Engagement and Retention of Nonabstinent Patientsin Substance Use Treatment

Clinical Consideration for Addiction Treatment Providers

Background

For more than a decade, the United States has been struggling to address an epidemic of overdose deaths. Despite these efforts, the rate of overdose deaths has continued to rise, with over 112,000 deaths within a 12-month period ending in 2023.[1] Many initiatives have focused on improving the quality of addiction treatment, including fostering the adoption of evidence-based interventions. However, the vast majority of people with substance use disorders (SUDs) do not receive any treatment. In 2022, over 48.7 million people in the US met criteria for an SUD, representing more than 17% of the population.[2] Of these, only 14.9% received SUD treatment in the past year.[2] Among those with an SUD who did not receive treatment, 94.7% did not perceive a need for treatment, while 4.5% perceived a need for treatment but did not seek it.[2]

Beyond initiation, ongoing engagement and retention in treatment are some of the most important predictors of SUD outcomes; longer duration of treatment predicts better clinical outcomes.[3] Individuals progress through addiction treatment at various rates, and positive outcomes are contingent on adequate treatment duration. Yet data from the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2021 Treatment Episode Data Set (TEDS) shows that among discharges across all levels of care, less than 43% of patients completed* the treatment episode, 25% of patients withdrew from treatment, and the facility terminated treatment (ie, administratively discharged) for nearly 5% of patients.[4]

Despite the low rates of treatment participation, patients are regularly dissuaded from initiating treatment until they are willing and able to commit to sustained abstinence from all substances. All too often, patients are administratively discharged from SUD treatment programs if they resume substance use.[5-7] **In essence, patients are denied admission to and/or discharged from care for exhibiting symptoms of the disease for which they need treatment.** These practices are inconsistent with our understanding of addiction as a chronic disease.[7,8]

Improving engagement and retention in SUD treatment is a multifaceted and nuanced challenge. People with SUDs often have complex medical and psychiatric comorbidities. Further, intoxication, withdrawal, and SUD can present with significant behavioral challenges, including psychosis, agitation, impulsivity, and compulsive use of substances. Treatment programs are tasked with balancing the needs of each patient with any potential risks to other patients and staff. While challenging, these complexities are part of the disease we are treating. It is incumbent upon us to design treatment systems that maximize engagement and retention in the face of them.

* Completed treatment episodes include (1) discharges from outpatient settings where "treatment completed" was indicated as the reason for discharge and (2) discharges from inpatient or residential treatment settings with documented admission to another level of care.

To improve outcomes, SUD treatment programs and providers need to focus on improving care quality as well as reaching those who are not engaged in treatment and increasing retention of those who do engage in care. To do this, we must take a fundamentally different approach by:

- proactively engaging individuals who would benefit from treatment at all stages of readiness for change, including those who are uninterested or ambivalent about receiving treatment; and
- designing programs with the intention of increasing patient retention in the continuum of care.

Promoting engagement and retention of nonabstinent patients does not mean treatment programs are encouraging or should encourage substance use. Rather, in supporting the engagement of nonabstinent patients, programs address substance use clinically without judgment while also recognizing that recurrence of substance use is a common part of most patients' recovery journeys.

Purpose

The purpose of this document is to provide SUD treatment programs and providers with guidance and support to:

- address the complexities of patient nonabstinence during treatment,
- reduce administrative discharges, and
- implement strategies focused on lowering barriers to care to improve engagement and retention of nonabstinent patients in the continuum of care.

This document outlines ten core strategies for treatment programs to optimize engagement and retention of all patients. This document also includes brief discussions on health disparities in SUD treatment engagement and retention, as well as how policymakers can support implementation of these strategies.

The intended audience for this document is SUD treatment program administrators and clinicians, including physicians, nurse practitioners, physician assistants, nurses, behavioral health professionals, and other healthcare and support workers employed by or associated with SUD treatment programs. This document may also be helpful for policymakers, insurers, and individuals who have lived experience with SUD.

Methodology

ASAM convened a Writing Committee of six subject matter experts to develop this Clinical Consideration. Development of the guidance was informed by a structured review of the literature (both primary research and gray literature). The detailed methodology and key questions can be found in Supplemental Materials. Eleven field reviewers provided detailed feedback on the full draft document, which informed updates prior to its release for public comment in May 2024. The Writing Committee reviewed all public comments and updated the document to address identified concerns. ASAM's Quality Improvement Council and Board of Directors approved the final document in July 2024.

A list of committee members and field reviewers, their areas of expertise, and conflict of interest disclosures are available in Supplemental Materials.

Summary of Recommended Strategies

1. Cultivate patient trust by creating a welcoming, nonjudgmental, and trauma-sensitive environment.
2. Do not require abstinence as a condition of treatment initiation or retention.
3. Optimize clinical interventions to promote patient engagement and retention.
4. Only administratively discharge patients from treatment as a last resort.
5. Seek to re-engage individuals who disengage from care.
6. Build connections to people with SUD who are not currently seeking treatment.
7. Cultivate staff acceptance and support.
8. Prioritize retention of front-line staff.
9. Align program policies and procedures with the commitment to improve engagement and retention of all patients, including nonabstinent patients.
10. Measure progress and strive for continuous improvement of engagement and retention.

ASAM recognizes that treatment programs may not be able to implement every strategy. For some strategies, regulatory barriers may impede adoption (see A Note for Policymakers). For others, funding or workforce limitations may hinder implementation. Clinicians and program administrators are encouraged to focus on the principles articulated throughout this document, including the importance of:

- providing a welcoming and nonjudgmental environment,
- meeting patients where they are,
- creating a culture of support that prioritizes meeting patients' core needs,
- developing treatment plans that are responsive to each patient's needs and priorities, and
- focusing on therapeutic strategies over punitive actions.

We encourage programs to work with payers and policymakers to promote the changes necessary to support more comprehensive adoption of these strategies over time.

ASAM also recognizes that implementation of these strategies will be more challenging in more intensive levels of care. If a patient is using substances in high-intensity residential or inpatient setting (ie, *The ASAM Criteria* Level 3.5 or 4, respectively), they are likely bringing substances into the facility. The program has a responsibility to protect other patients from exposure to substances. In addition, a patient who is intoxicated can affect other patients and the therapeutic milieu. This can be particularly challenging in residential and inpatient settings where patients are often in a more fragile stage of recovery. If a patient's use of substances is posing a risk of harm to other patients, the program may need to discharge them or transition them to another level of care. These issues are discussed in more detail in The Impact of Nonabstinence on Other Patients in Strategy #4.

Addiction is a chronic condition. Periods of illness exacerbation are common during the course of a person's recovery. If abstinence is the central goal, then patients may view continued use or return to use as a failure instead of a chance to learn and grow. Patients should feel confident that programs will support them without judgment or punishment. Early in the treatment process, clinicians should discuss how they will respond to return to use with patients, including through reassessment of their treatment plan and adjustments to the services and supports provided. Having goals focused on functionality or improvements in overall health rather than abstinence can help patients see the progress they are making through treatment, which may build confidence in their ability to take on larger goals.

