

Intensive Outpatient Treatment for Alcohol and Other Drug Abuse

Treatment Improvement Protocol (TIP) Series 8

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Chapter 2 -- Placement Criteria and Expected Treatment Outcomes

The treatment of alcohol and other drug (AOD) use disorders can be understood as a spectrum of treatment options with differences in setting, type and range of services, and number of services used.

The severity of AOD use disorders differs among patients. Indeed, the severity of an individual's AOD disorder will fluctuate over the course of time. Since patients have a range of treatment needs, there is a corresponding need for a range of treatment options. The goal of AOD treatment is to place patients in the appropriate level of care, to match the intensity of service to the severity of illness, and to select the services needed to meet patients' individual needs.

Description of IOT

Levels of Care

Levels of care reflect both service intensity and setting. Within the context of AOD treatment, the term *treatment setting* describes the characteristic environmental features needed in the various levels of care. *Treatment intensity* refers to the scope and frequency of service provision and the number of resources utilized in providing such services.

What are the levels of care? How should clients be matched to an appropriate level of care? At what point should clients be moved from one level of care to another? To provide effective AOD treatment, answers to these questions must be understood.

It is apparent that objective placement criteria -- such as the *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders* ([Hoffman et al., 1991](#)) Care needed. These criteria describe in detail the different levels of care and provide specific guidelines for patient placement decisions. Although not empirically evaluated, these guidelines were developed through extensive collaboration with providers, payers, and other addiction experts and were published by the American Society of Addiction Medicine (ASAM). The guideline development process included a review of the AOD treatment literature and extensive field testing. The criteria continue to be reviewed and studied.

In addition to the criteria developed by ASAM, States and other agencies and groups may have their own guidelines regarding levels of care. For example, the Addiction Group of the American Psychiatric Association is establishing AOD abuse treatment guidelines that can be considered by intensive outpatient treatment (IOT) programs when clarifying placement criteria. Not all patients will neatly fit into any one set of guidelines, a fact that should be weighed when considering placement criteria. The ASAM guidelines are recognized in this TIP because of their broad acceptance and application.

The overall intent of patient placement guidelines is to place a person in the least intensive level of care that will achieve AOD treatment objectives without sacrificing safety or security. The ultimate goals of the guidelines are to improve the effectiveness of care, to ensure access to affordable care, and to support the development of cost-effective treatment systems. They are also an attempt to establish patient placement criteria that are acceptable to all treatment providers and payers. They support efforts to establish a common language for AOD abuse treatment, to agree on consistent placement decisions, and to provide a focus for future research efforts. These criteria should be considered dynamic, not fixed. Future revisions are likely to be driven by research results and further review and application in the field.

Goals of Patient Placement Guidelines

- Improve quality of care
- Ensure access to affordable care
- Support development of cost-effective treatment systems.

Four levels of care for AOD abuse treatment are described in ASAM's patient placement criteria as follows:

- **Level I** -- Outpatient treatment
- **Level II** -- Intensive outpatient treatment
- **Level III** -- Medically monitored intensive inpatient treatment
- **Level IV** -- Medically managed intensive inpatient treatment.

The guidelines describe *outpatient treatment* as an organized nonresidential treatment service or an office practice with designated addiction professionals and clinicians providing professionally directed AOD treatment. This treatment occurs in regularly scheduled sessions usually totaling fewer than 9 contact hours per week. Examples include weekly or twice-weekly individual therapy, weekly group therapy, or a combination of the two in association with participation in self-help groups.

Intensive outpatient treatment (which includes partial hospitalization) is a planned and organized service in which addiction professionals and clinicians provide several AOD treatment service components to clients. Treatment consists of regularly scheduled sessions within a structured program, with a minimum of 9 treatment hours per week. Examples include day or evening programs in which patients attend a full spectrum of treatment programming but live at home or in special residences.

Medically monitored intensive inpatient treatment can be described as an organized service conducted by addiction professionals and clinicians who provide a planned regimen of around-the-clock professionally directed evaluation, care, and treatment in an inpatient setting. This level of care includes 24-hour observation, monitoring, and treatment. A multidisciplinary staff

functions under medical supervision. An example is a program with 24-hour nursing care under the direction of physicians.

Medically managed intensive inpatient treatment is an organized service in which addiction professionals and clinicians provide a planned regimen of 24-hour medically directed evaluation, care, and treatment in an acute care inpatient setting. Patients generally have severe withdrawal or medical, emotional, or behavioral problems that require primary medical and nursing services.

