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CHANGES IN THE LAST TEN YEARS IN SUBSTANCE ABUSE COUNSELING

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In order to give a complete picture of the changes in counseling substance abuse clients in the last ten years I believe it's appropriate to discuss many other important aspects of substance abuse that make up what led to the changes we have seen. Accordingly, we will discuss the following:

- **The effects and cost in lives and money;**
- **The history and subsequent problems that exist in substance abuse counseling and treatment;**
- **The cost of counseling and/or treatment;**
- **Changes that have occurred in the last ten years;**
- **What is to be done?**

For the purposes of simplicity treatment, counseling, and therapy will be used interchangeably in this paper unless otherwise noted.

Any discussion regarding changes in substance abuse counseling, therapy, or treatment must begin with an explanation of **the effects and costs in lives and money** related to alcoholism and drug abuse in the United States.

Before we discuss financial costs I believe it's imperative that we discuss the effects, both from a prevalence of use and from a fatality perspective, of drug and alcohol abuse on Americans. According to the Centers for Disease Control and Prevention (CDC), 52% of Americans over the age of eighteen describe themselves as "current regular drinkers" (CDC, Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2009). Regular drinkers are described as those who drank at least twelve drinks in the last year. Perhaps more importantly, according to the CDC, 14,406 people died in 2007 from alcohol-related liver disease

deaths, along with 23,199 deaths attributed to other alcohol-induced deaths, excluding accidents and homicides (CDC, National Vital Statistics Reports, 2010). Additionally, 38,371 people died of drug-induced causes (CDC, National Vital Statistics Reports, 2010). This is not just an American problem. Throughout the world, alcoholism accounts for 4% of the "global disease burden" (World Health Organization, 2002). While these statistics are staggering, it is important to note that they don't include deaths and other physical and emotional wreckage *caused* by those under the influence of alcohol or drugs, in the commission of a crime involving alcohol or drugs, or deaths that occurred in the procurement of drugs.

The effects of statistics such as those seen above in comparison to other disease-related deaths paint an even grimmer picture. For example, in a 2004 article in the Journal of the American Medical Association (Mokdad, Marks, Stroup, & Gerberding, 2004) the writers describe deaths related to "indulgence". Their findings showed that in 2000 illicit drugs were identified as the direct cause of 17,000 deaths. In comparison, alcohol directly led to the deaths of 85,000 people that year. That means that five times as many people died from alcohol than from illicit drugs. In short, alcohol is the number one drug problem in America besides addiction to nicotine (Learn-About-Alcoholism.com, 2009). Not surprisingly, the largest number of "indulgence-related" deaths were attributed to smoking, 435,000, more than five times as many as alcohol (Mokdad, Marks, Stroup, & Gerberding, 2004). None of these statistics show the true depth of the problem though. Many deaths are reported as accidents, such as falling in one's own home, but not reported as alcohol-related. Additionally, suicides are also often related to alcohol and drug use or performed by those under the influence, though not reported that way. Finally in this area, alcohol and drugs play a leading role in deaths from other causes which are not directly reported. Heart attacks, strokes and tobacco use are a prime example of this. A

comparison of smokers attending residential treatment centers or 12-step meetings with the average population would show a marked higher percentage of smokers in those populations, although I'm not aware of any specific studies on the matter. Cigarette smoking also acts as a proponent of cirrhosis of the liver. Studies have found that alcoholics who smoke a pack or more of cigarettes per day have a three times higher risk of developing cirrhosis, in comparison to non-smoking alcoholics (NIAAA, 1997). It is believed that approximately 10% of those diagnosed as alcoholics will develop cirrhosis of the liver (Benshoff & Janikowski, 2000), a dangerous condition that can lead to a painful death.

What does this mean? Counseling and treatment for alcoholics and drug abusers is desperately needed to stem the tide. According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2002), on any given day approximately one million people in the United States received treatment or counseling for alcohol or other drugs (AOD). Nearly half were in treatment for both alcohol and drugs, while 29% were in for drug abuse only and 23% were in for alcohol only. At the same time 4.7 million people were in need of treatment (Office of Applied Studies, (2002). Finally, 14 million Americans have alcohol abuse or alcohol dependence problems according to the National Institute on Alcohol Abuse and Alcoholism (NIAAA, (2000). Clearly there is a problem that is not adequately being addressed.

The financial costs of substance abuse (including alcoholism) are many-fold. They include the cost of lost productivity at work, effects on the crime rate, the cost of housing inmates in jails and prisons, the cost of emergency hospital visits, treatment, and ongoing expenses relative to outpatient treatment of substance abusers. This is, by far, not an all-inclusive list of costs associated with the diseases of alcoholism or substance abuse. However,

they are the largest expenses and will serve to illustrate the effect of drugs and alcohol on the economy and society as a whole.

