Screening and Assessment for Medication Assisted Treatment for Opioid Addiction

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4 Initial Screening, Admission Procedures, and Assessment Techniques

In This Chapter...

Initial screening or intake procedures determine an applicant's eligibility and readiness for medication-assisted treatment for opioid addiction (MAT) and admission to an opioid treatment program (OTP). Ongoing assessment should begin as soon as a patient is admitted to an OTP. It provides a basis for individualized treatment planning and increases the likelihood of positive outcomes.

No single tool incorporates all the important elements for assessing patients in MAT. The Addiction Severity Index (ASI) (McLellan et al. 1992), although not comprehensive, can guide collection of the basic information needed to measure patient conditions and progress objectively. Recent research (e.g., Bovasso et al. 2001) continues to support the validity of ASI composite scores. The consensus panel recommends that OTPs develop tools and methods for more extensive assessment. This chapter describes screening and assessment procedures and important considerations that might be made during and shortly after admission to an OTP, as well as assessment techniques and considerations that are important to ongoing MAT.

Initial Screening

First Contact

The screening process begins when an applicant or family member first contacts an OTP, often via telephone or a visit to the OTP. This contact is the first opportunity for treatment providers to establish an effective therapeutic alliance among staff members, patients, and patients' families. Careful planning for and interaction with new applicants and their families contribute to positive MAT outcomes. Staff members should be prepared to provide immediate, practical information that helps potential applicants make decisions about MAT, including the approximate length of time from first contact to admission, what to expect during the admission process, and types of services offered. A brief exploration of

applicants' expectations and circumstances can reveal other information they need for considering MAT.

Goals of Initial Screening

The consensus panel recommends the following goals for initial screening:

- **Crisis intervention.** Identification of and immediate assistance with crisis and emergency situations (see "Screening of Emergencies and Need for Emergency Care" below)
- **Eligibility verification.** Assurance that an applicant satisfies Federal and State regulations and program criteria for admission to an OTP
- **Clarification of the treatment alliance.** Explanation of patient and program responsibilities
- **Education.** Communication of essential information about MAT and OTP operations (e.g., dosing schedules, OTP hours, treatment requirements, addiction as a brain disease) and discussion of the benefits and drawbacks of MAT to help applicants make informed decisions about treatment
- **Identification of treatment barriers.** Determination of factors that might hinder an applicant's ability to meet treatment requirements, for example, lack of childcare or transportation.

Along with these primary goals, initial screening can begin to identify other medical and psychosocial risk factors that could affect treatment, including factors related to mental disorders; legal difficulties; other substance use; and vocational, financial, transportation, and family concerns. Cultural, ethnic, and spiritual factors that affect communication and might affect treatment planning should be noted as early as possible. Staff members should obtain enough information from applicants to accommodate needs arising from any of these factors if necessary.

Screening of Emergencies and Need for Emergency Care

The consensus panel recommends that providers develop medically, legally, and ethically sound policies to address patient emergencies. Emergencies can occur at any time but are most common during induction to MAT and the acute treatment phase (see chapter 7). In particular, patients who exhibit symptoms that could jeopardize their or others' safety should be referred immediately for inpatient medical or psychiatric care. If possible, staff members who conduct initial screening and assessment should make appropriate referrals before applicants are admitted to an OTP. Identifying and assessing emergencies may require staff familiarity with the components of a mental health status examination (see "Psychosocial Assessment" below).

Suicidality

In a study of population data from the U.S. National Comorbidity Survey, a significant association was found between opioid addiction and increased risk of suicide (Borges et al. 2000). Initial screening and periodic assessments should help determine whether those indicating risks of suicide need additional services (e.g., hospitalization for protection or treatment, outpatient mental treatment, or evaluation for antidepressant medication). Exhibit 4-1 lists some indicators of suicidality. Exhibit 4-2 lists recommended responses.

Homicidality and threats of violence

Threats should be taken seriously. For example, if an individual with knowledge of OTP procedures and schedules makes a threat, patterns of interaction between staff and this individual should be shifted. It might be necessary to change or stagger departure times, implement a buddy system, or use an escort service (National Institute for Occupational Safety and Health 1996). Counseling assignments can be changed, or patients can be transferred to another OTP.

Exhibit 4-1

Suicide Risk Factors

Behavioral and Circumstantial Indicators of Suicide Risk	
• Talk about committing suicide	• Giving away prized possessions
• Trouble eating or sleeping	• History of suicide attempts
• Drastic changes in behavior	• Unnecessary risk taking
• Withdrawal from friends or social activities	• Recent severe losses
• Loss of interest in hobbies, work, or school	• Preoccupation with death and dying
• Preparations for death, such as making a will or final arrangements	• Loss of interest in personal appearance
	• Increased use of alcohol or drugs
Expressed Emotions That May Indicate Suicide Risk	
• Can't stop the pain	• Can't make the sadness go away
• Can't think clearly	• Can't see a future without pain
• Can't make decisions	• Can't see oneself as worthwhile
• Can't see any way out	• Can't get someone's attention
• Can't sleep, eat, or work	• Can't seem to get control
• Can't get out of depression	

Source: Adapted from American Association of Suicidology n.d.

Exhibit 4-2

Recommended Responses to Indicators of Suicidality

- Be direct. Talk openly and matter-of-factly about suicide.
- Be willing to listen. Allow expressions of feelings. Accept the feelings.
- Be nonjudgmental. Don't debate whether suicide is right or wrong or feelings are good or bad. Don't lecture on the value of life.
- Get involved. Become available. Show interest and support.
- Don't dare an individual to do it.
- Don't act shocked. This puts distance between the practitioner and the individual.
- Don't be sworn to secrecy. Seek support.
- Offer hope but not glib reassurances that alternatives are available.
- Take action. Remove means, such as guns or stockpiled pills.
- Get help from persons or agencies specializing in crisis intervention and suicide prevention.

Source: Adapted from American Association of Suicidology n.d.

The consensus panel recommends that OTP staff members receive training in recognizing and responding to the signs of potential patient violence. OTPs should develop policies and procedures for homicide and other violent situations. The OTP's policy on violence and threats of violence should be explained at the beginning of treatment. Emergency screening and assessment procedures should include the following:

- Asking the patient questions specific to homicidal ideation, including thoughts, plans, gestures, or attempts in the past year; weapons charges; and previous arrests, restraining orders, or other legal procedures related to real or potential violence at home or the workplace.
- Documenting violent incidents and diligent monitoring of these records to assess the nature and magnitude of workplace violence and to quantify risk. When a threat appears imminent, all legal, human resource, employee assistance, community mental health, and law enforcement resources should be readied to respond immediately (National Institute for Occupational Safety and Health 1996).

Admission Procedures and Initial Evaluation

After initial applicant screening, the admission process should be thorough and facilitate timely enrollment in the OTP. This process usually marks patients' first substantial exposure to the treatment system, including its personnel, other patients, available services, rules, and requirements. The admission process should be designed to engage new patients positively while screening for and assessing problems and needs that might affect MAT interventions.

Timely Admission, Waiting Lists, and Referrals

The longer the delays between first contact, initial screening, and admission and the more appointments required to complete these procedures, the fewer the applicants who actually enter treatment. Prompt, efficient orientation and evaluation contribute to the therapeutic nature of the admission process.

If a program is at capacity, admitting staff should advise applicants immediately of a waiting list and provide one or more referrals to programs that can meet their treatment needs more quickly. A centralized intake process across programs can facilitate the admission process, particularly when applicants must be referred. For example, if an applicant accepts referral to another provider, telephone contact by the originating program often can facilitate the applicant's acceptance into the referral program. If an applicant goes willingly to another program for immediate treatment but prefers admission to the original OTP, the admission process should be completed and the applicant's name added to the waiting list.

Patients who prefer to await treatment at the original site should be added to the waiting list and contacted periodically to determine whether they want to continue waiting or be referred. For individuals who are ineligible, staff should assess the need for other acute services and promptly make appropriate referrals. The consensus panel recommends that each OTP establish criteria to decide which prequalified patients should receive admission priority, especially when a program is near capacity. For example, some programs offer high-priority admission to pregnant women, addicted spouses of current patients, applicants with HIV infection or other serious medical conditions, or former patients who have tapered off maintenance medication but subsequently require renewed treatment.

Interim Maintenance Treatment

For eligible individuals who cannot be admitted to a public or nonprofit program for comprehensive maintenance services within a reasonable geographic area and within 14 days of applying, 42 Code of Federal Regulations (CFR), Part 8 § 12(j), provides for "interim maintenance treatment," in which medication is administered to patients at an OTP for up to 120 days without formal screening or admission

and with only minimal drug testing, assuming the existence of reasonable criteria at the OTP to prioritize admissions.

Denial of Admission

Denial of admission to an OTP should be based on sound clinical practices and the best interests of both the applicant and the OTP. Admission denial should be considered, for example, if an applicant is threatening or violent. Continuity of care should be considered, and referral to more suitable programs should be the rule. Due process and attention to applicant rights (see CSAT 2004*b*) minimize the possibility that decisions to deny admission to an OTP are abusive or arbitrary.

Admission Team

OTPs should have qualified, compassionate, well-trained multidisciplinary teams (see chapter 6) that efficiently collect applicants' information and histories, evaluate their needs as patients, and orient them to MAT. Team members should be cross-trained in treating addiction and co-occurring disorders. Those conducting admission interviews should be culturally competent, and their interactions with applicants should not be stigmatizing. They also should be able to communicate OTP policies and services and make appropriate referrals.

Information Collection and Dissemination

Collection of patient information and dissemination of program information occur by various methods, such as by telephone; through a receptionist; and through handbooks, information packets, and questionnaires. Medical assessments (e.g., physical examinations, blood work) and psychosocial assessments also are necessary to gather specific types of information. Although collection procedures differ among OTPs, the consensus panel recommends that the following types of information be collected, documented, or communicated to patients:

- **Treatment history.** An OTP should obtain a new patient's substance abuse treatment history, preferably from previous treatment providers, including information such as use of other substances while in treatment, dates and durations of treatment, patterns of success or failure, and reasons for discharge or dropout. Written consent from a patient is required to obtain information from other programs (see CSAT 2004*b*). (See below for details on other components to include in this history.)
- **Orientation to MAT.** All patients should receive an orientation to MAT, generally extending over several sessions and including an explanation of treatment methods, options, and requirements and the roles and responsibilities of those involved. Each new patient also should receive a handbook (or other appropriate materials), written at an understandable level in the patient's first language if possible, that includes all relevant program-specific information needed to comply with treatment requirements. Patient orientation should be documented carefully for medical and legal reasons. Documentation should show that patients have been informed of all aspects of the multifaceted MAT process and its information requirements, including (1) the consent to treatment (CSAT 2004*b*), (2) program recordkeeping and confidentiality requirements (e.g., who has access to records and when, who can divulge information without patient consent [see CSAT 2004*b*]), (3) program rules, including patient rights, grievance procedures, and circumstances

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under which a patient can be discharged involuntarily, and (4) facility safety instructions (e.g., emergency exit routes). OTPs should require patients to sign or initial a form documenting their participation in the orientation process. Also, patients must receive and sign a written consent to treatment form (see Appendix 4-A; see also CSAT 2004*b*), which is kept on file by the OTP.

- **Age of applicant.** Persons younger than age 18 must meet specific Federal and State requirements (at this writing, some States prohibit MAT for this group), and an OTP must secure parental or other guardian consent to start adolescents on MAT (see discussion below of exemptions from the Substance Abuse and Mental Health Services Administration's [SAMHSA's] 1-year dependence duration rule).
- **Recovery environment.** A patient's living environment, including the social network, those living in the residence, and stability of housing, can support or jeopardize treatment.
- **Suicide and other emergency risks.** (See above.)
- **Substances of abuse.** A patient's substance abuse history should be recorded, focusing first on opioid use, including severity and age at onset of physical addiction, as well as use patterns over the past year, especially the previous 30 days. A baseline determination of current addiction should meet, to the extent possible, accepted medical criteria. Many people who are opioid addicted use other drugs and alcohol; this multiple substance use has definite implications for treatment outcomes (see "Substance Use Assessment" below and chapter 11). Therefore, screening and medical assessment also should identify and document nonopioid substance use and determine whether an alternative intervention (e.g., inpatient detoxification) is necessary or possible before an applicant is admitted to the OTP.
- **Prescription drug and over-the-counter medication use.** All prescription drug and over-the-counter medication use should be identified. Procedures should be in place to determine any instances of misuse, overdose, or addiction, especially for psychiatric or pain medications. The potential for drug interactions, particularly with opioid treatment medications, should be noted (see chapter 3).
- **Method and level of opioid use.** The general frequency, amounts, and routes of opioid use should be recorded. If opioids are injected, the risk of communicable diseases (e.g., HIV/AIDS, hepatitis C, endocarditis) increases. Patient reporting helps providers assess patients' substance addiction and tolerance levels, providing a starting point to prescribe appropriate treatment medication for stabilization (American Psychiatric Association 2000; Mee-Lee et al. 2001*a*).
- **Pattern of daily preoccupation with opioids.** A patient's daily pattern of opioid abuse should be determined. Regular and frequent use to offset withdrawal is a clear indicator of physiological dependence. In addition, people who are opioid addicted spend increasing amounts of time and energy obtaining, using, and responding to the effects of these drugs.
- **Compulsive behaviors.** Patients in MAT sometimes have other impulse control disorders. A treatment provider should assess behaviors such as compulsive gambling or sexual behavior to develop a comprehensive perspective on each patient.
- **Patient motivation and reasons for seeking treatment.** Prospective patients typically present for treatment because they are in withdrawal and want relief. They often are preoccupied with whether and when they can receive medication. Because successful MAT entails not only short-term relief

but a steady, long-term commitment, applicants should be asked why they are seeking treatment, why they chose MAT, and whether they fully understand all available treatment options and the nature of MAT. Negative attitudes toward MAT may reduce patient motivation. However, concerns about motivation should not delay admission unless applicants clearly seem ambivalent. In such cases, treatment providers and applicants can discuss the pros and cons of MAT. The consensus panel believes that identifying and addressing concerns about and stressing the benefits of MAT as early as possible are essential to long-term treatment retention and maintaining patient motivation for treatment.

- **Patient personal recovery resources.** A patient's comments also can identify his or her recovery resources. These include comments on satisfaction with marital status and living arrangements; use of leisure time; problems with family members, friends, significant others, neighbors, and coworkers; the patient's view of the severity of these problems; insurance status; and employment, vocational, and educational status. Identification of patient strengths (e.g., stable employment, family support, spirituality, strong motivation for recovery) provides a basis for a focused, individualized, and effective treatment plan (see chapter 6).
- **Scheduling the next appointment.** Unless the program can provide assessment and admission on the same day, the next visit should be scheduled for as soon as possible. To facilitate an accurate diagnosis of opioid addiction and prompt administration of the initial dose of medication when other documentation of a patient's condition is unavailable, the applicant should be instructed to report to the OTP while in mild to moderate opioid withdrawal.

Medical Assessment

Medical assessment plays a substantial role in determining MAT eligibility. Some assessment tools and methods mentioned briefly in this chapter are explained further in chapter 10.

