BEST PRACTICE STANDARDS IN THE TREATMENT OF SUBSTANCE ABUSE DISORDERS

1. OVERVIEW, DESCRIPTION, AND RATIONALE

1.1 **General Description**

A review of the research and literature relating to most effective elements and dynamics of a successful treatment program was conducted to determine what is considered best practices in the treatment of substance abuse disorders. The current research-based best practices tend to merge the biopsychosocial theoretical perspective of addictive disorders. This includes supportive counseling, motivating client readiness for change and coping skills-training techniques. The goals of treatment are to establish and maintain abstinence from the illicit use of all psychoactive drugs, foster development of (nonchemical) coping and problem-solving skills to stop and ultimately eliminate impulses to "self-medicate" with psychoactive drugs, and to enhance and sustain client motivation for change. The approach is based on 12- Step facilitation therapy, cognitive-behavioral, motivational, and insight-oriented techniques according to each client's individual needs. These best practices counseling standards can be applied in any level of care and throughout the continuum of addictions treatment.

The therapeutic approach is empathic, client centered, and flexible. Strong emphasis is placed on developing a good working alliance with the client to facilitate behavioral change. With clients who are referred from Criminal or Dependency Courts, the counselor takes advantage of the leverage from this referral to help motivate the client to participate in a treatment/recovery process.

The counselor attempts to work with and through rather than against a client's resistance to change. Aggressive confrontation of denial, the hallmark of traditional addiction counseling, is seen as counterproductive and antithetical to this approach.

Group and individual counseling are delivered within the context of a flexible treatment program that also includes psych-education (PE), pharmacotherapy for coexisting psychiatric disorders and where indicated, urine testing and alcohol breathalyzer tests to encourage and verify abstinence. Client participation in self-help is encouraged but not mandated.

1.2 **Treatment Goals**

The broad goals of treatment are reduction of drug/alcohol use and/or abstinence. In order to attain these goals, clients need to: recognize their problem, understand the effect of drugs/alcohol on their lives and the implications for recovery, and learn to successfully apply effective coping and relapse prevention skills.

1.3 **Theoretical Rationale/Mechanism of Action**

Psychoactive drug addiction is viewed as a multidetermined addictive behavior and maladaptive (self-medication) coping style with biological, psychological, and social components (a biopsychosocial perspective).

Accordingly, treatment must provide the structure, support, and feedback required to break the behavioral cycle of compulsive psychoactive drug use and provide opportunities to learn adaptive (nonchemical) problem solving skills to prevent relapse.

1.4 **Agent of Change**

Best practice standards promotes the development of a strong therapeutic alliance between client and counselor along with positive bonding among clients within a group. Caseload size may vary according to the given needs of each program.

1.5 **Conception of Drug Abuse/Addiction - Causative Factors**

According to the American Society on Addiction Medicine (ASAM) drug addiction is seen, and clinically treated as a chronic disease that is progressive, relapsing, incurable and potentially fatal with genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is set into motion by experimentation with a drug by a susceptible host in an environment conducive to drug misuse. The susceptible user quickly experiences a compulsion to use and will continue to use despite adverse physical, emotional or life consequences.

2. CONTRAST TO OTHER COUNSELING PRACTICES

2.1 **Most Similar Counseling Practices**

This set of best practice principles incorporates features of other methods, including systems approaches described by Duncan (1993), social learning dynamics, motivational counseling techniques described by Miller and Rollnick (1991), relapse prevention (RP) strategies described by Marlatt and Gordon (1985), and psychodynamic techniques described by Tarnoff (1998) and also by Brehm and Khantzian (1992). Participation in self-help programs is actively encouraged and is seen as helpful and highly desirable, but it is not mandatory. Self help groups can provide clients with the benefits of social learning dynamics and can bridge the gap between clinic appointments and counseling sessions.

2.2 **Most Dissimilar Counseling Practices**

The hallmarks of these best practice standards are clinical flexibility and careful attention to individual needs. As such, they contrast sharply with aggressive confrontational approaches commonly found in traditional treatment programs. In addition, the program should conform to the client's needs rather than the client conforming to the program.