According to a 2004 article in U.S. News & World Report, productivity is negatively affected by an astronomical $134 billion annually due to alcohol use. This is due to on-the-job accidents, compensation claims, and absenteeism (Brink, 2004). Alcohol and other drugs (AOD) of abuse are believed to result in a loss of motivation. Specifically, they result in the loss of a need to achieve or have fun. The brain is too busy storing the emotional memories of the high that was originally produced (Johnson, 2004).

Finally, in this area, there is no productivity loss measure that I'm aware of for those who come to work impaired in some way due to the effects of alcohol use the previous night. This number would assuredly be very high, if measurable, particularly on Fridays, Mondays, and in industries where alcohol is served as part of the normal business. In addition to lost productivity, the costs associated with healthcare and automobile accidents relative to alcohol misuse add another $185 billion (National Institute on Alcohol Abuse and Alcoholism, NIAAA, 2006). This at a time where health insurance coverage for substance abuse treatment, especially residential treatment, is inexorably moving towards minimal coverage. This will be discussed further in this paper.

Finally regarding substance-related deaths, the age of death as a result of overdose has continued to rise steadily over the last four decades. An article in *Psychiatric Times* (Sherer, 2006) shows statistics based in California that the average drug overdose death occurred in 1970 at the age of 22. That number rose to 32 in 1985, and 43 in 2005. On a nationwide basis it is estimated that people aged 35 to 54 make up more than half of drug deaths at this time (van

Wormer & Davis, 2008). This is another important issue that will be discussed further regarding treatment and counseling in 2011.

The history and subsequent problems that exist in substance abuse counseling and treatment shows that empirical research has not had the same effect on the substance abuse field as it has on other disciplines. This is true even though research and related knowledge about alcohol and other drug addiction burgeoned in the 1990s; however, this knowledge has been little used to guide addiction treatment. Specifically, there exists an ideology and folk wisdom in substance abuse treatment that doesn't occur to the same degree in other fields. The gap has grown so great that the National Institute on Alcohol Abuse and Alcoholism (NIAAA) sponsored a 1990 conference entitled "Linking Alcoholism Treatment Research with Clinical Practice" (Gordis, 1991). In theory, alcohol researchers seek knowledge about alcohol-related health conditions, and practitioners use this knowledge to help their patients recover. In practice, however, we often find that alcohol researchers and alcohol practitioners travel in two largely unrelated circles; they speak different languages, attend different meetings, and generally view problems, and their solutions, from very different perspectives. (Gordis, 1991).

For example, there has been a long-held belief that unlike other disciplines, substance abuse counselors and therapists need to be in recovery themselves. One of the single greatest barriers to integrating theory, research, and clinical practice is this strong tradition within most treatment communities of relying on personal experience, clinical anecdotes, and testimonials to help others. Counselors self-disclose for credibility purposes. Furthermore, they tend to rigidly cling to their favorite theory, most often without a full understanding of all its concepts and implications. At the same time, other theories may be unwittingly disregarded. Clearly, the classic disease models have helped many individuals who are chemically dependent. However,

as judged by the large number of people with addictions who refuse treatment, drop out of treatment, and/or relapse, it can be reasonably asserted that these models are not a "good fit" for many, or perhaps even most, individuals with chemical dependencies. It is imperative that practitioners consider alternative models of recovery for clients who cannot work within the disease model (Scott, 2000).

It is the above type of belief, or folk wisdom if you will, that has led to many non-recovering researchers and therapists to cast a jaundiced eye towards the discipline of substance abuse counseling. That being said, many writers have described the alcoholic as defiant and manipulative to an extreme degree (Wilson, 1939). Supporters of this type of "folk wisdom" will argue that it takes being in recovery and having "been there" for a therapist to not easily be manipulated by the newly-sober alcoholic and drug addict. The defiance mentioned above comes out quickly because addicts and alcoholics will find any excuse to not trust a counselor due to the fact that in the final analysis they don't really want to be abstinent, they have just tired of the consequences associated with drinking and using.

Another major issue that exists within the profession is a lack of agreement on professional credentials. Secondary to that is a strict adherence to demanding the credentials of every counselor within a treatment center. A review of websites for South Florida treatment centers shows that many people who call themselves therapists are not, and some that are credentialed have allowed their credentials to expire. This should be not be allowed to continue.

The clinical standards for providing addiction counseling have historically been lower than those necessary to perform other kinds of counseling. In many states, the minimum formal education requirements for entry-level addictions counselors do not even include the

baccalaureate degree. Moreover, some states exempt addictions treatment personnel from licensure or other standards, and some states have developed separate standards for individuals counseling clients with addiction problems (George, 1990).

