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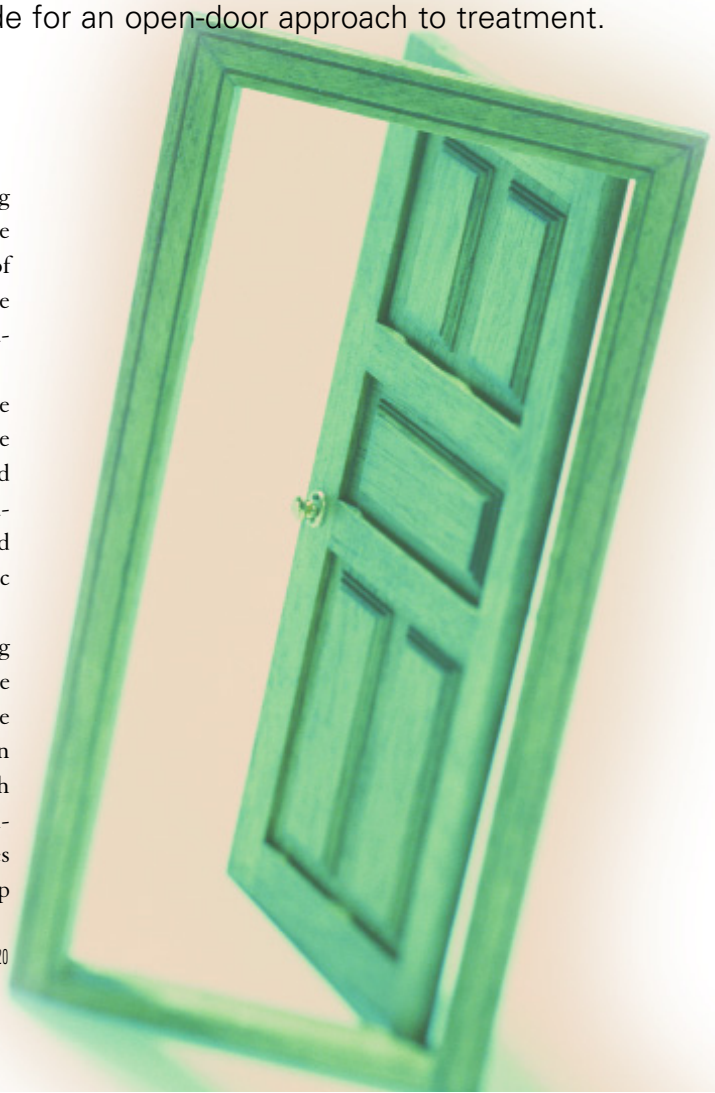
Substance abuse 12 principles to more effective outpatient treatment

Robert F. Forman, PhD
Assistant professor of psychiatry
Treatment Research Institute
University of Pennsylvania, Philadelphia

Charles Dackis, MD
Assistant professor of psychiatry
Chief of Psychiatry,
Presbyterian Medical Center
University of Pennsylvania
Health Systems, Philadelphia

Rick Rawson, PhD
Matrix Center and Institute
Deputy director, UCLA Addiction Medicine Services
University of California, Los Angeles

Addiction is a complex biopsychosocial problem that requires long-term outpatient treatment. Even after extended abstinence, individuals with substance use disorders are vulnerable to relapse. The case is made for an open-door approach to treatment.



Outpatient treatment of substance abuse is changing as research and experience teach us more about the nature of addictive illness and the principles of recovery. The recommended approach now emphasizes ease of access, chronic rather than acute treatment, and collaboration rather than confrontation.

As psychiatrists, we should be familiar with these changes, so that we can offer our addicted patients effective treatment and referrals. In particular, those of us who lead multidisciplinary teams in mental health clinics and outpatient programs need strategies that will help us make sound clinical decisions on detoxification, medical or psychiatric stabilization, and rehabilitation goals.

A new protocol that addresses these needs is being developed by a consensus panel of the Center for Substance Abuse and Treatment (*Box 1*).[1,2] Two of us (RFF, RR) are members of that panel, and we all are recognized experts in the outpatient treatment of addicted individuals, with combined experience of more than 70 years. Based on available evidence and expert opinion, we offer you 12 principles of outpatient substance dependence treatment that can help you achieve the most favorable results (*Table 1*).

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Wanted: Your Pearls

The editors of *Current Psychiatry* value the wisdom that you and other readers have gained in practice.

Please share your pearls with other readers—the clue to a frequently missed diagnosis, the words that calm an angry patient, the adjustment in medication that has made a difference—what has worked for you and might work for your colleagues.

To submit a *Current Psychiatry* Pearl, follow these guidelines:

1. Stick to a single topic, narrowly focused.
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If accepted, we'll send you a check for $75, and enter you in the competition for Best Pearl of the Year (prize to be a surprise)!