3. TREATMENT FORMAT

The American Society of Addiction Medicine (ASAM) Patient Placement Criteria for Substance Related Disorders, Second Edition (PPC-2R), is used as the basis for determining client placement at every stage in the treatment process.

Each client is provided with a comprehensive assessment utilizing the ASAM PPC-2R to determine the most appropriate level of care and to develop a treatment plan. An individualized treatment plan contains concrete and behaviorally measurable short and long term goals. Treatment plans are updated every 3 months at a minimum.

Treatment involves group therapy at a rate determined by the clients need and program capacity and can be supplemented by individual counseling as needed. If the program cannot meet the individual needs of the client, the client is referred to another program that can best meet their needs. Although group therapy is the core treatment modality, those clients who are not "group ready" are given the option of individual counseling.

Many of these clients subsequently agree to enter group therapy once they have formed a positive relationship with their assigned primary counselor and worked through their initial concerns about participating in a group. Some clients are not able to tolerate group as a result of psychiatric and/or interpersonal impairments, and are seen individually.

3.1 **Treatment Approach**

This clinical approach takes into account the biopsychosocial perspective of the client's various needs. Regardless of the type of treatment setting, the biopsychosocial approach recognizes that the client is continuously faced with the pressures and stressors of daily life and has easy access to psychoactive drugs. Treatment should take into account that a driving motivational force for the chemically dependent person is the severity and intensity of drug craving behaviors, the desire to self-medicate the symptoms of drug withdrawal and the compulsive need to change the way they feel. It also recognizes that typical for any treatment setting, the client is always free to drop out of treatment; accordingly, strong emphasis is placed on therapeutic engagement and retention strategies.

3.2 **Duration of Treatment**

A distinguishing feature from the best practices research is the variable-length treatment format. The length of a client's participation in the program from admission through completion can range from several weeks to many years as determined by modality of treatment and the objective measures of clinical progress (i.e., providing clean urines, attending scheduled sessions, developing a sober support network that includes involvement in self-help, and exercising adaptive (nondrug) problem solving skills). For instance, in methadone maintenance treatment, which can last for the client's lifetime, reducing medication dose levels and/or defining a medication/treatment program completion date are not necessarily goals in the client's treatment.

3.3 **Compatibility With Other Treatments**

Operating from a basic philosophy of using whatever best-practice treatment intervention seems to work best, these best practice standards are compatible with a variety of other treatment approaches. For example, there is no anti-medication bias so long as the medications being offered are clinically appropriate and monitored closely if they are mood enhancing (i.e. pain medication, benzodiazepines, OTCs, etc.). Clients with diagnosed psychiatric disorders are treated with psychotropic medication (e.g., antidepressants, antipsychotics) as clinically required.

3.4 **Role of Self-Help Programs**

The program actively encourages but does not mandate the client's participation in self-help groups. All clients are given a basic orientation to self-help and what it has to offer that professional treatment does not. They are also given a list of meetings in their community. Clients are not threatened with termination from treatment for failure to attend self-help meetings, nor is their reluctance or refusal to attend self-help meetings seen as intractable resistance or denial.

4. CLINICAL DECISIONS

All clinical decisions, i.e. assessment, level of care placement and treatment, continued services, transfers, and discharge plans are based on an evaluation of the client using the six ASAM PPC assessment dimensions and the client's stage of change.

4.1 **Continued Service**

Clients are continually assessed during the course of treatment. During the assessment process, problems and priorities are identified which justify admission and continued treatment. The resolution of those problems and priorities determines when a client may be ready for discharge. The appearance of new problems and priorities may require continued service either at the current level of service or at a more or less intensive level of service. The six ASAM PPC assessment dimensions are reviewed to assess the clients progress and to determine the need for continued, more or less intensive services.

