Pacific Behavioral Health Collaborating Council (PBHCC)

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

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

Trainer Guide

Pacific Southwest
ATTC
(HHS Region 9)

UCLA

IC&RC Alcohol and Drug Counselor Academy, Day 3

Table of Contents

IC&RC Alcohol and Drug Counselor Academy, Day 3

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 3

Core Competencies of Addiction Counselors: Knowledge and Skill Acquisition of Case Management, Crisis Intervention, Client and Family Education, Referral, Rapport and Record Keeping, and Consultation

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]

Pacific Behavioral Health Collaborating Council
Alcohol and Drug Counselor (ADC) Academy, 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

Enter location here
Enter dates here

Enter trainer names and credentials here

- *Welcome participants to day 3.*

- *Ask participants if they have any questions from day 2.*

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).

Disclaimer for Training

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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.

Slide 3: Disclaimer for Training

INSTRUCTIONS

- *[READ THE SLIDE]*

Today's Agenda (1)

- Review and check-in
- Twelve Core Functions (continued)
  - **Case Management**
  - Crisis Intervention
  - Client and Family Education
  - Referral
  - Report and Record keeping
  - Consultation

Slide 4: Today's Agenda (1)

- *Ask participants if they have any questions.*

- *Orient participants to the agenda.*

- *The focus of day 3 is on the last 6 core functions.*

PEDAGOLOGICAL SUGGESTIONS:

- *[ASK PARTICIPANTS] Please succinctly describe the six previous core functions.*

Agenda for Case Management

- Definition
- Distilling the core elements
- Core competencies
- Core functions of case management
- Core functions of case management across the treatment continuum of care
- Global Criteria

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Slide 5: Agenda for Case Management

- Orient participants to the session's agenda.

- Facilitate a conversation that helps participants recognize that many people across the treatment continuum of care, regardless of title, assume many of the responsibilities and core functions of case management.

PEDAGOLOGICAL SUGGESTIONS:

- *[ASK PARTICIPANTS] What does case management look like in your community?*

- *[ASK PARTICIPANTS] What do you consider to be the core functions of case management?*

Definition of Case Management

- "The administrative, clinical, and evaluative activities that bring the client, treatment services, community agencies, and other resources together to focus on issues and needs identified in the treatment plan" (CSAT, 2006, p.79).
- "Activities which bring services, agencies, resources, or people together within a planned framework of action toward the achievement of established goals. It may involve liaison activities and collateral contacts" (IC&RC, 2013)

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. [SMA] 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 6: Definition of Case Management

- The CSAT and IC&RC offer complimentary definitions of case management. Take a moment to review these two definitions.

- *[ASK PARTICIPANTS] What are you thoughts on these two definitions? What would you add or change?*

(Notes for Slide 6, continued)

Slide 6: Definition of Case Management

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Definition of Case Management (continued)

- Case management and the role of case managers is contextually defined.
- Case management models vary in their focus, purpose, and intensity for different populations.
- Case management also contingent on the access and availability of different resources, as well as to the client's needs, preferences, and priorities.

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 7: Definition of Case Management (continued)

- Case management activities and the role of case managers are contextually defined, meaning that they are contingent on the community and from the perspective of where the counselor supports their clients within the treatment continuum of care. Case management and the role of case managers will be different for persons receiving prevention services than to persons actively receiving outpatient treatment. The role and functions of case management are also contingent on the population being served, access and availability of different resources, as well as to the client's needs, preferences, and priorities.

(Notes for Slide 7, continued)

Slide 7: Definition of Case Management (continued)

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Distilling the Core Elements of Case Management

- A set of social service functions that helps clients access a variety of resources, both internal and external.
- Identify and utilize the client's own strengths.
- Advocacy is a hallmark of case management.
- Therapy is focused on intra- and interpersonal change while case management aims to enhance resource acquisition.

Reference
Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment.*
Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance
Abuse and Mental Health Services Administration.

Slide 8: Distilling the Core Elements of Case Management

- Another way of delineating the core functions of case management is by distilling its practice elements from other types of services. A core element of case management is educating, orienting, referring, and coordinating, when applicable, clients to various community resources and social services that may benefit clients as they move forward in their own recovery. Individuals in recovery may have access to and agree to involve a network of supporters, including family and other loved ones, and that a key function of case management is educating and orienting these supporters to different community resources and supports to help them as they support their friend or loved one in their own recovery. For example, in communities where mutual support and self-help is valued and available, family members and other supporters may be interested in attending and participating in support groups with other family members who have similar lived experiences.

(Notes for Slide 8, continued)

Slide 8: Distilling the Core Elements of Case Management

- In both cases, the case manager should be familiar with and educate the their clients to the various rules, regulations, application processes, expectations and level of involvement and other essential information that helps clients make an informed decision on whether to use services, either within their own organization or to others in the community. We will later discuss the core function of referrals and the need to have specific knowledge before referring a client to another provider. An often overlooked, but essential aspect of case management is the identification and use of client strengths. Case managers should aim to capitalize on and connect the individual's own internal resources (e.g., knowledge, skills, abilities) to their service goals.

Slide 8: Distilling the Core Elements of Case Management

- A hallmark of case management is advocacy. Case management, according to the CSAT, "is dedicated to making services fit clients, rather than making clients fit services" Often, the various systems that clients may be involved with may contradict what is being recommended by other providers the client is involved with or contradict what is outlined in the client's the treatment plan. Case management aims to coordinate services and holds agencies and clients accountable. The functions of therapy and case management are different. Therapy focuses on intrapersonal change, meaning change within oneself, and interpersonal change, how others relate and understand others. Case management, on the other hand, focuses on capitalizing on, coordinating with, and acquiring various resources to support clients as they move forward in their own recovery.

Slide 8: Distilling the Core Elements of Case Management

- *[ASK PARTICIPANTS] What do you consider to be the core functions of case management?*

REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Core Functions of Case Management

- Engagement
- Assessment
- Planning, goal setting, and implementation
- Linking, monitoring, and advocating
- Disengagement

Reference
Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 9: Core Functions of Case Management
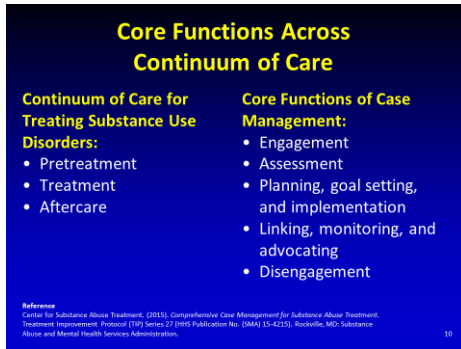
- *Review the list of core functions and highlight how each relates to one or more of the twelve core functions.*

REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

**Core Functions Across
Continuum of Care**

Continuum of Care for Treating Substance Use Disorders:	Core Functions of Case Management:
• Pretreatment • Treatment • Aftercare	• Engagement • Assessment • Planning, goal setting, and implementation • Linking, monitoring, and advocating • Disengagement

Reference
Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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**Pre-Treatment and
Case Management**

Slide 10: Core Functions Across Continuum of Care

- The CSAT's TAP 27 outlines the various core functions of case management across the continuum of care for treating substance use disorders. We will go through each phase of treatment and highlight specific examples of common case management activities.
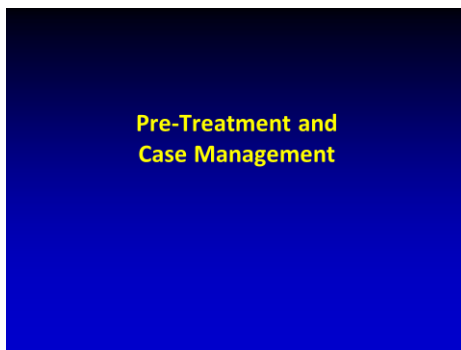
REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 11: Pre-Treatment and Case Management

- First, we begin with pre-treatment. Essentially, the goal at this stage in the continuum of care is to reduce barriers that prevent an individual with a SUD from accessing treatment.

Engagement in Pre-Treatment (1)

- Review meeting agenda.
- Orient clients to process.
- Engage individuals using stage-appropriate services.
- Use motivational interviewing or motivational enhancement approaches.
- What are the stages of change?

Reference
Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment.*
Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance
Abuse and Mental Health Services Administration.

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Slide 12: Engagement in Pre-Treatment (1)

PEDAGOLOGICAL SUGGESTION:

- ***If time permits, ask for examples for each stage of change to help other participants better understand and distinguish them apart.***

- All client encounters should begin with a brief orientation and review of the meeting agenda. Many individuals, regardless of whether they are in recovery from substance use disorders, benefit from structure, predictability, and safety. Clients often don't know what to expect when they walk into an office or meet with a counselor, especially if this is their first time in the organization. Individuals will present different feelings about their first encounter. Some may feel anxious, concerned, frustrated or angry. Others may feel delighted, relieved, or hopeful. Reviewing, and whenever possible, negotiating the meeting agenda helps to build client rapport.

(Notes for Slide 12, continued)

Slide 12: Engagement in Pre-Treatment (1)

- We want to begin with where the client is. What are they bringing to the encounter or visit? Many individuals in early recovery are ambivalent about treatment or may be faced with external pressures to stop using alcohol or drugs. We want to listen. We want to take the time to understand from their perspective the impact addiction is having on their lives and the impact addiction is having on the lives of their loved ones. Use of motivational interviewing or motivational enhancement techniques is helpful in guiding counselors to understand their client's needs, preferences, and priorities. Our efforts to engage clients should focus on using stage-appropriate services. A best practice to engage individuals with SUDs is to match interventions to their stage of change for each substance used. Interventions should be consistent with the client's view of the problem and/or their stage of change for that specific substance.

(Notes for Slide 12, continued)

Slide 12: Engagement in Pre-Treatment (1)

- Before we continue on and discuss engagement and the role of case management, let's take a few minutes and discuss state-appropriate services as people move through the stages of change. So, what are stage-appropriate services? These are directly related to the Transtheoretical Model of Change, otherwise known as the stages of change.

- *[ASK PARTICIPANTS] What are the stages of change?*

- *[ASK PARTICIPANTS] What are the differences between each stage?*

(Notes for Slide 12, continued)

Slide 12: Engagement in Pre-Treatment (1)

REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 13: Stages of Change

PEDAGOLOGICAL SUGGESTIONS:

- ***Offer personal examples that are not directly tied or related to use of psychoactive substances. The use of self and personal examples highlight that pre-contemplation is normal and that ambivalence to change is normal and expected in most change efforts.***

- According to the CSAT (2013), "The change process has been conceptualized as a sequence of stages through which people typically progress as they think about, initiate, and maintain new behaviors. [Prochaska and Diclemente's Transtheoretical Model of Change] emerged from an examination of 18 psychological and behavioral theories about how change occurs, including components that compose a biopsychosocial framework for understanding addiction. In this sense, the model is "transtheoretical" (p.16).

Slide 13: Stages of Change

- The five stages of change are precontemplation, contemplation, preparation, action and maintenance. It is important to emphasize that when we refer to each stage, especially in the context of SUDs, we are referring to the drug or to a specific behavior. We are not referring to the person in their entirety. For example, an individual may be in the maintenance stage of change for their opioid use disorder and in the preparation stage of change for their alcohol use disorder. In the precontemplation stage of change, individuals are not considering change and have no intention to change. They may be unaware or under-aware that a problem exists. Further, as TIP 35 points out, they may be unwilling or discouraged to change. In the contemplation stage, individuals become aware or recognize that a problem exists.

Slide 13: Stages of Change

- They begin to consider and recognize that their use of one or more substances may be a cause for concern. Many remain ambivalent to change. They are vacillating between wanting to change and not wanting to change.

REFERENCES

Center for Substance Abuse Treatment (2013). *Enhancing motivation for change in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 35 (HHS Publication No. (SMA) 13-4212). Rockville, MD: Substance Abuse and Mental Health Services Administration,

Substance Abuse Mental Health Services Administration. (2015). *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.

Stages of Change (continued)

- **Preparation**
  – Ready to change.
  – Action planned in foreseeable future.
- **Action**
  – Modify behavior, experiences, ands/or environment to overcome a specific problem.
- **Maintenance**
  – Prevent relapse.
  – Sustains the change beyond 6 months.

Reference
Substance Abuse Mental Health Services Administration. (2015). 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.

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PEDAGOLOGICAL SUGGESTIONS:

- *Offer personal examples that are not directly tied to substance use. Continue to use examples for preparation, action, and maintenance. The use of self and personal examples emphasizes that ambivalence to change is normal and expected.*

- *[ASK PARTICIPANTS] Please identify stage-appropriate behaviors that you or your clients engaged in when moving between stages. Please first identify the behavior, the stage, and the intervention employed.*

- In the preparation stage, individuals enter a stage where they begin planning for change. Their commitment to change strengthens. They begin to set goals for themselves. In the action stage of change and in the context of addiction, individuals are actively modifying habits and engaging in behaviors that are helping them to change their use of or relationship to one or more substances.

Slide 14: Stages of Change (continued)

- This does not necessarily mean that individuals have chosen to be completely abstinent from one or more drugs. It is possible that they may not be engaged in a behavior that allows them to safely use the drug. In other cases, individuals may have stopped using one or more drugs and actively engaged in treatment, 12 step and other forms of peer support. In the maintenance stage of change and in the context of addictions, individuals are maintaining positive gains they made during the action stage using the same or new interventions.

- *[ASK PARTICIPANTS] What are stage-appropriate interventions (e.g., providing food and shelter) and services (e.g., access to healthcare providers) for individuals during the engagement stage.*

(Notes for Slide 14, continued)

Slide 14: Stages of Change (continued)

REFERENCES

Center for Substance Abuse Treatment (2013). *Enhancing motivation for change in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 35 (HHS Publication No. (SMA) 13-4212). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse Mental Health Services Administration. (2015). *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 15: Engagement in Pre-Treatment (2)

- There are a number of stage-appropriate interventions that you may want to consider during the engagement stage. During this stage, your aim is to reduce internal and external barriers that impede or prevent individuals with one or more substance use disorders from accessing treatment. There are a number of different interventions that you could employ. Let's review the list together.

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

- Remember the importance of person-centered planning and listening. Emphasize choice. And remember that addiction is a brain disorder and that sustained use of one or more substances impacts abilities of individuals to make logical, rational decisions. Emphasize that the client's health and safety are your primary concern.

(Notes for Slide 15, continued)

Slide 15: Engagement in Pre-Treatment (2)

REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Assessment in Pre-Treatment

- Prescreen and assess for program eligibility – refer to external provider if not eligible.
- Assess for specific skill deficits, level of functioning, basic support needs, and risk status.
- Identify strengths, needs, desires, and deficits.
- Assess for harm to self or others.

Reference
Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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- *[ASK PARTICIPANTS] What standardized screening and assessment tools do you use in your agencies?*

- *[ASK PARTICIPANTS] How do you orient your client to the assessment process?*

- *[ASK PARTICIPANTS] What types of questions are asked and how do you manage participants who refuse to answer questions?*

- You should aim to facilitate safe, private conversations that are non-judgmental. Your aim is to collect valid information. It is essential that counselors orient all individuals to screening and assessment processes, and orient prospective clients to the types of questions that they will be asked. You should only ask the questions that are necessary for determining eligibility and whatever is required by your funder and accreditation body. Assessments should not only assess for the use of substances, but also for other specific needs. For example, the client's access to and use of primary care services.

Slide 16: Assessment in Pre-Treatment

- Also, you want to communicate your concern regarding their health and safety and inquire, if individuals are actively using, how do they use one or more drugs (e.g., route of administration)? It is important that all clients be screened for suicidal and homicidal ideation and intent at every encounter.

REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Assessment: Use of a Decisional Balance

- Decisional balance exercise
  - What are the good things about...?
  - What are the not-so-good things about...?
  - What are the not-so-good things about changing?
  - What are the good things about changing?

Reference
Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment.*
Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance
Abuse and Mental Health Services Administration.

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Slide 17: Assessment: Use of a decisional balance

- *Before reviewing the TRAINER NOTES, draw a 2x2 matrix on a dry erase board. Label each quadrant the following:*
  - *First column, first row: The good things about ___*
  - *First column, second row: The not-so-good things about ___*
  - *Second column, first row: The not-so-good things about changing ___*
  - *Second column, second row: The good things about changing ___*
- *After reviewing the TRAINER NOTES, ask participants to pair up and have one person interview the other and ask that they identify a behavior that they are ambivalent about changing. Remind participants to keep it light.*

(Notes for Slide 17, continued)

Slide 17: Assessment: Use of a Decisional Balance

- ***The point of this exercise is to allow individuals to hear different arguments and to model what its like to facilitate nonjudgmental conservations about change and ambivalence to change. Encourage the participants being interviewed to document and list the pros and consequences to change and not change.***

- An effective and stage-appropriate strategy that is helpful to use when engaging and assessing individuals in recovery during the pre-treatment phase and as you are collecting information for your assessment, is use of a decisional balance matrix. In moving toward any decision, most people weigh the costs and benefits of the action being contemplated.

Slide 17: Assessment: Use of a Decisional Balance

- In behavioral change focused on alcohol and/or drug use, these considerations are known as decisional balancing, a process of cognitively appraising or evaluating the "good" aspects of substance use – the reasons not to change (what they get out of the targeted behavior and what the cost is of the targeted behavior), and the "not-so-good" aspects – the reasons to change. It is best to remain nonjudgmental and allow the person enough time to describe all the reasons why they want and not want to change. You begin by drawing a 2X2 matrix or table consisting of two columns and two rows. You label at the top of each quadrant the pros and consequences to change and not change. Before asking individuals to complete the matrix with you, please be thoughtful and careful in determining whether the person can read or write. If persons are unable to read and/or write, document the statements made by individuals for your notes and verbally reiterate what was offered during the exercise.

