

PRACTICE GUIDELINES
FOR THE
TREATMENT OF CLIENTS WITH SUBSTANCE USE
DISORDERS, ALCOHOL, COCAINE, OPIOIDS,
AND OTHER DRUGS

Practice Guidelines For the Treatment of Clients with Substance Use Disorders Alcohol, Cocaine, Opioids, and Other Drugs

I. Disease Definition, Epidemiology, and Natural History

By any measure, substance use disorders constitute a major public health problem, costing our society in excess of \$300 billion annually, including the costs of treatment, related health problems, absenteeism, lost productivity, drug-related crime and incarceration, and efforts in education and prevention (1)

The motivation for using any psychoactive substance is, in part, related to the acute and chronic effects of these agents on mood, cognition, and behavior. In some individuals the subjective changes (e.g., euphoria, tension relief) that accompany substance intoxication are experienced as highly pleasurable and lead to repetitive use. About 15% of regular users become psychologically dependent in that they come to believe that they are unable to function optimally in social, work, or other settings without experiencing some degree of substance intoxication. These individuals, in turn, are at high risk of developing one or more substance use disorders as defined in the DSM-IV criteria (2).

A. DSM-IV Criteria Defining Substance Dependence And Abuse

1) Criteria for Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

- a) Tolerance, as defined by either of the following:
 - i) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
 - ii) markedly diminished effect with continued use of the same amount of the substance
- b) Withdrawal, as manifested by either of the following:
 - i) the characteristic withdrawal syndrome for the substance
 - ii) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
- c) The substance is often taken in larger amounts or over a longer period than was intended
- d) There is a persistent desire or unsuccessful efforts to cut down or control substance use
- e) A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long

- distances), use the substance (e.g., chain-smoking), or recover from its effects
- f) Important social, occupational, or recreational activities are given up or reduced because of substance use
 - g) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

2) **Criteria Defining Substance Abuse**

- A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
 - 1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
 - 2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
 - 3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
 - 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 consequences of intoxication, physical fights)
- B. The symptoms have never met the criteria for substance dependence for this class of substance.

In using the DSM-IV criteria, one should specify whether substance dependence is with physiologic dependence (i.e., there is evidence of tolerance or withdrawal) or without physiologic dependence (i.e., no evidence of tolerance or withdrawal). In addition, clients may be variously classified as currently manifesting a pattern of abuse or dependence or as in remission. Those in remission can be divided into four subtypes—full, early partial, sustained, and sustained partial—on the basis of whether any of the criteria for abuse or dependence have been met and over what time frame. The remission category can also be used for clients receiving agonist therapy (e.g., methadone maintenance) or for those living in a controlled drug-free environment.

II. Substance Use Disorders:

A. General Treatment Principles and Alternatives

Individuals with substance use disorders are heterogeneous with regard to a number of clinically important features.

- the number and type of substances used;
- the severity of the disorder and the degree of associated functional impairment;
- the associated general medical and psychiatric conditions;
- the client's strengths (protective/resiliency factors) and vulnerabilities; and
- the social/environmental context in which the individual lives and will be treated.

Treatment for individuals with substance use disorders includes an assessment phase, the treatment of intoxication and withdrawal when necessary, the development and implementation of an overall treatment strategy and the development of an aftercare plan. Two general treatment strategies are used, depending on the clinical circumstances: drug free and substitution.

Substance use disorders may affect many domains of an individual's functioning and frequently require multimodal treatment. Goals of treatment include reduction in the use and effects of substances or achievement of abstinence, reduction in the frequency and severity of relapse, and improvement in psychological and social functioning.

Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success. To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems (3).

1. Assessment

A comprehensive assessment is essential to guide the treatment of a client with a substance use disorder. With the assessment, client learning styles, conceptual and cognitive abilities, as well as diagnostic screening and assessment are synthesized to create, in conjunction with the client, an appropriate theory-based approach that is client-centered and customized to the unique need of the client. The assessment includes a) a detailed history of the client's past and present substance use and its effects on cognitive, psychological, behavioral, and physiologic functioning; b) a general medical history; c) a history of prior substance abuse treatments; d) a family and social history; e) psychiatric history; and f) legal history. In evaluating the client, a comprehensive substance abuse instrument for evaluation is

essential. Such instruments may include but are not limited to; Addiction Severity Index (ASI), Alcohol Use Disorders Identification Test (AUDIT), Michigan Alcohol Screening Test (MAST), DAST, and the Substance Abuse Subtle Screening Inventory (SASSI).

