Certificate of Need Application

Recovery Services of Connecticut
Establishment of Intensive Outpatient Program (IOP)

March 31, 2017

	Table of Contents	
Section		
I.	**OHCA-Related Documents**	
	Checklist	
	List of Supplemental Forms	
	Proposal Information & Applicant Information	
	Affidavit	
	Check	
	Evidence of Public Notices	
II.	**CON Application**	
	Executive Summary	
	Project Description	
	Public Need & Access to Health Care	
	Financial Information	
	Utilization	
	Supplemental Form	
III.	**Attachments:**	
	Attachment A: DPH licenses	
	Attachment B: Key personnel resumes	
	Attachment C: SAMHSA CBHSQ Report	
	Attachment D: DMHAS Triennial State Substance Abuse Plan	Separate attachment due to large size
	Attachment E: Substance Abuse: Clinical Issues in Intensive Outpatient Treatment (TIP 47)	Separate attachment due to large size
	Attachment F: NIH Substance Abuse IOP	
	Attachment G: Letters of support	
	Standards of Practice Guidelines	

Checklist

Instructions:

Review each item below and check box when completed. **[Checklist *must* be submitted as the first page of the CON application.]**

☒ A completed CON Main Form, including an affidavit signed and notarized by the appropriate individuals. CON forms can be found at OHCA Forms.

☒ A completed Supplemental Form specific to the proposal type (see next page to determine which Supplemental Form to include in the application).

☒ Attached is the CON application filing fee in the form of a certified, cashier or business check in the amount of **$500** paid to "**Treasurer State of Connecticut.**"

☒ Attached is evidence demonstrating that public notice has been published for 3 consecutive days in a newspaper that covers the location of the proposal. Use the following link to help determine the appropriate publication: Connecticut newspapers. **The application must be submitted no sooner than 20 days, but no later than 90 days from the last day of the newspaper notice.**

The following information **must** be included in the public notice:

- A statement that the applicant is applying for a certificate of need pursuant to section § 19a-638 of the Connecticut General Statutes;
- A description of the scope and nature of the project;
- The street address where the project is to be located; and
- The total capital expenditure for the project.

(Please fax (860-418-7053) or email (OHCA@ct.gov) a courtesy copy of the newspaper order confirmation to OHCA at the time of publication.)

☒ A completed Financial Worksheet specific to the application type.

☒ All confidential or personally identifiable information (e.g., Social Security number) has been redacted.

☒ Submission includes one USB flash drive containing:

1. A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.
2. An electronic copy of the applicant's responses in MS Word (the application) and MS Excel (the Financial Worksheet).

Note: OHCA hereby waives requirement to file any paper copies.

☒ All submissions should be emailed to **OHCA@ct.gov**.

For OHCA Use Only:

Docket No.: ______________ **Check No.:** ________

OHCA Verified by: _________ **Date:** __________

Supplemental Forms

In addition to completing this **Main Form** and **Financial Worksheet (A, B or C)**, the applicant(s) must complete the appropriate **Supplemental Form** listed below. Check the box of the **Supplemental Form** to be submitted with the application, below. If unsure which form to select, please call the OHCA main number (860-418-7001) for assistance. All CON forms can be found on OHCA's website at OHCA Forms.

Check form included	Conn. Gen. Stat. Section 19a-638(a)	Supplemental Form
X	(1)	**Establishment of a new health care facility (mental health and/or substance abuse)** - *see note below**
☐	(2)	**Transfer of ownership of a health care facility** (excludes transfer of ownership/sale of hospital – see "Other" below)
☐	(3)	**Transfer of ownership of a group practice**
☐	(4)	**Establishment of a freestanding emergency department**
☐	(5) (7) (8) (15)	**Termination of a service:** - inpatient or outpatient services offered by a hospital - surgical services by an outpatient surgical facility** - emergency department by a short-term acute care general hospital - inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended
☐	(6)	**Establishment of an outpatient surgical facility**
☐	(9)	**Establishment of cardiac services**
☐	(10) (11)	**Acquisition of equipment:** - acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners - acquisition of nonhospital based linear accelerators
☐	(12)	**Increase in licensed bed capacity** of a health care facility
☐	(13)	**Acquisition of equipment utilizing [new] technology** that has not previously been used in the state
☐	(14)	**Increase of two or more operating rooms** within any three-year period by an outpatient surgical facility or short-term acute care general hospital
☐	Other	**Transfer of Ownership / Sale of Hospital**

*This supplemental form should be included with all applications requesting authorization for the establishment of a **mental health and/or substance abuse treatment facility.** For the establishment of other "health care facilities," as defined by Conn. Gen. Stat § 19a-630(11) - hospitals licensed by DPH under chapter 386v, specialty hospitals, or a central service facility - complete *the Main Form* only.

Proposal Information

Select the appropriate proposal type from the dropdown below. If unsure which item to select, please call the OHCA main number (860-418-7001) for assistance.

Proposal Type (select from dropdown)	Establishment of a new health care facility (IOP)
Brief Description	Recovery Services of Connecticut is requesting to establish an Intensive Outpatient Program (IOP) for adults with substance use disorders located in Madison, CT.
Proposal Address	11 Woodland Road, Madison, CT 06443
Capital Expenditure	$ 15,000
Is this Application the result of a Determination indicating a CON application must be filed? X No ☐ Yes, Docket Number: Click here to enter text.	

Applicant(s) Information

	Applicant One	**Applicant Two*** (if applicable)
Applicant Name & Address	Recovery Services of Connecticut LLC 11 Woodland Road Madison, CT 06443	N/A
Parent Corporation Name & Address (if applicable)	Not Applicable	
Contact Person Name	Jay Seigel or Reinhard Straub	
Title	Owners	
Email Address	jayseigel@gmail.com Reinhardwstraub@gmail.com	
Phone	(203) 303-7387	
Fax Number	(203) 303-7387 * same as phone *	
Tax Status (check one box)	X For Profit ☐ Not-for-Profit	☐ For Profit ☐ Not-for-Profit

**For more than two Applicants, attach a separate sheet with the above information*

FOR OFFICE USE ONLY	
Docket #:	Staff Assigned :
Date Received:	

Affidavit

Applicant: Recovery Services of Connecticut, LLC

Project Title: Establishment of Intensive Outpatient Program Services

I, *Jay Seigel, APRN*, CEO
(Name) (Position – CEO or CFO)

of *Recovery Services of Connecticut, LLC* being duly sworn, depose and state that the Recovery Services of Connecticut, LLC complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

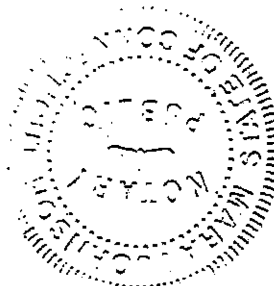
Signature: ______ 3-30-17
Date

Subscribed and sworn to before me on 3/30/17

Notary Public/Commissioner of Superior Court

My commission expires: ____________

MARA I JOHNSON
Notary Public
Connecticut
My Comm. Expires 04/30/2021



OFFICIAL CHECK

VERIFY THE AUTHENTICITY OF THIS MULTI-TONE SECURITY DOCUMENT. CHECK BACKGROUND AREA CHANGES COLOR GRADUALLY FROM TOP TO BOTTOM.

WebsterBank®   OFFICIAL CHECK   0001705320

145 Bank St.
Waterbury, CT 06702   00040 103907   03/30/2017   51-7010 / 2111

********$500.00

PAY TO THE ORDER OF   **500 DOLLARS AND 00 CENTS**

TREASURER STATE OF CT

REMITTER RECOVERY SERVICES OF CT, LLC

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE (TWO SIGNATURES REQUIRED OVER $25,000)

Security Features Included. Details on Back

AFFIDAVIT OF PUBLICATION

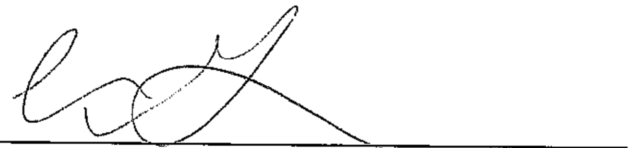
New Haven Register

STATE OF CONNECTICUT

County of New Haven

I Chris Gibson of New Haven, Connecticut, being duly sworn, do depose and say that I am a ***Sales Representative*** of the New Haven Register, and that on the following date 2/13, 2/14 & 2/15 to wit............

there was published in the regular daily edition of the said newspaper an advertisement,

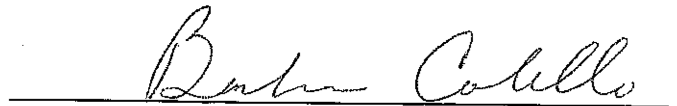


PUBLIC NOTICE
Notice is hereby given that pursuant to CGS 19a-638, Recovery Services of Connecticut, LLC intends to establish a substance abuse and psychiatric outpatient treatment program at 11 Woodland Rd, Madison CT with an associated capital expenditure of $10,000. Contact the State Department of Public Health, Office of Health Care Access.

And that the newspaper extracts hereto annexed were clipped from each of the

above-named issues of said newspaper.

Subscribed and sworn to this 27th day of March 20 17 Before me.



My commission expires July 31, 2019

HOW TO PLACE A CLASSIFIED AD:

CALL ▸ 1.800.922.7066 (Toll Free)

EMAIL ▸ classifiedads@nhregister.com
WEBSITE ▸ www.nhregister.com
FAX ▸ 1-888.243.0060

Classified is open Monday through Friday from 8am to 5pm.
The ad deadline is 5pm for publication the following day (Friday @ 5pm for publication Sunday or Monday).

Please check your ad on the first day it is published to make sure it is correct. If you find an error, please report it IMMEDIATELY. Call 1.800.922.7068. The New Haven Register will be responsible for only ONE incorrect insertion

APARTMENTS FOR RENT (UNFURNISHED)

#1 Rental Company in NEW HAVEN

Apartments for Rent, starting at $575 and Up! 1, 2 ,3, 4, 5 & 6 Bedroom Apartments for Rent. High Rises, Multi-Family Houses, Single Family. Commercial Rentals, Free Parking (some include Free Heat/ Hot water, Free Parking) and much more!

203-773-9710

LOOK!

ANSONIA 1 & 2 BR townhouse units available at Beaver Brook Apts. Located in wooded setting yet 10 minutes to New Haven and Bridgeport with no traffic lights! Prices from 1 BR, $875-$1025; 2 BR $975-$1175; Incl. heat & hot water. Fall Special: 1/2 off 1 month's rent. Call for your appointment today. 203-734-5117

DERBY, 1 BR- $740 + utils. & park. Ready to move in. Some w/ river views. No pets. 203-937-6933 or 203-499-8183

HAMDEN 5 rm, 2 br, 1st or 2nd flr, newly remodeled, no pets/ smoking, good credit/ref, $1100 + util. (203) 671-9644

NEW HAVEN 1 & 2 BR Starting at $790. FREE HEAT & HOT WTR. Fridge, Range. On-site laundry/more. (866)-490-2528 17013@newhome1.com

An Apartment You'll Love

NEW HAVEN- 5 lg rooms, 3 BR apt. on busline. $1250/mo. Call 203-430-7996

West Haven & Orange Dogwood Rd. Apts 1 & 2 Bdrms & Efficiencies. Carpeted & Laundry Rooms Starting at $685 When Avail. 203-795-3748

RENT NOW!

WEST HAVEN 1 BR, $850-$995; w/heat, HW included. Avail now! For appt 203-931-7700

CONDOS/TOWNHSE FOR RENT (UNFURNISHED)

HAMDEN, 2 BR TOWNHOUSE 1.5 BA, central AC, garage. $1,175 + utils. 2 mo. security. Credit & bkgd. check. No pets. 203-288-2196.

ROOMS FOR RENT

Hamden, Furnished room Share house, Kitchen, Cable TV, Internet, Wash/Dryer, On bus. $200/wk. 203-214-4343

CEMETERY LOTS

1 Cemetery plot at All Saints - Queen of the Universe section. $999. 919-812-0402

COMMERCIAL RENTALS

Offices For Rent $4,999.00 Within walking distance to Yale & New Haven's CBD. Close to I91 & I95. Perfect for Small group practice or single business requiring 7 private rooms, pivoting from a central location. Front & rear entrance with exceptional parking facilities. Full eat in Kitchen with two half bathrooms. Handicap accessible, inside and out. Contact info@winchestercapital.com 203 787 5029

CLASSIFIED IS OPEN
8:00 AM - 5:00 PM MON-FRI
Call 1.800.922.7066 or email: CLASSIFIEDS@NHREGISTER.COM

YOU GET QUICK action at a low cost when you advertise in the Insider classifieds.

HELP WANTED GENERAL

Due to continued grown and expansion **RAF** is looking for the following positions for 2nd shift.

- **Davenport Setup/ Operators**
- **Brown and Sharp Setup/ Operators**
- **CNC Swiss Setup / Operators**

Must be able to read blueprints, use necessary measuring tools, troubleshoot and repair equipment as necessary. Follow all safety procedures and quality standards

Benefits Including: Medical, dental, life, disability, 401(k) plan with employer match, vacation pay, holiday pay, and more.

Send Resumes to Bstach@rafhdwe.com or apply in person at 95 Silvermine rd. Seymour, CT 06483 Fax 203-888-9860

HELP WANTED FULL TIME

LeadMultimedia Animator(s) (Job #01): Create special effects using animation & music for cross-media marketing firm. Resume to: M. McKeown, Job #01, Digital Surgeons LLC, 1175 State St, #219, New Haven, CT 0651

CLEANING OUT YOUR ATTIC OR GARAGE? CALL 1-800-922-7066 TO ADVERTISE YOUR ARTICLES FOR SALE

DRIVERS

CLASS A CDL DRIVER Looking for local Class A CDL driver/ owner/operator, 2yr min exp, F/T or P/T. Good Pay, options avail. Please call 203-692-4439 or go to our website intelliapp.driverapponline.com/c/ckgreenhouses

HEALTHCARE

MEDICAL BILLING SPECIALIST with at least 5 yrs exp for medical office in North Haven Ct. Part time/ full time position avail. Good computer skills essential. Salary based on experience. Please reply via email: medicalbiller108@gmail.com

SALES

Earn money selling the New Haven Register papers around various locations, New Haven, Hamden, etc. Please call Emmett at 203-589-2910.

CALL TOLL-FREE **1-800-922-7066** TO PLACE YOUR CLASSIFIED AD

SKILLED LABOR

ELECTRICIAN, E-2 - FT Permanent opportunity with large Stamford based Co. Must be committed, self-motivated, self-disciplined, 5 plus yrs' experience. Bnft's Inc. Medical/Dental/ 401k. **Call 203-327-1120 Or email resume to: info@camsaninc.com**

LEGAL NOTICES

Derby Zoning Board of Appeals -Monthly meeting February 16, 2017 at 6:00 p.m. at the Derby City Hall. Application - Applicant: Priority Sign/AT&T -Spring Mobile. Location of affected premises – 70 Pershing Dr., Derby Appealing Section 195-69 (B) and Section 195-71 (C)(3) of the Derby Zoning Regulations, for an additional wall sign on the south face of the multi-tenant building.

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REMEMBER - when placing a classified to get fast results be sure to include:
1) all the details
2) include the price
3) be available to callers
As easy as 1 - 2 - 3!

LEGAL NOTICES

LEGAL NOTICE
CONNECTICUT LOTTERY CORPORATION
NOTICE OF START OF SCRATCH GAME

The Connecticut Lottery hereby gives notice that sales of the scratch games "Lucky 7s", (#1387) and "Diamond Bingo", (#1382) will begin on 2/14/2017 and will continue until the games end.
The Official Procedures for All Scratch Games will apply to this new game. Those Official Procedures are available at ctlottery.org (under the "Games & Winning Numbers" tab) and from CT Lottery Games Dept., 777 Brook St., Rocky Hill, CT 06067.

CARPENTERS! PAINTERS! LANDSCAPERS!
Place your ad in our Business Card Section or our Service Directory. Our readers will call you! They trust our advertisers to do the job right!
Call 203-880-6628

IS YOUR CLOSET overflowing with odds and ends, this and that? Place a classified to help end the clutter.

LEGAL NOTICES

LEGAL NOTICE
TOWN OF BRANFORD

The Planning & Zoning Commission of the Town of Branford, Connecticut hereby gives notice of Public Hearings to be held on Thursday, February 16, 2017 at 7:00 P.M. at the Branford fire Headquarters, 45 North Main Street,Branford to consider the following:
1. Application #17-1.5 ReSubdivision(to create one new lot) located at 19 Parish Farm Road. Alex Vigliotti (Vigliotti Construction)-Applicant. Daniel P. Cosgrove -Owner

At said hearings all persons will have the right to be heard and written communications will be received. Copies of the applications are on file in the Planning & Zoning Office.

BRANFORD PLANNING & ZONING COMMISSION
C. ANDRES, CHAIRMAN

IT'S THE CONVENIENCE that keeps people coming back to the great deals found in the classifieds.

LEGAL NOTICE
TOWN OF GUILFORD
INVITATION TO BID #11-1617
STATE PROJECT NO. 060-0102 EC

Abraham Baldwin Middle School Window & Door Replacement

The Town of Guilford is seeking competitive bids for the window and door replacement at Abraham Baldwin Middle School located at 68 Bullard Drive. Sealed Bids will be due on Monday, March 20, 2017 at 2:00 p.m. at the Office of the First Selectman, Town Hall, Second Floor, 31 Park Street, Guilford, CT 06437, at which time they will be opened publicly. Bids received after this date and time will be rejected. Sealed Bid envelopes (including overnight packaging) should be clearly labeled with bid number, bid title and marked 'time sensitive'.

Bid plans and specifications may be obtained at the Office of the First Selectman for a non-refundable purchase price of Fifty Dollars ($50.00), payable by check made out to the "Town of Guilford" or by CD for non-refundable purchase price of Ten Dollars ($10.00). Legal Notice and Addenda will be posted to the Town of Guilford's website at www.ci.guilford.ct.us and the Department of Administrative Services procurement website. Documents will be available beginning Friday, February 10, 2017.

A mandatory walk-through will be held at 3:00 p.m. on Thursday, February 16, 2017 at the site. Please meet outside the front entrance.

Any questions regarding the specifications may be directed, in writing only, to Clifford Gurnham, Director of Operations at gurnhamc@guilford.k12.ct.us with a copy to the Purchasing Department at millmanp@ci.guilford.ct.us.

Each bidder will be required to submit to the Office of the First Selectman, their original proposal with one (1) copy and a bid bond or cashier's check in the amount of ten percent (10%) of the base bid. Each bidder shall honor the bid price for ninety (90) business days from the date of the bid opening, without modification. Upon award of the bid, the winning bidder shall be bound by the bid proposal price throughout the contract period.

The minimum rates to be paid labor of the various classifications on this project shall be in accordance with current schedule of Prevailing Wages as established by the State of Connecticut, Department of Labor, Wage and Workplace Standards Division.

The Town of Guilford reserves the right to reject any or all bids; or to waive defects in same, if it deems such to be in the best interest of the Town.

In accordance with Connecticut General Statute Sections 4a-100 and 4b-91, a responsible bid must contain two (2) documents: The Contractor Prequalification Certificate and the Update (Bid) Statement. The classification GENERAL CONSTRUCTION B is required as a minimum.

This contract is subject to state set-aside and contract compliance requirements.

Joseph S. Mazza
First Selectman

NEW TODAY

Our newest Classified ads are right here!

MISCELLANEOUS

WANTED FISHING TACKLE Old stuff for my collection, or new stuff to fish with. Highest prices paid. Call Dave 860-463-4359 anytime

APARTMENTS FOR RENT (UNFURNISHED)

An Apartment You'll Love

NEW HAVEN- 5 lg rooms, 3 BR apt. on busline. $1250/mo. Call 203-430-7996

CONDOS/TOWNHSE FOR RENT (UNFURNISHED)

HAMDEN, 2 BR TOWNHOUSE 1.5 BA, central AC, garage. $1,175 + utils. 2 mo. security. Credit & bkgd. check. No pets. 203-288-2196.

ROOMS FOR RENT

Hamden, Furnished room Share house, Kitchen, Cable TV, Internet, Wash/Dryer, On bus. $200/wk. 203-214-4343

SAY HELLO to the most mobile marketplace in the area - the Insider Classifieds.

AUTOS WANTED

NICHOLS Salvage - Will buy your scrap steel, cars, trucks, alum., trailers, copper, batteries, heavy equip. 46 Meadow Rd. Clinton CT. 860-669-2808

Monday, February 13, 2017

GOREN BRIDGE

WITH BOB JONES
©2017 Tribune Content Agency, LLC

WEEKLY BRIDGE QUIZ ANSWERS

Q 1 - Neither vulnerable, as South, you hold:

♠ 10 9 5 3 2 ♡ K J ◇ K Q 4 ♣ A Q 10

As dealer, what call would you make?

A - Even players who "never" open one no trump with a five-card major should choose that call with this hand. Bid one no trump.

Q 2 - North-South vulnerable, as South, you hold:

♠ A 8 5 4 ♡ 4 ◇ A Q J 7 ♣ K J 10 2

SOUTH	WEST	NORTH	EAST
1◇	Pass	1NT	2♡
?			

What call would you make?

A - Bid three clubs. Partner has to have a four-card minor and might have five or six clubs. He will never give a preference back to three diamonds with only three-card support.

Q 3 - East-West vulnerable, as South, you hold:

♠ A Q ♡ K 10 ◇ K Q J 9 6 ♣ K Q 10 5

As dealer, what call would you make?

A - This hand wants the lead coming up to it, not through it. You can pretty much guarantee that by opening two no trump.

Q 4 - Both vulnerable, as South, you hold:

♠ 2 ♡ A Q 8 7 ◇ K J 6 2 ♣ 8 6 5 2

WEST	NORTH	EAST	SOUTH
2♠*	Dbl	4♠	?

*Weak two-bid

What call would you make?

A - It's tempting to bid something, but there is no safety without a long suit. Just double, showing values. You should certainly be able to defeat this contract.

Q 5 - North-South vulnerable, as South, you hold:

♠ A K J 9 5 ♡ 9 2 ◇ Q J 9 7 ♣ 8 2

EAST	SOUTH	WEST	NORTH
1♣	1♠	Pass	1NT
2♣	?		

What call would you make?

A - You really don't have the values for another bid, but the alternative is to sell out to two clubs. We can't stand that! Bid two diamonds.

Q 6 - East-West vulnerable, as South, you hold:

♠ A Q J 7 ♡ J 4 ◇ A ♣ A Q 9 7 6 3

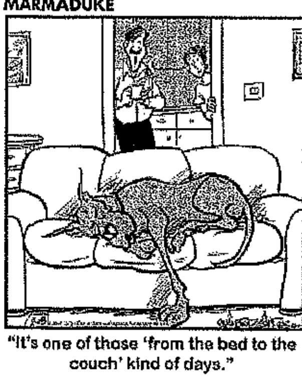
SOUTH	WEST	NORTH	EAST
1♣	Pass	1NT	Pass
?			

What call would you make?

A - A balanced hand would just raise no trump. Bidding two spades, a suit where you can't possibly have an eight-card fit, shows an unbalanced hand with long clubs. We think that's more descriptive than jumping to three clubs.

(Bob Jones welcomes readers' responses sent in care of this newspaper or e-mails sent to tcaeditors@tribpub.com)

MARMADUKE



"It's one of those 'from the bed to the couch' kind of days."

HOW TO PLACE A CLASSIFIED AD:

CALL ▸ 1.800.922.7066 (Toll Free)

EMAIL ▸ classifiedads@nhregister.com
WEBSITE ▸ www.nhregister.com
FAX ▸ 1-888.243.0060

Classified is open Monday through Friday from 8am to 5pm.
The ad deadline is 5pm for publication the following day (Friday @ 5pm for publication Sunday or Monday).

Please check your ad on the first day it is published to make sure it is correct. If you find an error, please report it IMMEDIATELY. Call 1.800.922.7066. The New Haven Register will be responsible for only ONE incorrect insertion

LOST AND FOUND

IMPOUNDED BY WEST HAVEN ANIMAL CONTROL, Brown & white female beagle. 203-937-3642

HOLIDAY

AUNTIE PAM
Happy Valentines Day
Sleeping on the couch
and lifting me up;
being a great aunt
since I was a pup.
Paw prints to you,
Love, Izee

Happy Valentines Day to my 2 beautiful daughters Jodymarie & Jaclynn and 3 Precious grandchildren, Princess Rose, Princess Star and Prince Romeo. Love Always, Your MeMa & Maxi Pupper xxoo beep beep

IZEE
To our 13 year old gurl,
you are our world.
We love you.
Happy Valentine's Day
Mom and Dad

MELISSA & ISABELLA
All my love forever,
Happy Valentines Day
Love Daddy

RIGSBEE, TROY LAMAR
(T-REAL)
You will forever
be the joy of my life.
HAPPY BIRTHDAY Son
LOVE YOU ALWAYS
West/Rigsbee

Terry
This past year has brought our family somebody new, A grandson who just loves to spit up on you, when you see him your eyes twinkle and you get all hyper, he looks at you and gets excited and wets his diaper, the family has decided your new name is Grandma Terry, but being with you is still like living with Moe, Curly & Larry.
Happy Valentine's Day, Love, Grady Bob & Big Bob

APARTMENTS FOR RENT (UNFURNISHED)

#1 Rental Company in NEW HAVEN
Apartments for Rent, starting at $575 and Up! 1, 2, 3, 4, 5 & 6 Bedroom Apartments for Rent. High Rises, Multi-Family Houses, Single Family. Commercial Rentals. Free Parking (some include Free Heat/ Hot water, Free Parking) and much more!
203-773-9710

LOOK!
ANSONIA 1 & 2 BR townhouse units available at Beaver Brook Apts. Located in wooded setting yet 10 minutes to New Haven and Bridgeport with no traffic lights! Prices from 1 BR, $875-$1025; 2 BR $975-$1175; incl. heat & hot water. Fall Special: 1/2 off 1 month's rent. Call for your appointment today. 203-734-5117

DERBY, 1 BR- $740 + utils. & park. Ready to move in. Some w/ river views. No pets. 203-937-6933 or 203-499-8183

APARTMENTS FOR RENT (UNFURNISHED)

HAMDEN 5 rm, 2 br, 1st or 2nd flr, newly remodeled, no pets/ smoking, good credit/ref. $1100 + util. (203) 671-9644

NEW HAVEN 1 & 2 BR
Starting at $790. FREE HEAT & HOT WTR. Fridge, Range. On-site laundry/more.
(866)-490-2528
17013@newhomel.com

An Apartment You'll Love

NEW HAVEN- 5 lg rooms, 3 BR apt, on busline. $1250/mo. Call 203-430-7996

West Haven & Orange
Dogwood Rd. Apts
1 & 2 Bdrms & Efficiencies.
Carpeted & Laundry Rooms
Starting at $685 When Avail.
203-795-3748

RENT NOW!
WEST HAVEN
1 BR, $850-$995; w/heat, HW included. Avail now! For appt 203-931-7700

ROOMS FOR RENT

Hamden, Furnished room Share house, Kitchen, Cable TV, Internet, Wash/Dryer, On bus. $200/wk. 203-214-4343

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8:00 AM - 5:00 PM
MON-FRI
Call 1.800.922.7066
or email:
CLASSIFIEDS@
NHREGISTER.COM

PLACING AN ad in classified is the way to go!

COMMERCIAL RENTALS

Offices For Rent
$4,999.00
Within walking distance to Yale & New Haven's CBD. Close to I91 & I95. Perfect for Small group practice or single business requiring 7 private rooms, pivoting from a central location. Front & rear entrance with exceptional parking facilities. Full eat in Kitchen with two half bathrooms. Handicap accessible, inside and out. Contact info@winchestercapital.com
203 787 5029

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HELP WANTED GENERAL

Due to continued grown and expansion **RAF** is looking for the following positions for 2nd shift.

•Davenport Setup/ Operators

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•CNC Swiss Setup / Operators

Must be able to read blueprints, use necessary measuring tools, troubleshoot and repair equipment as necessary. Follow all safety procedures and quality standards

Benefits Including:
Medical, dental, life, disability, 401(k) plan with employer match, vacation pay, holiday pay, and more.

Send Resumes to Bstach@rafhdwe.com or apply in person at 95 Silvermine rd. Seymour, CT 06483 Fax 203-888-9860

REMEMBER - when placing a classified to get fast results be sure to include:
1) all the details
2) include the price
3) be available to callers
As easy as 1 - 2 - 3!

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CLERICAL/ ADMINISTRATIVE

ADMINISTRATIVE ASSISTANT
The United Way of Northwest CT seeks an enthusiastic, attention to detail, self starter, who is motivated to join our dedicated staff and volunteers. This position will include coordinating our fundraising efforts and administration of programs run by our 26 agencies throughout Northwest CT. Specialized and core competencies include but are not limited to: Microsoft office, Publisher, Power Point, Web-site management, Social media, and fund raising software. Applicants can apply in confidence by sending their resume to The United Way of Northwest CT. PO Box 1001, Torrington CT 06790

DRIVERS

CLASS A CDL DRIVER
Looking for local Class A CDL driver/ owner/operator, 2yr min exp. F/T or P/T. Good Pay, options avail. Please call **203-692-4439** or go to our website **intelliapp.driverapponline.com/c/ckgreenhouses**

HEALTHCARE

MEDICAL BILLING SPECIALIST with at least 5 yrs exp for medical office in North Haven Ct. Part time/ full time position avail. Good computer skills essential. Salary based on experience. Please reply via email: medicalbiller108@gmail.com

SALES

Earn money selling the New Haven Register papers around various locations, New Haven, Hamden, etc. Please call Emmett at 203-589-2910.

SKILLED LABOR

ELECTRICIAN, E-2 - FT
Permanent opportunity with large Stamford based Co. Must be committed, self-motivated, self-disciplined, 5 plus yrs' experience. Bnft's Inc. Medical/Dental/ 401k.
Call 203-327-1120
Or email resume to: info@camsaninc.com

LEGAL NOTICES

PUBLIC NOTICE
Notice is hereby given that pursuant to CGS 19a-638, Recovery Services of Connecticut, LLC intends to establish a substance abuse and psychiatric outpatient treatment program at 11 Woodland Rd, Madison CT with an associated capital expenditure of $10,000. Contact the State Department of Public Health, Office of Health Care Access.

LEGAL NOTICES

Ansonia Planning and Zoning Commission
Notice of Public Hearing
February 27, 2017

Notice is hereby given that the Ansonia Planning and Zoning Commission will hold a public hearing Monday, February 27, 2017 at 6:30 p.m. at the Ansonia City Hall, 253 Main Street, Ansonia, CT for the following review:
Application for Special Exception – Westley St. Properties, LLC – property location, 32 & 33R Wesley St. – for excavation, land filling, grading or removal

At said hearing interested persons may appear and be heard and written communications will be received.

Dated at Ansonia Connecticut this February 27, 2017

Ansonia Planning and Zoning Commission
Joseph A. Jaumann,
Chairman

CITY OF DERBY PLANNING & ZONING COMMISSION LEGAL NOTICE

The Planning & Zoning Commission of the City of Derby will conduct a public hearing on Tuesday, February 21, 2017 at 7:00 p.m. in the Aldermanic Chambers, City Hall, 1 Elizabeth Street, Derby on the following applications:
1. Application from Burtville Associates for Zone Text Amendment to allow Personal Services Businesses in an I-1 Zone.
2. Application from Burtville Associates for special exception use for 328 Derby Avenue for use as a hair salon.
3. Application from Derby Planning and Zoning Commission for zone text amendment.
4. Application from Derby Planning and Zoning Commission for Zone Map Amendment for Derby Avenue I-1 and R-5 Zones to B-1 Zone.

At the hearings interested persons may be heard and written communications received.

Dated at Derby, Connecticut, this 1st day of February, 2017.

THEODORE J. ESTWAN, JR., CHAIRMAN
MARYANNE DETULLIO, CLERK

REQUEST FOR PROPOSALS
Resetarits Construction is accepting proposals from subcontractors for a new 77 unit apartment building in Hamden, CT. Bids are due at noon on 2/20/17. This contract is subject to state set-aside and contract compliance requirements. Please email Matthews@rcorporation for plans and specs and any questions.

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Call 203-850-6628

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An Apartment You'll Love

NEW HAVEN- 5 lg rooms, 3 BR apt, on busline. $1250/mo. Call 203-430-7996

ROOMS FOR RENT

Hamden, Furnished room Share house, Kitchen, Cable TV, Internet, Wash/Dryer, On bus. $200/wk. 203-214-4343

AUTOS WANTED

NICHOLS Salvage - Will buy your scrap steel, cars, trucks, alum., trailers, copper, batteries, heavy equip. 46 Meadow Rd. Clinton CT. 860-669-2808

Tuesday, February 14, 2017

GOREN BRIDGE

WITH BOB JONES
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PARRY AND THRUST

East-West vulnerable, East deals

NORTH
♠ J 10 4
♡ J 8 7 5 4 3
◇ 9 5 2
♣ 4

WEST
♠ 9 5 3
♡ 9
◇ Q J 8 7 4
♣ J 10 8 6

EAST
♠ 6 2
♡ A Q 6
◇ A K 10 6 3
♣ A 7 3

SOUTH
♠ A K Q 8 7
♡ K 10 2
◇ Void
♣ K Q 9 5 2

The bidding:

EAST	SOUTH	WEST	NORTH
1♣*	1♠	Pass	2♠
Dbl	4♠	All pass	

*Strong and artificial, at least 16 points

Opening lead: Nine of ♡

Today's deal features a lovely battle between the declarer and the defense. The artificial opening bid kept West out of the auction. He had no idea what a useful hand he held. The auction would have been dramatically different had East opened with one diamond. East won the opening heart lead with the ace. Had he returned a heart, the defense would have prevailed as long as West shifted to a club and not a diamond — no certainty. South, however, smoothly played his 10 of hearts under the ace at trick one.

South's clever play meant that East could not be certain that the lead was a singleton. East decided to cash a diamond first to see what partner played. South ruffed this with the queen of spades, cashed the ace of spades and led a low spade to the board's 10. Declarer led dummy's eight of hearts and run it when East played low. Had West ruffed, declarer would have had 10 tricks, so he correctly discarded. South countered by leading dummy's club. East had to duck this or, again, South would have had 10 tricks. Declarer won with the king and led the king of hearts. West again correctly discarded, but when South ruffed a club and led a good heart from the dummy, West had to ruff. South ruffed the diamond shift and led a low club from his hand. The ace of clubs, now singleton, fell "on air" and South finally had his 10 tricks. A beauty of a hand!

(Bob Jones welcomes readers' responses sent in care of this newspaper or to Tribune Content Agency, LLC., 16650 Westgrove Dr., Suite 175, Addison, TX 75001. E-mail: tcaeditors@tribpub.com)

MARMADUKE

"These are beautiful Valentine's Day flowers, and I'm not going to ask how you got them."

LEGAL NOTICES

NOTICE OF VESSEL LIEN AUCTION SALES

Pursuant to CT. Gen. Stats. Sec. 49-55a (c) notice is given of the intent to sell the following described vessels at public auction on February 23, 2017 at 10:00 am at Brewer Bruce & Johnson's Marina (Bruce & Johnson's of Branford Marina Inc.), 145 South Montowese Street, Branford, CT 06405:

Boat Name: KRIS-ANDREW; Last CT Reg.#: CT-300188; Description: 2006 24FT SEARAY 240 Sundeck Blue/White Powerboat; HIN: SERV4657K506; Claim Amount: $6,212.80 plus legal interest; Basis of Claim: Unpaid charges for vessel storage, related marine service & late fees from June 2016 to present; Last Known Owner(s): Luciano Barbara, 132 Warner Rd., North Haven, CT 06473; Luciano Barbara, 1496 Hartford TPKE, North Haven, CT 06473-1240.

Boat Name: PRIORITY; Last CT Reg.#: CT1154AV; Description: 1980 33.3FT Tiara Open Powerboat; HIN: SSUP1024M80H; Claim Amount: $5,648.81 plus legal interest; Basis of Claim: Unpaid charges for vessel storage, related marine service & late fees from January 2015 to present; Last Known Owner(s): David N. Garthwait, 39 Sheffield Rd., N. Haven, CT 06473.

Terms of Sale will be cash or certified check and the removal of the vessel by March 9, 2017. A $250 cash deposit will be due from the successful bidder immediately after the auction along with payment in full within 24 hrs of the auction. If payment in full is not made in 24 hrs, at Bruce & Johnson's of Branford Marina Inc. discretion, the vessel will go to the next highest bidder. If payment in full is made in 24 hrs, any boat remaining on the property after the allotted 14 days will incur a storage fee of $100 per day. The money will be held in escrow by Bruce & Johnson's of Branford Marina Inc. until such time as the Bill of Sale is delivered to you on or before March 9, 2017.

PUBLIC HEARING NOTICE
Planning & Zoning Commission

Certain public hearings will be held on **Wednesday, March 1, 2017** at the East Haven Community Center, 91 Taylor Avenue, East Haven, CT at 7:00 p.m. in order to hear the following:

Public Hearing #1: 92, 100, 110, 118, 126, 180, 242 Strong St – Application for a Special Exception : Elderly Living – non assisted facility (§ 33.19). Public Hearing Remains Open.

Public Hearing #2: 35 & 37 Sharon Drive – Proposed 12 lot Re-Subdivision Application.

Public Hearing #3: 444 Short Beach Road – Application for Special Exception: Building Contractors, business & Storage Yards (Sched. A, Line #56)

Submitted by:
Peter Cianelli – Chairman
Christopher Soto – Zoning Enforcement Officer

PUBLIC NOTICE

Notice is hereby given that pursuant to CGS 19a-639, Recovery Services of Connecticut, LLC intends to establish a substance abuse and psychiatric outpatient treatment program at 11 Woodland Rd, Madison CT with an associated capital expenditure of $10,000. Contact the State Department of Public Health, Office of Health Care Access.

great BIG ADS great BIG RESULTS

LEGAL NOTICES

Request for Specialty Crop Block Grant Concept Proposals

The Connecticut Department of Agriculture is seeking concept proposal for projects that solely enhance the competitiveness of specialty crops. Specialty crops are defined by the USDA as fruits and vegetables, dried fruit, tree nuts, maple syrup, honey, horticulture, and nursery crops.

Projects must impact and produce measurable outcomes for the specialty crop industry and/or the public. Projects cannot begin until after January 1, 2018, and must be completed by September 29, 2020. The maximum award is $75,000.

More info and complete application guidelines are available at www.CT-Grown.gov/grants, or by contacting Jaime Smith at 860-713-2559 or jaime.smith@ct.gov.

Concept proposals are due to the Connecticut Department of Agriculture by 4:00 p.m. on April 6, 2017.

State of Connecticut
Court of Probate, District of Central Connecticut Regional Children's Probate District

NOTICE TO Joshua Buddington, whose last known residence was in the town of East Haven, CT

Pursuant to an order of Hon. Philip A. Wright, Jr., Judge, a hearing will be held at Central Connecticut Regional Children's Probate Court, 1501 East Main Street, Suite 203, Meriden, CT 06450 on March 14, 2017 at 9:30 AM, on a petition for Termination of Parental Rights concerning Alexa L.S. D., a minor child born to Christine Doheny on May 31, 2007 at New Haven, Connecticut. The court's decision will affect your interest, if any, as in the petition on file more fully appears.

RIGHT TO COUNSEL: If the above named person wishes to have an attorney, but is unable to pay for one, the Court will provide an attorney upon proof of inability to pay. Any such request should be made immediately by contacting the court office where the hearing is to be held.

By Order of the Court
Philip A. Wright, Jr. Judge

STATE OF CONNECTICUT JOINT COMMITTEE ON LEGISLATIVE MANAGEMENT
REQUEST FOR PROPOSAL

Notice is hereby given pursuant to Section 2-71p of the Connecticut General Statutes, as amended, that the Joint Committee on Legislative Management of the Connecticut General Assembly has issued a Request for Proposal for State Capitol Cooling Tower Repairs – JCLM17REG0030.

Proposal responses are due no later than March 7, 2017 at 12 p.m. (noon). All Proposals must be submitted in accordance with the specifications and forms supplied in the specifications. Forms and specifications are available in the Office of Legislative Management, Room 5100 Legislative Office Building, Hartford, CT 06106 (Phone 860-240-0100; Fax 860-240-0122). This Request for Proposal is posted on the portal website which can be found at the following address: http://www.biznet.ct.gov/scp_search/BidResults.aspx?groupid=128.

Responses must be received by the time and date indicated above at the Office of Legislative Management, Room 5100 Legislative Office Building, Hartford, CT 06106.

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LEGAL NOTICES

STATE OF CONNECTICUT
SUPERIOR COURT
Judicial District of New Haven at New Haven
Hines, Leonard
Plaintiff
vs.
Hines, Romdon
Defendant

NOTICE TO:
Hines, Romdon

Return Date: 2/28/17
The Court has reviewed the Motion for Order of Notice and the Complaint/Application/Motion which asks for: divorce (dissolution of marriage). The Court finds that the current address of the party to be notified is unknown and that all reasonable efforts to find him/her have failed. The Court also finds that the last known address of the party to be notified was: Read St. New Haven, CT. The Court orders that notice be given to the party to be notified by having a State Marshal or other proper officer place a legal notice in: New Haven Register, a newspaper circulating in New Haven, CT, containing a true and attested copy of this Order of Notice, and, if accompanying a Complaint for divorce (dissolution of marriage), complaint for dissolution of civil union; legal separation or annulment, or if accompanying an Application for custody or visitation, a statement that Automatic Court Orders have been issued in the case as required by Section 25-5 of the Connecticut Practice Book and are a part of the Complaint/Application on file with the Court. The notice should appear once before 2/16/17 for one time publication and proof of service shall be filed with this Court.
Nancy Bauer
Asst. Clerk
1/19/17

THE GUILFORD HOUSING AUTHORITY

is currently accepting applications for COUPLES ONLY for its one bedroom apartments at Guilford Court and Boston Terrace in Guilford, CT. Applicants must be age 62 and over or on 100% social security or federal disability and over the age of 18. Applications may be obtained by calling the application line at 203-453-6262, ext. 107. An information packet will also be provided with the application. Applications will be accepted until March 31, 2017. Credit, police and landlord checks are procured by the authority. Smoke free housing.

EQUAL OPPORTUNITY HOUSING

PROBATE NOTICES

NOTICE TO CREDITORS
ESTATE OF:
Donald G. McDuff,
AKA Donald Gene McDuff,
AKA Donald McDuff

The Hon. Mark J. DeGennaro, Judge of the Court of Probate, District of West Haven Probate Court, by decree dated February 13, 2017, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Sally S. Skerritt,
Assistant Clerk

The fiduciary is:

Joan Beatty c/o James E. Fischer, Esq., Fischer and Fischer, 568 Washington Avenue, P.O. Box 568, West Haven, CT 06516

NOTICE TO CREDITORS
ESTATE OF:
Illuminato Manganello

The Hon. Clifford P. Hoyle, Judge of the Court of Probate, District of Derby Probate Court, by decree dated January 24, 2017, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Merissa Lawlor,
Assistant Clerk

The fiduciary is:

Lorenza Manganello c/o Alyson R. Marcucio, Esq., Chipman, Mazzucco, Land & Pennarola, LLC, 39 Old Ridgebury Road, Suite D-2, Danbury, CT 06810

A HOME OF YOUR OWN
The Job of Your Dreams
A Pet for the Children
A Second Car for Commuting
A Tag Sale "Buried Treasure"
Find these and more in the New Haven Register Classifieds.

PROBATE NOTICES

NOTICE TO CREDITORS
ESTATE OF:
Laura Jean Marden

The Hon. Mark J. DeGennaro, Judge of the Court of Probate, District of West Haven Probate Court, by decree dated February 2, 2017, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Sally S. Skerritt,
Asst. Clerk

The fiduciary is:

Joanne Tyndall, 90 Washington Ave., West Haven, CT 06516

NOTICE TO CREDITORS
ESTATE OF:
Lillian W. Firmender

The Hon. Beverly K. Streit-Kefalas, Judge of the Court of Probate, District of Milford-Orange Probate Court, by decree dated January 12, 2017, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Karen Adams,
Assistant Clerk

The fiduciary is:

Randy Firmender c/o Roger M. Klinger, Esq., 244 Bridgeport Avenue, Milford, CT 06460

NOTICE TO CREDITORS
ESTATE OF:
Lucy Pompilio

The Hon. Edward C. Burt, Jr., Judge of the Court of Probate, District of Hamden-Bethany Probate Court, by decree dated January 31, 2017, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Debra P. Caseria,
Assistant Clerk

The fiduciary is:

Jo-Ann McLaughlin c/o Vincent R. Falcone, 334-336 Main Street, P.O. Box 463, West Haven, CT 06516

NOTICE TO CREDITORS
ESTATE OF:
Mary Jane Ladutko

The Hon. Mark J. DeGennaro, Judge of the Court of Probate, District of West Haven Probate Court, by decree dated January 30, 2017, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Maureen B. O'Connor,
Chief Clerk

The fiduciary is:

Paul E. Whitaker, Esq., 3074 Whitney Avenue, Building 2, Second Floor, Hamden, CT 06518

NOTICE TO CREDITORS
ESTATE OF:
Michael Bedrin

The Hon. Beverly K. Streit-Kefalas, Judge of the Court of Probate, District of Milford-Orange Probate Court, by decree dated February 2, 2017, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Karen Adams,
Assistant Clerk

The fiduciary is:

Eric H. Opin, Esq., 266 Broad St., P.O. Box 412, Milford, CT 06460

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PROBATE NOTICES

NOTICE TO CREDITORS
ESTATE OF:
Rosemarie Dagostino,
AKA
Rosemarie D'Agostino

The Hon. Michael R. Brandt, Judge of the Court of Probate, District of East Haven-North Haven Probate Court, by decree dated February 1, 2017, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Eileen Sweeney, Clerk

The fiduciary is:

Luke A. Dagostino c/o Benjamin S. Trachten, Esq., 679 State Street, New Haven, CT 06511

NOTICE TO CREDITORS
ESTATE OF:
Todd L. Massari

The Hon. Edward C. Burt, Jr., Judge of the Court of Probate, District of Hamden-Bethany Probate Court, by decree dated January 18, 2017, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Debra P. Caseria,
Assistant Clerk

The fiduciary is:

Rose Massari c/o William S. Colwell, Esq., Parrett, Porto, Parese & Colwell, 2319 Whitney Avenue, Hamden, CT 06518

FORECLOSURES

LEGAL NOTICE FORECLOSURE AUCTION SALE

Docket No.
NNH-CV-16-6063868-S
Case Name:
Wilmington Trust
v.
Bobsie Perry, Et Al

Property Address:
157 Howard Ave.,
New Haven, CT
Property Type:
Residential

Date of Sale:
February 25, 2017 at 12:00 noon on the premises

Committee Name:
Linda A. Subbiole, Esq.
Committee phone number: (203) 562-2961

See Foreclosure Sales at www.jud.ct.gov for more detailed information

LEGAL NOTICE FORECLOSURE AUCTION SALE

Docket No:
NNH-CV-16-6060089-S

CASE NAME:
CIT Bank, NA
V
Shirley Ceratto, et al

Property Address:
95 Chester Street
Hamden, CT

Property Type:
Residential

Date of Sale:
February 25, 2017

Committee Name:
Gordon Demetre, Esq.
Committee
Phone Number:
203-230-9549

See Foreclosure Sales at: www.jud.ct.gov for more detailed information

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FORECLOSURES

LEGAL NOTICE FORECLOSURE AUCTION SALE

Docket No.:
NNH-CV-16-6064945-S
Case Name:
Savin Rock Condominiums Association, Inc.
vs.
Robert E. Leger, et al
Property Address:
46 Marshall Street
Milford, CT
Property Type:
Residential Condominium
Date of Sale:
Sat., February 25, 2017 at 12:00 p.m., on premises
Deposit: $14,000.00
Committee Name and Address
Richard Altschuler, Esq.
509 Campbell Avenue
West Haven, CT 06516
Committee
Phone Number:
203-932-6464

See Foreclosure Sales at www.jud.ct.gov for more detailed information

LEGAL NOTICE FORECLOSURE AUCTION SALE

Docket No:
NNH-CV-15-6054001-S
Case Name:
Reverse Mortgage Solutions, Inc.
vs.
Dorothy D. Staley, Et Al
Property Address:
908 Boston Post Road
Madison, CT 06443
Property Type:
Residential

Date of Sale:
February 25, 2017

Committee Name:
Attorney Frank Bonito
Committee Phone Number:
(203) 458-7288
Sale is subject to right of redemption in the USA

See Foreclosure Sales www.jud.ct.gov for more detailed information

LEGAL NOTICE FORECLOSURE AUCTION SALE

Docket No.:
NNH-CV-15-6058299-S
Case Name:
City of New Haven
V.
Victoria-Layton Properties
Property Address:
776 Grand Avenue
New Haven, CT 06511
Property Type:
Vacant Land
Date of Sale:
Sat., February 25, 2017 at 12:00 p.m.
Committee Name:
Brian C. Fournier, Esq.
Committee
Phone Number:
(203) 389-9500

See Foreclosure Sales at www.jud.ct.gov for more detailed information

LEGAL NOTICE FORECLOSURE AUCTION SALE

Docket No.
NNH-CV15-6057022-S
Case Name:
Deutsche Bank, National Trust Company, as Trustee for GSRPM Mortgage Loan Trust 2006-1
v.
Michael J. Nuzzi, a/k/a Michael Nuzzi, Et Al
Property Address:
75 Fenway Drive
Hamden, CT 06517
Property Type:
Residential

Date of Sale:
February 25, 2017

Committee Name:
Chris R. Nelson
Committee Phone
Number: 203.787.2000

See Foreclosure Sales at: ww.jud.ct.gov for more information

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or visit Dept. of HR, 200 Orange St, New Haven, CT 06510. Minority applicants encouraged to apply.
EOE, M/F/D.

Executive Summary

The purpose of the Executive Summary is to give the reviewer a conceptual understanding of the proposal. In the space below, provide a succinct overview of your proposal (this may be done in bullet format). Summarize the key elements of the proposed project. Details should be provided in the appropriate sections of the application that follow.

Jay and Reinhard Recovery Services LLC d/b/a Recovery Services of Connecticut (RSCT) propose to establish an outpatient treatment facility providing Intensive Outpatient Program ("IOP") services in Madison, CT for adults with Substance Use Disorders and Behavioral Health Disorders. We estimate beginning on, or after, July 1, 2017.

RSCT Co-owner Jay Seigel, APRN currently doing business as Connecticut Psychiatric Services, LLC has been providing outpatient psychiatric services in the Madison, CT community for over 10 years, and has been practicing in Connecticut for more than 20 years. Mr. Seigel does not currently offer IOP substance abuse services to his clients. The proposed IOP treatment population would primarily come from Mr. Seigel's practice and provide a much-needed level of care to the primarily dual diagnosed clients that Mr. Seigel serves.

RSCT will provide intensive outpatient substance abuse treatment and psychopharmacological treatment for clients in the Shoreline area. RSCT will be in-network with most commercial insurances and will also take Medicaid clients. The proposed outpatient service will improve health care services in the area, improve client outcomes including reduced recidivism, and reduce medical costs and costs to society by enabling clients to increase the likelihood of achieving sustained recovery.

The proposed service will have little if any impact on existing IOP providers and will greatly improve services and therefore, treatment outcomes in the area.

Project Description

1. ***Provide a detailed narrative describing the proposal. Explain how the Applicant(s) determined the necessity for the proposal and discuss the benefits for each Applicant separately (if multiple Applicants). Include all key elements, including the parties involved, what the proposal will entail, the equipment/service location(s), the geographic area the proposal will serve, the implementation timeline and why the proposal is needed in the community.***

Jay Seigel, APRN currently doing business as Connecticut Psychiatric Services, LLC has been providing outpatient psychiatric services in the Madison, CT community for over 10 years and has been practicing in Connecticut for more than 20 years. Reinhard Straub, LICSW d/b/a Reinhard Recovery LLC has worked in the Substance Use Disorder and mental health field since 1989 and initiated practice in Connecticut in 2006 as an interventionist and therapist. Reinhard has a long history of developing and operating Intensive Outpatient Programs (IOP) in the Northeast. Over the past several years they both have become acutely aware of how fragmented treatment options are for those suffering with substance abuse and mental health issues. The patients under their care that meet criteria for intensive outpatient treatment find that their options are limited and not always readily and logistically accessible. Other Connecticut inpatient residential facilities, group practices and clinicians (e.g. Yale & The Stonington Institute) will call seeking information about local services, specifically, whether local intensive treatment is offered. For instance, due to financial, employment constraints and transportation challenges, many local Medicaid and commercially insured patients prematurely drop out of or do not avail themselves of substance abuse treatment if it requires daily travel to, for example, New Haven or New London to access Intensive Outpatient care.

Recovery Services of Connecticut intends to establish an intensive outpatient treatment program (IOP) for adults (18-65+ years old) with Substance Use Disorders. The IOP program will deliver structured individual, group and IOP addiction services to patients with co-occurring mental health disorders in Madison, Connecticut. Services will greatly improve access to IOP in towns located in Connecticut's south-central region and eastern Connecticut shoreline. The program will serve those clients covered through commercial insurance and Medicaid.

Our goal is to expand our existing services to provide the most efficient continuum of care that will keep clients engaged in treatment in a more seamless and responsive way. Upon completion of the outpatient program, our clients would transition back to a lower level of care within the organization that will include individual therapy, relapse prevention group therapy and medication management if indicated.

IOP is traditionally a 4 to 8 week, three hours per day, 3-4 sessions per week, intensive outpatient treatment program. The IOP is designed to help people struggling with addiction to all substances including heroin, opioid pain relievers, alcohol, benzodiazepines, marijuana, cocaine, and other stimulants. The goal is to expand our services to provide the most efficient continuum of care at the outpatient level of care. Upon completion of the outpatient program, patients would transition back to a lower level of care within the organization that will include individual therapy, relapse prevention group therapy, medication management and medication assisted treatment if indicated. Additionally, if any underlying psychiatric disorders (e.g., anxiety, depression) are identified, the program, internally, will have the ability to treat co-occurring and co-morbid clinical presentations.

The introduction of this service will have minimal impact on the existing licensed providers in the area as the demand exceeds the availability of a continuum of Substance Use Disorder treatment with a robust psychiatric component at this time. The program will function as a step-down program from partial hospitalization, detoxification/withdrawal support, or residential services and will also be utilized to prevent or minimize the need for a more costly level of treatment to reduce overall healthcare costs. The proposal will also provide an immediate "step-up" from outpatient care. The proposed outpatient service will improve health care services in the area, improve client outcomes including reduced recidivism, and reduce medical costs and costs to society by enabling clients to increase the likelihood of achieving sustained recovery.

Jay Seigel and Reinhard Straub are passionate about providing high quality, coordinated patient care and this passion drives their wish to expand outpatient services for their patients. Proposed clinical staff bring an extensive history and expertise in treating substance use and mental health disorders. Our health care practitioners have specialized in substance use disorders and have spent most of their professional careers providing care for clients with substance use and co-occurring disorders and psychiatric conditions such as major depression, anxiety disorders, bipolar disorder, and post-traumatic stress disorders.

The estimated timeline to establish such services is approximately one month after receiving all approvals and licenses from the State.

2. *Provide the history and timeline of the proposal (i.e., When did discussions begin internally or between Applicant(s)? What have the Applicant(s) accomplished so far?).*

Jay Seigel and Reinhard Straub have been contemplating establishing the proposed IOP services for several years.

Incorporating evidence-based treatment approaches with strengths and quality outcomes is a passion unique to these providers that has provoked extensive discussion about the current need to develop integrated models of substance use and mental health disorders to ensure that quality treatment is provided.

So far, the accomplishments toward establishing the IOP services have been related to creating a business plan and working on professional relationships to identify future provider expertise for such a program. Identifying and recruiting effective providers who share a philosophy of treatment based on recovery is critical to realizing the desired vision and mission.

3. ***Provide the following information:***

   a. ***utilizing <u>OHCA Table 1</u>, list all services to be added, terminated or modified, their physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;***

TABLE 1 APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination
Intensive Outpatient Programs (IOP)	11 Woodland Rd. Madison, CT	Adults with diagnosed substance use issues	M,W,Th F: 9:00 AM-Noon	New Service

The intensive outpatient program is clearly identified as a distinct program that provides the appropriate clinical and culturally appropriately services for individuals, and in the case of the proposal, their families and loved ones as well. The IOP is a rigorous series of sessions designed to fulfill the unique treatment plan for each person served. Reinhard Straub will either supervise or directly provide intervention services for persons and their families who are in crisis. The program will function as a step-down program from partial hospitalization, detoxification/withdrawal support, and/or residential services and will also be utilized to prevent or minimize the need for a more intensive level of care to reduce overall healthcare costs.

Core components and clinical strategies vital to the proposed IOP level of care include but are not limited to treatment programming that will include:

- 12-Step recovery and participation
- Cognitive–Behavioral Therapy
- Motivational Interviewing
- Matrix model

A more detailed description of the treatment programs are in the table below.

Therapy	Description
12-Step model	12-Step meetings are free, widely available, and an ongoing source of support. Metropolitan areas in particular offer many meetings with a specialized focus (e.g., meetings for young people, women, newcomers to treatment, lesbians, gay men, Spanish-language speakers). The 12-Step approach emphasizes an array of recovery tasks in the cognitive, spiritual, and health realms. The 12-Step approach is effective with clients from diverse backgrounds.
Cognitive–behavioral Therapy (CBT)	CBT actively engages clients in therapy and experiential learning. Numerous manuals on CBT are available. CBT is suitable for clients from diverse backgrounds and with varying histories of alcohol and drug use. CBT provides

	structured methods for understanding relapse triggers and preparing for relapse situations.
Motivational Interviewing	Motivational Interviewing (MI) follows four basic principles (CSAT 1999c): Express empathy. The counselor communicates that the client always is responsible for change and respects the client's decision on this issue. Identify discrepancies. The counselor encourages the client to focus on how current behavior differs from his or her ideals and goals. Roll with resistance and avoid arguing. The counselor uses strategies to reduce resistance. Support self-efficacy. The counselor recognizes client strengths and encourages him or her to believe that change is possible. MI is client centered and relevant to clients' personal interests. MI focuses on realistic, attainable goals. MI encourages client self-efficacy and self-sufficiency. MI emphasizes positive, empathic support that does not undermine or elicit anger from clients.
Matrix Model	The model integrates a cognitive–behavioral approach with family involvement, psychosocial education, 12-Step Support, and urine testing. The model follows a manual, providing therapists with specific instructions and practical exercises. A version of the Matrix materials is available free from NCADI (CSAT 2006c, 2006d). The model has been used extensively with people dependent on stimulants and has been shown to be effective.

Source: SAMHSA TIP 47 (Attachment E of this CON application)

b. identify in <u>OHCA Table 2</u> the service area towns and the reason for their inclusion (e.g., provider availability, increased/decreased patient demand for service, market share);

Jay Seigel's practice (Connecticut Psychiatric Services, LLC) has been located in Madison, CT for 10 years. The proposed location for the IOP services was determined by using the existing patient base and the towns where the clients reside. An analysis of our 456 cases in 2016, showed that 70% of caseload originates from the 20 towns listed in Table 2.

TABLE 2 SERVICE AREA TOWNS

Town	Reason for Inclusion
Branford	Existing patient base
Chester	
Clinton	
Colchester	
Deep River	
Durham	
East Haven	
East Lyme	
Essex	
Guilford	
Haddam	
Killingworth	

Madison	
Niantic	
North Branford	
Old Lyme	
Old Saybrook	
Salem	
Waterford	
Westbrook	

Furthermore, our existing location in the town of Madison is along one of Connecticut's main south central corridors and will provide a convenient setting and location for clients, providing accessibility, proximity and privacy in the local community.

4. List the health care facility license(s) that will be needed to implement the proposal;

Upon CON approval, we will be submitting to DPH the license application for "Private freestanding facility for the care or treatment of substance abusive or dependent persons". We are currently working with DH to make sure all necessary licenses will be applied for. Based on the definition for 'day or evening treatment" which means a non-residential service to which a person may be admitted for the provision of counseling and other supervised activities, whose daily unit of service to each person is a minimum of 4 hours, which are designed and developed to arrest, reverse, or ameliorate the disorder or problem. (19a-495-570)

Once the DPH facility license for Intensive Outpatient and Outpatient Substance Abuse is finalized, Recovery Services of Connecticut will apply to contract with and become a Medicaid provider.

5. Submit the following information as attachments to the application:

a. a copy of all State of Connecticut, Department of Public Health license(s) currently held by the Applicant(s);

The licenses for Jay Seigel, APRN and Reinhard Straub, LICSW are attached.

(see ATTACHMENT A)

b. a list of all key professional, administrative, clinical and direct service personnel related to the proposal and attach a copy of their Curriculum Vitae;

The list of key staff of the proposed IOP services include:

Jay Seigel, APRN – CEO
Reinhard Straub, LICSW – President/Clinical Director
TBD - Clinical Coordinator

(see ATTACHMENT B)

*c. **copies of any scholarly articles, studies or reports that support the need to establish the proposed service, along with a brief explanation regarding the relevance of the selected articles;***

ATTACHMENT C: SAMHSA The CBHSQ Report "America's Need For and Receipt of Substance Use Treatment in 2015
Details the need and service utilization of substance use treatment suggest the majority of those 12 years and older do not get the treatment they need for treatment when medically necessary.

ATTACHEMNT D: State of Connecticut DMHAS Triennial State Substance Abuse Plan
The impact of the opioid epidemic in all levels of care and the need for rapid link opioid users to treatment. Discusses how overdose deaths are steadily increasing especially opiate and combination of opiate and benzodiazepine related deaths.

ATTACHEMNT E: NIH: Substance Abuse Intensive Outpatient Programs: Assessing the Evidence
IOP's are an important part of treatment and the care continuum for substance use disorder.

*d. **letters of support for the proposal;***

We have received letters of support from the following:

- Tidal Counseling LLC, Old Saybrook, CT
- Mark Ostrowski, Psy.D. Guilford, CT
- Post Traumatic Stress Center, LLC, New Haven, CT
- Family Medicine Associates

(see ATTACHMENT F)

*e. **the protocols or the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet the protocols or guidelines.***

The most relevant and current standards of practice applicable to the proposed project outlined in Treatment Improvement Protocol (TIP) 47, published by the Substance Abuse and mental health Services Administration (SAMHSA) (2006). **Please see CON Attachment G**. This publication titled Substance Abuse: Clinical issues in Intensive Outpatient Treatment, clearly identifies principles of Intensive Outpatient Treatment:

- Make treatment readily available
- Incorporate evidence-based approaches
- Ease of entry
- Provide ongoing care
- Provide medication assisted treatment and prescription monitoring

- Provide treatment for SUD and co-occurring disorders
- Engage families

RSCT will abide by the standards of practice as delineated in the 14 principles of Intensive Outpatient treatment in the Treatment Improvement Protocol (TIP 47), SAMHSA. The applicants will develop policies and procedures, make sure staff is properly trained and will implement and monitor the IOP requirements.

(see ATTACHMENT G)

f. copies of agreements (e.g., memorandum of understanding, transfer agreement, operating agreement) related to the proposal. If a final signed version is not available, provide a draft with an estimated date by which the final agreement will be available.

Recovery Services of Connecticut does not currently have any agreements related to the proposal.

Public Need and Access to Care

6. Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Connecticut Department of Public Health.

The proposed IOP services comply with DPH's Certificate of Need laws and regulations. Also the proposed IOP services will be applying for a DPH license for Outpatient Substance Abuse Treatment services.

No standards in Connecticut Department of Public Health exist that would directly apply specifically to this CON application for Intensive Outpatient licensure. The facility would be required to adhere to the following section of DPH Regulations (Public Health Code): "19a-495-570. Licensure of private freestanding facilities for the care or the treatment of substance abusive or dependent persons."

Recovery Services of Connecticut will be applying for licensure and consequently, will develop and operate the proposed facility in accordance with the applicable regulations set forth in 19a-495-570.

All clinical staff providing direct patient care will be licensed and supervised in compliance with the Public Health Code CT DPH Regulations Title 20: Professional Licenses.

7. Describe how the proposed project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan, available on OHCA's website.

The proposed IOP services are in alignment with the Statewide Health Care Facilities and Services Plan, the Healthy Connecticut 2020 document and several other reports widely noting the substance abuse crisis CT is facing.

The following are quotes from the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan:

"In 2013, the largest proportion of emergency department (ED) visits was among patients with Medicaid (38%)." "From 2009 to 2013, there were almost 8 million visits made to an ED in Connecticut by state residents. Of these visits, one million were for psychiatric, drug or alcohol-related mental disorders."

"**Behavioral Health Determinants and Services** As discussed in the SHIP, SIM and numerous hospital community health needs assessments (CHNAs), improving access to treatment for mental health and substance abuse is a priority for the State as a whole and each of the communities in Connecticut."

Relevant objectives as presented in the Healthy Connecticut 2020 report:

- "Decrease by 5% the rate of mental health emergency department visits."
- "Reduce by 5% the proportion of people (from grade 9 and older) who drink excessively across the lifespan." Pg.122

- "Reduce by 5% the rate of emergency department visits for people who are alcohol dependent across the lifespan." Pg.123
- "Reduce by 5% the non-medical use of pain relievers across the lifespan (ages 12 and older)." Pg. 125
- "Reduce by 5% the use of illicit drugs across the lifespan (ages 12 and older)."

As we propose and plan as a facility to take Medicaid for Intensive Outpatient and Outpatient Substance Abuse Treatment, we predict that we will be able to better predict and therefore, manage emergent crises. In our experience with patients, we have found that they tend to call us in times of need and before they seek higher levels of care. As a smaller program, we will have a communicative and intimate relationship with patients and especially with their families as we will also be engaging families affected by addiction under our care.

The proposed project will increase access to care for those who need it most and for those who need to use their in-network insurance benefit in order to be able to afford care. The proposal will establish the only Substance Abuse program in Madison and its' environs. The proposed project will take Medicaid and contract as an in-network commercial insurance provider with the closest outpatient programs that do the same at significant distance in New Haven, Middletown and New London.

8. With respect to the proposal, provide evidence and documentation to support clear public need.

Connecticut has surpassed the national average for drug-related deaths since 2013, experiencing a 76% increase from 1999 to 2013 according to the Connecticut Department of Public Health. Over the past five years Connecticut has seen deaths related to opioid overdose soar. Drug-induced death is currently the leading cause of injury-related death in Connecticut.

Furthermore, according to a recent publication from the Agency for Healthcare Research and Quality (AHRQ), Connecticut's rate of opioid-related inpatient stays ranked 7th highest when compared across all states. The national rate in 2014 was 224.6 inpatient stays per 100,000 population and Connecticut's rate was 286.9. The same data showed Connecticut's rate of opioid-related emergency department visits for 2014 at 243.0 per 100,000 population and the national rate at 177.7. This report demonstrates a growing need for treatment options for residents in Connecticut. With inpatient stays at a rising level, the availability of IOP for patients at time of hospital discharge is critical to their successful and ongoing recoveries.

Jay Seigel, owner of Connecticut Psychiatric Services has been integrating psychiatric and addiction treatment methodologies since 2008, providing services to over 450 patients annually. The proposed project will address the need to provide continuing treatment for the clients returning from higher levels of care e.g. inpatient hospitals, detoxification, and residential treatment. The proposed outpatient service will begin operation immediately upon award of a CON and issuance of a license by the DPH.

a. *identify the target patient population to be served;*

The target patient population to be served will be young adults, adults and their families working or living in towns nearby to Madison, CT and its' environs in need of intensive treatment for their substance use disorders and mental health disorders and education and supportive counseling, respectively. The proposed project will be accepting clients with commercial and Medicaid coverage, as well as those without insurance coverage based on ability to pay, a sliding scale and financial assistance for those in need.

b. *discuss how the target patient population is currently being served;*

The proposed target patient population is currently receiving outpatient therapy and/or psychopharmacological services from Jay Seigel, Reinhard Straub and from their licensed behavioral healthcare professional colleagues in the Madison, CT community and its' environs. Those patients in need of intensive outpatient level of care are obliged to travel several times per week and only can do so if they have available transportation and time off from work or family commitments. Not having local IOP creates barriers to care for many in need of more accessible services including work priorities, time constraints, family priorities, child care, transportation, etc. While Jay Seigel and Reinhard Straub do their utmost with client consent to coordinate care with other programs, with clients and their families and other stakeholders, communication and continuity of care are frequently a concern best addressed directly and locally.

c. *document the need for the equipment and/or service in the community;*

The need for IOP in the Madison, CT community is validated in detail in the previous response and by the clinical realities and experience of Connecticut Psychiatric Services. Jay Seigel has been providing psychiatric care in this community for 20 years and have watched the evolution of addiction medicine and the harsh impact addiction has on his patients, their families and on the community as a whole.

Many local patients have no choice but to engage in residential treatment at facilities at a distance in Connecticut due to the realities of insurance reimbursement and the logistical challenges as previously detailed. Connecticut Psychiatric Services receives frequent queries from CT facilities such as Yale, Stonington Institute and Silver Hill regarding local patients for the following reasons:

- Need for an IOP closer to home after acute stabilization
- Patients do not meet criteria for higher levels of care
- Insurance policies require that the patient "fail" at a lower level of care first
- Patients are in need of a local prescriber expert in addictions with concurrent outpatient substance abuse treatment

Regardless of where patients seek initial acute services, in CT or out of state, the majority will return to their families and to their local homes. Substance Use Disorders are incurable illnesses requiring ongoing local chronic disease management and active personal recovery. The high rate of recidivism

post residential substance abuse treatment is well known. When a patient under the care of the applicant(s) relapses, all of the aforementioned challenges immediately return. It is more realistic and clinically appropriate for the relapsing or actively addicted patient to immediately enter a local IOP within the same provider system that knows the patient best regarding their medical, clinical, family and social history. Intervening early and locally while continuing to work with the patient's family will provide an invaluable service to the community and reduce healthcare costs and burdens to the overtaxed CT hospital ED's.

d. explain why the location of the facility or service was chosen;

Existing office location:

The location for the proposed project was chosen because Connecticut Psychiatric Services has had an office in Madison, CT for many years and Jay Seigel is well known in the area as a local go to expert in addiction medicine and psychiatry. Jay has first-hand knowledge of and on the ground experience as a fixture in the Madison area. Providers at all levels of care, acute stabilization to outpatient therapists, are continuously seeking additional options to refer their patients to in this region on Connecticut.

The proposed project will improve health care services in the area, improve client outcomes, reduce recidivism, and reduce medical costs to society by enabling clients to increase the likelihood of achieving sustained recovery where they live. The introduction of this service will have minimal impact on the existing licensed providers in the area.

Accessibility:

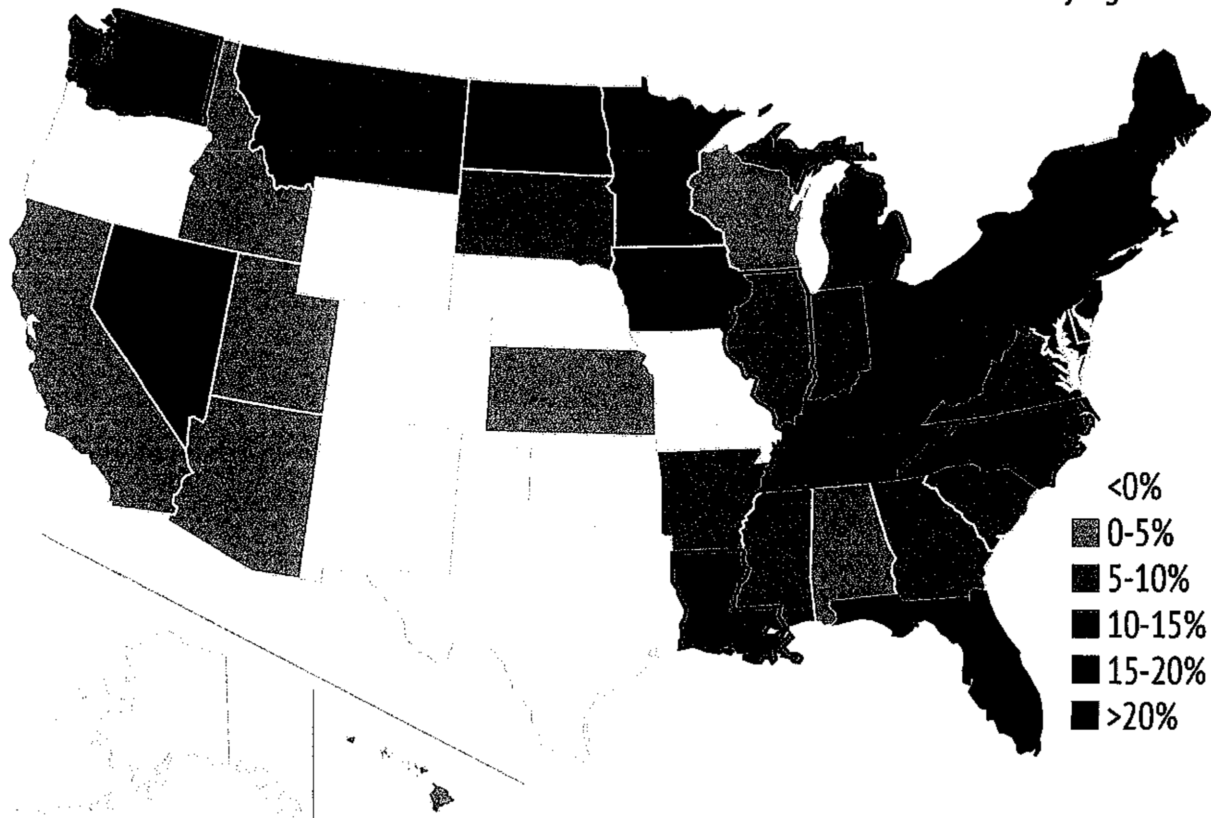
The proposed location is less than a half mile from the existing location of Connecticut Psychiatric Services and easily accessible locally and conveniently located next to major transportation routes and public transportation. The proposed location is right off Exit 61 on I95, the railroad station is located within walking distance, and bus lines are readily accessible. Clients and families in local towns will find it easy to travel.

e. provide incidence, prevalence or other demographic data that demonstrates community need;

Accidental deaths associated with "the opiate epidemic" have created a major public health crisis. The uniquely high rate of relapse to opiates, and the extreme risk of overdose among those achieving initial abstinence, compels treatment providers to attend to the continuing needs of discharging clients back into the local communities from other regions of the state and the country.

The need for intensive outpatient addictions treatment within Connecticut far exceeds capacity. The current epidemic of opiate (e.g., heroin, prescription opioids) addiction is overburdening an already overburdened system. Heroin and prescription opiate abuse is "epidemic". Heroin and prescription pain pills have single handedly caused a significant increase of accidental overdoses in Connecticut year after year which has now exceeded the national average reported by the Drug Poisoning Death Rate per

100,000, by County, 2010-2014. (see graphic below). Connecticut's Chief Medical Examiner Dr. James Gill said in a news release that between January 1 and June 30, of 2016 the first half of the year, 444 people died of accidental drug intoxications in the state. Gill is projecting 888 people will die of drug overdoses this year, which would be a sharp increase from the 729 fatal drug overdoses in 2015. With all accidental deaths combine Connecticut has more than doubled in the last 25 years according the Office of the Chief Medical Examiner annual statistic report from 1990-2015.



Furthermore, according to a recent report from the Substance Abuse and Mental Health Services Administration (SAMHSA), recovery is built on access to evidence-based clinical treatment and recovery support services for all populations. This report focuses on results from the 2016 National Drug Control Strategy that states ***a leading indicator of unmet substance use treatment need is the number of people who need substance use treatment but do not receive it*** at a specialty facility. Highlights from this study include:

- The 2015 National Survey on Drug Use and Health (NSDUH) data indicate that **8.1%** or 21.7 million people aged 12 or older **needed substance use treatment in the past year**
- In 2015, an estimated 2.3 million people aged 12 or older who needed substance use treatment received treatment at a specialty facility in the past year. This number represents 10.8% of the 21.7 million people who needed treatment in the past year.
- Among the estimated 19.3 million people aged 12 or older who were classified as needing but not receiving treatment, about 18.4 million or 95.4% did not think they needed treatment in the past year.

To bring these findings closer to home in Connecticut, SAMHSA provides data for the five regions throughout Connecticut (known as substate). The table below shows SAMHSA NSDUH data from 2012, 2013, and 2014.

The town of Madison is located in the South Central Region which shows that 8.8% of the population above the age of 18 years old was classified as having dependence or abuse of illicit drugs or alcohol in the past year. The SAMSHA data shows that of the adult population (18+ years of age) in the South Central Region of CT "needing but not receiving treatment for illicit drug use (2.2%) or alcohol use (6.9%)". The data are alarming and yet these are results as reported in 2012, 2013, and 2014. Many of us are only too aware that the substance abuse crisis in CT has been growing in the past few years.

Table in Report	Title	Percentage Estimates for 18+	95% Confidence Interval
19	***Dependence or Abuse of Illicit Drugs or Alcohol in the Past Year***		
	Eastern Region of CT	10.22	8.33-12.47
	North Central Region of CT	9.25	7.62-11.20
	Northwestern Region of CT	8.09	6.47-10.07
	South Central Region of CT	**8.86**	**7.32-10.70**
	Southwest Region of CT	8.52	6.91-10.47
	All Connecticut	**8.94**	7.88-10.13
20	***Needing But Not Receiving Treatment for Illicit Drug Use in the Past Year***		
	Eastern Region of CT	2.60	1.92-3.51
	North Central Region of CT	2.68	2.00-3.59
	Northwestern Region of CT	2.01	1.46-2.76
	South Central Region of CT	**2.27**	**1.69-3.05**
	Southwest Region of CT	2.25	1.65-305
	All Connecticut	**2.38**	1.92-2.94

21	***Needing But Not Receiving Treatment for Alcohol Use in the Past Year***		
	Eastern Region of CT	7.55	5.92-9.59
	North Central Region of CT	7.20	5.66-9.13
	Northwestern Region of CT	6.64	5.19-8.47
	South Central Region of CT	**6.94**	**5.45-8.81**
	Southwest Region of CT	6.85	5.27-8.86
	All Connecticut	**7.02**	5.96-8.26

For a conservative estimate of prevalence, we used a percentage of 2% for "in need of illicit drug treatment" and a 6% for "in need of alcohol use treatment". Therefore, we estimate 8% of the population in the South Central Region of CT are in need of treatment but not receiving it. We then took the population in our "service area" (designated as service area based on 70% of our current patient base resides in these towns), approximately 248,000 population, and calculated 8% of this population. The resultant is 19,840 people may be in need of treatment but not receiving it. We realize that this method is not scientific, and may be flawed, but it certainly makes the point that there are many people in our proposed service area that are in need of substance abuse treatment.

Town	Estimated Population
Branford	27,764
Chester	3,996
Clinton	13,125
Colchester	16,543
Deep River	4,581
Durham	7,623
East Haven	29,696
East Lyme	19,162
Essex	6,644
Guilford	22,481
Haddam	8,784
Killingworth	6,608
Madison	18,133
Niantic	Dna
North Branford	14,469
Old Lyme	7,576
Old Saybrook	9,993
Salem	4,244
Waterford	19,543
Westbrook	7,187
GRAND TOTAL	248,152

f. discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;

The proposed project plans to accept Medicaid. Connecticut Psychiatric Services has increasingly received calls from clients on public assistance who are in need of substance abuse treatment at all levels of care. Reinhard Straub, LICSW is a Husky provider and has worked with underserved groups for his entire career.

Despite a relatively high percentage of commercially insured persons in the Madison area when compared to Hartford and other urban areas of CT, rates of Medicaid enrollment in Madison and its' surrounding towns are significant especially when rates of ED utilization are factored in.

"In 2013, the largest proportion of emergency department (ED) visits was among patients with Medicaid (38%)." "From 2009 to 2013, there were almost 8 million visits made to an ED in Connecticut by state residents. Of these visits, one million were for psychiatric, drug or alcohol-related mental disorders." Pg.2

The rate of Medicaid enrollment in Madison is 7.3% but ranges up to 18% in nearby towns within 10 miles. Due to their direct clinical experience with CT Medicaid enrollees, the applicants are certain the proposed project with provide a much needed and hereto unavailable local resource to the underserved in Madison and its' environs.

g. list any changes to the clinical services offered by the Applicant(s) and explain why the change was necessary;

The proposed project seeks to provide local IOP and other substance abuse services that do not currently exist or as previously mentioned are difficult for the underserved to access. The change is necessary because of the increasing number of patients in the area who are seeking substance abuse treatment locally or would avail themselves of ongoing care if it was readily accessible.

h. explain how access to care will be affected; and

An IOP in Madison would eliminate many barriers to treatment and therefore, access will be positively affected. This is especially true for clients with Medicaid and/or financial challenges who might not otherwise engage in treatment. These clients and their families would have immediate access to realistic accessible treatment options and to treatment.

The proposed program will seek to become part of the fabric of the community by educating and engaging families affected by substance abuse. The program will aspire to intervene with the substance abuser as early as possible by engaging the family educationally and therapeutically. The strategy is proactive rather than reactive to the inevitable next crisis that many families repeated experience.

i.discuss any alternative proposals that were considered.

Alternative proposals were not considered.

9. *Describe how the proposal will:*

a. *improve the quality of health care in the region;*

Jay Seigel, APRN is an expert in addiction medicine, addiction psychiatry and psychopharmacology with many years of practice experience in CT. A large percentage of the prescribing of psychotropic medications in the US and CT is done by practitioners with little direct experience in the treatment of Mental Health, let alone, Substance Use Disorders.

The proposed project will provide the necessary intensive clinical component to Mr. Seigel's existing judicious prescribing practice, and by doing so, improve quality and outcomes.

Reinhard Straub, LICSW, as proposed Clinical Director, brings 28 years of direct clinical, program development and administrative experience to the proposed project. Mr. Straub has conducted over 1000 interventions, treated over 15,000 patients with substance use disorders and has initiated, developed and operated numerous treatment programs and modalities of monitoring and care in New York, Rhode Island and Connecticut.

The applicants' many years of combined experience and their commitment to helping others suffering from Substance Use Disorders as well as their interest in training and developing an effective clinical team will greatly improve the quality of healthcare in the region.

b. *improve accessibility of health care in the region; and*

The proposed IOP services will improve accessibility of health care in the region primarily in these three ways:

- geographic location
- additional capacity to IOP
- accepting of commercial and Medicaid coverage

The majority of patients suffering from Substance Use Disorders who present for treatment are initially identified and referred by or leveraged by their families, treating physicians, schools, law enforcement, employers, etc. The Applicants of the proposed project have long-standing strategic community and clinical relationships that will further benefit and improve accessibility of healthcare in the region. The proposed project will coordinate efforts and advocate, when appropriate and with patient consent, with referents on behalf of its patients.

We plan to continue our professional relationships with other providers in the area which will improve access for patients that they are aware of are in need of such services.

The proposed location, along one of Connecticut's main south central corridor that will provide a convenient setting and location for clients, providing accessibility, proximity and privacy in the local community.

c. ***improve the cost effectiveness of health care delivery in the region.***

The proposed project will reduce the cost of health care delivery by engaging Substance Use Disorder patients and their families in a continuum of long-term case management and outpatient care and monitoring. By proactively addressing each patient's unique clinical presentation e.g. co-morbid psychiatric issues, medical concerns, etc. as well as each patient's potentially toxic family, social and employment issues, expensive "over-use of repeated acute care episodes" can be averted. Effective Substance Use Disorder treatment is analogous to the chronic management of diabetes.
Connecticut Psychiatric Services will be working to build a behavioral health systems that enables clients to find effective treatments locally.

Treating co-occurring conditions at the same time is associated with lower costs and better outcome such as:

- Reduced substance use
- Improved psychiatric symptoms and functioning
- Decreased hospitalization
- Increased housing stability
- Fewer arrests
- Improved quality of life

Source: Substance Abuse and Mental Health Services Administration. Integrated Treatment for Co-Occurring Disorders: The Evidence. DHHS Pub. No. SMA-08-4366, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.
"It is widely understood in the addictions field that time-in-treatment is linearly associated with improved outcomes. In other words, the longer one remains engaged in treatment, the better their odds are for achieving sustained recovery (e.g. long-term abstinence). According to the national Drug Abuse Treatment Outcome Study (DATOS), "The length of time clients stayed in treatment was directly related to improvements in follow-up outcomes, replicating findings from previous national treatment evaluations". Providing continuing, uninterrupted treatment, extending it into the community, enables clients to increase their health outcomes. This results in a reduction in the over-use of repeated acute care episodes, reduced costs to society and improved functioning."

Source: Hubbard, R.L., Craddock, S.G., et al. (1997) Overview of 1-year follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). Psychology of Addictive Behaviors, 11(4), 261-278.

Another example and reference recommended by Strategy 5: Strategies Related to Collaboration and Cost Effectiveness in the Department of Mental Health and Addiction Services Triennial State Substance Abuse Plan:

"Action Step: Increase the % of SA clients that have continuous treatment exposures that exceed 90 days."

10. How will the Applicant(s) ensure that future health care services provided will adhere to the National Standards on culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality and help eliminate health care disparities in the projected service area. (More details on CLAS standards can be found at http://minorityhealth.hhs.gov/).

Both Applicants are licensed professionals, and therefore bound by their licensure & their respective profession's Code of Ethics. In Mr. Straub's case this would be the NASW's Code and in Mr. Seigel's case, The American Nursing Association's Code. However, in order to ensure the proposed project's adherence to the National CLAS Standards both Applicants will take and mandate all direct care clinicians under their supervision during pre-employment orientation to take the U.S. Department of Health & Human Services course: *A Physician's Practical Guide to Culturally Competent Care that is available to "Any direct service provider interested in learning about culturally and linguistically appropriate services".*

11. How will this proposal help improve the coordination of patient care (explain in detail regardless of whether your answer is in the negative or affirmative)?

The proposed project will improve coordination of care through the establishment of a multidisciplinary team that would work closely together on each case and through the establishment of an Intensive Outpatient level of care that will extend the continuum of care internally and be readily available for coordination of care externally for providers and facilities in the community.

The applicants routinely refer patients to physicians, medical practices, hospitals, residential treatment facilities, psychologists for testing, etc. and do their utmost to ensure that patients address their medical and behavioral health issues. The Applicants routinely communicate with all other providers and organizations to ensure that healthcare is coordinated appropriately.

Conversely, the aforementioned practitioners and clinical facilities have routinely referred patients to the Applicants given their experience and expertise in the treatment of Substance Use Disorders for a myriad of services such as interventions, evaluation, consultation, treatment placement and referral, psychiatric care and addiction medicine, individual counseling, group counseling, professional monitoring, etc.

12. Describe how this proposal will impact access to care for Medicaid recipients and indigent persons.

The proposed project will accept clients with Medicaid coverage. This will greatly improve the access for Medicaid recipients in this area since other providers do not accept Medicaid or the uninsured.

As detailed in the recent Triennial State Substance Abuse Plan 2016, the proposed project plans to include goals, strategies, and initiatives that will be the focus of the state's efforts to expand access to substance abuse treatment across the state of Connecticut.

13. Provide a copy of the Applicant's charity care policy and sliding fee scale applicable to the proposal.

Because the IOP services are proposed, we do not have an existing charity care policy. Upon CON approval, we will develop a charity care policy that will include multiple levels of financial assistance. The applicants are committed to providing the highest quality treatment while expanding access to care and therefore, will provide financial assistance, a sliding scale and discounted rate to individuals in need and ability to pay on a case by case basis.

14. If the charity care policies will be changed as a result of the proposal, list all changes and describe how the new policies will affect patients.

Not applicable since there is no existing program.

15. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation of good cause for doing so.

The proposed project will increase access by Medicaid recipients as we plan to accept Medicaid coverage and assist people without insurance coverage. We anticipate approximately 25% of our patient base to be either Medicaid or uninsured.

16. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees.

The proposed project will not adversely affect patient health care costs. The proposed project will not impose additional fees for services it provides.

Financial Information

17. Provide the Applicant's fiscal year: start date (mm/dd) and end date (mm/dd)

Fiscal year will start January 1 and will ends on December 31. The proposed outpatient service will begin operation immediately upon award of a CON and issuance of a license by DPH.

18. Describe the impact of this proposal on the financial strength of the state's health care system or demonstrate that the proposal is financially feasible for the applicant.

Financial and service utilization data provided in *Financial Worksheet B (Attachment II)* clearly demonstrate that the proposed service will produce incremental net gains from the beginning of operations, and increasing through the first three full years of projections. The proposed IOP services are projected to be financially feasible within the first full year operation in 2018.

Furthermore, this proposal will have a positive financial impact on the state's health care system as it will accept Medicaid recipients. Providing high quality IOP services will ensure successful recovery and therefore, reduce the costs associated with those individuals that do not receive IOP and may seek services at an emergency department or even inpatient hospitalization.

19. Provide an estimate of the capital expenditure/costs for the proposal using <u>OHCA Table 3.</u>

TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE

Purchase/Lease	**Cost**
Equipment (Medical, Non-medical, Imaging)	0
Land/Building Purchase*	0
Construction/Renovation**	0
Other (specify) office furniture & supplies, copier, phone system, etc.	$15,000
Total Capital Expenditure (TCE)	$15,000
Lease (Medical, Non-medical, Imaging)***	0
Total Lease Cost (TLC)	$13,500
Total Project Cost (TCE+TLC)	$28,500

20. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.

The proposed project will not receive any outside funding or financing. The estimated capital outlay of $15,000 (see *Table 3*) will be available using cash on hand. Since we plan on receiving clients immediately upon opening of the new service, there will be no delay in revenue generation – and no need for developmental operations outlay.

21. Included as an attachment

a. ***audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g., unaudited balance sheet, statement of operations, tax return, or other set of books). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current;***

This IOP service is new and therefore no previous financial statements exist.

b. a completed **Financial Worksheet A (non-profit entity), B (for-profit entity) or C (§19a-486a sale)**, available on OHCA's website under OHCA Forms, providing a summary of revenue, expense, and volume statistics, "without the CON project," "incremental to the CON project," and "with the CON project." **Note: the actual results reported in the Financial Worksheet must match the audited financial statement that was submitted or referenced.**

We have attached OHCA's Financial Worksheet B (see separate **Attachment)**

22. Complete OHCA Table 4 utilizing the information reported in the attached Financial Worksheet.

TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 2017 (07/01 – 12/31)	**FY 2018**	**FY 2019**	**FY 2020**
Revenue from Operations	$ 67,500	$225,000	$281,250	$337,500
Total Operating Expenses	$92,025	$217,150	$239,913	$262,675
Gain/Loss from Operations	($24,525)	$7,850	$41,338	$74,825

23. Fully identify and explain all assumptions used in the projections reported in the Financial Worksheet. In providing these detailed assumptions, please include the following:

a. Identify general assumptions for projected amounts that are estimated to be the same, both with or without this proposed project (i.e., project-neutral increases or decreases that occur between years). Explain significant variances (+/- 25% variances) that occur between years for the project neutral changes;

Firstly, there are no assumptions made based on "without" this proposal as this is a new service. If the CON does not receive approval, there will be no IOP services offered by RSCT. Volume projections are based on our experience of offering IOP services in other locations. Year One is a partial year and will have volume estimated at 560 visits. The first full year of operation (2018), we assume a volume of 1,800 visits and 2 FTEs, the second full year of operation we project a volume of 2,250 visits, and the third full year we project a volume of 2,700 visits. We feel strongly that based on our experience and the need for IOP services in the area, that these volumes are reasonable and achievable.

b. Identify specific assumptions for all projected amounts that are estimated to change as a result of implementation of the proposed project (i.e., project-specific increases or decreases). Address projected changes in revenue, payer mix, expense categories and FTEs. In addition, connect any service, volume (utilization) or payer mix changes described elsewhere in the CON application narrative or tables with these financial assumptions;

The Applicants project an estimated increase in the utilization of the IOP services as the program becomes established in the Madison area and a referral base is strengthened. Any increase in FTE and expenses are directly associated with the increase in volume. We made the assumptions regarding payer mix to the best of our ability based on our experience with such services. We are assuming the largest portion (65%) of IOP sessions from the commercial population, the next largest portion (30%) from Medicaid.

c. If the Applicant does not project any specific increases or decreases with the project in the Financial Worksheet, please explain why.

The Applicant projects increases in the utilization of the IOP services each year as it will be a new service in the Madison area and therefore, we anticipate incremental increases as the program becomes established.

24. Explain any projected incremental losses from operations resulting from the implementation of the CON proposal.

No incremental losses are projected for the proposal.

Utilization

25. Complete <u>OHCA Table 5</u> and <u>OHCA Table 6</u> for the past three fiscal years ("FY"), current fiscal year ("CFY") and first three projected FYs of the proposal, for each of the Applicant's existing and/or proposed services. Report the units by service, service type or service level.

In Table 5 we present the number of clients for each year that has been seen at the existing office for outpatient psychiatric services provided by the existing single practitioner, Jay Seigel, APRN. This data <u>does not include</u> any IOP services as the Applicant does not provide IOP level of care.

TABLE 5
HISTORICAL UTILIZATION BY SERVICE

	Actual Volume (Last 3 Completed FYs) NOT IOP SERVICES VOLUME			CFY Volume
Service	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017 (10/01 – 12/31)**
Office-based psychiatric services client	347*	389*	452*	515*
Total	347	389	452	515

* Historical volumes provided are for outpatient psychiatric services and not IOP services

In Table 6 we provide OHCA our projections of IOP services based on our assumptions of need in the service area.

TABLE 6
PROJECTED UTILIZATION BY SERVICE

	Projected Volume IOP SERVICES VOLUME			
Service*	**FY 2017 (07/01 – 12/31)**	**FY 2018**	**FY 2019**	**FY 2020**
IOP sessions/visits	337	1,200	1,500	1,800
Individual	225	600	750	900
Total	562	1,800	2,250	2,700

26. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHCA Table 5 and 6.

The following assumptions were used in completing *Tables 5 and 6:*

- A utilization rate of 100% is projected
- Outpatient treatment is projected to begin upon receiving CON approval and DPH licensing. Estimated to begin in July 2017.
- Volume are based on years of experience working in the field

27. Provide the current and projected patient population mix (number and percentage of patients by payer) for the proposal using OHCA Table 7 and provide all assumptions. Note: payer mix should be calculated from patient volumes, not patient revenues.

The current single practitioner provides psychiatric services and therefore we have not provided the payer mix associated with those existing services. However, by expanding our services to include the proposed IOP, our population payer mix will change. We have provided the most realistic payer mix for such services based on our experience with the operation of other like programs.

TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	Current FY 2017*		Projected					
			FY 2018		FY 2019		FY 2020	
	Dischgs	%	Dischgs	%	Dischgs	%	Dischgs	%
Medicare*	0	0	0	0	0	0	0	0
Medicaid*		30		30		30		30
CHAMPUS & TriCare	0	0	0	0	0	0	0	0
Total Government	**168**	**30**	**540**	**30**	**675**	**30**	**810**	**30**
Commercial Insurers	365	65	1,170	65	1,463	65	1,755	65
Uninsured/self-pay	28	5	90	5	113	5	135	5
Workers Compensation	0	0	0	0	0	0	0	0
Total Non-Government	**392**	**70**	**1,260**	**70**	**1,575**	**70**	**1,890**	**70**
Total Payer Mix	**560**		**1,800**	**100**	**2,250**	**100**	**2,700**	**100**

The assumptions from which these numbers are based include:

- A review of the geographic demographics
- Projections of payer mix are based on experience of working in the field for several years
- Medicare and TriCare do not provide coverage to IOP as proposed in this proposal

28. ***Describe the population (as identified in question 8(a)) by gender, age groups or persons with a specific condition or disorder and provide evidence (i.e., incidence, prevalence or other demographic data) that demonstrates a need for the proposed service or proposal. Please note: if population estimates or other demographic data are submitted, provide only publicly available and verifiable information (e.g., U.S. Census Bureau, Department of Public Health, CT State Data Center) and document the source.***

The estimated population of the Recovery Services of Connecticut's service area is 248,000 (see Table below). To be conservative, in our assumptions of "need" for IOP services we chose to use the lower limit of the 95% Confidence Interval for the South Central Region of CT. These percentages were then applied to the estimated service area population of 248,000.

The table below shows SAMHSA NSDUH data from 2012, 2013, and 2014.

The town of Madison is located in the South Central Region which shows that 8.8% of the population above the age of 18 years old was classified as having dependence or abuse of illicit drugs or alcohol in the past year. The SAMSHA data shows that of the adult population (18+ years of age) in the South Central Region of CT "needing but not receiving treatment for illicit drug use (2.2%) or alcohol use (6.9%)". The data are alarming and yet these are results as reported in 2012, 2013, and 2014. Many of us are only too aware that the substance abuse crisis in CT has been growing in the past few years.

Table in Report	Title	Percentage Estimates for 18+	95% Confidence Interval
19	***Dependence or Abuse of Illicit Drugs or Alcohol in the Past Year***		
	Eastern Region of CT	10.22	8.33-12.47
	North Central Region of CT	9.25	7.62-11.20
	Northwestern Region of CT	8.09	6.47-10.07
	South Central Region of CT	**8.86**	**7.32-10.70**
	Southwest Region of CT	8.52	6.91-10.47
	All Connecticut	**8.94**	7.88-10.13
20	***Needing But Not Receiving Treatment for Illicit Drug Use in the Past Year***		
	Eastern Region of CT	2.60	1.92-3.51
	North Central Region of CT	2.68	2.00-3.59
	Northwestern Region of CT	2.01	1.46-2.76
	South Central Region of CT	2.27	**1.69-3.05**
	Southwest Region of CT	2.25	1.65-305
	All Connecticut	**2.38**	1.92-2.94
21	***Needing But Not Receiving Treatment for Alcohol Use in the Past Year***		
	Eastern Region of CT	7.55	5.92-9.59

	North Central Region of CT	7.20	5.66-9.13
	Northwestern Region of CT	6.64	5.19-8.47
	South Central Region of CT	**6.94**	**5.45-8.81**
	Southwest Region of CT	6.85	5.27-8.86
	All Connecticut	**7.02**	5.96-8.26

For a conservative estimate of prevalence, we used a percentage of 2% for "in need of illicit drug treatment" and a 6% for "in need of alcohol use treatment". Therefore, we estimate 8% of the population in the South Central Region of CT are in need of treatment but not receiving it. We then took the population in our "service area" (designated as service area based on 70% of our current patient base resides in these towns), approximately 248,000 population, and calculated 8% of this population. The resultant is 19,840 people may be in need of treatment but not receiving it. We realize that this method is not scientific, and may be flawed, but it certainly makes the point that there are many people in our proposed service area that are in need of substance abuse treatment.

Town	Estimated Population
Branford	27,764
Chester	3,996
Clinton	13,125
Colchester	16,543
Deep River	4,581
Durham	7,623
East Haven	29,696
East Lyme	19,162
Essex	6,644
Guilford	22,481
Haddam	8,784
Killingworth	6,608
Madison	18,133
Niantic	Dna
North Branford	14,469
Old Lyme	7,576
Old Saybrook	9,993
Salem	4,244
Waterford	19,543
Westbrook	7,187
GRAND TOTAL	248,152

29. Using OHCA Table 8, provide a breakdown of utilization by town for the most recently completed fiscal year. Utilization may be reported as number of persons, visits, scans or other unit appropriate for the information being reported.

In Table 8 we provide our utilization for the existing practice which is operated by a single practitioner and provides office-based psychiatric services. These existing services will continue in the practice and offering IOP services will be in addition.

TABLE 8
UTILIZATION BY TOWN

Town	Utilization FY 2016 (Jan-Dec)	Percent Total
Branford	8	1.7%
Chester	2	0.4%
Clinton	43	9.4%
Colchester	4	0.8%
Deep River	5	1.0%
Durham	3	0.6%
East Haven	4	0.8%
East Lyme	12	2.6%
Essex	9	1.9%
Guilford	20	4.3%
Haddam	3	0.6%
Killingworth	20	4.3%
Madison	41	11%
Niantic	28	6.0%
North Branford	3	0.6%
Old Lyme	15	3.2%
Old Saybrook	39	8.5%
Salem	2	0.4%
Waterford	39	8.5%
Westbrook	14	3.0%
SUBTOTAL % Patient Base	314	69.6%
Remaining Patients from Other Towns	138	30.4%
GRAND TOTAL	452	100%

30. Using OHCA Table 9, identify all existing providers in the service area and, as available, list the services provided, population served, facility ID (see table footnote), address, hours/days of operation and current utilization of the facility. Include providers in the towns served or proposed to be served by the Applicant, as well as providers in towns contiguous to the service area.

TABLE 9
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS

Service or Program Name	Population Served	Facility ID*	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization
IOP	Young Adults/Adults	NPI: 1306042700	BH Care 14 Sycamore Way Branford, CT 06405	M-F (8am-9pm)	
IOP	Adolescents /Young Adults	NPI: 1659716405	Project Courage 251 Main Street, Suite 101, Old Saybrook CT, 06475	Monday - Friday: 9:00 am to 7:00 pm	

31. Describe the effect of the proposal on these existing providers.

The introduction of this service will have minimal impact on the existing licensed providers in the area. The two existing programs within the area mostly serve adolescent and private pay clients. The proposed outpatient service will improve health care services in the area, improve client outcomes including reduced recidivism and reduced medical costs and costs to society by enabling clients to increase the likelihood of achieving sustained recovery.

32. Describe the existing referral patterns in the area served by the proposal.

The known referral patterns include two population segments: public sector and private sector. The majority of existing providers of IOP services in the area primarily service clients covered by commercial insurance or self-pay.

33. Explain how current referral patterns will be affected by the proposal.

The addition of the proposed IOP services will improve referral patterns in the area. Currently providers have a limited access to refer their patients that live in and nearby Madison for this level of care. Furthermore, the two existing providers focus their care toward adolescents and young adults; and they do not accept Medicaid.

34. If applicable, explain why approval of the proposal will not result in an unnecessary duplication of services.

Currently the area does not offer community options and has very limited capacity to IOP services especially for those covered by Medicaid.

35. Explain in detail how the proposal will impact (i.e., positive, negative or no impact) the diversity of health care providers and patient choice in the geographic region.

The proposal will have a positive impact on patient choice in the region by offering adults more capacity to needed IOP services, especially for those covered by Medicaid.

Supplemental CON Application Form

Establishment of a New Health Care Facility (Mental Health and/or Substance Abuse Treatment) *

Conn. Gen. Stat. § 19a-638(1)

Applicant: Recovery Services of Connecticut, LLC

Project Name: Establishment of IOP

*This supplemental form should be included with all applications requesting authorization for the establishment of a **mental health and/or substance abuse treatment facility**. For the establishment of other "health care facilities," as defined by Conn. Gen. Stat § 19a-630(11) - hospitals licensed by DPH under chapter 386v, specialty hospitals, or a central service facility - complete *the Main Form* only.

1. Project Description: New Facility (Mental Health and/or Substance Abuse)

a. Describe any unique services (i.e., not readily available in the service area) that may be included in the proposal.

The applicants intend to establish an intensive outpatient treatment program (IOP) for adults with Substance Use Disorders. The IOP options in the Madison area are limited. The IOP program will deliver structured individual, group and IOP addiction services to patients with co-occurring mental health disorders in Madison, Connecticut. Services will greatly improve access to IOP in towns located in Connecticut's south-central region and eastern Connecticut shoreline. The program will serve those clients covered through commercial insurance and provide unavailable IOP services to persons with Medicaid.

b. List the type and number of DPH-licensed health care professionals that will be required to initiate the proposal.

The applicants propose the following healthcare professionals to initiate the proposal:

- Jay Seigel, Advanced Nurse Practitioner (APRN)
- Reinhard Straub, Licensed Clinical Social Worker (LCSW)
- TBD, License Professional Counselor (LPC)

2. Projected Volume

a. For each of the specific population groups to be served, report the following by service level (include all assumptions):

(i) An estimate of the number of persons within the population group by town that need the proposed service; and

We used SAMHSA data (substate report) to estimate the number of persons within the population by town to have dependence to illicit drugs or alcohol in the South Central Region of CT (8.8%), the estimated 2.2% of the population that needed but did not receive treatment for illicit drug use, and the 6.9% of the population that needed but did not receive treatment for alcohol abuse.

Since the 8.8% of the population was similar in percentage of population when combined the two estimates for "needed but did not receive treatment" (2.2% plus 6.9%); we decided to be conservative and use an average of 8% of the population likely needing the proposed IOP services (see table below).

Measure	All CT	South Central Region of CT
Dependence to Illicit/Alcohol	8.9%	
RSCT Service Area Only		8.8%
Needed but not received/illicit	2.3%	
RSCT Service Area Only		2.2%
Needed but not received/alcohol	7.0%	
RSCT Service Area Only		6.9%

Source: SAMHSA data using substate information

We then applied the 8% to the town population to arrive at the results listed in the table below.

Town	Estimated Population	Estimated 8% Substance Use Prevalence
Branford	27,764	2,221
Chester	3,996	319
Clinton	13,125	1,050
Colchester	16,543	1,323
Deep River	4,581	366
Durham	7,623	609
East Haven	29,696	2,375
East Lyme	19,162	1,532
Essex	6,644	531
Guilford	22,481	1,798
Haddam	8,784	702
Killingworth	6,608	528
Madison	18,133	1,450
Niantic	Dna	Na
North Branford	14,469	1,157
Old Lyme	7,576	606
Old Saybrook	9,993	799
Salem	4,244	339
Waterford	19,543	1,563
Westbrook	7,187	574
GRAND TOTAL	248,152	19,842

(ii) The number of persons in need of the service that will be served by the proposal (estimated patient volume).

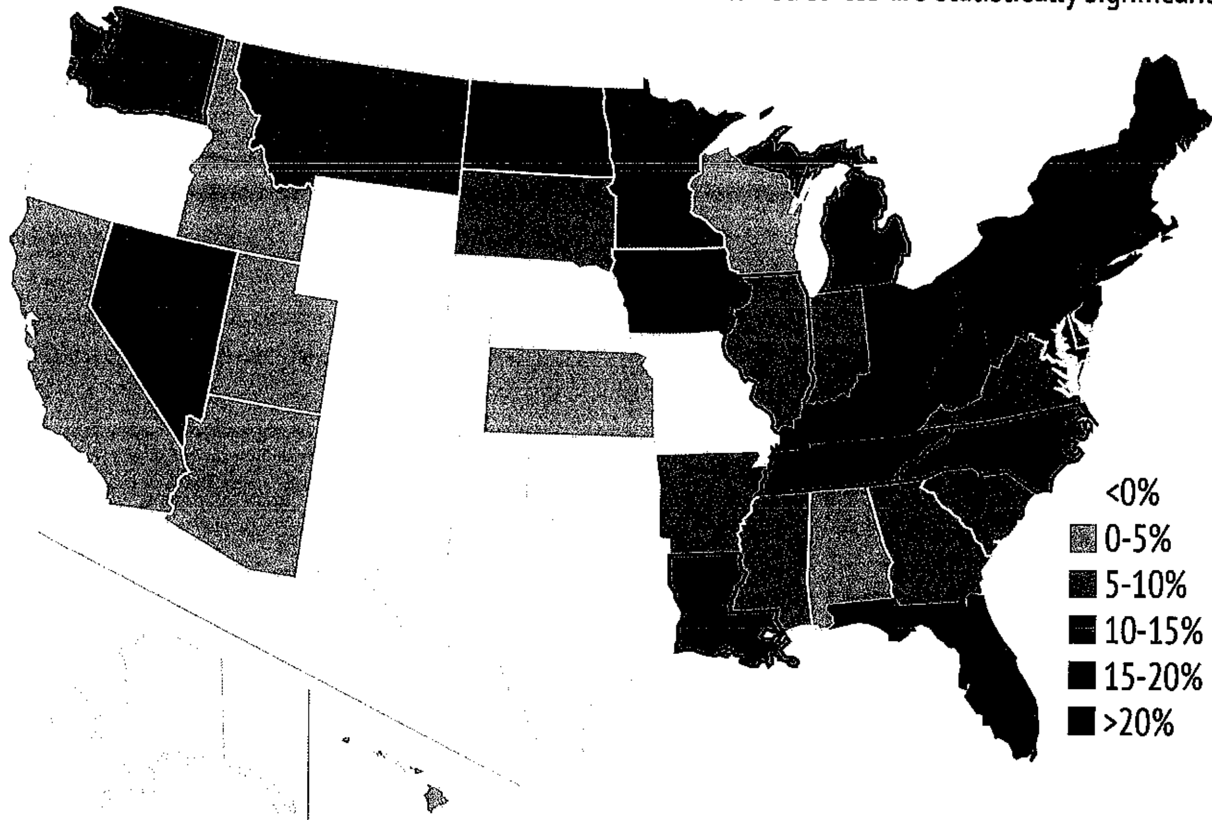
The applicants estimate that in the first full year of intensive outpatient treatment operation, approximately 300 IOP clients will be served.

b. Provide statistical information from the Substance Abuse and Mental Health Administration ("SAMSHA"), or a similar organization demonstrating that the target population has a need for the proposed services.

The need for intensive outpatient addictions treatment within Connecticut far exceeds capacity. The current epidemic of opiate (e.g., heroin, prescription opioids) addiction is overburdening an already overburdened system. Heroin and prescription opiate abuse is "epidemic". Heroin and prescription pain pills have single handedly caused a significant increase of accidental overdoses in Connecticut year after year which has now exceeded the national average reported by the Drug Poisoning Death Rate per 100,000, by County, 2010-2014. (see graphic below). Connecticut's Chief Medical Examiner Dr. James Gill said in a news release that between January 1 and June 30, of 2016 the first half of the year, 444 people died of accidental drug intoxications in the state. Gill is projecting 888 people will die of drug overdoses this year, which would be a sharp increase from the 729 fatal drug overdoses in 2015. With all accidental deaths combine Connecticut has more than doubled in the last 25 years according the Office of the Chief Medical Examiner annual statistic report from 1990-2015.

