provided for under the regulations in this subpart.

ii) In the second 90 days of treatment, the take-home supply (beyond that of paragraph (i)(1) of this section) is two doses per week.

iii) In the third 90 days of treatment, the take-home supply (beyond that of paragraph (i)(1) of this section) is three doses per week.

iv) In the remaining months of the first year, a patient may be given a maximum 6-day supply of take-home medication.

v) After 1 year of continuous treatment, a patient may be given a maximum 2-week supply of take-home medication.

vi) After 2 years of continuous treatment, a patient may be given a maximum one-month supply of take-home medication, but must make monthly visits.

(4) No medications shall be dispensed to patients in short-term detoxification treatment or interim maintenance treatment for unsupervised or take-home use.

(5) OTPs must maintain current procedures adequate to identify the theft or diversion of take-home medications, including labeling containers with the OTP's name, address, and telephone number. Programs also must ensure that take-home supplies are packaged.
in a manner that is designed to reduce the risk of accidental ingestion, including child-proof containers.

*Interim maintenance treatment*

1. The program sponsor of a public or nonprofit private OTP may place an individual, who is eligible for admission to comprehensive maintenance treatment, in interim maintenance treatment if the individual cannot be placed in a public or nonprofit private comprehensive program within a reasonable geographic area and within 14 days of the individual's application for admission to comprehensive maintenance treatment. An initial and at least two other urine screens shall be taken from interim patients during the maximum of 120 days permitted for such treatment. A program shall establish and follow reasonable criteria for establishing priorities for transferring patients from interim maintenance to comprehensive maintenance treatment. These transfer criteria shall be in writing and shall include, at a minimum, a preference for pregnant women in admitting patients to interim maintenance and in transferring patients from interim maintenance to comprehensive maintenance treatment. Interim maintenance shall be provided in a manner consistent with all applicable Federal and State laws, including sections 1923, 1927(a), and 1976 of the Public Health Service Act (21 U.S.C. 300x-23, 300x-27(a), and 300y-11).

2. The program shall notify the State health officer when a patient begins interim maintenance treatment, when a patient leaves interim maintenance treatment, and before the date of mandatory transfer to a comprehensive program, and shall document such notifications.

3. SAMHSA may revoke the interim maintenance authorization for programs that fail to comply with the provisions of this paragraph (j). Likewise, SAMHSA will consider revoking the interim maintenance authorization of a program if the State in which the program operates is not in compliance with the provisions of § 8.11(g).

4. All requirements for comprehensive maintenance treatment apply to interim maintenance treatment with the following exceptions:
(i) The opioid agonist treatment medication is required to be administered daily under observation;
(ii) Unsupervised or “take-home” use is not allowed;
(iii) An initial treatment plan and periodic treatment plan evaluations are not required;
(iv) A primary counselor is not required to be assigned to the patient;
(v) Interim maintenance cannot be provided for longer than 120 days in any 12-month period; and
(vi) Rehabilitative, education, and other counseling services described in paragraphs (f)(4), (f)(5)(i), and (f)(5)(iii) of this section are not required to be provided to the patient.

Multiple Substance Use And Mental Health

Patients who are afflicted with multiple substance use disorders and mental health disorders will require treatment that can address both conditions. In the addiction field, there are three treatment approaches that can be used with these patients: sequential, parallel, and integrated treatment. There are advantages and disadvantages to each form of treatment. Therefore, the clinician will need to identify factors such as dual disorder combinations, symptom presence and severity, and types of substances being used prior to determining which treatment approach to use (as outlined in the table below).65

| **Sequential Treatment** | The first and historically most common model of dual disorder treatment is sequential treatment. In this model of treatment, the patient is treated through one system (addiction or mental health) and then through the other. Indeed, some clinicians believe that addiction treatment must always be initiated first, and that the individual must be in a stage of abstinent recovery from addiction before treatment for the psychiatric disorder can begin. On the other hand, other clinicians believe that treatment for the |
psychiatric disorder should begin prior to the initiation of abstinence and addiction treatment. Still other clinicians believe that symptom severity at the time of entry to treatment should dictate whether the individual is treated in a mental health setting or an addiction treatment setting or that the disorder that emerged first should be treated first.

The term sequential treatment describes the serial or non-simultaneous participation in both mental health and addiction treatment settings. For example, a person with dual disorders may receive treatment at a community mental health center program during occasional periods of depression and attend a local substance treatment program following infrequent alcoholic binges. Systems that have developed serial treatment approaches generally incorporate one of the above orientations toward the treatment of patients with dual disorders.

| Parallel Treatment | A related approach involves parallel treatment: the simultaneous involvement of the patient in both mental health and addiction treatment settings. For example, an individual may participate in substance education and drug refusal classes at an addiction treatment program, participate in a 12-step group such as Alcoholics Anonymous (AA), and attend group therapy and medication education classes at a mental health center. Both parallel and sequential treatment involves the utilization of existing treatment programs and settings. Thus, mental health clinicians provide mental health treatment, and addiction treatment clinicians provide addiction treatment. Coordination between settings is quite variable. |

| Integrated Treatment | Integrated Treatment is an approach that combines elements of both mental health and addiction treatment into a unified and comprehensive treatment program for patients with dual disorders. Ideally, integrated treatment involves clinicians cross-trained in both mental health and addiction, as well as a unified case |
management approach, making it possible to monitor and treat patients through various psychiatric and substance crises.

### Treatment Process

Substance use treatment is an ongoing process that requires continuous monitoring and regular adjustment. The following components of treatment should all be included in a thorough treatment program:

- Repeating assessments to evaluate a patient's changing medical, psychological, social, vocational, educational, and recreational needs, especially as more basic and acute deficits or crises are resolved and new problems emerge or become amenable to treatment. For example, homelessness or acute withdrawal symptoms will need to be treated before family interactions can be identified or resolved. Suicidal thoughts or actions will need prompt attention whenever they emerge.

- Developing a comprehensive treatment plan that clearly reflects all identified problems, has explicit goals and strategies for their attainment, and specifies techniques and services to be provided by designated specialists at particular frequencies or intensities.

- Monitoring progress and clinical status is through written notes or reports that describe responses to treatment approaches and outcomes of services provided, including counseling sessions, group meetings, urine or other biological testing, physical examinations, administered medications, and referrals for other care. Each patient should have an individual treatment record.
that includes all appropriate materials yet maintain the patient's privacy.

- Establishing a therapeutic alliance with an empathic primary therapist or counselor who can gain the confidence and trust of the patient and significant others or family members and take responsibility for continuity of care. This is particularly important in the early stages of treatment to prevent dropout and encourage participation.
- Providing education to help the patient and designated others understand the diagnosis, the etiology and prognosis for the disorder, and the benefits and risks of anticipated treatment(s). Patients with special problems will need more extensive information. As with other medical treatments, informed consent to potentially risky procedures should always be obtained.

**Treatment Setting**

A treatment setting is the place or environment where substance use treatment services are provided. These environments may look very different to the outside observer and range from most restrictive to least restrictive. A restrictive environment refers to the degree of physical and social structure provided by the professional staff for the recovering substance user. For example, a highly restrictive environment would be considered a locked, inpatient hospital setting where clients are encouraged to live and receive their treatment. The DSM-5 descriptor category of severe would be used for individuals in restrictive settings that have been classified with a substance use disorder. In contrast, a weekly voluntary outpatient substance use
treatment program would be considered a setting of less restriction where clients generally reside in their homes and attend scheduled meetings with professionals at designated agencies, offices, churches, and/or treatment facilities. A moderate category would be used in these cases.\textsuperscript{67}

Clients fall within a range of diagnoses and severity of illness. In general, the more severe the substance use disorder diagnosis, the more restricted the environment or setting that is recommended. Therefore, clients need settings that match their diagnosis and descriptor category for treatment to be effective. Selection of a treatment setting is similar to the manner in which health providers prescribe different medications, medication strengths, and dosing schedules for patients. The treatment setting, much like an individualized medical therapy plan, should fit the diagnosis and meet the client’s presenting problems and health needs.

Clients can move between settings depending on their progress in treatment and the recommendations of treatment staff. The goal is always to provide the least restrictive environment that offers the optimal types of services that match client needs. This approach ensures respect for the client’s autonomy and ability to move away from an unhealthy substance use. It embraces the client’s self-determination needs, which are essential in initiating and maintaining substance use or addiction recovery.\textsuperscript{61}

The following is a list of the seven most common treatment settings. It is not an exhaustive list but will provide a working knowledge of
traditional treatment settings, ranging from most restrictive to least restrictive.65

1. Medical detoxification and stabilization
2. Dual-diagnosis hospital inpatient
3. Free-standing rehabilitation and residential programs
4. Partial hospitalization
5. Temporary recovery or halfway homes
6. Intensive outpatient
7. Outpatient DUI/DWAI/DUID (driving while intoxicated or under the influence) programs

Important distinctions among the settings exist even though similar services may be offered such as prevention, counseling, education, and/or self-help. Clients involved in any one setting can be either voluntary or involuntary participants. This means that within any one setting, some participants may be court ordered or mandated, while others enter treatment without legal requirements.

Settings do not consistently reflect the client’s voluntary or involuntary status. An exception to this rule would be prison-based drug treatment facilities and driving under influence (DUI) diversion programs. Otherwise, many substance use treatment professionals argue that most “voluntary” clients entering treatment have an “involuntary” element to their decision to enter treatment. These “voluntary” clients can often feel pressured by coworkers, family members, and/or physicians.

Coerced treatment, although popular and successful for some, may have little benefit. In many instances, self-motivation is essential for long-term success. Important considerations determining the client’s
success or failure include quality and effectiveness of the treatment program.\textsuperscript{68}

**Outpatient Treatment**

Outpatient treatment is the most frequently used treatment option for individuals with substance use disorders. This treatment option allows individuals to maintain a function of their daily lives while continuing to receive treatment for their substance use disorder. In outpatient treatment programs, patients live at home and maintain regular appointments with a practitioner or through an outpatient treatment center. They receive their therapy during the visits and then continue to work on components of their recovery while at home.

Outpatient treatment programs can be short or long-term and will fluctuate based on the individual’s needs. In many instances, the program duration will be determined as the patient progresses through treatment and makes progress. If less time is needed, the program can be shortened, and if more time is needed, it can be extended. In addition to providing the patient with therapy, outpatient programs include elements of family support and therapy and encourage a family-based approach to treatment. Most outpatient treatment programs will include group therapy and individual counseling, and some will include pharmacotherapy and medication management, many of which are reviewed below.\textsuperscript{69},

*Group Therapy*

Group therapy is an integral component of outpatient treatment programs as it provides an opportunity for the individual to engage in social and support networks with other individuals who are in the same
Successful group therapy programs have the following characteristics:

- Providing opportunities for clients to develop communication skills and participate in socialization experiences.
- 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.

**Individual Counseling**

Individual counseling provides an opportunity for patients to explore some of the issues surrounding their substance use disorder and develop some strategies for recovery. Individual counseling also enables a patient to identify other issues or concerns that are contributing to their addiction. Typically, patients will attend individual counseling sessions as a supplement to group therapy. However, in some instances, patients will only receive individual counseling.

**Major Types of Outpatient Treatment**

- Brief intervention:
Typically includes a short screening tool and advice from a medical provider.

- **Outpatient detox:**
  Typically offered through a local substance use disorder/addiction agency.

- **Intensive outpatient program:**
  Typically a program in which the client spends the day in individual therapy, group therapy, or both, as well as other activities such as psychoeducation (or education offered to individuals with mental illness and their families).

- **Traditional individual substance use counseling:**
  Undertaken weekly, biweekly, or monthly and arranged through the client’s employer, health insurance coverage, or the local mental health or community service agency.

- **Group therapy:**
  Typically offered through a local private or public agency that may have a specific client population, such as a men’s group or a women’s group.

- **Family therapy or behavioral couples therapy.**

- **Methadone maintenance.**
Other pharmacologic interventions:

Acamprosate, buprenorphine, or Naltrexone.

**Inpatient Treatment**

Inpatient treatment is a more intensive treatment format, and is typically reserved for individuals who are unable to refrain from using substances without being removed from them completely. Inpatient programs typically last 30 – 60 days. However, in extreme instances, the inpatient program can be extended to six months or a year. Throughout the duration, the individual lives at a treatment center with other individuals recovering from substance use. Daily activities are tailored to recovery and include group therapy, individual counseling, and life skills instruction. The benefits of inpatient treatment include the following:

- Access to therapy on a daily basis
- Interaction with other people who are recovering
- Provision of meals

Structured inpatient treatment programs have a cost attached to them, which can be prohibitive for some patients. While some insurance providers will cover inpatient treatment programs, many will not. Therefore, if a patient does not have access to adequate funding, this treatment program may not be an option. If a patient is receiving Medicaid, the treatment will be covered. Most inpatient treatment programs will range in cost from $350 - $500 per day.

Inpatient treatment programs are almost exclusively abstinence-based and do not typically offer the option of harm-reduction (which aims to
reduce the adverse consequences of substance use without necessarily reducing consumption of a substance). Abstinence is a hallmark of inpatient programs. Clients who use drugs and alcohol are typically immediately discharged from the program. Of the many rules in any inpatient program, maintaining abstinence is by far the most important. If some clients or residents are allowed to use alcohol or drugs while others are trying to maintain abstinence, it creates a challenging treatment environment and puts people working on abstinence at greater risk of relapse.

The safety of clients and staff members is an important consideration in all inpatient programs. Clients in earlier phases of alcoholism or drug use may be successful in a harm-reduction program or in an abstinence-based outpatient program. This is in keeping with offering the least restrictive treatment that provides a client a good chance of success. If a client is in need of medical detoxification (detox), this can mean a short stay in an inpatient program or an intensive outpatient detox program.