2. Specific treatments

From the Assessment of the client, treatment placement is determined. Placement is based on the current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and the current American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-2R, Appendix 1). Within the Treatment programs a number of different treatment modalities may be used. It is uncommon for a single treatment to be effective when used in isolation.

3. Treatment Modalities Research has indicated that no single treatment is appropriate for all individuals with substance abuse/addiction issues. Treatment for substance abuse benefits significantly by matching treatment settings, interventions, and services to each client's unique problems and issues. Several well-established theoretical approaches can be utilized when working with the substance abuse/addiction population, which include the following:

- Cognitive Behavioral Therapy
- Rogarian Client Centered Therapy
- Gestalt Therapy
- Narrative Therapy
- Rational-Emotive Therapy
- Reality Therapy
- Solution-Focused/Brief Therapy
- Dialectical Behavioral Therapy (DBT)

(Information on each modality can be found in social work journals or text books)

4. Pharmacologic treatments

Pharmacologic treatments are beneficial for selected clients with substance use disorders. The categories of pharmacologic treatments are a) medications to treat intoxication and withdrawal states; b) medications to decrease the reinforcing effects of abused substances; c) medications that discourage the use of substances by inducing unpleasant consequences through a drug-drug interaction or by coupling substance use with an unpleasant, drug-induced condition; d) agonist substitution therapy; and e) medications to treat comorbid psychiatric conditions.

5. Psychosocial treatments

Psychosocial treatments are essential components of a comprehensive

treatment program. Examples that may be used in a treatment program are as follows: cognitive behavioral therapies, behavioral therapies, psychodynamic/interpersonal therapies, group and family therapies, and participation in self-help groups.

6. Formulation and implementation of a treatment plan

The treatment plan is the foundation for all clinical decision making and is the primary guide to set the course of treatment. It should identify long and short term goals and methods to reach these goals. The goals of treatment and the specific choice of treatments needed to achieve those goals vary among clients and, for the same client, among different phases of the illness. Since many substance use disorders are chronic, clients can require long-term treatment, although the intensity and specific components may vary over time.

Decisions regarding the site and components of treatment depend on individual client factors, with the least restrictive setting that is likely to be safe and effective being preferable. This setting is based on an assessment that includes a biopsychosocial history and the ASAM criteria.

On the basis of the assessment and the ASAM criteria, a treatment plan is developed. As part of the philosophy of empowering the client to take responsibility for their recovery, it is also expected that the client will have an active role in the review of information and design of the treatment plan. The components of a treatment plan and the factors that go into their choice are summarized in the following list. It must be kept in mind, however, that the separation of components is done for heuristic reasons: in practice, the components, and the factors that underlie their potential utility, overlap considerably.

1. A strategy for achieving abstinence or reducing the effects or use of illicit substances (or non-illicit substances that exacerbate the substance use disorder) must be developed and implemented. The range of available strategies depends, in part, on the severity of the disorder.
2. Efforts to enhance ongoing compliance with the treatment program and prevent relapse and improve functioning are critical. The likelihood of success in continued treatment compliance is improved by decreasing the client's access to abusable substance(s); optimizing the use of any specific pharmacologic treatments; addressing factors that help precipitate and/or perpetuate substance use, including both external factors (e.g., living/social environment) and internal factors (e.g., other psychopathology); providing disincentives for substance use (e.g., through the use of monitoring or pharmacologic strategies); and helping the client develop cognitive and behavioral strategies to support a substance-free lifestyle (11). Referral to self-help groups is frequently helpful during this phase of treatment. Specific rehabilitative interventions to improve functioning may be necessary for clients whose functional level is impaired to the extent that it

interferes with their ability to comply with treatment or is not expected to improve satisfactorily with cessation of substance use.

3. Clients with comorbid conditions generally require additional treatments (e.g., a specific psychotherapy, an antidepressant medication) in order to achieve optimal outcomes.