Rising drug deaths

Increase in overdose deaths from 2014-2015. Data for outlined states are statistically significant.



Source: Centers for Disease Control and Prevention | Graphic by Nicholas Wells CNBC

Furthermore, according to a recent report from the Substance Abuse and Mental Health Services Administration (SAMHSA), recovery is built on access to evidence-based clinical treatment and recovery support services for all populations. This report focuses on results from the 2016 National Drug Control Strategy that states a leading indicator of unmet substance use treatment need is the number of people who need substance use treatment but do not receive it at a specialty facility. Highlights from this study include:

- The 2015 National Survey on Drug Use and Health (NSDUH) data indicate that **8.1%** or 21.7 million people aged 12 or older **needed substance use treatment in the past year**
- In 2015, an estimated 2.3 million people aged 12 or older who needed substance use treatment received treatment at a specialty facility in the past year. This number represents 10.8% of the 21.7 million people who needed treatment in the past year.
- Among the estimated 19.3 million people aged 12 or older who were classified as needing but not receiving treatment, about 18.4 million or 95.4% did not think they needed treatment in the past year.

To bring these findings closer to home in Connecticut, SAMHSA provides data for the five regions throughout Connecticut (known as substate). The table below shows SAMHSA NSDUH data from 2012, 2013, and 2014.

The town of Madison is located in the South Central Region which shows that 8.8% of the population above the age of 18 years old was classified as having dependence or abuse of illicit drugs or alcohol in the past year. The SAMSHA data shows that of the adult population (18+ years of age) in the South Central Region of CT "needing but not receiving treatment for illicit drug use (2.2%) or alcohol use (6.9%)". The data are alarming and yet these are results as reported in 2012, 2013, and 2014. Many of us are only too aware that the substance abuse crisis in CT has been growing in the past few years.

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	Eastern Region of CT	7.55	5.92-9.59
	North Central Region of CT	7.20	5.66-9.13
	Northwestern Region of CT	6.64	5.19-8.47
	South Central Region of CT	**6.94**	**5.45-8.81**
	Southwest Region of CT	6.85	5.27-8.86
	All Connecticut	**7.02**	5.96-8.26

Please note: provide only publicly available and verifiable information and document the source.

ATTACHMENT A

State of Connecticut

Lookup Detail View

Name

Name
JAY M SEIGEL APRN

License Information

License Information

License Type	License Number	Expiration Date	Granted Date	License Name	License Status	Status Reason	Practice Without Collaborative Agreement	Licensure Actions or Pending Charges
Advanced Practice Registered Nurse	3815	02/28/2018	06/25/2008	Jay M. Seigel	ACTIVE	CURRENT	Yes	None

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State of Connecticut

Lookup Detail View

Name

Name
REINHARD W STRAUB

License Information

License Information

License Type	License Number	Expiration Date	Granted Date	License Name	License Status	Status Reason	Licensure Actions or Pending Charges
Licensed Clinical Social Worker	6234	05/31/2018	07/06/2006	Reinhard W. Straub	ACTIVE	CURRENT	None

Generated on: 3/24/2017 8:19:44 PM

ATTACHMENT B

CURRICULUM VITAE

JAY M. SEIGEL, APRN-BC
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Certification:

American Nurses Credentialing Center
Board Certified Psychiatric Mental Health Nurse Practitioner
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National Council Licensure Examination for Registered Nurses
Licensed Registered Nurse CT License # 64153
National Provider identification #1447416086

Education:

Columbia University, New York, NY
Masters of Science – Psychiatric Nurse Practitioner – 2005

Southern Connecticut State University – New Haven, CT
Bachelor of Science – Nursing – 2000

Honors:

Florence Nightingale Award 2005
Yale New Haven Hospital, Nurse of the Year 2003
Connecticut League of Nurses Peer Recognition Award – 2000

Experience:

2008 – to present – Solo Private Practice in New London CT

2008 – to present – Solo Private Practice in Madison, CT

2011 – 2012 - Sound Community Services – Adult Outpatient (part-time)

2008 – 2011 Stonington Institute – Adult Outpatient Services (full-time)

2007 – 2008 the Watershed Addiction Treatment Programs – Nurse Manager.

2006 – 2007 Stanford University Medical Center – Staff Nurse Adult – Psychiatry.

2001 – 2006 Yale New Haven Hospital – Staff Nurse – Dual diagnosis Unit/Hospital Supervisor – Psychiatric Department.

2000 – 2001 West Haven Veterans Hospital, Medical Unit – Staff Nurse.

1993 – 2000 Yale Psychiatric Institute, Inpatient Units Psychiatric Assistant.

1988 – 1993 United States Navy – Navy Hospital Corpsman – Balboa Hospital San Diego, CA, New London Naval Hospital, New London, CT.

Reinhard W. Straub, LICSW
(401) 741-5109 reinhardwstraub@gmail.com

EDUCATION

1992 – 1994 Adelphi University - Masters Degree, Social Work
1990 – 1992 Empire State College, State University of New York - B.S., Human Services
1968 – 1970 Syracuse University - Major: English/Creative Writing

CREDENTIALS

CT LCSW #006234 MA LICSW #116196
RI LICSW #ISW01730 & RI Licensed Chemical Dependency Clinical Supervisor (LCDCS) #00059
(CT Licensed Alcohol and Drug Counselor Inactive) (New York State LCSW-R & CASAC Inactive)

PROFESSIONAL EXPERIENCE

1995 to Present Private Practice 3 Sites 33 College Hill Road, Building 31C Warwick, RI 02886. 24 Channing Street, New London, CT 06320. 11 Woodland Road, Suite 2 Madison, CT 06443.
Provide intervention/consultation services and therapy for children, adolescents, adults, and families with Psychiatric Disorders, Substance Use Disorders, and Dual Diagnoses. Referral to all levels of care nationwide. Case management services provided re: licensing boards, schools, legal systems, regulatory agencies, employers, employee assistance programs, etc.

2015 to 2017 National Clinical & Business Development Liaison, American Addiction Centers

2010 to 2015 Clinical Services of Rhode Island, Inc., Greenville, Portsmouth & S Kingstown
Owner, Clinical Director, President
Provide clinical supervision, leadership and administrative oversight for three RI State Licensed substance abuse facilities. Services provided include medical and clinical assessment, ambulatory detoxification, addiction medicine, intensive outpatient, group and individual, and treatment/urine monitoring.

2006 to 2007 Stonington Institute Waterford, CT
Director, Intensive Outpatient Program

2005 to 2006 Family Services of Rhode Island, Providence
Director, Outpatient Program

1995 – 2005 Empire State College, State University of New York, Adjunct Faculty

Designed and instructed courses entitled "Counseling Theory", "Adolescent Development & Substance Abuse", "Children of Alcoholics", "Death and Dying: A Sociological Study", "Group Dynamics", "Perspectives on Alcoholism and Substance Abuse", "Professional and Ethical Responsibilities of the Alcoholism Counselor", "Social Welfare Policy", and "America's War on Drugs".

1995 – 2003 The Medical Society of the State of New York, Cmte. For Physician Health (CPH)

Senior Clinical Coordinator, (1995-03); Admissions Director, (1997-00).

Conducted hundreds of crisis interventions with impaired physicians.
Coordinated intervention efforts with hospitals, physician groups, attorneys, etc.
Developed and executed successful marketing strategies.
Created referent and provider databases that broadly advanced networking efforts.
Evaluated regional & national treatment centers providing them with guidelines and training.
Delivered formal presentations to metropolitan & upstate hospitals, medical institutions, etc.
Testified and advocated on behalf of physicians successfully participating in the CPH program.

1990 – 1995 Clinical Services and Consultation, Inc. - Latham, NY
Clinical Administrator, (1994-1995); Intake Counselor/Therapist, (1993-1994); Substance Abuse Coordinator/Counselor, (1990-1993).

Created a senior mgt. position that integrated administrative and clinical operations at three clinical sites.
Designed & administrated a case management system that effectively dealt with managed care.
Created, developed, and administrated the Adolescent Treatment Program.
Co-Created, developed, and facilitated the Family Program.
Created and facilitated the Substance Abuse Group.
Created and facilitated the Parenting Group.
Designed and established the Children's Playroom for assessment & play therapy.
Evaluated all new patients, assigned to primary therapists, and formulated initial treatment planning.
Provided individual and team supervision and provided staff and inter-agency training and in-services.
Coordinated efforts with consulting psychiatrists re psychopharmacological and clinical interventions.
Conducted inpatient and residential treatment referrals.
Provided individual, group, and family psychotherapy for children, adolescents, and adults.

1989 – 1990 Conifer Park - Scotia, NY
Alcoholism/Substance Abuse Counselor

Presented regularly scheduled lectures to a patient population of 200.
Coordinated the Evening Crisis Intervention Team.
Monitored therapy and patient compliance.
Coordinated treatment efforts with clinical and medical teams.
Acquired considerable experience with detoxification protocol and acute psychiatric crisis.

ATTACHMENT C

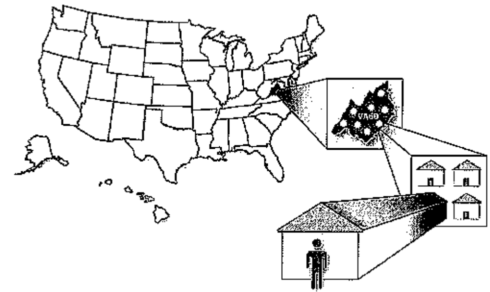
Attachment C

National Survey on Drug Use and Health

The CBHSQ Report

Short Report September 29, 2016

AMERICA'S NEED FOR AND RECEIPT OF SUBSTANCE USE TREATMENT IN 2015



AUTHORS

Rachel N. Lipari, Ph.D, Eunice Park-Lee, Ph.D., and Struther Van Horn, M.A.

In Brief

- The 2015 National Survey on Drug Use and Health (NSDUH) data indicate that 8.1 percent or 21.7 million people aged 12 or older needed substance use treatment in the past year.
- In 2015, an estimated 2.3 million people aged 12 or older who needed substance use treatment received treatment at a specialty facility in the past year. This number represents 10.8 percent of the 21.7 million people who needed substance use treatment in the past year.
- Among the estimated 19.3 million people aged 12 or older who were classified as needing but not receiving substance use treatment at a specialty facility, about 18.4 million or 95.4 percent did not think that they needed treatment in the past year for their substance use.

INTRODUCTION

Substance use disorders (SUDs) represent clinically significant impairment caused by the recurrent use of alcohol or illicit drugs (or both), including health problems, disability, and failure to meet major responsibilities at work, school, or home.[1] The consequences of SUD can be costly to people and the nation as a whole because they are often associated with negative outcomes, such as involvement with the justice system,[2,3] occurrence of chronic health conditions,[4] and poorer health outcomes.[5]

People who experience SUDs can take many pathways to recovery. Many individuals may benefit from evidence-based substance use treatment that addresses their specific needs, which may include physical, psychosocial, and environmental issues. Although there are benefits to getting substance use treatment, recent research indicates that many people do not get the treatment they need.[1] According to the 2016 National Drug Control Strategy, a leading indicator of unmet substance use treatment need is the number of people who need substance use treatment but do not receive it at a specialty facility.[6] The overall health of the nation are improved by the extent to which the population has access to needed substance use treatment. Hence, the Substance Abuse and Mental Health Services Administration (SAMHSA) states that recovery is built on access to evidence-based clinical treatment and recovery support services for all populations.[7]

The National Survey on Drug Use and Health (NSDUH) is an annual survey of the civilian, noninstitutionalized population of the United States aged 12 years or older. NSDUH gathers information on substance use treatment need and service utilization. NSDUH respondents who used alcohol or illicit drugs[8] in their lifetime are asked whether they ever received substance use treatment. Those who received substance use treatment in their lifetime are asked whether they received treatment in the 12 months before the survey interview (i.e., the past year). Substance use treatment refers to treatment or counseling that was received for illicit drug or alcohol use, or for medical issues associated with illicit drug or alcohol use. NSDUH also collects information on the receipt of substance use treatment at a specialty facility (i.e., substance use treatment at a hospital [only as an inpatient], a drug or alcohol rehabilitation facility [as an inpatient or outpatient], or a mental health center).[9]

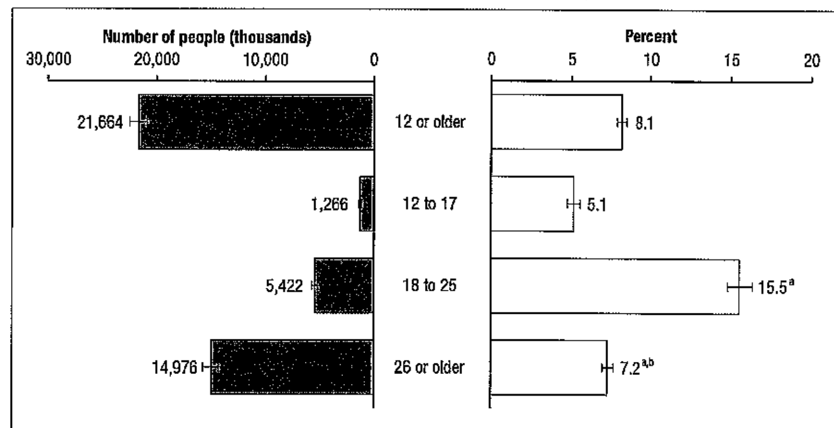
This issue of *The CBHSQ Report* also examines respondents' perception of their need for substance use treatment. This report uses 2015 NSDUH data to examine the need for and receipt of substance use treatment at a specialty facility among people aged 12 or older. Comparisons are made between adolescents aged 12 to 17, young adults aged 18 to 25, and adults aged 26 or older. All differences between age groups discussed in this report are statistically significant at the .05 level.

NEED FOR SUBSTANCE USE TREATMENT

NSDUH classifies people as needing substance use treatment if they met the criteria for having SUD[10] in the past year (based on symptoms they report) or if they received substance use treatment at a specialty facility in the past year.[11] In 2015, an estimated 21.7 million people aged 12 or older needed substance use treatment in the past year (Figure 1). Stated another way, about 8.1 percent of the population aged 12 or older needed substance use treatment in the past year. SUD is defined as meeting criteria for illicit drug or alcohol dependence or abuse based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).[10]

The percentage of people identified as needing substance use treatment was highest among young adults aged 18 to 25 and was lowest among adolescents aged 12 to 17. In 2015, approximately 1.3 million adolescents (5.1 percent of this age group), 5.4 million young adults (15.5 percent of this age group), and 15.0 million adults aged 26 or older (7.2 percent of this age group) needed substance use treatment in the past year (Figure 1). Stated another way, about 1 in 20 adolescents, 1 in 6 young adults, and 1 in 14 adults aged 26 or older were classified to be in need of substance use treatment in the past year.

Figure 1. Need for substance use treatment in the past year among people aged 12 or older, by age group: 2015



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2015.

[a] Difference between this estimate and the 12 to 17 estimate is statistically significant at the .05 level.

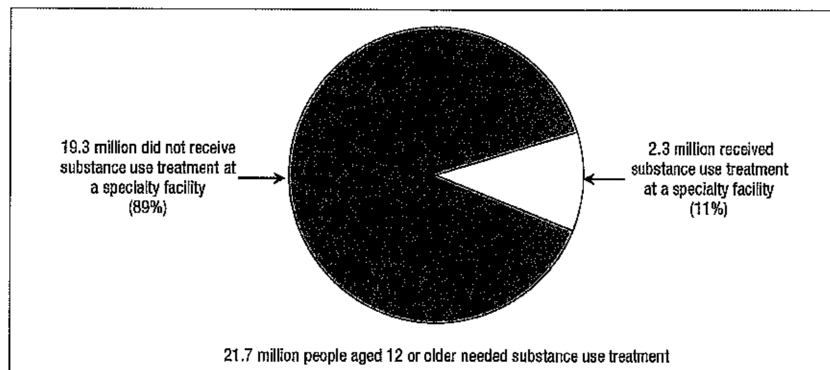
[b] Difference between this estimate and the 18 to 25 estimate is statistically significant at the .05 level.

RECEIPT OF SUBSTANCE USE TREATMENT AT A SPECIALTY FACILITY AMONG PEOPLE WHO NEEDED SUBSTANCE USE TREATMENT

The extent of the unmet substance use treatment need in the United States is measured by calculating the number of people aged 12 or older who were classified as needing substance use treatment but who did not receive substance use treatment at a specialty facility in the past year. This section focuses on the receipt (or lack of receipt) of treatment at a specialty facility among people who needed substance use treatment in the past year.

In 2015, an estimated 2.3 million people aged 12 or older who needed substance use treatment received treatment at a specialty facility in the past year (Figure 2). This number represents 0.9 percent of all people aged 12 or older and 10.8 percent of the 21.7 million people who needed substance use treatment. Conversely, there were about 19.3 million people aged 12 or older who needed substance use treatment but did not receive substance use treatment at a specialty facility; this represents 89.2 percent of people who needed substance use treatment in the past year.[12]

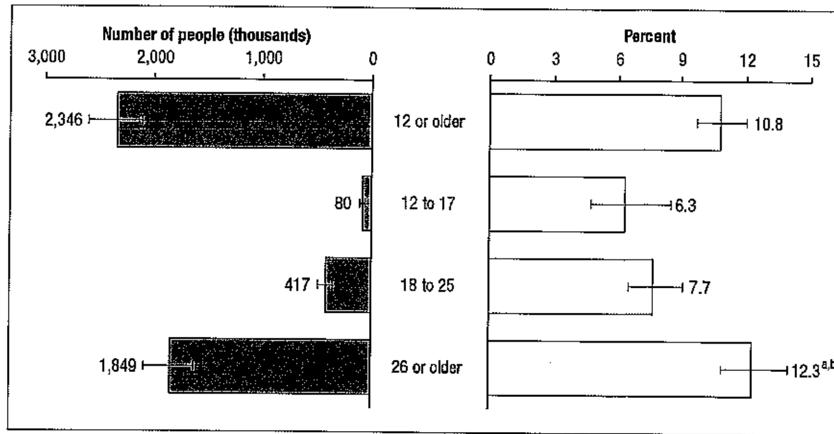
Figure 2. Receipt of substance use treatment at a specialty facility in the past year among people aged 12 or older who needed substance use treatment in the past year: 2015



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2015.

As shown earlier, in 2015, an estimated 1.3 million adolescents aged 12 to 17, 5.4 million young adults aged 18 to 25, and 15.0 million adults aged 26 or older needed substance use treatment in the past year. Of those who needed substance use treatment, about 80,000 adolescents (or 6.3 percent of this age group), 417,000 young adults (or 7.7 percent of this age group), and 1.8 million adults aged 26 or older (12.3 percent of this age group) received substance use treatment at a specialty facility in the past year. Among people who needed substance use treatment, adults aged 26 or older were more likely to have received treatment at a specialty facility in the past year than adolescents or young adults (12.3 vs. 6.3 and 7.7 percent, respectively). Conversely, among people in specific age groups who needed substance use treatment, 93.7 percent of adolescents, 92.3 percent of young adults, and 87.7 percent of adults aged 26 or older did not receive treatment at a specialty facility in the past year (Figure 3).

Figure 3. Receipt of substance use treatment at a specialty facility in the past year among people aged 12 or older who needed substance use treatment in the past year, by age group: 2015



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2015.

[a] Difference between this estimate and the 12 to 17 estimate is statistically significant at the .05 level.

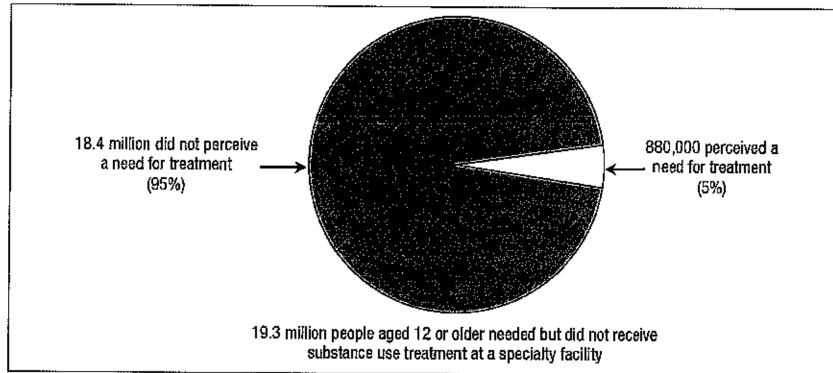
[b] Difference between this estimate and the 18 to 25 estimate is statistically significant at the .05 level.

PERCEIVED NEED FOR SUBSTANCE USE TREATMENT AMONG PEOPLE WHO NEEDED BUT DID NOT RECEIVE SUBSTANCE USE TREATMENT AT A SPECIALTY FACILITY

In 2015, among the estimated 19.3 million people aged 12 or older who were classified as needing substance use treatment but who did not receive substance use treatment at a specialty facility in the past year, about 880,000 (or 4.6 percent of this population) perceived a need for substance use treatment. The vast majority (95.4 percent), on the other hand, did not think that they needed treatment in the past year for their substance use (Figure 4).

Among those who needed but did not receive substance use treatment at a specialty facility in 2015, adolescents were less likely to have felt a need for treatment than young adults or adults aged 26 or older (data not shown). Of the estimated 1.2 million adolescents aged 12 to 17 who needed but did not receive substance use treatment at a specialty facility in the past year, 17,000 (1.4 percent) perceived a need for substance use treatment. Among the estimated 5.0 million young adults aged 18 to 25 who needed but did not receive substance use treatment at a specialty facility in the past year, about 138,000 (2.7 percent) perceived a need for substance use treatment. Of the estimated 13.1 million adults aged 26 or older who needed but did not receive substance use treatment at a specialty facility in the past year, approximately 725,000 (5.5 percent) perceived a need for substance use treatment.

Figure 4. Perceived need for substance use treatment among people aged 12 or older who needed but did not receive substance use treatment in the past year: 2015



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2015.

DISCUSSION

As previously stated, many people in need of substance use treatment may benefit from evidence-based substance use treatment that addresses their specific needs; however, the research suggests that few Americans receive any or adequate substance use treatment.[1] The 2015 NSDUH data presented in this report suggest that the majority of people aged 12 or older who needed substance use treatment in the United States do not receive treatment at a specialty facility. The report finds that about 21.7 million or 8.1 percent of people aged 12 or older needed substance use treatment in the past year. In addition, among the 19.3 million people aged 12 or older who were classified as needing substance use treatment because they either met the criteria for having a substance use disorder or they have been in substance use treatment at a specialty facility in the past year, a large proportion of this population indicated they did not perceive that they had a need for substance use treatment. In addition, receipt of substance use treatment at a specialty facility and perceived need for substance use treatment among those who needed substance use treatment varied by age group. For example, compared with adults aged 26 or older, lower percentages of adolescents and young adults who needed substance use treatment received treatment at a specialty facility. Similarly, lower percentages of adolescents and young adults who were classified as needing substance use treatment felt that they needed treatment for their substance use than adults aged 26 or older.

The substance use recovery process is highly personal and occurs via many pathways. For many Americans, this recovery process includes access to and use of substance use treatment at specialty facilities, such as a hospital (only as an inpatient), a drug or alcohol rehabilitation facility (as an inpatient or an outpatient), or a mental health center. Having access to substance use treatment and supportive services to address various needs associated with substance use disorders is critical for those who are in need of treatment. In order to aid individuals in need of treatment, SAMHSA provides information about where to find substance use and mental health treatment at https://findtreatment.samhsa.gov.

ENDNOTES

1. Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from http://samhsa.gov/data/
2. Glasheen, C., Hedden, S. L., Kroutil, L. A., Pemberton, M. R., & Goldstrom, I. (2012, November). *CBHSQ Data Review: Past year arrest among adults in the United States: Characteristics of and association with mental illness and substance use*. Retrieved from http://samhsa.gov/data/
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5. McCusker, J., Cole, M., Ciampi, A., Latimer, E., Windholz, S., & Belzile, E. (2007). Major depression in older medical inpatients predicts poor physical and mental health status over 12 months. *General Hospital Psychiatry, 29*(4), 340–348. doi:10.1016/j.genhosppsych.2007.03.007
6. Office of National Drug Control Policy. 2015. *2015 National Drug Control Strategy*. Retrieved from https://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/2015_national_drug_control_strategy_0.pdf
7. Substance Abuse and Mental Health Services Administration. (2015). *Recovery and recovery support* [Web page]. Retrieved from http://samhsa.gov/recovery

8. NSDUH estimates of "illicit drug use" include the data from 10 drug categories: the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine; or the misuse of prescription pain relievers, tranquilizers, stimulants, or sedatives.
9. Information on the receipt of substance use treatment at nonspecialty treatment facilities such as emergency rooms, private doctors' offices, prisons or jails, and self-help groups is reported elsewhere. For more information, see Park-Lee, E., Lipari, R. N., Hedden, S. L., Copello, E. A. P., & Kroutil, L. A. (2016, September). Receipt of services for substance use and mental health issues among adults: Results from the 2015 National Survey on Drug Use and Health. NSDUH Data Review. Retrieved from http://www.samhsa. gov/data/
10. NSDUH includes a series of questions about past year SUDs among respondents who used alcohol or illicit drugs in the past 12 months. These questions are used to classify people as having an SUD in the past 12 months based on criteria specified in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*. The criteria include symptoms such as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference with major obligations at work, school, or home during the past 12 months.
11. In 2015, about 96.0 percent of the adults who needed treatment for a substance use issue were defined as such because they had an SUD in the past year, regardless of whether they received substance use treatment at a specialty facility.
12. People who are classified as needing substance use treatment may receive treatment at a nonspecialty facility for their substance use issues; however, the majority of people who needed treatment do not receive any substance use treatment. For example, about 679,000 people aged 12 or older in 2015 who needed substance use treatment received nonspecialty treatment, whereas 18.6 million people did not receive any treatment.

SUGGESTED CITATION

Lipari, R. N., Park-Lee, E., and Van Horn, S. *America's need for and receipt of substance use treatment in 2015*. The CBHSQ Report: September 29, 2016. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.

SUMMARY

Background: Substance use disorders (SUDs) affect people of all age groups and from different socioeconomic statuses. These disorders are common and recurrent, but people experiencing these disorders may benefit from treatment. The Substance Abuse and Mental Health Services Administration (SAMHSA) reports information from the National Survey on Drug Use and Health (NSDUH) on substance use treatment (i.e., treatment for problems related to the use of alcohol or illicit drugs) in the United States to help evaluate access to and use of substance use treatment. **Method:** This report uses 2015 NSDUH data to examine the need for and receipt of substance use treatment at a specialty facility among people aged 12 or older. **Results:** The findings in this report suggest that the majority of people aged 12 or older who needed substance use treatment in the United States do not receive treatment at a specialty facility. Also, a large proportion of those who need substance use treatment do not perceive a need for it. In addition, receipt of substance use treatment at a specialty facility and perceived need for treatment among those who needed substance use treatment varied by age group. Compared with adults aged 26 or older, lower percentages of adolescents and young adults who needed substance use treatment received treatment at a specialty facility, and lower percentages of adolescents and young adults felt they needed treatment for their substance use. **Conclusion:** This report provides the most current findings from NSDUH on the receipt of substance use treatment among people aged 12 or older in the United States. Findings presented in the report can be useful for monitoring the need for substance use treatment among all people aged 12 or older and assessing whether they receive treatment at a specialty facility for their substance use.

Keywords: National Survey on Drug Use and Health, NSDUH, treatment, substance use

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KEYWORDS

Age Group, Short Report, Population Data, Public Officials, Substance Abuse, People with Substance Use or Abuse Problems as Population Group, Access to Care, Treatment, All US States Only, 2015

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The National Survey on Drug Use and Health (NSDUH) is an annual survey sponsored by The Substance Abuse and Mental Health Services Administration (SAMHSA). The data used in this report are based on information obtained from 68,073 people aged 12 or older in 2015. The Survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their place of residence.

The NSDUH Report is prepared by The Center for Behavioral Health Statistics and Quality (CBHSQ), SAMHSA, and by RTI International in Research Triangle Park, North Carolina. (RTI International is a trade name of Research Triangle Institute.)

Information on the most recent NSDUH is available in the following publication:

Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from http://samhsa.gov/data/

Also available online: http://www.samhsa.gov/data/population-data-nsduh.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Substance Abuse & Mental Health Services Administration
Center for Behavioral Health Statistics and Quality
www.samhsa.gov/data

ATTACHMENT D

State of Connecticut DMHAS Triennial State Substance Abuse Plan

Separate attached file due to size of document

Attachment D

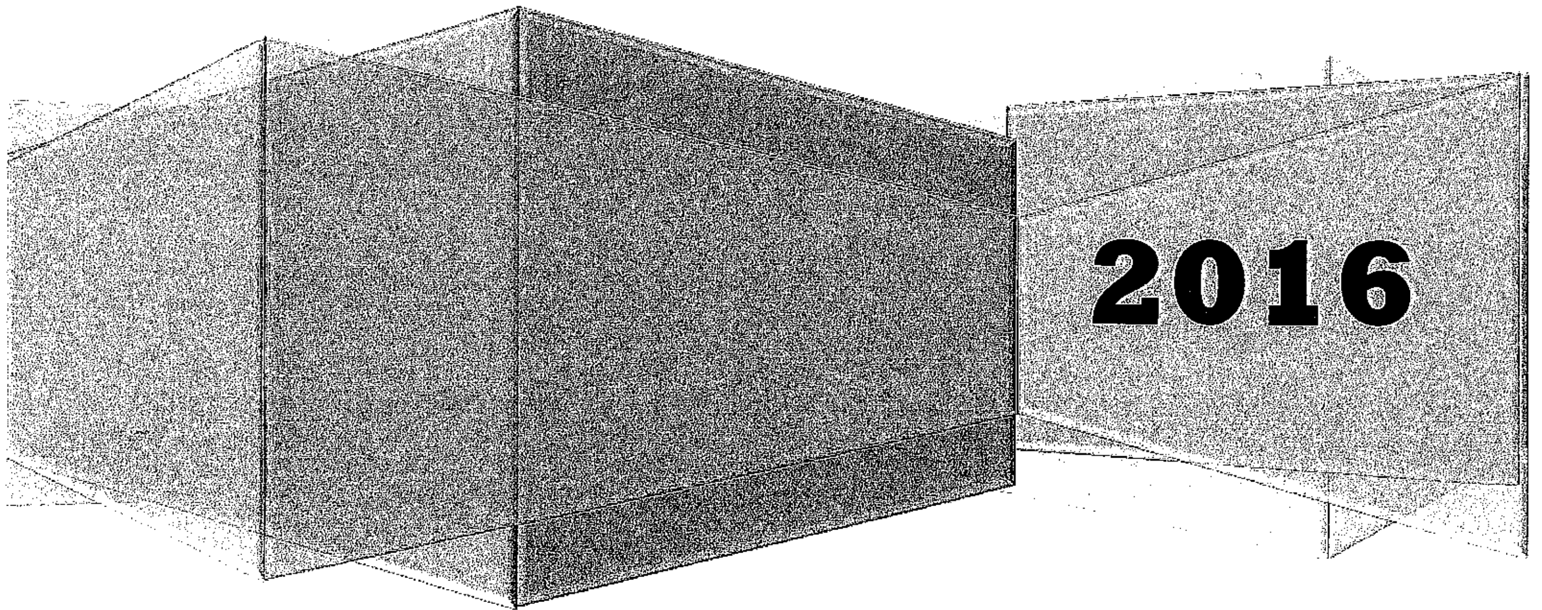
(separate attachment)

State of Connecticut

Department of Mental Health and Addiction Services

Triennial State Substance Abuse Plan

Miriam Delphin-Rittmon Ph.D. Commissioner
Nancy Navarretta M.A., L.P.C., NCC, Deputy Commissioner



ATTACHMENT E

Attachment E

NIH Public Access
Author Manuscript

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Psychiatr Serv. 2014 June 1; 65(6): 718–726. doi:10.1176/appi.ps.201300249.

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Substance Abuse Intensive Outpatient Programs: Assessing the Evidence

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Abstract

Objective—Substance abuse intensive outpatient programs (IOPs) are direct services for people with substance use disorders or co-occurring mental and substance use disorders who do not require medical detoxification or 24-hour supervision. IOPs are alternatives to inpatient and residential treatment. They are designed to establish psychosocial supports and facilitate relapse management and coping strategies. This article assesses their evidence base.

Methods—Authors searched major databases: PubMed, PsycINFO, Applied Social Sciences Index and Abstracts, Sociological Abstracts, Social Services Abstracts, Published International Literature on Traumatic Stress, the Educational Resources Information Center, and the Cumulative Index to Nursing and Allied Health Literature. They identified 12 individual studies and one review published between 1995 and 2012. They chose from three levels of research evidence

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Disclosures of Conflicts of Interest: Dennis McCarty is the Principal Investigator on Research Service Agreements with Alkermes and Purdue Pharma. He is the Principal Investigator on three awards from the National Institute on Drug Abuse (R21 DA035640, R01 DA029716, U10 DA015815) and an investigator on four awards from the National Institutes of Health (R01 MH1000001, P50 DA018165, R01 DA030431, R21 DA031361).

(high, moderate, and low) based on benchmarks for the number of studies and quality of their methodology. They also described the evidence of service effectiveness.

Results—Based on the quality of trials, diversity of settings, and consistency of outcomes, the level of evidence for IOP research was considered high. Multiple randomized trials and naturalistic analyses compared IOPs with inpatient or residential care; these types of services had comparable outcomes. All studies reported substantial reductions in alcohol and drug use between baseline and follow-up. However, substantial variability in the operationalization of IOPs and outcome measures was apparent.

Conclusions—IOPs are an important part of the continuum of care for alcohol and drug use disorders. They are as effective as inpatient treatment for most individuals seeking care. Public and commercial health plans should consider IOP treatment as a covered health benefit. Standardization of the elements included in IOPs may improve their quality and effectiveness.

Substance abuse intensive outpatient programs (IOPs) are ambulatory services for individuals with substance use disorders who do not meet diagnostic criteria for residential or inpatient substance abuse treatment or for those who are discharged from 24-hour care in an inpatient treatment facility and continue to need more support than the weekly or bi-weekly sessions provided in traditional outpatient care (1). IOP services offer a minimum of 9 hours of service per week in three, 3-hour sessions; however, some programs provide more sessions per week and/or longer sessions per day, and many programs become less intensive over time (1,2). Because services are provided in outpatient settings, the duration may be longer than that required for inpatient services. IOPs allow individuals to remain in their own homes and communities, which may improve their adjustment to community life (1).

Since 2002, the annual census of specialty addiction treatment facilities in the United States has consistently identified intensive outpatient treatment programs as second in prevalence only to regular outpatient treatment for alcohol and drug use disorders. In 2011, there were 6,089 programs in the United States that reported offering IOPs (44% of 13,720 addiction treatment programs), and IOPs served 141,964 patients—12% of the 1.2 million patients in care (3).

This article reports the results of a literature review that was undertaken as part of the Assessing the Evidence Base Series (see text box 1). The purpose of this review was to provide policymakers, treatment providers, and consumers with extant information on IOPs so that they can make informed decisions when comparing these programs with alternative treatments. Public and commercial health plan administrators may use this information to assess the need to include IOPs as a covered benefit. Our assessment of IOPs defines the programs as a level of care, reviews available research, and evaluates the quality of the evidence, most notably compared with the effectiveness of inpatient treatment services.

Description of the service

IOPs treat individuals with substance use disorders or co-occurring mental and substance use disorders who do not require medical detoxification or 24-hour supervision. They

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provide a specified number of hours per week of structured individual, group, and/or family therapy as well as psychoeducation about substance use and mental disorders.

The American Society of Addiction Medicine (ASAM) defines five levels of care to guide practitioners in selecting the appropriate intensity for treating alcohol and drug use disorders: Level 0.5 (early intervention services), Level I (outpatient services), Level II (intensive outpatient services), Level III (residential and inpatient services), and Level IV (medically managed intensive inpatient services) (2). Thus, IOPs represent a higher level of care than usual outpatient services and a lower level of care than residential and inpatient services.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a set of core services for inclusion in IOPs, such as a specified number of hours of structured programming per week; individual, group, and/or family therapy; and psychoeducation about substance use and mental disorders (1). Table 1 summarizes the service.

IOP goals help the individual learn early-stage relapse management and coping strategies, ensure that the person has psychosocial support, and address individual symptoms and needs. However, broad variation across programs in terms of service delivery (e.g., mechanisms for screening and assessment), treatment planning and provision, crisis management, discharge planning, and the intensity and duration of care limit attempts to assess the quality and effectiveness of care across IOPs. Moreover, IOP services vary by setting: hospitals, community behavioral health centers, or day treatment programs. The ASAM criteria note that the duration of treatment varies with the severity of the person's illness and his or her response to the treatment intervention. Therefore, progress in a particular level of care, rather than a predetermined length of stay, determines an individual's movement through the treatment continuum.

In the clinical and research literature, IOPs may also include partial hospitalization and day treatment (ASAM Level II.5), both of which are used to treat people who have serious mental illness and/or substance use problems. For the purposes of this review, partial hospitalization and day treatment for substance use are included in the definition of an IOP. Day treatment models operate full-day schedules 5 to 7 days per week and may treat patients with co-occurring serious mental illness.

Methods

Search strategy

We identified and reviewed research from 1995 through 2012. We conducted a survey of major databases: PubMed (U.S. National Library of Medicine and National Institutes of Health), PsycINFO (American Psychological Association), Applied Social Sciences Index and Abstracts, Sociological Abstracts, Social Services Abstracts, Published International Literature on Traumatic Stress, the Educational Resources Information Center, and the Cumulative Index to Nursing and Allied Health Literature. We also examined bibliographies of major reviews and meta-analyses. We used combinations of the following search terms:

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intensive outpatient treatment, substance abuse treatment, addiction treatment, drug rehabilitation, and alcohol treatment.

Inclusion and exclusion criteria

This review was limited to U.S. and international studies in English and included the following types of articles: randomized controlled trials (RCTs), quasi-experimental studies, naturalistic assessments, and qualitative reviews. Studies were included if they compared levels of care (that is, inpatient or residential versus IOP or day treatment) for adult study participants seeking treatment for alcohol or illicit drug use. The ASAM Patient Placement Levels of Care (2) and the Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocol (TIP) on intensive outpatient programs (1) were also examined. Studies were excluded that examined residential treatment only, ambulatory treatment only, aftercare only, treatment for mental disorders only, developmental disability programs, hospital-based inpatient treatment programs without comparisons to less intensive services, and treatment services for adolescents.

Strength of the evidence

The methodology used to rate the strength of the evidence is described in detail in the introduction to this series (http://ps.psychiatryonline.org/Article.aspx?ArticleID=1759202). The research designs of the identified studies were examined. Three levels of evidence (high, moderate, and low) were used to indicate the overall research quality of the collection of studies. Ratings were based on predefined benchmarks that considered the number and quality of the studies. If ratings were dissimilar, a consensus opinion was reached.

In general, high ratings indicate confidence in the reported outcomes and are based on three or more RCTs with adequate designs or two RCTs plus two quasi-experimental studies with adequate designs. Moderate ratings indicate that there is some adequate research to judge the service, although it is possible that future research could influence reported results. Moderate ratings are based on the following three options: two or more quasi-experimental studies with adequate design; one quasi-experimental study plus one RCT with adequate design; or at least two RCTs with some methodological weaknesses or at least three quasi-experimental studies with some methodological weaknesses. Low ratings indicate that research for this service is not adequate to draw evidence-based conclusions. Low ratings indicate that studies have nonexperimental designs, there are no RCTs, or there is no more than one adequately designed quasi-experimental study.

We accounted for other design factors that could increase or decrease the evidence rating, such as how the service, populations, and interventions were defined; use of statistical methods to account for baseline differences between experimental and comparison groups; identification of moderating or confounding variables with appropriate statistical controls; examination of attrition and follow-up; use of psychometrically sound measures; and indications of potential research bias.

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Effectiveness of the service

We described the effectiveness of the service—that is, how well the outcomes of the studies met the service goals. We compiled the findings for separate outcome measures and study populations, summarized the results, and noted differences across investigations. We evaluated the quality of the research design in our conclusions about the strength of the evidence and the effectiveness of the service.

Results

Level of evidence

The level of evidence for IOPs was considered high. Multiple randomized clinical trials and quasi-experimental studies have been conducted on IOPs that were designed to treat substance use disorders. We identified five studies based on four randomized trials that compared intensive outpatient or day treatment services with inpatient or residential treatment (4–8) and two studies of inpatient treatment versus IOPs that included both randomized study participants and individuals who refused randomization (9,10). Our search also revealed six naturalistic analyses of patients treated in inpatient and intensive outpatient settings (11–16) and one qualitative review of research published after 1995 (17). Table 2 contains a summary of the studies included in this review.

Most of the randomized trials had good internal validity and used the Addiction Severity Index (ASI), a well-validated treatment outcome measure. However, samples sometimes had small to modest sizes, and insufficient statistical power may have contributed to a lack of strong findings. Conversely, the naturalistic studies reported large sample sizes but had more variability in outcome measures. Nonetheless, findings from the randomized trials and naturalistic analyses appeared to complement each other.

Patient populations and service settings

Alcohol dependence (7,8,13,17) and cocaine dependence (4,14) were the primary diagnoses of participants in studies of intensive outpatient services. Two randomized trials (5,18) and four naturalistic analyses (11,12,15,16) included people with alcohol and drug (undefined) diagnoses. There was demographic variation across study populations, including individuals who were uninsured and homeless in inner cities (11,12), employed men and women with commercial health plans (4,10,13), patients in the Veterans Affairs (VA) health system (9,16), and men and women treated in public systems of care (5,9,12,14,15). One study compared a 1-year day treatment program with a 1-year residential program (5,6). African Americans were the primary racial/ethnic group studied, and most study populations had good racial/ethnic mixtures. No studies compared the effects of IOPs across racial or ethnic groups.

Service settings for these studies included hospital-based inpatient and day treatment in VA (9,16) and community hospitals (4,7,8,13), residential programs (5,6,10), community-based public (5,6,9,12,14,15) and private (4,10,12,13) substance use treatment centers, and one drug treatment program based on therapeutic community principles (5,6). The services varied in intensity (i.e., hours per week), duration, content of the sessions, and therapeutic

approaches. Follow-up periods ranged from 3 months to 18 months. The dependent variables used to assess patient outcomes also varied, but abstinence (4,7,8) and changes in Addiction Severity Index scores (4,5,9–12,15,16) were most common. See columns 3 through 6 in Table 2 for details about the variability across studies.

Effectiveness of the service

Variation in the operationalization of IOPs across studies and differences in outcome measures slightly tempered our assessment of inpatient and IOP equivalence. In most studies, the inpatient and outpatient services differed on many dimensions (e.g., setting, duration, intensity), although one investigation (7) used the same staff, facility, and therapeutic process and altered only the setting (inpatient versus outpatient) between experimental and control groups. The primary commonality was treatment in an intensive outpatient setting versus an overnight stay in a more controlled residential or inpatient setting (4–16), but variation in the operationalization of IOPs and outcome measures limited direct comparisons.

The randomized trials and quasi-experimental studies consistently reported significant reductions in problem severity and increases in days abstinent at follow-up interviews (between 3 and 18 months after baseline assessment) for study participants receiving intensive outpatient or day treatment services and for individuals in inpatient or residential care (Table 2). One trial with small sample sizes found higher rates of abstinence 3 months after treatment among individuals who received inpatient care compared with day treatment (63% versus 38%), but this effect was not observed at 6 months after treatment (4). In addition, all randomized trials reported similar reductions in Addiction Severity Index measures when inpatient and intensive outpatient settings were compared (5,6,9,10). Lastly, the studies that included participants who were randomized and those who self-selected levels of care reported a similar lack of overall differences in study outcomes when levels of care were compared (9,10). Indeed, a study based in the VA reported that two-thirds of the participants refused randomization, but outcomes were similar for randomized and nonrandomized study participants (9).

Although analyses of natural cohorts generally assume that patients treated in residential settings have more severe substance use problems than those treated in outpatient treatment settings, differential effectiveness based on problem severity was elusive in the articles we reviewed. Only two of six naturalistic analyses reported main effects for treatment setting. One was an analysis of Washington State treatment programs (15). Results showed that patients treated in an inpatient setting who stepped down to intensive outpatient treatment improved more than those treated only in intensive outpatient settings, because problem severity was greater at baseline among those admitted to inpatient care. Another analysis of a cohort of patients treated in a psychiatric hospital reported that patients who were alcohol dependent and treated in intensive outpatient care returned to "significant" drinking more quickly than those treated in inpatient care (13). The other four analyses did not find main effects for treatment setting (11,12,14,16).

There is some evidence that disorder severity may influence the effectiveness of IOPs compared with inpatient or residential treatment. In Minnesota treatment programs, patients

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with recent suicidal ideation had better outcomes following residential care than patients who participated in intensive outpatient care (12). A secondary analysis of treatment for cocaine dependence noted that patients with more severe drug problems were more likely to benefit from long-term residential care than from less intensive levels of care (14). Finally, an analysis of patients in a VA program also suggested that those with more severe alcohol or drug problems had better response when treated in residential settings than in IOPs (16). Although there is still some debate about the equivalence of inpatient and intensive outpatient care for patients with the most severe levels of dependence, there appears to be general consensus that for most patients the levels of care are equivalent.

It is noteworthy that the current assessment of intensive outpatient services echoes findings from similar reviews conducted since the 1960s (18–28). Despite changing research methods and study populations, results are consistent—patient outcomes from inpatient, residential, and intensive outpatient services are positive and more similar than different. This consistency over time enhances confidence in the stability of the findings and the value of intensive outpatient services.

Conclusions

Overall, the current literature suggests that a wide range of service intensities can be effective for individuals with substance use disorders. There is a high level of evidence—with the caveats we have noted—that IOPs are equally effective when compared with inpatient and residential treatments (see text box 2). IOPs have emerged as a critical facet of 21st century addiction treatment for people who need a more intensive level of service than usual outpatient treatment, and they allow participants to avoid or step down successfully from inpatient services. This is an important consideration for policymakers, providers, and individuals engaged in substance abuse treatment services when deciding which level of care is most appropriate for specific clinical situations.

Taken together, randomized trials and quasi-experimental studies consistently reported equivalent reductions in problem severity and increases in days abstinent at follow-up for participants who received intensive outpatient or day treatment services compared with those in inpatient or residential care. We found no studies comparing the service with wait-list or no-treatment control groups. Reviews of the literature point out many design and treatment differences that may affect conclusions about the effectiveness of inpatient versus outpatient services. A chapter in an ASAM-sponsored text (29) reiterated the debate on inpatient versus outpatient settings and concluded that engagement in longer, less-intensive services may have greater benefit than brief, intensive interventions without ongoing support, especially among individuals with more severe histories of addiction. The important feature appears to be continuity of care over a long duration, and this perspective is consistent with emerging models of recovery-oriented systems of care. However, the interaction between severity of alcohol and drug problems and setting of care has been elusive, and the effect (when present) appears to be small. Overall, studies found that 50% to 70% of their participants reported abstinence at follow-up, and most studies found that this outcome did not differ for inpatient versus outpatient settings of care. This makes cost,

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treatment duration, and living in the community the major points of comparison between inpatient and IOP substance use services.

It is difficult to say which aspects of IOPs are most likely to be effective with specific populations. Naturalistic studies using large sample sizes found subtle improvements among people with the most serious substance use problems, suggesting that this level of institutional treatment may be helpful and/or necessary for a subset of people. However, a primary ongoing research need is to identify individuals with severe alcohol and drug use for whom inpatient or residential care is of greatest value. One complication is the variation in how residential care and intensive outpatient care are defined. This is an important distinction that needs clarification as provider systems move into an increasingly risk-based financing environment. Payers and providers should collaborate to define IOP services more consistently, so that effects are replicable across settings and patient populations. Likewise, there is a need for more research on the most effective length of IOP treatment. IOP models should clearly identify the type, duration, and intensity of IOP services. Researchers also need to determine the optimal type and level of stabilization services following discharge from IOP that will sustain the gains made during the IOP treatment episode.

Although African Americans were the dominant racial/ethnic group in many of the investigations comparing residential and inpatient services with intensive outpatient services, race/ethnicity varied substantially across the studies. The finding that IOP services are equivalent in outcomes to residential or inpatient care appears to generalize across racial and ethnic groups; however, we cannot make specific recommendations for IOP services related to race/ethnicity based on the current literature. Future studies may systematically vary components of IOPs to determine the more critical features for efficient and effective care.

Surprisingly, none of the studies examined in this review included the use of pharmacotherapy, which improves treatment outcomes when used in conjunction with therapeutic interventions. We believe that 21st century systems of addiction treatment should provide ongoing pharmacological and behavioral therapies within a continuing care model that increasingly relies on intensive outpatient settings rather than residential and inpatient care. Recent trials also document the value of enhancing intensive outpatient care with contingency management during intensive care (30) and during aftercare (31).

Without increased standardization, patients, payers, and policymakers will continue to have difficulty comparing IOP services with other levels of substance abuse treatment services. Requirements to adhere to the National Quality Forum Consensus Standards, for example, could help ensure that IOPs provide consistent and effective pharmacological and behavioral addiction treatments (32). Accordingly, this calls for improved assessment of the specific needs of each person requiring intensive substance use services in order to determine the appropriate level of care. Policymakers, payers, and consumers should consider demanding these assessments, and providers across all levels of care should receive the necessary training to complete them properly.

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In summary, study conclusions are consistent and similar—outcomes reflecting alcohol and drug use at follow-up show reductions in substance use and increases in abstinence, and outcomes do not differ significantly between inpatient and intensive outpatient service settings. Although a few studies suggest that more impaired patients may have better outcomes if treated in inpatient settings as opposed to intensive outpatient settings, such differential effectiveness appears elusive and may apply only to the most severely impaired individuals. Compared with inpatient care, IOP services have at least two advantages: increased duration of treatment, which varies with the severity of the patient's illness and his or her response, and the opportunity to engage and treat consumers while they remain in their home environments, which affords consumers the opportunity to practice newly-learned behaviors. IOP treatment is an important service for inclusion as a covered benefit for people with substance use disorders. The diversity of settings and range of outcomes assessed, combined with the consistency of improvement over time, suggest that the effectiveness reflects the intensity and duration of treatment rather than a specific setting or patient population.

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Text box 1

About the AEB Series

The Assessing the Evidence Base (AEB) Series presents literature reviews for 14 commonly used, recovery-focused mental health and substance use services. Authors evaluated research articles and reviews specific to each service that were published from 1995 through 2012 or 2013. Each AEB Series article presents ratings of the strength of the evidence for the service, descriptions of service effectiveness, and recommendations for future implementation and research. The target audience includes state mental health and substance use program directors and their senior staff, Medicaid staff, other purchasers of health care services (for example, managed care organizations and commercial insurance), leaders in community health organizations, providers, consumers and family members, and others interested in the empirical evidence base for these services. The research was sponsored by the Substance Abuse and Mental Health Services Administration to help inform decisions about which services should be covered in public and commercially funded plans. Details about the research methodology and bases for the conclusions are included in the introduction to the AEB Series (http://ps.psychiatryonline.org/Article.aspx?ArticleID=1759202).

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Text box 2

Evidence for the effectiveness of substance abuse intensive outpatient programs (IOPs): high

Despite some variations in programming and design, substance abuse IOPs compared with control conditions demonstrate consistent evidence for the following outcomes:

- Reduced drug and/or alcohol use from baseline to follow-up
- Few differences between IOPs and inpatient programs

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Table 1

Summary of substance abuse intensive outpatient programs

Feature	Description
Service definition	Substance abuse intensive outpatient programs (IOPs) are direct services for people with substance use disorders or co-occurring mental and substance use disorders who do not require medical detoxification or 24-hour supervision. The programs supply treatment for symptoms and/or disabilities associated with the disorder. Core services generally include a specified number of hours of structured programming per week; individual, group, and/or family therapy; and psychoeducation about substance use and mental disorders.
Service goals	• Learn early-stage relapse management • Develop coping strategies • Establish or re-establish psychosocial supports • Address problems related to social, psychological, and emotional well-being
Populations	• Adults with substance use disorders (both alcohol and drug diagnoses)
Settings for service delivery	• Hospital-based inpatient and day treatment in Veterans Affairs and community hospitals • Social model residential programs • Community-based public and private substance abuse treatment centers

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Table 2

Summary of studies included in the intensive outpatient program (IOP) review[a]

Study	Design, participants, setting	IOP treatment	Comparison treatment	Primary outcome measures	Primary outcome and between-group effects
Randomized controlled trials					
Schneider et al., 1996 (4)	Day treatment (n=32) versus inpatient (n=42). Study participants were seeking treatment for cocaine dependence from a large health maintenance organization in metropolitan Boston.	Day treatment: 2 weeks, Monday through Friday, 5 hours of services per day; weekly aftercare for up to 6 months (47% completed 14 days)	Inpatient care: 14 days in a nonhospital facility with 6 hours of services per day; referral to halfway house, aftercare, or a mental health provider (95% completed 14 days)	ASI at baseline and telephone interviews at 3 months (91% completed) and 6 months (85% completed) after treatment; self-report of abstinence	ASI problem severity declined for both groups at 3 and 6 months after treatment and did not differ between groups. Inpatients were more likely to report abstinence at 3 months (63%) compared with the day treatment group (38%). The groups did not differ at 6 months (46% versus 35%).
Guydish et al., 1998 (5) and 1999 (6)	Day treatment (n=114) versus residential treatment (n=147) in a therapeutic, community-oriented drug treatment program	Day treatment: 8 hours of treatment per day, 7 days per week for 6 to 8 months	Residential therapeutic community with 1-month orientation; 3 to 6 months active treatment; 3 to 6 months reentry	ASI at baseline and 6, 12, and 18 months follow-up; treatment retention; days of treatment	ASI problem severity scores (Alcohol, Drug, Employment, Legal, Medical, Psychological, and Social) declined significantly from baseline; improvements were maintained at 6, 12, and 18 months. Residential patients had more improvement on social and psychiatric problems; remaining outcomes did not differ.
Rychtarik et al., 2000 (7)	Individuals seeking treatment for alcohol dependency were randomized to IOP (n=63) versus inpatient and outpatient (n=58) versus outpatient (n=61)	IOP: 5 days per week for 28 days plus 3 months of weekly aftercare	Inpatient and outpatient: 28 days plus 8 sessions of outpatient plus weekly aftercare; OR, outpatient: 8 sessions in 28 days	Percentage of days abstinent	Days abstinent increased from pretreatment for all groups, and groups did not differ at 18-month follow-up: inpatient, 37% to 81%; IOP, 50% to 75%; outpatient, 41% to 76%. Patients with high alcohol involvement had better outcomes when treated in inpatient care.
Weithmann and Hoffman, 2005 (8)	Day hospital (n=56) versus inpatient (n=54) care in a German psychiatric hospital	Day hospital (same services and staff as inpatient)	Inpatient: same services and staff as day hospital	Percentage of days abstinent, assessed quarterly.	Days abstinent for both groups. There were no differences between levels of care.
Randomized controlled trials that included study participants who refused randomization					
McKay et al., 1995 (9)	Day hospital versus inpatient care: patients randomized (n=48) plus patients who refused randomization and self-selected level of care (n=96)	Day hospital: 27 hours per week for 4 weeks	Inpatient: 48 hours per week of group and individual counseling plus psychoeducation	ASI at baseline and at follow-up 3, 6, and 9 months after treatment	ASI problem severity declined in both groups at all measurement intervals. There were no differences between levels of care. Randomized and self-selected participants had similar outcomes.

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Study	Design, participants, setting	IOP treatment	Comparison treatment	Primary outcome measures	Primary outcome and between-group effects
Witbrodt et al., 2007 (10)	Day hospital versus residential care: patients randomized (n=293) plus patients who refused randomization (n=403) and self-selected level of care	Day hospital (n=154 randomized; n=321 self-selected)	Social model residential care (n=139 randomized; 82 assigned)	ASI at baseline and at follow-up interviews at 6 and 12 months	ASI problem severity declined in both groups at both measurement intervals. There were no differences between levels of care.
Analyses of natural cohorts					
McLellan et al., 1997 (11)	Naturalistic analysis of adults (N=918) from 10 outpatient and 6 IOP programs	IOP: 3 or more hours per day at least 3 days per week (n=338)	Outpatient: 2 or fewer hours per session, 2 or fewer days per week (n=580)	ASI at baseline and 7 months after baseline	ASI problem severity declined in both groups There were no differences between levels of care. Patients seen in. IOP had more severe problems at admission.
Harrison and Asche, 1999 (12)	Naturalistic analysis of inpatient versus outpatient programs	Outpatient: 145 programs in Minnesota providing intensive levels of care (n=3,007)	Inpatient: 38 programs in Minnesota (n=1,156)	ASI at intake and at 6 months after intake	ASI problem severity declined in both groups. There were no differences between levels of care. Patients with recent suicidal ideation had better outcomes in inpatient care.
Pettinati et al., 1999 (13)	Naturalistic analysis of alcohol-dependent patients admitted to inpatient (n=93) or outpatient (n=80) care in a psychiatric hospital	Inpatient: 4 weeks of 12-step programming plus individual, group, and family therapy	IOP: 8 weeks of 12-step programming plus individual, group, and family therapy	SCL-90R; number of drinking days; return to significant drinking (days of drinking 3 or more drinks) or return to inpatient care	Survival analysis suggested that IOP patients returned to significant drinking more quickly (50% at 2 months) than inpatients (25% at 2 months). Six months after discharge, the percentage of patients with heavy drinking stabilized at about 50% in both groups.
Simpson et al., 1999 (14)	Naturalistic analysis—secondary analysis of data from DATOS assessing cocaine-dependent patients in three levels of care	Outpatient: 24 drug-free programs (n=458)	Residential: 19 long-term programs (n=542).Inpatient: 12 short-term programs (n=605)	Weekly cocaine use 1 year after discharge	Weekly cocaine use declined from 73% before treatment to 23% at follow-up and did not differ across groups. A significant interaction between level of care, problem severity, and retention in care suggested that patients with more severe problems were less likely to report weekly cocaine use following long-term residential care (23%) versus short-term residential care (37%).
McKay et al., 2002 (15)	Naturalistic analysis of inpatient plus outpatient (n=167) versus IOP only (n=96)	IOP: 2 programs in Washington State	Inpatient: one, 28-day inpatient program in Washington State	ASI at baseline and at 3 and 9 months after baseline	ASI problem severity declined in both groups at 3 months and 9 months. Participants in inpatient plus outpatient programs improved more because they were more severe at baseline.

Study	Design, participants, setting	IOP treatment	Comparison treatment	Primary outcome measures	Primary outcome and between-group effects
Tiet et al., 2007 (16)	Naturalistic analysis of outpatient and IOP (n=1011) versus inpatient and residential care (n=1520) among Veterans Affairs clients	Intensive outpatient (n=601) and outpatient (n=410)	Inpatient and residential: inpatient (n=224), residential (n=390), and domiciliary (n=906) settings	ASI at baseline and at 6 months after baseline	ASI problem severity declined in both groups after baseline. There were no differences between levels of care except for the most severe cases.
Qualitative review of studies published in 1995 or earlier					
Finney et al., 1996 (17)	Qualitative review of 14 studies of inpatient versus outpatient programs	Settings where patients do not stay over night	Residential, 24-hour settings	Varied, as reported in the publications	Treatment intensity was related to better outcomes. Inpatient outcomes were superior in 5 studies (2 based on naturalistic cohorts). Day hospital outcomes were superior in 2 studies. There were no differences in 7 randomized studies.

[a] Studies are listed in chronological order under type of research design

Abbreviations: ASI, Addiction Severity Index; DATOS, Drug Abuse Treatment Outcome Study; SCL-90R, Symptom Checklist 90-Revised.

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

ATTACHMENT F

Post Traumatic Stress Center, LLC

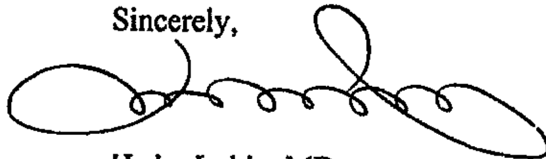
19 Edwards Street, New Haven, Connecticut 06511 *203-624-2146*

1/7/17

To whom it may concern,

It is my pleasure to write this letter of reference for Jay Seigel, APRN. I have known Mr. Seigel for many years, first in my role as the co-director and supervisor of his practicum at the Post Traumatic Stress Center and most recently in my role as his collaborating physician. I feel I have sufficient knowledge of his professional performance and his personal qualities.
Mr. Seigel is a knowledgeable, competent, industrious, and responsible practitioner. He uses his knowledge and personal skills to provide the most competent care for his patients. His patients' care reflected excellent clinical expertise and often led to excellent outcomes. His interest in the interplay of addiction and other mental illness has been long and he demonstrated growing expertise with this population.
I have no doubt that he will become a valuable and valued clinical addition to your clinical team. I will recommend him to this appointment without any reservations. If you have further questions please contact me.

Sincerely,



Hadar Lubin, MD
Co-Director, Post Traumatic Stress Center

February 18, 2017

To whom it may concern,

This is a letter of strongest support for the "Certificate of Need" for an Intensive Outpatient Pr(specializing in substance use disorders and coocurring disorders proposed by Jay Seigel APF located in Madison, Connecticut. As a family physician in practice in Old Saybrook, Connectic last 30 years our patients and our community has been handicapped by a substantial lack of addiction and psychiatric care that is desperately needed. The heavy toll on the lives of my pa families, and our community is unacceptable and completely avoidable. Even though the majc patient population is fortunate in having health insurance coverage it has been impossible to g to management for addiction treatment in the shoreline area. In the last 15 years I have comm regularly with major institutions for the great need for substance abuse treatment on the shore there has been little change. The program proposed by Jay Seigel APRN will be a much welc needed resource for our community.

I have personally worked with Mr. Seigel who is an experienced mental health provider in prac years. He has vast experience in psychiatry including addictions and dual diagnosis. A skilled diagnostician, Mr. Seigel is experienced in psychopharmacology and has an excellent rapport patients. The intensive program presented By Mr. Seigel specializing in substance use disorde coocurring Disorders is desperately needed in our community.

Sincerely,

Dr. Susanna Thomas

Medical Director, Family Medicine Associates

MARK J. OSTROWSKI, PSY.D.
CLINICAL PSYCHOLOGIST

February 6, 2017

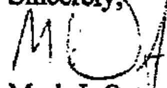
To Whom It May Concern:

I am pleased to provide this letter of support for Jay Seigel, APRN-BC as he moves forward with plans for an Intensive Outpatient Program for substance use disorders and co-occurring disorders in Madison Connecticut. Jay has been a trusted colleague since 2007. I have worked closely with him in two outpatient treatment settings where I observed him to be highly respected by the clinical team for his expertise and sound clinical judgement and by program participants for his attentiveness, responsiveness, and effectiveness.

In my many interactions with Jay, I have consistently found him to be dedicated, engaged, and highly motivated to deliver quality care. I have no doubts about his ability to successfully implement the mission of this much needed program. Jay's proposal for an Intensive Outpatient Program within the shoreline community comes at a critical time as the incidence of opiate addiction in the State continues to rise. In short, this is a much needed resource.

Please feel free to contact me for any further assistance.

Sincerely,



Mark J. Ostrowski, Psy.D.

1575 Boston Post Road Suite C9 • Guilford CT 06437 • 999 Summer Street Suite 200 • Stamford CT 06905
(203) 967-4995 • (203) 357-9030 (fax) • markjostrowski@comcast.net

Tidal Counseling LLC

'Supporting you through the tides of life'

Emily G. Reynolds, M.S., LPC
263 Main Street
Suite 304
Old Saybrook, CT 06475-2326
P. 860.876.7488
F. 860-391-8706

To: State of Connecticut – Dept. of Public Health

2/26/2017

Re: CON application for IOP level of care

My professional relationship with Jay Seigel, APRN was established in 2011 and since that time we have collaborated on many psychiatric and substance abuse cases with significant complexities including complex co-morbid medical conditions. Mr. Seigel's offers insight, clinical skills, a scope of knowledge and most importantly a passion for treating a most complex co-occurring client population.

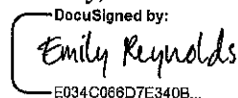
It has been a privilege working alongside Mr. Seigel on several cases, but all to often we run in to problems with access to appropriate levels of care, long wait times, limited aftercare and quite simply, a model that is not working for many that we see.

Mr. Seigel has a vision and one that is evidence based. He has thoughtfully put together a team of professionals and has developed a program model that will meet clinical needs as well as offer access to those on the Connecticut Shoreline.

It is with great enthusiasm that I fully support Mr. Seigel's vision and application requesting approval to open an Intensive Outpatient Program in this area.

Please do not hesitate to contact me should you have questions.

Sincerely,



Emily G. Reynolds, M.S., LPC

ATTACHMENT G

Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

A Treatment Improvement Protocol TIP 47
SAMHSA

Separate attached file due to size of document

State of Connecticut

Department of Mental Health and Addiction Services
Triennial State Substance Abuse Plan

Miriam Delphin-Rittmon Ph.D. Commissioner
Nancy Navarretta M.A., L.P.C., NCC, Deputy Commissioner

Table of Contents

Introduction 2
Background and Legislative Intent 3
DMHAS Mission and Vision 4
DMHAS Statewide Substance Abuse Service System 5
Evidence Based Practices in the DMHAS Substance Abuse Treatment System 6
Legislative Initiatives Impacting Substance Abuse Service Delivery 8
Connecticut Alcohol and Drug Policy Council 9
Emerging Trends in Substance Abuse 12
Plan Development 13
6 Key Strategies for a Comprehensive and Coordinated State Substance Abuse Plan 14
Strategy 1: Strategies Related to Prevention and Education 15
Strategy 2: Strategies Related to Treatment 18
Strategy 3: Strategies Related to Recovery 21
Strategy 4: Strategies Related to Criminal Justice 23
Strategy 5: Strategies Related to Collaboration and Cost Effectiveness 25
Strategy 6: Strategies Related to Accountability and Quality Care 27
Other State Agency Substance Abuse Initiatives and Accomplishments 30
State Spending for Substance Abuse Services in Connecticut 52
Department of Mental Health and Addiction Services Triennial Report 2016 Opioid Annex 53
Introduction 54
Connecticut's Opioid Epidemic 55
6 Key Strategies for a Comprehensive and Coordinated Response to the Opioid Epidemic 61
Strategy 1: Strategies Related to Rescue 62
Strategy 2: Strategies Related to Prevention and Education 64
Strategy 3: Strategies Related to Treatment 66
Strategy 4: Strategies Related to Criminal Justice 68
Strategy 5: Strategies Related to Law Enforcement 69
Strategy 6: Accountability and Patient Care 70
Conclusion 71

Introduction

The Connecticut Department of Mental Health and Addiction Services has been directed through legislation to triennially develop a state substance abuse plan. The plan historically has served to capture information about all of the state funded substance abuse services regardless of which agency provides them. The plan is expected to include goals, strategies, and initiatives that will be the focus of the state's efforts over the next three years. Therefore this report includes information from any of the state agencies that are involved in delivering substance abuse services. The report defines a range of strategies that will guide the state's efforts and then includes information about the accomplishments that have been achieved over the past three years.

Since the last plan was developed, one issue has heavily influenced many of the activities that state agencies are focused on. Connecticut has been in the grips of an opioid epidemic that has resulted in increasing numbers of overdose deaths across the state. At the same time, the substance abuse treatment system has seen substantial growth in treatment admissions that are directly related to opioid use. Overdose deaths and an increase in treatment admissions have rapidly intensified over the past three years. This issue has now become perhaps the single most important health concern we as a state are facing. The Governor has recognized this and has proactively introduced legislation designed to reverse this epidemic. At the same time he has re-invigorated the Alcohol and Drug Policy Council (ADPC), charging the group with the development of a plan to address the opioid crisis.

As a substance abuse service system, DMHAS must maintain a comprehensive treatment system while also dealing with emerging issues or threats. A triennial plan must include goals and strategies that support the breadth of services available to individuals with a wide range of substance use issues while also developing new strategies that address the opioid crisis. This year's plan will include core strategies and actions that are necessary to maintain and enhance the overall system of care. However, this year's plan will also recognize the opioid epidemic by including a Triennial Report Opioid Annex. The core strategies will have significant overlap but all strategies and accomplishments that are specifically related to opioids will be separated from the "larger" report and will be included in the Opioid Annex.

As Commissioner, I would like to thank the Governor, legislature and all of the state agencies that are involved in this important work. Connecticut is seen as a national leader in the provision of behavioral health services thanks to the leadership at multiple levels within the state. The Commissioners and senior leadership at each of the agencies providing substance abuse services in the state are involved in a number of activities designed to enhance our service system while also working to address the opioid crisis. It is my hope that this report details the significant accomplishments that have already been achieved while highlighting areas that require our concerted efforts.

Background and Legislative Intent

Legislation originally enacted in 2002 required the Department of Mental Health and Addiction Services to submit the state's substance abuse plan biennially. That legislation required DMHAS to submit the Report to the Legislature, Office of Policy and Management and the Alcohol and Drug Policy Council. The legislation was amended in 2013, shifting the report cycle to a triennial basis and the language requiring DMHAS to submit the plan to the groups described above was eliminated. Based on these legislative changes the state's substance abuse plan must be completed by July 2016. The last Biennial Report completed in 2013 can be found at the following link: http://www.ct.gov/dmhas/lib/dmhas/eqmi/biennialreport.pdf

The state's substance abuse plan is expected to include comprehensive strategies for the prevention, treatment and reduction of alcohol and drug abuse problems. The legislation specifies a number of elements that must be included in the report such as a mission statement, a vision statement, and goals for providing treatment and recovery support services to adults with substance use disorders. In addition, the Department is supposed to report on emerging substance use trends, statistical and demographic information about the individuals being served in the state substance abuse treatment system, and the performance measures used to evaluate program effectiveness in addressing substance use issues. The plan organizes actions under key strategy areas.

This year's Triennial Report is closely aligned to the reconstituted Alcohol and Drug Policy Council (ADPC) and the charge that was given to them by Governor Malloy. During the 2015 legislative session, Governor Dannel Malloy introduced and signed "An Act Concerning Substance Abuse and Opioid Overdose Prevention" into law. That bill, Public Act 15-198, reconstitutes the Alcohol and Drug Policy Council with Commissioners Miriam Delphin-Rittmon (DMHAS) and Joette Katz of the Department of Children and Families (DCF) as the co-chairs. The Council will help direct the state's efforts to coordinate substance use prevention and treatment throughout Connecticut's system of care. This reconstituted council includes new members from the medical, recovery and treatment communities and is uniquely positioned to make expert recommendations to guide our prevention and treatment efforts. Governor Malloy directed the ADPC to focus on the emerging opiate epidemic in Connecticut. The ADPC began meeting again in fall 2015 and subcommittees are currently working to develop recommendations related to the charge given to them by the Governor.

DMHAS Mission and Vision

Mission Statement

The mission of the Department of Mental Health and Addiction Services is to improve the quality of life of the people of Connecticut by providing an integrated network of comprehensive, effective and efficient mental health and addiction services that foster self-sufficiency, dignity and respect.

Vision Statement

Connecticut envisions a recovery-oriented system of behavioral health care that will offer all State's citizens, across the lifespan, an array of accessible services and recovery supports. Also, that people will be able to choose those services which are most effective in addressing their particular behavioral health condition or combination of conditions. These services and supports will be culturally and gender responsive, build on personal, family, and community strengths, and have as their primary and explicit aim promotion of the person/family's resilience, recovery, and inclusion in community life. Finally, services and supports will be provided in an integrated and coordinated fashion within the context of a locally managed system of care in collaboration with the surrounding community, thereby ensuring continuity of care both over time (e.g., across episodes) and across agency boundaries, thus maximizing the person's opportunities for establishing, or re-establishing, a safe, dignified, and meaningful life in the community of his or choice. Connecticut's vision is based on the following underlying values:

- The shared belief that recovery from mental illnesses and substance use disorders is possible and expected;
- An emphasis on the role of positive relationships, family supports, parenting in maintaining recovery, achieving sobriety, and promoting personal growth and development;
- The priority of an individual's or family's goals in determining their pathway to recovery, stability, and self-sufficiency;
- The importance of cultural inclusion, cultural competence and gender- and age-responsiveness in designing and delivering behavioral health services and recovery supports;
- The central role of hope and empowerment in changing the course of individual's lives; and
- The necessity of state agencies, community providers, and consumer/recovery communities coming together to develop and implement a comprehensive continuum of behavioral health promotion, prevention, early intervention, treatment, and rehabilitative services.

DMHAS Statewide Substance Abuse Service System

The Department of Mental Health and Addiction Services (DMHAS) promotes and administers comprehensive, recovery-oriented services in the areas of mental health treatment and substance abuse prevention and treatment throughout Connecticut.

While the Department's prevention services serve all Connecticut citizens, its mandate is to serve adults (over 18 years of age) with psychiatric or substance use disorders, or both, who lack the financial means to obtain such services on their own. DMHAS also provides collaborative programs for individuals with special needs, such as persons with HIV/AIDS infection, people in the criminal justice system, those with problem gambling disorders, substance abusing pregnant women, persons with traumatic brain injury or hearing impairment, those with co-occurring substance abuse and mental illness, and special populations transitioning out of the Department of Children and Families.

DMHAS is the state's lead agency for the prevention and treatment of alcohol and other substance abuse. As such, it provides a variety of treatment services on a regional basis to persons with substance use disorders, including residential detoxification, long-term rehabilitation, intensive and intermediate residential services, medication assisted treatment including methadone maintenance, outpatient, partial hospitalization, and recovery supports. DMHAS' budget for substance abuse services is approximately $148,000,000 and blends state general funds with federal block grant funds. The DMHAS substance abuse treatment system includes approximately 51providers with over 300 programs. These services focus on individuals with co-occurring disorders as many people who struggle with mental illnesses also struggle with alcohol or drug problems as well. Building our capacities to treat co-occurring disorders has been a major priority of DMHAS for the past 10 years.

DMHAS also provides these substance abuse services within state-operated facilities, namely Connecticut Valley Hospital. Detoxification and intensive residential services are provided in Middletown and in Hartford at the Blue Hills location. Other state-run facilities including Connecticut Mental Health Center and the Southwest Connecticut Mental Health System offer specialized addiction services as well. Specialized services for HIV-infected clients include counseling, testing, support and coping therapies, alternative therapies and case management. Where appropriate referrals are made to DPH's Partner Notification Services and clients are linked to follow-up treatment.

The department also provides prevention services, designed to promote the overall health and wellness of individuals and communities by delaying or preventing substance use; these include information dissemination, education, alternative activities, strengthening communities, promoting positive values, problem identification, and referral to services. Through this model, attitudes and behaviors that contribute to alcohol and other drug abuse are changed, leading to healthier communities.

DMHAS served almost 60,000 unduplicated substance abuse clients in FY 15. There were almost the same numbers of admissions to funded or operated substance abuse programs over the course of the year. The most highly utilized levels of care or programs were the Pre-Trial Intervention Program, methadone maintenance, inpatient and residential, and outpatient services. For a more complete analysis of DMHAS' annual statistical information, please reference the 2015 Annual Statistical Report at the following link: http://www.ct.gov/dmhas/lib/dmhas/eqmi/annualreportsfy2015.pdf. This provides a much more comprehensive analysis of our substance abuse service system.

DMHAS administers and funds 122 prevention coalitions covering 169 towns, and 60 community-based prevention programs provide services statewide or at the regional or local level.

The Commissioner and the DMHAS Executive Group are advised by many constituency and stakeholder groups. These include the State Board of Mental Health and Addiction Services, a 40-member advisory group consisting of 15 gubernatorial appointees, the chairperson, one designee each from the 5 Regional Mental Health Boards, and one designee each from the 15 substance abuse Regional Action Councils.

Connecticut also has a number of other state agencies that are involved to some extent in the delivery of substance abuse treatment and prevention services. The Departments of Children and Families (DCF), Social Services (DSS), Public Health (DPH), Correction (DOC) and the Judicial Branch Court Support Services Division (CSSD) all provide a range of treatment and prevention services that are focused on the unique clients that these agencies serve. The report will detail major initiatives that each Department is involved in and the amount of funding that is being used to support substance abuse prevention and treatment services.

Evidence Based Practices in the DMHAS Substance Abuse Treatment System

DMHAS is actively working to expand the adoption of evidence-based practices within our substance abuse treatment system. Evidence-based practices (EBP's) are typically categorized under two classifications, pharmacotherapies, or behavioral therapies. Both are used in the DMHAS treatment system. Pharmacotherapies include treatments like Methadone, Buprenorphine and Naltrexone, which are commonly used to treat opiate addiction. Evidence-based behavioral therapies include Cognitive Behavioral Therapy (CBT), Contingency Management, and Motivational Interviewing, which have been shown to be effective with certain populations.

Connecticut utilizes a number of evidence-based practices within our substance abuse system. In 2010, DMHAS initiated the EBP Governance Committee as a means to further the use of EBP's within our service system. The group is chaired by the DMHAS Commissioner and meets quarterly to promote the adoption of EBP's. Foremost among these services is DMHAS' use of Medication Assisted Treatment (MAT), which is considered the gold standard for treating opiate addiction. DMHAS has a statewide network of funded methadone maintenance providers that serve over 15,000 individuals annually. This number increases to 18,300 when one adds in unduplicated clients served in non-funded methadone programs. There are over 25 distinct clinics, some of which have opened in response to growing needs of certain communities. For example, the Torrington area has seen a significant growth in persons using opiates and the Hartford Dispensary responded by opening a clinic in that area several years ago.

DMHAS has also been actively working to increase the number of physicians who prescribe buprenorphine, another form of MAT that has proven to be effective at dealing with opiate addiction. Like methadone, which is tightly regulated, the federal government restricts who can prescribe buprenorphine and the number of individuals they can "treat". The drug is a synthetic opioid medication that does not produce the euphoria and sedation caused by heroin. It has other advantages in that it reduces withdrawal symptoms and has a low risk for overdose. It can be provided in its pure form or may be combined with naloxone in a more common formulation of the drug called Suboxone. The federal government is proposing to relax the restrictions on the numbers that can be treated at any one time from 100 to 275 individuals. If approved, this may increase access to an evidence-based option to people addicted to opiates.

Behavioral therapies are used across the DMHAS system at many of our provider agencies. This includes CBT and Motivational Interviewing (MI), a counseling approach that is intended to engage clients and increase motivation to make positive changes. In recent years, DMHAS has focused more heavily on MI because of its effectiveness in engaging clients in treatment.

For years DMHAS has focused on promoting best practices in the areas of co-occurring disorders, trauma informed treatment, and specialty services that are responsive to the needs of women in treatment. These discrete areas of practice have been fostered by training, expert consultation, learning collaboratives, the use of data to improve services, and other practice improvement activities. Each of these is described in greater detail below:

- **Co-Occurring Disorders Initiatives -** Many individuals with substance use disorders have mental health disorders as well. For over 10 years, DMHAS has focused heavily on fostering integrated care. One aspect focused on ensuring that providers were screening all clients for both mental health and substance use disorders. Efforts have been directed at increasing system capacities to provide co-occurring treatment, regardless of where a client presents for treatment. Progress is measured by using a fidelity scale developed by Dartmouth Medical School: Dual Diagnosis Capability in Addiction Treatment (DDCAT). As part of this initiative a practice improvement collaborative has been used

to foster the implementation of integrated services. Hundreds of DDCAT fidelity reviews have been completed across DMHAS addiction service agencies.

- **Trauma Initiative -** Similarly many individuals with substance use disorders have histories that include trauma. DMHAS partners with the CT Women's Consortium for training on trauma-informed care and trauma-specific models. As part of this initiative a fidelity scale has been developed and is being utilized to measure a program's adherence to trauma informed, trauma specific, and gender-responsive care. A Quarterly newsletter ***Trauma Matters*** is disseminated system-wide to further inform system development.
- **Women's Services Practice Improvement Collaborative –** This is another collaborative venture with the Women's Consortium designed to promote gender sensitive practices in the DMHAS system. DMHAS funds a number of specialty treatment programs for women or women and children. These programs, DMHAS, and the Consortium meet on a regular basis to exchange lessons learned and problem solve about how to implement gender responsive treatment within these agencies.

Legislative Initiatives Impacting Substance Abuse Service Delivery

A number of legislative initiatives related to substance abuse have been introduced over the past three years. A primary emphasis of these activities has related to the growing opioid epidemic. These legislative activities date back to state fiscal year 2011 when legislation was first introduced to address the increase in overdose deaths. PA 12 -159 *An Act Concerning Treatment for a Drug Overdose*) became effective October 1, 2012. This bill was designed to make Naloxone/Narcan more widely available. This prescription medication reverses an opioid overdose. This initial piece of legislation allowed physicians to prescribe Naloxone to families that had members that were using opiates and at-risk for overdose. This early effort has continued to be developed as Connecticut has aggressively worked to make Narcan more widely available.

Other pieces of legislation related to increasing access to this life saving drug include the following:

Narcan legislation:

- http://www.cga.ct.gov/2011/sum/2011sum00210-R02HB-06554-sum.htm
- http://www.cga.ct.gov/2012/act/PA/2012PA-00159-R00HB-05063-pa.htm
- http://www.cga.ct.gov/2014/ACT/PA/2014PA-00061-R00HB-05487-PA.htm
- http://www.cga.ct.gov/2015/FC/2015HB-06856-R000913-FC.htm

The 2011 bill was part of Good Samaritan legislation providing protection for individuals who intervened in a medical emergency. The 2012 bill provided protections to physicians, permitting them to prescribe Naloxone to family members. The 2014 legislation provided additional protections to medical personnel who intervene with someone who is believed to be overdosing as a result of using opiates.

In 2015 Governor Malloy introduced comprehensive legislation to combat the opioid crisis (an Act Concerning Substance Abuse and Opioid Overdose Intervention). There were a number of pieces contained in this legislation but one of the hallmarks was that pharmacists could prescribe and dispense Narcan after completing an approved certification course. This meant that family members and other interested parties could simply go to a participating pharmacy and receive Narcan without having to consult a physician. Department of Consumer Protection (DCP) implemented an online training program in summer 2015 and almost 600 pharmacists are now certified and willing to prescribe Narcan. Major pharmacy chains in Connecticut utilize separate continuing education programs. Legislation passed in the most recent legislative session focused on ensuring that municipality's primary emergency medical services provider is equipped with Narcan and its personnel has received training, approved by the Commissioner of Public Health, in how to administer the medication.

Another component of the 2015 legislation focused on physician training related to prescription opiates in an attempt to reduce the overuse of these drugs. Another component focused on strengthening legislation related to the state's Prescription Drug Monitoring Program and the legislation limited initial prescriptions for opioids to 7 days. This same legislation underscored the gravity of the opiate crisis by re-constituting the ADPC with a clear charge that the group was to focus on the opiate epidemic.

Legislation regarding criminal offenders has been introduced that has relevance to the state's substance abuse efforts. Over the past several years the Governor has introduced legislation aimed at assisting offenders to re-integrate into society. The legislation has been framed as "Second Chance Initiatives" a package of innovations that assists offenders in the area of employment, housing, and the reduction of penalties for non-violent drug offenses.

Connecticut Alcohol and Drug Policy Council

The Connecticut **Alcohol and Drug Policy Council (ADPC)** is a legislatively mandated body comprised of representatives from all three branches of State government, consumer and advocacy groups, private service providers, individuals in recovery from addictions, and other stakeholders in a coordinated statewide response to alcohol, tobacco and other drug (ATOD) use and abuse in Connecticut. Governor Malloy reconstituted the ADPC through legislation that was enacted in 2015. The Council, co-chaired by DMHAS and DCF, is charged with developing recommendations to address substance-use related priorities from all State agencies on behalf of Connecticut's citizens -- across the lifespan and from all regions of the state. The Governor

provided a charge to the ADPC in late October 2015 which was focused on the opioid crisis in Connecticut. He requested that they study and make recommendations in the following areas:

- Best practices in the treatment of alcohol and substance use disorders, including Medication Assisted Treatment (MAT) and other evidence-based treatment strategies.
- A coordinated, audience specific, prevention message including modern messaging to be used by school districts, parents, medical professionals, municipal leaders, state, agencies, and law enforcement.
- A collaborative effort, with medical professionals including doctors, nurse practitioners, dentists, and physician assistants to educate all prescribers on the dangers of overprescribing narcotics and the current best practices in identifying substance use disorder and the resources available for treatment.
- A strategy to make the overdose reversing drug naloxone widely available and affordable to first responders, in pharmacies and to any individual who may be able to use it to reverse an overdose.

In his charge to the Council he encouraged them to make recommendations on issues requiring legislative change, administrative actions and statewide cooperation.

The ADPC began meeting again in late October 2015 after a several year hiatus. The ADPC has created three subcommittees that are working in areas related to the general charge. The subcommittees have begun to meet and are expected to have recommendations available later in the summer of 2016. The subcommittees and their areas of focus are described in greater detail below:

ADPC Committee 1: Prevention, Screening & Early Intervention

Co-Chairs: Ingrid Gillespie, Judith Stonger, Dr. Mark Grossman

Mission:

Recommend policies, programs, and services to prevent the onset of illegal drug use; prescription drug misuse, abuse and proper disposal; alcohol misuse and abuse; and underage alcohol and tobacco use.

Promote effective substance abuse prevention practices that enable communities and other organizations to apply prevention knowledge effectively.

Work-to Date

Three meetings of the Prevention, Screening and Early Intervention Subcommittee were held since its establishment in February 2016. Membership on the subcommittee includes elected officials, state agencies, medical and behavioral health providers, and representatives from the

Regional Action Councils (RACs). The membership will be expanded to include representatives from the recovery, pharmaceutical, faith-based as well as other communities.

The work of the subcommittee will focus in a number of areas:

- Increasing statewide public awareness of the dangers of non-prescription opioid use and addiction via public service announcements, billboard messages, and the state's website – ensuring that resources are available for parents, youth, users, family members, medical and other professionals.
- Increasing prescribers' awareness of the risks and dangers of sharing medication and over prescribing, and increasing their engagement in the Prescription Drug Monitoring Program. The subcommittee will recommend training and assist in disseminating information.
- Promoting awareness and use of naloxone, and screenings for opioids and heroin in SBIRT initiatives.
- Developing an inventory of evidence-based and effective strategies for prevention, screening and early intervention and promoting increased use of them.

ADPC Committee 2: Treatment & Recovery Supports

Co-Chairs: Dan Rezende, Dr. Charles Atkins, Phil Valentine

Mission:

Recommend policies, programs and services to improve access, reduce barriers, and promote high quality, effective treatment and recovery services.

Recommend strategies to close the gap between available treatment and recovery supports capacity and demand.

Promote the adaptation and adoption of evidence-based and best practices by community-based treatment and recovery programs and services.

Recommend policy to improve and strengthen substance abuse treatment and recovery organizations and systems.

ADPC Committee 3: Recovery & Health Management

Co-Chairs: Shawn Lang; Deb Henault

Mission:

Recommend policy that incorporates a spectrum of strategies to promote harm reduction including safer use, managed use and abstinence, and overdose prevention.

Promote recovery-oriented care and recovery support systems that help people with mental and/or substance use disorders manage their health and behavioral health conditions successfully.

Recommend other policies that support recovery including but not limited to housing, employment, medical care, and community re-entry.

Previous state plans submitted by DMHAS were expected to describe actions that the ADPC was taking to address substance use issues in Connecticut. This report will focus heavily on activities that are being taken by DMHAS and other state agencies to address the opiate crisis. While the ADPC has not yet created a formal plan, a number of activities are underway and these activities and progress that is being made will be detailed in this report. Recent legislation that was passed is requiring the ADPC to develop by January 1, 2017 a comprehensive inter-agency plan that details how the state will reduce overdose deaths

Emerging Trends in Substance Abuse

The State Substance Abuse Plan that will be presented is responsive to emerging trends that affect substance abuse service delivery in the State. Over the past three years various trends have impacted the substance abuse prevention and treatment system in Connecticut. Certain trends relate to increases in the use of opioids, other trends relate to political or administrative changes that are impacting the substance abuse service delivery system in Connecticut. For example Connecticut and the rest of the nation have seen a huge spike in opioid use and overdose deaths related to this increase. During the same period, the Affordable Care Act was fully implemented which created changes in terms of who was insured and how substance abuse services were funded. The trends related to the opioid crisis will be presented in Opioid Annex at the end of this report.

Impact of Affordable Care Act

The Affordable Care Act (ACA) was introduced during this report period. The introduction of ACA has created changes in how substance abuse services are delivered, funded, and has increased the number of individuals that are eligible to receive these services. The ACA in Connecticut through the Medicaid Expansion has increased the number of clients that are now eligible for Medicaid. Access Health CT, Connecticut's insurance exchange has significantly reduced the number of people in the state who do not have insurance. In FY 13, the number of uninsured was believed to be approximately 13.2% of the state's population and this was reduced to approximately 4% in late 2015. While the Medicaid substance abuse benefit available to these individuals has not changed over that period, more individuals are eligible to receive substance abuse services.

The ACA has impacted how substance abuse services are funded in Connecticut. Approximately 150 million in mental health and substance abuse funds that previously supported Low Income Adults (LIA) in Connecticut were shifted out of DMHAS' budget into DSS' budget beginning in FY 14. Similarly, the clients that have found insurance through the state's health care exchange have resulted in higher numbers of individuals being served for substance abuse services. DMHAS' own data system shows a 10% increase in clients served in non-funded substance abuse treatment programs over the past 4 years. This is believed to be attributable to the increase in clients who are eligible for Medicaid or purchase insurance through the state's health care exchange.

Plan Development

The 2016 State Substance Abuse Plan is organized under key strategy areas. Each strategy area lists a number of action steps that will be taken over the next three years to address substance use issues. The plan and the Opioid Annex cuts across all state agencies involved in substance abuse treatment and prevention and is heavily influenced by recent trends in Connecticut. Many action steps relate to the opioid crisis as much attention has been focused on trying to reverse this epidemic. However, many action steps focus on managing and maintaining a comprehensive substance abuse system which focuses on prevention and health promotion and treatment of substance use disorders. Each strategy area will be followed by a summary of the accomplishments that have occurred over the past three years.

6 Key Strategies for a Comprehensive and Coordinated State Substance Abuse Plan

1 STRATEGIES RELATED TO PREVENTION AND EDUCATION

- Prevent substance use through education aimed at teens, parents, school and university faculty and staff, and other caretakers including medical professionals. Reduce stigma associated with seeking treatment.

2 STRATEGIES RELATED TO TREATMENT

- Expand access to broad spectrum of substance abuse services.
- Increase the use of evidence-based treatments (EBP's) including methadone maintenance and buprenorphine

3 STRATEGIES RELATED TO RECOVERY

- Increase the use of peers and natural supports.
- Maintain recovery supports.

4 STRATEGIES RELATED CRIMINAL JUSTICE

- Implement criminal justice reforms that will increase diversionary options and the availability of substance abuse treatment, especially medication-assisted treatment in jails and prisons.
- Reduce barriers and adverse consequences faced by prisoners when they are released from prison or jail

5 STRATEGIES RELATED TO COLLABORATION AND COST EFFECTIVENESS

- Increase inter-agency coordination and collaboration in order to more effectively prevent and treat substance use disorders.

6 STRATEGIES RELATED ACCOUNTABILITY AND QUALITY CARE

- Ensure that providers deliver high quality services.
- Use data to improve care throughout the system.

Strategy 1: Strategies Related to Prevention and Education

- Achieve quantifiable decreases in substance use and abuse, and suicide and suicide attempt rates statewide through the skilled delivery of timely, efficient, effective, developmentally appropriate, and culturally sensitive evidence-based prevention strategies, practices, and programs.

Action Step: Provide data collection, management, analysis, and dissemination; survey development and implementation; technical assistance and training on data and evaluation-related topics; house the State Epidemiological Outcomes Workgroup; and serve as a clearinghouse for epidemiological and evaluation-related services for prevention through the Center for Prevention Evaluation and Statistics.	**Action Step:** Develop, enhance, implement, and integrate sustainable, comprehensive, culturally competent, evidence-based suicide prevention, intervention and response strategies statewide to reduce non-fatal suicide attempts and suicide deaths through the CT Suicide Advisory Board and the Garrett Lee Smith Youth Suicide Prevention-CT Networks of Care for Suicide Prevention Initiative.
Action Step: Increase youth access to behavioral healthcare and supports for early childhood development, and reduce substance use and exposure to violence through an enhanced, integrated and coordinated state behavioral health infrastructure through the Safe Schools Healthy Students Initiative.	**Action Step:** Support prevention efforts within the state by building the capacity of individuals and communities to deliver alcohol, tobacco and other drug abuse prevention services directed at schools, colleges, workplaces, media and communities through the Governor's Prevention Partnership.
Action Step: Identify and engage youth and young adults who have or are at risk for behavioral health disorders and connect them to high quality care through the Now is the Time – Healthy Transitions, CT Seamless Transitions & Recovery Opportunities for Network Growth Initiative.	**Action Step**: Educate tobacco merchants, youth, communities and the general public about the laws prohibiting the sale of tobacco products to youth under the age of 18 through the Tobacco Merchant & Community Education Initiative.
Action Step: Provide leadership on substance abuse prevention through engagement of senior college administrators and implementation of evidence based policies, practices and strategies through the CT Healthy Campus Initiative.	**Action Step**: Increase the rate at which young adults encountered by Crisis Intervention Teams (CIT) are connected to appropriate treatment and support services and diverted from arrest through the Specialized CIT for Young Adults Initiative.
Action Step: Conduct activities focusing on the prevention of community problem substance misuse or abuse utilizing the five-step Strategic Prevention Framework (SPF) through CT SPF Coalitions, and the Partnerships for Success Initiative.	**Action Step:** Enforce State laws that prohibit youth access to tobacco products by inspecting retailers across the state in order to maintain a retailer violation rate at or below 20 percent through the Synar Program.
Action Step: Prevent youth access to tobacco by enforcing Federal laws that prohibit sales of tobacco products to minors and restrict advertising and labeling through the FDA CT Tobacco Compliance Program.	**Action Step**: Disseminate information via print and electronic media on substance abuse, mental health and other related issues through the Connecticut Center for Prevention, Wellness and Recovery.

Action Step: Assist prevention providers/local communities in assessing prevention needs and coordinating resources to address these needs through Regional Action Councils.	**Action Step:** Deliver training and technical assistance to substance abuse and mental health practitioners through the Training and Technical Assistance Service Center.
Action Step: Develop and implement municipal-based alcohol and other drug prevention initiatives through Local Prevention Councils.	

Accomplishments:

Community Prevention Activities

The DMHAS Prevention and Health Promotion (PHP) Division utilizes the SAMHSA Strategic Prevention Framework (SPF) comprised of five steps: needs assessment, capacity building, planning, implementation, and monitoring and evaluation. Since 2013, the PHP has reorganized and re-procured its SAMHSA SAPT Block Grant-funded initiatives to align with the SPF. The new initiatives are as follows: the CT SPF Coalitions (2015-2020-12 communities); the Training and Technical Assistance Service Center, and the Center for Prevention Evaluation and Statistics. In addition, the PHP has been awarded and is directing multiple SAMHSA-funded discretionary grants impacting communities statewide: the Safe Schools Healthy Students Initiative (2013-2018-3 communities); Now is the Time – Healthy Transitions, CT Seamless Transitions & Recovery Opportunities for Network Growth Initiative (2014-2019-3 communities); Specialized CIT for Young Adults Initiative (2013-2016-8 communities); Partnerships for Success Initiatives (2009-2014- 19 communities; 2015-2020-8 communities); Garrett Lee Smith State Youth Suicide Prevention Initiatives (2011-14-34communities, 5 regions; 2015-2020-5 regions and 1 community).

Tobacco Cessation

The State Tobacco Prevention and Enforcement Program (TPEP) enforces the federal Synar Act, and annually submits the Synar Report to SAMHSA that details tobacco compliance activities and success at reducing underage use and enforcing tobacco retail. For years CT's violation rate has been below the required rate of 20%, and was 9% in 2015. Through the TPEP, with a grant from the CT Tobacco and Health Trust Fund (2014-2015), the Urban Tobacco Inspection Program provided funded four urban areas to: 1) conduct tobacco compliance inspections to enforce state law at the point of sale; and 2) provide retailers with education and awareness material including information about the new online training program. Lastly, the TPEP established the Tobacco Sales: Do the Right Thing interactive online training in 2014 designed to build the skills and knowledge of tobacco retail owners, managers, and front line retail personnel

to prevent retailer sales of tobacco products to youth under the age of 18. The learning components feature real-life scenarios, state and federal tobacco laws and the associated legal requirements. This training is now mandated via 2015 legislation for first time violators.

Prescription Drugs

With support from multiple DMHAS-contracted prevention providers, the state now has over 70 drop boxes where unused medication can be disposed of and has hosted the annual DEA Drug Take Back Day in multiple communities. DMHAS, in collaboration with the Regional Action Councils, has conducted approximately 15 public forums on opioids statewide, and 10 more are scheduled to occur this year. The forums include local substance abuse experts, persons in recovery, and leaders from state agencies who provide information about the scope of the problem. Information and awareness materials, instructions for accessing Narcan, and treatment resources are available at the forums. Additional contracted prevention providers, like the Connecticut Clearinghouse and the Governor's Prevention Partnership have collected and posted a range of resources to help inform the public and providers about this issue.

Suicide Prevention

Since 2006, the DMHAS PHP Division has received three SAMHSA-funded Garrett Lee Smith (GLS) Youth Suicide Prevention grants. Over the past 10 years the PHP has been working to integrate substance abuse and suicide prevention and mental health promotion, and build the capacity and readiness of communities, campuses, and prevention and treatments providers to address these issues, and has become a national model to other states. Results of the 2011-2014 grants proved statistically significant increases in the capacity and readiness of communities to implement suicide prevention and response efforts. The PHP staff, along with the CT Department of Children and Families (DCF), co-leads the CT Suicide Advisory Board, and has collaborated with multiple stakeholders, many of them DMHAS-funded prevention providers, to advance this objective.

Accomplishments and contributions since 2013 include: cooperative braiding of GLS and mental health, substance abuse, public health, and maternal and child health block grant dollars via DMHAS, DCF and Department of Public Health sub-recipient non-profits; consultation to and partnership with multiple systems and settings to enhance suicide prevention efforts and reduce risk to community members; statewide dissemination and adoption of evidence-based practices and free training and education in multiple settings; participation in the Zero Suicide for Health and Behavioral Health Care Systems Academy, Baltimore, MD June 24-25, 2015 and initiation of the CT Zero Suicide Learning Community October 2015; support to and engagement of survivors of suicide death and attempt and their foundation efforts in collaboration with the Office of the Child Advocate, Office of the Chief Medical Examiner and the CT Chapters of the American Foundation for Suicide Prevention; and development and release of the CT Suicide Prevention Plan 2020.

Strategy 2: Strategies Related to Treatment

- Expand access to broad spectrum of substance abuse services.
- Increase the use of evidence-based treatments (EBP's)

Action Step: Create statewide network of walk-in assessment centers to rapidly assist clients to find appropriate treatment.	**Action Step:** Maintain comprehensive substance abuse treatment system
Action Step: Provide specialized services to DCF involved parents with substance abuse problems (Project SAFE and RSVP)	**Action Step:** Increase access to specialized substance abuse services for persons involved with CSSD, DOC, DCF through ATR IV
Action Step: Increase capacity in substance abuse outpatient programs to prescribe buprenorphine.	**Action Step:** Apply for federal funding being made available to expand substance abuse services.
Action Step: Maintain screening for substance abuse and early intervention after grant expiration. (SBIRT)	**Action Step:** Improve linkages from detoxification programs to follow-up care
Action Step: Implement a statewide toll free call line to connect callers to treatment options.	**Action Step:** Increase adoption and expansion of EBP's through learning collaboratives

Accomplishments:

Comprehensive Treatment System

DMHAS is the state's lead agency for the prevention and treatment of alcohol and other substance abuse. As such, it provides a variety of treatment services on a regional basis to persons with substance use disorders, including ambulatory care, residential detoxification, long-term care, long-term rehabilitation, intensive and intermediate residential services, methadone or chemical maintenance, outpatient, partial hospitalization, and aftercare. DMHAS' budget for substance abuse services is approximately $148,000,000 and blends state general funds with federal block grant funds. The DMHAS substance abuse treatment system includes approximately 51providers with over 300 programs. The state as a whole spends almost 335 million for a range of substance abuse services.

Call Line

Rapid access to treatment is another essential component of a comprehensive strategy designed to address the opiate epidemic. Connecticut has responded to the opiate crisis by implementing a toll free number where services related to opiate addiction can be accessed. The toll free line is staffed 24/7 and links callers to a network of walk-in centers where somebody can receive a same day evaluation of their needs. The 24/7 call line is as follows: **1-800-563-4086**.

Walk-In Evaluation Centers

Over 50 programs have agreed to conduct same-day evaluations in order to link the clients to the most appropriate level of care. These walk-in centers and their locations can be accessed at the following link: http://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=577738

Follow-up Care

DMHAS implemented what is called the **Opioid Agonist Treatment Protocols** (OATP) over 10 years ago. These are procedures designed to rapidly link individuals who are being detoxed from heroin to methadone maintenance programs. These procedures were originally designed for frequent users as a way to reduce repetitive admissions to detoxification programs while quickly connecting clients to the most desirable treatment option, methadone maintenance. Eligibility criteria for participation in these protocols have been relaxed and more people are now eligible to use this service. This remains an area for enhancement as many people who enter detoxification programs with opiates being reported as their primary drug are not being connected to medication-assisted treatment.

Brief Screening and Intervention SBIRT

In 2011 DMHAS was awarded a federal grant for Screening and Brief Intervention and Referral to Treatment (SBIRT). This was a five-year grant that will end in August 2016. The purpose of the grant is to dramatically increase identification and treatment of adults age 18 or older that are at-risk for substance use disorders or have been diagnosed with one. The program was implemented in 12 federally qualified health centers (FQHC's) across the state at 29 locations. Over the 5-year period 64,000 individuals have been screened. 14,000 individuals screened positive for alcohol and another 6,000 screened positive for substance use. Three additional FQHC's have implemented SBIRT but were not funded to provide data. Outcomes have been closely tracked for those individuals who were referred to treatment. A random sampling showed significant reductions in binge drinking, illegal drug use, and marijuana use. Efforts are being directed at sustaining the project after the funds end.

Expanding Access to Recovery - ATR IV

The award notice for ATR 4 was received April 30, 2015 for a 3 year contracting period. During the first year of CT ATR IV, the call center received 2740 calls and scheduled 2612 intakes across 35 access centers. Of the scheduled intakes, 1900 face to face intakes were completed for a 73% completion rate. 84.7% of ATR 4 participants were between the ages of 25-54 and 64.7% were male. As for the racial split, 43.5% reported as white, 33.9% as African American and 16.4% as "none of the above. Client portals at Department of Correction facilities and Community Support Services Division accounted for 46.5% and 21.5% respectively of those who accessed ATR 4 services. The highest utilized services were Recovery Assessment, Transportation and Care Coordination followed by Basic needs (Gift Cards for clothing/household items), Medical Care/Wellness, Recovery Management, Faith Recovery Oriented Services and Supported Recovery Housing Services. As part of the award and a federal mandate, all grantees are required to collect and report performance data under the Government Performance and Result Act (GPRA) collected at the intake and at the follow-up (6 month) assessment. Grantees are required to obtain a minimum of 80% Follow-up GPRA rate. The FGPRA rate for the first year reflected a rate of 89.8% as compared to the average of all grantees with an average of 72.1%.

Federal Grant Opportunities

Besides the federal grants described above, DMHAS is applying for 5 federal grants focused on prevention and treatment. In total, the grants are worth several million dollars and would provide supplement funding for overdose prevention and would provide additional treatment for individuals struggling with opioid addiction.

Project SAFE and Recovery Specialist Voluntary Program (RSVP)

Project SAFE is a legislatively mandated collaboration between DCF and DMHAS that has evolved into a joint contract between the state agencies and Advanced Behavioral Health (ABH), an Administrative Services Organization. Project SAFE provides DCF social workers access to a centralized referral system for substance use services for adult caregivers involved with child protective services.

The Recovery Specialist Voluntary Program (RSVP) model is an intensive case management recovery support service for caregivers involved with child protective services who have had a child(ren) removed under an Order of Temporary Custody, and where substance use was a significant contributing factor in the removal

Strategy 3: Strategies Related to Recovery

- Increase the use of peers and natural supports.
- Maintain recovery supports.

Action Step: Expand the use of peers in DMHAS funded or operated services	**Action Step:** Continue to develop certified peer workforce
Action Step: Increase use of telephonic aftercare	**Action Step:** Provide short-term Supported Recovery Housing and other recovery supports
Action Step: Expand wellness programs	**Action Step:** Maintain high levels of consumer satisfaction
Action Step: Expand use of natural supports	

Accomplishments:

DMHAS has worked with Connecticut's recovery community on a number of initiatives that support recovery. These activities include the development of peer supports, telephonic support following treatment, the use of recovery centers, use of peers in treatment programs, and programs oriented at wellness. These are described in further detail below.

Recovery University

Advocacy Unlimited, a Hartford-based consumer run organization, has developed an 80 hour certification program for Peer Specialists. The program trained almost 100 individuals last year at locations across the state. The training is designed to develop a pool of certified Recovery Specialists who can be used in programs that are seeking to expand their use of peer staff.

CCAR Telephonic Aftercare

As part of DMHAS' contract with the Connecticut Community for Addiction Recovery, CCAR provides telephonic aftercare to individuals who have been discharged from addiction treatment facilities. Last year CCAR reports that they are calling over 1,000 persons a week and had over 12,500 conversations with persons in recovery over the course of the year. The Aftercare Program is seen as a cost effective method to provide support to persons in recovery and quickly link those individuals back to treatment when they may require additional treatment. It also helps connect persons in recovery with 12 step groups and other natural supports within the community.

Wellness and Integrated Health

Connecticut's advocacy community offer a number of activities focused on wellness and holistic health. Examples include things like Toivo, CCAR's Recovery Centers, and wellness programs like those at Connecticut Valley Hospital. Toivo, by Advocacy Unlimited is an initiative that includes statewide classes, workshops, and a mind/body focused wellness center where people can engage in yoga, meditation, fitness activities, and other creative and expressive activities.

Supported Recovery Housing

DMHAS contracts with Advanced Behavioral Health to maintain a network of short-term Supported Recovery Housing. Statewide there are 14 contracted Recovery House providers offering structured sober living in 47 locations which have over 200 beds. Approximately 1,300 individuals were served in the last year. The program provides short-term funding to support persons in recovery who may be transitioning out of treatment programs back into the community. The program provides temporary assistance until an individual can gain more permanent housing and work.

Recovery Centers

CCAR's Recovery Centers are community anchors for recovery offering a range of supports including employment and housing services, training, and recovery social events. CCAR has three distinct Recovery Centers; Hartford, Windham, and Bridgeport. A range of supports are offered at these centers by persons in recovery.

Annual Consumer Satisfaction Survey

DMHAS administers a Consumer Satisfaction Survey which typically receives over 25,000 respondents. The instrument was developed by states across the country that were looking for a tool that allowed them to compare results to national data. DMHAS consistently receives high marks on this survey and typically exceeds national results.

Strategy 4: Strategies Related to Criminal Justice

- Implement criminal justice reforms that will increase diversionary options and the availability of substance abuse treatment in jails and prisons.
- Reduce barriers and adverse consequences faced by prisoners when they are released from prison or jail

Action Step: Investigate the effectiveness of Law Enforcement Assisted Diversion (LEAD) programs, a pre-booking program that diverts to services as an alternative to arrest. Seattle has one example of such a program	**Action Step:** Transition offenders with drug convictions to community substance abuse programs
Action Step: Eliminate mandatory sentencing laws for those convicted of non-violent narcotics possession.	**Action Step:** Increase housing opportunities for ex-offenders
Action Step: Implement diversionary services for individuals arrested for crimes related to substance use.	**Action Step:** Increase employment training and job opportunities for ex-offenders.
Action Step: Provide substance abuse services to persons who are incarcerated.	

Accomplishments: Many individuals that are involved with the criminal justice system have struggled with substance use and may be at-risk for continued use when they return to the community. Others have been arrested for low-level crimes that were related to substance use. Connecticut has developed strong collaborations between DMHAS, DOC, Judicial Branch CSSD, and DCF that focus on diverting individuals, where appropriate from prison or jail or focus on community re-entry after being released from prison.

Second Chance Initiatives

Legislation signed by Governor Malloy in June 2015 reduced penalties for drug possession and eliminated mandatory sentencing requirements. Funding was approved in that year's budget for three initiatives that are part of the "Second Chance Society" including funding for the following programs: I-BEST, an employment program for ex-offenders in the Hartford area, Connecticut Collaborative on Re-Entry, a successful housing program aimed at individuals that repeatedly cycle in and out of the homeless service and correction systems, and a School-Based Diversion Initiative aimed at reducing suspension, expulsions, and school-based arrests in grades K-12.

DOC Methadone Maintenance Pilot

DOC, in collaboration with DMHAS, implemented a pilot program at New Haven Community Correctional Center in October of 2013, offering methadone maintenance to offenders who enter the facility already on a verified dose of methadone. A second program was added at Bridgeport Community Correctional Center in November 2014. Clients are provided treatment, as well as continued dosing, for their term of incarceration followed by re-entry planning services to continue the treatment upon release. More than 650 clients have participated in the two programs.

Collaborative Contracting with DOC and Judicial Branch CSSD

DMHAS is currently involved in collaborative contracting projects with the Judicial Branch CSSD and DOC. This project combines funding and jointly purchases intensive, intermediate, and recovery house beds from DMHAS-contracted substance abuse providers. A certain number of beds are reserved for clients from DOC or CSSD. The beds are used for diversion from jail and re-entry to the community. However, this initiative is likely to be scaled back due to fiscal constraints.