4.2 Client Transfers

Throughout a treatment episode clients may be transferred from one level of care to another as their treatment needs change. Providers: (a) continually assess a client's treatment needs and treatment progress to determine when the client should be transferred to another level of care, (b) arrange the client's transfer, and (c) collaborate with staff at the next Provider site in order to facilitate a smooth transition for the client.

4.3 Client Discharge

It is appropriate to discharge the client from the current level of service when the client has achieved the goals articulated in the individualized treatment plan, thus resolving the problem(s) that justified admission to the current level of service. Each of the six ASAM PPC assessment dimensions is reviewed to assess the progress related to the problem(s) that justified admission. When these have been resolved and there are no new problems to address at the current level of service, the client is considered for discharge.

5. COUNSELOR CHARACTERISTICS AND TRAINING

5.1 **Educational Requirements**

Psychologists have master's degrees or doctorates. Services they provide include:

- Assessment and diagnosis
- Drug and alcohol counseling including relapse prevention education and planning
- Crisis intervention
- Psychological testing and evaluation (doctoral level)
- Psychotherapy, including family therapy, for clients with dual diagnoses and with complicated psychiatric conditions
- Pre- and posttest HIV counseling
- Skills training, including vocational skills, parenting skills, and life skills
- Supervision of other staff who provide these services
- Consultation to program staff about behavioral therapy strategies
- Research and development

Marriage/Family Therapists and Clinical Social Workers typically have master's degrees, may be licensed and have training in a wide range of useful skills. Depending on their background and training, they can provide a similar range of services as described above.

Addiction Specialists and Drug Counselors
Most chemical dependency treatment programs hire persons with bachelor's degrees or less formal education to serve as addiction specialists or rehabilitation counselors (RC). Many have no training in a specific discipline but have an interest in treating addicted individuals. Many have learned drug-counseling techniques through their work experience in drug treatment programs or through their own recovery experiences. Generally, they provide services such as:

- Assessments
- Address addiction issues and concrete problems via individual and group counseling
- Drug and alcohol counseling including relapse prevention education and planning
- Psycheducational groups on addiction and related topics
- Case management and referrals.
- Training in vocational and general life skills
- Crisis intervention

5.2 **Counselor's Recovery Status**

A counselor's recovery status (i.e. they are or they are not in recovery) should not effect hiring decisions. Rather, hiring decisions should be based on demonstrated clinical competence. However, counselors who are in recovery are expected to have a minimum length of sobriety (2 years), which may vary according to the modality.

5.3 **Ideal Personal Characteristics of Counselor**

Ideally, the counselor should be warm, empathetic, engaging, tolerant, nonjudgmental, and flexible in interacting with clients. The counselor should have a well-developed observing ego and be able to receive and use constructive feedback, particularly with regard to the types of countertransference and control problems likely to arise with highly ambivalent (resistant) clients. The counselor must have excellent verbal communication skills and be capable of defining and implementing appropriate behavioral limits with clients in a consistently therapeutic (nonpunitive) manner.

5.4 **Counselor's Behaviors Prescribed**

The counselor's role is to motivate, engage, guide, educate, and retain clients during their treatment episode in the program. Using an array of, client-centered, problem solving and motivational techniques, counselors are expected to:

- Emphasize the client's strengths rather than weaknesses.
- Join rather than assault resistance.
- Avoid aggressive confrontation and power struggles.
- Negotiate rather than dictate treatment goals.
- Emphasize the client's personal responsibility for change.

5.5 **Counselor's Behaviors Proscribed**

The counselor is cautioned against being dogmatic and controlling, especially in response to reluctant and resistant clients. It is easy for the counselor to lose sight of the fact that the first and foremost goal of treatment is to engage the client in a friendly, cooperative, positive interaction that increases the client's willingness to examine and change his or her drug-using behavior. Counselors are taught how to avoid the most common therapeutic blunders and negative countertransferential responses with drug-abusing clients. These blunders include:

- Predicting abject failure and misery if the client does not follow the counselor's advice.
- Telling the client that what he or she really needs is more drug-related negative consequences to acquire the motivation for change.