The choice of treatments for clients with substance use disorders depends on the client's clinical status and preferences. Client preferences are particularly important since adherence to a treatment plan over time is a powerful predictor of its effectiveness.

7. Treatment settings

Treatment settings vary with regard to the availability of specific treatment modalities, the degree of restricted access to substances that are likely to be abused, the availability of general medical and psychiatric care, and the overall milieu and treatment philosophy.

Clients should be treated in the least restrictive setting that is likely to be safe and effective. Decisions regarding the site of care should be based on clients' ability to cooperate with and benefit from the treatment offered, the need for structure and support, clients' ability to refrain from illicit use of substances, their ability to avoid high-risk behaviors, the ASAM criteria and the need for particular treatments that may be available only in certain settings. Clients can move from one level of care to another on the basis of these factors and an assessment of their ability to safely benefit from a different level of care.

Commonly available treatment settings include, hospitals, residential treatment facilities, partial hospital care, outpatient programs, and support groups.

8. Clinical features influencing treatment

Treatment planning and implementation should reflect consideration of gender-related factors (including the possibility of pregnancy), age (e.g., for children, adolescents, and the elderly), social milieu and living environment, cultural factors, comorbid psychiatric and general medical conditions and family characteristics. The high prevalence of comorbid psychiatric disorders and the diagnostic distinction between substance use symptoms and other disorders should receive particular attention, specific treatment for comorbid disorders should be provided when necessary (See NorthCare's practice guidelines for Co-Occurring Disorders).

B. Alcohol and Marijuana Use Disorders: Treatment Principles And Alternatives

1. Treatment settings

Based on the ASAM criteria, clients are referred to the level of care that addresses their need for treatment in which a variety of treatment modalities are simultaneously used and in which the focus is the maintenance of

abstinence. This mode of treatment is effective for most clients with alcohol and marijuana use disorder.

2. Psychosocial treatments

Psychosocial treatments found effective for selected clients with alcohol/marijuana use disorders include cognitive behavioral therapies, behavioral therapies, psychodynamic/interpersonal therapy, brief interventions, marital and family therapy, and group therapies. Client participation in self-help groups, such as Alcoholics Anonymous, is frequently helpful for clients with a alcohol disorder.

3. Managing intoxication and withdrawal states

Clients who present with severe withdrawal symptoms are managed by a medical team, ie physician driven process, that stabilizes the client to the point that the client can safely engage in a treatment modality.

In general, acutely intoxicated clients (alcohol) require reassurance and maintenance in a safe and monitored environment, with efforts to decrease external stimulation and provide orientation and reality testing. Clinical assessment is directed toward ascertaining which substances have been used, the route of administration, dose, time since the last dose, whether the level of intoxication is waxing or waning, and other diagnostic information as already described. Management of acute intoxication is also directed toward hastening the removal of substances from the body.

Not all individuals that are under the influence will develop withdrawal symptoms. Withdrawal symptoms usually occur in tolerant and/or physically dependent individuals who discontinue or reduce their substance use after a period of heavy and prolonged use. The specific signs and symptoms of withdrawal vary according to the substance used, the time elapsed since the last dose, the rate of elimination and duration of action of the substance in question, the associated use of other prescribed or nonprescribed drugs, the presence or absence of concurrent general medical or psychiatric disorders, and individual biological and psychosocial variables.

Many clients use multiple substances simultaneously to enhance, ameliorate, or otherwise modify the degree or nature of their intoxication or to relieve withdrawal symptoms. Intoxication with alcohol and cocaine, use of heroin and cocaine ("speedball"), and the combined use of alcohol, marijuana, and/or benzodiazepines by opioid-dependent clients are particularly frequent. Clients using multiple substances (including alcohol) are at risk for withdrawal from each of these.

Symptoms of alcohol withdrawal typically begin within 4-12 hours after cessation or reduction of alcohol use, peak in intensity during the second day of abstinence, and generally resolve within 4-5 days. Serious complications include seizures, hallucinations, delirium and may even cause death.

Clinical assessment of intoxicated clients and those manifesting signs and symptoms of withdrawal should include laboratory determination of the presence of other substances. The treatment of clients in moderate to severe

withdrawal includes efforts to reduce central nervous system (CNS) irritability and restore physiologic homeostasis.

