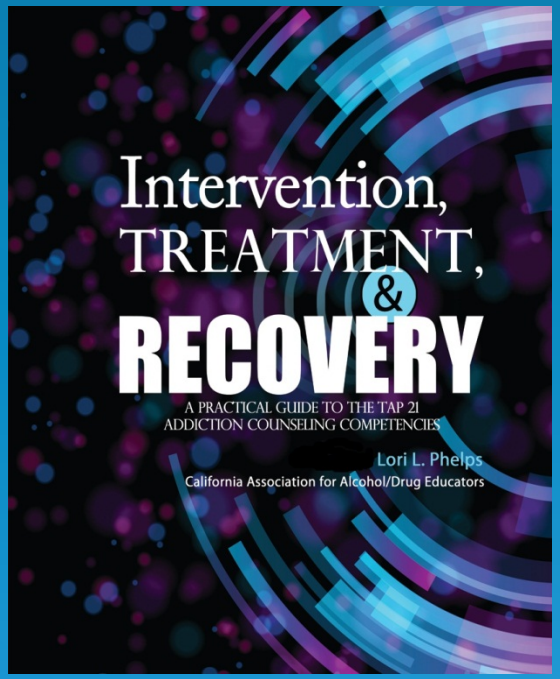
Intervention, TREATMENT, & RECOVERY

First Edition



Chapter 1
INTRODUCTION TO THE TAP 21

Contributor: Lori Phelps

Lori L. Phelps
California Association for Alcohol/Drug Educators, 2013

RATIONALE FOR HIGHER EDUCATION FOR ADDICTION COUNSELORS

- Birch and Davis study (1986)
- 12 core functions
- Obsolete “national standard” of 315 hours
- New developments in our understanding of addiction
- College degrees have replaced the old standard

THE TIERED SYSTEM

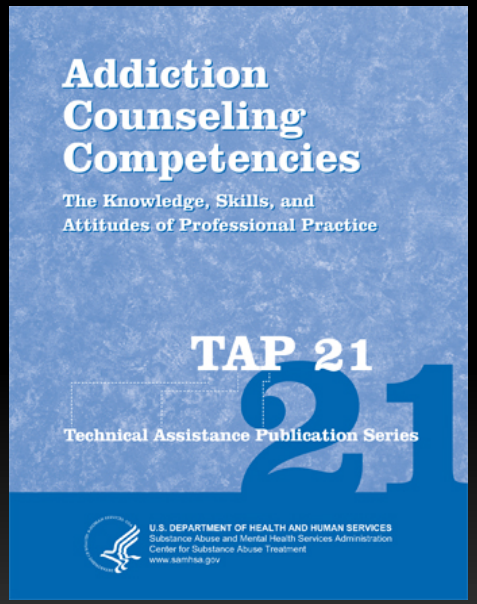
- Based on increasing levels of education
- The tiers are graduated in a way that makes advancing up the ladder both desirable and achievable
- A national model

CAADE's Tiered System

- CATC I (certificate)
- CATC II (AA/AS degrees)
- CATC III (BA/BS degree)
- CATC IV (MA/MS degrees)
- CATC V (Doctorate)
- CATC N (Nursing)

TAP 21: What is it?

- *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*, Technical Assistance Publication (TAP) Series 21.
- First published in 1997 by
  - Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Substance Abuse Treatment (CSAT)
- Evidence-based
- 123 competencies and underlying Knowledge, Skills and Attitudes (KSAs)
- Revised in 2000
- Repackaged and presented in a new format in 2005



HISTORY OF THE COMPETENCIES

- Addiction Technology Transfer Centers (ATTCs)
- National Curriculum Committee
- Researched existing practice and professional literature
- Developed extensive list of addiction practice competencies
- Conducted a national survey to validate the competencies

THE MODEL: KNOWLEDGE, SKILLS, AND ATTITUDES

- Three characteristics of competency: knowledge, skills, and attitudes (KSAs)
- Transdisciplinary foundations (four discrete building blocks)
  - understanding addiction
  - treatment knowledge
  - application to practice
  - professional readiness
- *Transdisciplinary* (e.g., medicine, social work, pastoral guidance, corrections, social welfare)

8 PRACTICE DIMENSIONS

- The professional practice needs of addiction counselors
  1. Clinical evaluation (screening and assessment)
  2. Treatment planning
  3. Referral
  4. Service coordination
  5. Counseling
  6. Client, family and community education
  7. Documentation
  8. Professional and ethical responsibilities
- Each practice dimension includes a set of competencies
- Within each competency are the KSAs necessary for effective addiction counseling

Comparing the 8 Practice Dimensions (Knowledge, Skills, Attitudes) and the 12 Core Functions

8 Practice Dimensions (KSAs)

1. Clinical evaluation (screening and assessment)
2. Treatment planning
3. Referral
4. Service coordination*
5. Counseling
6. Client, family and community education
7. Documentation
8. Professional and ethical responsibilities

Service Coordination

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.