For most counseling-related professions, the standard is that counselors providing treatment should have a master's degree or higher, and, where required, they should meet the licensure standards as professional counselors (Cottone & Robine, 1998). As the research on addictive behaviors unfolds, its complexity becomes increasingly evident. Because of this, it is important that counselors working in the addictions field have specialized training in many complex areas, including both chemical and behavioral addictions, relapse prevention and other cognitive strategies, neuropsychological processes in addiction, assessment, and individualized treatment planning. Further, because treatment practices have changed very little, even though there is training available in these areas, treatment plans are typically uniform rather than individualized for people based on their personal needs and clinical presentation.

Given the current state of knowledge regarding the complexity of the addictive process related to both chemical and behavioral addictions, not only should addictions counselors be held to the same standards as other counseling professionals, they should also have the necessary specialized coursework, continuing education, and experience necessary to keep them literate in and abreast of current information about addiction and its treatment. Of course, higher education bears some responsibility in this area as most Master’s level Mental Health or Rehab Counseling programs offer only one substance abuse related class.

Several credentials can be obtained as an adjunct to a master's degree. The National Board of Certified Counselors (NBCC) offers a specialty designation of master of addiction

counseling (MAC). This credential requires the broader certification of the sponsoring certifying board and in addition may require specialty coursework or continuing education related to addictions or chemical dependency treatment, experience under supervision in a setting where addictions are treated, and/or passing a specialty examination developed by the board. Unfortunately, most treatment centers don't recognize the NBCC or the CRCC, for that matter. Very few people become credentialed in this manner because the recovering person who becomes a counselor often only has a high school diploma prior to beginning their training. They then become "interns" to gain enough hours to take the state licensing test. In the state of Florida the state license designation most commonly attained is the Certified Addiction Professional. Six thousand hours of training and a passing grade on the exam are necessary for certification (Florida Certification Board, 2011).

As far as history is concerned, most lay people believe that alcohol and drug treatment began with Alcoholics Anonymous (A.A.). While there is some truth to this, in the early days alcoholics did not go to treatment centers through A.A., they simply went through a detoxification process, usually in their local hospital, and then went to A.A. meetings in hopes of staying sober. Supporters of A.A. and other twelve-step groups, believe it is the most effective way of treating addiction and should be the primary "treatment program" (McCaul & Furst, 1994). The more conservative proponent of A.A. would say that it is best used as a support to supplement professional treatment services (Lewis, Dana, & Blevins, 1988). Accordingly, it became the norm that clients needing help with alcoholism or substance abuse were referred, and still are, to twelve-step support groups either in lieu of professional help or as supportive to professional treatment (Johnson, 2004). Recent studies back up the wisdom of the referrals. A study conducted in 2009 showed that rates of abstinence among attendees of Alcoholics

Anonymous were twice as high as those attempting to stop drinking without A.A. The same study showed that higher levels of attendance showed an even higher rate of abstinence (Kaskutas, 2009). However, studies have also shown that attendance tends to drop off over time, perhaps when a client becomes complacent, believing he no longer has to go to meetings. A 2011 conference/study found that a large majority of twelve step meeting attendees (between 85% and 91%) stopped attending for at least a month or longer after their abstinence had been established (Krentzman, et al., 2011).

Prior to A.A., the first group of its kind to have long term success, there were various temperance groups that ultimately led to the Oxford Group. The Oxford Group, was religious in nature and the fervor surrounding it, along with the politics and power struggles within the group ultimately brought it down. The Oxford Group was used to some degree as a model by Bill Wilson and Bob Smith when they started Alcoholics Anonymous (Alcoholics Anonymous, 1939), but Bill Wilson was convinced by others in his group to stay away from concentrating the group on God and religion. He was finally convinced to refer to God as one's own definition of their higher power so that people would not be intimidated by what might be seen as a cult or highly religious group. To this day, many newcomers to A.A. struggle with the thought that it may be a cult that brainwashes its members into believing in God, even though Bill Wilson made every attempt to downplay that. However, Alcoholics Anonymous says that alcoholism is a progressive, often fatal, disease that is incurable and can only be arrested on a day to day basis through a "spiritual awakening" (Alcoholics Anonymous World Services, 2001). Statements like these, in what the fellowship calls the "Big Book" make it hard for some to not believe that it's a religious cult. Furthermore, because Alcoholics Anonymous began two years after the end of national Prohibition many still believe that it is philosophically a direct extension of the political

and religious beliefs that drove the temperance movement (Bufe, 1991), which was also seen as cult-like. Another way that A.A. defines itself as not being cult-like is to state that recovered alcoholics have the "spiritual awakening" mentioned above. They try to be careful that this is not to be confused with religion as they make a clear distinction between spirituality and religion (Wallace, 1996). A. A. states that the difference between spirituality and religion is that spirituality refers to one's own relationship with their higher power and that religion refers one to a specific god of their individual religion. Alcoholics Anonymous identifies with no specific religious group or doctrine (Alcoholics Anonymous, 1981).