DMHAS Forensic Services

The DMHAS Division of Forensic Services funds community agencies to provide services to people with mental illness and/or addictions who are justice involved. These programs are designed and operated in collaboration with criminal justice agencies to divert adults from jail, assist with reentry from jail/prison, and reduce recidivism.

The Women's Jail Diversion, Jail Diversion Substance Abuse (JDSA), Alternative Drug Intervention programs provide a full complement of clinical and support services to criminal court defendants with substance use disorders. The Pretrial Intervention Program is a suspended-prosecution diversion program for first-time DUI offenders and drug possession offenders that provides alcohol and drug education groups or referral to a substance abuse treatment program. Transitional Case Management is a re-entry program that provides pre-release engagement and discharge planning and post-release OP substance abuse treatment and support services for men.

In SFY16 DMHAS received additional funding to expand JDSA to two additional courts and also received a MacArthur Safety and Justice Challenge to a third court.

Strategy 5: Strategies Related to Collaboration and Cost Effectiveness

- Increase inter-agency coordination and collaboration in order to more effectively prevent and treat substance use disorders.

Action Steps: Improve quality of care through the expansion of data sharing	**Action Steps:** Increase inter-agency collaboration for treatment services.
Action Steps: Increase inter-agency collaboration for prevention services.	**Action Steps:** Maximize federal and state funding and avoids costly duplication of efforts

Accomplishments: State agencies are involved in multiple collaborations that focus on inmates, community re-entry and jail diversion, substance-abusing parents, and specialized supports for adolescents. Some of these collaborations are described under other strategies but they will be briefly reviewed below.

Collaborative Contracting with DMHAS, DOC, and Judicial Branch CSSD

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Recovery Specialist Voluntary Program (RSVP)

The Recovery Specialist Voluntary Program (RSVP) model is an intensive case management recovery support service for caregivers involved with child protective services who have had a child(ren) removed under an Order of Temporary Custody, and where substance use was a significant contributing factor in the removal. This is a joint DCF/DMHAS program.

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Multi-Dimensional Family Therapy (MDFT)

MDFT is a comprehensive, family-centered treatment program for adolescent and young adult ages 11-18 with drug abuse and related behavioral and emotional problems. MDFT addresses the areas of adolescent and parent functioning known to create problems while enhancing the factors that solve problems, improve relationships, and restore positive development. CSSD has also implemented the same program through a MOA with the Department of Children and Families.

Suicide Prevention

A number of state agencies are involved in Suicide Prevention efforts including DCF, DMHAS, CSSD, Education, and DPH. Other stakeholders are involved in these efforts to reduce suicides and to develop a coordinated and supportive response when suicides occur.

Pharmacist Online Narcan Training

DCP developed an online training for pharmacists. The training was informed by experts from other state agencies that participated in the development and review of the training tool.

Strategy 6: Strategies Related to Accountability and Quality Care

- Ensure that providers deliver high quality services.
- Use data to improve care throughout the system.

Action Step: Ensure providers submit timely and accurate data	**Action Step:** Establish performance measures for all SA levels of care and benchmark performance annually
Action Step: Implement and enhance the DMHAS provider performance measurement system	**Action Step:** Monitor emerging needs and trends by compiling and reviewing Annual Statistical Data
Action Step: Increase the % of SA clients that have continuous treatment exposures that exceed 90 days.	**Action Step:** Utilize data systems to identify and address health disparities.
Action Step: Ensure services are well utilized	

Accomplishments:

Data Systems

The Department uses two systems to capture substance abuse data. The DMHAS Data Performance system (DDaP) captures client level data from private not-for-profit providers and was implemented in 2009. The second system WITS collects client level data from state-operated facilities. This system was implemented in mid-May 2014. Both systems capture a broad range of data including demographics, admission and discharge info, diagnostic information and the services individuals receive within our programs. These new data systems have greatly enhanced the department's ability to collect and report on the all clients served within our system and track measureable outcomes.

Provider Quality Reports

The data described above feeds our Performance Measurement System. The Department of Mental Health and Addiction Services (DMHAS) introduced Provider Quality Dashboard Reports as part of a performance evaluation system in 2009. This system uses contractually specified performance measures for each mental health and substance abuse level of care (i.e., detoxification, intensive residential, outpatient) and benchmarks for performance. The quality reports are issued quarterly and posted to the DMHAS website. These reports can be found at the following link: http://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=489554 .

The FY 15 annual performance measures are benchmarked and can be found at the following link:
http://www.ct.gov/dmhas/lib/dmhas/eqmi/SA.LOC.FY15_Performance_Measure_Goals_and_Statewide_Avge.pdf

The link shows each performance measure for substance abuse levels of care, the goal, and the state average for each measure. This allows DMHAS' Quality and Monitoring Departments to review system averages as well as those of individual providers.

Outlier Database

DMHAS launched a companion database to the Provider Quality Reports in 2013 called the Outlier Database. This database allows DMHAS staff to easily compare provider and program performance and is used to focus on quality improvement efforts. In early spring 2016, the database began to include functionality that allowed DMHAS to stratify agency and program performance based on race and ethnicity. While just launched, this innovation will help DMHAS and provider agencies to identify and address health disparities that may exist within the system.

Annual Statistical Report

DMHAS developed an Annual Statistical Report that was first published in December 2016. That report examined two fiscal year's data. A second report was released in December 2015 which reported on Fiscal Year 15 activity. The report includes information on clients served, demographics, substance use trends and service utilization data. The report was intended to annually capture essential information about service delivery in the DMHAS behavioral health system. The Annual Statistical Report can be found at the link listed below:

http://www.ct.gov/dmhas/lib/dmhas/eqmi/annualreportsfy2015.pdf

Prescription Drug Monitoring Program

The State's Department of Consumer Protection has already taken steps that partially address some of the action steps identified above. The state implemented a Prescription Monitoring Program (PMP) in 2008. The PMP was designed to collect prescription data for Schedule II through V drugs into a central database which can be used by medical providers and pharmacists in the active treatment of their patients. Recently enacted legislation (October 1, 2015) requires health care professionals to check the PMP prior to prescribing opioid medications for greater than a 72-hour period. Additional provisions require that pharmacists enter controlled substance prescription data after July 1, 2016 immediately or no later than 24 hours. This will improve the data as previous requirements specified that data must be entered within a one week period. New legislation limited initial prescriptions for opioids to 7 days.

Continuous Treatment Exposure

National research has shown that continuous treatment episodes that exceed 90 days or more result in better outcomes. DMHAS first reported on this measure in our last report. DMHAS examined clients that were active or admitted during a fiscal year to determine the percentage that remained in treatment with no interruption for greater than 90 days. The information for FY 13, 14, and 15 is as follows:

FY 13: 59%

FY 14: 61%

FY 15: 62%

Other State Agency Substance Abuse Initiatives and Accomplishments

➢ *Department of Children and Families*

During the last three years DCF has expanded its commitment to serving youth and families in their communities using evidence-based substance use treatment approaches that integrate treatment for mental health, trauma and victimization, and family therapy. All of the Department's community-based services for adolescent substance use are evidence-based and equipped to address problems related to the use of any substance, including heroin and prescription drugs. Community-based services include outpatient and intensive in-home services for youth, as well as services for caregivers who are involved with child protective services who have substance use problems. DCF also funds residential treatment services for adolescents with substance use problems with or without co-occurring mental health problems.

DCF has prioritized community-based and family-focused care.

In the past decade, as a proportion of total spending, there has been:

86% reduction in spending for residential treatment

149.5% growth in spending for community based services

All substance use treatment programs receiving DCF funds are required to use an evidence-based assessment called the Global Appraisal of Individual Needs (GAIN). Data from the GAIN is used to inform individualized treatment plans, local program evaluation, and statewide program planning by the Department. In SFY09, the Department implemented the Programs and Services Data Collection and Reporting System (PSDCRS), since renamed the Provider Information Exchange (PIE), to improve monitoring of the services DCF funds. PIE standardizes the information reported to DCF by providers while retaining the ability to assess program-specific goals. Data from the GAIN and PIE systems enhance DCF's ability to identify the population served, conduct needs assessment, compare client information across programs, implement systematic monitoring of outcomes and meet its statutory obligation to report on programs to the legislature.

Adolescent Substance Use Services

Over the past decade, DCF has shifted considerable funding for adolescent substance use treatment from residential treatment programs to community and family-focused services, particularly toward intensive in-home services. Intensive in-home services include Multi-

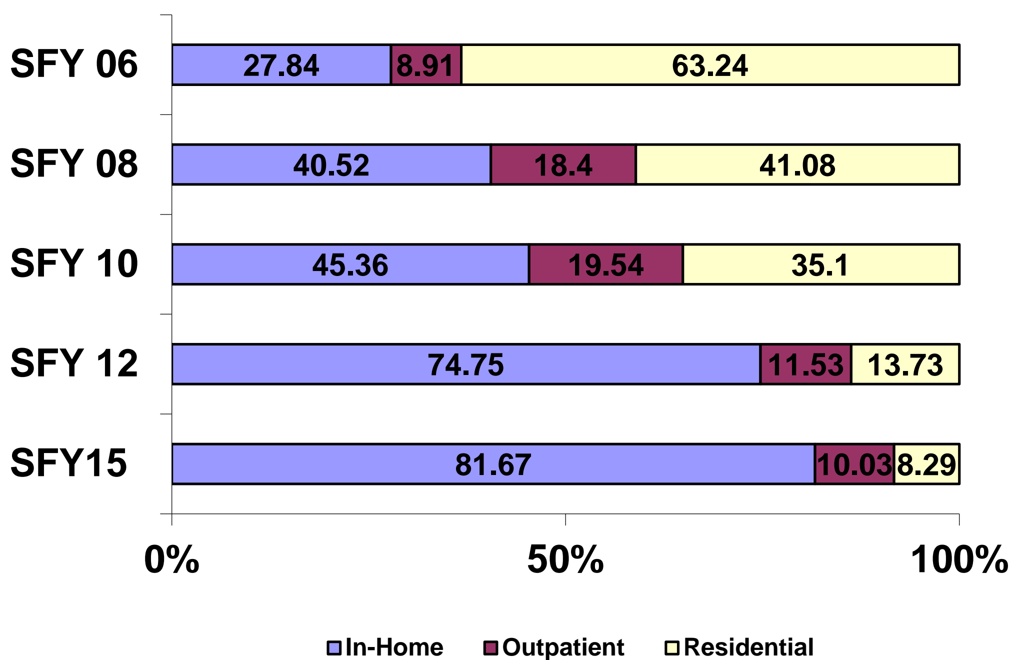
Systemic Therapy (MST) and Multidimensional Family Therapy (MDFT), as well as targeted adaptations to these models to meet the specific needs of special populations. DCF funds

Adolescent Community Reinforcement Approach with Assertive Continuing Care (ACRA-ACC) programs to provide evidence-based outpatient treatment services to adolescents. A description follows of each service and their adaptations for special populations of youth.

In response to concerns related to youth and family access to local community-based care and to provide alternatives to care in congregate settings, DCF repurposed some funding for residential treatment programs. This shift in allocations expanded access to care in less restrictive environments, particularly among evidence-based intensive in-home services in local communities. DCF's network of providers throughout the state currently includes:

- 29 MDFT teams across 13 providers statewide
- 6 MST teams across 3 providers covering nearly the entire state
- 6 ACRA/ACC teams across 4 providers statewide
- 1 Seven Challenges residential treatment program
- 1 MDFT residential program (under development)

Figure 1. Adolescent Substance Use Treatment: Outpatient (ACRA), Intensive In-home (MDFT, MST) and Residential Services. Percent of Total Funding by State Fiscal Year (SFY).



Outpatient Substance Use Services

Adolescent Community Reinforcement Approach with Assertive Continuing Care (A-CRA-ACC)

A-CRA is a three-month clinic-based outpatient behavioral therapy for adolescents age 12-17 inclusive with a substance use disorder diagnosis, and their caregivers. A-CRA is a behavioral intervention that seeks to replace environmental contingencies that have supported alcohol or drug use with pro-social activities and behaviors that support recovery. A-CRA works with adolescents alone, parents/caregivers alone, and adolescents and parents/caregivers together. When the recovery goals are achieved, adolescents may be referred to ACC which provides recovery support and case management in the youth's home or community for an additional three months.

Intensive In-Home Substance Use Services

Multidimensional Family Therapy (MDFT)

MDFT is a family-based intensive in-home treatment for adolescents, typically 11-18 years of age, with significant behavioral health needs and either alcohol or drug related problems, or who are at risk of substance use problems. MDFT simultaneously addresses substance use, delinquency, antisocial and aggressive behaviors, mental health disorders, and school and family problems, and helps to prevent out-of-home placements of children. MDFT services typically occur three times a week for four to six months. During this time MDFT provides individual, caregiver and family therapy, and case management services to each family in their home. Some MDFT treatment teams will provide services to at-risk children as young as 9 years old.

MDFT Re-entry and Family Treatment (MDFT RAFT)

An enhanced MDFT approach for youth involved with parole who have problems related to substance use and who are re-entering their communities after a year or more in a controlled environment. Initially MDFT RAFT began services with youth and their families an average of 30 days prior to anticipated or scheduled release from the controlled environment. Program outcome data indicated that longer pre-release services improved successful re-entry for youth and their families. Referrals now must be made at least 60 days prior to anticipated or scheduled release from the facility. Services begin 60 days prior to release to better prepare both the family and the youth for return home and successful re-entry into the community. Pre-release services are provided to youth in secure settings, and with families in their homes. Upon release MDFT-RAFT services are provided to youth and families together in their homes. MDFT-RAFT aims to shorten lengths of stay in secure facilities and admissions to out of home placement, reduce costs associated with out of home placements, stimulate faster re-entry by eliminating or reducing step-down to residential programs, and improve youth outcomes related to substance use, illegal

activity, family relationships and educational and vocational engagement. The typical length of service and service intensity of MDFT RAFT is similar to standard MDFT.

Multi-systemic Therapy (MST)

MST is an intensive family- and community-based treatment program that addresses environmental systems that impact chronic and violent juvenile offenders. The environmental systems MST typically addresses include homes and families, schools and teachers, neighbourhoods, and friends. MST typically serves adolescents 12-17 years inclusive who have returned or are returning home from out-of-home care or who are at imminent risk of placement due to problems related to substance use, risk of substance use problems, or conduct disorders. MST services usually include two to three home visits each week over a three to five month period.

MST Family Integrated Transitions (MST-FIT) is a re-entry service for youthful offenders age 12-17.5 years who are placed in secure facilities, and their families. Integrated individual and family services are provided during the 60-day period prior to anticipated or scheduled re-entry to the community from residential or juvenile justice facilities. Pre-release services are provided to youth in the secure facilities, and with families in their homes. Upon release MST-FIT services are provided to youth and their families in their homes. It is a promising practice that combines three evidence-based interventions targeting multiple determinants of antisocial behavior and systemic factors that create the context for problematic behavior. MST-FIT aims to shorten lengths of stay in secure facilities and admissions to out of home placement, reduce costs associated with out of home placements, stimulate faster re-entry by eliminating or reducing step-down to residential programs, and improve youth outcomes related to substance use, illegal activity, family relationships and educational and vocational engagement. MST-FIT services typically are provided two to three times weekly during a period of six months.

MST Transition Age Youth (MST-TAY) is an intensive home-based service for older adolescents age 17-20 years inclusive who are involved with the juvenile or criminal justice system, and who have a serious mental health condition with or without a substance use disorder. MST-TAY services focus on building skills of independent living and addressing problems that impact healthy functioning as an emerging adult. The program aims to improve youth outcomes related to substance use, illegal activity, and educational and vocational engagement. MST-TAY treatment services typically last four to eight months, in conjunction with up to 14 months of life coaching services.

MST Problem Sexual Behavior (MST-PSB) is an intensive in-home family service with clinical interventions for children and adolescents age 10-17.5 years who are returning home from an out of home placement that has provided sex offender specific treatment, or for adolescents with problem sexual behaviors living in the community who are at high risk for incarceration or residential treatment if intensive community based services are not provided. MST-PSB aims to reduce out of home placements and improve child and youth outcomes related to problem behaviors, family relationships, illegal activity, and educational and/or vocational

engagement. The length of service and service intensity of MST-PSB is five to seven months with up to three home visits weekly.

DCF Residential Substance Use Treatment Programs

Multi-Dimensional Family Therapy Residential program at CT Junior Republic (*Coming online at the end of May 2016)* is an 8-bed, short-term (4 months), family-centered Multidimensional Family Therapy (MDFT) residential program that will serve males, ages 15-18, who are committed delinquent to the Department of Children and Families and who are experiencing substance use problems. This program will integrate the MDFT model into all aspects of residential and clinical programming and will provide an expansive array of educational, vocational, clinical, and residential programming.

Seven Challenges at Rushford Academy is a 6-bed residential treatment program that utilizes the Seven Challenges evidence based practice model to treat males age 13-17 years inclusive. The average length of stay is six (6) months. Rushford Academy provides individual, group and recreational therapy, as well as year-round educational programming.

Caregiver Substance Use Services

Project SAFE

Project SAFE is a legislatively mandated collaboration between DCF and DMHAS that has evolved into a joint contract between the state agencies and Advanced Behavioral Health (ABH), an Administrative Services Organization. Project SAFE provides DCF social workers access to a centralized referral system for substance use services for adult caregivers involved with child protective services. Project SAFE services include screening (urine toxicology and hair testing), treatment evaluations, outpatient treatment (partial hospitalization, intensive outpatient, and group, individual and family counseling) and access to specialty residential programs for women and children through ABH. Funding for Project SAFE is braided; DCF funds substance use screenings and evaluations while DMHAS funds are used to support access to adult treatment services. Funds from both state agencies are used to support management by ABH of Project SAFE referrals and payments for treatment services.

Project SAFE Percent of Referred Clients Receiving Treatment Services (FY 06-FY 15)

	# Referred for Treatment	# of Referrals Receiving Treatment	Percent of Referrals Receiving Treatment
FY 06	2,437	1,244	51.05%
FY 07	2,559	1,342	52.44%
FY 08	2,554	1,447	56.66%
FY 09	2,480	1,417	57.14%
FY 10	2,217	1,558	70.28%
FY 11	2,347	1,577	67.19%
FY 12	2,605	1,399	53.70%
FY 13	2,214	1,204	54.38%
FY 14	2,284	1,185	51.88%
FY 15	2,231	1,141	51.14%

Recovery Supports for Caregiver Substance Use

Recovery support and intensive case management services have been added to Project SAFE to help families enter treatment and navigate the multiple systems with which they are often connected.

Recovery Case Management (RCM)

Recovery Case Management (RCM) is an intensive recovery support and case management service for DCF involved families with problems related to substance use, and whose child(ren) are at risk of removal due to a parent or caregiver's substance use. RCM aims to prevent out of home placement of children by child protective services by rapidly engaging caregivers into treatment services and helping the family to build community and natural supports for recovery. RCM typically involves at least weekly contact for six to nine months.

Recovery Specialist Voluntary Program (RSVP)

The Recovery Specialist Voluntary Program (RSVP) model is an intensive case management recovery support service for caregivers involved with child protective services who have had a child(ren) removed under an Order of Temporary Custody, and where substance use was a significant contributing factor in the removal. RSVP is modeled after the STARS program in Sacramento, CA which is implemented within a drug-court system and has shown promising results. The aims of RSVP are to facilitate caregiver engagement and retention in treatment, to promote abstinence and recovery from substance use; to better coordinate with treatment providers and the court to improve the time to permanency for children; and to develop a practice

model that can be replicated. RSVP services typically involve at least weekly contact over an eight month period.

Treatment for Caregiver Substance Use and Child Maltreatment

DCF has extended its implementation of evidence-based practices to include intensive in-home services for caregivers with problems related to substance use that also have involvement with child protective services. These services target the Department's most vulnerable children and families including families with very young children, families who have had their children removed because of problems related to substance use, or families whose children are at high risk for removal related to caregiver substance use.

Family Based Recovery (FBR)

The Family-based Recovery Model (FBR) is an attachment-based substance abuse treatment model for parents of children under 2 years of age who are involved with DCF child protective services. The model integrates two treatment modalities to focus on attachment, parenting, substance abuse recovery, and psychotherapy: Coordinated Intervention for Women and Infants (CIWI), an attachment-based parent-child therapeutic approach that was developed at the Yale Child Study Center and Reinforcement-Based Treatment (RBT), a contingency management substance abuse treatment model that was developed at John Hopkins University. The aims of FBR are to promote safe, secure, drug-free family environments where children can live with their parents; to facilitate parenting skills that promote optimal child development; and to develop an evidence-based practice model that can be replicated.

Multi-systemic Therapy-Building Stronger Families (MST-BSF)

Multi-systemic Therapy-Building Stronger Families (MST-BSF) was developed through a collaboration between DCF, Wheeler Clinic and Johns Hopkins University with support from the Annie E. Casey Foundation to address the problem of co-occurring parental substance abuse and child maltreatment. This program integrates an innovative evidence-based treatment for adult substance abuse (i.e., Reinforcement-Based Therapy [RBT]) with an evidence-based treatment of child abuse and neglect (i.e., Multi-systemic Therapy for Child Abuse and Neglect [MST-CAN]). MST-BSF is a comprehensive integrated treatment intervention that addresses the individual, family, peer, school, and community-level problems that brought the family to the attention of child protective services. MST-BSF works closely with a family's natural support systems to achieve abstinence, reduce risk to children, and sustain treatment gains without ongoing child welfare involvement. MST-BSF targets families with children between the ages of 6-17 years of age. The aims of MST-BSF are to promote safe, secure, drug-free family environments where children can live with their parents or be quickly reunified.

Table 1: SFY15 DCF Substance Use Expenditures by Service Type.

Service Type	FY2015 Expenditure
Adolescent Outpatient treatment (Individual, Family and Group)	1,668,587.00
Adolescent Home-based treatment services	13,581,515.00
Adolescent Residential treatment	1,378,760.00
Adolescent Evidence-based Practice Quality Assurance	754,406.00
Adolescent Services Total	**$ 17,383,268.00**
Recovery Support Programs (RSVP and RCM)	1,637,942.00
MST-Building Stronger Families	1,658,949.00
Family Based Recovery	2,894,460.00
MST-BSF Consultation & Quality Assurance	341,840.00
Caregiver Services Total	**$ 6,533,191.00**
TOTAL Substance Use Expenditures	**$23,916,459.00**

Table 2: Statewide Distribution of Substance Use Services by DCF Region and Area Office

R	Area Office	Substance Use Services									
		MDFT	ACRA/ ACC	FBR	MST-PSB	MST-TAY	MST	MDFT- RAFT	MST- FIT	MST-BSF	RSVP / RCM
1	Bridgeport	X	X	X	X	X	X	X			X
	Norwalk	X	X	X	X						X
	Stamford	X	X	X	X						X
2	New Haven	X	X	X	X	X	X	X	X	X	
	Milford	X	X	X	X	X	X	X	X		
3	Middletown	X	X	X	X				X		RCM only
	Norwich	X	X	X	X		X				X
	Willimantic	X	X	X	X		X				X
4	Hartford	X	X	X	X		X	X	X	X	X
	Manchester	X	X	X	X		X		X		X
5	Waterbury	X	X	X	X	X	X	X	X	X	
	Danbury	X	X	X	X				X		
	Torrington	X	X	X	X				X		
6	New Britain	X	X	X	X		X	X	X	X	X
	Meriden	X	X	X	X	X		X		X	X

DCF Substance Use Initiatives & Accomplishments

Adolescent Screening, Brief Intervention and Referral to Treatment (A-SBIRT)

DCF in partnership with DMHAS, UConn Health, Boston University Medical Center and CT Clearinghouse has initiated an A-SBIRT program within the Emergency Mobile Psychiatric Service (EMPS) and other community settings. Using federal funding from SAMHSA's Center for Substance Abuse Treatment, the A-SBIRT partners have developed a train-the-trainer model to increase the ability of youth-serving organizations statewide to train their staff to identify substance use problems among adolescents using the CRAFFT tool and implement an age-appropriate brief intervention protocol. In addition to the training on the CRAFFT screening tool and brief intervention approach, the A-SBIRT training model includes a number of stand-alone modules on adolescent development and substance use, motivational interviewing, and training skills development that can be configured to best meet the needs of diverse training audiences. The primary aim of the A-SBIRT initiative is to embed screening for substance use problems into the EMPS service. DCF Enhanced Care Clinics (ECC's) already use a screening tool for substance use. The A-SBIRT partners plan to enhance the utility of the screening tool by adding the brief intervention approach to this service. In addition to EMPS and ECC's, A-SBIRT has included DMHAS Regional Action Councils, youth service bureaus, and youth prevention organizations in the program.

The Connecticut Substance Exposed Infant (CT SEI) Initiative

The CT SEI program was developed through an In-Depth Technical Assistance (IDTA) award from the National Center for Substance Abuse and Child Welfare (NCSACW) to build a statewide infrastructure to address substance exposed infants, particularly infants exposed to opioids in utero. Until recently, CT was one of the few states in the country that did not have a dedicated position to address problems related to substance exposed infants. The state has not adopted legislation that directly addresses this issue nor is there any funding specifically designated for prevention, screening, early intervention or treatment efforts for these infants and their families. These policy gaps mean that decisions to conduct screening to detect infant exposure and to make reports to child protective services when an infant is substance exposed is left up to interpretation that could result in bias, disparities and inequalities in access to care and needed support services. DCF is leading the **CT SEI Initiative,** with ABH as the coordinating entity, through an inter-agency and community collaboration using the IDTA to guide and direct the development of that state's infrastructure to do the following:

- **Establish a Fetal Alcohol (FASD)/Neonatal Abstinence (NAS) statewide coordinator**. DCF and DMHAS jointly funded this position in 2015 at Advanced Behavioral Health.
- **Complete a shared values inventory** with project partners to identify mutual priorities related to the six IDTA goals (screening and assessment, engagement and retention in treatment, data and information sharing, joint accountability and shared outcomes, services for pregnant women and substance exposed infants, and safety, permanency and well-being of children and families),

- **Assess the state's capacities and needs** related to SEI that will serve as the architecture for establishing policy and developing infrastructure for prevention and intervention services including workforce development, and identification and implementation of best-practice models.
- **Develop a statewide plan** to address SEI in a coordinated fashion to offer a continuum of services to vulnerable families, including prevention, early intervention and intensive intervention.
- **Conduct financial mapping** to identify and maximize fiscal resources to support ongoing SEI efforts.

CT's SEI IDTA project will mark the state's first attempt at a coordinated cross-agency effort to address substance exposure among infants.

Family Stability Project (FSP)

The Family Stability Project (FSP) is an expansion of the Family Based Recovery (FBR), a promising practice model. FSP will bring the FBR program to an additional 500 DCF-involved families over 4 years. The Department received Technical Assistance from Harvard's Kennedy School of Government to develop a Pay for Success funding mechanism to support this expansion. FBR serves caregivers with substance use disorders and their children (age 0-3) in a community and home based setting.

Improving Access Continuing Care and Treatment (IMPACCT) Project

DCF was awarded a two-year planning grant from SAMHSA's Center for Substance Abuse Treatment (CSAT) to develop a three-year comprehensive statewide strategic treatment and communications plan to improve treatment for adolescents (age 12-18) with substance use disorders with or without co-occurring mental health disorders. The project period is 9/30/15 – 9/29/17. DCF is partnering with the Judicial Branch Court Support Services (CSSD), the CT Behavioral Health Partnership (CT BHP), Department of Mental Health and Addiction Services (DMHAS) and State Department of Education (SDE), youth and families, and local and national technical experts to develop the state's plan for youth. The plan will be informed by a comprehensive financial map of substance use and co-occurring mental health expenditures, and it will include strategies to enhance workforce development, to increase access to evidence-based treatment, and social marketing strategies to increase awareness of and access to available services.

Medication Assisted Treatment Education Sessions

Recognizing that many caregivers involved with the Department are receiving medication assisted treatment (MAT), the DCF in partnership with DMHAS and the Judicial Branch launched a statewide training initiative in September 2015 aimed at improving knowledge of MAT treatments across the child welfare system, the provider network, and the Judicial branch. To date, 261 individuals have been trained in the *ABC's of MAT* at 12 DCF Area Offices throughout the state.

Naloxone®/Narcan Training

The heroin and prescription drug abuse epidemic in the northeast also prompted DCF to provide Narcan awareness training for its staff. Two voluntary training sessions were held in March 2016 to gauge staff interest in Narcan education. Both sessions reached capacity and nearly 60 staff received training in prescription drug abuse, harm reduction approaches, problem recognition, Connecticut's legislation regarding Narcan, and Narcan administration. The high level of interest in these grant-sponsored trainings as prompted DCF's Academy for Workforce Development to add these sessions to its regular course offerings. DCF also has drafted a Narcan policy for staff and facilities that currently is under internal review. The Department also is partnering with its congregate and therapeutic foster care providers to develop a policy specific to the use of Naloxone in these settings.

Randomized Controlled Trial of recidivism in MST-TAY services

Drs. Maryann Davis (University of Massachusetts Medical School), Ashli Sheidow (Oregon Social Learning Center), and Mike McCart (Oregon Social Learning Center), in collaboration with the Connecticut Department of Children and Families, were awarded a grant from the National Institute of Mental Health (NIMH; #R01MH108793) to conduct a randomized controlled trial of Multisystemic Therapy for Emerging Adults (MST-EA). MST-EA, referred to in Connecticut as a Transition Age Youth (TAY) program, will be evaluated for recidivism reduction and mental illness outcomes, as well as other functional outcomes. The 4-year trial will take place in Connecticut, with the NIMH grant providing all research costs and nearly $50,000/year of the MST-EA program's costs. This will represent the first randomized controlled trial ever conducted in the U.S. or internationally that focuses on reducing recidivism in emerging adults.

Substance Abuse Family Evaluation, Recovery & Screening (SAFERS) Project

Since 2013 DCF has been piloting a screening protocol in three DCF offices using a federal grant from the Children's Bureau to enhance identification of trauma and behavioral health needs for families at risk of losing their children due to problems related to substance use. The SAFERS project aims to improve identification of needs among caregivers, infants and young children through enhanced screening, establish cross-agency service planning and rapidly engage families in community-based services. The goals are to increase rates of treatment compliance and recovery as well as decrease the rate of child removals and improve children's overall well-being. SAFERS builds upon the partnership between DCF, the Department of Mental Health and Addiction Services (DMHAS), the Judicial Branch, Advanced Behavioral Health, Inc., (ABH), and the University of Connecticut Health Center (UCHC) established to implement the RCM program. The target population for SAFERS is DCF-involved caregivers with problems related to substance use and that have a child 6 months to 6- years old.

Workforce Development Collaborative

Through the Project SAFE and RSVP programs DCF is partnering with DMHAS, the Judicial Branch, the Connecticut Women's Consortium and Advanced Behavioral Health to offer a series of trainings related to substance use, treatment, recovery, and trauma to staff at partnering agencies. Trainings are jointly funded by the partnering state entities and sessions are offered free to staff. The aim of the workforce development collaborative is to increase education of staff to improve services to children and their families, and to help staff assist families in obtaining care and support that limits their involvement with child protective services and the courts.

➢ *Judicial Branch Court Support Services Division*

Multi-Systemic Therapy (MST)

MST is an intensive, evidence-, family- and community-based treatment program for serious, chronic, and violent juvenile offenders. It blends clinical treatments including cognitive behavioral therapy, behavior management training, family therapies and community psychology. The overriding goal of MST is to keep adolescents who have exhibited serious clinical problems—drug abuse, violence, severe emotional disturbance—at home, in school and arrest free.

Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS)

This program addresses the comprehensive needs for youth with psychiatric and co-occurring disorders; helping families manage behaviors and keeping youth safe at home and in community; used when traditional outpatients services are not sufficient to avoid psychiatric hospitalization or facilitate re-entry thereafter.

Child and Youth Family Support Center (CYFSC)

CYFSCs are multi-modal centers that provide targeted services for status offenders and medium risk delinquent children ages 11-17. CYFSCs conduct intakes, assessments, and provide cognitive-behavioral interventions, and case management services to address basic needs and pro-social activities, and discharge planning. Services are gender- specific and trauma-informed. MET/CBT/FSN is the substance abuse curriculum used.

Multi-Dimensional Family Therapy (MDFT)

MDFT is a comprehensive, family-centered treatment program for adolescent and young adult ages 11-18 with drug abuse and related behavioral and emotional problems. MDFT addresses the areas of adolescent and parent functioning known to create problems while enhancing the factors that solve problems, improve relationships, and restore positive development. CSSD has also implemented the same program through a MOA with the department of Children and Families.

Intermediate Residential (IR)

Brief (4 month) out-of-home Treatment service targeting youth with substance abuse, behavioral health or co- occurring needs. MDFT is clinical model, and is provided to the client in the program and to the family as well. MDFT is also offered following discharge from the program in the home community. There is a boys' program and a girls' program.

New Choices (MOA w/DCF)*

Brief substance (90 days) abuse Treatment program for boys younger than 18 years old. ACRA / ACC is the treatment model. DCF holds contract, but CSSD refers most participants.

*This program has been removed from CSSD's service continuum effective 7/1/2016

Court Based Assessment (CBA)

Psychological and substance abuse evaluations as ordered by the court to determine service that best match treatment needs of child and family.

Adolescent Community Reinforcement Approach (A-CRA)

Evidence-based behavior therapy for substance using adolescents and caregivers; identified population is 12-17 years old with substance use and meet ASAM criteria for outpatient level of care.

Drug Intervention Program (DIP)

Program conducts clinical evaluations, prepares treatment plans, and delivers a full continuum of SA treatment, case management, residential (long and short term) and support services.

DMHAS Collaborative (via MOA)

Substance abuse treatment and prevention for men and women ages 18 and older.

Adult Behavioral Health Services (ABHS)

Services include a continuum of behavioral health outpatient treatment services. The primary treatment modality is cognitive behavioral treatment with skills training and practice. Services include: Integrated substance abuse and mental health evaluations, individual and group substance abuse, co-occurring, mental health, anger management and relapse prevention ; intensive outpatient treatment substance abuse testing, medication evaluations and medication management. Clinics serve male and female clients ages 18 or older.

Alternative in the Community (AIC)

The Alternative In the Community (AIC) and associated transitional housing are center based programs that administer validated assessments, provide case management services including addressing clients

basic needs, cognitive behavioral skill building group interventions that emphasize individual accountability and teach cognitive skills that enable clients to think and behave in a more pro-social manner. Group interventions include substance abuse, cognitive skills, employment services and job development that are based on the clients risk and needs. Group services and transitional housing are gender specific.

➢ *Department of Public Health*

Practitioner Licensing and Investigations Section (PLIS)

- The Department of Public Health collaborated with the Connecticut State Medical Society through a $10,000 grant from the Federation of State Medical Boards (FSMB) to offer a live continuing education opportunity for Connecticut physicians and other prescribers entitled "Extended Release & Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy (REMS)". Four (4) three-hour REMS educational sessions were held for 260 licensed prescribers during the fall of 2014. Others who were not able to take the course in person were encouraged to take the free training on line through the FSMB. The Department has also promoted other local opioid prescribing trainings to licensed prescribers sending out notifications through the e-license system.

- Physicians, advanced practice registered nurses (APRNs), dentists, and physician assistants (PAs) licensed by the Department of Public Health are now required to take continuing education in prescribing controlled substances and pain management effective October 1, 2015 pursuant to Public Act 15-198.

- The Department added an attestation requirement to the online physician license renewal process to acknowledge aware of this requirement that includes a link to the Department of Consumer Protection's PDMP website in case the physician has not yet registered. Public Act 15-198 also required practitioners to check the Department of Consumer Protection's Prescription Drug Monitoring Program (PDMP) prior to prescribing more than a 72 hour supply of controlled substances, and to review the PDMP at least every 90 days for patients on long term treatment with controlled substances.

Office of Emergency Medical Services (OEMS)

- The Department is a member of DESPP's Naloxone Advisory Committee, and as such shares data on first responder use of naloxone across state agencies. Civilians, state police, municipal police and all levels of EMS providers have the ability, after training, to administer naloxone in

the event of an opioid overdose. Almost every community in CT has one or more equipped providers.

HIV Prevention Program

- **Community Naloxone Distribution Activities**- This program is integrated into current syringe exchange programs that are under contract with the DPH HIV Prevention Program. The funding source is **state** (AIDS) funding and at this time provides funds ($189,000) to purchase naloxone and syringes.
- **Overdose Prevention Activities**- In 2015, the DPH HIV Prevention program developed OPEN Access CT trainings, organized an Overdose Prevention Summit, developed a social marketing campaign (billboard), and developed Overdose prevention Kits (without naloxone). The funding for these activities was through a **one-time carry-forward request** under our **federal** HIV Prevention Cooperative grant with the CDC in the amount of $190,000.

Tobacco Program

- **Prevention Activities-**DPH is implementing evidence-based programs that incorporate interventions into local communities through policy, systems, and environmental changes. These programs will be working with youth groups to perform activities that include visiting and talking to retailers about the placement and sale of tobacco products.

- **Tobacco Use Cessation Activities-**The tobacco use cessation telephone Quitline is operated 24 hours a day 7 days a week under a contract with DPH that is in place until 2019.DPH offers tobacco use cessation programs at various locations. Although tobacco use cessation services are covered under health insurance policies pursuant to the Affordable Care Act, select policies do not yet cover these services so these programs try to cover the gaps.

- **Training Institute-**DPH provides training for community partners based on needs and updated research, and sends resource materials to assist with various community initiatives. During the fall of 2015 DPH offered two policy workshops about working with communities that included point of sale initiatives.

  Funding provided for these activities includes:
  CDC funding for tobacco control program $824,868

  Tobacco and Health Trust Funds $1,171,722

Office of Injury and Violence Prevention

DPH organized a workshop in the fall of 2014 to streamline and build on an action plan developed at the Prescription Drug Abuse Policy Academy in Bethesda Maryland sponsored by SAMHSA. The workshop focused on primary prevention by addressing these two objectives (1) implementation of action steps to increase prescribers' engagement in preventing prescription drug abuse; (2) launching a multi-level public awareness and prevention campaign across communities in Connecticut.

To date, one of the workgroups created after the workshop has completed and launched two major deliverables.

- A Public Service Announcement to address the misuse and abuse of prescription medication and opioid-based drugs in youths
- A comprehensive state website www.drugfreect.org that is a compendium of opioid information from overdose prevention, addiction treatment and re-integration back into the community.

The two activities listed have no budget.

➢ *Department of Consumer Protection (DCP)*

The Department is tasked with promoting access to safe and effective pharmaceutical care services in Connecticut and protects consumers against fraud, deception, and unsafe practices in the distribution, handling, and use of pharmaceuticals and medical devices. The Program has statutory responsibility to set standards for the control of prescribing, dispensing, and administration of pharmaceuticals by health care providers as well as distribution of pharmaceuticals by health care facilities (e.g. hospitals, clinics, long-term care) and other entities (e.g. manufacturers, distributors, community-based programs)

Major Substance Abuse Initiatives and Accomplishments:

The DCP' substance initiatives fall into 4 major categories: the Connecticut Prescription Drug Monitoring Program (PDMP), increasing access to Naloxone, safe storage and disposal of over the counter and prescription medications, educational programs supporting these efforts, and the implementation of Connecticut's Medical Marijuana Program.

Prescription Drug Monitoring Program

The PDMP was designed to collect prescription data for Schedule II through V drugs into a central database which can be used by medical providers and pharmacists in the active treatment of their patients. Recently enacted legislation (October 1, 2015) requires health care professionals to check the PMP prior to prescribing controlled substances for greater than a 72-hour period. Additional provisions require that pharmacists enter controlled substance prescription data after July 1, 2016 immediately or no later than 24 hours. This will improve the accuracy of the data as previous requirements specified that

data must be entered within a one week period. Connecticut now shares data with 20 states, with New York being a state recently added.

DCP has provided educational campaigns targeting prescribers and pharmacists on drug-seeking behavior and how to use the PDMP. They have also provided educational campaigns to law enforcement personnel on prescription fraud and the use of the PDMP. The agency is also in the process of finalizing a Proper Prescribing Course for practitioners

Community Drug Take Back Programs

Another important initiative of DCP has been the establishment of a prescription drop box program. There are now over 70 in operation and the state police, as part of this effort, recently launched the program in 13 new locations. DCP has also sponsored Community Drug Take back days. DCP also offers educational campaigns for the general public about prescription drug abuse and safe storage and disposal of over-the-counter and prescription medications.

Medical Marijuana Program

DCP has established and implemented Connecticut's Medical Marijuana Program. The Program utilizes a pharmaceutical model for the manufacturing and dispensing

Access to Naloxone

DCP passed legislation allowing pharmacists to prescribe and dispense Naloxone after completing a certifying training course. DCP implemented an online continuing education training course last summer and has also collaborated with major chains regarding an existing training tool they use for the same purpose. To date almost 600 pharmacists are certified and can now prescribe Naloxone in the state.

➢ *Connecticut Office of Policy and Management*

Residential Substance Abuse Treatment for State Prisoners

Grant funds are sub-granted to the Connecticut Department of Correction to use as follows:

Enhance the provision of residential substance abuse treatment services to offenders in prison; Increase overall completion rates in RSAT; Maintain individual treatment gains made in prison within the community; and Ensure staff has training and knowledge about best practices and sufficient training hours to maintain certification required to deliver substance abuse treatment services.

Type of Programs to be Implemented: Prison-based Substance Abuse Treatment.

Description of Strategies: The majority of grant funds will continue to support (1) FT Correctional Substance Abuse Counselor to provide counseling and prepare participants for reentry. The balance will

fund the following: professional development and technical assistance in evidence-based practices for DOC Addiction Services staff; provide partial payment for up to 10 staff to attend substance abuse certification training; purchase supplies such as substance abuse curriculum aids; and travel for two individuals to attend the BJA grantees conference.

Major Deliverables: Provide in-prison substance abuse treatment services, and to establish links to after care for offenders completing in-patient treatment.

Coordination Plans: The RSAT program is coordinated by Correctional Counselor Supervisor Deborah Henault with the DOC Health and Addiction Services Division.

➢ *Department of Corrections*

The Department of Correction has a dedicated Addiction Services unit that provides a graduated system of substance abuse treatment programs. According to the agency's Objective Classification System greater than 80% of the inmates who come into the system have a significant need for substance abuse treatment. A range of treatment options are available to meet offenders individual needs, from brief treatment focusing on re-entry and reintegration issues for offenders returning to the community; intensive outpatient (IOP), with cognitive behavioral therapy curriculum; residential substance abuse treatment in a modified therapeutic community setting. The Addiction Services Unit provides an aftercare program designed to provide a continuum of care and maintenance of recovery. The Addiction Services unit also provides specialized services for youth, women, DUI offenders, clients on methadone maintenance and parolees at risk for violation of parole.

Major Initiatives and Accomplishments:

DUI Offenders

Legislation in 2011 (CGS 18 – 100h) provides the Department of Correction the discretion to allow eligible offenders convicted of Driving Under the Influence to serve a portion of their sentence under supervision of a parole officer in the community under home confinement. The first focuses on DUI offenders serving the mandatory portion of their sentence. These offenders are assessed by addiction services staff to determine the required level of treatment prior to release, provided that treatment and released to serve the remainder of their sentence on home confinement. They are supervised by a specially trained Parole unit. This program has assessed, treated, and successfully supervised more than 1600 offenders, since it began in 2012.

In-prison Addiction Treatment

The DOC Addiction Services Unit provides in-prison treatment services to approximately 5,000 offenders annually. These services include brief treatment, intensive outpatient, therapeutic community

treatment, youth specific intensive outpatient treatment, DUI specific treatment, Time Out of Parole for at risk parolees. An addition 650 was supported in methadone maintenance groups.

Community Aftercare

As a sub-grant recipient of the Residential Substance Abuse Treatment (RSAT) grant from OPM, DOC has increased its ability to provide continuity of care from in-prison to community care for prisoners following participating in residential substance abuse treatment. These services include behavioral health treatment as well as recovery supports such as employment and housing assistance, transportation and more.

Naloxone Project

In the summer of 2015 DOC sponsored training for DPH staff to train parole officers and halfway house staff in the use of Naloxone for opiate overdose reversal. DPH donated kits to be carried by all parole officers as well as maintained in all of the halfway houses where DOC clients reside.

Medication Assisted Therapy

A pilot program began at New Haven Community Correctional Center in October of 2013, offers methadone maintenance to offenders who enter the facility already on a verified dose of methadone. A second program was added at Bridgeport Community Correctional Center in November of 2014. Clients are provided treatment, as well as continued dosing, for their term of incarceration followed by re-entry planning services to continue the treatment upon release. More than 650 clients have participated in the two programs.

Tobacco Cessation and Prevention

Over the past several years, the Tobacco and Health Trust Fund Board provided funding to the DOC to develop tobacco education and cessation support programs in several jails. In 2016, DOC expanded this program to provide similar programs in the DOC funded halfway houses. Smoking prevalence data was collected as part of this project. The results show that correctional populations have 4 to 5 times higher smoking prevalence rates than the general population, and female prisoner rates were even higher. This indicates that the criminal justice population has not benefitted from the national public health efforts to reduce the health consequences of tobacco, as has the general population.

➢ *Department of Education*

The Connecticut State Department of Education (CSDE) offers several programs that provide substance abuse education, substance use prevention and referrals for counseling or treatment. Many of these programs are aimed at positive youth development including social-emotional and physical development and the prevention of behavioral health problems of which substance use is often an area of focus.

After School Grant Program

The After School Grant Program was established by the Connecticut General Assembly for the purpose of creating high-quality after school programs outside of regular school hours. After school programs are defined as programs that: take place when school is not in session; provide educational enrichment and recreational activities for students in Grades K-12; and include parent involvement and wellness components. After school programs provide students with academic enrichment opportunities, as well as additional activities designed to complement academic programs. These programs, located in elementary or secondary schools or community-based facilities, can provide a range of high-quality services to support student learning and development. Services include tutoring and mentoring; homework help; academic enrichment (such as hands-on science or technology programs); and may also include youth development activities; drug, violence and pregnancy prevention programming; counseling; project-based learning; art, music, and technology education programs; service learning; and character education and recreation programs that are designed to reinforce and complement the regular academic program of participating students, as well as provide parent involvement opportunities for families.

Youth Service Bureaus

The CSDE provides supports to Youth Service Bureaus (YSB) financially and through technical assistance. Each year the Connecticut General Assembly commits approximately $3-million to support the activities provided by YSBs. YSBs offer a broader scope of services than most other youth-serving agencies. Direct services offered by YSBs include: behavioral health counseling; individual and family therapy; employment and training counseling; recreational and enrichment activities; outreach programs for children, youth and families; and preventive and positive youth development programs. YSBs are also responsible for assessing the needs of youth; identifying gaps in services and coordinating services for youth to fill gaps; and avoiding duplication of services. Many YSBs also play a special role in working with the juvenile justice system to meet the needs of children and youth found to be delinquent, by providing and/or making referrals to various health services including behavioral health and substance use counseling.

Safe Schools/Healthy Students

The CSDE is participating in a federal Safe Schools/Healthy Students (SS/HS) Grant Program in collaboration with DMHAS. It is an $8.6-million award over four years. Bridgeport, New Britain and Middletown are partner districts that are allocated $2-million each. Element 4 of the SS/HS grant: Preventing Behavioral Health Problems including Substance Use, includes developing substance use prevention partnerships with community, advocacy and health care delivery organizations; implementing student surveys and improving substance use data collection activities; providing training to teachers, administrators and behavioral health staff; and enhancing referral systems. The SS/HS State Management Team is also involved with developing and/or implementing support to 12 Coalitions that were identified to receive funds to utilize the Strategic Prevention Framework (SPF) and have begun to

receive training. District specific funding is allocated based on their activities within Element 4. These specific dollars are varied based on district focus and need. On the SS/HS State Management Team level, DMHAS, DCF and DPH are all providing certain levels of support or funding to this effort with the SS/HS districts.

➢ *Department of Veterans Affairs*

Intensive Outpatient Program

DMHAS in collaboration with the DVA has developed an eight week Intensive Outpatient Program with an additional four week outpatient component offered to veterans with substance use disorders. Admissions are voluntary. The twelve week **Intensive Outpatient Program** consists of scheduled group sessions including the following: Relapse Prevention 1 and 2, Peer-led Meditation, 12 Step, "Search for Meaning", Therapy Base Group, Community Meeting, Anger Management 1 and 2, Exercise & Relaxation, "Man to Men", Leisure Education and two optional groups: Recovery And Spirituality and Exploring Trauma. In addition, each participant is assigned and individual counselor.

➢ *Department of Social Services*

The Department of Social Services (DSS), the state Medicaid agency, provides Medicaid fee for service reimbursement for Connecticut's substance abuse treatment related levels of care in a variety of settings including Methadone Maintenance, Routine Outpatient, Intensive Outpatient, Partial Hospitalization, Ambulatory Detoxification, and Medical Detoxification services.

State Spending for Substance Abuse Services in Connecticut

Connecticut spends over $334,000,000 on substance abuse services within the state. Over 293 million is spent on treatment and over 37 million on prevention. Each state agency submitted their expenditures for substance abuse spending for fiscal year 2015. The data is shown is the table below.

Agency (FY 15 data)	Prevention	Deterrence	Treatment	Total
DMHAS	$15,718,326	$0	$132,403,326	$148,121,652
DSS			$84,316,657	$84,316,657
JUDICIAL-CSSD JUV.	*$6,827,825	$0	$5,703,422	$12,531,247
JUDICIAL-CSSD ADULT	$11,725,682		**$19,003,439	$30,759,121
DCF	$6,533,191	$0	$17,281,268	$23,814,459
DOC	$0	$0	$16,168,892	$16,168,892
DOT	$2,351,968	$3,778,866	$0	$6,130,834
DPH	$2,375,590	$0	$0	$2,375,590
DCP	$1,471,260			$1,471,260
DVA	$0	$0	0	0
OPM	$349,879	$0	$0	$349,879
SDE	$8,600,000	$0	$0	$8,600,000
TOTAL	$37,400,214	$3,778,866	$293,460,511	$334, 639, 591

***CSSD's juvenile prevention funding includes some treatment service dollars**

****CSSD"s adult services treatment dollars includes some prevention dollars**

Department of Mental Health and Addiction Services Triennial Report 2016 Opioid Annex

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Commissioner
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Deputy Commissioner

DMHAS Triennial Report Subsection Responding to the Opioid Epidemic

Introduction

Connecticut, like most states in the country has seen a significant increase in opioid use over the past five years. This increase in heroin and other opioid use has been described by the Centers for Disease Control (CDC) as an epidemic. This increase in use is reflected in escalating numbers of overdose deaths attributable to opioid use; it is also reflected in increases in admissions to Connecticut's treatment system specifically related to opioid use. Many of these overdose deaths involve the use of multiple substances. Overdose deaths involving Fentanyl comprise a particularly troubling trend. Fentanyl is a far more potent opioid that is being mixed with or substituted for heroin, leaving unwitting users at much higher risk for fatal overdoses.

Governor Malloy, recognizing this problem, has introduced a number of pieces of legislation focused on this epidemic. During the 2015 legislative session, the governor introduced and signed "An Act Concerning Substance Abuse and Opioid Overdose Prevention" into law. One element of this legislation, reconstituted the Alcohol and Drug Policy Council (ADPC) with Commissioners Miriam Delphin-Rittmon of the Department of Mental Health and Addiction Services (DMHAS) and Joette Katz of the Department of Children and Families (DCF) as the co-chairs. The Council will help direct the state's efforts to coordinate substance use prevention and treatment throughout Connecticut's system of care. In fall 2015, Governor Malloy requested that the ADPC focus on the emerging opioid epidemic in Connecticut.

This year's Triennial Substance Abuse Plan includes a special annex related to the opioid crisis in Connecticut. Numerous state agencies and community organizations have already taken many steps to address this crisis. This subsection is intended to describe what has occurred and identify key elements and strategies that will guide Connecticut's continuing response to the opioid crisis. The annex details strategies and action steps in the areas of overdose reversal, prevention, treatment, criminal justice, and law enforcement. The plan's strategies and action steps involves multiple players alongside state agencies, including treatment and prevention providers, the recovery community, community organizations, and other stakeholders. Recently the Governor has requested that experts from Yale University assist the state to create an overarching strategy to reduce opioid addiction and overdoses. Yale has begun that work and will be collaborating with the Alcohol and Drug Policy Council over the coming months to develop a comprehensive plan that will better coordinate the state's efforts.

Connecticut's Opioid Epidemic

Connecticut's epidemic primarily involves heroin use but the use of other opioids has made an impact on our state as well. Other opioids include prescription opioids such as hydrocodone, oxycodone, codeine, and morphine. Methadone prescribed for pain may be abused as well. More recently, Connecticut has been impacted by an increased use of Fentanyl. Fentanyl is being mixed with or substituted for heroin placing users at greater risk due to the much greater potency of this drug. The clearest impact of the epidemic in Connecticut can be seen in the escalating overdose deaths related to opioids, especially over the past three years. Evidence of the epidemic has also been felt in the substance abuse treatment system where admissions related to opioids have increased substantially over the past five years.

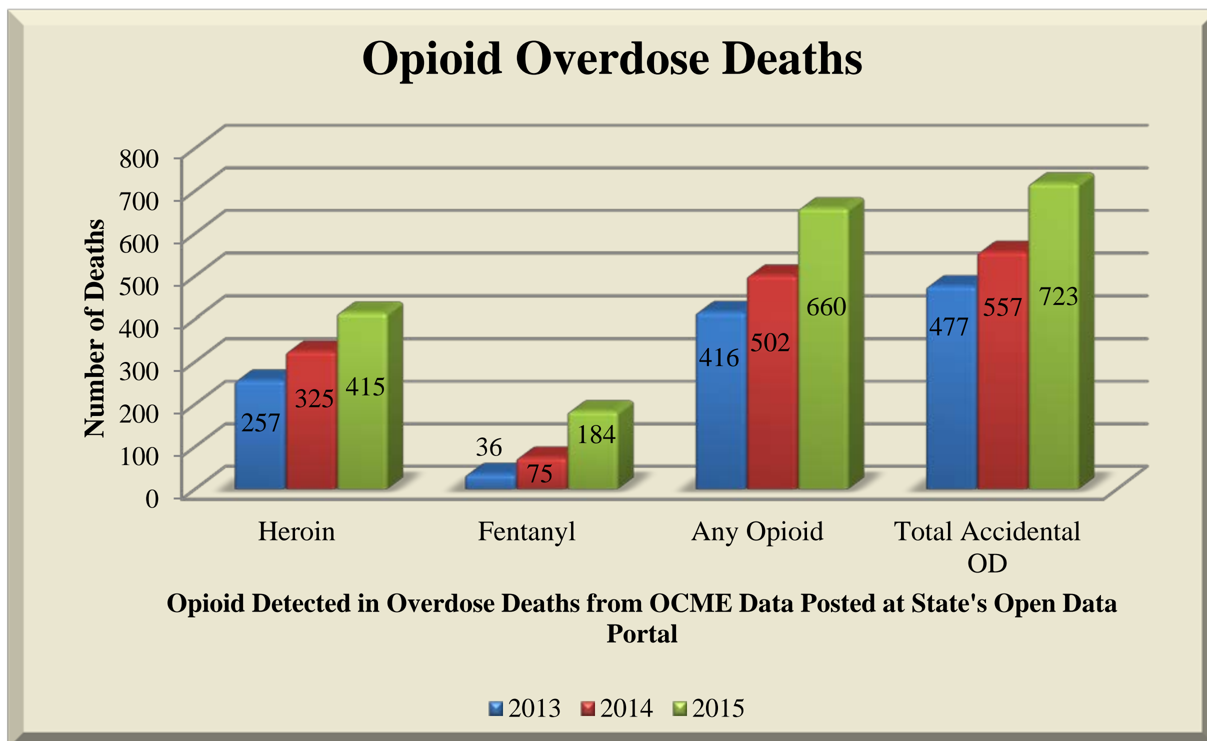

Figure 1: Opioid Overdose Deaths, FY13-15

Overdose deaths have been steadily rising in the state. Data produced by the Office of the Chief Medical Examiner (OCME) available through the State's Open Data portal (https://data.ct.gov/Health-and-Human-Services/Accidental heroin. Heroin alone was detected in over 400 deaths last year. Perhaps even more alarming is the fact that opioids were detected in almost 90% of the overdose deaths reported last year. The OCME data also illustrates the growing impact of fentanyl in overdose deaths. In Calendar Year 2013, fentanyl was detected in 36 overdose deaths. This increased in CY 2014 to 75 and grew even further in CY 2015 where it was detected in 184 of the total overdoses.

DMHAS research staff recently began to examine how many deaths are related to combinations of benzodiazepines and opioids. A very preliminary analysis shows that benzodiazepines were involved in 474 (26.8%) deaths over this three-year period. Opioids and benzodiazepines were both present in 415 of the overdose deaths (23.4% of total deaths and 87% of benzodiazepine related deaths), highlighting the dangers of co-prescribing these medications.

The increase in heroin use has also been evident in Connecticut's treatment system over the past five years. Heroin and other opioid related admissions were in a slow decline from 2006 through 2010. However, admissions increased slightly in 2011 and have been steadily increasing since that time. Opioid-related admissions increased by 54% - from 17,553 in FY 11 to 27,103 in FY 15.

-Drug-Related-Deaths-2012-2015/ecj5-r2i9 , shows that 1,771 individuals died of a drug overdose over the past 3 calendar years. Many of these overdose deaths involved poly-substance use. In FY 15, 723 overdose deaths were reported with almost 60% related to

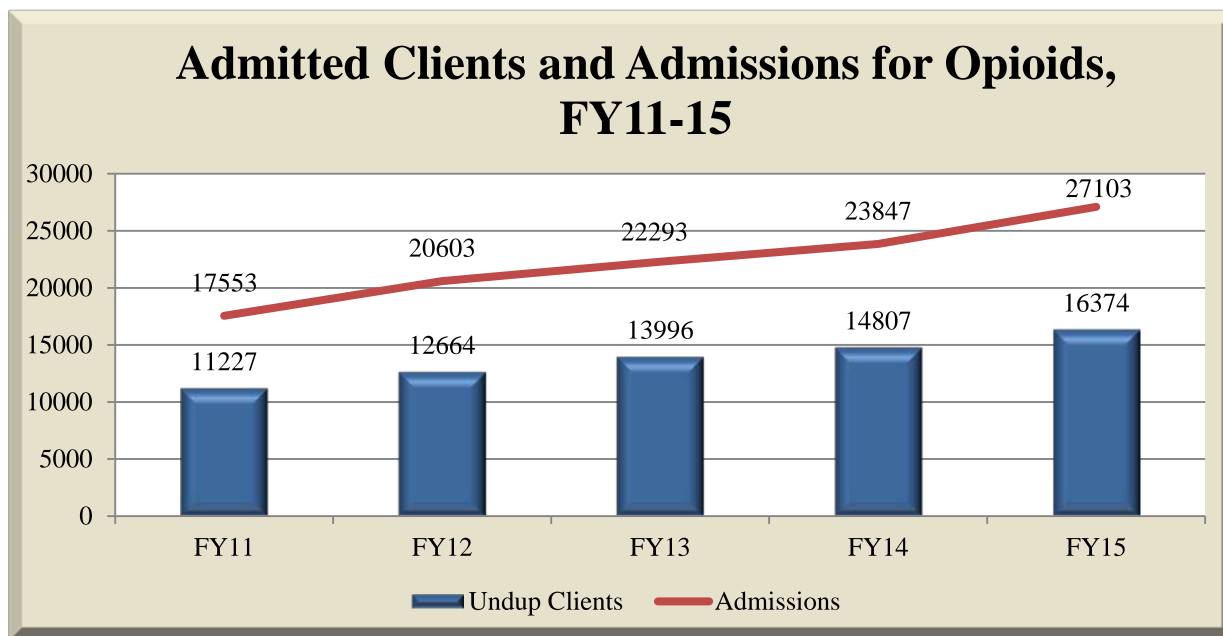

Figure 2: Admitted Clients and Admissions for Opioids, FY11-15

(*Data from DMHAS EDW; includes all funding sources)

The impact is not just seen in admissions to DMHAS treatment programs. Unduplicated clients involved in these admissions have also increased significantly. When individuals are admitted to DMHAS substance abuse services they report their "primary drug" of choice. DMHAS served 11,227 unduplicated clients with heroin or other opioids as their primary drug in FY 11 and served 16,374 in

FY 15, an increase of 46%. For years, alcohol was the most frequently reported primary drug at admission. Heroin has now replaced alcohol as the primary drug reported at admission within the SA treatment system. In FY 15, heroin, along with prescription opioids, accounted for almost 40% of all SA treatment admissions.

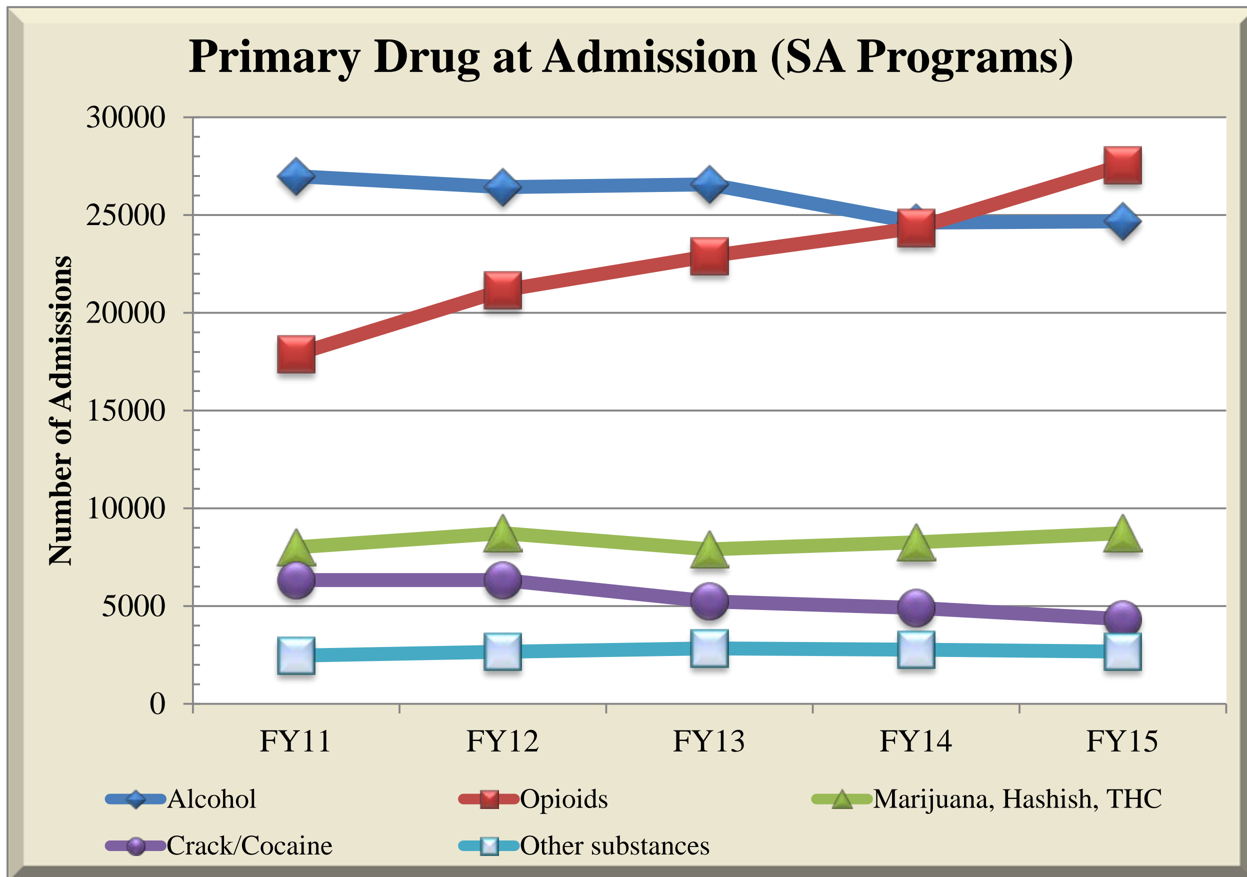

Figure 3: Primary Drug at Admission, FY11-15

(*Data from DMHAS EDW; includes all funding sources)

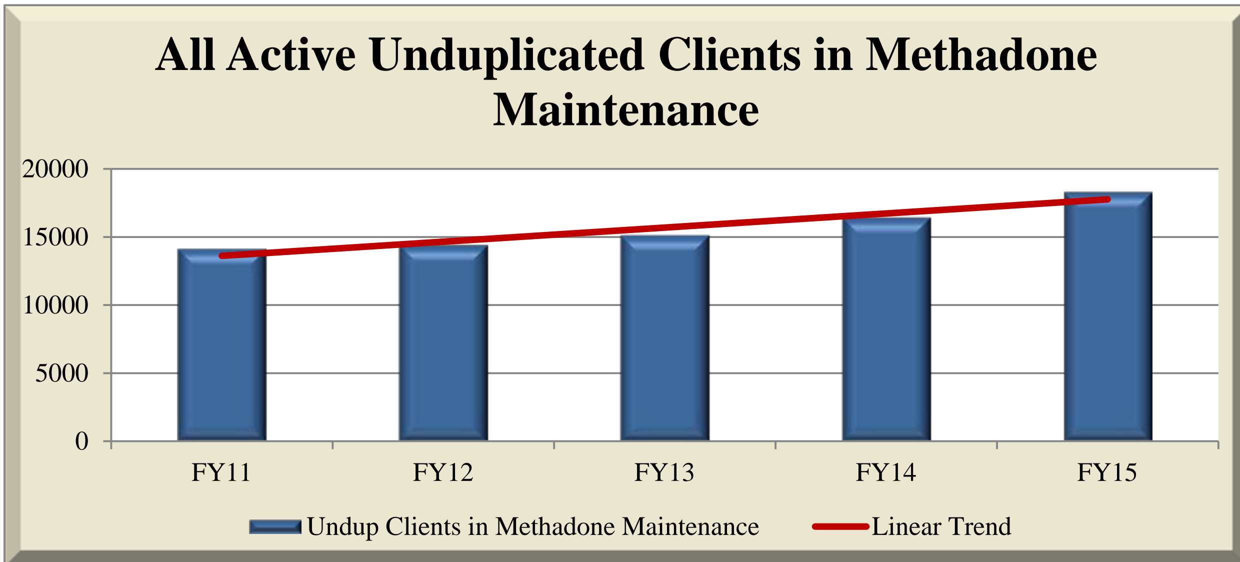

Figure 4: Unduplicated Clients in Methadone Maintenance, FY11-15
(*Data from DMHAS EDW; includes all funding sources)

The impact of the opioid epidemic has been evident in certain treatment levels of care. In FY 11 DMHAS served 14,148 in methadone maintenance programs and that number grew to 18,315 in FY 15, a 29% increase. Based on data submitted through March 31, 2016, approximately 20,000 individuals will be served in methadone maintenance programs by the end of FY 16. Below, the graph illustrates the yearly increases in admissions and unduplicated clients served in methadone maintenance programs.

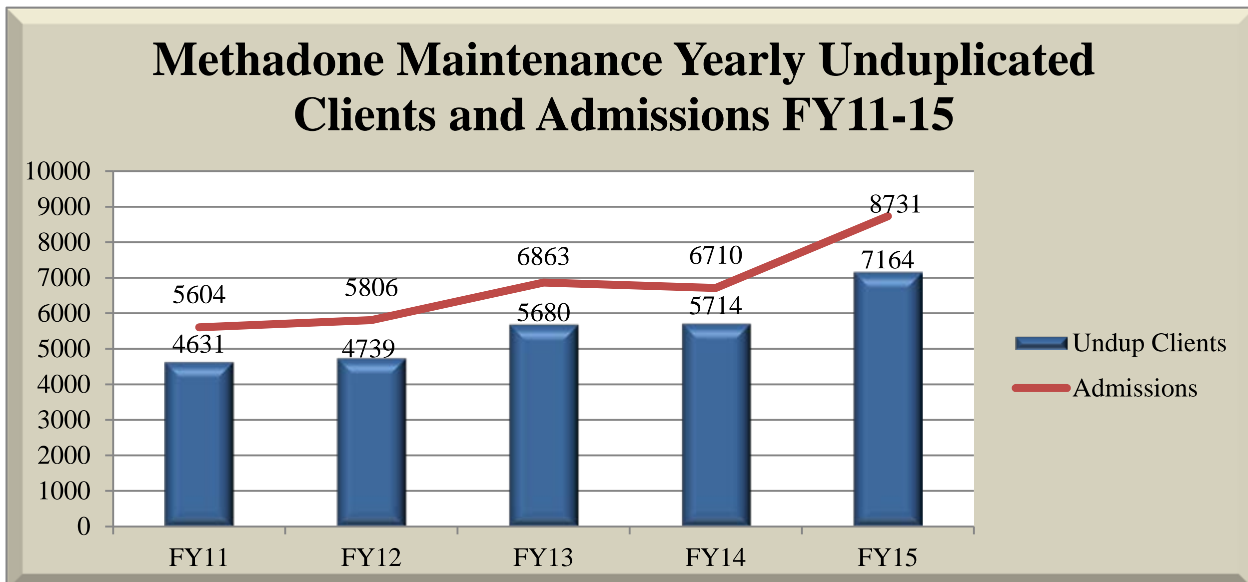

Figure 5: Yearly Admissions and Clients in Methadone Maintenance, FY11-15
(*Data from DMHAS EDW; includes all funding sources)

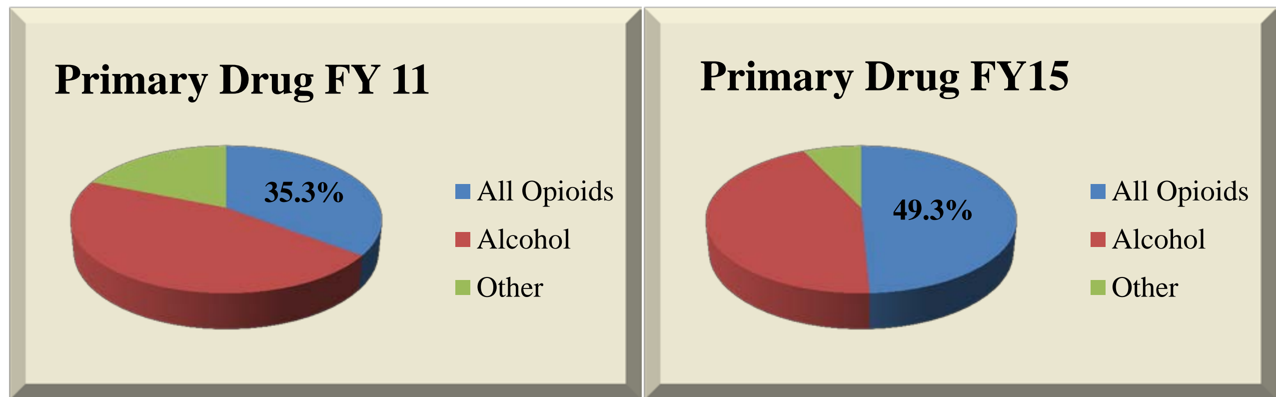

Figure 6: Primary Drug at Admission in Detoxification Programs, FY11-15

(*Data from DMHAS EDW; includes all funding sources)

Detoxification programs had over 15,300 admissions in FY 15. Almost **50%** of all detoxification program admissions are now related to heroin or other opioids. For comparison, the number was **35%** in FY 11. Many of these individuals are not being connected to evidence-based medication assisted treatment services such as methadone maintenance or buprenorphine treatment. Instead, many of these opioid users have multiple admissions to detoxification programs.

The demographics associated with opioid users are also changing. Males have consistently accounted for about 70% of all opioid-related admissions. However, over the past five years there has been an increase in white, non-Hispanic males that are being admitted into our treatment system. While the largest number of admissions continues to originate in our most populated cities, most cities in Connecticut are represented in admissions to our treatment programs. A DMHAS report which shows the towns of origin for all admissions related to opioids over the past five years, shows how opioid use has increased. Smaller cities like Bristol, Torrington, and New Britain have seen a substantial increase in admissions and in the number of unduplicated clients being treated for opioids during that period.

Another changing demographic relates to the age of individuals using opioids. There has also been a substantial increase in one age group. Admissions for individuals between the ages of 25-34 have almost doubled over the past five years from about 3,500 in FY 11 to almost 7,000 in FY 15. This shift deviates from some national data which appears to show that more young people (18-25) are being admitted for opioid treatment. No age group has been spared from the epidemic as admissions have been reported for individuals over 65 and as young as 18.

The opioid epidemic shows no signs of abating. Overdose deaths continue to increase and opioid-related admissions into our treatment system in FY 16 look as if they will exceed FY 15's count. Similarly, nine-month data for FY 16 shows that more people will be served in methadone maintenance programs than at any other time in the past 20 years. Stopping the course of an epidemic requires multi-pronged strategies that target various components of this crisis. These efforts must include the reduction of overdose deaths through widespread availability of Narcan, aggressive enforcement of drug laws, especially as they relate to trafficking, diversion of non-violent offenders into treatment, prevention and

education activities designed to keep individuals from being introduced to opioid use, and rapid access to a broad range of treatment alternatives once somebody has begun to use opioids. The plan will incorporate necessary legislative and policy changes that are supportive of the overall state efforts as well.

The Triennial Report's Opioid Annex details six over-arching strategies that are believed to be essential in combatting an epidemic such as the one we face. As will be demonstrated in this report, many of these strategies are already in place and can be built upon in order to effectively stop this epidemic. A range of actions or objectives will be presented under each of these strategies. The report will also detail accomplishments related to each strategy and areas for further enhancement.

6 Key Strategies for a Comprehensive and Coordinated Response to the Opioid Epidemic

1 STRATEGIES RELATED TO RESCUE

- Reduce overdose deaths by expanding the availability of naloxone (Narcan) to first responders, law enforcement, treatment providers, community organizations, and families in order to reverse overdoses and save lives

2 STRATEGIES RELATED TO PREVENTION AND EDUCATION

- Prevent opioid use through education aimed at teens, parents, school and university faculty and staff, and other caretakers including medical professionals.

3 STRATEGIES RELATED TO TREATMENT

- Expand access to medication-assisted treatments (MAT) including methadone maintenance and buprenorphine.

4 STRATEGIES RELATED TO CRIMINAL JUSTICE

- Implement criminal justice reforms that will increase the availability of MAT in jails and prisons.
- Reduce barriers and adverse consequences faced by prisoners who may be dealing with opioid addiction or have drug convictions related to opioid use or distribution.

5 STRATEGIES RELATED TO LAW INFORCEMENT

- Foster improved coordination between law enforcement and Connecticut's treatment system in order to divert individuals arrested for opioid related crimes into treatment.
- Enforce laws related to trafficking of heroin and other opioids.

6 ACCOUNTABILITY AND QUALITY CARE

- Ensure that medical professionals screen for opioid misuse and dangerous combinations of prescription medications, establish limits for opioid prescriptions, and regularly review patients that are receiving prescription painkillers to assess continued need.

Adapted from the Addiction Policy Forum-Key Elements of a Comprehensive Response to the Heroin Epidemic

Strategy 1: Strategies Related to Rescue

- **Reduce overdose deaths by expanding the availability of Naloxone (Narcan) to first responders, law enforcement, treatment providers, community organizations, and families in order to reverse overdoses and save lives**

Action Step: Expand the statewide network of pharmacists that are trained and willing to prescribe and dispense naloxone.	**Action Step:** Widely disseminate the names and locations of pharmacists that have completed the Dept. of Consumer Protection training program and are willing to prescribe and dispense Narcan.
Action Step: Require that any state-operated or funded provider serving persons with opioid use disorders has a "rescue plan" for those individuals.	**Action Step**: Obtain and distribute Narcan kits to all state-run or contracted providers that are serving persons with opioid use disorders.
Action Step: Provide in-person training to law enforcement, first responders, treatment providers, community organizations and families regarding proper use of Narcan.	**Action Step:** Ensure that all first responders maintain a supply of Narcan as part of normal operating procedures.
Action Step: Make online training regarding Narcan available to the general public.	**Action Step:** Educate opioid users, family members, and the general public about Narcan.
Action Step: Distribute Narcan through syringe exchange programs.	**Action Step**: Ensure that all insurance carriers reimburse pharmacists for prescribing Narcan.
Action Step: Eliminate insurer's pre-authorization requirements for Narcan.	**Action Step:** Explore the feasibility of a database to collect information regarding overdose reversals.
Action Step: Apply for federal funding being made available to expand overdose prevention training.	**Action Step**: Expand or modify legislation in order to ensure Emergency Medical Technicians and other first responders carry Narcan
Action Step: Ensure Narcan is available in schools and universities in CT.	

Accomplishments: Narcan is becoming increasingly more available throughout Connecticut due to a succession of actions dating back to 2011. At that time, a Good Samaritan law was enacted providing protection to those who assisted an individual that was overdosing. Subsequent legislation allowed doctors to prescribe Narcan to family members. It was felt that the legislation did not go far enough and new legislation was approved in 2015 that permitted pharmacists to prescribe and dispense Narcan after completing an online training course.

This training was launched in summer 2015 by the state's Department of Consumer Protection and a statewide network of almost 600 pharmacists are now certified and willing to prescribe

Narcan. This information is now posted on various websites in order to be more broadly available to the public. Most recently, new legislation was passed by the CT House that requires municipalities to ensure that all first responders receive training in how to use Narcan and have it available at all times. While all of these activities have broadened access to Narcan greater emphasis must be placed on growing the pharmacy network while making Narcan more widely available to the general public.

Narcan Training has been delivered throughout the state by DMHAS and the Department of Public Health (DPH). These trainings "teach" participants how to administer Narcan and where it can be accessed. Almost 1,700 persons have been trained in Narcan administration through over 90 trainings offered by DMHAS. These trainings have been provided to substance abuse treatment providers, law enforcement, family members, and other stakeholders. Additionally, DPH has offered training to Connecticut's State Police and Narcan kits are now being carried by all State Police officers. These Narcan kits were made available through a cooperative agreement with the Medical Director of the Department of Correction. As a result of these training efforts most of DMHAS' substance abuse providers now have Narcan kits available to them.

DCF has incorporated Narcan training into its Training Academy. DCF also has drafted a Narcan policy for staff and facilities that currently is under internal review. The Department also is partnering with its congregate and therapeutic foster care providers to develop a policy specific to the use of Naloxone in these settings.

The DPH has been actively working to get Narcan kits out across the state. To date, DPH has distributed approximately 6,700 kits; DMHAS received 200 of these kits and has focused distribution of these kits on our residential programs and other treatment providers within our system. Efforts are ongoing to secure additional kits from the manufacturer in order to expand distribution efforts.

Anecdotally, Narcan is believed to have had a significant impact in Connecticut but its effectiveness has been difficult to quantify. Currently, the state police and the Connecticut Syringe Exchange are tracking the number of overdose reversals that have occurred. The state police have recorded 82 reversals since November 2014 and the CT Syringe Exchange has recorded 53 reversals since February 2015. While capturing this data is difficult, this is another area that could be enhanced. A centralized database that captured information about reversals could be supportive of Connecticut's efforts.

Strategy 2: Strategies Related to Prevention and Education

- **Prevent opioid use through education aimed at teens, parents, school and university faculty and staff, and other caretakers including medical professionals**

Action Step: Host community forums throughout the state to educate the public regarding risks of opioid use, benefits of Narcan and how to access it, and community resources available for the treatment of opioid use.	**Action Step**: Apply for federal funds being made available to prevent opioid use and overdose deaths associated with heroin and other prescription opioids.
Action Step: Inform the public about risks of opioid use and prescription drug abuse through videos, social media, websites, PSA's, and posters and billboards	**Action Step**: Continue efforts through the state's prevention and treatment network to de-stigmatize addiction which is often a barrier to help-seeking.
Action Step: Develop and disseminate educational materials regarding opioids for students, parents, and school personnel.	**Action Step**: Expand community disposal sites for unused and expired prescription medications.
Action Step: Work with CT Medical Schools to ensure basic addiction training is included in core curriculums.	

Accomplishments: Connecticut has already initiated a number of prevention activities that are focused on prescription drugs or opioids. Some of this work began several years ago when the state hosted a conference focused on preventing prescription drug abuse. That conference resulted in actions that have focused on increased public awareness about the dangers of prescription drugs. Related to that is the safe disposal of prescription drugs as many adolescents access prescription opioids through their parent's medicine cabinet. The state now has over 60 drop boxes where unused medication can be disposed of. The State Police just added 10 additional disposal sites. The list of the these drop boxes and their location can be found at: http://www.ct.gov/dcp/cwp/view.asp?q=501922 .

A goal of any prevention effort related to heroin is to increase public awareness about the dangers of opioid use while educating Connecticut's citizens about the resources that are available to combat this problem. DMHAS has now conducted approximately 15 public forums across the state focusing on the opioid crisis across the state. Another 10 are scheduled to occur over the next several months. The forums include policymakers, local substance abuse experts, persons in recovery, and leaders from state agencies who provide information about the scope of the problem, ways to access Narcan, and treatment resources that are available for opioid users. Posters and other informational materials are made available as well.

State agencies have begun collaborating with partners to ensure that information about heroin and other opioids is broadly accessible to the public. The Governor's Office has introduced a website that focuses on the opioid problem, providing a range of resources to interested parties. Other state agencies have followed suit, providing information regarding agency specific resources. At the same time, contracted providers including the Connecticut Clearinghouse, Regional Action Council's, and the Governor's Prevention Partnership have collected and posted a range of resources to help inform the public and providers about this issue.

Strategy 3: Strategies Related to Treatment

- **Expand access to medication-assisted treatments (MAT) including methadone maintenance, buprenorphine, and naltrexone.**
- **Rapidly link opioid users to treatment**

Action Step: Create a statewide network of walk-in assessment centers to rapidly assist opioid users to find appropriate treatment.	**Action Step**: Establish and implement protocols to attempt to rapidly engage into treatment those individuals that were rescued from an overdose
Action Step: Implement a statewide toll free call line to connect callers to treatment options.	**Action Step:** Maintain and expand as necessary the statewide network of methadone maintenance programs.
Action Step: Increase capacity for outpatient programs to prescribe buprenorphine and naltrexone.	**Action Step**: Develop and implement a statewide buprenorphine expansion program.
Action Step: Apply for federal funding being made available to expand access to MAT.	**Action Step**: Improve linkages from detoxification programs to MAT

***Accomplishments*:** In order to address the opioid crisis effectively, Connecticut must have a comprehensive system of medication assisted treatment programs (MAT), an evidence-based treatment for opioid addiction. It is also important to offer a range of alternatives to individuals hoping to recover from opioid addiction. Connecticut has successfully built a statewide network of methadone maintenance programs, one type of MAT that served over 18,300 unique clients in fiscal year 2015. There are currently 25 methadone maintenance programs in operation in all areas of the state. These programs have demonstrated their capacity to meet additional demand for services. These programs have experienced substantial growth over the past 5 years. In FY 2011, approximately 14,148 people were served in these programs. The number served grew to over 18,300 in FY 15, a 29% increase in the numbers served in these programs. Current data should be evaluated in order to assess whether these programs can be accessed in rural areas in the state.

Alternatives to methadone maintenance like buprenorphine are not yet widely available in Connecticut or largely serve clients with private insurance or those that pay for these alternatives. This is not an option readily available to "public" clients in Connecticut. Buprenorphine is another form of medication that is similarly effective in treating opioid addiction. This treatment option is "physician driven" and is dependent on doctors that are "waivered" and willing to prescribe the medication. Many doctors have been uninterested in prescribing buprenorphine or may opt to serve higher income clients who can pay out-of-pocket. The federal government has placed restrictions on the numbers of persons a doctor may treat, limiting the availability of this drug. Connecticut's response to the opioid crisis could be

enhanced by developing a comprehensive statewide plan to expand the use of buprenorphine in clinics, especially for public sector clients.

Rapid access to treatment is another essential component of a comprehensive strategy designed to address the opioid epidemic. Connecticut implemented a toll free number for referral to services related to opioid addiction. The toll free line **1-800-563-4086** is staffed 24/7 and links callers to a network of walk-in centers where a person can receive a same day evaluation of their needs. Over 50 programs have agreed to conduct same-day evaluations in order to link the clients to the most appropriate level of care. These walk-in centers and their locations can be accessed at the following link: http://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=577738

DMHAS implemented what is called the *Opioid Agonist Treatment Protocols* over 10 years ago. These are procedures designed to rapidly link individuals who are being detoxed from heroin to methadone maintenance programs. These procedures were originally designed for "high utilizers" of services as a way to reduce repetitive admissions to detoxification programs and to quickly connect clients to the most desirable treatment option, methadone maintenance. Eligibility criteria for participation in these protocols have been relaxed and more people are now eligible to use this service. This remains an area for enhancement as many people who enter detoxification programs with opioids being reported as their primary drug are not being connected to follow-up care. Stigma is often a barrier to accepting treatment and a comprehensive plan must include activities to reduce stigma.

Strategy 4: Strategies Related to Criminal Justice

- **Implement criminal justice reforms that will increase the availability of MAT in jails and prisons.**
- **Reduce barriers and adverse consequences faced by prisoners who may be dealing with opioid addiction or have drug convictions related to opioid use or distribution**

Action Step: Investigate the effectiveness of Law Enforcement Assisted Diversion (LEAD) programs, a pre-booking program that diverts to services as an alternative to arrest.	**Action Step:** Evaluate opportunities to replicate the New Haven methadone pilot in other jails and prisons or re-entry programs.
Action Step: Transition offenders with drug convictions to community substance abuse programs.	**Action Step:** Eliminate mandatory sentencing laws for those convicted of non-violent narcotics possession.
Action Step: Increase employment training and job opportunities for ex-offenders.	**Action Step:** Implement diversionary services for individuals arrested for crimes related to opioid use.

Accomplishments: Many individuals that are involved with the criminal justice system have struggled with substance use and may be at-risk for continued use when they return to the community. A pilot program began at New Haven Community Correctional Center in October of 2013, offering methadone maintenance to offenders who enter the facility already on a verified dose of methadone. A second program was added at Bridgeport Community Correctional Center in February of 2015. Clients are provided treatment, as well as continued dosing, for their term of incarceration followed by re-entry planning services to continue the treatment upon release. More than 350 clients have participated in the two programs. This needs to be further evaluated to determine if this "pilot" can be expanded into other jails or prisons.

The DMHAS Division of Forensic Services funds community agencies to provide services to people with mental illness and/or addictions who are justice involved. These programs are designed and operated in collaboration with criminal justice agencies to divert adults from jail, assist with reentry from jail/prison, and reduce recidivism.

The Women's Jail Diversion, Jail Diversion Substance Abuse (JDSA), Alternative Drug Intervention programs provide a full complement of clinical and support to criminal court defendants with substance use disorders. The Pretrial Intervention Program is a suspended-prosecution diversion program for first-time DUI offenders and drug possession offenders that provides alcohol and drug education groups or referral to a substance abuse treatment program. Transitional Case Management is a re-entry program that provides pre-release engagement and discharge planning and post-release OP sub abuse treatment and support services for men.

In SFY16 DMHAS received additional funding to expand JDSA to two additional courts and also received a MacArthur Safety and Justice Challenge to a third court.

Strategy 5: Strategies Related to Law Enforcement

- **Foster improved coordination between law enforcement and Connecticut's treatment system in order to divert individuals arrested for opioid related crimes.**

Acton Step: Provide DMHAS access line number to state and local police departments.	**Action Step:** Develop pilot to divert individuals addicted to opioids into treatment.
Action Step: Ensure law enforcement personnel have access to Narcan and are trained to administer the drug.	

Accomplishments: Law enforcement plays a critical role in interdiction and stopping criminal behavior related to opioid distribution. However, this section focuses on the interaction between law enforcement and behavioral health such as diversion or linkage to treatment. Preliminary steps have been taken to increase connections to law enforcement.

Both DMHAS and DPH have been involved in trainings focused on law enforcement personnel. DPH conducted training of State Police that resulted in all troopers carrying Narcan. The state police have recorded 82 reversals since November 2014. A number of other police departments have received training in the administration of Narcan and are now carrying the medication.

Strategy 6: Accountability and Patient Care

- **Ensure that medical professionals screen for opioid misuse and dangerous combinations of prescription medications, establish limits for opioid prescriptions, and regularly review patients that are receiving prescription painkillers to assess continued need**

Action Step: Provide continuing education training to medical professionals regarding risks involved in using painkillers and dangers associated with co-prescribing (i.e. opioids and benzodiazapines).	**Action Step:** Require medical professionals to query the state's Prescription Monitoring Program when initially prescribing opioids and at regular intervals for patients receiving pain medications for chronic conditions.
Action Step: Require pharmacies to enter data into the State's PMP as prescriptions are filled (real time data entry) in order to ensure PMP is complete and up-to-date.	**Action Step:** Limit opioid prescriptions for acute conditions to no more than 7 days.

Accomplishments: The State's Department of Consumer Protection has already take steps that partially address some of the action steps identified above. The state implemented a Prescription Monitoring Program (PMP) in 2008. The PMP was designed to collect prescription data for Schedule II through V drugs into a central database which can be used by medical providers and pharmacists in the active treatment of their patients. Recently enacted legislation (October 1, 2015) requires health care professionals to check the PMP prior to prescribing controlled substances for greater than a 72-hour period. Additional provisions require that pharmacists enter controlled substance prescription data after July 1, 2016 immediately or no later than 24 hours. This will improve the accuracy of the data as previous requirements specified that data must be entered within a one week period.

Both DCP and DPH have offered training programs to prescribers regarding safe prescribing practices. DPH has trained over 260 individuals and has developed a capacity to offer the training online.

New bills recently passed by the Connecticut Legislature imposed limits on the length of opioid prescription for acute conditions. This will result in prescriptions for shorter amounts of time. These more stringent restrictions apply to adults or children who receive prescription opioids for pain.

Conclusion

This Annex is designed to be an initial step to formalize key strategies and to highlight the major efforts that have been ongoing as Connecticut attempts to address the opioid epidemic. Recently the Governor has requested that experts from Yale University assist the state to create an overarching strategy to reduce opioid addiction and overdoses. Yale has begun that work and will be collaborating with the Alcohol and Drug Policy Council over the coming months to develop a comprehensive plan that will better coordinate the state's efforts.

Attachment G

(separate file)

Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

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Consensus Panel Chair

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

A Treatment Improvement Protocol

TIP 47

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

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Rockville, MD 20857

Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

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Disclaimer

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

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Contents

What Is a TIP? ix

Consensus Panel xi

KAP Expert Panel and Federal Government Participants xiii

Foreword xv

Executive Summary xvii

Chapter 1—Introduction 1

Forces Affecting IOT and the Contents of This TIP 2
Terminology and Definitions 3
Summary of This TIP 5

Chapter 2—Principles of Intensive Outpatient Treatment 7

Principle 1: Make Treatment Readily Available 8
Principle 2: Ease Entry 9
Principle 3: Build on Existing Motivation 9
Principle 4: Enhance Therapeutic Alliance 10
Principle 5: Make Retention a Priority 10
Principle 6: Assess and Address Individual Treatment Needs 11
Principle 7: Provide Ongoing Care 11
Principle 8: Monitor Abstinence 12
Principle 9: Use Mutual-Help and Other Community-Based Supports 12
Principle 10: Use Medications if Indicated 13
Principle 11: Educate About Substance Use Disorders, Recovery, and Relapse 14
Principle 12: Engage Families, Employers, and Significant Others 14
Principle 13: Incorporate Evidence-Based Approaches 15
Principle 14: Improve Program Administration 15

Chapter 3—Intensive Outpatient Treatment and the Continuum of Care 17

Overview of a Continuum of Care 17
Conceiving of a Continuum of Care 18
Key Aspects of IOT (Level II) 19

Key Aspects of Outpatient Treatment (Level I) 23
Continuing Community Care 24

Chapter 4—Services in Intensive Outpatient Treatment Programs 27

Core Services 27
Enhanced IOT Services 44
IOT Services: A Case Illustration 46
Appendix 4-A. A Case Study of Intensive Outpatient Treatment 48
Appendix 4-B. Induction Protocol for Disulfiram 56

Chapter 5—Treatment Entry and Engagement 59

Elements of Engaging the Client in IOT 60
Collect Screening Information 62
Assessing Barriers to Treatment 64
Crises and Emergencies 67
Components of the IOT Admission Process 67
Sample Treatment Plans 76
Appendix 5-A. Substance Use History Form 84
Appendix 5-B. Instruments for Determining Substance-Related and Psychiatric Diagnoses 85
Appendix 5-C. DSM-IV Criteria for Substance Dependence and Substance Abuse 87
Appendix 5-D. Supplements to the Six Assessment Domains in the ASI and Other Topics 88

Chapter 6—Family-Based Services 93

Planning for Family Involvement 94
Engaging the Family in Treatment 95
Family Services 98
Family Clinical Issues in IOT 102
Appendix 6-A. Format and Symbols for Family Genogram 107
Appendix 6-B. Family Social Network Map 109
Appendix 6-C. Resources for Family-Based Services 112

Chapter 7—Clinical Issues, Challenges, and Strategies in Intensive Outpatient Treatment 115

Client Retention 115

Relapse and Continued Substance Use 117
Substance Use by Family Members 119
Group Work Issues 120
Safety and Security 125
Client Privacy 128
Clients Who Work 130
Boundary Issues 132
Appendix 7-A. Instruments for Assessing Relapse Potential 135

Chapter 8—Intensive Outpatient Treatment Approaches 137

12-Step Facilitation Approach 138
Cognitive–Behavioral Approach 140
Motivational Approaches 141
Therapeutic Community Approach 142
The Matrix Model 146
Community Reinforcement and Contingency Management Approaches 148

Chapter 9—Adapting Intensive Outpatient Treatment for Specific Populations 153

Justice System Population 153
Women 157
Populations With Co-Occurring Psychiatric Disorders 162
Adolescents 171
Young Adults 175

Chapter 10—Addressing Diverse Populations in Intensive Outpatient Treatment 179

What It Means To Be a Culturally Competent Clinician 180
Principles in Delivering Culturally Competent IOT Services 181
Issues of Special Concern 183
Clinical Implications of Culturally Competent Treatment 188
Sketches of Diverse IOT Client Populations 189
Appendix 10-A. Cultural Competence Resources 197

Appendix A—Bibliography ... 205

Appendix B—Urine Collection and Testing Procedures and Alternative Methods for Monitoring Drug Use ... 237

Appendix C—Resource Panel ... 247

Appendix D—Cultural Competency and Diversity Network Participants ... 249

Appendix E—Field Reviewers ... 251

Index ... 255

CSAT TIPs and Publications Based on TIPs ... 265

Exhibits

3-1 Goals, Duration, Activities, and Completion Criteria of Stage 1 ... 21
3-2 Goals, Duration, Activities, and Completion Criteria of Stage 2 ... 22
3-3 Goals, Duration, Activities, and Completion Criteria of Stage 3 ... 25
3-4 Goals, Duration, Activities, and Completion Criteria of Stage 4 ... 26
4-1 Core and Enhanced Services for IOT Programs ... 28
4-2 Groups Conducted in Intensive Outpatient Treatment ... 29
4-3 Typical Sequence of Topics Addressed in Psychoeducational Group ... 33
4-4 Case Management Services ... 39
4-5 Examples of 24-Hour Crisis Coverage Implementation ... 41
4-6 Alternatives to Traditional 12-Step Groups ... 43
4-7 Key Features of a Hospital-Based Suburban IOT Program ... 46
4-8 A Protocol for Ambulatory Detoxification and Disulfiram Induction ... 56
5-1 Effective Interviewing Techniques ... 63
5-2 ABC Model for Psychiatric Screening ... 66
5-3 The Six Dimensions of the ASAM PPC-2R for Level II.1 IOT ... 69
5-4 Brief Screening Instruments That Assess Motivational Stage ... 70
5-5 Mild Withdrawal Symptoms for Four Drug Classes That Can Be Managed in Level II.5 Ambulatory Detoxification ... 71

6-1 Suggestions for Engaging Family Members at Intake ... 96

6-2 A Treatment Calendar for Family Members ... 99

6-3 Social Network Grid Used in Conjunction With Network Map ... 111

7-1 Examples of Immediate Safety Concerns and Counselor Responses ... 126

8-1 Strengths and Challenges of 12-Step Approaches ... 139

8-2 Strengths and Challenges of Cognitive–Behavioral Approaches ... 141

8-3 Strengths and Challenges of Motivational Approaches ... 143

8-4 Strengths and Challenges of the Therapeutic Community Approach ... 145

8-5 Strengths and Challenges of Matrix Model Treatment ... 147

8-6 Strengths and Challenges of Community Reinforcement and Contingency Management Approaches ... 151

9-1 Core Treatment Needs and Service Elements for Women ... 160

9-2 SAMHSA's Service Coordination Framework for Co-Occurring Disorders ... 164

9-3 The Family Intervention Program ... 174

9-4 Characteristics and Behaviors of Adolescents and Treatment Suggestions ... 176

B-1 Urine Toxicology Detection Periods for Different Substances ... 240

B-2 Effectiveness of Drug Detection Methods That Use Different Biological Products ... 243

What Is a TIP?

Treatment Improvement Protocols (TIPs), developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration, within the U.S. Department of Health and Human Services, are best-practice guidelines for the treatment of substance use disorders. CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private treatment facilities to include practitioners in mental health, criminal justice, primary care, and other health care and social service settings.

CSAT's Knowledge Application Program expert panel, a distinguished group of experts on substance use disorders and professionals in such related fields as primary care, mental health, and social services, works with the State Alcohol and Drug Abuse Directors to generate topics for the TIPs. Topics are based on the field's current needs for information and guidance.

After selecting a topic, CSAT invites staff from pertinent Federal agencies and national organizations to be members of a resource panel that recommends specific areas of focus as well as resources that should be considered in developing the content for the TIP. These recommendations are communicated to a consensus panel composed of experts on the topic who have been nominated by their peers. Consensus panel members participate in a series of discussions. The information and recommendations on which they reach consensus form the foundation of the TIP. The members of each consensus panel represent substance abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A panel chair (or co-chairs) ensures that the contents of the TIP mirror the results of the group's collaboration.

A large and diverse group of experts closely reviews the draft document. Once the changes recommended by these field reviewers have been incorporated, the TIP is prepared for publication, in print and on line. TIPs can be accessed via the Internet at www.kap.samhsa.gov. The online TIPs are consistently updated and provide the field with state-of-the-art information.

Although each TIP strives to include an evidence base for the practices it recommends, CSAT recognizes that the field of substance abuse treatment is evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. For this reason, recommendations proffered in the TIP are attributed to either panelists' clinical experience or the literature. If research supports a particular approach, citations are provided.

This TIP, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment*, was written to help clinicians address the expansion of intensive outpatient treatment (IOT) represented by the development and adoption of new approaches to treat a wider variety of clients. Researchers and clinicians have begun to question the acute care model of treatment for substance use disorders; this reexamination has led to a more robust collaboration between researchers and practitioners. The resulting focus on evidence-based treatment approaches informs most of the material in this TIP. The consensus panel presents 14 guiding principles of IOT, supported by research and clinical experience. This TIP also situates IOT within the continuum of care framework established by the American Society of Addiction Medicine, including outpatient treatment and continuing community care. The volume describes the core services every program should offer, the enhanced services that should be available on site or through links with community-based services, and the process of assessment, placement, and treatment planning that helps clinicians address each client's needs. Based on research and clinical experience, the consensus panel discusses major clinical challenges of IOT and surveys the most common treatment approaches used in IOT programs, including family-based services. More specialized sections address treatment of specific groups of clients: women; adolescents and young adults; persons involved with the criminal justice system; individuals with co-occurring disorders; racial and ethnic minorities; persons with HIV/AIDS; lesbian, gay, and bisexual individuals; persons with physical or cognitive disabilities; rural populations; individuals who are homeless; and older adults.

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This TIP is a consensus-based document, developed by the experts listed below. Although all panelists made significant contributions in the development of the TIP as a whole, some panelists took on the additional responsibility as writers for upfront development of particular chapters. Those chapters are listed after their names.

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Foreword

The Treatment Improvement Protocol (TIP) series supports SAMHSA's mission of building resilience and facilitating recovery for people with or at risk for mental or substance use disorders by providing best-practices guidance to clinicians, program administrators, and payers to improve the quality and effectiveness of service delivery and thereby promote recovery. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and client advocates debates and discusses its particular areas of expertise until it reaches a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs' panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators who serve, in the most current and effective ways, people who abuse substances. We are grateful to all who have joined with us to contribute to advances in the substance abuse treatment field.

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Executive Summary

This volume, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment*, and its companion text, *Substance Abuse: Administrative Issues in Outpatient Treatment*, revisit the subject matter of Treatment Improvement Protocol (TIP) 8, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse*, published in 1994 (CSAT 1994*c*). When TIP 8 was published, one volume of about 100 pages sufficed to address relevant topics in intensive outpatient treatment (IOT). Today, the same task requires two volumes, each devoted to a distinct audience, clinicians and administrators. The primary audience for this volume is clinicians working in IOT programs.

The Changing IOT Landscape

Arnold M. Washton (1997) points out that the first large expansion of IOT took place during the 1980s, when White, middle-class individuals with cocaine addiction, many of whom were business professionals, sought treatment and did not want to take time away from work or face the stigma of checking into a residential treatment facility. A second expansion of IOT was ushered in by managed care with a focus on cost containment. Throughout the 1990s, IOT grew, becoming the dominant setting for most clients with substance use disorders. This growth was spurred by the expansion of IOT's population from clients with a moderate range of problems to include clients who are homeless, adolescents, and persons with co-occurring mental disorders, all of whom formerly were considered too difficult for IOT programs to treat successfully. This expansion in clients and services means that IOT clinicians must keep abreast of a broadening array of treatment approaches and services provided beyond their programs. The current volume's focus on clinicians reflects both the increased treatment options available and the expanded range of knowledge and skills required.

Defining Substance Abuse Treatment and IOT

For most of the 20th century, substance abuse was considered an acute disorder. Viewing substance abuse more like pneumonia than like chronic diseases such as hypertension or diabetes had shaped the expectations and treatment choices of clinicians. As McLellan and colleagues (2000) point out, regarding substance abuse as a chronic disorder means realigning treatment and outcome expectations so that they resemble those for other chronic disorders. Today, many IOT programs are involved in treatment beyond the traditional 4 to 12 weeks. Increasingly, IOT programs focus on ongoing care that addresses many areas of clients' lives through case management and the involvement of other service providers and families and communities.

A parallel development has been the frequent application of research findings into practice in the field of substance abuse treatment. Research has yielded new understanding about the complexity of substance use disorders that takes into account biochemical processes, learning, spirituality, and environment. IOT programs are integral to the process of translating scientific findings into clinically effective treatments. The collaboration between research and practice has moved some treatments out of research centers and into IOT programs. Cognitive–behavioral interventions, relapse prevention training, motivational enhancement, and case management are used in community-based treatment settings as a result of the cross-fertilization of research and treatment.

One result of the convergence of research and practice is the development of evidence-based principles that shape and guide substance abuse treatment. The consensus panel recommends 14 principles for IOT programs. These principles lay a theoretical foundation for discussions of IOT services, clinical challenges, and treatment approaches and adaptations. In their focus on client engagement and retention, individualizing treatment, using the entire continuum of care, and reaching out to families, employers, and the community, the 14 principles help define the IOT program's contemporary role.

Continuum of Care and IOT Services

An IOT program is most effective at helping its clients if it is part of a continuum of care. The American Society of Addiction Medicine has established five levels of care: medically managed intensive inpatient, residential, intensive outpatient, outpatient, and early intervention. In addition, continuing community care (e.g., 12-Step support groups), which a client participates in after the conclusion of formal treatment, is another important level of service. A continuum of care ensures that clients can enter substance abuse treatment at a level appropriate to their needs and step up or down to a different intensity of treatment based on their responses. Clinicians enhance the capabilities of their programs when they are informed about and willing to refer clients to other treatment providers. Close monitoring of clients' progress toward treatment goals is key to determining when they are ready for the next appropriate level of care. Any transition in treatment increases the likelihood that a client will drop out. A step-up or stepdown in treatment intensity in the same program or a referral to a nonaffiliated provider can be disruptive for the client. Mee-Lee and Shulman (2003) recommend that a continuum of care feature seamless transfer between levels, congruence in treatment philosophy, and efficient transfer of records. Clinicians need to be thoroughly familiar with local treatment options, including support groups, so that they can orient clients as the clients transition to new treatment situations.

Services integral to all IOT programs are core services. The consensus panel believes that these core services, such as group and individual counseling, psychoeducational programming, monitoring of drug use, medication management, case management, medical and psychiatric examinations, crisis intervention coverage, and orientation to community-based support groups, are indispensable and should be available through all IOT programs. Additional services that are offered at the program site or through links with partner organizations are enhanced services. This concept is flexible, and what might be considered enhanced services for some programs may be essential services for a program with a different client population. (Clients whose first language is not English might need language classes to find work and participate in mutual-help groups, whereas a program that primarily serves native speakers would have little call for such a service.) Enhanced services include adult education classes, recreational activities, adjunctive therapies (e.g., biofeedback, acupuncture, meditation), child care, nicotine cessation treatment, housing, transportation, and food.

Entry, Engagement, and Treatment Issues

Many clients who enter substance abuse treatment drop out in the early stages (Claus and Kindleberger 2002). Entry and engagement are crucial processes; how an IOT program addresses them can influence strongly whether clients remain in treatment. Client intake and engagement can involve contradictory processes such as collecting intake information from clients while initiating a caring, empathic relationship. Balancing administrative tasks and therapeutic intervention is a challenge clinicians face during a client's first hours in an IOT program. To help clinicians achieve that balance, the consensus panel recommends assessing potential clients' readiness for change and using strategies that motivate them to enter and continue treatment. Clinicians should begin to establish a therapeutic relationship as soon as clients present themselves for treatment. Any barriers to treatment must be addressed. Based on screening and assessments, clients should be matched with the best treatment modality and setting to support their recovery. An individualized treatment plan should be developed with the cooperation of the client to address the client's needs.

Client retention is a priority throughout treatment. The consensus panel draws on research and the experience of practiced clinicians to address the issues of engagement and retention. Clients can become distracted from recovery if family members continue to use substances, boundaries between clients and staff are not established clearly, work conflicts with treatment, or they receive incompatible recommendations from different service systems. Clinicians need to know how to ensure the privacy of their clients and the safety and security of the program facility while maintaining open and productive therapeutic relationships with their clients. Clinicians also need to be familiar with common issues that can derail clients in group therapy such as intermittent attendance and other clients who are disruptive, ambivalent, or withdrawn. When clinicians understand and prepare for these problems, their clients have a better chance of being retained in and benefiting from treatment. A major factor in client retention is the quality of the relationship between client and counselor. The client is more likely to do well in treatment if a strong therapeutic alliance exists.

Treatment Approaches Used in IOT

IOT is compatible with different treatment approaches. Involving clients' families in their recovery is an effective strategy. Substance-using behavior may be rooted in part in a client's family history—whether family of origin or family of choice. Families

can play a crucial role in a client's recovery. Providers should prepare for family involvement, education, and other services so that family members can support recovery. Family involvement in treatment has been linked to positive outcomes for clients in substance abuse treatment (Rowe and Liddle 2003). For IOT providers, adopting a family systems approach means including family members in every stage of treatment: the intake interview, counseling sessions, family dinners or weekends, and graduation celebrations. If family members are to support a client's recovery, they must be disabused of unrealistic expectations and learn about relapse prevention. IOT providers should consider offering family education groups, multifamily groups, and family support groups. If family therapy (which in most States requires a licensed, master's-level clinician) is warranted and an IOT clinic cannot offer it, referral relationships can be developed with an organization that provides individual family therapy, couples therapy, and child-focused therapy.

Providers should be familiar with the strengths and challenges of different treatment approaches so they can serve their clients better by modifying and blending approaches as necessary. The 12-Step facilitation approach is common in the treatment environment. Twelve-Step-oriented treatment helps clients achieve abstinence and understand the principles of Alcoholics Anonymous and other 12-Step groups through group counseling, homework assignments, and psychoeducation. The 12-Step approach emphasizes cognitive, behavioral, spiritual, and health aspects of recovery and is effective with many different types of clients.

Cognitive–behavioral therapy focuses on teaching clients skills that will help them understand and reduce their relapse risks and maintain abstinence. Clients must be motivated and counselors must be trained extensively for cognitive–behavioral therapy to succeed.

Motivational approaches, such as motivational interviewing and motivational enhancement therapy, also rely on extensive staff training and high levels of client self-awareness. Through empathic listening, counselors explore clients' attitudes toward substance abuse and treatment, supporting past successes and encouraging problemsolving strategies. These approaches are client centered and goal driven and encourage client self-sufficiency.

Therapeutic community approaches are used most often in residential settings but have been adapted for IOT. In therapeutic community approaches, a structured community of clients and staff members is the main therapeutic agent—peers and counselors are role models, the work at the facility is used as therapy, and group sessions focus on self-awareness and behavioral change. The intensity of the treatment calls for extensive staff training and can result in high client dropout. However, therapeutic communities have proved successful with difficult clients (e.g., those with long histories of substance use and those who have served time in prison).

The Matrix model integrates a number of other treatment approaches, including mutual-help, cognitive–behavioral, and motivational interviewing. A strong therapeutic relationship between client and counselor is the centerpiece of the Matrix approach. Other features are learning about withdrawal and cravings, practicing relapse prevention and coping techniques, and submitting to drug screens.

Contingency management and community reinforcement approaches encourage clients to change behavior; these approaches reinforce abstinence by rewarding some behaviors and punishing others. Programs select a goal that is reasonable, is attainable, and contributes to overall treatment objectives and then reward small steps the client makes toward that goal. Contingency management and community reinforcement

approaches have been successful with clients who have chronic substance use disorders, when the costs for staff training and incentives can be addressed.

Treating Different Populations

Many of the approaches used in IOT programs were developed to treat substance use disorders in White, middle-class men. Adaptations to these approaches are necessary to treat a variety of clients such as those in the justice system, women, clients with co-occurring disorders, and adolescents.