12 Core Functions

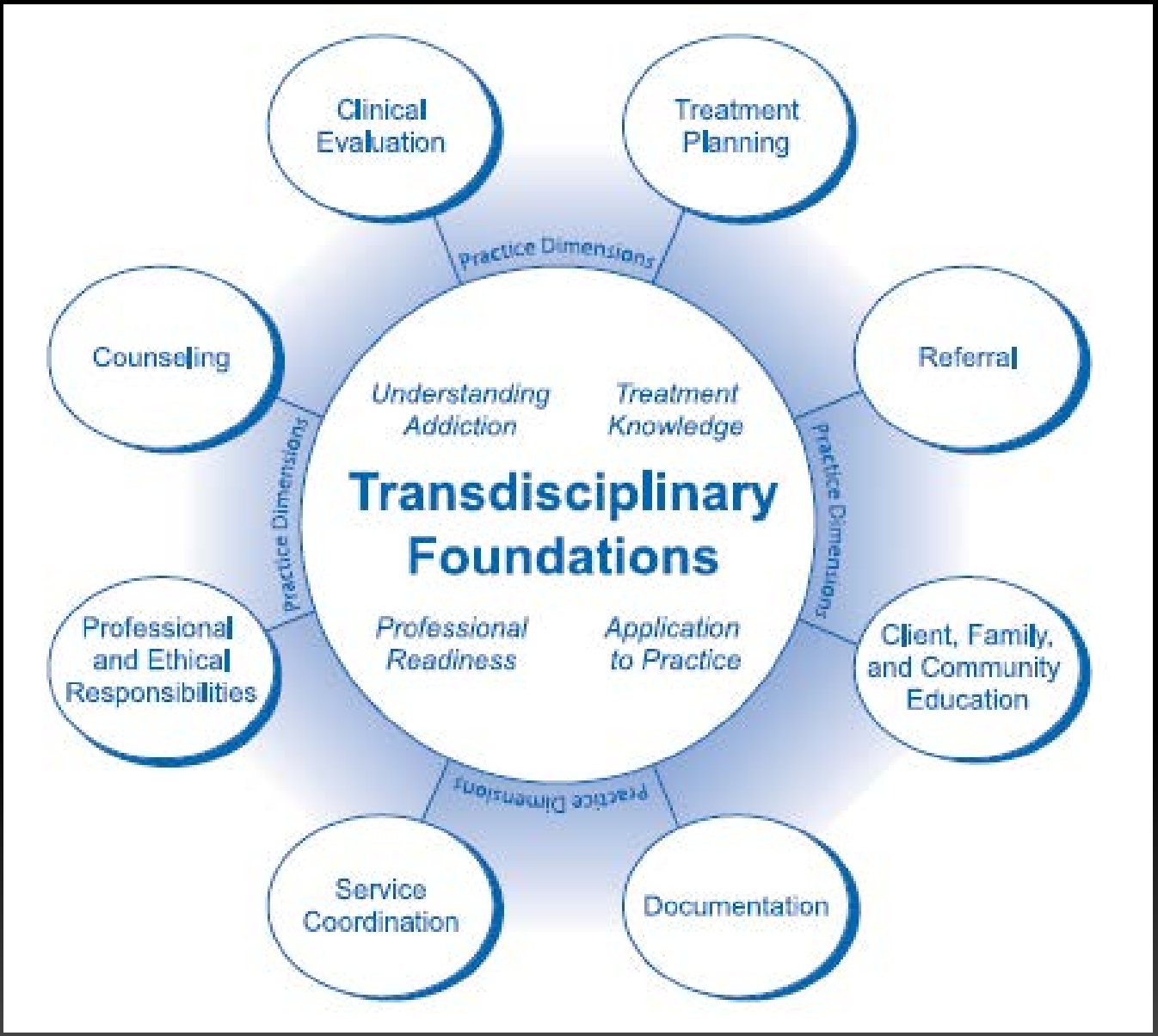
1. Screening
2. Intake
3. Orientation
4. Assessment
5. Treatment planning
6. Counseling
7. Case management*
8. Crisis intervention
9. Client education
10. Referral
11. Reports and record keeping
12. Consultation

Case Management

Activities intended to 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.

Source: Waters, 2005

COMPONENTS IN THE COMPETENCIES MODEL



COMPONENTS IN THE COMPETENCIES MODEL

STANDARDIZED CURRICULUM

- Professionalizing Addiction Counseling
- CAADE (California Association for Alcohol/Drug Studies)
  - *Guidelines for Alcohol/Drug Studies within Higher Education* (1985)
- National Addiction Studies Accreditation Commission (NASAC)
  - 2010

INTERNET RESOURCES

- California Association for Alcohol/Drug Educators: www.caade.org
- California Department of Alcohol and Drug Programs: www.adp.ca.gov
- Center for Substance Abuse Treatment: www.samhsa.gov/about/csat.aspx
- International Certification and Reciprocity Consortium: internationalcredentialing.org/
- International Coalition of Addiction Studies Education: www.incase.org
- National Association of Alcoholism and Drug Abuse Counselors: www.naadac.org
- National Addiction Studies Accreditation Commission: www.nasacaccreditation.com/
- Substance Abuse and Mental Health Services Administration Publication Ordering: www.store.samhsa.gov

VIDEOS/WEBCASTS

- *Imagine Who You Could Save*
  - *http://youtu.be/Ny5tahlSA5I*
- *Amazing Grace*
  - youtu.be/90cfMSqAj0o