(Notes for Slide 17, continued)

Slide 17: Assessment: Use of a Decisional Balance

- Your aim is to facilitate safe and supportive conversation about change. Starting with the top left hand quadrant, we ask our clients "what are the good things about ___." Then, we move to the adjacent cell to the right and ask the client, "what are the not so good things about ___." We then move to the bottom right hand quadrant and ask, " what are the not-so-good things about changing ____. We end by asking the client, "what are the good things about changing?" After reviewing all four quadrants with the client, ask whether there is anything missing.

- This process of guiding individuals to discuss the pros and consequences to change and to not change. The exercise is a person-centered approach to care that demonstrates your ability to listen and to understand the client's perspective from a nonjudgmental and safe space.

Slide 17: Assessment: Use of a Decisional Balance

- The objective in moving a client toward positive change, of course, is to help that person recognize and weigh negative aspects of substance use so that the scale tips toward beneficial behavior change.

- This tool is particularly helpful with difficult-to-engage clients, especially if you begin with the functional elements of their substance use ("the good things about…"). Four overall objectives exist in using a decisional balance exercise with clients.

- The intent of such exercises, which weigh substance use and change separately, is to: (1) accentuate or in a subtle manner make salient from the client's perspective the costs of the client's substance use; (2) lessen, when possible, the perceived rewards of substance use; (3) make the benefits of change apparent; and (4) identify and accentuate, if possible, potential obstacles to change.

(Notes for Slide 17, continued)

REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 18: Planning, Goal Setting, Implementation (1)

- Your aim in pre-treatment is to reduce internal and external barriers that impede or prevent individuals with substance use disorders from accessing treatment. Your assessment may identify specific needs that may or will need to be addressed for the individual to access treatment.

Planning, Goal Setting, Implementation (1)

- Focus on immediate needs and entry into SUD treatment.
- Negotiate and work on agreed—upon goals, especially if the client is actively using.
- Coordinate multiple service plans.

Reference
Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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(Notes for Slide 18, continued)

Slide 18: Planning, Goal Setting, Implementation (1)

- *[ASK PARTICIPANTS] What examples of immediate needs can you think of that may be external barriers to care?*

- During pre-treatment, aim to establish agreed-upon goals outlined in an initial plan of care. Acquire consents and the individual's service plans from partnering agencies. It is possible and expected that there may be duplicative services, and it is also expected that there will be different expectations from each provider and that these expectations may conflict with yours and other program expectations. As a counselor, you may be called upon to advocate for your client and to hold your client and the programs, including your own, accountable for their actions. You may also be called upon to negotiate and find compromises with other programs.

(Notes for Slide 18, continued)

Slide 18: Planning, Goal Setting, Implementation (1)

REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Linking, Monitoring, and Advocating (1)

- Enhance the client's commitment to contacting the potential provider or resource.
- Identify and problem solve potential obstacles and barriers.
- Outline next steps – create a plan for establishing and maintaining contact.
- Model and rehearse the plan.

Reference
Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 19: Linking, Monitoring, and Advocating (1)

- During the pre-treatment phase, individuals in recovery may be ambivalent from contacting or making their appointments to different agencies for a variety of reasons. It is important that you consider the various obstacles and barriers preventing them from moving forward.

- *[ASK PARTICIPANTS] What could be potential barriers or obstacles?*
  - Listen for:
    - Lack of transportation to and from program.
    - Lack of access to phone or internet.
    - Idiosyncratic program rules and processes that make it difficult for individual to access treatment (e.g., you need to call between these times; attend X amount of AA or NA meetings).

Slide 19: Linking, Monitoring, and Advocating (1)

- Programs that do not admit anyone using any medication, including psychotherapeutic medications for treating various mental disorders.

- Health insurance.

- It is recommended that you review SAMHSA's TIP 57 on trauma-informed care in behavioral health settings . This text provides context on the high prevalence of trauma among individuals served in behavioral health service systems and the need for human service systems to change how they interact with and treat their clients. Many of us have been trained to assess and emphasize our client's pathology. We need to move beyond asking others "what is wrong with them" and emphasize and prioritize and asking service users "what happened to them?"

Slide 19: Linking, Monitoring, and Advocating (1)

- Once you have a better understanding of the client's barriers and obstacles and potential strategies to overcome them, it is helpful to outline a plan that is understandable to both you and the client.The plan should outline clear steps for establishing and maintaining contact with your program and others involved in the client's care. Normalize the use of checklists, and if possible, providing examples of your own or examples of flowcharts used by other organizations. This helps clients see the value of using these types of tools.

- The plan should outline strategies for anticipated barriers. It is sometimes helpful for some clients to engage in role playing activities where they can safely test the strategies outlined in the plan. Some counselors choose to model the behavior first.

(Notes for Slide 19, continued)

Slide 19: Linking, Monitoring, and Advocating (1)

- *[ASK PARTICIPANTS] Do any of you have examples of developing a plan in pre-treatment?*

- *[ASK PARTICIPANTS] Did the plan involve modeling and role playing, and if so, please describe what it looked like.*

REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Disengagement in Pre-Treatment

- Disengagement is a process that should be planned and deliberate.
- Emphasis on client involvement, investment, and participation in service planning.
- Assess for suicidal ideation, harm to self and/or others.

Reference
Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 20: Disengagement in Pre-Treatment

- Termination or disengagement should be planned and deliberate. As discussed earlier, we should orient individuals to each encounter, especially in pre-treatment. We should begin planning for termination or discharge from the client's first encounter. Always screen and assess for suicidal ideation, harm to self and/or others.

REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 21: Treatment

- The next stage in the continuum of care refers to a broad term that encompasses different categories of treatment based on their frequency, intensity, and duration. These categories include early intervention, outpatient services, intensive outpatient or partial hospitalization services, residential or inpatient services, and medically managed intensive inpatient services.

REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 22: Engagement in Treatment

Engagement in Treatment

- Orient client to program rules and requirements.
- Elicit client expectations.
- Address immediate concerns to ensure client's focus remains on addressing their substance use disorder.
- Assess for suicidal ideation, harm to self and/or others.

Reference
Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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- Across the different types of treatment, it's essential to orient the clients to the program and to provide them with an overview of what they can expect. Think about different medical procedures you or a loved one had been involved with in the past. Many would agree that it is helpful when the medical team provides an overview of what to expect. Treatment in addiction settings should be no different. Orienting clients reduces anxiety and helps build therapeutic rapport. As a reminder, you should always screen for suicidal or homicidal ideation.

REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Assessment in Treatment

- Assess functional skills deficits and strengths
  - Service procurement skills
  - Pre-vocational and vocation-related skills
- Assess for suicidal ideation, harm to self and/or others

Reference
Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment.*
Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance
Abuse and Mental Health Services Administration.

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Slide 23: Assessment in Treatment

- The focus of assessment within the context of case management is on the acquisition and need of community resources. Case managers look beyond SUD services to determine the impact of the client's addiction in other life domains. At this stage, a core function of case management is to assess for functional skills deficits and strengths, "including personal living skills, social or interpersonal skills, service procurement skills, and vocational skills" (CSAT, 2015, p. 22).

- *[ASK PARTICIPANTS] What would you consider to be service procurement skills?*

- Service procurement skills refer to the ability to access and navigate different systems to acquire different resources and supports available through a variety of health and human services.

Slide 23: Assessment in Treatment

- According to the CSAT (2015), clients should be assessed for:

    - "Ability to obtain and follow through on medical services

    - Ability to apply for benefits

    - Ability to obtain and maintain safe housing

    - Skill in using social services agencies

    - Skill in accessing mental health and substance abuse treatment services" (p. 22)

- In addition to assessing clients for service procurement skills, case managers should also assess their clients for prevocational and vocation-related skills.

- *[ASK PARTICIPANTS] What would you consider to be pre-vocational and vocational related skills?*

Slide 23: Assessment in Treatment

- The CSAT (2015) recommends assessing clients for:

    - "Basic reading and writing skills

    - Skills in following instructions

    - Transportation skills Manner of dealing with supervisors

    - Timeliness

    - Punctuality

    - Telephone skills" (p.22)

- Again, it is critical that you screen clients for suicidal and homicidal ideation.

REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Planning, Goal Setting, Implementation (2)

- Develop individualized person-centered service plans.
- Provide ongoing motivation.
- Remind clients of potential consequences.
- Coordinate service plans.
- Coordinate interventions among various providers.
- Facilitate acquisition of basic survival needs.
- Coordinate transitions between programs.
- Respond to relapses.
- Support clients with activating crisis plans.

Reference
Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 27* (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 24: Planning, Goal Setting, Implementation (2)

- Planning, goal setting, and implementation are considered core to case management. As reminders to what we have already discussed, the CSAT suggests:

  - Goals, objectives, and action steps (specific strategies/interventions or steps to help the client move forward with achieving objectives) should be developed in partnership with the client.

  - Goals and objectives "should be framed in a positive context – as something to be achieved rather than something to be avoided" (p. 23)

  - Objectives should be specific, measurable, achievable, realistic and time-specific. Timeframes should specify the completion of objectives and action steps.

Slide 24: Planning, Goal Setting, Implementation (2)

- *[ASK PARTICIPANTS] Developing individualized person-centered plans also benefit clients in other ways. How?*

- The CSAT (2015) emphasizes that the careful and deliberate approach and task of guiding clients with developing goals goes beyond the benefits of achieving goals and objectives. The CSAT (2015) explains that clients benefit by: "Learning a process for systematically setting goals; understanding how to achieve desired goals through the accomplishment of smaller objectives; gaining mastery of themselves and their environment through brainstorming ways around possible barriers to a particular goal or objective, [and]; experiencing the process of accessing and accepting from others in goal-setting and goal attainment." (p.23). The service plan at this stage should focus on addressing and prioritizing problems while the client is in treatment.

Slide 24: Planning, Goal Setting, Implementation (2)

- The plan will need to be adjusted accordingly based on the type of treatment the client is receiving. SUD treatment may be difficult for some clients. In fact, clients can feel discouraged and frustrated. Client may lack adaptive coping skills to manage the various stressors they will encounter during treatment. Providing hope and encouragement throughout this stage may benefit clients to stay engaged. Others may benefit from being reminded of the disincentives of not continuing in treatment. As a case manager and in your role as an advocate, you may need to support clients with managing and coordinating service plans. In fact, some plans may contradict others and some goals and objectives may require staging and coordination. Later, we will describe the importance of establishing crisis plans. However, it is important to point out that development of a crisis plan should always be a priority.

Slide 24: Planning, Goal Setting, Implementation (2)

REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Linking, Monitoring, and Advocating

- Monitor client progress and adjust service plans.
- Advocate for clients to support them in achieving goals established in the service plan.

Reference
Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 25: Linking, Monitoring, and Advocating (2)

- As clients are actively engaged in treatment, case managers (or those assuming the roles and responsibility of case management) should focus on monitoring client progress and adjusting service plans accordingly. Further, in your role as an advocate, you may need to support clients with managing and coordinating service plans.

REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Disengagement in Treatment

- Disengagement is a process that should be planned and deliberate.
- Facilitate discussion and reinforce what clients have learned.
- Review and summarize client progress.
- Emphasize client strengths.

Reference
Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Rapp, C.A. & Goscha, R. J. (2006). *The strengths model: case management for people with psychiatric disabilities* (2nd ed.). New York, NY: University Press.

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Slide 26: Disengagement in Treatment

- Like pre-treatment, termination and transition planning at any level in treatment should be planned and deliberate. At this stage, it is recommended to facilitate conversations with clients and their supporters acknowledging gains, lessons learned, progress made and next steps. Here, we also recognize and acknowledge client strengths. Client strengths may include, but not be limited to: talents, skills, and abilities; environmental strengths; personal qualities and characteristics; and the client's hopes, wishes, interests and aspirations.

REFERENCE

- Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP)Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 27: Aftercare

- The next stage in the continuum of care is aftercare, which also encompasses anticipatory roles of discharge and community reentry.

REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Engagement in Aftercare

- Ensure continuity between providers and among different resources.
- Address needs, including but not limited to: housing, healthcare, income, education and/or employment, and social supports.

Reference
Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 28: Engagement in Aftercare

- CSAT (2015) highlights and reminds us that "it is not until discharge that the day-to-day realities of living assume the most urgency" (p. 21). It is important to ensure there is continuity between providers and that case managers revisit the client's real world needs to support clients in their own recovery from substance use disorders.

REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 29: Assessment

Assessment

- Assess readiness for reintegration into the community throughout the treatment continuum.
- Support clients with identifying relapse triggers and other stressors.
- Empower clients by helping them develop action plans for managing triggers.
- Help clients with activating action plans by teaching and rehearsing adaptive coping skills.
- Assess for harm to self or others.

Reference
Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

- The potential for relapse is high immediately following completion of treatment. Case managers should continue to asses clients for new, recurring, or unresolved problems. Prior to aftercare, it is particularly helpful to help clients identify potential triggers and to outline adaptive and effective coping strategies endorsed and used by the client to prevent potential relapse. Again, emphasis on normalizing and endorsing the use of checklists and other tools are helpful. In aftercare, case managers can introduce, revisit, model and engage in role playing to reinforce the use of coping skills or strategies to manage triggers.

- *[ASK PARTICIPANTS] What types of strategies have you introduced to clients to support them with preventing or managing triggers?*

PEDAGOLICAL SUGGESTION:

- *Invite participants to model or role play strategies used to prevent or manage triggers.*

Slide 29: Assessment

REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 30: Planning, Goal Setting, Implementation

In aftercare, case managers may introduce and support clients with learning basic skills needed to function independently. For example, you may offer supports and education on managing their budget. Again, normalize that many people, not just persons in recovery, have difficulty with managing their budgets and that many individuals would benefit from financial counseling. It is also helpful to facilitate conversations and guide clients with developing log-term goals that compliment their commitment to recovery.

Planning, Goal Setting, Implementation

- Help clients with mastering basic skills needed to live and function independently/interdependently in the community.
- Emphasize long-term goals to support clients in their own recovery.
- Ensure that service plans emphasize and reinforce emphasis on clients accepting greater responsibility for their actions.

Reference
Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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(Notes for Slide 30, continued)

Slide 30: Planning, Goal Setting, Implementation

- ***[ASK PARTICIPANTS] What types of life goals have clients identified with you that compliment their recovery?***

- Identifying goals that help the client move forward in their own recovery also communicates and reflects their acceptance of taking greater responsibility for themselves.

REFERENCE

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Global Criteria for Case Management

28. Explain the rationale of case management activities to the client.
29. Coordinate services for client care.

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

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Slide 31: Global Criteria for Case Management

- The IC&RC have identified two criteria as necessary skills needed to perform the core function of case management.

- Herdman (2018) explains that competence in the first criteria is evident by the counselor explaining the core functions, rationale, and purpose of case management to their clients.

- Herdman (2018) describes competence in the second criterion to be evident by a counselor's ability to implement and coordinate service provision and explain in detail the "traditional who, what, when, where, and why questions" (p. 59).

REFERENCES

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 27 (HHS Publication No. (SMA) 15-4215). Rockville, MD: Substance Abuse and Mental Health Services Administration.

(Notes for Slide 31, continued)

Group Activity for Case Management

- In yesterday's training, you created a checklist for creating client-centered, collaborative services plans.
- Create an outline or specific criteria to guide you and others in your agency to create client-centered, collaborative discharge or transition plans.
- Be prepared to report out.
- Be prepared to ask questions and offer suggestions to support your colleagues.

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Slide 31: Global Criteria for Case Management

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

Slide 32: Group Activity for Case Management

- *Ask participants to gather into their small groups.*

- *Instruct participants to create an outline or specific criteria to guide themselves and others in their program with creating client-centered, collaborative discharge or transition plans.*

- *Allow 20 minutes for participants to create criteria for discharge.*

- *After each group has presented,*

Slide 32: Group Activity for Case Management

- *[ASK PARTICIPANTS] Do you have any recommendations for ways this group can improve their orientation process?*

- Allow enough time to have one or two groups share how they approached discharge planning with the client.

Slide 33: Today's Agenda

Today's Agenda (2)

- Review and check-in
- Twelve Core Functions (continued)
  - Case Management
  - **Crisis Intervention**
  - Client and Family Education
  - Referral
  - Report and Record keeping
  - Consultation

Check-in with participants to see if they have any questions regarding case management before moving on to crisis intervention.

Slide 34: Agenda for Crisis Intervention

- *Orient the participants to the agenda.*

PEDAGOLOGICAL SUGGESTIONS:

- *Facilitate and invite participants to discuss protocols they employ when their clients are in crisis.*

- *[ASK PARTICIPANTS] What do you do when a client discloses that she or he wants to kill themselves?*

- *[ASK PARTICIPANTS] What do you do when you suspect your client is suicidal or homicidal?*

Slide 35: Definition of Crisis

- Yeager and Roberts offer the following definition of a crisis.

- *[READ THE SLIDE]*

Agenda for Crisis Intervention

- Definition
- Keeping yourself and clients safe in crisis situations
- Keeping others safe when clients are in crisis
- Roberts (2005) Seven-Stage Crisis Intervention Model
- Addressing suicidal thoughts and behaviors
- Global Criteria

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Definition of Crisis

- "A crisis can be defined as a period of psychological disequilibrium, experienced as a result of a hazardous event or situation that constitutes a significant problem that cannot be remedied by using familiar coping strategies. A crisis occurs when a person faces an obstacle to important life goals that generally seem insurmountable through the use of customary coping patters" (Yeager & Roberts, 2015, p. 4)

Reference
Yeager, K. R. & Roberts, A. R. (2015). *Crisis intervention handbook: assessment, treatment, and research* (4th ed.). New York, NY: Oxford University Press.

