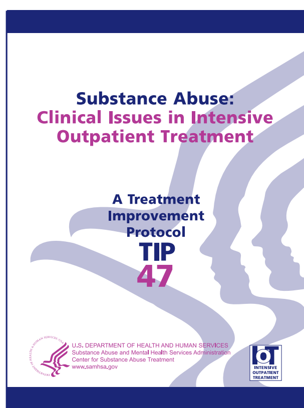
Knowledge Application Program

KAP Keys

For Clinicians

Based on TIP 47

Substance Abuse: Clinical Issues in Intensive Outpatient Treatment



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

Introduction

KAP Keys were developed to accompany the Treatment Improvement Protocol (TIP) Series published by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA). These KAP Keys are based entirely on TIP 47 and are designed to meet the needs of the busy clinician for concise, easily accessible "how to" information.

For more information on the topics in these KAP Keys, readers are referred to TIP 47.

Other Treatment Improvement Protocols (TIPs) that are relevant to these KAP Keys:

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

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

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

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

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

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

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

Typical Sequence of Topics Addressed in Psychoeducational Groups

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

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 effects 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 on back

Typical Sequence of Topics Addressed in Psychoeducational Groups

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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

See TIP 47, pages 32–34.

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.

See TIP 47, pages 38–40.

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.

See TIP 47, pages 56–57.

- 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.

See TIP 47, pages 61–63.

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

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

See TIP 47, pages 65–66.

Mild Withdrawal Symptoms for Four Drug Classes That Can Be Managed in Partial Hospitalization or Day Treatment Detoxification (Level II.5)

Alcohol	Mild withdrawal without need for treatment with sedative-hypnotics; no hyperdynamic state; Clinical Institute Withdrawal Assessment-Alcohol, Revised (CIWA-Ar) score of 8; no significant history of morning drinking.
Sedative-hypnotics	Mild withdrawal with history of almost daily sedative-hypnotic use; no hyper-dynamic 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, D., Shulman, G. D., Callahan, J. F., Fishman, M., Gastfriend D., Hartman, R., & Hunsicker, R. J. (Eds.). (2001). *Patient Placement Criteria for the Treatment of Substance-Related Disorders: Second Edition-Revised* (PPC-2R). Chevy Chase, MD: American Society of Addiction Medicine.

See TIP 47, pages 70–72.

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). *The Matrix Model of Outpatient Chemical Dependency Treatment: Family Education Guidelines and Handouts*. Los Angeles: The Matrix Center.

See TIP 47, pages 98–106.

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?

See TIP 47, pages 117–119.

Urine Toxicology Detection Periods for Different Substances

Substance	Typical Urine Detection Period
Amphetamines or methamphetamines	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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See TIP 47, pages 237–245.

Effectiveness of Drug Detection Methods That Use Different Biological Products

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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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See TIP 47, pages 237–245.

Ordering Information

TIP 47

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Three Ways to Obtain Free Copies of All TIP Products

1. Call SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at **800-729-6686**, TDD (hearing impaired) **800-487-4889**.
2. Visit NCADI's Web site at **www.ncadi.samhsa.gov**.
3. Access TIPs online at **www.kap.samhsa.gov**.

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