The results of medical assessment, including toxicology tests, other laboratory results, and psychosocial assessment, usually are reviewed by a program physician and then submitted to the medical director in preparation for pharmacotherapy. Programs should minimize delay in administering the first dose of medication because, in most cases, applicants will present in some degree of opioid withdrawal.

Determination of Opioid Addiction and Verification of Admission Eligibility

Federal regulations on eligibility

Federal regulations state that, in general, opioid pharmacotherapy is appropriate for persons who currently are addicted to an opioid drug and became addicted at least 1 year before admission (42 CFR, Part 8 § 12(e)). Documentation of past addiction might include treatment records or a primary care physician's report. When an applicant's status is uncertain, admission decisions should be based on drug test results and patient consultations.

Exemptions from SAMHSA's 1-year dependence duration rule

If appropriate, a program physician can invoke an exception to the 1-year addiction history requirement for patients released from correctional facilities (within 6 months after release), pregnant patients (program physician must certify pregnancy), and previously treated patients (up to 2 years after discharge) (42 CFR, Part 8 § 12(e)(3)).

A person younger than 18 must have undergone at least two documented attempts at detoxification or outpatient psychosocial treatment within 12 months to be eligible for maintenance treatment. A parent, a legal guardian, or an adult designated by a relevant State authority must consent in writing for an adolescent to participate in MAT (42 CFR, Part 8 § 12(e)(2)). Patients younger than 18 should receive age-appropriate treatments, ideally with a separate treatment track (e.g., young adult groups).

Cases of uncertainty

When absence of a treatment history or withdrawal symptoms creates uncertainty about an applicant's eligibility, OTP staff should ask the applicant for other means of verification, such as criminal records involving use or possession of opioids or knowledge of such use by a probation or parole officer. A notarized statement from a family or clergy member who can attest to an individual's opioid abuse might be feasible.

The consensus panel does not recommend use of a naloxone (Narcan®) challenge test (see chapter 5) in cases of uncertainty. Physical dependence on opioids can be demonstrated by less drastic measures. For example, a patient can be observed for the effects of withdrawal after he or she has not used a short-acting opioid for 6 to 8 hours. Administering a low dose of methadone and then observing the patient also is appropriate. Administering naloxone, although effective, can initiate severe withdrawal, which the consensus panel believes is unnecessary. It also requires invasive injection, and the effects can disrupt or jeopardize prospects for a sound therapeutic relationship with the patient. The panel recommends that naloxone be reserved to treat opioid overdose emergencies.

History and Extent of Nonopioid Substance Use and Treatment

The extent and level of alcohol and nonopioid drug use and treatment also should be determined, and decisions should be made about whether these disorders can be managed safely during MAT (see "Substance Use Assessment" below and chapter 11).

Medical History

A complete medical history should include organ system diagnoses and treatments and family and psychosocial histories. It should cover chronic or acute medical conditions such as diabetes, liver or renal diseases, sickle cell trait or anemia, and chronic pulmonary disease. Documentation of infectious diseases, including hepatitis, HIV/AIDS, tuberculosis (TB), and sexually transmitted diseases (STDs), is especially important. Staff should note patients' susceptibility to vaccine-preventable illnesses and any allergies and treatments or medications received for other medical conditions. Women's medical histories also should document previous pregnancies; types of delivery; complications; current pregnancy status and involvement with prenatal care; alcohol and drug use, including over-the-counter medications, caffeine, and nicotine, before and during any pregnancies; and incidences of sudden infant death syndrome.

Complete Physical Examination

Each patient must undergo a complete, fully documented physical examination by the program physician, a primary care physician, or an authorized health care professional under the direct supervision of the program physician, before admission to the OTP. The full medical examination, including the results of the serology and other tests, must be documented in the patient's record within 14 days following admission. States may have additional requirements, and OTPs must comply with

these requirements. The examination should cover major organ systems and the patient's overall health status and should document indications of infectious diseases; pulmonary, liver, and cardiac abnormalities; dermatologic sequelae of addiction; vital signs; general appearance of head, eyes, ears, nose, throat, chest,
abdomen, extremities, and skin; and physical evidence of injection drug use and dependence, as well as the physician's clinical judgment of the extent of physical dependence. Women should receive a pregnancy test and a gynecological examination at the OTP site or by referral to a women's health center. Again, the results of all tests, laboratory work, and other processes related to the initial medical examination are to be contained in the patient's file within 14 days following admission.

Laboratory Tests

Although Federal regulations no longer require OTPs to conduct a full panel of laboratory tests, some States do. The consensus panel recommends that laboratory tests include routine tests for syphilis, hepatitis, TB, and recent drug use. SAMHSA regulations stipulate "at least eight random drug abuse tests" annually per patient, performed according to accepted OTP practice (CFR 42, Part 8 § 12(f)(6)). Given that some drugs are metabolized extensively and excreted quickly, it is important that analytic procedures provide the highest sensitivity for substances of interest, such as breath testing for alcohol use.

TB testing

The risk of TB infection and disease is high among individuals involved with drugs (Batki et al. 2002). Rates of active TB among people who use substances and are HIV infected are high (Gourevitch et al. 1999), and cases of multidrug-resistant TB in this group are increasing. All patients should undergo screening and medical examination for TB every 12 months. Anergy panel tests should be administered to anergic patients (those with diminished reactivity to certain antigens). Patients who are immune system compromised might have a negative purified protein derivative test, even with active infection. A chest x ray or sputum analysis should be done if there is doubt. If a patient has a positive TB test, medical staff should treat the patient accordingly (see chapter 10) or refer him or her to a primary care clinic for treatment.

Hepatitis testing

People who inject drugs are at high risk for hepatitis virus infection (see chapter 10) and should be tested at admission to an OTP. Hepatitis A is an important liver infection that affects people who abuse drugs at higher rates than people who do not. Most patients in OTPs are seropositive for surface antigen or antibody to hepatitis B virus (HBV) core antigen, and some exhibit signs of chronic hepatitis. Any patients whose tests are negative for hepatitis A virus or HBV infection should be vaccinated for these infections at the OTP or by referral.

> [R]esults of…the medical examination are to be…in the patient's file within 14 days following admission.

Hepatitis C virus (HCV) accounts for most new hepatitis cases among people who inject drugs, infects between 70 and 96 percent of this population, and is the country's leading cause of chronic liver disease (Sylvestre 2002*b*). The consensus panel strongly recommends that HCV diagnosis and referral be an integral component of initial MAT assessment. Programs that do not offer onsite HCV antibody testing should provide appropriate referrals. (A simple blood test for hepatitis C antibodies is available; a positive result does not necessarily signal current infections, only that antibodies have developed.)

HIV testing

OTPs are required to provide adequate medical services, and the program sponsor must be able to document that these services are fully and reasonably available to patients. HIV testing on site or by referral, with pretest and posttest counseling, is a recommended medical service. OTPs should make HIV testing part of their medical services as recommended by the Centers for Disease Control and Prevention (2001*a*). Medical care and other supportive services can be offered if patients' HIV and HCV statuses are known early in treatment and monitored continuously.

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Rapid HIV tests have been approved by the U.S. Food and Drug Administration (FDA) and are recommended by the U.S. Public Health Service to facilitate early diagnosis of HIV infection among at-risk populations involved in substance abuse (Centers for Disease Control and Prevention 2002*a*). Rapid tests can detect antibodies to HIV in blood obtained by fingerstick or venipuncture, or in oral fluid and provide reliable and valid results in 20 minutes or less. Thus, the rapid HIV test provides a measure of exposure to HIV and requires confirmatory testing for a diagnosis of HIV infection. In studies by the manufacturer, the blood antibody test correctly identified 99.6 percent of people infected with HIV and 100 percent of those not infected, which is comparable to the results of FDA-approved enzyme immunoassays. FDA expects clinical laboratories to obtain similar results (Centers for Disease Control and Prevention 2003*b*). OTPs performing rapid HIV tests should comply with the guidelines provided in SAMHSA's Rapid HIV Testing Initiative. As a preliminary positive test, positive results should be confirmed by supplemental HIV testing. In addition, some States have other requirements for laboratory testing in general and HIV testing specifically.

STD testing

Early testing for STDs in patients receiving MAT usually is a State health requirement. Persons who inject drugs are at higher risk of STDs, primarily from increased likelihood of involvement in sex trading to finance drug use and the disinhibiting effects of psychoactive substances (Sullivan and Fiellin 2004). Therefore, all patients in MAT should receive serologic screening for syphilis and, for women and symptomatic men, genital cultures for gonorrhea and chlamydia (Sullivan and Fiellin 2004). In the early stages of admission and treatment, patients should be educated about the effects of STDs and their correlation with other communicable diseases, such as HIV/AIDS and hepatitis C, to increase patients' knowledge of the ways they can avoid these risks.

For many patients who are opioid addicted, sexual activities are intertwined with drug use behaviors (Calsyn et al. 2000*b*). Documenting the sexual histories of heterosexual and lesbian, gay, and bisexual (LGB) patients, in terms of timing of sexual encounters and partners, is essential to determine their potential exposure to HCV, HIV, and other STDs, as well as the risk of infection for other sexual partners. Several studies have pointed to increased high-risk sexual behavior among populations that are substance addicted, homeless, and mentally ill, in addition to higher levels of psychological distress and psychiatric symptoms (McKinnon et al. 2002; Stoskopf et al. 2001).

Additional drug testing

After initial drug testing, subsequent assessment should include further review of urine, blood, oral fluid, or other drug test results. Ideally, drug tests should be conducted regularly and randomly during treatment. The first test is

especially important because it is part of the initial evaluation and may serve as documentation of current opioid use. As noted in Federal regulations, the presence of opioids in test results does not establish a diagnosis of opioid addiction, and the absence of opioids does not rule it out. Clinical examination and an applicant's medical history are keys to determine the appropriateness of MAT. Chapter 9 discusses drug-testing procedures and Federal regulations governing these procedures.

Women's Health

Women in MAT should receive information on their particular health needs, for example, family planning, gynecological health, and menopause (see the forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* [CSAT forthcoming *f*]). Women of childbearing age should be counseled on pregnancy testing during admission before making decisions about detoxification (42 CFR, Part 8 § 12(e)(3)). Pregnancy testing, along with onsite access to or referral for family planning services, should be available in all OTPs as part of an overall women's health initiative (see chapter 13).

Induction Assessment

Induction is the riskiest stage of MAT (see chapter 5), and proper medical assessment during induction requires an understanding of the pharmacology of treatment medication (see chapter 3). A patient should be assessed at least daily during induction for signs of overmedication or undermedication, and dose adjustments should be made accordingly.

Comprehensive Assessment

Completion of induction marks the beginning of stabilization and maintenance treatment and ongoing, comprehensive medical and psychosocial assessment conducted over multiple sessions. This assessment should include, but not be limited to, patient recollections of and attitudes about previous substance abuse treatment; expectations and motivation for treatment; level of support for a substance-free lifestyle; history of physical or sexual abuse; military or combat history; traumatic life events; and the cultural, religious, and spiritual basis for any values and assumptions that might affect treatment. This information should be included in an integrated summary in which data are interpreted, patients' strengths and problems are noted, and a treatment plan is developed (see chapter 6) that matches each patient to appropriate services.

Data should be collected in a respectful way, taking into consideration a patient's current level of functioning. Motivational interviewing techniques (Miller and Rollnick 2002) can help engage applicants early. The information collected depends on program policies, procedures, and treatment criteria; State and Federal regulations; and the patient's stability and ability to participate in the process. The psychosocial history can reveal addiction-related problems in areas that might be overlooked, such as strengths, abilities, aptitudes, and preferences. Most information can be analyzed by using standardized comprehensive assessment instruments tailored to specific populations or programs, such as those described by Dodgen and Shea (2000).

SAMHSA regulations require that patients "accepted for treatment at an OTP shall be assessed initially and periodically by qualified personnel to determine the most appropriate combination of services and treatment" (42 CFR, Part 8 § 12(f)(4) [*Federal Register* 66(11):1097]). Treatment plans should be reviewed and updated, initially every 90 days and, after 1 year, biannually or whenever changes affect a patient's treatment outcomes. Ongoing monitoring should ensure that services are received, interventions work, new problems are identified and documented, and services are adjusted as problems are solved. Patients' views of their progress, as well as the treatment team's assessment of patients' responses to treatment, should be documented in the treatment plan.

Patient Motivation and Readiness for Change

Patient motivation to engage in MAT is a predictor of early retention (Joe et al. 1998) and is associated with increased participation, positive treatment outcomes, improved social adjustment, and successful treatment referrals (CSAT 1999*a*).

Starting with initial contact and continuing throughout treatment, assessment should focus on patient motivation for change (CSAT 1999*a*). OTP staff members help patients move beyond past experiences (e.g., negative relationships with staff, inadequate dosing) by focusing on making a fresh start, letting go of old grievances, and identifying current realities, ambivalence about change, and goals for the future. It often is helpful to enlist recovering patients in motivational enhancement activities. TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*a*), provides extensive information about stages of change, the nature of motivation, and current guidelines for enhancing patient motivation to change.

Substance Use Assessment

As discussed previously, a patient's lifetime substance use and treatment history should be documented thoroughly. The following areas should be assessed:

- Periods of abstinence (e.g., number, duration, circumstances)
- Circumstances or events leading to relapse
- Effects of substance use on physical, psychological, and emotional functioning
- Changing patterns of substance use, withdrawal signs and symptoms, and medical sequelae.

Reports of psychiatric symptoms during abstinence help treatment providers differentiate drug withdrawal from mental disorder symptoms and can reveal important clues to effective case management, for example, the need to refer patients for treatment of co-occurring disorders.

Chapter 11 discusses treatment methods and considerations for patients with histories of multiple substance abuse. Most of these patients fall into one of three groups, which should be determined during assessment: those who use multiple substances (1) to experience their psychoactive effects, (2) to self-medicate for clinically evident reasons (e.g., back pain, insomnia, headache, co-occurring disorders), or (3) to compensate for inadequate treatment medication (Leavitt et al. 2000). Multiple substance use should be identified and addressed as soon as possible because of the risk of possible overdose for patients who continue to abuse drugs or alcohol during treatment. Continued substance abuse while in MAT might indicate that another treatment option is more appropriate. A challenge in treating patients who abuse substances for clinically evident reasons is to determine whether the patients are attempting to medicate undiagnosed, misdiagnosed, or undertreated problems. If so, then effectively addressing these related problems may reduce or eliminate continuing drug or alcohol abuse and improve outcomes.

Cultural Assessment

A comprehensive assessment should include patients' values and assumptions; linguistic preferences; attitudes, practices, and beliefs about health and well-being; spirituality and religion; and communication patterns that might originate partly from cultural traditions and heritage (Office of Minority Health 2001). Staff knowledge about diverse groups is important for effective treatment services. Of particular importance are experiences and coping mechanisms related to assimilation and acculturation of groups into mainstream American culture that may affect how they perceive substance abuse and MAT. Gathering pertinent information often must rely on subjective sources (e.g., interviews and

questionnaires). Even so, staff members involved in screening and assessment should be cautioned against making value judgments about cultural or ethnic preferences or assumptions about "average" middle-class American values and beliefs. (See the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* [CSAT forthcoming *b*].)