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Slide 35: Definition of Crisis

REFERENCE

Yeager, K.R. & Roberts, A.R. (2015). *Crisis intervention handbook: Assessment, treatment, and research* (4th ed.). New York, NY: Oxford University Press

Slide 36: Definition of Crisis Interventions

- The IC&RC offer the following definition for crisis interventions.

- *[ASK PARTICIPANTS] What are your thoughts on this definition of crisis intervention?*

(Notes for Slide 35, continued)

Definition of Crisis Interventions

- The IC&RC defines crisis interventions as "those services which respond to an [individual, who meets diagnostic criteria for one or more substance use disorders,] needs during acute emotional and/or physical distress."

Reference
Yeager, K. R. & Roberts, A. R. (2015). *Crisis intervention handbook: assessment, treatment, and research* (4th ed.). New York, NY: Oxford University Press. 36

Slide 37: Keeping Yourself Safe in a Crisis Situation

Keeping Yourself Safe in a Crisis Situation

- Draw your office and layout of your office furniture.
- Note where you sit and where the client sits.

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- *Invite two participants to move their chairs and table, if space allows, and ask that they recreate their office or interview room. Ask them to explain the configuration of their office and make note of where the client and counselor sit in proximity to the door. Make note of any barriers between the client, the counselor, and the door.*

Slide 38: Keeping Yourself Safe (continued 1)

- We want to ensure that we feel safe and that our clients feel safe. One way to minimize risk and promote safety is by ensuring clients and counselors have immediate access to an exit. Clients who are in distress may become more upset if and when they are placed in a space where they feel trapped. Of course, this is contextual. If you are operating as a counselor in an inpatient (i.e., hospital) environment, the client may be admitted against their will for their safety and the safety of others. However, for the sake of this training, we will assume that most of you are working in outpatient settings. You should know when, where, and who to ask for help.

- *[ASK PARTICIPANTS] If you are in a crisis situation and the client's behavior suggests that the situation is escalating, what do you do?*

(Notes for Slide 38, continued)

Keeping Yourself Safe (continued 2)

- Know your limits.
  - Do I have the training to manage this situation?
  - Do I feel confident managing this situation?
- Recognizing your limitations is a **strength**, not a weakness!
  - Know where and when to ask for help.
  - If necessary, contact emergency personnel.
- If and when clients are in distress:
  - Be careful not to reflect negative emotional states.
  - Be aware of your body language.
  - Stay calm and keep your tone of voice low and soft.
  - Be careful not to stand over or lean into client.

Slide 38: Keeping Yourself Safe (continued 1)

- In some cases, it is best for you to get help from someone else. However, never leave the client alone and do your very best to communicate to the client what is happening.

Slide 39: Keeping Yourself Safe (continued 2)

- It is important to know your limits and to know where and when to find help. Do you have the training and experience to manage the situation? Questions to ask yourself and to reflect on include:
  - What are your nonverbal behaviors communicating to the client?
    - Are you sitting or standing at eye level or above the client?
    - How close are you to the client?
    - What are your hands communicating?

Slide 39: Keeping Yourself Safe (continued 2)

- Are your arms crossed?

- How would you feel if you are experiencing a crisis and someone is standing over you?

- Are you leaning into the client?

- Are you allowing the client to speak without being interrupted?

  - Are you using simple reflections?

  - Has the pitch and tone of your voice changed?

  - Are you talking faster than normal?

  - Is your voice higher than normal?

Slide 40: Keeping Others Safe

Keeping Others Safe

- Remove the situation to a quiet, safe place. This will help to:
  – Calm the participant (and you)
  – Protect confidentiality
  – Protect other clients from direct harm
  – Protect other clients from "helping"

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- If the crisis situation is occurring in public (e.g., in a group setting, office lobby), invite and guide the client to a calm, safe space where you and others can assist. The behaviors of a distressed client may trigger distressing behaviors or uncomfortable feelings in other clients. In some cases, other clients may feel compelled to help staff or they may align themselves with the client in crisis. It is critical for the health and safety of you, the client in distress, and other clients that they, the other clients, be advised to not help. In fact, the faster you are able to guide the client to a safe, secure space, the better. If the client refuses to leave the space, it is recommended that you advise others to exit. You will minimize risk and potential harm.

Seven-Stage Crisis Intervention Model (1)

- "Plan and conduct a thorough biopsychosocial and lethality/imminent danger assessment;
- Make psychological contact and rapidly establish the collaborative relationship;
- Identify the major problems, including crisis precipitants;
- Encourage an exploration of feelings and emotions;
- Generate and explore alternatives and new coping strategies;

Reference
Roberts, A. R. & Ottens, A. J. (2005). The seven-stage crisis intervention model: a road map to goal attainment, problem solving, and crisis resolution. Brief Treatment and Crisis Intervention, 5(4), 329 – 399. doi: 10.1093/brief-treatment/mhi090
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Slide 41: Seven-Stage Crisis Intervention Model (1)

- Besides the points just made on your own comfort and training in managing crises, Roberts et al (2005) suggests that logical and orderly processes for managing a crisis may minimize the potential of exacerbating the situation. Thus, Roberts and others suggest use of a framework or model when responding to crises. Models are analogous to maps. They provide direction. There are different crisis intervention models to choose from. Here, we present Roberts' seven-stage crisis intervention model as an example of a stepwise model that has applicability across different types of crisis situations. According to Roberts, the stages in this model are "essential, sequential, and often overlap in the process of a crisis intervention" (p. 332).

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

(Notes for Slide 41, continued)

Slide 41: Seven-Stage Crisis Intervention Model (1)

REFERENCE

Roberts, A.R. & Ottens, A.J. (2005). The seven-stage crisis intervention model: A road map to goal attainment, problem solving, and crisis resolution. *Brief Treatment and Crisis Intervention, 5*(4), 329 – 339. doi: 10.1093/brief-treatment/mhi030

Slide 42: Seven-Stage Crisis Intervention Model (2)

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

- Now, we will go through each stage of the model.

Seven-Stage Crisis Intervention Model (2)

- Restore functioning through implementation of an action plan (implement an action plan); and
- Plan follow-up booster sessions" (Roberts & Ottens, 2005, p. 332-333)

Reference
Roberts, A. R. & Ottens, A. J. (2005). The seven-stage crisis intervention model: a road map to goal attainment, problem solving, and crisis resolution. Brief Treatment and Crisis Intervention, 5(4), 329 – 339. doi: 10.1093/brief-treatment/mhi030

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Slide 42: Seven-Stage Crisis Intervention Model (2)

REFERENCE

Roberts, A.R. & Ottens, A.J. (2005). The seven-stage crisis intervention model: A road map to goal attainment, problem solving, and crisis resolution. *Brief Treatment and Crisis Intervention, 5*(4), 329 – 339. doi: 10.1093/brief-treatment/mhi030

Conduct a
Lethality and Psychosocial Assessment

- Environmental supports and stressors
- Medical needs and current medications
- Current use of alcohol or drugs
- Internal and external coping methods and resources
- Suicide attempt
- **Suicidal and homicidal ideation**

Reference
Roberts, A. R. & Ottens, A. J. (2005). The seven-stage crisis intervention model: a road map to goal attainment, problem solving, and crisis resolution. Brief Treatment and Crisis Intervention, 5(4), 329 – 339. doi: 10.1093/brief-treatment/mhi030

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Slide 43: Conduct a Lethality and Psychosocial Assessment

- The first stage of the model is to plan and conduct a biopsychosocial and lethality assessment. At minimum, the biopsychosocial component of the assessment should include, at minimum, a review of the client's:

  - environmental supports and stressors,

  - immediate medical needs and other health concerns,

  - use of over-the-counter medications (ask for specifics and pay particular attention to misuse),

  - use of alcohol and drugs (ask for specifics), and

(Notes for Slide 43, continued)

- internal and external coping resources and supports

- It is critical to ask whether the client is considering killing themselves or having thoughts of killing another. If the person articulates, verbalizes, or suggests that they are considering killing themselves, it is important that you first ask whether the person initiated a suicide attempt. If so, what did they do? Ask for specifics. Ask whether the client needs immediate medical attention? In cases where persons report having ingested potentially fatal doses of medications or poisons, it is important that you immediately connect them to a healthcare provider. If necessary, call 911 or the number you use in your community for emergency medical services. If you are not a medical professional, it is outside your scope and training to determine whether the person is safe. If the client has not initiated an attempt and has articulated, verbalized, or suggested suicide, ask them directly if they are considering killing themselves.

(Notes for Slide 43, continued)

Slide 43: Conduct a Lethality and Psychosocial Assessment

- If yes, it is important to ask the following questions:

    - Have they attempted suicide in the past? If so, ask about their history (e.g., how many times, how did they try to kill themselves in the past, have they been hospitalized in the past)

    - What is their current plan?

    - How specific is their plan?

    - How lethal is their plan?

    - Does the person have the means to carry out the plan?

    - What is their timeline?

    - Is the intent serious enough to warrant an immediate intervention?

- It is equally important to ask whether the person is considering harming or killing another individual. Ask for specifics. What is their plan? How specific is their plan? What is their timeline? If you have reason to believe that another individual is at risk of being killed, you may be legally required to report your concerns to the proper authorities.

Slide 43: Conduct a Lethality and Psychosocial Assessment

Across the United States, all health care professionals have a duty to warn and report harm to self, harm to others, neglect and abuse of children and the elderly.

- *[ASK PARTICIPANTS] What are your laws regarding duty to warn and report?*

REFERENCE

Roberts, A.R. & Ottens, A.J. (2005). The seven-stage crisis intervention model: A road map to goal attainment, problem solving, and crisis resolution. *Brief Treatment and Crisis Intervention, 5*(4), 329 – 339. doi: 10.1093/brief-treatment/mhi030

Slide 44: Rapidly Establish Rapport

Rapidly Establish Rapport

- Assume non-judgmental attitude
- Listen to understand
- Listen and respond selectively
- Demonstrate respect by minimizing distractions, offering to meet in a safe, secure space

Reference
Roberts, A. R. & Ottens, A. J. (2005). The seven-stage crisis intervention model: a road map to goal attainment, problem solving, and crisis resolution. Brief Treatment and Crisis Intervention, 5(4), 329 – 339. doi: 10.1093/brief-treatment/mhi030

- The second stage of the model is to rapidly establish rapport. Listen to understand. Offer simple reflections. Minimize distractions. Communicate that you care. Be conscious of the tone of your voice. Often, providers not accustomed to managing crises tend to speak a little higher and faster. Remember to breathe, slow down, and make an effort to slightly deepen your voice.

REFERENCE

Roberts, A.R. & Ottens, A.J. (2005). The seven-stage crisis intervention model: A road map to goal attainment, problem solving, and crisis resolution. *Brief Treatment and Crisis Intervention, 5*(4), 329 – 339. doi: 10.1093/brief-treatment/mhi030

Identify Major Problems/Precipitants

- Why now?
- What was the precipitating event?
- Seek to understand how the precipitating event escalated into a crisis – what about it triggered the crisis?
- Explore and prioritize problem(s)
- Identify and listen for other factors (e.g., faulty thinking, mistaken beliefs) that may have contributed to the crisis.

Reference
Roberts, A. R. & Ottens, A. J. (2005). The seven-stage crisis intervention model: a road map to goal attainment, problem solving, and crisis resolution. Brief Treatment and Crisis Intervention, 5(4), 329 – 339. doi: 10.1093/brief-treatment/mhi030

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Slide 45: Identify Major Problems / Precipitants

- The third stage of the model is to identify the precipitating event(s) or the immediate problems the client experienced that led to the crisis. Why now? What led the client to seek help? During crises, clients often lose track of the specific precipitating event and may feel like they are spiraling out of control, thinking about *every* negative aspect of their life. Rather than be drawn into a discussion of multiple topics, bring client's attention back to what had happened to provoke the current crisis. Besides identifying the precipitating event, Roberts et al (2005) suggests that you have clients identify and prioritize other major problems, and to consider which ones to work on first.

(Notes for Slide 45, continued)

Slide 45: Identify Major Problems / Precipitants

REFERENCE

Roberts, A.R. & Ottens, A.J. (2005). The seven-stage crisis intervention model: A road map to goal attainment, problem solving, and crisis resolution. *Brief Treatment and Crisis Intervention, 5*(4), 329 – 339. doi: 10.1093/brief-treatment/mhi030

Slide 46: Deal with Feelings and Emotions

Deal with Feelings and Emotions

- Employ active listening.
- Pay attention to the client's affect.
- Validate feelings.
- Offer reflective, empathic statements that communicate understanding of the client's emotions.
- Eventually and carefully offer information with the client's permission, reframe, and offer alternative interpretations of the event.

Reference
Roberts, A. R. & Ottens, A. J. (2005). The seven-stage crisis intervention model: a road map to goal attainment, problem solving, and crisis resolution. Brief Treatment and Crisis Intervention, 5(4), 329 – 339. doi: 10.1093/brief-treatment/mhi030

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- The fourth stage of the model is comprised of two processes: The first allows clients to express their feelings and emotions. The second facilitates a guided conversation that challenges the client's maladaptive beliefs. It is recommended in the first process that you use active listening to support clients in expressing their feeling and emotions.

- *[ASK PARTICIPANTS] What are examples of active listening?*

- Eventually, cautiously, and carefully and with permission, offer new information or provide alternative interpretations of the situation. This again is contextual. The goal is to "help loosen clients' maladaptive beliefs and to consider other behavioral options" (p. 335).

Slide 46: Deal with Feelings and Emotions

(Notes for Slide 46, continued)

- ***[ASK PARTICIPANTS] What kinds of examples can you think of or experienced where clients benefited from being offered new information or alternative explanations to that helped towards resolving the immediate crisis?***

- An example may include an individual in recovery who relapsed and now sees themselves as worthless. They are considering suicide.

- ***[ASK PARTICIPANTS] What information would you offer to this client?***

(Notes for Slide 46, continued)

Slide 46: Deal with Feelings and Emotions

REFERENCE

Roberts, A.R. & Ottens, A.J. (2005). The seven-stage crisis intervention model: A road map to goal attainment, problem solving, and crisis resolution. *Brief Treatment and Crisis Intervention, 5*(4), 329 – 339. doi: 10.1093/brief-treatment/mhi030

Generate and Explore Alternatives

- Explore options collaboratively with the client.
- Brainstorm alternatives to ensuring client safety
- Offer advice (with permission) and make direct suggestions about possible action plans.
- Evaluate short-term vs. long-term benefits of each possible plan of action.
- Examine pros & cons of specific actions.

Reference
Roberts, A. R. & Ottens, A. J. (2005). The seven-stage crisis intervention model: a road map to goal attainment, problem solving, and crisis resolution. Brief Treatment and Crisis Intervention, 5(4), 329 – 339. doi: 10.1093/brief-treatment/mhi030

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Slide 47: Generate and Explore Alternatives

- Often, clients in crisis don't know what to do in terms of next steps. The fifth stage of the model is to collaborate with clients and explore potential options to resolving or addressing the crisis that is beyond what the client has identified. The emphasis and focus should be on their safety.

- *[ASK PARTICIPANTS] Consider the last example where a client relapsed and has verbalized suicide - what alternatives or options would you discuss with them?*

REFERENCE

Roberts, A.R. & Ottens, A.J. (2005). The seven-stage crisis intervention model: A road map to goal attainment, problem solving, and crisis resolution. *Brief Treatment and Crisis Intervention, 5*(4), 329 – 339. doi: 10.1093/brief-treatment/mhi030

Implement an Action Plan

- Create an explicit, time-limited plan with concrete steps that the client is to take.
- Educate client that emotions may recur, and develop at least 2 concrete behavioral coping strategies that client can use if they do manifest in the near future.
- Aim is to create a plan that restores equilibrium and psychological balance and to make meaning of the event to gain mastery over the situation or similar situation in the future.

Reference
Roberts, A. R. & Ottens, A. J. (2005). The seven-stage crisis intervention model: a road map to goal attainment, problem solving, and crisis resolution. Brief Treatment and Crisis Intervention, 5(4), 329 – 339. doi: 10.1093/brief-treatment/mhi030

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Slide 48: Implement an Action Plan

- The sixth stage of the model is focusing on crisis resolution by organizing an explicit, time-limited action. Be concrete and clear. Identify who will do what by when. Outline specific steps for activating adaptive behavioral coping strategies.

- *[ASK PARTICIPANTS] What specific action steps would you suggest to the client who relapsed and is now suicidal?*

- Roberts also suggests the importance of making meaning from the crisis event. Roberts et al (2005) suggests use of the following open questions to guide this process:

    - "Why did it happen?

    - What does it mean?

    - What are alternative constructions that could have been placed on the event?

    - Who was involved?

Slide 48: Implement an Action Plan

- How did actual events conflict with one's expectations?

- What responses (cognitive or behavioral) made things worse" (p. 336)

- The rationale and importance for meaning making is to help the client gain mastery over the situation or similar situations in the future and prevent them from becoming crisis events.

REFERENCE

Roberts, A.R. & Ottens, A.J. (2005). The seven-stage crisis intervention model: a road map to goal attainment, problem solving, and crisis resolution. *Brief Treatment and Crisis Intervention, 5*(4), 329 – 339. doi: 10.1093/brief-treatment/mhi030

Follow-up Following A Crisis

- Post-crisis evaluation may include but not be limited to:
  - Physical condition
  - Overall functioning (e.g., social, vocational, spiritual)
  - Cognitive mastery of the precipitating event (i.e., "does the client have a better understanding of what happened and why it happened" (Roberts & Ottens, p. 336)
  - Progress in treatment
  - Current stressors and strategies for managing these stressors
  - Need for possible referrals

Reference
Roberts, A. R. & Ottens, A. J. (2005). The seven-stage crisis intervention model: a road map to goal attainment, problem solving, and crisis resolution. Brief Treatment and Crisis Intervention, 5(4), 329 – 339. doi: 10.1093/brief-treatment/mhi030

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Slide 49: Follow-up Following A Crisis

- The final stage following the crisis is ensuring that there is timely follow-up and to complete a post-crisis evaluation. The term *timely* is somewhat subjective since the types of crises will vary as will the clinical appropriateness of follow-up. In most cases, it is probably best to follow-up later in the day, the next day, or several days following the incident. We suggest reviewing your program's policies and procedures for guidance on what your organization would determine and define as timely follow-up. Here are a list of items or elements to consider in your post-crisis evaluation plan.

