

Pacific Behavioral Health Collaborating Council (PBHCC)

IC&RC Alcohol and Drug Counselor (ADC) Academy Curriculum

Day 2: Core Competencies of Addiction Counselors – Knowledge and Skill Acquisition of Screening, Intake, Orientation, Assessment, Treatment Planning, and Counseling

Trainer Guide

Developed in 2018 by the Pacific Southwest Addiction Technology Transfer
Center and UCLA Integrated Substance Abuse Programs



IC&RC Alcohol and Drug Counselor Academy, Day 2

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IC&RC Alcohol and Drug Counselor Academy, Day 2

Background Information

The IC&RC Alcohol and Drug Counselor (ADC) Academy curriculum is a weeklong training designed to prepare individuals based in the six U.S.-affiliated Pacific Jurisdictions to successfully pass the IC&RC ADC certification exam. The duration of the ADC Academy is forty hours of content spread across five full days of training. Funding for the development of the ADC Academy was provided by the Pacific Behavioral Health Collaborating Council (PBHCC). The curriculum is broken into five modules/days, which include:

- Day 1: Introduction to the IC&RC ADC Performance Domains and Review of Psychoactive Drugs
- Day 2: Core Competencies of Addiction Counselors – Knowledge and Skill Acquisition of Screening, Intake, Orientation, Assessment, Treatment Planning, and Counseling
- Day 3: Core Competencies of Addiction Counselors – Knowledge and Skill Acquisition of Case Management, Crisis Intervention, Client and Family Education, Referral, Report and Record Keeping, and Consultation
- Day 4: Core Competencies of Addiction Counselors – Prevention and Treatment of HIV/AIDS and Sexually Transmitted Infections
- Day 5: Course Review and Test-Taking Strategies

What Does the Training Package Contain?

- PowerPoint Training Slides (with notes)
- Trainer's Guide with detailed instructions for how to convey the information and conduct the interactive exercises

What Does This Trainer's Guide Contain?

- Slide-by-slide notes designed to help the trainer effectively convey the content of the slides themselves
- Supplemental information for select content to enhance the quality of instruction
- Suggestions for facilitating group discussions

How is This Trainer's Guide Organized?

For this guide, text that is shown in bold italics is a ***"Note to the Trainer."*** Text that is shown in normal font relates to the "Trainer's Script" for the slide.

It is important for trainers to become acquainted with the slides and practice delivering the content of the presentation, ensuring a successful, live training experience.

General Information about Conducting the Training

The training is designed to be conducted in medium-sized groups (20-30 people). It is possible to use these materials with larger groups, but the trainer may have to adapt the small group exercises/case studies and discussions to ensure that there is adequate time to cover all of the content.







Materials Needed to Conduct the Training

- Computer with PowerPoint software installed (2010 or higher version recommended) and LCD projector to show the PowerPoint training slides.
- When making photocopies of the PowerPoint presentation to provide as a handout to training participants, it is recommended that you print the slides three slides per page with lines for notes. Select **"pure black and white"** as the color option. This will ensure that all text, graphs, tables, and images print clearly.
- Flip chart paper and easel/white board, and markers/pens to write down relevant information, including key case study discussion points.

Overall Trainer Notes

It is critical that, prior to conducting the actual training, the trainer practice using this guide while showing the slide presentation in Slideshow Mode in order to be prepared to use the slides in the most effective manner.

Icon Key

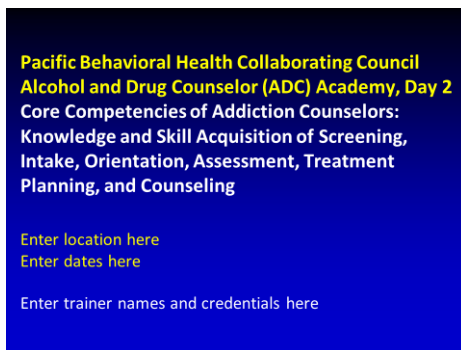
	Note to Trainer		Activity
	References		Audience Response System (ARS)-Compatible Slide
	Image Credit		Video Source

PBHCC Alcohol and Drug Counselor (ADC) Academy, Day 2

Core Competencies of Addiction Counselors: Knowledge and Skill Acquisition of Screening, Intake, Orientation, Assessment, Treatment Planning, and Counseling

Slide-By-Slide Trainer Notes

The notes below contain information that can be presented with each slide. This information is designed as a guidepost and can be adapted to meet the needs of the local training situation. Information can be added or deleted at the discretion of the trainer(s).



Slide 1: [Title Slide]



- ***Welcome participants to day 2.***
- ***Ask participants if they have any questions from day 1.***
- ***Orient participants to the training room/facility and to the nearest bathroom.***

Acknowledgements

This training was developed by Dr. Thomas E. Freese, PhD (Director of Training of UCLA ISAP and Director of the Pacific Southwest ATTC), Alex R. Ngiraingas, MEd, CSAC II, ICADC, ICPS, and Dr. Christopher C. C. Rocchio, PhD, LCSW, CSAC, ICADC (Clinical Specialist, UCLA) in August of 2018 under contract number 2018-002 by the University of California Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP) and the Pacific Southwest Addiction Technology Center (PSATTC) for the Pacific Behavioral Health Collaborating Council (PBHCC).

Slide 2: Acknowledgements

- This training was developed by Drs. Thomas Freese and Christopher Rocchio from the University of California Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP) and with Alex Ngiraingas, an addictions counselor and educator from the Republic of Palau. We would like to acknowledge and thank the Pacific Behavioral Health Collaborating Council (PBHCC) for their commitment to train individuals across the Pacific to effectively prevent, treat, and support individuals in their own recovery from substance use disorders, and for their financial support for the development and delivery of this curriculum. Additional resource provided by SAMHSA, grant number UR1TI080211.

Disclaimer for Training

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Slide 3: Disclaimer for Training



- **[READ THE SLIDE]**

Today's Agenda (1)

- Review and check-in
- Twelve Core Functions
 - **Screening**
 - Intake
 - Orientation
 - Assessment
 - Treatment Planning
 - Counseling

Agenda for Screening

- Definition of screening
- Importance of establishing rapport
- Importance of using diagnostic criteria
- DSM-5 Criteria for Substance Use Disorders
- Context of treatment settings
- Common screening tasks
- Global Criteria

Slide 4: Today's Agenda (1)



- ***Orient participants to the day's agenda.***
- ***The focus of day 2 is on the first 6 core functions.***

Slide 5: Agenda for Screening



- ***Orient participants to the session's agenda.***

PEDAGOGICAL SUGGESTIONS:

- ***[ASK PARTICIPANTS] How do you screen clients for substance use disorders in your current employment settings?***
- ***[ASK PARTICIPANTS] Why is systematic screening critical and necessary for treating substance use disorders?***
- ***[ASK PARTICIPANTS] What are the differences between screening and assessment?***

(Notes for Slide 5, continued)

Definition of Screening

- “Screening is the process by which the counselor, the client, and available significant others review the current situation, symptoms, and other available information to determine the most appropriate initial course of action, given the clients needs and characteristics and the available resources within the community” (CSAT, 2006, p.39).
- “The process by which a client is determined to be appropriate and eligible for admission to a particular program” (IC&RC)

Reference:
Center for Substance Abuse Treatment. (2006). *Addiction counseling competencies: the knowledge, skills, and attitudes of professional practice*. Technical Assistance Publication (TAP) Series 21 (HHS Publication No. (DMM) 11-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Hendricks, S. W. (2015). *Global criteria: the 12 core functions of the substance abuse counselor* (7th ed.). Lincoln, NE: Parallel: Pathways to Change.

Slide 5: Agenda for Screening

- ***Distribute copies of non-proprietary screening measures (e.g., AUDIT, DAST) with which you are familiar. The measures should vary in length and complexity.***

Slide 6: Definition of Screening

- The CSAT and IC&RC offer the following definitions for screening.



- ***[READ THE BULLETED LIST ON THE SLIDE]***

- Eligibility criteria are generally determined by the focus, target population and funding requirements of the program or agency



- ***[ASK PARTICIPANTS] What are your thoughts on these two definitions?***

(Notes for Slide 6, continued)

Slide 6: Definition of Screening



REFERENCES

Center for Substance Abuse Treatment. (2006). *Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice.*

Technical Assistance Publication (TAP) Series 21 (HHS Publication No. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Herdman, J.W. (2018). *Global criteria: The 12 core functions of the substance abuse counselor* (7th ed.). Lincoln, NE: Parallels: Pathways to Change.

Importance of Establishing Rapport

- Consider the different pathways the client has arrived in your agency.
- Screening presents hope.
- Screening provides an opportunity to establish rapport.
- Screening may influence how the individual engages the SUD system of care.

Slide 7: Importance of Establishing Rapport

- Clients arrive to treatment through many different pathways. Some are court-ordered to receive treatment; others were encouraged by family and friends to seek help for their use of alcohol or drugs. In some cases, clients recognized their own need for treatment. This may be the first time a client is seeking help for one or more substance use disorders. Individuals may have limited insight into the negative impact substance use is having on their life and the lives of their loved ones. Others may have relapsed after a period of abstinence and may feel guilt or shame.

(Notes for Slide 7, continued)

Establishing Rapport (continued)

- Orient the client to the meeting/screening agenda
- Listen to understand: use active listening
 - Use open, non-threatening and non-judgmental questions
 - Use simple reflections
 - Use encouraging prompts (e.g., tell me more about that)
 - Use a warm tone of voice
 - Ask clarifying or follow-up questions

Slide 7: Importance of Establishing Rapport

- Regardless of the pathway, screening presents an opportunity to provide emotional support and to establish rapport. This may be the only time that you interact with the client; however, your actions may impact how the individual chooses to engage the system of care.



- ***[ASK PARTICIPANTS] What are some steps that we as counselors can take to establish rapport with our clients?***

Slide 8: Establishing Rapport (continued)

- When we first meet with the client, we should begin with a brief orientation and review of the meeting agenda. We describe the purpose of screening and outline what the client can expect during the encounter. If you are using screening tools, you explain why you are using them and their purpose.

(Notes for Slide 8, continued)

Slide 8: Establishing Rapport (continued)

- If your agency uses laboratory testing, you clearly explain the process, rationale, and potential outcomes if the client tests positive for one or more substances.



- ***[ASK PARTICIPANTS] How do you describe the use of screening tools to your clients?***
- ***[ASK PARTICIPANTS] How do you explain the process and rationale for the use of laboratory testing?***
- We remember and make a conscious effort to listen to our clients. We want to begin with understand where the client is in their recovery. What are they bringing to the encounter? We are clear about the time we have allocated to meet with them and what will transpire during the meeting. We use open questions.

(Notes for Slide 8, continued)

Slide 8: Establishing Rapport (continued)



- ***[ASK PARTICIPANTS] What is the difference between a closed and open question? Please offer examples to differentiate between***
- We use simple reflections.



- ***[ASK PARTICIPANTS] What is the difference between a question and reflection?***
- We are thoughtful about the tone and intonation of our voice. Often, we use upward intonations when asking a question. We should be mindful and purposeful to use a downward intonation when offering reflections. In addition, we purposefully and intentionally ensure to speak slowly. We use clarifying and follow-up questions as well as reflections to suggest and make a concerted effort to listen.

(Notes for Slide 8, continued)

Slide 8: Establishing Rapport (continued)



- ***[ASK PARTICIPANTS] Why do we want to establish rapport?***
- We want clients to feel safe and secure. Further, we want our clients to provide us with honest, meaningful, and relevant information to help us make the best decision in partnership with the client to ensure they are receiving the right treatment at the right time at the right frequency and the right intensity.

Importance of Using Diagnostic Criteria

- All counselors must use objective criteria to determine whether the applicant's alcohol and drug use constitutes a substance use disorder (SUD).
- All counselors must be familiar with and recognize specific examples of the various psychological, physiological, and social signs and symptoms of SUDs.

Slide 9: Importance of Using Diagnostic Criteria

- The use of honest and valid information helps us determine whether clients meet diagnostic criteria for one or more substance use disorders. Further, information collected at screening will help us with determining whether clients are eligible or appropriate for admission. Accurate and reliable data will help us with making an informed decision on placing the client in the most appropriate level of care or service setting within the addiction continuum of care, and to make an informed decision when referring clients to other health and social service providers.

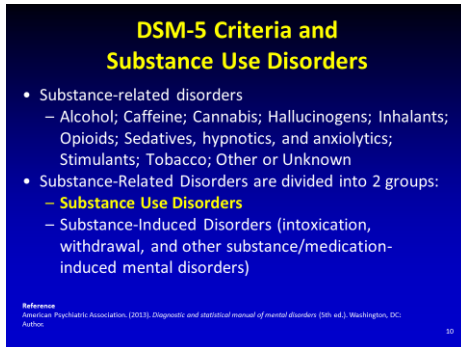
(Notes for Slide 9, continued)

Slide 9: Importance of Using Diagnostic Criteria

- Entry-level counselors are expected to know the diagnostic criteria outlined by the most current version of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual for Mental Disorders or DSM for substance related disorders. At this time, the most current version is the fifth edition of the DSM.



- ***[ASK PARTICIPANTS] What do you know about substance-related disorders?***



Slide 10: DSM-5 Criteria and Substance Use Disorders

- According to the APA, substance related disorders are mental disorders. Mental disorders are syndromes characterized by significant disturbances in an individual's thinking, emotion regulation, and behaviors. Disturbances reflect dysfunction in biological, developmental, psychological, or psychosocial processes and are associated with significant distress or disability in social functioning, occupational functioning, and other importance life activities. Substance related disorders are organized by substance and divided into 2 groups: substance use disorders and substance-induced disorders. We will only focus on substance use disorders in today's training.

(Notes for Slide 10, continued)

Slide 10: DSM-5 Criteria and Substance Use Disorders

GENERAL NOTES FOR TRAINER

- According to the APA, DSM-5 does not separate the diagnoses of substance abuse and dependence as it did in previous editions. Rather, criteria are provided for substance use disorder, accompanied by criteria for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders, where relevant. The DSM-5 substance use disorder criteria are nearly identical to the DSM-IV substance abuse and dependence criteria combined into a single list, with two exceptions. The DSM-IV recurrent legal problems criterion for substance abuse has been deleted from DSM-5, and a new criterion, craving or a strong desire or urge to use a substance, has been added.

(Notes for Slide 10, continued)

DSM-5 Criteria (continued)

- “Cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems” (APA, 2013, p. 483).
- Eleven (11) criteria organized into four groupings:
 - Impaired control (criteria 1 – 4),
 - Social impairment (criteria 5 – 7),
 - Risky use (criteria 8 - 9), and
 - Pharmacological criteria (criteria 10 – 11)

Reference
American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

11

Slide 10: DSM-5 Criteria and Substance Use Disorders



REFERENCE

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Slide 11: DSM-5 Criteria (continued)

- Substance use disorders are a...



- **[READ THE FIRST BULLET]**
- Eleven (11) criteria are organized into four groups. The four groups are impaired control or loss of control, social impairment, risky use, and pharmacological criteria. Please note, the DSM-5 re-conceptualized substance use disorders and no longer uses the terms abuse and dependence; rather, the number of criteria denotes whether the SUD is classified as mild, moderate or severe. Let's start with the first four criteria.

(Notes for Slide 11, continued)

Impaired Control / Loss of Control

- **Criterion 1:** Increased amounts over longer periods of time. The substance is often taken in larger amounts or over a longer period than was intended.
- **Criterion 2:** Individual may express desire to cut down or regulate substance use or describe unsuccessful efforts to decrease or quit the substance.
- **Criterion 3:** A great deal of time is dedicated to obtaining, using, or recovering from the effects of the substance.
- **Criterion 4:** Cravings – an intense desire or urge for the substance.

Reference
American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

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Slide 11: DSM-5 Criteria (continued)



REFERENCE

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Slide 12: Impaired Control / Loss of Control

- Four criteria have been classified as signs and symptoms of impaired control. The first criterion is that the individual is consuming the specific substance in larger amounts or over longer periods of time than what was intended. The second criterion for impaired control is that the individual expresses their desire to decrease or regulate intake or consumption of the substance; however, they are unable to do so or unable to quit altogether. The third criterion is that the individual is dedicating a great deal of time in obtaining, using, and recovering from the effects of the substance.

(Notes for Slide 12, continued)

Slide 12: Impaired Control / Loss of Control



- ***[ASK PARTICIPANTS] What are specific examples regarding impaired control that have been reported to you or that you have seen from your clients?***
- The fourth criteria is that the individual describes experiencing periodic cravings to use.



- ***[ASK PARTICIPANTS] What have clients described to you when they experience cravings for alcohol or illicit drugs?***
- ***[ASK PARTICIPANTS] Are there any questions regarding the first four criteria?***



REFERENCE

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Social Impairment

- **Criterion 5:** Recurrent use of the substance may result in a failure to fulfill major obligations at work, school, or home.
- **Criterion 6:** Continued use of the substance despite persistent or recurrent social and interpersonal problems cause or exacerbated by the effect of the substance.
- **Criterion 7:** Reduction or end to social, recreational, or occupational activities because of substance use.

Reference
American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. Washington, DC: Author.

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Slide 13: Social Impairment

- Three criteria relate to social impairment. The first criterion is that use of the specific substance has resulted in failure to fulfill obligations at work, school or home.



- ***[ASK PARTICIPANTS] What are specific examples of this criterion that have been reported to you by your clients?***
- The second criterion is that the individual continues to use despite ongoing and recurrent social and interpersonal problems.