For many patients, abstinence is the healthiest long-term option; programs may recommend this as the ideal while also promoting harm reduction. However, it is important to respect the patient's preferences and ensure that pressure to comply with the program's desires does not drive them from care. This reflects a patient-centered approach that validates patient preferences while also gently encouraging patients to seek the greatest opportunity for risk reduction and improved health over time. Leading by example has great value: meeting patients where they are while showing them the benefits experienced by peer support specialists and others who have chosen abstinence as a path to recovery.

Shame is a powerful driver of addictive behaviors. If patients are made to feel ashamed in response to return to use, they can be driven out of treatment and into more severe SUD.

Meet patients where they are

Each patient enters treatment with diverse needs and at different stages of readiness to change. A patient's needs, motivations, and preferences are not static and may evolve throughout the course of their treatment, necessitating programs to provide individualized care and flexibly adapt where possible. As patients move through the continuum of care or engage with various treatment services, navigating these many considerations is a difficult but important priority.

Instead of mandating abstinence, the addiction treatment system should seek to:

- meet each patient where they are; and
- tailor individualized treatment plans based on each patient's goals and preferences, which may include harm reduction and nonabstinence health improvement goals.

Shared goals that focus on harm reduction or improved health can help create trust, enabling patients to be more open about their struggles with continued use.

Use drug testing as a therapeutic tool

Many programs mandate drug testing, at times responding punitively to positive results. Some programs require a positive drug test prior to treatment admission or medication initiation, perhaps considering recent substance use as a proxy for SUD. However, a positive drug test is neither necessary nor sufficient to establish a diagnosis of SUD and requiring a positive test can unintentionally encourage substance use prior to treatment initiation.

Drug testing can have important clinical purposes, such as:

- screening for withdrawal risk,
- determining use objectively when clinical findings do not match patient self-report,
- monitoring medication adherence,
- helping patients understand what substances they have been exposed to,
- monitoring substance use as a component of contingency management (CM), and
- measuring treatment progress.

As with self-reported substance use, unexpected drug test results should be addressed as part of therapy. Drug test refusal can be similarly addressed in therapy. Typically, the clinician will have a sense of the reason for a patient's refusal. Is the patient pregnant and afraid of the potentially serious consequences of a false positive? Is the patient very uncomfortable with the sample collection process? Does the patient's recent behavior suggest a return to substance use?

Clinicians should work with each patient to explore denial, motivation, and actual use. Negative test results present opportunities to demonstrate support and build trust with patients and should be positively reinforced. As trust grows, clinicians can educate patients on the clinical reasons for drug testing and encourage those who have refused testing to participate in the future. When drug testing is handled punitively, patients can be driven out of treatment.

Drug testing can have significant negative consequences for patients who are pregnant, as well as for those involved with the criminal justice system or child protective services (CPS). Clinicians should carefully consider the clinical benefits and potential harms of each test on an individual basis before ordering them and with the patient's informed consent. Correct interpretation of results is particularly important in these instances, and definitive testing should be used to confirm any findings that do not align with the patient's self-reported use.

As discussed in ASAM's *Appropriate Use of Drug Testing in Clinical Addiction Medicine Consensus Document*[39]:

> Drug testing should be used as a tool for supporting recovery rather than exacting punishment. Every effort should be made to persuade patients that drug testing is a therapeutic, rather than punitive, component of treatment. This process may require time and multiple conversations. If drug testing is used in such a way that it creates an "us versus them" mentality, it is at odds with the therapeutic alliance.

Patients have a right to refuse any treatment service, including drug testing. Treatment programs should not attempt to coerce patients into participating. Admission and discharge decisions should not be based solely on drug test results or refusal of drug testing. Drug test refusal should be well-documented, along with the clinician's interpretation of its clinical relevance for the given patient. If the patient is court mandated to complete drug testing or the program is required to share test results (eg, with a probation or parole officer, CPS, or treatment court), this requirement should be discussed with the patient at the outset. When reporting is required, clinicians should report clinical progress along with test results.

Rethink expectations regarding use of secondary substances

Research has considered how to address concurrent use of substances other than the primary substance of concern during treatment (eg, a patient's use of marijuana while receiving treatment for opioid use disorder [OUD]). Requiring abstinence from any—let alone all—substances as a condition of treatment is unnecessary and ultimately restricts our ability to prevent serious harms, including overdose deaths, and improve public health.[40] It may also discourage patients from disclosing their use of other substances.

While patients should be offered treatment for all substance use concerns, current use should not prevent the patient from accessing care. Similar to the management of tobacco use disorder†, patients should be screened for risky patterns of use of all substances and offered evidence-based treatment for all substance use concerns accordingly.[41] However, a patient's current use or decision to decline certain care options should not jeopardize their access to treatment, including addiction medications.‡

Clinicians should consider patients' drivers of secondary substance use and related treatment needs. For example, does the patient's stimulant use suggest untreated attention-deficit/hyperactivity disorder (ADHD)? Are they experiencing poor impulse control after a traumatic brain injury (TBI)? Consider how the treatment plan can begin addressing underlying drivers, even if the patient is not ready to establish a goal of cessation.

If a patient's use of secondary substances does not threaten safety or treatment outcomes and they are not interested in including a related treatment goal, the program can seek to address risky use of other substances over time through motivational interventions and in alignment with each patient's individual treatment goals.[8,42] If other substance use is undermining progress in treatment, the program should work with the patient to address it within their treatment plan. For example, if cannabis use is a trigger for alcohol use in a patient with alcohol use disorder, the treatment plan should address this interaction.

An important caveat is discussed in The Impact of Nonabstinence on Other Patients in Strategy #4. One patient's use of substances can affect other patients and the therapeutic milieu. Engagement of nonabstinent patients can be particularly challenging in residential and inpatient settings where patients are often in a more fragile stage of recovery. If a patient's use of substances is posing a risk of harm to other patients, the program may need to discharge them or transition them to another level of care.

Strategy #3: Optimize clinical interventions to promote patient engagement and retention.

The treatment gaps in engagement and retention are well known.[43] For example, of patients who meet criteria for OUD, roughly half receive a diagnosis. Of those who are diagnosed, less than half are engaged in care. Of those engaged in care, less than one quarter are retained for more than six months. Addiction treatment programs should be designed with a focus on improving engagement and retention in care given the known importance of these factors for long-term clinical outcomes. One key component of this is implementation of clinical strategies tailored to these goals.

† See ASAM's Integrating Tobacco Use Disorder Interventions in Addiction Treatment.[41]

‡ Clinicians have an ongoing responsibility to avoid interventions for which the likely harms outweigh benefits for the given patient. Nothing in this Clinical Consideration is intended to contradict this responsibility.