- *[ASK PARTICIPANTS] What types of questions would you ask the client has contemplated suicide, but was no longer suicidal?*

- *[ASK PARTICIPANTS] Any questions to ask or explore before we move on and discuss suicide.*

(Notes for Slide 49, continued)

Suicide in America

- Suicide is a serious public health issue.
- In 2016, it is estimated that more than 44,000 Americans died by suicide.
- 1 completed suicide every 12 minutes.
- Suicide is the tenth leading cause of death in America
- Suicide rates remain the highest among adults between 45 and 65.
- Men four times more likely to die by suicide than women.

Reference
American Foundation for Suicide Prevention. (2006). Suicide statistics. Retrieved from https://afsp.org/about-suicide/suicide-statistics/

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment*. Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 49: Follow-up Following A Crisis

REFERENCE

Roberts, A.R. & Ottens, A.J. (2005). The seven-stage crisis intervention model: A road map to goal attainment, problem solving, and crisis resolution. *Brief Treatment and Crisis Intervention, 5*(4), 329 – 339. doi: 10.1093/brief-treatment/mhi030

Slide 50: Suicide in America

- Suicide is a taboo topic that is not discussed openly in many communities; yet, it is the tenth leading cause of death in America. One person dies by suicide every 12 minutes. In 2016 more than 44000 people died by suicide. Men are more likely to die by suicide than woman. It is believed that the reason that more men die by suicide is the means used to kill themselves. For example, men are more likely than women to use firearms.

(Notes for Slide 50, continued)

Slide 50: Suicide in America

REFERENCES

American Foundation for Suicide Prevention. (2006). Suicide statistics. Retrieved from https://afsp.org/about-suicide/suicide-statistics/.

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Increased Risk of Suicide for Individuals with SUDs

- Increased risk of suicide for individuals with SUDs
    - 10 times greater risk
    - 14 times for individuals who inject drugs

Reference
Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 51: Increased Risk of Suicide for Individuals with SUDs

- Individuals who meet criteria for one or more substance use disorders or who are in early recovery are 10 times more likely than others who do not meet criteria for a substance use disorder to die by suicide. The risk is even greater for individuals who use drugs intravenously.

REFERENCE

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Types of Suicidal Thoughts and Suicidal Behaviors

- Suicide attempt
- Suicidal ideation (thoughts)
- Suicide plans
- Suicidal intention (intent)
- Suicide preparation
- Non-suicidal self-injury (e.g., self mutilation or self-injury by cutting) does not include suicidal intent and is distinguished from suicide attempts and suicide

Reference
Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment*. Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 52: Types of Suicidal Thoughts and Suicidal Behaviors

- Here, we will discuss different suicide-related terms and concepts. Suicide attempts refer to the deliberate act of self-harm with intent of varying degrees to kill oneself, but does not result in death. Suicide, on the other hand, is the deliberate act of self-harm with intent of varying degrees to kill oneself resulting in death. Suicidal ideation refers to thoughts of killing oneself. Ideation exist on a continuum - thoughts can be fleeting or persistent, vague or highly specific. Suicide plans refer to the specific behaviors the individual is considering to kill themselves. Suicide plans, like suicidal ideation, exist on a continuum from vague and unrealistic to highly specific and feasible. Suicidal intention, or intent, refers to the acute or elevated risk that someone intends to make a suicide attempt. Suicide preparation, as defined by CSAT (2015), refers to various "behaviors that suggest preparation signal high, acute risk for suicidal behavior.

(Notes for Slide 52, continued)

Slide 52: Types of Suicidal Thoughts and Suicidal Behaviors

- Preparation may come in many forms, such as writing a suicide note… giving away possessions, writing a will, acquiring a method of suicide… making a method more available, visiting a site where suicide may be carried out, rehearsing suicide, and saying goodbye to loved ones directly or symbolically" (p. 10-11). Non-suicidal self-injury refers to deliberate self-harm and is often described as suicidal gestures; however, individuals engaging in these behaviors do not wish to die and have no expectation of dying. Non-suicidal self-injuries are distinguished from suicidal behaviors since they do not include suicidal intent.

Slide 52: Types of Suicidal Thoughts and Suicidal Behaviors

REFERENCE

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Ten Key Points to Remember

1. Almost all clients who are suicidal are ambivalent about dying.
2. "Suicidal crises can be overcome… acute suicidality is a transient state" (CSAT, p. 6).
3. There is no way predict all suicides; however, screening and assessing suicide may save a life.
4. Suicide screenings and assessments should not be limited to acute crisis – they should be done at every encounter.
5. "Suicide contracts are not recommended and are never sufficient" (CSAT, 2015, p.6).

Reference
Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 53: Ten Key Points to Remember

- Here are ten key points to consider and remember when working with clients who are at higher risk of suicide. First, clients who have or articulate suicidal ideation are ambivalent about dying. They recognize and may be endorsing the reasons for dying, but may have reasons to live. Second, CSAT explains "that suicidal crises can be overcome – acute suicidality is a transient state. Even individuals at high, long-term risk spend more time being non-suicidal than being suicidal. .. The challenge is to help clients survive the acute, suicidal crisis period until such time as they to live again" (p. 6). Third, there is no way to predict suicides; however, asking directly whether a person is considering killing themselves may save a life. Although we will discuss various warning signs, risk factors, and protective factors, it is critical, as highlighted here in point 4 that we screen for suicide at each encounter. CSAT and others remind us that suicide contracts are not effective, and that they in fact, make litigation more likely if "suicide prevention efforts appear to be hinged on the contract" (p. 6).

Slide 53: Ten Key Points to Remember

(Notes for Slide 53, continued)

REFERENCE

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Ten Key Points (continued)

6. All clients are at-risk for suicide.
7. Suicide attempts must always be taken seriously.
8. Individuals considering suicide generally show warning signs.
9. It is best to **ask clients directly about suicide – being direct and asking the question can save lives.**
10. The outcome of whether an individual survives or dies by suicide does not tell the entire story.

Reference
Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.   54

Slide 54: Ten Key Points (continued)

- Many of us, not just clients, are at risk for suicide. All suicide attempts must be taken seriously. Survivors may have chosen a method that was not foolproof. They may have been rescued. They may have been interrupted. Regardless, individuals who attempted suicide and survived are more likely than others to die by suicide. In most cases, individuals considering suicide show warning signs. Almost all suicide prevention practices actively endorse the practice of asking individuals directly whether they are considering suicide. Asking directly can save a life. The last point is that whether individuals die by suicide "does not, by itself, equate to improper treatment of suicidality" (CSAT, 2015, p. 7).

(Notes for Slide 54, continued)

Slide 54: Ten Key Points (continued)

REFERENCE

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 55: Suicide Warning Signs

- Warning signs refer to acute indications of increased risk for suicidal behavior in the near or immediate future. Warning signs can be direct or indirect.


- *[ASK PARTICIPANTS] What are some of the direct indications of acute suicidality?*

- *[ASK PARTICIPANTS] What are some examples of indirect warning signs?*

REFERENCE

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 154318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Direct and Indirect Warning Signs of Suicide

- Direct warning signs:
  - Suicidal communications
  - Seeking access to method
  - Making preparations
- Indirect warning signs:
  - IS PATH WARM

Reference
Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment. Treatment Improvement Protocol (TIP) Series 50* (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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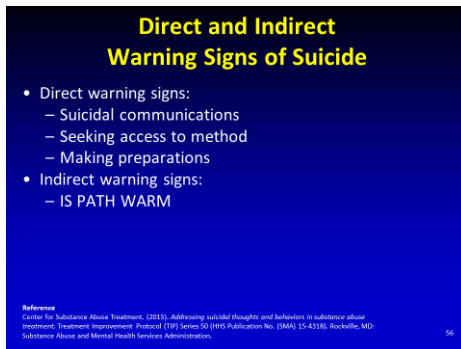
Slide 56: Direct and Indirect Warning Signs of Suicide

- Direct warning signs are observable indications that suggests elevated or acute risk of suicide. They include, but are not limited to:

  - Verbal or written statements that the individual is going to kill themselves.

  - The individual investigates or secures one or more methods to kill themselves. Examples include stockpiling medications, purchasing a gun, or purchasing rope that can support their weight.

  - Uncharacteristic verbal or written communications made by individuals discussing death, dying or suicide.

  - Indirect warning signs are observable clues that suggest potential risk of suicide. CSAT offers the following mnemonic to help us remember indirect warning signs that requires rigorous follow-up. The mnemonic IS PATH WARM.

(Notes for Slide 56, continued)

Indirect Warning Signs of Suicide

- Ideation
- Substance use that meets criteria for a SUD
- Purposelessness
- Anxiety
- Trapped
- Hopelessness
- Withdrawal
- Anger
- Recklessness
- Mood Change

Reference
Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.   57

Slide 56: Direct and Indirect Warning Signs of Suicide

REFERENCE

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 57: Indirect Warning Signs of Suicide

- The letter "I" refers to any type of suicidal ideation. As a reminder, suicidal ideation refers to thoughts of killing oneself. Again, suicidal ideation exists on a continuum – suicidal thoughts can be fleeting or persistent, vague or highly specific.

- S" refers to alcohol or drug use that meets criteria for one or more substance use disorders.

- "P" refers to purposeless, the lack of any sense of purpose in life or reason for living.

(Notes for Slide 57, continued)

Slide 57: Indirect Warning Signs of Suicide

- "A" refers to the many different symptoms of anxiety.

- "T" refers to the real or perceived feeling of being trapped in a terrible situation where there is no exit or escape.

- "H" refers to hopelessness, the feeling or state of despair.

- "W" refers to increased social isolation, withdrawing from friends, family, and to different social obligations.

- "A" refers to increased, uncontrollable anger, and in some cases, seeking revenge on others.

- "R" refers to individuals engaging in reckless behaviors.

- "M" refers to dramatic mood changes or shifts in emotions.

(Notes for Slide 57, continued)

Slide 57: Indirect Warning Signs of Suicide

- *[ASK PARTICIPANTS] Are there other indirect warning signs that you are familiar with that were not mentioned here?*

- *[ASK PARTICIPANTS] Are there other indirect warning signs that we as counselors should be aware of when working with specific populations?*

REFERENCE

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Stressful Life Events and Suicide

- Ending of a relationship
- Family conflict
- Financial crisis
- Legal event or involvement
- Loss of employment
- Relapse
- Trauma

Reference
Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 58: Stressful Life Events and Suicide

- A number of acute stressful life events can also be a precipitating factor for suicidal ideation. Here are some examples

- *[READ THE BULLETED LIST ON THE SLIDE; EXPAND ON EACH BULLET]*

REFERENCE

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Risk Factors for Suicide

- Prior history of suicide attempts
- Family history of suicide
- Chronic pain
- Early onset of substance use disorders
- Co-occurring mental disorders
- History of child abuse
- Stressful life circumstances (e.g., unemployment, divorce or separation, legal difficulties, financial loss, social isolation)
- Firearm ownership or access to a firearm

Reference
Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment*. Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 59: Risk Factors for Suicide

- Besides direct and indirect warning signs, it is critical as counselors to be aware of risk factors for suicide. Risk factors are "indicators of long-term (or ongoing) risk" (CSAT, 2016, p. 12). This list, although not exhaustive, include risk factors for suicide, especially among adults actively using AOD or in recovery from SUDs.

- *[READ THE BULLETED LIST ON THE SLIDE; EXPAND ON EACH BULLET].*

REFERENCE

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Protective Factors for Suicide

- Regular attendance at a place of worship
- Presence of a child in the home
- Intact marriage
- Trusted relationship with a service provider or healthcare professional
- Employment
- Trait optimism

Reference
Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment. Treatment Improvement Protocol (TIP) Series 50* (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 60: Protective Factors for Suicide

- In addition to risk factors, there are protective factors that act as "buffers that lower long-term risk" of suicide (CSAT, 2016, p. 12). Protective factors vary across cultures and are contextual. Here are a list of protective factors or reasons for living that have been identified in the literature.

- ***[ASK PARTICIPANTS] Besides what is listed here, what other protective factors do you believe or know to be buffers in your community?***

- It is important to emphasize that protective factors may offer a false sense of security. CSAT warns, protective factors "do not immunize clients from suicidal behavior and may afford no protection in acute crises" (p. 12).

(Notes for Slide 60, continued)

Slide 60: Protective Factors for Suicide

REFERENCE

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 61: GATE

- The CSAT offers a brief four-step process and procedure for identifying and responding to suicidal thoughts and behaviors. The process is to (1) gather information, (2) access supervision, (3) take action, and (4) extend the action. The elements in GATE, the acronym used to refer to this process, are within the scope of entry-level counselors.

REFERENCE

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Gather Information

- Screen all clients for suicide.
- Identify potential warning signs.
- Be direct – ask the question!
- Ask open-ended, follow-up questions to assess previous history, current plan, method, intent, and preparation.

Reference
Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 62: Gather Information

- The first element is to gather information. There are two steps: First, systematically screen all clients for suicide and be aware of specific warning signs. Second, ask follow-up questions.

- *[ASK PARTICIPANTS] How do you systematically screen all clients for suicide?*

- *[ASK PARTICIPANTS] What kinds of questions do you ask?*

- *[ASK PARTICIPANTS] How do you approach these questions within the context of your conversation?*

- *[ASK PARTICIPANTS] How do you manage vague or ambiguous answers to questions asked about suicide?*

Slide 62: Gather Information

- All clients should be screened for suicide. In fact, you should screen clients at every encounter. The timing of when you ask the question is important. Questions should be asked within the context of a larger discussion.

- The CSAT suggests that you ask the same screening questions for all clients (p. 16):

    - Begin with introducing the topic of suicide.

        - I am going to ask you a few questions about suicide.

    - Screen for suicidal thoughts:

        - Have you thought about killing yourself?

    - Screen for suicide attempts:

        - Have you ever attempted suicide OR

        - Have you ever tried to end your life?

- If a client answers yes to any of the above questions, it is critical to follow-up:

Slide 62: Gather Information

- Follow-up questions identified by the CSAT (2015, p. 17-18) for suicidal thoughts include:

    - Please tell me more about the suicidal thoughts.

    - What brings them on?

    - How strong are they?

    - How long do they last?

- Thereafter, and if the client does not voluntarily share the following information, ask:

    - Have you made a plan?

    - What is your plan?

    - How would you go about killing yourself (assessing for means)?

    - Do you have access to this method? Do you intend on killing yourself? When do you intend on killing yourself?

Slide 62: Gather Information

- Follow-up questions identified by the CSAT (2015, p. 18) for suicide attempts include:

    - Please tell me more about the event.

    - What brought it on?

    - How did you go about killing yourself?

    - Did you receive medical treatment?

    - Did you want to die?

    - After having survived the attempt, please tell me more about how you felt … were you relieved or would you have rather died?

REFERENCE

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Access Supervision and Consultation

- Never manage suicidal clients alone.
- Never make judgments regarding the seriousness of risk without consulting a supervisor or other members of your team.
- Ask for specific instructions and direction from a licensed, qualified professional who has advanced training in suicide risk management OR who has been identified by the agency for this purpose (e.g., your supervisor).

Reference
Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment*. Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.   63

Slide 63: Access Supervision and Consultation

- The second element is to access supervision and consultation.

- *[ASK PARTICIPANTS] When should you seek immediate supervision or consultation?*

- The emphasis here is, as an entry-level counselor, is that you should never make a judgment regarding the seriousness of suicidal risk. Further, you should not manage suicide risk on your own. Get help! Immediately notify your supervisor and/or the person who has been identified by your agency for this purpose. We strongly advise you to know your agency's policies and procedures for issues of suicidality.

(Notes for Slide 63, continued)

Slide 63: Access Supervision and Consultation

REFERENCE

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 64: Take Responsible Action

Take Responsible Action

- Gather additional information from the client and (only with consent) from collateral contacts.
- Arrange a referral to:
  – A clinician
  – An emergency provider
  – A mental health crisis team
  – Another treatment setting

Reference
Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

The third element is to take responsible action. Responsible action refers to the actions that make sense in light of the seriousness of suicide risk. The CSAT emphasizes and reminds us that "Judgements about the degree of seriousness of risk should be made in consultation with a supervisor and/or treatment team, not by a counselor acting alone" (p. 20). There are many potential actions to take and all are contingent on the seriousness of suicide risk. Actions may be intensive. For example, in cases where individuals in your clinic articulate the intention to kill themselves in the immediate or near future, and outline a feasible and lethal plan, the most appropriate response may be to arrange for safe travel to a hospital emergency department for further evaluation. Of course this action is contingent on your agency's policies and procedures, state laws, resources in your community, and on instructions provided to you by your supervisor. In other cases, actions may be less intensive.

Slide 64: Take Responsible Action

- For example, individuals may have suicidal thoughts, but no plan and articulate no intention of killing themselves. Expediting a referral to an outpatient mental health provider, in this case, may be the most appropriate action.

REFERENCE

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 65: Take Responsible Action (continued)

- Here are a list of common actions. This list is clearly not exhaustive, but exemplifies some of the many different types of activities that match seriousness or risk to intensity of actions.