- ***[ASK PARTICIPANTS] What are examples that you have seen or been reported to you by your clients?***
- The third criterion is that individuals will reduce or stop engaging in social, recreational or occupational activities because of their use.

(Notes for Slide 13, continued)

Slide 13: Social Impairment



- **[ASK PARTICIPANTS] Are there any questions regarding these criteria?**



REFERENCE

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Slide 14: Risky Use

- Two criteria relate to risky use. The first criterion is that individuals will continue to use in situations where it is physically dangerous or hazardous. The second is that the individual continues to use despite their knowledge of having recurrent physical or psychological problems that were either caused by or made worse by the substance.

Risky Use

- **Criterion 8:** Recurrent use in situations where it is physically hazardous to use the substance.
- **Criterion 9:** Continued use of the substance despite knowledge of having a persistent or recurrent physical or psychological problems likely to have been caused or exacerbated by the substance.

Reference
American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

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(Notes for Slide 14, continued)

Slide 14: Risky Use



- ***[ASK PARTICIPANTS] When have you seen clients continue to use despite them knowing that their continued use contributes to a problem or makes the problem worse?***
- ***[ASK PARTICIPANTS] Are there any questions regarding these criteria?***



REFERENCE

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Pharmacological Criteria

- **Criterion 10:** Tolerance
 - Increased dose to achieve desired effect.
 - Reduced effect when usual dose is consumed.
 - Tolerance may be difficult to determine by history alone, consider laboratory tests or other methods (e.g., alcohol).
 - Individual variability of the initial sensitivity to the effects of different substances.

Reference
American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

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Slide 15: Pharmacological Criteria

- Two criteria relate to pharmacological criteria. The first is tolerance.



- **[ASK PARTICIPANTS] What is tolerance?**
- Tolerance is the individual's need to increase the amount used to achieve a desired effect.



REFERENCE

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Pharmacological Criteria (continued)

- **Criterion 11: Withdrawal**
 - Blood or tissue concentrations of a substance decline...prolonged heavy use.
 - Use to maintain homeostasis or to relieve symptoms.
 - Variability in symptoms across different classes of substances.
 - Marked and measurable physiological signs common in some substances (e.g., alcohol) whereas none in others (e.g., hallucinogens).
- **Neither tolerance or withdrawal are necessary for a diagnosis of a substance use disorder.**

Reference
American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. Washington, DC: Author.

Slide 16: Pharmacological Criteria (continued)

- The second criterion for pharmacological criteria is withdrawal.



- ***[ASK PARTICIPANTS] What is withdrawal?***
- Withdrawal is characterized by signs and symptoms that manifest upon cessation of (usually heavy and/or prolonged) use. Each class of substances have its own characteristic withdrawal syndromes. Withdrawal often manifests as a return to use of the substance to relieve or avoid typically unpleasant and/or painful symptoms.



- ***[ASK PARTICIPANTS] Are there any questions regarding tolerance or withdrawal?***

(Notes for Slide 16, continued)

**Slide 16: Pharmacological Criteria
(continued)**

- We want to emphasize here, especially for those who are familiar with or accustomed to using previous versions of the DSM, neither tolerance or withdrawal are necessary for a diagnosis of a substance use disorder.



REFERENCE

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Severity and Specifiers

- Severity is based on the number of symptom criteria endorsed:
 - Mild: Presence of 2 – 3 symptoms
 - Moderate: Presence of 4 – 5 symptoms
 - Severe: Presence of 6 or more symptoms
- Severity may change over time.
- Specifiers
 - In early remission (e.g., individual just stopped using)
 - In sustained remission
 - On maintenance therapy (e.g., methadone)
 - In a controlled environment (e.g., hospital or residential treatment center)

Reference:
American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC:
Author.

Slide 17: Severity and Specifiers

- In order to meet diagnostic criteria for one or more substance use disorders, the individual must have 2 or more of the 11 criteria. According to the APA, “substance use disorders occur in a broad range of severity, from mild to severe, with severity based on the number of symptoms criteria endorsed” (p. 484). As a general estimate, severity of a substance use disorder is based on the number of symptom criteria endorsed. An individual may meet mild criteria if they present 2 or 3 symptoms, moderate if they present 4-5 symptoms, and severe if they present 6 or more symptoms. Severity may change based on the individual’s decision and efforts to increase or decrease use, changes in what is reported by the client, reports made by others, including the client’s collateral contacts, your observations and results from different laboratory testing. There are also different course specifiers for each class of substances. Definitions of each are provided in the DSM-5 within their respective criteria set.

(Notes for Slide 17, continued)

Slide 17: Severity and Specifiers



- ***[ASK PARTICIPANTS] Are there any questions regarding severity and specifiers?***



REFERENCE

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Recording Procedures and the DSM-5

- Record the name of the specific substance.
- Substances not categorized into 10 classes should be recorded as other substance use disorder, and specify the specific substance.
- Identify and record **ALL** substance use disorders.

Reference
American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

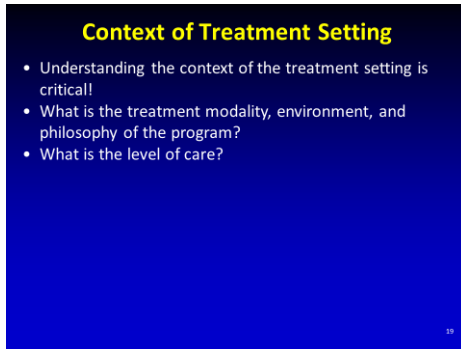
Slide 18: Recording Procedures and the DSM-5

- It is important that only licensed, qualified health care professionals diagnose and use specific diagnostic codes when recording the client's diagnosis in the client's chart. The qualified health care professional is expected to use the appropriate diagnostic code(s) and to document all disorders in accordance to specific standards.



REFERENCE

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.



Slide 19: Context of Treatment Setting

- Besides the knowledge and skills necessary for establishing provisional diagnoses, the counselor is responsible for considering a number of factors for determining the most appropriate course of action to support the client. The counselor should be familiar with the context of their treatment setting. The counselor must be able to answer the following questions:
 - What are the admission/eligibility criteria for the program?
 - What specific role or function does the agency provide?
 - How soon are services available – is there a wait list?
 - What are other specific access-related issues or concerns?
 - What is the agency's philosophy or agency's philosophy of care?
 - What are the costs to attend the program or to participate in treatment?

(Notes for Slide 19, continued)

Slide 19: Context of Treatment Setting

- What are the programs' policies on use of psychotherapeutic medications?
- What are the program's policies on the use of pharmacotherapy for substance use disorders?
- How is the program structured?
- What is the estimated length of stay or number of days for different levels of care?
- What is the intensity of services?

Slide 20: Context (continued)

- In addition to the questions just asked, other factors for appropriateness may include, but are not limited to:
 - The physical and mental condition of the client to the specific level of care,
 - The presence of a serious mental or medical issue that needs to be addressed,

Context (continued)

- The determination of a potential client's appropriateness for a program requires a great degree of judgment and skill.
- **Important factors include:**
 - Physical health condition of the client
 - The psychological functioning of the client
 - Outside supports and resources
 - Previous treatment efforts
 - Motivation for change

Reference
Henderson, L. W. (2018). Global criteria: the 12 core functions of the substance abuse counselor (7th ed.). Lincoln, NE: Paradigm Pathways to Change.

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(Notes for Slide 20, continued)

Slide 20: Context (continued)

- The availability of community supports and resources to support the client as they move forward in their own recovery,
- The success or failure of previous treatment efforts, and
- The client's legal status.



REFERENCE

Herdman, J.W. (2018). *Global criteria: The 12 core functions of the substance abuse counselor* (7th ed.). Lincoln, NE: Parallels: Pathways to Change.

Slide 21: Common Screening Tasks

- Here are some common screening tasks. The aim is to implement systematic and fair processes for determining whether a client should continue with the intake process or be referred to another program.

Common Screening Tasks

- Assemble and complete screening forms.
- Screening forms generally ask questions regarding the client's demographics (age, sex, residence), presenting problems, previous treatment efforts, level of commitment to change, outside recovery supports, and insurance.
- Analyze all information to determine client eligibility and appropriateness for program.
- If client is appropriate, begin arrangements for intake.
- If client is not appropriate, investigate referral options and discuss options with the client (see Referral).

(Notes for Slide 21, continued)

Slide 21: Common Screening Tasks



- ***[READ THE BULLETED LIST ON THE SLIDE]***
- ***[ASK PARTICIPANTS] What screening forms are currently being used at your agency?***
- ***[ASK PARTICIPANTS] How do you determine whether a client should be referred to intake?***
- ***[ASK PARTICIPANTS] What other types of screening questions are asked at your agency?***
- ***[ASK PARTICIPANTS] What happens after a determination is made that the client meets initial eligibility criteria?***
- ***[ASK PARTICIPANTS] How and when do you refer the client to another provider?***
- We will discuss the core function of referral in tomorrow's training.

Global Criteria for Screening

1. Evaluate the psychological, social, and physiological signs & symptoms of alcohol and other drug abuse.
2. Determine the client's appropriateness for admission or referral.
3. Determine the client's eligibility for admission or referral.
4. Identify any coexisting conditions (medical, psychiatric, physical, etc.) that indicate the need for additional assessment and/or services.
5. Adhere to applicable laws, regulations, and agency policies governing alcohol and drug abuse services.

Reference
Herdman, S. W. (2018). Global criteria: the 12 core functions of the substance abuse counselor (7th ed.). Lincoln, NE: Paradigm Pathways to Change.

Slide 22: Global Criteria for Screening

- The IC&RC have identified five criteria as necessary skills needed to perform the core function of screening. Herdman (2018) explains that the skills in the first criterion are many and varied. Counselors must have knowledge of and recognize the psychological, social, and physiological signs & symptoms of substance use disorders. Knowledge of the program's eligibility criteria, target population, program focus and funding is critical as evident in the second criterion that asserts that counselors must demonstrate the ability for determining appropriateness for admission or referral. The third criterion is determining appropriateness by understanding different levels of care. Knowledge of the American Society of Addiction Medicine, or ASAM Criteria, which we will discuss shortly, is widely used and aids in this process. The fourth criterion highlights the expectation of counselors to identify and screen for co-occurring or co-existing conditions and refer if and when the client would benefit from additional professional assessment and services.

(Notes for Slide 22, continued)

Slide 22: Global Criteria for Screening

- Herdman (2018) reiterates that importance of counselors to practice within their scope and to facilitate further evaluation and treatment when necessary. The last criterion is ensuring compliance to all applicable laws, regulations, and policies of the program.



- ***[ASK PARTICIPANTS] What are specific laws governing privacy and confidentiality for individuals receiving SUD services?***



REFERENCE

Herdman, J.W. (2018). *Global criteria: The 12 core functions of the substance abuse counselor* (7th ed.). Lincoln, NE: Parallels: Pathways to Change.

Group Activity for Screening

- Establish your own outpatient treatment center.
- What is the name of your outpatient treatment center?
- Who does your center serve?
- What screening tools and processes will you use?
- Be prepared to report out
- Be prepared to ask questions and offer suggestions to support your colleagues



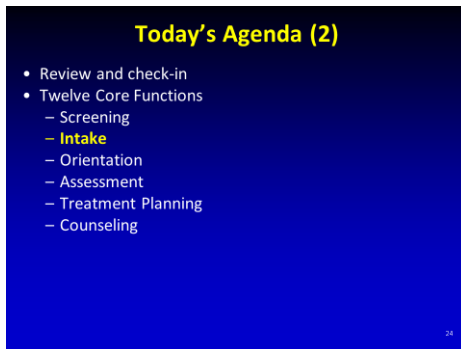
Slide 23: Group Activity for Screening

- ***Assign participants to work in small groups.***
- ***Consider having participants count off in numbers to ensure that participants are assigned to work with others with whom they do not know.***
- ***Groups should be no smaller than 3 people and no larger than six.***
- ***Advise everyone to gather in their small group.***
- ***Each group will be tasked with establishing their own outpatient treatment center.***
- ***The group will first need to come up with a group name. Allow no more than 3 minutes for this task.***
- ***After, the group will need to decide and be able to describe their target population and their scope of services.***
- ***Distribute copies of non-proprietary screening measures with which you are familiar with. The measures should vary in length and complexity.***

(Notes for Slide 23, continued)

Slide 23: Group Activity for Screening

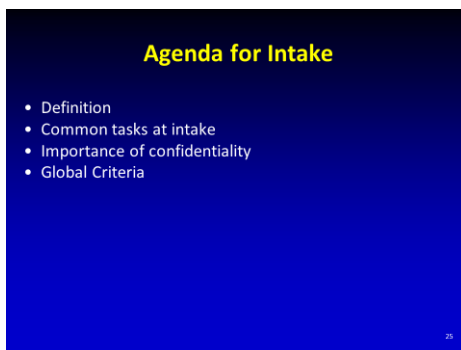
- *Allow 15 minutes for participants to:*
 - *(1) Choose a measure that they will use for their program. They may choose to use another screening form or develop their own; however, they will need to describe why they chose to use another tool or develop their own. Regardless, all groups will need to succinctly describe why they chose one or more measures and*
 - *(2) Describe (in detail) their processes for screening participants.*
- *Randomly choose one or two groups to report out.*
- *After each group presents, [ASK PARTICIPANTS] Do you have any questions for this group? Do you have any recommendations on ways this group can improve their processes for screening potential clients?*



Slide 24: Today's Agenda (2)



- ***[ASK PARTICIPANTS] Do you have any questions regarding the first core function of screening?***
- ***Orient participants to the day's agenda.***



Slide 25: Agenda for Intake



- ***Orient participants to the session's agenda.***

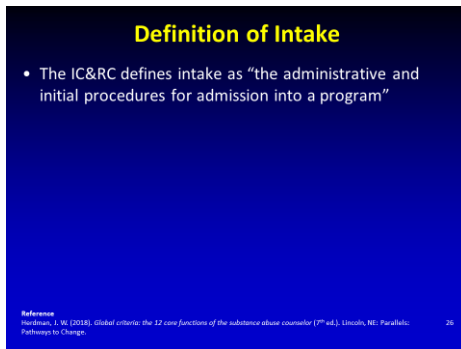
PEDAGOGICAL SUGGESTIONS:

- ***One of the UCLA trainers distributes a form while reviewing the agenda for this session and asks participants to sign and date the form. The form includes very small print on the bottom of the form that most participants will ignore. The first three sentences includes standard language that is specific to the training. The remaining part of the document includes statements that suggest that participants will send monthly payments to the trainer.***

(Notes for Slide 25, continued)

Slide 25: Agenda for Intake

- *The last sentence emphasizes that the document is for training purposes only, is not valid, and that participants should not sign the document. Participants who have read the statement and did not sign the document are asked to pass the form to their neighbor and to not say anything until all participants had an opportunity to review and sign/not sign the form. Most often, participants will not pay attention to the fine print and sign the document. After the form is returned to the trainer, the trainer asks for a volunteer. The volunteer is asked to read the fine print. The trainer asks for the document back and shreds it. Thereafter, the trainer asks participants to explain the relevance to intake. This should be done prior to reviewing the slide on common tasks of intake.*
- *[ASK PARTICIPANTS] What does intake look like at your agency?*
- *[ASK PARTICIPANTS] What are the common tasks that occur during intake at your agency?*



Slide 26: Definition of Intake

- The IC&RC offers the following definition for intake



- **[READ THE FIRST BULLET ON THE SLIDE]**
- **[ASK PARTICIPANTS] What are your thoughts on this definition?**

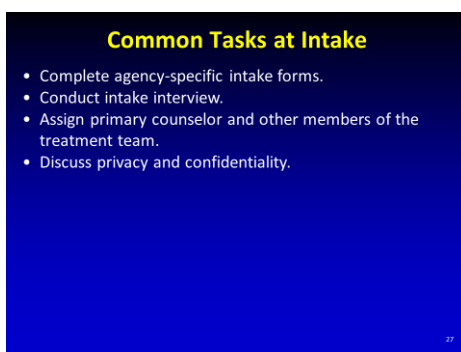


REFERENCE

Herdman, J.W. (2018). *Global criteria: The 12 core functions of the substance abuse counselor (7th ed.)*. Lincoln, NE: Parallels: Pathways to Change.

Slide 27: Common Tasks at Intake

- Intake is often considered an extension of screening. Clients most likely have completed some form of screening to be deemed eligible and appropriate for the program. There are some common tasks that occur across SUD programs during intake. However, these tasks may look different depending on the program and the specific level of care.



(Notes for Slide 27, continued)

Slide 27: Common Tasks at Intake

- For example, consider intake processes and procedures at a residential program and compare them to intake processes and procedures at an outpatient program. Almost all clients will be asked to review and complete a number of forms specific to the program, including client information forms, client rights and responsibilities, consent for treatment, and release of information forms. It is important that you take the time to review each form with the client. It is unethical to have a client sign a form without them understanding what they are signing and making an informed decision on whether to sign it.



- ***[ASK PARTICIPANTS] How do you ensure clients know what they are signing?***
- In some settings, clients are asked a series of questions after reviewing specific paperwork and prior to signing forms.

(Notes for Slide 27, continued)

Slide 27: Common Tasks at Intake

- Many of us have become complacent simply signing or clicking agreements without reading the fine print for various types of agreements.



- ***[ASK PARTICIPANTS] How many of you have smart phones? Raise your hand. How many of you have read the user agreements for various applications or to updates to your phone's operating system? What did the agreement say about your privacy and how the company will use your data?***
- ***[IF APPLICABLE, ASK PARTICIPANTS] How did it feel for those of you who signed the form not knowing what was stated in the fine print?***
- ***[ASK PARTICIPANTS] What types of assumptions do your clients make when signing forms?***
- At intake, you may be tasked with completing an intake interview. The interview may focus on establishing initial treatment goals and objectives.

