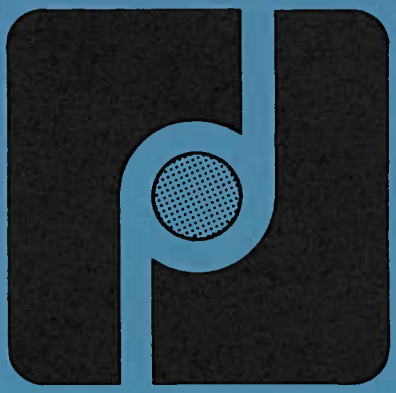
special action office monograph

SERIES C, NUMBER 4
AUGUST, 1974



OUTPATIENT DRUG-FREE TREATMENT MANUAL

EXECUTIVE OFFICE OF THE PRESIDENT
SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION

Outpatient Drug-Free Treatment
Manual

EXECUTIVE OFFICE OF THE PRESIDENT
SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTON

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Washington, D.C. 20402 - Price $1.45

Stock Number 017-024–00440-5

PREFACE

This is one of a series of Monographs developed by the Special Action Office for Drug Abuse Prevention to help present ideas regarding efficient and effective ways of providing drug abuse treatment services. This "how to" manual is intended for guidance only and in no way implies that this is the *only* way of providing quality care. We hope you will consider this information in light of your individual program and modify it accordingly.

This Monograph is to serve as a guide for the program administrator or official who wishes to understand, establish, and operate an Outpatient Drug-Free program. The concept of an outpatient, drug-free program, its goals, treatment plans, and methods of operation, are described in this Monograph with specific implementation guidelines.

We hope you find this Monograph helpful and are able to tailor it to meet your specific drug treatment goals.

Robert L. DuPont, M.D.
Director

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EXHIBITS

I Introduction

Outpatient drug-free has served as a useful label for a grab-bag of drug abuse programs which usually have little in common except for the fact that they are *not* residential *nor* do they use methadone. To introduce some order into our discussion of this approach to drug abuse treatment, outpatient drug-free programs will be discussed in terms of three separate categories: drug-free day-care; outpatient counseling; and rap centers. The primary reason for sub-dividing outpatient drug-free programs is that differences and similarities can be clarified, and, consequently, reasonable program designs can be described.

For the purposes of this manual, outpatient drug-free will be directed towards opiate and polydrug users desiring highly-structured, day-long programs; opiate and polydrug abusers who have been detoxified and require periodic counseling and urine surveillance to reenforce their committment to abstinence; and opiate and polydrug experimenters who need assistance in pursuing drugless alternatives to their current life styles. Each of these populations differs in terms of age, economic status, education, and severity of its drug problems. For that reason, facility type and location, staffing patterns, program design, and budget will differ radically among the three categories described. To be effective, though, each program requires a common effort in terms of planning. The guidelines that follow are intended to serve the designated program administrator as a reference in planning and then implementing the agreed upon outpatient drug-free program.

II Planning

Once a community believes there is a need for an outpatient drug-free program, the administrator's first response should be the development of a reasonable plan. As a first step, the population requiring services should be defined. Arrest records, by precinct, probation and parole statistics, emergency room records, reports generated by school personnel, clerical counseling programs, community resources such as Family Services, Health and Welfare agencies, and existing methadone and therapeutic community programs provide data helpful in estimating the need for outpatient drug-free programs. Careful review of this information, in conjunction with a series of community sponsored discussions, will often pinpoint a target treatment population. Once this population is identified, a decision can then be made concerning which of the three categories of outpatient drug-free programs is most appropriate. At this point, the administrator should consider the establishment of a community advisory board composed of local elected officials, church and community group representatives, concerned members of the business sector, and interested rehabilitated drug abusers. (If a Rap Center program is decided on, the Community Advisory Board should seek a rehabilitated abuser who can contribute a degree of credibility to the Board's role and heighten the Advisory Board's sensitivity to the needs of the client population.) A Community Advisory Board can be vital in enlisting community support, soliciting funds and equipment, establishing liaisons with appropriate community agencies, and serving as spokesmen for the program. A note of caution about the Advisory Board's role should be interjected here. Experience has demonstrated that Boards should not be directly involved in setting program policy, hiring staff, or directing the program's daily operations. These functions clearly fall under the purview of the program administrator and should not be delegated to anyone else.

The following are separate category descriptions which discuss facilities' location and acquisition, budget, staffing, and treatment regimen.

III Administrator's Guide to Planning a Drug-Free Day-Care Center

A. What is Drug-Free Day-Care?

Drug-free day-care, referred to throughout this manual as day-care, is a self-help daily program that treats drug abuse as a psychosocial dysfunction. Essentially, day-care is directed to the detoxified opiate or polydrug abuser who needs the reenforcement of a highly structured environment in order to remain drug-free. The day-care center strives to encourage the drug abuser to:

1. confront his problems,
2. change or modify his behavior, and
3. learn to function effectively, drug-free.

To function effectively means that the client (called a participant in the Center) exhibits an accurate understanding of himself, his actions, and the behavior of others around him; an ability to initiate and conduct satisfactory interpersonal relationships; an ability to secure and maintain employment; an ability to remain uninterested and uninvolved in anti-social activity; an ability to remain totally drug-free (including abstention from alcohol abuse).

To accomplish this the day-care center depends on the successful integration of:

1. a highly-structured system of well-supervised group activities;
2. an intense schedule of varied therapeutic techniques;
3. an atmosphere of support and pressure brought about by the participants and the staff.

These components work together to guide the participant toward assuming responsibility, toward understanding his motivations, and ultimately toward a productive, independent existence in the community.

B. How does Day-Care differ from a Therapeutic Community?

In essence, day-care is quite similar in approach to a therapeutic community (T.C.) but differs in two major respects:

1. While it fosters a closely-knit spirit, its daytime as opposed to full-time commitment prevents it from replacing the family and/or community structure. Rather, day-care emphasizes reconciliation and improved relationships between participant and family and integration into the community.
2. Because the client returns to the community each day and faces the anxiety and pressures associated with that return, day-care centers do not attempt to create or arouse tension through such techniques as confrontation. Instead, they try to help the participant to handle the tensions existing in the community. In this sense, participants and staff have an advantage because the effectiveness of therapy is tested on a daily basis, and therapy, then, can be modified according to the feedback received and the behavior observed.

C. Facility Planning

According to the Federal Funding Criteria (See Exhibit 1) and the "Descriptions and Budgets for Treatment Modules" (See Exhibit 2), Day-Care Centers should be capable of treating 40 participants on a six-day-a-week basis, ten hours per day, and may provide the participants with lunch. The day-care center, then, is probably best located in a residence with kitchen facilities or a commercial property easily renovated to provide such kitchen facilities. In either case, the facility selected should be in a high-drug area and convenient to public transportation. It should be large enough to provide common areas for group

therapy, job readiness activities, and group dining. The dining area should be large enough for staff and residents to dine together as this minimizes distances between the two. Meals should be served family style, as well, since cafeteria style may be reminiscent of institutional living. Although the facility should foster a warm atmosphere, it is important that a reception area be conveniently but prominently located close to the entrance so visitors can be screened and controlled. In addition, provision should be made for at least two individual counseling offices and an administrative/clerical office where participants' records can be securely stored. Part of the therapy inherent in a day-care center is participants' involvement in renovating and maintaining the facility, and this fact should be kept in mind when selecting a site.

Toilet facilities should be adequate in number for the population and designed to provide urine surveillance when appropriate.

Selecting and gaining public approval for the location of a day-care facility is often a major hurdle to program establishment. As a first step, the administrator should familiarize himself with appropriate zoning ordinances and other applicable health and housing regulations. He should then mobilize the resources of the Community Advisory Board to expedite approval of the chosen facility.

D. Budget

A budget for a 40 client facility is attached (See Exhibit 2), which totals about $110,000, meaning that the total cost per client per year is $2,750. While the budget figures are approximations based on average costs from existing day-care facilities, it is clear that the cost of day-care treatment is high (personnel costs, alone, are over $73,000). However, administrators can institute procedures to reduce expenses. Minimal fees may be charged for services, and volunteers (discussed in detail in Section 2.d.) can be used to cut down on personnel costs. Furthermore, for the purposes of this manual, the day-care center is viewed as an independent unit which may contract out or utilize existing sources for physical exams and urine testing. Again, administrators may opt to join with another drug treatment program to contract for these services, a step which should reduce costs. Of course, many day-care centers may be located in areas with central intake units which already provide such services. By actively participating in the central intake process as a referral source, significant savings can be realized.

E. Security

The need for security measures should be minimal as there is no medication and little money on the premises. Any petty cash belonging to the program should be locked in the administrative/clerical office with limited access. Entrance doors should be locked when the reception area is unattended to prevent entrance by unauthorized outsiders. Visitors should be screened to assure that they are legitimate guests.

F. Staff

Staff selection for day-care programs is a critical area and requires careful planning. The planning aspect principally involves thorough and clear descriptions of each position, the responsibilities which accompany it, and the design of a meaningful table of organization. In addition, recruiting strategies must be developed, qualifications must be considered, training needs must be continuously assessed, and the roles of individual staff must be defined. These areas are covered in the following discussion.

1. *Staffing Patterns*

The principal considerations in designing a staffing pattern are:

a. the total number of *direct* services that can be offered in-house,
b. the number of staff responsible for each of these services; and
c. the number of individuals reporting directly to the administrator.

Program components or units are developed in view of these considerations. In the day-care center, the treatment unit constitutes the major component, and most services fall under this category. However, if an exceptionally large variety of services are provided in-house, the administrator may choose to establish additional units. For example, if a program employed three vocational rehabilitation specialists, four social workers, and two public assistance aides, the administrator might organize a social services unit and designate a supervisor.

Staffing requirements, then, will vary depending on the anticipated size of the program, the treatment philosophy, and the availability and quality of ancillary community resources.

In a day-care center, the need to provide 10 hour coverage for 6 days a week should be taken into consideration when determining the number of staff. One practical way to handle 10 hour coverage is to rotate treatment staff on a regular basis and make ample use of volunteers. The minimal paid treatment staff required under this system would consist of a chief counselor, two counselors, and one vocational rehabilitation specialist. A sample organizational chart is attached (See Exhibit 3).

Once the administrator has decided on an organizational structure and staffing pattern, he should immediately begin the recruitment process.

2. *Recruitment and Staff Qualifications*

A primary vehicle for providing treatment to the day-care participant is the use of peer support in therapeutic groups and activities. Like a therapeutic community, day-care centers insist that those individuals who have successfully overcome a problem make excellent therapists for those participants experiencing similar problems. For this reason, day-care centers usually employ trained ex-addicts with therapeutic community backgrounds. It is beneficial if the staff recruited has some employment experience outside the drug abuse field. In a day-care center, all staff function primarily as counselors, so the emphasis during recruitment should be on therapeutic skills. New administrators should consider contacting administrators of ongoing, highly regarded T.C.'s to request staff recommendations. Often, the recent T.C. graduate will be recommended because successful completion of the T.C. program usually means that the graduate has had extensive exposure to and experience in conducting groups and understands the principles underlying peer support. Administrators should remember, however, that it is both unwise and unethical to contact participants in T.C. treatment directly. It is also unwise to hire persons who have failed to complete treatment.

Because day-care centers are directed to the polydrug as well as opiate abuser, it is recommended that a psychiatric social worker or a clinical psychologist with experience in a mental health center or hospital be recruited for the chief counselor position. Familiarity with psychological problems and the ability to recognize which problems can be handled in-house and which should be referred out are skills that can contribute to the center's effectiveness in dealing with the participants. Again, day-care centers are encouraged to utilize volunteers, and one excellent source for qualified volunteers is graduate schools of social work. The psychiatric social worker could establish the liaison with the school and, more importantly, provide the required field work supervision. Many day-care programs have had notable success in integrating professionals and paraprofessionals, but administrators should be aware of certain problems that may arise when a professional is hired. Required duties such as urine surveillance may prove distasteful and result in the professional's use of his "academic status" to evade them, a practice which contributes to poor morale. Again, a professional may become uncooperative when asked to work with a paraprofessional on a peer level. To avoid these problems, the administrator must clearly explain the full range of duties to each staff member and clarify the professional/paraprofessional relationship at the outset.

During the recruitment process, extensive interviews are very helpful because they give an indication of the candidate's ability to relate well to others. In addition to private interviews, group interviews should be given to each job candidate whenever possible. Group interviews expose qualities which might otherwise go unnoticed. When interviewing the ex-addict, the administrator should ask himself the following questions:

1) Has the candidate demonstrated responsible behavior in previous volunteer or paid jobs?
2) How long has the candidate been drug-free?

3) Is the candidate a graduate of a T.C. or does he have therapeutic experience which is appropriate for day-care centers?
4) Does he have a problem with alcohol?
5) Has the candidate any formal training in group or individual counseling?
6) If he has been institutionalized, what is his attitude about working with professionals?
7) Is he an appropriate role model?

Unless the ex-addict demonstrates positive values and self-esteem, he will be unable to provide the leadership necessary for a day-care center. Administrators should be aware of the intense pressure placed on staff in a day-care center and realize that only candidates who react positively to that pressure can be considered. While other treatment modalities can tolerate occasional instances of poor staff adjustment, this is not the case in a day-care center. The staff is highly visible. Rehabilitation depends upon the residents' identification with staff; therefore, a consistent level of positive staff performance is essential.

