Knowledge Application Program

KAP Keys

For Clinicians

Based on TIP 47
Substance Abuse: Clinical Issues in Intensive Outpatient Treatment
KAP Keys Based on TIP 47
Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

Introduction

KAP Keys were developed to accompany the Treatment Improvement Protocol (TIP) Series published by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA). These KAP Keys are based entirely on TIP 47 and are designed to meet the needs of the busy clinician for concise, easily accessible “how to” information.

For more information on the topics in these KAP Keys, readers are referred to TIP 47.

Other Treatment Improvement Protocols (TIPs) that are relevant to these KAP Keys:

TIP 25: Substance Abuse Treatment and Domestic Violence (1997) BKD239

TIP 31: Screening and Assessing Adolescents for Substance Use Disorders (1999) BKD306

TIP 32: Treatment of Adolescents With Substance Use Disorders (1999) BKD307

TIP 39: Substance Abuse Treatment and Family Therapy (2004) BKD504

TIP 41: Substance Abuse Treatment: Group Therapy (2004) BKD507

TIP 45: Detoxification and Substance Abuse Treatment (2006) BKD541

TIP 46: Substance Abuse: Administrative Issues in Outpatient Treatment (2006) BKD545
Treatment Engagement

- Understanding motivation and committing to treatment
- Counteracting ambivalence and denial
- Determining the seriousness of the drug or alcohol problem
- Conducting self-assessment, setting goals, and self-monitoring progress
- Overcoming common barriers to treatment

Early Recovery

- Learning about biopsychosocial disease and recovery processes
- Understanding the effects of specific drugs and alcohol on the brain and body
- Placing symptoms of substance use disorders in the context of other behavioral health problems
- Learning about early and protracted withdrawal symptoms for specific drugs and alcohol
- Knowing the stages of recovery and the client’s place in the continuum of care
- Learning strategies for quitting and finding the motivation to stop
- Minimizing risks of HIV/AIDS, hepatitis C, and sexually transmitted diseases (STDs)
- Identifying high-risk situations that are cues or triggers to substance use: people, places, and things
- Identifying peer pressures and compulsive sexual behavior as triggers
- Understanding cravings and urges, learning to extinguish thoughts about substance use, and coping with cravings
- Structuring personal time
- Coping with high-risk situations
- Understanding abstinence and the use of prescription and over-the-counter medications
- Understanding the goals and practices of various 12-Step or other mutual-help groups
- Identifying and using positive support networks
Typical Sequence of Topics Addressed in Psychoeducational Groups

KAP Keys Based on TIP 47
Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

Maintenance and Continuing Care

- Understanding the relapse process and common warning signs
- Identifying tools to prevent relapse
- Developing personal relapse plans
- Counteracting euphoria and the desire to test control
- Improving coping and stress management skills
- Learning anger management and relaxation techniques
- Enhancing self-efficacy for handling risky situations
- Responding safely to slips and avoiding escalation
- Finding recovery resources
- Structuring leisure time and finding recreational activities
- Knowing the importance of personal health: diet, exercise, hygiene, and checkups
- Taking a personal inventory
- Handling shame, guilt, depression, and anxiety
- Understanding family dynamics: enabling and sabotaging behaviors
- Rebuilding personal relationships
- Understanding sexual dysfunction and healthy sexual behavior
- Developing educational and vocational skills
- Learning daily living skills: money management, housing, and legal assistance
- Embracing spirituality and recovery and finding meaning in life
- Recognizing grief and loss and the relationship to substance use
- Learning about parenting: basic needs of children and their developmental stages and developmental tasks
- Maintaining balance in life

See TIP 47, pages 32–34.
Functions

- Provide a core set of social services that includes assessment, planning, linkage, monitoring, and advocacy.
- Provide the client with a single contact person who is responsible for finding and mobilizing needed resources, negotiating formal systems, and bartering informally with other service providers to gain access to appropriate services.
- Respond to client’s needs, tailoring resources to the individual rather than fitting the client into existing services.
- Intervene with many systems and providers on behalf of the client.
- Operate in the community and transcend facility boundaries.
- Focus on pragmatic, immediate ways to meet needs (e.g., clothing, shelter).
- React sensitively and competently to clients’ ethnic, gender, and cultural differences.

Models

- **Single agency model.** Case managers personally establish relationships with counterparts in other agencies to find and access services for individual clients.
- **Informal partnership model.** Staff members from several agencies link into collaborative teams or networks that consult about individual cases and share services.
- **Formal consortium model.** Case managers and service providers are joined through written agreements or contracts that define roles, responsibilities, shared services, and costs. This model usually is organized by a lead agency that has primary responsibility and receives most or all of the funding.

