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Substance Abuse Counseling: Theory and Practice

Patricia Stevens Robert L. Smith

Fifth Edition

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alcohol dependence. *Arab Journal of Psychiatry, 17*(1), 52–65.

National Institute on Drug Abuse. (2009). *Treatment approaches for drug addiction.* Washington, DC: Author.

O'Connell, O. (2009). Introducing mindfulness as an adjunct treatment in an established residential drug and alcohol facility. *The Humanistic Psychologist, 37*, 178–191.

Orman, J. S., & Keating, G. M. (2009). Spotlight on buprenorphine/naloxone in the treatment of opioid dependence. *CNS Drugs, 23*(10), 899–902.

Patra, J., Gilksman, L., Fischer, B., Newton-Taylor, B., Belenko, S., Ferrari, M., . . . Rehm, J. (2010). Factors associated with treatment compliance and its effects on retention among participants in a court mandated treatment program. *Contemporary Drug Problems, 37*, 289–313.

Redko, C., Rapp, R. C., & Carlson. R. G. (2007). Pathways of substance users linking (or not) with treatment. *Journal of Drug Issues. Summer 37*(3), 597–617.

Rogers, C. R. (1977). *Carl Rogers on personal power*. New York: Delacorte Press.

Rothenberg, L. (1988). The ethics of intervention. *Alcoholism & Addiction, 9*(1), 22–24.

Senbanjo, R., Wolff, K., Marshall, J., & Strang, J. (2009). Persistence of heroin use despite methadone treatment: Poor coping self-efficacy predicts continued heroin use. *Drug and Alcohol Review, 28*, 608–615.

Shearer, J. (2007). Psychosocial approaches to psychostimulant dependence: A systematic review. *Journal of Substance Abuse Treatment, 32*(1), 41–52.

Smith, D. E., Lee, D. R., & Davidson, L. D. (2010). Health care equality and parity for treatment of addictive disease. *Journal of Psychoactive Drugs, 41*(2), 121–126.

Suh, J. J., Pettinati, H. M., Kampman, K. M., & O'Brien, C. (2006). The status of disulfiram: A half century later. *Journal of Clinical Psychopharmacology, 26*(3), 290–302.

Vader, A. M., Walters, S. T., Houck, J. M., Prabhu, G. C., & Field, C. A. (2010). The language of motivational interviewing and feedback: Counselor language, client language, and client drinking outcomes. *Psychology of Addictive Behaviors, 24*(2), 190–197.

Walker, M. A. (2009). Program characteristics and the length of time clients are in substance abuse treatment. *Journal of Behavioral Health Services and Research, 36*(3), 330–342.

Wesson, D. R., & Smith, D. E. (2010). Buprenorphine in the treatment of opiate dependence. *Journal of Psychoactive Drugs, 42*(2), 161–175.

West, S. (2008). The utilization of vocational rehabilitation services in substance abuse treatment facilities in the U.S. *Journal of Vocational Rehabilitation, 29*(2), 71–75.

Treatment Setting and Treatment Planning

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Methods for developing accurate assessments and diagnoses for substance abusers and dependents are described elsewhere in this text. The proposed *DSM*5 will be used to identify a category or level (*moderate* or *severe*) of individuals diagnosed with a substance use disorder. This essential first step provides the theoretical and practical base for making future decisions about how to develop and organize an effective treatment experience for clients.

We continue the study of substance abuse by presenting the next step in organizing treatment. By building on the concepts of accurate assessment and diagnosis, this text introduces the reader to the basic terms and processes of treatment settings and treatment planning. Each element is defined, described, and illustrated, providing a strong base by which to understand topics, including treatment modalities, working with special populations, and relapse prevention. In this chapter, it is assumed that case examples received adequate and reliable assessment and diagnosis, which paved the way for the treatment considerations of setting and planning.

WHAT IS A TREATMENT SETTING?

A *treatment setting* is the place or environment where substance abuse treatment services are provided. These environments may look very different to the outside observer and range from most restrictive to least restrictive. *Restrictive* refers to the degree of physical and social structure provided by the professional staff for the recovering substance abuser. For example, a highly restrictive environment would be considered a locked, inpatient hospital setting where clients are encouraged to live and receive their treatment. The *DSM*5 descriptor category of *severe* would be used for individuals in restrictive settings that have been classified with a *substance use disorder*. In contrast, a weekly voluntary outpatient substance abuse treatment program would be considered a setting of less restriction where clients generally reside in their homes and attend scheduled meetings with professionals at designated agencies, offices, churches, and/or treatment facilities. A *moderate* category would be used in these cases.