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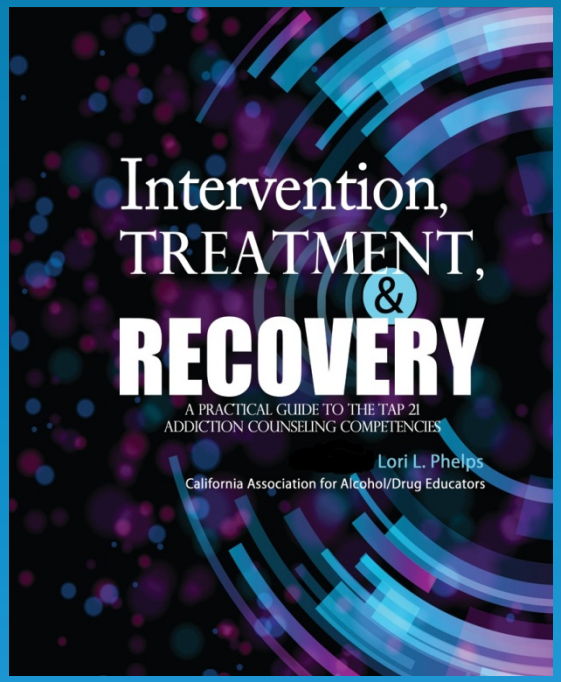

Chapter 2
TRANSDISCIPLINARY FOUNDATION I: UNDERSTANDING ADDICTION

Contributors: Barbara Lawrence, Lori Phelps

Kendall Hunt publishing company

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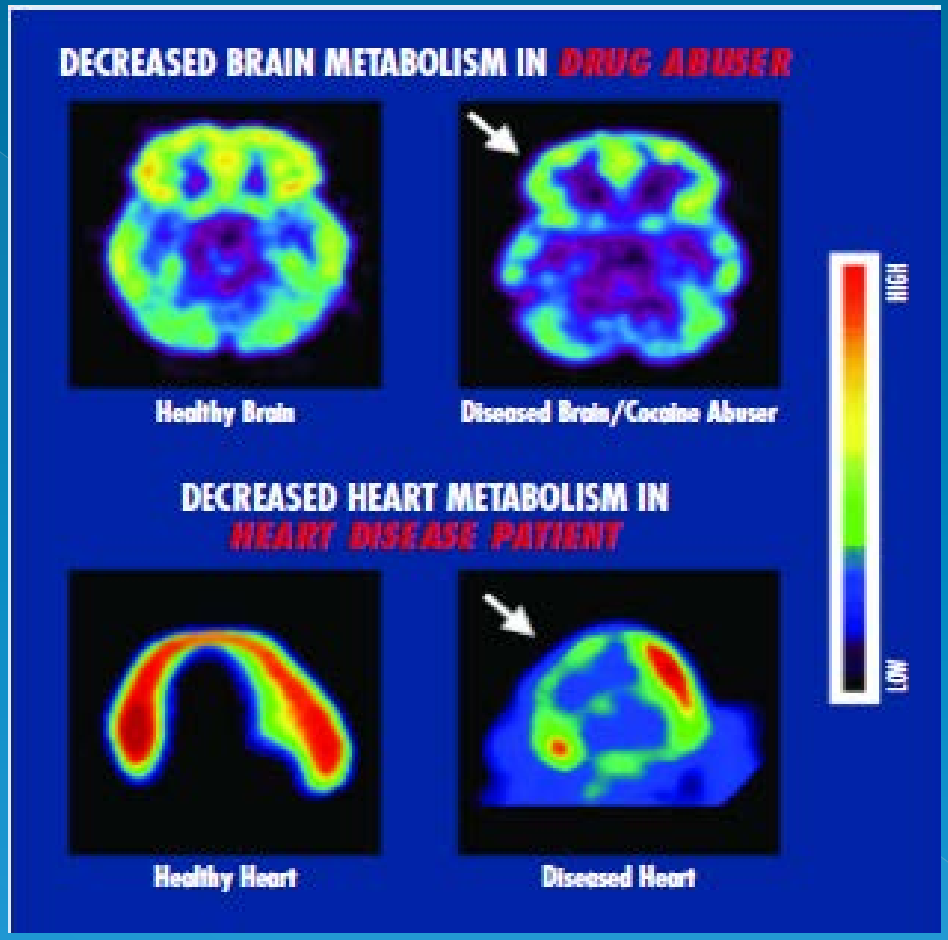
California Association for Alcohol/Drug Educators, 2013

COMPETENCY 1

- Understand a variety of models and theories of addiction and other problems related to substance use.
- What is Addiction?
  - *Addiction* is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences.
  - It is considered a brain disease because drugs change the brain—they change its structure and how it works. These brain changes can be long lasting, and can lead to the harmful behaviors seen in people who abuse drugs.