In order to assist administrators in recruiting and hiring, position descriptions are included in Exhibit 4. These specifically detail the responsibilities involved in the job. The following is a brief overview of the counselor's role to give the administrator an idea of how the counselor should function. Hopefully, this will assist him in the recruitment and review of candidate's qualifications.

a. *Counseling Overview*

Under the direct supervision of the chief counselor, the counselor provides participants with individual and group therapy, schedules and leads all group activities, proposes new therapeutic policies, and implements those approved by the administrator.

The day-care counselor is responsible for:

1) Collecting supplemental information on designated participants using families, previous employers or co-workers, social and drug histories, and other sources as indicated.
2) Conducting orientation sessions for new participants.
3) Preparing individual treatment plans for participants, and revising them when necessary.
4) Evaluating treatment plans at least every 30 days.
5) Observing participant behavior, and, with input from other counselors, documenting such behavior and other pertinent data in organized, consistent progress notes (these notes are submitted to the administrator for periodic review).
6) Conducting urine testing on an as needed basis.

The administrator, then, is responsible for evaluating and assessing the needs of the counselor. The administrator must determine when increased supervision, additional training, or termination of employees is necessary. In addition, the administrator bears the ultimate responsibility for ensuring that participants are receiving all appropriate therapeutic services, including vocational assistance.

b. *Training*

Training is an on-going need in drug treatment programs and is essential if quality care is to be provided. Training can be conceptualized in two ways: 1) as fundamental training; and 2) as specific skills training.

1) *Fundamental Training*

Fundamental training is the key to effective program operations. It focuses on how to train the employee to fit into an efficient therapeutic setting. Although this may appear unsophisticated, administrators should note that technical skill is meaningless without it.

Programs have found that fundamental training is best communicated through preliminary job orientation followed up by continuing on-the-job training.

On-the-job training can be accomplished in several ways, but a useful and cost-effective method is the weekly case review or treatment team meeting. This occurs within the program and should involve the entire staff, including any consultants used. Simply stated, the case review is a forum for exchanging information on individual cases. Issues are explained and the status of each participant is discussed. This process permits each member of the case review team to learn from the successes and failures of others, and it offers an ideal setting to explain new concepts because the case, itself, affords an opportunity to realistically understand them and then apply them. Again, the case review demonstrates the proper and improper use of certain techniques and provides the kind of informal discussion necessary to ensure that all staff members grasp the point being made.

At this point, a clear distinction should be drawn between case reviews and staff meetings. Staff meetings should focus on administrative matters: hours, staff rotations, pay increases, need for supplies, etc., and they should be kept separate from case reviews. Given the attention required in a well-run case review session, the administrator probably should schedule staff meetings and case reviews on separate days.

Finally, it should be stated that regardless of how effective case reviews may be for training, they cannot replace good daily supervision (See Exhibit 5 for sample training aids).

2) *Specific Skills Training*

Once the program is established and operating smoothly, specific skills weaknesses may be detected or, because of changing participant needs, new techniques should be introduced.

One method of revitalizing and updating staff techniques and program procedures is to send one or two staff members at a time to another day-care center to observe their program. Usually other centers are most receptive, and the cost is minimal or non-existent. Also, conferences or seminars might offer new perspectives which would be useful to the program, so the administrator might want to budget accordingly.

Other resources available for training are state and federally funded training conferences and centers. Here again, the administrator may find subjects of value to himself and his staff.

Outside the drug abuse/mental health area, numerous educational resources exist which the administrator might want to consider. Courses in effective writing or management techniques are possibilities. Although few programs have the financial resources available to pay for them, the administrator might want to encourage staff to enter on their own, explaining the benefits in terms of personal growth and opportunities for advancement.

c. *Counselor Reporting Requirements*

In accordance with the CODAP client management standards, certain kinds of information should be collected by counselors on individuals entering and undergoing treatment in day-care centers. In all cases, this information should be the basis for continuing or modifying the treatment plan. For example, when the treatment plan is initially developed during the intake process, short- and long-term goals are described, and the type and frequency of counseling and supportive services are detailed. However, as the participant continues in treatment, the original plan may be modified to reflect information collected regarding the participant's progress. This information falls into four separate categories and includes:

1) Counseling and Supportive Services
2) Medical Services
3) Urinalysis
4) Participant Progress

1) *Counseling and Supportive Services*

The data to be recorded under this category generally include the type of services scheduled (e.g., individual or group therapy, educational counseling, vocational rehabilitation referral), the type of services *actually* provided, and the amount of services provided (single contact, seven sessions, etc.).

2) *Medical Services*

These data, considered together, indicate if the medical service is provided in-house or out-of-house, give a summary of the resident's medical problems identified during the intake physical and the follow-up indicated, specify the resident's current medical problems, and describe any medication prescribed, the name of the physician, dosages, directions, and limitations.

3) *Urinalysis*

These data include the date the tests were scheduled, the date the tests were administered, i.e., when the specimen was taken, and the results of the testing.

4) *Participant Progress*

Participant response to treatment should be reviewed at least monthly. This review is to include drug, employment, behavioral, and psychiatric/psychological problems. Progress reports should relate to the goals of the treatment plan.

The counselor usually records participant information through running progress notes. Unfortunately, these notes are often incomplete and of low quality. The implementation of documentation standards will encourage a thorough approach to recording participant information. To adequately record participant information, it is essential to understand the relationship between those four categories of information mentioned earlier. The first three of these categories must be the basis upon which the assessments of participant progress are made. This means that the kinds of data specified by those first three categories must appear in the participant's record and must bear a clear and consistent relationship to the judgments of category four. For example, if a participant has shown four dirty urines during the course of a month, has not cooperated in a number of counseling sessions, and has been irresponsible about his work assignment, there should not be an entry stating that the participant is being given a special privilege (e.g., matinee theatre ticket). Rather, the counselor's notes should reflect an appropriate action that is consistent with the participant's performance.

Not only should participant progress assessments be made consistent with the recorded data, but the rationale for other activities, such as referrals, should be documented. The treatment plan is an example of this. If that plan includes referrals to vocational rehabilitation services or for legal help, then the reasons for including these elements in the plan ought to be clearly spelled out. If this is not done, reasons for changing such a plan are going to appear vague or arbitrary. Furthermore, such referrals must be followed-up by the counselor. There is nothing wrong with a drug counselor keeping closely in touch with a remedial education counselor to whom the former has referred his client. In fact, this should be encouraged, and contacts between them should be recorded.

The following is a list of information that must be included in a counseling record:

- A record must be made of the initial participant-counselor interview. The participant's name, age, race, and sex should be the first information obtained, followed by the length of primary drug abuse, attempts at prior treatment, and reason for seeking treatment at this time. Next, the counselor should describe the day-care program to which the participant has been assigned and comment on the participant's understanding of this drug treatment modality. Finally, the participant's problems should be addressed, e.g., does he have housing, does he have legal problems, etc? If problems are discovered which necessitate referral to another person or agency, this should be done and recorded. In the event of a

readmission, some assessment must be recorded regarding the circumstances of prior discharge(s), attitude changes, and motivation. All notes must be signed.

- A treatment plan must be developed as part of the intake process and should be thoroughly explained to the participant. The plan should include both short- and long-term goals (the participant's and clinician's), the assignment of a primary counselor, a description of the type and frequency of counseling services to be provided, a description of those additional supportive services required by the participant, and the number of urine specimens which must be given. This plan must be reviewed every 30 days.
- A note should be written after each meaningful participant/counselor contact and should include the counselor's observations, problem(s) presented, resolution proposed, and the approximate length of time spent with the participant.
- Copies of referral forms should be included in the participant's folder. Specific reasons for referrals and information regarding the results of referrals should be obtained and documented.
- The results of counseling performed by any other person in the day-care center should be noted on the participant's chart, either by the participant's counselor or the staff member involved.
- A participant's progress should be reviewed at least monthly and summarized. The treatment plan should be reconsidered in view of the progress and either altered or continued. The summary must include the participant's legal status (both criminal and civil), employment status, current drug use including alcohol, and any other current problems and their severity. The monthly summary should reflect a composite picture of the participant's progress and not merely repeat entries made during the month.
- The date urine specimens are scheduled to be given, *are* given, and the *results* must appear in the counselor's record.
- If a participant fails to keep a scheduled appointment (e.g., individual counseling, referral service appointment, etc.), it must be documented.

It is suggested that a copy of the intake form be reviewed by the counselor prior to the initial participant interview (See Exhibit 6 for sample intake form). This form provides much of the information required in the admission note and eliminates duplicate processing.

d. *Volunteers*

In a day-care center, small groups (5-7 participants), intensive individualized counseling, and vigorous follow-up are the goals. However, a cost-effective staffing pattern, given the numbers receiving treatment, does not provide sufficient personnel to accomplish those goals. For this reason, day-care centers are encouraged to utilize volunteers as a staff supplement. The volunteers recruited must meet certain criteria in terms of understanding, dependability, and attitude. There has been positive experience with volunteers from graduate schools of social work; however, administrators may find many other sources of volunteers acceptable. Because staff influence plays such an important role in rehabilitation, the volunteer's commitment to the center must be strong. The ideal situation for the day-care center is to offer itself as a field practice placement site for a school of social work. Volunteers are then tied in to a firm schedule and reliability generally disappears as a problem. The center's chief counselor or administrator also reaps the benefit of a relationship with the field practice supervisor which means that there is an opportunity for continuous exposure, through the supervisor, to innovations and new ideas in the field.

Once volunteers have been recruited, they can assist the center staff in a number of areas. As a first step, they can direct a work assignment for more advanced residents, thus relieving the counselor so he can attend to individualized counseling or up-dating progress notes. Most social work students take courses in community resource development and can help set up referral networks for the center. In addition, they can follow up on referrals made and assist participants in dealing with the confusing community service

systems of public health, education, and other social service departments. Once they have been involved in the center, are accepted by both staff and participants, and have demonstrated their interest through consistent attendance and willingness to assume responsibility, they can begin to work as co-leaders of the informal rap sessions and to participate in the vocational readiness seminars. To both of these groups, volunteers bring new points of view and ideas, thus providing diversion for all group participants.

In order to utilize fully the volunteer so that both the center and the volunteer gain from the work experience, centers are encouraged to develop an orientation program. Given the center's limited personnel resources, the orientation/training program will have to be brief but comprehensive. A suggested volunteer orientation training format is described in Exhibit 7.

G. Treatment Regimen

The day-care center may be part of a larger drug program, but for the purposes of this manual it will be considered as an independent unit which performs its own intake and utilizes community resources for medical and supportive services (e.g., educational, legal, jobs placement).

In discussing the treatment regimen, five phases will be described: intake, orientation, therapy, re-entry, and termination. Essentially, these five phases trace the participant from entry into treatment until completion. Furthermore, it should be noted that standards imposed on the day-care center's treatment regimen are based on the Federal Funding Criteria (See Exhibit 1).

1. *Intake*

Admission Interview—When an individual requests day-care treatment, an appointment should be arranged to interview the applicant at the program. The intake interview should be conducted by the chief counselor or an experienced counselor. If the applicant is being referred from a therapeutic community or detoxification program, a copy of his prior treatment record should precede him to the center. The client should sign a release form for the transfer of his records to the receiving center. The admission procedure is viewed as the first step in treatment. Therefore, the applicant must be prompt for his appointment and in a non-drugged condition at the time. The purpose of the admission interview is to determine whether the day-care center is the most appropriate form of treatment for the applicant and to ensure that the applicant understands the nature of the program, the program's expectations of him, and the fact that day-care treatment may last from 3-6 months, depending on the participant's progress. During the interview, the admission team must get an initial personal history, medical history, and drug history from the applicant.

Recommended admission criteria for traditional day-care center are as follows:

a. The candidate for treatment should be at least 16 years old and mature enough to accept therapeutic situations aimed at making him/her a *responsible adult.*

b. The applicant should not be experiencing psychotic manifestations or serious physical illness requiring immediate, intensive psychiatric or medical aid.

c. The applicant must have been previously or be currently abusing narcotics or other drugs. If an applicant is currently addicted, the day-care center will refer him to another program for detoxification and then admit him into the center upon completion of that procedure.

d. Ideally, the applicant should enter day-care voluntarily. This places the responsibility for rehabilitation on the applicant, himself. In reality, however, the courts may provide an excellent source of referral through their various diversion programs, and it is recommended that day-care programs accept these applicants as well.

Once the applicant is found eligible for day-care treatment, he must undergo a physical examination which in accordance with the Federal Funding Criteria (See Exhibit 1) must include the following tests:

- complete blood count and differential
- serologic test(s) for syphilis
- urine screening for drug (toxicology)

- routine and microscopic urinalysis
- SMA 12/60 or equivalent
- chest x-ray
- Australian antigen, as indicated
- sickle cell, as indicated
- pap smear and gonorrhea, as indicated
- tetanus toxoid, as indicated
- EKG and biological test for pregnancy, as indicated.

The intake physical should stress infectious disease, pulmonary, liver, and cardiac abnormalities, dermatologic sequelae of addiction, and possible concurrent surgical problems. Most day-care centers will find it more cost-effective to contract out for physical exams or develop an arrangement with an existing facility; however, the center must ensure that the examination results are carefully reviewed by a medical consultant.

At the point of completion of intake, the intake counselor reviews the intake information and the results of the physical in order to draw up an initial treatment plan. The plan should be sensitive to the goals and potentials of the client. According to the Federal Funding Criteria, the plan must include long- and short-term goals for treatment, assignment of a primary counselor, type and frequency of counseling services, and supportive services needed. This plan must be documented and reviewed every 30 days. Likewise, it should be a joint decision and signed by the participant. Day-care centers may find it helpful to consider the treatment plan as the participant's contract with the program. The center can then hold the participant accountable for any breach in contract, a technique which has proven useful in rehabilitation.