- Actions may include:

    - Restricting access to means of suicide. For example, if the client has been stockpiling medications but reiterates that they have no intention of killing themselves, ask the client to return unused medications to their prescriber or to their pharmacy for safe storage or disposal. Remind clients that their health and safety are your primary concern and ask that they provide you consent to contact their provider or pharmacy. If possible, involve family members or other supporters in the intervention.

    - Increase the frequency of contact or expedite referral to a higher level of care

Slide 65: Take Responsible Action (continued)

- Involve the client's case manager, primary care provider, family members and other loved ones.

- Create a safety plan.

- *[ASK PARTICIPANTS] What is a safety plan? What elements should be included in the safety plan?*

REFERENCE

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 66: Safety Plan

Safety Plan

At minimum, the plan should include:
• Phone number to 24-hour crisis line
• Phone number and address to nearest hospital
• Counselor contact information
• Contact info for additional supporters

Reference
Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.   66

- It is ideal to create a safety plan with the client and that it be created on a wallet-sized card that is easily accessible by the client especially during a crisis. The plan should include, at minimum, information to a toll-free 24-hour suicide crisis phone line, contact information for the nearest hospital, and contact information for other supporters. It is helpful and recommended to outline the signs and situations when the client should use the plan. CSAT recommends to create backup copies in case the safety plan is misplaced. Also CSAT recommends to periodically check-in with the client to see whether they have safety plan and are willing to use it if the need arises.

Slide 66: Safety Plan

REFERENCE

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 67: Extend the Action

Extend the Action

- Suicide risk continues beyond the intervention.
- Continue to observe and check-in with the client and their family and other supporters.
  – Follow-up on all referrals, especially when to mental health service providers and hospitals.
  – Coordinate care with case management and mental health treatment providers.
  – Regularly review and update the client's safety plan.
  – Follow-up with clients about suicidal thoughts, especially when experiencing stressful life events.

Reference
Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment*. Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

- The fourth element is to extend the action. CSAT (2015) highlights "a common misconception is that suicide risk is an acute problem, that once dealt with, ends… individuals who are suicidal commonly experience a return of suicide risk following any number of setbacks, including relapse to substance use, a distressing life event, increased depression, or any number of other situations" (p. 23). Suicidal ideation can also occur as people get better and as they move forward and progress in their own recovery. Thus, it is important to always monitor for suicidal thoughts and behaviors, and pay particular attention to warning signs. Extending the action refer to the importance of staying vigilant and watching for a return of suicidal thoughts or behaviors. Extending the action is not limited to providing care in an outpatient center. Imagine you were working with someone in prevention and had referred them to a provider after they articulated thoughts of killing themselves.

Slide 67: Extend the Action

- After having consulted with your supervisor, it was believed that the best and most appropriate course of action would be to refer them to an outpatient mental health provider.

- *[ASK PARTICIPANTS] What would be examples of extending the action for this client?*

    - Confirm that the client followed-up with the provider.

    - Contact the provider to confirm.

    - Confirm the client has access to their safety plan.

- There are a number of actions that counselors can take to extend the action. This includes, but is not limited to:

    - Confirming appointments with providers.

    - Coordinating care with the client's mental health professional and with the client's case manager.

Slide 67: Extend the Action

- Observing clients for warning signs.

  Checking-in with family members and other supporters.

- Minimizing access to methods (e.g., gun, medications).

REFERENCE

Center for Substance Abuse Treatment. (2015). *Addressing suicidal thoughts and behaviors in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 15-4318). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Global Criteria for Crisis Intervention

30. Recognize the elements of the client crisis
31. Implement an immediate course of action appropriate to the crisis
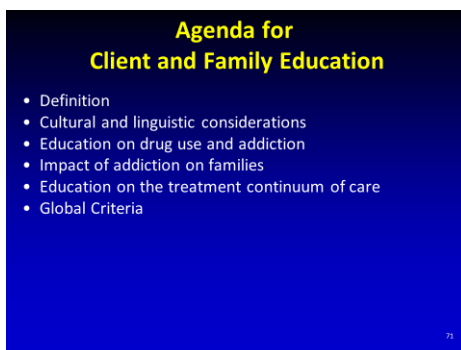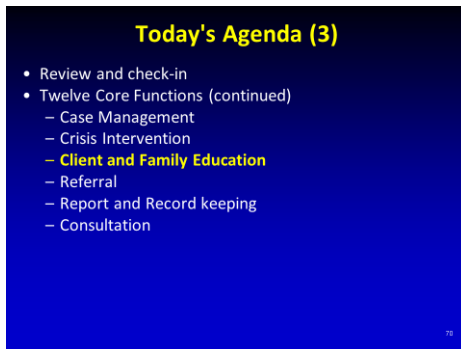32. Enhance overall treatment by utilizing crisis events

Reference

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

68

Slide 68: Global Criteria for Crisis Intervention

- The IC&RC have identified three criteria as necessary skills needed to perform the core function of crisis management.

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

- Herdman (2018) explains that competence in criterion 30 is evident by the counselor's knowledge of crisis elements and the ability to relate those elements to the client. Competence for criterion 31, as described by Herdman (2018), is evident by the counselor's knowledge of specific steps and actions that are appropriate to the nature of the client's crisis. Lastly, counselors should be able to relate and understand how the crisis can be used and incorporated into the client's treatment, regardless of where they are served in the continuum of care (Herdman, 2018).

Group Activity for Crisis Intervention

- Outline your program's procedures for managing crisis situations.
- Begin with outlining procedures for systematically screening clients for suicide.
- After, outline procedures for managing clients who are actively suicidal in your agency.
- Be prepared to discuss these processes with the larger group.

Slide 68: Global Criteria for Crisis Intervention

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 69: Group Activity for Crisis Intervention

- *Ask participants to gather into their small groups.*

- *Instruct participants to outline a procedure for managing crisis situations.*

- *Allow 20 minutes for participants to outline crisis procedures.*

- *Randomly select one or two groups to review their crisis procedures.*

- *After each group presents,*

- *[ASK PARTICIPANTS] Do you have any recommendations or comments to share with this group?*

Today's Agenda (3)

- Review and check-in
- Twelve Core Functions (continued)
  – Case Management
  – Crisis Intervention
  – **Client and Family Education**
  – Referral
  – Report and Record keeping
  – Consultation

70

**Agenda for
Client and Family Education**

- Definition
- Cultural and linguistic considerations
- Education on drug use and addiction
- Impact of addiction on families
- Education on the treatment continuum of care
- Global Criteria

71

Slide 70: Today's Agenda (3)

- *Check-in with participants to see if they have any questions regarding crisis intervention before moving on to the next core function.*

Slide 71: Agenda for Client and Family Education

- Orient the participants to the agenda.

PEDAGOLOGICAL SUGGESTIONS:

- *Facilitate and invite participants to discuss ways they educate clients and family on the impact of SUD on individuals, families, and communities.*

- *Facilitate and invite participants to discuss how they educate and orient clients and their supporters to different treatment modalities, the continuum of care, and to various community resources?*

Slide 71: Agenda for Client and Family Education

- *[ASK PARTICIPANTS] How do you provide culturally relevant formal and informal education programs on substance use disorders?*

- *[ASK PARTICIPANTS] How do you educate clients, families, and the community about the impact of substance use disorders on the family, couple, or significant others?*

- *[ASK PARTICIPANTS] How do you explain the family's potential positive or negative influence on the development and continuation of a substance use disorder?*

Slide 72: Definition for Client and Family Education

- The CSAT (2006) offers the following definition of client and family education:

- *[READ THE SLIDE]*

- *[ASK PARTICPANTS] What are your thoughts on this definition?*

**Definition for
Client and Family Education**

- "The process of providing clients, families, significant others, and community groups with information on risks related to psychoactive substance use, as well as available prevention, treatment and recovery resources" (CSAT, 2006, p.133)

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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(Notes for Slide 72, continued)

Cultural and Linguistic Considerations

- Knowledge of cultural attitudes towards consumption of alcohol and drugs.
- Identifying, creating, and modifying information and client education materials to meet the needs of the intended audience.
- Format and delivery (e.g., individual, group, formal, lecture, online, public presentations).
- Clarify the purpose for educating or disseminating information.
- Consider different learning styles.

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 72: Definition for Client and Family Education

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 73: Cultural and Linguistic Considerations

- As counselors, we are expected to provide culturally relevant information regarding the risks related to psychoactive substance use, as well as available prevention, treatment and recovery resources in the community. To begin with, we should be knowledgeable of different cultural attitudes towards the consumption of psychoactive substances in the client's community.

(Notes for Slide 73, continued)

Slide 73: Cultural and Linguistic Considerations

- *[ASK PARTICIPANTS] What is the community's attitudes towards the use of coffee? Alcohol? Beetlenut?*

- As outlined in by the CSAT in TAP 21, we need to understand the "difference between educating and providing information" to clients and their supporters while "appreciating the historical, social, cultural, and other influences that shape the perceptions of psychoactive substance use" (p. 133). This appreciation also emphasizes the importance of being aware of our own cultural biases. There are many different resources that we may choose to use to educate our clients and their families and others supporters; however, we recognize the potential need to adapt or enhance educational materials to be culturally relevant. We need to take into consideration the format and delivery of information to make sure that it is culturally relevant and informed. We need to ask ourselves:

(Notes for Slide 73, continued)

Slide 73: Cultural and Linguistic Considerations

- How will we educate clients and their families in a culturally relevant and meaningful way?

    - What is the purpose or goal(s) of education and disseminating information on substance use disorders and on the continuum of care?

- We also need to recognize and appreciate that each of us learns differently and that we should consider different learning styles when we are educating or providing information to clients and their family members and other supporters.

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 74: Education on Drug Use and Addiction

- *ASK PARTICIPANTS] How and why would you explain to a family member of a person in recovery why people use alcohol and drugs?*

- *[ASK PARTICIPANTS] How and why would you explain to a family member that addiction is a chronic brain disorder?*

- *[ASK PARTICIPANTS] Why do you believe this would help or hinder your efforts in supporting your clients?*

REFERENCES

National Institute on Drug Abuse (2018). Drugs, brains, and behavior: the science of addiction. Retrieved from https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction.

(Notes for Slide 74, continued)

Slide 74: Education on Drug Use and Addiction

REFERENCES, continued

National Institute on Drug Abuse (2016). The science of drug abuse and addiction: the basics. Retrieved from https://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics.

Impact of Addiction on Families

- Effects on nuclear and extended family.
- Effects of addiction may continue for generations.
- "Intergenerational effects of substance abuse can have a negative impact on role modeling, trust, and concepts of normative behavior" (CSAT, 2015, p. 22).
- Encourage all members of the family to participate in family therapy.

Reference
Center for Substance Abuse Treatment. (2015). Substance abuse treatment and family therapy. Treatment Improvement Protocol (TIP) 39 (HHS Publication No. (SMA) 15-4219). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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.

Substance Abuse and Mental Health Services Administration (2013). Family therapy can help: for people in recovery from mental illness or addiction. Retrieved from https://store.samhsa.gov/shin/content//SMA13-4784/SMA13-4784.pdf

75

Slide 75: Impact of Addiction on Families

- Besides understanding and considering culturally informed and respectful approaches to educating clients and family members to the science of addiction, it is also helpful to explore, reflect on, and educate clients and their family members to the various ways addiction impacts families.

- *[ASK PARTICIPANTS] How does addiction affect family members and/or significant others in their community and in general?*

- Addiction "has distinct effects on different family structures" (CSAT, 2015, p. 21). For example, children to parents with substance use disorders "may act as surrogate spouses" … creating complex and "elaborate systems of denial to protect themselves against the reality of their parent's addiction" (CSAT, 2015, p. 21).

Slide 75: Impact of Addiction on Families

- Children may feel guilty and assume responsibility for their parents' use of drugs. These children may "grow up to be an overprotective and controlling parent who does not allow his or her children sufficient autonomy" (CSAT, 2015, p. 22). The impact of addiction to different family structures and in different communities is beyond the scope of this training; however, we strongly recommend and encourage you to review SAMHSA TIP 39. After having reviewed TIP 39, you will see why it is essential and critical for most clients and their families to participate in family therapy. There are free resources that you may choose to use in practice, including the SAMHSA brochure on family therapy highlighted here under resources, to educate and orient clients and their family members to family therapy.

(Notes for Slide 75, continued)

Slide 75: Impact of Addiction on Families

REFERENCES

Center for Substance Abuse Treatment (2015). Substance abuse treatment and family therapy. Treatment Improvement Protocol (TIP) 39 (HHS Publication No. (SMA) 15-4219). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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.

Substance Abuse and Mental Health Services Administration (2013). Family therapy can help: for people in recovery from mental illness or addiction. Retrieved from https://store.samhsa.gov/shin/content//SMA13-4784/SMA13-4784.pdf.

Education on the SUD Continuum of Care

- Levels of care (e.g., inpatient, residential, partial hospitalization, outpatient and intensive outpatient)
- Treatment modalities
- Self-help and mutual support groups

Reference
Center for Substance Abuse Treatment (2014). What is substance abuse treatment: a booklet for families (HHS Publication No. (SMA) 14-4126). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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.

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Slide 76: Education on the SUD Continuum of Care

- *[ASK PARTICIPANTS] How would you educate clients (and their families) to various service providers and organizations that support clients in their own recovery from substance use disorders?*

- As counselors, we should be familiar with and be able to describe, in clear and specific language, treatment services within the SUD continuum of care and resources available to clients and their family members. We must be able to describe the different levels of care that is available in our community. We also want to be familiar with and be able to describe the various types of treatment modalities and treatment resources, including local health, allied health, and behavioral health resources.

(Notes for Slide 76, continued)

Slide 76: Education on the SUD Continuum of Care

REFERENCES

Center for Substance Abuse Treatment (2015). *Substance abuse treatment and family therapy*. Treatment Improvement Protocol (TIP) 39 (HHS Publication No. (SMA) 15-4219). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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.

Continuum of Care (continued)

- Admission/eligibility criteria, access, and availability
- Agency philosophy
- Cost
- Program structure, including frequency, duration, and intensity of services
- Treatment methods
- Orientation to intake
- Program rules
- Discharge criteria

Reference
Center for Substance Abuse Treatment (2014). What is substance abuse treatment: a booklet for families (HHS Publication No. (SMA) 14-4126). Rockville, MD: Substance Abuse and Mental Health Services Administration.   77

Slide 77: Continuum of Care (continued)

- Later, we will discuss the role and core function of making referrals. In making referrals, we suggest that you create a checklist, outline, or guide, something similar to what we are presenting here, when orienting clients and their supporters to different levels of care and to different treatment modalities. Explaining the continuum of care and resources available to clients and their supporters in clear and specific language increases the likelihood of clients understanding and follow through (CSAT, 2006, p. 72). Begin by discussing what is available and what is most appropriate (based on results from your multidimensional assessment that explores clients' risks and needs, as well as strengths, skills and resources) in your community. Be sure to only identify treatment programs that your client is eligible for. What are the programs' policies on use of psychotherapeutic medications?

Slide 77: Continuum of Care (continued)

- What are the policies on the use of pharmacotherapy for substance use disorders? After, it is helpful to explain how clients access services – a brief review of screening processes and estimated wait times. Every effort should be made to clearly articulate and explain, to the best of your knowledge, the general philosophy of different programs and providers. Is the program faith-based? Are clients expected to participate in 12-step? Are there specific attributes of the program that make it special or unique from others? Clients should be informed of program costs. Clients should be oriented to the structure of different programs.

- What is the estimated length of stay or number of days for different programs? Describe the intensity of services. Do clients participate in individual and group meetings? Are they expected to work? If possible, provide a short overview on what is involved at intake.

(Notes for Slide 77, continued)

Does assessment happen at intake? If the client is being admitted to or referred to residential treatment programs, it is likely that program staff will search their belongings for contraband. Clients may also have limited access to their cell phones. Review the basic rules. For example, clients in residential settings may be expected to participate in all group meetings and classes. Clients who choose to not attend may be discharged or referred to a different program or level of care. When are clients discharged or transitioned to a lower level of care? Briefly describe discharge and remind participants that addiction is a brain disease. Recovery from addiction is unique to each individual and may require ongoing treatment. Normalize the process and acknowledge the client and their family for taking time to learn about different options to help them make an informed decision on how to move forward.

(Notes for Slide 77, continued)

Slide 77: Continuum of Care (continued)

REFERENCE

Center for Substance Abuse Treatment (2014). *What is substance abuse treatment: A booklet for families* (HHS Publication No. (SMA) 14-4126). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 78: Global Criteria for Client and Family Education

- The IC&RC have identified two global criteria for client and family education:

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

- Herdman (2018) explains that competence in criterion 33 is evident by the counselor's ability to use a variety of methods, both formally and informally, about addiction and substance use disorders.

**Global Criteria
for Client and Family Education**

33. Present relevant alcohol and other drug use/abuse information to the client through formal and /or informal processes
34. Present information about available alcohol and other drug services 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.
78

(Notes for Slide 78, continued)

Slide 78: Global Criteria for Client and Family Education

- Competence for criterion 34, as described by Herdman (2018), is evident by the counselor's ability to educate and orient clients to treatment services within the continuum of care and to different community resources that will support them and their supporters through different stages of treatment. Orienting clients to these services also requires the counselor to explain why they are recommending a particular resource or service for the clients' presenting problem(s).

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 Client and Family Education

- How would your program educate family members and other supporters to addiction?
- What methods would you employ and why?
- Be prepared to report out to the larger group.