Increasing numbers of people with substance use disorders are involved with the justice system. Justice agencies and treatment providers need to work closely with each other, communicating clearly and coordinating their efforts. Cooperation of a different kind must exist between clinicians and clients. Therapeutic alliance is especially important when working with clients in the justice system who may have difficulty trusting a clinician and forming meaningful relationships outside the criminal environment.

The number of treatment programs for women is increasing. These programs add enhanced services designed to address substance abuse in the context of pregnancy and parenting, self-esteem issues, and histories of physical, sexual, and emotional abuse. To treat women, clinicians often avoid confrontational techniques and focus on providing a safe and supportive environment with clearly established boundaries between client and counselor.

Many people with co-occurring mental and substance use disorders are not receiving appropriate care (Watkins et al. 2001) and find themselves shuttling between psychiatric and substance abuse treatment, caught between two systems (Drake et al. 2001). Integrated treatment attends to both disorders together, adapts standard interventions to allow for clients' cognitive limitations, and provides comprehensive services to care for both disorders. Programs that do not adopt an integrated approach are advised to coordinate services with mental health providers.

A comprehensive approach to services also is important for adolescents who are using substances. Adolescents experience incredible upheaval in their lives and often need habilitation rather than rehabilitation. Many are in treatment for the first time and need to be oriented to treatment culture. Because adolescents often are living at home, family involvement is crucial. A behavioral contract—stipulating desired behaviors and rewards—and case management—addressing medical, social, and psychological needs—are also beneficial treatment tools.

IOT programs are being called on to serve an increasingly diverse client population. Almost one-third of Americans belong to an ethnic or racial minority group, and more than 10 percent of the U.S. population was born outside the country (Schmidley 2003). Although there is widespread agreement that clinicians should be culturally competent, no consensus exists about what cultural competence means. As a starting point, clinicians should understand how to work with someone from outside their own culture and strive to understand the specific culture of the client being served. Whereas the ability to treat clients from outside one's culture is an extension of the skills of a good clinician, understanding the cultural context of individual clients is more demanding. Clinicians need to strike a balance between a broad cultural background and the specific cultural context of a client's life; an observation that is applicable to a large group may be misleading or harmful if applied to an individual.

For foreign-born clients, level of acculturation often is an issue. Most research shows that the more acculturated clients are, the more their substance use approximates U.S. norms. Programs that serve substantial numbers of foreign-born clients may consider

offering language-specific programs and linking clients to language classes, job training, and employment services. Clients from other cultures may be averse to the emphasis on self-disclosure and self-sufficiency in substance abuse treatment. Counselors must be prepared to work within the client's value system, which may be at odds with values promoted by the treatment program.

Likewise, programs should ensure that program practices and materials do not pose a barrier to clients of non-Christian faiths. Many mutual-help programs have a strong Christian element; clients from other faiths should be informed of this orientation and provided with information about secular or religion-specific mutual-help groups.

Other general guidelines for programs that treat clients from other cultures include assessing policies and practices to spot potential barriers for diverse clients, training staff members in cultural competence, providing materials at an appropriate reading level or translating materials into clients' languages, and using outreach to promote awareness of the program.

The consensus panel offers an extensive list of resources for further research as well as demographic, substance use, and treatment information on members of racial and ethnic groups; persons with physical or cognitive disabilities; persons with HIV/AIDS; persons who are lesbian, gay, or bisexual; rural populations; and homeless populations. These resources are found in appendix 10-A.

1 Introduction

In This Chapter...

Forces Affecting IOT and the Contents of This TIP

Terminology and Definitions

Summary of This TIP

The current volume addresses clinical issues and a companion volume, TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), discusses administration. Together, these TIPs break new ground as the first two-volume TIP issued by the Center for Substance Abuse Treatment (CSAT). This volume represents the most extensive discussion in a TIP of clinical issues for intensive outpatient treatment (IOT) programs.

Several developments in health care and the treatment of substance use disorders have prompted this full revision of TIP 8, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse* (CSAT 1994*c*). Since the original TIP was published, substantial changes have occurred in almost every aspect of how treatment services are conceptualized and delivered. By the late 1990s, IOT had moved from being a peripheral and relatively circumscribed clinical service, serving a small range of clients, to a robust, multidimensional treatment modality that plays a central role in the care of many individuals with substance use disorders. TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), provides a full history of IOT.

As with all TIPs sponsored by CSAT, this volume represents the thinking, experience, and work of a consensus panel. The rapidity of recent changes in the IOT field and the variety of challenges and opportunities that accompany them compelled this TIP's consensus panel to draw on its clinical experience and current research to create a TIP that is both practical and evidence based. *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* examines significant and sometimes perplexing issues facing IOT providers and offers analytical discussions and incisive opinions. In writing the TIP, the consensus panel attempted to reflect the changes of the past decade and anticipate directions that IOT may take.

Forces Affecting IOT and the Contents of This TIP

Chronic Disease Management

Recognizing that substance abuse is a chronic disorder similar to diabetes, hypertension, and asthma led the panel to question the acute care model of service delivery that has characterized substance abuse treatment for the past 50 years (McLellan et al. 2000). Panel members felt strongly that IOT providers—like providers in the rest of the health care system—should rethink the acute care approach to treating substance use disorders. Increasingly, IOT programs are involved in substance abuse treatment beyond the initial 4 to 12 weeks. Much of the discussion in this volume is devoted to continuing care and to finding ways to include case management service providers, families, communities, and mutual-help groups in the ongoing care of individuals with substance use disorders.

Practice–Research Collaboration

In the past decade, emphasis on the blending of evidence-based interventions with community-based service delivery has increased. The longstanding divide between practitioners and researchers needed to be bridged. This disparity, described in the Institute of Medicine 1998 report, *Bridging the Gap Between Practice and Research*, was a major impetus behind the creation of the National Institute on Drug Abuse's (NIDA's) Clinical Trials Network and CSAT's Addiction Technology Transfer Centers and Practice Improvement Centers. Research has resulted in new knowledge about how biochemical processes, learning, spirituality, and environment affect people who abuse substances. These advances may make it easier for clinicians, clients, family members, and the public to understand that substance use disorders are complex illnesses with important biological—as well as social, psychological, and spiritual—dimensions. IOT programs play a central role in translating scientific findings into clinically meaningful information and treatments.

The discussions of treatment and the clinical recommendations in this TIP are informed by the links between practice and research that are becoming the norm in the IOT field.

New Treatment Approaches

A growing interest in evidence-supported interventions has led practitioners to examine long-held assumptions about treatment and the recovery process. Several therapeutic approaches, previously applied primarily in university-based research centers, have begun to emerge as viable and effective interventions that can be implemented successfully in community-based treatment settings. Discussions on cognitive–behavioral interventions, relapse prevention training, motivational enhancement therapy, the use of incentives, and case management approaches have been incorporated into this TIP. Similarly, the TIP describes the benefits of integrating pharmacotherapies into IOT to help manage withdrawal and stabilize people with co-occurring disorders.

Convergence of Systems

Approximately 10 years ago, substance abuse treatment services were viewed widely as specialty services that interacted with a variety of other important stakeholders, such as the mental health, welfare, and criminal justice systems. A profound and important change affecting the delivery of IOT services is the convergence of these previously distinct systems and the substance abuse treatment system. The divisions among services have long been based on administrative convenience and funding streams, not the clinical needs of clients. Programs must be prepared to treat clients who simultaneously may be receiving public welfare, have children in

protective services, and be under criminal justice supervision. Each system may place substance abuse treatment requirements on the client, and, as a consequence, these systems can play an important role in supporting the goals of treatment. This TIP addresses the importance of simultaneously working with multiple systems.

Client and Program Diversity

IOT programs serve a greater variety of clients than they did when TIP 8 was published in 1994. The current volume makes a broader and deeper study of how individual differences affect treatment needs. Ten years ago IOT was offered primarily to privately insured clients with mild-to-moderate levels of dysfunction. Since then, IOT programs have adjusted their models to treat adolescents, clients who are homeless or economically disadvantaged, clients with mental disorders, clients involved with the criminal justice system, clients who are disabled, and those with other special needs once considered beyond the scope of IOT programs. Most programs also are responding to the needs of increasingly diverse racial and ethnic client populations. Many IOT programs now incorporate onsite ambulatory detoxification services, medication management, and infectious disease interventions.

Terminology and Definitions

IOT vs. IOP

Just as the treatment field has yet to settle on a commonly accepted name for itself (e.g., "substance abuse" versus "addiction" versus "substance use disorder" versus "chemical dependence"), there is also no agreed-on term to describe this intensive level of care. Because use of the terms "intensive outpatient treatment" and "intensive outpatient program" (IOP) varies by region, for the sake of consistency, the consensus panel agreed to use the term "intensive outpatient treatment" ("IOT") to refer to this level of care instead of the equally acceptable term "intensive outpatient program." Because of the variety of definitions applied by clinicians and researchers to "intensive outpatient treatment," IOT studies cited in this volume also include day treatment, day hospital treatment, and partial hospitalization programs, in addition to IOT programs.

Increasingly, IOT programs are involved in substance abuse treatment beyond the initial 4 to 12 weeks.

Outpatient Care vs. Aftercare vs. Continuing Care

The term "aftercare" is avoided throughout this TIP in favor of "continuing care." Research literature occasionally uses the term "aftercare" when discussing traditional outpatient treatment that follows residential or intensive outpatient treatment. Others use the term "aftercare" when discussing clients' participation in mutual-help groups after formal treatment is completed. In this volume, the term "continuing care" designates the mutual-help groups (including 12-Step and other support groups) available in the community after formal treatment ends. Even during the continuing community care phase or treatment, many clients return to the IOT clinic for occasional followup visits, similar to regular medical checkups for other chronic diseases.

Substance Abuse Treatment vs. Mutual-Help Groups

The distinction between substance abuse treatment programs and mutual-help groups, such as 12-Step support groups, often is misunderstood by managed care organizations and the public. The American Medical

...mutual-help groups are an important component of treatment, but they cannot substitute for substance abuse treatment...

Association (1998) has adopted a policy stating that clients with substance use disorders should be treated by qualified professionals and that mutual-help groups should serve as adjuncts to a treatment plan devised within the practice guidelines of the substance abuse treatment field. Likewise, the American Psychiatric Association, American Academy of Addiction Psychiatry, and American Society of Addiction Medicine (ASAM) have issued a joint policy statement that asserts that treatment involves at least the following (American Society of Addiction Medicine 1997):

- A qualified professional is in charge of treatment.
- A thorough evaluation is performed to determine the stage and severity of illness and to screen for medical and mental disorders.
- A treatment plan is developed.
- The treatment professional or program is accountable for the treatment and for referring the client to additional services, if necessary.
- The treatment professional or program maintains contact with the client until recovery is completed.

According to the policy statement adopted by these treatment professionals' associations, mutual-help groups are an important component of treatment, but they cannot substitute for substance abuse treatment as outlined above.

What Constitutes IOT?

Although IOT traditionally has consisted of at least 9 hours of treatment per week, usually delivered in three 3-hour sessions, some programs have substantially longer hours and others provide only 6 contact hours per week. The consensus panel agrees that a program that schedules treatment daily, for 6 hours per day, should be considered a partial hospitalization program. But does such a program differ by kind or just by degree from an IOT program? At what point does an IOT service become a partial hospitalization program? Programs in which clients attend sessions 9 hours per week are clearly more intensive than once-a-week outpatient programs. But where does outpatient end and IOT begin? According to ASAM's Patient Placement Criteria, IOT programs provide 9 or more hours of structured programming per week; ASAM does not specify a minimum duration of treatment (Mee-Lee et al. 2001).

This TIP is intended to be equally useful to all IOT programs, regardless of the number of contact hours per week. But for the discussions and guidelines in this TIP to be meaningful, IOT must be delimited. The consensus panel agreed that IOT has the following features:

- **Contact hours per week:** 6 to 30
- **Stages:** Stepdown and step-up stages of care that vary in intensity and duration
- **Duration:** Minimum of 90 days followed by outpatient continuing care
- **Core features and services:**
  - Program orientation and intake
  - Comprehensive biopsychosocial assessment
  - Individual treatment planning
  - Group counseling
  - Individual counseling
  - Family counseling
  - Psychoeducational programming
  - Case management
  - Integration of clients into mutual-help and community-based support groups
  - 24-hour crisis coverage

- Medical treatment
- Substance use screening and monitoring (urine or breath tests)
- Vocational and educational services
- Psychiatric evaluation and psychotherapy
- Medication management
- Transition management and discharge planning

- **Enhanced services:**
  - Adult education
  - Transportation
  - Housing and food
  - Recreational activities
  - Adjunctive therapies
  - Nicotine cessation treatment
  - Child care
  - Parent skills training

Summary of This TIP

The following topics are covered in this volume:

Chapter 2—Principles of Intensive Outpatient Treatment presents 14 guiding principles of IOT and the research that supports them. The principles combine the findings of substance abuse research with the experiences of practiced clinicians. The principles are drawn from NIDA's *Principles of Drug Addiction Treatment* (National Institute on Drug Abuse 1999), but the chapter focuses on issues that are critical to effective delivery of IOT services.

Chapter 3—Intensive Outpatient Treatment and the Continuum of Care places IOT within a broad substance abuse treatment continuum that includes outpatient treatment and continuing community care. This chapter situates IOT within the framework of ASAM's levels of care and discusses goals, intensity and duration of treatment, treatment setting, and stages for Level I and Level II care. The chapter discusses IOT as both an entry point for substance abuse treatment and a stepdown or step-up level of care for clients and addresses the importance of transitioning clients to continuing community care.

Chapter 4—Services in Intensive Outpatient Treatment Programs describes the core services a program should provide and enhanced services that often are delivered on site or through established links with community-based providers. Core services include group counseling and therapy, individual counseling, psychoeducational programming, pharmacotherapy and medication management, monitoring substance use, case management, 24-hour crisis coverage, induction into community-based support groups, medical treatment, psychiatric screening and therapy, and vocational training and employment services. Enhanced services include adult education, transportation, adjunctive therapies, and parenting classes.

Chapter 5—Treatment Entry and Engagement addresses the complex and critical processes of screening and diagnosis, placement, assessment, and treatment planning. The desired result of these processes is the client's engagement in treatment at the appropriate level of care and the implementation of treatment that addresses his or her needs. This chapter discusses specific steps in the IOT admission process, including engaging and screening the client, assessing barriers to treatment, and attending to crises; it also illustrates them in two case studies.

Chapter 6—Family-Based Services discusses a family systems approach to IOT that acknowledges and supports the important role and influence of family members on treatment outcomes. The chapter includes goals and outcomes of family-based services and strategies for engaging families in treatment. The chapter also describes various types of family services (family education, multifamily groups, family therapy, retreats, support groups) and clinical issues that often arise when including families in treatment,

such as unrealistic expectations and sabotage of the client's recovery.

Chapter 7—Clinical Issues, Challenges, and Strategies in Intensive Outpatient Treatment looks at issues and problems that arise in clinical practice and offers solutions grounded in research and clinical experience. The chapter covers client retention, relapse and continued substance use, family members who abuse substances, group work issues, safety and security, client privacy, conflicting mandates, clients who work, and boundary issues.

Chapter 8—Intensive Outpatient Treatment Approaches provides detailed descriptions of established IOT program models and approaches. The chapter describes 12-Step facilitation, cognitive–behavioral, motivational, therapeutic community, Matrix model, and community reinforcement and contingency management approaches. The descriptions address the key aspects, research outcomes, and strengths and challenges of each approach.

Chapter 9—Adapting Intensive Outpatient Treatment for Specific Populations highlights the flexibility and adaptability of the IOT model to meet the diverse needs of specific populations: those involved with the criminal justice system, women, individuals with co-occurring disorders, and adolescents and young adults. The chapter provides a demographic overview of each group and discusses implications for IOT programming as well as clinical issues and strategies to use with each population.

Chapter 10—Addressing Diverse Populations in Intensive Outpatient Treatment examines the importance of cultural competence to substance abuse treatment. Reviewing research that supports the need for individualized treatment, the chapter describes principles for the delivery of culturally competent services and explores topics of special concern: foreign-born clients, women from other cultures, and religious considerations. Sketches of diverse populations include Hispanics/Latinos; African-Americans; Native Americans; Asian Americans and Pacific Islanders; persons with HIV/AIDS; lesbian, gay, and bisexual individuals; persons with physical or cognitive disabilities; rural populations; individuals who are homeless; and older adults. The sketches describe each group's demographic characteristics, statistics on substance use, clinical considerations, and implications for IOT. A chapter appendix contains an extensive list of resources on culturally competent treatment and on treating members of each population.

2 Principles of Intensive Outpatient Treatment

In This Chapter...

Principle 1: Make Treatment Readily Available

Principle 2: Ease Entry

Principle 3: Build on Existing Motivation

Principle 4: Enhance Therapeutic Alliance

Principle 5: Make Retention a Priority

Principle 6: Assess and Address Individual Treatment Needs

Principle 7: Provide Ongoing Care

Principle 8: Monitor Abstinence

Principle 9: Use Mutual-Help and Other Community-Based Supports

Principle 10: Use Medications if Indicated

Principle 11: Educate About Substance Use Disorders, Recovery, and Relapse

Principle 12: Engage Families, Employers, and Significant Others

Principle 13: Incorporate Evidence-Based Approaches

Principle 14: Improve Program Administration

This chapter presents 14 principles that integrate the findings of addictions research with the opinion of the consensus panel. By synthesizing research and practice, the consensus panel will assist clinicians in applying these principles to the clinical decisions they face daily. The 14 principles are expressed throughout this TIP in the form of specific recommendations. They are summarized here to provide a concise overview of effective intensive outpatient treatment (IOT) principles.

The *Principles of Drug Addiction Treatment: A Research-Based Guide* (National Institute on Drug Abuse 1999) offers a valuable starting point for the principles that are described in this chapter. The National Institute on Drug Abuse (NIDA) principles pertain to the full spectrum of addiction treatment modalities, not only to IOT. The consensus panel chose to accentuate the principles that are critical to effective IOT.

The 14 principles described in this chapter are

1. Make treatment readily available.
2. Ease entry.
3. Build on existing motivation.
4. Enhance therapeutic alliance.
5. Make retention a priority.
6. Assess and address individual treatment needs.
7. Provide ongoing care.
8. Monitor abstinence.
9. Use mutual-help and other community-based supports.
10. Use medications if indicated.
11. Educate about substance abuse, recovery, and relapse.
12. Engage families, employers, and significant others.
13. Incorporate evidence-based approaches.
14. Improve program administration.

Principle 1: Make Treatment Readily Available

Accommodate a Wide Spectrum of Clients Who Are Substance Dependent

Clinical research and practice have established that IOT is an effective and viable way for individuals with a range of substance use disorders to begin their recovery. In the 1980s, it commonly was believed that only clients who were relatively high functioning, employed, and free of significant co-occurring psychiatric disorders could benefit from IOT and that IOT was not effective with clients who were compromised by significant psychosocial stressors such as homelessness or co-occurring disorders. Today substantial research and clinical experience indicate that IOT can be effective for clients with a range of biopsychosocial problems, particularly when appropriate psychiatric, medical, case management, housing, and other support services are provided.

IOT programs have adjusted successfully to the challenges of working with many special population groups that include

- Clients who are economically disadvantaged (Gruber et al. 2000; Milby et al. 1996)
- Clients who are psychiatrically compromised (Drake et al. 1998*a*, 1998*b*; Rosenheck et al. 1998)
- Pregnant women (Eisen et al. 2000; Howell et al. 1999)
- Individuals involved with the criminal justice system and other clients coerced into treatment

IOT programs have modified their treatment models to be responsive to the needs of adolescents (Jainchill 2000) and women with children (Nardi 1998; Volpicelli et al. 2000). In addition, panel members have described the benefits of IOT programs with culturally specific components for Native American and Spanish-speaking clients and IOT services for clients at various stages of treatment readiness. The unique needs of specific client populations often can be met in IOT by adding services and creating linkages with other service providers.

Comparing Inpatient Treatment With Intensive Outpatient Treatment

Several studies comparing intensive outpatient treatment with residential treatment have found no significant differences in outcomes (Guydish et al. 1998, 1999; Schneider et al. 1996). Finney and colleagues (1996), however, in a review of 14 studies, found that the available evidence tended to favor inpatient slightly over outpatient treatment. The consensus panel has concluded that clients benefit from *both* levels of care and that comparing inpatient with outpatient treatment is potentially counterproductive because the important question is not which level of care is better but, rather, which level of care is more appropriate at a given time for each client. Matching clients with enhanced services also improves client outcomes. McLellan and colleagues (1998) found that compared with control subjects, clients with access to case managers who coordinated medical, housing, parenting, and employment services had less substance use, fewer physical and mental health problems, and better social function after 6 months. It is in the best interest of clients to have a broad continuum of treatment options available. Some clients entering IOT may be able to engage in treatment immediately, whereas others may need referral to a long-term residential program or a therapeutic community. Some clients can be detoxified successfully in an ambulatory setting, whereas others need residential services to complete detoxification successfully.

Principle 2: Ease Entry

Make Access to Treatment Straightforward and Welcoming

IOT programs need to examine policies and procedures to remove unnecessary hurdles in the admission process. From the moment a client or family member first contacts the program, efforts should be made to communicate that IOT exists to serve the client. Delays in the admission process contribute significantly to premature dropout from treatment (Festinger et al. 2002). IOT programs should strive to make the initial appointment available on demand.

Programs should address the following:

- Can the admission process be streamlined without hurting revenues?
- Are the program's hours convenient for clients?
- How can the program facilitate transportation for clients?
- How can the program accommodate clients with childcare responsibilities?
- Is the program individualizing treatment for each client?

The initial encounter with the IOT program should help the client feel like a welcomed participant who is responsible for his or her recovery. IOT programs need to develop a strong customer-focused orientation, making entry into treatment a positive and therapeutic experience.

Principle 3: Build on Existing Motivation

Employ Strategies That Enhance the Client's Motivation

One of the oldest, yet still surviving, misconceptions in the substance abuse treatment field is the notion that people have to "hit bottom" before they can be helped. Studies indicate that individuals who enter treatment for "the wrong reasons" (e.g., complying with external pressures) have outcomes that are comparable with outcomes of those who come into treatment for the "right reasons" (e.g., personal commitment to recovery) (Lawental et al. 1996).

Internal or external pressures drive people to enter treatment. Reasons include negative consequences related to substance use such as an arrest for driving under the influence, pressure from family or friends, fear that substance use is out of control, despair, job insecurity, or a trauma. An IOT program should accept that a client's presence in its office indicates some desire for treatment services.

Regardless of how well or poorly motivated clients appear at treatment entry, their motivation is likely to waver repeatedly over time. Both IOT programs and clients benefit when counselors keep clients mindful of what led them to treatment. Counselors should try to understand what clients care about and connect client concerns with addressing substance use. For example, if a client talks frequently about her daughter, the counselor might ask the client to consider how substance use affects her relationship with the child.

Because of the central importance of motivation in substance abuse treatment, strategies to enhance and maintain client motivation have been a priority in substance abuse research. Two well-researched approaches offer insights into and strategies for maximizing client motivation:

- Contingency management and related behavioral interventions use incentives to increase client retention in treatment and abstinence. Contingency management in addiction treatment has been studied for more than 30 years, but recent studies have focused on how its principles can be applied in community-based settings (Budney and Higgins 1998; Higgins and Silverman 1999; Katz et al. 2001; Kirby et

al. 1999*a;* Petry 2000). These behavioral intervention studies show that motivation is negotiable and can be increased when incentives are applied strategically and systematically. IOT programs are encouraged to find creative ways to use incentives to increase treatment adherence and enhance outcomes.

- Motivational enhancement and interviewing are techniques whereby the counselor responds to client denial and resistance by proposing thoughtful and detailed strategies that are designed to increase client readiness to change (CSAT 1999*c;* Miller and Rollnick 2002; Prochaska and DiClemente 1984). The approach is based on the theory that clients being treated for substance use disorders go through five stages of change: precontemplation, contemplation, action, relapse, and maintenance. Client resistance to treatment indicates that the counselor may be attempting to move the client to the next stage too quickly.

Principle 4: Enhance Therapeutic Alliance

Implement Strategies That Build Trust Between Counselor and Client

In treating mental and substance use disorders, research repeatedly has found one factor to be particularly important in influencing positive outcomes: therapeutic alliance (Martin et al. 2000). In fact, therapeutic alliance is one of the few aspects of treatment that consistently has been linked with increased retention in treatment and improvement in a variety of treatment outcomes. The achievement and maintenance of therapeutic alliance are high priorities in treatment.

Therapeutic alliance has four components (Gaston 1991):

- The client's capacity to work on his or her problem
- The client's emotional bond with the therapist
- The therapist's empathic understanding of the client
- The agreement between client and therapist on the goals and tasks of treatment

Therapeutic alliance tends to be enhanced when clinicians are active listeners, empathic, and nonjudgmental and approach treatment as an active collaboration (Mercer and Woody 1999).

Clinical supervisors should consider the counselors' ability to establish and maintain a therapeutic alliance when hiring and evaluating staff. Staff training and supervision should emphasize consistently that therapeutic alliance is an important element of any clinical interaction. Performance monitoring and quality improvement activities can capture and measure data on therapeutic alliance, so staff members can improve their skills at fostering this important treatment element (see CSAT 2006*f*).

Principle 5: Make Retention a Priority

Place a Premium on Retaining Clients

Early termination of treatment harms the client and staff morale. When clients drop out of treatment prematurely, they are at increased risk of relapse. Completing a prescribed treatment episode is associated with better outcomes, regardless of the length of the treatment (Gottheil et al. 1998).

Given the large number of clients who drop out in the first few weeks of treatment, programs should use strategies and approaches that ensure that clients will complete treatment, such as conducting preadmission interviews (Martino et al. 2000), delivering phone reminders and mailed reminders,

using phone orientations, and decreasing the initial call-to-appointment delay (Stasiewicz and Stalker 1999).

A major strength of IOT is that clients have the opportunity to cope with their illness and make changes in their behavior while living at home. Individual differences in how quickly clients adopt new behaviors call for clinical sophistication and flexibility on the part of counselors and the program as a whole. It can be frustrating when clients do not accept immediately the clinical approach that the IOT program is using. Clients can be frustrated when they are forced into making major lifestyle changes that do not yet make sense to them. Under such circumstances, clients may drop out. Programs need counseling approaches that help clients move toward higher levels of healthy functioning.

Principle 6: Assess and Address Individual Treatment Needs

Match Treatment Services to Clients' Needs

At intake, treatment providers gather preliminary information from clients; then, shortly after admission, programs typically complete a comprehensive biopsychosocial assessment. Many programs administer standardized assessments, such as the Addiction Severity Index (McLellan et al. 1992*a*, 1992*b*) as well as other specific and multidomain assessments. After collecting detailed information about clients' histories and future goals, programs need to use this information to tailor treatment services to clients.

When clients have unmet psychiatric, medical, legal, housing, social, family, or other personal needs, their ability to focus on recovery can be compromised. When programs match the individual treatment needs of clients to treatment services that address those needs, outcomes improve (Hser et al. 1999; McCaul et al. 2001; McLellan et al. 1998, 1999). NIDA's *Principles of Drug Addiction Treatment* notes that "matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society" (National Institute on Drug Abuse 1999, p. 3). IOT programs need to find increasingly efficient strategies for assessing treatment needs and implementing individualized care plans.

The achievement and maintenance of therapeutic alliance are high priorities in treatment.

Principle 7: Provide Ongoing Care

Employ a Chronic Care Model, Adjusting Intensity According to Clients' Needs

A substance use disorder is a complex biopsychosocial illness that is not amenable to a quick fix. In addition to their substance use disorders, clients often have significant psychiatric disorders, criminal involvement, histories of physical and sexual trauma, serious medical illnesses, or profound economic challenges or are homeless. IOT programs contribute to society when they successfully assist clients in improving their ability to function in the community, in the workplace, and in their families. The successful initiation and maintenance of this transformation require sustained and conscientious efforts by the client, his or her support system, and a clinical team.

Substance abuse is a chronic illness similar in many respects to other chronic diseases

such as asthma, diabetes, and hypertension (McLellan et al. 2000). During the early phase of treatment, intensive interventions may be required, including hospitalization. As the client's condition changes, the intensity of treatment gradually can be increased or decreased depending on the client's condition. Eventually client care may be reduced to periodic checkups that evaluate the client's status and adjust treatment accordingly. A substance use disorder often is treated as if it were an acute illness that responds to a brief, acute course of treatment. Frequently, a 6-week IOT experience is not followed by a stepped-down phase of counseling sessions. For many clients, this abrupt shift from intensive treatment to discharge is destabilizing. Because substance abuse is a chronic condition and relapse is always a possibility, IOT programs are encouraged to examine how they can provide smoother stepdown processes and continuing care services that are responsive to the chronic nature of substance use disorders.

Following their successful completion of an intensive phase of treatment, clients should be evaluated for their readiness to be transferred to less intensive levels of care. Gradually, clients should be transitioned from several therapeutic contacts per week to weekly contact to semimonthly contact and so on. The concept of graduation should be reframed to convey clearly—as it is in colleges and universities—not an ending but a commencement or a new beginning.

Principle 8: Monitor Abstinence

Recognize the Progress That Clients Make in Achieving and Maintaining Abstinence

Programs might consider requiring 30 days of abstinence before transitioning clients to a less intense level of care because extended abstinence is associated with positive long-term outcomes (McKay et al. 1999). Although it is true that not all clients readily can achieve abstinence without relapsing a few times, it also is true that outcomes are best for those clients who have stopped using drugs and have submitted a drug-free urine sample before entering treatment (Ehrman et al. 2001). To monitor abstinence, IOT programs should use urine drug screens, Breathalyzer™ tests, or other laboratory tests to confirm self-reported abstinence. Urine drug screens can be an effective adjunct in treatment and can contribute to improved treatment outcomes (National Institute on Drug Abuse 1999). Although cost considerations may limit the frequency of urine drug screens and Breathalyzer tests, the consensus panel strongly encourages the use of these objective measures of abstinence.

Principle 9: Use Mutual-Help and Other Community-Based Supports

Assist Clients in Successfully Integrating Into Mutual-Help and Other Community-Based Support Groups

Participation in mutual-help programs, such as 12-Step programs and treatment programs that facilitate 12-Step membership, is associated with better outcomes than participation in types of treatment that do not facilitate 12-Step membership (Humphreys et al. 1997; Moos et al. 1999; Project MATCH Research Group 1997; Vaillant 1983; see McCrady and Miller 1993, for a review of the Alcoholics Anonymous [AA] research literature). Clients who become involved in 12-Step programs after they step down from IOT tend to do significantly better than those who do not participate in such programs (Moos et al. 1999). IOT programs should facilitate clients' becoming integrated

successfully into healthy, community-based mutual-help groups, such as AA (www.alcoholics-anonymous.org) and Narcotics Anonymous (NA) (www.na.org), during treatment. IOT programs should assist clients directly in locating a home group and a sponsor and in becoming oriented to the culture of 12-Step programs.

It is not sufficient simply to refer clients to AA or other 12-Step groups. Just as a physician works with patients to find the right medication and dosage, counselors need to help clients identify the right type of meeting and frequency of attendance (Forman 2002). Just as patients often have unwanted side effects from medications, particularly when they first start taking them, clients who begin attending 12-Step and other mutual-help groups often experience some minor side effects. IOT programs can help clients minimize the negative side effects by providing orientation and support as clients adjust to this important treatment element. (There are many 12-Step meetings for the family, such as Al–Anon/Alateen [www.al-anon.alateen.org] and Nar-Anon [naranon.com], as well as groups for compulsive behaviors such as sex, gambling, spending, and eating.)

Many individuals who are substance dependent find abstinence through participation in faith-based organizations, and many religious groups offer support for individuals who are seeking recovery. Other individuals have benefited from support groups such as Rational Recovery (www.rational.org), Smart Recovery (www.smartrecovery.org), or Women for Sobriety (www.womenforsobriety.org) that offer an alternative to 12-Step meetings. Giving clients a choice of support groups is empowering because it enables them to make informed decisions.

Principle 10: Use Medications if Indicated

Use Appropriate Medications To Manage Co-Occurring Substance Use and Psychiatric Disorders

A substantial percentage of clients with substance use disorders also have co-occurring psychiatric conditions (Kessler et al. 1996; Marlowe et al. 1995). Psychiatric medications are critically important in the treatment of these co-occurring conditions (Carroll 1996*a*; Drake et al. 1998*b*; Minkoff 1997). Ideally, IOTs should provide psychiatric evaluation and medication management on site. If funding limitations make it impossible to offer this care on site, then efficient and functioning links with mental health providers need to be maintained.

Resistance to the use of psychiatric medications by substance abuse treatment clinicians is gradually being replaced by an appreciation for the valuable role these medications can play when used appropriately. Likewise, both NA and AA historically had been averse to medications of any kind, but both have published statements supporting the appropriate use of medications (Alcoholics Anonymous World Services 1991; Narcotics Anonymous 1998).

> Substance abuse is a chronic illness similar...to other chronic diseases such as asthma, diabetes, and hypertension.

A number of pharmacotherapies have been shown to be effective adjuncts to the treatment of substance abuse. Naltrexone has

been effective with some people who are alcohol dependent (Guardia et al. 2002). However, a multisite study by Krystal and colleagues (2001) found that naltrexone was not effective in treating men with chronic, severe alcohol dependence. Under certain conditions, naltrexone has been effective in treating individuals addicted to opioids (Cornish et al. 1997). Similarly, disulfiram (Antabuse®) has been an effective adjunct in the treatment of alcoholism (O'Farrell et al. 1998). Some IOT programs have implemented treatment tracks for clients maintained on methadone. Buprenorphine (Ling et al. 1998; O'Connor et al. 1998) and buprenorphine combined with naloxone (Fudala et al. 1998; Mendelson et al. 1999) are now available for the treatment of opioid dependence and can be prescribed at IOT programs that have medical personnel on staff.

> Ideally, IOTs should provide psychiatric evaluation and medication management on site.

Principle 11: Educate About Substance Use Disorders, Recovery, and Relapse

Provide Clients and Family Members With Information About Substance Use Disorders, Recovery Skills, and Relapse Prevention

An important task in IOT is educating clients about substance use disorders and the skills they need to live comfortably in recovery. A wealth of accurate, free information about substance abuse and recovery skills is available to clinicians through Web sites and other sources mentioned throughout this volume, but a good starting place is chapter 4 of TIP 33, *Treatment for Stimulant Use Disorders* (CSAT 1999*e*). IOT programs are encouraged to develop recovery curricula for clients (or use one already developed) and to facilitate opportunities for clients to practice recovery skills while in treatment. Substance refusal training, stress management, assertiveness training, relapse prevention, and relaxation training are important behavioral techniques that can be incorporated into IOT programs (Carroll 1998; CSAT 1999*e*; Daley 2001, 2003; Marlatt and Gordon 1985; Mercer and Woody 1999). Clients should be provided with up-to-date information about the biology of substance use disorders, mutual-help programs, and appropriate use of medications.

Given the significant body of information that clients might need to support their recovery, programs are encouraged to explore the use of videotapes, written materials, and Web-based resources to help clients understand addiction and recovery. Consideration should be given to multiple approaches to educating clients, including lectures, discussions, workbook assignments, behavioral rehearsals or role plays, and daily logs or journals. Evaluation processes, such as feedback sessions, that monitor the clients' comprehension of key recovery skills are needed.

Principle 12: Engage Families, Employers, and Significant Others

Include Others Throughout the Treatment Process

The therapeutic involvement of families throughout the recovery process is associated with improved treatment outcomes (Epstein and McCrady 1998; McCrady et al. 1999; O'Farrell and Fals-Stewart 2003; Szapocznik and Williams 2000; White et al.

1998; Winters et al. 2002). Families can be a vital resource and a source of support and encouragement. Conversely, families also can influence the client adversely and undermine recovery. All clients are part of a group that functions as a "family" and as such are subject to the values, traditions, and culture of that family. IOT programs can marshal families' powerful positive influences or counter their negative influences by educating, counseling, and providing therapeutic family services. Referrals to therapists and organizations that provide family therapy should be considered when family therapy is unavailable in the IOT program.

When an individual has been referred for treatment by an employee assistance or student assistance program, representatives of the employer and school can play a potent role in supporting adherence to the treatment plan and ongoing recovery.

Principle 13: Incorporate Evidence-Based Approaches

Seek Out Evidence-Based Training Opportunities and Materials

Over the past 30 years a number of treatment approaches have been developed, tested, and demonstrated to be effective in a variety of settings (see chapter 8 for more information). These approaches include

- Cognitive–behavioral therapy (Carroll 1998)
- Motivational enhancement therapy (CSAT 1999*c*; Miller and Rollnick 2002; Prochaska and DiClemente 1984)
- Individual drug counseling (Mercer and Woody 1999)
- Relapse prevention training (Carroll et al. 1998; Daley 2001, 2003; Daley and Marlatt 1997; Daley et al. 2003)
- Contingency management and incentives (Budney and Higgins 1998; Petry 2000)
- 12-Step facilitation (Nowinski et al. 1992)
- Case management (McLellan et al. 1998, 1999)

IOT programs can adopt methods from these various treatment interventions. NIDA, the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the Center for Substance Abuse Treatment (CSAT) have published manuals about these approaches, and most of these manuals are available free of charge. A number of other evidence-based manuals are listed throughout this TIP, including documents from NIAAA Project MATCH and CSAT's Addiction Technology Transfer Centers and other CSAT publications.

Some counselors who enter the substance abuse treatment profession do not have extensive training. For them, the needed skills are learned on the job. Evidence-based manuals summarize the experience of knowledgeable clinicians and researchers, passing on effective techniques and approaches that have been refined over the years. Not all IOT programs are the same—some achieve better outcomes than others. IOT programs can improve their outcomes by successfully incorporating evidence-based approaches. The consensus panel encourages the use of evidence-based approaches as a means of improving treatment outcomes.

Principle 14: Improve Program Administration

Focus on Financial, Information, and Human Resource Management

Clinicians frequently are promoted into the role of IOT program director without any formal training in how to function as an administrator. The tasks of management differ significantly from those of a clinician, and the transition from one role to the other is not always a smooth or natural one. IOT

managers focus on the program's finances, regulatory compliance, human resource management, information management, administrative report preparation, and a host of other tasks that were not in their list of responsibilities as clinicians. TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), addresses the administrative issues that IOT managers need to master to manage programs effectively.

3 Intensive Outpatient Treatment and the Continuum of Care

In This Chapter...

Overview of a Continuum of Care

Conceiving of a Continuum of Care

Key Aspects of IOT (Level II)

Key Aspects of Outpatient Treatment (Level I)

Continuing Community Care

Overview of a Continuum of Care

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

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

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

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

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

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

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

Conceiving of a Continuum of Care

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

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

IOT Programs and the Continuum of Care

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

- **An entry point into substance abuse treatment.** The client comes to the IOT program, an assessment reveals that the client would benefit from IOT (see chapter 5 of this TIP for placement criteria), a treatment plan is developed, and services are begun.

- **A stepdown level of care.** The client is transitioned to the IOT program from an inpatient or residential facility. In this case, the client may have been stabilized in a hospital facility or residential treatment program and now needs intensive treatment services to achieve or maintain abstinence as well as address other problems.

- **A step-up level of care.** The client is referred to the IOT program if he or she has been unsuccessful in outpatient treatment or continuing community care and is assessed as needing an intensive and structured level of care to regain abstinence, work on relapse prevention skills, and address other issues.

Assisting the Client Along the Continuum

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

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

organization, coordination and case management needs increase.

Key Aspects of IOT (Level II)

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

IOT Goals

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

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

Intensity of Treatment

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

Duration of Treatment

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

Treatment Settings

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

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

Stages of Treatment

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

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

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

Stage 1—Treatment engagement

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

Stage 2—Early recovery

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

Transition to Outpatient Treatment

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

Compatible models of care

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

Exhibit 3-1

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

Goals of the treatment engagement stage:

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

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

Counselor activities of the treatment engagement stage:

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

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

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

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

Exhibit 3-2

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

Goals of the early recovery stage:

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

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

Counselor activities of the early recovery stage:

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

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

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

Transition planning

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

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

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

Key Aspects of Outpatient Treatment (Level I)

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

Outpatient Treatment Goals

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

Comparison of IOT and Outpatient Treatment

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

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

Stepdown Treatment

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

Stage 3—Maintenance

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

Transfer to Continuing Community Care

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

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

Continuing Community Care

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

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

Services in Continuing Community Care

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

Stage 4—Community support

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

Exhibit 3-3

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

Goals of the maintenance stage:

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

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

Counselor activities of the maintenance stage:

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

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

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

Exhibit 3-4

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

Goals of the community support stage:

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

Duration of the community support stage: Years, ongoing

Counselor activities of the community support stage:

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

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

Intensity and Duration of Continuing Community Care

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

4 Services in Intensive Outpatient Treatment Programs

In This Chapter...

Core Services

Enhanced IOT Services

IOT Services: A Case Illustration

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

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

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

Core Services

Group Counseling and Therapy

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

Exhibit 4-1

Core and Enhanced Services for IOT Programs

Core IOT Services Provided On Site

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

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

Enhanced IOT Services
Delivered On Site or Via Functional Linkages

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

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

Types of groups

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

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

Exhibit 4-2

Groups Conducted in Intensive Outpatient Treatment

Psychoeducational groups

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

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

Skills-development groups

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

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

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

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

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

(continued)

Exhibit 4-2 (continued)

Groups Conducted in Intensive Outpatient Treatment

Interpersonal process groups

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

Key aspects of groups

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Individual Counseling

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

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

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

Psychoeducational Programming

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

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

Pharmacotherapy and Medication Management

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

Exhibit 4-3

Typical Sequence of Topics Addressed in Psychoeducational Group

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

(continued)

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

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

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

Exhibit 4-3 (continued)

Typical Sequence of Topics Addressed in Psychoeducational Group

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

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

Ambulatory detoxification

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

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

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

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

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

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

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

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

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

Pharmacotherapies for addiction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Monitoring Alcohol and Drug Use

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

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

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

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

Case Management

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

Qualifications and Roles of Case Managers

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

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

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

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

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

Exhibit 4-4

Case Management Services

Functions

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

Models

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

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

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

Research outcomes and findings

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

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

24-Hour Crisis Coverage

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

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

Community-Based Support Groups

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

Exhibit 4-5

Examples of 24-Hour Crisis Coverage Implementation

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

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

Key aspects of community support groups

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

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

The 12-Step fellowship

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

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

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

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

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

Alternatives to community-based 12-Step groups

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

Medical Treatment

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

Psychiatric Examinations and Psychotherapy

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

Vocational Training and Employment Services

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

Exhibit 4-6

Alternatives to Traditional 12-Step Groups

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

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

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

Enhanced IOT Services

Adult Education

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

Transportation Services

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

Housing and Food

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

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

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

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

Recreational Activities

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

Adjunctive Therapies

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

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

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

Nicotine Cessation Treatment

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

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

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

Licensed Child Care

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

Parent Skills Training

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

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

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

IOT Services: A Case Illustration

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

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

Exhibit 4-7

Key Features of a Hospital-Based Suburban IOT Program

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

(continued)

Exhibit 4-7 (continued)

Key Features of a Hospital-Based Suburban IOT Program

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

  - Partial hospitalization (ASAM Level II.5) for up to 10 hours per day for medically monitored ambulatory detoxification.
  - Intensive outpatient (ASAM Level II.1) for 3 hours per day for rehabilitation. Clients initially are seen 5 days per week. The frequency gradually is tapered to once weekly for a total of 10 to 30 sessions, depending on clinical need. Separate individual and family sessions also are scheduled.
  - Nonintensive outpatient (ASAM Level I) once weekly for 2 hours for continuing care for up to 2 years.

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

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

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

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

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

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

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

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

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

Appendix 4-B. Induction Protocol for Disulfiram

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

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

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

Exhibit 4-8

A Protocol for Ambulatory Detoxification and Disulfiram Induction

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

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

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

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

Dosage Levels

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

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

Contraindications and Cautions

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

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

Monitoring Procedures

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

5 Treatment Entry and Engagement

In This Chapter...

Elements of Engaging the Client in IOT

Collect Screening Information

Assessing Barriers to Treatment

Crises and Emergencies

Components of the IOT Admission Process

Sample Treatment Plans

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

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

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

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

A major challenge of the admission process is to balance a rapid and empathic response to a client's request for treatment with the need to obtain information about many aspects of the client's life that can affect the treatment response. The need for detailed assessment information must not impinge on the main admission activities: to engage the individual in treatment, ameliorate immediate crises, and remove barriers to treatment. Attention needs to be given to clinicians' interviewing styles and the program's intake procedures, as well as to the content and sequence of the screenings or assessments conducted.

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

Elements of Engaging the Client in IOT

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

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

Program Surroundings

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

Create a welcoming environment

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

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

Ensure availability

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

Communicate cultural competence

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

Reinforce privacy and confidentiality

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

Initial Response Procedures

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

Ensure a rapid response

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

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

Convey respect

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

Intake Interviews

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

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

Use informal approaches for initial interviews

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

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

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

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

The counselor can offer an explanation such as, "We started talking rather informally about what brought you to treatment. Now, we need to shift gears and complete some forms to gather more detailed information. When we are finished, we can go back to discussing questions you still may have about treatment and this program."

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

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

Adjust interviewing styles

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

Collect Screening Information

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

Exhibit 5-1

Effective Interviewing Techniques

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

Record Basic Information

The following information often is documented on an intake form:

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

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

Use Short Screening Instruments To Document a Substance Use Disorder

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

Not all screening instruments perform equally well for specific populations. A study comparing the effectiveness of eight frequently used screening instruments for ascertaining substance use disorders used the Structured Clinical Interview for Diagnosis of DSM-IV, Version 2, Substance Abuse Disorders module (Peters et al. 2000), a well-accepted, comprehensive diagnostic criterion for measuring substance-related disorders. The study found that only three instruments had high rates of accuracy, positive predictive value, and sensitivity, in addition to the capacity to distinguish between substance abuse and dependence disorders. These three instruments are

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

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

Assessing Barriers to Treatment

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

Intoxication or Withdrawal

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

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

Each IOT program needs guidelines that indicate whether sick or intoxicated persons can be observed and assisted at the facility, should be transferred immediately to a more intensive level of care (e.g., detoxification facility, hospital emergency room), or are ready to return home. IOT program medical staff members must make the decision about who can be admitted safely. If medically trained staff members are unavailable on site to assess clients and to make these decisions, the IOT program should have access to immediate medical consultation or emergency treatment. Direct affiliations must be in place with other levels of care in the local alcohol and drug treatment system and with mental health facilities. If clients are too sick or intoxicated to transport themselves, the IOT program must arrange safe transportation home or to another treatment facility.

Acute or Chronic Medical Conditions

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

Psychiatric Stability

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

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

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

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

Physical Disabilities or Cognitive Limitations

The consensus panel recommends that IOT programs conduct early screening for physical, sensory, and cognitive disabilities because these conditions may affect clients' ability to participate in treatment. Modifications in the treatment regimen or environment can help these clients function well in treatment.

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

Exhibit 5-2

ABC Model for Psychiatric Screening

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

Adapted from CSAT 1994*b*, p. 16.

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

Crises and Emergencies

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

Potential for Violence or Suicide

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

Immediate Threats to the Client's Safety

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

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

Components of the IOT Admission Process

Admitting a potential client to substance abuse treatment entails

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

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

Eligibility

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

Apply patient placement criteria

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

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

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

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

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

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

Assess readiness for change

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

Exhibit 5-3

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

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

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

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

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

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

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

Source: Mee-Lee et al. 2001.

Exhibit 5-4

Brief Screening Instruments That Assess Motivational Stage

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

More information about the psychometric properties, target populations, scoring, utility, ordering, and other references for these instruments can be found at www.niaaa.nih.gov by typing "Alcoholism Treatment Assessment Instruments" and clicking on Search.

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

Beginning Treatment

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

Provide for detoxification

Detoxification, if necessary, should be accomplished before a client is admitted into the full IOT program. Clients experiencing symptoms of mild withdrawal from alcohol, sedative-hypnotics, opioids, or stimulants can undergo ambulatory detoxification in a Level II.5: Partial hospitalization or day treatment program (see exhibit 5-5). To undertake ambulatory detoxification of these clients, IOT programs should offer 20 hours of clinical programming per week and have direct access to medical services.

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

Exhibit 5-5

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

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

Source: Mee-Lee et al. 2001.

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

- Have a slow response (more than 2 hours) or allergic reactions to the medications used for detoxification
- Have unstable vital signs, confusion, or delirium
- Have serious and unstabilized medical disorders (e.g., heart, lung, liver disease; seizure disorders; HIV infection)
- Are older adults or adolescents
- Have a history of serious psychiatric disorders and complications
- Have a history of seizures, delirium, or psychosis during previous withdrawals
- Have a history of drug overdoses
- Abuse alcohol, sedatives, barbiturates, and anxiolytics in combination
- Have an unstable, unsupportive, or unsafe home environment without supportive friends or relatives to monitor medication use

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

(Fuller and Gordis 1994). The CIWA-Ar is not copyrighted and is available from the ASAM's Web site (www.asam.org) by typing "Addiction Medicine Essentials" and clicking on Search. Appendix 4-B of this TIP provides additional resources for the clinician regarding ambulatory detoxification. TIP 45, *Detoxification and Substance Abuse Treatment* (CSAT 2006*e*), provides additional information on detoxification.

Program staff should work with clients to plan a treatment schedule around available transportation.

Conduct informal orientation

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

Conduct formal orientation

A formal orientation offers an opportunity for staff members, including the program director, to introduce themselves and welcome new clients, reinforce clients' motivations to remain in treatment, and induct clients into appropriate roles. New clients need to hear—and believe—that they are respected as individuals and will be involved in planning their treatment. Although the primary treatment objective is to assist clients in achieving and maintaining abstinence, clients also need to know that the program will help them accomplish other positive and realistic goals (e.g., getting off probation, regaining child custody, enrolling in a vocational school). An orientation also should help clients allay any fears they may have about treatment. Ample time needs to be left in orientation sessions to answer questions. Topics for program orientation include

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

Address immediate barriers to treatment entry

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

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

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

Comprehensive Biopsychosocial Assessment

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

Understand purposes of assessment

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

Develop assessment methods and protocols

IOT clinicians gather evidence about each client's problems through

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

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

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

Multidimensional Assessment

Client records, which are a crucial part of multidimensional assessment, may include notes from the intake interview, toxicology results, reports from the referring agency or previous treatment providers, findings from other clinicians, self-administered screening tests, and specially ordered diagnostic consultations. To round out the assessment, some IOT programs design intake screening and comprehensive assessment forms, and others use standardized, multidimensional assessment instruments as the basic admission document. The ASI is a commonly used, multidimensional assessment instrument that can serve as a basic assessment document. Together, these clinical impressions and assessment instruments provide the foundation for initial treatment plans.

Using the Addiction Severity Index

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

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

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

Summary of Assessment Findings

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

Compile the summary report

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

Present assessment findings to the client

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

The counselor notes which findings seem most disturbing to the client. The counselor tries to elicit the client's reactions to the effects of substance abuse on his or her health, relationships, and legal and employment statuses. These reactions direct the clinician to the problems the client is most interested in solving. They also point out discrepancies between the client's values or goals and the adverse effects of substance abuse. These concerns can be highlighted in the treatment process to enhance motivation for change.

The Treatment Plan

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

Prepare the treatment plan

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

An Emphasis on the Client's Prioritizing Problems

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

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

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

Most treatment plans also incorporate the following elements:

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

Plan for continuing community care

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

Sample Treatment Plans

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

Sample Case 1

Clinical summary

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

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

Lewis has been incarcerated for a drug charge for the past year; he will be in prison for at least the next 5 years and will be unable to provide support for his children or for Alice. Alice had moved back with her mother when Lewis began his incarceration, but her mother threw Alice out of her house after Alice stole money from her mother's purse. Alice has been living with anyone who will take her in for the last 9 months.

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

Alice has a history of criminal justice system involvement, mostly for prostitution. Her current probation officer has told her if she does not seek treatment, she will be violating her probation. Alice has entered treatment twice before but dropped out both times after only a few sessions. She is now shocked at the loss of her children and terrified that she could do some long jail time. She believes she is ready to change her life and appears motivated for treatment. Although her mother is angry at Alice and appalled at the placement of her grandchildren into foster care, she has agreed to let Alice move back as long as she gets into and stays in treatment. Her mother stresses, however, that this cannot be a long-term living situation for Alice. The probation officer referred Alice to a local IOT program, where she was evaluated and admitted.

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

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

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

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

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

Master problem list

- Children, ages 8 and 4, removed from custody and placed in foster care
- Crack cocaine and alcohol dependence
- Ongoing illegal activities and a pending criminal charge
- No permanent residence
- No apparent job skills or work history
- Lack of positive support system
- Strained relationship with mother and family members
- No recent physical or dental examination; at high risk for HIV, STDs, and hepatitis
- History of dropping out of substance abuse treatment
- Possible depression, but never evaluated (family history of substance use disorders and suicide)

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

Short-term goals

1. **Address cocaine and alcohol dependence**
   Objective: Help client understand the importance of abstaining from all psychoactive drugs
   Action: Enroll client in appropriate psychoeducation and early recovery groups in the IOT program; encourage her to attend mutual-help groups in the community (AA and Cocaine Anonymous [CA]); regularly monitor urine and breath drug tests
   Target date: Immediately
   Responsible persons: Client, counselor

2. **Engage client's mother in treatment**
   Objective: Increase emotional support for client's recovery
   Action: Explore mother's interest in attending family education group and participating in family therapy
   Target date: Contact mother immediately, with client's consent; if mother is willing, begin family education immediately
   Responsible persons: Mother, client, primary counselor, family counselor

3. **Establish communication with child welfare services and client's children**
   Objective: Begin process of family reunification; facilitate reasonable visitation schedule

Action: Obtain client consent to contact child welfare representative to ascertain conditions for return of child custody and negotiate an action plan (This plan may include regular reports about the client's treatment progress, having the client attend parenting classes, and having the client participate in regular, observed visits with her children.)
Target date: Within 2 weeks
Responsible persons: Client, case manager, child welfare representative

4. **Establish communication with criminal justice system**
Objective: Avoid client's probation violation; seek leniency for client's shoplifting charge
Action: Obtain client consent to contact probation officer; get officer's perspective on client and what conditions may be negotiated (e.g., regular reports to probation officer about treatment attendance and compliance, community service for shoplifting conviction)
Target date: Within 2 weeks
Responsible persons: Case manager, client, probation officer

5. **Obtain medical and dental evaluation**
Objective: Assess client's health; prevent client's potential transmission of infectious diseases
Action: Refer client for medical and dental evaluations, including testing for HIV infection and other drug-related diseases; enroll client in health education group with counseling about HIV testing; encourage the client to stop high-risk behaviors, consent to testing, and follow through on needed medical care
Target date: Within 2 weeks
Responsible persons: Client, case manager, health care coordinator, medical staff

6. **Evaluate psychological functioning**
Objective: Evaluate client's mental health; assess her suicide risk; treat her depression if necessary
Action: Observe signs of continuing depression after client is stabilized; refer her for psychological evaluation, if indicated
Target date: Within 30 days; ongoing
Responsible persons: Client, primary counselor, clinical supervisor, consulting psychologist or psychiatrist, medical director

Intermediate goals

1. **Sustain abstinence from cocaine and alcohol**
Objective: Reinforce treatment progress; assist client in meeting other goals by sustaining abstinence
Action: Help client identify cues for drug use; teach client relapse prevention techniques; monitor drug test results; encourage continuing participation in AA or CA groups in the community
Target date: Ongoing
Responsible persons: Client, case manager, medical staff, group counselor

2. **Obtain transitional housing**
Objective: Move client into safe, stable housing that supports continuing recovery
Action: Obtain client consent to contact local transitional housing program to arrange for placement and daily transportation to IOT program
Target date: Initiate within 60 days; ongoing
Responsible persons: Client, case manager, case aide, transitional housing admission staff

3. **Undergo vocational testing; begin working toward a general equivalency diploma (GED)**
Objective: Enhance client's employability and self-esteem
Action: Refer client to an educational specialist for testing; have client attend GED classes

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

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

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

Long-term goals

1. **Sustain abstinence from cocaine and alcohol**
Objective: Assist client in meeting life goals by remaining abstinent
Action: Encourage ongoing participation in AA or CA groups in the community
Target date: Ongoing
Responsible persons: Client

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

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

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

Sample Case 2

Clinical summary

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

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

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

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

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

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

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

Integrated problems list

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

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

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

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

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

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

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

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

Initial Treatment Plan

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

(continued)

Initial Treatment Plan (continued)

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

Appendix 5-A. Substance Use History Form

Client's Name: Date: Interviewer:

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

* Note if just released from controlled environment.
† Circle observed signs, if any, of currently used drugs:

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

Sources: CSAT 1994*a*, 1994*f*.

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

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

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

- **The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I), Clinical Version**—The SCIDI-I uses the comprehensive "gold standard" for psychiatric diagnoses of not only substance-related disorders but other psychiatric disorders (First et al. 1997). A skilled mental health professional needs 1 hour or more to administer the complete and detailed version, but because the instrument is modular, only 10 minutes is required for a substance abuse or dependence diagnosis.
- **The Substance Dependence Severity Scale (SDSS)**—The SDSS is a semistructured interview that provides current (last 30 days) diagnoses of DSM-IV substance abuse or dependence (Miele et al. 2000). In addition, the SDSS assesses current severity level of dependence and has items that can yield diagnoses using the ICD-10 classification system. The instrument was designed specifically to measure changes in diagnostic severity over time. It measures quantity and frequency of recent drug use and is thereby sensitive to variation in client clinical status. The SDSS requires 30 to 45 minutes to administer. Training typically requires 2 to 3 days but may take longer if staff members have little or no background in clinical diagnosis and assessment. Computerized data entry and scoring programs are available. There are no licensing fees. (Order from New York State Psychiatric Institute, Columbia Presbyterian Medical Center, Department of Research, Assessment and Training, [212] 960-5508; www.nyspi.cpmc.columbia.edu.)
- **Texas Christian University Drug Screen (TCUDS)**—This instrument consists of 25 questions and can be administered and scored in less than 5 minutes. TCUDS often is used with incarcerated persons but is appropriate for the general population. TCUDS quickly identifies individuals who report heavy drug use or dependence (based on the CIDI—see above). TCUDS is available free of charge. (Order from Institute of Behavioral Research, Texas Christian University, TCU Box 298740, Fort Worth, TX 76129; [817] 257-7226; visit www.ibr.tcu.edu.)

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

DSM-IV Diagnostic Criteria for Substance Dependence

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

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

Specify:

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

DSM-IV Diagnostic Criteria for Substance Abuse

A. The individual has a maladaptive pattern of substance use with clinically significant impairment or distress manifested by one or more of the following criteria, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major obligations at work, school, or home
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile, operating a machine when impaired by substance use)
3. Recurrent substance-related legal problems
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about the consequences of intoxication)

B. Symptoms have never met the criteria for substance dependence for this class of substance (i.e., a diagnosis of substance dependence preempts a diagnosis of substance abuse).

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

Six Assessment Domains

Medical status

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

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

Employment or support status

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

- Sources of income, number of dependents, perception of socioeconomic status, and financial solvency or indebtedness
- Eligibility for or receipt of benefits such as Medicaid or Medicare or employer health benefits
- Work history, marketable skills, access to transportation, job qualifications, and satisfaction with job and pay
- History of job terminations, previous referrals to an employment assistance program, and outcomes
- Education, including highest grade completed and educational accomplishments or difficulties
- Attitude toward money and ability to manage money

Patterns of alcohol and drug use

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

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

Criminal history and legal status

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

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

Family and social relationships

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

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

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

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

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

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

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

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

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

- Verbal abuse or belittling of children or wrongly blaming them for the client's mistakes or frustrations
- Taking inadequate safety precautions (e.g., leaving young children alone at home or with underage babysitters, letting them roam by themselves in unsafe places)
- Child's indiscriminate attachment to persons other than the parent or the child's flinching or cowering unnecessarily when the parent is present
- Expressing unrealistic, age-inappropriate behavioral expectations
- Describing children in sexual terms
- Reports of inappropriate punishment of children by oneself or a partner
- Children's consistently unkempt appearance, obvious underweight condition or hunger, or unexplained bruises or other injuries

Psychiatric status

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

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

Questions about the mental health status of clients should determine

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

Other Topics

Sexuality

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

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

Self-concept

The clinician can observe or ask about

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

Recreation and leisure activities

Non-substance-related recreation and leisure activities are important components of sustained recovery. They can remove the client from social pressures to use alcohol and drugs and provide a healthy outlet for new energies. If the client does not have any active recreational interests—and has spent most leisure time in substance-related pursuits—maintaining abstinence may be difficult without assistance in finding appealing alternatives. The counselor can ask the client about

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

Spirituality and personal values

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

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

6 Family-Based Services

In This Chapter...

Planning for Family Involvement

Engaging the Family in Treatment

Family Services

Family Clinical Issues in IOT

Substance use disorders exist within several social contexts, one of which is the family. Family members, whether they are from the family of origin or family of choice, are important forces in a client's life. Each client has a family, a family history, and a family story that play important roles in recovery. Many clients come from substance-using families and have been raised with alcohol abuse or drug use as part of their lives. Addressing this legacy is part of their recovery. In addition, a client's family members often have significant substance use and other psychiatric problems of their own. Intensive outpatient treatment (IOT) programs that take a comprehensive approach to evaluating the family are likely to identify other individuals who would benefit from being admitted to a substance abuse or mental health treatment program. Some family members may be in treatment already. For these reasons, many IOT programs incorporate a family systems approach. Family education, family therapy, and other services are necessary in an IOT program's process so that the contributions and influence of family members support recovery.

A complete discussion of family therapy for substance use disorders in IOT programs is not within the scope of this TIP. This chapter introduces features of family involvement in IOT programs and briefly discusses family therapy as an enhanced service that IOT programs may offer or, more frequently, to which they may refer clients and their families. The Center for Substance Abuse Treatment has developed TIP 39, *Substance Abuse Treatment and Family Therapy* (CSAT 2004*c*), that addresses how a substance use disorder affects the family, how family therapy works to change the interactions among family members, and the integration of family therapy into substance abuse treatment.

Families of people who abuse substances live in a world shaped by substance use. This world may include inconsistent behaviors and few or very rigid rules. Family members may have difficulty expressing their emotions, achieving intimacy, and solving problems. They frequently may experience but may not express anger, shame, guilt,

sadness, and hopelessness. To function, families often subscribe to the following: don't trust, don't feel, and don't talk. The result can be an unhealthy environment in which individuals may be isolated, engage in destructive alliances, be overly involved with other family members, or develop significant medical and stress-related problems.

...family members... are critical to the strength and duration of the client's recovery.

Increasingly, treatment professionals view substance use disorders from a family systems perspective (Crnkovic and DelCampo 1998). Research findings document a relationship between family involvement in treatment and positive outcomes and attest to the need for family-based services (Rowe and Liddle 2003). Family involvement in treatment seems to work equally well for adults and adolescents (Stanton and Shadish 1997). When the family is ready and able to shift from old, negative behaviors to new, healthier ones, family members become collaborators in the treatment process (Edwards and Steinglass 1995). Most IOT programs do not offer couples- or family-based therapies (Fals-Stewart and Birchler 2001). However, potential benefits of family therapy are such that IOT programs should have well-established links with organizations that provide these services.

No matter how alienated family members may be, they are critical to the strength and duration of the client's recovery. Family members are the individuals who were part of the client's life before treatment and will be part of his or her life after treatment. Family-based services that are part of IOT help ensure that family functioning adjusts to and positively influences the recovery of the client.

Planning for Family Involvement

IOT planning for family-based services involves defining the client's family in broad and flexible terms, setting essential goals, and determining the desired outcomes.

Defining the Family

In recent years, the concept and definition of family have broadened significantly to include people who are important to the client. These people can include a spouse, a boyfriend or girlfriend, a same-sex partner, parents, siblings, children, extended family members, friends, co-workers, employers, members of the clergy, and others. The term "family of origin" commonly is used to describe individuals related by blood, such as parents, grandparents, and siblings. The term "family of choice" is used to describe a family created by marriage, partnership, or friendships and other associations.

When determining the client's concept of family, the key is to identify who will be supportive of recovery and who might seek to undermine it. The treatment provider can begin this process by creating a genogram (see appendix 6-A, page 107) to assess the family of origin or choice. Similarly, a social network map (see appendix 6-B, page 109) can help the counselor identify and understand the family of origin and family of choice.

- **Creating a family genogram.** This technique renders the client's family relationships schematically and helps the counselor identify trends or patterns in the family history and understand the client's current situation. As treatment progresses, the genogram is revised to reflect new knowledge and changes in the family (CSAT 2004*c*).
- **Assessing the client's social supports with a social network map.** A social network map displays the links among individuals who have a common bond, shared social status, similar or shared functions,

or geographic or cultural connection. Highly flexible, social networks form and disband on an ad hoc basis depending on specific need and interest. A social network assessment is used in social service arenas, including substance abuse treatment. When the assessment is used in IOT, individuals are identified who can support the client or participate in the treatment process (Barker 1999).

Goals and Outcomes of Family Services

One main goal of involving families in treatment is to increase family members' understanding of the client's substance use disorder as a chronic disease with related psychosocial components. Edwards (1990) states that family-based services can have the following effects:

- **Increase family support for the client's recovery.** Family sessions can increase a client's motivation for recovery, especially as the family realizes that the client's substance use disorder is intertwined with problems in the family.
- **Identify and support change of family patterns that work against recovery.** Relationship patterns among family members can work against recovery by supporting the client's substance use, family conflicts, and inappropriate coalitions.
- **Prepare family members for what to expect in early recovery.** Family members unrealistically may expect all problems to dissipate quickly, increasing the likelihood of disappointment and decreasing the likelihood of helpful support for the client's recovery.
- **Educate the family about relapse warning signs.** Family members who understand warning signs can help prevent the client's relapses.
- **Help family members understand the causes and effects of substance use disorders from a family perspective.** Most family members do not understand how substance use disorders develop or that patterns of behavior and interaction have developed in response to the substance-related behavior of the family member who is in treatment. It is valuable for individuals in the family to gain insight into how they may be maintaining the family's dysfunction. Counselors should help family members address feelings of anger, shame, and guilt and resolve issues relating to trust and intimacy.
- **Take advantage of family strengths.** Family members who demonstrate positive attitudes and supportive behaviors encourage the client's recovery. It is important to identify and build on strengths to support positive change.
- **Encourage family members to obtain long-term support.** As the client begins to recover, family members need to take responsibility for their own emotional, physical, and spiritual recovery.

A comprehensive IOT program views the client as part of a family system. When the family is involved in treatment, the following treatment outcomes are possible:

- The client is encouraged to enter treatment.
- The client is motivated to remain in treatment.
- Relapses are minimized.
- A supportive and healthy environment for recovery is provided.
- Other family members who may need treatment or other services are identified and treated.
- Changes in the family's longstanding dysfunctional patterns of communication, behavior, and emotional expression may protect other family members from abusing substances.

Engaging the Family in Treatment

Difficulties with engaging the family in treatment often are cited as reasons for not using

a family systems approach and, in many cases, substantial obstacles exist. Family members may be resistant, or the client may be ambivalent or object to the family's involvement in treatment. But given the potential benefits associated with taking a family approach to service delivery, engaging the family in treatment is worthwhile.

Strategies To Engage the Family

The following approaches have proved helpful in encouraging families to engage in the treatment of a family member:

- **Include family members in the intake session.** The counselor can involve family members in the treatment process from the beginning. If a family member makes the initial call to the program, the counselor can ask that person to come with the client. If the client calls, the client can be asked to bring a family member. If the client is reluctant at this point, the counselor can gently encourage the client to include family members but should not make it a condition of the person's entry into treatment. In another approach, the counselor can ask, "Who close to you is concerned about your substance use and might be willing to serve as a support to you during your recovery?" The client then might be asked to invite these supportive people to come to the initial intake interview. During the intake interview, family members can be asked to complete a brief written family assessment. A more comprehensive family systems approach can involve multiple private and family interviews. These interviews and other early meetings with the family develop support from a family that is empowered to address systemic issues. Similarly, the initial meeting helps family members learn about substance use disorders, their influence on a family, and the services the program can offer to the family (see exhibit 6-1).
- **Use client-initiated engagement efforts.** The counselor and client collaborate on a plan to engage family members in treatment. The client can be given the opportunity to invite chosen family members to participate in the program. If this effort is unsuccessful, then, with the client's written permission, the counselor telephones, visits, or sends a personal note to the identified family members. Federal confidentiality rules require that client permission be documented (CSAT 2004*b*).
- **Offer a written invitation.** The IOT provider can give the client written invitations, with the clinic's contact information, to deliver to family members. Giving the client

Exhibit 6-1

Suggestions for Engaging Family Members at Intake

- Emphasize the need to gather information from family members.
- State the program's policy about family members' participation in treatment.
- Indicate the program's desire to hear family members' concerns about the client's substance abuse.
- Acknowledge family members' influence over the client and their desire to help.
- Make clear that family members' participation will help the client on the road to recovery.
- Emphasize how the program can help family members maintain a relationship with the client and manage their own feelings (anger, frustration, depression, and hopelessness).

the invitations allows the provider to determine whether the client is willing to involve family members in treatment and which family members the client wants to involve in the process. The invitation briefly describes the treatment program and identifies activities family members will be asked to participate in. For example, a family member may be asked to attend family education sessions, complete an assessment questionnaire, remove all substances from the home (if applicable), participate in family counseling sessions, or attend a celebration of the completion of a treatment phase.

- **Offer incentives.** Incentives may help address recruitment problems. Family members can be provided with coupons (e.g., for pizza, movies) for attending sessions or completing assignments. Refreshments also help family members feel welcome. In addition, providers can facilitate transportation (e.g., arrange carpools) and childcare services and remove other obstacles to family members' participation.
- **Plan picnics or dinners for families.** Multifamily picnics and dinners are a part of some IOT programs and can be scheduled for holidays or weekends. These events can be held on the program's grounds or in nearby parks or community centers and provide a supportive and nonthreatening environment where individuals can have fun and learn about substance use disorders, recovery, and the IOT program. The client and family members are asked to bring a dish, but all are welcome. Immediately after the meal, a counselor conducts an hour-long educational session covering topics such as recovery support groups, family-oriented services, and characteristics of substance use disorders. Participants are told of the educational nature of the sessions when invited.
- **Use community reinforcement training (CRT) interventions.** CRT interventions have improved the retention of family members in treatment and induced people who abuse substances to enter treatment (Meyers et al. 1998, 2002). Among other strategies, the CRT approach teaches family members that substance abuse is not a moral failing but a disease and that they are not the cause of and cannot be the cure of their loved one's substance use disorder. They also learn to identify and pursue their own interests, communicate in nonjudgmental ways, encourage drinking of nonalcoholic beverages during social occasions, manage dangerous situations, and discuss treatment entry with the family member who abuses substances when the consequences of abuse are severe (Kirby et al. 1999*b*).
- **Use the resources of the program.** To create a family-friendly environment, IOT staff at all program levels need to work together toward the goal of engaging families. For example, flexible program hours and large offices or meeting rooms may be needed to accommodate family schedules and large families. Safe toys should be made available for children so that they are less likely to disrupt a session. Front office staff should be trained to encourage and reinforce the efforts of family members who call or come in with the client for the initial visit. Programs can organize their client record systems and procedures so that staff members have easier access to family-related information for each client.
- **Provide a safe, welcoming environment.** Family members may be anxious or reluctant to participate in the treatment process. A welcoming environment encourages them to participate despite their concerns. A safe, clean, and cheerful meeting space is important. Good lighting, a well-marked and well-maintained exterior, culturally appropriate décor, comfortable furniture, and amusements for children convey the message that family members are welcome, valued by the treatment team, and essential to the recovery of the client. Ice-breaking activities, simple games, and role-play activities can make the group meeting inviting and encourage family involvement.

Overcoming Barriers to Engaging Family Members in Treatment

Not all family members participate in the treatment process. Sometimes individuals are reluctant to become involved with treatment, even though they care about the client. Women are more likely to be involved in their male partners' treatment; men are less likely to participate in their female partners' treatment (Laudet et al. 1999). Also, the client may not want family members to be involved because of threats of domestic violence or past abuse by a family member, guilt about the substance abuse, fear that family secrets may be revealed, concern about adding to the family burden, or other reasons. All family members who *do* participate must feel free to raise pertinent issues, even if another family member objects. Because of the risk of domestic abuse that comes with raising difficult issues, providers must assess carefully the potential for violence within the family (CSAT 2004*c*).

Despite these barriers, the IOT provider is encouraged to take every possible action to engage families of clients in the treatment process. Better client retention, fewer relapses, improved family functioning, and family healing are all possible outcomes (O'Farrell and Fals-Stewart 2001).

Supportive supervision of the counselors providing these family services

- Gives staff members confidence that they are providing appropriate levels of service while addressing clinical issues that inevitably arise
- Ensures that counselors and staff members understand their limitations in working with family members
- Guards against counselors and staff members attempting to provide therapy for which they have not been trained

When working with families, programs can make use of existing partnerships with agencies and groups that provide enhanced family services, individual counseling for other family members, health care, and financial and legal services to support clients' families.

Family Services

Family members

- May need guidance on how to address many issues that can arise during early recovery
- May have questions or misconceptions about substance use disorders
- May need to find healthy ways to handle their justifiable feelings of anger, frustration, shame, helplessness, guilt, and sadness that stem from attempts to fix the client's substance use disorder
- May need the counselor's intervention to understand and avoid behaviors that contribute to the client's continued use of alcohol and drugs

The types of services described in this section can support the efforts of family members as the client moves through the course of treatment. Although every family is different, and the pace of recovery varies from family to family, a sample treatment calendar is provided in exhibit 6-2. IOT services can assist family members in accomplishing the tasks described in the calendar.

Family Education Groups

Family education groups provide information about the nature of a substance use disorder; its effects on the client, the family, and others; the nature of relapse and recovery; and family dynamics. These groups often motivate families to become more involved in treatment.

The family education group typically meets weekly for 2 to 3 hours, often in the evening or on weekends, and includes between 10 and 40 individuals. The group is facilitated by a counselor and usually covers these topics:

Exhibit 6-2

A Treatment Calendar for Family Members

Beginning stage: 1–5 weeks

- Commit to treatment.
- Understand that a substance use disorder is a chronic illness.
- Support abstinence.
- Begin to identify and discontinue behaviors that support substance use.
- Learn about the family support groups:
  - Al-Anon (www.al-anon.alateen.org)
  - Nar-Anon (www.naranon.com)
  - Families Anonymous (www.familiesanonymous.org)

Middle stage: 6–20 weeks

- Assess the relationship with the client.
- Develop a realistic perspective on addiction-related behaviors so the family member remains involved with the client but establishes some protective personal distance.
- Work to eliminate behaviors that encourage the client's substance use (i.e., enabling behaviors).
- Move past behaviors that are primarily a response to the client's substance use (i.e., codependence).
- Seek new ways to enrich the family member's life.
- Begin practicing new communication methods.

Advanced stage: 21+ weeks

- Work to develop a healthy, balanced lifestyle that supports the client and addresses personal needs.
- Exercise patience with recovery.
- Evaluate and accept changes, adaptations, and limitations.

Source: Matrix Center 1989.

- Medical aspects of addiction and dependence
- Relapse and relapse prevention
- Addiction as a family disease
- Subconscious refusal to admit that the client has a substance use disorder (i.e., denial)
- Enabling behaviors
- Communication
- Reasons for testing and monitoring of the client
- Leisure time planning
- Parenting skills
- Community support groups and resources

Group members listen to lectures, discuss topics, and engage in exercises that help them become knowledgeable about substance use disorders and their effects on the family.

Multifamily Groups

Multifamily groups can be thought of as microcosms of the larger community. They offer more opportunities for learning, adaptation, and growth than do groups of one client and family members. These groups provide family members with a sense of normalcy and a support network. Individuals learn that other families face similar difficulties. This discovery may reduce the stigma and shame commonly found among families struggling with substance use disorders. Families often exhibit mutually supportive, spontaneous involvement with one another and reinforce one another's problemsolving approaches. Cross-learning—in which, for example, a man learns to understand his wife better by listening to other husbands and wives—is one of the most powerful effects of multifamily therapy. Incorporating multifamily groups into IOT has been shown to increase the length of treatment for female clients, increase completion rates for men, and improve family functioning and children's behavior (Boylin and Doucette 1997; Meezan and O'Keefe 1998). Treatment providers report that having more than one generation present in the group can help institute a family's commitment to abstinence and recovery (Conner et al. 1998).

Multifamily groups typically engage several clients and their family members in group exercises that teach them how to develop healthy communication techniques, avoid enabling behaviors, reduce codependence, and get help. Until a multifamily group coalesces, it may be helpful for members' participation to be structured (e.g., talking only about themselves, not about the person in IOT).

Cross-learning...is one of the most powerful effects of multifamily therapy.

IOT providers should foster an atmosphere of acceptance and emotional safety so that learning occurs in a relaxed setting. Group sessions generally are scheduled weekly and last for 2 to 4 hours with group size ranging from 12 to 30 members (6 to 8 families) (Crnkovic and DelCampo 1998). Clients' recovery may be aided by the inclusion of supportive individuals from outside the family (e.g., sponsors, friends, religious leaders, co-workers). The consensus panel recommends that multifamily groups be co-led by two therapists trained in this process. Membership may change frequently, and clients and their families join the group as others graduate from the treatment program.

Family Therapy Groups

In 1997, Stanton and Shadish conducted a meta-analysis that compared the effectiveness of family education, family therapy, and other forms of family intervention for people with substance use disorders. Their results suggested family therapy is more effective than family education groups and other family services. However, family therapy can be delivered only by specially trained therapists. Forty-two States require that people practicing as family therapists be licensed. In most States, a family therapist must have a master's degree to practice independently (CSAT 2004*c*). Family therapy addresses the dynamics in the family that may encourage substance abuse and offers support for changing these dynamics. It emphasizes that the family as a dynamic system, not merely the inclusion of family members in treatment, is the hallmark of family therapy (CSAT 2004*c*). These sessions may include individual family, couples, and child-focused therapy. (Family therapy for adolescents is discussed in chapter 9.) Because not all IOT programs provide these types of therapy groups, providers should consider establishing referral agreements with other community service organizations that provide family therapy.

Individual family therapy

This type of therapy helps family members look at their interactions and identify the factors in the family that contribute to a substance use disorder. Family members are encouraged to restructure negative patterns of behavior and communication into interactions that are more conducive to recovery for everyone. Through family therapy, adults and children express to the client how behavior has affected them and how new coping skills now are affecting their lives. The client has the opportunity to use new skills learned in treatment and to receive constructive feedback from family members in a safe environment. During these sessions, families may address issues such as irresponsible behavior, indebtedness, substance use in the home by other family members, availability of alcohol on special occasions, and how to reveal treatment and recovery to others. The content of these sessions varies significantly, based on the needs and motivations of the family members. Family therapy may be scheduled monthly or more frequently.

Couples therapy

Couples counseling is useful in improving certain aspects of functioning in families with substance use disorders (O'Farrell and Fals-Stewart 2002). This therapy focuses on improving a couple's relationship and reducing problems related to substance abuse. The spouse or significant other is taught to reinforce abstinence, decrease behaviors that cue substance use, and avoid protecting the client from the adverse consequences of substance use. Both partners are taught to increase positive exchanges, improve communication, and work together to solve problems. The number of sessions can be six or more and can include sessions for one couple or groups of couples (Fals-Stewart et al. 1996).

Child-focused therapy

Play and structured recreational activities for children and parents can reduce conflict in families with substance use disorders. In groups with their children, parents are taught parenting and problemsolving skills and are given information about normal childhood development. Parents recovering from substance use disorders have a chance to experience pleasurable recreational activities with their children (e.g., volleyball, soccer) and learn to interact with them in a structured, therapeutic setting. Older children can be educated about substance use and how it can affect them and their families.

Family Retreats

Some IOT providers have found that family retreats can be effective in helping families harmed by substance use disorders, although research is unavailable on this topic. Participants can take important steps toward healing damaged relationships. Some participants have described family retreats as the most important aspect of their experience in treatment.

Most family retreats cover 2 days, usually over a weekend; participants spend nights at home. Retreats provide clients and their family members with the opportunity to work intensively with one another to address powerful emotions such as shame and guilt and to restore lost intimacy and trust. Participants take part in education sessions, exercises, and group activities. Day 1 activities can include family education on

- Communication skills
- Experiencing and working with feelings
- Developing trusting relationships within the family
- Creating healthy expectations
- Reestablishing roles

Participants receive an assignment the evening of day 1 to work on at home. Assignments may focus on developing relapse contracts, reading from journals, or sharing positive family memories. Day 2 can focus on a therapeutic event during which

- Participants discuss the assignments they completed the night before.
- Family members are encouraged to tell one another important things, which may never have been said or discussed before.
- Family sculpting exercises are conducted; this activity dramatically illustrates relationships and communication patterns that need to change. In family sculpting, each family member takes a turn positioning the other family members in relation to one another, posing them as he or she sees fit, and explaining the choices (CSAT 1999*a*).

Programs that conduct retreats find that executing a "contract for participation" with the client helps ensure that the retreats are well attended. Therapists may need to assist the client in recruiting family members to attend. Retreats should be staffed by therapists who are experienced in managing highly emotional events.

Support Groups for Families

Mutual-help groups provide the continuing emotional, educational, and interpersonal support that family members often need as clients complete their treatment. Attending support group meetings helps family members adjust to changes being made by the recovering member and begin new lives of their own. Family support groups may be sponsored on an ongoing basis by the IOT program or consist of community-based fellowships such as Al-Anon, Nar-Anon, Alateen, Adult Children of Alcoholics (www.adultchildren.org), Adult Children Anonymous (www.12stepforums.net/acoa.html), and Families Anonymous.

When a family support group is sponsored by the IOT program, it usually meets weekly. Family members can discuss problems and concerns that arise because of the client's recovery and reconnection with the family. Such groups offer continuity for family members during the difficult treatment and recovery periods. Surrounded by familiar program staff members and other family participants, family members build on the momentum of their previous experiences in treatment. Examples of the issues discussed include parenting, decisionmaking, conflicts, sexual functioning, intimacy, anger management, mood swings, reestablishing trust, adjusting roles, learning what is "normal," renegotiating relapse prevention contracts, and substance use by other family members.

Community-based 12-Step support groups such as Al-Anon, Nar-Anon, and Alateen are independent from the IOT program. Because family members may be reluctant to initiate contact with such groups, IOT providers can assist family members by providing information about meetings, such as what happens at these meetings, the rituals observed, who attends, how meetings are conducted, the purpose of the meetings, and where to find them. Members of mutual-help groups can be invited to give talks to the family members in the IOT program. Providers also should emphasize that the meetings are anonymous. By encouraging family members to attend at least three meetings before deciding whether to continue, the IOT provider increases the probability that family members have a positive experience and continue to attend. IOT staff can encourage members of multiple families from the program to attend meetings together so that they can reinforce and reassure one another.

Family Clinical Issues in IOT

Diverse questions, concerns, and behaviors are presented by family members during IOT sessions. The complexity of human relationships and interactions is revealed in treatment and can challenge both participants and counselors to use the opportunities and experiences therapeutically. Long suppressed anger, family secrets, shame, and confusion may surface. Family members may harbor feelings and thoughts that can affect the client and the family adversely and that require resolution within a therapeutic environment.

Changing Realities: Working With Clients Who Are Estranged From Their Families

In one IOT program, some clients revealed that they did not participate in family groups, family nights, and other family-oriented activities because they had no family. The clients had been ostracized by or estranged from family members for an extended period.

The counselors suggested that clients and staff rename the "family" events so that clients could feel more comfortable bringing other individuals such as co-workers or friends who made up their family of choice. Instead of Family Night, the program sponsored Support Network Night.

The results

- Participation in the events increased. More clients and their supporters attended treatment activities.
- Clients were encouraged to build an abstinent support network that included friends, co-workers, neighbors, or others as well as members of their family of origin.

Unrealistic Expectations About Treatment Outcomes

Family members often have unrealistic expectations about treatment and the client's recovery. Family members may not understand the nature of a substance use disorder or are unable to accept that it is a chronic, relapsing disease and recovery is a lifelong process. Some family members, for instance, can be so fatigued and emotionally depleted from the stress of living with the person who abuses substances that they have unrealistic hopes for treatment. Strategies and solutions to address unrealistic expectations and common fallacies about treatment and recovery include the following:

- **Informing the family early in treatment about common but unrealistic expectations.** By gently raising this issue early in treatment during individual family sessions, the IOT counselor can draw attention to and begin to dispel any fallacies. The counselor can probe for related family beliefs, answer family members' specific questions, and provide real-life examples before unrealistic expectations lead to an undermining of family and client functioning. This process also can identify specific educational needs.
- **Using a variety of formats to provide clear, understandable information about substance use disorders.** A family education group is a basic component of IOT programming that is effective in debunking many fallacies about substance use disorders. For instance, the group can be used to dispel the idea that once a client is in treatment, he or she will stop having the urge to use; that once use stops, everything will be "perfect"; or that doctors and counselors will teach how to get well. A counselor can obtain or develop written materials (fact sheets, brochures, posters) at appropriate reading levels and in relevant languages. These materials need to be available at the program facility and distributed to family members at intake and during treatment. A brief, informative video can be played during family sessions, in counselors' offices, or in the waiting room.
- **Reaching many family members.** It is important to educate as many family members as possible and to ensure that the most influential family members become knowledgeable about substance use disorders and then redirect other family members if necessary.

Family Responses to Relapse

Clients can relapse, and family members may be unwilling or unable to be compassionate or nonjudgmental about episodes of relapse. Typically, relapse is an unpopular topic with family members. If relapse occurs, counselors need to be prepared for a range of emotional responses from families, including anger, panic, blame, depression, spitefulness, and relief. Some families may abandon or withdraw from the client; others may attempt to engage the client in substance-using activities; still other families may be caught in patterns of depression and resignation or panic and fear.

The following therapeutic options may help counselors in assisting families that may experience a family member's relapse:

- **Prepare the family members as well as the client for the possibility of relapse.** Family members are likely to be the first to know when a client relapses. IOT programs focus on strengthening the client's relapse prevention skills, but families also need assistance. IOT staff members can help families
  - Understand that relapse can happen and that each family reacts in unique ways.
  - Accept that their reactions to the relapse crisis do not necessarily indicate that the family is in deep trouble.
  - Prepare a plan that identifies steps the family will take if relapse occurs.
  - Identify ways that family members can support one another.
  - Seek help if the plan fails.
- **Assist family members in engaging support services and resources.** Community-based support groups such as Al-Anon, Nar-Anon, Alateen, and Alatot (for children of parents who abuse alcohol) are available in most areas and are indispensable sources of help for many families. Family members should be encouraged to attend meetings regardless of the client's recovery status. In these groups, family members focus on their own needs, accept what they cannot change, and engage in healthy, satisfying activities. To facilitate

Living the Treatment Process

Anthony's wife and son were relieved and optimistic when he entered treatment. Soon they would be able to enjoy the husband and father they had missed during many years of substance abuse. As the weeks passed, however, Anthony's family grew more angry and disappointed. He rarely spent time with them and was always at recovery meetings. He showed little interest in their lives and was not physically or emotionally available to them. "I thought treatment would make our lives better, but it's just not true," said his wife.

Counselor's response

- Validate the feelings of family members.
- Explain that Anthony's recovery requires his full attention. For a time, he will be unable to devote much attention to the needs or expectations of others. Only as his recovery progresses and risk of relapse recedes can he become less self-focused.
- Discuss the warning signs of relapse.
- Emphasize the family members' need to focus on enhancing their own lives, independent of the addicted loved one, including involvement in support groups such as Al-Anon.

attendance, some IOT programs offer these groups space at their facility. Others sponsor their own family support groups, led by alumni of the programs, that are open to all who wish to attend for as long as they desire.
- **Seek interventions for individual family members when their responses to relapse are unhealthy.** The IOT counselor needs to be alert to the possibility that relapse by a client may require additional family interventions and referrals to other service professionals. For example, another family member also may be in recovery and may need additional assistance from a support group. Another family member may become depressed as a result of the client's relapse, or an adolescent may act out. The client and other family members may benefit from psychological or psychiatric interventions.

Sabotage by Family Members

A family can sabotage the client's progress when one or more family members behave in ways that undermine the client's abstinence or treatment. For example, family members may continue to use or leave alcohol or drugs where the client is likely to see them. They may state to the client or others that the client is likely to fail or may refuse to let the client use the family car to go to a support meeting or treatment session. Examples of successful clinical approaches to discourage sabotage and encourage positive participation are as follows:

- Schedule individual family sessions to discuss the specific behaviors that are sabotaging recovery efforts.
- Discuss alternative behaviors that support recovery, and offer support for making the behavioral changes.
- Determine whether individual therapy is needed, and support family members with a referral to a family therapist as appropriate.
- Work with family members to create a contract that specifies how their behavior is to change.
- Monitor progress.

Family Life Without Substance Abuse

As recovery begins, some family problems resolve with abstinence. Issues of trust and worries about how the family will be different are likely to emerge. Here are a few common questions and some suggested answers on how IOT counselors can help families:

1. **How do we reestablish trust?**

    - Teach family members that a lack of trust is a normal and natural reaction in early recovery but, at the same time, the recovering person may sense this lack of trust and may become angry or sad.
    - Indicate that the newly abstinent member may suffer from a "time warp" in which a week seems more like a month. Such different perceptions of time can add to conflict around the trust issue because the client may expect the family's trust after what is, in reality, only a short period of abstinence.
    - Discuss the idea that mistrust transforms into trust only as the client maintains abstinence and demonstrates positive changes in behavior. Ask the client to accept that family members may not trust him or her for a period.
    - Suggest that family members agree to extend their trust incrementally to the client. For example, an adolescent client may be given permission to use the family car for an outing if the adolescent's school attendance is satisfactory for a specific period.

2. **How do we have fun again?**

   - Suggest creating new family rituals to replace old ones that involved substance use.
   - Suggest establishing and celebrating "family" abstinence anniversaries.
   - Encourage participation in events sponsored by Al-Anon, Nar-Anon, and other family support groups.
   - Urge participation in multifamily groups sponsored by the treatment program.
   - Ask each member to identify a favorite "family fun" activity for the entire family to enjoy.
   - Ask members to consider separate couples and parent–child activities to create new relationships between family members.
   - Ask members to keep a family journal that includes ideas, feedback, and comments from family members on various activities, rituals, and other family events.

3. **What do we say to friends, neighbors, and associates about treatment and recovery?**

   - Assist family members in discussing and coming to decisions about what information they want to share with others and when. Write down this information, give it to all family members in the form of an agreement, and have each member sign the agreement.
   - Review the privacy and confidentiality provisions that govern treatment programs with family members to remind them that providers will not discuss these topics with others and that family members are in control of what others know. Use family support group sessions to discuss this issue so that members learn from the experiences and examples of other families.
   - Have family members "rehearse" situations they are likely to encounter to practice appropriate responses.

4. **First the bottle, now the meetings. Will it ever get better?**

   - Acknowledge that the spouse or significant other is disappointed and frustrated.
   - Point out that recovery is the first and most important goal during this difficult period and that people in recovery often immerse themselves in recovery activities with the same intensity with which they used substances.
   - Assist the spouse or significant other in focusing instead on his or her own recovery and in attending Al-Anon, Nar-Anon, or other support groups.

Appendix 6-A. Format and Symbols for Family Genogram*

The genogram is useful for engaging the client and significant family members in a discussion of important family relationships. Squares and circles identify parents, siblings, and other household members, and an enclosed square or circle identifies the client. Marital status is represented by unique symbols, such as diagonal lines for separation and divorce. Different types of connecting lines reflect the nature of relationships among household members. For instance, one solid line represents a distant relationship between

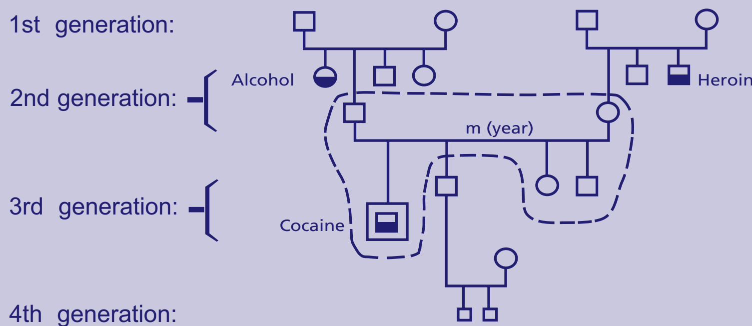
Format for Family Genogram

1st generation:

2nd generation:

3rd generation:

4th generation:



Symbols Useful for Genograms

Symbols

= male

= female

= client

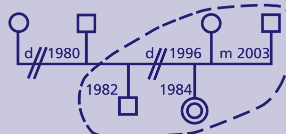
= alcohol or drug abuse (indicate drug of abuse)

= mental or physical illness

= alcohol or drug abuse and mental or physical problems

= deceased

Members of client's household (dotted lines):



Relationships

m 1981 Marriage (give year)

s 1990 Marital separation (give year)

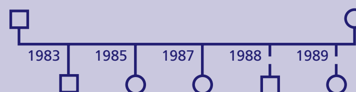
d 1992 Divorce (give year)

1992 Living together relationship or liaison (give year)

Induced abortion

x

Children: List in birth order with birth year
Adopted or foster children = dotted line
Note any changes in custody



Family Interaction Patterns (nature of relationships)

Distant

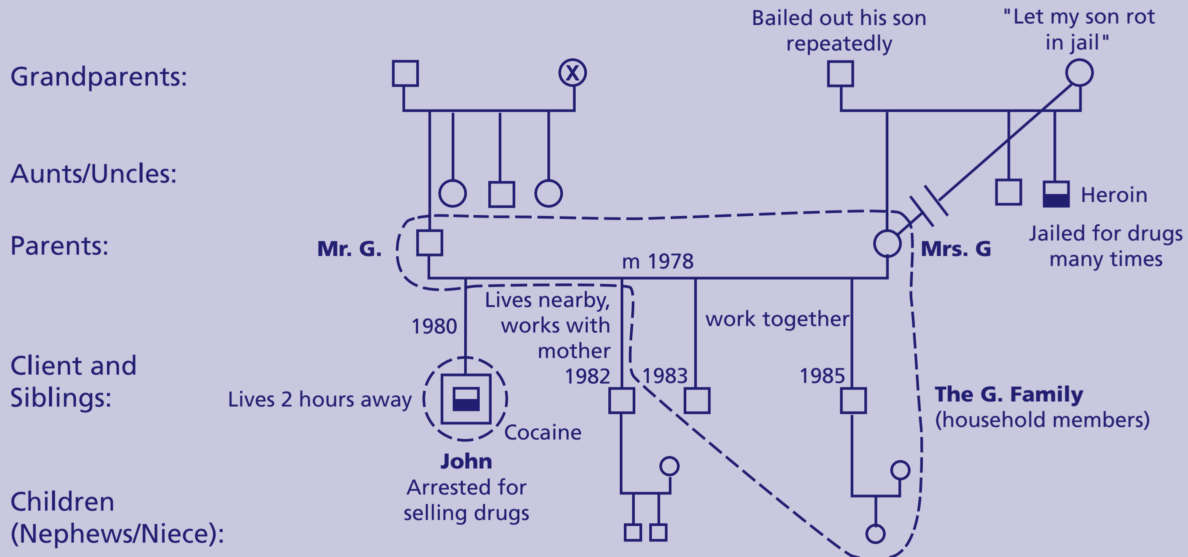
Very close

Estranged/cut off

Conflictual

Fused and conflictual (a bond of ongoing conflict that is mutually satisfying and/or rewarding)

*Source: New Jersey Division of Addiction Services, New Jersey Department of Health and Senior Services.



two individuals; three solid lines represent a very close relationship. Other key data, such as arrest information, are written on the genogram as appropriate.

This sample genogram depicts a family that initially was seen as a close, loving family unit. The son, John, had come under the influence of some "bad friends" and had become involved in abusing and selling substances. While expressing their willingness to help, the family denied the seriousness of the situation and minimized any problems in the nuclear or extended family.

When the discussion was extended to one of John's maternal uncles, Mrs. G. admitted that her brother had been arrested a number of times for heroin possession. Questions about the maternal grandmother's reaction to John's "problem" caused the united family front to begin to dissolve. It became apparent that Mrs. G.'s mother took an "insensitive position" regarding John's substance use disorder and there was a serious estrangement between her and her daughter. In discussing the details of the uncle's criminal activity (which was a family secret that even John and his brothers did not know), it emerged that Mrs. G. had for years agonized over her mother's pain. Now, desperately afraid of reliving her parents' experiences, Mrs. G. had stopped talking to her mother. John's brothers felt free to open up and expressed their resentment of their brother for putting the family in this position.

Mr. G., who had been most adamant in denying any family problems, now talked about the sense of betrayal and failure he felt because of John's actions. It was only through the leverage of the family's experience that the family's present conflict became evident.

Appendix 6-B. Family Social Network Map*

Designing a social network map is a practical strategy to survey various aspects of social support available to clients and their families. Mapping a client's social network is a two-stage process. First, the client uses a segmented circle to categorize people in the network (e.g., friends, neighbors). Then, a grid is used to record a client's specific responses about the supportive or nonsupportive nature of relationships in the network (Tracy and Whittaker 1990). This approach allows both clinicians and clients to evaluate (1) existing informal resources, (2) potential informal resources not currently used by the client, (3) barriers to involving resources in the client's social network, and (4) whether to incorporate particular informal resources in the formal treatment plan. Mapping also can identify substance-using behaviors of individuals in the client's social network. The map takes an average of 20 minutes to complete and provides a concise but comprehensive picture of a family's social network. Practitioners report that the social network map identifies and assesses stressors, strains, and resources within a client's social environment (Tracy and Whittaker 1990). This interactive, visual tool allows clients to become actively engaged and gain new insight into how to find support within their social networks.

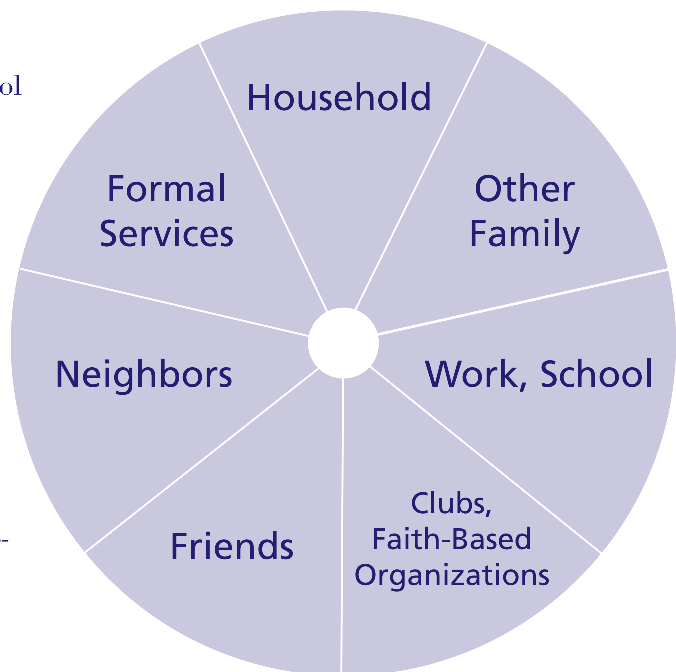
Instructions

Step one. Explain to the client that you would like to take a look at who is in the client's social network by putting together a network map. The client can use a first name or initials for each important person in his or her life; either the clinician or the client can enter the names in the appropriate segment of the circle shown at right.

Sample script. Think back over this past month, say since [date]. What people have been important to you? They may have been people you saw, talked with, or wrote letters to. This includes people who made you feel good, people who made you feel bad, and others who just played a part in your life. They may be people who had an influence on the way you made decisions during this time.

There is no right or wrong number of people to identify. Right now, just list as many people as you can think of. Do you want me to write, or do you want to do the writing? First, think of people in your household—whom does that include? Now, going around the circle, what other family members would you include in your network? How about people from work or school? (Proceed around each segment of the circle.) Finally, list professional people or people from formal agencies whom you have contact with.

Look over your network. Are these the people you would consider part of your social network this past month? (Add or delete names as needed.)



* Source: Tracy and Whittaker 1990, pp. 463–466. Reprinted with permission from *Families in Society* (www.familiesinsociety.org), published by the Alliance for Children and Families.

Step two. Number the sections of the circle 1 through 7, as shown in the Area of Life section of the grid (exhibit 6-3). If there are more than 15 names on the circle, the client selects the top 15 people to enter on the social network grid. Transfer the 15 names and the numbers that correspond to the sections of the map to the social network grid. Names of people in the network also should be put on individual slips of paper for the client to use in preparing the network grid.

Step three. After the names from the social network map have been added to the leftmost column of the social network grid, ask the client to consider the nine categories in the column headings. The client uses the 15 slips of paper with the names from the social network map to respond, sorting the slips into groups corresponding to the numerical options that accompany each category in the grid. For example, when considering how critical of the client each individual in his or her life is, the client sorts the slips into piles representing those who (1) hardly ever, (2) sometimes, or (3) almost always criticize. The name of each person and the appropriate number for his or her level of support are then entered onto the network grid in each life area. The finished grid gives an overall picture of support in the client's social network.

Sample script. Now, I'd like to learn more about the people in your network. I've put their names on this network grid with a number for the area of life. Now I'm going to ask a few questions about the ways in which they help you.

The first three questions have to do with the *types of support* people give you. Who would be available to help you out in *concrete* ways? For example, who would give you a ride if you needed one or pitch in to help you with a big chore or look after your belongings for a while if you were away? Divide your cards into three piles: those people you can hardly ever rely on for concrete help, those you can rely on sometimes, and those you'd almost always rely on for this type of help.

Now, who would be available to give you *emotional* support? For example, who would comfort you if you were upset or listen to you talk about your feelings? Again, divide your cards into three piles. (Proceed through remainder of the questions.)

Clinical Application

Mapping a client's social network provides a visual and numerical depiction of the client's significant relationships. The following aspects of social functioning are highlighted:

- Network size
- Availability of support
- Criticism client faces
- Closeness
- Reciprocity
- Direction of help
- Stability
- Frequency of contact

Exhibit 6-3. Social Network Grid Used in Conjunction With Network Map

ID ________ Respondent ________		Area of Life	Concrete Support	Emotional Support	Infor-mation/ Advice	Critical of Client	Direction of Help	Closeness	How Often Seen	How Long Known
		1. Household 2. Other family 3. Work/School 4. Organizations 5. Other friends 6. Neighbors 7. Formal services	1. Hardly ever 2. Sometimes 3. Almost always	1. Hardly ever 2. Sometimes 3. Almost always	1. Hardly ever 2. Sometimes 3. Almost always	1. Hardly ever 2. Sometimes 3. Almost always	1. Goes both ways 2. You to them 3. They to you	1. Never very close 2. Sort of close 3. Very close	0. Does not see 1. Few times/yr. 2. Monthly 3. Weekly 4. Daily/twice or more per week	1. < 1 yr. 2. 1-5 yrs. 3. >5 yrs.
Name	#									
	01									
	02									
	03									
	04									
	05									
	06									
	07									
	08									
	09									
	10									
	11									
	12									
	13									
	14									
	15									

Appendix 6-C. Resources for Family-Based Services

Publications and Videos

A helpful reference is *Family Therapy: An Overview* (Goldenberg and Goldenberg 1985). This book presents a comparison of six theoretical models of family therapy, including the psychodynamic, experiential/humanistic, structural, communication, and behavioral models. Meyers and colleagues (2003) offer an overview of community reinforcement and family therapy (CRAFT) that emphasizes the approach's empirical support. Using concerned family members and friends, CRAFT works to bring those who deny they have a substance use disorder into treatment.

American Outreach Association (AOA) (www.americanoutreach.org). AOA is a private, nonprofit organization that produces pamphlets to help families cope with alcohol and substance abuse. The pamphlets can be downloaded from AOA's Web site. Topics include strategies on confronting children who use substances, effective ways for parents to communicate with their children, and ways to help someone with alcohol and drug abuse problems.

Films for the Humanities and Sciences (www.films.com). This organization offers 150 educational films on substance abuse, covering topics such as treatment issues and the effects of addiction on family members and including a series on young adults and substance abuse.

Gerald T. Rogers Productions (www.gtrvideo.com). This company produces films and videos on substance abuse for many audiences, from first graders to families with members who abuse substances.

Hazelden Foundation (www.hazeldenbookplace.org). Hazelden Bookplace is an online resource center and marketplace for products and services from Hazelden Publishing & Educational Services and provides resources to help individuals, families, and communities prevent and recover from substance use and related disorders.

Johnson Institute (johnsoninstitute.org). This organization offers books, booklets, and videos that are distributed through the Hazelden Bookplace Web site. Some family-related videotapes available are *Parenting Issues for Recovering Families*, *The Kid and Me: Parenting for Prevention*, *The Enabler*, *Intervention*, and *Intervention: How to Help Someone Who Doesn't Want Help.*

National Families in Action (NFIA) (www.nationalfamilies.org). NFIA is a national drug education, prevention, and policy center with the mission of helping families prevent substance abuse among children by promoting science-based policies. NFIA offers books, pamphlets, and afterschool programs to keep young people substance free. NFIA has collaborated with other organizations on several projects, including Allied Systems Strengthening Families Project and the Drug-Free America Foundation.

NIMCO, Inc. (www.nimcoinc.com). This organization offers videos on alcohol, tobacco, and drug education and prevention topics. Videos cover such issues as drinking and driving, steroid use, substance abuse in the workplace, and the effects of substance abuse on the mind and body.

Pyramid Media (www.pyramidmedia.com). This company offers films and videos about substance abuse that are appropriate for training, educational groups, and individual and family viewing.

Substance Abuse and Mental Health Services Administration's National Clearinghouse for Alcohol and Drug Information (NCADI) (www.ncadi.samhsa.gov). NCADI is a national resource center

funded by the Federal Government that offers a large inventory of publications and videos for treatment professionals, clients, families, and the general public, including *Alcoholism Tends To Run in Families*. This fact sheet presents important information about the influence of parental alcoholism on children and families. It considers evidence that links alcoholism to dysfunctional marital relationships, child abuse, depression, physical problems, and impaired school performances, among other undesirable effects.

Moyers on Addiction: Close to Home (www.pbs.org/wnet/closetohome). This is the online companion to the PBS show. It features real-life stories of struggles with addiction, information on treatment and prevention, and downloadable resources such as family guides, viewer's guides, teacher's guides, and health professional's guides to the PBS series.

Family Support Groups

Adult Children of Alcoholics (ACOA) (www.adultchildren.org). ACOA is a 12-Step, 12-Tradition program that offers support for grown children of parents with alcohol or drug addiction.

Al-Anon family groups (www.al-anon.org). Al-Anon is a fellowship of relatives and friends of people who have alcohol problems who share their experiences, strengths, and hopes. Members believe that alcoholism is a family illness and that changed attitudes can aid recovery. The program is based on the 12 Steps and 12 Traditions of Alcoholics Anonymous.

Families Anonymous (FA) (www.familiesanonymous.org). FA is a 12-Step, mutual-help, recovery support group for relatives and friends of those who have alcohol, drug, or behavioral problems. FA pamphlets, booklets, newsletters, and daily inspirational thought book are written by the members.

Nar-Anon family groups (www.naranon.com). Similar to Al-Anon, Nar-Anon is a fellowship of relatives and friends of people who abuse substances and offers a constructive program for members to achieve peace of mind and to gain hope for the future. Contact information is available in local telephone directories.

National Asian Pacific American Families Against Substance Abuse (www.napafasa.org). This nonprofit organization is dedicated to addressing the alcohol, tobacco, and drug issues of Asian and Pacific Islander (API) populations in the continental United States, Hawaii, and the six Pacific Island jurisdictions, as well as elsewhere. Its nationwide network consists of approximately 200 API and human service organizations, and its Web site lists resources, services for public and professional audiences, and current activities.

7 Clinical Issues, Challenges, and Strategies in Intensive Outpatient Treatment

In This Chapter...

Client Retention

Relapse and Continued Substance Use

Substance Use by Family Members

Group Work Issues

Safety and Security

Client Privacy

Clients Who Work

Boundary Issues

Once clients are engaged actively in treatment, retention becomes a priority. Many obstacles may arise during treatment. Lapses may occur. Frequently, clients are unable or unwilling to adhere to program requirements. Repeated admissions and dropouts can occur. Clients may have conflicting mandates from various service systems. Concerns about client and staff relationships, including setting appropriate boundaries, can compromise care. Intensive outpatient treatment (IOT) programs need to have clear decision-making processes and retention strategies to address these and other circumstances.

This chapter discusses common issues that IOT programs face and offers practical approaches to retaining clients in treatment. Experience has taught IOT clinicians that every problem can have many solutions and that the input and ideas of colleagues lead to creative approaches and solutions. The chapter presents specific scenarios and options from clinical practice and experience for clinicians to consider, modify, or implement.

Client Retention

Reducing client attrition during treatment must be a priority for IOT providers. Compared with clients who drop out, those who are retained in outpatient treatment tend to be White, male, and employed (McCaul et al. 2001). Client attributes associated with higher dropout rates are labeled "red flags" by White and colleagues (1998); these red flags include marginalized status (e.g., racial minorities, people who are economically disadvantaged), lack of a professional skill, recent hospitalization, and family history of substance abuse. Being aware of these red flags can help clinicians intervene early to assist clients at increased risk of dropping out. Veach and colleagues (2000) found that clients who abuse alcohol were more likely to be retained and those who abuse cocaine were less likely to be retained in outpatient treatment. Other studies have

found that the substance a client abuses is not a good predictor of retention (McCaul et al. 2001).