4. Other clinical features influencing treatment

The treatment of pregnant women with alcohol use disorders is complicated by the risk of fetal alcohol syndrome and the corresponding urgency of minimizing the intake of alcohol. According to State mandate these clients are Priority 1.

C. Cocaine Use Disorders: Treatment Principles And Alternatives

1. Treatment settings

Based on the ASAM criteria, clients are referred to the level of care that addresses their need for treatment in which a variety of treatment modalities are simultaneously used and in which the focus is the maintenance of abstinence. This mode of treatment is effective for most clients with cocaine use disorders .

2. Pharmacologic treatments

Pharmacologic treatment is not ordinarily indicated as an initial treatment for clients with cocaine dependence

3. Psychosocial treatments

Psychosocial treatments focusing on abstinence are effective for most client with cocaine use disorders. The following specific types of psychotherapies have been evaluated and have been shown to have variable efficacy with different groups of clients: cognitive behavioral therapies, behavioral therapies, and psychodynamic psychotherapy. In addition, regular participation in self-help groups may improve the outcome for selected clients with cocaine use disorders.

4. Management of cocaine intoxication and withdrawal

This can be a physician driven process to the point client is stable enough to begin treatment. Cocaine intoxication can produce hypertension, tachycardia, seizures, and paranoid delusions. The syndrome is usually self-limited and typically requires only supportive care.

5. Other clinical features influencing treatment

The treatment of pregnant women with cocaine use disorders is complicated by the increased risk of premature delivery, low birth weight, stillbirth, and sudden infant death syndrome and the corresponding urgency of minimizing the intake of cocaine.

D. Opioid Use Disorders: Treatment Principles And Alternatives

Some opioid-dependent clients will be able to achieve abstinence from all opioid drugs; others may require long-term maintenance with opioid agonists (e.g., methadone or LAAM [L-a-acetylmethadol or levomethadyl acetate]).

1. Treatment settings

Based on the ASAM criteria, clients are referred to the level of care that

addresses their need for treatment in which a variety of treatment modalities are simultaneously used and in which the focus is the maintenance of abstinence. This mode of treatment is effective for most clients with opioid use disorders.

2. Pharmacologic treatments

Maintenance on methadone or LAAM may be appropriate for clients with a prolonged history (>1 year) of opioid dependence and has been shown to reduce the morbidity associated with opioid dependence. The goals of treatment are to achieve a stable maintenance dose and to facilitate engagement in a comprehensive program of rehabilitation.

For some clients, abstinence can never be achieved, but important reductions in morbidity and mortality can be achieved through efforts to reduce the effects of opioid use.

3. Psychosocial treatments

Psychosocial treatments are effective components of a comprehensive treatment plan for clients with opioid use disorders. Cognitive behavioral therapies, behavioral therapies, psychodynamic psychotherapy, group and family therapies, and self-help groups have been found effective for some clients with opioid use disorders. The choice of treatment should be made after consideration of the client's preferences, the clinical issues to be addressed, associated comorbid psychopathology, and past response to various treatment modalities.

4. Management of opioid intoxication and withdrawal

Acute opioid intoxication of mild to moderate degree usually does not require specific treatment. However, severe opioid overdose, marked by respiratory depression, may be fatal and requires treatment in a hospital emergency room or inpatient setting.

5. Other clinical features influencing treatment- There are some opioid-dependent clients that have comorbid psychiatric disorders that need to be identified and treated concurrently with the clients substance use disorders.

The use of opioids by injection is associated with high risk of general medical complications, such as bacterial endocarditis, hepatitis, HIV infection, and tuberculosis.

The treatment of pregnant women with opioid use disorders is complicated by the increased risk of low birth weight, prematurely, neonatal abstinence syndrome, stillbirth, and sudden infant death syndrome and the corresponding urgency of minimizing the intake of opioids. According to State Mandate these clients are Priority 1.

III. Treatment Settings

Clients with substance use disorders may receive their care in a variety of settings. The choice of setting should be guided by the demands of the treatment

(as determined by the client's clinical status, the DSM-IV, and the ASAM placement criteria) and the characteristics of available settings. Treatment settings vary with regard to the availability of various treatment capacities (e.g., general medical care, psychotherapy, and cultural focus), the relative restrictiveness with respect to access to substances or involvement in other high-risk behaviors, hours of operation, and overall milieu and treatment philosophy.