- Ignoring the client's goals in favor of the counselor's or the program's goals

- Feeling frustrated and angry with clients who do not meet the counselor's expectations.

- Wanting to impose negative consequences on noncompliant clients (e.g., depriving them of further help by "throwing them out of treatment") rather than negotiating a change in a treatment plan based on clarification of the client's ambivalence about change.

5.6 **Counseling Supervision and Training**

The counselor's job is a demanding one, and clinical supervision is required to sharpen clinical skills, ensure consistency in treatment approach, and provide the counselor with emotional support and encouragement. Clinical supervisors use various reports to monitor each counselor's client caseload and work performance. These reports also include data on client treatment plans and updates, progress notes, attendance at sessions, urine test results, and treatment plan goal attainment levels.

Measures of all counselors' work performance should include data on quantity of clinical services provided to clients (i.e., numbers of sessions), responses to positive urine test results and missed sessions, timeliness of follow-up on clients who fail to show up for sessions, and counselors' compliance with chart-noting requirements. Supervisors pay special attention to client treatment response, since progress and retention are key factors in determining treatment success. Supervisors may sit in on counselors' group sessions to directly observe their therapeutic skills in action. In addition to supervisory meetings, best practices recommends at least a twice monthly case conference attended by all counselors for discussing special problems. Clinical supervisors may also want to develop a series of in-service trainings for counselors to augment and/or refresh their skills as clinicians in areas related to the client population.

6. CLIENT-COUNSELOR RELATIONSHIP

6. 1 **What Is the Counselor's Role?**

The counselor serves a multidimensional role as collaborator, teacher, adviser, and change-facilitator. Counseling staff is not expected to function outside the scope of their training. Referring clients for additional therapy or to someone who is trained to deal with certain situations is essential. The counselor must become knowledgeable with the resources available in the community.

6.2 **Who Talks More?**

In general, the client talks more. The counselor does not hesitate to ask questions to elicit the client's participation and involvement in the treatment process.

6.3 **How Directive Is the Counselor?**

The counselor takes an active role, asking questions, offering advice and direction, particularly during the early phases of treatment where immediate behavioral changes are required to establish and maintain abstinence.

6.4 **The Therapeutic Alliance**

One of the most important aspects of the therapeutic alliance (TA) is the development of a cooperative relationship between client and counselor. Building a positive TA requires the counselor to start where the client is (i.e., to accept and work within the client's frame of reference). This stands in marked contrast to traditional approaches, which demand that the client submit to the counselor's (program's) frame of reference as the starting point of treatment. For example, if the client at first minimizes the seriousness of his or her drug use problem or rejects the idea that it is a problem at all, the counselor refrains from accusing the client of being in denial (a tactic likely to heighten rather than reduce the client's defensiveness) and instead asks the client to cooperate in a time-limited experiment (usually involving a trial period of abstinence) to assess the nature and extent of his or her involvement with psychoactive drugs.

Coerced or mandated clients pose the greatest challenge to getting a TA started. Typically, these clients appear for treatment angry, suspicious, mistrustful, and ready to do battle. Building a relationship under these trying circumstances requires a great deal of clinical finesse on the part of the counselor, who makes every effort to:

- Empathize with the client's experience and the fact that no one likes to be told what to do.
- Accept without challenge the client's primary motivation for coming to treatment—to get the coercing agent (e.g., court, employer) "off my [the client's] back."
- Compliment the client for facing the realities of the situation by showing up at the session.
- Offer to help the client solve the problem or problems that led to the current situation.

6.5 **Counselor's Clinical Paperwork**

The clinical counseling staff, whether licensed or unlicensed, has significant record keeping responsibilities. They play a major role in developing the initial treatment plan, monitoring its implementation, explaining the importance of treatment to the client, updating the plan at specified intervals (at least every 3 months from admit date), and making sure the client understands the reasons for modifications or adjustments in treatment. Behavioral health care treatment today relies heavily on documentation of the client's treatment episode. Therefore, good charting practices, time-management skills, multi-tasking and the ability to focus on the charting aspects of the clinic operations is essential.