The following strategies improve retention of clients in treatment:

- **Form a working relationship with the client.** The counselor should foster a respectful and understanding relationship with the client. This therapeutic relationship reduces resistance and successfully engages the client in working toward mutually defined treatment goals.
- **Learn the client's treatment history.** If the client has dropped out of treatment previously, the counselor should find out why. If the client has engaged and been retained successfully in treatment before, the counselor should ask what made treatment appealing.
- **Use motivational interviewing.** The counselor should help clients work through ambivalence by supporting their efforts to change and helping them identify discrepancies between their goals and values and their substance use. Involving clients in activities, such as support groups, also is effective.
- **Provide flexible schedules.** IOT providers need to consider the client populations they serve and schedule groups accordingly. For example, morning groups can be for clients who work swing and night shifts and for women with school-age children and evening groups for those working regular business hours. It can be difficult for clients to fit many hours of treatment into their week.
- **Use the group to engage and reengage the client.** The counselor should encourage members to talk about their ambivalence, how they are overcoming it, and their experiences of dropping out of treatment, as well as the negative consequences of dropping out. The counselor can supply all group members with an updated telephone list and encourage them to talk to at least two other members daily. The counselor can ask members to call those who are absent to let them know that they were missed and are important to the group. It is important to check with clients to be sure that they are receptive to these phone calls; some may view them as intrusive and disrespectful.
- **Increase the frequency of contact during the early treatment period.** Clients often feel vulnerable or ambivalent during the first few weeks of treatment. Counselors need to contact each client frequently during this period to enhance retention. These contacts can be brief and made by telephone, e-mail, or letter. At the same time, counselors should encourage clients to contact other group members to reinforce the value of reaching out for support.
- **Use network interventions.** Counselors need to work with individuals in the community who are invested in the client's recovery to encourage the client to stay in treatment. These individuals can be

Multiple Retention Challenges

Clinical issue. A man, age 35, single, and an immigrant from El Salvador, has failed to return to treatment or contact his counselor in the last 3 days.

Approach

- The counselor writes a note to the client in Spanish, encouraging him to return to treatment.
- The counselor arranges for the client to get a ride to the next group session and for public transportation vouchers for subsequent sessions.
- The counselor schedules an individual counseling session for the client to discuss several retention problems, which include lack of transportation, language barriers, and shame over lapses to his previous drinking pattern.

probation officers, ministers, employee assistance program counselors, friends, and co-workers. If the program identifies supportive individuals early in treatment and obtains a written consent for release of information from the client, the counselor can ask these individuals to encourage the client to attend sessions or increase his or her commitment to recovery.

- **Deliver additional services throughout the treatment period.** Fishman and colleagues (1999) found that attrition was lower during the intensive "services-loaded" phase of IOT and, conversely, that attrition increased during the less rigorous program phases.
- **Never give up.** The counselor should make continual efforts to follow up with clients who have dropped out. Successful techniques include telephone calls, letters, and home visits to encourage the client to return to the program. This level of dedication can affect the client's attitude and willingness to complete treatment.

Relapse and Continued Substance Use

Lapses often happen in the difficult early months in treatment. These brief returns to substance use can be used as a therapeutic tool; the goal is to keep them from becoming full relapses with a return to substance use. IOT clients living in the community are exposed to pressures to relapse, often while struggling with cravings and their own resistance to change. Clients need to use relapse prevention strategies when they are exposed to alcohol and drugs, experience cravings, are encouraged by others to return to substance use, or are exposed to personal relapse triggers (Irvin et al. 1999). (See appendix 7-A, page 135, for descriptions of several instruments for assessing clients' relapse potential.)

General relapse prevention strategies are to

- **Educate clients and their family members about addiction and recovery.**

The Difference Between a Lapse and Relapse

Jack's experience: A lapse.

Jack comes to group distressed because he drank on the weekend. He has been abstinent for 2 months and is concerned that he has jeopardized his employment and the return of his driver's license. He discusses the episode with his counselor, and they identify treatment options. The therapeutic goal is to reinforce Jack's desire to stay abstinent, and the episode becomes an opportunity to strengthen his relapse prevention skills.

This is a lapse, that is, a brief return to substance use following a sustained period of abstinence (a month or more). The client still is committed to his recovery and has not experienced loss of control. The event is used to help the client identify relapse triggers and increase his understanding and ability to withstand pressures to use substances.

Phil's experience: A relapse.

Phil is in treatment for methamphetamine use. He has disappeared from treatment again.

When he returns, he is hyperactive, has a positive drug test, and refuses to talk about the test results or his return to drug use. He then fails again to return to the program. He is seen on the street obviously intoxicated. The compulsion to use is strong.

This is a relapse, that is, a prolonged episode of substance use during which the client is not open to therapeutic intervention or learning. Often a relapse can lead to dropout and indicates a continuing struggle by the client with his or her disease.

Clients and family members need information about the disease of addiction and its stages, cues to relapse, early signs of relapse, how addiction affects relationships, and how to find resources for support (e.g., Al-Anon). Counselors need to enlist the support of family members and significant others to keep them from sabotaging treatment. Family members need advice on how to support the client in recovery and how to cease enabling behaviors.

- **Conduct an early assessment of specific relapse triggers.** Together with the counselor, clients can conduct a functional analysis of their substance use, working to identify and understand with whom, where, when, and why they use substances. Functional analysis is a tool that identifies not only clients' high-risk circumstances for substance use but also the ways in which triggers are linked to the effects that substance use produces. TIP 33, *Treatment for Stimulant Use Disorders* (CSAT 1999*e*), and TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*c*), explain how to perform a functional analysis.
- **Develop a relapse prevention plan immediately.** A relapse prevention plan should include coping strategies developed by the counselor and client, such as going to support group meetings, avoiding places where the client used substances in the past, identifying good things about a substance-free life, and telephoning the client's sponsor regularly. TIP 33 (CSAT 1999*e*) contains information and worksheets to develop a relapse prevention plan. Technical Assistance Publication (TAP) 8, *Relapse Prevention and the Substance-Abusing Criminal Offender* (Gorski et al. 1993), and TAP 19, *Counselor's Manual for Relapse Prevention With Chemically Dependent Criminal Offenders* (Gorski and Kelley 1996), are helpful in developing a relapse prevention plan.
- **Provide intensive monitoring and support.** These activities include random drug testing (including urine samples that are collected under observation of program staff to prevent tampering), family counseling or education sessions about supporting the client during and after treatment, and the client's self-monitoring of exposure and response to substance use triggers.

A Relapse Prevention Quiz

This quiz can be a tool to support and strengthen a client's readiness to avoid relapse. Having senior members in a group answer the questions reinforces their knowledge while they educate newer members in relapse prevention skills.

- What might you say to co-workers if they ask you to have a drink or get high with them?
- Craving a drink or drug is quite natural for people who are dependent on alcohol or drugs. What three things can you do to get past the craving?
- What are three common reasons for feeling that you don't belong in a support group such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)?
- What two things can you do if someone at an AA or NA meeting annoys you?
- Why must recovery from your disease be your highest priority?
- What three qualities should you look for in a sponsor?
- Emotional discomfort takes a variety of forms. What are the three biggest problems for you? Anger, depression, self-pity, loneliness, boredom, worry, frustration, shame, guilt, or another emotion?
- What three things can you do to handle each emotional discomfort you identified?
- What are the key elements of an assertive response when offered alcohol or drugs?
- Why is it important to avoid starting romantic relationships during early recovery?

Multiple Dropouts and Readmissions

Some clients relapse or drop out of treatment and return repeatedly to treatment before they achieve a stable recovery. Providers may be reluctant to keep offering scarce treatment resources to the same individuals or to readmit individuals who drop out continually. Programs can respond to multiple dropouts and readmissions strategically by

- Conducting a comprehensive evaluation of each client to determine whether IOT is the appropriate level of care. Some clients, for example, may benefit from a brief inpatient placement to ready them for IOT (see chapter 5).
- Reviewing the client's cycle of dropouts and admissions. Several cycles may be appropriate for a client with severe, complex needs and issues. Arbitrary rules regarding the number of permitted admissions and dropouts may be too rigid to support recovery of a severely impaired individual.
- Establishing an admissions committee to review and recommend action regarding clients who seek readmission following repeated dropouts. The committee can include staff and alumni representatives.
- Developing a profile of clients likely to drop out and designing a plan for them.
- Arranging a psychiatric evaluation for the client, which may indicate that psychiatric treatment and medication are required.

- **Evaluate and review all slips and lapses.** Despite their negative consequences, lapses can be used therapeutically. The counselor and client can learn more about what constitutes high-risk situations for the client. The client needs to consider the slip or lapse a discrete, unique event that does not need to be repeated or continued. The client should remember that abstinence can be regained and that the client can renew his or her commitment to abstinence. Clients should be reminded to contact the counselor, other group members, their sponsor, or other mutual-help group members when they sense that they are verging on relapse.
- **Use the behavioral contract with clients.** A behavioral contract spells out treatment expectations and goals, the rewards when goals are met, and the consequences if the contract is broken. The counselor should involve clients in writing the contract, encouraging them to use their own words. The behavioral contract helps bind clients to their commitment to abstinence and change. TIP 35 (CSAT 1999*c*) provides more information on behavioral contracts.
- **Introduce the stages of change.** Marlatt and Gordon (1985) and Prochaska and colleagues (1994) recommend using relapse prevention interventions that are matched to the client's stage of change. Joe and colleagues (1998) and Connors and colleagues (2001*a*) argue that for clients who are ambivalent about abstinence, for example, initial interventions might focus on strengthening their resolve by analyzing the pros and cons of use, rolling with resistance, and never directly confronting clients. Subsequent interventions support abstinence by altering stimulus control and developing skills for negotiating high-risk situations. After a client experiences a period of abstinence, emphasis shifts to lifestyle modifications that promote long-term abstinence.

Substance Use by Family Members

A client may have one or more family members who also actively abuse substances. In fact, research shows that individuals with substance use disorders are more likely than others to have family histories of substance use disorders (Johnson and Leff 1999). The client may be in regular contact with

members of the extended family, a close friend, spouse, or a boyfriend or girlfriend who uses substances. Active substance use by someone living in the same place as the client or who is part of the client's social support network clearly threatens a client's recovery. The IOT counselor can consider using these options:

- **Stay alert for others using substances.** Construct and update regularly a genogram or social network assessment (see chapter 6) to identify possible substance use among family members, significant others, and friends who are likely to influence the client's recovery. Gather information from the family and client about the nature, extent, and frequency of any substance use.
- **Request that the family and client develop an agreement about substance use in the home.** It is important to enlist family members in the treatment process to help the client and any other family members who are using substances (see chapter 6). A substance use agreement, signed by family members, identifies substances that will not be kept or consumed in the home and the consequences for violating the agreement. Part of the agreement can be to report all substance use to IOT program staff for discussion during group and individual sessions.
- **Assist the client in identifying alternative housing if needed.** Recovery homes, halfway houses, and shelters, among others, may be necessary temporary alternatives for a client who needs alcohol- or drug-free housing during and after treatment. If the client's recovery is undermined continually in current housing, the counselor should consider such a housing referral.
- **Provide information about treatment to a family member who needs it.** Offer information about treatment options or referrals to a family member with a substance use disorder in a manner that ensures the privacy of the individual and does not divert attention from the client's treatment and recovery.

Group Work Issues

Group work is a core service of IOT and offers many opportunities for educating, supporting, and nurturing clients. Clients' feelings toward their peers are important factors in shaping the way clients view the treatment experience. Clients are more likely to continue with treatment when they feel accepted, supported, and "normal" and receive empathy and kindness from others in the treatment group.

Many issues can affect group work and impede the progress of clients. For example, clients may be disruptive or withdrawn, have poor English or comprehension skills, and attend sessions sporadically. TIP 41, *Substance Abuse Treatment: Group Therapy*, provides additional information on working with clients in therapeutic groups (CSAT 2005*f*).

Developing Group Cohesion

Group cohesion can be a central element in a client's recovery process. Frequent changes in group membership make it difficult to build group cohesion. Washton (1997) suggests that frequent shifting of clients among groups can result in higher dropout rates. This observation argues for limiting changes in group composition that sometimes occur in a "phased" or "stage-oriented" IOT program. Adding new clients to groups generates challenges for the counselor who must become oriented to new clients. The following approaches help create effective IOT groups and group cohesion:

- **Create group rituals.** When new clients join a group or others depart, group rituals promote a sense of acceptance, safety, and support. Current members should orient new members to group rules and speak about their group experience. A ritual can mark a client's graduation from the program and celebrate his or her success. Departure rituals may include a client's demonstration of recovery knowledge and

skills, a group discussion of the departing client's strengths and how group members can be supportive, a review of the client's relapse prevention plan and options if the plan should fail, and presentation of the program's emblem (see below).

- **Institute a program emblem.** Staff and clients can design a program emblem to build and sustain group cohesion. The emblem is a visual symbol that represents the essence of the treatment program. For example, a coin, badge, or cup might be inscribed with a recovery motto such as "Serenity and Strength Day by Day" or "Hope, Freedom, and Recovery." A logo might feature the rising sun, a stately oak, or clasped hands. These emblems can incorporate and reflect various cultural and ethnic values and designs. Some programs leave space in the emblem to inscribe each client's name and his or her program completion date. Programs that have emblems have found that clients keep them and use them as reminders of their commitment to recovery and their success in remaining abstinent. The emblem and motto should convey a message of support while maintaining the confidentiality of the client (e.g., by not including the name of the treatment program).
- **Explore the group's feelings about clients who drop out.** When a member relapses and drops out of the group, the group provides a safe environment for other members to discuss their feelings or fears about failure and relapse and their own relapse prevention strategies. Because a client's perception of his or her ability to complete the program influences the outcome, counselors need to support group members with positive statements about their potential to do well in treatment.
- **Encourage identification with the program in addition to the group.** It can be helpful if clients develop a sense of belonging to the group and the treatment program. For instance, IOT staff can share information about the overall goals of the program, use guest counselors or supervisors to co-facilitate groups, and encourage former clients to return to share their experiences. Contacts with alumni outside treatment can be valuable, too.
- **Maintain effective group size and staffing.** The ideal adult IOT group consists of 8 to 12 clients, although up to 15 clients may be on the group roster (CSAT 2005*f*). Programs may need to adjust group sizes according to staff resources, the availability of co-therapists, the experience of the counselors, and the composition of the client population (e.g., adult or adolescent, women or men, people with co-occurring mental disorders).

At least one therapist should have the required academic credentials for group therapy; a co-therapist can be an intern or trainee

Example of a Sendoff for a Treatment Program Graduate

As a client leaves treatment, he or she is invited to take a marble from a bowl of marbles. The group leader then tells the graduate: "Now that you have begun this new stage in your recovery, keep this marble with you always—perhaps in your pocket or purse. Keep it where you will see it often to remind you of how hard your addiction was on you and your family. More important, it will remind you of how firm and resolved you must be in your commitment to stay clean and work on a healthy recovery program.

"Each time you reach into your pocket or purse and touch that marble, you will be reminded of the hard times that are behind you and those that may lie ahead. If, after all this, you decide that you do not care about the hard times and suffering that your addiction has caused and may cause again, and you decide that you want to sink back down into the mess of your addiction, then take the marble and toss it as far as you can, because you will have already lost the rest of your marbles!"

who assists with managing client behaviors and observing the dynamics of the group.

Preparing Clients for Group

IOT programs should orient new clients about how group therapy is conducted and how they are to use the group counseling sessions (see chapter 4). One way to do this is with a pregroup interview that allows the counselor to assess clients' readiness for treatment, learn more about clients' circumstances, and help shape clients' expectations by answering questions and supplying information (CSAT 2005*f*). This information should include group norms and expectations and be reviewed with clients so that it is clear from the outset. Programs also should consider posting group norms on the wall of the meeting room and having clients read them aloud at the beginning of each group session.

Working With Uncommitted, Ambivalent Clients

Some clients in group treatment may not be committed to their recovery from substance use disorders. Clients who have been mandated to treatment by the justice system may feel that they do not have a problem but are only following a judge's orders. Some clients may be late habitually or talk about their continuing interest in a substance-abusing lifestyle. The counselor cannot permit the client to attend group while under the influence of drugs or alcohol because this behavior can compromise the progress of other members of the group. However, the counselor can address behaviors displayed by uncommitted clients by

- Discussing the behaviors with the client individually to identify the issues and discuss options
- Moving the client to a precontemplator or other group or terminating the client from the program
- Introducing more structure into the group to enhance its therapeutic value for all members (e.g., by combining theme-oriented information with client discussion and concentrating less on process and more on organized content)

Working With Clients Who Have Severe Mental Disorders

Individuals diagnosed with severe mental disorders often require a high level of management by trained medical and substance abuse treatment professionals. These clients may have difficulty bonding with a group and may be disruptive or unable to focus for long periods. To enhance the effectiveness of group for individuals diagnosed with severe mental disorders, IOT providers are encouraged to consider these approaches:

Treating Individuals Who Have Severe Mental Disorders

Sam increasingly was unable to control his outbursts when in group. Although he usually was able to return to a calm state, the incidents persisted. His counselor was aware that Sam experienced hallucinations and, with input from Sam's psychiatrist, determined that Sam was receiving little benefit from being in a group. His treatment plan was revised to increase his individual counseling sessions in place of group participation.

Marjorie was diagnosed with bipolar disorder and functioned well while taking prescribed medications. Her counselor noticed behavior changes in group (such as flirting with male members, hyperactivity) over several days. After Marjorie was referred to her psychiatrist, it was determined that she had stopped taking her medications. After she resumed taking her medications, her symptoms disappeared.

- Treatment should be coordinated with the client's psychiatric care provider to determine how best to respond to crises that may arise during group.
- Group treatment should be guided by clients' readiness for and ability to engage in group work (Substance Abuse and Mental Health Services Administration 2002).
- Group treatment staff members should be educated and trained about mental disorders so that they are familiar with the signs and symptoms of psychoses and crisis intervention techniques.

For more information about treating this population, see chapter 9 of this volume or TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*e*).

Working With Disruptive Clients

Clients in group express a wide range of feelings, thoughts, and behaviors. Some members may disrupt the work of the group by challenging or interrupting others, demonstrating their impatience and restlessness, or otherwise offending other group members. Some strategies to address these disruptions are to

- Ensure that all clients know the group rules; provide them in writing, if possible.
- Consistently point out group rules about disruptive behaviors and the consequences for engaging in them.
- Reassess the client's level of readiness to change, and assign the client to another group if appropriate.
- Hold individual counseling sessions to discuss specific disruptive behaviors, how they are disruptive, and why they are not allowed; then explore and identify factors that may underlie the behaviors.
- Refer the client to a mental health professional if needed.

Working With Quiet, Withdrawn Clients

Clients may be reluctant to participate in group therapy for many reasons. They may be fearful or ashamed of revealing to strangers the extent of their substance use and related behaviors. Cultural values may inhibit the sharing of personal problems with

The Angry Client in Group

Problem behaviors

- Yelling
- Foul language
- Interrupting
- Being mean or insulting to others

Key concepts for counselors

- Be in control.
- Avoid a power struggle.
- Address the behavior, not the content.
- Don't raise your voice.

What to do

Listen reflectively to validate the client's feelings and to deescalate the situation. If the client remains angry, use these approaches:

- State that you are there to protect and safeguard the members of the group.
- Identify specific behaviors that are inappropriate.
- State that these behaviors are not allowed.
- Identify the consequences if the behaviors continue (e.g., being removed from the group, not being permitted to participate in discussion for the remainder of the group session).
- Follow through with the stated consequences if the behaviors are repeated.
- Transfer the client to a different group or clinical service.

those outside the family. Language and comprehension barriers may make it difficult to follow or participate in the conversation.

Clients may refuse to take part in group discussions beyond the level of perfunctory comments because they resent being in treatment, are depressed or have some other mental disorder, find the group boring, or are uncomfortable in a group. Some clients resist treatment because they believe that they do not have a disease or do not belong in treatment.

Some strategies to assist withdrawn clients are to

- Ask clients individually why they are quiet; then explore options based on the feedback.
- Assess and diagnose language and comprehension skills, and assign clients to a group that functions at an appropriate pace and level.
- Provide individual mentoring to ensure that treatment information is conveyed and understood.
- Create a "buddy system," pairing clients to encourage a sense of acceptance and belonging among the members of the group.
- Contract with the client to increase participation in the group incrementally.
- Refer the client for psychiatric evaluation, if needed.
- Adjust the client's treatment plan to include individual rather than group counseling if that seems to be in the client's best interest.

Responding to Intermittent Attendance

It takes time for a group to become a cohesive unit, and clients who do not attend sessions regularly can impede the group process. The client who misses sessions may

Helping the Client "Speak"

A counselor noted that, time after time, a client sat quietly in group and spoke only a few words, usually when she was called on. Despite gentle, persistent encouragement from the members of the group and the counselor, the client was quiet and watchful.

After a week, the counselor suggested this reticent client write out whatever she might want to communicate. The client was instructed to take an open-ended approach to the writing, similar to writing in a journal.

The counselor also asked the client to complete the following statements:

- My health concerns are
- The most stress this week came from
- This week I'd rate my stress level as ____, with 1 being low and 10 being high.
- The best thing that happened this week was
- I'm working on my treatment goals by
- How I'm feeling about group is
- My most likely relapse trigger is
- I get support for the healthy changes I'm making from
- I participated in the following substance-free activities this week

After several days, the client returned with a sheet containing her thoughts and comments about daily events, her concerns for her children, and the statements completed. The counselor used the information to begin developing a relationship with the client that helped her feel more comfortable in the program and ultimately with the group.

feel left out of discussions and may jeopardize the development of trust among group members that is at the heart of forthright communication. Counselors may find that such clients are strongly ambivalent about being in treatment, have practical barriers that prevent them from attending regularly, or feel uncomfortable in the group.

Some strategies to assist these clients are to

- Assess their readiness to change, and assign them to a precontemplator or other group whose members are at a similar stage of readiness.
- Identify and address any barriers such as lack of reliable transportation, conflicting work hours, lack of child care, protests by the spouse or significant others to treatment, and fear of violence from a domestic partner.
- Assign these clients to a group whose members share a similar cultural orientation, age range, gender, substance used, or level of psychological functioning.
- Provide refreshments on days when attendance is high to reward desired behavior.
- Monitor attendance and seek guidance from the supervising clinician.

Safety and Security

Clients, family members, and staff members must feel comfortable and safe when coming to the IOT program. IOT programs that treat high-risk clients need to monitor these clients carefully, anticipate problems, and plan appropriate interventions. Common safety and security issues that IOT programs face are identified by examples in exhibit 7-1 along with the counselor responses.

Presence of Drug Dealers or Gang Members at the Facility

Every IOT program should post prominent signs (in multiple languages where appropriate) inside and outside its facility that prohibit loitering, drug-related activity, or unauthorized persons on the premises. One or more trained staff members promptly and firmly should ask individuals not in treatment or not participating as family members to leave. Police assistance should be requested if there is any resistance to the request or if unauthorized individuals return.

In some cases, a client may encourage the presence of drug dealers or gang members. Criminal justice-mandated clients and individuals who are ambivalent about treatment, for example, may be susceptible to the influence of individuals who use substances and are part of their social networks. If the counselor finds this to be true, the counselor should inform the client that program rules prohibit such activity and explain the consequences of the client's continued involvement with drug dealers or gang members. A client may need the encouragement of the counselor and the support of program rules and policies to end harmful associations.

Stalking, Domestic Violence, and Threats Against Clients

IOT programs must take appropriate steps to ensure the safety of clients and staff members during treatment. Safety may be threatened by stalkers, violent domestic partners, former spouses and significant others, drug-related associates, or gang members. Counselors should consider following these steps:

- Privately and in a nonjudgmental way, ask the client about restraining orders, threats, or violent incidents that have occurred or that may occur. Knowing about possible problems helps staff members and the client take needed precautions. They can be alert for evidence of any immediate danger and attempt to prevent it. Treatment staff have a duty to warn if the danger is clear and imminent, provided that confidentiality regulations are met (CSAT 2004*b*).
- Intervene early to deescalate any situation that potentially could become violent.

Exhibit 7-1

Examples of Immediate Safety Concerns and Counselor Responses

Threat of violence against another. While in group, a male client expressed strong feelings of anger toward another man involved with the client's ex-wife. The client stated that he had a gun and wanted to kill the other man.

Counselor response. The counselor removed the client from the group and engaged him in a discussion about his feelings and remarks. The counselor expressed concern about the client's well-being and assessed whether he understood the seriousness of his statements. The client's anger began to subside, and the counselor had him sign a "no violence" contract.

For several days thereafter, the counselor telephoned or spoke in person with the client to assess his feelings and thoughts. The client stated he would "never do anything like that" and had regretted his outburst.

Threat of suicide. A female client telephoned her counselor and said she was tired of struggling with her addictions and other problems and was thinking about killing herself.

Counselor response. The counselor assessed the immediacy of the threat by reviewing the case record to determine whether there had been any previous attempts at suicide and asking the client whether she had a specific plan and the means to carry out the plan. If the counselor were still concerned, he or she would have consulted immediately with the supervisor or program director to develop and document a plan to inform the police, relatives, and the client's doctor and scheduled an immediate one-on-one session. Because these criteria were not met, the counselor, with the agreement of the client, scheduled an individual therapy session. During the session the counselor and client negotiated a "no suicide" contract that included a commitment by the client to see a psychiatrist for evaluation as soon as possible.

The counselor recorded the incident in the case record and discussed it further with the supervisor.

- Place violence-related information, such as occurrences of stalking, in the client's case record. Help the client create a detailed, personal safety plan, and include it in the case record. (See TIP 25, *Substance Abuse Treatment and Domestic Violence* [CSAT 1997*b*], for a sample plan.)
- Require the client to sign a no-contact agreement that prohibits contact with a batterer during the course of treatment, with clearly delineated consequences for violations.
- Assist the client in obtaining a civil protection order that prohibits harassment, contact, communication, or physical proximity by a batterer, stalker, or other threatening individual.
- Connect the client to community services that address domestic violence, such as advocates, counselors, emergency housing, and financial assistance.

Treating Violent Clients

Occasionally, a client may display violent behaviors while in treatment, such as brandishing a weapon or threatening others. IOT staff can take these steps:

- Have all newly admitted clients sign a client code of conduct that states that threats of violence or acts of violence result in immediate termination of treatment and possible criminal prosecution. Give examples.
- Notify a law enforcement agency if a threat to safety exists or an assault or other crime occurs on the program premises; report the incident and client's name, address, and treatment status, as permitted by Federal regulations.
- If the client is mandated into treatment from the justice system, follow the steps prescribed in the program's agreement with the justice agency. Certain rule violations, for instance, may require that the IOT provider notify the justice agency. Response to other violations may fall within the discretion of the treatment program. (See TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* [CSAT 2005*d*].)
- Notify supervisors about threats.

Clients Arriving Under the Influence of Drugs or Alcohol

Clients in IOT programs are expected to attend sessions drug and alcohol free. Arriving under the influence interferes with clients' participation, their ability to recall material covered, and the ability of other group members to benefit from therapy. It also indicates that a client's substance use disorder is active and that an alternative treatment plan is indicated, at least for that day. Strategies to respond to such occurrences are as follows:

Under the Influence in Group

George arrives at group intoxicated. His speech is slurred, he staggers somewhat, and he laughs loudly and inappropriately.

Counselor response.

- Inserts an educational video, and instructs the group to continue on its own for the next 15 minutes. Alternatively, asks another staff member to sit in temporarily with the group.
- Escorts George from the group.
- Obtains a urine sample and conducts a Breathalyzer™ test to determine the substances consumed.
- Asks George in a one-on-one session how he will return home. Because George drove to the facility, the counselor tells him that he cannot drive home and that the counselor will contact police if George tries to drive. The counselor reviews with George the names of family members who can provide a ride home. The counselor follows applicable Federal, State, and local laws regarding contacts with authorities (CSAT 2004*b*).
- Allows George to use the phone to call his wife to pick him up. Note: Some programs pay for a cab.
- Expresses concern about the substance use and encourages George to return to the next session where the episode will be discussed therapeutically.

Key point. The counselor did not engage George in a discussion about his substance use, such as why it occurred and the circumstances. Instead, the counselor immediately focused on confirming George's substance use, ensuring his safety, encouraging him to return to treatment when sober, and preserving group time for the benefit of the other clients.

- **Develop clear program rules regarding use of drugs during treatment.** If a client arrives under the influence, a therapeutic response is called for. The counselor takes the client aside, reviews the rules, and helps the client arrange alternative transportation if the client drove to the program. The client is instructed to return when abstinent and is informed that the substance use will be discussed in the next session. The counselor also can write a note to or call the client to emphasize that the client is expected to return to the group—actions that are intended to normalize the event and reduce any feelings of failure and shame.
- **Assess the client's health status.** When a client arrives under the influence of drugs or alcohol, the counselor should assess the client's need for acute care or detoxification. If it is indicated, the counselor should refer the client to detoxification. In a life-threatening overdose situation, no signed release is required to arrange for emergency medical care. If indicated, emergency personnel can be called. If acute care is refused, the counselor should contact a family member or significant other to escort the client home. (Unless the situation is life threatening, the significant other can be contacted only if the client has signed a release specifying such contact is permitted.) The counselor also should provide the family member with emergency care numbers.

Client Privacy

Treatment programs often receive inquiries about clients or unsolicited information about clients. Some clients in treatment may be HIV positive but indicate they have not reported their status to their partners or a well-known leader or celebrity may enter the program. Each situation presents client privacy and ethical issues for IOT providers.

Inquiries About Clients

Federal confidentiality regulations do not permit providers to reveal, even indirectly, that someone is a client unless a signed release has been obtained from the client and is on file. IOT staff members must consult a list of client-approved individuals before they (CSAT 2004*b*)

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

Unsolicited Information About Clients

Clients' spouses, domestic partners, or other acquaintances may leave messages with information about clients' continued substance abuse or other activities and history while they are in treatment. Sometimes these individuals share their identities but do not want them revealed to clients because they fear for their safety. The counselor can respond to unsolicited information by (1) raising the general topic with the client during individual counseling and revising the treatment plan accordingly and (2) increasing the frequency of drug testing if substance use has been reported.

Knowledge of HIV Status Withheld From Partner

Substance abuse, particularly the injection of drugs, increases risk of HIV infection (Pickens et al. 1993). During treatment the IOT counselor may learn that a client has not informed a partner of his or her HIV-positive status, exposing the partner to potential infection. The following approaches help reduce this risk while maintaining client confidentiality:

- Ensure that the client is informed fully about the connections among drug use,

The Informant

Maria calls the IOT counselor to say that her husband Juan (an IOT client) is drinking almost every night and gets really drunk every weekend. She insists that the program "has to do something about it—treatment isn't working."

Counselor response. Because Juan has signed a release that permits the counselor to speak with Maria, the counselor asks for her permission to confront Juan with this information. Maria refuses permission because she is afraid Juan will be angry with her. The counselor schedules a session with the couple to discuss problems at home.

The counselor tells Maria that, without her permission, the information will not be conveyed directly; rather, it will be used in the most therapeutic manner possible. That is, the counselor will pay increased attention to Juan's behavior and communications and will perform breath tests more frequently to obtain evidence of alcohol use.

Key points.

- The counselor avoids being drawn into keeping the wife's secrets; a couples session is scheduled to discuss openly the relationship and the husband's drinking.
- IOT staff members must have a written release to discuss Juan's behavior with anyone.
- Spouses and others who provide information about clients need to be protected from possible harm.
- Information obtained "anonymously" can be therapeutically useful.
- Clients may continue in the program, even though they may be surreptitiously using substances, if all other program criteria are met.

unprotected sex, and the transmission of HIV/AIDS.

- Acknowledge and discuss with the client any fears, feelings of embarrassment, and guilt about revealing his or her HIV status to a partner.
- Include information about HIV transmission in educational materials and presentations made to family members.
- Assist the client in finding ways to talk about the issue with the partner, offer assistance in informing the partner if the client consents, and refer the client to an HIV/AIDS counselor for assistance.
- Encourage the client to participate in a support group for HIV-positive individuals, and provide a specific program referral.
- Discuss possible referrals to community-based providers if notifying the partner results in a need for services.

(See TIP 37, *Substance Abuse Treatment for Persons With HIV/AIDS* [CSAT 2000*c*].)

Entry of a Well-Known Individual Into Treatment

Recovery from substance use disorders is the focus of treatment for all clients, regardless of their position or visibility in the community. When a well-known person, such as a political leader, sports personality, artist, member of the clergy, or media representative, enters an IOT program, a variety of issues may surface. Examples include

- **Increased risk to maintaining privacy and confidentiality.** Interest in the client may result in inquiries by media representatives, curious callers, or program visitors. Remind all staff, including administrative and support personnel, as well as clients, to adhere to the program's confidentiality procedures that protect the privacy of every client.
- **Feelings of privilege.** Well-known clients may enter treatment with a belief that they do not need to follow all the program's procedures or meet each requirement.

Counselors must assist these clients in assimilating as quickly as possible into the treatment milieu by (1) relating to the private and not the public individual, (2) communicating treatment procedures and requirements, and (3) securing a signed behavioral contract. Individuals who are well known in the community may be concerned about protecting their privacy. The IOT counselor can assist these clients by (1) acknowledging their concerns while assuring them that others in similar circumstances have completed treatment and are recovering successfully, (2) evaluating the feasibility of their being treated out of town, (3) reviewing and discussing the program's confidentiality regulations and policies, and (4) encouraging clients to attend support group meetings, which have a strong tradition of protecting the identity of participants.

- **Effect on the treatment milieu.** The presence of high-profile clients or relatives and friends of such clients may mean that the treatment environment is tense or unsettled because of media attention; group cohesion based on trust may be slow to develop. The IOT counselor might consider these approaches: (1) discuss interpersonal issues that a client may have with other clients in individual counseling sessions, (2) use the group process to discuss confidentiality, trust, or other concerns, and (3) place any clients who express a concern about being in a group with a high-profile client in different groups.
- **Dual relationships.** High-profile clients may offer to help the counselor or program financially, through a personal appearance, or through their influence. Acceptance of such an offer from a client introduces a "dual relationship," which is unethical. Programs should not accept gifts or favors from clients beyond the published fee schedules. Only after a client has been out of treatment for an extended period (which many programs consider to be 1 year or longer) should the person be considered a successful alumnus and eligible to support the program in these ways.

Clients Who Work

Many clients have employment-related challenges, which can include schedule conflicts, associating with co-workers who use substances, and unrealistic employer requests.

Conflicting Work and Treatment Schedules

Individuals who enter IOT may face conflicts between work responsibilities and attending IOT group sessions. Some clients may rotate shifts or be asked to work overtime or work on weekends. Work schedules may interfere with treatment sessions. This situation most likely occurs when the employer is unaware that the employee is in treatment. The following approaches may be helpful, depending on the client's situation:

- Encourage clients to make treatment and recovery their first priority; help clients understand that by doing so they are better able to meet their work obligations.
- Support clients in making treatment a high priority by being flexible with treatment schedules.
- Encourage clients to inform their employers that they have a health condition and to ask the employers to cooperate with efforts to address the health condition.

Working and Socializing With Co-Workers Who Use Substances

Clients may have used substances with co-workers and may find it difficult to renegotiate their relationships with co-workers and to avoid circumstances that can lead to relapse. Options for addressing these issues include

- Assisting the client in identifying specific work-related circumstances that may be

uncomfortable or increase the risk of relapse
- Encouraging the client to distance himself or herself from co-workers who use substances
- Using role plays and other counselor–client interactions so the client can practice responding to questions about treatment and invitations to use substances in ways that preclude uncomfortable discussions and limit risk-oriented situations
- Encouraging the client to transfer to another work environment that is more supportive of recovery, if possible

Employer Requests

If the employer referred the client to treatment, the employer may expect information from the IOT provider about whether the client can assume his or her job responsibilities. Many large employers have policies that address this question, specifying when an employee can resume driving a bus or carrying a gun and mandating regular drug testing for a specified period. Key points concerning this issue include that

- IOT providers do not have the expertise to determine whether a client can perform his or her job duties. Only the employer can determine this.
- IOT providers can inform an employer (with the client's consent) about the client's progress in treatment and the drug test results.
- IOT providers can refer the employer to resources such as professional associations and the drug-free workplace information available on the Internet from the Center for Substance Abuse Prevention Workplace Resource Center (workplace.samhsa.gov).
- IOT providers can negotiate with the employer for an additional period of continuing care for the employee; this period reinforces treatment gains and reduces the risk of relapse.

Millions of private-sector workers in the aviation, maritime, railroad, mass transit, pipeline, and motor carrier industries are governed by Federal legislation (the Omnibus Transportation Employee Testing Act of 1991) that makes workplace drug testing mandatory. If an employee of one of these industries fails a workplace drug test and is mandated to treatment, the treatment program is required to inform the employer in writing of assessment results and treatment recommendations (Macdonald and Kaplan 2003).

Helping Clients Achieve Balance

Once in treatment, clients sometimes try to make up for past harmful behavior during periods of substance abuse. Feeling guilty and remorseful, clients may take on additional work, extend their workdays, and try to become perfect employees. IOT providers should caution clients about the risk of

Conflicting Schedules

Emily decided to seek treatment for her substance use disorder. She was employed at a firm that depended on her to work on key projects. During treatment entry, the IOT counselor learned that Emily's supervisor sometimes expected her to work beyond regular hours. On these occasions she would be unable to attend IOT group sessions consistently.

Counselor response. After exploring this issue, the counselor concluded that Emily was unable to resolve her schedule conflicts with her employer without jeopardizing her position. The counselor then arranged for Emily to attend a Saturday group session and to increase the number of individual counseling sessions to compensate for the reduced number of group sessions. Emily was able to complete treatment successfully.

Co-Workers Who Use Substances

John and several co-workers went out together every Friday evening after work and drank heavily. They drank on Saturday and continued drinking during the Sunday football games they watched together. After making a decision to stop drinking and enter treatment, John wondered what he could say to his co-workers.

Counselor response. The counselor suggested that John follow these steps:

- Maintain distance from friends and co-workers who use substances.
- Avoid explaining or defending his decision to enter treatment.
- Avoid giving detailed explanations for refusing invitations to activities where substances are used.
- Practice using concrete statements to avoid situations in which substances are used, such as "I need to attend to personal problems in the family"; "Thanks, but no." Practice these statements in group sessions; role play the responses in individual counseling sessions.

The counselor also worked with John to develop a new social network and find recreational activities that would support his recovery.

compromising their recovery efforts by taking on too much responsibility too quickly. The following responses may assist a client who tries to overcompensate:

- Remind the client that recovery is the first priority.
- Encourage the client to maintain balance and perspective with respect to the type and intensity of activities that are undertaken.
- Assist the client in understanding that there will be time to address past mistakes once recovery is solidly underway.

Boundary Issues

Clients in treatment and IOT program staff members interact with one another on many levels—intellectual, emotional, and spiritual. The IOT experience is intense for all participants. Forming a therapeutic relationship with the client helps the counselor focus on the client's recovery and influence the client's behavior. At the same time, clients work together in group sessions over weeks and months on issues of profound significance to them. Furthermore, group members may attend community-based support groups together during and after IOT. In the process, they often develop trust and genuine concern and caring for one another. The intensity and environment of an IOT program can lead to behaviors and issues that challenge the boundaries between staff members and clients. The following are examples of these challenges and suggested responses.

Clients Giving Gifts to Staff

Gift giving is relatively common and may have meanings and consequences that require careful consideration by counselors. For example, the customs and traditions of some cultures encourage gift giving to show respect for someone who offers a valuable service. Recent immigrants from these cultures may continue this practice and bring a small gift or food item to the IOT counselor or other program staff members. In some cases, failure to accept the gift may be viewed as a lack of courtesy and result in the client's dropping out of treatment.

Other gifts given by clients to IOT staff members may be inappropriate and should be refused politely and tactfully. Most program rules prohibit staff members from accepting gifts if they

- Exceed a certain value (e.g., more than $20)

The Meaning of Gifts: A Cultural Perspective

A gift has meaning both to the individual who gives it and to the one who receives it. Understanding and appropriately acknowledging the true meaning of a gift always require an awareness of the giver's cultural background.

For example, many cultures place significant value on relationships rather than on individual priorities or achievement. The giving of a gift recognizes and reflects the value of the relationship and signals respect and caring. Gifts are given frequently and generally are not connected to an expectation of favor or privilege. By accepting modest and especially handmade gifts from these clients, IOT staff members acknowledge the respect, cultural values, and practices of these individuals.

- Are not the result of a religious or cultural tradition
- Are offered in anticipation of some response or benefit (e.g., special treatment or favor)
- Are obviously personal in nature
- Are likely to cause discomfort, questions, or confusion for others about the relationship between counselor and client

Other programs permit only such gifts as flowers, candy, cookies, or plants that can be shared by all staff members and clients rather than given to an individual staff member.

IOT providers should develop program rules that discourage gift giving and discuss these rules with clients. However, the rules should permit some flexibility for individual circumstances. It is recommended that programs require staff members to report all gifts to supervisory personnel and in the case record. Counselors should be familiar with the program's policies on these issues.

Socializing Among Clients

IOT programs differ in the degree of socializing expected outside group sessions. Some programs encourage clients to attend mutual-help meetings together and support one another in other aspects of their lives. Other programs discourage contact between clients except within the program. Most IOTs have rules regarding dating, sexual involvement, or other pairing of clients that could undermine treatment.

Client Relationships Involving Substance Use

Sometimes clients meet in an IOT program and decide to use drugs or alcohol together. Others may be acquainted before entering treatment and continue a relationship that includes substance use. Options for the counselor include the following:

- Reassess the readiness of clients for treatment and recovery.
- Develop a written contract for abstinence, and have clients sign it.
- Refer clients to separate treatment programs.
- Provide individual therapy for one client until the other client graduates from the program.

Socializing Between Staff and Clients

The therapeutic relationship between an IOT counselor and a client is built on caring, trust, and genuine interest in the recovery of the client. These three elements form a basic building block of the treatment alliance. To safeguard the therapeutic dyad and maintain the quality of the treatment environment, IOT programs typically prohibit staff–client activities such as socializing and doing favors. Program consequences for violations of these rules of professional conduct should be clear and applied consistently to all program staff, from administrators to support personnel. Consequences may vary,

Counselor Observes the Client Using Substances in the Community

Residents in a small, rural community occasionally enjoy dancing at the local nightspot. One evening an IOT counselor observes a client drinking at the bar.

Counselor response. The counselor leaves the establishment as soon as possible and does not acknowledge the client. Subsequently, in the treatment setting, the counselor meets with the client one on one. The counselor states the facts of the incident, expresses concern about the possible relapse, reminds the client of the agreement not to use substances, and, using motivational interviewing techniques, asks the client to determine how to handle the return to drinking.

based on the circumstances, and can include supervisory reprimand and counseling, oral or written warnings, probation, and dismissal. In some cases, the counselor who violates prohibitions must be reported to his or her licensing or certification board.

Counselors With Dual Roles

Many IOT counselors are also members of mutual-help programs and must maintain appropriate boundaries between these two roles. For example, it would not be appropriate for an IOT counselor to become a client's sponsor. A counselor also might meet an IOT program client by chance at a mutual-help meeting, particularly in a small community. Counselors should avoid attending meetings that current or former clients attend. When this is not possible, an IOT counselor should avoid sharing his or her personal issues at that meeting. If a counselor in this situation needs to talk, he or she should take someone aside after the meeting or call his or her sponsor. Some cities have "counselor only" meetings that are not listed in directories. The mutual-help program's intergroup office or other counselors are good resources for locating such meetings.

The Client Is My Neighbor

The IOT counselor recognizes a new client in the waiting room as her neighbor. The neighbor is surprised to see the counselor.

Counselor response. The counselor asks to speak privately to the neighbor in her office. The counselor acknowledges the social relationship that exists between them and states that she will not be involved in any way with the neighbor's treatment. The counselor also explains confidentiality regulations and indicates that the neighbor is in charge of how they relate to each other outside the treatment setting. The counselor also discloses the relationship to his or her supervisor to ensure that the counselor is not involved, even tangentially, in the client's case.

Appendix 7-A. Instruments for Assessing Relapse Potential

Clinicians have access to several instruments that help clients identify situations that pose high risks of relapse and understand their personal relapse triggers. Most instruments are not under copyright and can be used free of charge. More information about these tools, including information on obtaining copies and links to downloadable versions, can be found at the National Institute on Alcohol Abuse and Alcoholism's Web site (www.niaaa.nih.gov) by entering "Alcoholism Treatment Assessment Instruments" into the site's search engine.

Alcohol Abstinence Self-Efficacy Scale (AASE)

AASE evaluates a client's confidence in the ability to abstain from drinking in 20 situations that present common drinking cues. The instrument comprises 40 items that gauge a client's risk of relapse on four scales: when the client is experiencing

- Negative emotions (e.g., depression, frustration)
- Feelings of well-being (e.g., celebrating, on vacation)
- Physical pain (e.g., headache, fatigue)
- Cravings (e.g., testing willpower, experimenting with one drink)

AASE is a paper-and-pencil instrument that can be administered and scored in 20 minutes. No training is required to use it. It can be used to evaluate clients admitted to an IOT program, to guide treatment, or to design individualized relapse prevention strategies. A user-friendly version of AASE can be found at adai.washington.edu/instruments/pdf/AASE.pdf.

Alcohol Effects Questionnaire (AEQ)

AEQ assesses the positive and negative effects that clients expect alcohol to have. Based on their beliefs about alcohol, clients respond "agree" or "disagree" to 40 statements. AEQ yields scores in eight different categories that describe the expected effects of alcohol: general positive feelings, social and physical pleasure, sexual enhancement, power and aggression, social expressiveness, relaxation and tension reduction, cognitive and physical impairment, and unconcern. Administration and scoring of the pencil-and-paper AEQ take 10 minutes, and no special training is required. Although AEQ has been used largely as a research instrument, it can be used therapeutically to assess the effects a client desires to achieve by drinking and to initiate discussions about alternative methods of attaining those effects. The AEQ has proved especially helpful with college students who use alcohol.

Alcohol-Specific Role Play Test (ASRPT)

ASRPT uses role playing to gauge client responses to 10 different situations that pose a threat of relapse. Clients listen to taped prompts and then act out their responses, which are videotaped for scoring purposes. Five of the situations involve clients playing out an interaction with another person (e.g., a scenario in which a business contact asks the person in recovery to complete a deal over drinks at a local bar); five require clients to act out their responses to an internal conflict (e.g., a scenario in which the person in recovery has been working in the yard all day and suddenly thinks that a cold beer sounds good). The ASRPT can be administered in 20 minutes; male and female role-play partners and a videotape technician

are necessary. Training is required to give the test, and trained judges must score it.

Situational Confidence Questionnaire (SCQ)

SCQ assesses a client's confidence in the ability to cope with eight types of high-risk drinking situations. For each of the SCQ's 39 items, clients indicate on a 6-point scale (ranging from "not at all confident" to "very confident") how they feel about their ability to resist the urge to drink. SCQ is available in paper-and-pencil and computerized versions and can be self-administered in 8 minutes. (Scoring for the paper-and-pencil version takes 5 minutes; the computerized version is scored as soon as the questionnaire is completed.) Required minimal training is available from a user's guide that can be purchased with SCQ.

8 Intensive Outpatient Treatment Approaches

In This Chapter...

12-Step Facilitation Approach

Cognitive–Behavioral Approach

Motivational Approaches

Therapeutic Community Approach

The Matrix Model

Community Reinforcement and Contingency Management Approaches

Intensive outpatient treatment (IOT) programs use a variety of theoretical approaches to treatment. No definitive research has established a best approach to treatment, and many factors (such as client characteristics and duration of treatment) influence research outcomes. However, studies have found positive associations between several treatment approaches and client outcomes.

Providers should be aware of the most commonly used approaches and their effectiveness so that they can make informed choices. This chapter contains descriptions of six commonly used and studied treatment approaches that form the core of treatment for many IOT programs:

- 12-Step facilitation
- Cognitive–behavioral
- Motivational
- Therapeutic community
- Matrix model
- Community reinforcement and contingency management

The chapter highlights each approach's distinguishing characteristics, theoretical orientation, research support, and other critical elements such as staffing requirements or funding considerations. Exhibits summarize the strengths and challenges of each approach.

These descriptions give readers only a basic overview; they are not recipes for implementing the approaches in an IOT program. Clients often have complex psychosocial needs that demand creativity on the part of providers. These approaches are a means for shaping clinical interventions, but none should be considered complete treatment on its own. Excellent information, books, and treatment manuals are available from the Hazelden Foundation (www.hazelden.org), the National Institute on Drug Abuse (NIDA) (www.nida.nih.gov), the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (www.niaaa.nih.gov), and the Substance Abuse and Mental Health Services

Administration's National Clearinghouse for Alcohol and Drug Information (www.ncadi.samhsa.gov) and Center for Substance Abuse Treatment (CSAT) (www.csat.samhsa.gov).

Although this chapter describes these six approaches as distinct, in reality IOT counselors increasingly use multiple approaches, modifying and blending them to address clients' specific needs. This type of tailoring is a hallmark of effective treatment, but combining approaches calls for the provider to recognize and adjust for conflicts that may undermine each approach's effectiveness.

12-Step Facilitation Approach

The Basics

The treatment approach of many IOT programs evolved from the Minnesota Model of treatment, so called because it was first conceptualized at Hazelden Foundation and Willmar State Hospital in Minnesota in the late 1940s (White 1998). The Minnesota Model (also known as 12-Step facilitation) is based on the concepts of 12-Step fellowships, such as Alcoholics Anonymous (AA). These programs' efforts were guided by the philosophical belief that alcoholism was a primary, progressive disease, with biological, psychological, and spiritual features.

The Minnesota Model used treatment teams of physicians, nurses, alcoholism counselors, family counselors, vocational rehabilitation counselors, and AA members in the treatment process. Basic to the process was a thorough introduction of clients to the principles of AA fellowship and the 12 Steps, education about the disease of alcoholism, and participation in AA groups inside and outside the hospital (M.M. Miller 1998).

Over time, the 12-Step approach evolved for use with people who use drugs and those with other compulsive disorders (such as eating disorders) (M.M. Miller 1998). Counselors, originally all in recovery themselves and often with little training, became more professional as training and credentialing standards were implemented (M.M. Miller 1998). Programs also were adapted to a variety of settings, including IOT. However, the basic principles and methods of the 12-Step treatment approach programs remained intact.

IOT programs that use a 12-Step approach focus on helping clients understand AA principles, start working through the 12 Steps, achieve abstinence, and become involved in community-based 12-Step groups, such as AA, Narcotics Anonymous (NA), or Cocaine Anonymous (CA). In these programs, educational efforts present alcoholism as a disease characterized by denial and loss of control. Homework assignments entail reading 12-Step literature, keeping a journal, and undertaking recovery tasks that personalize the 12 Steps. Much of the group work focuses on accepting the disease, assuming responsibility for the recovery process and one's own actions, renewing hope, establishing trust, changing behavior, practicing self-disclosure, developing insights into one's behavior, and making amends. Problems often are addressed in the context of step work. Clients are encouraged strongly to accept their addiction, develop or adopt spiritual values, and develop a sense of fellowship with others in recovery. IOT programs using a 12-Step approach usually invite AA, NA, CA, or other 12-Step groups to hold onsite meetings. Clients are encouraged strongly to attend meetings in the community and to find a sponsor and home group for ongoing peer support following completion of the formal treatment program. Ideally, 12-Step-oriented IOT programs are in touch with a network of persons in recovery who can accompany ambivalent or reluctant clients to meetings in the community and help them find compatible groups.

Exhibit 8-1 summarizes the strengths and challenges of 12-Step facilitation.

Exhibit 8-1

Strengths and Challenges of 12-Step Approaches

Strengths	Challenges
• 12-Step meetings are a free, widely available, ongoing source of support. Metropolitan areas in particular offer many meetings with a specialized focus (e.g., meetings for young people, women, newcomers to treatment, lesbians, gay men, Spanish-language speakers). • The 12-Step approach emphasizes an array of recovery tasks in cognitive, spiritual, and health realms. • The 12-Step approach is effective with clients from diverse backgrounds (Tonigan 2003).	• It can be difficult to monitor accurately clients' compliance with assigned step tasks, including meeting attendance. • 12-Step groups' emphasis on a higher power may be unacceptable to some clients. • Some communities may not be large enough to sustain 12-Step meetings or appropriate meetings for people with significant psychiatric disorders.

Other Important Aspects

Staff

Staff members who are not in recovery themselves should read AA, NA, and CA literature and consider regularly attending open meetings to ensure that they understand the beliefs, values, and mores of 12-Step fellowships. Likewise, staff members should familiarize themselves with local meetings and with the level of acceptance of clients with special needs (e.g., those with mental disorders). Familiarity with 12-Step culture and with local meetings help staff members orient departing clients to 12-Step recovery and to the available options.

Clients

Research has attempted to identify the individual characteristics that seem most predictive of affiliation with 12-Step programs, particularly AA, but results often have been contradictory for some variables (McCrady 1998). The 12-Step approach may not be appropriate for every client, but 12-Step groups clearly serve a widely diverse group of people.

Research Outcomes and Findings

The NIAAA-funded Project MATCH compared treatment outcomes for persons dependent on alcohol who were exposed to one of three different treatment approaches: 12-Step facilitation (a 12-Step approach that followed a manual), cognitive–behavioral coping skills therapy, and motivational enhancement therapy (MET). All three approaches resulted in positive outcomes regarding drinking behavior from baseline to 1 year following treatment. The study found little difference in outcomes by type of treatment, although 12-Step facilitation showed a slight advantage over the 3 years following treatment (Project MATCH 1998).

Brown and colleagues (2002) investigated matching client attributes to two types of aftercare: structured relapse prevention and 12-Step facilitation. Overall, the 12-Step

facilitation approach provided more favorable outcomes for most people who abuse substances. In particular, the study found that clients reporting high psychological distress, women, and clients reporting multiple substance use at baseline maintained abstinence for longer periods following treatment with 12-Step facilitation than with structured relapse prevention.

Cognitive–Behavioral Approach

The Basics

Cognitive–behavioral therapy (CBT) is based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.

The CBT approach focuses on teaching clients skills that help them recognize and reduce relapse risks, maintain abstinence, and enhance self-efficacy. Clients learn to identify personal "cues" or "triggers"—the people, situations, or feelings that may lead to drinking or drug use. Such triggers may be internal (such as physiological craving or stress reactions) or external (such as seeing friends with whom the client has used drugs). Clients then are taught new coping and problemsolving skills and strategies for effectively counteracting urges to drink or use drugs.

By analyzing their triggers, deciding on recovery-oriented responses and strategies, and role playing high-risk situations and responses, clients gain confidence that they can resist triggered urges to use substances. CBT approaches also are applied to other challenges in recovery, such as interpersonal relations, depression, anxiety, and anger management.

IOT programs are ideal for implementing cognitive–behavioral interventions. Clients usually continue to live and work in their normal environments, which are filled with relapse triggers. These situations provide material for problemsolving exercises, homework, and role plays during group or individual counseling and offer clients opportunities to use new coping strategies, cognitive skills, and behaviors.

The number, duration, and focus of treatment sessions vary widely in CBT-oriented programs. The CBT and 12-Step approaches are compatible, and many CBT-oriented programs encourage participation in 12-Step meetings.

Exhibit 8-2 summarizes the strengths and challenges of CBT.

Other Important Aspects

Staff

Counselors must be familiar with the theory and practice of CBT and have basic counseling skills. It is sometimes helpful to have co-therapists lead cognitive–behavioral groups, particularly those involving role plays and other interactive exercises.

Clients

CBT has been effective with a broad range of clients. However, clients with low literacy or intellectual skills or those for whom English is a second language may struggle with homework or group exercises that require reading or writing. Also, people with significant psychiatric disorders that have not been stabilized may be unable to participate sufficiently.

Research Outcomes and Findings

CBT models have been evaluated extensively, and randomized clinical trials found CBT-based relapse prevention treatment to be superior to minimal or no treatment (Carroll 1996*b*). When CBT was compared with other active therapeutic interventions,

Exhibit 8-2

Strengths and Challenges of Cognitive–Behavioral Approaches

Strengths	Challenges
• CBT actively engages clients in therapy and experiential learning. • Numerous manuals on CBT are available. • CBT is suitable for clients from diverse backgrounds and with varying histories of alcohol and drug use. • CBT provides structured methods for understanding relapse triggers and preparing for relapse situations.	• Clients with poor reading or cognitive skills may need alternatives to written assignments. • The approach requires counselor training in CBT principles and techniques. • Client motivation is critical because of the extent of homework assignments. • CBT was developed as an individual, not group, counseling approach.

results were mixed. Project MATCH found CBT to be comparable with MET and 12-Step facilitation for decreasing alcohol use and alcohol-related problems. All three therapies resulted in positive improvements in participants' outcomes that persisted for up to 3 years (Project MATCH 1998). Farabee and colleagues (2002) found that clients who received CBT reported more frequent engagement in substance-use avoidance activities 1 year after treatment than did clients who received treatment with contingency management.

Motivational Approaches

The Basics

In practice, motivational approaches include both motivational interviewing (MI) and MET. These motivational approaches can be incorporated into every stage of treatment (see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT 1999*c*], pages 31–32, for specific suggestions).

MI techniques developed by Miller and Rollnick (2002) were derived from a variety of theoretical approaches to how people recover in progressive stages from addiction and other problem behaviors (Prochaska and DiClemente 1984, 1986). MI is a client-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problemsolving or solution-focused strategies that build on clients' past successes. Motivational approaches acknowledge that drugs of abuse have rewarding properties that can disguise, at least temporarily, their hazards and negative long-term effects. Through empathic listening and skillful interviewing, the counselor encourages the client to

- Identify discrepancies between significant life goals and the consequences of substance abuse.
- Believe in his or her capabilities for change.
- Choose among available strategies and options.
- Take responsibility for initiating and sustaining healthy personal behavior.

MI requires the counselor to relate to clients in a nonjudgmental, collaborative manner. Counselors pose questions to clients in a way that solicits information while strengthening clients' motivation and commitment to positive change. The counselor acts as a coach or consultant rather than as an authority figure. Counselors using MI follow four basic principles (CSAT 1999c):

- **Express empathy.** The counselor communicates that the client always is responsible for change and respects the client's decision on this issue.
- **Identify discrepancies.** The counselor encourages the client to focus on how current behavior differs from his or her ideals and goals.
- **Roll with resistance and avoid arguing.** The counselor uses strategies to reduce resistance.
- **Support self-efficacy.** The counselor recognizes client strengths and encourages him or her to believe that change is possible.

MET uses structured instruments for assessing dimensions of substance use (e.g., consumption, biomedical and social consequences, family history, readiness for change, risk factors). (Several of these instruments are reproduced in appendix B of TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT 1999c].) Counselors provide feedback about assessment results in relation to societal norms and discuss clients' responses to this feedback.

Exhibit 8-3 summarizes the strengths and challenges of MI and MET.

Other Important Aspects

Staff

Staff members' educational levels are not critical to a motivational approach. Successful counselors may have graduate degrees and professional certification or be recovering peers. However, to become effective practitioners, counselors need special training as well as ongoing supervision to become proficient. Counselors also need to be flexible and have a high level of therapeutic empathy. Counselors are seen as collaborators or consultants rather than as experts.

Clients

MET was developed for, and has been effective with, clients exhibiting varying severities of alcohol-related problems. Court-mandated clients appear to benefit as much from MET as do self-referred clients.

Research Outcomes and Findings

A four-session version of MET was one of three 12-week approaches tested in Project MATCH. MET was found to be as effective as the other, more intensive interventions (CBT and 12-Step facilitation). Clients who rated high in anger fared better with MET, having more abstinent days (Project MATCH 1998).

Miller and Sanchez (1994) report that studies conducted in at least 14 countries indicate that relatively brief motivational interventions can have lasting, positive effects on drinking behavior that are comparable with the effects obtained with longer term treatment interventions.

Therapeutic Community Approach

The Basics

Therapeutic communities (TCs) have provided residential substance abuse treatment since the 1960s. Some programs have developed a modified, community-based IOT component either to provide treatment on an outpatient basis or to help graduates successfully transition from residential treatment into the community. Some traditional,

Exhibit 8-3

Strengths and Challenges of Motivational Approaches

Strengths	Challenges
• MI and MET are client centered and relevant to clients' personal interests. • MI and MET focus on realistic, attainable goals. • MI and MET encourage client self-efficacy and self-sufficiency. • MI and MET emphasize positive, empathic support that does not undermine or elicit anger from clients.	• MI and MET rely heavily on clients' capabilities and level of self-awareness. • Commonly used problem-oriented assessment instruments are incompatible with a motivational approach. • Although MET provides some guidance about effective interpersonal strategies for treating ambivalent clients, the approach does not specify session content. • Motivational approaches require significant staff training, reorientation, and ongoing supervision. • Motivational approaches may be difficult to combine with disease- or therapeutic community-oriented approaches that expect adherence to program-imposed goals. • MI and MET were developed as individual approaches; their effectiveness for use with groups is unproved.

community-based IOT programs serve clients who participated in TCs while the clients were incarcerated. IOT providers should understand the TC process to ensure continuity for clients.

TCs use an approach known as "community as method" (De Leon 2000). This approach sees the community as a whole—its social organization, its staff and clients, and its daily activities—as the therapeutic agent.

The TC model considers a substance use disorder as a disorder of the whole person. TC program staff members assess each participant's problems along dimensions of psychological dysfunction and social deficits (e.g., problems with authority, poor impulse control, dishonesty) as well as substance use patterns. The TC approach assumes that recovery is a developmental process entailing mutual help and social learning. The beliefs and values that are essential to a client's recovery include (De Leon 2000)

- Demonstrating truth and honesty in all situations
- Remaining in the "here and now"
- Assuming personal responsibility for one's behavior and future
- Demonstrating concern for others
- Developing a work ethic and understanding that rewards must be earned
- Understanding the distinction between external behavior and inner self
- Accepting that change is the only certainty
- Valuing the learning process

- Developing economic self-reliance
- Becoming involved in one's community
- Developing good citizenship

Because many clients served by TCs have histories of severe substance use disorders and criminal behavior, TCs typically strive to habilitate, rather than rehabilitate, clients. TCs focus on all aspects of the client's life, and all activities in the TC promote recovery and habilitation. TCs follow highly structured schedules, centering daily activities on group sessions and hierarchical job functions that teach participants specific behaviors and skills. In general, participants move from job to job in the community for different learning experiences. Peers confront negative behaviors and erroneous thinking in one another within a supportive milieu.

TCs include the following components (De Leon 1995):

- **A sense of community.** Community is created partly by a separation from other agency or institutional programs and, more important, from the drug-using environment. A TC facility contains communal space for promoting a sense of commonality during collective activities. Treatment or educational services (except individual counseling) must be delivered within the peer community.
- **Peers and staff members as role models.** TC members and staff members serve as positive role models by demonstrating expected behaviors and reflecting the values and teachings of the community. The strength of the community for social learning rests on the number and quality of its positive role models.
- **Work as therapy and education.** Consistent with the TC's self-help approach, all clients are responsible for the daily management of the facility, and work roles are designed to bring about essential educational and therapeutic effects.
- **Peer encounter groups, awareness training, and emotional growth training.** The encounter session is the main therapeutic group and heightens clients' awareness of specific attitudes or behavioral patterns that need to change. Other groups focus on helping clients identify feelings and express them appropriately and constructively.

TCs feature a structured day that includes ordered, routine activities to counter the characteristically disordered lives of clients and distract them from negative thinking and boredom. The treatment protocol is organized into phases and stages. When a client masters the objectives in one phase, he or she moves to the next phase. The length of treatment depends on the client's needs and progress in recovery. Continuing services are part of the TC approach. Clients benefit from a peer network that assists them with ongoing community-based services to sustain recovery.

De Leon (2000) describes the basic stages of a TC program as

- Admission evaluation (a preprogram stage)
- Induction (an orientation stage)
- Primary treatment
- Reentry (into the outside community)

Exhibit 8-4 summarizes the strengths and challenges of the TC approach.

Other Important Aspects

Staff

TC staff members are generally a mix of trained clinicians (certified counselors, nurses, physicians, and case managers) and TC graduates who have had at least some additional training (many become certified). All staff members are part of the community and serve as role models. Staff members typically receive considerable training in TC philosophy and methods. Management staff in particular must be well trained to work effectively in a TC.

Exhibit 8-4

Strengths and Challenges of the Therapeutic Community Approach

Strengths	Challenges
• The TC approach is effective for people with long histories of substance dependence and antisocial behavior. • The TC approach is particularly effective in teaching clients how to plan, set, and achieve goals and to be accountable. • The TC approach is effective in reducing recidivism among clients who have served time in prison.	• The approach may be too confrontational for some clients. • Effective TC treatment requires extensive staff training. • Treating clients with mental disorders can pose difficulties. • Finding an effective mix of professional clinicians and recovering staff (who may not be trained in assessment, treatment planning, and counseling) can take time.

Clients

Clients appropriate for TC treatment typically have educational and employment deficits and histories of poverty, relationship problems, criminal behavior experiences or criminal associations, housing instability, psychiatric disorders, or antisocial or other dysfunctional behavior. Many have had previous treatment episodes.

TC approaches should be modified for women, adolescents, and those with co-occurring mental disorders because the confrontational nature and strict hierarchical structure of a standard TC may not be as effective with these groups.

Training Manuals

CSAT has developed the *Therapeutic Community Curriculum* (CSAT 2006*g*, CSAT 2006*h*) to help supervisors provide TC staff members with an understanding of the essential components and methods of the TC and an appreciation that they are part of a long tradition of community as a method of treatment. The curriculum provides detailed session-by-session instructions for trainers and exercises for participants.

Special considerations

For clients in an outpatient TC, it is important to arrange for drug-free housing.

Research Outcomes and Findings

NIDA has funded treatment outcome studies that have found that TC treatment is associated with positive outcomes. For example, the Drug Abuse Treatment Outcome Study, a long-term study of treatment outcomes, found that clients who completed TC treatment had lower levels of cocaine, heroin, and alcohol use; criminal behavior; unemployment; and depression than they had before treatment (National Institute on Drug Abuse 2002).

Clinical trials of TC day treatment have found that client outcomes for residential TC and for day TC treatment are not significantly different (Guydish et al. 1999).

A study of the effectiveness of extending the TC model from prisons to community-based settings showed that inmates who participated in an institutional TC followed by a TC-oriented outpatient work-release program

had lower rates of drug use and recidivism than offenders who participated only in the institutional program (Inciardi 1996).

The Matrix Model

The Basics

The Matrix model was developed during the 1980s as an effective way to treat the increasing number of people dependent on stimulant drugs, particularly cocaine. Developers designed the Matrix model as a more intensive intervention than the then-standard weekly outpatient counseling or 28-day inpatient treatment. The Matrix model is a good fit for clients who require comprehensive care.

The Matrix model, originally known as neurobehavioral treatment, integrated several research-based techniques (including cognitive–behavioral, 12 Step, and motivational enhancement) to target clients' behavioral, emotional, cognitive, and relationship issues. More research is needed to determine optimal combinations of treatment approaches; the Matrix model is one of many programs that combine various approaches. The Matrix model has been selected for discussion because its approach is comprehensive and manual based and assessment data are available.

The Matrix approach is predicated on

- Establishing a strong therapeutic relationship between the client and counselor
- Teaching clients how to structure time and initiate an orderly and healthy lifestyle
- Imparting accurate, comprehensible information about acute and subacute withdrawal effects and cravings for substances
- Providing opportunities to learn and practice relapse prevention and coping techniques
- Involving family and significant others in the therapeutic and educational processes to gain their support for—and prevent their sabotaging of—treatment
- Encouraging clients to participate in community-based mutual-help groups
- Conducting random urinalyses or breath tests to assess treatment effectiveness

Several variations of the Matrix model have been developed. The original 12-month version began with 6 months of intensive treatment that included 56 individual counseling sessions (including conjoint sessions with the client and family members); clients attended treatment sessions 3 or 4 times a week. The individual sessions were supplemented by several types of educational, relapse prevention, family, and social support groups (Obert et al. 2000). The original cocaine-specific treatment protocol was followed by versions for people who used alcohol or opioids primarily. Because of cost constraints, a 16-week version of the Matrix model was developed that cut the number of individual sessions to three and emphasized group work.

In all versions of Matrix model treatment, a primary therapist coordinates the client's treatment experience. The relationship between the primary therapist and the client (and his or her family) is critical to treatment progress (Obert et al. 2000).

Individual sessions focus on treatment planning and evaluating progress and may include members of the client's family for at least part of the session. In addition to the individual sessions, the treatment protocol for the 16-week program includes specific structured groups (Obert et al. 2000):

- **Early recovery groups.** These groups are for those in the first month of treatment and are small to maximize the attention each client receives. Early recovery groups focus on teaching clients cognitive tools for managing cravings and emphasize time management. Clients create a daily schedule and monitor their activities with group input and support. Early recovery groups assist clients in connecting with community support services.

- **Family education sessions.** Family education is presented as a 12-week series and includes both clients and family members. These sessions include slide presentations, videos, panel presentations, and group discussions on topics such as the biology of addiction, medical effects of substances, conditioning and addiction, and effects of addiction on the family.
- **Relapse prevention groups.** These groups are the primary component of treatment. Group sessions are highly structured and focus on cognitive and behavioral change and on connecting clients to mutual-help programs. The group protocol includes 32 specific topics.
- **Social support groups.** These groups begin in the last month of treatment and focus on helping clients pursue drug-free activities and develop friendships with people who do not use substances. They are less structured than the other groups, and the content is determined by the needs of the group members.

Matrix programs orient clients to 12-Step programs and often schedule onsite 12-Step meetings. Clients are encouraged strongly to attend additional meetings in the community and to find a 12-Step sponsor.

Exhibit 8-5 summarizes the strengths and challenges of the Matrix model.

Other Important Aspects

Staff

Trained therapists are crucial to Matrix model treatment. They are expected to create nurturing, nonjudgmental relationships; maintain a supportive attitude in the face of a client's relapse; foster each client's self-esteem and dignity; and function as teachers or coaches without being either parental or confrontational. Clients with established long-term abstinence sometimes co-lead groups, serving as role models who put a human face on the recovery process.

Clients

The Matrix model has been used in many different settings (including prisons,

Exhibit 8-5

Strengths and Challenges of Matrix Model Treatment

Strengths	Challenges
• The model integrates a cognitive–behavioral approach with family involvement, psychosocial education, 12-Step support, and urine testing. • The model follows a manual, providing therapists with specific instructions and practical exercises. A version of the Matrix materials is available free from NCADI (CSAT 2006*c*, 2006*d*). • The model has been used extensively with people dependent on stimulants and has been shown to be effective.	• Some materials may need to be modified for clients whose cognitive functioning is impaired. • The program requires special staff training and supervision. • The highly structured content may not appeal to all clients. • The tight structure and schedule may not leave time for identification and stabilization of other non-drug-specific problems.

substance abuse treatment centers, and hospitals) and with a varied client population across the United States and in Mexico, Thailand, and the Middle East (Rawson 2003).

Treatment manuals

The Matrix model treatment materials contain instructions for therapists on conducting individual, group, and family education sessions (visit www.matrixinstitute.org). Handouts for clients and family members cover therapeutic session topics. Some materials have been translated into Spanish, Arabic, Thai, and other languages. CSAT has adapted the Matrix treatment manuals and made them available as a package called *Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders* (CSAT 2006*c*, 2006*d*).

Research Outcomes and Findings

Studies support the utility of Matrix model treatment. In a 1985 pilot study, individuals who selected Matrix treatment over a 28-day inpatient hospital program or participation in 12-Step groups reported significantly lower rates of cocaine use 8 months after treatment than those in either of the other groups (Rawson et al. 1986).

A controlled trial of the model found that people from lower income groups who smoke crack are more difficult to retain in Matrix treatment than those who used cocaine intranasally and had more social stability and resources (Obert et al. 2000).

Researchers conducting a CSAT-supported outcome study of Matrix model treatment (Rawson et al. 2002) interviewed a nonrandomized sample of clients who had used methamphetamine and received Matrix model treatment. They found that 2 to 5 years after completing treatment these clients had reduced their methamphetamine and other drug use substantially compared with their pretreatment levels. In addition, a substantial number of the former clients were employed and were not in the criminal justice system.

Shoptaw and colleagues (1998) developed a 48-session variation of Matrix treatment for gay and bisexual men who abuse methamphetamine. The model was found to be an important tool for preventing HIV infection because clients reduced their risky sexual behaviors concurrently with reductions in their stimulant use—without any specific focus on HIV/AIDS during treatment (Shoptaw et al. 1997, 1998).

Community Reinforcement and Contingency Management Approaches

The Basics

Community reinforcement (CR) and contingency management (CM) are treatment approaches based on operant conditioning theory. This theory maintains that future behavior is based on the positive or negative consequences of past behavior. For example, drug use is maintained by the positively reinforcing effects of the drug itself or by the negative reinforcement of relieving the pain of withdrawal. Abstinence, in and of itself, may not be sufficiently reinforcing to maintain a person's motivation to stop using drugs, particularly in early abstinence. Other rewards must be found that reinforce ongoing abstinence and lifestyle change.

CM is an approach in its own right, but its operant interventions are also the main treatment tool used in CR. In CR, the positive and negative reinforcers that characterize CM are understood to be socially mediated. CR uses aspects of the client's life—relationships with family and friends,

job, hobbies, social events—to provide the positive reinforcement that motivates the client to stop using substances. CR is successful when the client chooses the rewarding relationship and activities over substance use. (See Chapter 6 for a discussion of how CR can be used to motivate family members to support the client.) CR and CM approaches motivate clients' behavioral change and reinforce abstinence by systematically rewarding desirable behaviors and ignoring or punishing others. Reinforcers are typically positive, pleasurable, and rewarding events or objects, but some negative reinforcers also are effective. Removing a fine or restriction after a client has complied with a specified regimen is an example of negative reinforcement.

A challenge in this treatment model is to identify a reward for a desired behavior that is both practical and sufficiently powerful—over time—to replace or substitute for the potent, pleasurable, or pain-reducing effects of the drug. The reward must be available without too much cost or expenditure of staff energy. The rewards and punishments must be tailored carefully to clients' responses, as well as program capabilities. For example, vouchers worth $5 may be motivators for some clients but not others or at a particular point in treatment but not later. Most of the financial or voucher-based CM interventions use an escalating series of rewards for achievement of the target behavior, such as drug-free urine specimens. The escalating rewards provide a greater incentive for sustaining the desired behavior. On the other hand, Kirby and colleagues (1998) found greater reductions in cocaine use when a larger reward was given at the beginning of treatment, coupled with increased requirements for earning vouchers as treatment progressed.

An example of this approach is described in a NIDA treatment manual, *A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction* (Budney and Higgins 1998). In this approach, abstinence is reinforced by awarding vouchers. Drug avoidance skills and relapse prevention techniques are taught along with social and recreational counseling, relationship counseling, and social and other skills training. Clients earn points for each urine screen that is negative for cocaine. For each consecutive negative urine screen, the number of points is increased. If a client submits a urine specimen that is positive for cocaine, the point value returns to baseline. The client can earn back the points lost by submitting five consecutive negative urine specimens. The client can "redeem" points for a variety of retail items that are purchased by program staff (clients are never given cash). Staff members have veto power over clients' requests. In general, staff members approve only items that are consistent with a client's treatment goals and encourage drug-free activities. Examples of items purchased for the program's clients include socks, toaster ovens, baby clothes, camera equipment, ski lift tickets, bicycle equipment, and continuing education materials.

> Abstinence...may not be sufficiently reinforcing to maintain a person's motivation to stop using drugs...

Effective CR and CM programs select a targeted behavior that is attainable in a reasonable amount of time and has a direct effect on the desired outcome. For example, expecting clients who have never submitted a drug-free urine sample to achieve immediate abstinence may be optimistic. Abstinence from a specific substance might precede abstinence from all substances. Targeting small changes is an effective strategy. More frequent reinforcers, even if small, have a greater effect than larger, more remote rewards or punishments. It is also important that the desired behavior contribute to the treatment goals. A person's merely attending counseling sessions may not affect his or her drug use. Of course,

all rewards must be delivered as promised for the treatment to remain credible (Crowley 1999; Morral et al. 1999).

Specialized assessment and treatment planning instruments are not required for successful implementation of a CM intervention. However, CM interventions depend on detailed and precise measurements of the targeted behavior. Because of the short half-life of alcohol, using CM procedures to monitor alcohol abuse can be difficult. Self-reported drug use status is not adequate for awarding vouchers. Rather, drug use status must be determined by frequent testing of observed urine specimens (Crowley 1999). Similarly, if work activity is the target behavior, it is not enough to ask clients about their attendance or productivity. Objective, verifiable measures that demonstrate accomplishments must be used.

Activity schedules used in CR and CM programs can vary dramatically. As an example, the activity schedule of an intensive reinforcement-based day hospital program provided abstinence-contingent partial support of housing and food and access to recreational activities, social skills training, and job-finding groups (Gruber et al. 2000). The program required clients recently detoxified from heroin and cocaine to attend treatment for 6 hours a day on weekdays and 3 to 4 hours a day on weekends for the first 2 weeks, then 1-hour individual counseling sessions three times per week for the next 6 weeks, and then two sessions per week for another 4 weeks. Abstinence-based contingencies were in effect for the first month of the program. By contrast, the schedule for a 6-month CR-plus-vouchers treatment entailed 60-minute individual counseling sessions two times a week and urine monitoring three times a week during the first 12 weeks. This was followed by weekly counseling and twice weekly urine testing in weeks 13 to 24 (Budney and Higgins 1998).

Exhibit 8-6 summarizes the strengths and challenges of CR and CM.

Other Important Aspects

Staff

Designing CR and CM treatment programs requires specialized training and knowledge of operant learning principles. In practical terms, however, operant learning principles can be applied by staff members who have proper training and supervision. Some counselors may feel that the theories of operant conditioning or behavioral learning are inconsistent with the disease concept of substance use disorders (Bigelow and Silverman 1999) and are incompatible with their training and practice because behaviorists view addiction as a learned behavior rather than an illness with biological, psychological, and spiritual roots.

Clients

Intensive CM interventions have been used with treatment-resistant clients and with clients who have severe problems related to employment or housing or who have psychological and medical conditions and have been unsuccessful in achieving abstinence through traditional counseling methods. Behavioral interventions have been effective with people who use cocaine (Higgins 1999), persons who are homeless (Milby et al. 1996), pregnant women (Higgins 1999), and individuals on methadone who need to discontinue other drug abuse (Higgins 1999).

Funding

The cost-effectiveness of CR and CM is affected by the expense of incentives, additional urine screens, and the additional time demands placed on staff members. In some research projects incentives cost $1,200 or more per client. This expense has limited application of CM techniques to research studies or small-scale project demonstrations. However, alternative low-cost incentives can be used to bolster the effect of traditional treatment interventions; donated goods and services can reduce the costs of CR and CM (Amass and Kamien

Exhibit 8-6

Strengths and Challenges of Community Reinforcement and Contingency Management Approaches

Strengths	Challenges
• CR and CM have been shown to reduce drug use significantly when incentives are used. • CR and CM can be combined readily with other psychosocial interventions and pharmacotherapies. • CR and CM can be implemented with a variety of low-cost incentives such as donated goods or services. • CR and CM have proved effective for reducing drug use and increasing treatment compliance among clients with severe problems who are chronically substance dependent. • CR and CM have extensive and robust scientific support in both laboratory and clinical studies.	• Clients may return to baseline drug use rates when incentives are terminated. • CM approaches can be labor intensive, require specialized staff or training for implementation, and entail frequent client attendance. • For maximal effectiveness, rewards must be sufficiently large—and increase in value—to have continuing appeal to clients. • Many research studies demonstrating CR and CM effectiveness have used small samples and incurred large costs for incentives. • Resources required for implementing CR and CM (e.g., onsite urine-testing capabilities or alternatives to costly incentives) may be unavailable. • Lack of emphasis on long-term supports is a potential drawback.

2004). Anniversary celebrations, special books, reductions in clinic fees, and letters of support to employers and protective service workers are among the incentives that can be used. Some programs have raised funds to support incentives or solicited local merchants for donations of goods or services (Kirby et al. 1999*a*).

Research Outcomes and Findings

Studies show that the CM approach to treating substance use disorders has proved effective in motivating clients to achieve and sustain abstinence as well as increase their compliance with other treatment objectives (Bigelow and Silverman 1999; Higgins 1999; Morral et al. 1999). Generally, these studies have been conducted in outpatient settings in which delivery of incentives is coupled with traditional individual or group counseling and education services. More recently, the CM approach has been applied in intensive outpatient and day treatment settings.

The NIDA treatment manual on community reinforcement (Budney and Higgins 1998) has provided an impetus for using empirically established CM techniques for treating cocaine abuse. The manual presents findings from five controlled clinical trials that supported the superiority of CR plus vouchers over standard care. In one study, 75 percent of the clients participating in CR plus vouchers completed the program, compared with

only 11 percent of standard care clients. Two subsequent studies showed that adding redeemable vouchers was more effective than CR as a standalone treatment (Higgins et al. 1995). A literature review of similar CR approaches found positive effects on cocaine dependence in 11 of 13 studies (Higgins 1996). Higgins and colleagues (2000) found that incentives delivered contingent on cocaine-free urinalysis results significantly increased abstinence during treatment and at 1-year followup.

Another landmark CM study examined the effectiveness of housing incentives for reducing crack cocaine use among people who are homeless (Milby et al. 1996). Incentives for drug-free housing and vouchers for social and recreational activities were more effective than 12-Step-oriented treatment alone for reducing alcohol and cocaine use as well as homelessness. At the 12-month followup, however, cocaine use in both groups had returned to baseline levels, suggesting the need for more intensive aftercare in this difficult-to-treat population.

9 Adapting Intensive Outpatient Treatment for Specific Populations

In This Chapter...

Justice System Population

Women

Populations With Co-Occurring Psychiatric Disorders

Adolescents

Young Adults

Many assumptions and approaches used in intensive outpatient treatment (IOT) programming were developed for and validated with middle-class, employed, adult men. This chapter presents information about how IOT can be adapted to meet the needs of specific populations: the justice system population, women, people with co-occurring mental disorders, and adolescents and young adults. Chapter 10 presents information on treatment approaches for other special groups, including minority populations.

Justice System Population

The number of people in the justice system with a history of substance use disorders has increased dramatically over the last 20 years because of increased drug-related crime, Federal and State legislation, and mandatory sentencing guidelines; many of these people are caught in a cycle of repeated incarcerations.

Between 1990 and 1999, the number of inmates sentenced to Federal prison for drug offenses rose more than 60 percent (Beck and Harrison 2001). About three-quarters of all prisoners reported some type of involvement with alcohol or drug abuse before their offenses, and an estimated 33 percent of State prisoners and 22 percent of Federal prisoners say that they had committed their current offenses while under the influence of drugs, with marijuana/hashish and cocaine/crack used most often (Mumola 1999).

Description of the Population

Justice system populations are younger than the general population, are overwhelmingly male, and are challenged with many psychosocial, medical, and financial problems (Brochu et al. 1999).

Psychosocial issues

People involved with the justice system typically have many problems related to employment and financial support, housing, education, transportation, and unresolved legal issues. Many inmates have not completed high school or earned a general equivalence diploma. Only about 55 percent were employed full time before their incarceration (Bureau of Justice Statistics 2000).

Medical and psychiatric problems

Offenders with a substance use disorder may have co-occurring psychiatric disorders. Approximately 16 percent of State inmates, 7 percent of Federal inmates, and 16 percent of jail inmates and probationers reported having mental illnesses, and nearly 60 percent of these offenders reported that they were under the influence of alcohol or drugs at the time of their offenses (Ditton 1999).

A major challenge to IOT providers is to integrate substance abuse treatment with justice system processes.

People in prison have a high incidence of HIV/AIDS (Maruschak 2002), tuberculosis, sexually transmitted diseases, and hepatitis C (National Institute of Justice 1999).

Female offenders

Between 1990 and 2000, the number of women involved with the justice system (incarcerated, on probation, or paroled) increased by 81 percent (Bloom et al. 2003). Women accounted for 15 percent of the total correctional population in 1998; 90 percent were under community supervision (Glaze 2003; Harrison and Beck 2003). Seventy-two percent of the women in Federal prisons were convicted of drug offenses or committed their crimes while under the influence of drugs or alcohol (Greenfeld and Snell 1999). Female offenders with substance use disorders experienced more health, educational, and employment problems; had lower incomes; reported more depression, suicidal behavior, and sexual and physical abuse; and had more mental and physical health problems than did male offenders with substance use disorders (Langan and Pelissier 2001). More than half the female inmates in prisons had at least one child younger than 18 (Mumola 2000). The National Institute of Corrections' *Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders* (Bloom et al. 2003) provides more information about female offenders.

Double stigma

Offenders often are affected by the stigma associated with involvement in the justice system, as well as the stigma associated with substance abuse. These two factors can impede an offender's ability to obtain appropriate employment or housing.

Implications for IOT

In response to the increase in drug-related judicial cases, several approaches for treating offenders who have a substance use disorder have been developed. IOT providers become involved in treating offenders when the offender is (1) referred to treatment in lieu of incarceration, (2) incarcerated, or (3) released.

Coercion frequently is used to compel offenders to participate in treatment. Coercion may be a sentence mandating treatment or a prison policy mandating treatment for inmates discovered to have a substance use disorder while incarcerated for a non-drug-related crime. For nonincarcerated offenders, a sanction for refusing to participate in treatment often is incarceration. Research indicates that treatment adherence and outcomes of clients legally referred to

treatment were the same as or better than those of clients entering treatment of their own volition (Farabee et al. 1998; Marlowe et al. 1996, 2003).

Working With the Judicial System

IOT programs provide treatment for the following justice system clients:

- **Offenders referred to treatment in lieu of incarceration.** IOT providers have developed effective partnerships with drug courts and Treatment Accountability for Safer Communities (TASC) programs to provide treatment (Farabee et al. 1998). Drug courts, begun in 1989, divert nonviolent offenders with substance use disorders into treatment instead of incarceration. Drug courts oversee the offender's treatment, coordinate justice and treatment systems procedures, and monitor progress. TASC, formerly known as Treatment Alternatives to Street Crime, identifies and assesses offenders involved with drugs and refers them to community treatment services.
- **Offenders discharged from residential substance abuse treatment who need continuing community-based treatment.** IOT programs provide stepdown, but structured, services and transitional services and links to other services for offenders who are discharged from residential treatment.
- **Offenders who need treatment and are placed under community supervision (pretrial, probation, or parole).** Many justice programs have been developed to support this type of treatment for people who are under the supervision of the justice system but are allowed to remain in the community.
- **Offenders reentering the community after incarceration.** Reentry management programs funded by various Federal agencies facilitate the transition and reintegration of prisoners released into the community. IOT providers, working closely with justice staff before individuals are released, engage offenders in treatment and support their continuing recovery through flexible, individualized approaches. TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT 1998*b*), provides more information on transition of prisoners to the community.
- **Offenders who participate in treatment while incarcerated.** IOT can be modified for use in prisons and jails, although this stretches the concept of outpatient treatment. Institutions that can segregate offenders in IOT from the rest of the incarcerated population provide a more effective and supportive structure (U.S. House Committee on the Judiciary 2000).

Forging a Working Partnership

A major challenge to IOT providers is to integrate substance abuse treatment with justice system processes. Partnerships are being forged effectively as justice agencies and treatment providers recognize that, although they have different perspectives, they can work together. Both parties need to be flexible and interact with clients on a case-by-case basis (Farabee et al. 1998). Justice officials and IOT providers need to agree on which clients are appropriate for treatment and establish clear screening and admission criteria.

Rules for Offenders in Treatment

Most justice system and IOT program partners agree that offenders in treatment must not commit another offense, must abstain from drug use, and must comply with treatment requirements. However, disagreements about additional rules may emerge. As a result, some policies and sanctions may work against the recovery they are designed to achieve. IOT program staff members can

help prevent or resolve such conflicts by discussing these matters with judges and other criminal justice officials. Staff members who are familiar with research on treatment outcomes are best suited to convey to others a realistic, convincing argument for treatment and to foster cooperation that leads to client recovery. Developing and agreeing on a process for resolving conflicts early in the collaboration may reconcile discordant opinions. For the collaboration to function smoothly, IOT program staff needs the discretion to make decisions about treatment, such as whether the offender needs a different level of care. The justice system staff needs to be confident that it will be informed of treatment progress or if sanctions are justified. The partners must agree on the following:

- **Consequences for lapses in abstinence and continued drug use.** When a client admits to a single episode of drug use in a treatment session, the counselor may view this as a positive development; this admission of use may indicate that the client has gone beyond denial and begun to work on treatment issues. Justice system staff, however, may disagree and consider any drug use grounds for incarceration. IOT staff members may agree to sanctions only when continued episodes of drug use indicate that the offender is not committed to treatment.
- **Consequences for use of alcohol.** The justice system considers alcohol a legal substance and is concerned only with illegal activity resulting from its use. Consequently, the justice agency may not apply sanctions for continued alcohol use. In contrast, treatment providers consider alcohol an addictive substance and usually enforce no-use-of-alcohol rules. The topic warrants extended conversation between partners to develop reasonable responses to alcohol use.
- **Discharge criteria.** Agreed-on discharge criteria that define treatment goals, conditions indicating therapeutic discharge, and behavior meriting immediate discharge are needed.
- **Uses of drug-testing results.** The justice system regards drug-screening test results as an objective measure of progress or nonadherence to treatment and can impose severe consequences for positive drug tests. Many IOT programs use drug test results therapeutically, to inform treatment plans and to deter clients from using substances. Both systems need to discuss how drug test results will be used.

Communication Between Systems

Clear communication between the two systems is essential. For all referrals from the justice system (pretrial services, probation, and parole), an IOT program should designate point-of-contact personnel. To ensure clients' privacy rights, programs need to have confidentiality release forms that specify the information to be shared and the length of time the forms are in effect; all clients must sign these forms. These forms permit the two agencies to communicate information about the offender for monitoring purposes.

IOT providers are advised to discuss and agree on the following communication issues with their justice system partners:

- The form and timing of updates on treatment progress from the treatment program to the justice agency
- Reportings of critical incidents, such as when an offender threatens to commit a crime or fails to appear for treatment
- Reportings from the criminal justice agency, such as when an offender is rearrested or incarcerated

Memorandum of Understanding

Once justice system and IOT program partners agree on rules, consequences, and elements of communication, the agreement

needs to be formalized in a written memorandum of understanding (MOU). The suggested elements of an MOU include

- Parameters of treatment, including the kinds of services
- Each partner's responsibilities (e.g., the criminal justice agency refers and monitors clients; the treatment program assesses and treats clients)
- The consequences for noncompliant behavior, recognizing that not every contingency can be foreseen
- Identification of which agency determines the consequences of noncompliant behavior
- The types, content, and timetable of communications and reportings required between the partners
- Definitions of critical incidents that require the treatment program to notify the justice agency

Clinical Issues and Services

Although working with clients involved with the criminal justice system is challenging, it can be rewarding. For example, approximately 60 percent of people involved with drug courts remained in treatment for at least a year, with a minimum 48-percent graduation rate (Belenko 1999). Clients involved with the justice system have unique stressors, including, but not limited to, their precarious legal situation. Clients may need help with transportation, educational services, family issues, financial issues such as obtaining welfare and Medicaid benefits and arranging restitution payments, housing such as arranging temporary shelter and permanent housing, and job skills and employment counseling. Case management can coordinate services for justice system clients.

TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* (CSAT 2005*d*), provides more information about treating this population.

Staff Training

Treatment is impeded when counselors have a negative attitude toward clients, believe that clients have a poor prognosis for recovery, or are reluctant to serve offenders in general. These issues should be included in staff training and cross-training.

To provide effective substance abuse treatment to criminal justice system clients, staffs in both systems need cross-training (Farabee et al. 1999). Topics include the philosophy, approach, goals, objectives, and boundaries of both systems. Treatment providers need information about the responsibilities, structure, operations, and goals of the justice system; public safety and security concerns; and how involvement with the justice system affects offenders. Criminal justice system personnel need information about the dynamics of substance use disorders, components of treatment, how treatment can reduce recidivism, confidentiality, and co-occurring psychiatric disorders.

> For all referrals from the justice system...an IOT program should designate point-of-contact personnel.

Women

In recent years, heightened awareness and new funding have encouraged the development of specialized programs to address the treatment needs of women. The number of treatment facilities offering programs for pregnant and postpartum women rose from 1,890 in 1995 to 2,761 in 2000, and more than 5,000 facilities offered special programs for women (Substance Abuse and Mental Health Services Administration 2002). The forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT forthcoming *b*), TIP 25, *Substance Abuse Treatment and Domestic Violence*

(CSAT 1997*b*), and TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000*b*), provide more information.

Description of the Population

Even though women and men who have substance use disorders have many similarities, they differ in some important ways. Women typically begin using substances later and enter treatment earlier in the course of their illnesses than do men (Brady and Randall 1999). Other differences with therapeutic implications are briefly surveyed below. Discussions of strategies for addressing women-specific treatment issues follow.

Violence

Women with substance use disorders are more likely than men with substance use disorders to have been physically or sexually abused as children (Bartholomew et al. 2002; Simpson and Miller 2002). In addition, women who have a substance use disorder are more likely to be victims of domestic violence (Chermack et al. 2001), with reported rates of women in treatment who have been victims of physical and sexual violence ranging from 75 percent (Oumiette et al. 2000) to 88 percent (B.A. Miller 1998).

Mental disorders

Compared with men, women with substance use disorders have nearly double the occurrence (30.3 percent vs. 15.7 percent) of serious mental illness and past year substance use disorders (Epstein et al. 2004). These higher rates of psychiatric comorbidity are particularly evident in mood and anxiety disorders (Zilberman et al. 2003).

Parenting issues

Women in treatment often bear the sole caretaking responsibility for their children, and this role can be a substantial obstacle to seeking and remaining in treatment. Women may have difficulty finding reliable and affordable child care. They may fear losing custody of their children because of their substance use, and this fear may deter them from entering treatment. At the same time, women (and men) who abuse substances are more likely to abuse or neglect their children (National Clearinghouse on Child Abuse and Neglect Information 2003).

Welfare issues

Some States require that individuals receiving welfare benefits be screened and treated for substance use disorders; failure to enroll in or dropping out of treatment may jeopardize benefits (Legal Action Center 1999). Such requirements can help retain a client in an IOT program, and a case manager should coordinate treatment with welfare staff.

Pregnancy

Substance use during pregnancy can mean poor prenatal care, unregistered delivery, and low-weight and premature babies (Howell et al. 1999). Heavy or binge alcohol or drug use during pregnancy can result in negative consequences for the child such as neurological damage, including fetal alcohol syndrome (American Academy of Pediatrics 2000).

Relationships

A woman's substance use disorder is often influenced by her partner. Women with male partners who use substances are retained in treatment for a shorter time than women with substance-free partners (Tuten and Jones 2003). Conversely, a woman's partner can have a positive influence on treatment through support and participation in treatment.

Implications for IOT

Effective treatment for women cannot occur in isolation from the social, health, legal, and other challenges facing female clients. Some studies suggest that gender-specific treatment may be advantageous for female

clients (Grella et al. 1999), producing higher success rates in women-only groups or programs. However, research to date on the best treatment for women is inconclusive (Blume 1998).

Barriers to treatment entry and retention

Once a woman decides to seek help, she may face a long wait because of the lack of appropriate treatment. In addition, she faces gender-specific barriers and issues that may affect entry and retention in treatment such as

- Concerns about fulfilling her responsibilities as a mother, wife, or partner
- Fears of retribution from an abusive spouse or partner
- Gender and cultural insensitivity of some treatment programs
- Threat of legal sanction, such as loss of child custody
- Lack of affordable or reliable child care
- The disproportionate societal intolerance and stigma associated with substance abuse in women compared with men
- Ineligibility for treatment medications if she is pregnant or may become pregnant
- Having few other women in treatment with her

Entry and assessment

A woman entering treatment needs to feel that the environment is safe and supportive. IOT program staff members who are understanding, respectful, optimistic, and nurturing can build a positive, therapeutic relationship. It may help if the intake counselor is a woman. The client may be fearful, confused, in withdrawal, or in denial, and staff members need to be patient and supportive, understanding that it is empowering for the client to choose when to provide information and what information to provide. Additional ways to facilitate entry include providing help with child care and extending program hours for working women.

Using a comprehensive assessment, staff members can identify the client's strengths and weaknesses and work with her to develop specific treatment goals and a treatment plan. Because of the likelihood of victimization and presence of co-occurring psychiatric disorders, female clients need careful assessments for psychiatric disorders and history of childhood trauma and adult victimization. Chapter 5 discusses intake forms that can be used or modified to gather these data. Victimization experiences may be hidden beneath shame and guilt but, as trust develops, the client can discuss these events.

A woman entering treatment needs to feel that the environment is safe and supportive.

Clinical Issues and Strategies

Some women-specific programs are based on the philosophy that supporting and empowering women improve treatment success. Some programs advocate using predominantly female staff in professional and support positions. Providing enhanced services that respond to the social service needs of women is important for effective substance abuse treatment for women with children (Marsh et al. 2000; Volpicelli et al. 2000).

Treatment components specific to women

Exhibit 9-1 identifies core clinical needs and service elements that should be addressed in IOT for women (CSAT 1994*d*).

It is important to identify issues that the client is uncomfortable discussing in a group setting. As a woman feels more comfortable, she may be able to discuss them. Relapse prevention techniques may need to be modified for women. There is some evidence that

Exhibit 9-1

Core Treatment Needs and Service Elements for Women

Core Treatment Needs	Service Elements
Relationships with family and significant others	Provide family or couples counseling
Feelings of low self-esteem and self-efficacy	Address in group and individual counseling Identify and build on the client's strengths
History of physical, sexual, and emotional abuse	Avoid using harsh confrontational techniques that could retraumatize the client Hold individual and group therapy sessions or refer for treatment
Psychiatric disorders	Refer for or provide evaluation and treatment of psychiatric disorders, medication management, and therapy
Parenting, child care, and child custody	Hold parenting classes Develop substance abuse prevention services for children Provide or arrange for licensed child care, including a nursery for infants and young children and afterschool programs for older children Assist with Head Start enrollment
Medical problems	Refer for medical care, including reproductive health, pregnancy testing, and testing for or treating of infectious diseases
Gender discrimination and harassment	Ensure that the program has policies against harassment and that they are enforced

women's relapses are related to negative mood, more so than men's (Rubin et al. 1996). Also, women may do better in women-only counseling groups (Hodgins et al. 1997).

Therapeutic styles

Women who abuse substances may benefit more from supportive therapies than from other approaches and need a treatment environment that is safe and nurturing (Cohen 2000). Safety includes appropriate boundaries between counselor and client, physical and emotional safety, and a therapeutic relationship of respect, empathy, and compassion (Covington 2002).

For women with low self-esteem and a history of abuse, harsh confrontational approaches may further diminish their self-image and retraumatize them. Less aggressive approaches based on understanding and trust are more likely to effect change (Miller and Rollnick 2002). The confrontational approach of "breaking down" a person in treatment and rebuilding her as a recovering person may be overly harsh and not conducive to treating women (Covington 1999).

Woman clients can be referred to mutual-help groups such as Women for Sobriety and 12-Step groups that are sensitive to the needs of women. Some areas have women-only Alcoholics Anonymous (AA) and Narcotics Anonymous meetings, and some groups provide onsite child care. *A Woman's Way Through the Twelve Steps* (Covington 1994) and its companion workbook can help women adapt the 12 Steps for their use (Covington 2000).

Considerations for domestic violence survivors

IOT providers need to consider the safety of the client, develop and implement a personal safety plan for her, and notify the proper authorities if she is in danger. TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT 1997*b*), provides additional information.

Treatment for pregnant women

Because of the possible harm to fetuses, it is important to provide comprehensive treatment services to pregnant women who abuse substances. IOT has produced positive results for pregnant women, and retention in treatment is facilitated by provision of support services such as child care, parenting classes, and vocational training (Howell et al. 1999). Elements of one model program for pregnant women include (CSAT 1993*a*; Howell et al. 1999)

- A family-centered approach with pregnancy and parenting education and mother–child play groups
- Interdisciplinary staff
- Counselor continuity
- Physical and mental health services
- Child care and transportation services
- Housing services that address homelessness or unstable and unsafe housing conditions

Other programs have found that being flexible and responsive to clients' needs and using nonconfrontational approaches improve the health of the women and newborns (Whiteside-Mansell et al. 1999).

Staffing and Training

Making a treatment program gender sensitive requires changes in staffing, training, and treatment approaches. Female program staff and advisory board members may be more sensitive to the needs of female clients. However, male clinicians can work effectively with female clients.

Training on issues and resources specific for women is necessary. Both female and male staff members should be trained about the ramifications for treatment of sexual, physical, and emotional abuse and partner violence. Training should overcome the tendency to blame the victim. Other training needs may include assessment techniques for violence or abuse, appropriate referrals

to mental health professionals, coordinating services with other agencies, and food programs that serve women and children. To prevent sexual harassment of female clients, program rules should be explicit and strictly enforced. Providers need to become familiar with the duty-to-warn requirement as it pertains to reporting child abuse and neglect and partner violence.

Populations With Co-Occurring Psychiatric Disorders

In the field of substance abuse treatment, people with both psychiatric and substance use disorders are said to have co-occurring mental disorders.

Description of the Population

Many clients with co-occurring disorders are in IOT. The Drug Abuse Treatment Outcome Study found that 39 percent of admissions to substance abuse treatment met *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised (DSM-III-R) (American Psychiatric Association 1987) diagnostic criteria for an antisocial personality disorder, 11.7 percent met criteria for a major depressive episode, and 3.7 percent met criteria for a general anxiety disorder (Flynn et al. 1996). Other studies support these findings (Compton et al. 2000; Merikangas et al. 1998).

> Most people with co-occurring mental and substance use disorders are not receiving appropriate care.

According to the Treatment Episode Data Set, people admitted to treatment who had a co-occurring psychiatric disorder were less likely than people admitted with only substance use disorders to be in the labor force. They were more likely to be women, abuse alcohol, and be referred through alcohol or drug abuse treatment providers and other health care providers than people admitted for substance abuse only (who were more likely to be have been referred by the criminal justice system) (Office of Applied Studies 2003*a*).

Group characteristics

When a client has co-occurring disorders, both the client and IOT counselor are presented with many challenges, such as

- Interacting symptoms that complicate treatment
- Increased biopsychosocial disruptions such as increased family problems, violent victimization, financial instability, homelessness, incarceration, suicidal ideation or attempts, and medical problems

Barriers to accessing treatment

Most people with co-occurring mental and substance use disorders are not receiving appropriate care (Watkins et al. 2001). Two of the numerous barriers to treatment are limited access to treatment and poor coordination between treatment systems.

In addition, historically, substance abuse and psychiatric treatments were provided in separate settings, and it was believed that one disorder must be stabilized before the other disorder could be treated, resulting in fragmented services. Clients were caught between two systems (Drake et al. 2001). The different treatment approaches led to misunderstandings between mental health and substance abuse treatment providers. Mental health providers may use more motivational and supportive techniques and professionally trained staff, whereas substance abuse treatment programs use more confrontational approaches, which may be distressing

for clients with co-occurring disorders, and often combine peer support with professionally trained counselors (Minkoff 1994). Some substance abuse treatment providers and recovering peers still may harbor anti-medication attitudes and not understand the benefit of psychotropic medications.

Implications for IOT

Although clients with co-occurring psychiatric disorders may be challenging, they benefit from treatment (Dixon et al. 1998). Treatment has produced marked reductions in suicide attempts, mental health visits, and reports of depression (Karageorge 2002). Clients with less serious mental disorders appear to do well in traditional substance abuse treatment settings (Sloan and Rowe 1998), and outpatient treatment can be an effective setting for treating substance use disorder in clients with less serious mental disorders (Flynn et al. 1996). Long-term approaches seem more effective than short-term acute care (Bixler and Emery 2000). Clients with psychotic conditions, however, might pose insurmountable challenges for most IOT programs.

Theoretical Background

Integrated treatment

For the past two decades, integrated treatment has been proposed as an effective treatment approach. Minkoff (1994) presents a theoretical framework that considers both disorders chronic, primary, biologically based mental illnesses that are likely to be lifelong, but he suggests that conjoint treatment could reduce symptoms of both disorders effectively and promote recovery. His general treatment principles follow:

- Recognize that the basic elements and processes of addiction treatment are the same for clients who have a psychiatric disorder as for those without one.
- Include education, empathic confrontation of denial, relapse prevention, and involvement with both professional- and peer-led groups.
- Modify standard substance abuse treatment by simplifying interventions, accommodating cognitive limitations if necessary, adapting step or group work, and using mutual-help groups for people with co-occurring psychiatric disorders.
- Develop interventions specific to each phase of treatment.
- Provide comprehensive services that cover treatment of both disorders.

In a review of the literature on treating substance use disorders and co-occurring schizophrenia, Drake and colleagues (1998*b*) found that integrated treatment, especially when delivered for 18 months or longer, resulted in significant reduction in substance abuse and, in some cases, in substantial rates of remission, reductions in hospitalizations, and improvements in other outcomes. Many IOT programs do not treat clients with serious mental disorders such as schizophrenia on a regular basis and do not have the advantages of the programs cited in Drake and colleagues' review (e.g., intensive case management, 18-month treatment window). Charney and colleagues had similar success treating clients with co-occurring depression over a 6-month period (2001). Treatment retention and outcome improved when psychiatric services were provided at the substance abuse treatment facility.

Integrated treatment coordinates substance use and mental disorder interventions to treat the whole client and

- Recognizes the importance of ensuring that entry into *one* system provides access to *all* needed systems
- Emphasizes the association between the treatment models for mental disorders and addiction
- Advocates the concomitant treatment of both disorders
- Follows a staged approach

- Uses treatment strategies from both the mental health and substance abuse treatment fields

Conceptual framework

The National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors, with support from the Substance Abuse and Mental Health Services Administration (SAMHSA), developed a conceptual framework of four quadrants to classify service coordination and help providers categorize treatment according to the severity of symptoms of both disorders (see exhibit 9-2) (Substance Abuse and Mental Health Services Administration 2002).

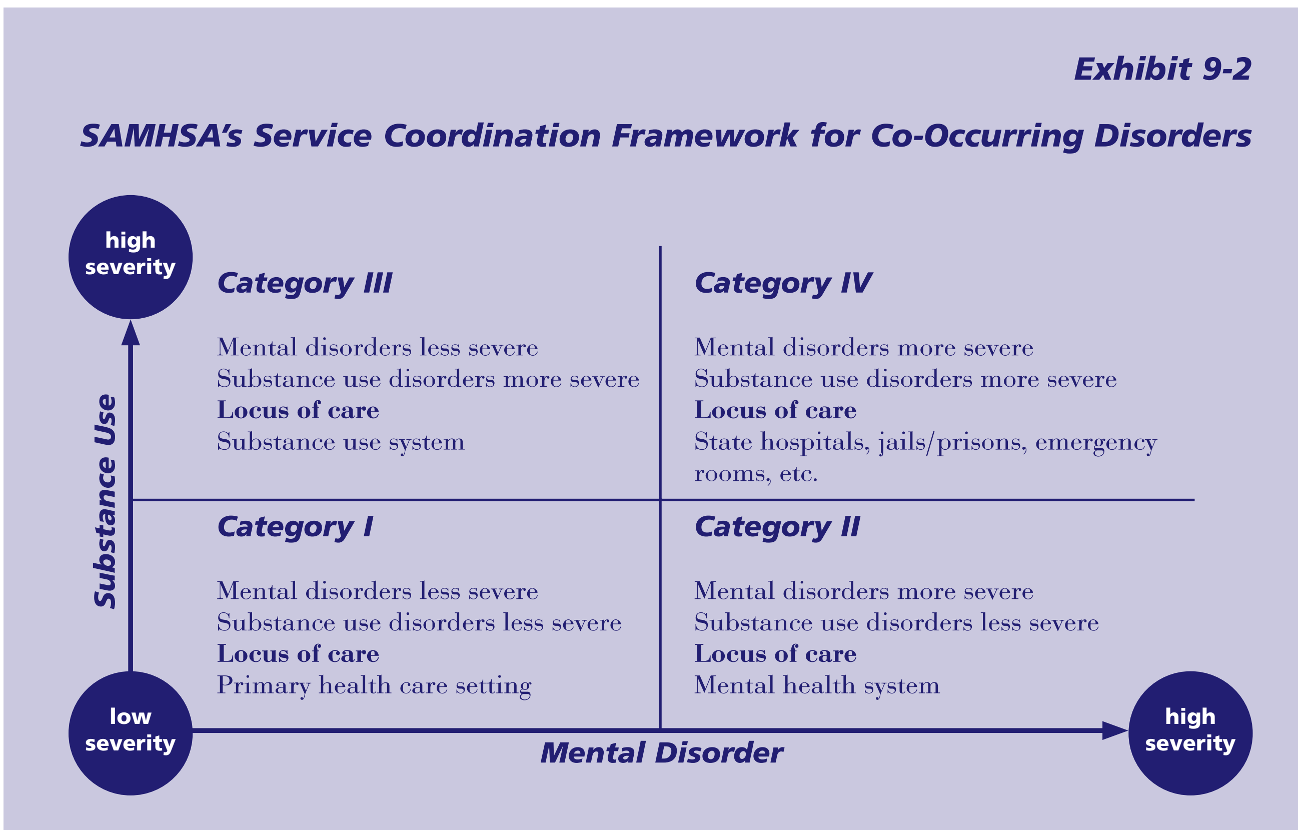
Clients in category I often are identified in primary care, educational, or community settings and may need consultation services for prevention and early intervention services. Clients in categories II and III generally present or are referred for treatment for their more severe disorder—either mental or substance use disorder—often leaving them with little or no care for the other disorder. These clients may be referred to IOT programs, and care requires collaboration between mental health and IOT providers. Clients in category IV generally need comprehensive, integrated treatment (Substance Abuse and Mental Health Services Administration 2002).

Clinical Issues and Strategies

Modifications to clinical approaches and service elements to assist clients with mental disorders are essential. When financial or other limitations require the provision of care in separate settings, treatment services need to be coordinated assertively and efficiently.