2. *Orientation*

During the first week, orientation sessions can be conducted by the assigned counselor daily in groups or individually, depending on the number of new participants. The purpose of orientation is to familiarize the new participant with the rules, procedures, activities, and concepts of the center. The center's expectation that each participant will share in treatment responsibilities as well as work assignments (See Section G.3.c.) must be explained. To reduce the number of dropouts during the orientation phase, it is helpful to assign a more advanced participant as a companion who can introduce the new participant to other participants and staff and acquaint him with the center's facilities.

3. *Therapy*

In a day-care center, therapy is a comprehensive concept which embraces treatment techniques, urine surveillance, a work program, creative recreational activities designed to spur self-development, and ancillary services (e.g., vocational, educational, and legal counseling and referrals). Each of these items will be dealt with in individual sections, but it is vital that the administrator appreciate how these separate items are related. In a day-care center, the daily schedule is the key to the integration of the five components listed above. The *schedule* is a fact of life for day-care participants. It structures their day, and its modifications reflect their progress. Planning the daily schedule is a major activity for staff and, consequently, demands regular concentrated time and attention. Participants may have input into this process, if this appears desirable. In planning a daily schedule, selection of activities and hours can be flexible. But it is critically important that the schedule coincide as closely as possible with a normal work day. Within that framework, participants carry out regularly assigned jobs and participate in a predetermined number of therapy groups. Recreational activities should be reserved for late afternoons, evenings, and Saturdays so the workday structure within the center reflects the outside community as accurately as possible.

Given the diversified life styles and varying responsibilities of the day-care population, the daily schedule should be organized in cycles to accommodate the participant's differing needs. A sample cyclical schedule follows:

Weekdays

Cycle I 10:00 A.M. - 3:00 P.M.

Target: Unemployed adults and school dropouts

Schedule: 11:00 A.M. - 12 Noon —preparation of lunch
general housekeeping
12 Noon - 1:00 P.M.—lunch
1:00 P.M. - 1:30 P.M.—clean up kitchen
individual counseling
1:30 P.M. - 3:00 P.M.—Group Therapy
work assignments

Cycle II 3:00 P.M. - 5:00 P.M.

Target: Students, Participants in Job Training Cycle I as they desire.

Schedule: 3:00 P.M. - 3:30 P.M.—Vocational Readiness
Seminar
3:30 P.M. - 5:00 P.M. —Group Therapy
work assignments

Cycle III 7:00 P.M. - 10:00 P.M.

Target: Employed, Cycle I and II as they desire

Schedule: 7:00 P.M. - 8:30 P.M.—Group Therapy
work assignments
8:30 P.M. - 9:45 P.M.—creative recreational activities
9:45 P.M. - 10:00 P.M.—preparation to return home

Saturday

Cycles I, II, III 10:00 A.M. - 11:30 A.M.—Seminar
11:30 A.M. - 12 Noon —informal rap (kitchen workers prepare lunch)
12 Noon - 1:00 P.M. —lunch
1:00 P.M. - 2:00 P.M. —work assignments
2:00 P.M. - 6:00 P.M. —specialized activities

a. *Therapy Techniques*

In general, four different types of therapy are conducted in a day-care center: informal rap, supportive group or probe, relatives group, and individual counseling. Participants will experience each therapy type, depending on their needs; therefore, centers should be flexible in their use of these techniques.

1) *Informal rap*

The purpose of the informal rap is for participants and staff to ventilate feelings and voice opinions about center problems, the progress of center projects, incidents that occurred either at home or in the center, current events which impact on their daily lives, et. al. The informal rap is non-directive and pragmatic; it does not attempt to focus on or elicit deep personal problems but, rather, tries to foster

openness and communication among participants and staff. Informal raps may be conducted by counselors, the vocational rehabilitation specialist, or a volunteer. These sessions are important because they provide a forum for gripes, complaints, and information exchange so that other groups and activities are not disrupted by these issues. Before closing the informal rap, the leader should attempt to direct the group to lighter topics so that participants and staff begin the next activity in a relaxed frame of mind.

2) *Supportive Group or Probe*

The purpose of the supportive group or probe is to provide a structured opportunity for participants to alleviate excessive guilt. The group meets several times a week in a relaxed setting. The discussion focuses on experiences from the past about which participants still feel guilt. Any group member may begin the session. Others in the group verbally identify with his experiences or give advice as to how to handle the guilt feelings. Acceptance of the person, regardless of his past behavior, is emphasized. Such material as homosexual activities (especially for people who have been incarcerated), mistreatment of relatives and friends, physical violence, feelings about self-image, etc. are discussed. No laughter or ridicule is allowed. Nothing said in the group can be repeated outside the group. No observers are ever allowed. Onlookers and observers, even in a staff role, are destructive to the process. It is often useful to have a few groups per week for all participants, and divide some so that males and females are separated and may express their concerns more freely. In the supportive group or probe, individuals are encouraged to develop a sense of conscience. The goal is not to eliminate all guilty feelings but to understand these feelings and to eliminate feelings so strong they have become debilitating.

The supportive group is a potent therapeutic tool and should not be attempted without a trained leader who is thoroughly versed in its conduct and experienced in nonjudgmental counseling. The group leader's experience is stressed because implementing a supportive group can be difficult. The leader must recognize when the group has lost direction and be strong enough to refocus it. Also, he must be able to elicit participation from passive members. Finally, he must understand when the group exhausts a subject and subtly redirect it to another topic about which the group may have some concern.

3) *Relatives Group*

The purpose of this group is to orient families to the program, its concepts, rules and regulations, and to help families learn about more constructive ways of dealing with the participant.

The relatives group is a weekly evening session conducted by a staff member for participants' relatives and close friends, but it excludes the participants, themselves. The group affords the family/friends opportunities to ventilate hostility or anxiety about the participant and/or the program without interfering with the participant's treatment. Problems concerning participants' demands on the family and methods for dealing with these are material for this group. This is a vital effort since the participant will return to his family and friends each evening, and they are instrumental in his rehabilitation. Family therapy with the participant present is another option.

4) *Individual Counseling Therapy*

Although day-care centers emphasize peer support through group counseling, work assignments, and activities, individual counseling is an important element in the treatment regimen, particularly as the participant gains employment and moves toward re-entry. In the day-care center, individual counseling is of two types. The first and more traditional type involves a close relationship between the primary counselor and the participant to work out problems of adjustment with family and friends, to discuss both progress and problems in treatment (e.g., modification of treatment plan, dirty urines), and to review the results of referrals made. The second type of individual counseling session involves the participant and the vocational rehabilitation specialist. In accordance with the Federal Funding Criteria, participants should be encouraged to enroll in an education or job training program or be gainfully employed after four months in treatment. The philosophy of the day-care center is to prepare the participant to assume responsibility in this area. Because talents, skills, educational backgrounds, and interests

impact so heavily on the participant's opportunities, intensive individual counseling sessions with the vocational rehabilitation specialist are encouraged. In a day-care center, individual counseling should not be viewed as a threat to the integrity of the group; instead, it serves to reenforce the headway made in the group. Here, individual counseling is based on a reality therapy model which emphasizes the development of a caring, non-judgmental relationship and concentrates on eliminating present, destructive behavior through positive action.

b. *Urine Surveillance*

In accordance with the Federal Funding Criteria (See Exhibit 1), day-care centers' urinalysis should be conducted on an as needed basis.

(Centers probably will contract out to a private lab for urinalysis, but administrators should note that the lab used must comply with Federal and State proficiency testing programs. Additionally, urine results should be recorded in the participant's on-going progress notes, and the notes should explain how the results are used in therapy.)

c. *Work Program*

A day-care center's work program consists of assigning participants to jobs in the various departments (Housekeeping, Public Relations, Expediting, et. al.), which are developed to constructively occupy the participant and assist in the smooth, daily operation of the center. Departments may be changed as the center's needs dictate. For example, a new center might want to establish a Renovation Department and later replace it with a different, more appropriate department.

Although the jobs keep participants busy, teach certain job skills, and may prove financially rewarding to the program, these issues are secondary to the main purposes of the assignments: namely, to teach individuals how to relate to others, give and take directions, and assume responsibility for their resocialization. The conflicts that arise, when discussed in groups, provide a means for participants to gain self-awareness.

The procedure for assigning jobs should be constantly reassessed, remembering that while participants may be adults, they are adults who are unable to handle their lives responsibly and need to *learn how*. It is as damaging to a participant to receive responsibility for which he is not yet ready as it is to receive a privilege he cannot yet handle. A system for the individual to handle gradually increased responsibility and authority is more beneficial. *Initially*, it is a staff responsibility to make job assignments in one of the established departments, based on participants' needs and potentials, and to supervise the performance of those duties. As treatment progresses, responsible participants are appointed department heads and assume supervisory roles. Whenever possible, a staff member oversees the department and advises the department head to assure continuity of procedure.

Workers are assigned to various tasks and have their performance closely supervised by the department head. When a job is done incorrectly or incompletely, the department head demands that it be done correctly. Workers are assigned tasks not in isolation but in small groups whenever possible. There will be numerous conflicts due to the job assignments and participants working together. These produce valuable material for group sessions.

1) *Housekeeping or Service Department*

The purpose of this department is *NOT* to train people to be janitors but to teach people to work together responsibly and to follow directions. This is the logical department to which new participants are assigned. A participant is promoted from this position based *not* on his housekeeping skills but on his ability to follow directions without hostility and on indications that he is able to handle increased responsibility.

The department head assigns a few workers to sweep floors daily, wash and polish floors as needed, wash windows and walls, and take responsibility for arranging furniture and equipment for any special activities. The housekeeping or service department is responsible for keeping coffee cups and

ashtrays clean and for cleaning bathrooms and offices, as well as all other areas of the facility. The members of this department thereby assume the responsibility for the discipline of other participants concerning cleanliness of the facility.

2) *Seminar or Creative Energy Department*

The purpose of the Seminar Department (Creative Energy Department) is multifold. It serves to expand the participants' horizons, it is educational, and it helps develop poise and self-confidence in areas such as public speaking and in daily life. As many staff as possible should be included in this department. This accelerates the getting acquainted process and serves to break down staff-participant barriers. Initially, a staff member will be important in assisting the department head with developing seminar schedules. Later, this function can be totally assumed by the participants.

The department head is responsible for arranging and occasionally presenting one or two seminars daily. Other participants assist the department head in planning and presenting seminars. Those participants who are reluctant to speak in groups or have difficulty verbalizing should be assigned to this department. Presentations can include consumer education, health care, poetry, literature, nutrition, birth control, etc. and may be given by guest lecturers, staff, or residents. Other topics that can be presented by participants in the department include various program rules, news items from the daily paper, discussions of books, debates on any topic, mock speaking engagements, charades, grab bag speeches, role playing of job interviews, and making dates.

3) *Acquisition Department or Hustling Crew*

The purpose of this department is to help develop the "self-help" concept and a sense of unity within the program. The participant gains self-esteem when the community responds with approval.

In executing the responsibilities of this department, all department heads notify the head of Acquisition Department about program needs such as food, clothing, furniture, and books. This department then makes contacts in the community with supermarkets, department stores, and other local outlets for contributions and makes arrangements to pick up donated items. This department is also responsible for writing prompt thank-you notes for all donations.

4) *Business Administration Department*

A participant is appointed to this department after having demonstrated a high degree of responsibility in performing the job assignments described above. It is a suitable assignment for those participants who lack confidence in their ability to organize and express themselves on paper. This department prepares and types program correspondence and internal memos. In addition, the department types material needed by other departments, such as requisitions for supplies, schedules, etc. The department head is responsible for assuring a smooth work flow and supervising the quality and quantity of work.

An important lesson learned from this department is how to function within a business-like setting. Much of the work is interdepartmental which requires coordination and teaches the participant to organize time in order to accomplish a list of assignments varying in length and difficulty.

5) *Public Relations Department*

This department is suitable for those participants who have already acquired a certain degree of organizational and business skill but are in need of more self-confidence and poise. The public relations department can prepare a regular weekly or monthly newsletter about program activities, handle speaking engagements, publicity, drug education for schools and community agencies, tours of the program for interested citizens, etc. Also, this department can compile basic statistics about program participants for brochures, budget justifications, etc. Public Relations serves as liaison between the program and other community agencies and the criminal justice department (for those day-care centers accepting parolees and probationers).

6) *Expediting Department*

The Expediting Department is responsible for coordinating all departmental activities, for providing initial orientation regarding job assignments to all newcomers, for rotating participants through departments, and for reporting the status of all departments and individuals to the administrator. Expeditors facilitate the smooth operation of all departments and are responsible for knowing the status of all individuals and departmental units and for reporting all significant occurrences to the appropriate staff. This department places considerable stress upon its workers and therefore is reserved for fairly advanced participants.

d. *Creative Recreational Activities*

During the time period allotted for creative recreational activities, individuals should be assigned to their special areas of need or interest. For those who require basic education or GED preparation, either volunteer instructors could be utilized, or arrangements could be made with local GED programs to accommodate center participants. If classes cannot be arranged during those hours, the time can be used for supervised study with assistance from volunteer tutors.

Individual and family counseling and individual vocational counseling should be available during those hours. Appointments for supportive services such as legal assistance, welfare, medical care, etc. should be scheduled during the specialized activities time.