ADDICTION IS LIKE OTHER DISEASES



Source: From the laboratories of Drs. N. Volkow and H. Schelbert (National Institute on Drug Abuse, 2007)

THEORIES OF ADDICTION

Model	Causal Factors	Interventions
Moral	Personal responsibility, self-control	Moral suasion, social and legal sanctions
Temperance	Alcohol, drugs	"Just say no," supply reduction
Spiritual	Spiritual deficit	Spiritual growth, prayer, AA/NA
Dispositional Disease	Irreversible constitutional abnormality of individual	Self-identification as alcoholic/addict, lifelong abstinence
Educational	Lack of knowledge and motivation	Education
Characterological	Personality traits, defense mechanisms	Psychotherapy
Conditioning	Classical and operant conditioning	Counterconditioning, extinction, altered contingencies

THEORIES OF ADDICTION

Model	Causal Factors	Interventions
Social Learning	Modeling, skills deficits	Skills training, appropriate behavioral models
Cognitive	Expectancies, beliefs	Cognitive-behavioral therapy, rational restructuring
Sociocultural	Environmental, cultural norms	Social policy, price and distribution, controls
General Systems	Boundaries and rules, family dysfunction	Family therapy, transactional analysis
Biological	Heredity, brain physiology	Risk identification, genetic counseling, medication-assisted therapies
Public Health	Agent, host, environment	Interdisciplinary, multiple levels of simultaneous intervention

COMPETENCY 2

- *Recognize the social, political, economic, and cultural contexts within which addiction and abuse exist including risk and resiliency factors that characterize individuals and groups and their living environments.*

CULTURE & THE CRIMINAL JUSTICE SYSTEM

- 53% of people in state prisons and 45% of people in federal prisons meet the criteria for drug abuse or dependence.
- 16.6% of people in state prisons and 18.4% in federal prisons reported committing their crimes to obtain money for drugs.
- One in three people in state prisons reported using drugs at the time of their crime.
- 64% of people in state prisons who committed a property offense reported drug use in the month prior to arrest.

COMPETENCY 3

- *Describe the behavioral, psychological, physical health, and social effects of psychoactive substances on the person using and significant others*.
- Addiction affects all ages
  - Babies
  - Adolescents
  - Adults

MEDICAL CONSEQUENCES OF DRUG ABUSE

- HIV, Hepatitis and Other Infectious Diseases
- Cardiovascular Effects
- Respiratory Effects
- Gastrointestinal Effects
- Musculoskeletal Effects
- Kidney Damage
- Liver Damage
- Neurological Effects
- Mental Health Effects
- Hormonal Effects
- Cancer
- Prenatal Effects
- Other Health Effects
- Mortality

COMPETENCY 4

- *Recognize the potential for substance use disorders to mimic a variety of medical and mental health conditions, and the potential for medical and mental health conditions to coexist with addiction and substance abuse.*

COMORBIDITY / CO-OCCURRING DISORDERS

- Surveys show:
  - 6 out of 10 people with a substance use disorder also suffer from another form of mental illness
- Causality
  - Drug abuse can cause a mental illness
  - Mental illness can lead to drug abuse
  - Drug abuse and mental disorders are both caused by other common risks factors.

WHY DO SA & MI COMMONLY CO-OCCUR?

- Overlapping genetic vulnerabilities
- Overlapping environmental triggers
  - Stress, trauma (e.g., physical or sexual abuse), and early exposure to drugs
- Involvement of similar brain regions
- Drug abuse and mental illness are developmental disorders
  - Often begin in adolescence or childhood when the brain is undergoing dramatic developmental changes.

HOW COMMON ARE CO-OCCURRING DISORDERS?

- Compared with the general population:
  - Patients with mood or anxiety disorders are about twice as likely to also suffer from a drug disorder.
  - Patients with drug disorders are roughly twice as likely to be diagnosed with mood or anxiety disorders.

DIAGNOSIS AND TREATMENT

- Comprehensive approach that identifies, evaluates, and simultaneously treats both disorders
  - *Integrated treatment*
- Careful diagnosis and monitoring to ensure that symptoms related to drug abuse are not mistaken for a discrete mental disorder.
  - *Differential diagnosis*

INTERNET RESOURCES

- Behavenet.com
  - www.behavenet.com/
- Glossary of Drug Terms (CNS Productions) www.cnsproductions.com/index.php?option=com_glossary&Itemid=26
- Drugs, Brains & Behavior: The Science of Addiction (NIDA) www.drugabuse.gov/scienceofaddiction/

VIDEOS/WEBCASTS

- *Moyers on Addiction: Close to Home*
  - http://www.thirteen.org/closetohome/home.html
- *This Emotional Life*
  - *http://video.pbs.org/program/this-emotional-life/#*

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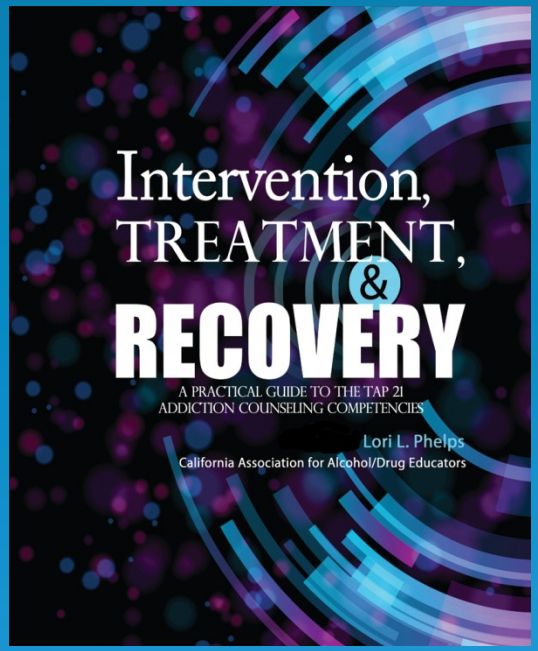