Finally regarding Alcoholics Anonymous, Bill Wilson and Bob Smith set it up as an organization with very little organization. There was no president or bosses, just "trusted servants" who helped to organize and run meetings (Alcoholics Anonymous, 1953). In fact, A.A. literature states that they have "no officers or executives who wield power or authority over the Fellowship" (Alcoholics Anonymous, 1952). This system has worked for more than seventy years. Today A.A. has over 115,000 independent groups throughout the world, with over 2,100,000 members (Alcoholics Anonymous, 2011). An additional push towards A.A. membership has come from drug courts, treatment center promotions, and counselor referrals (Humphrey & Moos, 1996).

The next major event in the treatment and counseling of alcoholics and other drug abusers was the opening of the Hazelden Treatment Center in Minnesota in 1949. They developed what later became known as the Minnesota Model, an amalgamation of several different approaches including therapy, spirituality, group treatment, and the Twelve Steps (White, 1998). At Hazeldon they integrated recovering, nonprofessionally trained, counselors as part of the alcoholism treatment team, the key component of this model. However, groups were

confrontational and harsh. The advent of "harm reduction" in the 1980s was instrumental in causing Hazelden to change its confrontational approach, making it more appealing to prospective clients. Hazeldon has since evolved to perhaps the most well respected alcohol and drug abuse organization in the world, with many campuses, a publishing arm, and a well-earned reputation for excellence.

Today most residential treatment centers are a variation of the Minnesota Model. That is, most revolve around five specific areas that they believe will help a client to reach and sustain abstinence, while promoting twelve-step meeting attendance as part of aftercare planning. A nationwide review of treatment centers show that 96% use substance abuse counseling as part of their program; 87% teach relapse prevention; 66% use cognitive-behavioral therapy; 56% either take clients to 12-step meetings or bring the meetings to the treatment center; and, 55% conduct motivational interviewing (SAMHSA, 2010). Additional services such as anger management, trauma therapy, meditation instruction, family counseling, and a myriad of other services are available from many treatment centers.

During the mid to late 1950's two major events occurred. The first was in 1956 when the American Medical Association designated alcoholism as a disease. This was the event that forced insurance companies to pay for treatment. That was soon followed by the development of the "disease concept" of alcoholism developed by E. Morton Jellinek. Subsequently he designed the alcoholics Jellinek's Curve, a chart which tracked the progression of the disease from "occasional relief drinking" through various stages where the alcoholic would hit his bottom at "obsessive drinking in vicious circles". This would be followed by either the alcoholic going on to a painful death or his acknowledgement of his "illness" and the beginning of his recovery (Jellinek, 1960).

By the late 1970's alcohol and drug treatment had hit the "big time". Betty Ford had admitted that she was an alcoholic, got sober, and ultimately put her name on the Betty Ford Clinic in Rancho Mirage, California. It was during this time that twenty-eight day treatment became the norm and we were beginning to approach what treatment is today. Because the American Medical Association had designated alcoholism as a disease during the 1950s, insurance companies were left with no choice but to pay for treatment. Treatment centers began to emerge all over the country and suddenly the treatment of alcoholics and drug abusers was an industry unto itself (White, 1998). As of May, 2009 there were over 11,000 treatment centers in operation in the United States (SAMHSA, 2009).

The final major step towards alcohol and drug treatment or counseling as we know it today was the advent of "harm reduction". The first treatment using harm reduction that was specific to addiction began in the 1980s in conjunction with the spread of Acquired Immune Deficiency Syndrome (AIDS). A grass roots movement began in England and Australia that encouraged intravenous drug users to modify their behavior in hopes of saving lives that were being lost to AIDS. The term "harm reduction" began as a strategy for drug users who were unwilling or unable to stop using (Butler, 2002). It was thought that through therapeutic techniques a counselor could help addicts to use their inner strengths and natural resources to avoid the disease. These strategies did not necessarily reduce the use of drugs, but were aimed at using in a way that would not put the user at risk of AIDS (Butler & Mayock, 2005).

"Harm reduction" eventually took on meaning in regards to drugs that were not associated with the transmission of AIDS. For example, with regards to alcoholism harm reduction focused on designated driver programs and moderate versus binge drinking. During this time motivational therapy was introduced in England by William Miller, an American

psychologist (Miller, 1996). This was considered an important advancement in the treatment of addiction because it de-emphasized the use of negative labels and viewed substance abusers as having the ability to change as the rest of the population can (Barber, 2002). As stated earlier, this was a major contributor to Hazelden becoming the pre-eminent substance abuse organization in the world.