(Notes for Slide 27, continued)

Slide 27: Common Tasks at Intake

- These goals and objectives should be informed by your client's needs, preferences, and priorities. It is also at intake that you may be assigning different members of the treatment team and explaining their roles and responsibilities. Finally, all clients should be informed about their rights to privacy and confidentiality.

Importance of Confidentiality and Intake

- Educate the client to various state and federal rules and regulations protecting their identity.
 - Explain in both oral and written form.
 - Explained in a way that can be easily understood
- Addressing confidentiality builds trust and rapport.
- Addressing confidentiality minimizes anxiety.

Slide 28: Importance of Confidentiality and Intake

- In tomorrow's training when discussing the core function of report and record keeping, we will be dedicating a significant amount of time reviewing two federal laws: (1) the Health Insurance Portability and Accountability Act (HIPAA), and (2) 42 Code of Federal Regulations (CFR) Part 2. It is critical that we educate clients to various federal and state laws addressing privacy and confidentiality. Information on privacy and confidentiality must be presented in a way that is easily understood.



- ***[ASK PARTICIPANTS] When can a program disclose information about a client receiving SUD treatment?***

Global Criteria for Intake

6. Complete the required documents for admission.
7. Complete the required documents for program eligibility and appropriateness.
8. Obtain appropriately signed consents when soliciting information from, or providing information to, outside sources to protect client confidentiality and rights.

Reference:
Henderson, S. W. (2018). Global criteria: the 12 core functions of the substance abuse counselor (7th ed.). Lincoln, NE: Paradigm Pathways to Change.

Slide 29: Global Criteria for Intake

- The IC&RC have identified three criteria as necessary skills needed to perform the core function of screening. The first and second criteria are straightforward. Counselors must know which forms must be signed or completed at admission. Counselors should be aware of specific procedures when clients choose to not sign specific forms or participate in specific tasks that are necessary for documenting eligibility and appropriateness.



- ***[ASK PARTICIPANTS] What is your agency's policy when a client chooses to not sign the consent to treatment form?***

The third criterion emphasizes (1) the counselor's knowledge of various laws and regulations regarding privacy and confidentiality specific to substance use disorder patient records, and (2) ability to facilitate authorizations to acquire or obtain information from another source, and to release information to a third party or other source.

(Notes for Slide 29, continued)

Slide 29: Global Criteria for Intake



- ***[ASK PARTICIPANTS] According to 42 CFR Part 2, what are the required elements for written consent?***



REFERENCE

Herdman, J.W. (2018). *Global criteria: The 12 core functions of the substance abuse counselor* (7th ed.). Lincoln, NE: Parallels: Pathways to Change.

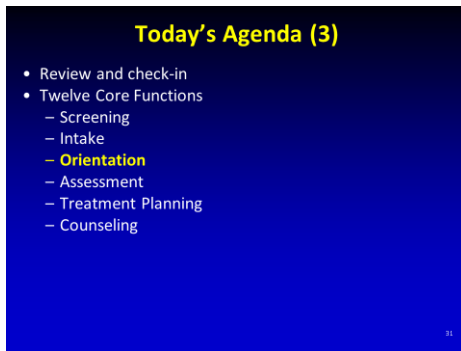
Group Activity for Intake

- What does intake look like in your outpatient center?
- What specific forms do clients need to complete at intake?
- What processes will you employ to ensure clients know what they are signing?
- Be prepared to report out to the larger group.
- Be prepared to ask questions and offer suggestions to support your colleagues.



Slide 30: Group Activity for Intake

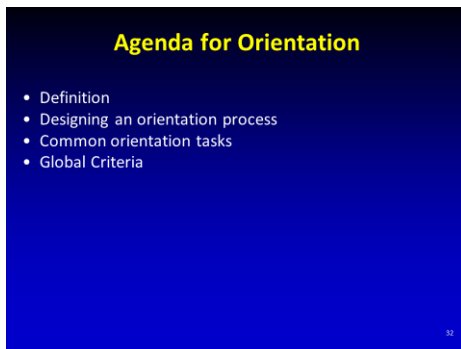
- **Ask participants to gather into their small groups.**
- **Instruct participants to create an intake process for their outpatient center that they established at screening.**
- **Allow 15 – 20 minutes for participants to:**
 - **(1) Outline intake procedures within their outpatient center,**
 - **(2) Identify all forms that would need to be completed at intake, and**
 - **(3) Describe (in detail) their processes for ensuring clients understand what they are signing.**
- **Randomly choose one or two groups to report out.**
- **After each group presents, [ASK PARTICIPANTS] Do you have any recommendations on ways that these outpatient centers (referring to the groups that reported out) can improve their intake process?**



Slide 31: Today's Agenda (3)



- ***[ASK PARTICIPANTS] Do you have any questions regarding intake?***
- ***Orient participants to the day's agenda.***



Slide 32: Agenda for Orientation



- ***Orient participants to the session's agenda.***

PEDAGOGICAL SUGGESTIONS:

- ***[ASK PARTICIPANTS] What does orientation look like in your agency?***
- ***[ASK PARTICIPANTS] What are the common tasks that occur during orientation at your agency?***
- ***[ASK PARTICIPANTS] Think about a time when you participated in some form of orientation. What do you remember most about the process? What would you have changed about the process and why?***

Definition of Orientation

- The IC&RC defines orientation as “describing to the client the general nature and goals of the program; the rules governing client conduct and infractions that can lead to disciplinary action or discharge from the program; in a non-residential program, the hours during which services are available; the treatment costs that are to be borne by the client, if any; and the client rights”

Reference
Herdman, J. W. (2018). *Global criteria: the 12 core functions of the substance abuse counselor* (7th ed.). Lincoln, NE: Parallels: Pathways to Change.

Slide 33: Definition of Orientation

- The IC&RC offers the following definition for orientation.



- [READ THE SLIDE]**
- [ASK PARTICIPANTS] What are your thoughts on this definition?**
- Orienting clients to the nature of the program may occur before, during, or after screening or intake.



REFERENCES

Center for Substance Abuse Treatment. (2006). *Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice.*

Technical Assistance Publication (TAP) Series 21 (HHS Publication No. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Herdman, J.W. (2018). *Global criteria: The 12 core functions of the substance abuse counselor* (7th ed.). Lincoln, NE: Parallels: Pathways to Change.

Designing an Orientation Process

- Describing essential information about the program to support clients with assimilating into the program so that the client can focus on treatment.
- Choosing culturally-and linguistically-informed processes for presenting information to diverse client groups.
- Presenting rules, regulations, and consequences for program infractions that is easily understood by clients.

Slide 34: Designing an Orientation Process

- One of the main goals of orientation is to support clients with assimilating into the program so that they can focus on treatment and on their recovery. It is critical that all orientation materials are culturally-and linguistically-informed.



- ***[ASK PARTICIPANTS] What does it mean to create orientation processes that are culturally and linguistically informed?***
- ***[ASK PARTICIPANTS] What are some processes that you could employ or your agency uses to ensure that clients understand program rules, client obligations, and consequences for program infractions?***

Designing a Process (continued)

- Aim to create a safe, warm and welcoming space where clients may discuss their fears and misconceptions about treatment.
- Aim to create a safe and secure space where clients are encouraged to ask questions about rules, regulations, and expectations.
- Aim to create a process to ensure clients understand their rights and responsibilities.

Slide 35: Designing a Process (continued)

- In addition to creating processes that are culturally and linguistically relevant and informed, it is important to consider how you may go about creating a safe and secure space where clients are encouraged to discuss their concerns, fears, assumptions and potential misconceptions of the program or treatment in general. We want to encourage clients to ask questions about their treatment and about program rules and regulations.



- ***[ASK PARTICIPANTS] What do you do in your current settings to create a warm and welcoming space?***
- ***[ASK PARTICIPANTS] What could you do differently in the future?***
- ***[ASK PARTICIPANTS] How do you ensure that clients understand their rights and responsibilities?***
- ***[ASK PARTICIPANTS] What could you do differently in the future?***

Common Orientation Tasks

- If applicable, complete an orientation checklist which may include, but not be limited to the following:
 - Overview of program philosophy and treatment modalities used, program expectations and client responsibilities, and program rules and regulations
 - Provide a tour of the facility.
 - If residential or inpatient, assign bed and screen clothing and personal belonging for contraband materials.

Slide 36: Common Orientation Tasks

- Most programs use a checklist for orientation. Here is a list of common orientation tasks:



- ***[READ THE BULLETED SLIDE]***

Slide 37: Common Orientation Tasks (continued)

Common Orientation Tasks (continued)

- Review and have clients sign an acknowledgement form that they have reviewed, understand, and have received a copy of their rights.
- Client rights should include, but not be limited to:
 - Assurance of privacy and confidentiality
 - Right to review and participate in treatment planning
 - Impartial access to treatment
 - Recognition of personal property
 - Visits, mail, and telephone calls



- ***[READ THE FIRST BULLET]***
- Although it may seem redundant and this may have occurred during intake, it is important to review client rights and responsibilities.



- ***[READ THE SECOND BULLET AND LIST]***
- ***[ASK PARTICIPANTS] What are other client rights and responsibilities that are specific to your agency?***

Global Criteria for Orientation

9. Provide an overview to the client by describing program goals and objectives for client care.
10. Provide an overview to the client by describing program rules and client obligations and rights.
11. Provide an overview of program operations.

Reference:
Henderson, S. W. (2018). Global criteria: the 12 core functions of the substance abuse counselor (7th ed.). Lincoln, NE: Paradigm Pathways to Change.

Slide 38: Global Criteria for Orientation

- The IC&RC have identified three criteria as necessary skills needed to perform the core function of orientation. The first criterion emphasizes the importance for counselors to provide a clear description of the program's goals and how the program aims to fulfill these goals by describing the program's philosophy of care and interventions employed. Orienting the client to the program's goals helps the client to make an informed decision on whether to participate or terminate from services.



- ***[ASK PARTICIPANTS] How do you orient client's to your program goals? What do you do when there is a disconnect between the program's goals and your client's personal goals?***
- The second criterion is specific to orienting all clients to program rules, client obligations, and client rights.

(Notes for Slide 38, continued)

Slide 38: Global Criteria for Orientation



- ***[ASK PARTICIPANTS] What are the rules of your program? How do you ensure clients understand program rules? How often do you review program rules with clients? What happens when clients violate one or more rules?***
- Herdman (2008) suggests thinking of client obligations as client responsibilities or client expectations.



- ***[ASK PARTICIPANTS] What are client responsibilities or expectations for your programs? How do you ensure that clients understand and honor their obligations?***

(Notes for Slide 38, continued)

Slide 38: Global Criteria for Orientation

- In addition to client obligations, clients should be aware of their rights. These rights are stated in various laws (e.g., confidentiality), through your program's accreditation boards, and in your program's policies and procedures. The last criterion is the expectation that counselors are familiar with and able to provide an overview of their program's operations. Essentially, what does a typical day look like in the program... what can a client expect their day to look like if they choose to participate or enroll.



[ASK PARTICIPANTS] Are there any questions regarding these three criteria?



REFERENCE

Herdman, J.W. (2018). *Global criteria: The 12 core functions of the substance abuse counselor* (7th ed.). Lincoln, NE: Parallels: Pathways to Change.

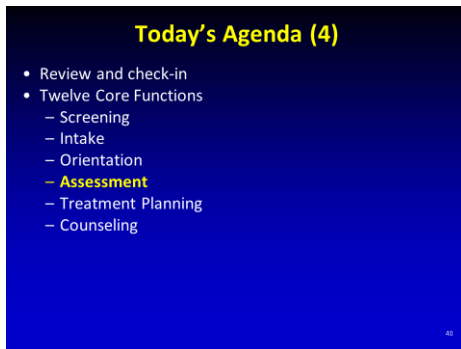
Group Activity for Orientation

- Who does orientation look like in your outpatient center?
- Create a checklist. What agenda items would you include would you include in your checklist?
- Be prepared to report out.
- Be prepared to ask questions and offer suggestions to support your colleagues.



Slide 39: Group Activity for Orientation

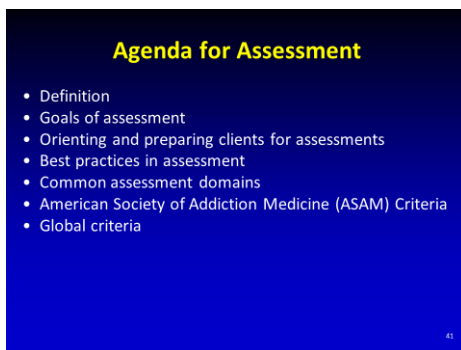
- **Ask participants to gather into their small groups.**
- **Instruct participants to create an orientation process for their outpatient center.**
- **Allow 15 – 20 minutes for participants to:**
 - **(1) Describe (in detail) their processes for orienting clients to their program,**
 - **(2) describe processes for reviewing program rules, client obligations, and client rights, and**
 - **(3) develop a list of agenda items that would be included in their orientation checklist.**
- **Randomly choose one or two groups to report out.**
- **After each group has presented, [ASK PARTICIPANTS] Do you have any recommendations for ways this group can improve their orientation process?**



Slide 40: Today's Agenda (4)



- ***[ASK PARTICIPANTS] Do you have any questions regarding orientation?***
- ***Orient participants to the day's agenda.***



Slide 41: Agenda for Assessment



- ***Orient participants to the session's agenda.***

PEDAGOGICAL SUGGESTIONS:

- ***[ASK PARTICIPANTS] What are the goals of assessment?***
- ***[ASK PARTICIPANTS] How do you assess clients at your agency or clinic? What types of questions do you ask?***

Definition of Assessment

- "Assessment is an ongoing process through which the counselor collaborates with the client and others to gather and interpret information necessary for planning treatment and evaluating client progress" (CSAT, 2006, p.46).
- Assessment is defined by the IC&RC as "those procedures by which a counselor/program identifies and evaluates an individual's strengths, weaknesses, problems and needs for the development of the treatment plan"

Reference
 Center for Substance Abuse Treatment. (2006). Addiction counseling competencies: the knowledge, skills, and attitudes of professional practice. Technical Assistance Publication (TAP) Series 22. (990) Publication No. (SMA) 02-41711. Rockville, MD: Substance Abuse and Mental Health Services Administration.
 Hardman, J. W. (2018). Global criteria: the 12 core functions of the substance abuse counselor (7th ed.). Lincoln, NE: Parallel: Pathways to Change.

Slide 42: Definition of Assessment

- The CSAT and IC&RC offer the following definitions for assessment.



- ***[READ THE SLIDE]***
- ***[ASK PARTICIPANTS] What are your thoughts on these definitions?***

Screening is a process for determining the possible presence of one or more substance use disorders and the possible need for treatment. Assessment on the other hand, is a process for defining the nature of the problem, determining a diagnosis, and developing specific treatment recommendations.

(Notes for Slide 42, continued)

Slide 42: Definition of Assessment



REFERENCES

Center for Substance Abuse Treatment. (2006). *Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice.*

Technical Assistance Publication (TAP) Series 21 (HHS Publication No. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Herdman, J.W. (2018). *Global criteria: The 12 core functions of the substance abuse counselor* (7th ed.). Lincoln, NE: Parallels: Pathways to Change.

Goals of Assessment

- Synthesize, integrate, analyze and interpret information **necessary for planning treatment and evaluating client progress.**
- First step in shared decision making.
- Ensure that the client is matched to the right level of care within the SUD treatment continuum.
- Identify client strengths and resources that may support them in their own recovery.
- Identify the client's unique needs and preferences.
- Identify potential and real barriers to treatment.
- Communicate findings and treatment recommendations to clients, their supporters, and to others involved in their care.

Reference
Adams, N. & Grieder, D. M. (2014). *Treatment planning for person-centered care: shared decision making for whole health* (2nd ed.). Waltham, MA: Elsevier Inc.

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Slide 43: Goals of Assessment

- The goals of assessment are to collect, integrate, synthesize, analyze and interpret information to ensure that the client is getting the right treatment, at the right time, at the right frequency, and at the right intensity. Assessment also provides us with information going forward to monitor and evaluate client progress. Assessment allows us to identify and appreciate the unique attributes and needs of individuals and their families. Assessment is not only about identifying what's wrong or what has happened to clients, but also to understand, appreciate, and to use their unique strengths, abilities, and past successes in treatment. We want to incorporate and integrate our clients' strengths and resources to support them in their own recovery. Adams & Grieder (2014) emphasize, "The importance of a strengths-based approach to assessment cannot be overstated. An immediate focus on problems and shortcomings all too often leads to feelings of shame, blame, and failure.

(Notes for Slide 43, continued)

Slide 43: Goals of Assessment

- This does not promote openness or support engagement and partnership; it does not set the stage for a successful recovery endeavor” We also want to pay particular attention to and incorporate our client's needs and preferences throughout treatment. The client’s needs and preferences should be clearly documented in the assessment and in the client’s treatment plan. Assessments should identify potential and real barriers to care, and how the treatment team will address or aim to resolve these barriers.



REFERENCE

Adams, N. & Grieder, D.M. (2014). *Treatment planning for person-centered care: Shared decision making for whole health* (2nd ed.). Waltham, MA: Elsevier Inc.

Goals of Assessment (continued)

- In a recovery-oriented, strengths-based, person-centered, culturally-and linguistically-informed approach to care, the focus is on action rather than on emphasizing and cataloging all deficits and problem areas.
- Individualized treatment requires comprehensive assessments.
- Assessment is more than gathering data – it is the initiation of building a trusting, helping, healing and therapeutic relationship.
- Assessments are not static.