Core treatment needs and service elements

Screening. All clients need to be screened for co-occurring psychiatric disorders to



determine whether they have signs and symptoms warranting a comprehensive psychological assessment. These signs and symptoms may be subtle, and clients may minimize or deny symptoms because of fear of stigma.

Assessment. A thorough assessment should be performed either by a clinician trained in both areas or by clinicians from each field. On occasion, symptoms of acute or chronic alcohol and drug toxicity or withdrawal can mimic those of psychiatric disorders. The client should be observed closely for worsening conditions that warrant transfer to a more appropriate facility or to determine whether treatment for withdrawal symptoms is needed. Conversely, substance abuse can mask psychiatric symptoms, which may appear during the initial stages of abstinence. Programs should be organized around the premise that co-occurring disorders are common; assessment should proceed as soon as it is possible to distinguish the substance-induced symptoms from other independent conditions. Particular attention should be paid to the following:

- Psychiatric history of the client and family including diagnoses, previous treatment, and hospitalizations
- Current symptoms and mental status
- Medications and medication adherence
- Safety issues such as thoughts of suicide, self-harm, or harming others
- Severe psychiatric symptoms that result in the inability to function, communicate effectively, or care for oneself

This information can be augmented by objective measurement with assessment tools such as those described in the TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*e*).

Many programs have rigid guidelines for the initial mental health assessment and evaluation, including the initial psychopharmacology evaluation, such as requiring a certain length of abstinence. Programs should be flexible about assessment, removing these barriers when possible. Similarly, denial of access to evaluation or treatment for a substance use disorder because an individual is taking a prescribed psychotropic medication is inappropriate. Clients should continue taking medication for a serious mental disorder while being treated for their substance use disorders (Minkoff 2002).

Treatment engagement. Some clients with co-occurring psychiatric disorders, especially severe disorders, may have difficulty committing to and staying in treatment. Providing continuous support and outreach, assisting with immediate problems (such as housing), monitoring individual needs, and helping clients access services help develop a therapeutic treatment relationship. In the absence of such support, clients with co-occurring psychiatric disorders may be at high risk for dropping out (Drake and Mueser 2000).

Treatment planning. Factors to consider when developing a treatment plan for these clients include the client's psychiatric status, housing, social support, income, medication adherence, and symptom management. By understanding the client's strengths and goals, IOT program staff can develop a treatment plan that is consistent with the client's needs. Regular reassessments monitor the client's progress in both conditions and are the basis for adjustments to the treatment plan. Increased individual sessions and smaller group sizes also are indicated.

Referral. Clients with psychiatric disturbances that require secure inpatient treatment setting, 24-hour medical monitoring, or detoxification (such as clients who are actively suicidal or hallucinating) should be referred to a facility equipped to provide appropriate care. The American Society of Addiction Medicine provides placement criteria for clients with co-occurring psychiatric disorders (Mee-Lee et al. 2001).

Mental health care

Any IOT program that serves a significant number of clients with co-occurring psychiatric

disorders should include mental health specialists and psychiatric consultants on the treatment team.

Prescribing psychiatrist. It is ideal to have a psychiatrist with substance abuse treatment expertise on site to provide assessment and treatment services, on a full-time, part-time, or consultant basis (Charney et al. 2001). This approach overcomes problems with offsite referral such as the client's lack of transportation and the difficulty of working with another agency. However, when funding or other constraints prohibit providing mental health care services on site, other options are (1) employing a master's-level clinical specialist who can treat clients, consult with other staff members on mental disorders, and function as the liaison with psychiatric consultants or (2) establishing a working relationship with a mental health care agency to provide onsite care.

Medication provision and monitoring. Appropriate psychotropic medications are essential. Pharmacological advances over the past decade have resulted in medications with improved effectiveness and fewer side effects. Psychotropic medications stabilize clients, control their symptoms, and improve their functioning. The IOT program counselor can

- Refer the client to a psychiatrist or other mental health care provider for treatment evaluation.
- Help arrange appointments with the mental health care provider and encourage the client to keep them.
- Become familiar with common psychotropic medications, their indications, and their side effects.
- Instruct the client on the importance of complying with the medication regimen.
- Report symptoms and behavior to the prescribing psychiatrist and other staff members to assist in the determination of medication needs.
- Use peers or peer groups to monitor medication and to support the client's proper use of medication.
- Monitor side effects.

A helpful resource is *Psychotherapeutic Medications 2003: What Every Counselor Should Know* (Mid-America Addiction Technology Transfer Center 2000).

Collaboration with mental health care agencies

If circumstances prevent the provision of mental health care services in the IOT program, a collaborative relationship with a mental health agency can be established. One way to form this relationship is through an MOU that ensures that psychiatric services are adequate and comprehensive. The MOU specifies referral procedures, responsibilities of both parties, communication channels, payment requirements, emergency contacts, and other necessary procedures. TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), provides more information about setting up formal mechanisms for working with other agencies.

Case management services provide assistance with service coordination when clients with co-occurring disorders require treatment in two or more systems of care. TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998*a*), provides extensive details about case management.

Modified program structure

Treating clients with co-occurring psychiatric disorders in an IOT program often necessitates modifying the program structure or approach.

Separate treatment tracks in IOT. Separate tracks for clients with both disorders allow clients to be grouped together to address issues pertinent to them in group sessions. This arrangement particularly helps clients

with severe co-occurring psychiatric disorders. Establishing a separate track may entail organizational change as the agency modifies its scheduling, staffing, and training needs.

Staged approaches. Staged approaches provide successive interventions geared to the client's current stage of motivation and recovery and address varying levels of severity and disability of the co-occurring disorders (Drake et al. 1998*a*; Minkoff 1989). The model developed by Osher and Kofoed (1989) includes four overlapping stages—engagement, persuasion, active treatment, and relapse prevention—that integrate treatment principles from both fields. The model advocates treatment components consisting of low-intensity, highly structured programs; case management services; provision of appropriate detoxification; toxicology screening; family involvement; and participation in mutual-help groups. Other staged approaches are described in Minkoff (1989) and Prochaska and DiClemente (1992).

Working with clients with co-occurring psychiatric disorders

When mental and substance use disorders co-occur, both disorders require specific and appropriately intensive primary treatment and need to be individualized for each client according to diagnosis, phase of treatment, level of functioning, and assessment of level of care based on acuteness, severity, medical safety, motivation, and availability of recovery support (Minkoff 2002).

The treatment of clients with substance use and high-severity psychiatric disorders (schizophrenia or schizoaffective disorder) differs from the treatment of clients who have anxiety or mood disorders and a substance use disorder. Clients with severe disorders often are the most difficult to treat. Examples of approaches that attempt to integrate and modify psychiatric and substance abuse treatments to meet the needs of the client are (1) a skills-based approach, (2) dual-recovery therapy, (3) assertive community treatment, and (4) money-management therapy (Ziedonis and D'Avanzo 1998).

The treatment of clients with substance use and mood or anxiety disorders incorporates approaches such as cognitive–behavioral therapy, which addresses both disorders. Several other components, such as relaxation training, stress management, and skills training, are emphasized in the treatment of both types of disorders (Petrakis et al. 2002).

Some clients may have cognitive deficits that make it difficult for them to comprehend written material or to comply with program assignments. Materials can be adapted to express ideas and concepts simply and concretely, incorporating stepped assignments and using visual aids to reinforce information. TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998*e*), provides more information on accommodating clients with disabilities.

> Pharmacological advances... have resulted in medications with improved effectiveness and fewer side effects.

The therapeutic relationship

Establishing a trusting, therapeutic relationship is essential during the engagement process and throughout treatment. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*e*), suggests the following guidelines for developing a therapeutic relationship with clients with both disorders:

- Maintain a belief that recovery is possible.
- Manage countertransference.

- Monitor psychiatric symptoms.
- Provide additional structure and support.
- Use supportive and empathic counseling.
- Use culturally appropriate methods.

The clinician's ease in establishing and maintaining a therapeutic alliance is affected by comfort with the client. IOT program clinicians may find working with some clients with psychiatric illnesses unsettling or feel threatened by them and may have difficulty forming a therapeutic alliance with them. Consultation with a supervisor is important, and with experience, training, supervision, and mentoring, the problem can be overcome.

Confrontational approaches may be ineffective for clients with co-occurring psychiatric disorders because they may be unable to tolerate stressful interpersonal challenges. When counseling clients with co-occurring psychiatric disorders, it is helpful if the counselor is empathic and firm at the same time. By setting limits on negative behaviors, counselors provide structure for clients. Another assertive intervention involves counselors' supplying feedback that consists of a straightforward and factual presentation of the client's conflicting thoughts or problem behavior. Provided in a caring manner, such feedback can be both "confrontive" and caring. The ability to do this well is often critical in maintaining the therapeutic alliance with a client who has co-occurring psychiatric disorders (see chapter 5 in TIP 42 [CSAT 2005*e*]). TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*c*, p. 41), provides more information.

Group treatment... is used widely and effectively with clients with co-occurring disorders.

Clients with co-occurring psychiatric disorders may become demoralized and despairing because of the complexity of having two disorders and the slow pace of improvement in symptoms and functioning. Inspiring hope is a necessary task of the IOT program clinician. Some suggestions include

- Demonstrating an understanding and acceptance of the client
- Helping the client clarify the nature of his or her difficulties
- Communicating to the client that the clinician will help the client help himself or herself
- Expressing empathy and a willingness to listen to the client
- Assisting the client in solving external problems immediately
- Fostering hope for positive change

Group treatment

Group treatment, a mainstay of IOT, is used widely and effectively with clients with co-occurring disorders (Weiss et al. 2000), including clients with schizophrenia (Addington and el-Guebaly 1998). Several approaches can be used: 12-Step based, educational, supportive, and social skills improvement. These group interventions have demonstrated success in increasing treatment engagement and abstinence rates and decreasing the need for hospitalization (Drake et al. 1998*a*). Some examples of groups follow:

- **Psychoeducational groups** increase clients' awareness of both problems in a safe and positive environment.
- **Psychiatric disorders groups** present topics such as signs and symptoms of mental disorders, use of medications, and the effects of mental disorders on substance use problems.
- **Medication management groups** provide a forum for clients to learn about medication and its side effects and help the counselor develop solutions to compliance problems.
- **Social skills training groups** provide opportunities to learn how to handle

common social situations by teaching clients to solicit support, develop drug and alcohol refusal skills, and develop effective strategies to cope with pressures to discontinue their prescribed psychiatric medication. Group participants role play situations and practice appropriate responses. Reinforcing the difference between substances of abuse and treatment medications is another simple but important activity of these groups.
- **Onsite support groups** are led by an IOT staff facilitator and provide an arena for discussing problems and practicing new coping skills.

Group treatment may need to be modified and augmented with individual counseling sessions for clients with both disorders. The clients' ability to participate in counseling depends on their level of functioning, stability of symptoms, response to medication, and mental status. Some clients cannot tolerate the emotional intensity of interpersonal interactions in group sessions or may have difficulty focusing or participating. Many clients with a serious mental illness (schizophrenia, schizoid and paranoid personality) have difficulty participating in groups but can be incorporated gradually into a group setting at their own pace. Clients with less severe psychiatric disorders may have little problem participating in group sessions. Some suggestions for working with groups of clients with co-occurring disorders include

- Orally communicate in a brief, simple, concrete, and repetitive manner.
- Affirm accomplishments instead of using disapproval or sanctions.
- Address negative behavior rapidly in a positive manner.
- Be sensitive and responsive to needs of the client.
- Shorten sessions.
- Organize smaller groups.
- Use more focused, but gentle directional techniques.

Mutual-help groups in the community

The consensus panel encourages the use of "double trouble" mutual-help recovery groups for people with co-occurring psychiatric disorders. Because all attendees have a co-occurring psychiatric disorder, they are less likely to be subject to the misunderstanding and conflicting messages about their psychiatric symptoms or use of psychotropic medications that sometimes occur in traditional 12-Step-oriented groups (Magura et al. 2003). These groups do not provide clinical or counseling interventions; members help one another achieve and maintain recovery and be responsible for their personal recovery.

Various dual recovery organizations have been established by people in recovery and usually are based on the AA model but adapted for people with both disorders, including

- Double Trouble in Recovery (www.doubletroubleinrecovery.org)
- Dual Disorders Anonymous
- Dual Recovery Anonymous (www.draonline.org)
- Dual Diagnosis Anonymous

The research on traditional 12-Step groups is not definitive, but attendance at such groups may be beneficial for some clients with co-occurring psychiatric disorders (Kelly et al. 2003). However, clients with severe mental disorders may have difficulty attending these groups (Jordan et al. 2002). Some people with co-occurring disorders attend both dual disorder and traditional mutual-help groups (Laudet et al. 2000*b*). In one study, most AA respondents had positive attitudes toward people with co-occurring disorders and 93 percent indicated that such individuals should continue taking their psychotropic medications (Meissen et al. 1999). AA has published *The A.A. Member–Medications and Other Drugs* (Alcoholics Anonymous World Services 1991), a helpful booklet that discusses AA members' use of

medications when prescribed by a physician knowledgeable about alcoholism (visit www.alcoholics-anonymous.org to order).

Relapse prevention

In addition to learning techniques to prevent relapse to substance abuse, clients with co-occurring psychiatric disorders may benefit from learning to recognize worsening psychiatric symptoms, manage symptoms, or seek support from a "buddy" or a mutual-help group. Some providers suggest that clients keep "mood logs" to increase their awareness of how they feel and the situational factors that trigger negative feelings or symptoms. Other techniques include affect or emotion management, including how to identify, contain, and express feelings appropriately. Several relapse prevention interventions for clients with both disorders have been developed (Evans and Sullivan 2000; Weiss et al. 2000).

Other issues

Family education and support. Clients with co-occurring disorders frequently have unsatisfactory relationships with their families. Some clients with psychiatric disorders remain dependent on their families for an extended period, creating complicated family dynamics. Other clients may be estranged from or have strained relationships with family members, partners, or children. Groups for family members can be a venue for education and support. Psychoeducation combines fundamental information, guidance, and support and allows for low-key engagement and continued assessment opportunities. Family members and significant others need to understand the implications of both disorders and the ways that one disorder, if not properly monitored and treated, can worsen the symptoms of the other.

At times more intensive family intervention may require removing clients from stressful family relationships and helping them toward independence. Some families may be in need of intensive family therapy and should be referred for appropriate care.

Peer networks. Developing supportive peer networks to replace friends who use substances is an important component of recovery and needs to be addressed in treatment. When a client's family is not supportive, other, more supportive networks can be sought.

Discharge planning and continuing care

Because people with co-occurring psychiatric disorders have two chronic conditions, they often require long-term care that supports their progress and can respond quickly to a relapse of either disorder. Some clients may need to continue intensive mental health care but can manage their substance use disorder by participation in support groups. Other clients may need minimal mental health care but require some form of continued formal substance abuse treatment. Participation in continuing care tends to improve treatment outcomes (Moggi et al. 1999).

Cross-Training

Ideally, an interdisciplinary staff that provides both substance abuse treatment and psychiatric services works as an integrated unit, and providers have training and expertise in both fields. Cross-training about the differing views of treatment and challenges helps staff members from both fields reach a common perspective and approach for treating clients with co-occurring psychiatric disorders.

A helpful training resource is the Mid-America Addiction Technology Transfer Center's *A Collaborative Response: Addressing the Needs of Consumers With Co-Occurring Substance Use and Mental Health Disorders*, an eight-session curriculum designed to promote a cross-disciplinary understanding between mental and substance use disorder clinicians (available at

www.mattc.org). SAMHSA's *Strategies for Developing Treatment Programs for People With Co-Occurring Substance Abuse and Mental Disorders* (Substance Abuse and Mental Health Services Administration 2003) provides information on starting a program for treating people with both disorders.

Adolescents

It is important to recognize that youth are not little adults, and IOT for adolescents should differ from that provided for adult populations (Deas et al. 2000). Adolescents experience many developmental changes, may require habilitation rather than rehabilitation, may be considered dependents legally, and may require parental consent for treatment.

Treatment for adolescents requires a comprehensive approach that addresses their social, medical, and psychological needs. The best candidates for adolescent IOT are youth who are experiencing problems as a result of recent, moderate-to-heavy use of legal or illegal substances, who have functional but ineffective coping skills, and who need a marginally structured setting, not complete removal from their living situation (CSAT 1999*f*).

TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT 1999*d*), and TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT 1999*f*), provide additional information about screening and treating adolescents for substance abuse.

Description of the Population

Developmental changes

Adolescence is a period characterized by physical, emotional, and cognitive changes. Developmental tasks include the many transformations that move adolescents from childhood to adulthood. Physical changes include rapid growth, development of secondary sex characteristics, and fluctuations in hormonal levels. Cognitively, adolescents often have shorter attention spans than adults, have limited perspectives on the future, may be inconsistent in applying abstract thinking skills, and may be impulsive. During adolescence, morals, values, and ideals continue to develop, and intellectual interests expand. During late adolescence, youth become more introspective and sensitive to the consequences of their actions (CSAT 1999*f*) and improve their capacity for setting goals.

IOT for adolescents should differ from that provided for adult populations.

Development of substance abuse in adolescents

Many factors are associated with the onset of substance use problems in adolescents including genetic background, parental substance use and troubled family relations, individual characteristics such as cognitive dysfunction, and to some extent peer influence (Weinberg et al. 1998). Risk factors for developing a substance use disorder include a history of personality problems such as aggression or an affective disorder, school failure, distant or hostile relations with parents or guardians, family disruption, or a history of victimization (Weinberg et al. 1998).

Implications for IOT

Adolescents reach IOT by a number of paths, including parental request, school referral, and juvenile justice system mandate. The IOT provider must be prepared to meet developmental, family, psychiatric, behavioral, and other treatment challenges that may resemble those of adult clients only superficially.

Adolescents need thorough biopsychosocial, medical, and psychological assessments and may need educational, medical, mental health, and social services. Unlike adult clients, adolescents are likely to be entering treatment for the first time, may have little knowledge of the treatment process, and need more orientation than adults.

The assessment process involves a comprehensive evaluation of the adolescent's risks, needs, strengths, and motivation. Psychosocial assessment instruments appropriate for adolescents should be used. Information to gather includes school records, class schedule, and school involvement; relationships with peers; sexual activity and pressures; relationship with family members; mental and physical health status; history of abuse and trauma; and involvement with the juvenile justice system.

Family assessment

The adolescent's family consists of the main caregivers (usually parents) and anyone the client considers family. Family issues to assess include family structure and functioning, financial and housing statuses, substance use history and treatment episodes, mental and physical health, the family's feelings about the adolescent, and family members' problems with violence and involvement in the legal system. The strengths and resources available to the family need to be identified as well. IOT program staff members may want to interview the adolescent in private initially and then meet with family members.

Psychiatric assessment

Every client can benefit from a thorough psychiatric assessment by a mental health professional trained in adolescent care. As many as 60 percent of adolescents with a substance use disorder also have co-occurring psychiatric disorders (Armstrong and Costello 2002), such as anxiety, mood disorders (Kandel et al. 1999), or attention deficit/hyperactivity disorder (Weinberg et al. 1998). Adolescents should be assessed for suicide risk as well.

Diagnosis

Although some adolescents may meet the diagnostic criteria for substance dependence, many are in the early stage of involvement with alcohol or drugs. The *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Text Revision (American Psychiatric Association 2000) does not contain diagnostic criteria specific to adolescent substance dependence, and some adult diagnostic criteria, such as withdrawal symptoms and alcohol-related medical problems, present differently in adolescents. For these reasons, the DSM criteria have limitations when applied to adolescents (Martin and Winters 1998).

Clinical Issues and Strategies

Family involvement

Because outpatient family therapy may offer benefits superior to other outpatient treatments (Williams et al. 2000), IOT providers are encouraged to work with the family as much as possible. Chapter 6 on family therapy in this TIP and TIP 39, *Substance Abuse Treatment and Family Therapy* (CSAT 2004*c*), provide more information.

Engaging the family. The IOT counselor can engage family members by

- Emphasizing how critical family members are to the adolescent's recovery
- Requiring (whenever possible) that a family member accompany the adolescent to the initial intake interview and including time for the family assessment during that meeting
- Encouraging family attendance at the program's family education and therapy sessions

- Helping family members participate in developing and reinforcing the behavioral contract (see below)
- Supporting family members in encouraging the adolescent to attend treatment

Treatment of the family. Family-oriented interventions have long been used to treat adolescents who abuse substances. Szapocznik and colleagues (1983, 1986) helped establish the effectiveness of family therapy in treating adolescents. The premise of family therapy is that the family plays a role in creating conditions leading to adolescent drug use and that family elements help adolescents recover (Liddle et al. 2001). Evidence shows that youth who receive family therapy have less drug use at treatment completion than those who receive peer group therapy or whose families participate in parent education or a multifamily intervention (Liddle et al. 2001).

Some family-based approaches are as follows:

- Multidimensional family therapy and multisystemic therapy expand classic family therapy models to focus on promoting change in four areas: (1) the adolescent, (2) family members, (3) family interaction patterns, and (4) influences from outside the family (Liddle 1999, 2002).
- Family cognitive–behavioral therapy integrates traditional family systems theory with techniques of cognitive–behavioral therapy. This approach considers adolescent substance abuse as a conditioned behavior that is reinforced by cues and contingencies within the family (Latimer et al. 2003).
- The adolescent community reinforcement approach focuses on teaching adolescents coping skills and changing environmental influences related to continued substance use (Godley et al. 2001).
- The family support network intervention increases parental support of an adolescent's recovery through developing a support group for parents, provides home therapy sessions combined with group sessions, and can be used with any standard adolescent treatment approach (Hamilton et al. 2001).
- The family intervention program (see exhibit 9-3) addresses many problems experienced by families with an adolescent who uses substances. It includes the family and systems that affect the family, such as schools and the community.

As many as 60 percent of adolescents with a substance use disorder also have co-occurring psychiatric disorders...

The behavioral contract

Adolescents who abuse substances may behave in disruptive, destructive, or sometimes criminal ways, such as skipping school, having poor school performance, violating curfew, being argumentative with or withdrawing from family members, joining gangs, or committing crimes.

To address these behaviors, a behavioral contract can be a valuable therapeutic tool. The clinician works with the adolescent (and his or her family) to develop a contract that specifies treatment goals, acceptable and unacceptable behaviors, and the rewards or consequences associated with each.

The conditions defined in the contract help the youth and the family understand the treatment process and what is expected of them. Once the contract is completed, the client and each family member indicate their agreement by signing the contract. IOT program staff uses the contract to guide discussions during family group sessions, to monitor progress, and to minimize the undermining of treatment by family members.

Exhibit 9-3

The Family Intervention Program

This approach partners a family therapist with a community resource specialist. The specialist helps the family establish healthy community networks. Working as a team, the therapist and specialist conduct five family therapy sessions and perform the following:

1. Assess the family system; explore the family's resources, concerns, and goals; and create a treatment plan.
2. Explore relationships among family members, identify areas of difficulty and stress, and determine the effect on the family system.
3. Determine the effect of other systems, such as schools, on the family.
4. Focus on the family's concerns and goals and include others who can help resolve problems.
5. Work on how the family can resolve issues without staff help and develop a followup plan.

Source: Fishman and Andes 2001.

Case management services for adolescents

The IOT provider may need to provide extensive case management services. The case manager works with schools to monitor a youth's compliance with the behavioral contract; coordinates medical, mental health, and social services; and works with the juvenile justice system, if needed. Caseloads are best kept to about 8 to 10 adolescents per staff member.

Group work strategies for adolescents

Treating adolescents involves bringing together youth from different areas, backgrounds, and developmental levels. Many practitioners recommend, if possible, that the groups consist of adolescents of the same gender, with similar levels of motivation for change, and of similar age. Clients in middle-to-late adolescence (ages 16 to 18) usually have different life experiences, developmental levels, and concerns than do younger adolescents. There is limited evidence of the effectiveness of treating adolescents in groups, perhaps because of the complexities just mentioned. The consensus panel reports that, with this population, approaches emphasizing structured discussions around a topic introduced by the counselor are more successful than open-ended sessions. Same-gender groups can provide a safe environment in which to explore such issues as sexuality, intimacy, self-esteem, and relationships. If programs do not have enough adolescent clients to have a treatment group, a gender-specific group session can be held weekly to discuss sensitive issues.

To foster productive group work, it is helpful to enforce clear, specific, concrete rules. IOT program staff can post the rules in the session room and ask each participant to sign a copy. Rules should prohibit bullying and teasing. Groups also commonly prohibit nostalgic stories of substance use.

Group members frequently are asked to sign a confidentiality statement promising that information shared in the group will not be repeated outside group. Other suggestions for treating adolescents in groups are

- Including activities and keeping discussions short
- Varying session content, activity level, and purpose
- Including frequent breaks

CSAT's Cannabis Youth Treatment Series offers many specific ideas for use with adolescents (Godley et al. 2001; Hamilton et al. 2001; Liddle 2002; Sampl and Kadden 2001; Webb et al. 2002).

A co-counselor is helpful in running groups for adolescents because of the complexity of adolescent issues and behavior management challenges.

Clinical considerations

Providing incentives acknowledges the efforts of youth and encourages them to persevere. Incentives should be meaningful to the youth, such as gift certificates from a music store, movie theater, or clothing store.

Other key points about treating adolescents include the following:

- A cognitive–behavioral model and motivational enhancement techniques are useful.
- Not all adolescents who use substances are dependent, and prematurely diagnosing or labeling adolescents or pressuring them to accept that they have an addictive disease may not work.
- Many adolescents respond better to motivational interviewing than to confrontation.

Exhibit 9-4 lists characteristics and behaviors of adolescents in treatment and practical treatment suggestions.

Staff Training

IOT program staff members need to understand adolescent development and treatment needs. Clinicians working with youth should

- Be flexible and able to interact warmly with adolescents.
- Observe clear and appropriate personal boundaries.
- Be able to set firm behavioral limits in a nonjudgmental or nonpunitive manner.
- Know about the substances and combinations that adolescents use, the slang in use, and the physical and behavioral effects of any new drugs.
- Have substantial knowledge of the school system.
- Understand family dynamics.

Core program staff members should include a clinical coordinator who is trained in adolescent treatment. Skills development training for staff should occur regularly on topics appropriate for adolescent treatment.

Young Adults

Some caregivers may find it difficult to recognize or accept that young adults (ages 18 to 24) are no longer legal dependents. Even though a youth still may live at home or be in school, parental responsibility changes and the young adult can make his or her own choices. Counselors may find that they need to help both the young adult client and parents realize that the client can make choices and is responsible for actions. Some young adult clients may be totally on their own, with little family contact.

The use of alcohol or drugs at an early age may have delayed normal development. Although these young clients are legally adults, they may not have grown into young adult social roles.

The young adult may be ready clinically for placement in an adult treatment group or may be placed more appropriately in an adolescent program. A thorough assessment is needed to determine appropriate placement.

IOT Programming for Young Adults

To engage and retain these clients, IOT programming can incorporate techniques used in adolescent programs. To involve young adult clients in treatment, it is important to

Exhibit 9-4

Characteristics and Behaviors of Adolescents and Treatment Suggestions

Characteristics and Behaviors of Adolescents in Treatment	Suggestions for Improving the Treatment Experience for Adolescents
Inconsistent ability for abstract thinking	Limit abstract, future-oriented activities Use mentors Avoid scare tactics and labels
Impulsive, often with short attention spans	Design activities to teach self-control skills; allow practice time
Need to belong and identify with others; vulnerability to peer influence	Create opportunities for group members to bond Help clients establish positive peer groups and develop skills in resisting negative peer pressure Promote positive peer feedback in group
Frequent emotional fluctuations	Validate feelings Acknowledge the pressures and stresses of adolescence Help youth improve stress management skills
Lack of involvement in healthy recreational activities	Help clients develop daily schedules Help youth find new recreational activities not involving substance use such as games, sports, hobbies, and religious or spiritual groups
Tendency toward pessimistic or fatalistic attitudes	Recognize fatalist attitudes such as "I'm going to die soon, anyway," and "Drugs are the only way out for me" Validate clients' anger, hopelessness, or perceived obstacles to success, but challenge youth to think positively

reach out to them through family, colleges, employers, and the court system. Treatment should be relevant to young adult concerns, interests, and social activities and be flexible enough to adapt to the client's developmental deficits. The following issues are relevant:

- **Education and employment.** Educational and job skill levels need to be assessed and addressed. Some clients who have grown up in poverty have witnessed the futility of working at a low-paying job versus the financial benefits of selling illicit drugs. These clients need special attention.
- **Family roles.** Some clients may have children and family responsibilities and need assistance in obtaining child care and developing parenting skills.
- **Separating from parents.** Young adults in treatment often have parents who are unwilling to set limits, which fosters dependence and intense attachment on the part of the clients. Parents need to understand that their enabling behavior is a barrier to their young adult's recovery. Young adult clients often require life skills development. Treatment should focus on habilitation, rather than rehabilitation.
- **Peer relationships.** Some clients may need assistance in developing and maintaining healthy peer networks and family relationships.
- **Mentoring.** A positive adult role model provides a meaningful example.
- **Community service.** Young adults in treatment can contribute to society and should be encouraged to participate in and volunteer for community or faith-based events.

10 Addressing Diverse Populations in Intensive Outpatient Treatment

In This Chapter...

What It Means To Be a Culturally Competent Clinician

Principles in Delivering Culturally Competent IOT Services

Issues of Special Concern

Clinical Implications of Culturally Competent Treatment

Sketches of Diverse IOT Client Populations

Intensive outpatient treatment (IOT) programs increasingly are called on to serve individuals with diverse backgrounds. Roughly one-third of the U.S. population belongs to an ethnic or racial minority group. More than 11 percent of Americans, the highest percentage in history, are now foreign born (Schmidley 2003).

Culture is important in substance abuse treatment because clients' experiences of culture precede and influence their clinical experience. Treatment setting, coping styles, social supports, stigma attached to substance use disorders, even whether an individual seeks help—all are influenced by a client's culture. Culture needs to be understood as a broad concept that refers to a shared set of beliefs, norms, and values among any group of people, whether based on ethnicity or on a shared affiliation and identity.

In this broad sense, substance abuse treatment professionals can be said to have a shared culture, based on the Western worldview and on the scientific method, with common beliefs about the relationships among the body, mind, and environment (Jezewski and Sotnik 2001). Treating a client from outside the prevailing United States culture involves understanding the client's culture and can entail mediating among U.S. culture, treatment culture, and the client's culture.

This chapter contains

- An introduction to current research that supports the need for individualized treatment that is sensitive to the client's culture
- Principles in the delivery of culturally competent treatment services
- Topics of special concern, including foreign-born clients, women from other cultures, and religious considerations
- Clinical implications of culturally competent treatment
- Sketches of diverse client populations, including
  - Hispanics/Latinos
  - African-Americans
  - Native Americans

– Asian Americans and Pacific Islanders
– Persons with HIV/AIDS
– Lesbian, gay, and bisexual (LGB) populations
– Persons with physical and cognitive disabilities
– Rural populations
– Homeless populations
– Older adults

- Resources on culturally competent treatment for various populations

What It Means To Be a Culturally Competent Clinician

It is agreed widely in the health care field that an individual's culture is a critical factor to be considered in treatment. The Surgeon General's report, *Mental Health: Culture, Race, and Ethnicity*, states, "Substantive data from consumer and family self-reports, ethnic match, and ethnic-specific services outcome studies suggest that tailoring services to the specific needs of these [ethnic] groups will improve utilization and outcomes" (U.S. Department of Health and Human Services 2001, p. 36). The *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) (American Psychiatric Association 1994) calls on clinicians to understand how their relationship with the client is affected by cultural differences and sets up a framework for reviewing the effects of culture on each client.

Mental Health: Culture, Race, and Ethnicity is the first comprehensive report on the status of mental health treatment for minority groups in the United States. This report synthesizes research data from a variety of disciplines and concludes that

- Disparities in mental health services exist for racial and ethnic minorities. These groups face many barriers to availability, accessibility, and use of high-quality care.
- The gap between research and practice is worse for racial and ethnic minorities than for the general public, with problems evident in both research and practice settings. No ethnic-specific analyses have been done in any controlled clinical trials aimed at developing treatment guidelines.
- In clinical practice settings, racial and ethnic minorities are less likely than Whites to receive the best evidence-based treatment. (It is worth noting, however, that given the requirements established by funders and managed care, clients at publicly funded facilities are perhaps *more* likely than those at many private treatment facilities to receive evidence-based care.)

Because verbal communication and the therapeutic alliance are distinguishing features of treatment for both substance use and mental disorders, the issue of culture is significant for treatment in both fields. The therapeutic alliance should be informed by the clinician's understanding of the client's cultural identity, social supports, self-esteem, and reluctance about treatment resulting from social stigma. A common theme in culturally competent care is that the treatment provider—not the person seeking treatment—is responsible for ensuring that treatment is effective for diverse clients.

Meeting the needs of diverse clients involves two components: (1) understanding how to work with persons from different cultures and (2) understanding the specific culture of the person being served (Jezewski and Sotnik 2001). In this respect, being a culturally competent clinician differs little from being a responsible, caring clinician who looks past first impressions and stereotypes, treats clients with respect, expresses genuine interest in clients as individuals, keeps an open mind, asks questions of clients and other providers, and is willing to learn.

This chapter cannot provide a thorough discussion of attributes of people from various cultures and how to attune treatment to those attributes. The information in this

chapter provides a starting point for exploring these important issues in depth. More detailed information on these groups, plus discussions of substance abuse treatment considerations, is found in the resources listed in appendix 10-A (page 197). The following resources may be especially helpful in understanding the broad concepts of cultural competence:

- *Mental Health: Culture, Race, and Ethnicity* (U.S. Department of Health and Human Services 2001) (www.mentalhealth.org/cre/default.asp). Chapter 2 discusses the ways in which culture influences mental disorders and mental health services. Subsequent chapters explain the historical and sociocultural context in which treatment occurs for four major groups—African-Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic/Latino Americans.
- Chapter 4 of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*). This chapter describes steps that an IOT administrator can take to prepare an IOT organization to treat diverse clients more competently and sensitively. Chapter 4 also lists resources not found in the appendix at the end of this chapter.
- The forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT forthcoming *a*) includes an inservice training guide.

Principles in Delivering Culturally Competent IOT Services

The Commonwealth Fund Minority Health Survey found that 23 percent of African-Americans and 15 percent of Latinos felt that they would have received better treatment if they were of another race. Only 6 percent of Whites reported the same feelings (La Veist et al. 2000). Against this backdrop, it clearly is important for providers to have a genuine understanding of their clients from other cultures, as well as an awareness of how personal or professional biases may affect treatment.

Most IOT counselors are White and come from the dominant Western culture, but nearly half of clients seeking treatment are not White (Mulvey et al. 2003). This stark fact supports the argument that clinicians consider treatment in the context of culture. Counselors often feel that their own social values are the norm—that their values are typical of all cultures. In fact, U.S. culture differs from most other cultures in a number of ways. IOT clinicians and program staff members can benefit from learning about the major areas of difference and from understanding the common ways in which clients from other cultures may differ from the dominant U.S. culture.

> ...an individual's culture is a critical factor to be considered in treatment.

Treatment Principles

Members of racial and ethnic groups are not uniform. Each group is highly heterogeneous and includes a diverse mix of immigrants, refugees, and multigenerational Americans who have vastly different histories, languages, spiritual practices, demographic patterns, and cultures (U.S. Department of Health and Human Services 2001).

For example, the cultural traits attributed to Hispanics/Latinos are at best generalizations that could lead to stereotyping and alienation of an individual client. Hispanics/Latinos are not a homogeneous group. For example, distinct Hispanic/Latino cultural groups—Cuban Americans, Puerto Rican Americans, Mexican Americans, and Central and South Americans—do not think and act

alike on every issue. How recently immigration occurred, the country of origin, current place of residence, upbringing, education, religion, and income level shape the experiences and outlook of every individual who can be described as Hispanic/Latino.

Many people also have overlapping identities, with ties to multiple cultural and social groups in addition to their racial or ethnic group. For example, a Chinese American also may be Catholic, an older adult, and a Californian. This individual may identify more closely with other Catholics than with other Chinese Americans. Treatment providers need to be careful not to make facile assumptions about clients' culture and values based on race or ethnicity.

Culture is only a starting point for exploring an individual's perceptions, values, and wishes.

To avoid stereotyping, clinicians must remember that each client is an individual. Because culture is complex and not easily reduced to a simple description or formula, generalizing about a client's culture is a paradoxical practice. An observation that is accurate and helpful when applied to a large group of people may be misleading and harmful if applied to an individual. It is hoped that the utility of offering broad descriptions of cultural groups outweighs the potential misunderstandings. When using the information in this chapter, counselors need to find a balance between understanding clients in the context of their culture and seeing clients as merely an extension of their culture. Culture is only a starting point for exploring an individual's perceptions, values, and wishes. How strongly individuals share the dominant values of their culture varies and depends on numerous factors, including their education, socioeconomic status, and level of acculturation to U.S. society.

Differences in Worldview

A first step in mediating among various cultures in treatment is to understand the Anglo-American culture of the United States. When compared with much of the rest of the world, this culture is materialistic and competitive and places great value on individual achievement and on being oriented to the future. For many people in U.S. society, life is fast paced, compartmentalized, and organized around some combination of family and work, with spirituality and community assuming less importance.

Some examples of this worldview that differ from that of other cultures include

- **Holistic worldview.** Many cultures, such as Native-American and Asian cultures, view the world in a holistic sense; that is, they see all of nature, the animal world, the spiritual world, and the heavens as an intertwined whole. Becoming healthy involves more than just the individual and his or her family; it entails reconnecting with this larger universe.
- **Spirituality.** Spiritual beliefs and ceremonies often are central to clients from some cultural groups, including Hispanics/Latinos and American Indians. This spirituality should be recognized and considered during treatment. In programs for Native Americans, for example, integrating spiritual customs and rituals may enhance the relevance and acceptability of services.
- **Community orientation.** The Anglo-American culture assumes that treatment focuses on the individual and the individual's welfare. Many other cultures instead are oriented to the collective good of the group. For example, individual identity may be tied to one's forebears and descendants, with their welfare considered in making decisions. Asian-American and Native-American clients may care more about how the substance use disorder

harms their family group than how they are affected as individuals.

- **Extended families.** The U.S. nuclear family consisting of parents and children is not what most other cultures mean by family. For many groups, family often means an extended family of relatives, including even close family friends. IOT programs need a flexible definition of family, accepting the family system as it is defined by the client.
- **Communication styles.** Cultural misunderstandings and communication problems between clients and clinicians may prevent clients from minority groups from using services and receiving appropriate care (U.S. Department of Health and Human Services 2001). Understanding manifest differences in culture, such as clothing, lifestyle, and food, is not crucial (with the exception of religious restrictions on dress and diet) to treating clients. It often is the invisible differences in expectations, values, goals, and communication styles that cause cultural differences to be misinterpreted as personal violations of trust or respect. However, one cannot know an individual's communication style or values based on that person's group affiliation (see appendix 10-A for more information and resources on cross-cultural communication).
- **Multidimensional learning styles.** The Anglo-American culture emphasizes learning through reading and teaching. This method sometimes is described as linear learning that focuses on reasoned facts. Other cultures, especially those with an oral tradition, do not believe that written information is more reliable, valid, and substantial than oral information. Instead, learning often comes through parables and stories that interweave emotion and narrative to communicate on several levels at once. The authority of the speaker may be more important than that of the message. Expressive, creative, and nonverbal interventions that are characteristic of a specific cultural group can be helpful in treatment. Cultures with this kind of rich oral tradition and learning pattern include Hispanics/Latinos, African-Americans, American Indians, and Pacific Islanders.

Common issues affecting the counselor–client relationship include the following:

- **Boundaries and authority issues.** Clients from other cultures often perceive the counselor as a person of authority. This may lead to the client's and counselor's having different ideas about how close the counselor–client relationship should be.
- **Respect and dignity.** For most cultures, particularly those that have been oppressed, being treated with respect and dignity is supremely important. The Anglo-American culture tends to be informal in how people are addressed; treating others in a friendly, informal way is considered respectful. Anglo Americans generally prefer casual, informal interactions even when newly acquainted. However, some other cultures view this informality as rudeness and disrespect. For example, some people feel disrespected at being addressed by their first names.
- **Attitudes toward help from counselors.** There are wide differences across cultures concerning whether people feel comfortable accepting help from professionals. Many cultures prefer to handle problems within the extended family. The clinician and client also may harbor different assumptions about what a clinician is supposed to do, how a client should act, and what causes illness (U.S. Department of Health and Human Services 2001).

Issues of Special Concern

The IOT consensus panel recommends that IOT programs look at the following areas of special concern:

- Whether the program is prepared to adequately serve foreign-born clients living within their catchment area

- Whether the special needs of their minority or foreign-born women clients are being addressed adequately
- Whether the program needs to make any content adjustments out of respect for the religious orientation of current or potential clients

Foreign-Born Clients

In 2002, according to the U.S. Census Bureau, about 32.5 million U.S. residents were foreign born, of whom 52 percent came from Latin America and 26 percent from Asia (Schmidley 2003). Eleven percent were born in another country and may be speaking or learning English as a second language. Migration is a stressful life event, and immigrants are at risk for substance abuse because of stress, isolation, and the lack of social support they experience in adjusting to their new country.

The reason for a person's immigration is considered an important factor in the level of stress that immigrants experience as they settle into a new life. Refugees typically have been forced to abandon their countries and former lives, leaving their belongings behind, to relocate to a different and sometimes unwelcoming new world in which language, social structures, and community resources may be totally unfamiliar (Jezewski and Sotnik 2001). This displacement can be particularly difficult for older refugees.

Clinical considerations

Having a personal history of abuse and trauma is recognized as a major factor in substance use disorders and in the inability to maintain recovery. A large percentage of Asian-American and Hispanic-American immigrants show clinical evidence of posttraumatic stress disorder (PTSD) as a result of exposure to severe trauma, such as genocide, war, torture, or extreme threat of death or serious injury (U.S. Department of Health and Human Services 2001). In some samples, up to 70 percent of refugees from Vietnam, Cambodia, and Laos met diagnostic criteria for PTSD, compared with about 4 percent with a prevalence for PTSD in the U.S. population as a whole (U.S. Department of Health and Human Services 1999). For this reason, treatment for foreign-born clients often needs to address both substance use and the client's background of abuse and violence.

Other clinical issues include the following:

- **Mistrust of authority.** Immigrants and refugees from many regions of the world feel extreme mistrust of government based on the atrocities committed in their countries of origin or fear of deportation by U.S. authorities. This mistrust can be a barrier to entering treatment and to obtaining services.
- **Extreme sense of stigma.** Clients from other cultures view mental disorders, including substance abuse, much more negatively than does the general U.S. population (U.S. Department of Health and Human Services 1999). In some Asian cultures, this stigma is so strong that a person's substance dependence is thought to reflect poorly on the family lineage, diminishing the marriage and economic prospects for the client and for other family members.
- **Level of acculturation.** Providers should take into account a client's level of acculturation in assessment and treatment. Generally speaking, foreign-born persons have rates of substance use lower than U.S.-born counterparts; the more acculturated the person is to the United States, the more that person's use approaches U.S. substance-using norms. Among Hispanics/Latinos, substance use disorders are less frequent in those who were born outside the United States (Turner and Gil 2002). For example, foreign-born Cuban Americans have lower lifetime use of alcohol and start drinking later in life than do U.S.-born Cuban Americans (Vega et al. 1993). However, being born in the United States does not mean necessarily that a

person is acculturated. In a later study, Vega and colleagues (1998) found that the highest rates of substance abuse among Hispanic/Latino adolescents were seen in those who were born in the United States but had low acculturation levels. The researchers attributed these results to the fact that these adolescents faced the language problems of foreign-born Hispanics/Latinos and the acculturation conflicts of U.S.-born Hispanics/Latinos.

Implications for IOT providers

IOT providers who want to reach out to foreign-born clients in their community and serve them better should become more knowledgeable about the history and experiences of the newcomers. One way to start is by researching and reading about these cultural groups. Providers also should get to know newcomer populations by visiting community refugee and immigrant organizations, such as their Mutual Assistance Associations. Representatives of these associations can identify the need for substance abuse treatment among their constituents, as well as provide advice and suggestions about designing culturally specific services.

Providers can consider setting up an IOT group in the immigrants' native language. For example, it has been found that linguistic Spanish-only groups are helpful for recently arrived Hispanic/Latino immigrants. One note on language: In addition to native-language treatment groups, programs should provide services in English for those clients who want them. Many immigrants understand that not knowing English can be a barrier, and they are motivated to improve their English-language skills.

Some suggestions for programs that establish language-specific groups include the following:

- A program catering to a language-specific population needs to facilitate communication in that language. All documents in the program should be adapted. The program also can have a phone message in the clients' native language, with calls returned by a counselor who speaks the language.
- The important issues that immigrants face need to be addressed as part of the treatment program. These issues include cultural differences between the dominant culture and their native culture, sense of displacement, lack of community, language problems, accessing social services, and finding employment.
- The clients' cultural attitudes and values about substance use should shape program content. Clients need to acquire an understanding of how their native cultural attitudes differ from the values of U.S. society, which involves understanding U.S. laws, social expectations, and way of life.
- Using the terminology of the treatment field becomes a challenge because many words are difficult to translate and the meanings can vary according to the culture. Often, the counselor needs to translate both a word *and* its meaning in the English language and U.S. culture. For example, in Russian the concept of denial is positive. This concept generally translates into Russian as "It is good to deny that you have a problem." Likewise, "defenses" also translates as a positive concept. The word "defense" in Russian refers to a tool for addressing rude or disrespectful behavior from another person. In translation, these words carry the connotation of "To be defended and in denial are good tools to handle one's problems."
- Immigrant clients may need many social and educational support services that may be difficult for the clients to access because of language and cultural barriers. Often clients are not familiar with the existence, range, and purpose of these needed

> ...mistrust can be a barrier to entering treatment and to obtaining services.

Cultural Issues in a Russian-Language IOT Program

The ChangePoint IOT Program for Russian immigrants in Portland, Oregon, usually has about 15 clients in treatment at a time. Clients are immigrants from all over Russia, and most are religious refugees. The newcomers generally stay in family groups that immigrate together, so these clients have close family connections.

Clients learn about the social and legal expectations regarding substance use in the United States. The group work focuses on the cultural attitudes that these Russian clients bring to their substance use and treatment. Examples of differing U.S.–Russian cultural values that the program helps clients understand include

- **Acceptable levels of alcohol use.** Alcohol use among Russian clients is higher than average for the United States. In Russia, drinking enormous quantities of alcohol is tolerated provided the person behaves appropriately.
- **Legal expectations.** Russians tend to view the law in a "black or white" context. In Russia, there is zero tolerance for any blood alcohol level (BAL) when driving. When clients hear that a BAL below 0.08 is legal in the United States, they think, "I can drink and drive as long as I'm under 0.08 or as long as I'm careful."
- **Attitudes about money and treatment.** Russian clients may assume that the program will understand if they cannot pay their bills on time. Russian people expect that they will be paid regularly, often lend money to family and friends, and feel a high level of trust that they will be paid back. This translates into an expectation that the program also will trust them to pay their bills at some time in the future.

supports, and some fear or are confused by the complexities of government procedures; their access to these services may be impeded by the documentation processes that bureaucracies often require. IOT case management can broker needed support services. One model for doing this, called culture brokering, consists of conflict resolution and problemsolving strategies designed to help two cultures communicate and cooperate. In the context of cultural competence, the two cultures are represented by clients who are foreign born or disabled and treatment providers. (See cirrie.buffalo.edu/cbrokering.html for more information.)

Women From Other Cultures

Immigrant women face the same barriers to treatment that confront many Anglo-American women—restricted availability of child care, low income, unsupportive spouses, lack of health insurance benefits, and lack of education and job skills—but have the added barrier of being outsiders to the culture.

- **View the woman's behavior and treatment goals in the context of her culture.** Treatment needs to be sensitive to the cultural mores and female roles in that woman's culture and to the client's level of acculturation. Some societies can be paternalistic and dominated by men, with women expected to play traditional roles as wives and mothers. A woman client may have values and attitudes that reflect that culture. Her substance use disorder, her attitudes about her addiction, and her perception of her recovery options occur within that cultural framework. It is therefore important to understand the client's level of comfort with what is expected in treatment. Treatment goals should depend on the woman's hopes and should conform to the cultural role she wants for herself.
- **Expect to work within complex, conflicting value systems.** Women from male-dominated cultures often are raised to be

gentle, passive, and selfless in serving their husbands and families. Some counselors may want to push such women toward independence and self-assertion but should be aware that these attributes may not be personally or culturally desirable for foreign-born female clients.

Often, treatment must be more intensive for poor immigrant women than for immigrant women with more economic resources. Treatment programs that enhance women's economic autonomy through social and employment support are effective in reducing substance use (Gregoire and Snively 2001). As with many women in treatment, foreign-born women may need transportation to their medical and legal appointments, as well as to substance abuse treatment sessions. Other services should include

- **Domestic violence intervention.** Staff members need to understand the factors in clients' home life that interfere with recovery, such as domestic violence or having a significant other who also uses substances.
- **Multidisciplinary meetings with other caregivers.** The IOT staff can organize multidisciplinary meetings for the client that involve all referring agencies. Staff from the referring agencies should be encouraged to attend and develop a plan to address any issues that may be interfering with the client's treatment.
- **Parenting classes.** Parenting classes help women meet some of the stipulations required by State departments of child and family services. In addition, some childrearing practices in other cultures may not be acceptable in American culture, and classes offer the chance for women to learn more acceptable practices.

Religious Orientation

IOT providers need to ensure that their program is welcoming to people from all religious faiths and that no treatment practices are a barrier to those from non-Christian religions. Programs should address specifically the following issues:

- **Religious acceptance and tolerance within the program.** Local religious leaders can educate substance abuse treatment providers about traditions and practices. Providers, in turn, can educate religious leaders about services that are available. In the years immediately following the attacks of September 11, 2001, American Muslims experienced increased incidents of bias, discrimination, overt hostility, abuse, and violence. Collaborating with local imams can help treatment providers and the religious community reach out and aid people more effectively (Goodman 2002). Intolerance by other clients in treatment should not be condoned and needs to be addressed. (For a brief introduction on responding to the mental health needs of Arab Americans and American Muslims in the wake of terrorism, see Goodman [2002].)
- **Knowledge of religious customs.** Providers need to understand and accommodate the religious customs of individual clients. A culturally sensitive IOT program should ask about clients' dietary preferences, special holidays, and religious customs (e.g., daily prayers).
- **Preparing clients for mutual-help programs.** Non-Christian clients who are referred to mutual-help programs for continuing care should be informed that meetings often incorporate elements of Christianity. As an example, the Lord's Prayer, which comes from the Christian Bible, frequently is selected for closing Alcoholics Anonymous (AA) meetings. Because this is a Christian prayer, it potentially is offensive to the religious point of view of such groups as Jews, Muslims, Hindus, and Buddhists. Jewish mutual-help meetings exist in many communities. The Web site of Jewish Alcoholics, Chemically Dependent Persons and Significant Others at www.jacsweb.org provides additional information. Many areas of the country have secular mutual-help

meetings. Providers should become familiar with these meetings, so they can direct their non-Christian clients to them.

- **Support from religious leaders.** Clients whose religious faith is central to their lives should be encouraged to seek help from their religious leaders and from fellow believers.

Clinical Implications of Culturally Competent Treatment

IOT programs should take the following steps to ensure culturally competent treatment for their clients:

- Assess the program for policies and practices that might pose barriers to culturally competent treatment for diverse populations. Removing these barriers could entail something as simple as rearranging furniture to accommodate clients in wheelchairs or as involved as hiring a counselor who is from the same cultural group as the population the program serves. Chapter 4 of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), provides more information about assessing program needs.
- Ensure that all program staff receive training about the meaning and benefits of cultural competence in general and about the specific cultural beliefs and practices of client populations that the program serves.
- Incorporate family and friends into treatment to support the client. Although family involvement is often a good idea in an IOT program, it may be particularly effective given the importance of family in many cultures. Some clients left families and friends behind when they came to the United States. Helping these clients build support systems is critical.
- Provide program materials on audiotapes, in Braille, or in clients' first languages. All materials should be sympathetic to the culture of clients being served.
- Ensure that client materials are written at an appropriate reading level. People who are homeless and those for whom English is a second language may need materials written at an elementary school reading level.
- Include a strong outreach component. People who are unfamiliar with U.S. culture may be unaware that substance abuse treatment is available or how to access it.
- Hire counselors and administrators and appoint board members from the diverse populations that the program serves. Chapter 4 of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), provides more information about recruiting and hiring diverse staff members.
- Incorporate elements from the culture of the populations being served by the program (e.g., Native-American healing rituals or Talking Circles).
- Partner with agencies and groups that deliver community services to provide enhanced IOT services, such as child care, transportation, medical screening and services, parenting classes, English-as-a-second-language classes, substance-free housing, and vocational assistance. These services may be necessary for some clients to be able to stay in treatment.
- Provide meals at the program facility. This may bring some clients (e.g., those who are elderly or homeless) into treatment and induce them to stay.
- Make case management services available for clients who need them.
- Emphasize structured programming, as opposed to open-ended discussion, in group therapy settings.
- Base treatment on clients' strengths. Experienced providers report that this approach works well with clients from many cultures and is the preferred approach for clients struggling with self-esteem or empowerment.
- Use a motivational framework for treatment, which seems to work well with clients from many cultures. Basic principles

of respect and collaboration are the basis of a motivational approach, and these qualities are valued by most cultures.

- Encourage clients to participate in mutual-help programs to support their recovery. Although the mutual-help movement's roots are in White, Protestant, middle-class American culture, data show that members of minorities benefit from mutual-help programs to the same extent as do Whites (Tonigan 2003).

Sketches of Diverse IOT Client Populations

The following demographic sketches focus on diverse clients who may be part of an IOT caseload. These descriptions characterize entire groups (e.g., number of people, geographic distribution, rates of substance use) and include generalized cultural characteristics of interest to the clinician. This type of cultural overview is only a starting point for understanding an individual. To serve adequately clients from the diverse groups described here, IOT providers need to get to know their clients and educate themselves. Appendix 10-A (page 197) contains an annotated list of resources on cultural competence in general, as well as resources listed by population group. These resources include free publications available from government agencies—in particular the Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention—and describe population-specific treatment guidelines and strategies.

Hispanics/Latinos

Hispanics/Latinos include individuals from North, Central, and South America, as well as the Caribbean. Hispanic people can be of any race, with forebears who may include American Indians, Spanish-speaking Caucasians, and people from Africa. Great disparities exist among these subgroups in education, economic status, and labor force participation. In 2002, the Hispanic/Latino population totaled 37.4 million, more than 13 percent of the total U.S. population, and it is now the largest ethnic group in the Nation. Mexican Americans are the largest subgroup, representing more than two-thirds of all Hispanics/Latinos in the United States (Ramirez and de la Cruz 2003).

All [program] materials should be sympathetic to the culture of clients being served.

Two-thirds of the Hispanic/Latino people in the United States were born here. As a group, they are the most urbanized ethnic population in the country. Although poverty rates for Hispanics/Latinos are high compared with those of Whites, by the third generation virtually no difference in income exists between Hispanic/Latino and non-Hispanic/Latino workers who have the same level of education (Bean et al. 2001).

Celebrations and religious ceremonies are an important part of the culture, and use of alcohol is expected and accepted in these celebrations and ceremonies. In the interest of family cohesion and harmony, traditional Hispanic/Latino families tend not to discuss or confront the alcohol problems of family members. Among Hispanics/Latinos with a perceived need for treatment of substance use disorders, 23 percent reported the need was unmet—nearly twice the number of Whites who reported unmet need (Wells et al. 2001). Studies show that Hispanics/Latinos with substance use disorders receive less care and often must delay treatment, relative to White Americans (Wells et al. 2001). De La Rosa and White's (2001) review of the role social support systems play in substance use found that family pride and parental involvement are more influential

among Hispanic/Latino youth than among White or African-American youth. The 2000 Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Household Survey on Drug Abuse (NHSDA) found that nearly 40 percent of Hispanics/Latinos reported alcohol use. Five percent of Hispanics reported use of illicit substances, with the highest rate occurring among Puerto Ricans and the lowest rate among Cubans (Office of Applied Studies 2001). Hispanics/Latinos accounted for 9 percent of admissions to substance abuse treatment in 2000 (Office of Applied Studies 2002).

...only 20 percent of American Indians and Alaska Natives live on reservations or trust lands...

Spanish-language treatment groups are helpful for recently arrived Hispanic/Latino immigrants. Programs in areas with a large population of foreign-born Hispanics/Latinos should consider setting up such groups, using Spanish-speaking counselors. AA has Spanish-language meetings in many parts of the country, especially in urban areas.

African-Americans

African-Americans make up 13 percent of the U.S. population and include 36 million residents who identify themselves as Black, more than half of whom live in a metropolitan area (McKinnon 2003). The African-American population is extremely diverse, coming from many different cultures in Africa, Bermuda, Canada, the Caribbean, and South America. Most African-Americans share the experience of the U.S. history of slavery, institutionalized racism, and segregation (Brisbane 1998).

Foreign-born Africans living in America have had distinctly different experiences from U.S.-born African-Americans. As one demographer points out, "Foreign-born African-Americans and native-born African-Americans are becoming as different from each other as foreign-born and native-born Whites in terms of culture, social status, aspirations and how they think of themselves" (Fears 2002, p. A8). Nearly 8 percent of African-Americans are foreign born; many have grown up in countries with majority Black populations ruled by governments consisting of mostly Black Africans.

The 2000 NHSDA found that 34 percent of African-Americans reported alcohol use, compared with 51 percent of Whites and 40 percent of Hispanics/Latinos. Only 9 percent of African-American youth reported alcohol use, compared with at least 16 percent of White, Hispanic/Latino, and Native-American youth (Office of Applied Studies 2001). Six percent of African-Americans reported use of illicit substances, compared with 6 percent of Whites and 5 percent of Hispanics/Latinos (Office of Applied Studies 2001). African-Americans accounted for 24 percent of admissions to substance abuse treatment in 2000 (Office of Applied Studies 2002). Among African-Americans with a perceived need for substance abuse treatment, 25 percent reported the need was unmet—more than twice the number of Whites who reported unmet need (Wells et al. 2001).

Native Americans

The Bureau of Indian Affairs recognizes 562 different Native-American tribal entities. (The term "Native American" as it is used here encompasses American Indians and Alaska Natives.) Each tribe has unique customs, rituals, languages, beliefs about creation, and ceremonial practices. On the 2000 census, about 2.5 million Americans listed themselves as Native Americans and 1.6 million Americans listed themselves as at least partly Native American, accounting for

4.1 million people or 1.5 percent of the U.S. population (Ogunwole 2002).

Currently only 20 percent of American Indians and Alaska Natives live on reservations or trust lands, where they have access to treatment from the Indian Health Service. More than half live in urban areas (Center for Substance Abuse Prevention 2001). The 2000 NHSDA found that 35 percent of Native Americans reported alcohol use. Thirteen percent of Native Americans reported use of illicit substances (Office of Applied Studies 2001). Among all youth ages 12 to 17, the use of illicit substances was most prevalent among Native Americans—22 percent (Office of Applied Studies 2001). Native Americans begin using substances at higher rates and at a younger age than any other group (U.S. Government Office of Technology Assessment 1994). Native Americans accounted for 3 percent of admissions to substance abuse treatment in 2000 (Office of Applied Studies 2002). More than three-quarters of all Native-American admissions for substance use are due to alcohol. Alcoholism, often intergenerational, is a serious problem among Native Americans (CSAT 1999*b*). One study found that rates for alcohol dependence among Native Americans were higher than the U.S. average (Spicer et al. 2003) but not as high as often had been reported. Thirty percent of men in culturally distinct tribes from the Northern Plains and the Southwest were alcohol dependent, compared with the national average of 20 percent of men. Among the Northern Plains community, 20 percent of women were alcohol dependent, compared with the national average of 8.5 percent. Only 8.7 percent of all women in the Southwest were found to be alcohol dependent.

Among Native Americans, there is a movement toward using Native healing traditions and healers for the treatment of substance use disorders. Spiritually based healing is unique to each tribe or cultural group and is based on that culture's traditional ceremonies and practices.

Asian Americans and Pacific Islanders

Asian Americans and Pacific Islanders are the fastest growing minority group in the United States, making up more than 4 percent of the U.S. population and totaling more than 12 million. They account for more than one-quarter of the U.S. foreign-born population. The vast majority live in metropolitan areas (Reeves and Bennett 2003); more than half live in three States: California, New York, and Hawaii (Mok et al. 2003). Nearly 9 out of 10 Asian Americans either are foreign born or have at least one foreign-born parent (U.S. Census Bureau 2003). Asian Americans represent many distinct groups and have extremely diverse cultures, histories, and religions.

Pacific Islanders are peoples indigenous to thousands of islands in the Pacific Ocean. Pacific Islanders number about 874,000 or 0.3 percent of the population. Fifty-eight percent of these individuals reside in Hawaii and California (Grieco 2001).

Grouping Asian Americans and Pacific Islanders together can mask the social, cultural, linguistic, and psychological variations that exist among the many ethnic subgroups this category represents. Very little is known about interethnic differences in mental disorders, seeking help, and use of treatment services (U.S. Department of Health and Human Services 2001).

The 2000 NHSDA found that 28 percent of Asian Americans and Pacific Islanders reported alcohol use. Only 7 percent of adolescent Asian Americans and Pacific Islanders reported alcohol use, compared with at least 16 percent of White, Hispanic/Latino, and Native-American youth (Office of Applied Studies 2001). Three percent of Asian Americans and Pacific Islanders reported use of illicit substances (Office of Applied Studies 2001). As a group Asian Americans and Pacific Islanders have the lowest rate of illicit substance use, but significant intragroup differences exist.

Koreans (7 percent) and Japanese (5 percent) use illicit substances at much greater rates than Chinese (1 percent) and Asian Indians (2 percent) (Office of Applied Studies 2001). Asian Americans and Pacific Islanders accounted for less than 1 percent of admissions to substance abuse treatment in 2000 (Office of Applied Studies 2002).

Persons With HIV/AIDS

In the United States, more than 918,000 people are reported as having AIDS (Centers for Disease Control and Prevention 2004). HIV is still largely a disease of men who have sex with men and people who inject drugs; these groups together account for nearly four-fifths of all cases of HIV/AIDS (Centers for Disease Control and Prevention 2004). Minorities have a much higher incidence of infection than does the general population. Although African-Americans make up only 13 percent of the U.S. population, they accounted for 50 percent of new HIV infections in 2004 (Centers for Disease Control and Prevention 2004). HIV is spreading most rapidly among women and adolescents. In 2000, females accounted for nearly half of new HIV cases reported among 13- to 24-year-olds. Among 13- to 19-year-olds, females accounted for more than 60 percent of new cases (Centers for Disease Control and Prevention 2002). HIV/AIDS is increasing rapidly among African-American and Hispanic/Latino women. Although they represent less than a quarter of U.S. women, these groups account for more than four-fifths of the AIDS cases reported among women; African-American women account for 64 percent of this total (Centers for Disease Control and Prevention 2004). Gay people who abuse substances also are at high risk because they are more likely to engage in risky sex after alcohol or drug use (Greenwood et al. 2001).

The development of new medications—and combinations of medications—has had a significant effect on the length and quality of life for many people who live with HIV/AIDS. However, these new treatment protocols require clients to take multiple medications on a complicated regimen. Clients with HIV often present with a cluster of problems, including poverty, indigence, homelessness, mental disorders, and other medical problems.

Lesbian, Gay, and Bisexual Clients

LGB individuals come from all cultural backgrounds, ethnicities, racial groups, and regions of the country. Cultural groups differ in how they view their LGB members. In Hispanic culture, matters of sexual orientation tend not to be discussed openly. LGB members of minority groups often find themselves targets of discrimination within their minority culture and of racism in the general culture.

Because of inconsistent research methods and instruments that do not ask about sexual orientation, no reliable information is available on the number of people who use substances among LGB individuals (CSAT 2001). Studies indicate, however, that LGB individuals are more likely to use alcohol and drugs, more likely to continue heavy drinking into later life, and less likely to abstain from using drugs than is the general population. They also are more likely to have used many drugs, including such drugs as Ecstasy, ketamine (“Special K”), amyl nitrite (“poppers”), and gamma hydroxybutyrate during raves and parties. These drugs affect judgment, which can increase risky sexual behavior and may lead to HIV/AIDS or hepatitis (Centers for Disease Control and Prevention 1995; Greenwood et al. 2001; Woody et al. 1999).

Persons With Physical and Cognitive Disabilities

Nearly one-sixth of all Americans (53 million) have a disability that limits their

functioning. More than 30 percent of those with disabilities live below the poverty line and generally spend a large proportion of their incomes to meet their disability-related needs (LaPlante et al. 1996). Most people with disabilities can and want to work. But those with skills tend to be underemployed or unemployed. The combination of depression, pain, vocational difficulties, and functional limitations places people with physical disabilities at increased risk of substance use disorders (Hubbard et al. 1996).

Those with cognitive or physical disabilities are more likely than the general population to have a substance use disorder but less likely to receive effective treatment (Moore and Li 1998). Many community-based treatment programs do not currently meet the Federal requirements of the Americans with Disabilities Act. An IOT program is likely to have clients who present with a variety of disabilities. Experienced clinicians report that an appreciable number of individuals with substance use disorders have unrecognized learning disabilities that can impede successful treatment. People who have the same disability may have differing functional capacities and limitations.

Treating substance use disorders in persons with disabilities is an emerging field of study. Culture brokering is a treatment approach that was developed to mediate between the culture of a foreign-born person and the health care culture of the United States. This model helps rehabilitation providers understand the role that culture plays in shaping the perception of disabilities and treatment (Jezewski and Sotnik 2001). Culture brokering is an extension of techniques that IOT providers already practice, including assessment and problemsolving.

Rural Populations

In 2000, nearly 20 percent of the U.S. population (55.4 million people) lived in nonmetropolitan areas; the nonmetropolitan population increased 10.2 percent from 1990 to 2000 (Perry and Mackun 2001). The economic base and ethnic diversity of these populations, not just their isolation, are critical factors. This population includes people of Anglo-European heritage in Appalachia and in farming and ranching communities of the Midwest and West, Hispanic/Latino migrant farm workers across the South, and Native Americans on reservations.

Treating substance use disorders in persons with disabilities is an emerging field of study.

Despite this diversity, rural communities from different parts of the country have commonalities: low population density, limited access to goods and services, and considerable familiarity with other community members. People living in rural situations also share broad characteristics that affect treatment. These characteristics are

- Overall higher resistance to seeking help because of pride in self-sufficiency
- Concerns about confidentiality and resistance to participating in group work because in small communities "everyone knows everyone else"
- A sense of strong individuality and privacy, sometimes coupled with difficulty in expressing emotions
- A culturally embedded suspicion of treatment for substance use and mental disorders, although this varies widely by area

Among adults older than age 25, the rate of alcohol use is lower in rural areas than in metropolitan areas. But rates of heavy alcohol use among youth ages 12 to 17 in rural areas are almost double those seen in metropolitan areas (Office of Applied Studies 2001). Women in rural areas have higher

rates of alcohol use and alcoholism than women in metropolitan areas (American Psychological Association 1999). However, in one study, urban residents received substance abuse treatment at more than double the rate of their rural counterparts (Metsch and McCoy 1999). Researchers attribute this disparity to the relative unavailability and unacceptability of substance abuse treatment in rural areas of the United States (Metsch and McCoy 1999).

Homeless Populations

Approximately 600,000 Americans are homeless on any given night. One census count of people who are homeless found about 41 percent were White, 40 percent were African-American, 11 percent were Hispanic, and 8 percent were Native American. Compared with all U.S. adults, people who are homeless are disproportionately African-American and Native American (Urban Institute et al. 1999). Homeless populations include groups of people who are

- **Transient.** These individuals may stay temporarily with others or have a living pattern that involves rotating among a group of friends, relatives, and acquaintances. These individuals are at high risk of suddenly finding themselves on the street. For some, continued living in other people's residences may be contingent on providing sex or drugs.
- **Recently displaced.** Some people may be employed but have been evicted from their homes. Their housing instability may be related to financial problems resulting from substance use.
- **Chronically homeless.** These individuals may have severe substance use and mental disorders and are difficult to attract into traditional treatment settings. Reaching these individuals requires the IOT program to bring its services to the homeless through a variety of creative outreach and programming initiatives.

Approximately two-thirds of people who are homeless report having had an alcohol, drug, or mental disorder in the previous month (Urban Institute et al. 1999). Three-quarters of people who are homeless and need substance abuse treatment do not receive it (Magura et al. 2000). For 50 percent of people who are homeless and admitted to treatment, alcohol is the primary substance of abuse, followed by opioids (18 percent) and crack cocaine (17 percent) (Office of Applied Studies 2003*b*). Twenty-three percent of people who are homeless and in treatment have co-occurring disorders, compared with 20 percent who are not homeless (Office of Applied Studies 2003*b*). People who are homeless are more than three times as likely to receive detoxification services as people who are not homeless (45 percent vs. 14 percent) (Office of Applied Studies 2003*b*).

In addition to the resources found in appendix 10-A, the following clinical guidelines will assist providers in treating people who are homeless:

- Clients who are homeless often drop out of treatment early. Meeting survival needs of clients who are homeless is integral to successful outcomes. An IOT program needs to provide safe shelter, warmth, and food, in addition to the components of effective treatment provided to other clients who use substances, including extensive continuing care (Milby et al. 1996).
- Individuals who are homeless benefit from intensive contact early in treatment. Clients who attend treatment an average of 4.1 days per week are more successful than those attending fewer days (Schumacher et al. 1995).
- The Alcohol Dependence Scale, the Alcohol Severity Index, and the personal history form have been found to be reliable and valid screening tools for this population (Joyner et al. 1996). Reliability is higher when items are factual and based on a recent time interval and when individuals are interviewed in a protected setting.

- Case management must be available to ease access to and coordinate the variety of services needed by clients who are homeless and abuse substances. Case management should arrange for stable, safe, and drug-free housing. The availability of housing is a powerful influence on recovery. Making such housing contingent on abstinence has been shown to be a useful strategy (Milby et al. 1996). Case management also should coordinate medical care, including psychiatric care, with vocational training and education to help individuals sustain a self-sufficient life.
- Providers should work with homeless shelters to provide treatment services. Strategies include (1) working with staff members at shelters and with public housing authorities to find and arrange for housing, (2) locating the IOT program within a homeless shelter or at least providing core elements of IOT at the shelter, and (3) placing a substance abuse treatment specialist at the shelter as a liaison with the IOT program.

Older Adults

The number of older adults needing treatment for substance use disorders is expected to increase from 1.7 million in 2001 to 4.4 million by 2020. This increase is the result of a projected 50-percent increase in the number of older adults as well as a 70-percent increase in the rate of treatment need among older adults (Gfroerer et al. 2003). America's aging cohort of baby boomers (people born between 1946 and 1964) is expected to place increasing demands on the substance abuse treatment system in the coming years, requiring a shift in focus to address their special needs. This older generation will be more ethnically and racially diverse and have higher substance use and dependence rates than current older adults (Korper and Council 2002).

As a group, older people tend to feel shame about substance use and are reluctant to seek out treatment. Many relatives of older individuals with substance use disorders also are ashamed of the problem and rationalize the substance use or choose not to address it. Diagnosing and treating substance use disorders are more complex in older adults than in other populations because older people have more—and more interconnected—physical and mental health problems. Barriers to effective treatment include lack of transportation, shrinking social support networks, and financial constraints.

Oslin and colleagues (2002) find that older adults had greater attendance and lower incidence of relapse than younger adults in treatment and conclude that older adults can be treated successfully in mixed-age groups, provided that they receive age-appropriate individual treatment. When treating older clients, IOT programs need to be involved actively with the local network of aging services, including home- and community-based long-term care providers. Older individuals who do not see themselves as abusers—particularly those who misuse over-the-counter or prescription drugs or do not understand the problems caused by alcohol and drug interactions—need to be reached through wellness, health promotion, social service, and other settings that serve older adults. In addition, IOT programs can broaden the multicultural resources available to them by working through the aging service network to link up with diverse language, cultural, and ethnic resources in the community.

...older adults ha[ve] greater attendance and lower incidence of relapse than younger adults...

IOT programs that develop geriatric expertise can provide an essential service by making consultation available to staff members at IOT programs that face similar challenges, along with inservice training, coordination of interventions, and care

conferences designed to solve problems and develop care plans for individuals. There also may be opportunities to make this expertise available to caregivers and participants in settings where older adults receive interdisciplinary care (e.g., a support group for family caregivers or a discussion group for participants at a social daycare or adult day health center).

Appendix 10-A. Cultural Competence Resources

Many resources listed below are volumes in the TIP and Technical Assistance Publication (TAP) Series published by CSAT. TIPs and TAPs are free and can be ordered from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at www.ncadi.samhsa.gov or (800) 729-6686 (TDD, [800] 487-4889). The full text of each TIP can be searched and downloaded from www.samhsa.gov/centers/csat2002/publications.html.

The Health Resources and Services Administration lists cultural competence assessment tools, resources, curricula, and Web-based trainings at www.hrsa.gov/culturalcompetence.

General

The Journal of Ethnicity in Substance Abuse—This quarterly journal (formerly *Drugs and Society*) explores culturally competent strategies in individual, group, and family treatment of substance abuse. The journal also investigates the beliefs, attitudes, and values of people who abuse substances to understand the origins of substance abuse for different populations. Visit www.haworthpress.com/web/JESA to find out more.

Cultural Issues in Substance Abuse Treatment (CSAT 1999*b*)—This booklet contains population-specific discussions of treatment for Hispanic Americans, African-Americans, Asian Americans and Pacific Islanders, and American Indians and Alaska Natives, along with general guidelines on cultural competence. Order from SAMHSA's NCADI.

Chapter 4, "Preparing a Program To Treat Diverse Clients," in TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*)—This chapter includes an introduction to cultural competence and why it matters to treatment programs, as well as information on assessing a diverse population's treatment needs and conducting outreach to attract clients and involve the community. This chapter also includes a list of resources for assessment and training, in addition to culture-specific resources.

The forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT forthcoming *a*)—This volume addresses screening, assessment, and treatment planning; case management; counseling for specific cultural groups; and engaging and retaining diverse clients in the context of cultural competence.

"Alcohol Use Among Special Populations" (National Institute on Alcohol Abuse and Alcoholism 1998)—This special issue of the journal *Alcohol Health & Research World* (now called *Alcohol Research & Health*) includes articles on alcohol use in Asian Americans and Pacific Islanders, African-Americans, Alaska Natives, Native Americans, and Hispanics/Latinos. Authors also address such topics as alcohol availability and advertising in minority communities, special populations in AA, and alcohol consumption in India, Mexico, and Nigeria. Visit pubs.niaaa.nih.gov/publications/arh22-4/toc22-4.htm to download the articles.

Mental Health: Culture, Race, and Ethnicity (U.S. Department of Health and Human Services 2001)—This publication describes the disparities in mental health services that affect minorities, presents evidence of the need to address those disparities, and documents promising strategies to eliminate them. Visit www.mentalhealth.samhsa.gov/cre/default.asp to download a copy of this publication.

Cultural Competence Works: Using Cultural Competence To Improve the Quality of Health Care for Diverse Populations and Add Value to Managed Care Arrangements (Health Resources and Services Administration 2001)—This booklet bases its recommendations for implementing cultural competence

on practices already in place in health care programs across the country. Along with its general discussions of culturally competent care, the publication includes descriptions of the programs from which the recommendations are drawn and a list of resources. Visit minority-health.pitt.edu/archive/00000278 to download a copy of this publication.

Counseling the Culturally Different: Theory and Practice, Third Edition (Sue and Sue 1999)—This book offers a conceptual framework for counseling across cultural lines and includes treatment recommendations for specific cultural groups, with individual chapters on counseling Hispanics/Latinos, African-Americans, Asian Americans, and Native Americans and special sections on women, gay and lesbian people, and persons who are elderly and disabled.

Bridges to Recovery: Addiction, Family Therapy, and Multicultural Treatment (Krestan 2000)—This volume of essays discusses substance abuse treatment for Native-American, African-American, West Indian, Asian-American, Mexican-American, and Puerto Rican families.

The Cultural Context of Health, Illness, and Medicine (Loustaunau and Sobo 1997)—This book, written by a sociologist and an anthropologist, examines the ways in which cultural and social factors shape understandings of health and medicine. Although its discussions are not specific to substance abuse, they address the effect of social structures on health, differing conceptions of wellness, and cross-cultural communication.

Pocket Guide to Cultural Health Assessment, Third Edition (D'Avanzo and Geissler 2003)—This quick reference guide has individual sections on 186 countries, each of which lists demographic information (e.g., population, ethnic and religious descriptions, languages spoken), political and social information, and health care beliefs.

American Cultural Patterns: A Cross-Cultural Perspective, Second Edition (Stewart and Bennett 1991)—This book focuses on aspects of American culture that are central to understanding how American society functions. The authors examine perceptions, thought processes, language, and nonverbal behaviors and their effect on cross-cultural communication.

Promoting Cultural Diversity: Strategies for Health Care Professionals (Kavanagh and Kennedy 1992)—This text discusses strategies for learning about diversity and techniques for communicating effectively with culturally diverse populations. Case studies are used to illustrate the practical applications of cross-cultural communication.

Hispanics/Latinos

Materials for clients

NCADI has publications and videotapes for clients, parents, and employers available in Spanish. Visit www.ncadi.samhsa.gov.

The National Institute on Drug Abuse (NIDA) offers a number of publications in Spanish. Visit www.nida.nih.gov.

Relapse prevention workbooks in Spanish can be purchased at www.tgorski.com.

The Hazelden Foundation offers a collection of Spanish fellowship books and videotapes approved by AA and Narcotics Anonymous. Visit www.hazelden.org.

Materials for counselors

CSAP Substance Abuse Resource Guide: Hispanic/Latino Americans (Center for Substance Abuse Prevention 1996*b*; www.ncadi.samhsa.gov/govpubs/MS441/)—This resource guide provides information and referrals to help prevention specialists, educators, and community leaders better meet the needs of the Hispanic/Latino community. Order from SAMHSA's NCADI.

Quality Health Services for Hispanics: The Cultural Competency Component (National

Alliance for Hispanic Health 2000)—This book includes sections on the culture, language, and history of Hispanics/Latinos in the United States, Hispanic/Latino health status, guidelines for education and outreach, recommendations for working cross-culturally, and case studies. Visit www.ask.hrsa.gov/detail.cfm?id=PC00029 to order this volume.

"Counseling Latino Alcohol and Other Substance Users/Abusers: Cultural Considerations for Counselors" (Gloria and Peregoy 1996)—This article discusses Hispanic/Latino cultural values as they relate to substance use and presents a substance abuse counseling model for use with Hispanic/Latino clients.

"Drugs and Substances: Views From a Latino Community" (Hadjicostandi and Cheurprakobkit 2002)—The researchers explore perceptions and use of licit and illicit substances in a Hispanic/Latino community. The primary concerns of the community are the increasing availability and use of substances among Hispanic/Latino youth.

"Acculturation and Latino Adolescents' Substance Use: A Research Agenda for the Future" (De La Rosa 2002)—This article reviews literature on the effects of acculturation to Western values on Hispanic/Latino adolescents' mental health and substance use, discusses the role that acculturation-related stress plays in substance use, and suggests directions for treatment and further research.

"Cultural Adaptations of Alcoholics Anonymous To Serve Hispanic Populations" (Hoffman 1994)—This article evaluates two specific adaptations to 12-Step fellowship: one adapts conceptions of machismo and the other is less confrontational.

African-Americans

Chemical Dependency and the African American: Counseling and Prevention Strategies, Second Edition (Bell 2002)—This book from the co-founder of the Institute on Black Chemical Abuse explores the dynamics of race, culture, and class in treatment and examines substance abuse and recovery in the context of racial identity.

Cultural Competence for Health Care Professionals Working With African-American Communities: Theory and Practice (Center for Substance Abuse Prevention 1998*a*)—This book provides tips for health care workers. Order from SAMHSA's NCADI or download at www.hawaii.edu/hivandaids/links.htm.

Relapse Prevention Counseling for African Americans: A Culturally Specific Model (Williams and Gorski 1997)—This book examines the way that cultural factors interact with relapse prevention efforts in African-Americans.

Relapse Prevention Workbook for African Americans: Hope and Healing for the Black Substance Abuser (Williams and Gorski 1999)—This workbook leads readers through clinical exercises designed to help them avoid relapse due to race-related issues.

"Drug Treatment Effectiveness: African-American Culture in Recovery" (Bowser and Bilal 2001)—This article endeavors to explain African-Americans' high rates of substance abuse and low rates of recovery. Culture is seen as both a problem and a solution; some African-American coping strategies act as barriers, but successful treatment programs incorporate African-American cultural elements.

Native Americans

Materials for clients

GONA (Gathering of Native Americans) is a community development and empowerment training process that uses Native-American trainers. A GONA curriculum provides structure for Native-American community gatherings and is available from SAMHSA. Visit p2001.health.org/CTI05/Cti05ttl.htm.

A significant recovery movement for Native-American people is the Red Road to Recovery developed by Gene Thin Elk, a Lakota elder. Many individuals, especially in urban areas, have achieved and maintained sobriety by following the Red Road. The Red Road to Recovery addresses the cognitive, affective, and experiential needs of Native Americans who are rebuilding their lives from substance use and mental disorders and presents a system of cultural values that promote an abstinent and balanced lifestyle. The following Web sites offer information on GONA, the Red Road to Recovery, and other Native-American recovery resources:

- www.naigso-aa.org. This Web site of the Native-American Indian General Service Office of Alcoholics Anonymous includes a link to information on Talking Circles. Talking Circles are common practice in Native-American treatment settings.
- www.whitebison.org. This Web site offers information about the Wellbriety Movement (a Native-American recovery movement that emphasizes health and abstinence), which includes information about Wellbriety for youth, children of people who abuse alcohol, and people in prison. The site also includes a Talking Circle chat room, training information and materials, and books, videotapes, and audiotapes on recovery.

Materials for counselors

Health Promotion and Substance Abuse Prevention Among American Indian and Alaska Native Communities: Issues in Cultural Competence (Center for Substance Abuse Prevention 2001)—This volume frames the development of substance abuse prevention and treatment efforts in the context of health disparities that have affected Native-American and Alaskan-Native communities in rural and urban settings, as well as on reservations. Grounded in traditional healing practices, the volume examines innovative approaches to substance abuse prevention. Order from SAMHSA's NCADI.

Substance Abuse Resource Guide: American Indians and Native Alaskans (Center for Substance Abuse Prevention 1998*b*)—A substance abuse resource guide for American Indians and Alaska Natives, including books, articles, classroom materials, posters, and Web sites. Order from SAMHSA's NCADI.

"Addiction and Recovery in Native America: Lost History, Enduring Lessons" (Coyhis and White 2002)—This journal article provides recommendations for treatment based on the history of addiction in Native-American communities.

Promising Practices and Strategies To Reduce Alcohol and Substance Abuse Among American Indians and Alaska Natives (American Indian Development Associates 2000)—This report collects descriptions of successful substance abuse prevention efforts by Native-American groups. It also includes a literature review and list of Federal resources. Visit www.ojp.usdoj.gov/americannative/promise.pdf to download the report.

"Morning Star Rising: Healing in Native American Communities" (Nebelkof et al. 2003)—This special issue of the *Journal of Psychoactive Drugs* is devoted to healing in Native-American communities, with 13 articles on various aspects of prevention and treatment. Contact Haight-Ashbury Publications at (415) 565-1904.

Walking the Same Land—This videotape presents young Indians who are returning to traditional cultural ways to strengthen their recovery from substance abuse. It includes aboriginal men from Australia and Mohawk men from New York. Order from SAMHSA's NCADI.

Asian Americans and Pacific Islanders

Asian and Pacific Islander American Health Forum (www.apiahf.org/resources/index.htm)— This site provides links to information and resources.

Asian Community Mental Health Services (www.acmhs.org)—This site provides links to information and describes a substance abuse treatment program in Oakland, California.

Substance Abuse Resource Guide: Asian and Pacific Islander Americans (Center for Substance Abuse Prevention 1996*a*; ncadi.samhsa.gov/govpubs/MS408)—This guide contains resources appropriate for use in Asian and Pacific Islander communities. It also contains facts and figures about substance use and prevention within this diverse group.

Asian American Mental Health: Assessment Theories and Methods (Kurasaki et al. 2002)—This compendium of essays highlights conceptual, theoretical, methodological, and practice issues related to Asian-American mental health assessment. This text focuses on important questions about the cultural nature of diagnostic and assessment processes.

Responding to Pacific Islanders: Culturally Competent Perspectives for Substance Abuse Prevention (Center for Substance Abuse Prevention 1999)—This book examines the culture-specific factors that affect substance abuse prevention in Pacific Islander communities. Order from SAMHSA's NCADI.

"Communicating Appropriately With Asian and Pacific Islander Audiences" (Center for Substance Abuse Prevention 1997)—This *Technical Assistance Bulletin* discusses population characteristics, lists cultural factors related to substance use in nine distinct ethnic groups, and presents guidelines on developing effective prevention materials for these populations. Visit ncadi.samhsa.gov/govpubs/MS701 to download the bulletin.

Opening Doors: Techniques for Talking With Southeast Asian Clients About Alcohol and Other Drug Issues—This program is available on videocassette in Vietnamese and Khmer with English subtitles. Order from SAMHSA's NCADI, and visit store.health.org/catalog/productDetails.aspx?ProductID=15136 to view it on the Web.

Persons With HIV/AIDS

TIP 37, *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT 2000*c*)—This TIP discusses the medical aspects of HIV/AIDS (epidemiological data, assessment, treatment, and prevention), the legal and ethical implications of treatment, the counseling of patients with HIV/AIDS, the integration of treatment and enhanced services, and funding sources for programs.

The Hawaii AIDS Education and Training Center has numerous resources available for download at www.hawaii.edu/hivandaids/links.htm.

LGB Populations

The Web site of the National Association of Lesbian and Gay Addiction Professionals is a clearinghouse for information and resources, including treatment programs and mutual-help groups, organized by State. Visit www.nalgap.org.

Substance Abuse Resource Guide: Lesbian, Gay, Bisexual, and Transgender Populations (Center for Substance Abuse Prevention 2000)—This publication lists books, fact sheets, magazines, newsletters, videos, posters, reports, Web sites, and organizations that increase understanding of issues important to lesbian, gay, bisexual, and transgender clients. Download the resource guide from ncadi.samhsa.gov/referrals/resguides.aspx?InvNum=MS489.

A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals (CSAT 2001)—This book addresses issues of interest to clinicians and administrators. It discusses treatment approaches for this population, ways to improve services to LGB clients, steps for starting LGB-sensitive programs, organizational missions, and strategies for building alliances to provide services. Order from SAMHSA's NCADI.

Counseling Lesbian, Gay, Bisexual, and Transgender Substance Abusers: Dual Identities, Second Edition (Finnegan and McNally 2002)—This guide examines different counseling approaches and provides practical treatment suggestions for LGB populations. The book includes an organization audit of attitudes and practices, plus a list of resources and other suggested readings.

Addiction and Recovery in Gay and Lesbian Persons (Kus 1995)—This book examines the incidence of substance use among gay and lesbian people and special concerns when treating this population, including HIV/AIDS, homophobia, gay and lesbian mutual-help groups, and special needs of rural gay and lesbian clients.

Addictions in the Gay and Lesbian Community (Guss 2000)—This volume includes personal experiences of substance use and recovery and research into the sources of and treatment for substance use disorders in gay and lesbian clients. The book also includes techniques for assessing and treating LGB clients, including adolescents.

Persons With Physical and Cognitive Disabilities

IOT programs should link with local groups that offer specialized housing, vocational training, and other supports for people who are disabled. The Centers for Independent Living (CILs) are organizations run by and for persons with disabilities to provide mutual-help and advocacy. CILs and Client Assistance Programs were developed to provide a third party to broker the interaction between clients and the service system. The Special Olympics may be able to help locate recreational activities appropriate for individual clients.

Materials for clients

For a catalog of AA literature available on audiocassettes, in Braille, and in large print, as well as a list of closed-caption videotapes, AA books in American Sign Language on videotape, and easy-to-read literature, contact Alcoholics Anonymous General Service Office, P.O. Box 459, Grand Central Station, New York, NY 10163 or orders@aa.org.

Materials for counselors

Coping With Substance Abuse After TBI—This report answers basic questions about substance use and traumatic brain injury (TBI) and includes recommendations from clients with TBI who are now abstinent. Download the publication at www.mssm.edu/tbicentral/resources/publications/tbi_consumer_reports.shtml.

TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998*e*)—This volume discusses screening, treatment planning, and counseling for clients with disabilities. The book includes a compliance guide for the Americans with Disabilities Act, a list of appropriate terms to use when referring to people with disabilities, and screening instruments for use with this population, including an Education and Health Survey and an Impairment and Functional Limitation Screen.

TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998*a*)—This TIP discusses various models of case management and provides information on linking with service providers and evaluation. Chapter 5 explores the use of case management services with special needs populations.

TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT 2000*a*)—This volume examines the role that employment plays in recovery from substance use disorders, with special attention to referral relationships and their capacity to expand the services available to clients and enhance the resources available to programs.

Substance Abuse Resources and Disability Issues Program at Wright State School

of Medicine (www.med.wright.edu/citar/sardi)—This Web site offers products for professionals and persons with disabilities, including a training manual with an introduction on substance abuse and the deaf culture, as well as a Web course on substance abuse and disability.

National Center for the Dissemination of Disability Research's Guide to Substance Abuse and Disability Resources (www.ncddr.org/du/products/saguide)—This Web site provides links to books, journal articles, newsletters, training manuals, audiotapes, and videotapes on substance abuse and individuals who are disabled.

Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals (www.mncddeaf.org)—This Web site includes links to articles on substance abuse treatment of individuals who are deaf and to manuals and videotapes for use in treatment.

Co-Occurring and Other Functional Disorders Cluster Cultural Diversity Training Guide (www.med.wright.edu/citar/sardi/publications.html)—This guide recommends topics and methods for initial staff training in cultural diversity for programs serving clients who are disabled and includes a list of references on multicultural counseling.

Ohio Valley Center for Brain Injury Prevention and Rehabilitation (www.ohiovalley.org/abuse)—This Web site includes guidelines for treating people with substance use disorders and traumatic brain injury and links to other resources.

Center for International Rehabilitation Research and Information Exchange (cirrie.buffalo.edu/mseries.html)—This Web site includes downloadable versions of cultural guides that describe the demographics and attitudes toward disability of 11 countries, including countries in Asia, Central America, and the Caribbean. The site also includes a booklet that describes culture brokering, a practice in which counselors mediate between cultures to improve service delivery.

Rural Populations

TAP 17, *Treating Alcohol and Other Drug Abusers in Rural and Frontier Areas* (CSAT 1995*b*)—The papers in this volume describe providers' experiences across a variety of treatment issues relevant to rural substance abuse treatment, including domestic violence, enhanced service delivery, building coalitions and networks, and practical measures to improve treatment.

TAP 20, *Bringing Excellence to Substance Abuse Services in Rural and Frontier America* (CSAT 1996)—The papers in this volume examine innovative strategies and policies for treating substance use disorders in rural and frontier America. Topics include rural gangs and crime, needs assessment approaches, coalitions and partnerships, and minorities and women in treatment.

Rural Substance Abuse: State of Knowledge and Issues (Robertson et al. 1997)—This NIDA Research Monograph examines rural substance abuse from many perspectives, looking at substance use among youth and at the health, economic, and social consequences of substance use. The final section of the book addresses ethnic and migrant populations, including rural Native Americans, African-Americans, and Mexican Americans. Visit www.nida.nih.gov/PDF/Monographs/Monograph168/Download168.html to download the monograph.

Homeless Populations

National Resource Center on Homelessness and Mental Illness (www.nrchmi.samhsa.gov/pdfs/bibliographies/Cultural_Competence.pdf)—This Web site has an annotated, online bibliography of journal articles, resource guides, reports, and books that address cultural competence. Many resources discuss substance use disorders.

"The Effectiveness of Social Interventions for Homeless Substance Abusers" (American Society of Addiction Medicine 1995)—This special issue of the *Journal of Addictive Diseases*

includes 11 articles that examine important aspects of treating people who are homeless, including retaining clients, residential versus nonresidential treatment, enhanced services, treating mothers who are homeless, and clients with co-occurring disorders.

The U.S. Department of Housing and Urban Development has compiled a list of local agencies by State and other resources to assist people who are homeless. Visit www.hud.gov/homeless/index.cfm.

The U.S. Department of Health and Human Services offers assistance and resources for people who are homeless. For example, the Health Care for the Homeless Program provides grants to community-based organizations in urban and rural areas for projects aimed at improving access for the homeless to primary health care, mental health care, and substance abuse treatment. Visit aspe.hhs.gov/homeless/index.shtml.

Substance Abuse Treatment: What Works for Homeless People? A Review of the Literature (Zerger 2002)—This report links research on homelessness and substance abuse with clinical practice and examines various treatment modalities, types of interventions, and methods for engaging and retaining people who are homeless. Download the report from National Health Care for the Homeless Council's Web site at www.nhchc.org/Publications/SubstanceAbuseTreatmentLitReview.pdf.

National Resource Center on Homelessness and Mental Illness (www.nrchmi.samhsa.gov)—This Web site lists trainings and workshops (such as the National Training Conference on Homelessness for People With Mental Illness and/or Substance Use Disorders), technical assistance, and fact sheets and other publications on homelessness.

Older Adults

TIP 26, *Substance Abuse Among Older Adults* (CSAT 1998*d*)—This volume discusses the relationship between aging and substance abuse and offers guidance for screening, assessing, and treating substance use disorders in older adults.

Substance Abuse Relapse Prevention for Older Adults: A Group Treatment Approach (CSAT 2005*c*)—This manual presents a relapse prevention intervention that uses a cognitive–behavioral and self-management approach in a counselor-led group setting to help older adults overcome substance use disorders. Order from SAMHSA's NCADI.

Substance Abuse by Older Adults: Estimates of the Future Impact on the Treatment System (Korper and Council 2002)—This report examines substance abuse treatment services for older adults in the context of increased demand in the future and calls for better documentation of substance abuse among older adults and prevention and treatment strategies that are tailored to subgroups of older adults, such as immigrants and racial and ethnic minorities. Download the report at www.drugabusestatistics.samhsa.gov/aging/toc.htm.

Alcohol and Aging (Beresford and Gomberg 1995)—This book for clinicians covers topics such as diagnosis and treatment, mental disorders, interactions of alcohol and prescription medications, and the biochemistry of intoxication for older adults.

Alcoholism and Aging: An Annotated Bibliography and Review (Osgood et al. 1995)—This volume surveys 30 years of research on older adults who use alcohol, providing abstracts of articles, books and book chapters, and research studies on the prevalence, effects, diagnosis, and treatment of alcohol use in older adults.

Administration on Aging (www.aoa.gov/prof/adddiv/adddiv.asp)—This Web site offers information on cultural competence, including resources on aging and ethnic minorities and the booklet, *Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans and Their Families*, which can be downloaded at www.aoa.gov/prof/adddiv/cultural/addiv_cult.asp.

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Appendix B— Urine Collection and Testing Procedures and Alternative Methods for Monitoring Drug Use

Urine testing is the best developed and most commonly used monitoring technique in substance abuse treatment programs. This appendix describes procedures for implementing this service and other methods for detecting clients' substance use. The Substance Abuse and Mental Health Services Administration (SAMHSA) has a number of documents about drug testing available in the Workplace Resources section of its Web site, www.samhsa.gov.

Testing Schedule

Urine specimens are collected

- As part of the intake process to confirm a newly admitted client's substance use history
- As a routine part of therapy
- To identify an intoxicated client or confirm abstinence

Each intensive outpatient treatment (IOT) program should consider establishing a schedule for urine testing that takes into account Federal and State requirements (e.g., for methadone programs) and balances the therapeutic needs of the population being served with costs to the program or payer. Clients generally need more frequent monitoring during the initial stages of treatment when they are trying to achieve abstinence but still may be using substances. Routine specimen collection after admission should take place in conjunction with regular clinic visits.

Under ideal conditions, the consensus panel believes that collection should occur not less than once a week or more frequently than every 3 days in the first weeks of treatment. It is important that the scheduled frequency of urine collection match the usual detection window for the primary drug. Too long an interval between urine tests can lead to unreliable results because most of the target drug and its metabolites will have been excreted. On the other hand, if the interval between tests is too short, a single incidence of drug use may

be detected twice in separate urine samples. Multiple positive urine test results produced by a single ingestion (carryover positives) can be discouraging for the client and misleading for the clinician (Preston et al. 1999).

Once clients are stabilized in treatment, they require less intensive monitoring of abstinence. At this point, most programs reduce the frequency of scheduled tests and randomize the collection times. Even with a decreased and randomized testing schedule, specimen collection should be scheduled on clinic days following weekends, holidays, or paychecks—the times when clients are most tempted to use.

During IOT, monthly testing is standard in most programs. Random testing can be achieved by

- Asking clients to produce specimens only on random days
- Requiring that all clients provide a specimen on every visit but analyzing only a randomly selected sample

Collection Procedures and Policies

Urine sample collection procedures need to strike a balance between trusting clients and ensuring that specimens are not contaminated or falsified. Some programs insist that a staff member of the same sex accompany a client into the bathroom to observe urine collection. Others find that monitoring through an open door and having clients leave packages and coats outside are sufficient. A sink that is separate from the toilet area also discourages attempts to dilute samples (Bureau of Justice Assistance 1999). Many programs use temperature strips to make certain that urine specimens are produced on site and are body temperature. Tests of creatinine or specific gravity can determine whether a sample has been diluted with water or the client is consuming excessive fluids to lower the concentration of drugs below detectable levels (Preston et al. 1999).

Information about how to beat the drug testing system is widely available. Web sites advertise inexpensive products that can be added to urine specimens to absorb toxins as well as herbal remedies for consumption for a few hours before testing to cleanse the urine. Concentrated, "clean" specimens can be purchased for mixing with warm water at the test site. A variety of low-cost, self-testing kits also are available to preview likely results from more formal testing procedures.

As part of their orientation to the IOT program, clients need to be informed about the urine collection and testing procedures. Clients also should be advised that informed consent is necessary for release of toxicology results to anyone other than staff (see chapter 7 of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* [CSAT 2006*f*]). Most IOT programs do not comply with workplace standards for testing or maintain an adequate chain-of-custody for specimens that would meet court challenges. If employers, representatives of the criminal justice system, or children's protection agencies feel that such reporting is necessary, they can be advised to conduct their own testing or to accept other clinical evidence of client progress in treatment.

Clients should report any substance use to their counselor before a urine sample is submitted so that the substance use can be addressed therapeutically. It may be helpful to remind clients that the clinic conducts drug monitoring to support their recovery. Because there may be some likelihood of cross-reactivity and false positive results on screening tests, clients need to keep counselors informed about any prescribed medications or over-the-counter (OTC) drugs they have used.

Appropriate attention needs to be given to handling and storing collected specimens. Collection bottles that are sent to an offsite laboratory should be clean and tamperproof. Waterproof labels attached to the bottles

should note either the client's name or identification number and be checked for accuracy by the client and the counselor or technician. Collected specimens need to be kept cool—or refrigerated—until transmitted to the laboratory and should be stored in a protected or locked room for security. Clients and staff members who touch the urine collection bottles need to be reminded to wash their hands thoroughly. Rubber gloves should be worn by technicians who perform onsite analyses.

Selection of Drug Batteries and Testing Techniques

Programs need to test for a standard battery of drugs, which may include such drug groups as amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, methadone, methaqualone, opioids, phencyclidine (PCP), propoxphene, or euphorics (Ecstasy). In programs where the majority of clients use only a few types of substances, the standard battery can be small, and only selected individual clients need be tested for other specified substances. Programs should add substances to the routine battery, temporarily or permanently, if patterns of substance use change in the target population or in the community. It is helpful to stay up to date about local drug use patterns identified by the nearest Community Epidemiology Work Group (www.nida.nih.gov/CEWG/CEWGHome.html) or the Single State Authority. For example, oxycodone (OxyContin®) has become a serious drug of abuse in particular locales. Fads come and go for abuse of a wide variety of substances (e.g., Ecstasy, PCP, pentazocine [Talwin®], propoxyphene [Darvon®]).

Detection Limits for the Substances Being Tested

The length of time during which different licit and illicit substances or their metabolites can be detected in urine samples depends on many interacting factors, including

- Chemical properties (e.g., half-life) of the selected drugs
- Metabolism rates and excretion routes
- Amount, administration route, frequency, and chronicity of the dose consumed
- Sensitivity and specificity of the assay
- Individual variations in clients' physical health, exercise, diet, weight, gender, and fluid intake that affect excretion rates

Most substances of abuse can be detected for approximately 2 to 4 days (see exhibit B-1). However, the higher the dose taken and the more frequently the substance has been used over an extended time, the more likely that it will be detected. Although substances are excreted at various rates, they accumulate in the body with continued use. Whereas a single use of cocaine may be detectable in urine for only a day or less, continued daily use is likely to be detectable for 2 to 3 days following its discontinuation (Preston et al. 1999). Chronic use of such drugs as marijuana, PCP, and benzodiazepines may be detectable for up to 30 days, whereas alcohol remains in the system for 24 hours or less. Realistically, it may be difficult to detect illicit substances in most clients who stop all use for several days before a drug screen. An accurate profile of a client's substance use over more than a few days requires both urine test results and a good retrospective history.

Selecting an Appropriate Testing Technique

A program should consider a variety of factors in selecting a method and source for drug testing. None of the methods are inexpensive, with costs ranging from less than $5 to more than $100 per assay for a particular drug. Turnaround time in receiving results is another important determinant. Whereas onsite methods can provide results in a matter of minutes, more accurate and expensive commercial laboratory analyses may take

Exhibit B-1

Urine Toxicology Detection Periods for Different Substances

Substance	Typical Urine Detection Period
Amphetamine or methamphetamine	2–4 days
Barbiturates	
Short-acting—Secobarbital	1–2 days
Long-acting—Pentobarbital	2–4 days
Phenobarbital	10–20 days
Benzodiazepines	
Therapeutic dose	3–7 days
Chronic dosing	Up to 30 days
Cocaine	1–3 days
Cannabinoids	
Casual use	1–3 days
Daily use	5–10 days
Chronic use	Up to 30 days
Ethanol (alcohol)	12–24 hours
Opioids (e.g., codeine, morphine)	1–3 days
Methadone	2–4 days
Propoxyphene	6–48 hours
Ecstasy/euphorics	1–5 days
PCP	
Acute use	2–7 days
Chronic use	Up to 30 days

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several days or longer. Reliability is a major consideration. However, substance abuse treatment programs that are using results for clinical purposes do not require the same accuracy (i.e., workplace standards) as agencies that make important, one-time decisions

about such issues as employment, safety, eligibility for sports competitions, or probation or parole violations. Some cities and States have assumed responsibility for selecting a single vendor for providers under their jurisdiction to use and choosing a standard battery of drugs to be tested. Providers may wish to create a buying collective to negotiate the best discounts from a local drug-testing laboratory.

Two categories of urine tests are available:

- **Screening tests.** These detect only the presumptive presence or absence of a class of drugs in the urine specimen, return results rapidly, are relatively inexpensive ($1 to $5 per assay), can be set to detect low concentrations of drugs (have high sensitivity), and are relatively simple to perform. But these screening tests—the ones most frequently used by substance abuse treatment programs—do not distinguish specific drug metabolites (only groups), provide only qualitative results (yes or no), and may mistake other chemically similar medications, OTC preparations, or substances for the target drug class (Preston et al. 1999). This potential for cross-reactivity is of more concern in detecting amphetamines, benzodiazepines, and opioids than cocaine or marijuana. More specifically, the following cross-reactive results may occur:
  - Some cough suppressors in OTC preparations may be reported as a positive result for opioids.
  - Phenylpropanolamine or ephedrine in cold remedies can cause false positives for amphetamines.
  - Ibuprofen and other anti-inflammatories may be interpreted as positives for marijuana on the enzyme-multiplied immunoassay technique (EMIT) test.
  - Amitriptyline (an antidepressant) can be mistaken for opioids.
  - Some antibiotics may cause false positives for cocaine.
  - Diazepam has been mistaken for PCP.
- **Confirmatory tests.** These provide more definitive information about the quantitative concentrations (nanograms/milliliter) of specific drugs or their metabolites in urine specimens and are more accurate than drug screens (have higher specificity and sensitivity). They are much more expensive (up to $100 per assay), technically complex, labor intensive, and time consuming—often taking days to complete. If the results of a drug test will be used as a basis for actions taken against an individual (e.g., in a justice system context), positive findings should be followed by a confirmatory test of equal or greater sensitivity and better specificity (Bureau of Justice Assistance 1999). Although results from these quantitative tests can be more useful than a simple positive or negative for monitoring intermediate changes in drug consumption patterns, the concentration in urine might be the same for a small amount of a drug administered recently as for a large amount of the drug consumed several days ago. In addition, concentrations can be affected by fluid consumption levels and may be misleading (Preston et al. 1999).

The Meaning of Test Results

Urine test results can be inaccurate. Counselors should keep this fact in mind when discussing findings with a client. Asking the client whether results are accurate and, if so, when and how much of a particular substance was used can be the beginning of a therapeutic discussion that includes the circumstances surrounding substance use and the client's triggers.

In interpreting test results, clinicians should know the following:

- Positive results show a presumptive or confirmed presence of targeted substances at a detectable level. Positive results also mean that the amount of the substance detected is above the cutoff point for labeling a specimen positive. (SAMHSA has

established Federal guidelines for cut-off levels; see workplace.samhsa.gov/DrugTesting/RegGuidance/UrineConcen.htm.) Findings cannot determine when, how much, or how a drug was administered or the degree of impairment the drug produced (Bureau of Justice Assistance 1999).
- Negative results do not guarantee that the individual did not consume the substances tested. Despite a client's use of the targeted substance, results could be negative because (1) most evidence may have been excreted or metabolized before testing took place, (2) the specimen may have been diluted or switched, (3) the client may have consumed an excessive amount of fluids to dilute the urine, or (4) the test may not have been sufficiently sensitive (Bureau of Justice Assistance 1999).
- False-positive results that mistakenly find the presence of a substance can result from laboratory errors (e.g., outdated reagents and labeling mistakes), specimen tampering, or cross-reactivity of an immunoassay test with a substance of similar chemical structure.

Urine-Testing Techniques

Most screening tests are immunoassays that take advantage of antigen-antibody interactions—using enzymes, radioisotopes, or fluorescent compounds—and compare the specimen with a calibrated quantity of the substance being tested (Bureau of Justice Assistance 1999).

- EMIT test is the least expensive, most widely used, and simplest test to conduct. It often is used on site at a cost of about $5 per screen. It also has the poorest performance record, returning up to 30 percent false positives. Although EMIT can be used to test for a wide variety of drugs and alcohol, some sources report that as many as 300 OTC preparations cause false-positive readings.
- Fluorescent polarization immunoassay TDx™ is highly sensitive and highly specific.
- Radioimmunoassay (RIA) is a more sensitive test than the EMIT and is used extensively by the military.
- Kinetic interaction of microparticles in solution is a screening test used with most substances.
- Thin-layer chromatography (TLC) involves the addition of a solvent to the specimen that causes the target drugs and metabolites to move up a porous strip, leaving colored spots at different distances that can be compared with known standards. The results are reported as positive or negative, without any quantitative information, and require skill to interpret. Because TLC returns many false positives, it is no longer used widely.

Confirmatory urine testing methods include

- Gas liquid chromatography
- High performance liquid chromatography
- Gas chromatography/mass spectrometry (GC/MS) (the gold standard for drug detection, but costly at $25 to $100 a test)

Alternative Testing Methods

Several other body products are gaining prominence in the search for simpler, less expensive, noninvasive, and more accurate techniques for detecting the recent and current use of substances. Exhibit B-2 compares the effectiveness of urine, breath, saliva, sweat, blood, and hair testing methodologies for detecting drugs.

Breath-Testing Techniques

Because alcohol is metabolized rapidly at an average rate of 15 to 25 milligrams per hour—and the detection period is hours, not days—drinking usually is not monitored by urine or blood tests. Instead, clinicians frequently rely on other observations of current use (e.g., an odor of alcohol, slurred speech)

Exhibit B-2

Effectiveness of Drug Detection Methods That Use Different Biological Products

Body Product	Drug Detection Time	Major Advantages	Major Limitations	Primary Use
Urine	2–4 days	Mature technique; established cutoffs for detecting many drugs of abuse	Detects only recent use; needs costly confirmation to be accurate	Monitors recent drug use in many populations
Breath (alcohol)	12–24 hours	Easy to use; readily available and well-established method	Short detection time	Confirms observed intoxication or impairment
Saliva	12–24 hours	Easy to obtain samples; good correlation with blood levels for some substances	Very short detection time; new method; oral cavity is contaminated easily	Links positive drug test to behavioral impairment and intoxication
Sweat	1–4 weeks	Cumulative measure; relatively tamper-proof collection method	High potential for contamination; new technique	Detects recent and less recent drug use
Blood	12–24 hours	Accurate results; established method	Invasive method; expensive; detects only current use or intoxication	Detects drug effects on crashes, medical emergencies
Hair	4–6 months	Measures long-term drug use; readily available samples; accurate results	New technique; costly and time-consuming; no dose-response relation established	Confirms drug use in past 4 to 6 months; prevalence studies

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or an easily administered Breathalyzer™ test to confirm alcohol intoxication or drinking within the past several hours. Blood alcohol concentrations—measured in milligrams (mg) of alcohol per deciliter (dl) of blood—usually are expressed as a percentage (i.e., 100 mg/dl equals 100 mg percent or 0.1 percent) and correspond closely with measures of alcohol on the breath. One drink increases the breath alcohol level (BAL) by approximately 0.025 percent.