A shared staff–patient cultural identity is attractive to some patients entering treatment. To the extent possible, patient preferences for staff members who share their cultural identity should be honored. Multilingual educational materials and displays of culturally diverse materials in the OTP help patients feel more at ease when English is not their primary language.

Psychosocial Assessment

The components and objectives of psychosocial assessment also are applicable to patients in MAT. A psychosocial assessment typically identifies the relevant dynamics of patients' lives and functioning both before the onset of illness (e.g., depression, anxiety) and currently. It identifies patients' specific strengths and resources (e.g., employment, supportive family relationships) as a basis for focused, individualized, effective treatment planning.

History of co-occurring disorders and current mental status

Mental status assessments identify the threshold signs of co-occurring disorders and require familiarity with the components of a mental status examination (i.e., general appearance, behavior, and speech; stream of thought, thought content, and mental capacity; mood and affect; and judgment and insight) as outlined in *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (American Psychiatric Association 2000). A mental status assessment also should look for perceptual disturbances and cognitive dysfunction.

Qualified professionals should train all staff members involved in screening and assessment to recognize signs and symptoms of change in patients' mental status. This training should be ongoing. After reviewing their observations with the program physician, staff members should refer all patients still suspected of having co-occurring disorders for psychiatric evaluation. This evaluation should identify the types of co-occurring disorders and determine how they affect patients' comprehension, cognition, and psychomotor functioning. Persistent neuropsychological problems warrant formal testing to diagnose their type and severity and to guide treatment. Consultations by psychologists or physicians should be requested or referrals made for testing. (See chapter 12 for typical methods of psychiatric screening and diagnosis in an OTP.)

A psychosocial assessment… identifies the relevant dynamics of patients' lives and functioning both before the onset of illness and currently.

Sociodemographic history

Sociodemographic data about an applicant should include employment, educational, legal, military, family, psychiatric, and medical histories, as well as current information, and should be supplemented by documents for identification, such as a driver's license, birth or baptismal certificate, passport, Social Security card, Medicaid card, public assistance card, or identification card from another substance abuse treatment program.

Family and cultural background, relationships, and supports

The effect of substance use on a patient's family cannot be overestimated, and family problems should be expected for most patients entering treatment. The comprehensive assessment should include questions about family relationships and problems, including any history of domestic violence, sexual abuse, and mental disorders (see below). When possible, the assessment should include input from relatives and significant others. Because families with members who abuse substances have problems directly linked to this substance abuse, at least one staff member should be trained in family therapy or in making appropriate referrals for this intervention.

During assessment, program staff should be sensitive to various family types represented in the patient population. For example, programs treating significant numbers of single parents should consider onsite childcare programs. Structured childcare services also enable OTP staff to observe and assess a patient's family functioning, which can be valuable in treatment planning.

Any counselor or treatment provider who might confront emergencies related to child or spousal abuse should be trained in how to identify and report these problems. TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT 1997*b*), provides screening, assessment, and response guidance when domestic violence is suspected. TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000*d*), focuses on screening and assessment when patients are suspected of being past victims or perpetrators of child abuse. Staff members should be trained to listen and prepared to hear traumatic stories and handle these situations, for example, by monitoring any intense symptoms and seeking special assistance when necessary (CSAT 2000*d*). Staff should be able to identify individuals who exhibit certain signs and symptoms associated with abuse (e.g., posttraumatic stress disorder [PTSD]) and provide or coordinate immediate services to address it (CSAT 1997*b*, 2000*d*).

Child abuse. All States require mandatory reporting of child abuse by helping professionals including OTP staff—particularly State-licensed physicians, therapists, nurses, and social workers (CSAT 2000*d*). Most States require that this reporting be immediate and offer toll-free numbers. Most also require that reports include the name and address of a parent or caretaker, the type of abuse or neglect, and the name of the alleged perpetrator. Failure to report indications of abuse that results in injury to a child can lead to criminal charges, a civil suit, or loss of professional licensure. Mandated reporters generally are immune from liability for reports made in good faith that later are found to be erroneous (CSAT 2000*d*).

Staff members who suspect domestic violence should investigate immediately whether a patient's children have been harmed. Inquiries into possible child abuse can occur only after notice of the limitations of confidentiality in MAT (42 CFR, Part 8 § 12(g)) has been given to the patient, who must acknowledge receipt of this notice in writing. Patients also must be informed, during orientation and when otherwise applicable, that substance abuse treatment providers are required to notify a children's protective services agency if they suspect child abuse or neglect.

Spousal or partner abuse. Generally, if a patient believes that she or he is in imminent danger from a batterer, the treatment provider should respond to this situation before addressing any others and, if necessary, suspend the screening or assessment interview to do so. Exhibit 4-3 summarizes the steps a treatment provider should follow. He or she should refer a patient to a shelter, legal services, or a domestic violence program if indicated. Providers should be familiar with relevant Federal, State, and local regulations on domestic violence (e.g., the Violence Against Women Act [visit http://www.ovw.usdoj.gov]) and the legal resources

Exhibit 4-3

Recommended Procedures for Identifying and Addressing Domestic Violence*

- Look for physical injuries, especially patterns of untreated injuries to the face, neck, throat, and breasts, which might become apparent during the initial physical examination.
- Pay attention to other indicators: history of relapse or treatment noncompliance; inconsistent explanations for injuries and evasiveness; complications in pregnancy; possible stress- and anxiety-related illnesses and conditions; sad, depressed affect; or talk of suicide.
- Fulfill legal obligations to report suspected child abuse, neglect, and domestic violence.
- Never discuss a patient without the patient's permission; understand which types of subpoenas and warrants require that records be turned over to authorities.
- Convey that there is no justification for battering and that substance abuse is no excuse.
- Contact domestic violence experts when battery has been confirmed.

*State laws may include other requirements.

available (e.g., restraining orders, duty to warn, legal obligation to report threats and past crimes, confidentiality).

Romans and colleagues (2000) identified the following methods for exploring potential domestic violence situations, which can be incorporated into effective assessment tools:

- Always interview patients in private about domestic violence.
- Begin with direct, broad questions and move to more specific ones; inquire how disagreements or conflicts are resolved (e.g., "Do you want to hit [him or her] to make [him or her] see sense?"); ask whether patients have trouble with anger or have done anything when angry that they regret; combine these questions with other types of lifestyle questions.
- Ask about violence by using concrete examples and specific hypothetical situations rather than vague, conceptual questions.
- Display information about domestic violence in public (e.g., waiting room) and private (e.g., restroom) locations.
- Use opportunities during discussions (e.g., comments about marital conflict situations or poor communication with partners) to probe further.
- Obtain as complete a description as possible of the physical, sexual, and psychological violence perpetrated by or on a patient recently; typically, those who commit domestic violence minimize, deny, or otherwise obscure their acts.

History of physical or sexual abuse

Some patients enter an OTP with a history of physical or sexual abuse, which frequently causes additional psychological distress (Schiff et al. 2002). Information about these types of abuse is important in treatment planning but not always easily accessible using specific assessment tools, especially early in treatment.

Some patients with abuse histories might deny their victimization. Many women are less likely to admit abuse to male counselors. Male staff should know when to request a staff change for counseling about physical or sexual abuse. Patients might not be ready to address the problem, think it is unrelated to substance abuse, or be ashamed. Gathering information from them about abuse, therefore, requires extreme care and respect during screening and assessment. Once patients are stabilized and their practical needs are addressed, counseling by qualified treatment providers can focus on this problem.

Peer relations and support

The extent of social deterioration, interpersonal loss, and isolation that patients have experienced should be documented thoroughly during screening and assessment. Assessment of a patient's support systems, including past participation in mutual-help groups (e.g., Alcoholics Anonymous, Methadone Anonymous [MA]), is critical to identifying peer support networks that provide positive relationships and enhance treatment outcomes. Some 12-Step groups are ill-informed about MAT and may be unaware of the treatment goals of MAT and less than supportive; in these cases, providers should help patients identify other sources of support (e.g., MA groups) and encourage continued development of some type of peer support network. In areas with limited resources, patients may be able to overcome initial discriminatory behavior in existing groups by increasing their knowledge of MAT and their ability to self-advocate.

> [A]ssessment and treatment… should focus on stopping the substance abuse that interferes with patients' well-being.

Housing status and safety concerns

Based on year 2000 estimates, approximately 10 percent of patients in MAT are homeless or living as transients when admitted to treatment (Joseph et al. 2000). Moreover, those who are not homeless often live with people who are addicted or in areas where substance use is common. In the opinion of the consensus panel, early intervention to arrange safe, permanent shelter for these patients should be a high priority, and a patient's shelter needs should be ascertained quickly during screening and assessment. OTPs should establish special support services to help patients secure appropriate living arrangements, such as referral agreements with housing agencies or other programs to locate housing that addresses the special needs of homeless patients.

Criminal history and legal status

Another purpose of screening and assessment is to identify legal issues that might interrupt treatment, such as outstanding criminal charges or ongoing illegal activity to support substance use; however, pending or unresolved charges are not a contraindication for MAT. Assessment may involve exploring personal circumstances such as child custody and related obligations. In the consensus panel's experience, many patients ignore legal problems during periods of substance use, but these problems pose a serious threat to recovery. In addition, a patient's arrest record, including age at first arrest, arrest frequency, nature of offenses, criminal involvement during childhood, and life involvement with the criminal justice system, should be clarified.

Insurance status

Patients' resources to cover treatment costs should be determined during screening and assessment. Often they are uninsured or have not explored their eligibility for payment assistance. The consensus panel believes that OTPs are responsible for helping patients explore payment options so that they have access to a

full range of treatment services, including medical care, while ensuring payment to the OTP.

In situations of inadequate funding or patient ineligibility for funds, another source of payment should be identified. OTP staff can assist patients in applying for public assistance or inquiring whether personal insurance will reimburse MAT costs. Counselors can help patients make decisions about involving their insurance companies and address fears that employers will find out about their substance use or that benefits for health care will be denied.

Employment history

Another important component of psychosocial assessment is a patient's employment history. Based on year 2000 estimates, only 20 percent of patients in MAT were employed when admitted to an OTP (Joseph et al. 2000). Until they are stabilized, employed patients often experience substance-related difficulties at the workplace, including lack of concentration, tardiness and absences, inability to get along with coworkers, on-the-job accidents, and increased claims for workers' compensation. Early identification of these difficulties can help staff and patients create a more effective treatment plan.

Patients who are employed often are reluctant to enter residential treatment or take the time to become stabilized on medication; however, most of these patients would take medical or other leave time if they were hospitalized for other illnesses, and they should be encouraged to take their addiction as seriously. A physician's note recommending time off work for some period might help, but it should be on letterhead that does not reference drug treatment.

Military or other service history

A patient's military or other service history can highlight valuable areas in treatment planning. In particular, was military service generally a positive or negative experience? If the former, treatment providers can help patients identify areas of strength or personal achievement, such as the ability to cope under stress, receipt of medals for service accomplishments, and honorable discharge; patients can learn to build on past strengths in current challenging situations and to progress in treatment. If the latter, providers should review patients' negative military experiences, including loss of friends and loved ones, onset of substance use, war-related injuries, chronic pain, PTSD, and co-occurring disorders (e.g., depression). This information might indicate patterns of behavior that continue to affect recovery.

Patients' military history also might reveal their eligibility for medical and treatment resources through U.S. Department of Veterans Affairs programs and hospitals or social service agencies.

Spirituality

"Spirituality" in this TIP refers to willing involvement in socially desirable activities or processes that are beyond the immediate details of daily life and personal self-interest. Attention to the ethics of behavior, consideration for the interests of others, community involvement, helping others, and participating in organized religion are expressions of spirituality.

A patient's spirituality can be an important treatment resource, and persons recovering from addiction often experience increased interest in the spiritual aspects of their lives. A study by Flynn and colleagues (2003) of 432 patients admitted to 18 OTPs found that those who remained in recovery for 5 years credited religion or spirituality as one factor in this outcome. Staff should assess patients' connections with religious institutions because these institutions often provide a sense of belonging that is valuable in the rehabilitative process.

Miller (1998) found a lack of research exploring the association between spirituality and addiction recovery but concluded that spiritual engagement or reengagement appeared to be correlated with recovery. In studies reviewed by Muffler and colleagues (1992), individuals with a high degree of spiritual motivation to recover reported that treatment programs that

included spiritual guidance or counseling were more likely to produce positive outcomes than programs that did not. OTPs should assess spiritual resources adequately. Counselors and other mental health professionals could benefit from training in patient spirituality if it is difficult for them to explore.

Sexual orientation and history

The assessment and treatment needs of heterosexual and LGB populations are similar and should focus on stopping the substance abuse that interferes with patients' well-being. Assessment of risk factors associated with sexual encounters and partners is essential. What often differs for an LGB population is the importance of assessing patients' sexual or gender orientation concerns, such as their feelings about their sexual orientation (CSAT 2001*b*). OTP staff should pay strict attention to confidentiality concerns for LGB patients because they may be at increased risk of legal or other actions affecting employment, housing, or child custody. Treatment modalities and programs should be accessible to all groups, and programs providing ancillary services should be sensitive to the special needs of all patients regardless of sexual orientation (CSAT 2001*b*).

Patients' ability to manage money

Financial difficulties are common among patients in MAT, who often have spent considerable money on their substance use that otherwise would have paid for rent, food, and utilities. Financial status and money management skills should be assessed to help patients understand their fiscal strengths and weaknesses as they become stabilized. Patients often need assistance to adjust to loss of income caused by reduced criminal activity and develop skills that enhance their legitimate earning power. Once financial factors are clarified, patients may be better prepared to devise realistic strategies to achieve short- and long-term goals.

Recreational and leisure activities

Recreational and leisure activities are important in recovery; therefore, assessment should determine any positive activities in which patients have participated before or during periods of substance use. Identifying existing recreational and leisure time preferences and gaining exposure to new ones can be significant steps in developing a recovery-oriented lifestyle.

Appendix 4-A. Example of Standard Consent to Opioid Maintenance Treatment

Consent to Participation in Opioid Pharmacotherapy Treatment

Patient's Name: _____ Date: _____

I hereby authorize and give voluntary consent to the Division and its medical personnel to dispense and administer opioid pharmacotherapy (including methadone or buprenorphine) as part of the treatment of my addiction to opioid drugs. Treatment procedures have been explained to me, and I understand that this will involve my taking the prescribed opioid drug at the schedule determined by the program physician, or his/her designee, in accordance with Federal and State regulations.

It has been explained that, like all other prescription medications, opioid treatment medications can be harmful if not taken as prescribed. I further understand that opioid treatment medications produce dependence and, like most other medications, may produce side effects. Possible side effects, as well as alternative treatments and their risks and benefits, have been explained to me.