Box 1

OUTPATIENT TREATMENT IS GROWING AND CHANGING

Many Americans are seeking outpatient treatment for substance dependence, according to recent federal surveys. In 1999, at least 1 million people were admitted to state-funded outpatient substance abuse treatment programs,[1] and an additional unknown number sought treatment from psychiatrists in private practice. Outpatient treatment, including intensive outpatient care, is the most common form of treatment and is offered at 82% of all addiction treatment facilities.[2]

A federally-sponsored national consensus panel on intensive outpatient treatment of substance abuse is revising the existing Treatment Improvement Protocol (TIP) on Intensive Outpatient Treatment. Dr. Forman is the chair and Dr. Rawson is a member of the consensus panel. The draft TIP is under review and planned for release in 2003 by the Center for Substance Abuse Treatment, a center of the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

1 Principle 1 Open the doors wider

Outpatient clinics were once considered inappropriate for addicted individuals with significant psychosocial problems (such as homelessness) or co-occurring psychiatric disorders. Successful outpatient treatment was thought possible only for high-functioning, employed addicts who were free of significant psychiatric comorbidity.

Today, it is accepted that outpatients with a wide range of biopsychosocial problems can be effectively treated IF they receive case management and housing support and their co-occurring medical and psychiatric conditions are stabilized.

Efforts to ease the addicted patient into treatment should begin the moment a potential patient or family member seeks help. The pleasure that substance abusers derive from drug use makes them typically ambivalent about stopping their compulsive behaviors, and delays or obstacles to admission lead to "no shows" and drop-outs.[3] Admissions increase when patients are given appointments the day they call for help.

From the initial outpatient encounter, the patient should feel like a welcomed participant who is responsible for his or her recovery. Access to outpatient programs increases when:

- child-care assistance is provided as needed;
- hours of operation are designed for the patient's (rather than the staff's) convenience;
- transportation assistance is provided, particularly for adolescents;
- the treatment plan is flexible and individualized to meet each patient's specific needs.

2 Principle 2 Do a comprehensive initial evaluation

The open-door approach is most successful when the psychiatrist performs a comprehensive initial psychiatric and medical evaluation and works closely with a specialized treatment team. The initial medical and psychiatric evaluation is beyond the scope of this article and has been previously reviewed.[4] Determining the need for medical detoxification is a priority during this phase of treatment.

Drug use patterns The treating physician should maintain a high index of suspicion for conditions associated with drug use. Cocaine causes seizures and cardiac arrhythmias, as well as vasoconstriction that leads to tissue necrosis (i.e., myocardial infarction, stroke, spontaneous abortion, and renal failure). Alcohol abuse affects brain, liver, cardiac, and endocrine tissue. Heroin produces acute overdose through respiratory depression, and its IV route of administration increases the risk of AIDS, viral hepatitis, pneumonia, sepsis, and endocarditis.

Function Structured interviews such as the Addiction Severity Index (ASI)[5] can be used to assess functional impairment. Because addicted patients may be reluctant to disclose sensitive personal information, it is important to collect collateral information from family and friends, laboratory tests, and medical records.

Psychiatric concerns Many psychiatric syndromes are caused by substance abuse. Cocaine intoxication is often associated with psychosis (paranoia, auditory and tactile hallucinations), panic anxiety, and aggressiveness, whereas cocaine withdrawal produces depressed mood. Depression is also highly associated with chronic alcohol and opiate dependence. Withdrawal from opioids, alcohol, and sedatives produces anxiety.

Patients with bipolar disorder, major depression, panic anxiety, and schizophrenia who present with co-occurring addiction require coordinated and simultaneous stabilization of their addictive and psychiatric disorders.

Table 1

12 PRINCIPLES OF EFFECTIVE OUTPATIENT ADDICTION TREATMENT

1. Open the doors wider
2. Do a comprehensive initial evaluation
3. Build on existing motivation
4. Forge a therapeutic alliance
5. Make retention a priority
6. Provide ongoing care
7. Match services with treatment needs
8. Monitor abstinence
9. Use 12-step and other community supports
10. Manage medications
11. Educate about addiction and recovery
12. Involve families in treatment

Principle 3 Build on existing motivation

That an addicted patient must "hit bottom" before successful treatment may begin is a common misconception. In truth, studies find similar outcomes in individuals who enter treatment voluntarily and those who are externally pressured or legally coerced.[6] Regardless of patients' motivation when they enter treatment, they are likely to alternate over time between being more *and* less motivated. For this reason, it is necessary to remind them why they sought treatment and to use existing external pressures.