7. TARGET POPULATIONS

7.1 **Targeted Clinical Populations**

These best practice principles are best suited for clients who meet DSM-IVTR criteria for substance abuse/dependence as a primary condition. Programs admit clients who are actively using alcohol and other drugs and who may also have co-occurring conditions of mental illness or medical problems. Chronically unemployed, dysfunctional clients are sometimes treated in separate groups from clients with substantially higher levels of psychosocial functioning.

While treatment programs are coeducational, a special men's and women's group should be available to explore those specific areas unique to gender. A special *dual-focus* group (separate from the mainstream program) can accommodate the special needs of clients with concurrent psychiatric illness.

7.2 **Clients With Co-occurring Disorders**

All treatment providers should be dual-diagnosis capable and provide services that address the client's co-occurring disorders.

7.3 **Clients With Prescription Medications**

Clients who are taking prescription medications for any physical or mental conditions are provided the same services and benefits as any other client.

7.4 **Pregnant Clients**

Best practices recognizes that pregnant women have special needs and make every effort to engage these clients in treatment where they can receive specialized, coordinated substance abuse treatment and perinatal care.

8. CLINICAL QUALITY ASSURANCES

8.1 **Assessment**

The ASAM PPC-2R assessment covers six key dimensions of:

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional/Behavioral Conditions and Complications
4. Treatment Acceptance/Resistance
5. Relapse/Continued Use Potential
6. Recovery Environment

The clinician gathers pertinent collateral information to complete the assessment where necessary (e.g. psychiatric, medical).

During the subsequent clinical interviews, the counselor continues to assess, clarify and expand on the information provided. Where indicated, the assessment may require one or more additional sessions and may also include a formal psychiatric assessment. Within the first two weeks of admission, the client and counselor develop a treatment plan.

8.2 **Client Data Collection and Review**

Clinical progress is reviewed and measured on a regular basis throughout the client's treatment episode. An office data management system stores and reports clinical information on all clients during the course of their participation in the program. These data include:

- Urine test results.
- Attendance at scheduled sessions.
- Progress toward achieving treatment goals.
- Client satisfaction and attitudes toward the treatment experience.
- Outcome evaluation measures

The data are reviewed on a regular basis to continuously adjust the treatment to improve overall treatment effectiveness.

9. SESSION FORMAT AND CONTENT

9.1 **Format for a Typical Session**

A typical group session begins with each client stating what issue he or she wishes to discuss in that session. Every client is expected to identify at least one issue for discussion at each session. The counselor or group leader may pull together the issues of two or more group members into a theme for that session or, alternatively, may begin the session with a specific topic as part of a revolving sequence.

In general, group sessions are devoted to day-to-day concerns and struggles raised by the clients themselves (with appropriate guidance and framing of the discussion supplied by the counselor); or to a specific informational or skills-training topic where the counselor presents a brief lecture and guides a focused discussion (i.e. environmental triggers and relapse prevention theory). A typical session may also review the clients treatment plan and progress made since the last review.

9.2 **Typical Session Topics or Themes**

The following is a partial list of topics and themes: tips for quitting; finding your motivation to quit; how serious is your problem—taking a closer look; identifying your high-risk situations; coping with your high-risk situations; dealing with cravings and urges; warning signs of relapse; rating your

relapse potential—a realistic assessment; tips for handling slips; managing anger and frustration; finding balance in your life; how to have fun without getting high; defining your personal goals; managing problems in your relationships; building your self-esteem; nutrition and personal health; AIDS and other sexually transmitted diseases—how to avoid them; overview of treatment and recovery; how your family can help without hurting—a look at coaddiction.