In an intensive outpatient (detox) treatment program the client spends the day in treatment and sleeps at home. If a client has had many detox treatments this provides good evidence that a longer-term inpatient treatment may be appropriate. Types of inpatient programs include:

- Detox programs
- Stabilization programs
- Inpatient rehabilitation programs
- Residential programs
Specific Treatment Settings

There are a variety of treatment settings that can be used to help patients as they attempt to recover from multiple substance use. The specific treatment setting will be determined based upon the individual needs of the patient, as well as the patient’s medical, mental, and financial status. In most instances, the clinician will work with the patient to select a treatment setting comfortable to the individual. However, in some instances, initial treatment will not be voluntary and may require a treatment setting that is not acceptable to the patient. The following table outlines various recovery programs and treatment guidelines.67

| Medical Detoxification | Detoxification is the safe and complete physical withdrawal of incapacitating substances such as alcohol, barbiturates, hallucinogens, and heroin. Detoxification units can be within hospitals or freestanding units. Research published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment describes a medical and social model of detoxification.

The medical model utilizes medical staff, including doctors and nurses, to administer medication to safely assist people through withdrawal. The social model, on the other hand, rejects the use of medication and relies on a supportive, non-hospital setting to help the client through withdrawals. Admittedly, there is no “pure” model for detoxification treatment; as both models utilize each other’s concepts in their respective programs with notable success. |
Medical models establish medical necessity before admission and refer to the risk of medical problems \(i.e.,\) seizures or psychiatric difficulties \(i.e.,\) suicidal ideation the client exhibits. In drug and alcohol detoxification facilities, doctors use medication to lessen the often uncomfortable and sometimes brutal side effects of drug withdrawal, while preparing the client for the counseling and addiction treatment. This process includes gradual tapering of the drug(s) over a period of several days or weeks. For example, heroin can be weaned from an individual and substituted with a longer-acting opioid such as methadone. Other medications may be administered to lessen physical and psychological symptoms associated with withdrawal. The length of stay is usually less than two weeks. Detoxification should be considered only the beginning of treatment. Although medical detoxification is an effective method of treatment, it alone is rarely sufficient to help clients achieve long-term sobriety.

It is important to establish a treatment plan that will outline the client’s intervention and goals well past the point of detoxification. Treatment planning, including discharge plans and long-term goals should begin upon client admission into a service and/or program and the discharge plan should continue to be updated during the course of the client’s treatment. Detoxification settings provide:

- screening for presence of withdrawal symptoms and/or psychiatric conditions
- on-site medical and psychiatric care that promotes safe and complete withdrawal
- staff who structure and nurture the environment
- staff who protect clients from self-harm or harm to others
- staff who educate and counsel clients about a substance use disorder and addiction
<table>
<thead>
<tr>
<th>Stabilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stabilization programs grew up around the needs of very poor and homeless populations that need further inpatient treatment yet do not have the insurance coverage or financial resources for private inpatient rehabilitation. For people in publicly funded detox centers, stabilization programs are a good alternative because this group may not have other inpatient treatment options.</td>
</tr>
</tbody>
</table>

A typical stay is 2 to 6 weeks. If the program is completed successfully, a client can go on to a halfway house or sober house.

Although stabilization programs are an important service today, there is little research on their effectiveness. One reason is that these programs are often considered not a part of the treatment continuum but rather a “holding” facility while other treatment options are considered.

In one study of homeless and non-homeless people, 76% self-reported continued use of alcohol, drugs, or both after release from the stabilization program: 77% homeless and 75% non-homeless. The homeless individuals who participated in the study were typically older White males with no full-time employment, and half (50%) stated alcohol was their drug of choice. In contrast, non-homeless participants were most likely to identify cocaine as their drug of choice (38%).

The homeless group that used a stabilization program after detox was far more likely to enter a residential program such as a halfway house than those in the group that did not use a stabilization program (79% versus 49%), a contrast not seen in the non-homeless group. Even during the relatively short time that has passed since this study was completed, the homeless population has grown younger. This is compelling
| **Dual Diagnosis Hospital Inpatient** | Evidence for the importance of stabilization programs. Usually based in psychiatric hospitals, dual-diagnosis programs are designed to treat clients with the presence of both serious psychiatric illness and substance use and addiction. Services are provided to diagnose and treat substance use and addiction as well as symptoms attributable to psychiatric illness.

Each condition must be assessed independently and in relation to the other presenting conditions or symptoms. This is done to withdraw the affected client safely from substances, stabilize the client emotionally and physically, and identify and treat the concomitant disorders. The personnel’s expertise is helping dually diagnosed clients stop using substances and maintain their psychiatric treatment regimens, which may include prescribed psychotropic medication (*i.e.*, antidepressants, antipsychotics, antianxiety drugs).

Specialized training in dual diagnosis requires staff and counselors to understand how concomitant disorders can interact and manifest in the clients’ lives. Individuals may reside in these hospital units from several days to several weeks. Programs are designed for either adult or youth treatment. Dual-diagnosis hospital inpatient settings provide:

- on-site medical and psychiatric care that includes 24-hour nursing and milieu
- supervision and locked units with limited access to family and friends
- personnel with specialized knowledge in dual diagnosis;
- 7-, 14-, or 28-day stays in a protective, restricted environment
- psychiatric and substance abuse crisis stabilization
- more intensive assessment and diagnostic services
- daily intensive group contact with other clients and staff
**Free Standing Rehabilitation Programs**

Rehabilitation programs are usually free-standing, non-hospital-based facilities. The well-recognized Minnesota Model of addiction treatment has been the dominant model for rehabilitation programs in the United States since its inception. It is the leading model for addiction treatment today for many (alcohol and other drug) treatment centers in the United States and worldwide.

Despite revisions in its basic model due to changes in insurance program reimbursement policies, it still remains a strong influence on both inpatient and outpatient rehabilitation programs. Founded in 1949, Hazelden pioneered the 28-day rehabilitation program for alcoholics. Today, the Minnesota model is known as the Hazelden model for its continuation of the legacy of the original model through ongoing evaluation of research and the enhancement of the model with newer and more effective techniques.

Two long-term treatment goals of the Minnesota Model are total abstinence from all mood-altering substances and an improved quality of life. Consistent with the philosophy of Alcoholics Anonymous, the objectives for the individual are to grow in transcendental, spiritual awareness, to recognize personal choice and responsibility, and to develop peer relationships. The resources for recovery, then, lie primarily within the client with treatment providing the opportunity to discover and utilize those resources and the therapeutic atmosphere conducive to change (client-centered approach).

Individualized treatment plans are used to guide treatment. These plans identify behavioral problems and develop goals and strategies for their resolution. Common problem areas are maintaining abstinence, family relations, career decisions, and social interactions. Often a “level system” for privileges and
benefits is used to encourage clients to participate successfully in the program.

The Minnesota Model denotes an effective and frequently used philosophy and methodology of delivering treatment. It incorporates medical, social, and self-help approaches. The importance of self-help and peer support is the foundation of the Minnesota Model of addiction treatment.

The 12 steps of social support in the Minnesota Model is so important to the ongoing recovery of chemically dependent persons that behavioral health professionals developed a series of parallel therapeutic approaches that maintained consistency with the steps themselves. This consistency allowed clients to transition from treatment to social support relatively easily.

The Minnesota Model allows for a consistent service model that transfers to the national 12 step programs, recovery clubs, and connected recreational or social events. Involvement in self-help groups Alcoholics Anonymous, Narcotics Anonymous and Cocaine Anonymous (AA, NA, and CA) is considered critical for long-term abstinence. The social/self-help elements of the Minnesota Model encourage clients to be responsible for developing their own recovery. Self-help groups have become an important part of the system of care for substance use clients; some studies have found correlation between clients who participate in self-help groups and lower relapse rates.

Self-help organizations are a key resource for addicted individuals. Additionally, potential strategies, including the encouragement of self-help group involvement, hold significant promise of helping more individuals recover from drug and alcohol problems. For most rehabilitation programs,
Psychiatric evaluations are usually done off site, but some may staff their own psychiatrists. This obviously depends on the site, personnel, and available resources. These programs provide treatment based on “levels of care,” including inpatient, outpatient, residential, in-hospital, and partial hospitalization. In inpatient settings, stays are typically 21 to 28 days and provide health care services. In inpatient treatment, the client stays overnight at an inpatient facility, typically a hospital.

On an outpatient basis, the typical length of treatment is 5 to 6 weeks of intensive therapy (3 to 4 nights a week, 3 to 4 hours a session) followed by 10 or more weeks of weekly aftercare sessions.

| **Free Standing Residential Programs** | Residential programs are often used as a bridge between the more restrictive dual-diagnosis inpatient and rehabilitation programs and the less restrictive outpatient programs. Many use a level system similar to the Minnesota Model but are designed for long-term treatment stays. Sometimes, with lower-income clients, residential programs are used as an alternative to outpatient programs because of their housing resources.

In residential treatment, the client stays in a residential setting that is not hospital based but is, rather, a freestanding facility. Residential programs are intermediate-care facilities that allow individuals to live within a residential setting, be employed during the day, and receive comprehensive treatment, including individual, group, and family therapy as well as education and relapse prevention services. Average stays can range from 4 months up to a year. Rehabilitation and residential programs are designed for either adult or adolescent/youth treatment.

Youth services offer rehabilitative and residential programs |
specially designed to meet the needs of children and adolescents. The general risk factors for alcohol use were leisure and peer problems, problems associated with family background and relationships, and criminal behavior for those aged between 12 and 18 years. These results suggest that drug use treatment planning should focus on altering the predisposing factors that exist in these areas. This study also found that alcohol and drug use–related crimes also appear to be problem areas.

The high numbers of the cases described above are being processed in juvenile courts. The implementation of juvenile drug courts is being utilized as an approach for addressing substance related issues. Youth participation in the drug court indicates a positive change in substance-related issues, delinquency and juvenile justice involvement, and sexual risk behaviors.

Youth involvement in a substance use and addiction disorder is well documented by recent research. Children can benefit from an alcohol-use prevention program that is carefully designed, implemented, and evaluated. The need for continued intervention and education for youth of all ages is crucial.

<table>
<thead>
<tr>
<th>Partial Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial hospitalization, occasionally referred to as day treatment, offers comprehensive substance-use treatment in a semi-restrictive program where clients live at home and attend treatment during the day. Similar to other more restrictive treatment settings, partial hospital programs require completion of a detoxification program.</td>
</tr>
</tbody>
</table>
| Only clients without medical or psychiatric complications requiring inpatient care are admitted. These settings are for clients who need a level of restrictiveness between hospital inpatient/rehabilitation/residential and intensive outpatient. It
is considered that the client should attend a daily, intensive, structured treatment program or otherwise be at high risk for relapse. Some treatment centers provide partial hospitalization treatment often described as a more intense form of outpatient treatment. The treatment sessions in partial hospitals are usually longer than in outpatient treatment. Partial hospitalization patients go to sessions for 3 ½ hours per day and 3–7 days per week.

Most partial hospitalization programs are less than six weeks. After the partial hospital program is completed, most experts suggest continued support and counseling through weekly meetings. Weekly meetings could include the family and counseling might take place with the individual or in a group.

This type of treatment is often very effective for many people because it combines the best parts of inpatient treatment (intensive care and strict goals), and outpatient treatment (the ability to continue working, being with family, a flexible schedule, and lower cost). Partial hospitalization offers:

- a cost-effective level of care between full hospitalization/rehabilitation and intensive outpatient;
- a professionally staffed structured environment providing treatment services.

<table>
<thead>
<tr>
<th>Temporary Recovery or Halfway Homes</th>
</tr>
</thead>
</table>

A recovery/halfway house is usually a community-based home or a building near a rehabilitation or residential facility. Resident clients rely on the safe and supportive group social structure of a transitional living arrangement with less monitoring than a more restrictive environment. Requirements for residence typically are abstinence, employment, attendance of 12-step recovery meetings, and possible urine testing to evaluate recovery progress and maintain a safe, sober house. Staff members are usually considered “paraprofessional,” and most often are self-
identified recovering alcoholics or addicts.

Stays can vary ranging from several weeks to several months. Recovery or halfway homes provide:
- a minimum structured transitional living in a recovering environment
- an opportunity to save money to live independently
- help maintaining a connection with a recovering community while dealing with day-to-day trials.

<table>
<thead>
<tr>
<th>Intensive Outpatient</th>
</tr>
</thead>
</table>
| Intensive outpatient treatment consists of substance-free treatment that can range from daily all-day activities to once-a-week meetings. In traditional comprehensive “intensive outpatient” programs, clients are initially enrolled to attend three evenings of 3-hour group therapy with 1 hour of family therapy per week. In addition, clients are expected to attend a certain number of AA/NA 12-step meetings established by treatment personnel. Group therapy meetings can range in theme from managing stress to handling dysfunctional family patterns. Random urine testing is usually an integral part of these programs. Continued participation is based on abstinence as evidenced by self-report and/or urine testing. Completion is usually determined by documented behaviors such as length of abstinence, attendance in groups, and keeping scheduled individual and family counseling appointments. Intensive outpatient programs are typically 90- to 120-day commitments. Weekly or biweekly outpatient settings are often for those clients who have successfully completed the intensive portion of treatment and demonstrated sustained abstinence, employment, and a sober or clean lifestyle (i.e., staying away from high-risk substance-using friends). Intensive outpatient treatment provides:
- comprehensive treatment with off-site living |
arrangements while establishing or maintaining employment
• graduated treatment services
• possibly longer-term, intensive treatment than hospitals and rehabilitation settings

Outpatient rehabilitation, a less restrictive environment, typically includes group therapy meetings three times per week. Homework is given to extend learning into home and work environments. Clients maintain their place of residence and employment while committing to a program of recovery that includes abstinence. A client unable to maintain sobriety and/or not making sufficient progress, might be recommended a more restrictive environment, *i.e.*, inpatient rehabilitation.