During the 1980s and 1990s the positive feelings towards treatment ended, ushering in a period of approximately fifteen years of anti-treatment backlash. This was caused in part by the Reagan administration's zero tolerance policy and several books which scoffed at the notion that alcoholics and drug addicts could be rehabilitated. One book in particular that was hurtful to the cause was entitled *Heavy Drinking: The Myth of Alcoholism as a Disease* (Fingarette, 1988). This was at a time when Nancy Reagan was saying "Just Say No" to drugs, leading many in the mainstream to believe that alcoholics and drug addicts had a choice. This was followed by a deluge of articles and books and ultimately insurance companies began to balk on payment for treatment services. As one would expect, many treatment centers began to close.

An additional problem that came to light during this period was the fact that there is no agreed upon standard that measures success of treatment. As van Wormer and Davis (2008) stated, for years researchers have argued about what scientific research says about treatment and clinical recovery rates. Many tie Alcoholics Anonymous or Narcotics Anonymous attendance to successful outcomes, but there is no consistency in an approach to what a successful outcome is. Many counselors believe that regular attendance at A.A. meetings or other twelve-step groups is the single most effective form of treatment (McCaul & Furst, 1994). Formal studies have, for the most part, failed to bear this out (Marvel, 1995). Whether studies have failed to prove the effectiveness conclusively, one way or the other (Watson et al., 1997), how can one make any

inference of the studies if, as stated above, there is no agreed upon standard to measure success. If one looks at standards on a much smaller basis, asking five independent treatment centers what they deem is a successful outcome, you are likely to get five different answers. This is generally believed to be due to the low rate of complete abstinence from alcohol and/or drugs for one, two, or five year periods after completing treatment. Some treatment centers believe that a "slip" is to be expected in the first or second year. Others believe that two are expected. It is generally thought that if you ask the operator of a treatment center what his success rate is he will tell you whatever it takes to shed the most positive light on his center. Standardization is desperately needed in this area in order to compare success rates or any consistent treatment effectiveness analysis. van Wormer and Davis (2008) believe that treatment effectiveness should be measured in a more "big picture" way. It should include an evaluation of improvement in the area of reduced healthcare needs, less dependence, lowered crime rates, successful employment, and an improvement of social and economic problems where they previously existed (van Wormer & Davis, 2008). Additionally, as stated earlier, it is believed that successful substance abuse treatment can have positive effects on criminal behavior, family functioning, and mental health, in addition to those areas mentioned above (Belenko, Patapis, & French, 2005).

In a 2001 Newsweek article Jonathan Alter reviewed studies showing that those who remain in treatment for at least one year are more than twice as likely as short-termers to remain clean and sober (Alter, 2001). In another article, written by Miller and Hester (1986), 26 controlled studies were reviewed and it was found that the most significant factor in successful treatment outcome was length of time in treatment (Miller & Hester, 1986). Clients were found to have a better chance of achieving long-term sobriety when they remained in treatment for one year or more. There are other studies that have shown similar findings leaving one to understand

that longer treatment equals longer abstinence. But how can someone submit to long-term treatment based on the cost, lack of willingness from third-party payers, and the disruption to one's life?

Although empirical evidence may not agree with them, treatment centers around the country continue the practice of twenty-eight day programs, as they have for the last fifty years. Why is this? I believe there are several justifications for staying with twenty-eight days, but in the final analysis, it usually amounts to money.

First, twenty-eight day programs have been around so long that a lot of assumptions are made about their success. Second, it is very hard to get someone to give up their life for a month. Any longer is out of the question for many people. If long-term treatment means residential treatment for the entire length of the treatment then twenty eight days is the most one can reasonably hope for. Third, and most telling, it is the longest period that third-party payers will approve for payment. Even twenty-eight days is now becoming a scarcity as far as third party payment is concerned.

In order to look at **the cost of counseling and treatment** one must look at all the forms of treatment available. For many clients who have reached the point that they feel they need counseling or treatment it begins with detoxification. This is particularly true if the client has a long and/or chronic history of drug abuse or has been abusing drugs known to cause physical dependence (Johnson, J. L., 2004). Although the detoxification process itself is not considered "treatment" (Mattick & Hall, 1996), it is necessary to medically stabilize the client so that he can ultimately move on to another course of treatment when the painful process of withdrawal has

been completed. This may take between three and twelve days depending on the length of time the drug has been abused and the type of drug used.

