program by easing the transition from the controlled therapeutic environment to one in which alcohol and drugs are readily available.

As of 2008, in the United States, most substance abuse treatment is provided in outpatient settings, with residential or inpatient treatment restricted to those with severe comorbid medical or psychiatric problems (McKay, 2005). The continuing care phase in the outpatient model is typically delivered in group sessions, focuses on substance use, and is often structured like twelve-steps mutual/self-help programs.

Differences exist between the role of continuing care in outpatient programs and aftercare programs from the old residential service delivery model. In contrast with the inpatient model, most graduates of an outpatient treatment program have already demonstrated some ability to achieve and maintain abstinence outside a controlled environment (McKay et al., 2004). While maintaining abstinence is paramount for these individuals, some researchers argue that continuing care should also include other components of recovery, such as focus on improving the individual's social support system and making use of recovery houses. These researchers assert the need for vocationally- and activities-focused skills-training programs (Donovan, 1998).

Aftercare also plays an important role in drug treatment programs within U.S. prisons, although the evidence for its effectiveness continued to be evaluated in the early twenty-first century. In awarding residential substance abuse treatment grants for state prisoners, the Bureau of Justice Assistance requires states to give preference to programs that provide aftercare services. Also, the standard of care established by the Office of National Drug Control Policy specifies that community-based aftercare must continue for at least six months. In addition to this emphasis on aftercare, researchers emphasize the need to understand better how different criminal justice systems conceptualize and implement these programs. Standard definitions and procedures are needed to determine the level and intensity of services required for different types of offenders in various types of settings (Pelissiera et al., 2007).

Given that long-term programs are expensive, it makes sense to select candidates who will be best served by them. Research shows that some individuals with substance use disorders recover without formal treatment (Sobell et al., 1993) and that others experience durable improvements following such brief interventions as motivational interviewing. Individuals who are unable to achieve sustained reductions in alcohol or drug use either on their own or following brief interventions may be the best candidates for extended interventions (McKay, 2005).

See also **Methadone Maintenance Programs; Relapse.**

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TREATMENT: OUTPATIENT VERSUS INPATIENT SETTING. The marketplace for treatment for substance use disorders (often referred to as SUDs) offers a range of options from which to choose. These options are commonly classified as either *inpatient* or *outpatient* treatment. Selecting treatment is based on matching an individual's care needs with the necessary supports and an appropriate level of treatment intensity. Although many frameworks exist for describing the variety of treatment options along a continuum of care, the levels of care framework provided by the American Society of Addiction Medicine (ASAM) is one of the most widely used; it is

helpful for describing and differentiating between inpatient and outpatient treatments, as reported by the Center for Substance Abuse Treatment (1994).

INPATIENT TREATMENT

Inpatient treatment generally refers to treatment that is provided in a controlled environment, such as a residential center or hospital. Patients remain in these settings until they are deemed to be ready for treatment in an outpatient setting. Patients with significant withdrawal symptoms, serious medical conditions, suicidal or homicidal ideation, and an inability to function in the community, or those who reside in highly disruptive and unsupportive environments, may benefit most from inpatient treatment (Fuller & Hiller-Sturmhofel, 1999).

The ASAM distinguishes two types of inpatient treatment: medically *managed* and medically *monitored* treatment. Medically managed is the most intensive form of treatment. Because of its high costs, it is typically reserved for persons with acute care needs and severe comorbid conditions (McKay, 2001). Services include ongoing primary care to manage withdrawal symptoms and other psychiatric, medical, and emotional problems associated with substance dependence. This treatment creates a safe environment for detoxification, while allowing clinicians to make differential diagnoses, stabilize symptoms, and develop care management plans.

Medically monitored treatment is also provided in a residential setting but does not include primary medical services. Medically monitored treatments may be provided in private or public treatment centers, as well as state and local psychiatric hospitals. Treatment may last from several days to several weeks. Depending on the specific care needs of the patient, treatment may focus on managing symptoms, developing coping skills, reducing risk of self-harm, improving independent living skills, and establishing supportive social networks (see Daley & Salloum, 2001).

OUTPATIENT TREATMENT

Outpatient treatment involves nonresidential services and does not include an overnight stay in a hospital or treatment center. This type of treatment allows an individual to receive treatment services while maintaining normal daily activities. Outpatient treatments rely heavily on individual- or group-based psychosocial interventions including (but not limited to) cognitive-behavioral therapy (CBT), motivational enhancement therapy (MET), and psychoeducation. A meta-analysis conducted by Dutra and colleagues (2008) showed that psychosocial interventions for substance use disorders exhibited effect sizes that were comparable to other efficacious treatments in psychiatry. Pharmacological treatment is also considered an important treatment component for many patients in outpatient treatment. Such therapies may be agonist medications (e.g., methadone and buprenorphine for opioid dependence), antagonist medications (e.g., naltrexone for opioid dependence), abstinence- and relapse-preventing medications (e.g., disulfiram, naltrexone, and acamprosate for alcohol dependence; bupropion and varenicline for tobacco dependence), or those used for the treatment of comorbid psychiatric conditions (e.g., antidepressants, antipsychotics, and mood stabilizers) (Work Group on Substance Use Disorders et al. & American Psychiatric Association Steering Committee on Practice Guidelines et al., 2006).