Programs can consider a variety of clinical strategies throughout the course of treatment to optimize patient engagement and retention, including:

- prioritizing patients' immediate needs,
- providing low-threshold access to medications,
- teaching patients alternative coping strategies,
- encouraging a culture of shared decision-making,
- focusing on building strong therapeutic alliances,
- creating a culture of support,
- using incentives (eg, CM)[§] and motivational enhancement strategies to encourage engagement and retention in care,[44,45]
- supporting effective care for comorbid conditions, and
- advocating for patients' access to evidence-based care.

Individuals often feel overwhelmed by the emotions that arise as they initiate treatment. They may fear the physical consequences of withdrawal and be nervous about how recovery will impact their relationships with friends, family, and significant others. To support patients through this transition, programs can offer frequent therapeutic check-ins early in treatment and work to create a strong social support system within the program.

Prioritize patients' immediate needs

It is difficult to effectively participate in treatment if you do not know when your next meal will be or where you will sleep that night. Similarly, engaging in care is challenging when you are physically uncomfortable due to withdrawal or know withdrawal is imminent. Patients and programs have highlighted the importance of prioritizing early assessment and triage of patients' immediate needs, such as food and shelter.[9,10,13] It is also important to proactively consider each patient's barriers to engagement in care, such childcare or transportation needs.

Programs should have established policies and procedures on screening for and responding to immediate needs, such as:

- screening for acute withdrawal risk and post-acute symptoms of withdrawal,
- recommending an appropriate level of care based on each patient's biopsychosocial needs as described in *The ASAM Criteria*,[12]
- providing or coordinating referral for withdrawal management services or addiction medication needs,
- supporting access to food (eg, helping patients access food vouchers and/or local food kitchens, having snacks on-site and available to those in need if possible),
- providing social service navigation or resources to support access to housing assistance,
- supporting access to transportation (eg, providing connections to local transportation assistance programs, identifying transportation options),

§ Incentives should comply with all federal and state laws and regulations, including the Federal anti-kickback statute (42 USC §1320a-7b) and beneficiary inducement statute (42 USC §1320a-7a).[44,45]

- providing or supporting access to childcare services,
- providing connections to local resources for interpersonal violence and human trafficking, and
- helping identify options for pet care while patients are in residential treatment.

Prioritizing immediate needs communicates that programs understand the challenges patients are facing. It tells patients that their health and wellness are important, that you see the whole person and not just the illness. This can help strengthen the therapeutic alliance and encourage retention in care.

Smaller programs with modest resources may experience greater challenges providing or facilitating these services. However, given the importance of these factors to engagement and retention, even smaller programs should consider the benefits of hiring case managers or developing peer support networks. Under-resourced programs should consider how nontraditional supports—such as volunteers and community organizations—can help them meet patients' needs.

Programs should consider maintaining lists of local resources (eg, food kitchens, shelters, transportation options, family assistance services) that can help support patients' immediate needs. These lists could be provided to patients at intake or in the waiting room, and allied health staff could assist patients in determining their eligibility for resources or services.

Provide low-threshold access to medications

Low-threshold treatment is an important strategy for meeting people "where they are" to engage them in care and create trusting relationships with the treatment system while stabilizing their symptoms and reducing their risk for overdose and death.

Sex- And Gender-Related Considerations

Many subpopulations, including sexual- and gender-minoritized and pregnant individuals, experience significant barriers to engagement and retention in SUD treatment above and beyond those experienced by the broader population. It is important for SUD treatment programs to identify, acknowledge, and assist patients in these subpopulations with addressing any individualized needs.

Examples of subpopulation-specific considerations may include, among others[21-24]:

- concerns related to pregnancy or postpartum, such as pain control during labor or the impact of medications on a fetus or breastfeeding child;
- the impact of treatment program schedules on family scheduling needs (eg, breastfeeding, shared custody, child school and health needs);
- additional stigma faced by pregnant and parenting individuals with SUDs;
- additional stigma due to identity or fear of personal disclosure (eg, of sexual orientation);
- patient comfort discussing issues related to their sexual orientation and/or gender identity in a general population setting; and
- the high prevalence of trauma among sexual- and gender-minoritized populations.

A central component of low-threshold access to treatment is that participation in counseling should not be a requirement for initiating or continuing medications.[46] *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder* highlights that[47]:

> Patients' psychosocial needs should be assessed, and patients should be offered or referred to psychosocial treatment based on their individual needs. However, a patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacotherapy, with appropriate medication management.

Some strategies that support low-threshold access to medications include telemedicine, street medicine, and same-day appointments for medication initiation. It is important that each patient's medications are titrated to a dose that prevents withdrawal and controls their cravings.[48-50]

Facilitate access to care through program services and policies

Many factors limit access to addiction care and undermine engagement and retention, particularly for individuals who are ambivalent about treatment or recovery. Programs should consider how their clinical service offerings can help patients overcome barriers and facilitate ongoing engagement, for example, by:

- offering telehealth services[51,52];
- offering mobile services, including mobile medication dispensing[53-55];
- applying a lower threshold for authorizing take-home methadone doses[56,57,¶]; and
- working with local hospitals, jails, and prisons to support rapid engagement in treatment following medication initiation in these settings.[58-61]

Teach patients alternative coping strategies

People with SUD, including those with co-occurring mental health concerns, often use substances to cope with negative emotions. Most patients will need to learn and practice alternative coping strategies before they are able to discontinue substance use.[62-66] Helping patients build distress tolerance and alternative coping skills is a foundational component of SUD and mental health treatment. Discussions on alternative coping skills should happen early in the treatment process to help patients understand the role substance use may have served in their management of stress, trauma, or mental health symptoms. Clinicians should explain how treatment will help them build skills to manage negative emotions in healthier ways. This is an important area where peers can share their lived wisdom and foster hope for the future.

Encourage a culture of shared decision-making

Patients have autonomy over which treatment services they engage in, even when treatment is mandated. Every patient has unique motivations for participating in treatment. If the provided care is not meeting their goals, patients are likely to disengage from care.

Treatment planning should involve shared decision-making with patients (and families for adolescent patients). Clinicians should work with patients to understand their individual needs, priorities, and motivations and construct a feasible and effective service plan. Treatment goals should have high personal significance that help fuel motivation to remain engaged in treatment. "Life worth living" goals—a concept from dialectical behavioral therapy (DBT)—help patients build lives that are meaningful and satisfying to them.

¶ In alignment with federal regulations.

Shifting from a treatment compliance mindset to a shared decision-making model where patients are active agents in their own care builds a collaborative relationship between clinicians and patients that prompts trust in the care team, better treatment buy-in, and active patient engagement.[7,11,67,68]

Fostering a culture of shared decision-making and trust regarding addiction medications is particularly important. Prescribers should educate patients on the risks and benefits of the different medication options and consider each patient's preferences when selecting a medication. Prescribers should encourage patients to communicate openly about their cravings and side effects. Some patients may fear being seen as drug-seeking if they raise concerns about their medication, but understanding their response is critical to determine if they are on the right dose and medication.