Such homemaking skills as cooking and serving classes could be arranged through volunteers. Female care and hygiene are other activities to be provided. Photography, ceramics, or other special interests could be offered for those who could utilize them. These activities would be most appropriate for the Saturday special activities sessions, thus reserving the business-like activities for weekdays. Such recreational activities as pool, card playing, etc. should be downplayed as these skills are already well-known to the participant; they relate to and re-enforce his past negative life style rather than redirecting his thinking to more positive areas. Arts and crafts activities should be carefully evaluated as they often are utilized in prisons and mental institutions and may remind the participant of past negative experiences.

e. *Ancillary Services*

As the day-care center is geared toward total rehabilitation of its residents, it is crucial to provide ancillary services, either by the program or through referral. (The Federal Funding Criteria require that legal, educational, and vocational services be provided, and, if achieved through referrals to outside agencies, these agreements must be documented. In addition, the day-care center must have a formal, written agreement with a community hospital for provision of emergency, inpatient, and ambulatory medical services.) Program staff, staff of other agencies, or volunteers may be utilized to provide seminars of courses on specific subjects or to work with selected individuals (e.g., how to handle landlord-tenant problems, where to get child day-care, etc.). As the participant progresses, educational and vocational exploration should begin. Once the participant is nearing the re-entry phase (120 days) and has given evidence of vocational readiness, referrals can be made to the in-house specialist (e.g., jobs development counselor) or preferably outside educational and vocational rehabilitation institutions. In all cases, frequency and type of service provided must be recorded by the participant's primary counselor and followed up. In addition, results and/or problems incurred must, likewise, be documented by the counselor.

4. *Re-entry*

No later than the fourth month in treatment, the participant should re-enter the mainstream of community life via employment or involvement in school or a job training program. During the re-entry phase, the participant is tested by the pressures of daily life, and the center is then able to assess how well the concepts and values of the rehabilitation process have been incorporated. At this point, intensive efforts are made to provide the participant with 4 or 5 sessions per week of vocational counseling, in order to

actively and vigorously support the participant's adjustment to work or training. The center also extends its involvement with the family during this period. If necessary, a day-care counselor will explore the situation with the family at home so that barriers imposed by the center's setting can be eliminated and honesty and frankness promoted. Throughout the re-entry phase, the day-care center serves as a crisis intervention point and will respond to calls for assistance. For example, the day-care center would send a counselor into the home or to the job site if indicated.

During re-entry, the participant gradually replaces the center with the community and is encouraged to move out of center group activities into neighborhood sports leagues, clubs, or associations.

If the participant experiences *serious* difficulties at any point in the re-entry process and the center's methods for resolving his problems have been exhausted, the participant should be able to return to the center without the stigma of failure. However, the participant's treatment plan should be reworked with provisions made to concentrate on specified problems. In some cases, participants will fear leaving the center and will deliberately obstruct their chances for success in the total community. Day-care staff should be aware of this possibility and should be prepared to cope with it.

5. *Treatment Termination*

There are two categories of clients who terminate their treatment. The first is comprised of those who complete the intake process but fail to return to the program for treatment. The intake counselor should attempt to contact the participant. The participant's counselor should report his efforts and results in writing to his supervisor. If the participant does not appear within a specified time (e.g., 14 days), he will be reported as a dropout upon intake. If he appears after the required time, he must undergo the entire intake process once again.

The second category of treatment termination involves the participant whose termination occurs after treatment has begun. There are four instances in which this situation might occur:

a. *Transfer*

Transfers may occur between facilities within the same program (intra-agency), or between programs which have no administrative relationship to each other (inter-agency). In either event, participants should not be transferred because they are seen as "problems" by the staff. A transfer is definitely not the positive way of dealing with the problem. Transfers may be indicated if the participant has a change of address or job and another day-care center is more conveniently located for him. Some participants may experience severe difficulty in remaining drug-free and, depending on the type and history of abuse, may be candidates for transfer to a therapeutic community or a methadone maintenance program. In some cases, participants are leaving town and will require out-of-town transfers. Whatever the situation, transfers should be handled as smoothly as possible so that there is no serious interruption in the provision of services.

The procedure for local transfer should involve the counselor, the chief counselor, the administrator, and whoever may be assigned the responsibility for delivering program records. After the counselor has received the request for transfer from the participant (or the need for transfer is clear from the participant's need for specific care), the administrator and chief counselor are informed. If they concur with this decision, the receiving program is contacted, and a transfer date is confirmed. (This may be a clerical function.) Treatment summaries are recorded in the counseling notes which indicate the reason for transfer, any specific problems, and the participant's general response to treatment. The last date of treatment at the transferring center and the date treatment is expected to begin at the receiving center should be included. *All records should precede the participant to the new center.* A signed release from the participant should be obtained. If possible, staff from the receiving center should meet the participant prior to his arrival there.

For participants who desire a transfer to a new program because they are relocating in another city, assistance is offered at the national level from Treatment Referral, Information, and Placement Services (TRIPS—202-466-2310). The procedure includes the same responsibilities as listed above, except the TRIPS Office acts as liaison between programs. In instances when a *permanent* transfer is requested, TRIPS provides the transferring program with the name, phone number, and contact between programs. This

minimizes misinterpreted information. One week lead time is required. The contact between the program and TRIPS should be routinely made by the same individual in an effort to maximize efficiency. This person has been identified by the TRIPS Office as an "Authorized Individual" and need not necessarily be a counselor. Other mechanisms can be used instead of TRIPS for arranging relocation. Some of these include direct contact with the receiving program, if this is known, or contact with the Single State Agency.

b. *Completed Medical Treatment*

A participant who has secured and maintained employment, remained free of drugs, is making a good adjustment to life in the community (evidenced by his relationships with family/friends, improved financial status, and meaningful involvement in an association or group), and discontinues treatment, should be considered as having successfully completed treatment. However, since there is a danger of relapse at this point, the day-care center should maintain telephone and personal contact with the ex-participant over the next several months. Not only is this procedure helpful to the individual concerned, but it serves as a follow-up method for the day-care center as well.

c. *Voluntary Dropout*

Dropouts occur most frequently in the beginning of treatment. They are less likely to occur when the counselor/participant relationship is strong because then the participant is more likely to feel that someone actually cares about him. Dropouts can also be reduced when immediate follow-up takes place.

The counselor and chief counselor should work strenuously in the first days of treatment to create a comfortable atmosphere for the client which will be conducive to fostering a positive attitude toward treatment. If dropouts occur, both the counselor and supervisory counselor should attempt to determine whether it was due to poor or inadequate counseling. If that was the case, increased counselor training would be indicated.

Centers must establish criteria for dropout status (e.g., number of absences over weeks) and make a decision about readmission procedures for this category.

d. *Suspension*

If a counselor determines that a participant should be suspended from treatment, the administrator and case review team must be informed, and they must approve the proposed action. Alternative suggestions should be offered by staff members as to techniques of therapy which have not been tried. The participant should be given at least two weeks on this trial period. The staff should work with him at this time in every possible way.

During the trial period, if the participant demonstrates a new desire to comply with the center's program, he should be given another chance. However, if the participant violates any of the center's prohibitions (prohibitions usually include: violence, use or threat of use of weapons, drug trafficking), he should be immediately suspended without benefit of the trial period. If the participant requests readmission, the case review team must make the final determination.

6. *Follow-up*

A formal written follow-up evaluation should be conducted after three months through a personal interview with the graduate. If possible, a semi-annual written questionnaire or personal interview should be conducted thereafter. The follow-up interview can also serve as a mechanism for an internal evaluation of the program.

IV Outpatient Counseling Services

For the purposes of this manual, outpatient counseling services will be divided into two types: services for opiate abusers, and services for polydrug users. This distinction is being made because of the differences between the two populations and the differences in terms of knowledge about how to treat these two groups.

Admittedly, little hard data is available which describes the polydrug user, and, in general, little effort has been made to provide unique treatment for this problem. As a result, the recommendations made regarding outpatient services have not been tested by experience but represent current thinking on how to approach treatment for this group. Suggestions about services for opiate abusers, on the other hand, are based largely on past, unsuccessful efforts to provide meaningful outpatient counseling for this group. The intent here is to avoid strategies which have proved unworkable and offer approaches which have been extensively discussed but practiced infrequently.

Administrators may question why they should concern themselves with outpatient counseling services given the poor results thus far. But the authors of this manual believe that this approach has potentially great value as a referral point and follow-up mechanism and, therefore, should be considered when assessing the need for drug-free treatment.

A. Services for Opiate Abusers

Communities with a sizeable opiate abusing population and a network of treatment programs often detect gaps in services for the detoxified heroin addict, the detoxified methadone maintenance client, the abstinence client confronting renewed drug hunger, and the drug experimenter or chipper. For many of these individuals a return or introduction to a methadone maintenance or day-care environment may represent a step backward. New associations, jobs or school, as well as newly adopted (or longstanding) responsible life styles, can be threatened by renewed or continued acquaintance with former friends in the drug subculture. Again, while this population requires counseling support, its level of funtioning is usually acceptable, so the rigid routine of the clinic or center may be distasteful and destructive.

The concept behind the outpatient service is to provide a therapeutic setting where clients are seen by appointment. While group counseling is available, the focus is on individualized counseling where short-term personal, family, and job/school problems can be discussed in relation to drug abuse or a return to drug abuse. For deeper, more complicated problems, outpatient counseling serves as a referral resource and advocate. With the counselor's assistance, the client is encouraged to take advantage of public and mental health services, legal aid, vocational counseling, and any other community resources which pertain to his particular problem. The outpatient service monitors the course of the referral closely and incorporates the insights gained into the counseling offered.

1. *Planning*

The administrator will find that a planning document gives him a program overview that is helpful in developing a budget, hiring staff, and explaining the program to interested government and community groups.

Many of the elements discussed in this manual can be incorporated into the plan, but the administrator must determine for himself such issues as the number of clients who will receive services and the range of services which can be provided in-house. Although the program plan may change for a variety of reasons, once the program is functioning, it is important that it be well-thought-out and complete.

2. *Fiscal Review*

The administrator should familiarize himself with the anticipated costs involved in the program so that the budget is both reasonable and meaningful to him. Administrators should be aware that a range in

cost exists based on the program size. As of January, 1974, a program treating 200 clients cost approximately $255,700 ($1,278 per client year). A detailed budget for a program this size is included in this manual (See Exhibit 8).

It is useful for administrators to remember that while personnel costs constitute the single largest budget item (approximately 80% of the budget), there is a savings involved in the abstinence program because of the reduced medical staff. (See Exhibit 9 for sample organization chart.) While flexibility is constrained by necessity in fiscal matters, some play can be found in certain line items, and usually that amount will be determined by regional costs for lab fees, rent, etc.

One major cost that administrators should anticipate is for urinalysis. The Federal Funding Criteria call for urine testing for morphine, cocaine, codeine, amphetamines, barbiturates, and other drugs, as indicated. Most programs will probably find it more efficient to contract out for this service. But administrators should know in advance that laboratories used for this purpose must be approved by the State. Furthermore, if the program should change labs, this too must be approved. Because testing is so costly, administrators should be cautious in their choice of laboratories and hold them to the agreed upon contract specifications.

3. *Facility*

a. *Site Selection*

Once the administrator understands his budget and has received approval to implement his program, the first step is to locate a facility. This should be convenient to public transportation so that staff are not required to act as chauffers for clients who have job interviews, medical appointments, etc. If community resources are concentrated in one section of the city or located in a catchment area in close proximity to the drug abusing population, the administrator should try to find a site close by. Occasionally, existing service agencies have available space, and the administrator might explore this as a possible location.

b. *Space Needs*

Unlike other treatment modalities, outpatient counseling does not have complicated space needs. However, enough room should be allotted for 10 individual counseling offices and a secure administrative/clerical office where confidential client records can be stored. In addition, space for group sessions, staff meetings, and treatment team meetings should be provided.

4. *Staff*

Staff selection, staffing pattern design, and staff recruitment should follow the same principles discussed in Day-Care (See Section F. 1. and 2.). However, given the kinds of problems anticipated in the outpatient counseling service, it is strongly recommended that both a psychologist and psychiatrist be hired half-time. Staff could then have access to them for intensive consultation on cases (particularly regarding the need for referrals for psychiatric help), and selected clients could receive regularly scheduled treatment from them as well. By limiting the psychiatrist/psychologist's caseload, it would be possible to allow him free time for supervisory training and evaluation of the effectiveness of specific techniques (e.g., psychotherapy) and, based on these documented results, assess and modify the counseling services provided to the entire population.

In selecting staff, administrators should strive for a mix that will reflect client needs. Counselors with therapeutic community experience as described in the day-care section provide strong role models for clients attempting abstinence. Young counselors with no drug history but strong backgrounds in adolescent counseling often can deal quite successfully with opiate experimenters. If possible, all counselors hired should have previous experience in providing services to minority or disadvantaged groups and have an understanding of the kinds of social and employment discrimination incurred by the ex-drug user. Past experience with outpatient abstinence programs has demonstrated that staff identification with clients is

not sufficient to hold clients in treatment. Therefore, counselors must have previous training in therapeutic techniques and must be skilled in negotiating the referral networks. If outpatient counseling cannot provide the client with something concrete (e.g., a job), it may lose credibility and consequently cannot attract clients. When reviewing candidates' job qualifications, the administrator must constantly ask himself if the person in question has the skills to open doors for clients.