### The Treatment Plan

Part of the treatment process involves the development of a treatment plan. Treatment plans are individualized documents that outline the problems and treatment goals of each individual patient. Treatment plans identify targets, identify interventions, suggest resources, clarify provider responsibilities, and provide indicators of progress. They are very specific to the needs of the patient and are used to set goals and chart the patient’s progress. While treatment plans are developed at the beginning of treatment, they must be flexible as they will need to be updated throughout the process to address any issues that arise. Key components in the treatment program include:

- addressing problems present along with drug use
- exploring solutions for problems
- expanding the patients worldview
• projecting long-term goals
• using measurable objectives
• using a variety of resources and interventions

The treatment plan is essentially the agenda that emerges from the assessment process. It is highlighted by a delineation of treatment goals and a corresponding set of clinical interventions designed to assist in the achievement of these goals. The treatment plan is unique to the individual because the presenting needs of clients vary considerably from person to person, as do their available strengths and resources for effecting change. The better and more precise the tailoring of the treatment plan to the client’s needs and resources, the better the potential fit and the greater the likelihood of achieving the specified treatment goals.

The clinician and the client must develop a list of treatment goals and then prioritize those goals. In many cases the primary goal is a decrease in, or cessation of, substance use. Focusing on this goal may have an impact on other key goals, such as improving a family or employment situation. Secondary goals might include extending one’s social support network, returning to school, and so on. Whatever the objectives are, it is important to prioritize them. While one obvious benefit of such prioritizing is that attention is focused on the most pressing problem areas, another advantage is that successes in these primary areas, such as cessation of substance use, often place the client in a much better position to address secondary goals.

As they identify and prioritize goals, the clinician and the patient also need to specify which are short-term goals and which are long-term
goals. Although there is no consensus about setting these terms, short-term goals often are identified as those that can be significantly addressed within 6 months. Long-term goals are those more likely to be achieved over longer periods, although this would not preclude initial efforts to address such goals in the short term and over time. The distinction between short-term and long-term goals is important to highlight, as clients move through the stages of change at different times and at different paces.74

A number of variables will influence the establishment of short-term and long-term goals. One of the key factors is the extent and seriousness of the problem. Any pretreatment evaluation of a substance will include assessment of severity of substance use and need for detoxification or some other form of medical management. Problems in this domain would require immediate attention.

Goal setting is also influenced by the nature and extent of the client’s motivation to invest in and pursue treatment goals. An assessment of the client’s stage of change will yield information on his or her extent of readiness to embark on the change process, along with insights on which processes of change might be targeted. The client in contemplation will likely be wavering between the advantages and disadvantages to making changes in his or her life. A client in the action stage will be more ready than one in an earlier stage to start the change process and much less likely to want to devote time and energy to deciding on whether to commit to change.68

The determination that a client is in the contemplation or action stage of change does not preclude the full development of the treatment
plan, but it has implications for how the treatment goals are established and operationalized. A possible short-term goal for the person in the contemplation stage would be evaluation of the pros and cons of making changes in substance use patterns, using principles of motivational counseling. Short-term goals for the client in the action stage could include, as examples, attendance at self-help groups and problem-solving alternatives to substance use, as such clients are going to be more ready to embark on such change efforts.

It is important to identify goals that are achievable, and where procedures can be established to allow the client to take small and progressive steps in gradually achieving these goals. There are two reasons for adhering to such a strategy. The first is that complex problems are not generally amenable to easy, one-step solutions, regardless of the person’s level of motivation. Rather, breaking down the problem into its subcomponents and successively addressing these is both a more manageable and a more successful approach to the larger problem. Second, developing a step-wise plan for addressing problems sets the stage for the client to experience a series of small but meaningful successes in pursuit of the client’s goals. This is particularly important when the client is not fully confident about possessing ability to succeed in the change process. Experiencing some initial successes lessens the likelihood of the discouragements clients often experience when their expectations or goals for treatment are too ambitious. Such discouragements are a major contributor to dropping out of treatment.

There are several other factors that can influence the development of short-term and long-term treatment goals. These include the
treatment setting, the availability of a support network, and the projected period of treatment involvement. In terms of setting, for example, the short-term goals for clients in an inpatient unit will differ in certain ways from those established for outpatient clients. Outpatient clients have the benefit of trying out treatment strategies in their actual living environments but do not have the benefits of the more protective inpatient unit, which affords more opportunities for regrouping and consolidation.

Availability of a support network and their investment in the client can influence the plans for achieving treatment goals. For example, spouses, other family members, and friends may be available to participate in treatment sessions or can be called upon by the client in other ways to support and contribute to his or her efforts to make changes.

The projected treatment period can influence treatment planning. The treatment plan for a client allocated 3 months of outpatient treatment will differ from that developed for a client with the opportunity for a lengthier treatment intervention. Insurance policies can determine treatment periods, but clients themselves bring their own expectations about how long treatment should last — and such expectations need to be acknowledged and respected. For the client who expects treatment to be briefer than the therapist thinks advisable, negotiating a treatment plan that incorporates a compromised duration, at the end of which the plan and progress to date would be reviewed, may be possible.77
It is important that the client and the therapist alike recognize the treatment plan as flexible and changeable. They should view the initial treatment plan, based on the pretreatment assessment and evaluation, as a working blueprint for change, and both should understand and acknowledge that changes can — and likely will — be made in the treatment plan over time. As such, treatment planning actually is a continuous and dynamic component of the treatment process.

There are multiple reasons underlying a substance use treatment plan that is flexible, continuous and dynamic. First, there may be some needs or problems that are not apparent during the pretreatment assessment. Second, progress on some treatment goals may need to await progress on other problem areas. In such cases, it may be necessary to rearrange treatment goal priorities. Third, some problems may take longer to address than other problems or than originally anticipated. Revisions of the treatment plan will help the client and the therapist to keep abreast of relative progress in the pursuit of treatment goals.

Finally, it is not unusual for new problems to arise during treatment, such as problems that may require immediate incorporation into the treatment plan. Common features of an individualized treatment plan include:  

- Development of the plan as a result of a comprehensive assessment, which is modified over time as warranted.
- Reflective of participation from appropriate disciplines (i.e., medicine, psychiatry, psychology, social work, vocational rehabilitation) as warranted.
- Reflective of the client’s presenting needs, specifying the person’s strengths and limitations.
- Consisting of specific goals that pertain to the attainment, maintenance, and/or reestablishment of physical and emotional health.
- Identifying specific objectives that relate directly to the treatment goals.
- Identifying the services and/or settings necessary for meeting the client’s needs and goals.
- Specifying the frequency of treatment contacts.
- Including provisions for periodic (and at other times, as indicated by changes in the client’s life-functioning) reevaluations and revisions, as warranted, by the treatment plan.
- Identifying specific criteria for determining whether goals have been achieved and for terminating treatment.

**Phases of Recovery**

Individuals with a multiple substance use disorder will go through four distinct phases in the recovery process. Each phase requires special consideration and individualized treatment planning to ensure the patient moves forward to the next stage of recovery. It is important to note that many patients do not make it through all four stages of recovery. However, for those able to succeed, the likelihood of relapse decreases significantly.

*Acute (detoxification)*

The acute phase is the stage of recovery that occurs immediately following cessation of drug activity. This period can last for a few days or a number of months, depending on the type of substances the
patient is consuming and the severity of any comorbid conditions. The presence of medical, legal, family, and social problems can also impact the duration of the acute phase of treatment. The goal during the acute phase is to eliminate the use of substances while minimizing the occurrence of other conditions, such as medical, legal, family, and social problems.61

Patients who use opioids will require a more involved acute treatment program than those eliminating substances with fewer physical withdrawal symptoms. Therefore, the primary goal when treating patients who use opioids is to eliminate use for at least twenty-four hours and begin the detoxification phase. In most instances, this process will involve the following:

- Initially prescribing a medication dosage that minimizes sedation and other undesirable side effects.

- Assessing the safety and adequacy of each dose after administration.

- Rapidly but safely increasing dosage to suppress withdrawal symptoms and cravings and discourage patients from self-medicating with illicit drugs or alcohol or by using prescription medications.

- Providing or referring patients for services to lessen the intensity of co-occurring disorders and medical, social, legal, family, and other problems associated with opioid addiction.
• Helping patients identify high-risk situations for drug and alcohol use and develop alternative strategies for coping with cravings or compulsions to use substances.

Detoxification programs are considered an essential part of substance use treatment. These services are designed to deal with the effects of alcohol and drugs and the potential for withdrawal symptoms, typically through the use of prescribed medications. Some substance use professionals consider detox a form of treatment; whereas for others, it is considered an entrance into treatment.79

Detoxification serves as the first step in determining the needs of a client. The essential components of detox are medical evaluation and stabilization, followed by making a plan to enter some type of inpatient or outpatient treatment. Detox programs typically offer a 3- to 5-day stay during which the client is medically withdrawn from the drugs and alcohol to avoid withdrawal and, in extreme cases, delirium tremens (DTs).80 The American Society of Addiction Medicine (ASAM) developed recommendations for the appropriate level of care for substance users. The five levels of care for detox range from mild- or low-level outpatient care to intensive hospital-level care: Level I-D is ambulatory detox without extended onsite monitoring, Level II-D is ambulatory detox with extended onsite monitoring, Level III.2-D is clinically managed residential detox, Level III.7-D is medically monitored inpatient detox, and Level IV-D is medically managed intensive inpatient detox.

Throughout the acute phase of treatment, it is important to monitor patient substance use, any increase in comorbid symptoms, as well as
the development of any secondary complications. Many substance users will slowly reduce the number of substances they consume during this phase, with the ultimate goal of eliminating all substances. Therefore, the acute phase may require additional time. If the patient continues to use substances during the acute phase, the practitioner should review the treatment plan and make any necessary adjustments. Since the acute phase is the phase of recovery with the highest level of attrition, it is necessary for practitioners to have frequent contact with patients. In addition, engaging the patient in sessions and activities that support and promote recovery can help maintain patient motivation. Therefore, patients should be engaged in individual and/or group counseling sessions, support groups, and any other programs that help maintain sobriety.\(^1\)

Individuals with co-occurring mental health disorders will require additional care and support during the acute phase of treatment, as physical and mental withdrawal from substances can exacerbate mental health symptoms. The following poignant statement supports the treatment team to understand:\(^2\)

> "Patients should be monitored closely for symptoms that interfere with treatment because immediate intervention might prevent patient dropout. Such disorders can be disruptive at the start of the acute phase, requiring immediate treatment. The course of recovery from substance-induced co-occurring disorders usually follows that of the substance use disorder itself, and these co-occurring disorders typically do not require ongoing treatment after the acute phase."
Some patients may require focused, short-term pharmacotherapy, psychotherapy, or both. However, many patients may have co-occurring disorders requiring a thorough psychiatric evaluation and long-term treatment to improve their quality of life.”

Since the acute phase of treatment is the first step toward sobriety, the patient may begin the program with a number of secondary complications that will need to be treated alongside the substance use problem. In most instances, treatment plans include a number of medical, social, and family issues that will need to be addressed. The following chart provides information on the treatment issues that may arise during the acute phase of treatment along with strategies to address each of the issues and indications for transitioning to the next phase of recovery.61

### Acute Phase of Treatment

<table>
<thead>
<tr>
<th>Treatment Issue</th>
<th>Strategies To Address Issue</th>
<th>Indications for Transition to Rehabilitative Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and drug use</td>
<td>Schedule weekly drug and alcohol testing</td>
<td>Elimination of opioid-withdrawal symptoms, including craving</td>
</tr>
<tr>
<td></td>
<td>Educate about effects of alcohol and drugs; discourage consumption</td>
<td>Sense of well-being</td>
</tr>
<tr>
<td></td>
<td>Ensure ongoing patient dialog with staff</td>
<td>Ability to avoid situations that might trigger or perpetuate substance use</td>
</tr>
<tr>
<td></td>
<td>Intensify treatment when necessary</td>
<td>Acknowledgment of addiction as a problem and motivation to change lifestyle</td>
</tr>
<tr>
<td>Treatment Issue</td>
<td>Strategies To Address Issue</td>
<td>Indications for Transition to Rehabilitative Phase</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Medical concerns</td>
<td>Refer patients immediately to medical providers</td>
<td>Resolution of acute medical crises</td>
</tr>
<tr>
<td>Infectious diseases (HIV/AIDS, hepatitis, tuberculosis)</td>
<td>Vaccinate as appropriate (i.e., for hepatitis A and B)</td>
<td>Established, ongoing care for chronic medical conditions</td>
</tr>
<tr>
<td>Sickle cell disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical needs, i.e, skin/lung abscesses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-occurring disorders</td>
<td>Identify acute co-occurring disorders that may need immediate intervention</td>
<td>Resolution of acute mental crises</td>
</tr>
<tr>
<td>Psychotic, anxiety, mood, or personality disorders</td>
<td>Identify chronic disorders that need ongoing therapy</td>
<td>Established, ongoing care for chronic disorders</td>
</tr>
<tr>
<td>Basic living concerns</td>
<td>Assess needs</td>
<td>Satisfaction of basic food, clothing, shelter, and safety needs</td>
</tr>
<tr>
<td>Legal and financial concerns</td>
<td>Refer patient to appropriate services</td>
<td>Stabilization of living situation</td>
</tr>
<tr>
<td>Threats to personal safety</td>
<td>Work cooperatively with criminal justice system</td>
<td>Stabilization of financial assistance</td>
</tr>
<tr>
<td>Inadequate housing</td>
<td>Explore transportation options</td>
<td>Resolution of transportation and childcare needs</td>
</tr>
<tr>
<td>Lack of</td>
<td>Link to legal advocate,</td>
<td></td>
</tr>
<tr>
<td>Treatment Issue</td>
<td>Strategies To Address Issue</td>
<td>Indications for Transition to Rehabilitative Phase</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>transportation</td>
<td>caseworker, or social worker</td>
<td></td>
</tr>
<tr>
<td>Childcare needs</td>
<td>Identify financial resources</td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Provide case management</td>
<td></td>
</tr>
<tr>
<td>Advocacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapeutic relationship</td>
<td>Advocate adequate dosage</td>
<td>Regular attendance at counseling sessions</td>
</tr>
<tr>
<td>Establishing trust and feeling of support</td>
<td>Remain consistent, flexible, and available; and, minimize waiting times</td>
<td>Positive interaction with treatment providers</td>
</tr>
<tr>
<td>Addressing myths about MAT</td>
<td>Provide incentives and emphasize benefits of treatment</td>
<td>Focus on treatment goals</td>
</tr>
<tr>
<td></td>
<td>Dispel myths about MAT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Educate patient about goals of MAT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Build support system</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Build trust</td>
<td></td>
</tr>
<tr>
<td>Motivation and readiness for change</td>
<td>Ensure adequate dosage</td>
<td>Commitment to treatment process</td>
</tr>
<tr>
<td>Ambivalent attitudes about substance use and addiction</td>
<td>Address ambivalence</td>
<td>Acknowledgment of addiction as a problem</td>
</tr>
<tr>
<td>Avoidance of counseling</td>
<td>Empower patient</td>
<td>Lifestyle changes and addressing addiction-related</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Treatment Issue</th>
<th>Strategies To Address Issue</th>
<th>Indications for Transition to Rehabilitative Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>(noncompliance)</td>
<td></td>
<td>issues</td>
</tr>
<tr>
<td>Negative relationships with staff</td>
<td>Emphasize treatment benefits</td>
<td></td>
</tr>
<tr>
<td>Inadequate dosage</td>
<td>Emphasize importance of making a fresh start</td>
<td></td>
</tr>
<tr>
<td>Negative attitude about treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involuntary discharge</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Once a patient has successfully completed treatment in the acute phase, he or she will transition to the next stage of treatment, which is **full abstinence**. Indications that patients have reached the goals of the acute phase can include:

- Elimination of symptoms of withdrawal, discomfort, or craving for opioids and stabilization.
- Expressed feelings of comfort and wellness throughout the day.
- Abstinence from illicit opioids and from use of opioids normally obtained by prescription, as evidenced by drug tests.
- Engagement with treatment staff in assessment of medical, mental health, and psychosocial issues.
- Satisfaction of basic needs for food, shelter, and safety.

**Abstinence**
The second phase of substance use treatment is the abstinence phase. This phase of treatment begins right after the patient completes the acute phase, and lasts a number of months. It continues until the patient enters the early remission phase of treatment. Once the patient completes the acute detoxification stage, he or she will begin to work on maintaining abstinence. During this phase of treatment, the focus is on:

- Recognizing the medical and psychological aspects of addiction and withdrawal.
- Identifying triggers to drug use and developing techniques for avoiding these triggers.
- Learning how to handle drug craving without using.

The goal of treatment during this phase involves encouraging the patient to remain substance free. This can be accomplished in a number of ways, but typically includes participation in self-help groups, support programs, and individual counseling sessions. During this phase of treatment, patients begin replacing drug related activities with healthy activities that do not include the use of substances.

Counseling sessions in the abstinence phase of treatment will involve addressing issues and concerns surrounding substance use. The patient will be encouraged to address any underlying issues that may increase the chance of a relapse. The specific issues addressed will depend on the patient and his or her needs. Therefore, the clinician and/or therapist will work to identify areas of concern and tailor treatment sessions to address these specific issues.
While sessions should address patient concerns and underlying issues, it is imperative that the number of concerns introduced at each session remains manageable. It is recommended that no more than two topics be introduced in a session. This will allow time to review topics previously addressed, while ensuring adequate time to process and identify the impact of the new topics that have been introduced. The introduction of more than two topics per session increases the chance that the patient will feel overwhelmed and will be less willing to participate fully in the session. The two topics of cravings and high-risk situations are a primary focus of treatment, and are typically discussed during the abstinence phase of treatment.

Cravings:

A primary focus during the abstinence phase is helping the patient cope with cravings. The clinician/counselor should discuss the concept of craving with the patient. Individuals appear to experience craving differently, but they usually describe physical and psychological symptoms. These symptoms may include heart palpitations, rapid breathing, obsessional thinking about the drug, and planning how one can get the drug or get the money needed to buy it. Craving is thought to be due in part to biological factors and in part to learning.

The patient must be helped to understand and recognize what craving or having an urge feels like. Being able to recognize craving will help the patient maintain abstinence; the clinician should educate the patient that he or she can experience and recognize a craving but choose not to act on it in the usual, self-damaging way. Craving, however strong, does not have to lead to drug use. One can just "sit the craving out," and it will pass. A useful analogy may be to liken the
craving to a strong ocean wave. The wave will feel very strong when one is in the throes of it, but it will wash over and pass. Also helpful is explaining that the strength of cravings will decrease over time if the patient does not use, but if he or she uses the drug, the craving phenomena will remain strong.

High-risk situations:

High-risk situations are those times that involve the people, places, and things that trigger substance use. The clinician should discuss situational triggers with the patient and help the patient to avoid them if possible or learn to cope by developing the alternative responses necessary to deal with these situations without using. This topic should be largely a review of what the patient has learned about people, places, and things in general but with an emphasis on the actual situations that recur in the patient's own life. Learning how to avoid these times or to develop alternative responses to whatever triggers the desire for substance use is central to recovery from addiction and bears regular repeating.

In treatment sessions, counselors will review with the patient actual and potential "high-risk" situations that might occur and what can be done to avoid them. Examples of high-risk situations are being offered drugs, being around a drug-using friend, or attending a social function where drugs are available. The clinician should rehearse with the patient alternative responses to exposure to these situations. Identifying such situations well in advance and rehearsing how one could deal with such exposure should provide a better chance of avoiding a relapse from such exposure. After the patient identifies his or her particular high-risk situations, the clinician and patient should work together to develop strategies for avoiding these situations.
Other potential high-risk situations also should be considered. The clinician should offer reasonable alternative responses to unavoidable high-risk situations, such as calling a friend or talking to one's partner or spouse. The patient should be encouraged to use the support of drug-free or recovering friends, family members, and AA/NA/CA acquaintances.69

**Abstinence Phase and Goals of Recovery**

The abstinence phase of treatment can be broken into two separate categories. The first phase is the early stage of treatment, and it involves the introduction of abstinence strategies and methods. The topics addressed above are the focus of the early abstinence phase. Once a patient has established abstinence, he or she will transition to the abstinence maintenance stage. In this second half of abstinence, the patient will focus on maintaining abstinence and modifying behaviors. In this stage of abstinence, the patient will “work toward...avoiding environmental triggers, recognizing his or her own psychosocial and emotional triggers, and developing healthy behaviors to handle life's stresses.” The patient will focus on establishing and maintaining a “recovery-oriented attitude”.85

The goals of the abstinence phase of treatment include:

1. Help the patient continue to maintain abstinence.
2. Make the patient aware of the relapse process, so it can be avoided or reversed quickly.
3. Assist the addict in recognizing emotional triggers.
4. Teach the patient appropriate coping skills to handle life stresses without returning to drug use.
5. Provide the opportunity for the patient to practice newly developed coping skills.

6. Keep encouraging the behavior and attitude changes necessary to make sobriety a lifestyle.

There are a number of treatment issues that can make this stage of recovery difficult. Therefore, the practitioner will need to address these issues with the patient, as well as be aware of them during the treatment planning process. Some issues will not be present at the beginning of the abstinence phase, but will likely develop as the patient moves through treatment.

Some issues will be triggered by the elimination of substances, while others will occur as a result of emotional or behavioral complications. The following is a list of the most common treatment issues present during the abstinence phase:

- Tools for preventing relapse
- Identification of the relapse process
- Relationships in recovery
- Development of a drug-free lifestyle
- Spirituality
- Shame and guilt
- Personal inventory
- Character defects
- Identification and fulfillment of needs
- Management of anger
- Relaxation and leisure time
- Employment and management of money
- Transfer of addictive behaviors
Once the patient successfully establishes abstinence, he or she will begin to focus on preventing future relapse. This is a key component in the recovery process and a primary focus of the abstinence phase of treatment. As part of this process, the patient will identify and develop strategies and skills that will help prevent future relapse. The patient will also begin working through the difficult and uncomfortable feelings associated with abstinence.

Prior to developing strategies and working through uncomfortable feelings, the patient will need to develop an awareness and understanding of the actual relapse process. This will enable the patient to identify when he or she is at risk of relapsing. The concepts below should be presented to the patient in whatever way he or she can best understand and use them. There are eleven steps in the relapse process, which are as follows:

1. A change in attitude in which the patient no longer feels participating in the recovery program is necessary or a change in the daily routine or life situation that signals a potentially stressful life event.

2. Elevated stress, as seen by overreactivity to life events.

3. Reactivation of denial, particularly as related to stress, as seen when the patient is stressed but refuses to talk about it or denies its existence. This behavior is of great concern because of its similarity to denial of drug use or addiction.
4. A recurrence of post-acute withdrawal symptoms, which are especially likely to occur at times of stress. They are dangerous because the patient may turn toward drugs or alcohol for relief.

5. There is behavior change. The patient begins to act differently, often after a period of stress, as signaled by a change in attitude or daily routine.

6. Social breakdown occurs. The social structure the patient has developed begins to change. For example, he or she no longer meets with his or her sober friends, or the patient starts to seclude him- or herself and withdraws from family.

7. Loss of structure develops. The daily routine that the patient has constructed in the recovery program is altered. For example, the patient sleeps too late, skips meals, or does not shave.

8. There is loss of judgment. The patient has difficulty making decisions or makes decisions that are very unwise. There may be signs of emotional numbing or over reactivity.

9. There is loss of control. The patient begins to make irrational choices and is unable to interrupt or alter them.

10. The patient feels loss of options. He or she feels stressed and believes that the only choices are to resume drug use or to undergo extreme emotional or physical collapse.
11. Relapse in which substance use is resumed.

The chance of relapse will be reduced if the patient is able to understand that he or she is in control of the process. As part of this process, the patient will identify and implement behavioral changes that can be used if a relapse begins to occur. The patient will use these changes to move out of the relapse process and return to recovery. The most common behavioral changes include:

- going to meetings more frequently
- spending time with people who support recovery
- maintaining structure in his or her lives
- avoiding external triggers (i.e., going back to the neighborhood where he or she obtained drugs)

While the patient is given primary responsibility for identifying triggers and developing strategies for moving out of relapse, it is also the clinician’s responsibility to monitor the patient’s status. The clinician should evaluate the patient throughout the abstinence phase of treatment as a means of identifying any signs that relapse is occurring. If the clinician observes any signs of relapse, he or she will need to address them with the patient and help the patient identify and implement strategies to prevent further relapse.86

The abstinence phase of treatment will require constant monitoring, and the provider will need to modify treatment throughout to decrease the risk of relapse. If patients can successfully complete the abstinence phase of recovery and transition to early remission, the chances of lifelong recovery increase significantly.
Early Remission

The early remission stage of treatment is classified as the period of full abstinence and recovery that lasts for at least one month after cessation of substance use, but no longer than twelve months. In this phase of treatment, the patient will have completed the process listed above, but will still be in the early stages of recovery. This stage of treatment will often overlap with the abstinence phase of treatment, and may co-occur with the maintenance phase of abstinence.85

Topics addressed during this phase of treatment are similar to those covered during the abstinence phase. The patient will continue to focus on relapse prevention strategies and will begin to make lifestyle changes that will support recovery. Counseling sessions may be reduced depending on the patient’s progress. At this point in the treatment process, the chance of relapse begins to decrease, although the patient will still have to exercise caution around trigger situations. If a relapse occurs during this phase, the patient may be able to recover more easily than in earlier phases.

Sustained Remission

Sustained remission occurs once a patient has remained abstinent for twelve or more months. This is the final stage in treatment and is maintained indefinitely. There are three levels of remission that may occur during this phase: sustained, sustained-full, and sustained-partial.

- Sustained Remission:
After 12 months of Early Remission have passed without relapse to substance use, the person enters into sustained remission.

- Sustained full remission:
  This specifier is used if none of the criteria for substance use and addiction have been met at any time during a period of 12 months or longer.

- Sustained partial remission:
  This specifier is used if full criteria for substance use have not been met for a period of 12 months or longer; however, one or more criteria for substance use and addiction have been met.

Once a patient enters the sustained remission phase of treatment, the focus will shift to maintenance. At this point, the patient will have developed effective coping skills and will have made significant lifestyle changes to prevent relapse. Regular monitoring and counseling sessions will be replaced with intermittent check-in meetings and, possibly, attendance at self-help support group meetings. During this phase, the patient has a greater understanding of what is necessary for relapse prevention, and is able to identify triggers that may impact recovery.85

**Detoxification And The Recovery Process**

Once a patient has completed the detoxification phase of treatment, it is important for the clinician to gather information that will aid in the recovery process. In this phase of treatment, the clinician addresses previous use of substances, usually beginning with alcohol and
proceeding down a list of the more common drugs of use (marijuana, cocaine, heroin, etc.). In many cases, the client will report struggling with only one or two drugs of choice, with possible experimentation with other substances. Another important element is the age of onset for the current substance of choice. Research has indicated that, at least for alcohol, the earlier the onset of use then the greater the relationship to heavy use in adulthood. Knowing how early one started using a substance can give clues as to the significance of the current use.

Any history of substance use must include questions about quantity of use, frequency of use, method of use, the last time the client used, and the effects of substance use on symptomology and functioning. This information provides the clinician with an overview of the extent of substance use and if the client has tried to stop before but failed. In addition to substance use history, the clinician must evaluate the patient’s prior treatment history. This includes information on previous medical care for addiction, previous counseling, past or present 12-Step group attendance and attitude toward these services, how long abstinence was maintained in the past (or, if currently abstinent, for how long), and factors contributing to relapse. Prior treatment information helps illuminate what has been tried in the past, what was successful, and what did not work.