Detoxification is the most expensive form of "treatment" due to the fact that it takes place under the supervision of a doctor, often in a hospital. Residential treatment facilities that do not offer detoxification generally have a referral agreement with hospital-based detox facilities. In the last ten years detoxification has become an entire business unto itself, separate from other treatment facilities because of the cost ($600 to $1200) per day and subsequent profitability, and the fact that because it is medically supervised insurers are willing to pay for it. Additionally, detox facilities have found that there is a significant income to be made from referring those in detox to treatment centers. This is not really ethical, but it happens as a normal course of business.

As in other forms of substance abuse treatment, insurance changes have had their effect on detoxification through the limits added to payment. Accordingly, in recent years physicians have begun to allow detox to occur on an outpatient basis if there is no immediate threat to the client's life (Mattick & Hall, 1996). For alcoholic patients it has been found that in excess of 90% can be detoxified on an outpatient basis (Abbott, Quinn, & Knox, 1995). This phenomenon has created the terms "ambulatory detox" (National Academy of Sciences, 1990) or "social detox" (Mattick & Hall, 1996). The problem with these types of detoxifications goes beyond the potential dangers. They also allow the alcoholic or drug user to continue to abuse their drug of choice when they are supposed to be withdrawing from it, thereby nullifying the detox.

Outpatient, or individual counseling is a form of treatment that is popular for many reasons, the first being the cost. Out-patient counseling can vary in price from free for

community based agencies, to $200 per hour for non-specialized treatment in South Florida. Specialized treatment regarding trauma for a substance abuse client can range as high as $750 per hour. Insurance often does not cover this cost, or if it does, only a very small part.

Additionally, outpatient treatment is generally very flexible and offers clients a less restrictive environment (Turbo, 1989). Third, because clients remain at home there is no reorientation period when they return home (Youngstrom, 1990). Finally, outpatient treatment has no time limitation, and can last semi-permanently. Since many claim that treatment should last at least one year (Nace, 1987), it can also be used to help the client with relapse prevention in the latter stages of outpatient treatment. For the alcoholic or drug addict who has hit a substantial "bottom" outpatient treatment appears to work best as an adjunct to inpatient or residential care (Johnson, 2004).

An innovation that has occurred in the last ten years or so has been Intensive Outpatient Treatment (IOP). There are many reasons for this. Prior to the advent of IOPs clients who required more intensive services than were available in outpatient programs were restricted to inpatient (hospitalization), or more commonly, residential treatment. Also, once residential treatment was completed there was no availability for any counseling between residential and outpatient. Intensive Outpatient treatment filled that gap by providing more structure than outpatient treatment for those that no longer required residential care. IOPs also allowed for providers to tailor their services to meet the needs of the individual client. Initially insurance companies vacillated on whether to pay for IOPs (Johnson, 2004). In the last ten years they have proven to be worthwhile, money-saving, and attractive to those who see a need for the bridge of treatment between residential and outpatient. Insurance companies have come to like them enough to try to get clients to use IOPs instead of residential treatment and will therefore pay

more easily for Intensive Outpatient treatment. As you would expect, this is due to cost. The price for an IOP is generally between $150 and $300 per day, with treatment occurring three to four days per week. For substance abuse it is generally considered the easiest method to receive third party payment. This is somewhat curious because, although there have been few if any outcome studies to determine effectiveness, within the industry IOPs are considered to have the poorest success rate. A very small percentage of clients stay abstinent, yet it is very popular with the client because it allows him to not lose time from work, not be away from his family, and have the highest portion paid for by insurance. However, many of the difficulties that exist in IOPs are related to the fact that each day at the end of treatment the client has the ability to go into the same environments that exacerbated their problem. The industry has a saying for this that one "must stay away from people, places, and things" which is hard to do, while still trying to have a normal life. Often the relapse happens while they are in treatment. Residential treatment brings the client out of that environment into a twenty-four hour therapeutic environment that is conducive to recovery. Perhaps if insurance companies would realize that IOP's are a part of treatment, not the entire thing, IOPs would be used as they were designed, a bridge, making treatment long term. As in other aspects of substance abuse, looking at raw dollars keeps the decision makers from making any decision that doesn't immediately show them to be saving money. This is short-sighted because invariably the client ends up in residential treatment after he has failed at Intensive Outpatient treatment. When empirical studies are done on IOPs these factors should be taken into consideration in order to get a proper view of whether or not IOPs work.