Another problem that outpatient counseling services face is that of alcohol abuse. Again, when interviewing applicants, administrators should look for at least one recruit with an alcoholism counseling background which includes a thorough understanding of the Alcoholics Anonymous concepts and antabuse.

Perhaps the most difficult staff selection is the choice of the vocational rehabilitation specialist. Not only should the counselor hired be experienced in jobs assessment and placement for the disadvantaged, but he must be capable of sharing his knowledge to other staff members. While the outpatient service cannot replace established vocational agencies, it will of necessity become heavily involved in opening the job market for ex-addicts. In this context, the vocational specialist functions as a trainer and must be capable of instructing staff and coordinating their activities in this area.

As in the day-care setting, counselors have extensive record keeping responsibilities. (See Day-Care Section F.2.c. for a detailed description of these activities.) Administrators, therefore, should ask for writing samples as part of the job interview to ensure that applicants can communicate clearly and accurately.

Training for outpatient staff is vital and can be patterned after that described in the Day-Care Section (See Section F.2.b.).

5. *Treatment Regimen*

The treatment regimen of an outpatient counseling service for opiate abusers is fairly straightforward and consists of four basic elements: intake, counseling (urine surveillance is considered part of the counseling effort), referral, and follow-up.

a. *Intake*

For the purposes of this manual, intake for outpatient counseling corresponds to intake for day-care and is conducted in accordance with the Federal Funding Criteria. Addicted clients should be referred for detoxification before acceptance into the program. Once a client is admitted, the drug and social history is compiled, and a treatment plan is developed. The physical examination is part of the treatment plan and should be given as soon as possible but certainly within 21 days. As was mentioned earlier, outpatient services are available on an appointment basis. The client is responsible for keeping the appointment but, in exchange, is able to schedule it at his convenience. The same philosophy underlies the treatment plan. The client and counselor carefully review what each sees as the client's primary needs and, based on that input, structure the plan together. Very specific time frames for achievement are incorporated into the plan, and both counselor and client must affirm their responsibility to see that the goal is accomplished by the agreed-upon time. In one sense, the plan is viewed as a consumer contract for services. During the course of treatment, it should be reviewed regularly and changed as the consumer/client's needs dictate. Generally, the plan should contain goals for employment or training, assumption of social responsibility (e.g., registering to vote, participation in a citizens group, appropriate fiscal management such as establishment of a savings account, payments on a car loan, prompt bill payment, etc.), ascertaining and meeting health needs, etc. Based on the client's goals and the program's conditions, an appointment schedule for counseling and other indicated services is determined and documented. The counselor then presents a frank description of the program's services and limitations. Once the counselor and client believe that the plan is clearly understood, both sign it.

b. *Counseling*

The content, frequency, and type of counseling will vary depending on the client's needs. For example, a youthful experimenter may require a one-hour individual counseling session five days a week

with an additional weekly group session with his peers. Family counseling may be indicated in this instance, as well as collaboration with a school guidance counselor or juvenile court probation officer. An older client may only require twice weekly counseling for his drug problem but require vocational rehabilitation sessions on a daily basis for several weeks. Regardless of the amount or type of counseling provided, it should be goal-oriented and reality-centered. The counselor should be supportive and nonjudgmental and direct the sessions toward present issues and problems. While information about the past may be helpful, it should be used only to gain insights about coping mechanisms used previously which may be effectively applied to the current situation. As the counselor/client relationship develops, it may become apparent that other serious problems exist. When this occurs, counseling is continued, but referrals are initiated.

c. *Referral*

A primary function of outpatient counseling is to serve as a referral point. A major responsibility of the program is to set up a referral liaison with the community's health, housing, legal, medical, vocational, and religious agencies. (It is helpful for outpatient services to establish a directory of community resources which is updated on a regular basis and to participate in local service agency consortiums so that referral mechanisms can be developed and promoted.) By liaison, it is meant that the outpatient service establish a relationship which assures that its clients receive responsive, consistent care from the referred agency and that the provider of the service is willing to collaborate with the outpatient counselor in the process of rehabilitation through willing information exchange and discussion.

The key to effective referral is to identify accurately the client's problem and to send him to the agency specifically designated to handle that problem. The counselor should make the preliminary contact with the involved agency, providing it with a description of the client's condition as perceived by the counselor and, with the client's permission, written information concerning the results of the physical exam, social and drug history, etc. An appointment for the client should be made and confirmed with the client, and then the counselor begins the collaboration process with the involved agency. Depending on the nature of the problem, collaboration may involve telephone contact, joint meetings, or a series of sessions with the counselor, client, and involved agency representative. The results of this process must be recorded in the client's records and appropriately incorporated into the client's treatment plan. Furthermore, once the referral process has been concluded, the counselor should assess its effectiveness and discuss it at the case review meetings.

d. *Follow-up*

The outpatient counseling service is not interested in retaining clients indefinitely but will see certain clients returning for assistance at various points in their continuing effort to remain drug-free. For example, a client may enter treatment in order to gain employment while remaining abstinent. Once he has attained that goal and adjusted to his job, he may discontinue treatment for several months. However, a crisis situation (a death, unexpected financial problems, etc.), may prompt the client to seek help again. For this reason it is important that follow-up occur. Weekly telephone calls for several weeks after discontinuation of treatment and periodic requests for a counseling contact at the program or in the client's home re-enforce the counselor's commitment or the client's rehabilitation and let the client know that the program is always available to him. Again, programs with the staff resources will want to follow up clients for evaluation purposes, as well, so that progress can be made based on long-term successes and failures.

B. Services for Polydrug Abusers

In many ways, services for polydrug abusers are identical to outpatient counseling services for opiate abusers, but there are certain striking differences which merit a separate discussion.

Although few extensive evaluations have been done on polydrug abusers, the few that have been completed indicate that the polydrug abuser may be more likely to have psychiatric problems which require

a different kind of care than that traditionally available to the opiate abuser. Likewise, it seems that the demographic characteristics of the polydrug abuser are quite different in terms of sex and economic status, a factor which impacts heavily on program location and style. For these reasons, the following suggestions are offered to administrators planning to provide outpatient services to polydrug abusers.

1. *Site Selection*

Typically, drug treatment services have been located in or near a community's high drug area (normally defined as the section where heroin abusers live or congregate). Polydrug abuse, however, appears more prevalent among middle and upper income adult females and adolescents who are unlikely to seek treatment in neighborhoods identified with extensive heroin use. Hospitals or anonymous commercial sites are probably better choices for polydrug services. Space needs are similar to those required for opiate abusers with the stipulation that sufficient private counseling offices are afforded and an emergency medical/physician's office is available. (If located in a hospital, this is unnecessary.)

2. *Staff*

Because of the possibility that psychiatric problems may be prevalent among this population, it is recommended that all staff members be experienced mental health professionals. To be cost-effective, the administrator may eliminate the vocational rehabilitation specialist and three counselor positions in order to support professional salaries and rely on volunteers to supplement staff. (Volunteers used in polydrug services should meet the criteria discussed in the Day-Care Section of this manual. See Section F.2.d.)

Recruiting staff for polydrug services may prove difficult since there are not a large number of on-going programs handling this population to serve as a personnel pool. When selecting recruits, administrators should understand that staff will, of necessity, go through a cooperative learning experience during at least the first year of operation. For this reason, flexibility and openness to new ideas is expected of all employees. Furthermore, the administrator should attempt to hire one staff member with an understanding of evaluative research. The polydrug program will have to continuously examine its approach to treatment since so little is known, and it is helpful if a staff member can define criteria against which effectiveness may be measured.

3. *Treatment Regimen*

At this point, two recommendations can be made about the treatment regimen of a polydrug service. The first refers to the intake process. Because of the speculation about the possibility of widespread psychological problems among the polydrug population, outpatient counseling services are encouraged to administer psychological tests (e.g., MMPI) as a part of the admission process. The tests can be scored and interpreted by the half-time psychologist, and the results should be discussed with the clients' counselor in detail. At specified intervals during treatment, tests should be readministered as one method of assessing the client's response. (This recommendation highlights the need to use mental health professionals who have the training and skill to use test results.) Secondly, while physical exams may be contracted out, it is essential that they be reviewed by a staff physician and that enough physician hours are budgeted so that the physician can consistently monitor the client's physical condition. The emphasis on psychological appraisal and physical observation is considered important at this time because not enough information is available to predict the kinds of problems which should be anticipated once drug use is eliminated. It may be that a change in drugs or a decrease in dose is indicated for some clients rather than total abstention; therefore, careful, consistent monitoring of the client's mental/physical reactions should be stressed. Additionally, outpatient services should establish a close relationship with the detoxification facility to ensure continuity of client care and to encourage information exchange. Administrators may want to consider monthly joint case review meetings as one means of promoting cooperation.

Finally, as in the outpatient service for opiate abusers, the need for accurate, complete client records cannot be underestimated. Polydrug counselors should follow the record keeping procedures outlined in the Day-Care Section of this manual but understand that, as insights are gained into the polydrug abusers, new information may have to be compiled.

V Rap Centers

With the exception of various State licensing standards (e.g., Florida), criteria do not exist to guide the administrator in the establishment of rap centers. The primary reason for this is that rap centers differ significantly in terms of organization, budget, and range of services; common denominators are not easily isolated. However, rap centers are a form of outpatient drug-free treatment, in the most narrow sense, and so will be briefly discussed in this manual.

Essentially, rap centers are youth-oriented, peer-directed efforts to: 1) contact the drug abuser in order to draw him into the treatment network; 2) provide information and advice about drug abuse intended to deter the curious from experimentation; and 3) offer the community (particularly concerned parents) consultation and assistance in approaching the drug abuse problem.

Rap centers employ a diverse staff ranging from clergy to ex-addicts to VISTA volunteers depending on the target population. But in almost all cases, the centers use their staff to provide youth counseling through the mechanism of rap sessions (defined as peer groups which delve into daily personal problems, self-awareness, decision-making, alternatives to drug abuse), individual and group parental counseling, and referral for treatment. To offer these services, rap centers may use storefront settings, their own facility replete with library, arts and crafts rooms, recreational areas, etc., or space in a church hall, Boys Club, or other community agency. (The facility chosen should depend on the extent and kind of services already available in the community so the rap center does not wastefully duplicate existing resources.)

In general, rap centers offer direct, in-house services to youths who are flirting with drug abuse but have not yet committed themselves to it. Their continued participation in the center's activities are an indication of their own desire to find alternatives to the drug abusing life style, and the peer pressure brought about by other center members reenforces this commitment. However, in addition to this population, rap centers often are approached by another group. These individuals have a drug abuse problem and want help. It is in this situation, that the rap center becomes a referral point and moves from a prevention to initial treatment role. Ideally, rap center staff should be familiar with the community's drug treatment resources and capable of making a reasonable referral. (Treatment programs have an obligation to up-date the rap center about their services and devise a referral mechanism which is efficient and rapid.) In some communities, rap centers use volunteers to transport referrals directly to the treatment program so that personal contact is not lost; in others, the treatment program arranges to pick up the individual at the rap center. Generally, rap centers have high visibility in a community and often will obtain referrals from school and religious personnel who are uncomfortable about handling drug-related problems. Again, through the rap center's referral network, treatment programs have an opportunity to reach a population they might not see otherwise.

Administrators planning to implement rap centers are encouraged to meet with existing treatment programs so that a cross-referral system can be established. A policy of inclusiveness rather than exclusiveness, despite differing populations, goals, and methods of treatment, assures that the drug curious as well as the drug abuser obtains the service appropriate to his problem as rapidly as possible.

Exhibit 1

Federal Funding Criteria

FEDERAL FUNDING CRITERIA FOR TREATMENT SERVICES*

The contractor/grantee, as an independent contractor/grantee and not as an agent of the Government, shall provide the necessary facilities, material, services, and qualified personnel to furnish treatment and rehabilitation to drug dependent persons in accordance with the following:

1. The contractor/grantee shall provide and operate or shall engage subcontractor/affiliate to provide and operate such _____ (modality), as may be appropriate, at a site or sites to be approved by the Government.

2. Criteria to be used for patient admissions and terminations shall be established.

3. All facilities shall be maintained in a clean, safe, and attractive condition and in accordance with appropriate local, state and Federal codes and other laws.

4. Appropriate furnishings for a _____ (modality) shall be provided.

5. At intake, an initial personal history, medical history, and drug history must be taken. It is important to conduct this intake process as rapidly as possible so that clients are not discouraged from pursuing treatment. An intake not exceeding three days is optimal. The purpose of taking a medical and drug history is to immediately identify the client experiencing flashbacks, psychotic manifestations and/or severe physical illness requiring immediate psychiatric or medical care. Only when this information is collected and reviewed can the program be reasonably assured of preparing the best possible treatment plan for the client. It is in this context that a complete personal, medical, and drug history is essential for all treatment modalities.

*For the following treatment modalities: Outpatient Methadone, Residential Methadone, Residential Drug Free, Outpatient Drug Free, and Day Care Drug Free.

Programs having difficulty complying with any of the Federal Funding Criteria should request technical assistance from their Program Development Specialist, Division of Community Assistance, National Institute on Drug Abuse, 11400 Rockville Pike, Rockville, Maryland 20852.