I understand that it is important for me to inform any medical provider who may treat me for any medical problem that I am enrolled in an opioid treatment program so that the provider is aware of all the medications I am taking, can provide the best possible care, and can avoid prescribing medications that might affect my opioid pharmacotherapy or my chances of successful recovery from addiction.

I understand that I may withdraw voluntarily from this treatment program and discontinue the use of the medications prescribed at any time. Should I choose this option, I understand I will be offered medically supervised tapering.

For Female Patients of Childbearing Age: There is no evidence that methadone pharmacotherapy is harmful during pregnancy. If I am or become pregnant, I understand that I should tell my medical provider right away so that I can receive appropriate care and referrals. I understand that there are ways to maximize the healthy course of my pregnancy while I am in opioid pharmacotherapy.

_____	_____	_____
Signature of Patient	**Date of Birth**	**Date**

Witness: _____

Adapted with permission from Department of Psychiatry and Behavioral Sciences, Albert Einstein College of Medicine, Division of Substance Abuse, Bronx, NY.

6 Patient–Treatment Matching: Types of Services and Levels of Care

In This Chapter...

This chapter describes a multidimensional, clinically driven strategy for matching patients in medication-assisted treatment for opioid addiction (MAT) with the types of treatment services and levels of care that optimize treatment outcomes, primarily within or in conjunction with opioid treatment programs (OTPs). Level of care refers to the intensity of a treatment (in terms of frequency, type of service—individual, group, family—and medication) and the type of setting needed for treatment delivery. For information on criteria and methods to determine levels of care in substance abuse treatment, see the American Society of Addiction Medicine (ASAM) patient placement criteria (Mee-Lee et al. 2001*b*). As explained by Mee Lee and colleagues (2001*b*), the ASAM model conceptualizes opioid pharmacotherapy as a service that can be provided at any level of care, although it is delivered most often in an outpatient setting (i.e., ASAM level I).

The chapter also provides information on developing a treatment plan with short- and long-range goals for each patient. In some cases, patient–treatment matching and treatment planning involve changes that can move a patient out of comprehensive MAT to a setting that better meets the patient's needs. Because this TIP is primarily about outpatient MAT in OTPs, other settings and programs are discussed only briefly.

In general, patient–treatment matching involves individualizing, to the extent possible, the choice and application of treatment resources to each patient's needs. The chapter explains recommended elements of a patient–treatment-matching process, including ways to accommodate special populations with distinct needs and orientations that affect their responses to specific treatments and settings.

Patients enter OTPs at various points along a continuum of substance abuse and addiction. Many also have co-occurring medical and mental health conditions that can be lifelong. Because of the complexity of patients' circumstances and needs and the range of services required to address these needs, MAT includes not only opioid pharmacotherapy but also other forms of treatment in a comprehensive treatment program

designed to address multiple disorders and needs (see chapter 8).

The consensus panel believes that OTPs not already offering comprehensive MAT services and those lacking resources to adjust levels of care to patient needs either should augment basic opioid pharmacotherapy with services that meet the mental health, medical, and social needs of patients who are opioid addicted—at the level of care each patient needs—or should provide referrals to programs that provide such services.

Steps in Patient–Treatment Matching

Patient Assessment

Patient–treatment matching begins with a thorough assessment to determine each patient's service needs (see chapter 4); then these needs are matched to appropriate levels of care and types of services. Assessment should include the extent, nature, and duration of patients' opioid and other substance use and their treatment histories, as well as their medical, psychiatric, and psychosocial needs and functional status. A comprehensive assessment should include a patient's gender, culture, ethnicity, language, motivation to comply with treatment, and recovery support outside the OTP.

Type and Intensity of Treatment Services Needed

Psychosocial treatment services

In a comprehensive MAT setting, patients often have access to a variety of psychosocial services, including individual, family, and group counseling, as well as case management (see chapter 8). Some programs may provide psychosocial services to patients in other settings. Both residential and outpatient programs may offer intensive individual and group counseling or counseling on a periodic or as-needed basis (De Leon 1994; Margolis and Zweben 1998). Ideally, service intensity should depend on the level of care required to help patients achieve and maintain successful treatment outcomes. Most patients in the acute phase of treatment need to see a counselor daily for counseling or case management, just to become stabilized, whereas others, who may be highly functioning with less severe addiction-related psychosocial problems, require fewer counseling services.

Mutual-help programs

Although not a form of treatment, mutual-help programs (e.g., 12-Step programs, Secular Organization for Sobriety groups, Women for Sobriety groups) offer effective reinforcement and motivation for individuals during and after discontinuation of active treatment. Such programs provide social support from others who are in recovery from addiction (Washton 1988). Many patients in MAT participate in mutual-help groups. However, patients with opioid addiction who are maintained on treatment medication can feel out of place in some group settings where continued opioid pharmacotherapy may be misunderstood. Researchers have described a variety of specialized groups and inventive strategies for mutual-help programs that meet the support needs of patients in MAT (Zweben 1991). Chapter 8 presents some of these strategies.

Matching Treatment Service Needs to Settings

After the types and intensities of services that patients need are defined, the next crucial step in patient–treatment matching is to identify the most appropriate available setting or settings for these services. MAT has been offered primarily in a dedicated outpatient OTP. However, as the importance of treating patients' varied medical, psychological, social, and behavioral needs as part of addiction recovery has become evident, more varied programs and settings have emerged.

Throughout this TIP, the consensus panel recommends that OTPs lacking the resources to accommodate all their patients' needs develop cooperative relationships with and refer patients to other treatment providers as appropriate. However, OTPs should coordinate these services. Based on its assessments of patients, the treatment team should collaborate with patients to determine the most appropriate treatment services, intensities of services, and settings needed to meet patient needs. This collaboration should continue throughout MAT, and patient progress should be the basis for adjustments in treatment services and intensities.

Patients' service needs may change throughout MAT. For example, one patient may need referral to an inpatient program for detoxification from alcohol or benzodiazepines and then return to the OTP setting. Another may need the environment of a residential treatment program while continuing MAT. Therefore, treatment matching in some cases can lead to multiple settings for an individual's treatment. In most cases, the originating OTP should provide case management and liaison for all treatment services.

Types of settings and programs offering opioid addiction treatment services

The following are examples of treatment programs and settings that offer some or all of the comprehensive services recommended in MAT.

Outpatient OTPs. Outpatient OTPs ideally treat patients who are opioid addicted during all phases of treatment and at most levels of care. In reality, many OTPs have capacity or resource limitations or payment requirements that cause them to refer at least some patients to other specialized treatment providers and settings, such as those described below, for services that match patient needs. Either on site or through other care providers, OTPs offer a wide spectrum of treatment services and levels of care for diverse patients.

Appropriate patients for treatment in outpatient OTPs are those who meet Federal and State requirements for opioid addiction treatment (e.g., 42 Code of Federal Regulations, Part 8), those who have done poorly in other types of programs (e.g., medically supervised withdrawal or residential treatment programs), and those who require opioid pharmacotherapy for long-term stabilization.

OTPs in hospital-based outpatient settings may provide a more enhanced continuum of care than freestanding OTPs because access to medical and psychosocial services is readily available. This availability, in turn, increases the likelihood that patients in MAT will engage in and adhere to other medical and psychosocial treatment regimens.

> [S]ervice intensity should depend on the level of care required to help patients achieve and maintain successful treatment outcomes.

Hospital-based MAT programs are appropriate for some patients who also are medically ill and require coordinated services or care by special teams. In addition, because hospitals can provide a one-stop-shopping model of care by incorporating some primary care services with MAT, some patients with histories of poor treatment compliance may be more likely to adhere to medical treatment. For example, one report from a 16-month prospective study of nearly 500 persons in a hospital-based outpatient methadone program found that 81 percent also used onsite primary care services (Selwyn et al. 1993). At this writing, the number of hospital-based programs offering MAT is limited in the United States.

Residential treatment programs. Residential treatment programs offer cooperative living

arrangements for patients in recovery, but they vary in their willingness or ability to accept MAT patients (Margolis and Zweben 1998). A residential treatment setting is indicated for patients who require residential placement to support treatment and ensure their physical or psychological safety and who are unlikely to continue MAT otherwise. Such patients generally exhibit high relapse potential, evidenced by an inability to control substance use despite active participation in less intensive outpatient programs (Margolis and Zweben 1998). On completion of treatment in these settings, patients should return to an outpatient setting to continue MAT.

The success of mobile treatment units…highlights the importance of program accessibility as a factor affecting… positive treatment outcomes.

If a patient in an OTP is referred to a residential program that does not offer or allow onsite opioid pharmacotherapy (i.e., when other residential options are unavailable) or methadone or buprenorphine dispensing or administration, some programs allow resident patients to travel to the OTP for medication. Some States allow exceptions to regulations governing OTP attendance and take-home medications so that concurrent treatment is possible.

Mobile treatment units. The success of mobile treatment units—that is, mobile vans—in such cities as Baltimore, Boston, San Francisco, and Seattle (Greenfield et al. 1996; Schmoke 1995) highlights the importance of program accessibility as a factor affecting length of stay in treatment and positive treatment outcomes (Greenfield et al. 1996). Mobile substance abuse treatment programs either offer comprehensive maintenance services (with medication, collection of samples for drug testing, and counseling provided in one or several mobile units) or work in conjunction with fixed-site outpatient programs that offer medical care and counseling and other psychosocial services, while medication is delivered via the mobile units.

Appropriate patients for treatment in mobile treatment units are those in locations where fixed-site programs are unavailable, those with ambulatory disabilities, and those initially stabilized in an OTP and then transferred to a mobile unit for continued treatment. Mobile units not staffed on weekends are appropriate only for patients who meet State and Federal regulations for weekend take-home medications.

Office-based opioid treatment settings. After achieving biomedical and psychosocial stabilization in an OTP, some patients might be eligible for referral to less intensive physician's office-based opioid treatment (OBOT) for medical maintenance. In these settings, patients receive the same level of monitoring and intervention as patients receiving other types of health care. When available, OBOT programs offer several advantages (Fiellin and O'Connor 2002), including

- Less intensive service requirements for stable patients (e.g., less restrictive environments, focus on maintenance with stable doses of opioid medication, provision of only those psychosocial services needed to prevent relapse)
- Minimized stigma associated with addiction treatment
- Increased opportunity for new treatment admissions to OTPs
- Expansion of treatment to geographic areas where there are no OTPs or there are waiting lists for admission to OTPs.

Criminal justice settings. At this writing, relatively few jails or prisons offer comprehensive MAT or selected MAT services, but these numbers are likely to increase (for information about substance abuse treatment in criminal

justice settings, see TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* [CSAT 2005*a*]). As a result, MAT services are often interrupted or discontinued when patients are incarcerated. Rikers Island, New York City's central jail facility, is an example of a model program that provides comprehensive MAT for this patient group (Magura et al. 1993). Patients who receive MAT there are guaranteed a slot at a community-based program in New York City after their incarceration. Other corrections facilities provide rapid medically supervised withdrawal from maintenance medication to patients. When this withdrawal is the only option, OTPs should work with criminal justice institutions to ensure that appropriate dose-tapering procedures are followed. Patients released from a criminal justice setting should be offered referral to an OTP when referral is desirable and feasible.

Other treatment settings. Numerous other settings and specialized programs offer some services and levels of care needed by patients who are opioid addicted. Any of these programs can be sources of referral by OTPs or can function as satellite OTPs to ensure that patients receive services and levels of care they need.

Choice of Medications

The consensus panel recommends that OTPs offer a variety of treatment medications. Chapters 3 and 5 provide more details about the pharmacology and appropriate use of methadone, levo-alpha acetyl methadol, buprenorphine, and naltrexone.

Patients With Special Needs

Effective treatment for opioid addiction should address the unique needs of each patient (O'Connor and Fiellin 2000; Rowan-Szal et al. 2000*a*). Culturally competent and creative treatment planning, implementation, and referrals should address the distinct needs of patients from different backgrounds. More staff training and research are required on the unique constellations of treatment needs for various populations served by OTPs. Findings for particular groups are summarized below. Other treatment groupings may be identified, for example, high-profile persons for whom unique treatment schedules and settings may be needed to protect confidentiality (CSAT forthcoming *e*).

Patients With Serious Medical Disorders

If a serious medical condition is discovered during medical evaluation or patient assessment, the patient should receive appropriate medical treatment either on site or by referral to a medical center. Chapter 10 describes medical conditions commonly encountered among patients in MAT and provides treatment recommendations. Most OTPs offer only basic medical services. OTPs should develop and maintain referral networks for patients who present for MAT and have other medical conditions. Moreover, OTP staff should coordinate referrals and follow up as needed to ensure compliance with medical treatments and to act as consultants about MAT and medication interactions.

Patients With Serious Co-Occurring Disorders

Many studies have focused on the co-occurrence of substance use and mental disorders (see chapter 12). The existence of co-occurring disorders should not prevent patients' admission to an OTP; however, diagnosis of these disorders is critical to match patients with appropriate services and settings. Therefore, OTPs should include professional staff trained to screen for the presence of co-occurring disorders, develop appropriate referrals to services (e.g., psychopharmacology or psychotherapy) for these disorders, and provide coordination of care (CSAT 2005*b*). Most staff members can be trained to recognize and flag major symptoms of co-occurring disorders. The OTP should maintain communication and followup with referral resources.

Patients With Housing, Family, or Social Problems

The following psychosocial problems should be addressed during or directly after admission to increase the likelihood that patients will engage successfully in treatment:

- Lack of stable housing
- Broken ties with family members; nonexistent or dysfunctional family relationships
- Poor social skills and lack of a supportive social network
- Unemployment; lack of employable skills.

Once these needs are identified during assessment, referrals can be made. Although some OTPs have social workers on site to manage the assessment and referral processes, most OTPs rely on counselors to assume this role. Case management duties should include arrangements for provision of psychosocial care when indicated. Family members need education about MAT, including information on how to support a partner or loved one in recovery, self-care of family members, signs and symptoms of active addiction, and support and assistance from family members willing to participate in family counseling. Programs can offer monthly classes to patients, their families, and the community, which can reduce the stigma connected with MAT.

Patients With Disabilities

OTPs should try to provide access for patients with physical disabilities. Treatment interventions for these patients usually include vocational rehabilitation, physical therapy, and social services that help procure prosthetic limbs, wheelchairs, and other assistive devices (CSAT 1998*c*). Alternative approaches in MAT, specifically those that reduce OTP visits, include take-home dosing and requests for medical exceptions through visiting-nurse services to provide equal access to treatment for persons with disabilities (see chapter 10).

Mobile medication units and office-based or home-nursing services may offer viable treatment options for patients with disabilities (Fiellin and O'Connor 2002; Greenfield et al. 1996). OTP staff should address these challenges with patients so that barriers to treatment are overcome.

The consensus panel recommends that OTPs engage in discussions with their Federal and State agencies to develop solutions for treating patients with disabilities. Such discussions should balance the medical needs of these patients and the safety issues involved in providing take-home medications for patients with disabilities who continue to engage in substance abuse or create a risk of medication diversion.