Focus on building strong therapeutic alliances

Research has consistently shown therapeutic alliance—the collaborative relationship between a patient and their clinician—to be an important factor in the success of psychotherapeutic interventions.[69-72] This mutual trust and respect allows the patient and clinician to work together to support the patient's well-being.

Research has also shown that dislike of staff is a leading cause of patients choosing to exit treatment.[9] Conversely, a strong patient–clinician relationship is a significant predictor of positive treatment outcomes.[5,9,67,73] Clinicians should thus prioritize building a strong therapeutic alliance. Key factors in developing a strong therapeutic alliance include[74]:

- demonstrating unconditional positive regard, conveying that the clinician cares for and accepts the patient without judgment;
- making genuine efforts to understand the patient's experiences and challenges; and
- being authentic, sincere, open, and honest with the patient.

Programs should regularly assess therapeutic alliance. Patient surveys can include items such as, "*I believe my therapist is genuinely concerned for my welfare*," "*We agree on what is important for me to work on*," and "*My therapist and I respect each other*."[68] If a patient's therapeutic alliance with their care team is insufficient, programs should offer to transition or refer them to an alternate clinician or care team who may be a better fit for that patient's needs. Similarly, if a patient asks for a different clinician, programs and staff should respond to the request without judgment or retribution. Programs may consider the underlying reasons for the request when deciding whether to offer a different clinician. For example, if a patient's request is attributed to an avoidant personality disorder, it would be appropriate to help the patient process the underlying issue rather than immediately changing clinicians.

Create a culture of support

Clinicians should create a culture of understanding around return to substance use, emphasizing early and often that return to use does not mean patients have failed, nor does it mean they cannot continue in treatment.[7] Clinicians should also ensure patients know they will be welcome to return to treatment if they disengage for a time; programs will be there to provide support when they are ready. This culture of support should be integrated into the therapeutic milieu. The community should understand that some patients may not be striving for abstinence. For those whose goal is discontinuing one or more substances, return to use should be viewed as an opportunity to learn and

grow. These occurrences should not be met with disappointment or shame but, instead, with insight and awareness. What contributed to the return to use? When was the patient aware they were at risk? What strategies did they try? What could they have done differently? Does the patient need additional or different services to meet their goals? How can the milieu support them?

Use incentives to encourage engagement and retention

Contingency management (CM) is an evidence-based practice that provides incentives for recovery-focused behaviors, such as attending appointments or substance use-related outcomes (eg, negative drug test results).[8] Incentives have been shown to be effective in promoting treatment enrollment, engagement, and retention.[75-84] Incentives come in various forms, including but not limited to cash, gift cards, transportation vouchers, food, food coupons, clothing, electronic equipment, and recreational items (eg, movie passes, athletic gear). Effective target behaviors for engagement and retention may include:

- attending individual or group treatment sessions,
- adhering to addiction medications,
- completing personalized goals as part of a treatment plan (eg, completing a job application, scheduling a doctor's appointment), and
- completing follow-up assessments.

See Rash (2023) for a full discussion of considerations for CM implementation.[85]

Currently, implementation of effective CM is limited by funding, regulatory barriers, and workforce training. As such, this strategy may be aspirational for many programs at the time of publication. However, efforts are ongoing across the country to address barriers to CM. SAMHSA's Addiction Technology Transfer Center (ATTC) is providing CM training and technical assistance resources.[86,87] California's Recovery Incentives Program is implementing policy changes and providing training for CM implementation in its Medicaid program. Other states are providing grant funding to help programs implement CM.[88]

Cost has been a significant barrier to providing CM incentives, but recent federal and state initiatives have been expanding funding for this purpose. For example, the Centers for Medicare & Medicaid Services (CMS) have issued several approvals under the Medicaid Section 1115 demonstration authority that authorize coverage of CM.[89] CM is currently permitted under several federal grant programs (eg, SAMHSA's State Opioid Response [SOR] and Tribal Opioid Response [TOR] grants, the Health Resources and Services Administration's [HRSA] Rural Communities Opioid Response Program's [RCORP] Psychostimulant Support Program). See *Contingency Management for the Treatment of Substance Use Disorders: Enhancing Access, Quality, and Program Integrity for an Evidence-Based Intervention* from the US Department of Health and Human Services (HHS) for additional discussion.[90]

While some grant funding mechanisms limit allowable incentives to a total of $75 per year—which evidence suggests is insufficient to achieve CM's clinical aims—other funding sources can provide an evidence-based incentive magnitude.[44,45,**] For example, California Advancing and Innovating Medi-

** Incentives should comply with all federal and state laws and regulations, including the Federal anti-kickback statute (42 USC §1320a-7b) and the beneficiary inducement statute (42 USC §1320a-7a).[44,45]

Cal (CalAIM) provides up to $599 per beneficiary per year. For a discussion of legal and policy issues related to CM, see the Legislative Analysis and Public Policy Association's (LAPPA) CM fact sheet.[91]

Although available research primarily uses cash, vouchers, or material goods as incentives, programs can consider alternatives when funding is a concern, such as increased flexibility in the patient's treatment schedule or increased autonomy in treatment-related decision-making. For example, programs can use increased telemedicine appointment flexibility as an incentive for treatment participation.

Use motivational enhancement strategies to encourage engagement and retention in care

Motivational interviewing (MI) and motivational enhancement therapy are highly effective evidence-based practices for increasing patients' internal motivation for change, which can increase engagement and retention in care.[92] MI principles can be integrated into program procedures at various points, from first contact with the program to intake, assessment, and clinical services and in both individual and group-based services.[33,38,93] Examples of MI include using open-ended, compassionate questions to connect with patients, understand their motivations for exploring or engaging in treatment, and communicate how the program will help meet their needs.[94]

Beyond MI's clinical effectiveness, research has demonstrated that it can be feasibly and effectively implemented in community-based settings when clinicians are provided training and supervision.[33,92] For further discussion and guidance on MI and its use in clinical treatment environments, see the Network for the Improvement of Addiction Treatment's (NIATx) resource on MI during the first contact.[94]

Support effective care for comorbid conditions

Addiction is a biopsychosocial illness. Diverse biological, psychological, social, and cultural factors influence the development of SUD, prognosis for recovery, and related treatment needs. Patients with SUDs commonly experience co-occurring mental health and comorbid physical health concerns that can interfere with effective participation in SUD treatment. A patient with significant pain, depression, or anxiety, for example, may be unable to reliably attend outpatient care or effectively engage in counseling or therapy. Addressing co-occurring concerns is vital to support engagement and retention in treatment.