A. Factors affecting choice of treatment setting

Clients should be treated in the least restrictive setting that is likely to prove safe and effective. Decisions regarding the site of care should be based on the client's assessment and the ASAM placement criteria. The areas that are covered include; a) capacity and willingness to cooperate with treatment and readiness to change; b) intoxication and/or withdrawal potential; c) biomedical conditions and complications; d) emotional behavioral, or cognitive conditions and complications; e) relapse, continued use problem/potential; and f) recovery environment following treatment.

Client may need to move from one level of care to another on the basis of these factors and the clinician's and the CDR's assessment of client readiness and ability to benefit from a less intensive level of care.

B. Commonly available treatment settings

The availability of different settings varies among communities. The settings described may be considered as points along a continuum of care.

- a. Hospitals.** The range of services available in hospital-based programs typically includes detoxification; assessment and treatment of general medical and psychiatric conditions; group, individual, and family therapies; psycho education; and motivational counseling. Other important components of hospital-based treatment programs include the willingness and ability to introduce clients to self-help groups and to develop a plan for post-hospital care that includes strategies for relapse prevention and, where appropriate, rehabilitation (4).

Clients in one or more of the specific following groups and who meet the ASAM PPC-2R criteria for level 3.5-Level 4 may require hospital-level care:

- Clients with drug overdoses that cannot be safely treated in an outpatient or emergency room setting (e.g., clients with severe respiratory depression or coma).
- Clients in withdrawal who are either at risk for a severe or complicated withdrawal syndrome (e.g., clients dependent on multiple drugs, clients with a past history of delirium tremens) or who cannot receive the necessary assessment, monitoring, or treatment in an alternative setting.
- Clients with acute or chronic general medical conditions that make detoxification in a residential or ambulatory setting unsafe (e.g., clients with severe cardiac disease).

- Clients with a documented history of not engaging in, or benefiting from, treatment in a less intensive setting (i.e., residential or outpatient).
- Clients with marked psychiatric comorbidity who are an acute danger to themselves or others (e.g., clients who have depression with a suicidal plan, acute psychosis).
- Clients manifesting substance use or other behaviors that constitute an acute danger to themselves or others.
- Clients who have not responded to less intensive treatment efforts and whose substance use disorder(s) poses an ongoing threat to their physical and mental health.

In general, the duration of hospital-based treatment should be dictated by the current need of the client to receive treatment in a restrictive setting and by the client's capacity to safely participate in, and benefit from, treatment in a less restrictive setting.

b. Residential treatment

Residential treatment is primarily indicated for clients whose lives and social interactions have come to focus exclusively on substance use and who currently lack sufficient motivation and/or drug-free social supports to remain abstinent in an ambulatory setting and who meet the criteria for ASAM PPC-2R Level 3.1 – Level 3.3. For such clients, residential facilities provide a safe and drug-free environment in which residents learn individual and group living skills. Residential treatment programs should, at a minimum, also provide psychosocial, occupational, and family assessments; psycho education; involvement in self-help groups; and referral for social or vocational rehabilitative services where necessary (5).

Many residential programs provide their own individual, group, and vocational counseling programs but rely on affiliated outpatient programs to supply the psychosocial and psychopharmacologic treatment components of their programs.

The duration of residential treatment is usually 30-60 days and is dictated by the time necessary to achieve specific criteria that would predict a successful transition to a less structured, less restrictive treatment setting (e.g., outpatient care); The goals of residential treatment may include that the client demonstrate motivation to continue in outpatient treatment, the ability to remain abstinent even in situations where drugs are potentially available, the availability of a living situation and associated support system conducive to remaining drug free (e.g., family, drug-free peers), stabilization of any comorbid general medical or psychiatric disorder to the point where treatment can take place in an outpatient setting, and the development of an adequate follow-up care plan.

In some areas, residential treatment programs specifically designed for adolescents (Great Lakes Recovery-Youth), Native Americans (Three Fires) pregnant or postpartum women, and women with young children (Women's New Hope House) are available, and such programs are preferred for these client populations.