For example, with the patient's consent it would be valuable to maintain contact with a parole officer who mandated a patient's substance-abuse treatment. Likewise, patients entering treatment under threat of divorce should be asked to consent to family contact and should receive family therapy. Families often provide useful clinical information and can exert powerful influence when the patient's motivation wanes. A patient's refusal to allow contact with family (or other important sources of collateral information) often represents resistance that should be explored clinically and addressed.

With open dialogue, resistance to treatment can be reduced with education, peer groups, and family therapy. Motivational enhancement and interviewing work described by Miller, Procaska, and DiClemente[7,8] is designed to reduce treatment resistance in a respectful and clinically effective manner while avoiding confrontation that might provoke dropout and relapse.

Principle 4 Forge a therapeutic alliance

A therapeutic alliance produces positive outcomes in substance-dependent outpatients.[9-11] A recent National Institute on Drug Abuse (NIDA) therapy manual notes that a therapeutic alliance exists when the patient perceives that:

- the clinician accepts and respects him or her;
- the patient's problems can be overcome by working together with the clinician;
- the clinician understands what the patient is hoping to get out of treatment.[12]

Clinicians can help forge this therapeutic alliance by being active listeners, by being empathic and nonjudgmental, and by approaching treatment as an active collaboration.[12]

Principle 5 Make retention a priority

It is simple but true: you cannot treat a patient who has dropped out.

Treatment retention is associated with better outcomes[13,14] and is a key indicator of the performance of an outpatient treatment program. High drop-out rates are demoralizing to patients who remain in treatment and to the clinicians who must document so-called "3-day treatments." Because admission and initial evaluation of patients is labor-intensive, premature attrition is costly and time-consuming. Strategies to increase retention are listed in *Table 2*.

Clinicians can improve retention by tolerating different rates of change and levels of motivation. Individuals adopt

Table 2

STRATEGIES TO RETAIN PATIENTS IN TREATMENT

- Preadmission telephone screening interviews
- Telephone and mailed reminders
- Telephone orientations
- Providing timely appointments

new behaviors at different rates. You might become frustrated when patients do not immediately "buy" a particular version of recovery. Patients, however, often drop out when they feel they are being "force-fed" recommendations for sacrifice and major lifestyle changes that make no sense to them (at least not at the moment).

6 Principle 6 Provide ongoing care

Addiction is a complex biopsychosocial problem that requires long-term treatment. Even after extended abstinence, substance abusers experience craving and are vulnerable to relapse.

Addicts often enter outpatient treatment with psychosocial, medical, and psychiatric problems. Transformation from active addiction to full functioning in society requires sustained and conscientious effort by the patient, support system, and treatment team. Like asthma, diabetes, and other chronic diseases, addiction requires ongoing care.[15]

Unlike other chronic conditions, however, addiction is pleasure-reinforced, and addicted individuals are particularly at risk for relapse. Ongoing care may interrupt a relapse or at least interrupt it sooner than if no ongoing treatment were provided.

Substance dependence treatment for less than 90 days is of little or no use, and treatment lasting significantly longer often is indicated, according to the NIDA.[16] When patients complete an intensive treatment phase, they should be evaluated for readiness to transfer to less-intensive care, with gradual transition from several therapeutic contacts per week, to weekly contact, to semimonthly contact, and so on. The concept of "graduation" should clearly convey not an ending but a "commencement" or beginning, as it does in college.

Unfortunately, the long-term approach to substance dependence is undermined by managed care organizations' insistence on brief treatments. Also, regulations that view addiction as an *acute episode* may require that patient charts be closed at the end of intensive treatment. Such failures to appreciate the chronic nature of addiction undermine access to treatment and service delivery and contribute to recidivism and medical, social, criminal, and economic consequences associated with active addiction.


Robert F. Forman, PhD


Charles Dackis, MD


Rick Rawson, PhD

7 Principle 7 Match services with treatment needs

Outcomes improve when treatment services meet individual needs.[17] Medical, psychiatric, psychosocial, legal, and housing problems can distract patients from the work of therapy. It is important to match each patient's problems and needs with appropriate treatment settings, interventions, and services, according to the NIDA's *Principles of Drug Addiction Treatment*.[16] Creating flexible, responsive programs means more work for the treatment team, but it enhances the quality of care.

Treating concomitant psychiatric illness often requires innovations in outpatient treatment programs. For example, psychiatrists must avoid undermining treatment by inappropriately prescribing addictive agents such as benzodiazepines. At the same time, drug counselors may benefit from education about the potential benefits of medications in treating co-occuring disorders and craving. Coordinated delivery of psychiatric and rehabilitative treatment requires open communication in regularly scheduled multidisciplinary team meetings.