9.3 **Session Structure**

The purpose of each session is to improve the client's ability to cope adaptively with the problems of everyday life without reverting to psychoactive drug use and also to enhance the client's motivation for change. To accomplish this task successfully, sessions are neither highly structured nor totally unstructured. The sessions serve more to stimulate discussion than present material in a didactic manner. The group leader takes an active role in helping each group member relate the topic to his or her own personal situation. The goal is to foster emotional and behavioral change rather than merely supply factual information.

9.4 **Strategies for Dealing With Common Clinical Problems**

Lateness, absenteeism and positive UAs are addressed therapeutically as behavioral manifestations of a client's ambivalence about change. The importance of clients arriving at counseling and group sessions on time and attending the program reliably is emphasized, starting with the initial intake interview.

9.5 **Strategies for Dealing with Denial or Treatment Resistance**

Enhancing a client's motivation for change is an essential part of the counselor's role in addiction treatment. Toward that end, it is counterproductive to label a client as being in denial, resistant to change, or poorly motivated. Instead, these issues are framed in terms of a client's natural reluctance, fear, and ambivalence about change. The counselor actively joins the client's reluctance and works collaboratively with the client to overcome obstacles to treatment.

Although best practices avoid the use of confrontational tactics, they do not take a laissez-faire, anything-goes attitude toward the client's progress in treatment. Limit setting and constructive feedback are essential features of the approach used to enhance a client's motivation for change.

9.6 **Counselor's Response to Relapse Behaviors**

A relapse to alcohol and/or other drug use during treatment is viewed and managed as a clinical issue. Every effort is made to retain clients in treatment, providing the level of care that is most appropriate to their changing needs.

Relapsing behaviors are treated as avoidable mistakes and manifestations of ambivalence. The thoughts, feelings, circumstances, and chain of setup behaviors leading up to the relapse are carefully reviewed. The first goal of this debriefing is to help the client recognize and accept the role of personal choice and responsibility in determining drug-using behavior. To decrease the likelihood

of further use, a relapse prevention plan is formulated that incorporates specific decision-making, problem solving, and behavioral avoidance strategies.

9.7 **Counselor's Response To Client Violence**

Violence is defined as a broad range of offensive behavior with varying degrees of severity. Client violence is managed on a case-by-case basis, using a range of standardized consequences.

9.8 **Counselor's Response To Client Sexual Relations At Treatment Facilities**

Sexual relations between consenting adult clients while they are at a treatment site can become an issue for the treatment provider and represents a barrier to recovery for the clients. Treatment providers manage this behavior as a clinical issue.

9.9 **Counselor's Response To Client Homicidality/Suicidality**

A client's threat to harm self or others is addressed in the standard, clinically appropriate manner. All applicable laws related to mandatory reporting will be followed.

9.10 **Clinical Documentation**

Progress notes describe the process of change and movement toward the completion of treatment plan goals. They provide a record that documents the counselor's interventions on the issues and concerns the client presented as well as the client's response toward the type of help that was provided.

Each entry of the progress notes should have some statements within the following 4 areas:

1. Identifies the issue(s) from treatment plan
2. Describes the type of intervention the counselor used
3. Describes any follow-up from previous issues
4. Identifies any new problems (may require a treatment plan update)

10. COMMUNICATION

10.1 **Inter-agency Referral**

Treatment Providers communicate and collaborate with referring agencies about their mutual clients using appropriate consent releases.

11. CONFIDENTIALITY

Treatment providers adhere to all federal and state confidentiality laws and regulations governing client alcohol and substance abuse treatment records.

12. CLIENT RIGHTS

A list of client rights are posted in a public area at each treatment site and clients are informed of their rights during the intake process. All clients have rights, which include, but are not limited to the following:

1. To be accorded dignity in their personal relationships with program staff and other persons.
2. To not be discriminated against on the basis of sex, race, color, creed, religion, or national origin.
3. To be assured of privacy and confidentiality.
4. To be informed of the procedure for protecting confidentiality and for registering complaints, including but not limited to, the name, address, and telephone number of the Client Rights Advocate.
5. To be afforded an appeal of placement, transfer, discharge and Fair Hearing decisions.

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