The ASAM recognizes two levels of outpatient treatment: intensive outpatient and standard outpatient. Intensive outpatient treatment is the highest and most comprehensive level of outpatient treatment. Also referred to as partial hospitalization, it is considered a *step-down* from inpatient services. This treatment option bridges inpatient and outpatient services, offering daily treatment groups and professional contacts while allowing patients to return to their primary residence rather than stay overnight in a hospital. Intensive outpatient treatment may last a few days to a few weeks. Standard outpatient treatment differs in intensity and duration from intensive inpatient treatment and is offered in a variety of settings that range from community mental health centers to patient-driven support groups. Depending on the care needs of the patient, standard outpatient treatment may involve a few treatment sessions a month or multiple sessions each week.

Other outpatient treatment options exist, although they do not fall within the ASAM level of care taxonomy. For example, self-help groups, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and other 12-step models, are outpatient treatments that may constitute a person's primary form of treatment, may be an

adjunct to existing professional services, or may be a way of providing additional support following intensive treatment, also referred to as aftercare. For example, Gossop and coworkers (2008) reported that attending AA or NA meetings after receiving inpatient services was associated with higher levels of abstinence for opioids and alcohol at one, two, and five years follow-up compared to those who did not attend AA or NA, or who attended infrequently.

Brief interventions delivered by health service providers from numerous disciplines are another type of treatment. These are structured interventions of short duration—typically 5 to 30 minutes—designed to help people think differently about their level of substance use. They have been shown to reduce substance misuse, particularly alcohol consumption, and are cost-effective. Brief interventions can also serve to enhance a person's motivation to participate in formal treatment services. In addition to reducing substance use, brief interventions have also been found to reduce utilization of health-care services (e.g., Fleming, Barry, Manwell, et al., 1997).

Case management is another form of treatment for substance use disorders. This type of treatment does not directly target the substance use disorder. Instead, it helps address many of the commonly co-occurring psychosocial, psychiatric, and medical problems associated with substance use disorders that interfere with treatment. For example, case management for a patient with limited resources and lacking health insurance may seek to connect this individual with existing public support programs, as suggested by the Center for Substance Abuse Treatment (1998). There is growing evidence of the utility of case management. A series of randomized, controlled trials demonstrated the significant positive effects of case management on measures of substance use, employment, quality of life, psychological functioning, and service utilization (Vanderplasschen, Wolf, Rapp, et al., 2007; see also Saleh et al., 2002).

CONCLUSIONS

Although various frameworks exist to describe the continuum of care options for treating substance use disorders, no framework fully captures the significant heterogeneity that exists within the various types of inpatient and outpatient treatment options. For example, these different types of services may have differing theoretical orientations, terms of attendance, completion requirements, physical settings, and staff training requirements. Moreover, although the framework can help guide the selection of treatments, other factors also determine where an individual receives treatment. This includes, but is not limited to, the availability of services, connection with the criminal justice or psychiatric system of care, cultural compatibility of services, and funding.

It is also important to consider how these service types will continue to change in the future. In the early twenty-first century inpatient services remain the treatment of choice for severe and acute conditions; however, to reduce cost and increase access for underserved populations, many efforts are being made to adapt inpatient services to outpatient settings. Across all types of treatment options, additional research is needed to identify the key ingredients of treatment and determine how treatments can be better tailored for comorbid conditions. Research is also needed to understand better how treatments can be adapted for at-risk populations, such as minorities, women, and adolescents, as advanced by Ashley, Marsden, and Brady (2003).

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TREATMENT ACCOUNTABILITY FOR SAFER COMMUNITIES (TASC). Developed in 1972, the Treatment Accountability for Safer Communities (TASC) was created by President Richard M. Nixon's Special Action Office for Drug Abuse Prevention (SAODAP) and funded by the Law Enforcement Assistance Administration (LEAA) and the National Institute of Mental Health (NIMH). The acronym originally stood for "Treatment Alternatives to Street Crime," reflecting the original emphasis of the program. Since its inception, TASC has provided leadership and advocacy to foster and improve the integrated delivery of substance abuse treatment to nonviolent offenders. The first TASC programs under SAODAP were operational in Wilmington, Delaware, and Philadelphia, Pennsylvania.

In the mid-1990s, TASC programs received support from the U.S. Department of Justice through the Bureau of Justice Assistance (BJA) Criminal Justice Block Grants, which are given to state and local governments. (LEAA was discontinued in 1982.) Many TASC programs have expanded their base of support so that state and federal funding is supplemented by private donations and grants or client fees. In 2008 TASC was operating in more than 100 jurisdictions in 28 of the U.S. states and territories. National TASC provides membership association and represents over 220 programs across the United States. The programs supported by National TASC are dedicated to the professional delivery of assessment and case management services to substance-involved individuals in the criminal justice and court systems. TASC has a large presence in some states, such as Florida, New York, North Carolina, Ohio, Pennsylvania, Illinois, Arizona, and Colorado.

Since the 1970s, TASC has evolved from providing the infrastructure to manage clients throughout the criminal justice system and supporting both justice and treatment independently to working in conjunction with drug courts, reentry management programs, and other efforts. The idea for the initial TASC programs derived from an analysis of the criminal justice system that indicated that many drug-addicted arrestees were released on bail while awaiting trial, and that these individuals were likely to continue to commit crimes. Although there were provisions for supervision of drug-dependent offenders after conviction (through probation) or after release from prison (through parole), no such mechanisms were in place to provide supervision of those awaiting trial. It was felt that if these arrestees could be directed to treatment, any success in treatment could be taken into consideration at the time of trial.

In addition to being an effective program model, TASC has also brought together the critical elements fundamental to integrating the criminal justice and substance abuse treatment systems. Both of these systems, as well as the offenders, are held accountable through the implementation of client-specific case