Reference
Adams, N. & Grieder, D. M. (2014). *Treatment planning for person-centered care: shared decision making for whole health* (2nd ed.). Waltham, MA: Elsevier Inc.

Slide 44: Goals of Assessment (continued)

- The focus of assessment should be on action. Helping clients move forward in their own recovery.



- ***[ASK PARTICIPANTS] How do you orient your clients to the assessment process?***
- ***[READ THE SECOND AND THIRD BULLET ON THE SLIDE]***
- ***[ASK PARTICIPANTS] Assessments are not static – what does that mean?***
- Assessment is a fluid process. They are ongoing. They are not limited to one event. People are highly complex and change. Change is constant.



REFERENCE

Adams, N. & Grieder, D.M. (2014). *Treatment planning for person-centered care: Shared decision making for whole health* (2nd ed.). Waltham, MA: Elsevier Inc.

Orienting and Preparing the Client for the Assessment

- Orient the client to the assessment process:
 - How long?
 - What kinds of questions will be asked?
 - What are the limits to confidentiality?
- Orienting the client to the use of laboratory testing.

Reference
Munich, J. (2014). *The first interview* (4th ed.). New York, NY: Guilford Press.

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Slide 45: Orienting and Preparing the Client for the Assessment

- Clients should receive information on how long the assessment process will take, the types of questions that will be asked, the client's rights and choice to not answer questions asked during the assessment, and most importantly, the limits to privacy and confidentiality.



- ***[ASK PARTICIPANTS] How do you address the limits of confidentiality when orienting clients to the assessment process?***
- Client should receive information on the use of laboratory testing and be forewarned regarding the potential consequences, if any, when clients test positive for one or more substances or when clients choose to not provide specimen at specified or random times. Clients should be informed why the agency uses laboratory testing. There are numerous forms of laboratory testing and it is important to review what types of testing are used in your agency for your client to provide informed consent.

(Notes for Slide 45, continued)

Slide 45: Orienting and Preparing the Client for the Assessment

- Laboratory tests vary depending on the type of drug being tested and the type of specimen being collected. It is important to review the accuracy of each test and to address myths and common excuses when clients test positive for one or more substances.



- ***[ASK PARTICIPANTS] How do you approach this topic in your organization or agency? What tests are used in your agency?***



REFERENCE

Morrison, J. (2014). *The first interview* (4th ed.). New York, NY: Guilford Press.

Best Practices in Assessment

- Be present
- Minimize potential distractions
- Be accepting and encouraging
- Be sensitive to culture and gender
- Ask for clarification
- Use a combination of open questions and reflections
- Allow for silence
- Focus on balancing present behavior with history
- If permitted and with consent, seek out information from collateral contacts

Reference
Substance Abuse and Mental Health Services Administration. (2003). Substance abuse treatment for persons with co-occurring disorders: Treatment Improvement Protocol (TIP) Series 42 (HHS Publication No. (SMA) 13-3992). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 46: Best Practices in Assessment



PEDAGOGICAL SUGGESTION:

- ***Ask participants a question specific to their knowledge of best practices in assessment and immediately look at your cell phone or at other materials while the participant answers your question. Refrain from making eye contact. Immediately after, ask the participant how it felt when they were answering your question and you were clearly distracted.***
- We want to create and maintain a safe, nonjudgmental, secure, comfortable, and private environment for our clients. We want them to feel welcomed. We want to give our clients our undivided attention by minimizing distractions. Our nonverbal behaviors are as important, if not more important, in how and what we are verbally communicating to clients. We accept our clients where they are in their own recovery.

(Notes for Slide 46, continued)

Slide 46: Best Practices in Assessment

- We don't necessarily agree with their choices, actions, behaviors, or opinions; however, we accept them for who they are in this moment in their own recovery and remember and appreciate that all individuals have the capacity for change. We recognize and appreciate that we may not share the same values and opinions of our clients. We provide encouragement to our clients. We recognize that clients come to treatment through different pathways and that we have little knowledge about their journeys and how they have arrived. We regularly review and orient the client to the assessment agenda. We use a combination of closed and open questions and we allow for moments of silence. The American Society of Addiction Medicine reminds us that we should focus on the present, the here and now, not solely on history. There needs to be a balance between the two. Human memory is fallible. Thus, it's important to collect information, with the client's consent, from collateral contacts (e.g., family members, friends, significant others).

(Notes for Slide 46, continued)

Slide 46: Best Practices in Assessment



- ***[ASK PARTICIPANTS] What other approaches are considered best practices in your community that is specific to assessment?***
- ***[ASK PARTICIPANTS] If you were tasked to promote or educate others outside of your community on culturally-informed practices that are specific to assessment, what is missing from this list?***

Common Assessment Domains

- History (comprehensive and longitudinal) and current use of substances
- SUD treatment history
- Acute safety risk related to intoxication or withdrawal
- Sociocultural history
- Interpersonal and family history, including parenting and caregiver history

Reference

Center for Substance Abuse Treatment. (2009). Substance abuse treatment: addressing the specific behavioral health needs of women. Treatment Improvement Protocol (TIP) Series 55 (HHS Publication No. (SMA) 09-4426). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2012). Addressing the specific behavioral health needs of men. Treatment Improvement Protocol (TIP) Series 55 (HHS Publication No. (SMA) 12-4796). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2005). Substance abuse treatment for persons with co-occurring disorders. Treatment Improvement Protocol (TIP) Series 42 (HHS Publication No. (SMA) 05-3992). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 47: Common Assessment Domains

- Assessments typically begin with asking the client why are they here now?
 - Why are they seeking services?
 - Why is the client seeking help now?
 - What brought them to your office?
 - What do they hope to accomplish by participating in treatment?
- Thereafter, the scope of any substance use assessment is contingent on the service setting, the specific issues of the individual client, state regulations as well as other standards set forth by the agency's accreditation body and funders. In this module, we provide a general overview of assessment domains that are often addressed in both inpatient and outpatient settings. We strongly recommend use of a tool or assessment instrument to guide this process. For example, the Addiction Severity Index is a widely used assessment instrument in clinical settings. However, do not rely solely on tools or assessment instruments.

(Notes for Slide 47, continued)

Slide 47: Common Assessment Domains

- Another consideration is use of a semi-structured interview or checklist to ensure all necessary information is obtained. Assessing for substance use disorders begins with asking specific questions regarding current and past use of alcohol and illicit drugs, including use of prescription medications not prescribed to the client. The assessment will (1) help us to determine whether the client meets diagnostic criteria for one or more substance use disorders; (2) better understand the reasons for initiation of use and continued use, as well as potential patterns of alcohol and drug use; (3) be aware of the history of use in previous and present relationships, including family members and significant others; and (4) understand the impact or effects alcohol and drugs have had on the client's life and the lives of their loved ones and other supporters. The assessment should provide a detailed chronological/ comprehensive longitudinal history of substance use, including periods of abstinence and involvement in treatment.

(Notes for Slide 47, continued)

Slide 47: Common Assessment Domains

- Questions should examine:
 - Inventory of all drugs used in the past and present
 - Age at first use for alcohol and all drugs
 - Patterns of use
 - Route of administration for each drug
 - Functional status
 - Frequency of use
 - Tolerance
 - Withdrawal
- In addition, the assessment should be contextual:
 - What are the client's expectations of use?
 - What are the immediate reinforcers?
 - What are the positive aspects of use?
 - What are the negative aspects of use?
 - What are the client's internal and external triggers to use?

(Notes for Slide 47, continued)

Slide 47: Common Assessment Domains

- Always remember is to aim for specificity! If the client has received treatment in the past, it is helpful to know what they received and what their response was to treatment. What was the outcome? All assessments should screen for acute safety risks related to intoxication and withdrawal. There are a number of tools available to support you with screening clients for safety; however, these tools should only be used as a starting point. Sociocultural history examines the client's social support network, its size and composition, and level of acceptance and support of the client's recovery. This domain examines cultural attitudes and beliefs pertaining to substance use and recovery, spiritual practices that should be considered or incorporated (if feasible) into treatment, acculturation conflicts and stressors, as well as cultural and linguistic needs, preferences, and supports. other caregiver support needs. Sociocultural, interpersonal and family history provides insights into the client's level of social isolation prior to entering treatment.

(Notes for Slide 47, continued)

Slide 47: Common Assessment Domains

- Interpersonal and family history specifically examines the client's family's level of acceptance and support of the client's recovery, history of substance use within the family, child care and other caregiver support needs. Sociocultural, interpersonal, and family history provides insights into the client's level of social isolation prior to entering treatment.



REFERENCES

Center for Substance Abuse Treatment. (2009). *Substance abuse treatment: Addressing the specific behavioral health needs of women*. Treatment Improvement Protocol (TIP) Series 55 (HHS Publication No. (SMA) 09-4426). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2013). *Addressing the specific behavioral health needs of men*. Treatment Improvement Protocol (TIP) Series 55 (HHS Publication No. (SMA) 13-4736). Rockville, MD: Substance Abuse and Mental Health Services Administration.

(Notes for Slide 47, continued)

Slide 47: Common Assessment Domains



REFERENCES, continued

Substance Abuse and Mental Health Services Administration. (2005). *Substance abuse treatment for persons with co-occurring disorders*. Treatment Improvement Protocol (TIP) Series 42 (HHS Publication No. (SMA) 13-3992). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Assessment Domains (continued)

- Educational, vocational, and military history
- Legal history
- Housing status
- Spirituality and religiousness
- Medical history and physical health
- Mental health and treatment history
- Motivation
- Strengths and coping skills

Reference
Center for Substance Abuse Treatment. (2009). Substance abuse treatment: addressing the specific behavioral health needs of women. Treatment Improvement Protocol (TIP) Series 55 (HHS Publication No. (SMA) 09-4426). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2013). Addressing the specific behavioral health needs of men. Treatment Improvement Protocol (TIP) Series 55 (HHS Publication No. (SMA) 13-4736). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 48: Assessment Domains (continued)

- Educational, vocational, and military history examines the client's educational attainment, current and past employment, vocational goals and training needs, financial self-reliance, and military history. If the person served in the military, it is helpful to ask how they separated from the military, and their history of traumatic events or violence. Legal history examines various issues, including past or current involvement with child protective services, current or past restraining orders, as well as any past history or current involvement with the justice system. Counselors should be aware of whether the clients is currently on probation or parole or being monitored by the justice system, and to what degree the client will consent to the counselor releasing information to the justice system. Housing examines the client's current living conditions and potential housing needs.

(Notes for Slide 48, continued)

**Slide 48: Assessment Domains
(continued)**

- The Substance Abuse and Mental Health Services Administration suggests that spiritual assessments, should at minimum, “determine the client’s denomination, beliefs, and spiritual practices, if any, should identify how these might affect [their] treatment or pose barriers to participation in mutual-help groups or other treatment practices... specific questioning about how spirituality has helped a client through difficult times can elicit spiritual strengths that might positively influence substance abuse treatment” (p. 19).



- ***[ASK PARTICIPANTS] What kinds of questions would you ask to learn about the client’s spirituality?***

(Notes for Slide 48, continued)

**Slide 48: Assessment Domains
(continued)**

- Medical history and physical health related questions should identify all allergies; history of major illnesses, including the diagnosis and treatment of infectious diseases; previous hospitalizations; co-morbid medical conditions; current use of over-the-counter and prescription medications, including hormone replacement therapy and medications to treat substance use disorders; general nutrition; sleep patterns; weight changes; last physical examination and last dental examination. In addition, assessments should take into consideration and examine the physical health care needs of women, men, transgender and gender non-conforming individuals.



- ***[ASK PARTICIPANTS] What kinds of questions do you currently ask your clients regarding their medical history and physical health related needs?***

(Notes for Slide 48, continued)

**Slide 48: Assessment Domains
(continued)**

- Mental health and treatment history should examine the clients (as well as their family's) history of mental illness, their prior treatment history, and relationships with prior and current mental health treatment providers. This domain should also ask specific questions regarding previous or current threats of suicide or homicide, interpersonal violence, including physical and sexual abuse, and history of prior traumatic events. Motivation to change examines the client's readiness for treatment and helps to determine whether the client is receiving stage appropriate services. We will discuss more about stage appropriate services in the context of the stages of change in tomorrow's training. All counselors should explore client strengths. Strengths may include, but are not limited to personal attributes, knowledge, skills, attitudes, interests, aspirations and hobbies.

(Notes for Slide 48, continued)

**Slide 48: Assessment Domains
(continued)**

- In the context of assessment for substance use disorders, examine the various challenges the client has endured and how they had managed to overcome or cope, review prior attempts to quit alcohol and/or drugs and ask the client to identify and describe strategies employed and their effectiveness. Further, the assessment should examine and identify other successes in making changes in other areas of the client's life.



- ***[ASK PARTICIPANTS] How do you go about learning about client strengths? How do you incorporate their strengths into treatment?***

(Notes for Slide 48, continued)

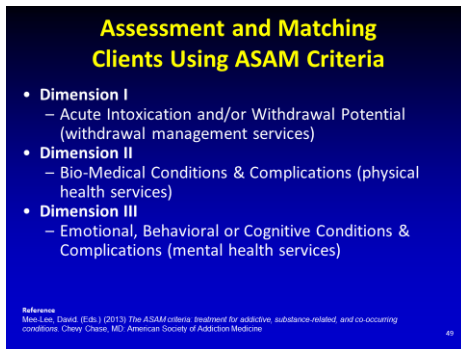
**Slide 48: Assessment Domains
(continued)**



REFERENCES

Center for Substance Abuse Treatment. (2009). *Substance abuse treatment: Addressing the specific behavioral health needs of women*. Treatment Improvement Protocol (TIP) Series 55 (HHS Publication No. (SMA) 09-4426). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2013). *Addressing the specific behavioral health needs of men*. Treatment Improvement Protocol (TIP) Series 55 (HHS Publication No. (SMA) 13-4736). Rockville, MD: Substance Abuse and Mental Health Services Administration.



Slide 49: Assessment and Matching Clients Using ASAM Criteria

- The American Society of Addiction Medicine or ASAM offers a system and process for matching clients to the most appropriate treatment setting through the use of a multidimensional assessment and treatment planning process. The ASAM Criteria is the most widely used and accepted standard for making decisions regarding client placement. There are six dimensions within the ASAM criteria's multidimensional assessment. They include:
 - Acute Intoxication and/or Withdrawal Potential
 - This dimension assesses the need for withdrawal management by examining the client's current level of intoxication, previous withdrawal history, and current physical and psychological signs and symptoms.

(Notes for Slide 49, continued)

**Slide 49: Assessment and Matching
Clients Using ASAM Criteria**



- ***[ASK PARTICIPANTS] When exploring an individual's past and current experiences of substance use and withdrawal, what questions would you ask in the assessment?***
- ***Listen for, acknowledge, and offer the following:***
- ***What risk is associated with current level of intoxication?***
- ***Are intoxication management services needed?***
- ***What is the risk of severe withdrawal symptoms, seizures or other medical complications?***

(Notes for Slide 49, continued)

Slide 49: Assessment and Matching Clients Using ASAM Criteria

- *Are there current signs of withdrawal?*
- *What are the scores of the standardized withdrawal rating scales?*
- *What are the client's vital signs?*
- *Does the client have support to complete an ambulatory withdrawal, if medically safe to consider?*
- Biomedical Conditions and Complications:
- This dimension assesses for co-occurring physical health conditions or complications.



- *[ASK PARTICIPANTS] When exploring an individual's health history and current physical condition, what questions would you ask in the assessment?*

(Notes for Slide 49, continued)

**Slide 49: Assessment and Matching
Clients Using ASAM Criteria**

- ***[INSTRUCTIONS] Listen for, acknowledge, and offer the following:***
- ***Other than withdrawal, what are the current physical illnesses that should be addressed?***
- ***What are the chronic conditions that need to be stabilized?***
- ***Is there a communicable disease present that could impact the well-being the client, other clients, or staff?***
- ***Is the client pregnant? What is her pregnancy history?***
- **Emotional, Behavioral, or Cognitive Conditions and Complications:**
- **This dimension assesses for co-occurring mental health conditions or complications.**



- ***[ASK PARTICIPANTS] When exploring an individual's thoughts, emotions, and mental health issues, what questions would you ask in the assessment?***

(Notes for Slide 49, continued)

**Slide 49: Assessment and Matching
Clients Using ASAM Criteria**

- ***[INSTRUCTIONS] Listen for, acknowledge, and offer the following:***
- ***Are there psychiatric, psychological, behavioral, emotional or cognitive conditions needing to be addressed?***
- ***What if any chronic conditions need to be stabilized (e.g., bipolar disorder or chronic anxiety)?***
- ***Are the behavioral or cognitive symptoms part of the addictive disorder?***
- ***If related to the substance use, do the emotional, cognitive, or behavioral conditions require mental health care (e.g., suicidal ideation and depression)***
- ***Is the client able to participate in daily activities?***
- ***Can she/he cope with the emotional, behavioral, or cognitive conditions?***

(Notes for Slide 49, continued)

**Slide 49: Assessment and Matching
Clients Using ASAM Criteria**



REFERENCE

Mee-Lee, D. (Eds.). (2013). *The ASAM criteria: Treatment for addictive, substance-related, and co-occurring conditions*. Chevy Chase, MD: American Society of Addiction Medicine.