It should be noted that several AOD treatment service models do not precisely fit within the four levels of care described here. These service levels include halfway houses and extended residential programs such as therapeutic communities. These programs are designed for people who do not have housing, who experience housing instability, or who lack an organized support system. These programs are often used in conjunction with IOT or inpatient treatment.

This TIP focuses on the second level of care -- IOT. Much like AOD abuse treatment in general, IOT represents a continuum of services that range from less to more intensive treatment. Thus, IOT can be described as a range of services within the larger range of AOD treatment services. Some of the services provided are withdrawal management, group therapy, relapse prevention training, individual counseling, family counseling, and pharmacotherapy.

IOT should not be described solely by the number of contact hours per week. Because of the number of services that are provided, the contact hours at IOT programs may range from a minimum of several hours (often described as about 9 hours) to 70 or more hours per week. Further, minimal requirements for IOT may vary by State law or regulation. Since IOT involves a structured therapeutic environment combined with living at home or in a therapeutic residence, IOT affords clients an opportunity to interact with the real world environment while benefiting from a structured program in a therapeutic milieu.

Whatever the level of care being provided, AOD treatment programs should provide services that reflect the treatment needs of the patients and should modify services according to cultural, demographic, and geographic differences.

Models and Examples

The emphasis in AOD treatment should be on a flexible intensity of service delivery that corresponds to the changing intensity of illness, not merely on a specific model of AOD treatment. As clients' treatment needs change, treatment intensity should change accordingly. Different models of treatment can be adapted to various levels of service intensity. Some IOT programs operate as day treatment programs. These models vary widely and include programs that offer AOD treatment from early morning to early evening, for 6 or 7 days per week. These programs can treat patients with significantly severe illness.

Some programs offer as few as 2 or 3 treatment contact hours daily. Some IOT programs operate as evening programs with treatment hours that range from 9 to 20 hours per week. Some IOT programs operate primarily as weekend programs. Programs that provide few hours per week may best benefit those who have meaningful social supports and are highly motivated for

treatment and recovery or who have progressed through more intensive levels of care. Programs can be designed to gradually reduce the number of patient contact hours as certain treatment goals are met.

In some IOT programs, clients live at home. In other IOT programs, they live in a homelike environment in special housing or leased apartments. These programs may involve minimal to moderate supervision during nontreatment hours. For instance, some programs have a designated residence manager who participates in residence group meetings, including therapeutic, daily living, and recreational group meetings. In other programs, a residence manager lives with the patients.

An IOT program can be established in association with a homeless shelter or within the confines of a prison. IOT programs may exist within hospital settings and may include various degrees of medical management. The intensity of IOT services can be adapted to various sites and models. However, the IOT level of care is not synonymous with the site of the service.

Clearly, there are several types of IOT programs that differ in intensity because of the differences in services provided. Compared with inpatient treatment, IOT is often (but not always) less intense but is generally provided for longer periods of time.

Clients should be exposed to at least a minimum core of didactic information and receive skill enhancement in several areas before they are discharged to a different level of care. Ideally, clients should experience measurable behavioral, cognitive, and affective changes that will support abstinence and recovery. These changes occur as the result of therapeutic and psychoeducational efforts.

Irrespective of the specific model, IOT should be individualized and open-ended. Lengths of stay and placement decisions should be based on the progress of patients -- specifically, on the attainment of their individualized treatment goals. Treatment programs and treatment decisions should not be based on rigid and standardized lengths of stay. Although the educational curriculum components of AOD treatment may be based on a rotating cycle of a specific number of weeks or months, the treatment process itself should be driven exclusively by the needs of patients.

Assessment and Placement Issues

AOD Abuse Screening

The processes of screening, assessment, and diagnosis of AOD use disorders are not synonymous. An AOD *abuse screening instrument* is a tool used to identify clients who have a high probability for AOD use disorders. It is used to determine whether a diagnostic assessment is needed. For example, the CAGE questionnaire, which consists of four questions, has demonstrated a fairly high validity. The Michigan Alcohol Screening Test (MAST) and the Substance Abuse Subtle Screening Inventory (SASSI) are other widely used screening instruments that have proven useful. The ideal screening tool identifies most people with the

disorder and will not select many people without the disorder. Screening tools identify people who require further diagnostic evaluation.

An AOD screening tool is generally a brief, rapidly administered tool that identifies clients who likely have an AOD problem. An *AOD diagnosis* is the confirmation of the existence of a specific AOD use disorder. The AOD diagnosis is determined by an *AOD assessment*, which is a multidimensional evaluation that appraises the severity and course of the disorder and identifies clients' strengths, weaknesses, and individual needs. The assessment is the basis of the treatment plan.