Adolescents and Young Adults

Adolescents and young adults present a unique challenge for MAT. Often, ethnic background, peer affiliations, and aspects of the "youth culture" require staff training and special expectations from both staff and patients. Differences in routes of administration for heroin or prescription opioids and in treatment needs between adolescents or young adults and older adults who are opioid addicted might be attributable in part to generational characteristics and life experiences. For example, older adults typically present for treatment after years (sometimes decades) of chronic substance abuse accompanied by loss of family, health, and employment and deterioration in other psychosocial domains. Youth who are opioid addicted tend to present after only a few years of addiction and with different attitudes toward addiction and the recovery process and distinct treatment needs. These youth may be more difficult to evaluate, because, as a result of other modes of administration (i.e., intranasally and by smoking), they do not exhibit some physical markers of opioid use (e.g., track marks).

Treatment for adolescents and young adults should integrate knowledge of their specific developmental and psychosocial concerns and needs. Some needs are related to identity formation and peer group preoccupation (e.g., the strong desire to be viewed as fearless or to feel invincible), legal complications regarding

consent for treatment (see CSAT 2004*b*), and, often, factors leading them to run away from their homes. TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT 1999*d*), provides background information.

Other risk factors for this group include possible sexual and physical abuse, young age at first sexual experience, incidents of trading sex for drugs (Astemborski et al. 1994; Fullilove et al. 1990), and co-occurring disorders (Fuller et al. 2002; Hawkins et al. 1992). These risk factors also can contribute to increased risk for HIV infection (Doherty et al. 2000; Fuller et al. 2001) and other sexually transmitted diseases (STDs).

The interaction of developmental and psychosocial factors affects the ability of adolescents and young adults to engage in MAT and therefore complicates the recovery process. OTPs should provide psychosocial services that address the unique needs of this age group, especially those needs that affect their substance use and recovery, or they should establish referrals and links to youth-oriented psychosocial counseling services.

Buprenorphine may be a particularly satisfactory treatment for some adolescents. Because buprenorphine can be administered in an OBOT setting, it should become more widely available and offer more privacy and less stigma for young patients (see CSAT 2004*a*).

Women

Pregnancy

The special needs of women who are opioid addicted and pregnant should be assessed thoroughly through a comprehensive medical evaluation, as discussed in chapter 13. Treatment matching for pregnant patients in MAT should provide optimal, comprehensive, and intensive services related to pregnancy and birth including prenatal care, maternal nutrition, and psychosocial rehabilitation, along with MAT. The integration of a women's overall health initiative into MAT improves an OTP's capacity to meet the special needs of these patients, to address potential biomedical and obstetrical complications, and to avoid adverse effects of substance use on the fetus (Finnegan and Kandall 1992). Chapter 13 offers a detailed overview of MAT for pregnant women (also see CSAT forthcoming *f*).

OTPs are required by regulation or accreditation standards to test for pregnancy, but the provision of prenatal care and ancillary services for pregnant women varies depending on the treatment setting. Hospital-based programs may be better suited for pregnant women in some cases because hospitals offer easy access to referrals and links to specialty care (on or off site).

Case management… should include arrangements for… psychosocial care when indicated.

Sexual or physical abuse

Patients' risks of ongoing abuse in their current relationships should be addressed, and appropriate plans or referrals made. Co-occurring disorders such as posttraumatic stress disorder can occur among both women and men who have experienced sexual or physical abuse. The best treatment settings to address women's needs in these cases include OTPs with onsite care provided by psychiatrists, psychologists, licensed social workers, or mental health professionals with special training in this area. In lieu of onsite services, OTPs should establish referral links to programs offering such services. Many social service agencies, as well as agencies responsible for domestic violence, offer training and support to OTP staff. TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000*d*), provides further details.

Complex medical problems

The complex medical problems commonly diagnosed in women in MAT include gynecological infections, amenorrhea, hypertension, and pneumonia (Brown et al. 1992). It is optimal to provide primary care services on site; hospital-based programs and OTPs with formalized medical referral systems are best equipped to deliver such services. Chapter 10 of this TIP and the forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT forthcoming *f*) provide additional information.

Parents

Because many patients in MAT are parents, the lack of adequate childcare services is often a barrier to OTP attendance and successful treatment. One solution is supervised onsite childcare services, which also may provide opportunities to observe how patients relate to their children. Problems in parenting skills can be addressed in treatment planning and through parenting groups for patients with children. However, onsite childcare services are available in few programs because of limited resources and licensing and insurance requirements. These obstacles might cause missed appointments or lack of privacy and concentration for parents who must bring their children to treatment and counseling sessions. Insufficient treatment may result.

> Most patients can be maintained on their MAT dosage while taking short-acting opioids for pain relief…

The consensus panel recommends that OTPs seek opportunities and funding for onsite childcare where appropriate and feasible to help patients with children engage successfully in psychosocial services. Where childcare is unavailable, program staff should offer referrals to community daycare agencies.

In most States, OTPs are mandated reporters of child abuse and neglect. When children are at imminent risk of harm or appear neglected, OTPs are required to notify local children's protective services (CPS) agencies so that an investigation can be conducted. This requirement can create conflict between an OTP and a patient, and the OTP should try to address this issue in a supportive way. Programs and treatment providers should not discriminate against patients because they have entered into pretreatment agreements or have difficulties with CPS agencies (see chapter 13).

Lesbian, Gay, and Bisexual Patients

Just as important as sensitivity to cultural differences based on race or ethnicity is providing a treatment climate that is available and sensitive to lesbian, gay, or bisexual (LGB) patients by openly acknowledging their heterogeneity and variations in sexual orientation and treating these individuals with dignity and respect (CSAT 2001*b*; Lombardi and van Servellen 2000). OTP staff should be prepared to assist LGB patients in coping with problems related to their sexual orientation and the need for HIV/AIDS and STD risk avoidance. Providers should help patients obtain appropriate medical care and secure their safety if, for example, they are threatened. OTPs also should acknowledge the unique social support structures of LGB patients, which can provide a way to counteract isolation and separation from community, peers, and immediate and extended family members (Hughes and Eliason 2002; also see CSAT 2001*b*). Finally, the consensus panel recommends that OTPs identify and refer LGB patients to community counseling, support, and spiritual and religious organizations that are sensitive to these groups and address any sexual- or gender-orientation concerns these patients have that could affect treatment.

Aging Patients

MAT treatment planners should consider the stressors common to the aging patient, such as loss of family, retirement, loneliness, and boredom, which can contribute to high risk of self-overmedication and addiction to alcohol and medications. The consensus panel recommends that OTPs focus on the following areas when working with elderly patients:

- Monitoring the increased risk for dangerous drug interactions; elderly patients often are prescribed multiple medications.
- Differentiating between co-occurring disorders and symptoms and disorders associated with aging (including dementia) (Lawson 1989).
- Differentiating between depression and dementia.
- Screening for and treating physical and sexual abuse (see chapter 4).
- Developing referral sources that meet the needs of elderly patients. Relationships with skilled nursing facilities and nursing homes are particularly important (Lawson 1989).
- Training staff to be sensitive to the elderly patient population.
- Providing psychosocial treatment for age-associated stressors and medical screening and referral for common medical conditions affected by the aging process (see CSAT 1998*b*).
- Assessing and adjusting dosage levels of medication for the slowed metabolism of many elderly patients.

Patients With Pain

Patients in MAT often are undertreated or denied medication for acute or chronic pain management (Compton and Athanasos 2003). Health care workers may misperceive pain medication requests by patients in MAT as drug-seeking behavior, in part because of patients' higher tolerance for opioids and, usually, their need for higher doses. Many physicians who treat pain do not have the necessary education to treat pain in this population (Prater et al. 2002). MAT providers should evaluate patient treatment needs for pain management and assist patients directly in obtaining optimal pain treatment. Medical providers in MAT should work collaboratively with primary care providers and pain and palliative-care clinicians to ensure establishment of appropriate pain interventions for patients in MAT. Providers need education about maintaining current opioid levels while adding sufficient immediate-release treatment agents to manage acute or chronic pain. More frequent dosing and short-term increased demand for pain treatment medication should be expected. Referrals to specialty pain clinics often provide patients a full spectrum of pain care, including pharmacological and psychological or behavioral treatments to alleviate pain symptoms. These services most often are accessible through hospital-based programs or referral linkages. Most patients can be maintained on their MAT dosage while taking short-acting opioids for pain relief; however, individualized pain treatment is usually necessary.

Treatment Planning

After patients' individual needs are assessed and the best available treatment services and most appropriate levels of care are determined, a treatment plan should be developed with the patient, as required by accreditation guidelines (CSAT 1999*b*).

Developing a Treatment Plan

Treatment planning for MAT should involve a multidisciplinary team, including physicians, counselors, nurses, case managers, social workers, and patients. Based on a thorough patient history and assessment, a treatment plan should be realistic and tailored to each patient's needs, strengths, goals, and objectives. Good treatment plans contain both short- and long-term goals and specify the actions needed to reach each goal. Treatment plans should indicate which goals and objectives require referral to and followup with outside

resources and which are provided by the OTP itself. Treatment plans should contain specific, measurable treatment objectives that can be evaluated for degree of accomplishment.

Role of the counselor in plan formulation

Counselors should ensure that treatment plans incorporate strategies to develop therapeutic relationships with patients, based on respect for patients' autonomy and dignity, while motivating patients to become willing partners in the change process (CSAT 1999*a*). This role, which places great responsibility on the counselor, usually incorporates cognitive behavioral approaches in which providers strive to enhance patient motivation for change by focusing on patient strengths and respecting patient decisions (CSAT 1999*a*). To engage patients in the process of treatment planning, counselors should encourage the inclusion of motivational enhancement strategies that highlight appropriate, realistic treatment goals (Di Clemente 1991). Research has shown that confrontational counseling or the use of negative contingencies often predicts treatment failure (Miller and Rollnick 2002).

Role of the patient in plan formulation

A patient in MAT should be an integral member of the treatment team with his or her needs and expectations considered respectfully and incorporated into the treatment plan. Patients who agree with the treatment rationale or therapeutic approach tend to experience increased determination to improve (Hubble et al. 1999). A patient's participation in treatment planning can enhance motivation to adhere to change strategies, leading to positive treatment outcomes such as higher rates of abstinence and better social adjustment (CSAT 1999*a*). When possible, the treatment plan should be written in a patient's own words to describe his or her unique strengths, needs, abilities, and preferences as well as his or her challenges and problems. The plan also should contain mutually approved goals that reflect awareness of and sensitivity to a patient's informed choices, cultural background, age, and medical status or disability.

Other factors in plan formulation

Treatment plans should incorporate an assessment of linguistic and cultural factors that might affect treatment and recovery either positively or negatively (U.S. Department of Health and Human Services 2001). Treatment providers should work collaboratively with patients to identify health-related cultural beliefs, values, and practices and to decide how to address these factors in the treatment plan (U.S. Department of Health and Human Services 2001).

Motivation for treatment

Patient motivational strategies should be incorporated throughout the treatment plan. As part of this process, the treatment team can benefit from an understanding of stages of change and their effects on patient progress. Prochaska and colleagues (1982, 1986, 1992), who formulated a useful model that explains how people change, observed five stages of readiness for change during addiction treatment: contemplation, determination, action, maintenance, and relapse. An earlier stage (precontemplation) also plays a role. Patients and treatment providers ideally should develop recommended treatment options in the plan based on each patient's readiness for treatment, which can be determined by identifying the patient's stage-of-change readiness. The stages-of-change model and corresponding counseling responsibilities are described in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*a*).

Elements of a Treatment Plan

Because some patients require assistance in many functional areas, treatment plans should address measurable, achievable goals relevant to the patient's current situation. Short-term goals, such as vocational rehabilitation

assessment or computer training, can evolve from a long-term goal, such as full-time employment. However, treatment plans should be simple and not so comprehensive that they overpower a patient with the tasks that must be achieved. Although both short- and long-term goals should be considered, the patient's involvement in defining measurable, achievable goals is important. Treatment plans should be modified periodically when progress can be assessed. Most OTPs have forms to use for treatment planning, many of which were developed to meet regulatory and accreditation requirements, specifying goals, actions, responsible parties, and measurable outcomes. The panel urges that these forms not be overly complex or overwhelming to the patient. Patients should receive a copy of the plan. Exhibit 6-1 provides a case study and an example of a treatment plan.

Exhibit 6-1

Case Study: Patient–Treatment Planning in MAT

Patient is a 30-year-old Hispanic mother of two children who has been divorced for 3 years. She dropped out of high school at age 15 when she became pregnant. As a single mother on public assistance, she first began using heroin intranasally at age 17 and began injecting 1 year later.

Patient was born in Puerto Rico, and her family came to the United States when she was 10 years old. She is the youngest of five children. Her father was an unemployed painter and alcoholic who physically abused her mother. He died in Puerto Rico from cirrhosis of the liver. Patient's relationship with her mother always has been strained. Her mother has had numerous relationships that the patient resented. Patient stated that, as the youngest child, she feels that she never received enough attention or love from her mother.

To support her lifestyle, which includes alcohol, cocaine, and heroin use, patient earned money through prostitution, which led to selling drugs, theft, and other criminal activities. Patient married after giving birth to her second child. Patient has an arrest history and a pending case for selling cocaine. After a divorce, patient lived with her mother. An anonymous call was made to CPS reporting her chronic drug abuse and criminal history. As a result, her children were placed in foster care. After the patient's arrest and the removal of her children, patient's mother asked her to move out of the house; she then lived with whomever she could.

Patient has enrolled in an OTP, motivated by her desire to regain custody of her children. She considers cessation of her cocaine habit secondary to cessation of her heroin abuse. She initially stated that she wanted to change her life, including having her own permanent housing, and she wanted to stop prostituting. Although stabilized on methadone, she continued to use cocaine on a regular basis during her first 6 months in treatment. While in the program, she tested positive for HIV infection. She was assessed as having severe depression, with suicidal ideation, and escalation of cocaine abuse.

Although attempts have been made to motivate patient to stop cocaine use, these attempts have been unsuccessful.

Patient's treatment plan might include the following short- and long-term goals:

(continued on following page)

Exhibit 6-1

Case Study: Patient–Treatment Planning in MAT (continued)

Short-term goals

1. Address imminent danger of suicide by developing a service plan in conjunction with mental health provider.

- Objective: To rule out suicide; to overcome patient's depression and assess need for medication.
- Action: Have patient sign a consent form for a psychiatric evaluation and communication between provider and OTP staff; set up appointment with psychiatrist; obtain evaluation, diagnosis, and treatment recommendations from the psychiatrist.
- Target date: Immediately for suicidal ideation; within 1 month for ongoing mental health needs.
- Responsible persons: Patient, counselor or caseworker, and psychiatrist.
- Measurable outcome: Patient is stable and no longer at high risk; medication needs are assessed.
- Long-term goal: Stable mental health status with ongoing treatment plan.

2. Obtain housing for patient, with long-term goal of stable permanent housing.

- Objective: To refer to a shelter.
- Action: Make appointment to apply for housing assistance program.
- Target date: Immediately.
- Responsible persons: Patient, counselor or caseworker, and housing staff.
- Measurable outcome: Copy of lease, patient self-report, or both.
- Long-term goal: Access to stable housing.