6. At intake a physical examination and laboratory examination shall be performed by qualified personnel. Programs shall perform physical examinations on clients as soon as possible after entering treatment but no later than 21 days. The physical examination shall be detailed in the treatment plan. It is particularly important that residential drug free programs perform physical examinations as soon as possible because of the possibility of infectious diseases and the close client contact. If the residential program has an induction phase, it is recommended that the physical examination be performed during this time period. This criterion is not meant to supercede FDA regulations requiring a physical examination at intake. The minimum for a physical and laboratory examination may consist of the following:

   a. Physical examination stressing infectious disease, pulmonary, liver, cardiac abnormalities, dermatologic sequelae of addiction and possible concurrent surgical problems.

   b. Complete blood count and differential.

   c. Serologic test(s) for syphilis.

   d. Routine and microscopic urinalysis.

   e. Urine screening for drugs (toxicology).

   f. SMA 12/60 or equivalent.

   g. Chest X-ray.

   h. Sickle cell, as appropriate.

   i. Australian antigen, as appropriate.

   j. EKG and biological test for pregnancy, as appropriate.

7. Each new admission or readmission shall be interviewed by a mental health professional. Mental health professional is defined as "a person who, by virtue of training and experience, is capable of assessing the psychological and sociological background of a client to determine the optimal treatment plan." The staff shall take a complete personal history: family; education; vocation; legal and related areas; drug history, including kinds of drugs abused and when begun, prior treatment attempts; and any other relevant information. The admission interview is regarded as the first step in treatment for all treatment modalities. The purpose of the admission

interview is to determine whether the selected mode of treatment is most appropriate for the client and to ensure that the client understands the nature of the program and the program's expectations of him. Again, our primary concern is that enough information is exchanged between the client and the program to ensure that the best possible treatment plan is designed for the client in light of his treatment needs and the program's expectations. (Note: Where a Central Intake Unit (CIU) provides the intake screening, it is the responsibility of the program to which the referral is made, to develop the individual treatment plan for each patient after careful review of the records and an interview with the client.)

Individual treatment plans shall be reviewed and redetermined by the treatment team no less than every 90 days for outpatient programs. For all other modalities, the individual treatment plan shall be reviewed and redetermined every 30 days. Evidence of this review shall be recorded in each patient's medical record. Every treatment plan must include documented evidence of:

a. A statement of short and long-term goals for treatment generated by both staff and client.

b. The assignment of a primary counselor.

c. A delineation of the type and frequency of counseling services to be provided.

d. A delineation of those supportive services needed by the individual patient.

8. The program shall designate a medical director who must take medical responsibility for the program and be licensed in the jurisdiction within which the program exists. He shall ensure that the initial evaluation is appropriately performed and that the medical needs of individual patients are periodically assayed and that, when appropriate, emergency medical services are provided. It is the responsibility of the medical director to determine what emergency medical equipment and supplies are needed in order to deal with possible overdoses and other medical emergencies. Medical services, in general, should be provided through city or county medical facilities. Provision of such services is not the program's responsibility.

For those patients receiving prescription medication (other than methadone), through the program, contact with a program physician is required at least once every four (4) weeks or more frequently, depending on patient needs.

9. A formal written agreement must exist between the program and a licensed hospital or hospitals in the community for provision of emergency, inpatient, and ambulatory medical services as appropriate. Such services will not be paid for under this contract/grant.

10. At least five hours per week of professional mental health consultation per 100 patients must be provided. The purpose of this consultation is to review selected cases and to provide assistance to staff in patient management or referral for psychiatric services.

11. A variety of counseling techniques may be utilized in individual, family or group counseling sessions conducted by trained personnel under the supervision of an appropriately qualified professional. In any group counseling, the size of the group shall, in general, range between 5 and 15 individuals. In outpatient methadone and outpatient drug free programs, each patient shall have available to him a minimum of 3 hours per week of counseling. In residential drug free, residential methadone, and day care drug free programs, a minimum of ten hours per week of formalized counseling shall be available for each patient. These counseling guidelines should be considered minimum for planning purposes; however, the actual counseling time allotted should be based upon individual client needs.

12. The following supportive services must be provided:

    a. Education.

    b. Vocational counseling and training.

    c. Job development and placement.

    d. Legal services.

    To the maximum extent possible, programs shall utilize community resources. Documentation of any agreements to provide the above services must be obtained. If any program can adequately demonstrate inability to obtain the requisite supportive services, it may submit a formal request for the direct provision of these services.

13. The following procedures must be observed for urine surveillance except for outpatient drug free:

    a. Urine specimens from each patient must be collected under appropriate supervision on a randomly scheduled

basis at least once a week and analyzed for morphine, methadone, cocaine, codeine, amphetamines, barbiturates, as well as other drugs if indicated. Breath analysis is acceptable for alcohol testing where appropriate.

b. Laboratories used for urine testing must comply with all state and Federal proficiency testing programs.

c. Urine testing results shall be used as a diagnostic tool and in patient management and in the determination of patient treatment plans. Patient records shall reflect the manner in which test results are utilized.

d. Provision for urine testing of outpatient drug free clients should be made, and used by program staff as appropriate.

14. Every patient shall be encouraged to enroll in either an education program, a job training program or gainful employment as soon as appropriate, but not later than 120 days; or in the case of a referral from a residential program, not later than 60 days after the date of transfer. Any exception to this requirement shall, in every instance, be recorded and justified in the patient's record. Clients have the right not to become involved in these programs; however, they should be encouraged to do so as a basic element of the treatment plan.

15. Each program shall establish a follow-up policy which encourages a schedule of minimum contact available for discharged patients.

16. Each program shall establish a patient record system to document and monitor patient care. This system must comply with all state and Federal reporting and confidentiality requirements.

17. An effort must be made to gear the program's hours of operation to meet client needs. For outpatient treatment programs, consideration should be given to those clients who are employed and consequently must be able to visit the clinic outside of working hours. Clients who are not employed or involved in school or training programs are expected to schedule other activities around clinic hours. The traditional 9:00 a.m. to 5:00 p.m. work day regimen is not adequate for outpatient treatment. In fact, in clinics with large client populations, twelve-

hour clinic operations may prove necessary. However, the minimum hours of operation shall be maintained.

a. Outpatient Methadone -- no less than 7 days per week: 5 days per week at 8 hours per day (in all cases at least 2 hours must be outside 9 a.m. - 5 p.m.) and 2 days per week at 4 hours per day.

b. Residential Methadone and Residential Drug Free -- 7 days per week, 24 hours per day.

c. Outpatient Drug Free -- no less than 6 days per week: 5 days at 8 hours per day (in all cases at least 2 hours must be outside 9 a.m. - 5 p.m.) and one day at 5 hours.

d. Day Care Drug Free -- 6 days at 10 hours per day.

e. Central Intake Unit -- 5 days per week at 8 hours per day.

18. Residential methadone and residential drug free programs must provide a minimum of 3 meals per day per patient. Day care drug free programs may provide one meal per patient per day.

19. All programs which use methadone for detoxification and maintenance treatment must comply with the regulations of the Food and Drug Administration and also must function in compliance with all other relevant Federal and state regulations and guidelines.

Exceptions to the underlined criteria, when in line with patient needs, may be granted by your Program Development Specialist, Division of Community Assistance, National Institute on Drug Abuse, 11400 Rockville Pike, Rockville, Maryland 20852. Exceptions to other criteria will be made by: Director, Division of Community Assistance, under the advisement of the Clinical Review Board.

FEDERAL FUNDING CRITERIA FOR TREATMENT SERVICES
CENTRAL INTAKE UNIT

The contractor/grantee, as an independent contractor/grantee and not as an agent of the Government, shall provide the necessary facilities, materials, services, and qualified personnel to provide central intake services to service delivery systems which furnish treatment and rehabilitation to drug dependent persons in accordance with the following:

A. The contractor/grantee shall provide and operate or shall engage a subcontractor/affiliate to provide and operate a Central Intake Unit (CIU) at a site approved by the Government.

B. The contractor/grantee shall require that each participating program submit criteria to be used for admissions and terminations.

C. The contractor/grantee shall make available a Central Intake Unit to provide uniform, standardized initial patient orientation, multi-phasic health screening and referral to an appropriate treatment modality for new and readmitted patients.

D. The CIU shall provide at least the following and such other items of patient care as may be prescribed by the Government:

1. A central intake facility for patients to remain open no fewer than 5 days per week, and no fewer than 8 hours per day.

2. A facility maintained in clean, safe and attractive condition and in accordance with appropriate local, state and Federal codes and other laws.

3. Appropriate furnishings for a central intake facility.

4. At intake, an initial personal history, medical history, and drug history.

5. At intake a physical examination and laboratory examination performed by qualified personnel.

   Physical examination stressing infectious diseases, pulmonary, liver, cardiac abnormalities, dermatologic sequelae of addiction and possible concurrent surgical problems.

Laboratory examination, including the following:

a. Complete blood count and differential

b. Serologic test(s) for syphilis

c. Routine and microscopic urinalysis

d. Urine screening for drugs (toxicology)

e. SMA 12/60 or equivalent

f. Chest X-ray

g. Australian antigen, as appropriate

h. Sickle cell, as appropriate

i. Pap smear and gonorrhea culture, as appropriate

j. Tetanus toxoid, as appropriate

k. EKG and biological test for pregnancy, as appropriate

6. Services of a medical director licensed in the jurisdiction within which the CIU exists. He shall insure that the initial evaluation is appropriately performed and that medical needs of individual patients are properly assessed and treated/referred, as appropriate. Medical services shall include initial diagnostic work-up, identification of medical and surgical problems for referral to other treatment facilities, and review of patient's records. The physician should, when appropriate, request a copy of the patient's previous medical records and forward them to the appropriate treatment center.

7. A formal written agreement between the CIU and a licensed hospital or hospitals in the community for provision of emergency, inpatient and ambulatory hospital services as appropriate. Such services will not be paid for under this contract/grant.

8. Interview of each new admission or readmission shall be performed by a mental health professional or by a qualified intake counselor under the supervision of the former. The intake staff shall take a complete personal history--family, education, vocation, legal and related areas, drug history, including kinds of drugs abused, when begun, and prior treatment attempts. The staff shall then present the various treatment modalities available for the patient. After

discussing these in light of the patient's particular situation (including the results of the physician's evaluation), a treatment modality shall be selected by mutual agreement with the applicant and the appropriate referral made.

9. A patient index of all drug dependent individuals referred for treatment through its screening and referral unit must be maintained. This index shall be updated by the participating agencies as transfers to other programs and termination occur.

10. The CIU must have the capability of referring a drug dependent individual with duplicate intake records to an appropriate treatment modality within 48 hours.

11. Uniform intake procedures must be established so that it will not be necessary for programs which receive patients from the CIU to duplicate services.

12. Urine surveillance according to the following procedures:

    Urine specimens from each patient must be collected under appropriate supervision during the intake process. The specimens must be analyzed for morphine, methadone, cocaine, codeine, amphetamines, barbiturates, as well as other drugs if indicated. Breath analysis is acceptable for alcohol testing.

    Laboratories used for urine testing must comply with all state and Federal proficiency testing programs.

E. If methadone is to be administered at the Central Intake Unit, the CIU must comply with the regulations of the Food and Drug Administration and also must function in compliance with all other relevant Federal and state regulations and guidelines.

F. Each CIU shall establish an approved patient record-keeping system adequate to fulfill state and Federal reporting requirements.

G. Each CIU shall establish and have evidence of formal agreements between the CIU and community-based drug treatment programs, documenting the program's agreement to utilize the CIU for patient intake functions and not to duplicate those functions; and to accept only patients who have been processed through the CIU.

H. Each CIU shall define: The procedures by which applicants shall be oriented to available treatment options; the decision-making process for determining recommended referral; the decision-making process for "mutual agreement" between applicants, programs, and CIU staff regarding referral; and procedures for meeting the needs of patients referred to the CIU for rescreening and re-referral to a more suitable modality or program. These shall be subject to state and Federal approval.

Exhibit 2

Day-Care Budget and Description

DAY-CARE DRUG-FREE PROGRAM

Description

The budget and staffing patterns for a day-care drug-free program treating 40 clients and operational six days a week for 10 hours per day are presented here.

The assumption will be made that this is an independent program which provides individual and group therapy, family counseling, and educational and vocational services on-site. Legal assistance is provided through a referral arrangement with a community legal aid program. While clients are referred to a community health facility for basic health care, initial physical examinations are contracted out and paid for at the cost of $75.00 per exam by the day-care program. The program additionally provides each client with lunch.

A day-care program is geared toward helping the drug abuser redirect his life with an emphasis on employment or education leading to employment as a major tool in accomplishing this end. Day-care is designed for both male and female drug abusers, 16 years old and older, who require a structured setting for rehabilitation but for whom a residential program is not feasible.

The major therapeutic activities under a day-care program include three-times-a-week encounter group therapy, daily vocational readiness seminars, three-times-a-week individual counseling, and family therapy when indicated. Individual vocational counseling is available as needed. Each client has a job assignment which is necessary to program functioning, such as housekeeping, clerical duties, and food preparation. As soon as possible and within 60 to 90 days each client will be enrolled in educational or job training programs or will be employed. At that time, the client participates in weekly groups and individual counseling as needed. Clients may be successfully terminated when client and counselor agree that a satisfactory adjustment to the community has been made. Follow-up will be conducted on all clients who terminate treatment.