See TIP 47, pages 38–40.
A Protocol for Ambulatory Detoxification and Disulfiram Induction

KAP Keys Based on TIP 47
Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

First day: Chlordiazepoxide 50 mg hourly until anxiety is relieved—50 mg to 300 mg

When BAL = 0: Disulfiram 125 mg*

First night: Chlordiazepoxide 50 mg at bedtime;† repeat hourly x 2 until asleep (3 doses provided)

Second day: No medication

Second night: Chlordiazepoxide 50 mg at bedtime; repeat in 1 hour if not asleep (2 doses provided)

Third night: Chlordiazepoxide 50 mg at bedtime; repeat in 1 hour if not asleep (2 doses provided)

*Disulfiram is dispensed only at the clinic.

†All unused chlordiazepoxide doses must be returned to the clinic the following morning.


See TIP 47, pages 56–57.
Effective Interviewing Techniques

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Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

- Begin with a brief overview of the topics to be covered, the expected duration of the interview, and confidentiality requirements.
- Ask the least threatening questions first.
- Listen attentively and reflectively. Restate what the individual said to determine the level of understanding. Provide enough time for the individual to express himself or herself.
- Support self-efficacy by communicating that the individual can change, make autonomous decisions, and act in his or her best interests.
- Affirm the strengths, and compliment the positive values of the client.
- Explain everything that is happening or planned in treatment, and allow time for questions.
- Ask open-ended questions that cannot be answered with a one-word response to encourage the individual to talk, describe feelings, and express opinions.
- Convey empathy through voice tone, facial expression, and body language as well as with direct expressions of caring.
- Observe the client for nonverbal expressions of feelings that may either be inconsistent with or confirm what the individual is saying.
- Avoid argument, remain nonjudgmental, and adjust to any resistance.
- Probe gently to clear up discrepancies and inconsistencies.
- Be completely candid and honest.
- Help the client move beyond anger, resentment, frustration, or defensiveness; even if the individual does not return, this single contact can be a constructive, positive influence.

See TIP 47, pages 61–63.
Appearance, Alertness, Affect, and Anxiety

- Appearance: How are general hygiene and dress?
- Alertness: What is the level of consciousness? Confusion?
- Affect: Are there signs of elation, anger, or depression in gestures, facial expression, and speech?
- Anxiety: Is the person nervous, phobic, or panicky?

Behavior

- Movements: Is the person hyperactive, hypoactive/subdued, abrupt, agitated, or calm?
- Organization: Is the person coherent and goal oriented?
- Purpose: Is behavior bizarre, dangerous, impulsive, belligerent, or uncooperative?
- Speech: What are the rate, coherence, organization, content, and sound level?

Cognition

- Orientation: To person, place, time, and condition
- Calculation: Memory and capability to perform simple tasks
- Reasoning: Insight, judgment, and problem-solving abilities
- Coherence: Delusions, hallucinations, and incoherent thoughts


See TIP 47, pages 65–66.
<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Mild withdrawal without need for treatment with sedative-hypnotics; no hyperdynamic state; Clinical Institute Withdrawal Assessment-Alcohol, Revised (CIWA-Ar) score of 8; no significant history of morning drinking.</td>
</tr>
<tr>
<td>Sedative-hypnotics</td>
<td>Mild withdrawal with history of almost daily sedative-hypnotic use; no hyperdynamic state; no need for treatment with sedative-hypnotics; no complicating exacerbation of affective disturbance; no dependence on other substances.</td>
</tr>
<tr>
<td>Opioids</td>
<td>Mild withdrawal in context of almost daily opioid use but no need for substitute agonist therapy; withdrawal symptoms respond well to symptomatic treatment; comfortable by the end of the day’s monitoring.</td>
</tr>
<tr>
<td>Stimulants</td>
<td>Mild withdrawal involving lethargy, agitation, or depression; the client has sufficient impulse control, coping skills, or support to engage in treatment and to prevent immediate continued use.</td>
</tr>
</tbody>
</table>


See TIP 47, pages 70–72.
A Treatment Calendar for Family Members

KAP Keys Based on TIP 47
Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

Beginning Stage: 1–5 Weeks
• Commit to treatment.
• Understand that a substance use disorder is a chronic illness.
• Support abstinence.
• Begin to identify and discontinue behaviors that support substance use.
• Learn about the family support groups:
  – Al-Anon (www.al-anon.alateen.org)
  – Nar-Anon (www.naranon.com)

Middle Stage: 6–20 Weeks
• Assess the relationship with the client.
• Develop a realistic perspective on addiction-related behaviors so the family member remains involved with the client but establishes some protective personal distance.
• Work to eliminate behaviors that encourage the client’s substance use (i.e., enabling behaviors).
• Move past behaviors that are primarily a response to the client’s substance use (i.e., codependence).
• Seek new ways to enrich the family member’s life.
• Begin practicing new communication methods.

Advanced Stage: 21+ Weeks
• Work to develop a healthy, balanced lifestyle that supports the client and addresses personal needs.
• Exercise patience with recovery.
• Evaluate and accept changes, adaptations, and limitations.


See TIP 47, pages 98–106.
This quiz can be a tool to support and strengthen a client’s readiness to avoid relapse. Having senior members in a group answer the questions reinforces their knowledge while they educate newer members in relapse prevention skills.