While the presence of co-occurring concerns is often associated with lower treatment involvement, programs that promote flexible and collaborative care networks can facilitate better outcomes for both individual patients and the broader community.[8,10,26] For example, patients with borderline personality disorder (BPD) are both more likely to self-discharge and be administratively discharged from treatment.[95,96] DBT is the standard of care for BPD and may also be an effective treatment for SUD.[97-99] Further, DBT is the only intervention shown to reduce withdrawal from treatment among patients with BPD.[95,97] A number of DBT strategies target mediators of early treatment termination and may help improve patient engagement and retention.[95] Given that approximately 25% of patients with SUD meet the diagnostic criteria for BPD, programs should consider how DBT or other dialectical strategies can be incorporated into their efforts to improve retention in treatment.[100]

In alignment with the Fourth Edition of *The ASAM Criteria*, all SUD treatment programs should be co-occurring capable at minimum.[12] Co-occurring capable refers to an approach in which addiction

treatment programs welcome patients who have co-occurring conditions with empathy and compassion and provide integrated services for mental health symptom management as part of routine operations.[12] Co-occurring capable programs have the capability to address patients' co-occurring mental health concerns, including trauma, in the routine course of addiction treatment.

In alignment with *The ASAM Criteria*, all programs should[12]:

- screen for biomedical and psychiatric concerns,
- conduct or coordinate referral for a physical examination that considers the patient's SUD-related needs (eg, addiction medications, post-acute withdrawal symptoms) as well as medical concerns (eg, HIV, hepatitis C virus [HCV], sleep, nutrition),
- consider the patient's need for integrated medical and/or mental health care when recommending a level of care,
- consider the patient's need for referrals to external medical and/or mental health providers during treatment planning, and
- either directly provide or coordinate care†† with external healthcare providers to support effective care for comorbid conditions that may interfere with the patient's recovery (eg, pain, TBI, depression).[10,26,101]

Admission criteria for addiction treatment programs should not exclude patients based on current or past psychiatric diagnoses alone; the appropriateness of admission should be determined by the severity and acuity of the patient's current psychiatric signs and symptoms. Similarly, suicidal ideation alone is not a reason to deny admission. Qualified staff should assess and triage any patient who reports suicidal ideation to determine the need for psychiatric assessment and/or transition to a more intensive level of care.

Advocate for patient access to evidence-based care

The mechanisms of action and effectiveness of some evidence-based practices for SUD—such as addiction medications—continue to be misunderstood and stigmatized. As a result, some courts, social service systems, and pharmacies limit access to them. Similarly, some recovery support organizations may directly or indirectly discourage the use of addiction medications. Some recovery residences may exclude an individual who is taking methadone or buprenorphine, and some mutual support groups have strong anti-medication cultures. However, addiction medications are lifesaving for many patients. SUD treatment providers should work to proactively counter the stigma and misperceptions underlying these harmful practices and advocate for their patients' access to evidence-based care with any system that limits access to or use of addiction medications.

†† In medically managed programs, care coordination may include collaborating with external medical providers on adjusting treatment or medications for SUD and/or comorbid conditions to support better outcomes. In clinically managed programs, care coordination may include patient navigation services, appointment and medication reminders, adherence monitoring, and psychoeducation.

Strategy #4: Only administratively discharge patients from treatment as a last resort.

Administrative discharge—sometimes called disciplinary discharge—refers to the termination of services when a patient fails to comply with a program's rules. SAMHSA's 2021 TEDS shows nearly 5% of patients were administratively discharged from treatment that year.[4] However, evidence suggests significant problems with underreporting, and the rate is likely much higher.[102] Administrative discharge is commonly attributed to:

- failure to follow program rules,
- failure to attend counseling sessions or other treatment services,
- poor adherence to treatment recommendations,
- substance use or possession of substances,
- diversion of medications,
- distribution of substances or other illegal behaviors,
- inability to pay for treatment services, and
- threatening or violent behavior.

Historically, administrative discharge has been viewed as a way to promote compliance with program rules, protect other patients and staff, manage threats to the therapeutic milieu, and focus limited resources on those who are perceived to be the most likely to benefit from treatment.[7] However, the theory and practice of administrative discharge is contrary to the disease model of addiction and core ethical principles of health care and, ultimately, ineffective at supporting both a patient's recovery and the larger treatment system.[7,67,103,104] When a patient with diabetes struggles to follow nutritional recommendations, they are not discharged from care. Challenges with adherence to the treatment plan are addressed clinically, as is appropriate for any health condition.

The perceived failure of an administrative discharge can contribute to a patient's shame, despair, and depression. In addition, administrative discharge can lead to secondary losses (eg, loss of employment or child custody), all of which can drive a person into more severe SUD.[7] A program culture that tolerates or normalizes administrative discharge ultimately characterizes itself as unsupportive to the patients in greatest need of its services.[7] While avoiding negative consequences (eg, avoiding incarceration through treatment court participation) can be motivating for some, consequences short of kicking a patient out of treatment could be applied. The therapeutic milieu will often apply social pressure in response to behaviors that impact the community. Consequences should be proportional to the infraction and applied fairly and should not undermine access to care.

Although administrative discharge may be necessary in some instances—such as in response to behaviors that pose a risk of harm to other patients or staff—SUD treatment programs should minimize the practice. Instead of discharging patients for policy infractions, disciplinary challenges,

and similar disruptions, programs should implement individualized, community-engaged, and contextualized responses. At its core, this involves the following considerations and actions:

- Programs should seek to understand the factors that contributed to a patient's policy infraction or disciplinary challenge, taking into account their age and developmental stage.
- Programs should develop contextualized and developmentally appropriate responses to policy infractions and disciplinary challenges—that is, responses tailored to the factors that led to the disruptive behavior. How can the program help address these factors? For example, if the patient is selling part of their prescription in order to afford the medication or other necessities, are local programs available to help the patient pay for their medication or access food or rent subsidies?
- The patient's community should be engaged in the response. This includes both the program community as well as the patient's broader community and support systems. Who in their community has the ability to positively influence them or provide them with extra support? How can the program leverage the patient's family, friends, mutual support sponsors, cultural and/or faith communities, and any other trusted support persons to address challenges and prevent them from escalating to the point of administrative discharge?

Challenges in addiction treatment often indicate more severe SUD or co-occurring psychiatric disorders and the need for clinical solutions. Some behavioral or psychiatric challenges may be beyond the capacity of a given program to address and should trigger referral for concurrent care with a psychiatrist or other mental health clinician or transition to a more intensive level of care or a co-occurring enhanced (COE) program. Some patients may be unable or unwilling to transition to a recommended more intensive level of care (eg, due to childcare responsibilities or lack of access). If a patient declines to transition to a more intensive level of care, the recommendation should be well-documented, along with the patient's stated reasons for declining. Clinicians should work with the patient to carefully consider all options for safely accessing care while protecting other patients and staff, which may include transition to a less intensive level of care.

A top priority in the care of every patient should be supporting continued engagement in the continuum of care. If the current care team has exhausted all treatment options at their disposal for a given patient, every effort should be made to transition that patient to an alternative provider that meets their immediate needs, ideally, with a warm handoff to the new care team. While such transitions are best practice, we recognize how challenging effective transition planning can be in these instances. Programs and clinicians have a primary obligation to do no harm; withholding specific treatment services (eg, medication) can result in serious harm, including death. It is particularly important to consider a patient's medication needs during such transitions, including withdrawal management, addiction, psychiatric, and overdose reversal medications.