Day-Care Drug-Free Program Budget

A. Personnel		
Administrator	$ 15,000	
Secretary	$ 8,000	
One Chief Counselor	$ 12,000	
Two Counselors	$ 18,000	
One Vocational Rehabilitation Specialist	$ 14,000	
Total	$ 67,000	
Employee benefits @ 10%	6,700	
Total Personnel Costs	$ 73,700	$ 73,700
B. Consultants		
Medical 4 hr./month	$ 600	$ 600
C. Travel		
Local for clients	$ 1,000	$ 1,000
D. Equipment	$ 4,228	$ 4,228
E. Intake Medical Examinations		
1.7 dynamic to static capacity X 40 clients X $75 per exam	$ 5,100	$ 5,100
F. Other		
Utilities and Communications	$ 3,600	
Rent ($300/month)	$ 3,600	
Renovations	$ 2,500	
Training	$ 300	
Food	$ 9,360	
*Laboratory Services Contract	$ 6,240	$ 25,600
TOTAL COST OF CLINIC WITH 40 CLIENT STATIC CAPACITY	$110,228	$110,228

*Because of the low volume of tests, it is assumed that 40 tests per week will be conducted at a cost of $3.00 per test. The total cost per client year is $2,750.

Exhibit 3

Day-Care Organizational Chart

Day-Care Drug-Free

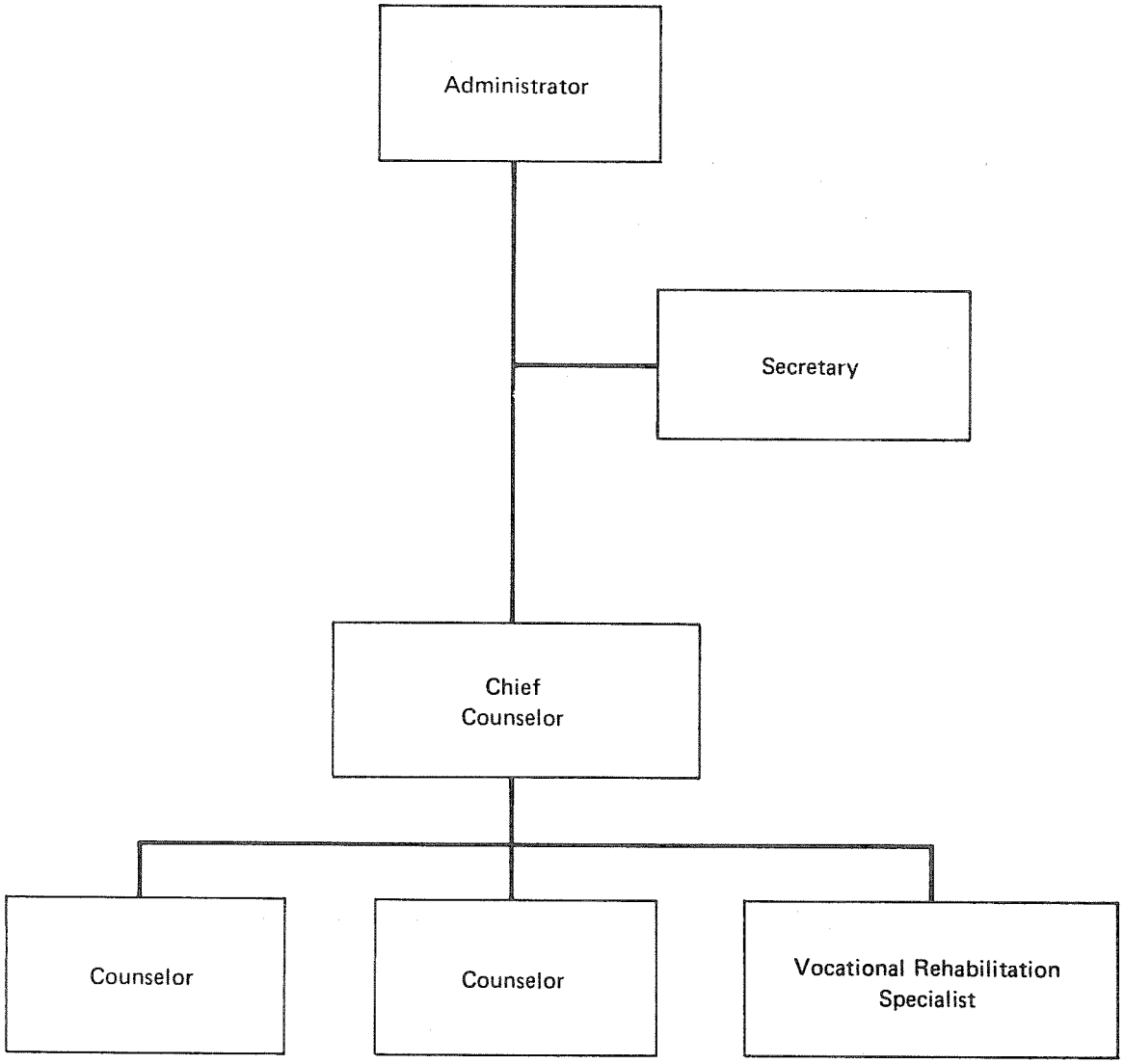


Exhibit 4

Sample Job Descriptions

Sample Job Descriptions

A. Supervisory Counselor

Position Controls:

Incumbent works under the direct supervision of the administrator. The supervisor is available for assistance on unforeseen problems encountered. Work is reviewed for adequacy and compliance with instructions and available guidelines.

Duties and Responsibilities

Supervises counselors in day-to-day client management. Independently assesses training needs of supervised staff and provides necessary training where feasible. In other instances, will report training needs to supervisor. Orients new personnel and volunteers.

Conducts and/or provides individual or group therapy. Acts as therapy supervisor for counselors and provides on-going training in this area.

Along with the administrator, formulates therapy policy and participates in the revision. Acts as program supervisor in absence of the administrator.

Coordinates the dropout and reentry programs and recreational activities within the program. Receives progress reports of same. Conducts treatment meetings in the absence of the administrator. May represent program in community meetings.

Attends professional meetings and conferences as approved by the administrator and performs other duties as assigned.

B. Counselor

Position Controls:

Receives general technical and administrative supervision from supervisory counselor. Assignments are well-defined, and on-the-job training is given to develop counseling skills. Supervisor is available for assistance on unforeseen problems with instructions and available guidelines.

Duties and Responsibilities:

Collects supplemental information on designated clients using families, previous employers or co-workers, social and drug histories, and other sources as indicated for effective rehabilitation. Conducts orientation session for newly admitted clients.

Records all client activity at intervals designated by program policy. Maintains data on clients in organized, well-documented fashion and submits such documents to supervisory counselor for periodic review.

Prepares individual treatment plans for clients upon intake, revising these when necessary. Evaluates treatment plans at least every 30 days.

Can initially establish and, if assigned, supervise the day-to-day functioning of a departmental unit.

Advises supervisor of problems encountered in caseload management and recommends various approaches (e.g., increased privileges, increased counseling, disciplinary measures). Presents these in weekly treatment team meetings.

Participates in group and individual counseling, using supervisory counselor as resource for problem clients.

Communicates with other members of treatment staff continuously about significant behavior of all clients. Documents all contacts and/or contacts of other staff with clients. Is very observant of clients' behavior.

Attends professional conferences and meetings as directed.

Participates in urine surveillance assignments, submits urines upon request, and performs other duties as assigned.

C. Vocational Rehabilitation/Job Development Counselor

Position Controls:

Works under the general supervison of the supervisory counselor. Technical supervision may be available from centralized vocational rehabilitation unit or the city vocational rehabilitation department. Work is reviewed by supervisory counselor and administrator.

Duties and Responsibilities:

Collects available social, educational, economic, and vocational information on the client which can be used in securing suitable employment. Contacts employment and social/civic service agencies in seeking employment for the client. Is responsible for follow-up contact with prospective employers, and provides counselors with follow-up information. Conducts employment adjustment sessions with clients (e.g., resume preparation promptness, etc.) to instruct them in applying for, winning, and maintaining a job.

Maintains good public relations and participates in team conferences and training with community agencies and local employment offices.

Maintains accurate records for statistical purposes of number of clients referred by counselors, number of clients referred to various agencies, employment retaining rates among residents, etc. Provides these to supervisory counselor upon request.

Keeps records collected on intake and updated periodically of employment needs, previous employment records, apprenticeships and skills of all clients, training needs, etc.

Participates in treatment team meetings.

Performs other duties as assigned.

Exhibit 5

Sample Training Aids

Day-Care Center

Training

Philosophy and Concepts

- Behavioral and Attitudinal Changes
- Self-help
- Self-awareness
- Love and concern
- Truth and honesty
- Staff/client relationship

Roles and Responsibility of Staff

Roles and Responsibility of Participants

Therapy

- Individual sessions
  - Purpose and types of material handled
- Group sessions
  - Purpose and types of material handled
    - Informal Rap Sessions
    - Supportive groups or probes
    - Family therapy or Relatives groups

Recreation

Educational Opportunities

Vocational Rehabilitation

Free Time

Client Management

Objectives: – To provide forum for discussion of program policy regarding client management.
– To provide staff with basics of effective management tools for addicts in treatment.

Points for Discussion:

A. Intake process

1. Elements
2. Duration
3. Staff

B. Client assignment and orientation

C. Record keeping

1. CODAP Standards
2. Individual program policy

D. Client types

Anger

Discussion points:

1. Angry clients are often resistant to their own feelings.
2. Carefully structure questions about the *source* of the anger. Otherwise, client may become further infuriated.
3. Attempt to point out area where client has directed immediate anger and deal from there.
4. Do not try to get at all causes of anger—especially if some have already been expressed. This minimizes those problems.
5. Do not give client the impression that you are avoiding his behavior.

Fear

Discussion points:

1. Avoid giving unsolicited advice.
2. Try to get client to explore feelings about a given situation.
3. Time your responses; avoid premature, investigating questions.
4. Explore possibilities to resolve conflict.

Anxiety

Discussion points:

1. Use approach that is sensitive to client's feelings.
2. Make responses emphasize sensitivity to feeling rather than content of conversation.
3. Attempt continuously to get information which adds to material already discussed.
4. Deal in the here and now if information about the past can be gathered later.
5. Avoid trying to resolve issue during the first interview.

E. Counseling

1. Individual

a. Assist client in taking risks. Help him discard old familiar ways of responding because he thinks they are safe.
b. Avoid stereotype labels. These allow the client to shift responsibility for his actions to the condition the label implies (i.e., dependent).
c. Assist clients in identifying his own faults instead of encouraging him to identify to society's.
d. Avoid comparisons (husband-wife, brother-sister, etc.) These allow the client to maintain a poor concept of himself and come out second best. Another excuse for irresponsibility.
e. Define client's fears with him. Do not allow him to bring up previous defeats as a motive for not venturing ahead.
f. Avoid (whenever possible) argumentative episodes with the client. He may often use this defense to prevent you from probing deeper areas.
g. Discourage client from blaming his past for his present behavior.
h. Attempt to define various client-defenses (i.e., clients with marital problems are often engaged in numerous activities to avoid admitting they may be lonely).
i. Note positive behavior.
j. Discard illusion that only you have problems.
k. Develop alternatives.
l. Avoid false accusations.

2. Groups

a. Encounter

- Soft pedals hostility, anger, and anxiety.
- Emotions are accepted, atmosphere is one of openness.
- Leader is compassionate, empathetic, directive; may even defend certain members.
- Recommended group type for amphetamine abusers.

b. Re-entry

Exhibit 6

Intake Forms

CENTRAL MEDICAL INTAKE FORM I

Patient Routing Card

Patient Name:_____ I.D. #_____

CMI Counselor_____ CMI Date_____

☐ Voluntary ☐ CJS ☐ Transfer _____

☐ Complete New or Re	☐ Partial Re	☐ Annual P.E.
☐ Clerk	☐ Clerk	☐ Clerk
☐ Blood	☐ Urine (drugs)	☐ Blood
☐ Urine (Complte)	☐ Rx update	☐ Urine (Medical)
☐ Medical Rx	☐ P.E. update	☐ Medical Rx
☐ Chest X-ray	☐ Other_____	☐ Chest X-ray
☐ Physical exam	_____	☐ Physical exam
☐ Footprint	_____	☐ Footprint
☐ Interview	☐ Interview	☐ Interview
☐ I.D. Card	☐ I.D. File	☐ I.D. File
Rec. Rx _____	Rec. Rx _____	Center _____
Center_____	Center_____	Time Out _____
Time Out _____	Time Out _____	

Comments_____

_____

CENTRAL MEDICAL INTAKE REPORT FORM III
MEDICAL HISTORY REPORT FORM

Patient Name: _____ Client No. _____

YES	NO	HAVE YOU EVER HAD:
____	____	Anemia or Blood Disease (Sickle Cell Disease)
____	____	Cancers or Tumors
____	____	Rheumatic Fever
____	____	Heart Disease
____	____	Varicose Veins
____	____	Phlebitis or Infected Veins
____	____	Tuberculosis
____	____	Pneumonia or Pleurisy
____	____	Asthma
____	____	Hay Fever
____	____	Sinus Trouble
____	____	Allergy to Drugs or Foods
____	____	Hives
____	____	Dermatitis or Skin Disease
____	____	Eye Infection
____	____	Blindness
____	____	Color Blindness
____	____	Deafness or hearing loss
____	____	Seizure disorders or epilepsy
____	____	Severe back disease
____	____	Arthritis or Joint Disease
____	____	Stomach ulcers or ulcer disease
____	____	Gall bladder disease
____	____	Diabetes
____	____	Thyroid disease
____	____	Syphilis – date_____ Where treated_____
____	____	Gonorrhea
____	____	Hepatitis
____	____	Hypertension or High Blood Pressure
____	____	Malaria
____	____	Kidney disease
____	____	Typhoid fever
____	____	Gout
____	____	Hemorrhoid

What other diseases not on this list have you had;

1. _____
2. _____
3. _____
4. _____

When did you have your last regular physical examination_____
When did you last see your dentist_____
Where are your most recent medical records_____
Are your teeth in good repair currently_____
Do you wear eye glasses or contact lenses_____
Do you need new eye glasses_____

Patient Name _____ Client No. _____

How many times have you been hospitalized _____
For more than 24 hours (include all operations, OB & GYN) _____

Name Hospital _____ Date _____ Disease _____
Name Hospital _____ Date _____ Disease _____
Name Hospital _____ Date _____ Disease _____
Name Hospital _____ Date _____ Disease _____

Indicate Health Status: Excellent _____ Good _____ Fair _____ Poor _____

Name of personal physician or clinic _____
Address _____ Telephone _____
Medicaid No. _____ Card Color _____
Hospitalization No. _____

. . . . . .