Clients fall within a range of diagnoses and severity of illness. In general, the more severe the substance use disorder diagnosis (*moderate, severe*), the more restricted the environment or setting that is recommended. This rationale suggests that clients need settings that match their diagnosis and descriptor category for treatment to be effective. Selection of a treatment setting is similar to the manner in which physicians prescribe different medications, medication strengths, and dosing schedules for patients. Settings, like medications, should fit the diagnosis, meeting the needs of the client and presenting problems.

Clients can move between settings depending on their progress in treatment and the recommendations of treatment staff. The goal is always to provide the least restrictive environment that offers the optimal types of services that match client needs. This approach ensures a respect for the client's autonomy and ability to move away from an unhealthy dependency. It embraces the client's self-determination skills, which are essential in initiating and maintaining substance abuse/dependency recovery.

This chapter provides examples of seven of the most common treatment settings. It is not an exhaustive list but will provide a working knowledge of traditional treatment settings, ranging from most restrictive to least restrictive. In addition treatment settings in the military are described at the conclusion of this chapter following the case of Andrew.

- Medical detoxification and stabilization
- Dual-diagnosis hospital inpatient
- Free-standing rehabilitation and residential programs
- Partial hospitalization
- Temporary recovery or halfway homes
- Intensive outpatient
- Outpatient DUI/DWAI/DUID programs

Important distinctions among the settings exist even though similar services may be offered such as prevention, counseling, education, and/or self-help. Clients involved in any one setting can be either voluntary or involuntary participants. This means that within any one setting, some participants may be court ordered or mandated, while others enter treatment without legal requirements.

Settings do not consistently reflect the client's voluntary or involuntary status. An exception to this rule would be prison-based drug treatment facilities and DUI

diversion programs. Otherwise, many substance abuse treatment professionals argue that most "voluntary" clients entering treatment have an "involuntary" element to their decision to enter treatment. These "voluntary" clients can often feel pressured by coworkers, family members, and/or physicians. Fisher and Roget (2009) support that coerced treatment, although popular and successful for some, may have little benefit, adding that self-motivation is essential for long-term success. Important considerations determining the client's success or failure include quality and effectiveness of the treatment program.

Case Discussion

Case 3 (Leigh).

To illustrate the concept of treatment settings, let us extend Case 3 and imagine Leigh, a 16-year-old marijuana and alcohol user who has run into trouble with her substance use. Her problems intensified one evening when she and her friends were brought into custody for questioning by police. Leigh was partying with some new friends in a wooded area close to the high school she attends. Police, responding to a complaint initiated by neighbors in the area, confronted the adolescents and found alcohol and marijuana. Officials were concerned about the underage drinking, illegal use of marijuana, and in particular Leigh's emotional state, which was hostile, disoriented, and apparently intoxicated.

Police contacted Leigh's mother and discussed the possibility of charging Leigh with possession of marijuana and disorderly conduct. After several unsuccessful attempts by police to persuade Leigh to seek immediate medical care, she was evaluated to be at risk to herself and was involuntarily admitted to medical detoxification. She spent several days in detoxification and getting "clear headed," and then she voluntarily agreed to attend a rehabilitation program. When she had 28 days of successful treatment, her counselors recommended an intensive outpatient program to continue her recovery.

This scenario illustrates that treatment settings are not stagnant environments but integrative opportunities to move clients toward recovery and health. The reverse is also possible. Leigh might have a relapse (or slip) and need a temporary, more restrictive setting to regain her hard-won progress.

Moving up and down this continuum of care provides a multitude of treatment services designed to fit the client's unique needs. The effectiveness of treatment settings comes from their flexibility, adaptability, and responsiveness to the client's current recovery needs.

TYPES OF TREATMENT SETTINGS

Medical Detoxification and Stabilization

Detoxification is the safe and complete physical withdrawal of incapacitating substances such as alcohol, barbiturates, hallucinogens, and heroin. Detoxification units can be within hospitals or freestanding units.

Research published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (2009) describes a medical and social model of detoxification (*Detoxification and Substance Abuse Treatment Training Manual*). The medical model

utilizes medical staff, including doctors and nurses, to administer medication to safely assist people through withdrawal. The social model, on the other hand, rejects the use of medication and relies on a supportive, non-hospital setting to help the client through withdrawals (Fisher & Roget, 2009). Admittedly, there is no "pure" model for detoxification treatment; as both models utilize each others concepts in their respective programs with notable success.

Medical models establish medical necessity before admission and refer to the risk of medical problems (e.g., seizures) or psychiatric difficulties (e.g., suicidal ideation) the client exhibits. In drug and alcohol detoxification facilities, doctors use medication to lessen the often uncomfortable and sometimes brutal side effects of drug withdrawal, while preparing the client for the counseling and addiction treatment (Grohsman, 2009). This process includes gradual tapering of the drug(s) over a period of several days or weeks. For example, heroin can be weaned from an individual and substituted with a longer-acting opioid such as methadone. Other medications may be administered to lessen physical and psychological symptoms associated with withdrawal.