**Evaluate History**

The history evaluation will attempt to identify other components in the patient’s life that may affect substance use. These include the following:
Current Life Functioning

Although not directly related to substance use, questions about problems in current living often reflect underlying substance use issues. Sometimes a simple question or two can suffice, such as: *How are things going now? Tell me about your life and what you would like to be different, if anything.*

Family History of Substance Use

Although genetics do not tell the whole story when it comes to substance use and addiction, they do play significant role in combination with environmental factors. Confirming that family members have struggled with addiction suggests the client may have a similar tendency and can provide greater confidence in making an assessment and treatment approach.

Religious or Spiritual Beliefs

This is not directly related to substance addiction; however, experts have long noted that many people with addiction problems struggle with a spiritual crisis or in some way have lost their grounding in life. Assessment of spiritual and existential issues usually brings forth a fruitful discussion about meaning and purpose and how substance use may serve as a cover for existential crises.

General Personal History

This component includes areas such as work history, legal history, relationship history, and emotional functioning. Some of these elements may come about in previous components of the interview, so
the counselor may simply need to cover what has not been discussed up to this point.

Work and legal history can provide a powerful lens to help understand the extent and intensity of someone’s substance addiction. For example, a client who has repeatedly missed work has been fired several times, and who has repeated DUIs has a serious problem with alcohol, and treatment should commence accordingly. On the other hand, a client who has maintained a steady job for 25 years and has had no legal trouble but nonetheless wants to cut down on nighttime drinking would have a much different treatment plan.

**Psychological Evaluation**

Many clients report symptoms of depression, anxiety, or other emotional problems and use substances to self-medicate or cope. In fact, psychological symptoms, such as depression and anxiety, are often associated with problematic substance use. Also associated with use are negative or difficult emotions such as guilt, shame, anger, or boredom. At minimum, practitioners should check in with clients who report severe negative emotions related to their substance use history, current behavior, and typical methods of coping.

**Summary**

As the health team continues to allow for ongoing evaluation and change to a patient’s individual substance use treatment and recovery plan, it is anticipated that more will be learned about the patient for incorporation into planning for successful transitions in the recovery process. Often the initial chronicity and severity of functional
impairment clouds efforts by the treatment team to obtain a complete comprehensive physical and mental health history, which can influence abstinence and long-term recovery goals. This course discussed approved medical and maintenance treatment programs. The final course in this series, *Substance Use And Addiction Disorders: Patient Education And Relapse Management*, will cover a more detailed discussion of the long-term recovery plan and community resources that health providers would need to liaise with and educate patients about during the transition to less restrictive levels of care and phases of recovery.

**Part 4: Patient Education And Relapse Management**

**Introduction**

A comprehensive assessment should provide an in-depth evaluation of the patient’s health history and the type of substances used. The patient’s treatment plan will vary based on new information obtained during the patient’s responses to various phases of recovery. Recovery refers to the period or state of deliberate and intentional non-use of substances. It includes efforts to abstain and implement behavioral changes that minimize the risk of relapse. This process can be difficult and lifelong. Individuals often make several attempts in striving for this goal before it is successfully reached. Although failures in recovery are to be expected, they also can be great learning opportunities for growth.

Recovery education provides patients with strategies that can help maintain recovery and minimize the risk of relapse. However, recovery education extends beyond maintaining abstinence. At this stage, the
patient will begin identifying skills and modifications that improve the quality of his or her life beyond the reduction in drug use. The path of recovery can vary for each individual, but a typical pattern might include changes in the flow of alcohol or drug use, with decreases in quantity and frequency, responses to triggers and stressors, and eventual stabilization.

**Identifying Stressors And Triggers**

Gaining control of one’s environment is an essential component in relapse prevention. While it is impossible for individuals to control every element of their environment, an individual with a substance use disorder can take many actions to minimize risk. One of the simplest strategies is to encourage clients to remove all items directly related to substance use from their homes, cars, and offices. This may include supplies, paraphernalia, pictures, and other objects associated with use.

Teaching stimulus control refers to three primary activities: avoidance, escape, and delay. The most obvious way to help prevent relapse is to avoid the environments or situations in which drug use occurs. Patients must understand that it is much safer for them to stay away from situations that place them at increased risk of a return to substance use. Many individuals recognize the importance of staying away from high-risk situations but lack the confidence in their ability to remain abstinent from substances.

*Escape* refers to removing oneself from a high-risk situation. Patients may not always be able to avoid experiences in which drugs and/or
alcohol are present. The following case example regarding an individual addicted to alcohol elucidates how this may occur:

A person recovering from alcohol addiction decides to go to a class reunion in his hometown. He sees many of his old high school friends and has a good time. Soon after, he is invited out to the bars to continue the party. He decides to attend the reunion, planning that he will just have a soda or water and he has been sober for nine months. He considers the risk of relapse to be low. When he gets to the bar, however, he experiences surprising cravings and a strong urge to have an alcoholic beverage. Since he is having difficulty managing his cravings, the client finds that he must escape the situation.

Although patients are advised to not place themselves in situations like the one described above, many people may underestimate high-risk situations. Clinicians should discuss an escape plan with clients should such a situation arise. If avoidance or escape seems difficult or impossible, the client might delay action as a way to interrupt negative cognitions and flow of experiences toward relapse. To delay action simply means to hold off on taking a drink until these strategies can be used effectively.

**Teaching Management Techniques**

One of the reasons many patients relapse is the failure to manage cravings for drug use. Even clients who have been sober for years may occasionally need to work through a spontaneous craving. Craving is one of the least understood concepts related to substance use. The
The traditional view of craving is that it is primarily a physiological phenomenon, based on biological susceptibility and exposure of the brain to drugs. However, craving has many cognitive elements. Regardless of what causes cravings, managing them goes a long way in helping clients avoid relapse.\(^9^1\)

A first step in managing cravings is to help individuals understand that they do occur, and to anticipate and even accept these reactions as normal learning responses. Another method for avoiding or minimizing cravings is teaching the client stimulus control. Cravings become stronger when one is exposed to sights, sounds, environments, or situations that either include alcohol or drugs or situations that strongly remind the individual of previous using behaviors.\(^8^9\)

Reminding oneself that a craving will eventually recede may offer little comfort when the intensity is high. Some clients may tolerate cravings well and are therefore able to ride them out, while others have limited psychological resources and mental strength and, therefore, struggle greatly. Additional strategies, such as relaxation training, breathing exercises, and removing oneself from the situation may offer some benefit.

Self-monitoring strategies can be an effective way for clients to monitor and have some control over their craving experiences; such as, using a craving diary in which the individual can record their experiences with drug cravings throughout the day. Patients are encouraged to write down internal and external cues in their diary, such as situations, the people they are around, what they are thinking, and so forth. Reviewing the diary can be an effective intervention as
the clinician and patient look for themes and design strategies to prevent relapse.92

**Relapse Management**

Relapse management refers to helping clients manage a lapse so that it does not spiral out of control, leading to a full-blown relapse. Relapse management differs from relapse prevention in that the focus is on managing a return to use. The goal of relapse management strategies is to minimize the degree of setback. Relapse management strategies are general, which involves helping clients to shift perceptions of a lapse and, specifically, to take behavioral actions to minimize the psychological impact of a lapse.93,94

One of the greatest risks for full-blown relapse is when a client slips, returns to drug use, and then determines that he or she is incapable of maintaining sobriety. General relapse management strategies help clients place a lapse into perspective. For example, a client might be told that a lapse is similar to a mistake or error in the learning process and that it is a specific, unique event in time and space. Clients can be taught that abstinence or control is always a moment away; and, although they might be in the throes of a lapse, they can decide to stop at any time.

Specific relapse management strategies involve behavioral skills and interventions that the client can do to avoid relapse. In the case of a lapse, the client is instructed to do the following:

- *Stop, look, and listen:*
In this instance, the individual is coached to enhance awareness of his or her surroundings and tune in to behavior. If the individual slips, he or she is instructed to stop, look around, and listen so as to interrupt the negative flow of events.

- **Make an immediate plan for recovery:**

A patient who slips and does not have a plan to address the aftermath is on a slippery slope. An individual with perceptions of low self-efficacy and a reduced positive outlook or expectancy contends with powerful forces that often pull them toward heavy substance use. The clinician and patient should co-construct an immediate plan for recovery. Preferably, a plan is written down so that the patient can take it to keep in important places such as a car, workspace, or home. The sooner the patient can implement the plan, the better the chance to avoid a full-blown relapse. There is no one right template for a plan; plans will vary depending on the patient’s circumstances. In addition, it is ideal to co-construct a plan that is realistic to the patient. If a patient does not feel confident that he or she can perform on an action plan, most likely the plan will be ignored when it is most needed.

- **Stay calm:**

After a slip, the patient is likely to experience a rush of negative emotions. It is important that the patient stay calm both physically and emotionally. Patients can be taught breathing exercises or brief relaxation methods to stem the tide of negative thoughts and feelings. Repeating some of the general strategies discussed earlier also may help with this process.

- **Renew commitment:**
Patients are often taught to shake off negative thoughts or setbacks in recovery similar to how an athlete is instructed to shake off a mild pain or injury in order to keep playing. Reaffirming a commitment to sobriety can empower patients and is effective in blocking negative and self-defeating self-statements. It can be helpful for patients to remove themselves from a situation, even if for a brief time, to renew their commitment to abstinence. For example, clients who attend social gatherings may be encouraged to go to the bathroom to get away from a difficult situation. While removed from a situation, they can have a moment of privacy to renew and strengthen their commitment.

- **Review the situation leading up to the slip:**

Patients are encouraged to pose questions to themself, such as, “what events led to the slip?” or “what warning signs preceded the relapse?” or “what was the high-risk situation that led to their return to use?”

- **Use support network:**

It is well known among addiction professionals that healthy human relationships provide a strong antidote to the isolating impact of addiction. Patients must seek out and find those who will support them in their recovery. Obvious examples of this include fellow members of 12-Step mutual help groups and sponsors. However, other supportive individuals include family members, members of a religious organization, and non-using friends. Patients should be encouraged to make a list of key people and their phone numbers to keep in case of a slip. If other people in the patient’s life are willing to help out and be supportive, the patient has a much greater chance of moving successfully through a lapse.
• Work through or process guilt and other negative emotions related to relapse:

Using many of the general strategies mentioned earlier can help minimize the relapse. Other self-statements that reaffirm recovery and address negative thinking also can be helpful, such as keeping a 3 × 5 card full of positive self-statements to refer to as many times as necessary.

Relapse management strategies are designed to minimize lapses and help the person recovering from addiction get back on track as soon as possible. Both general and specific strategies rely on cognitive and behavioral skills and interventions to accomplish this goal.

Building Coping Skills

A key part of relapse prevention requires learning how to successfully cope with high-risk situations. When a person using substances faces a high-risk situation, he or she can either use an effective coping response and subsequently avoid relapse or not use a coping response, thus greatly increasing the probability of relapse. Therefore, one of the first sets of skills a clinician should assess is the patient’s ability to cope. If coping skills are lacking, the clinician should attempt to teach new skills and help the patient practice them in therapy.

Clinicians should not assume that patients have all the skills necessary to cope with high-risk situations. Some individuals may think they can resist temptation only to be disappointed at their subsequent loss of
control. Conversely, they may be intensely aware of an inability to cope.95

The clinician assesses for strengths and limitations across several areas — family, work, recreation, diet, exercise, stress management — and helps promote behavioral action to improve the patient’s life. If a patient possesses strong coping skills and uses them regularly, then his or her self-efficacy increases and the risk of relapse is low. If he or she possesses poor or nonexistent coping skills, then the chances of relapse increase greatly.

**Cognitive Behavior Therapy**

Cognitive behavior therapy lends itself well to the treatment and counseling of substance use and addiction issues. The application of cognitive methods to the treatment of substance use problems can be comprehensive and complex. Behavior therapy serves as the foundation for many approaches to substance use counseling. Well-established substance use intervention models such as Rational Emotive Behavior Therapy (REBT) and Dialectical Behavior Therapy (DBT) use cognitive and behavioral principles as primary components to help individuals change substance use patterns.96

Cognitive and cognitive behavioral therapy has proven to be an effective form of treatment for individuals struggling with substance-related problems. For example, cocaine users rated the cognitive model and cognitive therapy as more helpful than supportive expressive therapy and general education. In a study on methamphetamine use, researchers found that cognitive behavioral therapy had superior outcomes and attendance compared to other
forms of therapy. In a systematic review of cognitive strategies used in the treatment of methamphetamine use, cognitive behavioral interventions showed positive changes as well as reductions in meth use, even after a few sessions, compared to controls. In general, research has supported the cognitive mechanisms of addiction as well as cognitive interventions when combined with behavioral strategies.

Irrational distorted thinking has been shown to be involved in several psychological problems, including depression, anxiety, PTSD (post-traumatic stress disorder), eating disorders, psychosis, and substance use. In the case of substance use, these distorted patterns serve to maintain and justify one’s addictive pattern. The connection between thinking, feeling, and behaviors is at the heart of cognitive behavioral theory, providing a framework from which clinicians can assess and help individuals that are struggling with substance use problems.

Cognitive theory rests on the assumption that thoughts, thought patterns, and cognitive themes, play a large role in psychological distress and behavior problems. Many patients have a particular internal dialogue that contains themes of self-blame, self-criticism, judgment, and negative interpretations. These negative themes may cause patients to experience negative emotions and problems, such as depression and anxiety. It is important to note that these cognitive processes are not considered the cause of all psychological disorders; however, they do play a major component. According to the cognitive theory of substance use and addiction:

“a major road-block to elimination of problematic substance use is the dysfunctional beliefs about substances and their effects. Examples of such beliefs include, ‘I cannot function without
cocaine’ or ‘Drugs are the only way to handle my stress.’ These dysfunctional beliefs are problematic in that they often distort reality, create negative mood states, and justify using substances to handle problems. It is interesting that a client’s dysfunctional beliefs often intensify when they experience deprivation. For example, the client might believe, ‘I can’t stand being without heroin’ or ‘These cravings are too strong for me to handle.’ In essence, such beliefs become self-fulfilling in that the client believes they can’t control their use or cravings, leading them to give up trying, which then leads to relapse, thus confirming the original belief.”