Implement systems to prevent administrative discharge

Programs should establish systems to prevent administrative discharge whenever possible. For example, programs can train all staff in de-escalation techniques and conflict resolution to reduce the likelihood of incidents that could lead to administrative discharge.

Programs could establish administrative discharge panels to implement standardized and thoughtful responses to disruptive behaviors. When rule infractions occur, the patient and their care team participate in an interdisciplinary conference to jointly re-evaluate the patient's treatment goals and discuss the infraction in an open and nonconfrontational manner.[11,105] Alternative explanations

for the patient's behavior would be carefully considered (eg, sleep deprivation versus intoxication). Motivational enhancement techniques can be integrated into this process, turning the situation into an opportunity for growth and insight.[33,101] These panels should be guided by clear program policies that articulate strategies for preventing administrative discharge. Programs can also consider incorporating patient advocates or ombudsmen to help mediate and resolve conflicts.

Standardized approaches to infractions can support equitable application of administrative discharge practices. Administrative discharge panels would review disciplinary situations on a case-by-case basis and guide the development of a contextualized response. Panels should have multidisciplinary oversight and adhere to clear and explicit policies in an effort to standardize decision-making and ensure discharge decisions are not made inappropriately or without fair consideration.[7,106]

Clearly explain the rules and responses to infractions early in treatment

Program policies, including the situations or behaviors that would lead to administrative discharge, should be clearly communicated to patients at the onset of treatment.[106] This conversation should cover medication use, misuse, and diversion. In order to minimize perceptions of stigma and engender trust in the patient–clinician relationship, the discussion should be framed from the viewpoint of seeking to provide the patient with good clinical care and optimizing their treatment continuation, not with undertones that are punitive, accusatory, or judgmental.[7,9]

When explaining program rules to patients:

- Explain the "why" behind each rule
- Explain how infractions can undermine clinical care or pose risks to staff or other patients
- Explain the program's legal responsibilities and boundaries
- Be transparent about the consequences of infractions for the patient, as well as for the clinician, the program, and other patients

Avoid administrative discharge related to return to substance use

SUDs are chronic health conditions commonly associated with periods of abstinence or reductions in use and return to or exacerbation of use. Many factors influence a patient's risk for substance use during SUD treatment, such as availability of substances, presence of stressors and triggers, and motivation and readiness for change. The primary goals of SUD treatment are to help patients gain insight into the reasons they use substances and teach them the skills necessary to avoid use. This is rarely a linear path.

Continued substance use despite related harms is a symptom of the disease and, in general, should not be met with administrative discharge. Instead, it should prompt re-evaluation of the treatment plan. If a patient is not meeting their substance use goals, a clinical response should be developed in partnership with the patient that considers the following questions:

- What factors contributed to their substance use?
- When did they become aware of their risk for use?

- What strategies, if any, did they use to try to avoid use?
- What skills, services, or supports could have helped them avoid use?
- Does their recent pattern of use suggest greater risk than originally thought? Does it indicate a need for a more intensive level of care?

Programs should view return to use or continued use as an opportunity for patients to gain insight into their substance use patterns, related risks, and the skills they can employ to avoid use and meet their treatment goals. It is also an opportunity for the program community to learn from one another. The therapeutic milieu can provide a nonjudgmental, compassionate response that seeks to understand which services and supports an individual may need to help them meet their goals.

The Impact of Nonabstinence on Other Patients

Although it is important for the addiction treatment system to adjust to reach a broader population of individuals with SUD, we recognize the complexity of this task. One patient's substance use can affect other patients and the therapeutic milieu. Some patients may have difficulty seeing other patients intoxicated, which may trigger cravings or negative emotions.

Programs are responsible for creating an environment in which patients are—and feel—safe. This Clinical Consideration is not intended to imply that programs should not have rules on substance use or intoxication. Programs should have rules on how to respond to active use in a way that protects all patients, staff, and the therapeutic milieu. Program rules play an important part in helping patients build self-efficacy and accountability to themselves and their communities. Teaching patients how to interact prosocially within the community and be thoughtful about how their actions impact others is an important role of treatment.

Programs and clinicians need to establish boundaries, as well as consequences for boundary violations, and proactively communicate them to patients. Programs have a primary duty to protect patients from exposure to substances in the treatment facility. It is particularly important for programs to protect patients from those who are selling or distributing substances. Patients who are engaging in these behaviors pose a direct risk to other patients and typically need to be discharged or transferred to another treatment setting.

Engagement of nonabstinent patients can be particularly challenging in residential and inpatient settings where patients are often in a more fragile stage of recovery. A patient who is attending sessions intoxicated or describing ongoing substance use can rapidly undermine the recovery mindset of other patients. This Clinical Consideration is intended to encourage programs to explore clinical options before administrative discharge. However, if a patient's ongoing substance use is posing a risk of harm to other patients, the program may need to discharge them or transition them to another level of care.

In intensive outpatient programs (IOPs; ie, Level 2.1), high-intensity outpatient programs (HIOPs‡‡; ie, Level 2.5), and low-intensity residential programs (ie, Level 3.1) where patients typically leave the treatment facility during the day, they may encounter people in the community who are intoxicated or glorifying substance use. In fact, mutual support group meetings (eg, Alcoholics Anonymous) typically encourage people who are actively using substances to participate. Treatment programs

‡‡ Also known as partial hospitalization programs (PHPs).

help patients learn crucial skills on how to cope with these situations and manage the resulting cravings and emotions. Substance use can be addressed directly within the therapeutic milieu through dialogue on the impact of the substance use on patients and those around them. This presents an opportunity for individual growth and for the community to learn from one another.

If a patient is using substances or discussing substance use in a way that violates the program's rules, clinicians should seek to understand why and identify solutions other than administrative discharge. Strategies should be tailored to the given patient's needs, level of care, and stage of readiness to change. If their substance use is negatively impacting another patient or the milieu, programs should consider strategies for keeping the patient engaged in treatment while preventing harm to other patients. Strategies in these cases may include:

- removing the patient from processing groups and providing more individualized treatment services while the issue is being addressed,
- providing more services or referrals to address underlying drivers of substance use or barriers to recovery (eg, housing, food insecurity, comorbidities, access to addiction medications), and
- offering groups tailored to those who are in the contemplative or precontemplative stages of change.

If such strategies prove insufficient, programs may consider referring the patient to a more intensive level of care to prevent access to substances (ie, Level 3.5, 3.7, or 4) or a less intensive level of care for motivational and harm reduction-focused interventions (eg, low-threshold access to medications, psychoeducation on safer use of substances and reducing risky behaviors). A less intensive level of care may be most appropriate for a patient who is currently uninterested in or ambivalent about recovery. Programs should explore clinical options before administrative discharge and consider how to train the workforce to manage the therapeutic milieu safely and effectively through these situations. Over time, this may better enable programs to safely accommodate a wider range of clinical scenarios.