Steps in Determining AOD Use Disorders

- Screening: Identifies persons likely to have an AOD use problem.
- Assessment: Evaluates identified persons for specific AOD use disorders.
- Diagnosis: Confirms existence of a specific AOD use disorder.

AOD Abuse and Dependence

Diagnostic assessment for IOT placement begins with a diagnostic evaluation based on the criteria for substance-related disorders described in the fourth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association, 1994) or other standardized criteria. The DSM-IV describes criteria for diagnosing substance abuse and substance dependence. Three or more of the criteria described in [Exhibit 2-1](#) must be present at any time in the same 12-month period in order to diagnose substance dependence.

There are circumstances when information about a patient's AOD use history is inadequate to substantiate the diagnosis of an AOD use disorder. In these situations, information obtained from collateral sources such as family members and legal guardians can be used to indicate a high level of probability of the diagnosis.

Dimensions for Assessment

Assessment should be an ongoing process that: 1) determines the level of care required at entry, 2) identifies patients' individual problems, 3) determines subsequent modification of treatment intensity, 4) determines to what extent patients are progressing toward the attainment of treatment goals, and 5) identifies the changes patients have made following planned interventions or treatment. Assessment is a continual process, not a single event. An assessment facilitates level-of-care decisions and determines what goals are included in individualized treatment plans. (See the TIPs *Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents and Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse*.)

Clinicians who assess clients must have specialized training in the assessment process. They should have the skills to effectively engage clients and to assess their potential for withdrawal and other biomedical and psychiatric problems. They should be competent to identify clients who require further medical or psychiatric assessment. Assessments should include information from observations of the client and from collateral sources and a history of previous treatment.

The primary purpose of an assessment is to provide a basis for the selection of the most appropriate treatment for the individual being assessed. To be as useful as possible, assessments should have certain features that enhance the value of the assessment information. Ideally, information gathered during an assessment should be quantitative, reliable (reproducible), valid (measures what it purports to measure), standardized (comparable to an established baseline), and recordable.

Assessments in IOT settings should be comprehensive and multidimensional. Six dimensions of illness have been described in the *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders* ([Hoffman et al., 1991](#)):

- Acute intoxication and/or withdrawal potential
- Biomedical conditions and complications
- Emotional and behavioral conditions or complications
- Treatment acceptance and resistance
- Relapse potential
- Recovery environment.

Within each dimension, the ASAM guidelines list specific assessment criteria that help determine the appropriate level of care for patients. [Exhibit 2-2](#) provides an overview of the adult admission criteria described in the ASAM guidelines. It is an approximate summary to illustrate the principal concepts and structure of the criteria. These assessment criteria do not represent the only assessment dimensions: others can be considered. For example, a client's developmental history and past treatment history can be useful in making patient placement decisions.

Assessing clients by using these six dimensions facilitates comprehensive and ongoing assessment and treatment planning. Based on an initial assessment, the level of care is determined, problem areas are identified, and a treatment plan is immediately initiated. The relationships between the six dimensions of illness and placement in an IOT level of care are briefly described below.

Acute intoxication or withdrawal potential. Patients who have severe withdrawal syndromes usually should be treated in an inpatient setting, although many of these patients may be safely managed in IOT with appropriate medical resources. Studies indicate that patients with minimal risk of severe withdrawal can be safely treated in an IOT setting with appropriate medical supervision and support from patients' significant others ([Hayashida et al., 1989](#)).

Biomedical conditions and complications. Serious medical complications necessitate inpatient treatment, but medical problems may often be managed in IOT programs or through linkages with health care providers.

Emotional and behavioral conditions or complications. Clients who require a protective environment or a 24-hour structure due to severe emotional or behavioral conditions or other complications should be treated in an inpatient setting. For placement in IOT, clients should be assessed as being in little danger of harming themselves or others. A wide range of emotional and behavioral problems can be safely and effectively managed in IOT programs -- as long as the problems are included in the treatment plan.

Treatment acceptance and resistance. Clients vary with regard to recognition and awareness of the presence and severity of their AOD use disorders and with regard to their acceptance of or resistance to treatment. To be appropriate for IOT, clients must at least agree to participate in treatment, even if they do not have a commitment to recovery. For example, as clinicians utilize motivational enhancement therapies, clients may initially attribute AOD-related problems to others or to external circumstances; ultimately, they may accept personal responsibility for these problems and for recovery.

Relapse potential. Relapse is not a single event but a process that can be interrupted at various points. AOD relapse includes ruminations about AOD use and cravings. It includes high-risk behaviors, including actual AOD use. Patients in IOT may experience AOD craving. However, patients with a persistent and severe lack of impulse control may require a more intense level of care such as inpatient treatment.