Have You Recently:

Yes	No	
___	___	Had a sore tongue
___	___	Had "fever sores"
___	___	Had difficulty swollowing
___	___	Had excessive gas
___	___	Had abdominal pain
___	___	Been constipated often
___	___	Had diarrhea frequently
___	___	Had blood in your bowel movements
___	___	Had black bowel movements
___	___	Had light gray or white bowel movements
___	___	Had burning or discomfort when you urinate
___	___	Had very dark (green-brown) urine
___	___	Had stiffness, swelling or pain in your joints
___	___	Had frequent or severe headaches
___	___	Had persistent numbness or weakness any place in your body
___	___	Had dizziness or light-headedness
___	___	Had unsteadiness in walking or balance
___	___	Had difficulty falling or staying asleep
___	___	Felt tired after having enough sleep.
___	___	Had difficulty trying to remember things
___	___	Had difficulty remaining awake during usual waking hours
___	___	Felt excessively tired or weak
___	___	Had any trouble with skin sores
___	___	Had excessive itching
___	___	Gained or lost 5 pounds or weight or more
___	___	Had any chills or fever
___	___	Had any difficulty with your vision
___	___	Been troubled with double vision
___	___	Had a buzzing or ringing in your ears
___	___	Had severe nose bleeds
___	___	Had difficulty breathing through either side of your nose

Patient Name _____ Client No. _____

HAVE YOU RECENTLY (continued)

Yes	No	
___	___	Had any hoarseness
___	___	Had a bad cough
___	___	Had night sweats
___	___	Felt short of breath easily
___	___	Noticed anything unusual about your heart beat
___	___	Had pain in your chest
___	___	Had hand swell
___	___	Had cramps while walking
___	___	Had a loss of appretite
___	___	Had nausea or vomiting
___	___	Had bleeding gums
___	___	Do you have unusual thirst or hunger
___	___	Had feet or ankles swell

Yes	No	Don't Know	
___	___	_____	Are you very shy or sensitive
___	___	_____	Are your feelings easily hurt
___	___	_____	Are you easily restless
___	___	_____	Are you nervous or "keyed up" most of the time
___	___	_____	Is it difficult for you to relax
___	___	_____	Are you easily irritated and upset
___	___	_____	Are you often depressed or blue
___	___	_____	Do you cry easily
___	___	_____	Do you have any unusual fears
___	___	_____	Have you had nightmares
___	___	_____	Do you worry very much
___	___	_____	Do you reguard yourself as being nervous
___	___	_____	Have you ever been examined or treated for a nervous illness
___	___	_____	Have you ever had a nervous breakdown
___	___	_____	Are there any sexual matters of difficulties you would like to discuss
___	___	_____	Have you been married more than once
___	___	_____	Do you have any work problems which produce emotional stress
___	___	_____	Do you enjoy school work
___	___	_____	Do you enjoy on-job-training

I hereby give my consent for the following:

1. A physical examination
2. A blood test for blood chemistries and syphilis
3. Urinalysis to screen for abnormalities and drug content
4. Chest X-ray
5. Pregnancy test (female only)

I also understand that if my syphilis test or X-ray indicate the presence of communicable disease. The results will be released to the Department of Public Health for further confidential follow-up.

_____
Signature and Date

FOR FEMALES ONLY

Patient Name: ______________________ Client No. __________

Age of your first period ______________________
Is your period regular ______________________
Period occurs every ______________________
Usual flow: Normal __________ Heavy __________ Light __________
Has there been an: Increase ( ) Decrease ( ) in flow recently
Date of last normal period ______________________
Are you tensed or irritable before or during periods ______________________
Have you, within the past year, had vaginal bleeding other than at the time of your period __________
Are you or do you think you are pregnant ______________________
Age of first pregnancy __________ Number of living children __________
Date of Birth ______________________
How many Abortions ______ Dates ______ Miscarriages ______ Dates ______
Stillbirth ______ Dates ______
Do you feel you have an unusual amount of vaginal discharge or itching __________
Note: If you have ever been treated for a female disorder or been told you had any trouble with your female organs list here ______________________
Do you have hot flashes ______________________
Have your breasts recently changed in size ______________________
Have you recently had any breast discharge ______________________
When was your last pelvic (GYN or Vaginal) examination ______________________
Are you on birth control pills ______________________
What kind of pill __________ How long __________

* *

PROGRAM ON METHADONE IN MOTHERS AND INFANTS

Patient Name: ______________________ Referred by __________
ID No. ______________________ Date of referral __________
Date of Birth __________ Marital status ( ) M ( ) D ( ) Sep. ( ) W ( ) S
Address ______________________ with whom living __________
Telephone: Home __________ Work __________
For Emergency Contact ______________________ __________
Name Phone
Employment current ( ) Yes ( ) No Date begun __________
Highest grade completed __________ Medicaid ( ) Yes ( ) No ( ) Eligible
Other Insurance ______________________
Length Heroin use ______ length present habit ______ other drug use __________

clinic patient attends ______________________
Counselor ______________________ Nurse __________
Treatment received: Meth. Maint. ______ Detox ______ Other __________
Date Rx begun __________ ended __________
Prenatal care at clinic __________ Hospital __________ Private __________
Name

None __________ Date begun ______________________
Patient to deliver at ______________________ Hospital
Expected date of confinement __________ Patient requests abortion __________
Referred to ______________________

Exhibit 7

Volunteer Orientation/Training Format

Volunteer Orientation/Training Format

Day One

I Introduction to Clinic Staff

A. Brief remarks from administrator on purpose of center
B. Remarks from chief counselor, vocational rehabilitation specialist, and secretary on their functions in center

II Chief Counselor gives a one hour presentation on addiction focusing on:

A. Similarities and differences between opiate and non-opiate abusers
B. How the day-care center came into being and why it needs volunteers

III Chief counselor entertains questions for about one hour about addiction in general.

IV Break

V Chief Counselor explains the kinds of group and individual therapy utilized in clinic and answers questions (one and a half hours).

VI Closes session by giving each potential volunteer a packet of information about the center as well as volunteer applicant forms.

Day Two

I Introduction to Center

A. Tour of facility
B. Participation in informal rap session

II Lunch with participants

III Role-playing using aids referenced in Exhibit 5

IV Assignments to volunteers

Days Three-Five

Supervised assignments (supervision given by Chief Counselor)

Days Six-Eleven

Trial supervision by designated supervisor.

Exhibit 8

Outpatient Counseling Budget

Outpatient Abstinence Module

Description

The module designed for outpatient abstinence will be designed to treat 200 patients. We will assume that the clinic is open seven days a week, eight hours a day, with an average of three visits per week per client. The program would operate in the same way as the outpatient methadone program except that no medication will be dispensed in this unit. However, in an outpatient abstinence program there is a greater chance of more polydrug abusers attending the clinic. Thus, the budget will reflect decreased medical costs for staff but increased professional counseling which would be necessary in a polydrug setting. The cost of this unit could, without violation of any Federal regulations, be decreased by changing the days of operation to five days per week. However, because of the crisis nature of many of the polydrug abuser's problems, a seven-day-a-week clinic would be optimal. This clinic would rely heavily on those counseling techniques which are appropriate to the drug abuser, as there is no medication to be used as a supportive mechanism.

Outpatient Abstinence Module Budget

A. Personnel

Administrator	$ 18,000	
Secretary	$ 8,000	
Clerk-typist	$ 7,000	
One half-time psychiatrist	$ 14,000	
One clinical psychologist	$ 18,000	
One psychiatric social worker	$ 16,000	
One vocational rehabilitation specialist	$ 14,000	
Six counselors	$ 54,000	
Total	$149,000	
Employee benefits @ 10%	$ 14,900	
Total Personnel Costs	$163,900	$163,900

B. Consultants

Medical	5,000	$ 5,000

C. Travel

Staff	$ 1,000	
Clients	$ 1,500	
Total	$ 2,500	$ 2,500

D. Equipment

Office	$ 3,000	
Clinic	$ 2,000	
Total	$ 5,000	$ 5,000

E. Intake Medical Examinations

340 intake examinations assuming 1.7 dynamic to static capacity ratio @ $75 per examination	$ 25,500	$ 25,500

F. Other

Utilities and Communication	$ 1,800	
Rent	$ 10,000	
Supplies and Materials	$ 8,000	
Training	$ 1,500	
*Laboratory Services Contract	$ 32,500	$ 53,800
TOTAL OUTPATIENT ABSTINENCE MODULE BUDGET COSTS	$255,700	$255,700

*$32,500 assumes 250 urines per week tested at $2.50 per urine for 52 weeks.

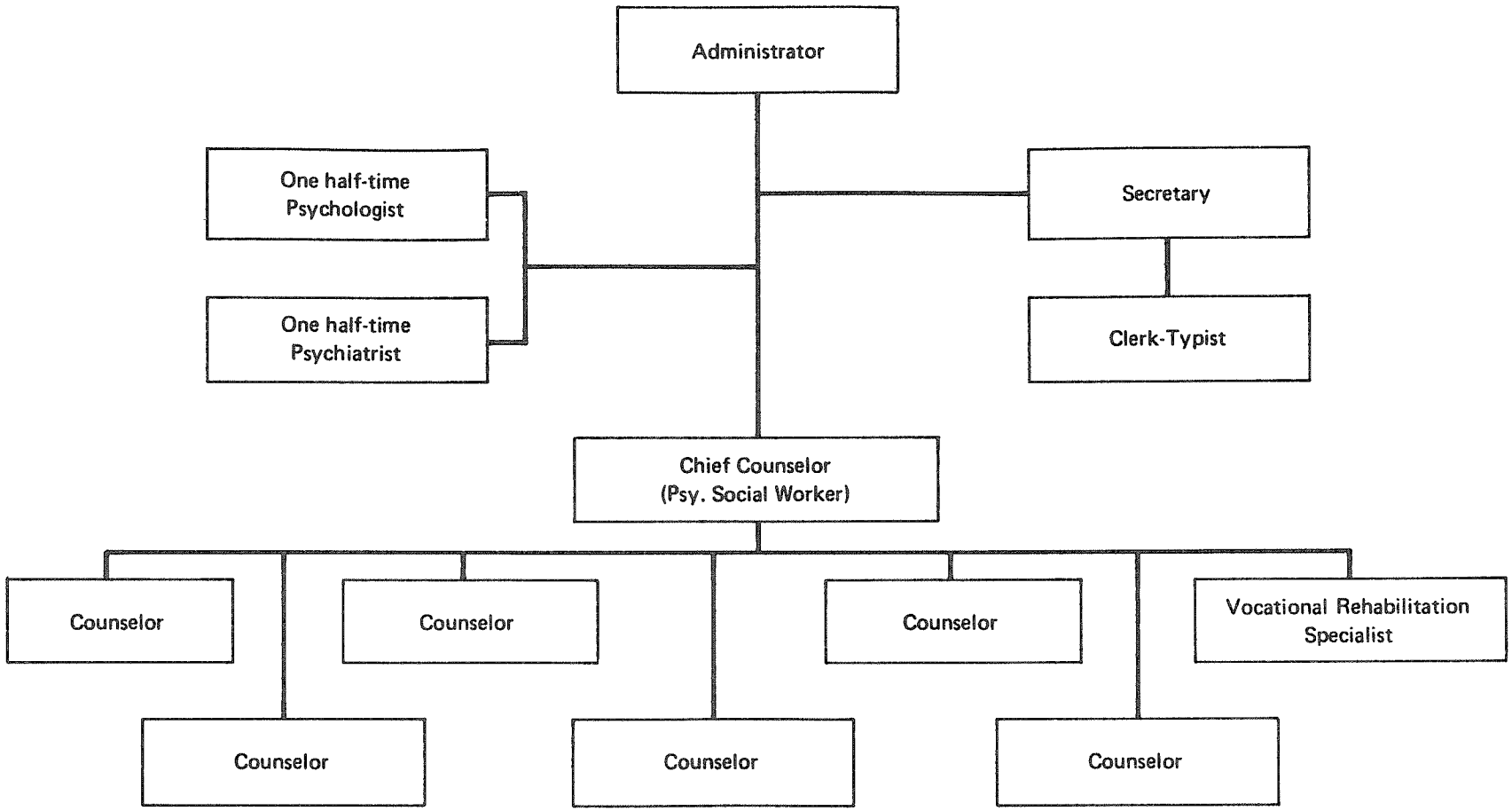
Budget Explanation

The total budget of $255,700 comes to a per client cost per year of $1,278. It is significant that there is a savings involved in the abstinence program because of the reduced medical staff.

Exhibit 9

Outpatient Organizational Chart

Outpatient Drug-Free



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