The length of stay is usually less than two weeks. Detoxification should be considered only the beginning of treatment. Although medical detoxification is an effective method of treatment, it alone is rarely sufficient to help clients achieve long-term sobriety (Grohsman, 2009). It is important to establish a treatment plan that will outline the client's intervention and goals well past the point of detoxification. Treatment planning, including discharge plans and long-term goals should begin upon client admission into a service and/or program and the discharge plan should continue to be updated during the course of the client's treatment (Baron, Erlenbusch, Moran, O'Conner, Rice, & Rodriguez, 2008).

Detoxification settings provide:

- screening for presence of withdrawal symptoms and/or psychiatric conditions,
- on-site medical and psychiatric care that promotes safe and complete withdrawal,
- staff who structure and nurture the environment,
- staff who protect clients from self-harm or harm to others, and
- staff who educate and counsel clients about substance abuse and dependency.

Dual-Diagnosis Hospital Inpatient

Usually based in psychiatric hospitals, dual-diagnosis programs are designed to treat clients with the presence of both serious psychiatric illness and substance abuse/dependency. Services are provided to diagnose and treat substance dependency as well as symptoms attributable to psychiatric illness. Each condition must be assessed independently and in relation to the other presenting conditions or symptoms. This is done to withdraw the affected client safely from substances, stabilize the client emotionally and physically, and identify and treat the concomitant disorders.

The personnel's expertise is helping dually diagnosed clients stop abusing substances and maintain their psychiatric treatment regimens, which may include prescribed psychotropic medication (e.g., antidepressants, antipsychotics, antianxiety drugs). Specialized training in dual diagnosis requires staff and counselors to understand how concomitant disorders can interact and manifest in the clients' lives. Individuals may reside in these hospital units from several days to several weeks. Programs are designed for either adult or youth treatment.

Dual-diagnosis hospital inpatient settings provide:

- on-site medical and psychiatric care that includes 24-hour nursing and milieu supervision and locked units with limited access to family and friends;
- personnel with specialized knowledge in dual diagnosis;
- 7-, 14-, or 28-day stays in a protective, restricted environment;
- psychiatric and substance abuse crisis stabilization;
- more intensive assessment and diagnostic services; and
- daily intensive group contact with other clients and staff.

Figure 1 defines some common staffing patterns for inpatient and partial hospital treatment settings.

Free-Standing Rehabilitation and Residential Programs

REHABILITATION PROGRAMS Rehabilitation programs are usually free-standing, non-hospital-based facilities. Doweiko (2011) maintains that the well-recognized Minnesota Model of addiction treatment has been the dominant model for rehabilitation programs in the United States since its inception. Fisher and Roget (2009) add that it is the leading model for addiction treatment today for many alcohol and other drug treatment centers in the United States and worldwide. Despite revisions in its basic model due to changes in insurance program reimbursement policies, it still remains a strong influence on both inpatient and outpatient rehabilitation programs. Hazelden, an inpatient and outpatient treatment facility dedicated to treating alcoholics, is considered to be one of the major contributors to the Minnesota Model (Stinchfield & Owen, 1998). Founded in 1949, Hazelden pioneered the 28-day rehabilitation program for alcoholics.

Today, the Minnesota model is known as the Hazelden model for its continuation of the legacy of the original model through ongoing evaluation of research and the enhancement of the model with newer and more effective techniques (Fisher & Roget, 2009). Two long-term treatment goals of the Minnesota Model are total abstinence from all mood-altering substances and an improved quality of life. Consistent with the philosophy of AA, the objectives for the individual are to grow in transcendental, spiritual awareness, to recognize personal choice and responsibility, and to develop peer relationships. The resources for recovery, then, lie primarily within the client with treatment providing the opportunity to discover and utilize those resources and the therapeutic atmosphere conducive to change (client-centered approach) (Derry, 2009).

Patricia Owen, director of the Butler Center for Research and Learning for the Hazelden Foundation, describes the Minnesota Model Counseling Approach in her work published in the National Institutes of Health (Owen, 2000). She describes the Minnesota Model's concept by stating "chemical addiction is seen as a primary, chronic, and progressive disease" (p. 117). It is a disease that is treated largely in group sessions. By engaging with counselors and members of the peer group, the client is encouraged to develop meaningful relationship experiences and clarify feelings and definitions of reality. Success of the process is characterized by relief, peace, increased sense of self-worth, acceptance by self and the group, and the existential restoration of meaning to life (Derry, 2009). Examples of the type of therapy offered by group treatment include: focusing on a broader reality; overcoming denial and gaining greater acceptance of personal responsibility and hope for change; learning about the disease and related