Cravings and urges present significant problems when trying to maintain abstinence. In many instances, dysfunctional beliefs contribute to the formation of urges. This process starts with a belief, which leads to an expectation, which then creates the internal urge to use. Most substance related beliefs center around pleasure seeking, problem solving, relief, and escape. Components of these dysfunctional beliefs include:

- The expectation that drugs will maintain internal balance
- The belief that drugs will make one more sociable and smarter
- The expectation that drugs will give one pleasure and fun
- The belief that drugs will increase energy and make one feel powerful
- The conviction that drugs will calm stress and tension
- The idea that drugs will relieve boredom and depression
- The belief that the only way to manage cravings is to take the drug
The cognitive model of substance use relies heavily on the impact of beliefs in the development of substance use and addiction. However, before core beliefs are activated, one must encounter an activating stimulus, which can be internal (feeling stressed, depressed, or anxious) or external (hanging out with friends, feeling awkward at a party). The stimulus serves as a trigger to core beliefs, setting in motion a series of additional thoughts, emotions, and cravings, ultimately leading to addictive behavior.

Cognitive therapy can be used at any point in the complete cognitive process, which includes as a means to modify core beliefs or address anticipatory or permissive beliefs that can lead to the development of substance use and associated problems. The nature of automatic thoughts is that they can occur spontaneously. Therefore, an individual can develop substance-related problems quickly and without much warning. One goal of cognitive therapy is to help individuals become more aware of their automatic thoughts and how they create cognitive vulnerabilities toward using substances.¹⁰⁰

When used as a framework for working with individuals that struggle with substance use problems, cognitive therapy is active, structured, and focused on goals that are generated in a collaborative manner.¹⁰¹ The spotlight of therapy is primarily on reducing faulty thought processes that contribute to emotional struggle and addictive behavior. Cognitive techniques and strategies also help reduce cravings and promote a stronger system of intrinsic control. Cognitive therapy for substance use is designed to decrease pressure and increase control. The mechanism to accomplish these objectives is challenging and
helping the individual to modify dysfunctional thinking related to substances and substance use.

In cognitive therapy for substance use, much more attention is centered on addressing underlying thought patterns that lead to or maintain one’s substance addiction. Sessions are geared toward helping individuals think more rationally and logically about their circumstances. Cognitive therapy offers a number of strategies and tools to aid in assessment and diagnosis of substance-related problems. While assessment is an important clinical skill across the spectrum of mental health disorders, it is particularly relevant when ascertaining the extent of problematic substance use.

The following is a partial list of critical elements in formulating a case using cognitive therapy:

1. Relevant history, including questions that assess when the substance use began:
   - Why did you start using drugs?
   - How did your use develop into a substance use disorder or addiction?
   - What has prevented you from stopping by yourself?

2. Current life difficulties:
   This involves assessing when life problems started, as well as when they began in reference to substance use. For example, did problems occur before substance use, as a result of substance use, or both?

3. Core beliefs or schemas:
Core beliefs or schemas are an essential component to understanding cognitive theory. Biased schemas can serve as the foundation for the development of cognitive distortions and automatic thoughts. Maladaptive schemas are usually global in nature, comprising one’s whole being, such as “I am unlovable,” “I am vulnerable,” or “I am ineffective”. These thoughts go to the core of who the person is as a human being. In other words, the thought is not “I was ineffective in that performance the other day” but rather “I am ineffective.” The assessment of these core beliefs becomes an essential practice when working with substance use through the lens of cognitive and cognitive behavioral theory.

4. Vulnerable situations:

Environmental stimuli often trigger core schemas leading to automatic thoughts and eventual substance use. For example, a client may engage in a period of abstinence from cocaine; yet upon driving through the client’s old neighborhood or seeing an old buddy who is a user, a chain reaction is set off in which schemas are triggered, leading to biased thinking, difficult emotions, and inappropriate coping (using substances). Assessing high-risk situations is a critical skill in determining the sequence of events leading to substance use. It also plays an important role in preventing relapse.

5. Automatic thoughts:

Automatic thoughts are triggered by environmental stimuli. Typical automatic thoughts among those who abuse substances include, “I can’t stand the urges and cravings,” “Just a little bit won’t hurt,” and “Go for it.” Automatic thoughts can be assessed through careful
questioning of what a person was thinking before he used or more formally through objective questionnaires, such as the Beliefs About Substance Use Scale.

In addition to the components listed above, the clinician will also attempt to identify emotions and behaviors that may play a role in maintaining problematic substance use. Although emotions and behaviors are not the central focus of therapy, they are associated with automatic thoughts. Cognitive techniques are often combined with behavioral interventions to help clients struggling with addiction.

The next step in the assessment process is to use the data to develop a comprehensive case conceptualization. The case conceptualization summary is composed of many elements designed to aid the clinician in developing treatment plans and goals. Major elements of the case conceptualization include:

- demographic information
- diagnoses
- assessment scores
- presenting problem
- developmental profile
- cognitive profile
- integration of cognitive and developmental profiles
- implications for therapy

Many clinicians use cognitive therapy because of its emphasis on structuring the counseling session. Structured sessions are especially important for those who use substances because topics can quickly spiral into nonproductive discussions. Cognitive therapists place a
premium on maximizing time and efficiency. Structured sessions are necessary to realize this aim.\textsuperscript{76}

Although there will be great variability from client to client and session to session, certain common elements operate in a cognitive therapy session with someone using substances:\textsuperscript{100}

- **Agenda:**
  The first element is setting the agenda. Agenda setting is an important skill, especially when there is a limited amount of time. It is appropriate for the clinician to share an agenda with the client as well as to provide an opportunity for the client to share what is on the mind. This strategy respects what the client brings to the session and facilitates a collaborative atmosphere. Clients who use substances may indeed come to sessions with numerous problems other than their use of drugs. This can make focusing on what is most pertinent a challenge. The danger of not setting an agenda, from the cognitive viewpoint, is that discussions too often steer in directions where not much is accomplished.

- **Mood Check:**
  The link between negative emotional states and substance use is well established, so a mood check is considered a second element in the structure of a cognitive therapy session for substance use. The most formal way to assess for mood status is to encourage clients to complete one or more short assessment instruments, such as the Beck Depression Inventory (BDI), the Beck Anxiety Inventory (BAI), the
Symptom Checklist 90, or the Beck Hopelessness Scale (BHS). Each of these instruments takes little time to administer, score, and interpret (except for the Symptom Checklist, which may take a little more time to hand score, so it would probably not be productive to do it every session). The advantage of using these instruments is that they provide an objective, quick way of checking in with clients regarding difficult emotions they are currently experiencing. Scores in the moderate-to-high range indicate that the client may be in a vulnerable state and at higher risk for relapse.

The clinician can use this information to either place it on the agenda or to at least check in with the client about his or her mental and emotional state. There is, of course, a less formal but effective way to conduct a mood check, which is simply to ask clients how they are feeling. One way to accomplish this is through a simple scaling-type question, such as, “On a scale of 1 to 10, where would you rate your mood, with 1 being not so good and 10 feeling great?” Ultimately, the mood check can be done a number of ways, depending on clinician preference and time.

- Bridging:

  The third element of the structure of a cognitive therapy session for substance use is bridging from the last session. Many clients who are addicted to substances lead chaotic lives where the potential exists for them to bounce from one issue or problem to the next between therapy sessions. To establish continuity from one session to the next, clinicians can
summarize the last session(s) and ask if the client has any unfinished business or unresolved issues to cover. As the counseling session begins, clinicians need to ask themselves, “How does our current topic connect to what we discussed the last time we met?” Rather than a formal technique, making a bridge from the last session is more about awareness on the clinician’s part of where the discussion was previously and how that connects to the current discussion. If the client veers too far astray from therapy goals and/or agenda items, the clinician can gently refocus the session in more productive directions.

- Discussion and questions:

The next steps in the session are the discussion of agenda items followed by Socratic questioning and other cognitive-based techniques. These elements are the foundation of the session, in which the most teaching and learning take place. Ideally, the majority of the session is allocated to exploration, discussion, and teaching of cognitive interventions.

- Recap

The clinician and client should recap what has been discussed, processed, and learned in every counseling session via a capsule summary. Some clinicians aim for a minimum of three capsule summaries; however, three summaries may be too ambitious and probably not necessary. Too many summaries can seem forced and redundant, especially when sessions are moving along slowly and not much information has been shared. As a general guideline, however, clinicians
should aim for two summaries: one at the middle of the session and one at the end. At the very least, a summary at the end of the session is recommended. The clinician usually does capsule summaries, at least initially. As time passes and rapport builds, summaries can become the responsibility of the client as well.

Many of the cognitive techniques used with clients in general can also be used with clients struggling with substance use. The techniques range from focusing on modifying dysfunctional thoughts to helping clients see the connections between their thinking, emotions, and behaviors. Some of the more common cognitive techniques used to address substance use are discussed below:

- **Daily thought record:**
  
  When clients who use substances become aware of their automatic schemas and thoughts, they are better able to see their dysfunctional patterns and how they contribute to substance use. This awareness also sets the stage for intervention; if clients are more aware of their negative thinking styles, they can choose to substitute negative thoughts with more positive or adaptive ones. The daily thought record is one of the most common and fundamental techniques in cognitive therapy.

- **Pros–cons analysis:**
  
  Many clients who use substances overestimate the advantages of using and underestimate the disadvantages. The pros–cons analysis is designed to help clients identify a
more balanced picture of their substance use. If successful, clients begin to see the disadvantages about using that they had not considered or that the advantages are not as great as they once thought. Pros–cons analysis can simply be discussed in the therapy session or written out on a piece of paper or flip chart.

- **Downward arrow technique:**

  The downward arrow technique can be a powerful avenue to get at one’s core belief or schema that is causing the misery. As an analogy, it is like peeling an onion, layer after layer, until one arrives at the core. In cognitive therapy, the peeling is moving away surface thoughts that cover deeper, more central thoughts that are leading to distress and problematic behavior. The strategy is to identify an automatic thought, usually through simple discussion or from the daily thought record.

  The clinician encourages the client to repeat the thought and then ask the question, “If that negative thought were true, what would it mean to me? Why would it upset me?” A simpler question might simply be, “And then what?” The client then shares another, related thought (although a little closer to the core schema), and the clinician follows with, “If that were true, why would that be upsetting?” (or “and then what?”) and so on, until a mutual stopping point is achieved. This stopping point should be at or near core belief or schema.
• Examining and challenging cognitive distortions:

There are several techniques to address the many cognitive distortions people hold about themselves, others, and the world. Many of these techniques are in the form of Socratic questioning, where the clinician asks a series of 10–13 questions designed to help clients better examine the distortion they hold. For example, a client who engages in dichotomous thinking might be asked, among other questions, to rate the degree of belief and emotions about the belief, conduct a cost-benefit analysis, and examine the evidence for and against his dichotomous thinking.

• Imagery:

Imagery can be a potent cognitive technique in helping a client prevent relapse. Making use of their imagination helps clients visualize working through difficult high-risk situations in which they might be tempted to use substances. Imagery is a type of cognitive rehearsal technique in which the client visualizes an upcoming situation (or any situation in which he or she would most likely be tempted to use) and concomitantly how this challenge would be managed. In essence, clients are taught to restructure their images in more positive directions. The client rehearses mentally several of the techniques he has been taught in counseling, leading to a satisfactory resolution to the situation.

The strengths, limitations, and ethical concerns of cognitive behavioral therapy are highlighted below:
Strengths of CBT:

Cognitive behavioral therapy is based on the interrelationship and reciprocal nature of thinking, feeling, and behaving and how these contribute to substance use. It is an integrative practice. Most variations of CBT allow for flexibility in therapeutic strategy and technique, which is critical when working with individuals struggling with addiction. The following are helpful points to consider when using CBT in the treatment plan for addiction; CBT provides:

- great value in confronting clients regarding core assumptions, beliefs, and values, which often maintains persistent substance use.
- for placing newly acquired insights into action via homework assignments so clients can practice abstinence supporting skills.
- strategies that allow clients to become their own best therapists outside of the counseling office.
- an effective, focused, and practical approach, which can appeal to a wide range of clients presenting with substance use problems (it is not a mysterious or complicated approach).
- education, which is a strong component of CBT, for clients struggling with addiction and who can benefit from a combined educational or therapeutic model.

Limitations of CBT:

The clinician’s level of training, knowledge, and skill correlates to how well CBT is implemented. Many clinicians may simply not have this level of training and continuing education. It is commonly assumed, although questionable, that exploration of the past is ineffective in helping clients change behavior. More research is needed in the
application of CBT with diverse populations as well as its application to substance use problems.

Ethical Issues of CBT:
The nature of many CBT approaches create a power differential by clinician’s imposing ideas as to what is rational or proper thinking. Clients who use substances may feel pressured to adopt the goals or values of the clinician. Many aspects of addiction, such as denial, rationalization, physical dependence, etc., would theoretically not be addressed by many CBT approaches. There is some concern about undue influence or manipulation from directive approaches such as CBT. Ethical issues may arise when the wishes for the client are different than the client’s own wishes.

**Hospital Resources During Recovery**
For many patients, the first step in the recovery process occurs in the hospital. Therefore, hospitals must be equipped with resources to assist patients with a substance use disorder. Typically, patients receive an initial screening and acute care in two different settings in the hospital - the emergency department and the psychiatric department.