79

Today's Agenda (4)

- Review and check-in
- Twelve Core Functions (continued)
  – Case Management
  – Crisis Intervention
  – Client and Family Education
  – **Referral**
  – Report and Record keeping
  – Consultation

80

Slide 79: Group Activity for Client and Family Education

- *Ask participants to gather into their small groups.*

- *Instruct participants to outline a process for educating family members and other supporters to addiction.*

- *Allow 20 minutes for participants to complete this activity.*

- *Randomly select one or two groups to review their process.*

- *After each group presents, [ASK PARTICIPANTS] Do you have any recommendations or comments to share with this group?*

Slide 80: Today's Agenda (4)

- *Check-in with participants to see if they have any questions regarding client and family education before moving on to discussing the core function of referral.*

Agenda for Referral

- Definition
- Referral versus consultation
- Establishing a referral network
- Evaluating referral network
- Knowing when to refer
- Arranging referrals
- Evaluating outcomes of referrals
- Global Criteria

81

Slide 81: Agenda for Referral

- *Orient the participants to the agenda.*

PEDAGOLOGICAL SUGGESTIONS:

- *Facilitate a discussion on what makes a good referral – does not need to be (and is preferable if it was not related) SUD services*

- *[ASK PARTICIPANTS] When do you seek out referrals? Traveling? Purchasing new equipment? Looking for a new restaurant?*

- *[ASK PARTICIPANTS] What do you consider to be a good referral source?*

- *[ASK PARTICIPANTS] If you were asked to make a referral, what is essential for you to know?*

- *Facilitate and invite participants to discuss ways they make referrals to other providers.*

    - *What do you do to prepare clients for referrals?*

    - *What is expected from your when making referrals to specific programs in your community?*

(Notes for Slide 81, continued)

Definition of Referral

- "The process of facilitating the client's use of available support systems and community resources to meet needs identified in clinical evaluation or treatment planning" (CSAT, 2006, p. 69)

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 81: Agenda for Referral

- *What would you consider to be best practices in making referrals?*

Slide 82: Definition of Referral

- The CSAT (2006) offers the following definition for referral.

- *[READ THE SLIDE]*

- *[ASK PARTICPANTS] Are there any comments, questions, or thoughts about this definition?*

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Establishing a Referral Network

- Establish and maintain relations with different providers and community organizations.
  - Core function(s)
  - Eligibility
  - Access-related issues or concerns
  - Costs
- Establish and nurture relationships with key contacts/points of contact.

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 83: Establishing a Referral Network

- The CSAT outlines specific competencies outlined in TAP 21 (see competencies 49-55) that addiction counselors must have to facilitate the client's use of available community resources to meet their needs. The first competency asserts that counselors have the ability "establish and maintain relations with civic groups, agencies, other professionals, governmental entities, and the community-at-large to ensure appropriate referrals, identify service gaps, expand community resources, and help to address unmet needs" (CSAT, 2006, p. 69).

- *[ASK PARTICIPANTS] What types of providers should we consider when thinking about the needs of our clients?*

(Notes for Slide 83, continued)

- Listen for examples of civic groups, crisis intervention programs, domestic violence programs, employment and vocational rehabilitation service programs, health and allied health care systems (managed care), housing, mutual aid or self-help organizations, primary care providers, psychiatrists, religious and faith-based organizations, therapists

- Listen for examples of different providers across the SUD continuum of care

- ***[ASK PARTICIPANTS] Why is it important to be knowledgeable of these individual providers and community organizations?***

Slide 83: Establishing a Referral Network

- Besides knowing about these individual provider and community organizations, it is important to know their function – what specific role or function(s) they serve, their admission/eligibility criteria, availability, including access-related issues or concerns, agency philosophy or philosophy of care, and costs. Also, it is critical that counselors establish and nurture relationships with key contacts or points-of-contact.

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 84: Evaluating Referral Network

Evaluating Referral Network

- Review publicly-available, agency-specific performance indicators (e.g., client satisfaction) or outcomes reports.
- Confirm accreditation status (if applicable) and licensing.

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

- Another competency outlined in TAP 21, is "continuously assess[ing] and evaluat[ing] referral resources to determine their appropriateness" and relevance to the client population being served (p. 50). There are a number of different ways to accomplish this task. For example, you could seek out reports on the agencies or providers' performance and outcomes. If applicable and relevant, confirm that the individual agency is accredited by a nationally recognized accreditation body. If it is not accredited, why not? Also, confirm that the individual and agency is licensed.

- *[ASK PARTICIPANTS] What other methods would you consider or should consider when evaluating your referral network?*

(Notes for Slide 84, continued)

Knowing When to Make a Referral

- Initiate and clarify whether the referral is:
  – For an outside entity to provide concurrent services
  – For an outside entity to provide services because the client will no longer receive services from you
- Assess capacity, ambivalence, and motivation (readiness, importance, confidence.
- Educate and orient the client about the referral process (e.g., signing consent forms).
- Educate the client about the specific individual, program or activity and its requirements.

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.   85

Slide 84: Evaluating Referral Network

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 85: Knowing When to Make a Referral

- Clients may be referred to an external agency because of their need to receive additional services at the same time that they are receiving services from you (i.e., concurrent services) or they may be referred to another agency and will no longer receive service from you.

(Notes for Slide 85, continued)

Slide 85: Knowing When to Make a Referral

- *[ASK PARTICIPANTS] When would you refer a client to another provider or agency?*

- There are many different situations where clients will be referred to another program or provider and will no longer receive services from you. Examples include:

    - The client's clinical or treatment needs are beyond the scope of yours and your program's expertise and training,

    - The client has advanced in your program and no longer meets criteria for your program's level of care – essentially, the client now meets criteria for a lower level of care or the client no longer needs any form of treatment.

(Notes for Slide 85, continued)

Slide 85: Knowing When to Make a Referral

- The client has experienced some setbacks, which are normal and expected in treating any chronic disease, and that they would be best served by returning to a higher level of care.

- The client is physically moving their residence and can access services from another provider.

- The client has violated one or more conditions of the program and is no longer eligible to receive treatment.

- There are situations when clients will be referred to another entity and will continue to receive services from you. Examples include:

    - The client would benefit from or requires services that are outside your scope of primary functions (e.g., vocational services, housing services).

Slide 85: Knowing When to Make a Referral

- The client's clinical or treatment needs are beyond the scope of yours and your program's expertise and training, and the client would receive concurrent services from a specialist.

- It is important to distinguish and differentiate between situations when clients should self-refer and instances when it would be in the best interest for the counselor to support the client throughout the referral process. First, counselors should assess whether clients are capable, given their current situations and to factors that led to the referral decision, of whether clients can follow-up independently to any referrals made by you.

- *[ASK PARTICPANTS] When and what circumstances would prompt you to have clients follow-up on any referrals provided by you without your support?*

(Notes for Slide 85, continued)

Slide 85: Knowing When to Make a Referral

- ***[ASK PARTICIPANTS] When would it not be clinically appropriate to not support or guide clients with referrals?***

- Counselors should also assess the client's motivation to follow-up on referrals.

    - Do they have the confidence to contact the agency or provider?

    - Do they believe it is important?

    - Are they ready to contact the provider?

    - Are they ambivalent about contacting the provider or ambivalent about receiving services?

- Once a decision has been made whether to support clients or allow them to follow-up on their own, clients should be educated and oriented to next steps.

(Notes for Slide 85, continued)

Slide 85: Knowing When to Make a Referral

- For example, clients should be reminded of yours and your organization's legal responsibility and their rights for you to maintain confidentiality; thus, consent forms will need to be signed and clients should be educated on what and why specific information will be released.

- Clients should be oriented to the program's admission/eligibility criteria, access, and availability, agency philosophy, cost, program structure, treatment methods (if applicable), intake processes (if known), program rules, and discharge criteria.

(Notes for Slide 85, continued)

Slide 85: Knowing When to Make a Referral

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 86: Arranging Referrals

- Counselors must demonstrate competency in arranging "referrals to other professionals, agencies, community programs, or other appropriate resources to meet client needs" (CSAT, 2006, p. 72).

Arranging Referrals

- Conform to all applicable protocols, rules, regulations, and laws (confidentiality) on consent and transmitting client-level information and data.
- Provide pertinent documentation, if necessary, and remember to only provide what is necessary
- Document the referral process.
- Maintain oral and written communication throughout the referral process to ensure successful referrals.

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.   86

(Notes for Slide 86, continued)

Slide 86: Arranging Referrals

- Counselors must conform to all local, state and federal rules, regulations and laws governing the release of and secure transmission of protected health information to external entities. As counselors, we must maintain respect for our clients rights to privacy. Counselors must maintain and be vigilant about releasing pertinent information that is applicable and relevant, as well as demonstrate the ability to use appropriate technology to access, collect, and transmit confidential information.

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 87: Arranging Referrals (continued)

Arranging Referrals (continued)

- Review informed consent form with client.
- Only release info that is applicable and within the parameters set by the client.
- Always include consent forms in all fax transmissions
- Never use email when communicating with other programs.
- Never use patient identifiers (e.g., client initials) in the subject line of any email (internal and external)
- Exercise caution when emailing protected health information when sending emails within a secure network.
- Never send protected health information via text messages.

- When reviewing and acquiring informed consent forms with clients, we need to ensure that clients agree to and understand the need for our programs to exchange relevant information with other professionals or programs. Counselors must explain the parameters of this exchange. Counselors must clearly explain to clients why specific information is being shared, and to differentiate why specific information will not be shared.

- *[ASK PARTICIPANTS] Let's consider that you are making a referral to an agency that provides education and support to a program that provides vocational services, what kind(s) of information would they need from you? What information would be withheld?*

Slide 87: Arranging Referrals (continued)

- We wanted to emphasize and remind you of a few best practices to safeguard you and your clients in maintaining conformance to applicable laws, rules and regulations when safeguarding and transmitting protected health information. First, always include a copy of the client's informed consent form to specific agency when transmitting specific information to them. This ensures that the consent on file is current. Never use email when communicating about clients to outside agencies. If your agency has a secure network and your privacy officer has agreed to allow you to communicate protected health information to others within your organization, never reference any protected health information in the subject line of your email. Refrain from communicating with clients by text and should refrain from communicating any protected health information to colleagues via text message.

Evaluating Referral Outcomes

- Systematically collect, report on, and document objective data?
  - How long did it take from the referral being made to the client being screened/assessed by the outside entity?
- Systematically collect, report on, and document subjective data.
  - Use standardized processes (measures).
  - What was the client's experience?
  - What was the outcome of the referral?

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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- We are expected to document all communications with external providers and collect, report on, and document objective and subjective data of the referral process. We begin by documenting when the referral was made. How long was it before the organization acknowledges receipt of our referral and contacts our client. We document the number of days, weeks, and months between the referral date and date of screening and/or intake. We document the outcome of our referral. We also account for the client's subjective experience.

- *[ASK PARTICIPANTS] What types of questions would you ask the client regarding their subjective experience? How would you document this information in the client record?*

(Notes for Slide 88, continued)

Slide 88: Evaluating Referral Outcomes

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Global Criteria for Referrals

35. Identify needs and or problems that the agency and/or counselor cannot meet.
36. Explain the rationale for the referral process to the client,
37. Match client needs and/or problems to appropriate resources.
38. Adhere to applicable laws, regulations and agency policies governing procedures related to the protection of the client's confidentiality.
39. Assist the client in utilizing the support systems and community resources available.

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

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Slide 89: Global Criteria for Referrals

- The IC&RC have identified five global criteria for referrals.

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

- Herdman (2018) explains that counselors must practice within their scope of expertise and training. They should know and understand the limitations of their education, training and experience (p. 70). They should also recognize when the clients' needs or problems are beyond the scope of the agency. Criterion 36 reminds us of the importance and the expectation that counselors are able to explain the rationale to a client why they are being referred to a different provider or agency. Criterion 37 is straightforward, counselors are expected to be able to match client needs and problems to available services and resources. and criterion 45 brings attention to the need for counselors to know what specific resources are available and how and when they will be used.

(Notes for Slide 89, continued)

Slide 89: Global Criteria for Referrals

- Herdman (2018) highlights that all healthcare paraprofessionals and professionals are expected and legally required to adhere to all applicable laws, regulations, and agency policies when seeking consultation internally or externally, paying particular attention to specific policies governing the disclosure and means used to disclose client-identifying information. Criterion 39 remind us of our responsibility to guide and support clients with navigating the system of care.

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 90: Group Activity for Referrals

Group Activity for Referrals

- Outline your program's procedures making referrals
- What processes will your program employ to ensure referrals are timely and relevant?
- Be prepared to discuss these processes with the larger group

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- *Ask participants to gather into their small groups.*

- *Instruct participants to outline their procedures for making referrals to outside agencies.*

- *Allow 20 minutes for participants to complete the activity.*

- *Randomly select one or two groups to review their procedures*

- *After each group presents,*

- *[ASK PARTICIPANTS] Do you have any recommendations or comments to share with this group?*

Slide 91: Today's Agenda (5)

Today's Agenda (5)

- Review and check-in
- Twelve Core Functions (continued)
  - Case Management
  - Crisis Intervention
  - Client and Family Education
  - Referral
  - **Report and Record keeping**
  - Consultation

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- *Check-in with participants to see if they have any questions regarding referrals before moving on to the next core function of report and record keeping.*

Slide 92: Agenda for Report and Record Keeping

> **Agenda for**
> **Report and Record Keeping**
>
> • Definition
> • Purpose of documentation
> • Case records: basic elements
> • Client contact/encounter or progress notes
> • Quality standards in documentation
> • Structured formats
> • Confidentiality
> • Global Criteria
>
> 92

- *Orient the participants to the agenda.*

PEDAGOLOGICAL SUGGESTIONS:

- *Facilitate and invite participants to discuss the importance of documenting client encounters and client progress in treatment.*

- *Facilitate and invite participants to elaborate and discuss local, state and federal laws, rules and regulations on confidentiality specific to SUD treatment.*

**Definition of
Report and Record Keeping**

- The CSAT (2006) defines documentation as "the recording of the screening and intake process, assessment, treatment plan, clinical reports, clinical progress notes, discharge summaries, and other client-related data" (p. 143)

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 93: Definition of Report and Record Keeping

- The CSAT (2006) offers the following definition for documentation.

- *[READ THE SLIDE]*

- *[ASK PARTICIPANTS] What is the purpose of developing, organizing, and managing client reports and records?*

    - *Listen for the following:*

        - *Facilitates utilization reviews*

        - *Allows for reimbursement*

        - *Defines problem(s) and current functional impairments*

        - *Guides treatment*

        - *Provides evidence of services rendered*

        - *Monitors for progression in treatment*

        - *Outlines continued need for services*

Slide 93: Definition of Report and Record Keeping

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 94: Purpose of Reports and Record Keeping

Purpose of Reports and Record Keeping

- Document services rendered.
- Ensures compliance to various federal and state laws and regulations, accreditation standards, and licensing requirements to protect the client, agency, and community.
- Supports the rationale, justification, and organization for the delivery of services.
- Decreases risk.
- Establishes medical necessity.
- Establishes appropriate level of care.

Reference
Council on Accreditation. (2018). Risk prevention and management (RPM): Case records. Retrieved from http://coanet.org/standard/rpm/7/
94

- The first competency that counselors must demonstrate in SUD settings is the necessary knowledge, skills, and attitudes regarding "accepted principles of client record management" CSAT, 2006, p. 147). Counselors and the agencies that employ them must remain vigilant and ensure compliance to various federal and state laws, rules and regulations, accreditation standards, and licensing requirements to protect the client, agency and community.

(Notes for Slide 94, continued)

Slide 94: Purpose of Reports and Record Keeping

- We are expected and legally required to protect the client's rights to "privacy and confidentiality in the preparation and handling of records, especially in relation to the communication of client information with third parties" (CSAT, 2006, p. 144). Case records should contain accurate and sufficient information to identify the client, support the rationale and decision process for choosing specific interventions and services, and document the delivery and client responses and outcomes to specific services rendered. Well maintained client records reduces risk when (1) we compose and enter timely, clear, accurate and concise screening, intake, and assessment and progress reports, (2) our information and documentation is objective, (3) and our progress or encounter notes, assessments, and treatment plans comply with various rules, regulations, and accreditation standards (if applicable).

(Notes for Slide 94, continued)

Slide 94: Purpose of Reports and Record Keeping

- *[ASK PARTICIPANTS] What are the basic elements in a client record? What would you find in well maintained client record?*

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.

Council on Accreditation. (2018). *Risk prevention and management (RPM): Case records*. Retrieved from http://coanet.org/standard/rpm/7/.

Slide 95: Basic Elements of Case Records

• The basic elements of a case record are contingent on the program type, funder, and purpose. Information should be organized in a presentable format for ease of access and review. Often, case records include the following:

• *[READ THE BULLETED LIST ON THE SLIDE; EXPAND ON EACH BULLET. STOP AT ASSESSMENT]*

• *[ASK PARTICIPANTS] What elements should be included in screening, intake and assessment reports:*

    • *Listen for the following:*

        • *psychoactive substance use and abuse history,*

        • *physical health,*

        • *psychological information,*

        • *social information,*

        • *history of criminality,*

        • *spiritual information,*

        • *recreational information,*

Slide 95: Basic Elements of Case Records

- *nutritional information,*

- *educational and/or vocational information,*

- *sexual information, and*

- *legal information.*

- *[READ AND EXPAND ON EACH BULLET]*

REFERENCE

Council on Accreditation. (2018). *Risk prevention and management (RPM): Case records*. Retrieved from http://coanet.org/standard/rpm/7/.