**Assessment and Matching Clients
(continued)**

- **Dimension IV**
– Readiness to Change (motivational services)
- **Dimension V**
– Relapse, Continued Use, Continued Problems Potential (relapse and prevention services)
- **Dimension VI**
– Recovery and Living Environment (recovery support services)

References
MacLure, David. (Eds.) (2013) *The ASAM criteria: treatment for addictive, substance-related, and co-occurring conditions*. Chevy Chase, MD: American Society of Addiction Medicine.

Slide 50: Assessment and Matching Clients (continued)

- Readiness to Change
 - This dimension assesses the client's readiness to change.



- ***ASK PARTICIPANTS] When exploring an individual's readiness and interest in changing, what questions would you ask in the assessment?***
- ***[INSTRUCTIONS] Listen for, acknowledge, and offer the following:***
- ***How aware is the client of the relationship between her/his substance use and behaviors involved in the pursuit of reward or relief of negative life consequences?***
- ***How ready, willing or able does the client feel to make changes to her/his behaviors?***
- ***How much does the client feel in control of his or her treatment service?***

(Notes for Slide 50, continued)

Slide 50: Assessment and Matching Clients (continued)

- Relapse, Continued Use, or Continued Problems Potential
 - This dimension assesses the client's readiness for managing future relapses or relapse potential. Here, the counselor examines the client's locus of control, risk factors, engagement and awareness of recovery, internal and external triggers, and coping strategies.



- ***[ASK PARTICIPANTS] When exploring an individual's relapse experiences and history of continued use, what questions would you ask in the assessment?***
- ***[INSTRUCTIONS] Listen for, acknowledge, and offer the following:***
- ***Is the client in immediate danger of continued mental health distress or substance use?***

(Notes for Slide 50, continued)

**Slide 50: Assessment and Matching
Clients (continued)**

- *Does the client have any understanding of how to manage his mental health condition, in order to prevent continued use?*
- *What is her/his experience with addiction and/or psychotropic meds?*
- *How well can she/he cope with protracted withdrawal, craving, or impulses?*
- *How well can the client cope with negative affects, peer pressure, and stress?*
- *How severe are the problems that may continue or reappear if the client isn't successfully engaged in treatment for substance use or mental health treatment?*
- *Is the client familiar with relapse trigger and does she/he possess the skills to control her/his impulses to use or harm her/himself?*

(Notes for Slide 50, continued)

Slide 50: Assessment and Matching Clients (continued)

- Recovery and Living Environment
 - The last dimension assesses the client's housing, financial, vocational, education, legal, transportation, and child care needs. Here, the counselor is exploring an individual's recovery or living situation, the surrounding people, places, tools, and resources that promote or detract from services and may help or hinder the client's recovery efforts.



- ***[ASK PARTICIPANTS] When evaluating an individual's living situation, environmental resources and challenges, including family and friends, what questions would you ask in the assessment?***

(Notes for Slide 50, continued)

Slide 50: Assessment and Matching
Clients (continued)



- ***[INSTRUCTIONS] Listen for, acknowledge, and offer the following:***
- ***What in the individual's environment poses a threat to the person's safety or ability to engage in treatment?***
- ***What are the environment resources the individual can draw upon, including family, friends, education, or vocational that can support her/his recovery?***
- ***Are there any legal, vocational or social mandates that may enhance treatment engagement?***
- ***What are environmental barriers that need to be addressed, including transportation, child care, housing, employment***
- These criteria are used to guide placement decisions to ensure clients have access to and use the most appropriate, least intensive, safest, and most cost effective treatment.

(Notes for Slide 50, continued)

**Slide 50: Assessment and Matching
Clients (continued)**



REFERENCE

Mee-Lee, D. (Eds.). (2013). *The ASAM criteria: Treatment for addictive, substance-related, and co-occurring conditions*. Chevy Chase, MD: American Society of Addiction Medicine.

Assessing Risk for Each Dimension

Severity and Level of Functioning Profile

- **Four:** Utmost severity. Critical impairments/symptoms indicating imminent danger
- **Three:** Serious issue or difficulty coping. High risk or near imminent danger
- **Two:** Moderate difficulty in functioning with some persistent chronic issues
- **One:** Mild difficulty, signs, or symptoms. Any chronic issue likely to resolve soon
- **Zero:** Non-issue, or very low-risk issue. No current risk and any chronic issues likely to be mostly or entirely resolved

References
Mee-Lee, David (Eds.) (2013) *The ASAM criteria: treatment for addictive, substance-related, and co-occurring conditions*. Chevy Chase, MD: American Society of Addiction Medicine

Slide 51: Assessing Risk for Each Dimension

- Each dimension is scored using a rating scale from 0-4, where 0 represents very low risk and 4 represents severe or high risk. Each dimension is equally important to all others. Each dimension is assessed independently and collectively. Scores from the assessment provide a severity and level of functioning profile. Dimensions are combined and contrasted to determine areas of highest risk and need. Further, the assessment emphasizes the need for identifying, incorporating, and capitalizing on the client's strengths. Collectively, information from the multidimensional assessment is then used to determine the most appropriate level of care within the continuum of available treatment options.



REFERENCE

Mee-Lee, D. (Eds.). (2013). *The ASAM criteria: Treatment for addictive, substance-related, and co-occurring conditions*. Chevy Chase, MD: American Society of Addiction Medicine.

Assessing Imminent Danger

- The strong probability that certain behaviors will occur (e.g., continued alcohol or drug use),
- That such behaviors will present a significant risk of serious adverse consequences to individual and/or others (e.g., driving while intoxicated, neglect of child), and
- The likelihood that adverse events will occur in the very near future (within hours or days, not weeks or months).

References
Mee-Lee, David. (Eds.) (2013) The ASAM criteria: treatment for addictive, substance-related, and co-occurring conditions. Chevy Chase, MD: American Society of Addiction Medicine.

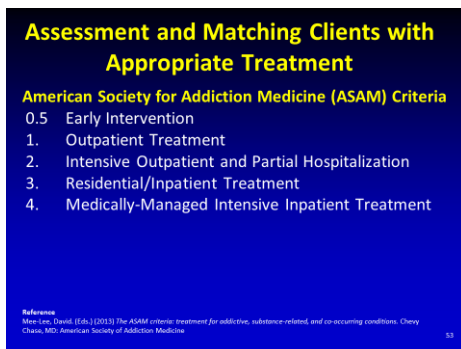
Slide 52: Assessing Imminent Danger

- Before discussing the ASAM levels of care, it is important to stop here and emphasize that all clients should be assessed for suicidal and homicidal ideation, and as described earlier, all should be assessed for acute safety risks related to intoxication and withdrawal. Besides assessing clients for suicidal and homicidal ideation and acute safety risks related to intoxication and withdrawal, counselors should also take into consideration other risks for imminent danger. The ASAM takes a broader view of imminent danger by examining risks specific to the six dimensions. Collectively, addressing risks for these dimensions creates an immediate need profile.
- When considering imminent danger, the ASAM suggests that you consider the following three components



- **[READ THE SLIDE]**
- **[ASK PARTICIPANTS] What kinds of questions would you ask to assess risk for each dimension?**

(Notes for Slide 52, continued)



Assessment and Matching Clients with Appropriate Treatment

American Society for Addiction Medicine (ASAM) Criteria

- 0.5 Early Intervention
1. Outpatient Treatment
2. Intensive Outpatient and Partial Hospitalization
3. Residential/Inpatient Treatment
4. Medically-Managed Intensive Inpatient Treatment

Reference
Mee-Lee, David (Eds.) (2013) *The ASAM criteria: treatment for addictive, substance-related, and co-occurring conditions*. Chevy Chase, MD: American Society of Addiction Medicine.

33

Slide 52: Assessing Imminent Danger



REFERENCE

Mee-Lee, D. (Eds.). (2013). *The ASAM criteria: Treatment for addictive, substance-related, and co-occurring conditions*. Chevy Chase, MD: American Society of Addiction Medicine.

Slide 53: Assessment and Matching Clients with Appropriate Treatment

- Each community will differ in their availability of SUD resources. The continuum of care for treating SUDs recognizes that clients are in varying points in their own recovery and that multiple treatment options are necessary. The ASAM Levels of care include early intervention, outpatient treatment, intensive outpatient treatment and partial hospitalization, residential/inpatient treatment, and medically-managed intensive inpatient treatment.

(Notes for Slide 53, continued)

**Slide 53: Assessment and Matching
Clients with Appropriate Treatment**



REFERENCE

Mee-Lee, D. (Eds.). (2013). *The ASAM criteria: Treatment for addictive, substance-related, and co-occurring conditions*. Chevy Chase, MD: American Society of Addiction Medicine.

Decisional Flow to Match Assessment and Treatment Placement

- What does the client want and why now?
- What are the client's immediate needs or imminent risk in each of the dimensions?
- What is the DMS-5 SUD diagnosis?
- What is the client's severity and level of functioning profile?
- Which dimensions are most important?
- What are the targets for each priority?
- What services are needed?

References
Mee-Lee, David. (Eds.) (2013). *The ASAM criteria: treatment for addictive, substance-related, and co-occurring conditions*. Chevy Chase, MD: American Society of Addiction Medicine.

Slide 54: Decisional Flow to Match Assessment and Treatment Placement

- Multidimensional assessments are intended to guide decisions for service planning and placement and level of care placement based on the client's risks, deficits, needs, strengths, skills, and resources. The ASAM recommends using a decisional flow by answering specific to guide placement decisions:



- ***[READ THE BULLETED LIST ON THE SLIDE]***



REFERENCE

Mee-Lee, D. (Eds.). (2013). *The ASAM criteria: Treatment for addictive, substance-related, and co-occurring conditions*. Chevy Chase, MD: American Society of Addiction Medicine.

Decisional Flow to Match Assessment and Treatment Placement (continued)

- What intensity of services is needed?
- Where are these services located (least intensive, but appropriate level of care)?
- What is the client's progress regarding the established treatment plan and placement decision?

Reference
Mee-Lee, David. (Eds.) (2013). *The ASAM criteria: treatment for addictive, substance-related, and co-occurring conditions*. Chevy Chase, MD: American Society of Addiction Medicine.

Slide 55: Decisional Flow to Match Assessment and Treatment Placement (continued)



- ***[READ THE BULLETED LIST ON THE SLIDE]***
- ***[ASK PARTICIPANTS] Are there any questions regarding the ASAM criteria?***
- ***[ASK PARTICIPANTS] What are the six dimensions?***
- ***[ASK PARTICIPANTS] Briefly describe the risk rating scale used in ASAM.***



REFERENCE

Mee-Lee, D. (Eds.). (2013). *The ASAM criteria: Treatment for addictive, substance-related, and co-occurring conditions*. Chevy Chase, MD: American Society of Addiction Medicine.

Global Criteria for Assessment

12. Explain the rationale for the use of assessment techniques in order to facilitate understanding.
13. Gather relevant history, including alcohol and other drug abuse using appropriate interview techniques.
14. Identify methods and procedures for obtaining corroborative information from significant secondary sources regarding client's alcohol and other drug abuse and psychosocial history.
15. Identify appropriate assessment tools.
16. Develop a diagnostic evaluation of the client's substance abuse and coexisting conditions based on the results of all assessments in order to provide an integrated approach to treatment planning based on the client's strengths, weaknesses, and identified problems and needs.

Reference:
Henderson, J. W. (2018). *Global criteria: the 12 core functions of the substance abuse counselor* (7th ed.). Lincoln, NE: Parallel Pathways to Change.

Slide 56: Global Criteria for Assessment

- The IC&RC have identified five criteria as necessary skills needed to perform the core function of assessment. The first criterion emphasizes the importance for counselors to explain and communicate all aspects of assessment to the client.



- ***[ASK PARTICIPANTS] How do you describe the assessment process to you clients?***
- The second criterion is specific to the counselor's ability to systematically collect historical and current information using a variety of techniques that are culturally relevant and informed.

(Notes for Slide 56, continued)

Slide 56: Global Criteria for Assessment



- ***[ASK PARTICIPANTS] Why do we gather data from collateral sources?***
- Identifying methods and procedures for collecting and obtaining corroborative information from collateral sources is the third criterion. The fourth criterion is knowledge or and application in using assessment tools to inform treatment planning.



- ***[ASK PARTICIPANTS] What assessment tools do you currently use in your agency settings? Please describe each tool. How do you know if the tool is valid or reliable?***
- The last criterion is the ability for counselors to synthesize all information, summarize all pertinent and relevant information to substantiate any SUD diagnosis. Further, the assessment should provide sufficient information and clear rationale for placement in a particular level of care.

(Notes for Slide 56, continued)

Slide 56: Global Criteria for Assessment

- The assessment should identify, incorporate, and capitalize on the client's strengths, skills, and resources.



REFERENCE

Herdman, J.W. (2018). *Global criteria: The 12 core functions of the substance abuse counselor* (7th ed.). Lincoln, NE: Parallels: Pathways to Change.

Slide 57: Group Activity for Assessment

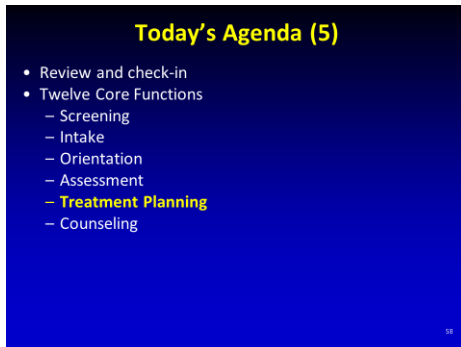


Group Activity for Assessment

- What would you include in your initial assessment?
- What assessment domains would be included?
- What would you prioritize?
- If time allows, what assessment tools would you incorporate into your assessment **OR** how would you go about finding a valid and reliable assessment tool for your agency?
- Be prepared to report out.
- Be prepared to ask questions and offer suggestions to support your colleagues.

- ***Ask participants to gather into their small groups.***
- ***Instruct participants to create an initial assessment for their outpatient center.***
- ***Allow 15-20 minutes for participants to create an outline for their assessment. If time permits, ask clients which assessment tools would they incorporate into their assessment and why.***

(Notes for Slide 57, continued)



Slide 57: Group Activity for Assessment

- *Randomly choose one or two groups to report out.*
- *After each group presents*
- *[ASK PARTICIPANTS] Do you have any recommendations for the groups that reported out on ways the groups can improve their orientation process?*

Slide 58: Today's Agenda (5)



- *[ASK PARTICIPANTS] Do you have any questions regarding assessment?*
- *Orient participants to the day's agenda.*



Slide 59: Agenda for Treatment Planning



- ***Orient participants to the session's agenda.***

PEDAGOGICAL SUGGESTIONS:

- ***[ASK PARTICIPANTS] Why is it necessary to conduct comprehensive assessments prior to developing person-centered treatment plans?***
- ***[ASK PARTICIPANTS] What do you consider to be important in treatment planning?***
- ***[ASK PARTICIPANTS] Please describe what treatment planning looks like in your agency setting.***

Definition of Treatment Planning

- "A collaborative process in which professionals and the client develop a written document that identifies important treatment goals; describes measurable, time-sensitive action steps toward achieving these goals with expected outcomes; and reflects a verbal agreement between a counselor and client" (CSAT, 2006, p. 55)
- The IC&RC defines treatment planning as "the process in which the counselor and the client identify and rank problems needing resolution, establish agreed upon immediate and long-term goals, and decide on the treatment methods and resources to be used"

References

Center for Substance Abuse Treatment. (2006). *Addiction counseling competencies: the knowledge, skills, and attitudes of professional practice*. Technical Assistance Publication (TAP) Series 21 (HHS Publication No. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Hendman, J. W. (2018). *Global criteria: the 12 core functions of the substance abuse counselor (7th ed.)*. Lincoln, NE: Parallel: Pathways to Change.

Slide 60: Definition of Treatment Planning

- The CSAT and IC&RC offer the following definitions for treatment planning.



- **[READ THE SLIDE]**
- **[ASK PARTICIPANTS] What are your thoughts on these two definitions?**
- **[ASK PARTICIPANTS] What do you believe are best practices in service planning?**



REFERENCES

Center for Substance Abuse Treatment. (2006). *Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice*.

Technical Assistance Publication (TAP) Series 21 (HHS Publication No. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

(Notes for Slide 60, continued)

**Slide 60: Definition of Treatment
Planning**



REFERENCES, continued

Herdman, J.W. (2018). *Global criteria: The 12 core functions of the substance abuse counselor* (7th ed.). Lincoln, NE: Parallels: Pathways to Change.

Developing Client-Centered, Collaborative Service Plans

- The counselor reviews assessment findings, insights, and interpretations with the client.
- The client and counselor develop a service plan by:
 - rank ordering and prioritizing needs and problems;
 - negotiating short and long-term goals that are directly linked to the problem list generated by the client and counselor through the assessment process;
 - incorporating client strengths, skills, and resources into the service plan; and
 - agreeing on methods and resources to be used.

Reference
Adams, N. & Grieder, D. M. (2014). *Treatment planning for person-centered care: shared decision making for whole health*. (2nd ed.). Waldport, MO: Elsevier Inc.

Slide 61: Developing Client-Centered Collaborative Service Plans

- Adams & Grieder emphasize that the importance of collecting, integrating, synthesizing, analyzing and interpreting information for creating comprehensive assessments cannot be overstated. Findings from comprehensive assessments should provide sufficient information and a starting point to understand the client deficits, needs, and challenges, as well as an appreciation and knowledge of their strengths, skills, and resources. An often overlooked but essential aspect of providing person-centered, recovery-oriented treatment is integrating and synthesizing data from the assessment and drawing upon insights and interpretations from various members of the treatment team to create a holistic understanding of the client.