Chapter 3
TRANSDISCIPLINARY FOUNDATION II: TREATMENT KNOWLEDGE

Contributor: Lori Phelps

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Chapter Competencies

- Competency 5
  - Philosophies, Practices, Policies & Outcomes
- Competency 6
  - Family, Social Networks & Community Systems
- Competency 7
  - Research & Outcome Data
- Competency 8
  - Interdisciplinary Approach to Addiction Treatment

Competency 5

Describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related problems.

- **Scientifically Supported Models of Treatment**
  - Pharmacotherapies
  - Behavioral Therapies
  - Approaches Used by Substance Abuse Treatment Facilities

PHARMACOTHERAPIES

- Opioid Addiction
  - Methadone
  - Buprenorphine
  - Naltrexone
- Tobacco Addiction
  - Nicotine Replacement Therapy (NRT)
    - Electronic Cigarettes, gum, patches
  - Bupropion (Zyban®)
  - Varenicline (Chantix®)
- Alcohol Addiction
  - Naltrexone
  - Acamprosate (Campral®)
  - Disulfiram (Antabuse®)
  - Topiramate (Topamax®)

BEHAVIORAL THERAPIES

- Cognitive Behavioral Therapy
- Community Reinforcement Approach Plus Vouchers
- Contingency Management Interventions & Motivational Incentives
- Motivational Enhancement Therapy
- The Matrix Model
  - Stimulants
- 12-Step Facilitation Therapy

Clinical or Therapeutic Approaches Used by Substance Abuse Treatment Facilities

In Brief

- In 2009, the majority of substance abuse treatment facilities always or often used substance abuse counseling (96%), relapse prevention (87%), cognitive-behavioral therapy (66%), 12-step facilitation (56%), and motivational interviewing (55%).
- More than one third of facilities always or often used anger management (39%) or brief intervention (35%). More than one quarter always or often used contingency management/motivational incentives (27%). More than one fifth always or often used trauma-related counseling (21%).
- More than half of all facilities either rarely or never used or were not familiar with community reinforcement plus vouchers (86%), Matrix Model (63%), or rational emotive behavioral therapy (51%).

BEHAVIORAL THERAPIES

- Behavioral Couples Therapy
- Behavioral Treatments for Adolescents
- Multisystemic Therapy
- Multidimensional Family Therapy for Adolescents
- Brief Strategic Family Therapy

Competency 6

Recognize the importance of family, social networks, and community systems in the treatment and recovery process.

- Families often do not understand substance use disorders or recovery
- Family education and opportunities to express their concerns during the recovery process are critical

Family Education Groups

- **Goals**
  - Present accurate information about addiction, recovery, treatment, and the resulting interpersonal dynamics.
  - Help clients and family members understand how the recovery process may affect current and future family relationships.
  - Provide a forum for families to discuss recovery issues.
  - Present accurate information about the effects of drugs.
  - Teach, promote, and encourage clients' family members to care for themselves while supporting clients in their recovery.
  - Provide a professional atmosphere in which clients and their families are treated with dignity and respect.
  - Encourage participants to get to know other recovering people and their families in a comfortable and nonthreatening environment

Competency 7

Understand the importance of research and outcome data and their application in clinical practice.

- Evidence-Based Practice (or Best Practice) Defined
  - Approaches to prevention or treatment that are validated by some form of documented scientific evidence.
  - Evidence often is defined as findings established through scientific research
  - Evidence-based practice stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence (SAMHSA OAS, 2010).

Multiple Streams of Evidence Approach

- **Best research evidence:** supporting clinically relevant research, especially patient-centered research
- **Clinician expertise:** using clinical skills and past experience to identify and treat the individual client
- **Patient values:** integrating the preferences, concerns, and expectations that each client brings to the clinical encounter into treatment planning (Institute of Medicine)