Therefore, the most consistently successful form of counseling and treatment has been thought to be twenty-eight day, residential treatment. There appears to be no scientific reason

why twenty-eight days is the required length. The *Minnesota Model* was based on 28 days (Larson, 1982) and it became the basis for which other treatment centers built their services, Over the years it has become the industry standard even though there is no empirical evidence to suggest better outcomes (Miller & Hester, 1986). In fact, many professionals and lay people alike began believing that 28 days of residential care were required for successful treatment. Even the movie industry produced feature-length movies about alcoholism and substance abuse that were based on the 28-day model with the thought that it was the requirement. In fact, twenty-eight days became the standard because of the limits imposed by major health insurance carriers (Klar, 1987). The insurance companies' influence, through their payment approval, led the Minnesota Model to become the industry standard. Some of the positive aspects of this approach are that the "model" is based on abstinence, it's comprehensive, and has a multi-professional approach to treatment based on the principles of Alcoholics Anonymous (Cook, 1988). Unfortunately, over the last ten years insurers have reduced benefits for residential treatment, in many cases down to seven days of primary residential care. In fact, treatment centers are now in a position that they have to do "pre-certification" for insurance payment for new patients that will generally allow only the first five days of treatment. Additional care is then approved on a case by case basis. This puts the added burden and cost on the treatment center of having to report to third party payers every third day. Most treatment centers now employ insurance specialists to deal with this. Who ultimately pays for that? In the final analysis it's the client, or his employer, whose insurance rates go up or his treatment shortened due to the limits imposed by the insurer.

Positive outcomes in substance abuse counseling and treatment do not *only* positively affect the individual client and his family, they also affect the community he or she lives in.

Substance abuse treatment continues to get the short shrift regarding states and insurance companies paying for treatment even though studies have shown more global effects. In 2006 the results of the California Treatment Outcome Project, a study based on 43 treatment centers, showed that the resultant drop in the crime rate caused the states to receive approximately a $7 return for every $1 spent (Ettner et al., 2006). Other studies throughout the United States show that this is not limited to one area of the country, but is similar in virtually every state (van Wormer & Davis, 2008).

Spending money on treatment appears to be myopic. It seems politicians don't want to be viewed as pandering to a part of society that many people want to ignore. According to a report from the Treatment Research Institute conducted by Belenko, et al (2005), only 26% of those needing substance abuse treatment and counseling actually receive it. The single biggest reason (42%) alcoholics do not seek treatment is that they are not ready to stop using drugs or alcohol (SAMHSA, 2009). This is closely followed by cost/insurance barriers, at 34.5%, and social stigma, at 18.8% (SAMHSA, 2009). Furthermore, the above study also reviews the prison population. It states that only 10-15% of those in state prisons receive treatment. These findings also state that approximately 80% of state prison inmates are in need of substance abuse treatment. Politicians however, have chosen the more expensive method of "shoveling up" the wreckage caused by substance abuse according to the Center on Addiction and Substance Abuse (Alter, 2001). This has led to 70% of the federal government's expenditure on the drug problem to law enforcement and only 30% to prevention and treatment (Drug Policy Alliance, 2003). Clearly the authorities are more interested in criminalizing the misuse of drugs and alcohol and focus on punishment instead of rehabilitation.

There have been very few substantive, positive **changes that have occurred in the last ten years.** As stated earlier, the substance abuse field is one that is steeped in folk wisdom that has been passed down for the last six decades. If anything, strong feelings between researchers and practitioners have increased. There seems to be no willingness to find common ground. Researchers continue to perform studies and write about them, while practitioners don't take them seriously because, for the most part, they "are not in the trenches" and most importantly, "aren't one of us". I don't see this changing any time soon. Treatment centers still balk at hiring people who are not in recovery. Private practice counselors are generally in recovery themselves because it is their passion to help others like them that drove them to become counselors in the first place. Additionally, most counselors in recovery have not reached the higher levels of education that help them to understand the researcher's point of view. That being said, below you will find the changes that have occurred in the last ten years in substance abuse counseling and treatment:

- An ever-decreasing willingness of insurers to pay for substance abuse counseling and treatment. Treatment centers are now put in the position of exaggerating or outright lying about a patient's condition in order to get them certified for insurance coverage. Additionally, the cost of service continues to increase because service providers have to hire people whose sole job is to deal with the third party payers;
- A plethora of Intensive Outpatient treatment centers have opened, either as extensions of residential treatment centers or by under-educated and under-trained counselors who see them as the only opportunity to continue to be paid by

insurance companies. As stated earlier, this is curious due to the fact that IOPs are generally considered to not be having long term effects on clients;

On a positive note, there have been some positive changes that may ultimately provide more positive outcomes for substance abuse clients. In some cases the sole purpose for the changes are to get a competitive advantage over other treatment centers. Below are the changes I believe will have a lasting, positive effect on the treatment of alcoholics and substance abusers:

- **Rapid Resolution Therapy** – Rapid Resolution Therapy is a form of hypnosis that trains a client's mind to leave the past where it belongs, in the past, often in one session. It has worked particularly well with alcoholics and substance abusers due to the fact that many of them have suffered abuse and other traumatic events in their lives which they continue to dwell on many years later.
- **Light and Sound Entrainment** – Light and sound entrainment is a system where headphones and goggles are worn to produce sounds and light waves that are manipulated depending on what the client is suffering from. For example, many substance abuse patients suffer from ruminating thoughts and cravings when they are new to treatment. There are settings for each of these problems which can help stabilize a new client. There are also settings which help someone concentrate, sleep, and various other positive changes in their brainwaves.
- **Life Coaching** – Many alcoholics and substance abusers don't know how to cope with life because they are emotionally stunted. Life coaching can help them deal with everyday problems, as well as resume' writing, job interviewing, dressing appropriately, and even balancing a checkbook.