(Notes for Slide 61, continued)

Slide 61: Developing Client-Centered Collaborative Service Plans

- Provider insights and perspectives from the assessment should be shared with the client to promote shared decision making about treatment options. Moreover, Adams & Grieder emphasize that “person-centered collaboration...is only truly when the [client’s] perspectives as well as expertise in their own life and recovery are acknowledged and incorporated into [an interpretive] summary.”



- ***[ASK PARTICIPANTS] How do you share assessment insights and interpretations with clients?***
- Integrated summaries provide a starting point for discussing and seeking agreement on treatment priorities. Most of us don’t need to be reminded that we may not share the same view on client needs and priorities with our clients. It is helpful to remind ourselves that decisions about a client’s recovery ultimately lie with the client.

(Notes for Slide 61, continued)

Slide 61: Developing Client-Centered Collaborative Service Plans

- As providers, we should be able to facilitate discussions where clients are encouraged to discuss their differences and disagreements with us as we move forward with establishing common ground with them. We focus on engaging the client and provide opportunities for them to examine and reflect on their own behaviors and reach their own conclusions. We negotiate and prioritize problems and look for opportunities to establish short-term and long-term goals with the understanding that the client service plans are not static. Goals should reflect the client's desire for change and improvement in their life. Statements in the service plan should be expressed in behavioral terms and be actionable. Goals should aim to resolve or mitigate one or more problems identified in the problem list. The client's strengths, skills, and resources should be incorporated into the service plan. For example, the client and counselor discuss and agree on whether to involve and how to involve family and other supporters. This is based on client preference and choice.

(Notes for Slide 61, continued)

Slide 61: Developing Client-Centered Collaborative Service Plans



- ***[ASK PARTICIPANTS] How do you incorporate other client strengths into the client's service plan?***
- Shortly, we will discuss setting client-centered, collaborative goals, objectives, and interventions. However, it is important here to reiterate and emphasize the importance of finding common ground and agreement on the various methods and resources that may be used to help clients move towards completion of specific objectives that aim to help clients move forward in their own recovery.



REFERENCE

Adams, N. & Grieder, D.M. (2014). *Treatment planning for person-centered care: Shared decision making for whole health* (2nd ed.). Waltham, MA: Elsevier Inc.

Developing Client-Centered, Collaborative Service Plans (continued)

- Service plans should be regularly reviewed and updated.
- Service plans should be flexible.
- Service plans should include agreed-upon end points.

Reference
Adams, N. & Gruber, D. M. (2014). Treatment planning for person-centered care: shared decision making for whole health
(2nd ed.). Baltimore, MD: Elsevier Inc.

Slide 62: Developing Client-Centered Collaborative Service Plans (continued)

- Service plans should be regularly reviewed and updated. The frequency of the review and update are often contingent on a number of factors, including but not limited to treatment settings; changes in client's priorities, needs and circumstances; and standards set forth by different accreditation bodies or by the program's funders.
- Service plans should always allow for flexibility and for change in addressing client problems, needs and goals.
- Service plans should include agreed-upon end points to guide transition and discharge planning.



- ***[ASK PARTICIPANTS] How do you discuss transition or discharge criteria with your clients?***
- ***[ASK PARTICIPANTS] What are some of agreed-upon end points that you have created in collaboration with your client?***

(Notes for Slide 62, continued)

Slide 62: Developing Client-Centered Collaborative Service Plans (continued)



- ***[ASK PARTICIPANTS] What are examples of long and short goals?***
- ***[ASK PARTICIPANTS] What is the difference between a goal and objective?***
- ***[ASK PARTICIPANTS] What is the difference between an objective and intervention?***



REFERENCE

Adams, N. & Grieder, D.M. (2014). *Treatment planning for person-centered care: Shared decision making for whole health* (2nd ed.). Waltham, MA: Elsevier Inc.

What are Goals?

- Goals capture the essence of the client's desire for change.
- Two types of goals: life goals and service goals.
- Service goals reflect resolution of a problem.
- Service goals should be used as a measure for determining readiness for discharge or transition.
- Goals should be written in the client's own words, but understood by all those involved in their care.
- Strive for parsimony.
- Goals are often comprised of specific objectives.

Reference:
Adams, N. & Grieder, D. M. (2014). Treatment planning for person-centered care: shared decision making for whole health (2nd ed.). Waltham, MA: Elsevier Inc.

Slide 63: What are Goals?



- **[READ THE FIRST BULLET]**
- Adams & Grieder (2014) suggest that there are 2 types of goals in behavioral health service settings: life goals and service goals. Life goals are aspects of the client's life where they hope for overall improvement and may include their aspirations for change.



- **[ASK PARTICIPANTS] What are some example of life goals?**
- **Listen for the following examples: I want to find meaningful employment, I want to find a partner, I want my relationship with my kids/partner to improve.**
- Life goals may not be specifically tied to service needs and are often not time specific. Life goals provide a focus of engagement, reflect the client's values, and may reflect the client's stage of change.

(Notes for Slide 63, continued)

Slide 63: What are Goals?

- Service goals, according to Adams and Grieder, “address the resolution of the needs and concerns that are a barrier to discharge or transition from services. These goals are often closely linked to the issues or needs that prompted the [client] to seek help and are responsive to their immediate circumstances” Service goals may be specific to the service setting or the specific level of care. They may be a subset of the client’s life goals. The distinction between the two are qualitatively different; however, the emphasis is creating client-centered, individualized service plans.



- ***[ASK PARTICIPANTS] What are some example of service goals?***
- ***[ASK PARTICIPANTS] What are some examples of service goals that are a subset of a client’s larger life goals?***
- Goals should be written in the client’s words, but understood by all those involved in their care.

(Notes for Slide 63, continued)

Slide 63: What are Goals?

- Also, there should be great care to refrain from establishing too many goals. This can be overwhelming for clients and potential set them up for failure.



- ***[ASK PARTICIPANTS] Besides passing the IC&RC ADC exam, what are your current life goals?***
- Most people have one or two goals that they would like to focus on at this point in their life. Our clients are no different. If and when we find there are too many goals, we should examine and consider prioritizing goals. Again, we do this with our client. It is their service plan.



- ***[ASK PARTICIPANTS] How would you support clients with prioritizing goals?***
- An area that often gets confused is the difference between goals and objectives.

(Notes for Slide 63, continued)

Slide 63: What are Goals?

- Objectives, according to Adams and Grieder, “may be one of several efforts to focus on a measurable and targeted change in behavior or capacity within a specified timeframe that helps the [client] to move forward...[service] goals are tied to discharge and transition; objectives are tied to the attainment of goals.”



REFERENCE

Adams, N. & Grieder, D.M. (2014). *Treatment planning for person-centered care: Shared decision making for whole health* (2nd ed.). Waltham, MA: Elsevier Inc.

What are Objectives?

- Objectives are focused, specific, incremental changes or manageable tasks that support clients with moving forward towards attaining or accomplishing specific goal(s).
- Objectives use action words.
- Objectives are time-specific.
- Objectives aim to organize a client's goal into smaller manageable steps.
- Objectives are **NOT** services, intervention, or action steps.
- Objectives describe the meaningful change in behavior, status or function that is recognized as a step towards reaching a larger goal.

Reference
Adams, N. & Grieder, D. M. (2014). Treatment planning for person-centered care: shared decision making for whole health (2nd ed.). Waltham, MA: Elsevier Inc.

Slide 64: What are Objectives?

- Treatment and services should be focused on client objectives. Objectives are the incremental changes and manageable tasks that support clients with moving forward with attaining or accomplishing their specific goal. Objectives use action words; they are not passive or abstract. They describe active, positive changes in behavior or functioning. Adams & Grieder suggest avoiding cessation of behaviors or the removal of barriers as objectives since this reinforces emphasis on the client's deficits. Further Adams and Grieder remind us that attendance or participation in an activity is not a good objective. Rather, the objective should highlight what the client hopes to gain in terms of skills or changes in behavior as a result of participating in the activity. However, point out that attendance and participation would be an appropriate objective if the client were withdrawn or avoided specific situations because of severe anxiety or some other reason (e.g., PTSD).

(Notes for Slide 64, continued)

Slide 64: What are Objectives?

- Objectives are about change. They are time-specific. They break down goals into smaller, management steps. Adams and Grieder (2014) explain, “a properly written objective should typically begin with a description of a significant and meaningful change in behavior, status or function as a step towards reaching the larger goal that will occur as a result of the services and interventions specified within the plan. The description of the change should be included and prefaced by the term ‘as evidenced by.’ Often, providers confuse objectives as activities, action steps, intervention, or services. Be careful not to confuse objectives with interventions. We will discuss this difference soon.



- ***[ASK PARTICIPANTS] What are some objectives for your goals?***
- ***[ASK PARTICIPANTS] Are the objectives you specified measurable and time-specific?***

(Notes for Slide 64, continued)

What are SMART Objectives?

- Simple, straightforward, and stage-appropriate
- **M** measurable
- **A** attainable
- **R** realistic
- **T** time-specific (change is expected)

Reference
Adams, N. & Grieder, D.M. (2014). Treatment planning for person-centered care: shared decision making for whole health (2nd ed.). Waltham, MA: Elsevier Inc.

Slide 64: What are Objectives?



REFERENCE

Adams, N. & Grieder, D.M. (2014). *Treatment planning for person-centered care: Shared decision making for whole health* (2nd ed.). Waltham, MA: Elsevier Inc.

Slide 65: What are SMART Objectives?

- Objectives should address or specify one change at a time. Objectives should be SMART. SMART is a popular mnemonic for remembering that objectives should be simple, measurable, attainable, realistic, and time-specific.
- **S** stands for simple and straightforward. We included stage appropriate which we will discuss in tomorrow's training when we discuss the stages of change.
- All objectives should be **M** measurable. They should be obvious and in most cases, observable.
- **A** reminds us that all objectives should be attainable or achievable.
- **R** is for realistic.

(Notes for Slide 65, continued)

Slide 65: What are SMART Objectives?

- And **T** is for time-specific. Specifying a timeframe for each objective is critical. It conveys hope. Specifying timeframes communicates to the client and team that change is expected.



- **[ASK PARTICIPANTS]** *What are some examples SMART objectives?*
- Objectives should be written in behaviorally specific language. The focus should be on the activation of new skills and abilities. Last, objectives should be appropriate to the treatment setting and appropriate to the age, development and culture of the client.



REFERENCE

Adams, N. & Grieder, D.M. (2014). *Treatment planning for person-centered care: Shared decision making for whole health* (2nd ed.). Waltham, MA: Elsevier Inc.

What are Interventions?

- **WHO** (internal to organization: specify name, credential, title; external: association, other provider or natural supports)
- **will do WHAT** (specify the activity or service) by
- **WHEN** (specify frequency [how often], intensity [how much], and duration [how long]),
- **WHERE** (specify the location),
- **and WHY** (specify the intended purpose, outcome or impact; how will the intervention support the desired change)?

Reference
Adams, N. & Grieder, D. M. (2014). Treatment planning for person-centered care: shared decision making for whole health (2nd ed.). Waltham, MA: Elsevier Inc.

Slide 66: What are Interventions?

- Interventions refer to the services, activities and actions that support clients with achieving objectives and goals. Adams and Grieder explain, “objectives describe desired changes in status, abilities, skills, or behavior for the [client], the intervention detail the various steps taken by the team, or self-directed actions and/o the natural supports in the person’s life to help bring about the changes described in the objective.” Interventions are an elaboration of the service plan. It is the contract between the various members of the treatment team, including the client and natural supports the client chooses to involve in their treatment. Interventions should delineate who will do what by when and where. It should also be clear why the specific intervention is being used. Aim for specificity! Be explicit. Describe the proposed activity or service. Describe who will be responsible for providing a service, facilitating an activity, or assuring the provision of a particular service.

(Notes for Slide 66, continued)

Slide 66: What are Interventions?

- Everyone on the team, including the client and their natural supports, should know their role and responsibilities. Specify the frequency (how often), the intensity (how much) and duration (how long) for each activity. Lastly, describe the intended purpose, impact, or outcome of the service or activity.



- ***[ASK PARTICIPANTS] Why do we describe the intended purpose, impact or outcome of each service or activity?***
- ***Listen for the following:***
- ***Helps to promote engagement and change,***
- ***The client, their supporters, and the providers understand expectations and value of each intervention, and***
- ***It explicitly describes medical necessity***

(Notes for Slide 66, continued)

Slide 66: What are Interventions?



REFERENCE

Adams, N. & Grieder, D.M. (2014).
*Treatment planning for person-centered
care: Shared decision making for whole
health* (2nd ed.). Waltham, MA: Elsevier
Inc.

Global Criteria for Treatment Planning

17. Explain assessment results to the client in an understandable manner.
18. Identify and rank problems based in individual client needs in the written treatment plan.
19. Formulate agreed upon immediate & long-term goals using behavioral terms in the written plan.
20. Identify the treatment methods and resources to be utilized as appropriate for the individual client.

Reference:
Henderson, S. W. (2018). Global criteria: the 12 core functions of the substance abuse counselor (7th ed.). Lincoln, NE: Paradigm Pathways to Change.

Slide 67: Global Criteria for Treatment Planning

- The IC&RC have identified four criteria as necessary skills needed to perform the core function of treatment planning.
- The first criterion emphasizes the importance for counselors to explain assessment findings, insights, and their interpretations with the client. The second criterion is identifying and reviewing the client's presenting problems with the client, and collaboratively rank ordering and prioritizing needs and problems.



- ***[ASK PARTICIPANTS] How do you find common ground or agreement when choosing and prioritizing client needs and problems?***
- The third criterion is the counselor's ability to develop short and long terms goals, their objectives, and intervention in a service plan. Finally, the fourth criterion refers to the counselor's ability to educate and orient the client to the various treatment modalities available to the client.

(Notes for Slide 67, continued)

Group Activity for Treatment Planning

- Create a checklist or outline to guide you and others in your agency to create client-centered, collaborative service plans.
- Be prepared to report out.
- Be prepared to ask questions and offer suggestions to support your colleagues.

Slide 67: Global Criteria for Treatment Planning



REFERENCE

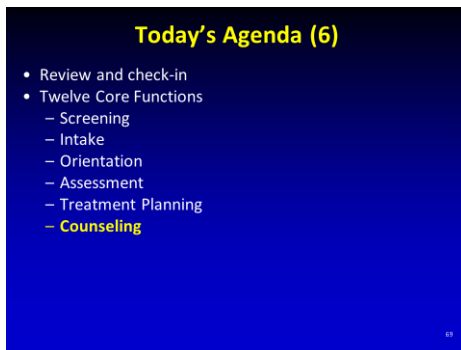
Herdman, J.W. (2018). *Global criteria: The 12 core functions of the substance abuse counselor* (7th ed.). Lincoln, NE: Parallels: Pathways to Change.

Slide 68: Group Activity for Treatment Planning



- ***Ask participants to gather into their small groups.***
- ***Instruct participants to create a checklist or other document to guide themselves and others in their program with creating client-centered, collaborative service plans.***
- ***Allow 20 minutes for participants to create the service planning checklist/outline.***
- ***Randomly choose one or two groups to report out.***

(Notes for Slide 68, continued)



Slide 68: Group Activity for Treatment Planning



- *After the groups present*
- **[ASK PARTICIPANTS] What would you change, if anything, to this group's outline or checklist?**

Slide 69: Today's Agenda (6)



- **[ASK PARTICIPANTS] Do you have any questions regarding treatment or service plans?**

Agenda for Counseling

- Definition
- Influence of models and use of theory
- Counseling models
- General counseling guidelines
- Global criteria

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Slide 70: Agenda for Counseling



- ***Orient participants to the session's agenda.***

PEDAGOGICAL SUGGESTIONS:

- ***[ASK PARTICIPANTS] What specific theories or counseling models inform the work you do (or your colleagues) do at your place of employment?***
- ***[ASK PARTICIPANTS] What are some examples of specific counseling techniques you use in practice? How did you learn them? What theory or model did they originate from?***

Slide 71: Definition of Counseling

- The CSAT and IC&RC offer the following definitions for counseling.



- ***[READ THE SLIDE]***
- ***[ASK PARTICIPANTS] What are your thoughts on these two definitions?***

Definition of Counseling

- The IC&RC defines counseling as "the utilization of special skills to assist individuals, families, or group in achieving objectives through exploration of a problem and its ramifications; examination of attitudes and feelings; consideration of alternative solutions; and decision making"
- The CSAT defines counseling as, "a collaborative process that facilitates the client's progress toward mutually determined treatment goals and objectives"

References
 Center for Substance Abuse Treatment. (2006). *Addiction counseling competencies: the knowledge, skills, and attitudes of professional practice*. Technical Assistance Publication (TAP) Series 22 (996). Publication No. (SMA) 05-4771. Rockville, MD: Substance Abuse and Mental Health Services Administration.
 Hordman, J. W. (2018). *Global criteria: the 12 core functions of the substance abuse counselor (7th ed.)*. Lincoln, NE: Parallel: Pathways to Change.

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(Notes for Slide 71, continued)

Slide 71: Definition of Counseling



REFERENCES

Center for Substance Abuse Treatment. (2006). *Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice.*

Technical Assistance Publication (TAP) Series 21 (HHS Publication No. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Herdman, J.W. (2018). *Global criteria: The 12 core functions of the substance abuse counselor* (7th ed.). Lincoln, NE: Parallels: Pathways to Change.

Slide 72: Influence of Models and Use of Theory

- Miller (2015) explains that different models of addiction influence how addiction professionals view their clients, how they understand and explain the cause of their client's addiction, and what treatments addiction professionals endorse or recommend.