- c. Partial hospitalization.** Partial hospital care can provide an intensive and structured treatment experience for clients with substance dependence who require more services than those generally available in traditional outpatient settings. Clients referred to partial hospitalization meet criteria for Level 2.5 of the ASAM-PPC-2R. The treatment components of partial hospital programs usually include individual, group, and family therapy; vocational and educational counseling; medically supervised use of adjunctive medications (e.g., narcotic antagonists, methadone); random urine screening for drugs of abuse; and may provide treatment for any comorbid psychiatric disorders that may be present. As in other treatment settings, partial hospital programs should provide opportunities for clients to learn and practice coping strategies to reduce drug craving and avoid relapse. Client and family education about substance use disorders and the opportunity to confront client or family denial are also important program components.
- d. Intensive Outpatient settings.** Clients who participate in Intensive Outpatient (IOP) settings meet the ASAM-PPC-2R criteria for Level 2.1. Clients in IOP typically begin by attending 4-5 hours per day, 3-5 days per week for four to six weeks. The availability of evening and weekend care is particularly desirable. The duration or frequency of IOP visits should be tapered as clients demonstrate that they can remain substance free and make progress toward rehabilitation. The availability of community-based supports (e.g., non-drug-using friends or family), a job, and a living situation conducive to remaining abstinent are also important considerations in deciding when to decrease or discontinue IOP.
- e. Outpatient settings.** Outpatient treatment of substance use disorders is appropriate for those whose clinical condition or environmental circumstances do not require a more intensive level of care. These clients meet the ASAM-PCC-2R criteria for Level 1 or lower. As in other treatment settings, a comprehensive approach is optimal. Treatment should encourage and be integrated with client participation in self-help programs where appropriate.

As in the case of residential and partial hospital programs, high rates of attrition are a problem in outpatient settings, particularly in the early phase (i.e., first 6 months). Since intermediate- and long-term outcomes are highly correlated with retention in treatment, specific efforts should be directed toward motivating clients to remain in treatment (6); such efforts may include the use of legal, family, or employer-generated pressure where available.

IV. Barriers to Treatment

Barriers to treatment participation include denial of the problem by the client and the client's family or social network; patterns of behavior that facilitate substance use (e.g., criminal activity or continued contact with drug-using peers); the likely re-emergence of craving for abused substances; unproductive attitudes about the value of work, treatment, or interpersonal relationships; continued psychosocial or vocational dysfunction; and comorbid psychiatric or general medical problems. These barriers should be discussed at the beginning and throughout the course of treatment.

The treatment program may address these barriers by actively attempting to increase motivation through specific techniques (7), encouraging the client to participate in self-help or professionally led groups that include recovering individuals; encouraging the development of a substance-free peer group and lifestyle; helping the client develop techniques to improve interpersonal relationships in family, work, and social settings; encouraging the client to seek new experiences and roles consistent with a substance-free existence (e.g., greater involvement in vocational, social, and religious activities); discouraging the client from instituting major life changes that might increase the risk of relapse; and providing, or arranging for, treatment of comorbid psychiatric and general medical conditions (8,9).

For the client with co-occurring problems, the frequency, intensity, and focus of psychiatric management should be tailored to meet each client's needs. The type of management is likely to vary over time, depending on the client's clinical status. With the co-occurring client, it is important that mental health services be organized to coordinate and integrate the clients care so that the client has the support they need to managed their mental health issues during and after treatment.

A. Relapse Prevention

Relapse prevention efforts may include helping clients anticipate and avoid drug-related cues (e.g., instructing the client to avoid drug-using peers), training clients in self-monitoring affective or cognitive states associated with increased craving and substance use, contingency contracting, teaching desensitization and relaxation techniques to reduce the potency of drug-related stimuli and modulate craving intensity, helping clients develop alternative, nonchemical coping responses to uncomfortable feelings and situations, and providing coping and social skills training to help clients become involved in satisfying drug-free alternative activities (10). A client and provider should begin developing an aftercare program, that will provide the support needed for the client, in the first few weeks of treatment.