- **"Toothbrush Therapy"** – Toothbrush Therapy is a method which teaches a client how to stay sober after they have left treatment. It includes disciplining oneself to do five things every day; pray and meditate, read four pages of sobriety literature, go to a twelve step meeting, talk to another alcoholic or addict; and prior to going to bed, writing a five point gratitude list in the form of a thank-you letter to one's higher power.
- **12-step programs** - especially Alcoholics Anonymous, continue to grow in treatment. Although there was a period during the nineties when treatment centers began to shun 12-step groups, the pendulum has swung back. The treatment industry understands that although A.A. and N.A. have their problems, they still have a higher "success" rate than other aftercare options that have been available. A visit to any recovery "clubhouse" on any given evening will see two to four vans full of residential patients being dropped off for meetings while they are in treatment.
- **Acupuncture** – Although acupuncture was introduced to alcohol and drug treatment in the 1970s it initially caught on slowly. Recently however, acupuncture was identified as one of the fastest growing complementary or alternative forms of treatment covered by private insurance companies. Acupuncture is used mostly during the detoxification stage of treatment to relieve the physical symptoms of withdrawal. Additionally, it has been found to increase feelings of relaxation during therapeutic rehabilitation and relieve or prevent cravings during relapse prevention. It has proven to be low-risk and low-cost

therapy that does not require medication, produces no side effects, and causes little to no discomfort (SAMSHA, 2009b).

- **H.I.V. testing and prevention** – An alcoholic or substance abuser generally acts in an irresponsible way under the influence. Therefore, most states have mandated that H.I.V. testing and prevention classes occur in residential treatment so that the client can find out if he has been exposed or afflicted. Additionally, the client is taught preventative measures.
- **Treatment is becoming more focused on the aging population** – As baby boomers age the average age of clients receiving treatment for alcoholism and substance abuse has grown. Furthermore, researchers project that for those over the age of fifty, alcohol and drug abuse will triple by 2020. Abuse of prescription medications by older adults will double in that time. It is estimated that 5,000,000 older adults will need treatment in 2020 (Gfroerer, et al., 2003). As stated earlier in this paper, the average age of an overdose victim has risen, as has the average age of those seeking treatment before succumbing to overdose. Society has easily disregarded elder alcoholism in the past, but integration of substance abuse treatment into primary care has proven viable (Lee, Mericale, Ayalon, & Arean, 2009). In the past few programs provided treatment services for elders. This has begun to change as Hazeldon has led the way creating elder-specific programs. As of 2004, it was estimated that 17.7% of drug and alcohol treatment facilities offered such programs (Gunter & Arndt, 2004). This number will continue to grow as demand grows.

What is to be done about all the issues in substance abuse counseling? While long term treatment, six months or more, has been far and away the most successful, who is to pay for that length of treatment? As stated above, insurance companies balk at even paying for twenty-eight days. This is short sighted based on many factors previously outlined. I believe the only way to bring all the differing parties together would be a summit of some sorts as occurred in 1990 (Gordis, 1991). This occurred again in 1998 when the Center for Substance Abuse Treatment convened the Washington Circle for the purpose of creating a group of providers, researchers, managed care representatives and public policymakers for the purpose of creating standardized performance measures for people who are seeking counseling and treatment for alcoholism and drug abuse McCorry, et al., 2000). However, standardized performance measures are not enough. There needs to be a review of all forms of treatment and standardization across all aspects. I propose that if the top researchers in the field submitted their findings and recommendations, along with clinicians and treatment centers doing the same thing perhaps a standardized method of treatment could be established. Treatment centers would then review the new standardized method along with the insurers. A measure of successful outcome would also be established in this process. When this is accomplished the insurers would then have approval over the standardized method. Those treatment centers that followed the standards would be the ones being able to accept insurance. This system would take a lot of thought to set up. However, once done perhaps all the different "schools of thought" could be heard from, treatment would become more cost-effective, and ultimately, the client would receive the most benefit. This may seem *pollyannic*, and perhaps it is. However, change is needed as soon as possible and the system is in need of more than a band-aid. People are dying needlessly every day under what we now have.

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