8 Principle 8 Monitor abstinence

Routine urine drug screens, Breathalyzer tests—administered at least weekly—and/or other laboratory tests to confirm self-reported abstinence can improve treatment outcomes. Regular drug and alcohol monitoring provides an objective indicator of progress, serves as a deterrent, and can help motivate the patient to withstand drug urges.

Individuals attempting abstinence from one substance have better outcomes if they abstain from all addictive substances[18] (although tobacco use is controversial and requires further research). Even so, patients often continue to use addictive substances during treatment. Patients struggling with abstinence should not be discharged from treatment programs for manifesting the symptoms for which they are seeking treatment.

Substance-dependent individuals progress at different rates during treatment, and creative strategies to enhance motivation and retention can ultimately produce positive results. Outpatient clinics should consider different treat-

Box 2

ADDICTION RESOURCES ON THE WEB

- Substance Abuse and Mental Health Services Administration and Center for Substance Abuse Treatment www.health.org
- National Institute on Drug Abuse www.nida.nih.gov
- National Institute on Alcohol Abuse and Alcoholism www.niaaa.nih.gov
- Center on Addiction and Substance Abuse www.casacolumbia.org
- Join Together (an organization that advocates community-based efforts to reduce, prevent, and treat substance abuse) www.jointogether.org
- 12-step resources www.onlinerecovery.org and www.healingresource.org

ment tracks for patients at different stages of readiness for recovery.

9 Principle 9 Use 12-step and other community supports

Patients who participate in 12-step programs and treatments have better outcomes than those who do not.[19-21] Still, patients in early recovery may find it difficult to join community-based support groups, such as Alcoholics Anonymous (AA). Patients are often ambivalent about—or strongly opposed to—joining AA because of embarrassment, negative experiences, or inadequate preparation for joining a 12-step fellowship. Substance abusers who are ambivalent about recovery often dispute 12-step directives on total abstinence, sweeping lifestyle changes, and the need to "give up control" over treatment recommendations. Common issues in early recovery include:

- how to select a 12-step home group and a sponsor;
- how to overcome uneasiness associated with being in a 12-step group;
- how to address any discomfort the patient may feel with the religious nature of 12-step meetings.[22]

Patients' resistance to 12-step treatment should be explored and addressed. Sometimes all they need is encouragement and help in finding a sponsor. Those with more difficult concerns may need a different approach. For example, social phobia is common in alcoholics and can be exacerbated by 12-step meetings; symptoms often respond to beta-adrenergic blockade. Patients with schizophrenia and those with paranoid features often do poorly in 12-step treatment if their paranoid symptoms cannot be successfully managed.

Patients who participate in 12-step programs and treatments have better outcomes than those who do not

10 Principle 10 Manage medications

To avoid drug interactions, all prescribers involved with the patient's care should coordinate their medication management efforts. Many substance abusers suffer from co-occurring psychiatric conditions[23] for which psychiatric medications are standard treatment.[24,25] In addition, medical detoxification is often necessary for heroin, alcohol, and sedative/hypnotic-dependent individuals. These treatments, which are beyond the scope of this article, are best integrated with drug rehabilitation.

Various medications for addiction have been reported to improve outcome:

- Agonist treatment with methadone, a long-acting opioid, can reduce heroin use, crime, and the risk of illnesses such as AIDS and viral hepatitis that are associated with IV drug use.
- Buprenorphine, a partial opioid receptor agonist with similar benefits, may soon be approved for the treatment of opiate dependence in outpatient settings.[26]
- Naltrexone, an opioid receptor antagonist, has long been proposed as a treatment for opiate dependence and has been shown to be effective in alcoholism.[27]

No effective pharmacologic treatment is available for cocaine dependence, although this is the focus of extensive government-sponsored research.

11 Principle 11 Educate about addiction and recovery

A wealth of accurate, free information about addiction and recovery is available through Web sites (*Box 2*) and other sources.

Ideally, outpatients in early recovery should be oriented in how to refuse offers of addictive substances, stress management, relapse prevention, information about the biology of addiction, 12-step fellowship integration, and appropriate use of medications.

Principle 12 Involve families in treatment

Treatment outcomes improve when addicts' families are involved in the recovery process.[28,29] Some family members enable addictive behavior by purchasing drugs for their relatives or providing money for this purpose, while other families are knowledgeable about treatment and can be a vital force supporting the recovery process

Treatment can help modify unhealthy behavior patterns that some families develop to compensate for a substance abuser's actions. Because substance use disorders often run in families, try to assess not only the identified patient but also others in the patient's life.

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Related resources

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DISCLOSURE

The authors report no financial relationship with any company whose products are mentioned in this article.

Bottom Line

Twelve treatment principles improve results by emphasizing ease of access, chronic rather than acute treatment, and collaboration with the patient rather than confrontation.

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