Many clients who experience AOD craving with subsequent use may nonetheless be effectively managed in IOT programs. When it occurs, the relapse experience can often be used as an effective therapeutic tool for further relapse prevention training. Relapse can often prompt the active use of learned but as yet unused or unpracticed relapse prevention and coping skills. For example, AOD use may be an opportunity for clients to reexamine their drug hunger triggers and to modify their coping strategies.

Recovery environment. Elements of the recovery environment that may indicate a need for inpatient treatment include a chaotic family with severe conflicts, AOD use within the family or living situation, and physical, sexual, or severe emotional abuse. Other elements that suggest poor matching for the IOT level of care include logistical problems such as lack of transportation or inadequate childcare. However, most AOD treatment clients experience some level of family or social dysfunction, which can generally be addressed in IOT.

Patients whose work potentially puts the public at risk (such as pilots, bus drivers, and physicians) may experience job restrictions, but are nonetheless potential candidates for IOT.

In order to participate in IOT, the basic food and housing needs of clients should be met. For some clients, meeting these basic needs may involve linkages to social services. Some clients may become engaged in AOD treatment because case management increases the availability of basic services.

Patient Transition From One Level to Another

Like any specific level of AOD treatment, IOT may not fully meet all patients' needs. Rather, IOT is a part of the larger continuum of services. As the treatment needs of patients change, clinicians should make recommendations for their transition from one level of care to another. (See [Exhibit 2-2](#) for a summary of assessment criteria for decisions about level of care.)

To make appropriate treatment recommendations, clinicians must have a thorough understanding of all available treatment resources. Thus, all clinicians and programs that provide AOD treatment and referral services should maintain and regularly update a list of all local and regional AOD and mental health treatment services. This list should also include social service programs, vocational rehabilitation programs, health care resources, churches, self-help programs, and other forms of support such as legal or financial resources. In other words, all AOD programs and clinicians should maintain a thorough and current list of services that can help meet the biopsychosocial and spiritual needs of patients. Ideally, AOD treatment providers will have formal or familiar relationships with community agencies that are most likely to provide needed services.

Clinicians often make referrals to a small group of personally known contacts. Instead, they should carefully identify the specific needs of each client and diligently seek treatment resources that can meet those needs. Clinicians should actively initiate and broaden their contacts with other treatment providers both within and outside of AOD treatment. To create effective and complete networks of health care services, such contacts should include medical, psychiatric, social, and vocational services. Appropriate consents should be secured early in the treatment process to ease communication between separate nonaffiliated treatment providers.

Since the IOT level of care is one component of the larger continuum of care, it is necessary to adequately document treatment services and to provide this documentation to the patient's next care provider. This is necessary to improve the quality of care and to ensure efficient utilization of health care resources.

As described in the following [chapter](#), family and significant others should be part of the treatment process, participating in family sessions and education. With the patient's consent, family members should participate in treatment decisions such as those involving transitions from one level of care to another. Family members and significant others should participate in and be knowledgeable about components of the treatment plan. They can be an important source of support for the patient during the recovery process.

Treatment Goals

The assessment process identifies specific problems that the clinical team and the client need to address and resolve. Thus, *treatment goals* are the expected therapeutic outcomes that are manifested in observable and measurable changes in behavior. Some of the treatment goals are immediate, some are long term, and others are lifetime goals. Thus, some treatment goals will be met during IOT, while others may be met during later phases of treatment and beyond. Also, treatment goals change over time, as progress is demonstrated.

While there are general treatment goals that are shared by most clients, clients will also have distinctive treatment goals that are based on their individualized needs as determined by a multidimensional, multidisciplinary assessment. Posttreatment goals and interventions should also be addressed in the treatment plan. Discharge planning begins with intake and placement and is a process that culminates in meeting minimal criteria for treatment outcome goals.

AOD treatment goals can be organized according to the six dimensions of illness described in ASAM's patient placement criteria.

Withdrawal Potential

The treatment goal relative to AOD withdrawal is an absence or reduction of the severity of the acute withdrawal syndrome so that intensive medical management is no longer needed. Some patients may have subacute or protracted withdrawal symptoms that are not severe enough to require medical management or to interfere with recovery.

Biomedical Conditions and Complications

For clients in an IOT level of care, biomedical treatment goals include the stabilization of medical problems so that medical monitoring is not required or so that the patient can receive medical management through another service provider. The treatment goal is to resolve biomedical problems enough to allow transition to a lower level of care. For example, severe hypertension can be stabilized with appropriate medication so that intensive monitoring is no longer required.