**Emergency Department Crisis Team**
The first stage of alcohol and other drug treatment is essentially emergency treatment for acute conditions. These conditions include opioid and sedative hypnotic (including alcohol) overdoses, acute adverse physical and mental reactions to hallucinogens, and stimulant drugs. Many acute drug reactions can be life threatening, potentially
fatal, if not treated quickly. Often an emergency situation may be the first warning that there is a drug problem. Treated properly, emergency treatment situations may provide a window for initiating the patient into more comprehensive treatment for his or her drug problem. Drug emergencies may occur in the home and result in the patient being treated on site by a mobile unit following a 911 call, or being taken to an emergency room, hospital, clinic, or poison center.

To assist patients with a substance use disorder who enter the emergency department in crisis, and emergency department crisis team is mobilized. This team provides immediate care for the physical problems that led to admittance to the emergency department. In these situations, medical and/or psychiatric stabilization is the first priority. The ED crisis team will assess the patient and provide acute care for any life-threatening complications. If the patient has been admitted to the emergency department because of psychiatric distress, the ED team will focus on immediate stabilization, at which point the patient will be referred to the psychiatric department for further care.

**Psychiatric Department**

Many substance users will enter the hospital due to mental health issues. In these instances, the psychiatric department will provide preliminary mental health care and develop an acute treatment plan that will minimize psychiatric symptoms. Typically, the patient will receive an initial drug screening and assessment as part of the psychiatric assessment, and treatment will account for substance use issues. In many instances, patients will undergo preliminary detoxification while admitted to the psychiatric department. This is
essential in instances where the patient has comorbid substance use and mental health issues.24

**Community Resources During Recovery**

Many individuals will rely on community resources as they move through the recovery process. In some instances, patients will reach out to community care centers for immediate assistance with crisis situations. In other instances, individuals will utilize a range of services to support them throughout the recovery process. Therefore, the development and maintenance of a variety of community resources is essential to the substance use treatment community.

**Community Crisis Centers**

Community crisis centers provide a variety of services to assist individuals with crisis concerns. The specific programs and services offered will vary depending on the individual center. However, most organizations will provide assistance with sexual assault, suicide concerns, substance use issues, housing and food needs, and mental health issues. In most instances, the center will provide immediate crisis management, and then refer the individual to specialized services once the acute issue has been addressed.

Individuals with substance use problems can receive assistance with a number of needs related to their use. The crisis center can help substance users obtain housing, clothing, and food if they do not have access to these items. In addition, crisis centers can provide substance users with assistance with mental health issues that may or may not be related to their drug use. Finally, crisis centers can provide referrals
to detox and drug treatment programs for individuals who are seeking assistance with their addiction problems.\textsuperscript{104}

\section*{Homeless Shelters}

As noted earlier, there is a direct correlation between substance use and homelessness. Therefore, many substance users will require assistance from a homeless shelter at some point in the recovery process. To address the link between homelessness and substance use, and to promote recovery within the homeless community, many shelters offer recovery programs on site.\textsuperscript{8}

\section*{Mental Health Outreach}

Mental health outreach programs provide mental health care and referrals for individuals living with various mental health conditions. They provide immediate assistance to individuals with mental health crises, as well as long-term education and support programs to individuals living with mental health problems.\textsuperscript{65} These programs assist individuals with substance use and mental health comorbidities. Individuals typically receive assistance and referrals to substance use treatment programs, as well as assistance with mental health treatment. In addition, these programs can help recovering users maintain abstinence while coping with mental health issues.

\section*{Community Corrections}

Community corrections are sanctions that are given to individuals who reside outside of jail or prison. The sanctions are legally enforced as a means of controlling destructive, criminal behavior. These programs
are typically intended to help the offender reintegrate into the community after a period of incarceration. However, they are sometimes used as an alternative to incarceration for individuals with non-violent offences, such as drug offenders. Agencies or courts enforce the sanctions with legal authority over the adult or juvenile offenders. Community corrections programs are generally operated by probation agencies (correctional supervision within the community instead of incarceration) and parole agencies (conditional, supervised release from prison). Common examples of community corrections programs include:

- probation
- parole
- work release
- study release
- furloughs
- halfway houses

According to recent research:

“community-based corrections is less costly, promotes normal social and community relationships, and is at least as effective as institution-based corrections. Critical managerial and organizational issues in community-based corrections are establishing program goals, selecting a target population, soliciting funds, determining how best to introduce the program into the community, enlisting community support, and choosing staff. Forms of treatment used in community-based corrections include reality therapy, behavior modification, guided group interaction, and transactional analysis.”
Police and Community Together (PACT)

In September of 1991, a partnership was formed between the West Los Angeles Community Police Station and a group of civic-minded citizens, resulting in the formation of "Police and Community Together (PACT)", a non-profit corporation. PACT's mission is to establish good relations and interaction between the West Los Angeles community and officers at the West Los Angeles Community Police Station. To enhance the ability of local law enforcement to communicate and interact with engaged community members – especially parents – The Partnership at Drugfree.org developed PACT360, a program of research-based, multimedia community education presentations. The presentations are designed to mobilize communities and empower and educate parents and teens about the dangers of drugs and alcohol in today’s ever-changing substance use landscape.

PACT360 contains five key programs: Meth360®, Parents360, Youth360, Latino360 and Padres360. These programs provide parents and teens with a “360-degree” view of existing and emerging drug and alcohol issues. They are designed to be delivered by local partners, law enforcement, prevention and treatment professionals and can be customized to reflect the needs and issues of the community.

To date, PACT360 has been officially implemented in more than thirty communities across the nation, but has been utilized in many more. More than 2,200 presenters have been trained in person, and approximately 40,000 people have attended PACT360 presentations. Many more – including visitors from all fifty states and more than 40 foreign nations – have accessed PACT360 online. Working with local parents, law enforcement officials, substance use professionals and
those in other key roles, The Partnership at Drugfree.org's Community Education website offers a unique way for community stakeholders to connect and help keep kids healthier and safer. The varied PACT programs are described in greater detail in the following table.

| **PACT Programs** | **Parents 360** (Parents: You Matter) is a community education program that engages parents through a presentation called *Parents: You Matter*. The presentation provides parents and other caring adults with valuable insights as to why kids use, how parents can start the dialogue about the dangers of substance use with their kids and what steps to take if they suspect or know their child is using. It underscores the need for parents to educate themselves about the dangers of drugs and alcohol, and to be the go-to source when their children have questions. |
| **Parents 360RX** | The Parents360 Rx Action Toolkit consists of a video, a discussion guide and a small number of documents, and is available to individuals and organizations at no charge. Program hosts show the short (11-minute) video, which addresses the impact of medicine use on real families, to stimulate an informal discussion. The focus of this video is prescription medicine use, considered by many to be the biggest substance use disorder threat currently faced and one that is unknown to many parents and underestimated by many others. While medicine use is the focus, the discussion may be guided to include other substance use and addiction disorder topics. Hosts can use this toolkit at meetings of groups to which they belong, such as parent-teacher organizations, faith groups or even in the workplace. The toolkit may also be used in more traditional Parents360 venues where there are stringent time constraints (i.e., Rotary Club meetings). Additionally, hosts may wish to invite a few friends, family, neighbors or any group of concerned adults to their home or to another place in their community where they are comfortable such as a library, schools, places of worship, or local |
| Youth 360 (wreckED) | Youth360 (wreckED) is a community-based program designed to educate youth about substance use through an engaging presentation meant to challenge their behavior toward drugs and alcohol. The program provides the opportunity for teens to fully reflect upon the choices and consequences associated with alcohol and drug use and to continually keep themselves and their friends in check. There are three components to the wreckED program that can be used interchangeably, including:

- **DVD**: A ten-minute video depicting various aspects of today’s drug and alcohol scene, showing real-life teens talking about their own addiction and recovery experiences.
- **Card Game**: An interactive card game designed to encourage teens to talk about the issues presented in the video, simulating real-life choices, behaviors and consequences.
- **Group Discussion**: The facilitator continues the conversation with teens to underscore the importance of taking personal responsibility for their actions. |

| Meth 360 | Meth360® is a methamphetamine prevention program uniting law enforcement, treatment professionals and prevention professionals to deliver meth prevention education presentations to local communities. The audience learns about all aspects of meth from experts with diverse perspectives on the issue—a true "360-degree" view. Informative and motivational, Meth360 also challenges concerned citizens to educate themselves about the dangers of meth and take action to stop the spread of this dangerous drug. |
Self-Help Programs
The "12-step" programs help many people, including Alcoholics Anonymous (AA) and related groups such as Narcotics Anonymous (NA) and Cocaine Anonymous (CA). These self-help groups operate around the world and provide a social support system for recovery and a process for personal development that encourages looking inward and addressing issues obscured by alcohol and drug use.

In general, these programs do not function as a form of treatment. Rather, the groups exist to support recovering alcoholics or drug users in their rehabilitation process. The description that is read at the beginning of most 12-step meetings is as follows:

Alcoholics Anonymous (Narcotics Anonymous) is a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problem. The only requirement for membership is a desire to stop drinking (drug abuse). There are no dues or fees for AA membership; we are self-supporting through our own contributions. AA is not allied with any sect, denomination, political group, organization, or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.¹⁰⁹

These organizations have minimal formal structure and they report that their only authority is shared experience. The Alcoholics Anonymous and Narcotics Anonymous programs are expressed in two sets of principles that have been developed since the inception of AA in
1935. The Twelve Steps came first as a program for personal recovery from drug or alcohol problems, and the Twelve Traditions, which are principles for relationships between groups, came second. NA, which was developed after AA, is a separate organization that uses most of the ideas and principles of AA.

The Twelve Steps of AA and NA are introduced with the following sentence:

1. Admitted we were powerless over alcohol (drugs) that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.
Step 8: Made a list of all persons we had harmed and became willing to make amends to them all.

Step 9: Made direct amends to such people wherever possible, except when to do so would injure them or others.

Step 10: Continued to take personal inventory and when we were wrong, promptly admitted it.

Step 11: Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

Step 12: Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics [drug users] and practice these principles in all our affairs.

As the Twelve Steps became more broadly known, self-help programs grew. This growth necessitated guidelines for the interrelationships among groups, and hence the Twelve Traditions of AA were developed. These were consequently melded into the experiences of other Twelve Steps groups: 111

- Our common welfare should come first; personal recovery depends upon AA unity. Each member of AA is but a small part of a great whole. AA must continue to live or most of us will surely die. Hence our common welfare comes first. But individual welfare follows close afterward.
• For our group purpose there is but one ultimate authority — a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.

• The only requirement for AA membership is a desire to stop drinking. Our membership ought to include all who suffer from alcoholism. Hence we may refuse none who wish to recover. Nor ought AA membership ever depend on money or conformity. Any two or three alcoholics gathered together for sobriety may call themselves an AA group.

• Each group should become autonomous except in matters affecting other groups or AA as a whole.

• Each group has but one primary purpose— to carry its message to the alcoholic who still suffers.

• An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.

• Every AA group ought to be fully self-supporting, declining outside contributions. No contributions or legacies from nonmembers are accepted at the General Service Office in New York City, and no more than $500,000 per year from any one member, and for only one year after death.

• Alcoholics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.
• Alcoholics Anonymous, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve. The small group may elect its secretary, the large group its rotating committee, and the groups of large metropolitan areas their central committee, which often employs a full-time secretary. The AA General Service Board serves as the custodian of AA tradition and is the receiver of voluntary AA contributions. It is authorized by the groups to handle our overall relations, and it guarantees the integrity of all our publications.

• Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.

• Our public relations policy is based on attraction rather than promotion; we need to always maintain personal anonymity at the level of press, radio, and film.

• Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

Alcoholics Anonymous and NA meetings are available almost everywhere. The recovering substance user can, if he or she looks hard enough, usually find at least one meeting each day. There are two types of meetings, open and closed. Anyone is welcome at the open meetings, where one or two members typically tell their own stories of “how I used to be” and “how I am now.” Only members are allowed to attend closed meetings, because these tend to be much more personal and intimate.
During these meetings, personal problems or interpretations of the Twelve Steps or Twelve Traditions are usually discussed. Alcoholics Anonymous and NA, then, are widely available, cost-effective support programs for those alcoholics or drug-dependent individuals who choose to use them.\textsuperscript{111} While a client is in the process of receiving professional services, participation in self-help can be seen as a support mechanism. Subsequently, twelve-step groups can serve as a source of support and inspiration throughout the recovery process. Therefore, some patients should be encouraged to try out twelve-step participation and to seek groups that are comfortable for them.