We recognize there are significant regulatory, payment, and workforce barriers to building a treatment system that is able to safely and effectively meet the care needs of the broader population of people with SUD. Some larger programs may be able to offer separate groups for patients who are committed to abstinence and those who are ambivalent, whereas smaller programs may not have the resources available to provide this type of flexible care. Interventions may be needed at the healthcare systems level to support these strategies.

Policymakers and payers should consider how regulatory rules and payment models can be updated to accommodate the treatment needs of patients in early stages of readiness to change. For example, if a patient needs more intensive services than an outpatient setting (eg, Level 1.5 or 1.7) can offer but they cannot participate safely in group sessions, could an IOP (ie, Level 2.1) provide this patient with individual counseling plus extensive wraparound services to address housing and social service needs and enhance their readiness to change despite providing fewer clinical hours per week than recommended? What regulatory rules and payment models would need to be updated to support this?

Avoid administrative discharge related to poor treatment adherence

Programs should avoid specifying thresholds of late or missed appointments as the sole reason for discharge. Such situations do not directly endanger the patient or others in the program, nor do they significantly disrupt provision of services. Instead, it may indicate poor treatment match, weak therapeutic alliance, or the need for increased program flexibility.[106]

- How to assess whether certain program changes (eg, new staff training, adjusted program policy) are associated with decreased wait times, greater patient satisfaction, or other identified metrics of success.
- How to meaningfully evaluate quality improvement efforts.[115] Programs should consider applying an evidence-based framework for process improvement such as the California Bridge Program's RE-AIM framework, the Plan-Do-Study-Act (PDSA) method, or the NIATx model.[33,123,124] Other examples may include:
    - a patient survey within the first month of treatment investigating early impressions (eg, Did you feel your needs were met? Was the intake environment safe and welcoming? Do you believe your counselor or therapist is genuinely concerned for your welfare?);
    - ongoing patient surveys focused on factors that influence retention in treatment;
    - staff surveys focused on whether clinical strategies, policies, and procedures are working well and how these can be improved; and
    - staff surveys focused on factors related to staff retention.

Where feasible, programs should engage staff and patient voices when developing survey measures and planning evaluations. Staff can provide front-line insights into program workflow, environmental considerations, and staff health and well-being.[123] Patients and others with lived experience can provide invaluable insight into meaningful patient health outcomes and program improvements. Incorporating staff and patient voices into quality improvement efforts also reflects a program's structural and cultural commitment to community engagement and shows they value lived experience.

RE-AIM Framework[33]

RE-AIM is a framework for assessing and improving the integration of evidence-based interventions within public health settings. RE-AIM considers five dimensions—reach, effectiveness, adoption, implementation, and maintenance—from which measurable outcomes and appropriate data sources can be identified for a given program. For instance, an outcome of interest in the effectiveness dimension might be the number of patients who attended an intake session, while the corresponding data source might be program intake records.

Plan-Do-Study-Act Method[123]

Plan

- Build a team
- Define the aim
- Describe the problem and its causes
- Develop an action plan

Do

- Implement your action plan

Study

- Gather data
- Determine what worked and what did not

Act

- Expand implementation of successful practices
- Adjust the action plan as needed and repeat the cycle

Five Key Principles of the NIATx Model[124]:

1. Understand and involve the customer
2. Fix key problems
3. Pick a powerful change leader
4. Get ideas from outside the organization or field
5. Use rapid-cycle Plan-Do-Study-Act (PDSA) testing to establish effective changes[123]

To optimize relevance and uptake, each treatment program should determine their quality improvement goals and identify measurement tools to evaluate them. Ideally, programs should consult with various stakeholders such as clinicians, other program staff, and patients to arrive at these determinations. Depending on their evaluation goals, programs might consider using quantitative, validated measures that explore[125,126]:

- patient health and functioning, such as the Brief Psychiatric Rating Scale (BPRS), Health of the Nation Outcome Scale (HoNOS), Outcome Questionnaire45 (OQ45), Outcome Rating Scale (ORS), and Treatment Effectiveness Assessment (TEA)[127-131];
- staff effectiveness, morale, and satisfaction, such as the Evidence-Based Practice Attitudes Scale (EBPAS) and Maslach Burnout Inventory (MBI)[132,133];
- program effectiveness and therapeutic alliance, such as the Implementation Leadership Scale (ILS), Treatment Perceptions Questionnaire (TPQ), Session Rating Scale (SRS), and Substance Use Treatment Barriers Questionnaire (SUTBQ)[134-137]; and
- clinician bias, such as the Medical Condition Regard Scale (MCRS).[138]

Health Disparities in Treatment Engagement and Retention

Significant racial and ethnic disparities exist in patient engagement and retention in SUD treatment. Ample research has demonstrated that various populations experience lower treatment initiation rates compared to White patients, including Black and American Indian people and those living in economically disadvantaged communities.[139] In 2018, only 18% of people who identified as needing treatment actually received it. In Black communities, only 10% of people diagnosed with an SUD received addiction treatment, and only 8% in Latinx communities.[140] Compared to White patients:

- Black and Latinx youth experience lower retention in SUD treatment,[141-143]
- Black patients are more likely to experience lost contact or administrative discharge by treatment programs,[144] and
- Black and Latinx patients experience lower treatment completion rates.[145]

A multitude of factors influence these trends; one suggested reason is that patients attending programs consisting primarily of people from a different social, economic, or cultural background may have difficulty connecting to and identifying with other patients and staff. This psychological isolation may decrease treatment engagement and retention.[145]

The ethnic and racial representation of program staff may also play a role in treatment disparities. Research suggests racial concordance between clinicians and patients impacts therapeutic alliance, perceptions of patient-centered care, and retention in treatment.[146-149]

Significant racial and ethnic disparities also exist in patient experience and quality of treatment received. While only 18.3% of people with a diagnosis of OUD received treatment with addiction medications in the past year, this falls to 16.4% among Hispanic/Latinx patients and 11.2% among Black patients.[2] Black patients in treatment have been shown to be 70% less likely to receive a prescription for buprenorphine than White patients when controlling for payment method, sex, and age.[150] Further, a study of privately insured people who received emergency room treatment for an overdose revealed that Black patients were half as likely to obtain post-overdose treatment compared to White patients.[151]

ASAM has recognized and discussed these significant and problematic health disparities in addiction medicine through a series of public policy statements (see ASAM's *Advancing Racial Justice and Health Equity in the Context of Addiction Medicine*).[152] These statements provide addiction medicine professionals with recommendations to improve the quality and equality of care delivered to racially and ethnically diverse popuations.[152] With specific regard to minimizing disparities in the engagement and retention of patients in SUD treatment, ASAM recommends treatment programs do the following:

- **Align program policies and procedures with the strategies outlined in this Clinical Consideration** in an effort to make care more accessible, continuous, and flexible and lower treatment barriers for all patients.
- **Identify and address health disparities within your own program.** Comprehensively examine potential disparities in patient engagement and retention by evaluating program data. Consider if differences based on race, ethnicity, sexual orientation, and gender are present in treatment duration, administrative discharges, self-discharges, patient satisfaction, use of medications, and treatment outcomes. Consider how to address the resulting findings.
- **Prepare staff to serve a diverse patient community.** This may involve efforts to hire and retain staff who reflect the community being served. Programs should train staff to deliver culturally humble care, including intentional efforts to incorporate cultural considerations of populations they are less familiar caring for. For resources related to culturally and linguistically appropriate services (CLAS) see ATTC's CLAS Resources.[153]
- **Consider marginalization and differential treatment based on factors other than race and ethnicity**, such as religious or spiritual beliefs, sexual orientation, gender identity, different primary or preferred language, or prior incarceration. Consider how these and other factors can contribute to misdiagnoses, misunderstandings, and patient challenges with program belonging or relatability.
- **Share knowledge with and learn from community partners.** Connect with other treatment programs serving both similar and different communities. Reflect on how different programs identify and address disparities and engage and retain a variety of populations. Federal, state, or community organizations that serve underrepresented groups may be able to provide resources or serve as partners to advocate for funding to enable programs to incorporate initiatives to address disparities—for example, by enhancing staff training and expanding services to include telehealth.
- **Proactively connect patients who are not receiving optimal care for reasons related to marginalization with alternative programs** that may better suit their needs and circumstances or other resources that may be able to assist them.

A Note for Policymakers

While this document is not intended to be policy focused, policymakers play a key role in supporting SUD treatment programs' efforts to improve patient engagement and retention. Some federal and state policies can limit a program's ability to treat patients who are not abstinent. We recommend policymakers consider how they can help SUD treatment programs adopt the strategies outlined in this Clinical Consideration, including the following:

- **Consider the impact of state licensing requirements.** In certain states, program licenses are specific to a level of care. A consequence of this structure is that if a patient enrolled in treatment requires a different level of care, they must be transferred to a new program; patients are often lost to care during these transitions. One possibility to address this challenge is exploring licensing programs that provide multiple levels of care, minimizing the need for patients to disengage from one treatment program and engage with another treatment program elsewhere and supporting better continuity of therapeutic relationships. As patients move through the continuum of care within a single treatment organization, they may be able to continue receiving services from the same clinical staff with whom they have forged therapeutic alliances and maintain connections to the same peer support staff.
- **Reconsider policies that reduce access to care for nonabstinent patients.** Some state policies pose barriers to accessing treatment services—for example, by specifying only addiction specialist physicians can prescribe controlled medications to patients who are not currently abstinent, requiring patients to attend counseling sessions in order to access addiction medications, or not allowing programs to provide services to patients who are intoxicated. States should consider how these types of policies may prevent patients from initiating and continuing necessary care.
- **Reconsider policies that unintentionally promote administrative discharge.** Some states have policies that mandate discharge or transitions in care—for example, by requiring transition to a more intensive level of care after a certain number of positive drug tests within a given timeframe. States should consider how such policies may inadvertently drive patients from care.
- **Consider adjusting mandated reporting standards and procedures.** Presently, many treatment programs face large burdens related to mandated reporting—such as when patients are in possession of contraband drugs and instances of return to substance use—that are not consistent with the principles outlined in this Clinical Consideration. Aligning reporting mandates and protocols is important to create a cultural shift toward acceptance of nonabstinent treatment goals.
- **Consider how to appropriately reimburse clinicians, case managers, and other program staff for their efforts to re-engage and retain patients.** Currently, payers routinely consider a patient's last day of service as their last day of enrollment in a treatment program; program staff are therefore unable to bill or receive any resources for the time and effort they commit to re-engage disengaged patients. Regardless of their success, these efforts are critical for optimizing patient retention in treatment and, ultimately, patient health outcomes. Consequently, it is vital that programs have resources for re-engagement efforts. Outreach efforts to engage prospective patients should be similarly supported.

- **Consider aligning insurance benefits more appropriately with the realities experienced by many individuals with SUD.** Often, patients' benefits are cut off due to life disturbances such as incarceration, causing complex and lengthy reenrollment procedures following release. This can result in treatment disruptions or gaps in care when patients may be particularly vulnerable and in need of services. To minimize healthcare disruptions, payers can explore opportunities that allow for more continuous patient coverage.
- **Consider how payment policies may unintentionally incentivize administrative discharge.** Typically, IOPs provide a minimum of nine hours of services per week. In some states, if a patient in an IOP program participates in six hours of services in a given week, programs are unable to bill for the services provided. This can have a significant impact on the program's ability to continue treating the patient and may lead to administrative discharge.
- **Consider how to reduce barriers to telehealth services.** The flexibility provided by telehealth can make SUD treatment services more accessible, particularly for patients who live in rural or remote locations.[154] It can also help programs address capacity issues and integrate more specialized services.[154] Policymakers should consider how to address the inter- and intrastate barriers currently limiting the feasibility and effectiveness of SUD-focused telehealth services.

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Key Terms Glossary

abstinence: Complete cessation of the use of alcohol and other drugs.

addiction: A treatable chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.[155]

addiction medication: Medications that are specifically indicated for and prescribed to treat SUDs as an initial lifesaving measure, a motivational engagement strategy (ie, withdrawal management), and part of a long-term treatment plan similar to medications used to treat other chronic diseases such as bipolar disorder or diabetes.

administrative discharge: Staff- or program-directed involuntary termination of treatment services.[156]

co-occurring capable: In *The ASAM Criteria*, programs that have the capability to address patients with co-occurring mental health concerns, including trauma, in the routine course of addiction treatment. All levels of care described in *The ASAM Criteria* are expected to be co-occurring capable.

co-occurring enhanced (COE): In *The ASAM Criteria*, programs that have enhanced resources to routinely serve patients with more serious co-occurring mental health or cognitive conditions.[157]

cultural humility: A process of entering a relationship with another person with the intention of honoring their beliefs, customs, and values. It entails an ongoing self-exploration and self-critique combined with a willingness to learn from others.[158]

recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.[159]

therapeutic alliance: According to the American Psychological Association, "a cooperative working relationship between [patient] and therapist, considered by many to be an essential aspect of successful therapy. Derived from the concept of the psychoanalytic working alliance, the therapeutic alliance comprises bonds, goals, and tasks. Bonds are constituted by the core conditions of therapy, the [patient's] attitude toward the therapist, and the therapist's style of relating to the [patient]; goals are the mutually negotiated, understood, agreed upon, and regularly reviewed aims of the therapy; and tasks are the activities carried out by both [patient] and therapist."[160]

therapeutic milieu: A safe and secure treatment environment that provides structured programming in a holistic person-centered approach to care and uses community dynamics to promote healing in a multipronged fashion.

warm handoff: A care transition in which the referring clinician facilitates a direct (ie, face-to-face) introduction of the patient to the receiving clinician at their next level of care.[159]

American Society of Addiction Medicine
11400 Rockville Pike, Suite 200
Rockville, MD 20852