Influence of Models and Use of Theory

- Models of addiction influence how counselors view their clients; the cause of their client's substance use disorders; and the approaches, modalities, and perspectives they endorse/utilize for treating substance use disorders.
- "Models impact our selection of theories and techniques used in treating" substance use disorders (Miller, 2015, p.34).
- Theories help us to understand, explain, and predict phenomena.

References

Corey, G. (2017). *Theory and practice of counseling and psychotherapy* (10th ed.). Boston, MA: Cengage.

Miller, G. (2015). *Learning the language of addiction counseling* (4th ed.). Hoboken, NJ: John Wiley & Sons, Inc.

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(Notes for Slide 72, continued)

Slide 72: Influence of Models and Use of Theory

- For example, the moral model of addiction views a person with a substance use disorder as a degenerate. According to this model, the root cause of their addiction is moral weakness. The preferred and ineffective approach to treating substance use disorders is punishment. The more recent model of addiction, the biopsychosocial model, recognizes the complex interplay among biological, psychological, social and spiritual factors when examining and understanding an individual's addiction. The model suggests use of comprehensive, individualized assessments and endorses client-centered treatment that is holistic. Miller (2015) highlights, “model[s] impact our selection of theories and techniques used in treating” substance use disorders...



- ***[ASK PARTICIPANTS] What are theories?***
- Theories are ways that we understand, explain, and predict phenomena.

(Notes for Slide 72, continued)

Slide 72: Influence of Models and Use of Theory

- They explain some aspect of human behavior and provide a framework for how we manage and interpret information. Theories are based on philosophical assumptions which influence how we perceive and understand human nature. It is important to remember that no one theory can explain or predict everything about human behavior. There are a variety of theoretical approaches and frameworks to explain addiction. Each theory will offer specific techniques and treatment options for treating substance use disorders. Most counselors have been exposed to a variety of theories in addiction treatment settings. Our counseling techniques evolve from our understanding and endorsement of different theories and (hopefully) from current research.



- ***[ASK PARTICIPANTS] What are some theories that you are familiar with? How would briefly describe this theory to someone else? What are their key points?***

(Notes for Slide 72, continued)

Slide 72: Influence of Models and Use of Theory

- Miller (2015) and Herdman (2018) agree that counselors should be knowledgeable, proficient, and flexible in their use of therapies based on the diversity of the various clients they work with and their own unique needs.



REFERENCES

Corey, G. (2017). *Theory and practice of counseling and psychotherapy* (10th ed). Boston, MA: Cengage.

Herdman, J.W. (2018). *Global criteria: the 12 core functions of the substance abuse counselor* (7th ed.). Lincoln, NE: Parallels: Pathways to Change.

Miller, G. (2015). *Learning the language of addiction counseling* (4th ed.). Hoboken, NJ: John Wiley & Sons, Inc.



Slide 73: Three Contemporary Counseling Models

There are a variety of theories applied to the treatment of substance use disorders. These theories inform different types of therapies. We will provide a general overview of three common contemporary counseling models or approaches used in the field of addiction. This overview will include a review of the basic philosophies and assumptions for each approach, key concepts, and application in the context of treating SUDs.

- We will review



- ***[READ THE BULLETED LIST].***
- We recommend closely reviewing CSAT's TIP 34 prior to taking the IC&RC ADC exam.

(Notes for Slide 73, continued)

Slide 73: Three Contemporary Counseling Models



REFERENCES

Corey, G. (2017). *Theory and practice of counseling and psychotherapy* (10th ed). Boston, MA: Cengage.

Miller, G. (2015). *Learning the language of addiction counseling* (4th ed.). Hoboken, NJ: John Wiley & Sons, Inc.

Psychodynamic Approaches

- Psychodynamic theories posit different explanations of personality formation, psychopathology, and techniques to use in SUD counseling.
- Unconscious motives and unresolved past conflicts are central in present behavior.
- Key concepts include: (1) the therapeutic alliance, (2) developmental stages and personality structure, (3) insight, (4) transference and countertransference, and (5) defense mechanisms.

Reference
Center for Substance Abuse Treatment (2012). *Brief interventions and brief therapies for substance abuse*. Treatment Improvement Protocol (TIP) Series No. 34 (HHS Publication No. (SMA) 12-3552. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Carey, G. (2017). *Theory and practice of counseling and psychotherapy* (20th ed.). Boston, MA: Cengage.

Milroy, G. (2015). *Learning the language of addiction counseling* (4th ed.). Hoboken, NJ: John Wiley & Sons, Inc.

Slide 74: Psychodynamic Approaches

- Psychodynamic therapies originated from and are informed by psychoanalytic theory. There are different schools of psychoanalytic theory each positing different propositions of personality formation, psychopathology, and techniques used in therapy. However, for the sake of this training, we present CSAT's broad definition of psychodynamic therapy as applied to treating substance use disorders. According to the CSAT, psychodynamic therapies attribute "a person's problems with substances are rooted in unconscious and unresolved past conflicts, especially in early family relationships. The goal [of therapy] is to help the client gain insight into underlying causes of manifest problems and understand what function substance abuse is serving" (CSAT, 2012, p. 43).

(Notes for Slide 74, continued)

Slide 74: Psychodynamic Approaches

- Key concepts of psychodynamic approaches that are applicable and useful in treating substance use disorders include (1) the therapeutic alliance, (2) developmental stages and personality structure, (3) insight, (4) transference and countertransference, and (5) defense mechanisms and resistance.



- ***[ASK PARTICIPANTS] Are you familiar with any of the following key concepts referenced here, and if so, please briefly explain them.***
- The therapeutic alliance is the working relationship between the counselor and client. Most counseling approaches, including psychodynamic approaches emphasize the importance of this relationship – it is regarded as critical and necessary. The alliance allows clients to feel safe – prompting them to self-disclose.

(Notes for Slide 74, continued)

Slide 74: Psychodynamic Approaches

- Psychoanalytic theories suggest that human nature and behavior are determined by unconscious motives and biological and instinctual drives that evolve through different psychosexual stages. Freud's psychosexual stages, that is the oral, anal, phallic, latency, and genital stages are chronological phases of personal and social development. According to Freud, the first three stages are formed in early childhood and if a child's needs are not adequately met, they may become fixated or stuck in a specific stage and behave in psychologically immature ways later in life. Erikson expanded Freud's psychosexual stages to explain personality development through psychosocial stages where individuals aim to master psychological and social tasks at various stages of life. "Addiction is linked to a developmentally primitive level of ego functioning;" thus, the client's level of functioning should inform the nature and type of intervention (p. 130).

(Notes for Slide 74, continued)

Slide 74: Psychodynamic Approaches

- Personality structures are made up of three systems: the id, ego, and superego. The id is present at birth. It is ruled by untamed drives, impulses and the pleasure principle. It is amoral. The id is driven to satisfy instinctual needs. The ego mediates between instincts and the environment. Unlike the id, the ego is logical and realistic. The superego judges what we do based on ideals and traditional values. It is essentially our moral compass.
- Insight broadly refers to self-realization, the realization of oneself, one's behaviors, and one's inner workings. Clients are able to recognize and connect experiences and conflicts from their past with present perceptions and behaviors. Insight also refers to the recognition of repressed feelings and motivations and how they manifest themselves in the present.

(Notes for Slide 74, continued)

Slide 74: Psychodynamic Approaches

- “Transference is the process of transferring prominent characteristics of unresolved conflicted relationships with significant others onto the therapist” (CSAT, 212, p. 131). Countertransference, on the other hand, is the process where counselor’s transfer prominent characteristics of unresolved relationships with significant others onto their client.
- Defense mechanisms are unconscious measures that deny, distort, or falsify reality to bolster one’s ego. These mechanisms aim to repress anxiety so that the ego can defend itself and continue to function. Defense mechanisms may be adaptive and support one’s growth. Others are maladaptive and hinder growth.

(Notes for Slide 74, continued)

Defense Mechanisms

- Compensation
- Denial
- Displacement
- Identification
- Projection
- Rationalization
- Reaction formation
- Regression
- Repression
- Sublimation

Reference
Center for Substance Abuse Treatment (2012). *Brief interventions and brief therapies for substance abuse: Treatment Improvement Protocol (TIP) Series No. 34* (HHS Publication No. (SMA) 12-3952). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Corey, G. (2017). *Theory and practice of counseling and psychotherapy* (10th ed.). Boston, MA: Cengage.

Miller, G. (2015). *Learning the language of addiction counseling* (4th ed.). Hoboken, NJ: John Wiley & Sons, Inc.

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Slide 74: Psychodynamic Approaches



REFERENCES

Corey, G. (2017). *Theory and practice of counseling and psychotherapy* (10th ed.). Boston, MA: Cengage.

Miller, G. (2015). *Learning the language of addiction counseling* (4th ed.). Hoboken, NJ: John Wiley & Sons, Inc.

Slide 75: Defense Mechanisms

- There are a variety of adaptive and maladaptive defense mechanisms.



- ***[ASK PARTICIPANTS] Are you familiar with one or more of the following defense mechanisms, and if so, how would you describe them?***
- Compensation is hiding perceived weaknesses or developing positive traits to hide perceived weaknesses.

(Notes for Slide 75, continued)

Slide 75: Defense Mechanisms

- Denial is pretending or simply ignoring that something (e.g., a threatening situation) does not exist.
- Displacement is directing energy or impulses towards a safer target instead of the original threatening object or person.
- Identification is identifying with various causes, organizations or people in the hope that others will perceive them as important or to feel better about themselves.
- Projection is ascribing or attributing an intolerable idea, feeling, unacceptable desire or impulse onto someone else.
- Rationalization are self-justifying explanations for bad behaviors.
- Reaction formation is actively expressing the opposite impulse or inner feelings in outward behaviors.
- Regression is reverting back to earlier phases of development to cope with anxieties by endorsing immature and developmentally inappropriate behaviors.

(Notes for Slide 75, continued)

Slide 75: Defense Mechanisms

- Repression is involuntarily forgetting threatening or painful thoughts or feelings from our consciousness and awareness.
- Sublimation is diverting aggressive or sexual energy into socially acceptable and even admirable channels.



REFERENCES

Center for Substance Abuse Treatment (2012). *Brief interventions and brief therapies for substance abuse. Treatment Improvement Protocol (TIP) Series No. 34* HHS Publication No. (SMA) 12-3952. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Corey, G. (2017). *Theory and practice of counseling and psychotherapy* (10th ed). Boston, MA: Cengage.

Miller, G. (2015). *Learning the language of addiction counseling* (4th ed.). Hoboken, NJ: John Wiley & Sons, Inc.

Application of Psychodynamic Approaches in Counseling

- Invest in the therapeutic relationship.
- Examine and explore culturally-appropriate/sanctioned developmental tasks at each stage of life.
- Offer psychoeducation and behavioral interventions.
- Examine the possibility of transference and countertransference.
- Help clients discern and recognize how defense mechanisms inhibit recovery.

Reference

Center for Substance Abuse Treatment. (2012). *Brief interventions and brief therapies for substance abuse: Treatment Improvement Protocol (TIP) Series No. 34* (HHS Publication No. (SMA) 12-1902). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Coney, G. (2017). *Theory and practice of counseling and psychotherapy* (3rd ed.). Boston, MA: Cengage.

Miller, G. (2015). *Learning the language of addiction counseling* (4th ed.). Hoboken, NJ: John Wiley & Sons, Inc.

Slide 76: Application of Psychodynamic Approaches in Counseling

- There are a variety of applications for using psychodynamic approaches in counseling. First, a concerted effort and careful attention to establishing and maintaining a good therapeutic alliance with clients is essential. Examine and explore culturally appropriate developmental tasks at each stage of life. Are clients fixated or stuck in a specific stage and behave in psychologically immature ways? Have they mastered psychological and social tasks at various stages of life within the cultural group(s) they identify with? Examine and explore early childhood experiences. Always exercise caution and practice within your scope of expertise when making the unconscious conscious. Insight involves thoughts and feelings. Yet, insight alone, according to CSAT (2012) does not lead to behavioral change and is not sufficient to creating change. Thus, it is essential to offer psychoeducation and concrete, behavioral interventions.

(Notes for Slide 76, continued)

Slide 76: Application of Psychodynamic Approaches in Counseling

- Make a conscious effort to examine the possibility of transference. Use these projections to help the client develop insight and awareness. Regarding countertransference, it is critical for counselors to be aware of their own projections based on personal and professional experiences, and to seek regular supervision.



- ***[ASK PARTICIPANTS] Without disclosing the person(s) involved, would any of you like to share an example of transference or countertransference?***
- Most counselors have often heard others and even described their clients themselves as being in denial when meeting a client early in their recovery. Denial, as well as other defense mechanisms, serve a purpose and it is recommended to consider different strategies when working with clients use defense mechanisms.

(Notes for Slide 76, continued)

Slide 76: Application of Psychodynamic Approaches in Counseling

- For example, avoid confrontation with a client who is in denial by making a concerted effort towards understanding their perspectives and worldview. Ask open questions and offer simple reflections. Guide them in their own discovery.



REFERENCES

Center for Substance Abuse Treatment (2012). *Brief interventions and brief therapies for substance abuse*. *Treatment Improvement Protocol (TIP) Series No. 34* HHS Publication No. (SMA) 12-3952. Rockville, MD: Substance Abuse and Mental Health Services Administration

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Humanistic, Experiential and Existential Therapies

- Person-centered Therapy
 - Unconditional positive regard, accurate empathy, and genuineness
 - Actualizing tendency
- Existential Therapy
 - Emphasis on freedom and choice
- Gestalt Therapy
 - Emphasis on the present - the here and now

Reference:
Center for Substance Abuse Treatment (2012). *Brief interventions and brief therapies for substance abuse*. Treatment Improvement Protocol (TIP) Series No. 34 (HHS Publication No. (SMA) 13-352). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 77: Humanistic, Experiential and Existential Therapies

- According to the CSAT, humanistic, experiential and existential therapies “assume that the underlying cause of substance [..]use disorders is a lack of meaning in one’s life, a fear of death, disconnectedness from people, spiritual emptiness, or other overwhelming anxieties. Through unconditional acceptance, clients are encouraged to improve their self-respect, self-motivation, and growth. The approach can be a catalyst for seeking alternatives to substances in order to fill the emptiness experienced and expressed” (p. 43). Person-centered therapy originated from the humanistic perspective, which essentially views people and human nature as good and that individuals have the ability to resolve problems on their own. This perspective assumes that people have the inherent capacity for self-direction and self-actualization. Counselors who use person-centered therapy recognize that acceptance, genuineness, caring and an ability to grasp and understand the worldview of their clients facilitates growth and change.

(Notes for Slide 77, continued)

Slide 77: Humanistic, Experiential and Existential Therapies

- A key concept of person-centered therapy is the actualizing tendency. This refers to the belief that humans are naturally inclined towards self-determination, fulfillment, and growth. The client is recognized as their own expert and the counselor is only a guide and not the authority who knows what is best for the client. Existential therapy is a philosophical approach to counseling, based on existentialism that invites clients to explore and reflect on the nature of being human and the realities of human suffering. Existentialism stresses individual responsibility, freedom, choice, and authenticity. The goals of existential therapy is to support clients with increasing their capacity for self-awareness, finding meaning, and moving beyond the belief that individuals are fixed or static beings to support themselves in accepting personal responsibility for change. Gestalt therapy is an experiential therapy that aims to expand the client's awareness and experience of the present moment.

(Notes for Slide 77, continued)

Slide 77: Humanistic, Experiential and Existential Therapies

- It promotes direct experiencing of thoughts and feelings rather than the abstractness of discussing them (Corey, 2017). Gestalt therapy assumes that all clients have the ability to self-regulate. Clients may be asked to bring the past into the present by reenacting it in the present. Emphasis is placed on context. Gestalt therapists pay close attention to and explore the boundaries between the client and their environment. Gestalt therapy challenges clients to invest in themselves as who they are in the present, rather than who they want to be or should be. It is believed that clients will grow when they experience themselves as who and what they are in the present.

(Notes for Slide 77, continued)

Slide 77: Humanistic, Experiential and Existential Therapies



REFERENCES

Center for Substance Abuse Treatment (2012). *Brief interventions and brief therapies for substance abuse. Treatment Improvement Protocol (TIP) Series No. 34* HHS Publication No. (SMA) 12-3952. Rockville, MD: Substance Abuse and Mental Health Services Administration

Corey, G. (2017). *Theory and practice of counseling and psychotherapy* (10th ed). Boston, MA: Cengage.

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Application Humanistic, Experiential and Existential Therapies

- Accept clients for who they are and where they are in their recovery process.
- Believe that clients are their own experts and that they have the innate capacity for change.
- Focus on the present.
- Be fully present.

Reference

Center for Substance Abuse Treatment (2012). *Brief interventions and brief therapies for substance abuse*. Treatment Improvement Protocol (TIP) Series No. 34 (HHS Publication No. (SMA) 13-352). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Carey, G. (2017). *Theory and practice of counseling and psychotherapy* (20th ed.). Boston, MA: Cengage.

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Slide 78: Application Humanistic, Experiential and Existential Therapies

- Across humanistic, experiential, and existential therapies, the counselor's attitude is believed to potentially influence and facilitate client change. Counselors move beyond diagnostic categories and recognize that their clients are individuals who have the innate capacity and ability to change and grow. All three emphasize the importance of being in the present moment. Focusing on the present moment may help clients to feel less overwhelmed, especially early in their recovery. According to Miller (2012), "staying in the present can help the client manage staying sober in the face of difficult memories from the past, stress of the present, or fear of the future" (p. 46).