MULTIPLE STREAMS OF EVIDENCE

EVIDENCE-BASED THINKING

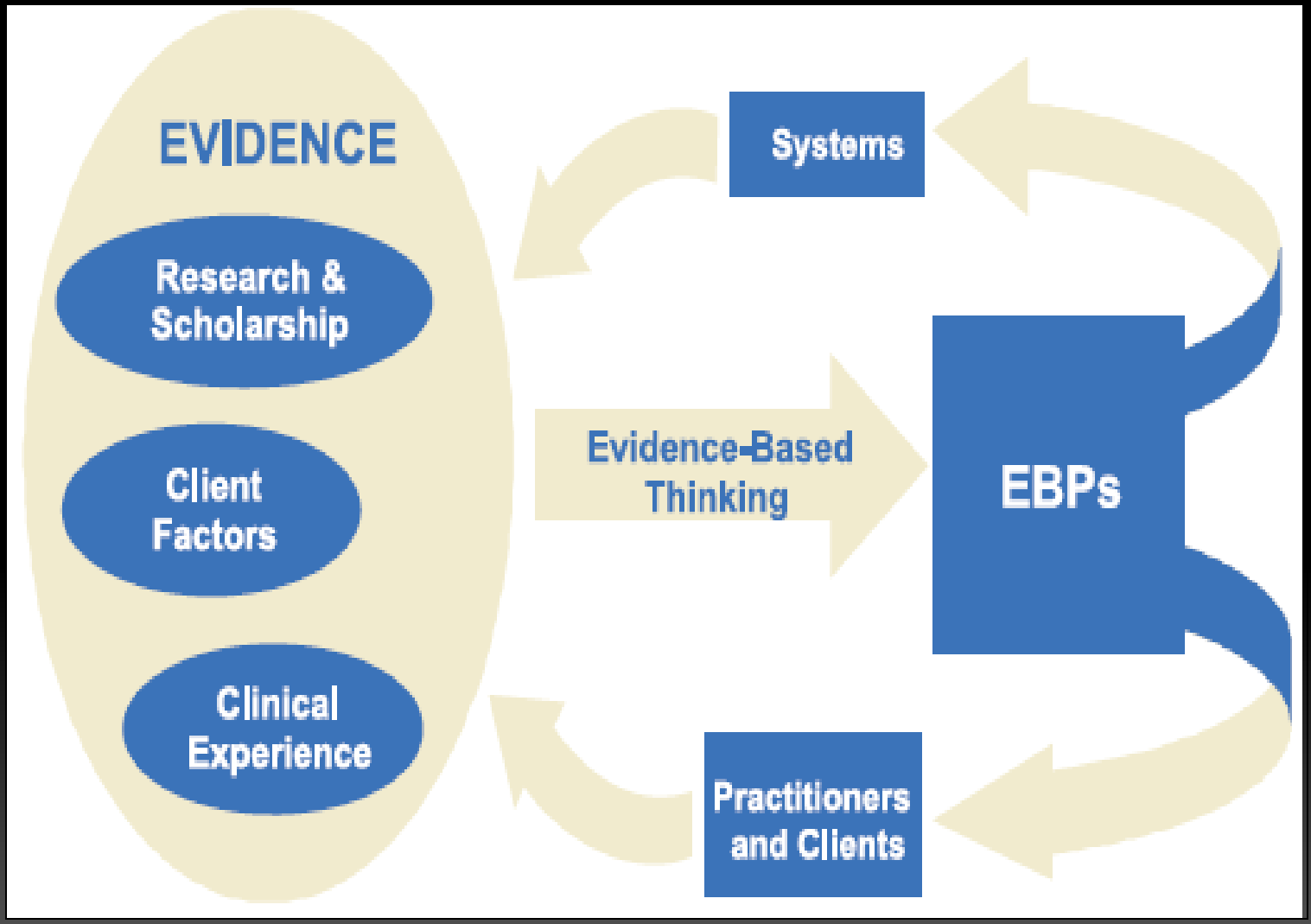

Figure 3.2: Evidence-Based Thinking

Source: CSAT (2007)

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California Association for Alcohol/Drug Educators, 2013

Competency 7 continued

- Why implement EBPs?
  - EBPs can help overcome the financial and organizational challenges that make change so difficult
- Implementing EPBs may:
  - Improve client outcomes
  - Increase access to effective treatment
  - Engage staff
  - Improve operating margins
  - Save time
  - Transform organizations from reactive to responsive
  - Provide justification for funding

Competency 8

Understand the value of an interdisciplinary approach to addiction treatment

- **PRINCIPLES OF EFFECTIVE TREATMENT** (interdisciplinary)
  - Addiction is a complex but treatable disease that affects brain function and behavior.
  - No single treatment is appropriate for everyone.
  - Treatment needs to be readily available.
  - Effective treatment attends to multiple needs of the individual, not only his or her drug abuse.
  - Remaining in treatment for an adequate time is critical.
  - Counseling—individual and/or group—and other behavioral therapies are the most commonly used forms of drug abuse treatment.

Principles of Effective Treatment (continued)

- Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
- An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.
- Many drug-addicted persons have other mental disorders.
- Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.
- Treatment does **not** need to be voluntary to be effective.
- Drug use during treatment must be monitored continuously, as lapses during treatment do occur.
- Treatment programs should assess patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling to help patients modify or change behaviors that place them at risk of contracting or spreading infectious diseases (NIDA, 2009).

INTERNET RESOURCES

- ***The Change Book: A Blueprint for Technology Transfer***
  http://www.nattc.org/pdf/The_Change_Book_2nd_Edition.pdf
- **National Registry of Evidence-Based Programs and Practices (NREPP)**
  http://nrepp.samhsa.gov/

Videos/Webcasts

Research to Practice: How Advancements in Science Are Helping People with Mental and Substance Use Disorders

- http://store.samhsa.gov/product/Research-to-Practice-How-Advancements-in-Science-Are-Helping-People-with-Mental-and-Substance-Use-Disorders/SMA12-4673DVD

Videos/Webcasts

- Addiction and the Family: Healing and Recovery http://store.samhsa.gov/product/Addiction-and-the-Family-Healing-and-Recovery-DVD-/DVD252

Replaces Tables 4.1 and 4.2, and narrative between the tables (pp. 66-67). Add Table 4.3

DSM-5 SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

Substance Use Disorder

Substance use disorder in DSM-5 combines the DSM-IV categories of substance abuse and substance dependence into a single disorder measured on a continuum from mild to severe. Ten classes of substances are included in DSM-5 (see Table 4.1). Each specific substance (other than caffeine, which cannot be diagnosed as a substance use disorder) is addressed as a separate use disorder (e.g., alcohol use disorder, stimulant use disorder, etc.), but nearly all substances are diagnosed based on the same overarching criteria. Mild substance use disorder in DSM-5 requires two to three symptoms from a list of 11; moderate substance use disorder requires four to five symptoms; severe substance use disorder requires six or more symptoms (see Table 4.2).