For most men, some impairment is observable at 0.05 percent BAL, and driving ability is appreciably affected at 0.07 percent. A woman weighing 150 pounds would reach a BAL of 0.1 percent if she consumed approximately four drinks in an hour (compared with six drinks in an hour for a 200-pound man), although individuals' metabolism of alcohol varies considerably according to gender, age, simultaneous ingestion of food, and physical condition, as well as weight and consumption rate. BALs between 0.10 percent and 0.20 percent without obvious signs of intoxication usually indicate tolerance for alcohol and regular, heavy drinking characteristic of dependence (CSAT 1997*a*).

Normally, with little or no tolerance for alcohol, the following impairment levels are observed:

- 0.40 percent = lethal
- 0.30 percent = unconscious
- 0.20 percent = decreased consciousness
- 0.10 percent = intoxication
- 0.07 percent = impaired driving ability
- 0.05 percent = detectable effect

In addition to Breathalyzer tests, several other simple-to-use but accurate techniques now exist for determining either a client's BAL or his or her approximate blood alcohol concentration. One is a relatively inexpensive, portable, and disposable unit the size of a cigarette containing crystals that turn a particular color—from yellow to blue—to signify a blood alcohol concentration of 0.02 percent, 0.08 percent, or 0.10 percent within 30 seconds after someone blows into the unit for 10 seconds.

Saliva

For alcohol, saliva is correlated closely with blood concentrations 2 hours after consumption. However, routes of drug administration that contaminate the oral cavity can change the pH levels of saliva. These changes can distort correlations of other drugs found in saliva with blood plasma levels (Magerl and Schulz 1995; Preston et al. 1999). One advantage of saliva testing is the ready availability of saliva specimens and the packaging for onsite testing. However, the short time window for detecting substances limits the effectiveness of this method to ascertaining only recent drug use (e.g., for accident investigations and for pilots or other employees about to engage in safety-sensitive activities). Most substances disappear from both blood and saliva within 12 to 24 hours of use; cannabinoids may be detectable for only 4 to 10 hours after marijuana is smoked. The U.S. Food and Drug Administration (FDA) recently approved limited use of RIA-based saliva tests. Kits that detect tetrahydrocannabinol (the active component of marijuana), opioids, and cocaine are available for about $30.

Sweat

Although a number of licit and illicit substances can be detected in perspiration (probably diffused from blood), perspiration is difficult to collect for monitoring purposes. Manufacturers have introduced a "sweat patch" with a tamper-proof adhesive that is worn for about a week. It has been used successfully to detect amphetamines, cocaine, ethanol, methadone, methamphetamine, morphine, nicotine, and PCP. The drugs are absorbed gradually into the pad, which must be applied carefully on clean skin and removed carefully for analysis. Although no rapid methods for analysis are available, and the pads must be mailed to laboratories, the FDA has approved their use for detecting

cocaine, amphetamines, and opioids. The pads are used primarily to monitor offenders on parole or probation.

Hair

Hair analysis can be used for detecting illicit substance use in the workplace and for drug treatment screening. The exact mechanism by which drug metabolites are absorbed into hair follicles remains unclear. Trace amounts of metabolites in the bloodstream enter hair follicles; these metabolites then are trapped in the core of each hair strand. It seems to take about a week after substance use for hair follicles to absorb drug residues. Because hair grows at a rate of about ½-inch per month, a 2-inch strand retains the record of a person's substance use over approximately the past 4 months—a much longer historical record than can be found through urine testing (Mieczkowski et al. 1998).

The advantages of this technique are

- The presence of larger concentrations of the substance use than in urine samples
- The ease of specimen collection; hair usually is taken from the scalp, but any body hair can be used
- The difficulties in falsification or tampering and the simplicity of storage and shipping

Certain objections to this technique have not been resolved. Few laboratories conduct the analyses. Questions exist about potential environmental contamination of hair, the relationship of dose to the concentrations of the substance in hair, and whether biophysical attributes affect outcome. However, a large random study of hair analysis found little evidence of any bias in assay results associated with hair color, race, or ethnicity (Kelly et al. 2000). Because hair grows slowly and recent drug use cannot be detected reliably, the methodology has limited application for routine monitoring of treatment compliance. It could be useful for corroborating an intake drug history and conducting prevalence research (Preston et al. 1999).

Hair testing involves dissolving about 50 strands of hair in solvents and testing the liquefied sample with GC/MS. The technique appears to be highly reliable for detecting cocaine and crack, opioids (heroin), methamphetamines, PCP, and synthetic substances such as methylenedioxyamphetamine and 3-4 methylenedioxymethamphetamine or Ecstasy. It may be less reliable for detecting marijuana (Mieczkowski and Newel 1997).

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Index

Because the entire volume is about clinical issues in intensive outpatient treatment (IOT), the use of these terms as entry points has been minimized in this index. Commonly known acronyms are listed as main headings. Page references for information contained in exhibits appear in *italics*.

12-Step facilitation, 138–139
  strengths and challenges of, *139*
12-Step groups. *See* mutual-help groups
24-hour crisis coverage, 40, *41*

A

abstinence
  family life, 105–106
  monitoring, 12
acamprosate, 36
Addiction Severity Index, 11, 64, 74, 85
  supplements to six assessment domains, 88–91
Addiction Technology Transfer Centers, 2
adjunctive therapies, 45
admission process, 9, 59–60
  components of, 67
adolescents, 171
  Asian Americans and Pacific Islanders, 191
  behavioral contract, 173
  case management, 174
  characteristics and behaviors of, *176*
  family involvement, 172–173
  group treatment, 174
  Hispanics/Latinos, 185
  HIV, 192
ADS. *See* Alcohol Dependence Scale
adult education, 44
African Americans, 190
  resources, 199
Alcohol Abstinence Self-Efficacy Scale, 135
Alcohol Dependence Scale, 64
Alcohol Effects Questionnaire, 135
Alcohol-Specific Role Play Test, 135
ambulatory detoxification, 34–35, *56*
American Society of Addiction Medicine
  continuum of care levels, 17
  Patient Placement Criteria, 68, *69*
Americans with Disabilities Act, 60, 193
anger, 123, 126. *See also* violence
approaches to treatment
  12-Step facilitation, 138–139
  cognitive-behavioral approach, 140–141
  community reinforcement and contingency management, 148–152
  Matrix model, 146–148
  motivational approaches, 141–142
  therapeutic community approach, 142–145
ASI. *See* Addiction Severity Index
Asian Americans and Pacific Islanders, 191–192
  resources, 200–201
assessment, biopsychosocial, 73–74
attrition of clients, 59

B

barriers to treatment
  addressing, 73
  assessing, 64–66
  engaging family members in treatment, 98
  language, 185
  mistrust of authority, 184
  people with psychiatric disorders, 162
  physical, 60
  religious orientation, 187
  women, 159, 186
biopsychosocial assessment, 73–74
boundary issues, 132–134
buprenorphine, 14, 36

C

CAGE questionnaire, 64
case management, 38–40
  adolescents, 174
  clients who are homeless, 194
  psychiatric disorders, 166

qualifications and role of managers, 38
research outcomes and findings, 40
services, *39*
child care, 45
barrier to treatment, 73, 159
child-focused therapy, 101
chronic medical conditions
screening for at intake, 65
substance abuse, 12
CIDI. *See* Composite International Diagnostic Interview
Circumstances, Motivation, Readiness, and Suitability Scales–Revised, *70*
CIWA–Ar scale. *See* Clinical Institute Withdrawal Assessment–Alcohol, Revised scale
client issues
attrition, 59
boundary issues, 132–134
counselor-client trust, 10
disruptiveness, 123
education, 14
employment-related challenges, 130–132
quiet, withdrawn clients, 123–124
retention, 10–11, 115–117
socializing, 133
under the influence in group, 127–128
Clinical Institute Withdrawal Assessment–Alcohol, Revised scale, 35, 64, 71–72
Clinical Trials Network, National Institute on Drug Abuse, 2
CMRS. *See* Circumstances, Motivation, Readiness, and Suitability Scales–Revised
cognitive-behavioral approach, 140–141
strengths and challenges of, *141*
community reinforcement and contingency management approaches, 148–152
research outcomes and findings, 151–152
strengths and challenges of, *151*
training, 97
community support, 40–41
goals of, 24, *26*
key aspects of, 41
compatible models of care, 20–21
Composite International Diagnostic Interview, 85
confidentiality, 61, 63, 72, 96, 128–130
contingency management, 9–10, 148–152
continuing care, 2
definition, 3
people with psychiatric disorders, 170
continuing community care, 24, 40–41
goals of, *25*
intensity and duration of, 26
plan for, 76
continuum of care, 17–18
ASAM levels of care, 17
assisting the client through, 18–19
IOT programs, 18
core services of IOT, 27–44, *28*
counselor-client trust, 10
couples therapy, 101
cross-training, 170–171
cultural competence, 61
African Americans, 190
Asian Americans and Pacific Islanders, 191–192
clinical issues, 184, 188–189
clinician issues, 180–181
disability, clients with, 192–193
foreign-born clients, 184
Hispanics/Latinos, 189–190
HIV/AIDS, 192
homeless populations, 194–195
lesbian, gay, and bisexual clients, 192
Native Americans, 190–191
older adults, 195
religious orientation, 187
resources, 197–204
rural populations, 193
staff issues, 185–186
treatment services, 181–182
women, 186–187
worldview differences, 182–183

D

definitions
continuing care, 3
family, 94
intensive outpatient treatment, 3
detoxification
ambulatory, 34–35, *56*
providing, 70–72
withdrawal symptoms for four drug classes, *71*
Diagnostic Interview Schedule, 85
DIS. *See* Diagnostic Interview Schedule

disability
  clients with, 60, 192–193
  resources, 202–203
  screening for, 66
disruptive clients, 123
domestic violence, 125–126, 161. *See also* violence
  barrier to family engagement, 98
dropouts, multiple, 119
drug dealers at facility, 125
DSM-IV criteria for substance dependence and substance abuse, 87
duration of treatment, 19

E

education
  adult, 44
  client, 14
eligibility for IOT, determining, 68
employment
  -related challenges, 130–132
  services, 42–44
enhanced IOT services, *28*, 44–46
enhancing motivation to treatment, 9–10
entry to treatment
  ease of, 9
  women, 159
evidence-based approaches, 15

F

family involvement in substance abuse treatment, 14–15, 94–95, 170
  abstinence, 105–106
  adolescents, 172–173
  definition of family, 94
  engaging the family in treatment, 95–97
  estrangement, 103
  Family Intervention Program, *174*
  genogram, 107–108
  resources, 112–113
  response to relapse, 104
  sabotage by family members, 105
  sample treatment calendar, *99*
  social network, 109–110, 111
  substance use by family members, 119–120
family services
  clinical issues, 102
  education groups, 98–99
  expectations about treatment outcomes, 103
  goals of, 95
  multifamily groups, 100
  mutual-help groups, 102
  retreats, 101–102
  sample treatment calendar, *99*
  therapy groups, 100–101
foreign-born clients, 184
funding, of community reinforcement and contingency management approaches, 150

G

gang members at facility, 125
genogram, 94, 107–108
gifts from clients to staff, 132–133
goals
  family services, 95
  IOT, 19
  outpatient treatment, 23
  stage 1 treatment, 20, *21*
  stage 2 treatment, 20, *22*
  stage 3 treatment, 24, *25*
  stage 4 treatment, 24, *26*
graduation from treatment program, 121
group counseling and therapy, 27
  adolescents, 174
  client under the influence, 127–128
  developing cohesion, 120–121
  difficult clients, 122–124
  family therapy groups, 100–101
  key aspects of, 30–32
  multifamily groups, 100
  psychiatric disorders, 168–169
  types of groups, 28–29, *29–30*

H

Health Insurance Portability and Accountability Act (HIPAA), 72
Hispanics/Latinos, 189–190
  resources, 198–199
history form, 84
HIV/AIDS, 128–129, 192
  resources, 201
homeless populations, 194–195
  housing programs, 44
  resources, 203–204

I

individual
  counseling, 32
  family therapy, 101
infectious diseases, 37
initial response procedures, 61
inpatient treatment, versus intensive outpatient treatment, 8
instruments, 85–86
  Addiction Severity Index (ASI), 11, 64, 74, 85
  Alcohol Abstinence Self-Efficacy Scale, 135
  Alcohol Dependence Scale (ADS), 64, 85
  Alcohol Effects Questionnaire, 135
  Alcohol-Specific Role Play Test, 135
  assessing relapse potential, 135–136
  CAGE questionnaire, 64
  Circumstances, Motivation, Readiness, and Suitability Scales–Revised (CMRS), *70*
  Clinical Institute Withdrawal Assessment–Alcohol, Revised scale, 35, 64, 71–72
  Composite International Diagnostic Interview (CIDI), 85
  Diagnostic Interview Schedule (DIS), 85
  MINI International Neuropsychiatric Interview, 85
  Mini-Mental State Examination (MMSE), 66
  Offender Profile Index, 64
  Psychiatric Research Interview for Substance and Mental Disorders (PRISM), 85
  Readiness Ruler, *70*
  Readiness to Change Questionnaire–Treatment Version, *70*
  Short Michigan Alcoholism Screening Test (S-MAST), 64
  Simple Screening Instrument, 64
  Situational Confidence Questionnaire, 136
  Stages of Change Readiness and Treatment Eagerness Scale, *70*
  Structured Clinical Interview for Diagnosis of DSM-IV, Version 2, Substance Abuse Disorders module (SCID), 64
  Structured Clinical Interview for DSM-IV Axis I Disorders, 86
  Substance Abuse Screening Instrument (SASI), 64
  Substance Dependence Severity Scale, 86
  Texas Christian University Drug Screen (TCUDS), 64, 86
  University of Rhode Island Change Assessment Scale (URICA), *70*
intake interviews, 61–62
  effective techniques, *63*
  including family members, 96
intensive outpatient treatment
  case illustrations, 46–55
  core features and services, 4–5
  culturally competent services, 181
  definition, 3, 19, 31
  engaging the client, 60–61
  functions of, 18
  goals of, 19
  versus inpatient treatment, 8
  the justice system, 155
  versus outpatient treatment, 23
intoxication, symptoms at intake, 65

J

justice system
  clinical issues, 157
  communication between systems, 156
  female offenders, 154
  memorandum of understanding, 156–157
  population in, 152–154
  staff issues, 157
  stigma, 154

L

LAAM, 36
lesbian, gay, and bisexual clients, 192
  resources, 201–202

M

matching treatment services to client needs, 11
Matrix model, 146–148
  research outcomes and findings, 148
  strengths and challenges of, *147*
medical treatment, 42
medication management, 13–14, 32–34
memorandum of understanding, 156–157
methadone, 36
Mini-Mental State Examination, 66
Minnesota Model. *See* 12-Step facilitation
MMSE. *See* Mini-Mental State Examination

models, 39, *66*
Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction (NIDA treatment model), 149
compatible models of care, 20–21
monitoring
abstinence, 12
alcohol and drug use, 38
motivational approaches, 9–10, 68, 141–142
case sample, 77
screening instruments to assess, *70*
strengths and challenges of, *143*
working with uncommitted clients, 122
mutual-help groups, 12–13, 41–42, 138–139. *See also* continuing community care
alternatives to, 42, *43*
families, 102
psychiatric disorders, 169
versus substance abuse treatment, 3–4

N

naltrexone, 14, 36
Native Americans, 190–191
resources, 199–200
nicotine cessation treatment, 45

O

Offender Profile Index, 64
older adults, 195
resources, 204
Omnibus Transportation Employee Testing Act of 1991, 131
ongoing care, 11–12
orientation to program, 72
outpatient treatment
goals of, 23
versus intensive outpatient treatment, 23
transition to, 20

P

parenting issues, 90, 158, 187
parent skill training, 45–46
Patient Placement Criteria, ASAM, 68
six dimensions of, *69*
pharmacotherapy, 13–14, 32–37, 166
pregnancy, 158, 161
principles of intensive outpatient treatment, 7
principle 1: make treatment readily available, 8
principle 2: ease entry, 9
principle 3: build on existing motivation, 9–10
principle 4: enhance therapeutic alliance, 10
principle 5: make retention a priority, 10–11
principle 6: assess and address individual treatment needs, 11
principle 7: provide ongoing care, 11–12
principle 8: monitor abstinence, 12
principle 9: use mutual-help and other community-based supports, 12–13
principle 10: use medications if indicated, 13–14
principle 11: educate about substance use disorders, recovery, and relapse, 14
principle 12: engage families, employers, and significant others, 14–15
principle 13: incorporate evidence-based approaches, 15
principle 14: improve program administration, 15–16
PRISM. *See* Psychiatric Research Interview for Substance and Mental Disorders
privacy. *See* confidentiality
program administration, 15–16
psychiatric disorders, 90
ABC model for psychiatric screening, *66*
barriers to treatment, 162
clinical issues, 164
establishing a therapeutic relationship, 167–168
group treatment, 168–169
the justice system, 154
medications to treat, 13–14
mutual-help groups, 169
people with psychiatric disorders, 165
symptoms at intake, 65
theoretical background, 162–163
working with clients who have, 122–123
Psychiatric Research Interview for Substance and Mental Disorders, 85
psychoeducational counseling, 32
topics addressed in, *33–34*
psychotherapy, 42

publications
A.A. Member—Medications and Other Drugs, 169
Alcoholics Anonymous (the "Big Book"), 42
Assessing Alcohol Problems: A Guide for Clinicians and Researchers, 64
Assessing Drug Abuse Among Adolescents and Adults: Standardized Instruments, 64
Bridging the Gap Between Practice and Research (Institute of Medicine report), 2
Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule, The, 63
Counselor's Manual for Relapse Prevention With Chemically Dependent Criminal Offenders (TAP 19), 118
Diagnostic Source Book on Drug Abuse Research and Treatment, 64
Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders, 154
It Works: How and Why, 42
Living Sober, 42
Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders, 148
Mental Health: Culture, Race, and Ethnicity (Surgeon General report), 180
Narcotics Anonymous, 42
Principles of Drug Addiction Treatment: A Research-Based Guide (National Institute on Drug Abuse), 5, 7, 11
Psychotherapeutic Medications 2003: What Every Counselor Should Know, 166
Relapse Prevention and the Substance-Abusing Criminal Offender (TAP 8), 118
Strategies for Developing Treatment Programs for People With Co-Occurring Substance Abuse and Mental Disorders (SAMHSA), 171
Therapeutic Community Curriculum (CSAT manual), 145
Twelve Steps and Twelve Traditions, 42
Woman's Way Through the Twelve Steps, A, 161

Q

quiet, withdrawn clients, 123–124

R

readily available treatment, 8
readiness for change, assessing, 68
Readiness Ruler, *70*
Readiness to Change Questionnaire–Treatment Version, *70*
recreational activities, 44, 91
relapse, 14, 36
family response, 104
instruments, 135–136
versus lapse, 117
prevention quiz, 118
prevention strategies, 117–118, 170
religious orientation, 187. *See also* spirituality
research outcomes and findings
12-Step approaches, 139–140
case management, 40
cognitive-behavioral therapy, 140–141
community reinforcement and contingency management approach, 151
Matrix model, 148
motivational approaches, 142
therapeutic community approach, 145
respect for clients, 61
retention, 10–11, 115–117
round-the-clock crisis coverage, 40, *41*
rural populations, 193
resources, 203

S

safety, 125–128, *126*. *See also* violence
SASI. *See* Substance Abuse Screening Instrument
SCID. *See* Structured Clinical Interview for Diagnosis of DSM-IV, Version 2, Substance Abuse Disorders module
screening
ABC model for psychiatric screening, 66
brief instruments that assess motivational stage, *70*
chronic medical conditions, 65
collecting information, 62–64
psychiatric disorders, 164–165
sexuality, 90–91
Short Michigan Alcoholism Screening Test, 64
Simple Screening Instrument, 64
Situational Confidence Questionnaire, 136

S-MAST. *See* Short Michigan Alcoholism Screening Test
socializing, 133
social network, 94–95, 109–110
social network grid, 111
spirituality, 91
staff issues
adolescents, 175
community reinforcement and contingency management approaches, 150
counselor-client trust, 10
counselors with dual roles, 134
cross-training, 170–171
cultural competence, 185–186
familiarity with 12-Step culture, 139
familiarity with cognitive-behavioral therapy, 140
female clients, 161–162
the justice system, 157
the Matrix model, 147
motivational approaches, 142
therapeutic community approaches, 144
Stages of Change Readiness and Treatment Eagerness Scale, *70*
stepdown treatment, 23–24
stigma, in the justice system, 154
Structured Clinical Interview for Diagnosis of DSM-IV, Version 2, Substance Abuse Disorders module, 64
Structured Clinical Interview for DSM-IV Axis I Disorders, 86
substance abuse, as a chronic illness, 12
Substance Abuse Screening Instrument, 64
Substance Dependence Severity Scale, 86
suicidality, screening for at intake, 67
summary report of assessment findings, 74–75

T

TCUDS. *See* Texas Christian University Drug Screen
Temporary Assistance for Needy Families, 77
Texas Christian University Drug Screen, 64, 86
therapeutic alliance, 10
therapeutic community approach, 142–145
research outcomes and findings, 145
strengths and challenges of, *145*
TIPs cited
Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction (TIP 40), 36
Comprehensive Case Management for Substance Abuse Treatment (TIP 27), 40, 166
Continuity of Offender Treatment for Substance Use Disorders From Institution to Community (TIP 30), 155
Detoxification and Substance Abuse Treatment (TIP 45), 35, 72
Enhancing Motivation for Change in Substance Abuse Treatment (TIP 35), 62, 118, 141, 142, 168
Guide to Substance Abuse Services for Primary Care Clinicians, A (TIP 24), 35
Improving Cultural Competence in Substance Abuse Treatment (forthcoming), 61, 181
Integrating Substance Abuse Treatment and Vocational Services (TIP 38), 44
Intensive Outpatient Treatment for Alcohol and Other Drug Abuse (TIP 8), 1
Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs (TIP 43), 37, 67
Naltrexone and Alcoholism Treatment (TIP 28), 36
Screening and Assessing Adolescents for Substance Use Disorders (TIP 31), 67, 171
Screening for Infectious Diseases Among Substance Abusers (TIP 6), 37
Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases (TIP 11), 64
Substance Abuse: Administrative Issues in Outpatient Treatment (TIP 46), 1, 16, 32, 61, 74, 166, 181, 188
Substance Abuse Treatment: Addressing the Specific Needs of Women (forthcoming), 157
Substance Abuse Treatment and Domestic Violence (TIP 25), 67, 89, 126, 157, 161
Substance Abuse Treatment and Family Therapy (TIP 39), 30, 93, 172

Substance Abuse Treatment for Adults in the Criminal Justice System (TIP 44), 127, 157
Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues (TIP 36), 90, 158
Substance Abuse Treatment for Persons With Co-Occurring Disorders (TIP 42), 37, 42, 123, 165, 167
Substance Abuse Treatment for Persons With HIV/AIDS (TIP 37), 37, 129
Substance Abuse Treatment: Group Therapy (TIP 41), 29, 120
Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities (TIP 29), 66, 167
Treatment for Stimulant Use Disorders, (TIP 33), 14, 118
Treatment of Adolescents With Substance Use Disorders (TIP 32), 171
Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers, The (TIP 18), 37
transition
outpatient treatment, 20
planning, 23
transportation services, 44
treatment
duration of, 19
entry to, 9, 159
graduation from, 121
intensity of, 19
interventions, 15
matching to client needs, 11
medical, 42
plan, 75–83
settings, 19
stages of, 20
well-known person, 129–130
trust between counselor and client, 10

U

University of Rhode Island Change Assessment Scale, *70*
URICA. *See* University of Rhode Island Change Assessment Scale
urine drug tests, 12

V

violence, *126*
domestic, 67, 89, 98, 125–126, 161
screening for at intake, 67
treating violent clients, 127
women, 158
vocational training, 42–44

W

Web sites cited
Adult Children Anonymous, 102
Adult Children of Alcoholics, 102
Al-Anon/Alateen, 13, *99*
Alcohol Abstinence Self-Efficacy Scale, 135
Alcoholics Anonymous, 13, 42, 170
American Family Physician, 35
assessment instruments, *70*
Center for Substance Abuse Prevention Workplace Resource Center, 131
Center for Substance Abuse Treatment, 138
children and families, 46
Clinical Institute Withdrawal Assessment–Alcohol, Revised scale, 72
Cocaine Anonymous, 42
Detoxification Clinical Practice Guidelines, 35
domestic violence assessment, 89
Double Trouble in Recovery, 169
Dual Recovery Anonymous, 169
Families Anonymous, *99*
Fortune Society, *43*
General Services Offices of Alcoholics Anonymous, 42
Hazelden Foundation, 137
Hispanic Health Council, *43*
Institute on Black Chemical Abuse, *43*
Jewish Alcoholics, Chemically Dependent Persons and Significant Others, 187
Medication Assisted Treatment, 37
Mini-Mental State Examination, 66
Nar-Anon, 13, *99*
Narcotics Anonymous, 13, 42
National Black Alcoholism and Addictions Council, *43*
National Clearinghouse for Alcohol and Drug Information, 138
National Head Start Association, 46
National Institute on Alcohol Abuse and Alcoholism, 135, 137

Office of Juvenile Justice and Delinquency Prevention, 46
Patient Placement Criteria, ASAM, 68
Principles of Addiction Medicine, 35
Rational Recovery, 13
resources for family-based services, 112–113
Save Our Selves, *43*
Secular Organizations for Sobriety, *43*
Self-Management and Recovery Training, *43*
Smart Recovery, 13
Women for Sobriety, 13, *43*
withdrawal
symptoms at intake, 65
symptoms for four drug classes, *71*
women, 157–158
barriers to treatment, 159
clinical issues, 159–161
culturally competent services, 186–187
domestic violence, 158, 161
entry to treatment, 159
the justice system, 154
pregnancy, 158, 161

Y

young adults, 175–177

CSAT TIPs and Publications Based on TIPs

What Is a TIP?

Treatment Improvement Protocols (TIPs) are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other Federal and non-Federal experts to reach consensus on state-of-the-art treatment practices. TIPs are developed under CSAT's Knowledge Application Program to improve the treatment capabilities of the Nation's alcohol and drug abuse treatment service system.

What Is a Quick Guide?

A Quick Guide clearly and concisely presents the primary information from a TIP in a pocket-sized booklet. Each Quick Guide is divided into sections to help readers quickly locate relevant material. Some contain glossaries of terms or lists of resources. Page numbers from the original TIP are referenced so providers can refer back to the source document for more information.

What Are KAP Keys?

Also based on TIPs, KAP Keys are handy, durable tools. Keys may include assessment or screening instruments, checklists, and summaries of treatment phases. Printed on coated paper, each KAP Keys set is fastened together with a key ring and can be kept within a treatment provider's reach and consulted frequently. The Keys allow the busy clinician or program administrator to locate information easily and to use this information to enhance treatment services.

TIP 1 **State Methadone Treatment Guidelines**—Replaced by TIP 43

TIP 2* **Pregnant, Substance-Using Women**—*BKD107*
- **Quick Guide for Clinicians** *QGCT02*
- **KAP Keys for Clinicians** *KAPT02*

TIP 3 **Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents**—Replaced by TIP 31

TIP 4 **Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents**—Replaced by TIP 32

TIP 5 **Improving Treatment for Drug-Exposed Infants**—*BKD110*

TIP 6 **Screening for Infectious Diseases Among Substance Abusers**—*BKD131*
- **Quick Guide for Clinicians** *QGCT06*
- **KAP Keys for Clinicians** *KAPT06*

TIP 7 **Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System**—Replaced by TIP 44

TIP 8 **Intensive Outpatient Treatment for Alcohol and Other Drug Abuse**—Replaced by TIPs 46 and 47

TIP 9 **Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse**—Replaced by TIP 42

TIP 10 **Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients**—Replaced by TIP 43

TIP 11 **Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases**—*BKD143*
- **Quick Guide for Clinicians** *QGCT11*
- **KAP Keys for Clinicians** *KAPT11*

TIP 12 **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**—Replaced by TIP 44

TIP 13 **Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders**—*BKD161*
- **Quick Guide for Clinicians** *QGCT13*
- **Quick Guide for Administrators** *QGAT13*
- **KAP Keys for Clinicians** *KAPT13*

TIP 14 **Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment**—*BKD162*

TIP 15 **Treatment for HIV-Infected Alcohol and Other Drug Abusers**—Replaced by TIP 37

TIP 16 **Alcohol and Other Drug Screening of Hospitalized Trauma Patients**—*BKD164*
- **Quick Guide for Clinicians** *QGCT16*
- **KAP Keys for Clinicians** *KAPT16*

TIP 17 **Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System**—Replaced by TIP 44

TIP 18 **The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers**—*BKD173*
- **Quick Guide for Clinicians** *QGCT18*
- **KAP Keys for Clinicians** *KAPT18*

TIP 19 **Detoxification From Alcohol and Other Drugs**—Replaced by TIP 45

TIP 20 **Matching Treatment to Patient Needs in Opioid Substitution Therapy**—Replaced by TIP 43

TIP 21 **Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System**—*BKD169*
- **Quick Guide for Clinicians and Administrators** *QGCA21*

TIP 22 **LAAM in the Treatment of Opiate Addiction**—Replaced by TIP43

TIP 23 **Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing**—*BKD205*
- **Quick Guide for Administrators** *QGAT23*

TIP 24 **A Guide to Substance Abuse Services for Primary Care Clinicians**—*BKD234*
- **Quick Guide for Clinicians** *QGCT24*
- **KAP Keys for Clinicians** *KAPT24*

TIP 25 **Substance Abuse Treatment and Domestic Violence**—*BKD239*
- **Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Treatment Providers** *MS668*
- **Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Administrators** *MS667*
- **Quick Guide for Clinicians** *QGCT25*
- **KAP Keys for Clinicians** *KAPT25*

**Under revision*

TIP 26 **Substance Abuse Among Older Adults—***BKD250*

Substance Abuse Among Older Adults: A Guide for Treatment Providers *MS669*

Substance Abuse Among Older Adults: A Guide for Social Service Providers *MS670*

Substance Abuse Among Older Adults: Physician's Guide *MS671*

Good Mental Health is Ageless PHD881 (English), PHD881S (Spanish)

Aging, Medicines and Alcohol PHD882 (English), PHD882S (Spanish)

Quick Guide for Clinicians *QGCT26*

KAP Keys for Clinicians *KAPT26*

TIP 27 **Comprehensive Case Management for Substance Abuse Treatment—***BKD251*

Case Management for Substance Abuse Treatment: A Guide for Treatment Providers *MS673*

Case Management for Substance Abuse Treatment: A Guide for Administrators *MS672*

Quick Guide for Clinicians *QGCT27*

Quick Guide for Administrators *QGAT27*

TIP 28 **Naltrexone and Alcoholism Treatment—***BKD268*

Naltrexone and Alcoholism Treatment: Physician's Guide *MS674*

Quick Guide for Clinicians *QGCT28*

KAP Keys for Clinicians *KAPT28*

TIP 29 **Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities—***BKD288*

Quick Guide for Clinicians *QGCT29*

Quick Guide for Administrators *QGAT29*

KAP Keys for Clinicians *KAPT29*

TIP 30 **Continuity of Offender Treatment for Substance Use Disorders From Institution to Community—***BKD304*

Quick Guide for Clinicians *QGCT30*

KAP Keys for Clinicians *KAPT30*

TIP 31 **Screening and Assessing Adolescents for Substance Use Disorders—***BKD306*

See companion products for TIP 32.

TIP 32 **Treatment of Adolescents With Substance Use Disorders—***BKD307*

Quick Guide for Clinicians *QGC312*

KAP Keys for Clinicians *KAP312*

TIP 33 **Treatment for Stimulant Use Disorders—***BKD289*

Quick Guide for Clinicians *QGCT33*

KAP Keys for Clinicians *KAPT33*

TIP 34 **Brief Interventions and Brief Therapies for Substance Abuse—***BKD341*

Quick Guide for Clinicians *QGCT34*

KAP Keys for Clinicians *KAPT34*

TIP 35 **Enhancing Motivation for Change in Substance Abuse Treatment—***BKD342*

Quick Guide for Clinicians *QGCT35*

KAP Keys for Clinicians *KAPT35*

Faces of Change *PHD1103*

TIP 36 **Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues—***BKD343*

Quick Guide for Clinicians *QGCT36*

KAP Keys for Clinicians *KAPT36*

Helping Yourself Heal: A Recovering Woman's Guide–*PHD981* (English), *PHD981S* (Spanish)

Helping Yourself Heal: A Recovering Man's Guide—*PHD1059* (English), *PHD1059S* (Spanish)

TIP 37 **Substance Abuse Treatment for Persons With HIV/ AIDS—***BKD359*

HIV/AIDS: Is Your Client at Risk? *MS965*

Drugs, Alcohol and HIV/AIDS: A Consumer Guide *PHD1126* (English), *PHD1134* (Spanish)

Quick Guide for Clinicians *MS678*

KAP Keys for Clinicians *KAPT37*

TIP 38 **Integrating Substance Abuse Treatment and Vocational Services—***BKD381*

Quick Guide for Clinicians *QGCT38*

Quick Guide for Administrators *QGAT38*

KAP Keys for Clinicians *KAPT38*

TIP 39 **Substance Abuse Treatment and Family Therapy—** *BKD504*

Quick Guide for Clinicians *QGCT39*

Quick Guide for Administrators *QGAT39*

TIP 40 **Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction—***BKD500*

Quick Guide for Physicians *QGPT40*

KAP Keys for Physicians *KAPT40*

TIP 41 **Substance Abuse Treatment: Group Therapy—** *BKD507*

Quick Guide for Clinicians *QGCT41*

TIP 42 **Substance Abuse Treatment for Persons With Co-Occurring Disorders—***BKD515*

Quick Guide for Clinicians *QGCT42*

Quick Guide for Administrators *QGAT42*

KAP Keys for Clinicians *KAPT42*

TIP 43 **Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs—***BKD524*

Quick Guide for Clinicians *QGCT43*

KAP Keys for Clinicians *KAPT43*

TIP 44 **Substance Abuse Treatment for Adults in the Criminal Justice System—***BKD526*

Quick Guide for Clinicians *QGCT44*

KAP Keys for Clinicians *KAPT44*

TIP 45 **Detoxification and Substance Abuse Treatment—** *BKD541*

TIP 46 **Substance Abuse: Administrative Issues in Outpatient Treatment—***BKD545*

Quick Guide for Administrators *QGAT46*

TIP 47 **Substance Abuse: Clinical Issues in Intensive Outpatient Treatment—***BKD551*

Treatment Improvement Protocols (TIPs) from the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT)

Place the quantity (up to 5) next to the publications you would like to receive and print your mailing address below.

___TIP 2* BKD107
___QG† for Clinicians QGCT02
___KK† for Clinicians KAPT02

___TIP 5 BKD110

___TIP 6 BKD131
___QG for Clinicians QGCT06
___KK for Clinicians KAPT06

___TIP 11 BKD143
___QG for Clinicians QGCT11
___KK for Clinicians KAPT11

___TIP 13 BKD161
___QG for Clinicians QGCT13
___QG for Administrators QGAT13
___KK for Clinicians KAPT13

___TIP 14 BKD162

___TIP 16 BKD164
___QG for Clinicians QGCT16
___KK for Clinicians KAPT16

___TIP 18 BKD173
___QG for Clinicians QGCT18
___KK for Clinicians KAPT18

___TIP 21 BKD169
___QG for Clinicians & Administrators QGCA21

___TIP 23 BKD205
___QG for Administrators QGAT23

___TIP 24 BKD234
___QG for Clinicians QGCT24
___KK for Clinicians KAPT24

___TIP 25 BKD239
___Guide for Treatment Providers MS668
___Guide for Administrators MS667
___QG for Clinicians QGCT25
___KK for Clinicians KAPT25

Under revision
†QG = Quick Guide; KK = KAP Keys

___TIP 26 BKD250
___Guide for Treatment Providers MS669
___Guide for Social Service Providers MS670
___Physician's Guide MS671
___Good Mental Health PHD881
___Good Mental Health PHD881S (Spanish)
___Aging, Medicine PHD882
___Aging, Medicine PHD882S (Spanish)
___QG for Clinicians QGCT26
___KK for Clinicians KAPT26

___TIP 27 BKD251
___Guide for Treatment Providers MS673
___Guide for Administrators MS672
___QG for Clinicians QGCT27
___QG for Administrators QGAT27

___TIP 28 BKD268
___Physician's Guide MS674
___QG for Clinicians QGCT28
___KK for Clinicians KAPT28

___TIP 29 BKD288
___QG for Clinicians QGCT29
___QG for Administrators QGAT29
___KK for Clinicians KAPT29

___TIP 30 BKD304
___QG for Clinicians QGCT30
___KK for Clinicians KAPT30

___TIP 31 BKD306
(see products under TIP 32)

___TIP 32 BKD307
___QG for Clinicians QGC312
___KK for Clinicians KAP312

___TIP 33 BKD289
___QG for Clinicians QGCT33
___KK for Clinicians KAPT33

___TIP 34 BKD341
___QG for Clinicians QGCT34
___KK for Clinicians KAPT34

___TIP 35 BKD342
___QG for Clinicians QGCT35
___KK for Clinicians KAPT35
___Faces PHD1103

___TIP 36 BKD343
___QG for Clinicians QGCT36
___KK for Clinicians KAPT36
___Brochure for Women (English) PHD981
___Brochure for Women (Spanish) PHD981S
___Brochure for Men (English) PHD1059
___Brochure for Men (Spanish) PHD1059S

___TIP 37 BKD359
___Your Client At Risk MS965
___Drugs, Alcohol & HIV/AIDS PHD1126
___Drogas, Alcohol y el VIH/SIDA PHD1134
___QG for Clinicians QGCT37
___KK for Clinicians KAPT37

___TIP 38 BKD381
___QG for Clinicians QGCT38
___QG for Administrators QGAT38
___KK for Clinicians KAPT38

___TIP 39 BKD504
___QG for Clinicians QGCT39
___QG for Administrators QGAT39

___TIP 40 BKD500
___QG for Physicians QGPT40
___KK for Physicians KAPT40

___TIP 41 BKD507
___QG for Clinicians QGCT41

___TIP 42 BKD515
___QG for Clinicians QGCT42
___QG for Administrators QGAT42
___KK for Clinicians KAPT42

___TIP 43 BKD524
___QG for Clinicians QGCT43
___KK for Clinicians KAPT43

___TIP 44 BKD526
___QG for Clinicians QGCT44
___KK for Clinicians KAPT44

___TIP 45 BKD541

___TIP 46 BKD545

___TIP 47 BKD551

Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone and e-mail: ______________________________

You can either mail this form or fax it to (240) 221-4292. Publications also can be ordered by calling SAMHSA's NCADI at (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889.

TIPs can also be accessed on line at www.kap.samhsa.gov.

-- **FOLD** --

STAMP

SAMHSA's National Clearinghouse for Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 20847-2345

-- **FOLD** --

Substance Abuse:
Clinical Issues in Intensive Outpatient Treatment

This TIP, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment,* addresses the practical needs of treatment providers as they design and implement intensive outpatient treatment programs. The TIP provides specific information on the principles of intensive outpatient treatment; services and treatment models; modifications for distinct population groups; culturally competent treatment; screening and patient placement criteria; counseling methods and techniques, including involvement of families; and the continuum of care. The TIP also covers such important issues as how to improve early retention, provide the appropriate length and intensity of services, provide the most promising mix of wrap-around services for positive client outcomes, and arrange ongoing care in the community.

Collateral Products
Based on TIP 47

Quick Guide for Clinicians
KAP Keys for Clinicians

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

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

FOR-PROFIT

Applicant Name:

Financial Worksheet (B)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY	FY	2017	FY	FY	2018	FY	FY	2019	FY	FY	2020	FY
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$0	$0	$67,500	$67,500	$0	$225,000	$225,000		$281,250	$281,250		$337,500	$337,500
2	Less: Allowances	$0	$0	$0	$0	$0	$0	$0			$0			$0
3	Less: Charity Care	$0	$0	$0	$0	$0	$0	$0			$0			$0
4	Less: Other Deductions	$0	$0	$0	$0	$0	$0	$0			$0			$0
	Net Patient Service Revenue	**$0**	**$0**	**$67,500**	**$67,500**	**$0**	**$225,000**	**$225,000**	**$0**	**$281,250**	**$281,250**	**$0**	**$337,500**	**$337,500**
5	Medicare	$0	$0	$0	$0	$0	$0	$0			$0			$0
6	Medicaid	$0	$0	$16,875	$16,875	$0	$56,250	$56,250		$70,313	$70,313		$84,375	$84,375
7	CHAMPUS & TriCare	$0	$0	$0	$0	$0	$0	$0			$0			$0
8	Other	$0	$0	$0	$0	$0	$0	$0			$0			$0
	Total Government	**$0**	**$0**	**$16,875**	**$16,875**	**$0**	**$56,250**	**$56,250**	**$0**	**$70,313**	**$70,313**	**$0**	**$84,375**	**$84,375**
9	Commercial Insurers	$0	$0	$47,250	$47,250	$0	$157,500	$157,500		$196,875	$196,875		$236,250	$236,250
10	Uninsured	$0	$0	$0	$0	$0	$0	$0			$0			$0
11	Self Pay	$0	$0	$3,375	$3,375	$0	$11,250	$11,250		$14,063	$14,063		$16,875	$16,875
12	Workers Compensation	$0	$0	$0	$0	$0	$0	$0			$0			$0
13	Other	$0	$0	$0	$0	$0	$0	$0			$0			$0
	Total Non-Government	**$0**	**$0**	**$50,625**	**$50,625**	**$0**	**$168,750**	**$168,750**	**$0**	**$210,938**	**$210,938**	**$0**	**$253,125**	**$253,125**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$0**	**$0**	**$67,500**	**$67,500**	**$0**	**$225,000**	**$225,000**	**$0**	**$281,250**	**$281,250**	**$0**	**$337,500**	**$337,500**
14	Less: Provision for Bad Debts	$0	$0	$0	**$0**	$0	$0	**$0**			**$0**			**$0**
	Net Patient Service Revenue less provision for bad debts	**$0**	**$0**	**$67,500**	**$67,500**	**$0**	**$225,000**	**$225,000**	**$0**	**$281,250**	**$281,250**	**$0**	**$337,500**	**$337,500**
15	Other Operating Revenue	$0	$0	$0	**$0**	$0	$0	**$0**			**$0**			**$0**
17	Net Assets Released from Restrictions	$0	$0	$0	**$0**	$0	$0	**$0**			**$0**			**$0**
	TOTAL OPERATING REVENUE	**$0**	**$0**	**$67,500**	**$67,500**	**$0**	**$225,000**	**$225,000**	**$0**	**$281,250**	**$281,250**	**$0**	**$337,500**	**$337,500**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$0	$0	$30,000	$30,000		$100,000	$100,000		$120,000	$120,000		$140,000	$140,000
2	Fringe Benefits	$0	$0	$3,000	$3,000		$10,000	$10,000		$12,000	$12,000		$14,000	$14,000
3	Physicians Fees	$0	$0	$0	$0			$0			$0			$0
4	Supplies and Drugs	$0	$0	$300	$300		$600	$600		$800	$800		$1,000	$1,000
5	Depreciation and Amortization	$0	$0	$1,000	$1,000		$2,000	$2,000		$2,000	$2,000		$2,000	$2,000
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0			$0			$0			$0
7	Interest Expense	$0	$0	$0	$0			$0			$0			$0
8	Malpractice Insurance Cost	$0	$0	$2,500	$2,500		$5,000	$5,000		$5,000	$5,000		$5,000	$5,000
9	Lease Expense	$0	$0	$27,000	$27,000		$54,000	$54,000		$54,000	$54,000		$54,000	$54,000
10	Other Operating Expenses	$0	$0	28,225	$28,225		45,550	$45,550		46,113	$46,113		46,675	$46,675
	TOTAL OPERATING EXPENSES	**$0**	**$0**	**$92,025**	**$92,025**	**$0**	**$217,150**	**$217,150**	**$0**	**$239,913**	**$239,913**	**$0**	**$262,675**	**$262,675**
	INCOME/(LOSS) FROM OPERATIONS	**$0**	**$0**	**($24,525)**	**($24,525)**	**$0**	**$7,850**	**$7,850**	**$0**	**$41,338**	**$41,338**	**$0**	**$74,825**	**$74,825**
	NON-OPERATING INCOME	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Income before provision for income taxes	**$0**	**$0**	**($24,525)**	**($24,525)**	**$0**	**$7,850**	**$7,850**	**$0**	**$41,338**	**$41,338**	**$0**	**$74,825**	**$74,825**

FOR-PROFIT

Applicant Name:

Financial Worksheet (B)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY**	**FY**	**2017**	**FY**	**FY**	**2018**	**FY**	**FY**	**2019**	**FY**	**FY**	**2020**	**FY**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
	Provision for income taxes[c]	**$0**	$0	$0	**$0**			**$0**			**$0**			**$0**
	NET INCOME	**$0**	**$0**	**($24,525)**	**($24,525)**	**$0**	**$7,850**	**$7,850**	**$0**	**$41,338**	**$41,338**	**$0**	**$74,825**	**$74,825**
C.	**Retained Earnings, beginning of year**	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Retained Earnings, end of year	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Principal Payments	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**0.0%**	**0.0%**	**-36.3%**	**-36.3%**	**0.0%**	**3.5%**	**3.5%**	**0.0%**	**14.7%**	**14.7%**	**0.0%**	**22.2%**	**22.2%**
2	Hospital Non Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**0.0%**	**0.0%**	**-36.3%**	**-36.3%**	**0.0%**	**3.5%**	**3.5%**	**0.0%**	**14.7%**	**14.7%**	**0.0%**	**22.2%**	**22.2%**
E.	**FTEs**	**0**	**0**	**1**	**1**		**2**	**2**		**2**	**2**		**2**	**2**
F.	**VOLUME STATISTICS[d]**													
1	Inpatient Discharges	0	0	0	**0**			**0**			**0**			**0**
2	Outpatient Visits	0	0	560	**560**		1,800	**1,800**		2,250	**2,250**		2,700	**2,700**
	TOTAL VOLUME	**0**	**0**	**560**	**560**	**0**	**1,800**	**1,800**	**0**	**2,250**	**2,250**	**0**	**2,700**	**2,700**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

User, OHCA

From:	Mitchell, Micheala
Sent:	Friday, April 21, 2017 10:22 AM
To:	'Reinhardwstraub@gmail.com'
Cc:	User, OHCA; Walker, Shauna; Riggott, Kaila; 'jayseigel@gmail.com'
Subject:	FW: 17-32160-CON Completeness Questions: Recovery Services of Connecticut
Attachments:	32160 Recovery Services of Connecticut LLC.docx

Mr. Straub,

Please see the email below. Due to a typographical error, the original correspondence was not delivered to your mailbox.

Thank you,
Micheala L. Mitchell
Staff Attorney, PHHO/OHCA
Connecticut Department of Public Health
410 Capitol Avenue, MS# 13-HCA, Hartford, CT 06134
Phone: (860) 418-7055
Email: micheala.mitchell@ct.gov

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From: Mitchell, Micheala
Sent: Friday, April 21, 2017 10:15 AM
To: 'jayseigel@gmail.com' <jayseigel@gmail.com>; 'Reinhardwstraub@gamil.com' <Reinhardwstraub@gamil.com>
Cc: Riggott, Kaila <Kaila.Riggott@ct.gov>; Walker, Shauna <Shauna.Walker@ct.gov>; User, OHCA <OHCA@ct.gov>
Subject: 17-32160-CON Completeness Questions: Recovery Services of Connecticut

Dear Mr. Seigel and Mr. Straub:

Attached are completeness questions associated with CON docket number 17-32160. Please confirm receipt of this correspondence.

Thank you,
Micheala L. Mitchell
Staff Attorney, PHHO/OHCA

Connecticut Department of Public Health
410 Capitol Avenue, MS# 13-HCA, Hartford, CT 06134
Phone: (860) 418-7055
Email: micheala.mitchell@ct.gov

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

April 20, 2017 Via Email Only

Mr. Jay Seigel
Mr. Reinhard Straub
Recovery Services of CT, LLC
11 Woodland Road
Madison, CT 06443
jayseigel@gmail.com
Reinhardwstraub@gmail.com

RE: Certificate of Need Application: Docket Number: 17-32160-CON
Establishment of a Substance Abuse or Dependence Treatment Clinic for Adults in Madison, CT
Certificate of Need Completeness Letter

Dear Mr. Seigel and Mr. Straub:

On March 31, 2017, OHCA received the Certificate of Need application from Jay and Reinhard Recovery Services, LLC, d/b/a Recovery Services of CT, LLC ("RSCT" or "Applicant"), seeking authorization to establish a freestanding facility for the care or treatment of substance abuse or dependence for adults in Madison. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please "reply all" to electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. ***Please email your responses to both of the following email addresses: OHCA@ct.gov and Kaila.Riggott@ct.gov.***

Paginate and date your response (i.e., each page in its entirety). Repeat each OHCA question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions, etc.) must be

numbered sequentially from the Applicant's preceding document. Begin your submission using **Page 459** and reference "**Docket Number: 17-32160-CON**."

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date this request was transmitted. Therefore, please provide your written responses to OHCA no later than **June 19, 2017, by 4:30 p.m.**, otherwise your application will be automatically considered withdrawn.

1. The published notices on pages 9-11 of the application list a capital expenditure of $10,000 for this project. Conversely, pages 5, 32 and 33 of the application indicate that the capital expenditure for the project is $15,000. Explain the discrepancy between the two figures and verify the appropriate amount.

2. Page 19 of the application states that RSCT does not have any agreements related to the proposal. Will RSCT have a transfer agreement with other facilities in the event of a crisis or emergency? If so, please provide a draft transfer agreement with an estimated date by which the final will be available.

3. Cite or provide a copy of the Agency for Healthcare Research and Quality ("AHRQ") publication cited on page 21 of the application.

4. Question 21a on page 33 of the application directs the Applicants to provide financial documents such as unaudited balance sheets, a statement of operations, tax returns, or other sets of books if audited financial statements do not exist. Please provide tax returns for the Applicant's existing practice(s) for the most recently completed fiscal year. Redact all personally identifiable information prior to submission (e.g.. EIN or Social Security numbers).

5. Page 26 of the application states that the population estimate of the South Central region of Connecticut is approximately 248,000. Provide the source of this population estimate.

6. Clarify or correct the following regarding Table 5 on page 35 of the application:
    a. the period covered for CFY 2017, as the timeframe is listed as October 1st through December 31st; and
    b. the unit of measure for "office-based psychiatric services" (e.g., patients, sessions or visits).

7. Clarify or explain the following regarding Table 6 on page 35 of the application:
    a. the method/calculation(s) used to project the service volume, in detail, for each fiscal year (including the large percentage increases between fiscal years);
    b. whether intensive outpatient treatment ("IOP") sessions/visits are counted individually or as group sessions; and
    c. the units of measure for individual services (e.g., patients, sessions or visits) and ensure that they are consistent with the units of measure utilized in Table 5.

8. Utilizing the format below, update Table 7 on page 36 of the application by verifying the total number of non-government visits for FY 2017 and FY 2019. Ensure visit totals are consistent with the totals provided in the "Outpatient Visits" row in Financial Worksheet (B) and the total projected volume in Table 6. Also, explain the basis, methods and calculations used to project the reported numbers.

CURRENT AND PROJECTED PAYER MIX FOR RECOVERY SERVICES OF CONNECTICUT, BY NUMBER OF CLIENTS AND VISITS

Payer	**Current**			**Projected**								
	FY 2017			**FY 2018**			**FY 2019**			**FY 2020**		
	Patient Vol.	**%**	**Visit Vol.**	**Patient Vol.**	**%**	**Visit Vol.**	**Patient Vol.**	**%**	**Visit Vol.**	**Patient Vol.**	**%**	**Visit Vol.**
Medicare*												
Medicaid*		30	168		30	540		30	675		30	810
CHAMPUS & TriCare												
Total Government		**30**	**168**		**30**	**540**		**30**	**675**		**30**	**810**
Commercial Insurers		65	365		65	1,170		65	1,463		65	1,755
Self-pay		5	28		5	90		5	113		5	135
Uninsured												
Workers Compensation												
Total Non-Government		**70**	**392**		**70**	**1,260**		**70**	**1,575**		**70**	**1,890**
Total Payer Mix		**100**	**560**		**100**	**1,800**		**100**	**2,250**		**100**	**2,270**

9. Describe how residents in Madison and surrounding towns, who are not clients of Jay Seigel, Reinhard Straub or their associated colleagues, will be referred to the proposed IOP program (e.g., self-referrals, referrals through behavioral health professionals, Connecticut state agencies, etc.). Where and at what level are these potential clients currently receiving services? Describe the impact of the proposal on these providers.

If you have any questions concerning this letter, please contact Kaila Riggott at (860) 418-7037.

User, OHCA

From: Walker, Shauna
Sent: Monday, May 22, 2017 7:05 AM
To: reinhardwstraub@gmail.com
Cc: jayseigel@gmail.com; Mitchell, Micheala; Riggott, Kaila; User, OHCA
Subject: CON 17-32160 Completeness Responses
Attachments: CONdocnbr17-32160compquestions.pdf

Thank you.

From: Reinhard Straub [mailto:reinhardwstraub@gmail.com]
Sent: Saturday, May 20, 2017 10:52 AM
To: Walker, Shauna <Shauna.Walker@ct.gov>
Cc: jayseigel@gmail.com; Mitchell, Micheala <Micheala.Mitchell@ct.gov>; Riggott, Kaila <Kaila.Riggott@ct.gov>
Subject: Re: CON 17-32160 Completeness Responses

Hello Ms. Walker

Attached please find the requested document: completeness responses, attachments and addendum in one PDF document pertaining to CON 17-32160.

Thank you

Reinhard W Straub, LICSW
Offices:
24 Channing Street
New London, CT 06320
11 Woodland Road, Suite 2
Madison, CT 06443
Cell 401.741.5109
reinhardwstraub@gmail.com
www.reinhardwstraub.com

On Thu, May 18, 2017 at 3:13 PM, Walker, Shauna <Shauna.Walker@ct.gov> wrote:

> Dear Mr. Seigel and Mr. Straub:
>
> On May 3, 2017, OHCA received completeness responses pertaining to CON 17-32160 with related attachments A, B, and C. Additionally, we received an addendum to the responses on May 8, 2017.
>
> The responses submitted on May 3 included tracked changes and comments. We are asking that you resend a finalized version of the May 3, 2017 responses (without tracked changes and comments), along with

attachments, A, B, C and the addendum, in one document. Please number the document beginning with page **459**. This document can be submitted to us as one PDF if necessary.

If you have any questions or concerns, please do not hesitate to contact us.

Regards,

Shauna L. Walker

Office of Health Care Access

Connecticut Department of Public Health

410 Capitol Avenue

Hartford, CT 06134

Phone: (860) 418-7069

Email: Shauna.Walker@ct.gov

CON docket number 17-32160
Completeness Questions

1. The published notices on pages 9-11 of the application list a capital expenditure of $10,000 for this project. Conversely, pages 5, 32 and 33 of the application indicate that the capital expenditure for the project is $15,000. Explain the discrepancy between the two figures and verify the appropriate amount.

The appropriate amount is $15,000. The discrepancy was an oversight on the Applicant's part.

2. Page 19 of the application states that RSCT does not have any agreements related to the proposal. Will RSCT have a transfer agreement with other facilities in the event of a crisis or emergency? If so, please provide a draft transfer agreement with an estimated date by which the final will be available.

See attached agreement with The Wheeler Clinic.
Attachment A

3. Cite or provide a copy of the Agency for Healthcare Research and Quality ("AHRQ") publication cited on page 21 of the application.

Weiss AJ (Truven Health Analytic), Elixhauser A (AHRQ), Barrett ML (M.L. Barrett, Inc.), Steiner CA (AHRQ), Bailey MK (Truven Health Analytics), O'Malley L (Truven Health Analytics). Opioid-Related Inpatient Stays and Emergency Department Visits by State, 2009–2014. HCUP Statistical Brief #219. December 2016. Agency for Healthcare Research and Quality, Rockville, MD.
http://www.hcupus.ahrq.gov/reports/statbriefs/sb219-Opioid-Hospital-Stays-ED-Visits-by-State.pdf.

4. Question 21a on page 33 of the application directs the Applicants to provide financial documents such as unaudited balance sheets, a statement of operations, tax returns, or other sets of books if audited financial statements do not exist. Please provide tax returns for the Applicant's existing practice(s) for the most recently completed fiscal year. Redact all personally identifiable information prior to submission (e.g.. EIN or Social Security numbers).

See attached 2016 tax returns
Attachment B & C

5. Page 26 of the application states that the population estimate of the South Central region of Connecticut is approximately 248,000. Provide the source of this population estimate.

Updated December 17, 2015
Data Provided by Connecticut State Data Center, Connecticut Open Data Initiative.
Results obtained April 24, 2017:

https://data.ct.gov/Government/Connecticut-Town-Population-Projections-2015-2025/mze8-865g/data

6. Clarify or correct the following regarding Table 5 on page 35 of the application: the period covered for CFY 2017, as the timeframe is listed as October 1st through December 31st; and the unit of measure for "office-based psychiatric services" (e.g., patients, sessions or visits).

See corrected Table 5 below. The volume per year indicates the volume or actual number of clients in treatment with Jay Seigel, APRN receiving office-based psychiatric services. For instance, to date in 2017, Jay Seigel, APRN has 515 active clients in treatment and in 2016, Jay Seigel, APRN had 452 active clients.

TABLE 5

HISTORICAL UTILIZATION BY SERVICE

	Actual Volume (Last 3 Completed FYs)			**Actual Volume to date April 2017.**
Service	**FY 2014**	**FY 2015**	**FY 2016**	**2017**
Number of clients for Office-based psychiatric services	347	389	452	515
Total	347	389	452	515

7. Clarify or explain the following regarding Table 6 on page 35 of the application: the method/calculation(s) used to project the service volume, in detail, for each fiscal year (including the large percentage increases between fiscal years); whether intensive outpatient treatment ("IOP") sessions/visits are counted individually or as group sessions; and the units of measure for individual services (e.g., patients, sessions or visits) and ensure that they are consistent with the units of measure utilized in Table 5.

TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service*	Projected Volume			
	FY 2017 (07/01 – 12/31)	FY 2018	FY 2019	FY 2020
IOP Sessions	337	1200	1500	1800
Individual Sessions	225	600	750	900
Total	562	1800	2250	2700

"IOP Sessions" per annum indicates the total number of IOP sessions or Dates of Service (DOS) for the year.

In 2017, the applicants project that 337 IOP sessions would be accomplished. This was calculated as follows: 7/1 to 12/31/17 = 25 weeks of operation (considering holidays). IOP groups meet 3 times per week. Projected number of clients attending IOP per week in the first months of operation is between 4 and 5 clients or 4.5 clients on average. Therefore, 25 weeks times 3 sessions per week times 4.5 clients = 337.5

In 2018, the applicants project that 1200 IOP sessions would be accomplished. This was calculated as follows: 50 weeks of operation (considering holidays). IOP groups meet 3 times per week. Projected number of clients attending IOP per week would be 8 on average. Therefore, 25 weeks times 3 sessions per week times 8 clients = 1200.

In 2019, the applicants project that 1500 IOP sessions would be accomplished. This was calculated as follows: 50 weeks of operation (considering holidays). IOP groups meet 3 times

per week. Projected number of clients attending IOP per week would be 10 on average. Therefore, 25 weeks times 3 sessions per week times 10 clients = 1500.

In 2020, the applicants project that 1800 IOP sessions would be accomplished. This was calculated as follows: 50 weeks of operation (considering holidays). IOP groups meet 3 times per week. Projected number of clients attending IOP per week would be 12 on average. Therefore, 25 weeks times 3 sessions per week times 12 clients = 1800.

"Individual Sessions" per annum indicates the total number of Individual Sessions or Dates of Service (DOS) for the year. Please note that these indicated "Individual Sessions" are independent of and not the weekly individual sessions that IOP Clients receive gratis as part of their IOP treatment.

In 2017, the applicants project that 225 Individual Sessions would be accomplished. This was calculated as follows: 7/1 to 12/31/17 = 25 weeks of operation (considering holidays). Individual sessions are conducted 1 time per week. Projected number of clients attending individual sessions per week in the first months of operation is 9 on average. Therefore, 25 weeks times 1 session per week times 9 clients = 225.

In 2018, the applicants project that 600 Individual Sessions would be accomplished. This was calculated as follows: 50 weeks of operation (considering holidays). Individual sessions are conducted 1 time per week. Projected number of clients attending individual sessions per week is 12 on average. Therefore, 25 weeks times 1 session per week times 12 clients = 600.

In 2019, the applicants project that 750 Individual Sessions would be accomplished. This was calculated as follows: 50 weeks of operation (considering holidays). Individual sessions are conducted 1 time per week. Projected number of clients attending individual sessions per week is 15 on average. Therefore, 25 weeks times 1 session per week times 15 clients = 750.

In 2020, the applicants project that 900 Individual Sessions would be accomplished. This was calculated as follows: 50 weeks of operation (considering holidays). Individual sessions are conducted 1 time per week. Projected number of clients attending individual sessions per week is 18 on average. Therefore, 25 weeks times 1 session per week times 18 clients = 900.

In response to "consistent with the units of measure utilized in Table 5": Table 5 indicates the actual number of clients per annum and to date in 2017 that Jay Seigel, APRN has under his care for psychopharmacological services. Table 5 only indicates the number of clients and not "IOP Sessions" and "Individual Sessions" as indicated in Table 6 as IOP services and agency sessions are not offered now. The Applicants contend that Table 5 indicates a sufficient number of potential IOP clients that would avail themselves of the proposed service.

8. Utilizing the format below, update Table 7 on page 36 of the application by verifying the total number of non-government visits for FY 2017 and FY 2019. Ensure visit totals are consistent with the totals provided in the "Outpatient Visits" row in Financial Worksheet (B) and the total projected volume in Table 6. Also, explain the basis, methods and calculations used to project the reported numbers.

The projected payer mix in Table 7 was determined by utilizing the actual payer mix of the current private practices of Jay Seigel, APRN and Reinhard Straub, LCSW. The Applicants project that the payer mix for the proposed project will be consistent with their current experience.

The visit totals for Table 6 and Table 7 are consistent with the Financial Worksheet (B) utilizing the following calculation: IOP income was averaged/calculated at $150 per session and Individual Sessions were averaged/calculated at $75 per session.

The projected total income for 2017 of $67,500 was calculated as follows: 337 IOP @ $150 Per = $50,550 and 225 Ind. Sessions @$75. Per = $16,875 Total $67,425. Rounded to $67,500.

The projected total income for 2018 of $225K was calculated as follows: 1200 IOP @ $150 Per = $180K and 600 Ind. Sessions @$75. Per = $45K Total $225K.

The projected total income for 2019 of $281,250 was calculated as follows: 1500 IOP @ $150 Per = $225K and 750 Ind. Sessions @$75. Per = $56,250 Total $281,250.

The projected total income for 2020 of $337,500 was calculated as follows: 1800 IOP @ $150 Per = $270K and 900 Ind. Sessions @$75. Per = $67,500 Total $337,500.

TABLE 7

PROJECTED PAYER MIX FOR RECOVERY SERVICES OF CONNECTICUT BY NUMBER OF VISITS

Payer	Projected 7/1 to 12/31		Projected					
	FY 2017		FY 2018		FY 2019		FY 2020	
	%	IOP & Ind. Session Volume	%	IOP & Ind. Session Volume	%	IOP & Ind. Session Volume	%	IOP & Ind. Session Volume
Medicare*								
Medicaid*	30	169	30	540	30	675	30	810
CHAMPUS & TriCare								
Total Government	**30**	**169**	**30**	**540**	**30**	**675**	**30**	**810**
Commercial Insurers	65	365	65	1,170	65	1,463	65	1,755
Self-pay	5	28	5	90	5	113	5	135
Uninsured								
Workers Compensation								
Total Non-Government	**70**	**393**	**70**	**1,260**	**70**	**1,575**	**70**	**1,890**
Total Payer Mix	**100**	**562**	**100**	**1,800**	**100**	**2,250**	**100**	**2,700**

9. Describe how residents in Madison and surrounding towns, who are not clients of Jay Seigel, Reinhard Straub or their associated colleagues, will be referred to the proposed IOP program (e.g., self-referrals, referrals through behavioral health professionals, Connecticut state agencies, etc.). Where and at what level are these potential clients currently receiving services? Describe the impact of the proposal on these providers.

The Applicants expect that the proposed project will receive referrals from sources such as the following: a significant of number of self-referrals seeking local treatment who will locate Recovery Services of Connecticut online through the website and various search engines; Mental Health Counseling Group Practices; Individual Therapists; Medical Practices; Hospitals; Residential Treatment Centers; Professional Organizations; Employee Assistance Programs; Colleges and University Student Health and Counseling Centers; Local Businesses; Attorneys; Diversion Programs e.g. Drug Court, Pretrial Services, etc.; DCF; Probation; and Insurance Companies.

As indicated in the SAMHSA Report in Attachment C, the vast majority or 94.5% of persons in need of Substance Use Disorder treatment are not in treatment. Therefore, it is the opinion of the Applicants, that the majority of potential local clients are not in treatment nor are they currently receiving services. Most potential clients who are receiving services are, in the Applicants' experience, receiving medical, psychiatric and mental health treatment that does not address their primary diagnosis, the disease of addiction. Due to the addiction epidemic, the impact on these providers would be very positive as they are finding it very difficult to refer and place clients suffering from Substance Use Disorders. Busy physicians, psychologists, etc. simply do not have the time or staff structure to adequately engage the client and their families to ensure treatment entry and retention.

Attachment A

Wheeler Clinical Support Services

Service Contract

This contract is established between Jay Seigel APRN (hereafter referred to as "Client") and the Wheeler Clinic. Its purpose is to establish the terms and conditions for providing Wheeler Clinical Support Services (hereafter referred to as "WCSS") to your private practice.

Clinical Support Services

WCSS is a designated phone line answered by Wheeler Clinic HelpLine staff. HelpLine is a 24 hour/7 day per week, crisis/helpline operated within the Emergency Services unit of Wheeler Clinic. WCSS staff are paid telephone counselors who receive rigorous training in order to handle the volume and type of calls received each day. This unit is specifically designed to assist clients who are in crisis and potentially suicidal.

Helpline operates with three primary goals: 1) to be a listening agency capable of addressing the range of issues from general support to serious crisis such as suicidal ideation, 2) to provide information, and 3) to be a referral source to other mental health agencies in Connecticut.

Scope of Service

1. WCSS counselors will screen every call for potential suicidality. If the caller is actively suicidal or homicidal, the caller will be referred for emergency services as needed. Please note that if WCSS refers your patient for emergency services, the patient may be billed for such services. If the patient carries health insurance the emergency service provider will likely bill the patient's insurance.
2. WCSS counselors will page/call the Client or designee and send written call records by fax if desired by the Client.
3. WCSS counselors cannot provide medical assistance other than to recommend the patient seek immediate medical attention.
4. WCSS counselors will receive faxed alerts/special instructions if Client anticipates a need for assistance for particular patients. WCSS fax number is 860 793-3523
5. Client may leave the WCSS phone number 860 793-3515 on Client's outgoing voicemail.

WCSS-Clinician Data Sheet

Name of Practice: connecticut psychiatric Svcs Recovery Svc of Connecticut Service Start Date: (contract update) ________

Address: 71 Bradley Rd. Madison CT 06443 / 24 Channing St, New London CT 06320 Phone: 203-303-7387

Office Hours: 9-5 M-F Fax: 203-303-7387

Scope of Practice: Adults (X) Children ( ) Both ( ) Other ________

Provide names and phone number(s) of therapists covered in this contract (up to 3 providers.) *Please include phone numbers WCSS will use to contact in case of emergencies.*

Therapist(s):

Reinhard Straub

Caroline Polsky

203-655-1616

Affiliated Hospital: Yale New Haven Hospital, Middlesex Hospital, Lawrence & Memorial Hospital Hospital Number: 860-358-6000, 860-442-0711

Other numbers/info to reach: ________

Please check all your choices below:

( ) Non-crisis support call, WCSS will leave a message on your voice mail.

(X) Urgent, at-risk calls, WCSS will make every effort to reach you directly.

( ) FCS clients should be urged to call the crisis team in their area, or to go to their nearest ED.

Specify other instructions: Clients would call for off hours M-F and weekend coverage for "urgent and at risk clients" in our private practice and intensive outpatient program.

467

04/24/2017 14:10 FAX ☒0002/0004

Fees and Terms

This contract shall be in effect on a rolling basis, periodic reviews and rate changes may occur as the costs of operating WCSS change. Either party may choose to discontinue this contract at any time but must do so in writing.

WCSS will bill on /about the 15th of June, September, December and March. Accounts are due on the 1st of the following month.

The fee schedule is as follows:

- For coverage of up to three providers: $60/month or $180.00/quarter.
- For coverage of four to six providers: $120/month or $360.00/quarter
- For coverage of seven to nine providers: $180/month or $540.00/quarter

My signature indicates agreement to the terms and conditions described above.

[signature] 4-24-17

Client Signature Date

Jay Seigel

Print Name

Practice Name

24 Channing St.

Billing Address

New London CT 06320

City, State, Zip

203-303-7387

Phone Number

[signature] 4/24/17

Marisa Giaccotto, LCSW Date

Program Manager, Wheeler Clinic Emergency Services.

Attachment B

Form 1040 U.S. Individual Income Tax Return (99) 2016

OMB No. 1545-0074 | IRS Use Only - Do not write or staple in this space.

For the year Jan. 1-Dec. 31, 2016, or other tax year beginning , 2016, ending , 20 | See separate instructions.

Your first name and initial	Last name	Your social security number
REINHARD W.	STRAUB	XX
If a joint return, spouse's first name and initial	Last name	
	STRAUB	
Home address (number and street). If you have a P.O. box, see instructions.	Apt. no.	▲ Make sure the SSN(s) above and on line 6c are correct.
24 CAROLINA MAIN STREET		
City, town or post office, state, and ZIP code. If you have a foreign address, also complete spaces below.		Presidential Election Campaign: Check here if you, or your spouse if filing jointly, want $3 to go to this fund. Checking a box below will not change your tax or refund. ☐ You ☐ Spouse
CAROLINA, RI 02812		
Foreign country name	Foreign province/state/county	Foreign postal code

Filing Status

Check only one box.

1 ☐ Single
2 ☒ Married filing jointly (even if only one had income)
3 ☐ Married filing separately. Enter spouse's SSN above and full name here. ▶
4 ☐ Head of household (with qualifying person). If the qualifying person is a child but not your dependent, enter this child's name here. ▶
5 ☐ Qualifying widow(er) with dependent child

Exemptions

6a ☒ **Yourself.** If someone can claim you as a dependent, **do not** check box 6a
b ☒ **Spouse**

Boxes checked on 6a and 6b: 2
No. of children on 6c who: • lived with you: 1
• did not live with you due to divorce or separation (see instructions):
Dependents on 6c not entered above:
Add numbers on lines above ▶ 3

c **Dependents:**

(1) First name	Last name	(2) Dependent's social security number	(3) Dependent's relationship to you	(4) ✓ if child under age 17 qualifying for child tax credit
XXXX	STRAUB	XXXXXX	DAUGHTER	X

If more than four dependents, see instructions and check here ▶ ☐

d Total number of exemptions claimed

Income

Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.

If you did not get a W-2, see instructions.

Line	Description		Amount	Line	Amount
7	Wages, salaries, tips, etc. Attach Form(s) W-2 STMT 3			7	268,878.
8a	**Taxable** interest. Attach Schedule B if required			8a	338.
b	**Tax-exempt** interest. **Do not** include on line 8a	8b			
9a	Ordinary dividends. Attach Schedule B if required			9a	
b	Qualified dividends	9b			
10	Taxable refunds, credits, or offsets of state and local income taxes			10	445.
11	Alimony received			11	
12	Business income or (loss). Attach Schedule C or C-EZ			12	-7,317.
13	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶ ☐			13	-3,000.
14	Other gains or (losses). Attach Form 4797			14	
15a	IRA distributions	15a	83,795.	15b (b Taxable amount)	0.
16a	Pensions and annuities	16a	62,844.	16b (b Taxable amount)	0.
17	Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E			17	
18	Farm income or (loss). Attach Schedule F			18	
19	Unemployment compensation			19	
20a	Social security benefits	20a		20b (b Taxable amount)	
21	Other income. List type and amount			21	
22	Combine the amounts in the far right column for lines 7 through 21. This is your **total income** ▶			22	259,344.

Adjusted Gross Income

Line	Description	Line	Amount	Line	Amount
23	Educator expenses	23			
24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24			
25	Health savings account deduction. Attach Form 8889	25			
26	Moving expenses. Attach Form 3903	26			
27	Deductible part of self-employment tax. Attach Schedule SE	27			
28	Self-employed SEP, SIMPLE, and qualified plans	28			
29	Self-employed health insurance deduction	29			
30	Penalty on early withdrawal of savings	30			
31a	Alimony paid b Recipient's SSN ▶	31a			
32	IRA deduction	32			
33	Student loan interest deduction	33			
34	Tuition and fees. Attach Form 8917	34			
35	Domestic production activities deduction. Attach Form 8903	35			
36	Add lines 23 through 35			36	
37	Subtract line 36 from line 22. This is your **adjusted gross income** ▶			37	259,344.

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XXXXXX

Section	Line	Description	Ref	Amount	Ref	Amount
Tax and Credits	38	Amount from line 37 (adjusted gross income)			38	259,344.
	39a	Check if: [X] You were born before January 2, 1952, [ ] Blind. [ ] Spouse was born before January 2, 1952, [ ] Blind. Total boxes checked ▶ 39a		1		
	b	If your spouse itemizes on a separate return or you were a dual-status alien, check here ▶ 39b [ ]				
	40	**Itemized deductions** (from Schedule A) **or** your **standard deduction** (see left margin)			40	97,639.
	41	Subtract line 40 from line 38			41	161,705.
	42	**Exemptions.** If line 38 is $155,650 or less, multiply $4,050 by the number on line 6d. Otherwise, see inst.			42	12,150.
	43	**Taxable income.** Subtract line 42 from line 41. If line 42 is more than line 41, enter -0-			43	149,555.
	44	**Tax.** Check if any from: a [ ] Form(s) 8814 b [ ] Form 4972 c [ ]			44	28,931.
	45	**Alternative minimum tax.** Attach Form 6251			45	19,531.
	46	Excess advance premium tax credit repayment. Attach Form 8962			46	
	47	Add lines 44, 45, and 46 ▶			47	48,462.
	48	Foreign tax credit. Attach Form 1116 if required	48			
	49	Credit for child and dependent care expenses. Attach Form 2441	49			
	50	Education credits from Form 8863, line 19	50			
	51	Retirement savings contributions credit. Attach Form 8880	51			
	52	Child tax credit. Attach Schedule 8812, if required	52			
	53	Residential energy credits. Attach Form 5695	53			
	54	Other credits from Form: a [ ] 3800 b [ ] 8801 c [ ]	54			
	55	Add lines 48 through 54. These are your **total credits**			55	
	56	Subtract line 55 from line 47. If line 55 is more than line 47, enter -0- ▶			56	48,462.
Other Taxes	57	Self-employment tax. Attach Schedule SE			57	
	58	Unreported social security and Medicare tax from Form: a [ ] 4137 b [ ] 8919			58	
	59	Additional tax on IRAs, other qualified retirement plans, etc. Attach Form 5329 if required			59	
	60a	Household employment taxes from Schedule H			60a	
	b	First-time homebuyer credit repayment. Attach Form 5405 if required			60b	
	61	Health care: individual responsibility (see instructions) Full-year coverage [X]			61	
	62	Taxes from: a [X] Form 8959 b [ ] Form 8960 c [ ] Inst.; enter code(s)			62	414.
	63	Add lines 56 through 62. This is your **total tax** ▶			63	48,876.
Payments	64	Federal income tax withheld from Forms W-2 and 1099	64	60,662.		STATEMENT 4
	65	2016 estimated tax payments and amount applied from 2015 return	65			
	66a	**Earned income credit (EIC)**	66a			
	b	Nontaxable combat pay election 66b				
	67	Additional child tax credit. Attach Schedule 8812	67			
	68	American opportunity credit from Form 8863, line 8	68			
	69	Net premium tax credit. Attach Form 8962	69			
	70	Amount paid with request for extension to file	70			
	71	Excess social security and tier 1 RRTA tax withheld	71			
	72	Credit for federal tax on fuels. Attach Form 4136	72			
	73	Credits from Form: a [ ] 2439 b [ ] Reserved c [ ] 8885 d [ ]	73			
	74	Add lines 64, 65, 66a, and 67 through 73. These are your **total payments** ▶			74	60,662.
Refund	75	If line 74 is more than line 63, subtract line 63 from line 74. This is the amount you **overpaid**			75	11,786.
	76a	Amount of line 75 you want **refunded to you.** If Form 8888 is attached, check here ▶ [ ]			76a	11,786.
	b	Routing number VVVVV c Type: [X] Checking [ ] Savings d Account number VVVVV				
	77	Amount of line 75 you want **applied to your 2017 estimated tax** ▶	77			
Amount You Owe	78	**Amount you owe.** Subtract line 74 from line 63. For details on how to pay, see instructions ▶			78	
	79	Estimated tax penalty (see instructions)	79			

Standard Deduction for - • People who check any box on line 39a or 39b **or** who can be claimed as a dependent, see instructions. • All others: Single or Married filing separately, $6,300; Married filing jointly or Qualifying widow(er), $12,600; Head of household, $9,300

If you have a qualifying child, attach Schedule EIC.

Direct deposit? See instructions.

Third Party Designee Do you want to allow another person to discuss this return with the IRS (see instructions)? [X] **Yes.** Complete below. [ ] **No**

Designee's name ▶ GERARD R. CAYER, CPA, MST Phone no. ▶ 401-732-8900 Personal identification number (PIN) ▶

Sign Here Under penalties of perjury, I declare that I have examined this return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and accurately list all amounts and sources of income I received during the tax year. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Joint return? See instructions. Keep a copy for your records.

Your signature	Date	Your occupation	Daytime phone number
		SOCIAL WORKER	
Spouse's signature. If a joint return, **both** must sign.	Date	Spouse's occupation	If the IRS sent you an Identity Protection PIN, enter it here
		LIBRARIAN	

COPY

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check [ ] if self-employed	PTIN
GERARD R. CAYER, CPA, MST	[signature]	4/3/17		XXXXXX

Firm's name ▶ CAYER CACCIA, LLP Firm's EIN ▶

Firm's address ▶ 931 JEFFERSON BLVD SUITE 2007 WARWICK, RI 02886 Phone no. 401-732-8900

610002 11-30-16

470

SCHEDULE A (Form 1040)

Department of the Treasury Internal Revenue Service (99)

Itemized Deductions

▶ Information about Schedule A and its separate instructions is at *www.irs.gov/schedulea*.
▶ Attach to Form 1040.

OMB No. 1545-0074

2016

Attachment Sequence No. 07

Name(s) shown on Form 1040: REINHARD W. & XXXX STRAUB

Your social security number: XX

Section	Line	Description	Box	Amount	Box	Amount
Medical and Dental Expenses		**Caution:** Do not include expenses reimbursed or paid by others.				
	1	Medical and dental expenses (see instructions)	1			
	2	Enter amount from Form 1040, line 38 [2]				
	3	Multiply line 2 by 10% (0.10). But if either you or your spouse was born before January 2, 1952, multiply line 2 by 7.5% (0.075) instead	3			
	4	Subtract line 3 from line 1. If line 3 is more than line 1, enter -0-			4	
Taxes You Paid	5	State and local (**check only one box**): a [X] Income taxes, or b [ ] General sales taxes — SEE STATEMENT 5	5	78,235.		
	6	Real estate taxes (see instructions)	6	7,815.		
	7	Personal property taxes	7	777.		
	8	Other taxes. List type and amount ▶	8			
	9	Add lines 5 through 8			9	86,827.
Interest You Paid	10	Home mortgage interest and points reported to you on Form 1098	10	8,112.		
	11	Home mortgage interest not reported to you on Form 1098. If paid to the person from whom you bought the home, see instructions and show that person's name, identifying no., and address ▶	11			
Note: Your mortgage interest deduction may be limited (see instructions).	12	Points not reported to you on Form 1098. See instructions for special rules	12			
	13	Mortgage insurance premiums (see instructions)	13			
	14	Investment interest. Attach Form 4952 if required. (See instructions.)	14			
	15	Add lines 10 through 14			15	8,112.
Gifts to Charity	16	Gifts by cash or check. If you made any gift of $250 or more, see instructions	16	2,700.		
If you made a gift and got a benefit for it, see instructions.	17	Other than by cash or check. If any gift of $250 or more, see instructions. You **must** attach Form 8283 if over $500	17			
	18	Carryover from prior year	18			
	19	Add lines 16 through 18			19	2,700.
Casualty and Theft Losses	20	Casualty or theft loss(es). Attach Form 4684. (See instructions.)			20	
Job Expenses and Certain Miscellaneous Deductions	21	Unreimbursed employee expenses - job travel, union dues, job education, etc. Attach Form 2106 or 2106-EZ if required. (See instructions.) ▶	21			
	22	Tax preparation fees	22			
	23	Other expenses - investment, safe deposit box, etc. List type and amount ▶	23			
	24	Add lines 21 through 23	24			
	25	Enter amount from Form 1040, line 38 [25]				
	26	Multiply line 25 by 2% (0.02)	26			
	27	Subtract line 26 from line 24. If line 26 is more than line 24, enter -0-			27	
Other Miscellaneous Deductions	28	Other - from list in instructions. List type and amount ▶			28	
Total Itemized Deductions	29	Is Form 1040, line 38, over $155,650? [X] **No.** Your deduction is not limited. Add the amounts in the far right column for lines 4 through 28. Also, enter this amount on Form 1040, line 40. [ ] **Yes.** Your deduction may be limited. See the Itemized Deductions Worksheet in the instructions to figure the amount to enter.			29	97,639.
	30	If you elect to itemize deductions even though they are less than your standard deduction, check here ▶ [ ]				

SCHEDULE C (Form 1040)
Department of the Treasury Internal Revenue Service (99)

Profit or Loss From Business
(Sole Proprietorship)

▶ Information about Schedule C and its separate instructions is at www.irs.gov/schedulec.
▶ Attach to Form 1040, 1040NR, or 1041; partnerships generally must file Form 1065.

OMB No. 1545-0074
2016
Attachment Sequence No. 09

Name of proprietor: REINHARD W. STRAUB
Social security number (SSN): XXXXX

A Principal business or profession, including product or service (see instructions): LICENSED SOCIAL WORKER - OUTPATIENT THERAPY
B Enter code from instructions ▶

C Business name. If no separate business name, leave blank.: REINHARD RECOVERY, LLC (SMLLC)
D Employer ID number (EIN), (see instr.): XXXXXXX

E Business address (including suite or room no.) ▶ 24 CAROLINA AVE
City, town or post office, state, and ZIP code: CAROLINA, RI 02812

F Accounting method: (1) [X] Cash (2) [ ] Accrual (3) [ ] Other (specify) ▶
G Did you "materially participate" in the operation of this business during 2016? If "No," see instructions for limit on losses [X] Yes [ ] No
H If you started or acquired this business during 2016, check here ▶ [ ]
I Did you make any payments in 2016 that would require you to file Form(s) 1099? (see instructions) [ ] Yes [X] No
J If "Yes," did you or will you file required Forms 1099? [ ] Yes [ ] No

Part I Income

1	Gross receipts or sales. See instructions for line 1 and check the box if this income was reported to you on Form W-2 and the "Statutory employee" box on that form was checked ▶ [ ]	1	1,977.
2	Returns and allowances	2	
3	Subtract line 2 from line 1	3	1,977.
4	Cost of goods sold (from line 42)	4	
5	**Gross profit.** Subtract line 4 from line 3	5	1,977.
6	Other income, including federal and state gasoline or fuel tax credit or refund (see instructions)	6	
7	**Gross income.** Add lines 5 and 6 ▶	7	1,977.

Part II Expenses. Enter expenses for business use of your home only on line 30.

8	Advertising	8		18	Office expense	18	350.
9	Car and truck expenses (see instructions) STMT 6	9	2,160.	19	Pension and profit-sharing plans	19	
				20	Rent or lease (see instructions):		
10	Commissions and fees	10		a	Vehicles, machinery, and equipment	20a	
11	Contract labor (see instructions)	11	400.	b	Other business property	20b	
12	Depletion	12		21	Repairs and maintenance	21	
13	Depreciation and section 179 expense deduction (not included in Part III) (see instructions)	13		22	Supplies (not included in Part III)	22	
				23	Taxes and licenses	23	500.
				24	Travel, meals, and entertainment:		
14	Employee benefit programs (other than on line 19)	14		a	Travel	24a	1,127.
15	Insurance (other than health)	15	311.	b	Deductible meals and entertainment (see instructions)	24b	169.
16	Interest:			25	Utilities	25	
a	Mortgage (paid to banks, etc.)	16a		26	Wages (less employment credits)	26	
b	Other	16b		27 a	Other expenses (from line 48)	27a	1,277.
17	Legal and professional services	17	3,000.	b	**Reserved for future use**	27b	

28	**Total expenses** before expenses for business use of home. Add lines 8 through 27a ▶	28	9,294.
29	Tentative profit or (loss). Subtract line 28 from line 7	29	-7,317.
30	Expenses for business use of your home. Do not report these expenses elsewhere. Attach Form 8829 unless using the simplified method (see instructions). **Simplified method filers only:** enter the total square footage of: (a) your home: ____ and (b) the part of your home used for business: ____ . Use the Simplified Method Worksheet in the instructions to figure the amount to enter on line 30	30	
31	**Net profit or (loss).** Subtract line 30 from line 29. • If a profit, enter on both **Form 1040, line 12** (or **Form 1040NR, line 13**) and on **Schedule SE, line 2.** (If you checked the box on line 1, see instructions). Estates and trusts, enter on **Form 1041, line 3.** • If a loss, you **must** go to line 32.	31	-7,317.
32	If you have a loss, check the box that describes your investment in this activity (see instructions). • If you checked 32a, enter the loss on both **Form 1040, line 12,** (or **Form 1040NR, line 13**) and on **Schedule SE, line 2.** (If you checked the box on line 1, see the line 31 instructions). Estates and trusts, enter on **Form 1041, line 3.** • If you checked 32b, you **must** attach **Form 6198**. Your loss may be limited.	32a [X] All investment is at risk. 32b [ ] Some investment is not at risk.	

LHA **For Paperwork Reduction Act Notice, see the separate instructions.** **Schedule C (Form 1040) 2016**

620001 11-07-16

Part III **Cost of Goods Sold** (see instructions)

33 Method(s) used to value closing inventory: a ☐ Cost b ☐ Lower of cost or market c ☐ Other (attach explanation)

34 Was there any change in determining quantities, costs, or valuations between opening and closing inventory? If "Yes," attach explanation ☐ Yes ☐ No

		Line	Amount
35	Inventory at beginning of year. If different from last year's closing inventory, attach explanation	35	
36	Purchases less cost of items withdrawn for personal use	36	
37	Cost of labor. Do not include any amounts paid to yourself	37	
38	Materials and supplies	38	
39	Other costs	39	
40	Add lines 35 through 39	40	
41	Inventory at end of year	41	
42	**Cost of goods sold.** Subtract line 41 from line 40. Enter the result here and on line 4	42	

Part IV **Information on Your Vehicle.** Complete this part **only** if you are claiming car or truck expenses on line 9 and are not required to file Form 4562 for this business. See the instructions for line 13 to find out if you must file Form 4562.

43 When did you place your vehicle in service for business purposes? (month, day, year) ▶ 03/01/14

44 Of the total number of miles you drove your vehicle during 2016, enter the number of miles you used your vehicle for:

a Business 4,000 b Commuting c Other 37,000

45 Was your vehicle available for personal use during off-duty hours? ☐ Yes ☐ No

46 Do you (or your spouse) have another vehicle available for personal use? ☐ Yes ☐ No

47a Do you have evidence to support your deduction? ☒ Yes ☐ No

b If "Yes," is the evidence written? ☒ Yes ☐ No

Part V **Other Expenses.** List below business expenses not included on lines 8-26 or line 30.

Expense	Amount
INTERNET	400.
LICENSES	272.
FILING FEES	153.
POSTAGE	37.
TELEHONE	168.
MISCELLANEOUS	247.
48 **Total other expenses.** Enter here and on line 27a (48)	1,277.

Attachment C

Form 1040 U.S. Individual Income Tax Return (99) 2016

OMB No. 1545-0074 | IRS Use Only - Do not write or staple in this space.

For the year Jan. 1-Dec. 31, 2016, or other tax year beginning , 2016, ending , 20 | See separate instructions.

Your first name and initial	Last name	Your social security number
JAY M.	SEIGEL	XXXXXXXXXXXX
If a joint return, spouse's first name and initial	Last name	Spouse's social security number
XXXXXXXX	SEIGEL	XXXXXXXXXXX

Home address (number and street). If you have a P.O. box, see instructions. Apt. no.
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Make sure the SSN(s) above and on line 6c are correct.

City, town or post office, state, and ZIP code. If you have a foreign address, also complete spaces below.
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Foreign country name | Foreign province/state/county | Foreign postal code

Presidential Election Campaign: Check here if you, or your spouse if filing jointly, want $3 to go to this fund. Checking a box below will not change your tax or refund. You Spouse

Filing Status

Check only one box.

1. Single
2. [X] Married filing jointly (even if only one had income)
3. Married filing separately. Enter spouse's SSN above and full name here. ▶
4. Head of household (with qualifying person). If the qualifying person is a child but not your dependent, enter this child's name here. ▶
5. Qualifying widow(er) with dependent child

Exemptions

6a [X] Yourself. If someone can claim you as a dependent, do not check box 6a
b [X] Spouse

Boxes checked on 6a and 6b: 2

c Dependents:

(1) First name	Last name	(2) Dependent's social security number	(3) Dependent's relationship to you	(4) ✓ if child under age 17 qualifying for child tax credit
	SEIGEL	XXXXXXXXXXXXXXXX	SON	X
	SEIGEL	XXXXXXXXXXXXXXXX	DAUGHTER	X

If more than four dependents, see instructions and check here ▶

No. of children on 6c who: lived with you: 2; did not live with you due to divorce or separation (see instructions):
Dependents on 6c not entered above:

d Total number of exemptions claimed — Add numbers on lines above ▶ 4

Income

Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.

If you did not get a W-2, see instructions.

Line	Description		Amount
7	Wages, salaries, tips, etc. Attach Form(s) W-2	7	
8a	Taxable interest. Attach Schedule B if required	8a	66.
b	Tax-exempt interest. Do not include on line 8a	8b	
9a	Ordinary dividends. Attach Schedule B if required	9a	
b	Qualified dividends	9b	
10	Taxable refunds, credits, or offsets of state and local income taxes	10	
11	Alimony received	11	
12	Business income or (loss). Attach Schedule C or C-EZ	12	179,721.
13	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶	13	
14	Other gains or (losses). Attach Form 4797	14	
15a	IRA distributions 15a; b Taxable amount	15b	
16a	Pensions and annuities 16a; b Taxable amount	16b	
17	Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E	17	
18	Farm income or (loss). Attach Schedule F	18	
19	Unemployment compensation	19	
20a	Social security benefits 20a; b Taxable amount	20b	
21	Other income. List type and amount	21	
22	Combine the amounts in the far right column for lines 7 through 21. This is your total income ▶	22	179,787.

Adjusted Gross Income

Line	Description		Amount
23	Educator expenses	23	
24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24	
25	Health savings account deduction. Attach Form 8889	25	6,012.
26	Moving expenses. Attach Form 3903	26	
27	Deductible part of self-employment tax. Attach Schedule SE	27	9,754.
28	Self-employed SEP, SIMPLE, and qualified plans	28	
29	Self-employed health insurance deduction	29	
30	Penalty on early withdrawal of savings	30	
31a	Alimony paid b Recipient's SSN ▶	31a	
32	IRA deduction	32	
33	Student loan interest deduction	33	
34	Tuition and fees. Attach Form 8917	34	
35	Domestic production activities deduction. Attach Form 8903	35	
36	Add lines 23 through 35	36	15,766.
37	Subtract line 36 from line 22. This is your adjusted gross income ▶	37	164,021.

610001 11-30-16

LHA For Disclosure, Privacy Act, and Paperwork Reduction Act Notice, see separate instructions. Form 1040 (2016)

Tax and Credits

Line	Description		Amount
38	Amount from line 37 (adjusted gross income)	38	164,021.
39a	Check if: You were born before January 2, 1952, Blind. Spouse was born before January 2, 1952, Blind. Total boxes checked ▶ 39a		
b	If your spouse itemizes on a separate return or you were a dual-status alien, check here ▶ 39b		
40	Itemized deductions (from Schedule A) or your standard deduction (see left margin)	40	28,798.
41	Subtract line 40 from line 38	41	135,223.
42	Exemptions. If line 38 is $155,650 or less, multiply $4,050 by the number on line 6d. Otherwise, see inst.	42	16,200.
43	Taxable income. Subtract line 42 from line 41. If line 42 is more than line 41, enter -0-	43	119,023.
44	Tax. Check if any from: a Form(s) 8814 b Form 4972 c	44	21,298.
45	Alternative minimum tax. Attach Form 6251	45	
46	Excess advance premium tax credit repayment. Attach Form 8962	46	
47	Add lines 44, 45, and 46 ▶	47	21,298.
48	Foreign tax credit. Attach Form 1116 if required	48	
49	Credit for child and dependent care expenses. Attach Form 2441	49	
50	Education credits from Form 8863, line 19	50	
51	Retirement savings contributions credit. Attach Form 8880	51	
52	Child tax credit. Attach Schedule 8812, if required	52	
53	Residential energy credits. Attach Form 5695	53	
54	Other credits from Form: a 3800 b 8801 c	54	
55	Add lines 48 through 54. These are your total credits	55	
56	Subtract line 55 from line 47. If line 55 is more than line 47, enter -0- ▶	56	21,298.

Standard Deduction for - • People who check any box on line 39a or 39b or who can be claimed as a dependent, see instructions. • All others: Single or Married filing separately, $6,300; Married filing jointly or Qualifying widow(er), $12,600; Head of household, $9,300

Other Taxes

Line	Description		Amount
57	Self-employment tax. Attach Schedule SE	57	19,507.
58	Unreported social security and Medicare tax from Form: a 4137 b 8919	58	
59	Additional tax on IRAs, other qualified retirement plans, etc. Attach Form 5329 if required	59	
60a	Household employment taxes from Schedule H	60a	
b	First-time homebuyer credit repayment. Attach Form 5405 if required	60b	
61	Health care: individual responsibility (see instructions) Full-year coverage [X]	61	
62	Taxes from: a Form 8959 b Form 8960 c Inst.; enter code(s)	62	
63	Add lines 56 through 62. This is your total tax ▶	63	40,805.

Payments

Line	Description		Amount
64	Federal income tax withheld from Forms W-2 and 1099	64	
65	2016 estimated tax payments and amount applied from 2015 return	65	
66a	Earned income credit (EIC)	66a	
b	Nontaxable combat pay election		
67	Additional child tax credit. Attach Schedule 8812	67	
68	American opportunity credit from Form 8863, line 8	68	
69	Net premium tax credit. Attach Form 8962	69	
70	Amount paid with request for extension to file	70	
71	Excess social security and tier 1 RRTA tax withheld	71	
72	Credit for federal tax on fuels. Attach Form 4136	72	
73	Credits from Form: a 2439 b Reserved c 8885 d	73	
74	Add lines 64, 65, 66a, and 67 through 73. These are your total payments ▶	74	

If you have a qualifying child, attach Schedule EIC.

Refund

Line	Description		Amount
75	If line 74 is more than line 63, subtract line 63 from line 74. This is the amount you overpaid	75	
76a	Amount of line 75 you want refunded to you. If Form 8888 is attached, check here ▶	76a	
b	Routing number ▶ c Type: Checking Savings ▶ d Account number		
77	Amount of line 75 you want applied to your 2017 estimated tax ▶	77	

Direct deposit? See instructions.

Amount You Owe

Line	Description		Amount
78	Amount you owe. Subtract line 74 from line 63. For details on how to pay, see instructions ▶	78	41,780.
79	Estimated tax penalty (see instructions)	79	975.

Third Party Designee

Do you want to allow another person to discuss this return with the IRS (see instructions)? [X] Yes. Complete below. No

Designee's name ▶ MICHAEL E. BAILEY, CPA , MST Phone no. ▶ 203-481-1120 Personal identification number (PIN) ▶ 46885

Sign Here

Under penalties of perjury, I declare that I have examined this return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and accurately list all amounts and sources of income I received during the tax year. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Joint return? See instructions. Keep a copy for your records.

Your signature	Date	Your occupation	Daytime phone number
		NURSE PRACTITIONER	
Spouse's signature. If a joint return, both must sign.	Date	Spouse's occupation	If the IRS sent you an Identity Protection PIN, enter it here

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed	PTIN
MICHAEL E. BAILEY, CPA , MST	MICHAEL E. BAILEY, CPA , MST	04/07/17		P00446885

Firm's name ▶ BAILEY SCARANO, LLC Firm's EIN ▶ 27 2562250

Firm's address ▶ 1224 MAIN STREET BRANFORD, CT 06405 Phone no. 203-481-1120

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SCHEDULE A (Form 1040)

Department of the Treasury Internal Revenue Service (99)

Itemized Deductions

▶ Information about Schedule A and its separate instructions is at www.irs.gov/schedulea .
▶ Attach to Form 1040.

OMB No. 1545-0074

2016

Attachment Sequence No. 07

Name(s) shown on Form 1: JAY M SEIGEL

Your social security number: XXXXXXXXXXXXXXXX

Section	Line	Description	Box	Amount	Box	Total
Medical and Dental Expenses		Caution: Do not include expenses reimbursed or paid by others.				
	1	Medical and dental expenses (see instructions)	1			
	2	Enter amount from Form 1040, line 38 [2]				
	3	Multiply line 2 by 10% (0.10). But if either you or your spouse was born before January 2, 1952, multiply line 2 by 7.5% (0.075) instead	3			
	4	Subtract line 3 from line 1. If line 3 is more than line 1, enter -0-			4	
Taxes You Paid	5	State and local (check only one box): a [X] Income taxes, or b [ ] General sales taxes — SEE STATEMENT 1	5	2,700.		
	6	Real estate taxes (see instructions)	6	5,751.		
	7	Personal property taxes	7	846.		
	8	Other taxes. List type and amount ▶	8			
	9	Add lines 5 through 8			9	9,297.
Interest You Paid	10	Home mortgage interest and points reported to you on Form 1098 STMT 2	10	15,872.		
	11	Home mortgage interest not reported to you on Form 1098. If paid to the person from whom you bought the home, see instructions and show that person's name, identifying no., and address ▶	11			
Note: Your mortgage interest deduction may be limited (see instructions).	12	Points not reported to you on Form 1098. See instructions for special rules	12			
	13	Mortgage insurance premiums (see instructions)	13			
	14	Investment interest. Attach Form 4952 if required. (See instructions.)	14			
	15	Add lines 10 through 14			15	15,872.
Gifts to Charity	16	Gifts by cash or check. If you made any gift of $250 or more, see instructions	16	3,129.		
If you made a gift and got a benefit for it, see instructions.	17	Other than by cash or check. If any gift of $250 or more, see instructions. You must attach Form 8283 if over $500 SEE STATEMENT 3	17	500.		
	18	Carryover from prior year	18			
	19	Add lines 16 through 18			19	3,629.
Casualty and Theft Losses	20	Casualty or theft loss(es). Attach Form 4684. (See instructions.)			20	
Job Expenses and Certain Miscellaneous Deductions	21	Unreimbursed employee expenses - job travel, union dues, job education, etc. Attach Form 2106 or 2106-EZ if required. (See instructions.) ▶	21			
	22	Tax preparation fees	22			
	23	Other expenses - investment, safe deposit box, etc. List type and amount ▶	23			
	24	Add lines 21 through 23	24			
	25	Enter amount from Form 1040, line 38 [25]				
	26	Multiply line 25 by 2% (0.02)	26			
	27	Subtract line 26 from line 24. If line 26 is more than line 24, enter -0-			27	
Other Miscellaneous Deductions	28	Other - from list in instructions. List type and amount ▶			28	
Total Itemized Deductions	29	Is Form 1040, line 38, over $155,650? [X] No. Your deduction is not limited. Add the amounts in the far right column for lines 4 through 28. Also, enter this amount on Form 1040, line 40. [ ] Yes. Your deduction may be limited. See the Itemized Deductions Worksheet in the instructions to figure the amount to enter.			29	28,798.
	30	If you elect to itemize deductions even though they are less than your standard deduction, check here ▶				

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SCHEDULE B (Form 1040A or 1040) (Rev. January 2017) Department of the Treasury Internal Revenue Service (99)

Interest and Ordinary Dividends

▶ Attach to Form 1040A or 1040.
▶ Information about Schedule B and its instructions is at www.irs.gov/scheduleb.

OMB No. 1545-0074 **2016** Attachment Sequence No. **08**

Name(s) shown: JAY M. SEIGEL | Your social security number: XXXXXXX

Part I Interest

1 List name of payer. If any interest is from a seller-financed mortgage and the buyer used the property as a personal residence, see instructions and list this interest first. Also, show that buyer's social security number and address ▶

Payer	Line	Amount
WELLS FARGO BANK	1	66.

Note: If you received a Form 1099-INT, Form 1099-OID, or substitute statement from a brokerage firm, list the firm's name as the payer and enter the total interest shown on that form.

		Line	Amount
2	Add the amounts on line 1	2	66.
3	Excludable interest on series EE and I U.S. savings bonds issued after 1989. Attach Form 8815	3	
4	Subtract line 3 from line 2. Enter the result here and on Form 1040A, or Form 1040, line 8a ▶	4	66.

Note: If line 4 is over $1,500, you must complete Part III.

Part II Ordinary Dividends

5 List name of payer ▶ | 5 | Amount

Note: If you received a Form 1099-DIV or substitute statement from a brokerage firm, list the firm's name as the payer and enter the ordinary dividends shown on that form.

6 Add the amounts on line 5. Enter the total here and on Form 1040A, or Form 1040, line 9a ▶ | 6 |

Note: If line 6 is over $1,500, you must complete Part III.

Part III Foreign Accounts and Trusts

You must complete this part if you **(a)** had over $1,500 of taxable interest or ordinary dividends; **(b)** had a foreign account; or **(c)** received a distribution from, or were a grantor of, or a transferor to, a foreign trust.

		Yes	No
7a	At any time during 2016, did you have a financial interest in or signature authority over a financial account (such as a bank account, securities account, or brokerage account) located in a foreign country? See instructions		X
	If "Yes," are you required to file FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR), to report that financial interest or signature authority? See FinCEN Form 114 and its instructions for filing requirements and exceptions to those requirements		
b	If you are required to file FinCEN Form 114, enter the name of the foreign country where the financial account is located ▶		
8	During 2016, did you receive a distribution from, or were you the grantor of, or transferor to, a foreign trust? If "Yes," you may have to file Form 3520. See instructions		X

627501 01-12-17

LHA **For Paperwork Reduction Act Notice, see your tax return instructions.** **Schedule B (Form 1040A or 1040) 2016**

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SCHEDULE C (Form 1040)
Department of the Treasury Internal Revenue Service (99)

Profit or Loss From Business
(Sole Proprietorship)

▶ Information about Schedule C and its separate instructions is at www.irs.gov/schedulec.
▶ Attach to Form 1040, 1040NR, or 1041; partnerships generally must file Form 1065.

OMB No. 1545-0074
2016
Attachment Sequence No. 09

Name of proprietor: JAY M. SEIGEL
Social security number (SSN): XXXXXXXXxXXX

A Principal business or profession, including product or service (see instructions): PSYCHIATRIC THERAPIST
B Enter code from instructions ▶ 621330
C Business name. If no separate business name, leave blank. CONNECTICUT PSYCHIATRIC SERVICES LLC
D Employer ID number (EIN), (see instr.) 80-0298944
E Business address (including suite or room no.) ▶ 24 CHANNING STREET
City, town or post office, state, and ZIP code: NEW LONDON, CT 06320
F Accounting method: (1) [X] Cash (2) Accrual (3) Other (specify) ▶
G Did you "materially participate" in the operation of this business during 2016? If "No," see instructions for limit on losses ..... [X] Yes No
H If you started or acquired this business during 2016, check here ▶
I Did you make any payments in 2016 that would require you to file Form(s) 1099? (see instructions) ..... Yes [X] No
J If "Yes," did you or will you file required Forms 1099? ..... Yes No

Part I Income

1	Gross receipts or sales. See instructions for line 1 and check the box if this income was reported to you on Form W-2 and the "Statutory employee" box on that form was checked ▶	1	270,083.
2	Returns and allowances	2	
3	Subtract line 2 from line 1	3	270,083.
4	Cost of goods sold (from line 42)	4	
5	**Gross profit.** Subtract line 4 from line 3	5	270,083.
6	Other income, including federal and state gasoline or fuel tax credit or refund (see instructions)	6	
7	**Gross income.** Add lines 5 and 6 ▶	7	270,083.

Part II Expenses. Enter expenses for business use of your home only on line 30.

8	Advertising	8		18	Office expense	18	15,116.
9	Car and truck expenses (see instructions) STMT 4	9	6,4[illegible].	19	Pension and profit-sharing plans	19	
10	Commissions and fees	10		20	Rent or lease (see instructions):		
11	Contract labor (see instructions)	11		a	Vehicles, machinery, and equipment	20a	
12	Depletion	12		b	Other business property	20b	12,700.
13	Depreciation and section 179 expense deduction (not included in Part III) (see instructions)	13		21	Repairs and maintenance	21	3,551.
				22	Supplies (not included in Part III)	22	10,274.
				23	Taxes and licenses	23	5,841.
14	Employee benefit programs (other than on line 19)	14		24	Travel, meals, and entertainment:		
				a	Travel	24a	1,697.
15	Insurance (other than health)	15	1,300.	b	Deductible meals and entertainment (see instructions)	24b	2,707.
16	Interest:			25	Utilities	25	
a	Mortgage (paid to banks, etc.)	16a		26	Wages (less employment credits)	26	
b	Other	16b		27a	Other expenses (from line 48)	27a	22,326.
17	Legal and professional services	17	1,250.	b	**Reserved for future use**	27b	

28	**Total expenses** before expenses for business use of home. Add lines 8 through 27a ▶	28	83,242.
29	Tentative profit or (loss). Subtract line 28 from line 7	29	186,841.
30	Expenses for business use of your home. Do not report these expenses elsewhere. Attach Form 8829 unless using the simplified method (see instructions). **Simplified method filers only:** enter the total square footage of: (a) your home: ____ and (b) the part of your home used for business: ____. Use the Simplified Method Worksheet in the instructions to figure the amount to enter on line 30	30	7,120.
31	**Net profit or (loss).** Subtract line 30 from line 29. • If a profit, enter on both **Form 1040, line 12** (or **Form 1040NR, line 13**) and on **Schedule SE, line 2.** (If you checked the box on line 1, see instructions). Estates and trusts, enter on **Form 1041, line 3.** • If a loss, you **must** go to line 32.	31	179,721.
32	If you have a loss, check the box that describes your investment in this activity (see instructions). • If you checked 32a, enter the loss on both **Form 1040, line 12,** (or **Form 1040NR, line 13**) and on **Schedule SE, line 2.** (If you checked the box on line 1, see the line 31 instructions). Estates and trusts, enter on **Form 1041, line 3.** • If you checked 32b, you **must** attach **Form 6198.** Your loss may be limited.	32a / 32b	All investment is at risk. / Some investment is not at risk.

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Part III Cost of Goods Sold (see instructions)

33 Method(s) used to value closing inventory: a ☐ Cost b ☐ Lower of cost or market c ☐ Other (attach explanation)

34 Was there any change in determining quantities, costs, or valuations between opening and closing inventory? If "Yes," attach explanation ☐ Yes ☐ No

35	Inventory at beginning of year. If different from last year's closing inventory, attach explanation	35	
36	Purchases less cost of items withdrawn for personal use	36	
37	Cost of labor. Do not include any amounts paid to yourself	37	
38	Materials and supplies	38	
39	Other costs	39	
40	Add lines 35 through 39	40	
41	Inventory at end of year	41	
42	**Cost of goods sold.** Subtract line 41 from line 40. Enter the result here and on line 4	42	

Part IV Information on Your Vehicle. Complete this part only if you are claiming car or truck expenses on line 9 and are not required to file Form 4562 for this business. See the instructions for line 13 to find out if you must file Form 4562.

43 When did you place your vehicle in service for business purposes? (month, day, year) ▶ 02/15/11

44 Of the total number of miles you drove your vehicle during 2016, enter the number of miles you used your vehicle for:

a Business 12,000 b Commuting c Other

45 Was your vehicle available for personal use during off-duty hours? ☐ Yes ☐ No

46 Do you (or your spouse) have another vehicle available for personal use? ☐ Yes ☐ No

47a Do you have evidence to support your deduction? ☒ Yes ☐ No

b If "Yes," is the evidence written? ☒ Yes ☐ No

Part V Other Expenses. List below business expenses not included on lines 8-26 or line 30.

PHONE/INTERNET	3,646.
SOFTWARE/CLEARINGHOUSE	562.
105 REIMBURSEMENTS	18,118.
48 **Total other expenses.** Enter here and on line 27a	48 22,326.

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SCHEDULE SE (Form 1040)

Department of the Treasury Internal Revenue Service (99)

Self-Employment Tax

▶ Information about Schedule SE and its separate instructions is at *www.irs.gov/schedulese.*

▶ Attach to Form 1040 or Form 1040NR.