Clinicians should also be aware of other self-help groups that might be of interest to some of their clients. For instance, Self Management and Recovery Training (SMART) is not “professional treatment,” rather, it offers freely available peer support groups based on a different philosophy of recovery. SMART offers free face-to-face and online mutual help groups to help people recover from all types of addictive behaviors, including alcoholism and drug use.\textsuperscript{112} SMART assumes that addictive behavior can arise from both substance use (\textit{i.e.,} psychoactive substances of all kinds, including alcohol, nicotine, caffeine, food, illicit drugs, and prescribed medications), and involvement in activities (\textit{i.e.,} gambling, sexual behavior, eating, spending, relationships, exercise, \textit{etc.}), and that there are degrees of addictive behavior, and that all individuals to some degree experience it. For some individuals the negative consequences of addictive behavior (which can involve several substances or activities) become so great that change becomes highly desirable. Much of the SMART rationale is based on the field of cognitive behavioral therapy.
The SMART program has been designed to provide an alternative for people whose approach to substance use is incompatible with that of AA.Outlined below are common ideas behind SMART and Rationale Recovery (another rational–emotive approach which is an alternative to traditional AA or NA groups):

- People are largely responsible for their drug and alcohol use behaviors.
- People do “get over,” that is, completely recover from their addictions.
- Lifetime membership is not a requirement. It is thought that some people recover quickly, others in one or two years.
- Labeling oneself as an addict or alcoholic is discouraged to avoid the negative outcomes associated with labeling.
- Alcohol use or other drug use(s) are not “diseases” in the common sense. They are, instead, life consuming, massive behavioral problems with broad ramifications and people with these problems need to learn to cope with them and take direct responsibility for their life course.
- People with alcohol and other drug use problems are good people. Removing the alcohol or drug problem makes people happier and healthier, but it does not in and of itself make them “better people.”
- Denial is a self-preservation method and counselors should work to help their clients get to a process of change that is internally motivated, safe, and productive. Confrontation of denial often mobilizes defenses even more so counselors can be most effective using motivational techniques to help ease the transition from problem use to nonuse.
Women for sobriety also provide an alternative to AA. Some women express the need for a philosophical approach that is positive in nature and that emphasizes empowerment, rather than powerlessness. The New Life Acceptance Program of Women for Sobriety has its own set of affirmations:

- I have a life-threatening problem that once had me.
- Negative thoughts destroy only myself.
- Happiness is a habit I will develop.
- Problems bother me only to the degree I permit them to.
- I am what I think.
- Life can be ordinary or it can be great.
- Love can change the course of my world.
- The fundamental object of life is emotional and spiritual growth.
- The past is gone forever.
- All love given returns.
- Enthusiasm is my daily exercise.
- I am a competent woman and have much to give life.
- I am responsible for myself and for my actions.

Alcoholics Anonymous

The Alcoholics Anonymous (AA) movement began when an alcoholic surgeon (Dr. Bob) and an alcoholic stockbroker (Bill W.) helped each other to maintain sobriety. From Ohio, they spread their idea that alcoholics need to help each other. Today, AA is an international organization. A few other alcoholic self-help groups, such as Alateen and Al-Anon, have been derived from AA. Alateen’s purpose is to help teenagers who have an alcoholic parent, whereas Al-Anon generally is aimed at spouses and others close to those with alcoholism.
The focus of the AA program is self-help recovery through following the Twelve Steps and group participation. The core of AA is the model of recovery outlined in the Twelve Steps. In the first step, AA absolutely dismisses the notion that people with alcoholism can control their drinking or can ever reach that position. The beginning of recovery occurs when those with alcoholism admit that they are powerless over alcohol; and, that without alcohol a return to health is possible, but with alcohol they will continue on a downward spiral to self-destruction.\textsuperscript{115}

One cause of controversy is the frequent reference to God in the Twelve Steps. An immediate reaction to this is that AA is only for those with alcoholism who accept Western religious beliefs. However, AA reinforces that the reference to God is truly just a reference to spirituality. The importance of referring to a Supreme Being is to emphasize that people with alcoholism have lost control over alcohol and their lives, and must enlist the assistance of a greater power in recovery.

The Twelve Steps are a guide designed for people to follow largely by themselves on the road to recovery. In addition to the twelve steps, there are other parts to the AA program. One of these is group participation. Two major types are discussion meetings and speakers’ meetings. In a discussion meeting, the chairperson of the group tells his or her personal history of alcoholism and recovery from it, and then the meeting is opened for members’ discussion of alcoholism and related matters. In a speaker’s meeting, a couple of members recite their personal histories of alcoholism and recovery. In open speakers’
meetings, anyone who is interested may attend while the closed
meetings are for alcoholics only.

_Twelve Steps of Alcoholics Anonymous_

The AA Twelve Steps are summarized below.¹¹⁶

1. We admitted we were powerless over alcohol — that our lives
   had become unmanageable.

2. Came to believe that a Power greater than ourselves could
   restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of
   God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the
   exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of
   character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to
   make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to other alcoholics, and to practice these principles in all our affairs.

One purpose of group meetings is to aid recovery through peer identification and learning from the experience of others. Building social relationships that do not revolve around alcohol represents an entirely new social life. The importance of forming sober social relationships may be seen in various AA functions such as “Sober Anniversaries” (the first day of a member’s current episode of continuous sobriety) and “Sober Dances” (dances without alcohol or drugs).\textsuperscript{117}

Other major activities in the AA program are “Twelfth Stepping” and sponsorship. \textit{Twelfth Stepping} refers to the twelfth of the Twelve Steps, which involves members reaching out to other alcoholics in a time of need. A member may help active alcoholics begin the AA program or help current AA members return to sobriety after they have begun drinking again.\textsuperscript{115} Sponsorship is similar to Twelfth
Stepping, but there are important differences. First, “sponsorship involves a stable one-to-one relationship between a member with more sobriety (the sponsor) and one with less (the sponsee)”. An individual with an alcohol use disorder who has made some progress in the recovery program shares that experience on a continuous, individual basis with another alcoholic who is attempting to attain or maintain sobriety through AA.

Another important difference is that the sponsor helps the sponsee in ways such as taking the newer member’s “inventory” (looking at what is behind a person’s behavior) when asked; and, guiding an individual to AA literature, such as the Big Book and Twelve Steps and Twelve Traditions, and explaining the AA program to family and others close to the sponsee. The sponsor–sponsee relationship is more varied and enduring than that involved in Twelfth Stepping. AA members view both types of activities as essential to their continued sobriety.118

**Narcotics Anonymous**

Narcotics Anonymous (NA) emerged as a non-alcohol focused twelve-step program in the 1950’s. The development of NA was directly related to the development of AA a decade earlier. The program was very small in its early years, with growth and expansion occurring in the 1970’s. Eventually, the program spread worldwide. Currently, “the organization is truly a worldwide multilingual, multicultural fellowship with more than 63,000 weekly meetings in 132 countries. NA books and information pamphlets are currently available in 45 languages, with translations in process for 16 languages”.119
Narcotics Anonymous is open to all individuals with a substance use disorder and does not differentiate between types of substances. The primary focus of the program is to “provide a recovery process and peer support network that are linked together. One of the keys to NA’s success is the therapeutic value of addicts working with other addicts”. As part of the program, members share their successes and challenges through attendance at regular meetings. In NA, members mentor and sponsor each other through the recovery process. Unlike AA, the NA program does not have roots in religion. Instead, “each member is encouraged to cultivate an individual understanding — religious or not — of the spiritual principles and apply these principles to everyday life.”

Membership in NA is open to everyone. There are no limitations based on social, religious, economic, racial, ethnic, national, gender, or class status. Members are not required to pay dues or membership fees. However, many members contribute to the group by helping to facilitate meetings and securing meeting space. Most programs utilize public, religious, or civic organizations for their meeting space, and individual members are responsible for leading each session. In addition, members are responsible for performing all other activities associated with conducting a meeting. The program does not utilize professional counselors. All therapy is conducted through the support network of members.

According to NA, the group has only one mission: to provide an environment in which addicts can help one another stop using drugs and find a new way to live. In addition to meetings, many NA programs also offer the following services:
- distribution of NA literature
- helpline information services
- presentations for treatment and healthcare staff, civic organizations, government agencies, and schools
- presentations to acquaint treatment or correctional facility clients with the NA program
- maintaining NA meeting directories for individual information and for any interested person

The following fact sheet, developed by NA, provides a thorough overview of the organizational structure and of NA membership.¹²⁰

**Narcotics Anonymous Fact Sheet**

**Structure**

Regional committees handle services within their larger geographical boundaries while the local or area committees operate local services. An international delegate assembly known as the World Service Conference provides guidance on issues affecting the entire organization. Primary among the priorities of NA’s world services are activities that support emerging and developing NA communities and the translation of NA literature.

In order to maintain its focus, NA has established a tradition of non-endorsement and does not take positions on anything outside its own specific sphere of activity. NA does not express opinions — either pro or con — on civil, social, medical, legal, or religious issues. Additionally, it does not take stands on addiction-related issues such as criminality, law enforcement, drug legalization or penalties, prostitution, HIV/HCV infection, or syringe programs. Narcotics Anonymous strives to be entirely self-supporting through member contributions and does not accept financial contributions from non-members. Based on the same principle, groups and service committees are administered by NA members, for members.

**Philosophy/Focus**
Narcotics Anonymous neither endorses nor opposes any other organization’s philosophy or methodology. NA’s primary focus is in providing a recovery environment whereby drug addicts can share their recovery experiences with one another. By remaining free from the distraction of controversy, NA is able to focus all of its energy on its particular area of purpose.

Although certain traditions guide its relations with other organizations, Narcotics Anonymous welcomes the cooperation of those in government, the clergy, treatment and healthcare professions, criminal justice organizations and private voluntary organizations. NA’s non-addict friends have been instrumental in getting Narcotics Anonymous started in many countries and helping NA grow worldwide.

Narcotics Anonymous strives to cooperate with others interested in Narcotics NA. Our more common cooperation approaches are: providing contact information, disseminating recovery literature, and sharing information about recovery. Additionally, NA members are often available to provide presentations for treatment centers and correctional facilities, offering information about the NA program to the professional staff and sharing with addicts otherwise unable to attend community meetings.

Membership

To offer some general informal observations about the nature of the membership, and the effectiveness of the program, the following observations are believed to be reasonably accurate:

- The socioeconomic strata represented by the NA membership vary from country to country. Usually, members of one particular social or economic class start and sustain most developing NA communities worldwide, but as their fellowship development activities become more effective, the membership becomes more broadly representative of all socioeconomic backgrounds.

- All ethnic and religious backgrounds are represented among NA members. Once a developing NA community reaches a certain level of maturity, its membership generally reflects the diversity or homogeneity of the background culture.

- Membership in Narcotics Anonymous is voluntary; no attendance records are kept either for NA’s own purposes or for others. Because of this, it is sometimes
difficult to provide interested parties with comprehensive information about NA membership. There are, however, some objective measures that can be shared based on data obtained from members attending one of our world conventions; the diversity of our membership, especially ethnic background, seems to be representative of the geographic location of the survey.

The following demographic information was gathered from a survey completed by approximately 16,750 NA members. The survey was made available at the 2013 World Convention of NA in Philadelphia, Pennsylvania in the international journal, The NA Way Magazine, and on the NA website:

- Gender: 57% male, 43% female.
- Age: 1% 20 years old and under, 12% 21–30 years old, 18% 31–40 years old, 28% 41–50 years old, 31% 51-60 years old, and 10% over 60 years old.
- Ethnicity: 76% Caucasian, 13% African-American, 5% Hispanic, and 6% other.
- Employment status: 59% employed full-time, 12% employed part-time, 11% unemployed, 9% retired, 6% students, and 4% homemakers.

Narcotics Anonymous members have an average of 11.07 years clean. This can be compared to NA’s last survey, which was the 2011 Membership Survey, showed members with an average of 10.87 years clean. In 2013 the two areas that received overwhelming improvement with NA attendance were family relationship, where 92% of members stated enrichment; and social connection, which was realized by 88% of the respondents. NA literature states that active addiction is marked by increased isolation and destruction with relationships. Recovery in NA has helped survey respondents to repair the damage in their lives from drug use and addiction.

Summary

At the beginning of this series on Substance Use And Addiction Disorders, it was highlighted that individuals with a substance use condition require a personalized treatment plan according to their unique medical, psychiatric, and substance use history. The treatment plan will need to include team considerations of the resources available
within the patient’s support network, hospital or treatment facility, and community throughout all stages of the patient’s recovery. From the time the patient enters into his or her initial treatment phase, the health team must begin to consider the patient’s unique history, comorbid conditions, and the patient’s views about their options to succeed in complete recovery.

It is important to understand the distinction between multiple substance use and single substance use, as individuals with multiple substance use and cross addiction issues will require different diagnostic and treatment strategies than those who are using a single substance. However, there are some similarities between the conditions, and those with multiple substance use will benefit from some of the strategies of treatment used with single substance users. *Substance Use And Addiction Disorders: Patient Education And Relapse Management* has provided the learner with a more detailed overview of long-term recovery options and community resources available to patients during transitions from acute or inpatient care to outpatient care and/or community support services, depending on the patient’s unique needs during recovery.

Substance use and addiction is a serious health and social concern that involves a vast area of research and the literature is ever evolving with regard to substance use and addiction criteria and treatment. Uni- or co-occurring disorders, such as psychiatric or chronic pain conditions, complicate the treatment plan and course of recovery. As mentioned in earlier courses of this four part series, another complicating factor is the treatment of individuals with multiple substance use and cross
addiction is the fact that they may use most any substance without having a preference for any single type.

There are multiple conditions that could require the health provider and treatment team to alter or change the treatment plan, depending on chronicity and severity of the patient’s condition. Future studies and courses on multiple substance use and cross addiction are needed to further assist health professionals to better understand options for treatment, and to plan the treatment and recovery program for patients on an individual basis.

References

35. Moyers TB, Houck J. Combining Motivational Interviewing With Cognitive-Behavioral Treatments for Substance Abuse: Lessons


59. Adoption of Evidence-Based Practices among Substance Abuse Treatment Providers [Internet]. [cited 2014 Feb 15]. Available from: http://baywood.metapress.com/app/home/contribution.asp?referrer=parent&backto=issue,6,6;journal,19,168;linkingpublicationresults,1:300320,1

60. The Substance Abuse and Mental Health Services Administration (SAMHSA) Website [Internet]. [cited 2014 Apr 3]. Available from: http://buprenorphine.samhsa.gov/about.html


77. Adoption of Evidence-Based Practices among Substance Abuse Treatment Providers [Internet]. [cited 2014 Feb 15]. Available from: http://baywood.metapress.com/app/home/contribution.asp?referrer=parent&backto=issue,6,6;journal,19,168;linkingpublicationresults,1:300320,1 (was 109)


82. Kelly TM, Daley DC, Douaihy AB. Treatment of substance abusing patients with comorbid psychiatric disorders. Addictive Behaviors. 2012. p. 11–24. (was 89)
95. Kiluk BD, Nich C, Babuscio T, Carroll KM. Quality versus quantity: Acquisition of coping skills following computerized cognitive-