(Notes for Slide 78, continued)

Slide 78: Application Humanistic, Experiential and Existential Therapies

- These therapies assert that the counselor's genuineness, acceptance, and ability to accurately and empathetically understand the client's perspectives and worldviews are necessary and critical in the therapeutic relationship.



REFERENCES

Center for Substance Abuse Treatment (2012). *Brief interventions and brief therapies for substance abuse. Treatment Improvement Protocol (TIP) Series No. 34* HHS Publication No. (SMA) 12-3952. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Corey, G. (2017). *Theory and practice of counseling and psychotherapy* (10th ed). Boston, MA: Cengage.

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Cognitive Behavioral Approaches

- Cognitive behavioral approaches posit that cognitions (thoughts, beliefs, attitudes, assumptions), behaviors, feelings/emotions, and physical reactions are reciprocally linked.
- Behavior Therapy
- Cognitive Therapy
- Cognitive Behavioral Therapy
 - Key concepts include: attributions, cognitive appraisals, and self-efficacy expectancies

Reference
Center for Substance Abuse Treatment (2012). *Brief interventions and brief therapies for substance abuse*. Treatment Improvement Protocol (TIP) Series No. 34 (HHS Publication No. (SMA) 12-3552. Rockville, MD: Substance Abuse and Mental Health Services Administration

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Slide 79: Cognitive Behavioral Approaches

- Contemporary behavioral therapies are diverse and differ in their levels of complexity; however, we will highlight some of the basic characteristics and assumptions of this approach. Behavioral therapies apply principles of classical conditioning, operant conditioning, and social cognitive theory to a variety of psychological and behavioral problems. Methods are primarily derived from operant and classical theories of learning. CSAT (2012) explains, “a major tenet of behavioral therapy is that because substance abuse is a learned behavior pattern, changing the reinforcement contingencies that govern this behavior can modify it... this can be achieved by focusing on either the classically conditioned craving responses and/or on the operant reinforcement patterns that are assessed and maintaining the substance abuse” (p. 52). Classical conditioning, or respondent conditioning, is learning an association between two stimuli.

(Notes for Slide 79, continued)

Slide 79: Cognitive Behavioral Approaches

- Individuals learn to associate a previously unrelated and neutral stimulus with another stimulus that later elicits a specific response or reaction.



- ***[ASK PARTICIPANTS] How would you explain classical conditioning and addiction?***
 - CSAT explains, “repeated pairings between the emotional, environmental, and subjective cues associated with the use of substances and the actual physiological and phenomenological effects produced by specific substances lead to the development of a classically conditioned response. Subsequently, when the [individual who meets criteria for a SUD] is in the presence of such cues, a classically conditioned withdrawal state or craving is elicited” (p. 52).

(Notes for Slide 79, continued)

Slide 79: Cognitive Behavioral Approaches

- Operant conditioning, or instrumental conditioning, involves learning in which behaviors are influenced by consequences. If the consequence provides a reward (known as positive reinforcement) or eliminates an aversive stimuli (known as negative reinforcement), operant conditioning suggests that the chances increase that the behavior will occur again. If the consequence produces no reward or an aversive stimuli, operant conditioning suggests that that chances decrease that the behavior will happen again. This is referred to as punishment.



- ***[ASK PARTICIPANTS] How would you explain operant condition and addiction?***

(Notes for Slide 79, continued)

Slide 79: Cognitive Behavioral Approaches

- According to CSAT, “Substance use in the presence of classically conditioned cues is instrumental in reducing or eliminating the arousal associated with a state of craving, thus serving to reinforce the substance use behavior. That is, the behavior serves a basic rewarding function for the individual. ...To the extent that they experience the effects they seek, the greater the likelihood they will use substances under similar circumstances in the future” (p. 52)
- Social cognitive theory posits that human behavior occurs within a social context and is shaped by the dynamic and reciprocal interaction among environmental influences, cognitions and other personal factors, and behavior all operating, interacting, and influencing each other. The emphasis of behavior therapy is on current problems. Counselors conduct thorough open-ended functional assessments to gather and analyze information about situational antecedents and the consequences associated with substance use behaviors.

(Notes for Slide 79, continued)

Slide 79: Cognitive Behavioral Approaches

- Counselors help clients to identify and understand the antecedents (e.g., environmental events) that trigger, maintain, and reinforce specific behaviors and what faulty learning had occurred in the development of their current substance use disorder. Assessment is ongoing and informs the treatment process. Interventions are individually tailored and specific to one or more of the client's problems. Client and counselors establish agreed-upon goals that are specific and measurable. Clients are expected to assume an active role in treatment. Counselors introduce clients to adaptive strategies and new behaviors to change behavior; clients are encouraged to practice these strategies and skills between sessions. Strategies are clearly defined, tested empirically, and continually revised. Clients are expected to monitor and report on their behaviors outside of therapy. Together, the client and counselor regularly evaluate and continually assess progress towards goal completion.

(Notes for Slide 79, continued)

Slide 79: Cognitive Behavioral Approaches

- Cognitive theory assumes that most problems, including substance misuse, derive from faulty thinking processes. Antecedent events, cognitions (beliefs, attitudes, thoughts), feelings, and behavior (actions) are interactive and dynamic, each affecting the other. Yet, the emphasis in cognitive theory is on cognitions. “The way we act and feel is most often affected by our beliefs, attitudes, perceptions, cognitive schema, and attributions” (CSAT, 2012, p. 61). Essentially, cognitive theory assumes that changing the way we think can change the way we feel and behave. According to CSAT, cognitive theory “posits that substance use disorders reflect habitual, automatic, negative thoughts and beliefs that must be identified and modified to change erroneous ways of thinking and associated behaviors. The desire to use substances is typically activated in specific, often predictable high-risk situations, such as upon seeing drug paraphernalia or experiencing boredom, depression, or anxiety” (p. 42).

(Notes for Slide 79, continued)

Slide 79: Cognitive Behavioral Approaches

- Cognitive therapy aims to help clients examine and change their negative, maladaptive, self-defeating automatic thoughts and faulty logic by modifying thought patterns and replacing distorted thoughts with rational alternatives.
- Cognitive behavioral therapy or CBT, integrates principles from cognitive and behavioral theories. CBT focuses primarily on cognitions, belief, and expectancies. According to Corey, CBT is based on the “assumption that beliefs, behaviors, emotions, and physical reactions are reciprocally linked. Changes in one area leads to changes in other areas.” CBT is structured, goal-oriented, individualized, and focused on current problems. Key concepts of CBT include attributions, cognitive appraisals, and self-efficacy expectancies. “An attribution is an individual’s explanation of why an event occurred” (CSAT, 2012, p. 69). Individuals develop attributional styles when describing emotional problems and dysfunctional behaviors.

(Notes for Slide 79, continued)

Slide 79: Cognitive Behavioral Approaches

- These styles often include the following attributional dimensions: internal/external, stable/unstable, and global specific. Internal and external dimensions refer to whether the client attributes the event and their causes to themselves or others. Stable and unstable refer to whether the individual believes the cause will continue to affect their future or that it can change or stop. Global or specific attributes refer to whether the individual believes that the cause of one negative circumstance affects only part or all areas of their life.
- Cognitive appraisals refer to an individual's assessment and perception of a stressful situation and their evaluation of their ability to meet the specific challenges or demands of the situation.
- Self-efficacy expectancies refer to beliefs about abilities for successfully executing an appropriate, culturally-sanctioned response to cope with specific situations.

(Notes for Slide 79, continued)

Slide 79: Cognitive Behavioral Approaches



REFERENCES

Center for Substance Abuse Treatment (2012). *Brief interventions and brief therapies for substance abuse. Treatment Improvement Protocol (TIP) Series No. 34* HHS Publication No. (SMA) 12-3952. Rockville, MD: Substance Abuse and Mental Health Services Administration

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**Application of
Cognitive Behavioral Approaches**

- Negotiate and establish agreed-upon goals.
- Determine which behaviors are the targets of change.
- Identify triggers.
- Individualize and introduce a variety of behavioral and cognitive coping strategies.
- Focus on relapse prevention.

Reference
Center for Substance Abuse Treatment (2012). *Brief interventions and brief therapies for substance abuse*. Treatment Improvement Protocol (TIP) Series No. 34 (HHS Publication No. (SMA) 13-3552). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Corey, G. (2017). *Theory and practice of counseling and psychotherapy* (20th ed.). Boston, MA: Cengage.

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Slide 80: Application of Cognitive Behavioral Approaches

- Miller (2012) suggests that behavior therapy is amenable to addiction counseling. There are a variety of techniques used and specific skills taught. For example, techniques specific to classical conditioning include cue exposure, where clients are exposed to specific cues, but choose not to use, resulting in eventual extinction, and counterconditioning, that is, introducing and repeatedly pairing a negative consequence to a behavior that had previously been associated with a positive outcome. Specific techniques based on operant conditioning include assertiveness training, behavioral self-control training, social skills training, contingency management and behavior contracting.

(Notes for Slide 80, continued)

Slide 80: Application of Cognitive Behavioral Approaches



- ***[ASK PARTICIPANTS] Do any of you have experience with these techniques, and if so, please describe how they were introduced in treatment and what were the outcomes?***
- An important and helpful application of CBT is helping clients identify triggers. Triggers are internal and external conditional cues that are associated with substance use. Internal triggers include thoughts and feelings (e.g., depression, anxiety, boredom). External triggers include people (e.g., dealers, significant others or friends who use or had used in the past), places (e.g., bars, parks, bridges, friend's homes), verbal phrases, time periods (e.g., holidays, anniversary dates, date of the passing of a loved one), and objects (e.g., paraphernalia). Triggers, consciously or unconsciously, influence our thoughts, which affect our feelings that may lead to cravings and potential use.

(Notes for Slide 80, continued)

Slide 80: Application of Cognitive Behavioral Approaches



- ***[ASK PARTICIPANTS] What other internal and external triggers have your clients identified?***
- A major focus and component of CBT is on developing coping skills and relapse prevention skills to help clients with effectively dealing with high-risk situations (e.g., triggers). Coping skills may be specific to either alcohol and drug use or to general interpersonal (e.g., refusal skills, assertiveness training) or emotional areas (e.g., coping with anxiety, rejection).



- ***[ASK PARTICIPANTS] What are some examples of interpersonal and intrapersonal coping skills?***

(Notes for Slide 80, continued)

Slide 80: Application of Cognitive Behavioral Approaches



REFERENCES

Center for Substance Abuse Treatment (2012). *Brief interventions and brief therapies for substance abuse. Treatment Improvement Protocol (TIP) Series No. 34* HHS Publication No. (SMA) 12-3952. Rockville, MD: Substance Abuse and Mental Health Services Administration

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General Counseling Guidelines

- Ask open questions
- Offer reflections
- Avoid the question-answer trap
- Refrain from making assumptions – listen to understand rather than be understood
- Be yourself
- Refrain from using professional jargon and acronyms
- Ask permission before giving information or advice
- Our nonverbal behaviors are as important, if not important, than our verbal behaviors
- If and when you choose to self-disclose or share an aspect of yourself with the client, ask yourself whether it is benefiting you or the client?

Slide 81: General Counseling Guidelines

- Before moving on to our next activity, we would like to take this opportunity to review best practices and some general counseling guidelines.
- First, aim to ask more open question than closed questions



- ***[ASK PARTICIPANTS] What is the difference between a closed and open ended questions? What are some examples of open ended questions?***
- Use reflective listening. Offer more reflections than questions. Simple reflections are statements that repeat or rephrase, paraphrase, or reflect back feelings.
- Avoid asking why questions. More importantly, use reflecting listening to prevent yourself and the client from entering the question and answer trap. If we begin asking too many questions, we train our clients to begin providing us with shorter answers.

(Notes for Slide 81, continued)

Slide 81: General Counseling Guidelines

- Listen to understand. Clarify. Never assume anything.
- Be yourself. Be genuine.
- Refrain from using jargon and acronyms. The use of jargons and acronyms is a way to exclude others.
- Offer information and education with the client's permission.
- In mainstream western culture, individuals often offer advice without asking. For example, a friend tells you that she is trying to lose weight.



- ***[ASK PARTICPANTS] What would you say to this friend? Do you feel compelled to offer advice.***
- Although it can be used therapeutically, be mindful and exercise caution with self-disclosure.

(Notes for Slide 81, continued)

Global Criteria for Counseling

21. Select the counseling theory(ies) that apply(ies).
22. Apply techniques to assist the client, group, and/or family in exploring problems and ramifications.
23. Apply techniques to assist the client, group, and/or family in examining the client's behaviors, attitudes, and/or feelings in the treatment setting.
24. Individualize counseling in accordance with cultural, gender, and lifestyle differences.
25. Interact with the client in a therapeutic manner.
26. Elicit alternative solutions and decisions from the client.
27. Implement the treatment plan.

Reference
Herdman, S. W. (2018). Global criteria: the 12 core functions of the substance abuse counselor (7th ed.). Lincoln, NE: Parallel Pathways to Change.

Slide 81: General Counseling Guidelines



- ***[ASK PARTICIPANTS] What are some other example of culturally appropriate and effective counseling guidelines for your community?***

Slide 82: Global Criteria for Counseling

- The IC&RC have identified seven criteria as necessary skills needed to perform the core function of counseling.

The first criterion emphasizes the importance for counselors to know several counseling theories and techniques, and to select the most appropriate approach based on the client's presenting problem or need. Herdman (2018) argues that counselors should be able to explain the rationale for selecting specific theories throughout the counseling process. The counselor may choose to integrate techniques from two or more approaches or use specific counseling approaches at different points in time in treatment.

(Notes for Slide 82, continued)

Slide 82: Global Criteria for Counseling

- The second criterion refers to the counselor's competence of different techniques to accurately understand the client's problem(s) and the various consequences associated with one or more of the client's problems. Similar to the first criterion, the counselor must be prepared to explain the rationale on why they chose a specific technique.
- The third criterion is similar to the second; however, the emphasis is on examining the impact of each problem on the client's attitudes, behaviors, and feelings.

The fourth criterion emphasizes the importance of developing cultural intelligence. Counseling should be individualized to each client. Counselors should be aware of, or seek consultation from others, regarding the effectiveness, appropriateness, and applicability of various counseling approaches/techniques when working with diverse client systems. It is strongly recommended to review TIP 59 on improving cultural competence.

(Notes for Slide 82, continued)

Slide 82: Global Criteria for Counseling

- The fifth criterion is specific to the counselor's knowledge of and compliance to applicable state and federal laws, rules, and regulations, as well as conformance to our professional and ethical responsibilities as addiction counselors.
- The sixth criterion refers to the counselor's competence in utilizing or applying specific techniques that encourages and supports clients with identifying and implementing strategies to address one or more presenting problems.
- The last criterion refers to the selection of specific counseling approaches based on the client's treatment goals and objectives.



REFERENCE

Herdman, J.W. (2018). *Global criteria: The 12 core functions of the substance abuse counselor* (7th ed.). Lincoln, NE: Parallels: Pathways to Change.

Group Activity for Counseling

- What prevents us from actively listening to our clients?
- What are different roadblocks to active listening?
- Write down your list on the paper provided to you.
- All groups will report out.



Slide 83: Group Activity for Counseling

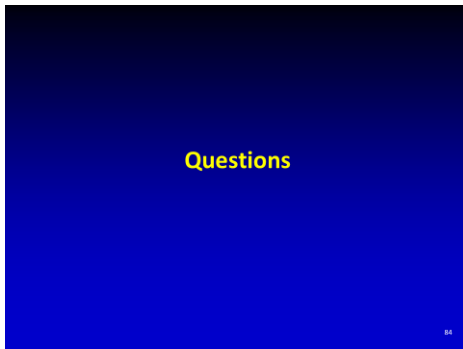
- ***Ask participants to gather into their small groups.***
- ***Instruct participants to generate a list of roadblocks barriers to listening.***
- ***If available, instruct clients to brainstorm and write down their list on easel pad paper.***
- ***Allow 15 minutes for participants to write down their lists.***
- ***Ask each group to review their list with the larger group.***

GENERAL NOTES FOR TRAINERS

Roadblocks to active listening, may include, but not be limited to the following:

- Advice giving
- Arguing
- Assuming

(Notes for Slide 83, continued)



Slide 83: Group Activity for Counseling

- Changing the subject
- Distracting
- Judging
- Labeling
- Lecturing
- Ordering
- Praising
- Probing (excessive)
- Ridiculing
- Threatening
- Using humor
- Warning

Slide 84: Questions



- *Ask participants if they have any final questions.*

Acknowledgements

Prepared in 2018 by: Pacific Southwest Addiction Technology Transfer Center

11075 Santa Monica Boulevard, Suite 200

Los Angeles, California 90025

T: (310) 267-5408

F: (310) 312-0538

pacificsouthwestca@attcnetwork.org

At the time of writing, Thomas E. Freese, Ph.D. served as the Principal Investigator and Director of the HHS Region 9, Pacific Southwest Addiction Technology Transfer Center, based at UCLA Integrated Substance Abuse Programs and Beth A. Rutkowski, MPH served as Co-Director of the HHS Region 9, Pacific Southwest Addiction Technology Transfer Center. Humberto M. Carvalho, MPH, served as the ATTC Government Project Officer. Dr. Louis Trevisan currently serves as Director of the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. The opinions expressed herein are the views of the authors and do not reflect the official position of the Pacific Southwest ATTC/SAMHSA-CSAT. No official support or endorsement of the Pacific Southwest ATTC/SAMHSA-CSAT for the opinions described in this document is intended or should be inferred.