Elements of Case Records (continued 1)

- Medical information
  – Psychological, medical, diagnostic and other evaluations
  – Prescribed and over the counter medications
  – Physician orders
  – Allergies
  – Adverse treatment responses
- Description of services provided to the client
- Routine documentation (see next slide)
- Referrals

Reference
Council on Accreditation. (2018). Risk prevention and management (RPM): Case records. Retrieved from http://coanet.org/standard/rpm/7/

Elements of Case Records (continued 2)

- Routine documentation
  – Client encounters and progress notes (see next slide)
  – Consultation with other helping professionals
  – Collateral contacts
  – Missed appointment and other non-adherent behaviors
  – Telephone encounters, including non-routine calls and reminder appointments
- Unauthorized discharges & elopements
- Discharge or aftercare plan

Reference
Council on Accreditation. (2018). Risk prevention and management (RPM): Case records. Retrieved from http://coanet.org/standard/rpm/7/

Slide 96: Elements of Case Records (continued 1)

INSTRUCTIONS

- *[READ THE BULLETED LIST ON THE SLIDE; EXPAND ON EACH BULLET]*

REFERENCE

Council on Accreditation. (2018). *Risk prevention and management (RPM): Case records*. Retrieved from http://coanet.org/standard/rpm/7/.

Slide 97: Elements of Case Records (continued 2)

- *[READ THE BULLETED LIST ON THE SLIDE; EXPAND ON EACH BULLET]*
- *[ASK PARTICIPANTS] What should be included in a client's discharge summary?*

(Notes for Slide 97, continued)	**Slide 97: Elements of Case Records (continued 2)**
	• *Listen for*
	• *"client profile and demographics,*
	• *presenting symptoms,*
	• *diagnoses,*
	• *selected interventions,*
	• *critical incidents,*
	• *progress toward treatment goals,*
	• *treatment outcome(s),*
	• *continuing care plan/aftercare plan,*
	• *prognosis, and*
	• *Recommendations" (CSAT, 2017, p. 147)*
	• *[ASK PARTICIPANTS] What are the minimum necessary elements that should be included in a client's progress or encounter note?*

(Notes for Slide 97, continued)

Slide 97: Elements of Case Records (continued 2)

REFERENCE

Council on Accreditation. (2018). *Risk prevention and management (RPM): Case records*. Retrieved from http://coanet.org/standard/rpm/7/.

Client Encounters/Progress Notes

- Client name and unique identifier
- Date, location, purpose and reason for client contact/encounter/interaction
- Start and stop times (length)
- Service type (e.g., individual counseling, group therapy)
- Specific problem, goal, objective or action step being addressed
- Content and topics covered
- Observed behaviors of client (info about client's presentation)
- Intervention(s) used
- Client response to intervention

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Slide 98: Client Encounters/Progress Notes

- All encounter or progress records must:

    - Include the client's full name, date or birth, and unique identifier on each page,

    - Be legible,

    - Written in ink, if you are not using an electronic health record,

    - include the date, location and purpose of the encounter – the purpose should be clear whether the visit or encounter was planned or in response to a crisis or others reasons,

    - Include the start and stop times

        Clearly identify the specific treatment goal or objective being addressed,

    - Describe what specific content or topic were covered,

Progress Notes (continued)

- Progress towards and/or completion of goals or objectives
- Identification of new problems, goals, or objectives
- Client status
- Plan going forward
- Name and signature of clinician/counselor and credentials

Reference
Council on Accreditation. (2018). Risk prevention and management (RPM): Case records. Retrieved from http://coanet.org/standard/rpm/7/

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Slide 98: Client Encounters/Progress Notes

- Describe the client's affect, their emotional expression, their mood, and other observed behaviors throughout the encounter, and

- Describe the specific interventions used (e.g., education) and the client's response to the intervention(s)

Slide 99: Progress Notes (continued)

- All encounter or progress records must:

Slide 99: Progress Notes (continued)

- Use appropriate clinical terminology and standard abbreviations to describe the client's progress in relation to treatment goals and objectives and the client's response to various interventions employed,

- Document changes in the treatment plan,

- Document next steps for planning, for example, scheduling next appointment and agenda,

- Document client strengths, and

- Name, signature, and credential of the counselor.

- *[ASK PARTICPANTS] What other information should be included in progress notes?*

Quality Standards for Progress Notes

- Be clear, concise, specific, descriptive and succinct.
- Be current!
- Organize information using headings.
- Use direct quotes from the client and other sources when relevant.
- Use relevant information – avoid superfluous details.
- Write in the present tense.
- Document facts and observations written in behavior specific terms.

Reference
Council on Accreditation. (2018). Risk prevention and management (RPM): Case records. Retrieved from http://coanet.org/standard/rpm/7/

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Slide 99: Progress Notes (continued)

REFERENCE

Council on Accreditation. (2018). *Risk prevention and management (RPM): Case records*. Retrieved from http://coanet.org/standard/rpm/7/.

Slide 100: Quality Standards for Progress Notes

- The following information will most likely not be on the ADC IC&RC exam; however, these standards can be used as a checklist for quality.

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

REFERENCE

Council on Accreditation. (2018). *Risk prevention and management (RPM): Case records*. Retrieved from http://coanet.org/standard/rpm/7/.

Slide 101: Quality Standards (continued)

- If and when possible, aim for specificity when describing behaviors and situations. We should avoid using vague and value-laden terms. For example, avoid using the term inappropriate. The term inappropriate is subjective and contextual. The question to ask ourselves is what about the situation or behavior of the client made it inappropriate. Describe the situation and behavior so that others would know what transpired rather than make assumptions or introduce their own biases to the encounter. Be clear to label your own impressions and consider using a checklist to conform to various quality standards and expectations.

REFERENCE

Council on Accreditation. (2018). *Risk prevention and management (RPM): Case records*. Retrieved from http://coanet.org/standard/rpm/7/.

Structured Format

- SOAP
    - Subjective, Objective, Assessment, Plan
- GIRP
    - Goal, Intervention, Response, Plan
- SIRP
    - Situation, Intervention, Response, Plan
- BIRP
    - Behavior, Intervention, Response, Plan

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- ***[ASK PARTICIPANTS] Does your agency require you to use a structured format when documenting client encounters or progress notes? If so, please describe the format used?***

- ***[ASK PARTICIPANTS] What is the benefit to using a structured format for documenting client encounters (e.g., visits) and client progress?***

- Here are four commonly used formats that healthcare and social service delivery settings often used to organize their progress notes to ensure consistency across providers within their agency.

- The first is SOAP. SOAP is an acronym that refers subjective, objective, assessment and plan. Progress notes are organized into the following four sections:

    - The subjective section of the note includes all client observations, thoughts, and statements.

Slide 102: Structured Format

- The objective section of the note includes counselor observations.

- The assessment section of the note includes the counselor's understanding of the client's problems and test results.

- The last section, or plan, refers to next steps to help the client with achieving their personal goals and objectives. This section highlights which intervention will be employed in the future and should include a statement that describes how the intervention reflects the client's preferences and needs.

- GIRP refers to goal, intervention, response, and plan.

  - Goal includes information regarding the client's current focus and/or short-term goals.

  - Intervention includes all information regarding the methods used to address the client's goal.

Slide 102: Structured Format

- Response includes all information regarding the client's response to and progress made toward achieving their goals and objectives.

- Plan includes information regarding the treatment plan moving forward.

- SIRP refers to situation, intervention, response, and plan.

  - Situation includes information regarding the client's presenting situation at the beginning of intervention.

  - Intervention includes all information regarding methods used to address the client's goal or presenting situation.

  - Response includes all information regarding the client's response and progress made toward goals and objectives.

  - Plan refers to the treatment plan moving forward, based on the clinical information acquired and the assessment.

(Notes for Slide 102, continued)

Slide 102: Structured Format

- BIRP refers to behavior, intervention, response, and plan.

- Behavior includes information regarding client statements that capture the theme of the session and provider observations.

- Intervention includes information regarding methods used.

- Response incudes information regarding the client's response to and progress made toward their goals and objectives.

- Plan refers to the treatment plan moving forward.

Slide 103: Confidentiality of Records and Report Keeping

Confidentiality of
Records and Report Keeping

- Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule
- 42 Code of Federal Regulations (CFR) Part 2
- State defined confidentiality rules and regulations

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- As stated throughout this section, counselors are expected to know, understand, honor, and apply all applicable local, state, and federal confidentiality rules, regulations, policies, and practice standards. Here, we focus primarily on 2 federal laws governing confidentiality for individuals seeking, receiving, or having received treatment for substance use disorders. We strongly recommend and advise you to take time to review all local and state laws that apply to your community.

Slide 104: HIPAA Privacy Rule

- The first of the two federal laws that we will discuss is HIPAA. HIPAA, or the Health Insurance Portability and Accountability Act of 1996, established regulations and standards for the protection of individually identifiable health information otherwise referred to as protected health information or PHI. We will not discuss all aspects of the law in its entirety; however, we will highlight specific aspects of the law that address the use and disclosure of PHI.

- *[ASK PARTICIPANTS] What is individually identifiable health information or PHI?*

    - *Listen for information that relates to:*

        - *"An individual's past, present, or future physical or mental health condition,*

        - *The provision of health care to the individual.*

Slide 104: HIPAA Privacy Rule

- ***The past, present, or future payment for the provision of health care to the individual"***

REFERENCE

US Department of Health and Human Services. (2016). *Summary of the HIPAA Privacy Rule*. Retrieved from https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.

Slide 105: What is Protected Health Information?

- PHI includes any data which there is a reasonable basis to believe that it can be used to identify an individual. There are 2 components to PHI: information that can identify the individual and information that (1) relates to "an individual's past, present, or future physical or mental health condition, the provision of health care to the individual, and the past, present, or future payment for the provision of health care to the individual" (HHS).

What is Protected Health Information?

- Identifies the client.
- Any information that is oral, written, electronic, created or received by a health care provider, health plan, public health authority, employer, insurer, or others (see law for covered entities).
- Relating to past, present or future physical or mental health status, health care, and payment for such services.

Reference
US Department of Health and Human Services. (2016). Summary of the HIPAA Privacy Rule. Retrieved from
https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

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Slide 105: What is Protected Health Information?

- *[ASK PARTICIPANTS] What are common identifiers?*

REFERENCE

US Department of Health and Human Services. (2016). *Summary of the HIPAA Privacy Rule*. Retrieved from https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.

Eighteen Identifiers of PHI (1)

1. Names;
2. All geographic subdivisions smaller than a state, with the exception of the first three digits of a zip code ONLY if and when there are more than 20,000 people that can be accounted for when combining all zip codes with the first three digits;
3. All elements of dates (except year) for dates directly related to an individual, including date of birth, admission and discharge dates, and date of death;
4. Phone numbers;
5. Fax numbers;

Reference
US Department of Health and Human Services. (2015). Guidance regarding methods for de-identification of protected health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Retrieved from https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html?language=es

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Slide 106: Eighteen Identifiers of PHI (1)

- Here are the 18 identifiers identified by the federal government and referenced in the law.

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

REFERENCE

US Department of Health and Human Services. (2015). *Guidance regarding methods for de-identification of protected heath information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule*. Retrieved from https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html?language=es.

Eighteen Identifiers of PHI (2)

6. Email addresses;
7. Vehicle identifiers and serial numbers, including license plates;
8. Device identifiers and serial numbers;
9. Social Security Numbers;
10. Web Universal Resource locators (URLs);
11. Internet Protocol (IP) addresses;
12. Medical record numbers;
13. Health plan beneficiary numbers;
14. Full face photographs and other comparable images;
15. Account numbers;

Reference
US Department of Health and Human Services. (2015). Guidance regarding methods for de-identification of protected heath information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Retrieved from https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html?language=es

107

Slide 107: Eighteen Identifiers of PHI (2)

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

REFERENCE

US Department of Health and Human Services. (2015). *Guidance regarding methods for de-identification of protected heath information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule*. Retrieved from https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html?language=es.

Slide 108: Eighteen Identifiers of PHI (3)

18 identifiers of PHI (3)

16. Biometric identifiers, including fingerprint and voice prints;
17. Certificate or license numbers; and
18. An other identifying number, characteristic or code (see law or exceptions)

Reference
US Department of Health and Human Services. (2015). Guidance regarding methods for de-identification of protected health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Retrieved from https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html?language=es

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

REFERENCE

US Department of Health and Human Services. (2015). *Guidance regarding methods for de-identification of protected heath information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule*. Retrieved from https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html?language=es.

Authorized Uses and Disclosures

- Obtain an individual's written authorization for any use or disclosure of PHI.
- Use plain language.
- Ensure the client understands:
  – Who is disclosing the information?
  – What is it being used for?
  – When will the consent expire?
  – How to revoke the consent?

Reference
US Department of Health and Human Services. (2016). Summary of the HIPAA Privacy Rule. Retrieved from
https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

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Slide 109: Authorized Uses and Disclosures

- All covered entities must obtain an individual's written authorization for any use or disclosure of PHI that is not for treatment, payment, or otherwise permitted or required by the Privacy Rule. "All authorizations must be in plain language, and contain specific information regarding the information to be used or disclosed, the person(s) disclosing and receiving the information, expiration, right to revoke writing and other data" (HHS, 2015).

REFERENCE

US Department of Health and Human Services. (2016). *Summary of the HIPAA Privacy Rule*. Retrieved from https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.

Principle of "Minimum Necessary"

- "A covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or the request" (HHS, 2015).
- Justify the use, disclosure or request of medical information.

Reference
US Department of Health and Human Services. (2016). Summary of the HIPAA Privacy Rule. Retrieved from
https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html
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Slide 110: Principle of "Minimum Necessary"

- One of the central aspects of the privacy rules in ensuring covered entities only request and/or release the minimum amount of PHI needed to accomplish the intended purpose of the use, disclosure or request.

- *[ASK PARTICIPANTS] When is a covered entity not required to acquire consent from an individual to use and disclose their PHI?*

REFERENCE

US Department of Health and Human Services. (2016). *Summary of the HIPAA Privacy Rule*. Retrieved from https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.

Permitted Uses and Disclosures

- An individual's authorization for a covered entity to use and disclose PHI is not require in the following cases:
  – To the individual,
  – Treatment, payment, health care operations,
  – Uses and disclosure with opportunity to agree or object,
  – Incidental use and disclosure,
  – Public interest and benefit activities, and
  – Limited data set
- All covered entities are required to document when PHI was used or obtained regardless of whether the individual authorized it.

Reference
US Department of Health and Human Services. (2016). Summary of the HIPAA Privacy Rule. Retrieved from
https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html
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Slide 111: Permitted Uses and Disclosures

- Here, we briefly describe a few situations and instances when covered entities are not required to receive an individual's authorization permitting the entity from using or releasing its PHI. Authorization for using or releasing PHI is not needed:

  - When the individual is the subject of information;

  - When health information is being used internally for the provision, coordination, and management of health care and related services;

  - When obtaining payment or reimbursement of the provision of healthcare to an individual;

  - When the entity is engaged in quality assessment and improvement activities, compliance activities, and competency assurance activities;

  - When the individual agrees to the release outright;

  - When the individual is in an emergency situation or incapacitated;

(Notes for Slide 111, continued)

Slide 111: Permitted Uses and Disclosures

- When required by the law, such as in cases there are court orders or administrative tribunal;

- When the individual has been identified by law enforcement as a suspects, fugitive, witness or missing person;

- When the individual has contracted or been exposed to a communicable disease and the covered entity is required by law to report the incident;

- When the individual has experienced an adverse event for an FDA regulated product or activity;

- When the individual is a victim of abuse, neglect or domestic violence; and

- When there is belief that an individual is a serious and imminent threat to the health and safety of themselves or someone else.

(Notes for Slide 111, continued)

Slide 111: Permitted Uses and Disclosures

- Please closely review the Privacy Rule for other situations and circumstances when authorization is not needed.

REFERENCE

US Department of Health and Human Services. (2016). *Summary of the HIPAA Privacy Rule*. Retrieved from https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.

Slide 112: 42 Code of Federal Regulations (CFR) Part 2

The second of the two federal laws is Title 42 Part 2 of the United States Code, otherwise known as 42 CFR Part 2. This law includes special privacy protections for the confidentiality of substance use disorder patient records. 42 CFR Part 2 applies to all individuals and entities that receive or have received federal funds in any form, directly or indirectly, is assisted by the IRS through tax exemption status, or is authorized to conduct business with the federal government (e.g., Medicare) to prevent, diagnose, treat, or refer to treat an individual with substance use disorders.

REFERENCE

US Government Publishing Office. (2006). *Electronic code of federal regulations: Title 42, Chapter 1, Subchapter A, Part 2: Confidentiality of substance use disorder patient records*. Retrieved from https://www.ecfr.gov/cgi-bin/text-idx?SID=0f9b2a146b539944f00b5ec90117d296&mc=true&node=pt42.1.2&rgn=div5.

Slide 113: 42 CFR Part 2: Disclosures

42 CFR Part 2: Disclosures

- All entities that meet criteria for 42 CFR Part 2 may NOT disclose PHI directly or indirectly (including referral and intake) unless:
  – Informed consent is provided by client in writing and the informed includes required elements
  – Crimes (or threats of) on program premises or against program personnel
  – Suspected child abuse or neglect
  – Court order meeting specifications of 42 CFR
  – Qualified service organizations
  – External auditors, evaluators, registries, and researchers

Reference
US Government Publishing Office. (2006). Electronic code of federal regulations: Title 42, Chapter 1, Subchapter A, Part 2: Confidentiality of substance use disorder patient records. Retrieved from https://www.ecfr.gov/cgi-bin/text-idx?SID=0f9b2a1466539944f00b5ec90117d296&mc=true&node=pt42.1.2&rgn=div5

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42 CFR Part 2 allows programs to disclose PHI when reporting suspected child abuse or neglect, when reporting a death, or with the existence of a valid court order. Program may also disclose PHI in medical emergencies, in reporting crimes that occur on program premises or against staff, to qualified service organizations, and to external auditors, evaluators, registries, and researchers. Qualified service organizations are individuals and entities that provide services to the program or have entered into a written agreement under which the individual or entity acknowledges and agrees to regulations set forth in the regulations when receiving, storing, processing, or dealing with client records.