A mutually acceptable therapeutic plan for intervening in situations in which there is a high likelihood of relapse to substance use should be developed in the early

stages (e.g., first few weeks) of treatment and reviewed on a regular basis (e.g., monthly or more frequently) for clients for whom relapse is an immediate concern. It is frequently helpful to obtain the client's agreement to 1) predetermined guidelines for obtaining information from family, friends, and employers with which to assess the client's ability to remain substance free and 2) the clinical criteria for altering the type, intensity, or site of treatment.

B. Cultural Factors

Current research suggests poorer prognoses for ethnic and racial minorities in conventional treatment programs (12). Treatment services that are culturally sensitive and address the special concerns of ethnic minority groups may improve acceptance of, compliance with, and, ultimately, the outcome of treatment. Training of staff and efforts to incorporate culture-specific beliefs about healing and recovery should be part of a comprehensive treatment program that serves different minority and ethnic groups (13). In the Upper Peninsula specific attention should be given to the culturally appropriate treatment of Native Americans.

V. Confidentiality and Reporting of Treatment Information

NorthCare Notice of Privacy Practice will be distributed to every client to ensure clients understand how personal health information will be handled by NorthCare.

To protect clients' privacy and encourage their entry into treatment, federal law and regulations mandate strict confidentiality for information about clients being treated for substance use disorders (i.e., 42 USC Section 290dd-3, ee-3; 42 C.F.R. Part 2). Disclosure of information from treatment records is prohibited unless the client has given written consent, the disclosure is in response to a medical emergency, or there is a court order authorizing disclosure. Other instances in which client confidentiality may be abrogated include disclosure in response to a crime committed at the treatment program or against program staff, and compliance with state laws addressing the professional's "duty to warn" third parties of a potential harm (by the client); the initial reporting of child abuse or neglect may also abrogate confidentiality requirements. With regard to the last situation, clinicians should be familiar with reporting laws concerning the possible abuse and neglect of children and other dependents who may be at risk in the families of both male and female substance users. Generally, federal law does not make specific reference to the confidentiality of information pertaining to the HIV/AIDS status of a client in alcohol or drug treatment. In Michigan the state law and HIPPA guidelines will be followed.

1. Confidentiality concerning clients with HIV/AIDS

On the Michigan Government site, the Michigan Law states from law: MCL 333.5131; Public Act 488 of 1988, as amended by Act 174 of 1989, Act 270 of 1989, Act 86 of 1992, Act 200 of 1994, and Act 57 of 1997, HIV-related information is confidential and cannot be released unless the patient authorizes disclosure, or a statutory exception applies. This authorization must be in writing and must contain a

SPECIFIC statement if the release is to also cover HIV-related information in the records.

Exceptions:

1. To protect the health of an individual
2. To prevent further transmission of HIV
3. To diagnose and care for a patient

These exceptions can only be release TO the Department, a local health department or other health care provider for one or more of the proceeding purposes. Other Confidentiality Exemptions

Disclosure to know contacts - physicians or local health officers can release information pertaining to an individual who is infected with HIV or is diagnosed with AIDS, if the information is released to a known contact of the infected individual, and if the disclosure is determined necessary to prevent a reasonably foreseeable risk of further transmission of HIV.

Disclosure to Individual's School District - Only the Michigan Department of Community Health or a local health department may disclose HIV/AIDS information about an infected individual to a school district for the purpose of preventing a reasonably foreseeable risk of transmission.

Disclosure as Part of Child Protection Law - Information pertaining to an individual infected with HIV, or diagnosed with AIDS, can be released if the information is part of a report required under the child protection law, PA 238 of 1975, MCL 722.621 to 722.636.

Disclosure to Foster Parents - Disclosure of a foster child's status is allowed if the foster parent is the legal guardian. Only the FIA, the State Dept. of Mental Health, the Probate Court, or a child placing agency may make such a disclosure to the foster parents.

2. Releases- No client identifying information will be released to any outside individual or organization without the appropriate release of information or valid court order.

Records and information covered are: Records of Identity, Records of Prognosis, Records of Diagnosis, Treatment Records, Attendance Records, Patient Status Records, and Physical Whereabouts Records. Information may be released only by written consent signed by the client and only to the extent that it is actually needed for the purpose stated on the signed consent form.