3. Obtain HIV counseling.

- Objective: To provide support and education about HIV status.
- Action: Provide education, resources, and counseling about safe sex and spread of HIV.
- Target date: 4 to 6 months.
- Responsible persons: Medical staff, counselor, and patient.
- Measurable outcome: Patient has obtained and integrated accurate information; myths are dispelled; patient reports readiness to explore treatment options.
- Long-term goal: Initiation of antiretroviral treatment.

4. Address cocaine abuse.

- Objective: To educate the patient on the psychological and physiological effects of cocaine abuse; to develop a recovery intervention.

- Action: Assess level of use and readiness for change; develop plan with patient to address use (e.g., motivational groups, Cocaine Anonymous, skill-building interventions, drug testing).
- Target date: 2 to 4 months.
- Responsible persons: Patient, counselor, group leader, and medical staff members.
- Measurable outcome: Patient decreases cocaine use, based on self-report, observable behavior, drug testing, and attendance to counseling plan.

Long-term goals

1. Manage or eliminate depression.

- Objective: To stabilize depression; to increase self-esteem and motivation to work on treatment goals.
- Action: Provide regular psychiatric treatment on site or by referral; communicate with providers.
- Target date: 6 months.
- Responsible persons: Patient, counselor, and psychiatric providers.
- Measurable outcomes: Patient regularly attends to psychiatric treatment plan, adherence to medication regimen if prescribed, elimination of or reduction in depression (as assessed by patient report, depression assessment tools, observed behavior).

2. Regain custody of children once in stable housing situation.

- Objective: To reconcile the patient with her family; to maintain a stable living situation.
- Action: Assist patient in obtaining public assistance to ensure stable, safe, appropriate environment for children; access legal assistance for custody issues; obtain permission to communicate with CPS; assist patient in remaining abstinent from substance use.
- Target date: 1 year.
- Responsible persons: Patient, counselor or caseworkers, internal or external social services worker, and lawyer.
- Measurable outcomes: Patient self-report, family and CPS agency reports, rent receipts, progress toward obtaining custody of children.

3. Continue HIV medical care.

- Objective: To obtain ongoing HIV education and treatment.
- Action: Provide access and communication with HIV and primary care providers; provide referral to support group meetings for individuals who are HIV positive.
- Target date: Ongoing.
- Responsible persons: Patient, health care providers, counselor and caseworkers, and group counselor or facilitator.
- Measurable outcomes: Patient self-report, health care providers' report, laboratory reports, and group leader reports about adherence to health care needs.

The Multidisciplinary Team Approach

The complexities of treatment planning for patients who receive MAT require a multidisciplinary treatment team, the composition of which varies with OTP resources and the population being treated. The consensus panel recommends that the treatment team consist of the following:

- A physician trained in addiction psychiatry, who provides leadership, health care, and medical stabilization; conducts detailed evaluations of the patient; monitors medications; and provides needed substance abuse interventions when indicated
- Nonphysician medical staff members (e.g., registered nurse, nurse practitioner, physician's assistant), who administer medications, assist in medical evaluations, maintain records, and facilitate referrals for medical and psychiatric treatments
- A pharmacist or pharmacy assistant, who dispenses (and sometimes administers) medications, orders controlled substances, maintains records, and consults with program staff on all aspects of patient care, particularly drug interactions
- Nonmedical professional staff members (e.g., case coordinator, social worker, psychologist, vocational and educational specialist), who provide a range of psychosocial services, including counseling and case management, psychotherapy and family therapy, psychological testing and evaluation, health education, and vocational skills assessment and training
- A certified or licensed addiction specialist or drug counselor
- Nontreatment and administrative staff members (e.g., office manager, clerical staff, receptionist, secretary), who often provide information to treatment teams and whose responsibilities include operational management, billing, receipt of payments, review of records, observation of patient interactions, and telephone coverage
- Security personnel, who ensure the safety and well-being of patients and staff on site.

More information on the multidisciplinary team approach is presented in chapter 14.

14 Administrative Considerations

In This Chapter...

This chapter describes policies, procedures, and considerations that make opioid treatment program (OTP) administrators and managers more effective, therefore contributing to improved treatment outcomes. OTPs are complex, dynamic environments, and their staffing and management are challenging. OTP directors influence patient outcomes positively by providing sound leadership and staff management (Magura et al. 1999). Managers are responsible for keeping staff members focused on patient care and improved treatment outcomes. Conflict or misunderstanding about treatment goals can increase the stress of working in an OTP (Bell 1998). Managers should set clear staff guidelines, supply the needed resources, and create a culture that nurtures professional growth and staff retention.

Staffing

> How . . . interactions [between OTP staff and patients] are conducted, and particularly the attitude of staff members, is probably the next most important determinant of treatment effectiveness after an adequate dose of methadone. (Bell 1998, p. 168)

Successful treatment outcomes depend on staff competence, values, and attitudes. To develop a stable group of competent personnel, OTP administrators should recruit qualified, capable, culturally competent people; offer competitive benefit packages; and provide careful supervision and ongoing training. Employees then can increase their understanding of medication-assisted treatment for opioid addiction (MAT).

Qualifications

Licensing, certification, and credentialing

The complexities of treating patients who are opioid addicted demand highly trained caregivers who can provide direct patient care and coordinate access to other services that their OTP cannot provide. To ensure these qualifications, OTPs should hire individuals who are

licensed or credentialed under State regulations and have a record of working effectively with the types of patients served by the OTP. Licensed and credentialed staff members also may be viewed as having more legitimacy by State regulators, community members, and third-party payers.

Staff interpersonal characteristics

In addition to hiring licensed or credentialed staff, administrators should employ people with empathy, sensitivity, and flexibility, particularly regarding patients in MAT. Empathic staff members create a therapeutic milieu (Joe et al. 2001). In addition, staff members should maintain appropriate professional boundaries with patients.

> [A]dministrators should recruit qualified,…culturally competent people; offer competitive benefit packages; and provide careful supervision and ongoing training.

Transference and countertransference. Some patients with addictions project feelings or emotions onto their treatment providers or cast providers in unintended roles, a phenomenon known as transference. Countertransference occurs when treatment providers project their feelings onto patients, which can interfere with treatment and be destructive to therapeutic relationships. OTP supervisors should ensure that staff members avoid countertransference (e.g., displaying anger toward patients or disappointment with them). TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000*d*), contains a detailed discussion of these topics.

Sensitivity to cultural, gender, and age issues. In a review of the literature on culturally relevant health care interventions and their effect on treatment outcomes, Kehoe and colleagues (2003) found that treatment provider knowledge of cross-cultural principles significantly improved outcomes for patients with drug addictions. OTP staff members should be willing to work with people from diverse backgrounds, explore and accept other value systems, and understand how culture and values can relate to patients' behavior. Support staff should be accepting and understanding of patients from diverse groups because these staff members often are the first people a new patient sees at the OTP and those with whom the patient interacts most. If possible, management should recruit employees who reflect patient demographics and should consider hiring people who are recovering from addiction (see below).

People working with diverse groups should remember that diversity also exists within cultures. It is important to be sensitive to cultural differences but to avoid acting on cultural assumptions. Understanding both a patient's cultural influences and his or her individuality requires taking time to know the patient.

Treatment staff should be sensitive to other factors that can affect recovery, such as patients' sexual orientations or ages, but should avoid generalizing about patients based on these factors. Correctly identifying such factors requires an effort to see the world through each patient's eyes. Information on cultural competence and diversity is available at Web sites of the National Association of Social Workers (http://www.socialworkers.org/diversity) and Substance Abuse and Mental Health Services Administration (SAMHSA) (http://www.samhsa.gov/search/search.html) and in "Cultural Competence for Social Workers" (Center for Substance Abuse Prevention 1995) and the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT forthcoming *b*).

Multicultural and multilingual representation. The consensus panel is aware of no published

data demonstrating improved outcomes from ethnic matching of patients and substance abuse treatment providers. Sterling and colleagues (2001) noted the existence of "equivocal findings of the effect that therapist and patient similarity plays in treatment outcome" (p. 1015) in substance abuse treatment programs and concluded that more research is needed. However, the panel believes that, when program staff generally reflects the demographics of the population served, patients are more likely to feel comfortable in the OTP. When multicultural representation among staff is limited, OTPs should find ways to communicate acceptance of diverse cultures and groups.

Programs with non–English-speaking patients should provide information in patients' first languages by employing staff members or interpreters who can communicate with patients. Federal and State resources are available for programs seeking literature in languages other than English. Community colleges, universities, and other institutions or agencies might assist in translating forms and pamphlets. Information about translation services is available via the Internet (visit http://www.atanet.org).

Flexibility in thinking, behavior, and attitudes. Staff attitudes about MAT and opioid addiction can affect patient outcomes. Administrators should seek staff members who are free of rigid biases, are not judgmental, and do not have punitive attitudes toward patients (Bell 2000).

OTP staff members sometimes hold negative attitudes toward patients (Caplehorn et al. 1997) or MAT (Forman et al. 2001). At least one study has associated such attitudes with lower rates of patient retention and poorer patient outcomes (Caplehorn et al. 1998). OTP managers should be vigilant about monitoring staff attitudes and conduct inservice training to create or sustain appropriate attitudes about patients and MAT.

The verbal expressions used by OTP staff members can reflect how they feel toward patients. Treatment staff members, who might have absorbed society's antipathy toward people in MAT, sometimes use counterthera-peutic language, for example, the phrase "dirty urine" to describe an unsatisfactory urine drug test ("positive test" is less judgmental). Staff should avoid terms suggesting the criminal justice system, such as "probation" or "probationary," to refer to the status of patients doing poorly in treatment. "Termination" should be avoided in reference to patient discharge. Other preferred expressions in MAT include "patients" not "clients" and "dose tapering" or "medically supervised withdrawal" not "detox" in reference to withdrawal from treatment medication. Applying words derived from "toxin" to treatment medication suggests that the medication is a toxin; "detoxification" should refer only to withdrawal from substances of abuse.

Inclusion of recovering patients. The consensus panel believes that employing treatment professionals and support staff who are in recovery also adds valuable perspectives to treatment and provides role models for patients. OTP policies on hiring people who are in addiction recovery should be in writing and include procedures for addressing staff members who relapse. State regulations may establish a minimum abstinence period before an OTP can hire someone in recovery. Policies also must comply with Federal and many State laws prohibiting discrimination against people who are addicted (CSAT forthcoming *b*). Staff members who are in recovery and their colleagues who have no addiction history should be treated similarly.

Staff Retention

Retaining staff is important for several reasons:

- Stability of treatment staff may affect treatment outcomes.
- High staff turnover can undermine relations with the community, funders, and others.
- Investment in recruitment and training is lost when staff members leave.
- Unfilled staff positions result in longer patient waiting lists.

- Reducing staff turnover minimizes disruption to patients' treatment.
- Accreditation standards place importance on the stability of OTP staff.

Factors that may contribute to high staff turnover include low salaries and benefits, negative stereotypes of MAT and its patients, job stress, excessive counselor workload, unreasonable operating hours, and unsafe OTP locations. Staff members can experience burnout when they work in isolation with difficult patients and inadequate support or feedback. Managers should take concrete steps to retain staff, including the following:

- Establish and maintain clear policies and procedures, and apply them consistently.
- Avoid excessive caseloads. Even the most professional, committed counselor struggles when the caseload is too large. Managers can use a monitoring system that focuses on the number of counseling hours a caseload requires, which can differ dramatically from the number of cases assigned per counselor, depending on the requirements of individual patients.
- Encourage a team approach. Staff members usually feel less isolated and overwhelmed when a team makes treatment decisions. When a lack of cohesion exists, staff members risk burnout, disillusionment, or cynicism. A well-coordinated team also reduces the level of intrastaff disagreements about patient care and decreases the likelihood of "staff splitting," when patients pit staff members against one another.
- Encourage a culture of mutual respect through team cooperation, clear and effective communication, and inclusive, interdepartmental decisionmaking. Managers should hold regular staff meetings. Staff cooperation also can be fostered through training and retreats. The program director or manager should mediate disputes among staff members.
- Establish job descriptions that clearly delineate roles, responsibilities, and lines of communication (Bell 1998), and review them annually with personnel.
- Establish objective performance standards derived from job descriptions, and conduct regular performance evaluations that include feedback based on patient outcomes.
- Establish regular consulting sessions among counselors, their supervisors, and other staff members. Supervisors should be well trained and supported.
- Provide opportunities for professional training, either by onsite training or by permitting staff members to attend offsite training during work hours.
- Encourage professional development by supporting staff certifications.
- Establish personnel policies that demonstrate concern for staff well-being, including flexible work schedules to reduce stress.
- Offer routine praise and recognition for staff contributions and achievements.

The forthcoming TIP *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT forthcoming *c*) provides more information on supervision, and Newman (1997) provides information on the therapeutic alliance between patients and treatment providers.

Training

Training should be offered for all staff members, including secretaries, nurses, counselors, supervisors, and managers, to ensure a strong knowledge base so that staff members do their best and to affirm that all staff members are valued members of the treatment team. The importance of training has increased because accreditation standards require OTPs to provide continuing staff education, with many States requiring such education for OTPs to maintain licensure. OTPs should help professional staff members acquire education credits to maintain their licensure by offering onsite training, collaborating with other agencies for reciprocal training, or paying for educational leave or tuition.

At minimum, training should focus on the following areas:

- **Facts about MAT and the health effects of treatment medications.** Educating OTP staff about the health effects of MAT medications and the value of remaining in treatment is essential. Some studies have revealed a high level of misinformation among OTP staff members about the health effects of maintenance medications (e.g., Kang et al. 1997). Other studies have shown that many staff members hold negative attitudes about MAT (e.g., Caplehorn et al. 1997), which negatively affect patient outcomes (Caplehorn et al. 1998). One way to address negative staff attitudes is to include successful patients in training (Bell 2000).
- **Up-to-date information about medications.** Staff should be able to discuss medications with patients. Medical staff members should be able to assess patients and determine, with input from other treatment team members, which medication is most appropriate.
- **Up-to-date information about drugs of abuse.** Training should ensure that staff members are knowledgeable about drug abuse trends in the community.
- **Up-to-date information about communicable diseases.** Training should focus on both diseases commonly experienced by patients in MAT, such as hepatitis C, and emerging diseases in the community, possibly including tuberculosis or HIV/AIDS.
- **Skills training.** Staff members should have access to generic skills training such as crisis management, communications, and problem-solving, as well as new evidence-based MAT treatments. They should have access to training about the populations the OTP serves, including cultural information and information about specific disorders.
- **Patient sensitivity training.** The importance of emphasizing sensitivity to patient needs should be reviewed periodically. No matter how creative and naturally sensitive a staff member may be, factors such as burnout can affect how he or she responds.

A large OTP can tap into its own staff to provide training. A program physician might educate staff members about the etiology of addiction and effects of medications. A psychiatrist might distinguish primary mental disorders from those that are substance related and provide information on psychotropic medications. Therapists and social workers might teach behavior management techniques, parenting, and resource allocation. Nurses might provide training on gender and wellness, as well as the side effects of pharmacologic regimens. Consistent inservice training can help staff members understand the program's mission and the effects of MAT.