OMB No. 1545-0074

2016

Attachment Sequence No. 17

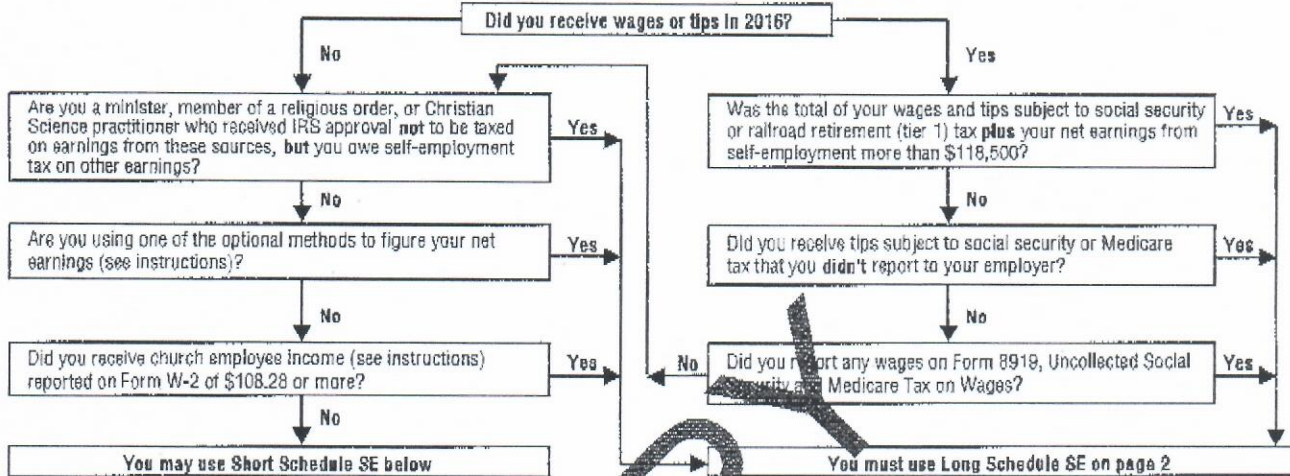
Name of person with **self-employment** income (as shown on Form 1040 or Form 1040NR): JAY M. SEIGEL

Social security number of person with **self-employment** income ▶ XXXXXXXXXX

Before you begin: To determine if you must file Schedule SE, see the instructions.

May I Use Short Schedule SE or Must I Use Long Schedule SE?

Note. Use this flowchart **only** if you must file Schedule SE. If unsure, see *Who Must File Schedule SE* in the instructions.



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Section A-Short Schedule SE. Caution. Read above ... you ... use Short Schedule SE.

Line	Description	No.	Amount
1a	Net farm profit or (loss) from Schedule F, line 34, and farm partnerships, Schedule K-1 (Form 1065), box 14, code A	1a	
b	If you received social security retirement or disability benefits, enter the amount of Conservation Reserve Program payments included on Schedule F, line 4b, or listed on Schedule K-1 (Form 1065), box 20, code Z	1b	
2	Net profit or (loss) from Schedule C, line 31; Schedule C-EZ, line 3; Schedule K-1 (Form 1065), box 14, code A (other than farming); and Schedule K-1 (Form 1065-B), box 9, code J1. Ministers and members of religious orders, see instructions for types of income to report on this line. See instructions for other income to report STMT 5	2	179,721.
3	Combine lines 1a, 1b, and 2	3	179,721.
4	Multiply line 3 by 92.35% (0.9235). If less than $400, you don't owe self-employment tax; **don't** file this schedule unless you have an amount on line 1b ▶	4	165,972.
	Note. If line 4 is less than $400 due to Conservation Reserve Program payments on line 1b, see instructions.		
5	**Self-employment tax.** If the amount on line 4 is: • $118,500 or less, multiply line 4 by 15.3% (0.153). Enter the result here and on **Form 1040, line 57,** or **Form 1040NR, line 55** • More than $118,500, multiply line 4 by 2.9% (0.029). Then, add $14,694 to the result. Enter the total here and on **Form 1040, line 57, or Form 1040NR, line 55**	5	19,507.
6	**Deduction for one-half of self-employment tax.** Multiply line 5 by 50% (0.50). Enter the result here and on **Form 1040, line 27, or Form 1040NR, line 27** — 6: 9,754.		

LHA **For Paperwork Reduction Act Notice, see your tax return instructions.**

Form **8889** Department of the Treasury Internal Revenue Service

Health Savings Accounts (HSAs)

▶ Information about Form 8889 and its separate instructions is available at *www.irs.gov/form8889*.
▶ Attach to Form 1040 or Form 1040NR.

OMB No. 1545-0074 **2016** Attachment Sequence No. 52

Name(s) shown on Form 1040 or Form 1040NR: JAY M. SEIGEL

Social security number of HSA beneficiary. If both spouses have HSAs, see instructions ▶ XXXXXXXXXXX

Before you begin: Complete Form 8853, Archer MSAs and Long-Term Care Insurance Contracts, if required.

Part I **HSA Contributions and Deduction.** See the instructions before completing this part. If you are filing jointly and both you and your spouse each have separate HSAs, complete a separate Part I for each spouse.

1	Check the box to indicate your coverage under a high-deductible health plan (HDHP) during 2016 (see instructions) ▶		☐ Self-only [X] Family
2	HSA contributions you made for 2016 (or those made on your behalf), including those made from January 1, 2017, through April 18, 2017, that were for 2016. **Do not** include employer contributions, contributions through a cafeteria plan, or rollovers (see instructions)	2	6,012.
3	If you were under age 55 at the end of 2016, and on the first day of **every** month during 2016, you were, or were considered, an eligible individual with the **same** coverage, enter $3,350 ($6,750 for family coverage). **All others,** see the instructions for the amount to enter	3	6,750.
4	Enter the amount you and your employer contributed to your Archer MSAs for 2016 from Form 8853, lines 1 and 2. If you or your spouse had family coverage under an HDHP at any time during 2016, also include any amount contributed to your spouse's Archer MSAs	4	
5	Subtract line 4 from line 3. If zero or less, enter -0-	5	6,750.
6	Enter the amount from line 5. But if you and your spouse each have separate HSAs and had family coverage under an HDHP at any time during 2016, see the instructions for the amount to enter	6	6,750.
7	If you were age 55 or older at the end of 2016, married, and you or your spouse had family coverage under an HDHP at any time during 2016, enter your additional contribution amount (see instructions)	7	
8	Add lines 6 and 7	8	6,750.
9	Employer contributions made to your HSAs for 2016 — 9		
10	Qualified HSA funding distributions — 10		
11	Add lines 9 and 10	11	
12	Subtract line 11 from line 8. If zero or less, enter -0-	12	6,750.
13	**HSA deduction.** Enter the **smaller** of line 2 or line 12 here and on Form 1040, line 25, or Form 1040NR, line 25	13	6,012.
	Caution: *If line 2 is more than line 13, you may have to pay an additional tax (see instructions).*		

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Part II **HSA Distributions.** If you are filing jointly and both you and your spouse each have separate HSAs, complete a separate Part II for each spouse.

14a	Total distributions you received in 2016 from all HSAs (see instructions)	14a	
b	Distributions included on line 14a that you rolled over to another HSA. Also include any excess contributions (and the earnings on those excess contributions) included on line 14a that were withdrawn by the due date of your return (see instructions)	14b	
c	Subtract line 14b from line 14a	14c	
15	Qualified medical expenses paid using HSA distributions (see instructions)	15	
16	**Taxable HSA distributions.** Subtract line 15 from line 14c. If zero or less, enter -0-. Also, include this amount in the total on Form 1040, line 21, or Form 1040NR, line 21. On the dotted line next to line 21, enter "HSA" and the amount	16	
17a	If any of the distributions included on line 16 meet any of the **Exceptions to the Additional 20% Tax** (see instructions), check here ▶		
b	**Additional 20% tax** (see instructions). Enter 20% (.20) of the distributions included on line 16 that are subject to the additional 20% tax. Also include this amount in the total on Form 1040, line 62, or Form 1040NR, line 60. Check box c on Form 1040, line 62, or box b on Form 1040NR, line 60. Enter "HSA" and the amount on the line next to the box	17b	

Part III **Income and Additional Tax for Failure To Maintain HDHP Coverage.** See the instructions before completing this part. If you are filing jointly and both you and your spouse each have separate HSAs, complete a separate Part III for each spouse.

18	Last-month rule	18	
19	Qualified HSA funding distribution	19	
20	**Total income.** Add lines 18 and 19. Include this amount on Form 1040, line 21, or Form 1040NR, line 21. On the dotted line next to Form 1040, line 21, or Form 1040NR, line 21, enter "HSA" and the amount	20	
21	**Additional tax.** Multiply line 20 by 10% (.10). Include this amount in the total on Form 1040, line 62, or Form 1040NR, line 60. Check box c on Form 1040, line 62, or box b on Form 1040NR, line 60. Enter "HDHP" and the amount on the line next to the box	21	

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Form **8829**

Department of the Treasury Internal Revenue Service (99)

Expenses for Business Use of Your Home

▶ File only with Schedule C (Form 1040). Use a separate Form 8829 for each home you used for business during the year.

▶ Information about Form 8829 and its separate instructions is at www.irs.gov/form8829.

OMB No. 1545-0074

2016

Attachment Sequence No. 176

Name(s) of proprietor(s): JAY M. SEIGEL

Your social security number: XXXXXXXXXXX

Part I Part of Your Home Used for Business

Line	Description			Line	Amount
1	Area used regularly and exclusively for business, regularly for daycare, or for storage of inventory or product samples			1	400
2	Total area of home			2	4,000
3	Divide line 1 by line 2. Enter the result as a percentage			3	10.0000 %
	For daycare facilities not used exclusively for business, go to line 4. All others, go to line 7.				
4	Multiply days used for daycare during year by hours used per day	4	hr.		
5	Total hours available for use during the year (366 days x 24 hours)	5	8,784 hr.		
6	Divide line 4 by line 5. Enter the result as a decimal amount	6			
7	Business percentage. For daycare facilities not used exclusively for business, multiply line 6 by line 3 (enter the result as a percentage). All others, enter the amount from line 3 ▶			7	10.0000 %

Part II Figure Your Allowable Deduction

Line	Description	Line	(a) Direct expenses	(b) Indirect expenses	Line	Amount
8	Enter the amount from Schedule C, line 29, **plus** any gain derived from the business use of your home, **minus** any loss from the trade or business not derived from the business use of your home (see instructions)				8	186,841.
	See instructions for columns (a) and (b) before completing lines 9-21.					
9	Casualty losses	9				
10	Deductible mortgage interest	10		17,636.		
11	Real estate taxes	11		6,390.		
12	Add lines 9, 10, and 11	12		24,026.		
13	Multiply line 12, column (b) by line 7		13	2,403.		
14	Add line 12, column (a) and line 13				14	2,403.
15	Subtract line 14 from line 8. If zero or less, enter -0-				15	184,438.
16	Excess mortgage interest	16				
17	Insurance	17		1,900.		
18	Rent	18				
19	Repairs and maintenance	19		16,256.		
20	Utilities	20		8,551.		
21	Other expenses	21				
22	Add lines 16 through 21	22		26,707.		
23	Multiply line 22, column (b) by line 7		23	2,671.		
24	Carryover of prior year operating expenses (see instructions)		24			
25	Add line 22, column (a), line 23, and line 24				25	2,671.
26	Allowable operating expenses. Enter the **smaller** of line 15 or line 25				26	2,671.
27	Limit on excess casualty losses and depreciation. Subtract line 26 from line 15				27	181,767.
28	Excess casualty losses		28			
29	Depreciation of your home from line 41 below		29			
30	Carryover of prior year excess casualty losses and depreciation (see instructions)		30			
31	Add lines 28 through 30				31	
32	Allowable excess casualty losses and depreciation. Enter the **smaller** of line 27 or line 31				32	0.
33	Add lines 14, 26, and 32				33	5,074.
34	Casualty loss portion, if any, from lines 14 and 32. Carry amount to **Form 4684** (see instructions)				34	0.
35	**Allowable expenses for business use of your home.** Subtract line 34 from line 33. Enter here and on Schedule C, line 30. If your home was used for more than one business, see instructions ▶				35	5,074.

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Part III Depreciation of Your Home

Line	Description	Line	Amount
36	Enter the **smaller** of your home's adjusted basis or its fair market value	36	
37	Value of land included on line 36	37	
38	Basis of building. Subtract line 37 from line 36	38	
39	Business basis of building. Multiply line 38 by line 7	39	
40	Depreciation percentage	40	%
41	Depreciation allowable. Multiply line 39 by line 40. Enter here and on line 29 above	41	

Part IV Carryover of Unallowed Expenses to 2017

Line	Description	Line	Amount
42	Operating expenses. Subtract line 26 from line 25. If less than zero, enter -0-	42	
43	Excess casualty losses and depreciation. Subtract line 32 from line 31. If less than zero, enter -0-	43	

620801 11-08-16 LHA **For Paperwork Reduction Act Notice, see your tax return instructions.** Form **8829** (2016)

15240424 781246 50411.001 2016.03030 SEIGEL, JAY M 50411.01

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Form **8829**

Department of the Treasury Internal Revenue Service (99)

Expenses for Business Use of Your Home

▶ File only with Schedule C (Form 1040). Use a separate Form 8829 for each home you used for business during the year.

▶ Information about Form 8829 and its separate instructions is at www.irs.gov/form8829.

OMB No. 1545-0074

2016

Attachment Sequence No. 176

Name(s) of proprietor(s): JAY M. SEIGEL

Your social security number: XXXXXXXXXXXX

Part I Part of Your Home Used for Business

Line	Description			
1	Area used regularly and exclusively for business, regularly for daycare, or for storage of inventory or product samples		1	400
2	Total area of home		2	3,739
3	Divide line 1 by line 2. Enter the result as a percentage		3	10.6980 %
	For daycare facilities not used exclusively for business, go to line 4. All others, go to line 7.			
4	Multiply days used for daycare during year by hours used per day	4 hr.		
5	Total hours available for use during the year (366 days x 24 hours)	5 8,784 hr.		
6	Divide line 4 by line 5. Enter the result as a decimal amount	6		
7	Business percentage. For daycare facilities not used exclusively for business, multiply line 6 by line 3 (enter the result as a percentage). All others, enter the amount from line 3 ▶		7	10.6980 %

Part II Figure Your Allowable Deduction

Line	Description		(a) Direct expenses	(b) Indirect expenses		
8	Enter the amount from Schedule C, line 29, **plus** any gain derived from the business use of your home, **minus** any loss from the trade or business not derived from the business use of your home (see instructions)				8	181,767.
	See instructions for columns (a) and (b) before completing lines 9-21.					
9	Casualty losses	9				
10	Deductible mortgage interest	10				
11	Real estate taxes	11				
12	Add lines 9, 10, and 11	12				
13	Multiply line 12, column (b) by line 7			13		
14	Add line 12, column (a) and line 13				14	
15	Subtract line 14 from line 8. If zero or less, enter -0-				15	181,767.
16	Excess mortgage interest	16				
17	Insurance	17				
18	Rent	18				
19	Repairs and maintenance	19				
20	Utilities	20				
21	Other expenses	21				
22	Add lines 16 through 21	22				
23	Multiply line 22, column (b) by line 7			23		
24	Carryover of prior year operating expenses (see instructions)			24		
25	Add line 22, column (a), line 23, and line 24				25	
26	Allowable operating expenses. Enter the **smaller** of line 15 or line 25				26	
27	Limit on excess casualty losses and depreciation. Subtract line 26 from line 15				27	181,767.
28	Excess casualty losses			28		
29	Depreciation of your home from line 41 below			29 2,046.		
30	Carryover of prior year excess casualty losses and depreciation (see instructions)			30		
31	Add lines 28 through 30				31	2,046.
32	Allowable excess casualty losses and depreciation. Enter the **smaller** of line 27 or line 31				32	2,046.
33	Add lines 14, 26, and 32				33	2,046.
34	Casualty loss portion, if any, from lines 14 and 32. Carry amount to **Form 4684** (see instructions)				34	0.
35	**Allowable expenses for business use of your home.** Subtract line 34 from line 33. Enter here and on Schedule C, line 30. If your home was used for more than one business, see instructions ▶				35	2,046.

Part III Depreciation of Your Home

Line	Description		
36	Enter the **smaller** of your home's adjusted basis or its fair market value	36	876,215.
37	Value of land included on line 36	37	350,486.
38	Basis of building. Subtract line 37 from line 36	38	525,729.
39	Business basis of building. Multiply line 38 by line 7	39	56,253.
40	Depreciation percentage	40	3.1750 %
41	Depreciation allowable. Multiply line 39 by line 40. Enter here and on line 29 above	41	2,046.

Part IV Carryover of Unallowed Expenses to 2017

Line	Description		
42	Operating expenses. Subtract line 26 from line 25. If less than zero, enter -0-	42	
43	Excess casualty losses and depreciation. Subtract line 32 from line 31. If less than zero, enter -0-	43	

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Addendum to Completeness Questions

7. Clarify or explain the following regarding Table 6 on page 35 of the application: the method/calculation(s) used to project the service volume, in detail, for each fiscal year (including the large percentage increases between fiscal years); whether intensive outpatient treatment ("IOP") sessions/visits are counted individually or as group sessions; and the units of measure for individual services (e.g., patients, sessions or visits) and ensure that they are consistent with the units of measure utilized in Table 5.

TABLE 6
PROJECTED UTILIZATION BY SERVICE

	Projected Volume			
Service*	**FY 2017 (07/01 – 12/31)**	**FY 2018**	**FY 2019**	**FY 2020**
IOP Sessions	337	1200	1500	1800
Individual Sessions	225	600	750	900
Total	562	1800	2250	2700

"IOP Sessions" per annum indicates the total number of IOP sessions or Dates of Service (DOS) for the year.

In 2017, the applicants project that 337 IOP sessions would be accomplished. This was calculated as follows: 7/1 to 12/31/17 = 25 weeks of operation (considering holidays). IOP groups meet 3 times per week. Projected number of clients attending IOP per week in the first months of operation is between 4 and 5 clients or 4.5 clients on average. Therefore, 25 weeks times 3 sessions per week times 4.5 clients = 337.5

In 2018, the applicants project that 1200 IOP sessions would be accomplished. This was calculated as follows: 50 weeks of operation (considering holidays). IOP groups meet 3 times per week. Projected number of clients attending IOP per week would be 8 on average. Therefore, 50 weeks times 3 sessions per week times 8 clients = 1200.

In 2019, the applicants project that 1500 IOP sessions would be accomplished. This was calculated as follows: 50 weeks of operation (considering holidays). IOP groups meet 3 times per week. Projected number of clients attending IOP per week would be 10 on average. Therefore, 50 weeks times 3 sessions per week times 10 clients = 1500.

In 2020, the applicants project that 1800 IOP sessions would be accomplished. This was calculated as follows: 50 weeks of operation (considering holidays). IOP groups meet 3 times per week. Projected number of clients attending IOP per week would be 12 on average. Therefore, 50 weeks times 3 sessions per week times 12 clients = 1800.

"Individual Sessions" per annum indicates the total number of Individual Sessions or Dates of Service (DOS) for the year. Please note that these indicated "Individual Sessions" are independent of and not the weekly individual sessions that IOP Clients receive gratis as part of their IOP treatment.

In 2017, the applicants project that 225 Individual Sessions would be accomplished. This was calculated as follows: 7/1 to 12/31/17 = 25 weeks of operation (considering holidays). Individual sessions are conducted 1 time per week. Projected number of clients attending individual sessions per week in the first months of operation is 9 on average. Therefore, 25 weeks times 1 session per week times 9 clients = 225.

In 2018, the applicants project that 600 Individual Sessions would be accomplished. This was calculated as follows: 50 weeks of operation (considering holidays). Individual sessions are conducted 1 time per week. Projected number of clients attending individual sessions per week is 12 on average. Therefore, 50 weeks times 1 session per week times 12 clients = 600.

In 2019, the applicants project that 750 Individual Sessions would be accomplished. This was calculated as follows: 50 weeks of operation (considering holidays). Individual sessions are conducted 1 time per week. Projected number of clients attending individual sessions per week is 15 on average. Therefore, 50 weeks times 1 session per week times 15 clients = 750.

In 2020, the applicants project that 900 Individual Sessions would be accomplished. This was calculated as follows: 50 weeks of operation (considering holidays). Individual sessions are conducted 1 time per week. Projected number of clients attending individual sessions per week is 18 on average. Therefore, 50 weeks times 1 session per week times 18 clients = 900.

In response to "consistent with the units of measure utilized in Table 5": Table 5 indicates the actual number of clients per annum and to date in 2017 that Jay Seigel, APRN has under his care for psychopharmacological services. Table 5 only indicates the number of clients and not "IOP Sessions" and "Individual Sessions" as indicated in Table 6 as IOP services and agency sessions are not offered now. The Applicants contend that Table 5 indicates a sufficient number of potential IOP clients that would avail themselves of the proposed service.

User, OHCA

From:	Mitchell, Micheala
Sent:	Thursday, May 25, 2017 12:48 PM
To:	'Reinhardwstraub@gmail.com'; 'Jay Seigel'
Cc:	Walker, Shauna; Riggott, Kaila; User, OHCA
Subject:	17-32160 CON Second Completeness Correspondence
Attachments:	32160 Recovery Services of Connecticut LLC Second Completeness.docx; 32160 Recovery Services of Connecticut LLC Second Completeness(2).pdf

Dear Mr. Seigel and Mr. Straub:

Attached are additional completeness questions associated with CON docket number 17-32160. Please confirm receipt of this correspondence.

Micheala L. Mitchell
Staff Attorney, PHHO/OHCA
Connecticut Department of Public Health
410 Capitol Avenue, MS# 13-HCA, Hartford, CT 06134
Phone: (860) 418-7055
Email: micheala.mitchell@ct.gov

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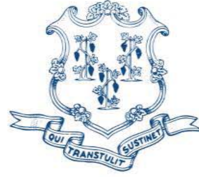
STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

May 25, 2017 Via Email Only

Mr. Jay Seigel, Owner
Mr. Reinhard Straub, Owner
Recovery Services of CT, LLC
11 Woodland Road
Madison, CT 06443
jayseigel@gmail.com
Reinhardwstraub@gmail.com

RE: Certificate of Need Application: Docket Number: 16-32160-CON
Facility for the Care or Treatment of Substance Abusive or Dependent Persons in Madison, CT
Certificate of Need Second Completeness Letter

Dear Mr. Seigel and Mr. Straub:

On May 3, 2017, the Department of Public Health ("DPH"), Office of Health Care Access ("OHCA") received completeness responses on behalf of Recovery services of Connecticut LLC ("RSCT") to establish a facility for the care or treatment of substance abusive or dependent persons in Madison, Connecticut.

OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please "reply all" to electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. *Please email your responses to both of the following email addresses:* **OHCA@ct.gov** and **kaila.riggott@ct.gov**.

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date that the request was transmitted. Therefore, please provide your written responses to OHCA no later than **July 24, 2017**, otherwise your application will be automatically considered withdrawn.

Repeat each question before providing your response and paginate and date your response, (i.e., each page, in its entirety). Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions and the like) must be numbered sequentially from the applicant's document preceding it. Please begin your submission using **Page 487** and reference "**Docket Number: 16-32160-CON**."

1. On page 459 of the application, the Connecticut State Data Center is cited as the source of the population estimates for the towns in the South Central Region of the state. The population estimates provided by that source are reflective of the entire population in that service area. Revise the population totals to include only adults, ages 18 and older. Recalculate the estimated prevalence using the revised population totals.

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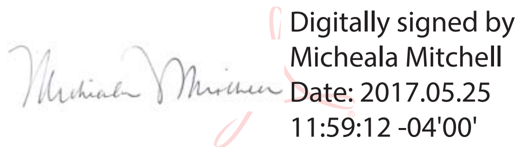
3. Using the table below, update Table 7 on page 463 of the application based on client volume. Ensure that the payer mix reflects any changes to the projected volumes reported in Table 6.

CURRENT AND PROJECTED PAYER MIX FOR
RECOVERY SERVICES OF CONNECTICUT, BY NUMBER OF CLIENTS AND VISITS

Payer	Current			Projected								
	FY 2017			FY 2018			FY 2019			FY 2020		
	Client Vol.	%	Visit Vol.	Client Vol.	%	Visit Vol.	Client Vol.	%	Visit Vol.	Client Vol.	%	Visit Vol.
Medicare*												
Medicaid*		30	168		30	540		30	675		30	810
CHAMPUS & TriCare												
Total Government		**30**	**168**		**30**	**540**		**30**	**675**		**30**	**810**
Commercial Insurers		65	365		65	1,170		65	1,463		65	1,755
Self-pay		5	28		5	90		5	113		5	135
Uninsured												
Workers Compensation												
Total Non-Government		**70**	**392**		**70**	**1,260**		**70**	**1,575**		**70**	**1,890**
Total Payer Mix		**100**	**560**		**100**	**1,800**		**100**	**2,250**		**100**	**2,270**

If you have any questions concerning this letter, please feel free to contact Kaila Riggott at (860) 418-7037.



User, OHCA

From: Mitchell, Micheala
Sent: Friday, May 26, 2017 9:35 AM
To: 'Reinhard Straub'; 'Jay Seigel'
Cc: Walker, Shauna; Riggott, Kaila; User, OHCA
Subject: Revised Completeness Letter/ CON 17-32160
Attachments: 32160 Recovery Services of Connecticut LLC Second Completeness.pdf; 32160 Recovery Services of Connecticut LLC Second Completeness.docx

Dear Mr. Seigel and Mr. Straub:

We revised the completeness letter that we electronically mailed to you on May 25, 2017 to include the correct docket number. All questions and associated deadlines within the revised letter remain consistent with those set forth in the May 25th correspondence.

We apologize for this oversight. Please confirm receipt of this email.

Thank you,
Micheala L. Mitchell
Staff Attorney, PHHO/OHCA
Connecticut Department of Public Health
410 Capitol Avenue, MS# 13-HCA, Hartford, CT 06134
Phone: (860) 418-7055
Email: micheala.mitchell@ct.gov

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

May 26, 2017 Via Email Only

Mr. Jay Seigel, Owner
Mr. Reinhard Straub, Owner
Recovery Services of CT, LLC
11 Woodland Road
Madison, CT 06443
jayseigel@gmail.com
Reinhardwstraub@gmail.com

RE: Certificate of Need Application: Docket Number: 17-32160-CON
Facility for the Care or Treatment of Substance Abusive or Dependent Persons in Madison, CT
Certificate of Need Second Completeness Letter

Dear Mr. Seigel and Mr. Straub:

On May 3, 2017, the Department of Public Health ("DPH"), Office of Health Care Access ("OHCA") received completeness responses on behalf of Recovery services of Connecticut LLC ("RSCT") to establish a facility for the care or treatment of substance abusive or dependent persons in Madison, Connecticut.

OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please "reply all" to electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. *Please email your responses to both of the following email addresses:* **OHCA@ct.gov** and **kaila.riggott@ct.gov**.

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Repeat each question before providing your response and paginate and date your response, (i.e., each page, in its entirety). Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions and the like) must be numbered sequentially from the applicant's document preceding it. Please begin your submission using **Page 487** and reference "**Docket Number: 17-32160-CON**."

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Total Payer Mix		**100**	**560**		**100**	**1,800**		**100**	**2,250**		**100**	**2,270**

If you have any questions concerning this letter, please feel free to contact Kaila Riggott at (860) 418-7037.

User, OHCA

From: Reinhard Straub <reinhardwstraub@gmail.com>
Sent: Sunday, May 28, 2017 9:46 PM
Cc: Jay Seigel; Riggott, Kaila; User, OHCA; Mitchell, Micheala
Subject: Re: Revised Completeness Letter/ CON 17-32160
Attachments: CON2ndCompletenessQuestionResponses.docx; CON2ndCompletenessQuestionResponses.pdf

Re: CON Application: Docket Number: 17-32160-CON
Responses to CON Second Completeness Letter

May 28, 2017

Dear Ms. Mitchell & Ms. Riggott:

Please find attached the responses to the questions sent to us on May 26, 2017 in both a Word document and PDF format.

Please contact me if I can be of service.

Sincerely,

Reinhard W Straub, LICSW
Offices:
24 Channing Street
New London, CT 06320
11 Woodland Road, Suite 2
Madison, CT 06443
Cell 401.741.5109
reinhardwstraub@gmail.com
www.reinhardwstraub.com

On Fri, May 26, 2017 at 9:35 AM, Mitchell, Micheala <Micheala.Mitchell@ct.gov> wrote:

> Dear Mr. Seigel and Mr. Straub:
>
> We revised the completeness letter that we electronically mailed to you on May 25, 2017 to include the correct docket number. All questions and associated deadlines within the revised letter remain consistent with those set forth in the May 25th correspondence.
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> We apologize for this oversight. Please confirm receipt of this email.

Thank you,

Micheala L. Mitchell

Staff Attorney, PHHO/OHCA

Connecticut Department of Public Health

410 Capitol Avenue, MS# 13-HCA, Hartford, CT 06134

Phone: (860) 418-7055

Email: micheala.mitchell@ct.gov

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May 30, 2017 Docket Number: 17-32160-CON Second Completeness Responses

"1. On page 459 of the application, the Connecticut State Data Center is cited as the source of the population estimates for the towns in the South Central Region of the state. The population estimates provided by that source are reflective of the entire population in that service area. Revise the population totals to include only adults, ages 18 and older. Recalculate the estimated prevalence using the revised population totals"

Town	Estimated population	Estimated population over 18 (78.7% of population)	8% of population over 18 in need of treatment not receiving it
Branford	27,764	21,850	1,748
Chester	3,996	3,145	252
Clinton	13,125	10,329	826
Colchester	16,543	13,019	1,042
Deep River	4,581	3,605	288
Durham	7,623	5,999	480
East Haven	29,696	23,371	1,870
East Lyme	19,162	15,080	1,206
Essex	6,644	5,229	418
Guilford	22,481	17,693	1,415
Haddam	8,784	6,913	553
Killingworth	6,608	5,200	416
Madison	18,133	14,271	1,142
Niantic	3,114	2,451	196
North Branford	14,469	11,387	911
Old Lyme	7,576	5,962	477
Old Saybrook	9,993	7,864	629
Salem	4,244	3,340	267
Waterford	19,543	15,380	1,230
Westbrook	7,187	5,656	452
Total	**251,266**	**197,746**	**15,820**

The table above determined the "Estimated population over 18" to be "78.7% of population" by utilizing the United States Census Quick Facts for Connecticut (see attached pages 491 & 492) (https://www.census.gov/quickfacts/table/AGE295215/09,00). The United States Census Quick Facts for Connecticut determined that "Persons under 18 years, percent July 1, 2015 (was) 21.3%". Therefore, the population over 18 years can be estimated to be 78.7%.

Utilizing the SAMHSA data referred to on pages 25 -26 of the application, Docket Number: 17:32160-CON and "For a conservative estimate of prevalence, we used a percentage of 2% for "in need of illicit drug treatment" and 6% for "in need of alcohol use treatment. Therefore, we estimate 8% of the population in the South Central Region of CT are in need of treatment but not receiving it."

May 30, 2017 Docket Number: 17-32160-CON Second Completeness Responses

The table above refers to the estimated prevalence for each town under the column "**8% of population over 18 in need of treatment not receiving it"** with a total estimated population of 15,820 adults over 18 in need of treatment but not receiving it.

"2. Revise Table 6 on page 461 of the application to include the projected number of clients for the project. Also, clarify whether the term "individual sessions" includes both individual and group sessions. If individual sessions do not include group sessions, add group sessions to the "Service" column and include the projected volume and number of clients for each fiscal year for that service."

TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service	FY 2017 (07/01 – 12/31)	FY 2018	FY 2019	FY 2020
IOP Sessions	**337**	**1200**	**1500**	**1800**
IOP Clients*	**23**	**80**	**100**	**120**
Ind. Sessions	**225**	**600**	**750**	**900**
Ind. Clients	**45**	**120**	**150**	**180**
Group Sessions	**150**	**600**	**900**	**1200**
Group Clients	**19**	**75**	**112**	**150**
Total Sessions	**712**	**2400**	**3150**	**3900**
Total Clients	**87**	**275**	**362**	**450**

Projected number of IOP Clients was calculated by projecting that each IOP Client would, on average, attend 15 IOP sessions. Therefore, for 2017, 337 IOP sessions divided by 15 IOP sessions would equal 23 Clients. For 2018, 1200 IOP sessions divided by 15 IOP sessions would equal 80 Clients. For 2019, 1500 IOP sessions divided by 15 IOP sessions would equal 100 Clients. For 2020, 1800 IOP sessions divided by 15 IOP sessions would equal 120 Clients.

Projected number of Individual Clients was calculated by projecting that each Individual Client would, on average, attend 5 individual sessions. Therefore, for 2017, 225 individual sessions divided by 5 sessions would equal 45 Clients. For 2018, 600 individual sessions divided by 5 sessions would equal 120 Clients. For 2019, 750 individual sessions divided by 5 sessions would equal 150 Clients. For 2020, 900 individual sessions divided by 5 sessions would equal 180 Clients.

"Group Sessions" per annum indicates the total number of Group Sessions or Dates of Service (DOS) for the year.

May 30, 2017 Docket Number: 17-32160-CON Second Completeness Responses

In 2017, the applicants project that 150 Group Sessions would be accomplished. This was calculated as follows: 7/1 to 12/31/17 = 25 weeks of operation (considering holidays). Group sessions are conducted 1 time per week. We project that only 1 group will be in operation for the first year of operation in 2017. Projected number of clients attending group sessions per week in the first months of operation is 6 on average. Therefore, 25 weeks times 1 session per week times 6 clients = 150.

In 2018, the applicants project that 600 Group Sessions would be accomplished. This was calculated as follows: 50 weeks of operation (considering holidays). Group sessions are conducted 1 time per week. We project that 2 groups will be in operation for the second year of operation in 2018. Projected number of clients attending each group session per week is 6 on average. Therefore, 50 weeks times 2 groups per week times 6 clients = 600.

In 2019, the applicants project that 900 Group Sessions would be accomplished. This was calculated as follows: 50 weeks of operation (considering holidays). Group sessions are conducted 1 time per week. We project that 3 groups will be in operation for the third year of operation in 2018. Projected number of clients attending each group session per week is 6 on average. Therefore, 50 weeks times 3 groups per week times 6 clients = 900.

In 2020, the applicants project that 1200 Group Sessions would be accomplished. This was calculated as follows: 50 weeks of operation (considering holidays). Group sessions are conducted 1 time per week. We project that 4 groups will be in operation for the fourth year of operation in 2018. Projected number of clients attending each group session per week is 6 on average. Therefore, 50 weeks times 4 groups per week times 6 clients = 1200.

Projected number of Group Clients was calculated by projecting that each Group Client would, on average, attend 8 group sessions. Therefore, for 2017, 150 group sessions divided by 8 sessions would equal 19 Clients. For 2018, 600 group sessions divided by 8 sessions would equal 75 Clients. For 2019, 900 group sessions divided by 8 sessions would equal 112 Clients. For 2020, 1200 group sessions divided by 8 sessions would equal 150 Clients.

In anticipation of financial questions regarding annual financial projections, adding Group Sessions as a service modality will add only a small percentage to the annual totals indicated on "Financial Worksheet B" on pages 257 & 458 of the application, Docket Number: 17:32160-CON. We project that Group Sessions will be reimbursed at an average of $25. per session. Therefore in 2017, 150 group sessions @ $25. adds $3750. to the projection for the year. In 2018, 600 group sessions @$25. adds $15k to the projection for the year. In 2019, 900 group sessions @$25. adds $22.5k to the projection for the year. In 2020, 1200 group sessions @ $25. adds $30k to the projection for the year.

May 30, 2017 Docket Number: 17-32160-CON Second Completeness Responses

"3. Using the table below, update Table 7 on page 463 of the application based on client volume. Ensure that the payer mix reflects any changes to the projected volumes reported in Table 6."

PROJECTED PAYER MIX FOR RECOVERY SERVICES OF CONNECTICUT, BY NUMBER OF CLIENTS & VISITS

Payer	2017 Client Vol.	2017 %	2017 Visit Vol.	2018 Client Vol.	2018 %	2018 Visit Vol.	2019 Client Vol.	2019 %	2019 Visit Vol.	2020 Client Vol.	2020 %	2020 Visit Vol.
Medicare	0	0	0	6	2	48	7	2	63	9	2	78
Medicaid	26	30	214	83	30	720	109	30	945	135	30	1170
CHAMPUS & Tricare	0	0	0	14	5	120	18	5	157	23	5	195
Total Government	26	30	214	103	37	888	134	37	1165	167	37	1443
Commercial Insurers	56	64	456	157	57	1368	206	57	1795	256	57	2223
Self-Pay	4	5	35	13	5	120	18	5	158	22	5	195
Uninsured	1	1	7	2	1	24	4	1	32	5	1	39
Workers Comp.	0	0	0	0	0	0	0	0	0	0	0	0
Total Non-Government	61	70	498	172	63	1512	228	63	1985	283	63	2457
Total Payer Mix	87	100	712	275	100	2400	362	100	3150	450	100	3900

The Applicants project that it will take until 2018 for Recovery Services of Connecticut to become an in-network provider for Medicare and Tricare. Please note that the Intensive Outpatient level of care (IOP) is not a covered service by Medicare and Tricare. Therefore these Clients would only be able to use their Medicare and Tricare coverage for individual and group counseling.

May 30, 2017 Docket Number: 17:32160-CON
2nd Completeness Response

QuickFacts

Connecticut

QuickFacts provides statistics for all states and counties, and for cities and towns with a ***population of 5,000 or more***.

All Topics	CONNECTICUT	UNITED STATES
People		
Population		
Population estimates, July 1, 2016, (V2016)	3,576,452	323,127,513
Population estimates, July 1, 2015, (V2015)	3,590,886	321,418,820
Population estimates base, April 1, 2010, (V2016)	3,574,114	308,758,105
Population estimates base, April 1, 2010, (V2015)	3,574,118	308,758,105
Population, percent change - April 1, 2010 (estimates base) to July 1, 2016, (V2016)	0.1%	4.7%
Population, percent change - April 1, 2010 (estimates base) to July 1, 2015, (V2015)	0.5%	4.1%
Population, Census, April 1, 2010	3,574,097	308,745,538
Age and Sex		
Persons under 5 years, percent, July 1, 2015, (V2015)	5.2%	6.2%
Persons under 5 years, percent, April 1, 2010	5.7%	6.5%
Persons under 18 years, percent, July 1, 2015, (V2015)	21.3%	22.9%
Persons under 18 years, percent, April 1, 2010	22.9%	24.0%
Persons 65 years and over, percent, July 1, 2015, (V2015)	15.8%	14.9%
Persons 65 years and over, percent, April 1, 2010	14.2%	13.0%
Female persons, percent, July 1, 2015, (V2015)	51.2%	50.8%
Female persons, percent, April 1, 2010	51.3%	50.8%
Race and Hispanic Origin		
White alone, percent, July 1, 2015, (V2015) (a)	80.8%	77.1%
White alone, percent, April 1, 2010 (a)	77.6%	72.4%
Black or African American alone, percent, July 1, 2015, (V2015) (a)	11.6%	13.3%
Black or African American alone, percent, April 1, 2010 (a)	10.1%	12.6%
American Indian and Alaska Native alone, percent, July 1, 2015, (V2015) (a)	0.5%	1.2%
American Indian and Alaska Native alone, percent, April 1, 2010 (a)	0.3%	0.9%
Asian alone, percent, July 1, 2015, (V2015) (a)	4.6%	5.6%
Asian alone, percent, April 1, 2010 (a)	3.8%	4.8%
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2015, (V2015) (a)	0.1%	0.2%
Native Hawaiian and Other Pacific Islander alone, percent, April 1, 2010 (a)	Z	0.2%
Two or More Races, percent, July 1, 2015, (V2015)	2.2%	2.6%
Two or More Races, percent, April 1, 2010	2.6%	2.9%
Hispanic or Latino, percent, July 1, 2015, (V2015) (b)	15.4%	17.6%
Hispanic or Latino, percent, April 1, 2010 (b)	13.4%	16.3%
White alone, not Hispanic or Latino, percent, July 1, 2015, (V2015)	68.2%	61.6%
White alone, not Hispanic or Latino, percent, April 1, 2010	71.2%	63.7%
Population Characteristics		
Veterans, 2011-2015	199,331	20,108,332
Foreign born persons, percent, 2011-2015	13.9%	13.2%
Housing		
Housing units, July 1, 2016, (V2016)	1,499,116	135,697,926
Housing units, April 1, 2010	1,487,891	131,704,730
Owner-occupied housing unit rate, 2011-2015	67.0%	63.9%
Median value of owner-occupied housing units, 2011-2015	$270,500	$178,600
Median selected monthly owner costs -with a mortgage, 2011-2015	$2,067	$1,492
Median selected monthly owner costs -without a mortgage, 2011-2015	$833	$458
Median gross rent, 2011-2015	$1,075	$928
Building permits, 2016	5,504	1,206,642
Families and Living Arrangements		
Households, 2011-2015	1,352,583	116,926,305
Persons per household, 2011-2015	2.57	2.64
Living in same house 1 year ago, percent of persons age 1 year+, 2011-2015	87.8%	85.1%
Language other than English spoken at home, percent of persons age 5 years+, 2011-2015	21.9%	21.0%
Education		
High school graduate or higher, percent of persons age 25 years+, 2011-2015	89.9%	86.7%
Bachelor's degree or higher, percent of persons age 25 years+, 2011-2015	37.6%	29.8%
Health		
With a disability, under age 65 years, percent, 2011-2015	7.1%	8.6%
Persons without health insurance, under age 65 years, percent	⚠ 6.9%	⚠ 10.5%

May 30, 2017 Docket Number: 17-32160-CON
2nd Completeness Responses

Economy		
In civilian labor force, total, percent of population age 16 years+, 2011-2015	67.2%	63.3%
In civilian labor force, female, percent of population age 16 years+, 2011-2015	62.8%	58.5%
Total accommodation and food services sales, 2012 ($1,000) (c)	9,542,068	708,138,598
Total health care and social assistance receipts/revenue, 2012 ($1,000) (c)	29,573,119	2,040,441,203
Total manufacturers shipments, 2012 ($1,000) (c)	55,160,095	5,696,729,632
Total merchant wholesaler sales, 2012 ($1,000) (c)	161,962,244	5,208,023,478
Total retail sales, 2012 ($1,000) (c)	51,632,467	4,219,821,871
Total retail sales per capita, 2012 (c)	$14,381	$13,443
Transportation		
Mean travel time to work (minutes), workers age 16 years+, 2011-2015	25.4	25.9
Income and Poverty		
Median household income (in 2015 dollars), 2011-2015	$70,331	$53,889
Per capita income in past 12 months (in 2015 dollars), 2011-2015	$38,803	$28,930
Persons in poverty, percent	⚠ 10.5%	⚠ 13.5%
Businesses		
Total employer establishments, 2015	89,232[1]	7,663,938
Total employment, 2015	1,503,102[1]	124,085,947
Total annual payroll, 2015 ($1,000)	92,555,072[1]	6,253,488,252
Total employment, percent change, 2014-2015	1.2%[1]	2.5%
Total nonemployer establishments, 2015	272,809	24,331,403
All firms, 2012	326,693	27,626,360
Men-owned firms, 2012	187,845	14,844,597
Women-owned firms, 2012	106,678	9,878,397
Minority-owned firms, 2012	56,113	7,952,386
Nonminority-owned firms, 2012	259,614	18,987,918
Veteran-owned firms, 2012	31,056	2,521,682
Nonveteran-owned firms, 2012	281,182	24,070,685
Geography		
Population per square mile, 2010	738.1	87.4
Land area in square miles, 2010	4,842.36	3,531,905.43
FIPS Code	09	00

1. Includes data not distributed by county.

⚠ This geographic level of poverty and health estimates are not comparable to other geographic levels of these estimates

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable. Click the Quick Info icon to the left of each row in TABLE view to learn about sampling error.

The vintage year (e.g., V2015) refers to the final year of the series (2010 thru 2015).
Different vintage years of estimates are not comparable.

(a) Includes persons reporting only one race
(b) Hispanics may be of any race, so also are included in applicable race categories
(c) Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

D Suppressed to avoid disclosure of confidential information
F Fewer than 25 firms
FN Footnote on this item in place of data
NA Not available
S Suppressed; does not meet publication standards
X Not applicable
Z Value greater than zero but less than half unit of measure shown

QuickFacts data are derived from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area Health Insurance Estimates, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits.

ABOUT US (//www.census.gov/about.html)
Are You in a Survey? (//www.census.gov/programs-surveys/are-you-in-a-survey.html)
FAQs (//ask.census.gov/)
Director's Corner (//www.census.gov/about/leadership...)
Regional Offices (//www.census.gov/about/regions.html)
History (//www.census.gov/about/history.html)
Research (//www.census.gov/about/our-research.html)
Scientific Integrity (//www.census.gov/about/policies/quality/scientific_integrity.html)
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2010 Census (//www.census.gov/programs-surveys/decennial-census/2010-census.html)
Economic Census (//www.census.gov/programs-surveys/economic-census.html)
Interactive Maps (//www.census.gov/geography/interactive-maps.html)
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Economic Indicators (//www.census.gov/topics/economy/economic-indicators.html)
Economic Census (//www.census.gov/programs-surveys/economic-census.html)
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International Trade (//www.census.gov/topics/international-trade.html)
Export Codes (//www.census.gov/topics/international-trade/schedule-b.html)
NAICS (//www.census.gov/topics/economy/classification-codes.html)
Governments (//www.census.gov/topics/public-sector.html)
Local Employment Dynamics (//www.census.gov/topics/employment/led.html)
Survey of Business Owners (//www.census.gov/programs-surveys/sbo.html)

PEOPLE & HOUSEHOLDS
2020 Census (//www.census.gov/2020census/)
2010 Census (//www.census.gov/programs-surveys/decennial-census/2010-census.html/)
American Community Survey (//www.census.gov/programs-surveys/acs/)
Income (//www.census.gov/topics/income-poverty/income.html)
Poverty (//www.census.gov/topics/income-poverty/poverty.html)
Population Estimates (//www.census.gov/topics/population/population-estimates.html)
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NEWSROOM (//www.census.gov/newsroom.html)
News Releases (//www.census.gov/newsroom/press-releases.html)
Release Schedule (//www.calendarwiz.com/calendars/calendar.php?crd=cens1sample&cid[]=31793)
Facts for Features (//www.census.gov/newsroom/facts-for-features.html)
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CONNECT WITH US (//www.census.gov/about/contact-us/social_media.html)
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User, OHCA

From:	Mitchell, Micheala
Sent:	Tuesday, June 27, 2017 4:14 PM
To:	'Reinhard Straub'; 'Jay Seigel'
Cc:	User, OHCA; Riggott, Kaila; Walker, Shauna
Subject:	17-32160 CON Third Completeness Correspondence
Attachments:	32160 Recovery Services of Connecticut LLC Third Completeness.pdf; 32160 Recovery Services of Connecticut LLC Third Completeness.docx

Dear Mr. Seigel and Mr. Straub:

Attached are a few additional completeness questions associated with CON docket number 17-32160. Once the record is deemed complete, we will proceed with the decision-making process. Please confirm receipt of this correspondence.

Thank you,

Micheala L. Mitchell
Staff Attorney, PHHO/OHCA
Connecticut Department of Public Health
410 Capitol Avenue, MS# 13-HCA, Hartford, CT 06134
Phone: (860) 418-7055
Email: micheala.mitchell@ct.gov

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

June 27, 2017 Via Email Only

Mr. Jay Seigel, Owner
Mr. Reinhard Straub, Owner
Recovery Services of CT, LLC
11 Woodland Road
Madison, CT 06443
jayseigel@gmail.com
Reinhardwstraub@gmail.com

RE: Certificate of Need Application: Docket Number: 17-32160-CON
Facility for the Care or Treatment of Substance Abusive or Dependent Persons in Madison, CT
Certificate of Need Third Completeness Letter

Dear Mr. Seigel and Mr. Straub:

On May 30, 2017, the Department of Public Health ("DPH"), Office of Health Care Access ("OHCA") received completeness responses on behalf of Recovery services of Connecticut LLC ("RSCT") to establish a facility for the care or treatment of substance abusive or dependent persons in Madison, Connecticut.

OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please "reply all" to electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. ***Please email your responses to both of the following email addresses: OHCA@ct.gov and Kaila.Riggott@ct.gov.***

Paginate and date your response (i.e., each page in its entirety). Repeat each OHCA question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions, etc.) must be numbered sequentially from the Applicant's preceding document. Begin your submission using **Page 493** and reference "**Docket Number: 17-32160-CON**."

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date this request was transmitted. Therefore, please provide your written responses to OHCA no later than **August 28, 2017, 4:30 p.m.**, otherwise your application will be automatically considered withdrawn.

1. Page 487 of the application estimates the target population for the service area towns at 78.7% (based upon the *overall* Connecticut population for adults ages 18 and older). Revise the estimated target population for each service area town utilizing a data source such as the one found at the following link: https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t&keepList=t.

2. Provide the calculation(s) used to:
    a. derive 4.5 clients for IOP sessions in fiscal year ("FY") 2017, as referenced on page 461 of the application;
    b. derive 9 clients for individual counseling in FY 2017, as referenced on page 462 of the application; and
    c. derive 6 clients for group counseling in FY 2017, as referenced on page 489 of the application.

3. The historical growth rates for Connecticut Psychiatric Services were 12% from FY 2014-15 and 16% from FY 2015-16. The data in Table 6 on page 488 of the application indicates that the projected year over year increase in IOP clients is 74% from FY 2017-18[1]; 25% from FY 2018-19; and 20% from FY 2019-20. Provide a calculation and rationale for the projected IOP growth rates.

4. Revise Financial Worksheet (B) to include the additional revenue, by payer, from group counseling sessions as referenced on page 489 of the application.

If you have any questions concerning this letter, please feel free to contact Kaila Riggott at (860) 418-7037.

[1] The data for the period between July 1, 2017 and December 31, 2017 was annualized to represent one full year.

User, OHCA

From: Reinhard Straub <reinhardwstraub@gmail.com>
Sent: Tuesday, July 04, 2017 1:45 PM
To: Mitchell, Micheala
Cc: Jay Seigel; User, OHCA; Riggott, Kaila; Walker, Shauna
Subject: Re: 17-32160 CON Third Completeness Correspondence
Attachments: con excel spreadsheet 6 27 17.pdf; CON3rdCompletenessQuestionResponsesJuly4.docx; CON3rdResponsesJuly4.pdf

Follow Up Flag: Follow up
Flag Status: Completed

Attached please find responses in PDF format as well as Word document and revised Financial Worksheet (B) in excel.

Thank you for all of your assistance.

We hope this will complete the initial application process.

Sincerely,

Reinhard Straub and Jay Seigel

Reinhard W Straub, LICSW
Offices:
33 College Hill Road, Building 31C
Warwick, RI 02886
24 Channing Street
New London, CT 06320
11 Woodland Road, Suite 2
Madison, CT 06443
Cell 401.741.5109
reinhardwstraub@gmail.com
www.reinhardwstraub.com

On Tue, Jun 27, 2017 at 4:13 PM, Mitchell, Micheala <Micheala.Mitchell@ct.gov> wrote:

> Dear Mr. Seigel and Mr. Straub:
>
> Attached are a few additional completeness questions associated with CON docket number 17-32160. Once the record is deemed complete, we will proceed with the decision-making process. Please confirm receipt of this correspondence.

Thank you,

Micheala L. Mitchell

Staff Attorney, PHHO/OHCA

Connecticut Department of Public Health

410 Capitol Avenue, MS# 13-HCA, Hartford, CT 06134

Phone: (860) 418-7055

Email: micheala.mitchell@ct.gov

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1. "Page 487of the application estimates the target population for the service area towns at 78.7% (based upon the overall Connecticut population for adults ages 18 and older). Revise the estimated target population for each service area town utilizing a data source such as the one found at the following link:
https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t&keepList=t."

The revised table below utilizes the recommended data source above.

Town	Population over 18	8% of pop over 18 in need of treatment not receiving it
Branford	23,327	1,866
Chester	3,441	275
Clinton	10,623	850
Colchester	12,184	975
Deep River	3,545	284
Durham	5,605	448
East Haven	23,625	1,890
East Lyme	15,367	1,229
Essex	5,402	432
Guilford	17,552	1,404
Haddam	6,628	530
Killingworth	5,137	411
Madison	13,348	1,068
North Branford	11,538	923
Old Lyme	6,013	481
Old Saybrook	8,122	650
Salem	3,162	253
Waterford	15,639	1,251
Westbrook	5,898	472
Total	196,156	**15,692**

The 15,692 refers to 8% of the population over 18 years of age in need of treatment not receiving it in the above list of CT towns that are in close proximity to the proposed project. As referred to on pages 25 and 26 of this application utilizing SAMHSA data, the applicants used a conservative estimate of prevalence of 2% "in need of illicit drug treatment" and 6% "in need of alcohol use treatment". Therefore the applicants conservatively estimate that 8% over the age of 18 are in need of treatment and not receiving it.

"2. Provide the calculation(s) used to:

a. derive 4.5 clients for IOP sessions in fiscal year ("FY") 2017, as referenced on page 461 of the application;

b. derive 9 clients for the individual counseling in FY 2017, as referenced on page 462 of the application; and

c. derive 6 clients for group counseling in FY 2017, as referenced on page 489 of the application."

The numbers of clients for each modality of treatment i.e. IOP, individual and group counseling, were the actual numbers of clients in the first 3 to 6 months at the state licensed outpatient substance abuse facility in Rhode Island owned and created by the applicant, Reinhard Straub and a RI physician in 2011 to 2015.

The circumstances in Rhode Island were nearly identical to Madison, CT as the IOP and other services were created from scratch in their respective communities and grew out of the existing clinical practices of the Applicant, Reinhard Straub and a prescriber.

"3. The historical growth rates for Connecticut Psychiatric Services were 12% from FY 2014-15 and 16% from FY 2015-16. The data in Table 6 on page 488 of the application indicates that the projected year over year increase in IOP clients is 74% from FY 2017-18; 25% from FY 2018-19; and 20% from FY 2019-20. Provide a calculation and rationale for the projected IOP growth rates."

TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service	FY 2017 (07/01 – 12/31)	FY 2018	FY 2019	FY 2020
IOP Sessions	337	1200	1500	1800
IOP Clients*	23	80	100	120

It has been the Applicant's first-hand experience that establishing consistent engagement of IOP Clients would start slowly in 2017. This would be a brand new service starting from scratch in a brand new area that does not have an IOP that accepts Medicaid. The first 3 to 6 months would be focused on promoting a new service.

As the clinical need arises for one client at a time, the Applicants, Jay Seigel d.b.a. Connecticut Psychiatric Services LLC and Reinhard Straub d.b.a. Reinhard Recovery LLC, would place clients from their clinical caseloads into the IOP. The Applicants are currently referring clients to CT IOP's in numbers consistent with the projection above for FY 2017 which is also consistent with the prior numerical experience of the Applicant referred to in response #2 above.

Therefore, it is the current experience of the Applicants in CT and the Applicant's experience in RI that the initial number of IOP clients would start slowly as indicated above in "FY 2017".

However in the Applicant's experience, once the word is out and the clinical operation is established in FY 2017 momentum would pick up at the start of the first full year of operation FY 2018.

Although the "*increase in IOP clients is 74% from FY 2017-18*", the numbers make sense when considering the following: a slow start in FY 2017 of 4 to 5 clients in IOP per week or 4.5 on average increasing to 8 clients in IOP per week in the first full year of operation in FY 2018. The rate of increase then flattens out consistently for FY 2019 at 10 IOP clients per week (*25% from FY 2018-19)* and 12 IOP clients per week in FY 2020 (*20% from FY 2019-20)*.

In other words, although the percentage of increase from year to year would appear to be large, the actual numbers of IOP clients were projected conservatively and based on the actual experience of the Applicants in CT and historically, in RI.

Analyzing the projected utilization of the proposed project from the perspective of those who receive treatment for substance abuse rather than those that need it and are not receiving it reveals the following:

"In 2015, an estimated 2.3 million people (nationally) aged 12 or older who needed substance use treatment received treatment at a specialty facility in the past year. This number represents 0.9 percent of all people aged 12 or older and 10.8 percent of the 21.7 million people who needed substance use treatment."
https://www.ncbi.nlm.nih.gov/books/NBK409172/

"..... in 2015, an estimated 1.3 million adolescents aged 12 to 17, 5.4 million young adults aged 18 to 25, and 15.0 million adults aged 26 or older needed substance use treatment in the past year. Of those who needed substance use treatment, about 80,000 adolescents (or 6.3 percent of this age group), 417,000 young adults (or 7.7 percent of this age group), and 1.8 million adults aged 26 or older (12.3 percent of this age group) received substance use treatment at a specialty facility in the past year."
https://www.ncbi.nlm.nih.gov/books/NBK409172/#SR-266_RB-2716.s4

Utilizing the national data sources for 2015 above, 0.009% of the entire population over 12 received substance abuse treatment and the population 12 to 18 receiving treatment represented 6.3% of the 0.009%. Therefore, 0.0084% of the entire national population over 18 received treatment for substance abuse in 2015. Applying this national percentage to the total population of 193,156 in the table in response #1, it could be estimated that 1629 persons are receiving substance treatment in the service area of the proposed project.

Utilizing Table 6 above and the estimated 1629 persons receiving treatment in the service area, the proposed project estimates it will treat 3% (46) of this population FY 2017 (annualized), 5% (80) in FY 2018, 6% (100) in FY 2019 and 7% (120) in FY 2020.

"4. Revise Financial Worksheet (B) to include the additional revenue, by payer, from group counseling sessions as referenced on page 489 of the application."

(See attached)

The revised Financial Worksheet (B) added the following group revenue referenced on page 489 to the annual projections: FY 2017 $3750, FY 2018 $15K, FY 2019 $22.5K and FY 2020 $30K. No increased expense is anticipated.

Applicant Name:
Financial Worksheet (B)

FOR-PROFIT

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format

LINE	Total Entity:	(1) FY	(2) FY	(3) 2017	(4) FY	(5) FY	(6) 2018	(7) FY	(8) FY	(9) 2019	(10) FY	(11) FY	(12) 2020	(13) FY
	Description	Actual Results	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$0	$0	$71,250	$71,250	$0	$240,000	$240,000		$303,750	$303,750		$367,500	$367,500
2	Less: Allowances	$0	$0	$0	$0	$0	$0	$0			$0			$0
3	Less: Charity Care	$0	$0	$0	$0	$0	$0	$0			$0			$0
4	Less: Other Deductions	$0	$0	$0	$0	$0	$0	$0			$0			$0
	Net Patient Service Revenue	$0	$0	$71,250	$71,250	$0	$240,000	$240,000	$0	$303,750	$303,750	$0	$367,500	$367,500
5	Medicare	$0	$0	$0	$0	$0	$0	$0			$0			$0
6	Medicaid	$0	$0	$21,375	$21,375	$0	$72,000	$72,000		$91,125	$91,125		$110,250	$110,250
7	CHAMPUS & TriCare	$0	$0	$0	$0	$0	$0	$0			$0			$0
8	Other	$0	$0	$0	$0	$0	$0	$0			$0			$0
	Total Government	$0	$0	$21,375	$21,375	$0	$72,000	$72,000	$0	$91,125	$91,125	$0	$110,250	$110,250
9	Commercial Insurers	$0	$0	$46,313	$46,313	$0	$156,000	$156,000		$197,438	$197,438		$238,875	$238,875
10	Uninsured	$0	$0	$0	$0	$0	$0	$0			$0			$0
11	Self Pay	$0	$0	$3,563	$3,563	$0	$12,000	$12,000		$15,188	$15,188		$18,375	$18,375
12	Workers Compensation	$0	$0	$0	$0	$0	$0	$0			$0			$0
13	Other	$0	$0	$0	$0	$0	$0	$0			$0			$0
	Total Non-Government	$0	$0	$49,875	$49,875	$0	$168,000	$168,000	$0	$212,625	$212,625	$0	$257,250	$257,250
	Net Patient Service Revenue[a] (Government+Non-Government)	$0	$0	$71,250	$71,250	$0	$240,000	$240,000	$0	$303,750	$303,750	$0	$367,500	$367,500
14	Less: Provision for Bad Debts	$0	$0	$0	$0	$0	$0	$0			$0			$0
	Net Patient Service Revenue less provision for bad debts	$0	$0	$71,250	$71,250	$0	$240,000	$240,000	$0	$303,750	$303,750	$0	$367,500	$367,500
15	Other Operating Revenue	$0	$0	$0	$0	$0	$0	$0			$0			$0
17	Net Assets Released from Restrictions	$0	$0	$0	$0	$0	$0	$0			$0			$0
	TOTAL OPERATING REVENUE	$0	$0	$71,250	$71,250	$0	$240,000	$240,000	$0	$303,750	$303,750	$0	$367,500	$367,500
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$0	$0	$30,000	$30,000		$100,000	$100,000		$120,000	$120,000		$140,000	$140,000
2	Fringe Benefits	$0	$0	$3,000	$3,000		$10,000	$10,000		$12,000	$12,000		$14,000	$14,000
3	Physicians Fees	$0	$0	$0	$0			$0			$0			$0
4	Supplies and Drugs	$0	$0	$300	$300		$600	$600		$800	$800		$1,000	$1,000
5	Depreciation and Amortization	$0	$0	$1,000	$1,000		$2,000	$2,000		$2,000	$2,000		$2,000	$2,000
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0			$0			$0			$0
7	Interest Expense	$0	$0	$0	$0			$0			$0			$0
8	Malpractice Insurance Cost	$0	$0	$2,500	$2,500		$5,000	$5,000		$5,000	$5,000		$5,000	$5,000
9	Lease Expense	$0	$0	$27,000	$27,000		$54,000	$54,000		$54,000	$54,000		$54,000	$54,000
10	Other Operating Expenses	$0	$0	28,263	$28,263		45,700	$45,700		46,338	$46,338		46,975	$46,975
	TOTAL OPERATING EXPENSES	$0	$0	$92,063	$92,063	$0	$217,300	$217,300	$0	$240,138	$240,138	$0	$262,975	$262,975
	INCOME/(LOSS) FROM OPERATIONS	$0	$0	($20,813)	($20,813)	$0	$22,700	$22,700	$0	$63,613	$63,613	$0	$104,525	$104,525
	NON-OPERATING INCOME	$0	$0	$0	$0			$0			$0			$0
	Income before provision for income taxes	$0	$0	($20,813)	($20,813)	$0	$22,700	$22,700	$0	$63,613	$63,613	$0	$104,525	$104,525
	Provision for income taxes[c]	$0	$0	$0	$0			$0			$0			$0
	NET INCOME	$0	$0	($20,813)	($20,813)	$0	$22,700	$22,700	$0	$63,613	$63,613	$0	$104,525	$104,525
C.	**Retained Earnings, beginning of year**	$0	$0	$0	$0			$0			$0			$0
	Retained Earnings, end of year	$0	$0	$0	$0			$0			$0			$0
	Principal Payments	$0	$0	$0	$0			$0			$0			$0
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	0.0%	0.0%	-29.2%	-29.2%	0.0%	9.5%	9.5%	0.0%	20.9%	20.9%	0.0%	28.4%	28.4%
2	Hospital Non Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	0.0%	0.0%	-29.2%	-29.2%	0.0%	9.5%	9.5%	0.0%	20.9%	20.9%	0.0%	28.4%	28.4%
E.	**FTEs**	0	0	1	1		2	2		2	2		2	2
F.	**VOLUME STATISTICS[d]**													
1	Inpatient Discharges	0	0	0	0			0			0			0
2	Outpatient Visits	0	0	560	560		1,800	1,800		2,250	2,250		2,700	2,700
	TOTAL VOLUME	0	0	560	560	0	1,800	1,800	0	2,250	2,250	0	2,700	2,700

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No 2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

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Applicant Name:

Financial Worksheet (B)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY**	**FY**	**2017**	**FY**	**FY**	**2018**	**FY**	**FY**	**2019**	**FY**	**FY**	**2020**	**FY**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$0	$0	$71,250	$71,250	$0	$240,000	$240,000		$303,750	$303,750		$367,500	$367,500
2	Less: Allowances	$0	$0	$0	$0	$0	$0	$0			$0			$0
3	Less: Charity Care	$0	$0	$0	$0	$0	$0	$0			$0			$0
4	Less: Other Deductions	$0	$0	$0	$0	$0	$0	$0			$0			$0
	Net Patient Service Revenue	**$0**	**$0**	**$71,250**	**$71,250**	**$0**	**$240,000**	**$240,000**	**$0**	**$303,750**	**$303,750**	**$0**	**$367,500**	**$367,500**
5	Medicare	$0	$0	$0	$0	$0	$0	$0			$0			$0
6	Medicaid	$0	$0	$21,375	$21,375	$0	$72,000	$72,000		$91,125	$91,125		$110,250	$110,250
7	CHAMPUS & TriCare	$0	$0	$0	$0	$0	$0	$0			$0			$0
8	Other	$0	$0	$0	$0	$0	$0	$0			$0			$0
	Total Government	**$0**	**$0**	**$21,375**	**$21,375**	**$0**	**$72,000**	**$72,000**	**$0**	**$91,125**	**$91,125**	**$0**	**$110,250**	**$110,250**
9	Commercial Insurers	$0	$0	$46,313	$46,313	$0	$156,000	$156,000		$197,438	$197,438		$238,875	$238,875
10	Uninsured	$0	$0	$0	$0	$0	$0	$0			$0			$0
11	Self Pay	$0	$0	$3,563	$3,563	$0	$12,000	$12,000		$15,188	$15,188		$18,375	$18,375
12	Workers Compensation	$0	$0	$0	$0	$0	$0	$0			$0			$0
13	Other	$0	$0	$0	$0	$0	$0	$0			$0			$0
	Total Non-Government	**$0**	**$0**	**$49,875**	**$49,875**	**$0**	**$168,000**	**$168,000**	**$0**	**$212,625**	**$212,625**	**$0**	**$257,250**	**$257,250**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$0**	**$0**	**$71,250**	**$71,250**	**$0**	**$240,000**	**$240,000**	**$0**	**$303,750**	**$303,750**	**$0**	**$367,500**	**$367,500**
14	Less: Provision for Bad Debts	$0	$0	$0	**$0**	$0	$0	**$0**			**$0**			**$0**
	Net Patient Service Revenue less provision for bad debts	**$0**	**$0**	**$71,250**	**$71,250**	**$0**	**$240,000**	**$240,000**	**$0**	**$303,750**	**$303,750**	**$0**	**$367,500**	**$367,500**
15	Other Operating Revenue	$0	$0	$0	**$0**	$0	$0	**$0**			**$0**			**$0**
17	Net Assets Released from Restrictions	$0	$0	$0	**$0**	$0	$0	**$0**			**$0**			**$0**
	TOTAL OPERATING REVENUE	**$0**	**$0**	**$71,250**	**$71,250**	**$0**	**$240,000**	**$240,000**	**$0**	**$303,750**	**$303,750**	**$0**	**$367,500**	**$367,500**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$0	$0	$30,000	$30,000		$100,000	$100,000		$120,000	$120,000		$140,000	$140,000
2	Fringe Benefits	$0	$0	$3,000	$3,000		$10,000	$10,000		$12,000	$12,000		$14,000	$14,000
3	Physicians Fees	$0	$0	$0	$0			$0			$0			$0
4	Supplies and Drugs	$0	$0	$300	$300		$600	$600		$800	$800		$1,000	$1,000
5	Depreciation and Amortization	$0	$0	$1,000	$1,000		$2,000	$2,000		$2,000	$2,000		$2,000	$2,000
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0			$0			$0			$0
7	Interest Expense	$0	$0	$0	$0			$0			$0			$0
8	Malpractice Insurance Cost	$0	$0	$2,500	$2,500		$5,000	$5,000		$5,000	$5,000		$5,000	$5,000
9	Lease Expense	$0	$0	$27,000	$27,000		$54,000	$54,000		$54,000	$54,000		$54,000	$54,000
10	Other Operating Expenses	$0	$0	28,263	$28,263		45,700	$45,700		46,338	$46,338		46,975	$46,975
	TOTAL OPERATING EXPENSES	**$0**	**$0**	**$92,063**	**$92,063**	**$0**	**$217,300**	**$217,300**	**$0**	**$240,138**	**$240,138**	**$0**	**$262,975**	**$262,975**
	INCOME/(LOSS) FROM OPERATIONS	**$0**	**$0**	**($20,813)**	**($20,813)**	**$0**	**$22,700**	**$22,700**	**$0**	**$63,613**	**$63,613**	**$0**	**$104,525**	**$104,525**
	NON-OPERATING INCOME	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Income before provision for income taxes	**$0**	**$0**	**($20,813)**	**($20,813)**	**$0**	**$22,700**	**$22,700**	**$0**	**$63,613**	**$63,613**	**$0**	**$104,525**	**$104,525**
	Provision for income taxes[c]	**$0**	$0	$0	**$0**			**$0**			**$0**			**$0**

FOR-PROFIT

Applicant Name:

Financial Worksheet (B)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY	FY	2017	FY	FY	2018	FY	FY	2019	FY	FY	2020	FY
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
	NET INCOME	**$0**	**$0**	**($20,813)**	**($20,813)**	**$0**	**$22,700**	**$22,700**	**$0**	**$63,613**	**$63,613**	**$0**	**$104,525**	**$104,525**
C.	**Retained Earnings, beginning of year**	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Retained Earnings, end of year	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Principal Payments	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**0.0%**	**0.0%**	**-29.2%**	**-29.2%**	**0.0%**	**9.5%**	**9.5%**	**0.0%**	**20.9%**	**20.9%**	**0.0%**	**28.4%**	**28.4%**
2	Hospital Non Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**0.0%**	**0.0%**	**-29.2%**	**-29.2%**	**0.0%**	**9.5%**	**9.5%**	**0.0%**	**20.9%**	**20.9%**	**0.0%**	**28.4%**	**28.4%**
E.	**FTEs**	**0**	**0**	**1**	**1**		**2**	**2**		**2**	**2**		**2**	**2**
F.	**VOLUME STATISTICS[d]**													
1	Inpatient Discharges	0	0	0	**0**			**0**			**0**			**0**
2	Outpatient Visits	0	0	560	**560**		1,800	**1,800**		2,250	**2,250**		2,700	**2,700**
	TOTAL VOLUME	**0**	**0**	**560**	**560**	**0**	**1,800**	**1,800**	**0**	**2,250**	**2,250**	**0**	**2,700**	**2,700**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

User, OHCA

From: Mitchell, Micheala
Sent: Thursday, July 20, 2017 3:24 PM
To: 'Reinhard Straub'; 'Jay Seigel'
Cc: User, OHCA; Walker, Shauna; Riggott, Kaila
Subject: Recovery Services of Connecticut, LLC Deemed Complete
Attachments: 32160 Notification of Application Deemed Complete.pdf

Good afternoon Mr. Seigel and Mr. Straub,

Attached is a letter deeming the above-referenced application complete. Please confirm receipt of this email and the attachment.

Thank you,
Micheala L. Mitchell
Staff Attorney, PHHO/OHCA
Connecticut Department of Public Health
410 Capitol Avenue, MS# 13-HCA, Hartford, CT 06134
Phone: (860) 418-7055
Email: micheala.mitchell@ct.gov

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

July 20, 2017 | Via Email Only

Jay Seigel, APRN
Reinhard Straub, LCSW
Recovery Services of Connecticut, LLC.
11 Woodland Road
Madison, CT 06443
jayseigel@gmail.com
Reinhardwstraub@gmail.com

RE: Certificate of Need Application: Docket Number: 17-32160-CON
Establishment of a Facility for the Care of Treatment of Substance Abusive or Dependent Persons in Madison, CT

Dear Mr. Seigel and Mr. Straub:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of July 20, 2017.

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7055.

Sincerely,

Digitally signed by Micheala Mitchell
Date: 2017.07.20 15:17:57 -04'00'

Micheala L. Mitchell
Staff Attorney

User, OHCA

From: Jay Seigel <jayseigel@gmail.com>
Sent: Thursday, July 20, 2017 3:38 PM
To: Mitchell, Micheala
Cc: Reinhard Straub; User, OHCA; Walker, Shauna; Riggott, Kaila
Subject: Re: Recovery Services of Connecticut, LLC Deemed Complete

Hello Mrs. Mitchell,
We herby confirm receipt of completed application notification.
Sincerely,
Jay Seigel

Sent from Jay's phone

On Jul 20, 2017, at 3:23 PM, Mitchell, Micheala <Micheala.Mitchell@ct.gov> wrote:

> Good afternoon Mr. Seigel and Mr. Straub,
>
> Attached is a letter deeming the above-referenced application complete. Please confirm receipt of this email and the attachment.
>
> Thank you,
> Micheala L. Mitchell
> Staff Attorney, PHHO/OHCA
> Connecticut Department of Public Health
> 410 Capitol Avenue, MS# 13-HCA, Hartford, CT 06134
> Phone: (860) 418-7055
> Email: micheala.mitchell@ct.gov
> <image001.jpg><image002.jpg>
>
> CONFIDENTIALITY NOTICE: This electronic message may contain information that is confidential and/or legally privileged. It is intended only for the use of the individual(s) and entity named as recipients in the message. If you are not an intended recipient of the message, please notify the sender immediately and delete the material from any computer. Do not deliver, distribute, or copy this message, and do not disclose its contents or take action in reliance on the information it contains. Thank you.
>
> <32160 Notification of Application Deemed Complete.pdf>

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Agreed Settlement

Applicant: **Recovery Services of Connecticut, LLC**
11 Woodland Road
Madison, Connecticut 06443

Docket Number: **17-32160-CON**

Project Title: **Establishment of a Facility for the Care or Treatment of Substance Abusive or Dependent Persons in Madison, CT**

Project Description: Recovery Services of Connecticut, LLC ("RSCT" or "Applicant") seeks authorization to establish a facility for the care or treatment of substance abusive or dependent persons in Madison, Connecticut.

Procedural History: The Applicant published notice of its intent to file a Certificate of Need ("CON") application in *The New Haven Register* (New Haven) on February 13, 14 and 15, 2017. On March 31, 2017, the Office of Health Care Access ("OHCA") received the CON application from the Applicants for the above-referenced project and deemed the application complete on July 20, 2017. OHCA received no responses from the public concerning the proposal. No hearing requests were received from the public per Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a(e). Deputy Commissioner Addo considered the entire record in this matter.

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Findings of Fact and Conclusions of Law

1. Recovery Services of Connecticut, LLC ("RSCT"), a for-profit entity, proposes to establish a facility offering intensive outpatient ("IOP") treatment to adults, ages 18 years or older, diagnosed with substance abuse and mental health disorders in Madison, CT ("Madison").[1] Ex. A, pp. 12-13, 23

2. The Applicant states that a lack of IOP treatment providers in Madison and the surrounding community has resulted in individuals traveling outside of their locale to receive services several times a week. Ex. A, p. 22

3. The Applicant's proposal is intended to improve health care delivery through the establishment of a collaborative, multi-disciplinary team that will extend the continuum of care internally and that will be readily available to coordinate care externally for providers and facilities in the community. Ex. A, p. 30

4. According to the Substance Abuse and Mental Health Services Administration ("SAMHSA"), treating co-occurring conditions simultaneously is associated with lower client costs, and improved outcomes such as reduced substance use, improved psychiatric symptoms and functioning, decreased hospitalization, increased housing stability, fewer arrests and an improved quality of life. Ex. A, p. 29

5. The core therapeutic components and clinical strategies associated with the Applicant's proposed IOP-level of care include, but are not limited to: following the 12-Step model; engaging clients in cognitive behavioral therapy ("CBT"); implementing motivational interviewing and employing a matrix model to integrate CBT; family involvement; 12-Step support; and urine testing. The Applicant will also offer individual and group counseling to clients with co-occurring mental health disorders. Ex. A, pp. 13, 15-16; Ex. C, p. 490

6. Clients will utilize IOP treatment as a "step-down" program from partial hospitalization, detoxification/withdrawal support and residential services or as an immediate "step-up" from outpatient care. Ex. A, p. 14

7. The duration of IOP treatment ranges from 4 to 8 weeks with clients attending 3 to 4 sessions per week, three hours per day. Ex. A, p. 13

8. The days and hours of the proposed program will be on Mondays, Wednesdays, Thursdays and Fridays from 9:00 a.m. until 12:00 p.m. Ex. A, p. 15

---

[1] At present, RSCT co-owner Jay Seigel, APRN, is a private practitioner providing outpatient psychiatric treatment to patients at Connecticut Psychiatric Services, LLC "(Connecticut Psychiatric Services") in Madison. Ex. A, pp. 12-13, 28, 49

9. The Applicant used the existing client base and town origin of Connecticut Psychiatric Services to determine the location for RSCT. The Applicant reports that in 2016, nearly 70% of Connecticut Psychiatric Services clients originated from the primary service area, as illustrated in Table 1, below.

TABLE 1
FISCAL YEAR ("FY") 2016 CLIENT ORIGIN FOR CONNECTICUT PSYCHIATRIC SERVICES, LLC

SERVICE AREA	NO. OF CLIENTS	PERCENT OF CT TOTAL
Clinton	43	9.5%
Madison	41	9.1%
East Lyme**	40	8.8%
Old Saybrook	39	8.6%
Waterford	39	8.6%
Guilford	20	4.4%
Killingworth	20	4.4%
Old Lyme	15	3.3%
Westbrook	14	3.1%
Essex	9	2.0%
Branford	8	1.8%
Deep River	5	1.1%
Colchester	4	0.9%
East Haven	4	0.9%
Durham	3	0.7%
Haddam	3	0.7%
North Branford	3	0.7%
Chester	2	0.4%
Salem	2	0.4%
Service Area Total	**314**	**69.4%**
Other Towns	**138**	**30.5%**
Grand Total	**452**	**100%***

Ex. A, p. 39
*Actual total varies due to rounding.
**Includes Niantic

10. The Agency for Healthcare Research and Quality ("AHRQ") ranked Connecticut the 7th highest state for opioid-related inpatient stays nationwide, based on 2014 data. Ex. A, p. 21; Ex. C, p. 459

11. Estimates predicated on national and state data indicate there are approximately 17,458 adults in the proposed service area classified as having dependence or abuse of illicit drugs or alcohol in the past year. Nearly 16,000 adults in the proposed service area are estimated to be in need of treatment, yet not receiving it.

TABLE 2
ESTIMATES OF DIAGNOSABLE SUBSTANCE USE DISORDERS AND UNMET NEED IN CONNECTICUT

SUBSTANCE USE DISORDER	POPULATION (18 years and over)[1]	PREVALENCE[2]	INCIDENCE	UNMET NEED[4]
Service Area	196,156	8.9%[3]	17,458	15,692
Connecticut	2,808,486	8.9%	249,955	224,679
Service area as percent of Connecticut	**7.0%**	**n/a**	**7.0%**	**7.0%**

[1]U.S. Census Bureau, 2011-2015 American Community Survey Demographic and Housing 5-Year Estimates (2015 version), available at https://factfinder.census.gov.
[2]Percentage estimates reflective of adult population ages 18 years and older classified as having dependence or abuse of illicit drugs or alcohol in the past year. Based on 2012, 2013, and 2014 SAMHSA National Survey on Drug Use and Health (NSDUH) data available at https://www.samhsa.gov/data/sites/default/files/NSDUHsubstateAgeGroupTabs2014/NSDUHsubstateAgeGroupTabs2014.pdf.
[3]Percentage based on South Central Region of Connecticut, as defined by SAMHSA.
[4]Conservative estimate of adult population ages 18 years and older in need of illicit drug or alcohol use treatment, yet not receiving it, based on 2012, 2013, and 2014 SAMHSA NSDUH data available at https://www.samhsa.gov/data/sites/default/files/NSDUHsubstateAgeGroupTabs2014/NSDUHsubstateAgeGroupTabs2014.pdf.
Ex. A, pp. 25-26; Ex. C, pp. 459-460; Ex. F, pp. 487, 491-492; Ex. H, p. 493

12. The 2016 Triennial State Substance Abuse Plan issued by the Connecticut Department of Mental Health and Addiction Services ("DMHAS") reported a significant increase in opioid-related deaths in the three years immediately preceding the release of the plan. Ex. A, pp. 21

13. On September 1, 2016, Connecticut's Chief Medical Examiner ("CME"), Dr. James Gill, stated that during the first six months of 2016, 444 people died of accidental drug intoxications within the state. Dr. Gill further projected that as many as 888 people would die of drug overdoses in 2016, a sharp increase from the 729 fatal drug overdoses that actually occurred in 2015. Ex. A, p. 24

14. Connecticut Psychiatric Services presently receives frequent inquiries from residential treatment providers about available IOP programs in Madison and the surrounding community after patients have been stabilized and on behalf of individuals who are ineligible for residential treatment. Ex. A, p. 22

15. The Applicant states that the proposed project will address the need to provide ongoing treatment for clients discharged from higher levels of care and clients who do not meet the criteria for admission to inpatient programs. Ex. A, p. 21

16. As illustrated in the table below, there are 2 existing IOP providers in the applicant's service area. The nearest IOP provider, located in Branford, CT, is approximately 12 miles from the Applicant's proposed location and both providers predominantly serve adolescents and private pay clients.

TABLE 3
PROVIDERS OF THE PROPOSED SERVICES IN SERVICE AREA

TOWN	PROVIDER	STREET ADDRESS	SERVICES
Branford	BH Care	14 Sycamore Way	IOP
Old Saybrook	Project Courage	251 Main Street, Suite 101	IOP

Ex. A, p. 40; https://findtreatment.samhsa.gov, accessed June 16, 2017

17. The table below shows the projected utilization volume for the proposed program:

TABLE 4
RSCT PROJECTED UTILIZATION

SERVICE/PROGRAM[1]	CURRENT	PROJECTED		
	FY 2017[2]	FY 2018	FY 2019	FY 2020
Group Counseling	19	75	112	150
Individual Counseling	45	120	150	180
IOP	23	80	100	120
Total	87	275	362	450

Fiscal Year is January 1 – December 31
[1]Unit of measure for listed programs is number of clients. Number of clients for each program is calculated as the projected annual number of sessions divided by the average number of sessions each client will attend.
[2]July 1, 2017 through December 31, 2017
The number of clients for each service/program is estimated based on actual clinical practice service/program volume experienced by the Applicant in Rhode Island.
Ex. A, pp. 35-36; Ex. C, pp. 461-462; Ex. F, pp. 488-489; Ex. H, pp. 494-495

18. In addition to self-referrals via its website, the Applicant expects to receive referrals from mental health counseling group practices; individual therapists; medical practices; hospitals; residential treatment centers; professional organizations; employee assistance programs; college and university student health and counseling centers; local businesses; attorneys; diversion programs (e.g., drug court, pretrial services, etc.); the Department of Children and Families; probation; and insurance companies. Ex. F, p. 464

19. The Applicant has a contract with the Wheeler Clinic for the provision of clinical support to clients in crisis or who require a higher level of care. Ex. C, pp. 459, 466-467

20. The Applicant's projected payer mix is as follows:

TABLE 5
PROJECTED PAYER MIX FOR RSCT BY NUMBER OF CLIENTS

Payer	Projected[2]								
	FY 2018			FY 2019			FY 2020		
	Client Volume	%	Visit Volume	Client Volume	%	Visit Volume	Client Volume	%	Visit Volume
Medicare[1]	6	2	48	7	2	63	9	2	78
Medicaid[1]	83	30	720	109	30	945	135	30	1,170
CHAMPUS & TriCare	14	5	120	18	5	157	23	5	195
Total Government	**103**	**37**	**888**	**134**	**37**	**1,165**	**167**	**37**	**1,443**
Commercial Insurers	157	57	1,368	206	57	1,795	256	57	2,223
Self-Pay	13	5	120	18	5	158	22	5	195
Uninsured	2	1	24	4	1	32	5	1	39
Workers Compensation	0	0	0	0	0	0	0	0	0
Total Non-Government	**172**	**63**	**1,512**	**228**	**63**	**1,985**	**283**	**63**	**2,457**
Total Payer Mix	**275**	**100**	**2,400**	**362**	**100**	**3,150**	**450**	**100**	**3,900**

[1]Includes managed care activity.
[2]Projections based on the actual payer mix of the current private practices of Jay Seigel and Reinhard Straub.
Ex. A, p. 36; Ex. C, p. 463; Ex. F, p. 490

21. Upon CON approval and issuance of a license by the Department of Public Health, the Applicant will register Recovery Services of Connecticut, LLC with the Connecticut Department of Social Services as a Medicaid provider.[2] Ex. A, pp. 17, 27

22. The Applicant will provide services on a sliding scale or at a discounted rate to clients that present with financial hardship. Ex. A, p. 31

23. The total capital cost for the proposal is $15,000 for non-medical equipment purchases and will be financed by the Applicant using cash on hand. Ex. A, pp. 5, 33

[2] The Applicant currently accepts clients covered by Medicaid at its existing private practice locations in Connecticut and Rhode Island.

24. The table below illustrates that, although the Applicant projects a loss from this proposal of $20,813 in the last two quarters of FY 2017, the Applicant projects incremental gains for FYs 2018 through 2020.

TABLE 6
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 2017*	FY 2018	FY 2019	FY 2020
Revenue from Operations	$71,250	$240,000	$303,750	$367,500
Total Operating Expenses	$92,063	$217,300	$240,138	$262,975
Gain/Loss from Operations	($20,813)	$22,700	$63,612	$104,525

*July 1 – December 31
Ex. A, p. 33; Ex. F, p. 489; Ex. H, p. 496

25. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations adopted by OHCA. (Conn .Gen. Stat. § 19a-639(a)(1))

26. This CON application is consistent with the State Health Care Facilities and Services Plan. (Conn. Gen. Stat. § 19a-639(a)(2))

27. The Applicant has established that there is a clear public need for its proposal. (Conn. Gen. Stat. § 19a-639(a)(3))

28. The Applicant has satisfactorily demonstrated that its proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4))

29. The Applicant has satisfactorily demonstrated that its proposal would improve the accessibility of health care delivery in the region and it has satisfactorily demonstrated a potential improvement in quality and cost effectiveness. (Conn. Gen. Stat. § 19a-639(a)(5))

30. The Applicant has shown that there will be an increase in access to the provision of health care services to the relevant populations and payer mix. (Conn. Gen. Stat. § 19a-639(a)(6))

31. The Applicant has satisfactorily identified the population to be served by its proposal and has satisfactorily demonstrated that this population has a need as proposed. (Conn. Gen. Stat. § 19a-639(a)(7))

32. The Applicant's historical provision of treatment in the proposed service area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))

33. The Applicant has satisfactorily demonstrated that the proposal will not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9))

Discussion

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in § 19a-639(a) of the Statutes. The Applicant bears the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013).*

The Applicant proposes to establish RSCT, an outpatient treatment facility providing IOP treatment to adults diagnosed with substance abuse and mental health disorders in Madison, CT. In support of its proposal, the Applicant cites data and reports reflecting a sharp increase in opioid addiction throughout Connecticut in the past three years. It is estimated that approximately 17,458 adults residing within the Applicant's service area were classified as drug or alcohol dependent in the past year. The data further indicates that 16,000 adults in the Applicant's service area are currently in need of substance abuse treatment but are not receiving it. *FF1; FF10-13*

There are only two IOP treatment facilities within a 15-mile radius of Madison; neither facility exclusively treats adults. The inception of the Applicant's IOP program will improve access to treatment not only because its target population is individuals ages 18 and older, but also because it will be the first to offer IOP programs to residents in Madison and the surrounding community. The Applicant states that the implementation of core therapeutic components and clinical strategies will benefit potential clients by lowering the cost of treatment, and improving outcomes such as reduced substance use, improved psychiatric symptoms and functioning, decreased hospitalization, increased housing stability and fewer arrests. *FF5; FF14-17*

In addition to self-referrals, the Applicant will accept clients from residential facilities, group practices, and state and privately funded professional organizations. The Applicant states that its proposal will not reduce or change access to services for Medicaid recipients or indigent persons. Conversely, the Applicant projects that at least 32% of its payer mix will consist of clients covered by Medicaid or Medicare in FY's 2018, 2019 and 2020. Moreover, the Applicant plans to provide services to indigent individuals using a sliding fee or discounted rate.

In order to ensure that access to care will improve for the population currently being served, including the Medicaid population, and that the proposal is consistent with the Statewide Health Care Facilities and Services Plan, OHCA requires that the Applicant agree to take certain actions as stated in the order attached hereto. *FF18; FF20; FF22*

Order

NOW, THEREFORE, the Department of Public Health, Office of Health Care Access ("OHCA") and Recovery Services of Connecticut, LLC ("Recovery Services" or "Applicant"), through their authorized representatives, hereby stipulate and agree to the following terms of settlement with respect to the Applicant's request to establish a facility for the care or treatment of substance abusive or dependent persons in Madison, CT:

1. Recovery Services shall provide notification to OHCA of the date of commencement of operations and shall provide a copy of the facility license(s) it has obtained. Such notification shall be provided within thirty (30) days of start of operations.

2. Upon execution of this Agreement, the Applicant shall immediately apply to the Connecticut Department of Social Services and be approved as a Medicaid provider and make all efforts to comply with the requirements of participation. The Applicant shall provide documentation to OHCA evidencing approval of its enrollment application. Such documentation shall be filed within thirty (30) days of approval as a Connecticut Medicaid provider.

3. OHCA and Recovery Services agree that this settlement represents a final agreement between OHCA and Recovery Services with respect to OHCA Docket No. 17-32160-CON. The execution of this agreed settlement resolves all objections, claims and disputes, which may have been raised by Recovery Services with regard to OHCA Docket Number 17-32160-CON.

4. OHCA may enforce this settlement under the provisions of Conn. Gen. Stat. §§ 19a-642; 19a-653 and all other remedies available at law, with all fees and costs of such enforcement to be paid by the Applicant.

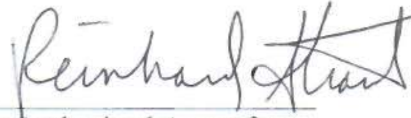
5. This settlement shall be binding upon Recovery Services and its successors and assigns.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

9/1/2017
Date

Yvonne T. Addo, MBA
Deputy Commissioner



9/1/17
Date

Duly Authorized Agent for
Recovery Services of Connecticut, LLC

Olejarz, Barbara

From:	Olejarz, Barbara
Sent:	Tuesday, September 05, 2017 8:31 AM
To:	'jayseigel@gmail.com'; 'Reinhardwstraub@gmail.com'
Subject:	Agreed Settlement
Attachments:	17-32160SignedCONAgreedSettlement.pdf

Tracking:

Recipient	Delivery
'jayseigel@gmail.com'	
'Reinhardwstraub@gmail.com'	
User, OHCA	Delivered: 9/5/2017 8:31 AM
Foreman, Rebecca	Delivered: 9/5/2017 8:31 AM
Jensen, Dana	Delivered: 9/5/2017 8:31 AM
Bruno, Anthony M.	Delivered: 9/5/2017 8:31 AM
Johnson, Colleen M	
'daniels@chime.org'	
Bauer, Sandra	Delivered: 9/5/2017 8:31 AM
Colleen.Johnson@ct.gov	Delivered: 9/5/2017 8:31 AM

9/5/17

Please see attached Agreed Settlement for Recovery Services of Connecticut, LLC, Docket Number: 17-32160-CON.

Barbara K. Olejarz
Administrative Assistant to Kimberly Martone
Office of Health Care Access
Department of Public Health
Phone: (860) 418-7005
Email: Barbara.Olejarz@ct.gov

Olejarz, Barbara

From: Microsoft Outlook
To: jayseigel@gmail.com; Reinhardwstraub@gmail.com
Sent: Tuesday, September 05, 2017 8:31 AM
Subject: Relayed: Agreed Settlement

Delivery to these recipients or groups is complete, but no delivery notification was sent by the destination server:

jayseigel@gmail.com (jayseigel@gmail.com)

Reinhardwstraub@gmail.com (Reinhardwstraub@gmail.com)

Subject: Agreed Settlement

User, OHCA

From: Clarke, Ormand
Sent: Thursday, March 15, 2018 3:26 PM
To: jayseigel@gmail.com; Reinhardwstraub@gmail.com
Cc: User, OHCA
Subject: Re: CON Application: Docket Number: 17-32160-CON.

Mr. Jay Seigel, APRN
Mr. Reinhard Straub, LCSW
Recovery Services of Connecticut, LLC.
jayseigel@gmail.com
Reinhardwstraub@gmail.com

Dear Messrs. Seigel and Straub:

Re: CON Application: Docket Number: 17-32160-CON.

On September 1, 2017, the Office of Health Care Access ("OHCA") issued a Certificate of Need ("CON") to Recovery Services of Connecticut, LLC under Docket Number: 17-32160-CON to establish a facility for the care or treatment of substance abusive or dependent persons in Madison, Connecticut.

According to Conditions 1 and 2, respectively, of the above captioned order:

1. *"Recovery Services shall provide notification to OHCA of the date of commencement of operations and shall provide a copy of the facility license(s) it has obtained. Such notification shall be provided within thirty (30) days of start of operations*."

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The records show that the Applicant commenced execution of the Agreement on January 11, 2018; however, OHCA has not yet received items (a) and (b), listed below:

(a) Date of commencement of operation, and
(b) Evidence of application to the Connecticut Department of Social Services for approval as a Medicaid provider and documentation evidencing approval of enrollment application.

It is requested that the Applicant respond to this email by providing the missing information and explaining the steps taken to meet the above stated obligations in terms of the Agreement by Thursday, March 29, 2018.
It is also requested that any response submitted to OHCA in relation to this Agreement be delivered to the general inbox at OHCA@ct.gov to form a part of the public record.
Please do not hesitate to contact me if there are any questions.

Respectfully,

Ormand Clarke

Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7047 / F: (860) 418-7053 / E: ormand.clarke@ct.gov

User, OHCA

From: Clarke, Ormand
Sent: Friday, March 16, 2018 7:39 AM
To: User, OHCA
Subject: FW: CON Application: Docket Number: 17-32160-CON.

From: Reinhard Straub [mailto:reinhardwstraub@gmail.com]
Sent: Thursday, March 15, 2018 3:56 PM
To: Clarke, Ormand <Ormand.Clarke@ct.gov>
Subject: Re: CON Application: Docket Number: 17-32160-CON.

Dear Mr. Clarke

I will have this back to you formally first on Monday? We opened on 1/29/18 and contracted with Husky last week.
We apologize for the oversight.

Thank you in advance for your understanding.

sincerely

Reinhard

Reinhard W Straub, LICSW
Offices:
Recovery Services of Connecticut
71 Bradley Road, Suite 6
Madison, CT 06443
24 Channing Street
New London, CT 06320
33 College Hill Road, Building 31C
Warwick, RI 02886
Main 203.421.6242
Cell 401.741.5109
Fax 203.421.6808
reinhardwstraub@gmail.com
www.reinhardwstraub.com

On Thu, Mar 15, 2018 at 3:26 PM, Clarke, Ormand <Ormand.Clarke@ct.gov> wrote:

> Mr. Jay Seigel, APRN
>
> Mr. Reinhard Straub, LCSW
>
> Recovery Services of Connecticut, LLC.

jayseigel@gmail.com

Reinhardwstraub@gmail.com

Dear Messrs. Seigel and Straub:

Re: CON Application: Docket Number: 17-32160-CON.

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Please do not hesitate to contact me if there are any questions.

Respectfully,

Ormand Clarke

Health Care Analyst

Office of Health Care Access

Connecticut Department of Public Health

410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308

P: (860) 418-7047 / F: (860) 418-7053 / E: ormand.clarke@ct.gov

User, OHCA

From: Reinhard Straub <reinhardwstraub@gmail.com>
Sent: Friday, March 16, 2018 4:44 PM
To: Clarke, Ormand; User, OHCA; Jay APRN
Subject: Re: CON Application: Docket Number: 17-32160-CON.
Attachments: RSCTFacilityLicense2018.pdf; HuskyConfirmation.pdf

Dear Mr. Ormand:

Re: CON Application: Docket Number: 17-32160-CON

Attached please find a copy of the Initial Outpatient Substance Abuse CT Facility License # 0560 dated January 11, 2018 for Recovery Services of Connecticut LLC located at: 71 Bradley Road Suite 6 Madison, CT 06443 as well as proof of approval for participation with the CT Medical Assistance Program dated and effective as of 1/1/18.

We are pleased to be able to provide much needed Substance Abuse Services to the residents of Connecticut.

Please do not hesitate to contact me if I can be of service.

Sincerely,

Reinhard Straub, Executive Director

Recovery Services of Connecticut
71 Bradley Road, Suite 6
Madison, CT 06443
Main 203.421.6242
Fax 203.421.6808
reinhardwstraub@gmail.com

On Thu, Mar 15, 2018 at 3:26 PM, Clarke, Ormand <Ormand.Clarke@ct.gov> wrote:

> Mr. Jay Seigel, APRN
>
> Mr. Reinhard Straub, LCSW
>
> Recovery Services of Connecticut, LLC.
>
> jayseigel@gmail.com
>
> Reinhardwstraub@gmail.com
>
> Dear Messrs. Seigel and Straub:

Re: CON Application: Docket Number: 17-32160-CON.

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Please do not hesitate to contact me if there are any questions.

Respectfully,

Ormand Clarke

Health Care Analyst

Office of Health Care Access

Connecticut Department of Public Health

410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308

P: (860) 418-7047 / F: (860) 418-7053 / E: ormand.clarke@ct.gov

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0560

Facility for the Care or Treatment of Substance Abusive or Dependent Persons

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Recovery Services of Connecticut LLC of Madison, CT d/b/a Recovery Services of Connecticut LLC is hereby licensed to maintain and operate a private freestanding Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

Recovery Services of Connecticut LLC is located at 71 Bradley Rd, Suite 6, Madison, CT 06443 with:

Reinhard Straub as Executive Director.

The service classification(s) and if applicable, the residential capacities are as follows:

Outpatient Treatment

This license expires **December 31, 2019** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 11, 2018. **INITIAL**

Raul Pino, MD, MPH
Commissioner

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03/01/2018

RECOVERY SERVICES OF CONNECTICUT, LLC
71 BRADLEY ROAD
STE 6
STONINGTON, CT 06443-2662

Dear RECOVERY SERVICES OF CONNECTICUT, LLC:

We are pleased to advise you that in accordance with the Department of Social Services' policy, your application for enrollment in the Connecticut Medical Assistance Program has been approved:

NPI/Non-medical Provider Identifier:	NPI 1578076360	
Program Participation/Effective Date:	Alcohol Treatment	01/01/2018
AVRS/Initial Web User ID*:	008078013	
Re-enrollment Due Date:	03/01/2020	

Based on the information provided on the enrollment application, you are enrolled with the following provider type, specialty, and primary taxonomy, as well as any additional taxonomies you provided. Please notify us in writing on office letterhead should any of these taxonomies change. Billing providers are required to submit claims for reimbursement using your National Provider Identifier (NPI) and taxonomy. If the billing provider is an atypical provider who does not have an NPI, claims must be submitted with the non-medical provider identifier. Claims may be submitted for dates of service on or after the effective date indicated above.

Type Description	**Specialty Description**	
Drug and Alcohol Abuse Center	Acute Care - Outpatient	
Primary Taxonomy	261QR0405X	Clinic/Center - Rehabilitation, Substance Use Disorder

Provider Agreement

If you are a billing provider or a performing provider within an organization, the effective date of your Provider Enrollment Agreement is 03/01/2018, and the Provider Enrollment Agreement shall thereafter be in effect until 03/01/2020, unless terminated by either DSS or the Provider prior to the stated ending date. As stated in the Provider Enrollment Agreement, this approval letter containing your enrollment period is incorporated into and made part of your Provider Enrollment Agreement. Please note that you will be required to successfully re-enroll by the re-enrollment due date provided above, which reflects the end date of this application/agreement. You must allow at least 30 days for processing by both DSS and DXC. If your applications is not finalized by your reenrollment due date, you will be dis-enrolled. A letter will be sent six (6) months in advance notifying you when you are due for re-enrollment. Nursing Home and

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Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) providers will receive their notice eight (8) months in advance of their re-enrollment due date.

Next Steps for Billing Providers

Now that you are successfully enrolled, you must:

1. **Review Provider Manuals** - Provider manuals explaining Connecticut Medical Assistance Program policy, claim billing procedures, and electronic data interchange options for such things as eligibility verification and access to electronic remittance advices should be reviewed by all providers. These provider manuals are available at www.ctdssmap.com by choosing Information > Publications.
2. **Associate Members to Your Organization** - In order to avoid future claim denials, organizations (such as provider groups, clinics, hospital outpatient clinics, and FQHC providers) must also ensure that each performing provider is both enrolled in the Connecticut Medical Assistance Program as an individual and associated to the organization.
   a. If the member is not already enrolled, he/she must utilize the online Web portal enrollment Wizard available at www.ctdssmap.com to do so.
   b. If the member was previously enrolled but is not currently active, the member must contact the Provider Assistance Center at the number listed below to request an application tracking number and then will use that to re-enroll at www.ctdssmap.com.
   c. If the member is already enrolled but simply needs to be associated to your organization, you must do so on the Secure Web portal via Demographic Maintenance.
   d. If the provider is enrolled only as an ordering/prescribing/referring provider, the provider must complete a full enrollment application at www.ctdssmap.com before they can be associated as a member of your organization.

Next Steps for All Providers

1. **Register for Email Notifications** - In order to receive updated Connecticut Medical Assistance Program information, it is critical that providers as well as any of your office staff that need to receive program information, register their email address(es) via the Email Subscription service. (Please note that you may have been auto subscribed, but providers have the option to modify the subscription at any time.) There is no limit to the number of email address subscriptions entered by a provider. Program information is **not** mailed to providers in paper format. To register for email notifications or modify an existing subscription, you must:
   - Access the www.ctdssmap.com Web site
   - Choose Provider > E-Mail Subscription from the drop-down menu
   - Once on the E-Mail Subscriptions page, enter the email address you wish to subscribe. (If you have been auto-subscribed, you will receive a message that the email address already exists. In this case, you may modify the existing subscription by entering your email address in the Existing Subscriber field.)
   - New subscribers will be required to re-enter the email address for verification.

- From the right hand side of the page, use the checkboxes to choose the type of notification you would like to receive.
- Once complete, click Save.

2. **Set up Secure Web Portal Account** - Billing providers will receive a separate letter with a Personal Identification Number (PIN) which will allow you access to the Connecticut Medical Assistance Program's secure provider Web portal. If you are an Advanced Practice Registered Nurse, Dentist, Physician, Certified Nurse Midwife, Resident, Physician Assistant, Podiatrist, or Optometrist performing provider, you will also receive a separate letter with a Personal Identification Number (PIN) which will allow you to access the Connecticut Medical Assistance Program's secure provider Web portal. You must log in to the Secure Web portal when you receive this PIN to set up your account.

3. **Complete Attestation for Enhanced Payment, if applicable** - In accordance with the Connecticut General Assembly's appropriated funding for primary care increased payments, referred to as the HUSKY Health Primary Care Increased Payments Policy, certain primary care providers are eligible to receive increased Medicaid payments for primary care services provided to Medicaid eligible individuals. To determine if you are eligible to receive these enhanced payments, please visit www.ctdssmap.com and access the Important Message titled "HUSKY Health Primary Care Increased Payments Policy". Providers may also refer to PB 2014-75 on the www.ctdssmap.com Web site, located by choosing "Information" from the Home page and then "Publications" and entering the appropriate year and bulletin number in the Bulletin Search panel. Physicians and mid-level/non-physician practitioners MUST REQUEST the enhanced reimbursement by self-attesting that they are an eligible provider through the Connecticut Self-Attestation survey available via:

   https://www.surveymonkey.com/r/HUSKYHealthpcattest

4. **Maintain Provider Data on an Ongoing Basis** - On an ongoing basis, it is the provider's responsibility to maintain and ensure that the data submitted during enrollment remains current. Please review the address you have identified as the ENTROLLMENT address in your application. All enrollment mailings are sent to that address, for example, the re-enrollment due notice, requests for additional information letters, etc. Billing providers and some performing providers (i.e., Advanced Practice Registered Nurses, Dentists, Physicians, Certified Nurse Midwifes, Residents, Physician Assistants, Podiatrists, or Optometrists) may update much of their demographic information via the Secure Web portal at www.ctdssmap.com. All other performing providers must submit requests to update their information, including address changes, to DXC Technology's Provider Enrollment Unit, at P.O. Box 5007, Hartford, CT 06102-5007.

Next Steps for Acquired Brain Injury (ABI), Connecticut Home Care Program for Elders (CHC), or Personal Care Assistance (PCA) Waiver and Home Health Agency Providers

Electronic Visit Verification (EVV) is mandatory for all providers who provide EVV Mandated

03-06-'18 10:37 FROM- T-101 P0003/0006 F-178

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services to clients with Acquired Brain Injury (ABI), Connecticut Home Program for Elders (CHC), or Personal Care Services (PCA) waivers and Home Health Agencies. If your agency is not sure if the services they provide are mandated for EVV use, please contact the EVV mailbox at ctevv@dxc.com. To obtain your next steps, including mandatory training, interface documents and instructions to obtain your Santrax system, please send an email to the EVV mailbox at ctevv@dxc.com.

Residents Only

If you are currently enrolled as a resident and you become fully licensed through the Department of Public Health prior to the time you are due to re-enroll, you must enroll in the Connecticut Medical Assistance Program as a fully-licensed provider. To enroll, please choose the Provider Enrollment option via the www.ctdssmap.com Web site. You will be asked to supply all relevant provider information, including your DPH license number. Upon enrollment under your licensed specialty, you will receive a new AVRS ID.

Contact Information

Connecticut's Department of Social Services also contracts with three Administrative Service Organizations (ASO). Depending on your type and specialty, you may need to contact one of the ASOs to assist with the day-to-day business of servicing our clients. Contact information for the ASOs can be found in Chapter 1 of the Provider Manual.

If you have any questions regarding your participation in the Connecticut Medical Assistance Program, please direct them to DXC Technology's Provider Assistance Center at the telephone number listed below.

We hope this information has been helpful to you. Please contact us if you need further assistance.

Sincerely,

Provider Assistance Center
1-800-842-8440

DXC.technology

03/01/2018

RECOVERY SERVICES OF CONNECTICUT, LLC
71 BRADLEY ROAD
STE 6
STONINGTON, CT 06443-2662

NPI/Non-medical Provider Identifier: 15******
AVRS ID: 00******13
(for security purposes, only the first two and last two digits of your NPI/Non-medical Provider Identifier and AVRS ID are shown)

(Please note the following taxonomy information only applies to providers that have been approved to bill with an NPI.)

Type Description	Specialty Description	Taxonomy	Description
Drug and Alcohol Abuse Center	Acute Care - Outpatient	261QR0405X	Clinic/Center - Rehabilitation, Substance Use Disorder

RE: Your Personal Identification Numbers (PINs) for accessing the Connecticut Medical Assistance Program's Secure Web Site and the Automated Voice Response System (AVRS)

Dear Provider:

As an approved provider, you have been assigned two Personal Identification Numbers that will be used to access your Connecticut Medical Assistance Program information via the Secure Web site and the Automated Voice Response System. The Secure Web site and the AVRS allow actively enrolled providers access to client eligibility verification. The Secure Web site allows all providers access to claim submission/adjustment/inquiry, as well as the capability to download a pdf copy of their Remittance Advice (RA) via the Secure Web site. The PINs are as follows:

1. PIN # DUBMirL99 (case sensitive) This PIN, along with the AVRS/Initial Web User ID (previously sent to you*), is for accessing the Secure Web site. The site is available at www.ctdssmap.com under Provider-> Secure Site. The instructions included with this letter will guide you through the process of establishing your User Account and setting up additional Clerk Accounts. Additional information regarding this PIN and use of the Secure Web site can be found at www.ctdssmap.com under Information -> Publications -> Provider Manuals -> Chapter 10, Web Portal and AVRS.

03-06-'18 10:37 FROM- T-101 P0005/0006 F-178

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2. PIN # 2312 This PIN, along with the AVRS ID (previously sent to you), is for accessing the AVRS. Additional information regarding this PIN and use of the AVRS can be found on our Web site, www.ctdssmap.com under Information -> Publications -> Provider Manuals -> Chapter 4, Eligibility and Chapter 10, Web Portal and AVRS.

It is recommended that you store your PINs in a safe place since they will be needed to access confidential information. Please note that these PIN codes were issued to you because only you and the Clerk Accounts that you create are permitted to utilize the system and data for your NPI/Non-medical Provider Identifier.

Important steps to set up a new Secure Web Portal User Account:

1. Log on to www.ctdssmap.com
2. Click on the Provider tab, then Secure Site
3. Click on setup account
4. Enter your AVRS/Initial Web User ID* in the field titled "Initial Web User ID"
5. Enter your Web PIN (provided above) in the field titled "Personal Identification Number"
6. Click setup account
7. Enter all required fields to complete the account set up

*Please note that your Initial Web User ID can be found on the Welcome Letter you received when you successfully enrolled in the Connecticut Medical Assistance Program. If you need assistance in locating this ID, please contact the Provider Assistance Center at the number below.

Important steps to set up a new Secure Web Portal Clerk Account:

1. Once your User Account has been established, sign on to the Secure Site using your new User ID and Password
2. Click on the Clerk Maintenance link under Account
3. Click on the Add Clerk button
4. Enter all required fields to complete the Clerk Account set up

The relationship between you and the Department of Social Services established by your current Provider Agreement allows you to use these electronic systems. All Connecticut Medical Assistance Program data accessed over the Internet and the AVRS should be treated with the same proper control and care as other information received from the agency.

Please note that, if not accessed within a 90 day time period, a Secure Web portal account will become inactive. You are encouraged to access your Secure Web portal account frequently. If your Secure Web portal account does become inactive, you must contact the Provider Assistance Center at the number below to reactivate your account.

We value your contribution to the Connecticut Medical Assistance Program and hope that you find these tools beneficial to your daily business operations. Please contact us if you need further assistance.

Sincerely,

Provider Assistance Center
1-800-842-8440