Addictive Disorders

Gambling disorder is the only addictive disorder included in DSM-5 as a diagnosable condition (Table 4.1). Internet gaming disorder is included in Section III of the manual. Disorders listed there require further research before their consideration as formal disorders.

10 Classes of Substances in DSM-5	Addictive Disorders

• Alcohol
• Caffeine
• Cannabis
• Hallucinogens
  o PCP
  o others
• Inhalants
• Opioids
• Sedatives, hypnotics, and anxiolytics
• Stimulants
• Tobacco
• Other
	• Gambling

Table 4.1: Substance Classes and Addictive Disorders in DSM-5
Source: APA, 2013

Diagnostic Criteria for Substance Use Disorders in DSM-5
• Using larger amounts or using for a longer time than intended • Persistent desire or unsuccessful attempts to cut down or control use • Great deal of time is spent obtaining, using, or recovering • Craving or a strong desire or urge to use • Failure to fulfill major roles at work, school, or home • Persistent social or interpersonal problems caused by substance use • Important social, occupational, recreational activities given up or reduced • Use in physically hazardous situations • Use despite physical or psychological problems caused by use • Tolerance • Withdrawal (not documented after repeated use of PCP, inhalants, hallucinogens)
Severity Criteria
› Mild: 2-3 symptoms › Moderate: 4-5 symptoms › Severe: 6 or more symptoms

4.2: Diagnostic Criteria and Severity Index for Substance-Related Disorders in DSM-5

Substance-Induced Disorders in DSM-5
• Intoxication • Withdrawal • Psychotic Disorder • Bipolar Disorder • Depressive Disorder • Anxiety Disorder • Sleep Disorder • Delirium • Neurocognitive • Sexual Dysfunction

4.3: Substance-Induced Disorder in DSM-5

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

DSM-5 Fact Sheet: http://www.dsm5.org/Documents/Substance%20Use%20Disorder%20Fact%20Sheet.pdf

INTERNET RESOURCES

DSM-5: http://www.dsm5.org

Psychiatry.org: http://www.psychiatry.org/practice/dsm

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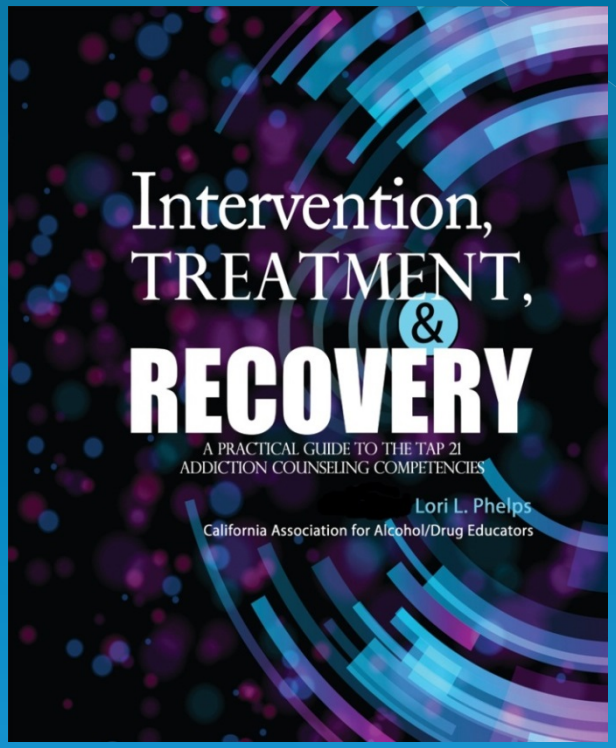

Chapter 4
TRANSDISCIPLINARY FOUNDATION III:
APPLICATION TO PRACTICE

Contributor: Lori Phelps

Kendall Hunt publishing company

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California Association for Alcohol/Drug Educators, 2013

Competency 9:

Understand the established diagnostic criteria for substance use disorders, and describe treatment modalities and placement criteria within the continuum of care.