Federal and State agencies and professional associations offer seminars, courses, and workshops. SAMHSA's Addiction Technology Transfer Centers (ATTCs) offer an array of training events and resource materials (http://www.attcnetwork.org/index.asp). Some States offer training leading to certification for addiction specialists and counselors. Hospitals and large OTPs sometimes allow staff from smaller programs to attend their sessions. Professional societies, such as the American Society of Addiction Medicine, American Academy of Addiction Psychiatry, and Osteopathic Academy of Addiction Medicine, offer training for medical personnel in various therapeutic techniques. National counseling organizations, such as the Association for Addiction Professionals, and professional nursing societies also offer treatment courses.

The importance of training has increased because accreditation standards require OTPs to provide continuing staff education…

OTP administrative, financial, clerical, maintenance, and custodial staff may lack direct treatment responsibilities, but they are very much part of the team. Reception staff members, often the first to speak with patients, play an important role. They should receive an

orientation about MAT to ensure that they understand how the OTP operates so that they develop favorable attitudes about patients. If possible, all staff members should receive annual training in such areas as confidentiality requirements, cultural competence, prevention of workplace violence, and patient rights.

Medication Diversion Control Plans

Federal opioid treatment standards state that an OTP must maintain a current diversion control plan (DCP) that includes measures to reduce the possibility of medication diversion and assigns responsibility for control measures to medical and administrative staff members (42 Code of Federal Regulations [CFR], Part 8 § 12(c)(2)).

A DCP should address diversion of medication both by patients, who might sell or give their take-home medication to others, and by staff, who might steal medication or spill or otherwise waste it.

Reducing the Possibility of Diversion by Patients

Patients considered for take-home medication must meet Federal criteria. The medical director makes decisions about take-home medications (42 CFR, Part 8 § 12(i)(2)), and these decisions and their basis must be documented (42 CFR, Part 8 § 12(i)(3)). Staff should ensure that patients can store medications safely in their homes (42 CFR, Part 8 § 12(i)(2)(vii)). All take-home medication must be labeled with the OTP "name, address, and telephone number and…packaged in a manner that is designed to reduce the risk of accidental ingestion, including child-proof containers"(42 CFR, Part 8 § 12(i)(5)).

> [A]n OTP must maintain a diversion control plan…to reduce the possibility of medication diversion…

Callbacks (see chapter 5) help prevent patient diversion of take-home medication. Callbacks require OTPs to select patients at random to return to the OTP with their remaining take-home medication. A random-callback policy avoids patient complaints of being unfairly "picked on" by staff members. Programs also can require patients to undergo drug tests when they bring in their medications. OTPs should document that patients have been informed of their responsibilities regarding callbacks (e.g., how much notice they will receive beforehand) and about the consequences of failure to respond or of discrepancies in medication amounts. The OTP callback policy should be stated clearly in the program DCP.

A no-loitering policy is part of an effective DCP. The policy should be clarified at the beginning of treatment and enforced consistently. Extending OTP hours helps eliminate overcrowding and loitering. The OTP should include routine meetings with community leaders, attendance at neighborhood civic association meetings, and open communications with local law enforcement officials to help resolve community concerns.

Reducing the Possibility of Diversion by Staff Members

OTPs rely on the integrity of employees who handle U.S. Drug Enforcement Administration (DEA)-scheduled substances. Even so, protocols should be in place to reduce the risk that staff will divert medications. All scheduled substances should be accounted for rigorously and inventoried continuously. Receipt and dispensing should be noted in logbooks. Working stocks should be logged and tracked from receipt through dispensing and measured at the beginning and end of each workday. Measurements and daily reconciliations should be monitored by supervisors and checked

periodically by dispensary managers. Any significant discrepancy should prompt an investigation. The dispensary manager, executive director, and medical director should follow up on investigation findings. The security of computerized records and systems also should be ensured to prevent employee theft of medication. Spills and other accidents should be reported immediately. Within the dispensary, employees should open the safe or work with scheduled substances only in the presence of other staff members. In matters of medication dispensing, OTPs must consult and comply with DEA regulations (Drug Enforcement Administration 2000).

The Community Effort

Community Opposition, Stigma, and the Importance of Community Relations

Community resistance to MAT has been chronicled for decades (e.g., Genevie et al. 1988; Joseph et al. 2000; Lewis 1999; Lowinson and Langrod 1975). The consensus panel believes that this resistance has been reduced since TIP 1, *State Methadone Treatment Guidelines* (CSAT 1993*b*), was published, particularly through efforts to improve scientific clarity about opioid addiction, to affirm the efficacy and benefits of MAT, and to educate professionals and the public about MAT. The expanding patient advocacy movement effectively may be countering some stereotypes and misunderstandings about MAT. Some treatment providers have overcome community opposition—sometimes called not-in-my-backyard (NIMBY) syndrome—through outreach and educational efforts (e.g., Weber and Cowie 1995). Many prevention and treatment programs are becoming increasingly responsive to the needs of cultural and ethnic groups (i.e., more culturally competent). These successes provide models for effective community relations in other settings.

Despite progress, MAT remains stigmatized and controversial in many U.S. communities (Joseph et al. 2000). The association of MAT with substantial improvements in individual health and employment and with reductions in HIV risk and criminal behavior has been validated by research (e.g., Krantz and Mehler 2004; Mueller and Wyman 1997), but MAT remains misunderstood even among some health care professionals.

Sensationalized media coverage and successful NIMBY-type opposition have continued to delay or preempt the siting of new facilities (Lawmakers may restrict 2000; Shepard 2001; Sissenwein 2000; Zoning fight over Michigan 1998). Introducing MAT into communities is difficult without community support. However, the consensus panel believes that, since the early 1990s, the willingness of treatment professionals and patients; government officials; agencies representing health, mental health, addiction treatment, research, and criminal justice; and the general public to learn more about MAT and opioid addiction has increased. Organizations appear more willing to include OTPs in community health planning as well-regarded community services, but this effort remains a work in progress.

Good Community Relations

Good community relations are part of good treatment. When TIP 1 was published in 1993, Federal regulations guiding the operation of OTPs did not mandate efforts to improve community relations or educate the community. Transition in Federal oversight of substance abuse treatment from the U.S. Food and Drug Administration (FDA) to SAMHSA altered the Federal regulatory perspective, as reflected in SAMHSA regulations guiding OTPs (21 CFR, Part 291, and 42 CFR, Part 8 [*Federal Register* 66:4076–4102]). In the panel's view, this change in oversight is bringing OTPs into the medical mainstream, under the purview of SAMHSA, by establishing an OTP accreditation system similar to the requirements of other medical services. Furthermore, the new rules have codified SAMHSA's earlier guidelines for

OTP accreditation (CSAT 1999*b*), which recognize community relations, education, and stigma reduction as necessary operational elements. SAMHSA's approved OTP-accrediting organizations—including at this writing the Commission on Accreditation of Rehabilitation Facilities, Council on Accreditation for Children and Family Services, Joint Commission on Accreditation of Healthcare Organizations, National Commission for Correctional Health Care, State of Missouri Department of Mental Health Division of Alcohol and Drug Abuse, and Washington State Department of Social and Health Services Division of Alcohol and Substance Abuse—require that MAT providers demonstrate effective community relations and stigma-reduction efforts.

OTPs serve both patients and the community. They affect public health, education, and citizens' sense of well-being. Publicly funded OTPs often rely on community support. Moreover, MAT's placement within the medical and behavioral spectrum of health care affects relations with the payer community (Edmunds et al. 1997), including government and private insurers and managed care organizations. These connections increase the need for effective outreach to other community services and entities.

Overcoming Negative Community Reactions to OTPs

Joseph and colleagues (2000) reported that most community resistance involves concern about patient loitering, drug sales, and the diversion of methadone (see "Medication Diversion Control Plans" above). Adding alternative care models and longer acting pharmacotherapies to the services continuum can decrease loitering, illicit transactions, illegal parking, and other activities that increase community concerns. These options enable highly functioning patients who meet specific criteria to receive ongoing medical care and pharmacotherapy with fewer visits to the OTP. In the view of the consensus panel, incorporation of primary medical care, day treatment, and short-stay residential models into treatment options can affect community perceptions positively because patients involved in MAT are less likely to loiter near the OTP.

Facilities for onsite patient activities to limit outside loitering are beneficial. Having adequate onsite staff is equally important in avoiding and resolving community problems. Glezen and Lowery (1999) provide other practical guidelines for addressing community concerns about substance abuse treatment facilities.

Community opposition can be triggered when community groups believe that they have been informed or consulted insufficiently. OTP administrators should meet regularly with community leaders to ensure that all parties are heard. The physical appearance of facilities should be conceived carefully. The OTP should be clean and orderly to distinguish it as a professional, responsible facility. Surrounding property (e.g., entrances, sidewalks, fencing, trash receptacles, signs) and OTP hours should not impede pedestrian or vehicle traffic. The availability of public transportation is important when considering an OTP's location (Glezen and Lowery 1999).

Some communities have found mobile treatment facilities more acceptable than fixed-site OTPs. Mobile services allow more people addicted to opioids to be treated without confronting NIMBY reactions. Pilot studies have confirmed their success (e.g., Gleghorn 2002; Ho 1999).

Whether institution or community based, fixed site or mobile, OTPs should be situated, designed, and operated in accordance with accreditation standards, Federal guidelines, and State and local licensing, approval, and operating requirements. The consensus panel recommends that MAT providers thoroughly know and understand their communities and provide the levels of input and support requested by community leaders, representatives, and constituents to site a facility and develop services that are responsive to community needs.

Community Relations and Education Plan

Each OTP should develop a community relations and education plan that extends from its general mission statement. Staff and patients should be part of a multifaceted, proactive effort to educate community entities affected by OTP operations, including the medical community, neighbors, and agencies and individuals providing support services. Although program activities differ in specificity and scope, a community relations plan should address the following:

- Learning about the community, its structures, and directly affected constituents
- Delineating the community relations mission, goals, protocols, and staff roles
- Initiating and maintaining contact with community liaisons
- Educating and serving the community
- Establishing effective media relations
- Developing policies and procedures to address community concerns about the OTP
- Documenting community contacts and community relations activities.

The forthcoming TIP *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT forthcoming c) provides additional information on developing a community relations and education plan.

Delineating the community relations, missions, goals, protocols, and staff roles

In the opinion of the consensus panel, community relations and education should be an inherent function of OTP staff. OTPs with sufficient resources might employ or retain a community relations professional to establish links with local leaders, coordinate staff and patient participation in community activities, determine who will represent the OTP at local events and when, and arrange speaking and other community education activities. If funding for dedicated community relations staff is unavailable, the OTP should develop an internal plan for community relations and education. If the OTP is affiliated with a larger institution, it should ensure full cooperation from the parent organization's community relations department.

Initiating and maintaining contact with community

Personal contact with community leaders permits open dialog, information sharing, and discussion of community developments, needs, and problems. Members of the consensus panel agree that such communication fosters trust in the OTP. Moreover, personal contact with community representatives

- Encourages leaders to use the OTP as a resource on addiction and related health issues
- Promotes MAT's public health benefits
- Highlights the value of the OTP for community members with addiction- and other health-related problems.

Regular contact with key liaisons should include onsite and offsite meetings. Demystification of MAT occurs when treatment is viewed firsthand. Community members who visit OTPs can observe operations and speak with staff and consenting patients, assuming OTP operation is unimpaired and patient confidentiality is maintained.

OTP administrators should meet regularly with community leaders…

Educating and serving the community

Information about MAT and the OTP can be presented through various media. Brochures and factsheets can be developed that cover the program's mission, its board membership, the

Highly visible community services demonstrate an OTP's commitment to community improvement and counter negative stereotypes.

types of services offered, and data on patients. Occasional press releases can notify the public about specific services, activities, accomplishments, announcements, improvements, or events. Highlights of an OTP's annual report can be shared with community officials, liaisons, and the general public. A program newsletter highlighting health and addiction issues and containing OTP information and patient and staff articles can be distributed. The Internet has enabled the public to view more information about opioid addiction and MAT. Government and private organizations, professional journals, sponsoring or research institutions, provider coalitions, advocacy organizations, and individual OTPs and patients offer Web sites that discuss MAT options, policies, services, and developments and frequently link to related Internet sites. Some examples are the following:

- American Association for the Treatment of Opioid Dependence, Inc. (AATOD)
- National Institute on Drug Abuse (NIDA)
- SAMHSA
- SAMHSA's National Help Line and Treatment Improvement Exchange
- White House Office of National Drug Control Policy.

Some OTPs have developed speakers' bureaus for local events. Interested, successful patients, patient advisory committees, patient family groups, and OTP alumni can be promoted as potential speakers. Advocacy groups are becoming increasingly instrumental in empowering patients as active participants in public relations, community outreach, and program support initiatives and in local, State, and national community education efforts.

OTPs should take an aggressive, proactive stance in community projects and events, including some not directly tied to MAT. Sponsoring conferences, forums, exhibits, and awareness events establishes an OTP as a leader, resource, and participant in the community. Staff members with community development expertise can support other organizations in advocacy, promotional, and support efforts. OTPs can provide noninvasive medical-screening services (e.g., blood pressure, pulse, and weight checks; nutritional advice) to community members. Hospital-based OTPs and those licensed to provide primary medical services can furnish immunizations to community residents. OTPs can donate surplus office items or other products to organizations or groups. Consenting patients and staff can organize projects such as community cleanups and neighborhood patrols. Highly visible community services demonstrate an OTP's commitment to community improvement and counter negative stereotypes.

OTPs also serve communities by providing addiction treatment for community residents and offering jobs for qualified residents. The panel recommends that efforts be made to recruit and hire responsible, qualified personnel from the local community.

OTP administrators and staff can be active as representatives, speakers, or planners at professional conferences and as members or leaders in professional and community coalitions, including advisory councils. Such affiliations augment community relations efforts through increased professional education and public awareness, providing an opportunity to exchange information with and counter MAT stigmatization among other treatment professionals. These forums also may present community relations models that can be adapt-

ed effectively by OTPs. Staff participation on local planning or development bodies can contribute to community improvement, particularly in social and health services.

OTPs are encouraged to participate in national SAMHSA campaigns, for instance, by supporting National Alcohol and Drug Addiction Recovery Month or sponsoring events to emphasize that addiction recovery is possible and facilitating MAT as compassionate and a sound investment.

Establishing effective media relations

Print, broadcast, and Internet media play critical roles in reporting and educating, as well as influencing public opinion. Local and national media differ widely in their portrayals of opioid addiction, MAT, and people addicted to opioids. These differences reflect a combination of factors including journalistic integrity, reporting style and philosophy, political leanings, regional influences, and business considerations. News accounts and other depictions of MAT often seem limited, misinformed, and negative.