• What might you say to co-workers if they ask you to have a drink or get high with them?

• Craving a drink or drug is quite natural for people who are dependent on alcohol or drugs. What three things can you do to get past the craving?

• What are three common reasons for feeling that you don’t belong in a support group such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)?

• What two things can you do if someone at an AA or NA meeting annoys you?

• Why must recovery from your disease be your highest priority?

• What three qualities should you look for in a sponsor?

• Emotional discomfort takes a variety of forms. What are the three biggest problems for you? Anger, depression, self-pity, loneliness, boredom, worry, frustration, shame, guilt, or another emotion?

• What three things can you do to handle each emotional discomfort you identified?

• What are the key elements of an assertive response when offered alcohol or drugs?

• Why is it important to avoid starting romantic relationships during early recovery?

See TIP 47, pages 117–119.
### Urine Toxicology Detection Periods for Different Substances

#### KAP Keys Based on TIP 47
Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

<table>
<thead>
<tr>
<th>Substance</th>
<th>Typical Urine Detection Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamines or methamphetamines</td>
<td>2–4 days</td>
</tr>
<tr>
<td>Barbiturates</td>
<td></td>
</tr>
<tr>
<td>Short-acting—Secobarbital</td>
<td>1–2 days</td>
</tr>
<tr>
<td>Long-acting—Pentobarbital</td>
<td>2–4 days</td>
</tr>
<tr>
<td>Phenobarbital</td>
<td>10–20 days</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td></td>
</tr>
<tr>
<td>Therapeutic dose</td>
<td>3–7 days</td>
</tr>
<tr>
<td>Chronic dosing</td>
<td>Up to 30 days</td>
</tr>
<tr>
<td>Cocaine</td>
<td>1–3 days</td>
</tr>
<tr>
<td>Cannabinoids</td>
<td></td>
</tr>
<tr>
<td>Casual use</td>
<td>1–3 days</td>
</tr>
<tr>
<td>Daily use</td>
<td>5–10 days</td>
</tr>
<tr>
<td>Chronic use</td>
<td>Up to 30 days</td>
</tr>
<tr>
<td>Ethanol (alcohol)</td>
<td>12–24 hours</td>
</tr>
<tr>
<td>Opioids (e.g., codeine, morphine)</td>
<td>1–3 days</td>
</tr>
<tr>
<td>Methadone</td>
<td>2–4 days</td>
</tr>
<tr>
<td>Propoxyphene</td>
<td>6–48 hours</td>
</tr>
<tr>
<td>Ecstasy/euphorics</td>
<td>1–5 days</td>
</tr>
<tr>
<td>PCP</td>
<td></td>
</tr>
<tr>
<td>Acute use</td>
<td>2–7 days</td>
</tr>
<tr>
<td>Chronic use</td>
<td>Up to 30 days</td>
</tr>
</tbody>
</table>


See TIP 47, pages 237–245.
### Effectiveness of Drug Detection Methods 10 That Use Different Biological Products

**KAP Keys Based on TIP 47**

**Substance Abuse: Clinical Issues in Intensive Outpatient Treatment**

<table>
<thead>
<tr>
<th>Body Product</th>
<th>Drug Detection Time</th>
<th>Major Advantages</th>
<th>Major Limitations</th>
<th>Primary Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urine</td>
<td>2–4 days</td>
<td>Mature technique; established cutoffs for detecting many drugs of abuse</td>
<td>Detects only recent use; needs costly confirmation to be accurate</td>
<td>Monitors recent drug use in many populations</td>
</tr>
<tr>
<td>Breath (alcohol)</td>
<td>12–24 hours</td>
<td>Easy to use; readily available and well-established method</td>
<td>Short detection time</td>
<td>Confirms observed intoxication or impairment</td>
</tr>
<tr>
<td>Saliva</td>
<td>12–24 hours</td>
<td>Easy to obtain samples; good correlation with blood levels for some substances</td>
<td>Very short detection time; new method; oral cavity is contaminated easily</td>
<td>Links positive drug test to behavioral impairment and intoxication</td>
</tr>
<tr>
<td>Sweat</td>
<td>1–4 weeks</td>
<td>Cumulative measure; relatively tamper-proof collection method</td>
<td>High potential for contamination; new technique</td>
<td>Detects recent and less recent drug use</td>
</tr>
<tr>
<td>Blood</td>
<td>12–24 hours</td>
<td>Accurate results; established method</td>
<td>Invasive method; expensive; detects only current use or intoxication</td>
<td>Detects drug effects on crashes, medical emergencies</td>
</tr>
<tr>
<td>Hair</td>
<td>4–6 months</td>
<td>Measures long-term drug use; readily available samples; accurate results</td>
<td>New technique; costly and time-consuming; no dose-response relation established</td>
<td>Confirms drug use in past 4 to 6 months; prevalence studies</td>
</tr>
</tbody>
</table>


See TIP 47, pages 237–245.
Ordering Information

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3. Access TIPs online at www.kap.samhsa.gov.

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