(Notes for Slide 113, continued)

Slide 113: 42 CFR Part 2: Disclosures

REFERENCE

US Government Publishing Office. (2006). *Electronic code of federal regulations: Title 42, Chapter 1, Subchapter A, Part 2: Confidentiality of substance use disorder patient records*. Retrieved from https://www.ecfr.gov/cgi-bin/text-idx?SID=0f9b2a146b539944f00b5ec90117d296&mc=true&node=pt42.1.2&rgn=div5.

Slide 114: Disclosures and Medical Emergencies

> All covered entities may release PHI without prior consent in the event of an emergency to medical personnel, but not to family, unless the individual signed a consent form authorizing the entity to contact authorized family members and the consent specifies what the program can disclose. If and when an entity releases PHI to medical personnel, it must document the names of medical personnel and the healthcare facility to which the disclose was made, the individual's name, title, date and time of when the disclosure was made, and the nature of the medical emergency.

Disclosures and Medical Emergencies

- Disclosure of PHI is permitted to medical personnel - but not family - if the client is experiencing a medical emergency.
- Documentation of disclosure must occur immediately afterward to include (1) Name of medical personnel and healthcare facility to who disclosure was made; (2) Name of individual making disclosure; date & time, and (3) Nature of Medical Emergency.

Reference
US Government Publishing Office. (2006). Electronic code of federal regulations: Title 42, Chapter 1, Subchapter A, Part 2: Confidentiality of substance use disorder patient records. Retrieved from https://www.ecfr.gov/cgi-bin/text-idx?SID=0f9b2a146b539944f00b5ec90117d296&mc=true&node=pt42.1.2&rgn=div5

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(Notes for Slide 114, continued)

Slide 114: Disclosures and Medical Emergencies

REFERENCE

US Government Publishing Office. (2006). *Electronic code of federal regulations: Title 42, Chapter 1, Subchapter A, Part 2:Confidentiality of substance use disorder patient records*. Retrieved from https://www.ecfr.gov/cgi-bin/text-idx?SID=0f9b2a146b539944f00b5ec90117d296&mc=true&node=pt42.1.2&rgn=div5.

Disclosures and Crimes on Premises or Against Personnel

- If a crime is committed, or threatened, on program premises or against program personnel, staff may disclose identifying information including:
  – suspect's name, address, last known whereabouts, and status as a client in the program.
- Duty to warn others

Reference
US Government Publishing Office. (2006). Electronic code of federal regulations: Title 42, Chapter 1, Subchapter A, Part 2: Confidentiality of substance use disorder patient records. Retrieved from https://www.ecfr.gov/cgi-bin/text-idx?SID=0f9b2a146b539944f00b5ec90117d296&mc=true&node=pt42.1.2&rgn=div5

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Slide 115: Disclosures and Crimes on Premises or Against Personnel

- All covered entities may release PHI without prior consent in the event that a crime was committed on site or against personnel. Also, all covered entities must notify the authorities if there is reason to believe the client is a danger to themselves or others.

- *[ASK PARTICIPANTS] What do you do if a client articulates their plan to kill another person?*

REFERENCE

US Government Publishing Office. (2006). *Electronic code of federal regulations: Title 42, Chapter 1, Subchapter A, Part 2: Confidentiality of substance use disorder patient records*. Retrieved from https://www.ecfr.gov/cgi-bin/text-idx?SID=0f9b2a146b539944f00b5ec90117d296&mc=true&node=pt42.1.2&rgn=div5.

Slide 116: Disclosures and Child and Elder Abuse

Disclosures and Child and Elder Abuse

- Reporting of child and elder abuse and neglect are governed by state laws.
- 42 CFR Part 2 allows for initial reporting and written confirmation of the report, but does not permit programs to disclose PHI for on-going investigations, without a court order.

Reference
US Government Publishing Office. (2006). Electronic code of federal regulations: Title 42, Chapter 1, Subchapter A, Part 2: Confidentiality of substance use disorder patient records. Retrieved from https://www.ecfr.gov/cgi-bin/text-idx?SID=0f9b2a1466539944f00b5ec90117d296&mc=true&node=pt42.1.2&rgn=div5

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- All covered entities may release PHI without prior consent in the event of that there is reason to believe that a child or older adult is being abused or neglected. Almost all states have mandatory reporting laws; however, the laws vary.

- *[ASK PARTICIPANTS] What are the laws here regarding mandatory reporting of child abuse and neglect?*

- *[ASK PARTICIPANTS] What about laws regarding mandatory reporting of elder abuse and neglect?*

- *[ASK PARTICIPANTS] What are the required elements for written consent?*

(Notes for Slide 116, continued)

Slide 116: Disclosures and Child and Elder Abuse

REFERENCE

US Government Publishing Office. (2006). *Electronic code of federal regulations: Title 42, Chapter 1, Subchapter A, Part 2: Confidentiality of substance use disorder patient records*. Retrieved from https://www.ecfr.gov/cgi-bin/text-idx?SID=0f9b2a146b539944f00b5ec90117d296&mc=true&node=pt42.1.2&rgn=div5.

Required Elements for Written Consent

A written consent to disclose under 42 CFR Part 2 may be paper or electronic and must include:
- Name of client;
- Name and description of the program making disclosure;
- How much & what kind of information will be disclosed, including an explicit description of the SUD information that may be disclosed;
- Name and title of the individual(s) to whom a disclosure is to be made;

Reference
US Government Publishing Office. (2006). Electronic code of federal regulations: Title 42, Chapter 1, Subchapter A, Part 2: Confidentiality of substance use disorder patient records. Retrieved from https://www.ecfr.gov/cgi-bin/text-idx?SID=0f9b2a146b539944f00b5ec90117d296&mc=true&node=pt42.1.2&rgn=div5
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Slide 117: Required Elements for Written Consent

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

REFERENCE

US Government Publishing Office. (2006). *Electronic code of federal regulations: Title 42, Chapter 1, Subchapter A, Part 2: Confidentiality of substance use disorder patient records*. Retrieved from https://www.ecfr.gov/cgi-bin/text-idx?SID=0f9b2a146b539944f00b5ec90117d296&mc=true&node=pt42.1.2&rgn=div5.

**Required Elements
for Written Consent (continued)**

- Purpose of disclosure;
- Statement of the client's right to revoke the consent
- Date, event, or condition upon which the consent will expire if not revoked – the date, event, or condition "will last no longer than reasonably necessary to service the purpose for which it is provide);
- Signature of client; and
- Date of which the client signed the consent

Reference
US Government Publishing Office. (2006). Electronic code of federal regulations: Title 42, Chapter 1, Subchapter A, Part 2: Confidentiality of substance use disorder patient records. Retrieved from https://www.ecfr.gov/cgi-bin/text-idx?SID=0f9b2a146b539944f00b5ec90117d296&mc=true&node=pt42.1.2&rgn=div5

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Slide 118: Required Elements for Written Consent (continued)

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

REFERENCE

US Government Publishing Office. (2006). *Electronic code of federal regulations: Title 42, Chapter 1, Subchapter A, Part 2: Confidentiality of substance use disorder patient records*. Retrieved from https://www.ecfr.gov/cgi-bin/text-idx?SID=0f9b2a146b539944f00b5ec90117d296&mc=true&node=pt42.1.2&rgn=div5.

**Global Criteria for
Reports and Record Keeping**

40. Prepare reports and relevant records integrating available information to facilitate the continuum of care
41. Chart pertinent ongoing information pertaining to the client
42. Utilize relevant information from written documents for client care

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

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Slide 119: Global Criteria for Reports and Record Keeping

- The IC&RC have identified three global criteria for reports and record keeping.

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

- There are various types of reports commonly used to support clients as they enter, move through, and eventually are discharged at different points throughout the continuum of care. Criterion 40 highlights the expectation that counselors should be familiar with and demonstrate the ability to prepare these reports, how these reports are integrated and used to facilitate care, especially in treatment and transition/discharge planning, and the types of information that should and should not be included (Herdman, 2018). Criterion 41, according to Herdman (2008), emphasizes the need for counselors to demonstrate the ability to document pertinent information in the client's chart.

Slide 119: Global Criteria for Reports and Record Keeping

- Counselors should be familiar with and demonstrate the ability to document relevant information according to agency-specific formats or practices. Lastly, counselors should understand "how information from written documents is used to benefit the client" (Herdman, 2018, p. 101). If and when information from other reports are used in treatment plans or assessments, counselors should document the source of data, including information regarding the author(s) and date(s).

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 120: Group Activity for Reports and Record Keeping

Group Activity for Reports and Record Keeping

- You have been tasked to build your program's electronic health record.
- Without reviewing the slides, what elements will your program include in client progress notes?
- Be prepared to discuss these processes with the larger group.

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- *Ask participants to gather into their small groups.*

- *Instruct participants to outline the specific elements that should be included in their progress notes template.*

- *Allow 20 minutes for participants to complete the activity.*

- *Randomly select one or two groups to review their template.*

- *After each group presents,*

- *[ASK PARTICIPANTS] Do you have any recommendations or comments to share with this group?*

Slide 121: Today's Agenda

Today's Agenda (6)

- Review and check-in
- Twelve Core Functions (continued)
  - Case Management
  - Crisis Intervention
  - Client and Family Education
  - Referral
  - Report and Record keeping
  - Consultation

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- *Check-in with participants to see if they have any questions regarding report and record keeping before moving on to the last core function of consultation.*

Slide 122: Today's Agenda (6)

Agenda for Consultation

- Definition
- Referral versus consultation
- Purpose
- When and how to consult
- Global Criteria

- *Orient the participants to the agenda.*

PEDAGOLOGICAL SUGGESTIONS:

- *Facilitate and invite participants to discuss how and when they use consultation?*

- *Invite feedback on what participants believe makes a good consultant?*

- *Facilitate a conversation on what makes a consultee*

Definition of Consultation

- "The administrative, clinical, and evaluative activities that bring the client, treatment services, community agencies, and other resources together to focus on issues and needs identified in the treatment plan" (CSAT, 2006, p.79).
- Consultation is "relating with counselors and other professionals in regard to client treatment (services) to assure comprehensive quality care for the client"

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. (SMA) 15-4171). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Slide 123: Definition of Consultation

- The CSAT and IC&RC offers the following definitions for consultation.

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

- *[ASK PARTICIPANTS] What is the difference between a referral and consultation?*

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.

Slide 123: Definition of Consultation

REFERENCES, continued

Substance Abuse and Mental Health Services Administration. (2013). *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 124: Referral versus Consultation

Referral versus Consultation

- Referral
  - "I can't do it, but somebody else can."
- Consultation:
  - "I can do it, but I can do it better with another's help."

Reference
Carney, J. M. & Jefferson, J. F. (2014). Consultation for mental health counselors: opportunities and guidelines for private practice. *Journal of Mental Health Counseling, 36*(4), 302 – 314.

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- Essentially, we make referrals to other professionals or programs when the requests or needs of our clients are outside our scope, education, or expertise. We seek consultation when we believe that we can adequately and safely address the need or request made by a client.

- *[ASK PARTICIPANTS] When have you sought consult from another helping professional? Why was it helpful or not helpful?*

  Formal consultation is often sought when counselors and other healthcare professionals encounter a difficult case or challenge. Often, consultation is confused with supervision. Consultants, unlike supervisors, do not hold power and control over the consultee. Further, the relationship between a consultant and consultee, unlike supervisors, tends to be nonhierarchical, temporary, and non-evaluative.

(Notes for Slide 124, continued)

REFERENCE

Carney, J.M. & Jefferson, J.F. (2014). Consultation for mental health counselors: opportunities and guidelines for private practice. *Journal of Mental Health Counseling, 36(4*), 302 – 314.

Slide 125: Purpose of Consultation

- **The aim of consultation is to empower the consultee, the person(s) receiving consultation services, to help them function more independently and to improve their overall job effectiveness.**

- *[ASK PARTICIPANTS] When should you seek formal consultation?*

Purpose of Consultation

- Consultation aims to empower consultees to address a challenging situation or case, function more independently, and to improve their overall effectiveness.

Reference
Carney, J. M. & Jefferson, J. F. (2014). Consultation for mental health counselors: opportunities and guidelines for private practice. *Journal of Mental Health Counseling, 36(4)*, 302 – 314.

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When to Seek Formal Consultation?

- When decisions or actions for treating clients with SUDs have serious uncertainty.
- When decisions or actions for treating clients with SUDs have legal or ethical dimensions.
- When care requires special expertise that is outside the scope, training, knowledge, and skills of the counselor.

Reference
Carney, J. M. & Jefferson, J. F. (2014). Consultation for mental health counselors: opportunities and guidelines for private practice. Journal of Mental Health Counseling, 36(4), 302 – 314.

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Slide 125: Purpose of Consultation

REFERENCE

Carney, J.M. & Jefferson, J.F. (2014). Consultation for mental health counselors: opportunities and guidelines for private practice. *Journal of Mental Health Counseling, 36(4*), 302 – 314.

Slide 126: When to Seek Formal Consultation?

- Counselors should consider seeking formal consultation with other professionals who have subject matter expertise when they are confronted with a potentially unethical or high-risk situations that cannot be adequately addressed by resources within your agency.

- Here are three potential scenarios that you will face of have already faced that may benefit from seeking formal consultation. They are:

(Notes for Slide 126, continued)

Slide 126: When to Seek Formal Consultation?

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

- *[ASK PARTICIPANTS] What other types of scenarios would benefit from formal consultation?*

- *[ASK PARTICIPANTS] What questions would you ask yourself or your supervisor before seeking formal consultation?*

REFERENCE

Carney, J.M. & Jefferson, J.F. (2014). Consultation for mental health counselors: opportunities and guidelines for private practice. *Journal of Mental Health Counseling, 36(4)*, 302 – 314.

**Questions to Ask Ourselves
Prior to Seeking Consultation**

- "What purpose is the consultation needed?"
- "Would informal peer consultation meet this need?"
- "Would formal expert consultation be more appropriate?"

Reference
Carney, J. M. & Jefferson, J. F. (2014). Consultation for mental health counselors: opportunities and guidelines for private practice. *Journal of Mental Health Counseling, 36(4)*, 302 – 314.

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Slide 127: When to Seek Formal Consultation?

- Carney and Jefferson (2014) recommend that consultees ask themselves the following questions before and during the consultation process:

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

- *[ASK PARTICPANTS] What should you look for in a consultant?*

- *[ASK PARTICPANTS] What specific characteristics and competencies should consultants possess?*

REFERENCE

Carney, J.M. & Jefferson, J.F. (2014). Consultation for mental health counselors: opportunities and guidelines for private practice. *Journal of Mental Health Counseling, 36(4*), 302 – 314.

Slide 128: Finding the Right Consultant

When choosing a consultant, ensure that they are culturally intelligent – they are self-aware, culturally anchored and informed. They should identify their subject matter expertise and provide evidence of how they acquired expertise in one or more areas. Consultants should have experience in planning and implementing change initiatives and interventions. Also, identify beforehand what interpersonal skills you are looking for in a consultant.

- *[ASK PARTICIPANTS] What types of interpersonal skills are important to you?*

REFERENCE

Carney, J.M. & Jefferson, J.F. (2014). Consultation for mental health counselors: opportunities and guidelines for private practice. *Journal of Mental Health Counseling, 36(4*), 302 – 314.

Consultee Responsibilities

- Be open to feedback.
- Maintain ongoing and collaborative communication.
- Provide pertinent information to support the consultant in making informed decisions and guidance.
- Be honest with the consultant whether recommendations are feasible.
- Provide evaluation feedback to the consultant throughout the process.

Reference
Carney, J. M. & Jefferson, J. F. (2014). Consultation for mental health counselors: opportunities and guidelines for private practice. *Journal of Mental Health Counseling, 36*(4), 302 – 314.

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Slide 129: Consultee Responsibilities

- You as a consultee also have responsibilities. To facilitate the consultation process…

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

- *[ASK PARTICIPANTS] What other responsibility should you assume as a consultee?*

REFERENCE

Carney, J.M. & Jefferson, J.F. (2014). Consultation for mental health counselors: opportunities and guidelines for private practice. *Journal of Mental Health Counseling, 36(4*), 302 – 314.

Global Criteria for Consultation

43. Recognize issues that are beyond the counselor's base of knowledge and/or skill
44. Explain the rationale for the consultation to the client, if appropriate
45. Consult with appropriate resources to ensure the provision of effective treatment services
46. Adhere to applicable laws, regulations and agency policies governing the disclosure of client-identifying data

Reference
Herdman, J. W. (2018). *Global criteria: the 12 core functions of the substance abuse counselor* (7th ed.). Lincoln, NE: Parallels: Pathways to Change.
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Slide 130: Global Criteria for Consultation

- The IC&RC have identified four global criteria for consultation.

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

   Herdman (2018) explains that counselors must practice within their scope of expertise and training. They should know and understand the limitations of their education, training and experience (p.70). Criterion 44 reminds us the importance of being able to explain the rationale to a client when counselors are considering the need or desire to seek consultation, and criterion 45 brings attention to the need for counselors to know what specific resources are available and how and when they will be used. Lastly, Herdman (2018) highlights the importance of adhering to all applicable laws, regulations, and agency policies when seeking consultation internally or externally, paying particular attention to specific policies governing the disclosure and means used to disclose client-identifying information.

(Notes for Slide, 130, continued)

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 131: Group Activity for Consultation

Group Activity for Consultation

- When and how will you seek formal consultation?
- Be prepared to discuss these processes with the larger group

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- *Ask participants to gather into their small groups.*

- *Instruct participants to outline their procedures for seeking formal consultation.*

- *Allow 20 minutes for participants to complete the activity.*

- *Randomly select one or two groups to review their process.*

- *After each group presents,*

- *[ASK PARTICIPANTS] Do you have any recommendations or comments to share with this group?*

Slide 132: Questions

Ask participants if they have any final questions.

Questions

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Acknowledgements