Nevertheless, many noteworthy, responsible features have been produced, providing important, accurate information to the public about the science and policy of opioid addiction and treatment (e.g., Barry 2002; Hammack 2002; Moyers and Moyers 1998). Although treatment providers sometimes are disciplined to resist media exposure in order to protect patient confidentiality and avoid misrepresentation, the consensus panel believes that successful media outreach enhances an OTP's image, improves understanding of a program's mission and methods, and generates supportive public policies. Media outreach can demystify treatment, counteract stigma, and improve fairness of coverage.

OTPs operating in larger institutions can work with institutional public affairs professionals. Administrators should respond to or address members of the local press when necessary, as an outgrowth of providing service to the public. The panel believes that providing quality treatment and operating OTPs responsibly position programs to interact openly and confidently with the media.

The forthcoming TIP *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT forthcoming *c*) provides additional details for establishing media relations.

Developing policies and procedures to address and resolve community concerns

The best intentions to educate and serve the community are undermined if they are not followed up to resolve problems and concerns about OTPs. The panel recommends that detailed strategies and procedures be in place to respond to sources of community anxiety and hostility.

It is essential for OTPs to take steps—possibly including staff or security patrols of the community, visits with local merchants or representatives, and establishment of a community hot line—to curtail loitering, drug sales, and the diversion of methadone before they prompt community complaints. These patrols should emphasize observation, not intervention. Logs summarizing observations should be maintained. Staff visibility reminds patients of the negative effect of loitering and similar behavior and demonstrates to neighbors that OTPs actively are committed to community safety and improving quality of life.

Patients observed loitering should be counseled, and their treatment plan should be revised to address this behavior. OTPs with loitering problems should investigate day treatment programs to provide increased treatment intensity. Discharge should be considered for patients observed in illegal transactions or medication diversion. Although discharge is counter to the mandates of voluntary treatment, patients who are unconcerned about an OTP's community acceptance might be better served by a facility equipped to handle their behaviors.

Decisions to discharge patients for loitering should balance consequences for the individual patient and public health against the need to ensure a stable OTP environment and maintain community-based services open to all patients. The panel recommends that loitering policies that culminate in patient discharge should first provide for progressive discipline and intervention and incorporate patient rights to a fair hearing and treatment (see discussion in Appendix D).

Community representatives should have OTP contact information to report problems involving patients. However, OTPs should clarify that they cannot assume a police role; in emergency and criminal matters, the police should be contacted first, not the OTP. Effective liaison with local law enforcement personnel is critical to OTP relations with the community. Although police officers are generally supportive, OTPs should correct any misconceptions police personnel have about OTPs. Patients should be differentiated from people actively using illicit drugs or abusing prescription drugs, and law enforcement personnel should be informed about OTP operations, with the understanding that police and OTPs share a purpose—addressing substance abuse in the community. Other community problems (e.g., drug sales, unsafe community conditions) identified during staff tours can be reported to law enforcement authorities. Local officers should be encouraged to contact the OTP about problems involving patients. Confidentiality remains paramount, so this relationship should be delineated carefully.

Documenting community contacts and community relations activities

Programs should document their efforts to establish productive community contacts and resolve community concerns. A database should be developed and updated (e.g., the number and nature of community complaints received and the program's response). Communications should be logged, and staff participation in community events should be summarized. Letters and communications substantiating community complaints and the program's followup should be on file. Records should be kept of staff participation in professional and community conferences, articles published in professional journals, and contributions to local news organizations.

Using this information, OTP administrators regularly should evaluate community relations efforts. Such reviews can identify organizations excluded from previous efforts or problems requiring revision of program policies or practices.

OTPs and National Community Education Initiatives

OTPs should be aware of and involved in the national dialog and efforts to promote MAT, improve and disseminate information about opioid addiction, and partner with other national organizations and agencies in public relations and community education efforts. In addition, OTPs should build on and contribute to these national initiatives within their communities.

Numerous resources are available to educate the public about MAT and assist OTPs with public relations. National organizations such as AATOD and the American Society of Addiction Medicine hold national and regional conferences that bring together treatment providers, policymakers, researchers, and advocates to share knowledge and discuss how to advance national drug policy and expand effective treatment models, including strategies to improve public relations and reduce stigma. Focused training sessions also provide critical information, for example, to encourage physicians not associated with OTPs to enter into MAT or explain how to improve their current treatment of patients who are opioid addicted. Other sessions may focus on improving staff attitudes and the treatment system regarding implementation of accreditation (Parrino 2001).

NIDA has invited professionals, practitioners, policymakers, and the public to sessions focused on merging research with everyday clinical practices in community-based drug treatment programs. For example, one conference, Blending Clinical Practice and Research—Forging Partnerships To Enhance Drug Addiction Treatment, held in April 2002 (National Institute on Drug Abuse 2002), incorporated a special forum focused on the media's role in presenting addiction treatment and research issues in the context of science reporting.

Publications and other information resources, often available without charge or at low cost, highlight stories about the life-changing effects of MAT (e.g., American Methadone Treatment Association, Inc. 2000; CSAT 2000*a*). To educate drug court judges and practitioners, AATOD has produced *Drug Court Practitioner Fact Sheet* (Parrino 2002). DEA and AATOD developed the first DEA-specific guidelines for OTPs, *Narcotic Treatment Programs: Best Practice Guideline* (Drug Enforcement Administration 2000), which is distributed nationally to MAT providers and addresses the safekeeping of and proper accountability for controlled opioid treatment medications. The Center for Substance Abuse Treatment's (CSAT's) *Siting Drug and Alcohol Programs: Legal Challenges to the "NIMBY" Syndrome* (Weber and Cowie 1995) provides assistance with problems related to siting treatment facilities including OTPs.

In 1999, SAMHSA convened expert panels and hearings to examine critical issues affecting the National Treatment Plan Initiative to improve and extend alcohol and drug treatment to all communities and people in need in the United States (CSAT 2000*b*). This extensive exploration documented widespread stigma and bias and its effect on public support and policy, such as delaying the acknowledgment of addiction as a disease; inhibiting prevention, care, treatment, and research efforts; and diminishing the life opportunities of those stigmatized. *Changing the Conversation—Improving Substance Abuse Treatment: The National Treatment Plan Initiative* (CSAT 2000*b*) affirmed the value of mass media public health education campaigns, comprehensive community-based health communications, media advocacy, and the application of commercial marketing technologies to programs to change social attitudes. This publication proposed a unique national approach to reducing stigma that incorporates science-based marketing research, a social marketing plan, facilitation and support of grassroots efforts by the recovery community, and promotion of the dignity of people in treatment.

NIDA's Community Epidemiology Surveillance Networks—multiagency work groups with a public health orientation—study the growth and development of drug abuse and related problems in communities nationwide. The primary objectives are to describe drug abuse patterns in defined geographic areas, identify changes in these patterns, detect emerging substances of abuse, and communicate and disseminate information so that appropriate community agencies and organizations can develop prevention and treatment strategies.

OTPs should be… involved in… efforts to promote MAT, improve and disseminate information about opioid addiction, and partner with other national organizations and agencies…

As government and provider-based organizations mobilize national efforts, patients in and providers of MAT, along with other interested citizens, have been encouraged to unite and organize, educate

health providers and their communities, and actively engage in public relations initiatives and other advocacy efforts that advance knowledge and change attitudes about MAT. CSAT's Recovery Community Support Program assists advocacy organizations in promoting their messages.

Evaluating Program and Staff Performance

Why Program Evaluation and Performance Improvement Are Important

Recent developments lend urgency to the development of good program evaluation and performance improvement procedures in OTPs. Federal regulations (42 CFR, Part 8 § 12(c)) and guidelines (*Guidelines for the Accreditation of Opioid Treatment Programs* [CSAT 1999*b*], Section III, Part C) require OTPs to establish performance improvement programs based on ongoing assessment of patient outcomes. SAMHSA-approved accrediting bodies (listed above) require performance improvement objectives in their guidelines. Many Single State Agencies and managed care organizations also require programs to collect and analyze outcome data. OTPs are pressed increasingly to demonstrate their effectiveness and efficiency. Administrators and staff must implement program evaluation processes that help meet these demands. Program evaluation contributes to improved treatment by enabling administrators to base changes in services on evidence of what works.

OTPs are pressed increasingly to demonstrate their effectiveness and efficiency.

Beyond the general information below about program and staff evaluation in an OTP, readers who want to know more about the specific questions to ask and the considerations that should be made during evaluation should refer to *Demystifying Evaluation: A Manual for Evaluating Your Substance Abuse Treatment Program—Volume 1* (CSAT 1997*a*).

Background

MAT is one of the most frequently studied addiction therapies, but evaluating program performance based on patient outcomes is relatively new to OTPs. Previous regulations (21 CFR, Part 291), which gave regulatory oversight to FDA, stressed process evaluation based on compliance with recommended treatment procedures. Process evaluation does not ask whether a recommended process has worked, only whether it has been followed.

The Institute of Medicine (IOM) was among the first organizations to recommend an outcome evaluation system for OTPs based on "direct and valid measures of reduction in opiate and non-opiate drug use and improvement in positive social function" (Institute of Medicine 1995, p. 228), which could be used by OTPs, regulatory and funding agencies, and researchers. IOM looked to the Methadone Treatment Quality Assurance System (MTQAS)—a NIDA-funded effort lasting from 1989 to 1998—to develop a performance-based reporting and feedback system as the foundation for a formal performance improvement system in OTPs. MTQAS was never fully adopted because most OTPs lacked the "focused technical assistance" (Ducharme and Luckey 2000, p. 87) required to translate feedback into action. Eight States participated in the MTQAS study, but only Massachusetts and North Carolina are using elements of the system at this writing. Many OTPs appear to be on their own in conducting program evaluations that comply with accreditation and State mandates.

Outcome and Process Evaluation

Both performance outcome and process evaluations have value, but they answer different questions and require different approaches. Performance outcome evaluation focuses on results, for example, patient progress. Process evaluation focuses on how results were achieved—the active ingredients of treatment. The forthcoming TIP *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT forthcoming *c*) and *Demystifying Evaluation: A Manual for Evaluating Your Substance Abuse Treatment Program—Volume 1* (CSAT 1997*a*) describe and contrast these two types of evaluations.

Outcome evaluation in OTPs

Outcome evaluation in OTPs focuses on patients and their progress during or after participation in MAT. It should focus on progress markers (see chapter 7) and behavioral improvements as guideposts and avoid terms such as "success" and "failure." Even small improvements may be significant. For example, an outcome evaluation might measure drug use (as quantified by drug testing) in patients who have spent various times in treatment. Such a study can set a baseline and provide a benchmark to evaluate the effects of changes in program practices, for example, prescribing individually appropriate dosages for patients. Researchers measure many variables to assess MAT treatment outcomes, including drug use, criminal activity, medical problems, vocational skills, employment, family relationships, and social activities. The measures selected by an OTP should agree with the target behaviors specified in program goals and objectives. For example, evaluation of a treatment initiative designed to reduce substance use, decrease criminal involvement, and increase job skills should be based on data in those areas. An OTP can measure other outcomes (such as patients' use of emergency rooms for medical care) to assess whether it has had other effects on patient behaviors or the community.

SAMHSA's accreditation guidelines list the following treatment outcomes as examples of what might be measured by OTPs:

- "reducing or eliminating the use of illicit opioids, other illicit-drugs, and the problematic use of prescription drugs
- reducing or eliminating associated criminal activities
- reducing behaviors contributing to the spread of infectious diseases
- improving quality of life by restoration of physical and mental health and functional status." (CSAT 1999*b*, p. 7)

Outcome evaluation also can be focused narrowly; it can assess the results of particular treatment approaches on patient behavior. For example, an OTP might provide patients with bus tokens to defray transportation costs to and from treatment (some cities fund this kind of intervention). After a certain period, the OTP could evaluate whether providing bus tokens improved program attendance. This simple evaluation would require only attendance data. The most reliable evaluation uses a control group for comparison (e.g., a group of patients who must purchase their bus tokens), but this is not always practical or ethical.

Process evaluation

Process evaluation describes what is happening in the treatment program: what kind of treatment, who conducts the sessions, how many and how long the sessions are, and where the sessions occur. A process evaluation documents what actually happens during an intervention, how a new program or initiative is put into operation, who the players are and what steps they take, specific problems and barriers encountered, strategies used to overcome these problems and barriers, and necessary modifications to the original plan. Process evaluation also may describe what is happening within the "black box" of the treatment program. Black box, a commonly used term in this context (Ball and Ross 1991, p. 5), refers to the unknown quality of some treatment programs—that is, the fact that patients go into a program as

known entities and come out with certain measurable outcomes, but what actually occurs in treatment is not readily apparent. Process evaluation permits others to replicate methods that achieve their goals by evaluating the factors responsible for those achievements. A process evaluation can lead to development of a manual describing the theories and practices of an OTP to guide others. Implementation analysis should document a process fully. It is well suited to documenting an OTP's efforts in community relations, which is required in the accreditation process.

A process evaluation can serve as a management tool for program development if it is used to assess the strengths and weaknesses of a program and suggest ways to improve operations. A process evaluation helps administrators understand how program resources, including both staff and time, are used and can lead to improved resource allocation. Process evaluation is useful for examining whether OTP procedures are congruent with its stated goals. For example, if a goal is to facilitate patients' use of peer support groups, the OTP could measure how often meetings of such groups are held on site, how often counselors provide patients with lists of local meetings, or whether patients actually receive interventions as intended. For example, an OTP intending to individualize care and match services to patients' needs may decide to use the Addiction Severity Index (ASI) as a guide to treatment planning because research shows that the ASI indicates effective patient–service matches (McLellan et al. 1997). A process evaluation might examine the degree to which treatment plans and service delivery were congruent with the needs identified by the ASI. If the program finds a lack of congruence, it can make corrections through training and supervision. The process evaluation also can measure the intensity and duration of services received by patients.

Resources for Program Evaluation and Performance Improvement

CSAT has published a comprehensive, detailed guide to program evaluation that provides a modularized learning approach, including exercises, for designing and conducting evaluations. *Demystifying Evaluation: A Manual for Evaluating Your Substance Abuse Treatment Program—Volume 1* (CSAT 1997*a*) is available from http://store.samhsa.gov.

For OTPs that want to use cost accounting as a form of program evaluation, NIDA has developed a manual based on a cost-procedure-process-outcome analysis model that has been well researched and tested in substance abuse treatment programs. *Measuring and Improving Costs, Cost-Effectiveness, and Cost-Benefit for Substance Abuse Treatment Programs—A Manual* is available at http://archives.drugabuse.gov/IMPCOST/IMPCOSTIndex.html.

The Institute of Behavioral Research at Texas Christian University has carried out a substantial body of research on treatment process and outcomes (Simpson, D.D., et al. 1997*a*, 2000). The institute's findings and experience in adapting assessments to field settings have guided development of a set of core instruments that are available at http://www.ibr.tcu.edu/pubs/datacoll/coresetforms.html. The Web site also contains useful program evaluation forms for gathering OTP data, including the organization's readiness to change and patient satisfaction with treatment.

The Change Book, a guidebook for organizational change in OTPs, is produced and distributed by the National ATTC (see http://www.attcnetwork.org/explore/priorityareas/techtrans/tools/changebook.asp).