The following are examples of treatment goals in the area of biomedical problems and complications. These goals may be achieved during IOT. When these goals are unmet during IOT, a treatment plan to achieve them may be initiated during IOT and included as part of the continuing care plan.

- The patient will obtain a personal physician.
- The patient will identify any outstanding medical and dental problems and establish a plan for treatment.
- The patient will develop a personal plan for health maintenance.
- The patient will develop a personal plan for wellness.

Emotional and Behavioral Conditions or Complications

For patients in an IOT level of care, emotional or behavioral treatment goals include the stabilization of problems so that intensive management is not required or so that problems may be adequately managed through another service provider.

Based on specific emotional or behavioral problems identified through a multidisciplinary and multidimensional assessment, the treatment goal is the resolution of problems sufficient to allow a transition to a lower level of care. For example, symptoms of depression may be improved through pharmacotherapeutic intervention so that intensive monitoring is no longer required.

The following are examples of treatment goals in the area of emotional and behavioral problems. These goals may be achieved during IOT, or a treatment plan may be initiated and included as part of the continuing care plan.

- The patient's emotional and behavioral conditions will diminish in severity so that intensive management is no longer necessary.
- The patient is able to appropriately express and process emotions. The patient has learned to recognize, label, and express emotions.
- The patient can identify and discuss feelings of shame and guilt associated with AOD use. The patient can recognize the association between AOD use and personal shame and guilt issues.
- The patient can identify problems that may require ongoing psychotherapeutic support and identify a plan for obtaining such support.
- The patient has learned anger management and impulse control techniques.
- The patient has learned cognitive techniques to diminish symptoms of depression.
- The patient has learned assertiveness skills.

Treatment Acceptance and Resistance

For patients in an IOT level of care, treatment goals that relate to the issues of treatment acceptance and resistance include: 1) awareness and self-recognition of the AOD use disorder and its consequences, 2) recognition of the severity of the AOD use disorder, and 3) a personal acceptance of the AOD problem and the general goals of AOD treatment.

The following are examples of treatment goals in the area of the acceptance of or resistance to treatment. These goals may be achieved during IOT, or a treatment plan may be initiated and included as part of the continuing care plan.

- The patient recognizes his or her inability to control the use of AODs.
- The patient accepts personal responsibility for recovery.
- The patient understands the association between negative consequences and continued use of AODs.
- The patient recognizes that his or her relationship with AODs is self-defeating.

Relapse Potential

Remaining abstinent from all drugs including alcohol is a usual goal for patients in AOD treatment. For patients in an IOT level of care, treatment goals regarding relapse potential include the integration of relapse prevention skills into their behavior in such a way that they can continue their recovery process without intensive treatment or intervention. For example, a patient may routinely call his or her 12-step sponsor and attend the first available meeting after an episode of stress or craving. Generally, these treatment goals include awareness, early identification, and management of progressive relapse signs, as well as early intervention planning for relapse.

The following are examples of treatment goals in the area of relapse potential. These goals may be achieved during IOT, or through a treatment plan initiated and included as part of the continuing care plan.

- The patient understands the relationship between triggers, craving, and relapse.
- The patient has identified personal triggers for AOD craving and use.
- The patient has developed, integrated, and internalized skills and strategies for coping with triggers and high-risk situations.
- The patient has stopped participating in high-risk behaviors and activities and has discontinued high-risk relationships.
- The patient has developed AOD-refusal skills.

Recovery Environment

For patients in an IOT level of care, the treatment goals that relate to recovery environment include either improvements in the patient's environment that are sufficient to support an ongoing recovery process or acquisition of skills that are sufficient to cope successfully with a problem environment.

The following are examples of treatment goals in the area of the recovery environment. These goals may be achieved during IOT or initiated and included as part of the continuing care plan.

- The patient will develop living habits that promote abstinence and recovery.
- The patient will develop community supports that specifically promote abstinent behavior and a healthy lifestyle.
- The patient will develop the skills necessary to establish and maintain close interpersonal relationships.
- The patient will learn strategies and skills that enhance personal socialization.
- The patient will develop a plan for educational or vocational improvement as necessary.
- The patient will develop a spiritual or moral environment.
- The patient will plan for structured participation in a 12-step recovery program or a reasonable alternative.
- The patient will develop a plan for sustaining family recovery and achieving positive family relationships.
- The patient will identify community resources that may provide assistance for recovery.

A Final Thought

In many ways, this TIP chapter describes ideal patient placement decisions. In practice, however, clinical issues may not be as neatly presented and organized. Also, limited resources may restrict or interfere with the opportunity to adhere to these or other guidelines. Thus, the reader is advised to apply these or other guidelines to his or her own treatment setting and to use them in ways that are most applicable.