- Substance-Related and Addictive Disorders
- **Diagnostic and Statistical Manual of Mental Disorders 5th edition, (DSM-5)**

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California Association for Alcohol/Drug Educators, 2013

DSM-5: Substance-Related and Addictive Disorders

- 10 classes of substances
- Addictive Disorders = Gambling
- Substance-related disorders divided into two groups:
  1. Substance Use Disorders
     - Previously split into abuse or dependence
     - Involves: impaired control, social impairment, risky use, and pharmacological criteria
  2. Substance-Induced Disorders

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Diagnostic Criteria Related to Substance Use Disorders

- *". . .a cluster of cognitive, behavioral, and psychological symptoms indicating that the individual continues using the substance despite significant substance-related problems."*
- *"A pathological pattern of behaviors related to the use of the substance."*

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10 Classes of Substances

- Alcohol
- Caffeine
- Cannabis
- Hallucinogens
  - PCP
  - others
- Inhalants
- Opioids
- Sedatives, hypnotics, and anxiolytics
- Stimulants
- Tobacco
- Other

Gambling

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Substance Use Disorder Dx Criteria

- Using larger amounts or for longer time than intended
- Persistent desire or unsuccessful attempts to cut down or control use
- Great deal of time is spent obtaining, using, or recovering
- Craving or a strong desire or urge to use
- Failure to fulfill major roles at work, school, or home
- Persistent social or interpersonal problems caused by substance use

Substance Use Dx Criteria (continued)

- Important social, occupational, recreational activities given up or reduced
- Use in physically hazardous situations
- Use despite physical or psychological problems caused by use
- Tolerance
- Withdrawal (not documented after repeated use of PCP, inhalants, hallucinogens)

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Severity: Mild, Moderate, Severe

- Severity
  - Depends on # of symptom criteria experienced
  - Mild: 2-3 symptoms
  - Moderate: 4-5 symptoms
  - Severe: 6 or more symptoms

Substance-Induced Disorders

- Intoxication
- Withdrawal
- Psychotic Disorder
- Bipolar Disorder
- Depressive Disorder
- Anxiety Disorder
- Sleep Disorder
- Delirium
- Neurocognitive
- Sexual Dysfunction

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Competency 10:

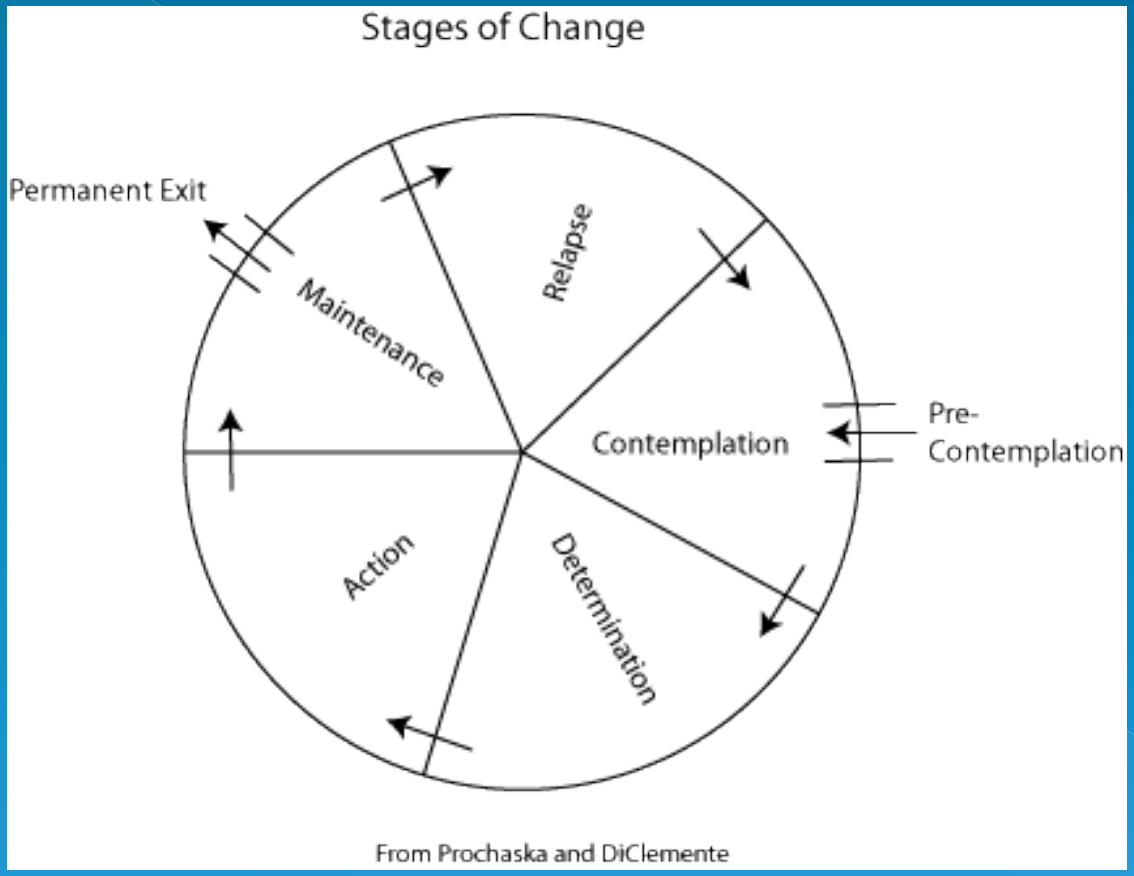
Describe a variety of helping strategies for reducing the negative effects of substance use, abuse, and dependence.

Competency 11:

Tailor helping strategies and treatment modalities to the client's stage of dependence, change, or recovery.

Stages of Change

Prochaska & DiClemente



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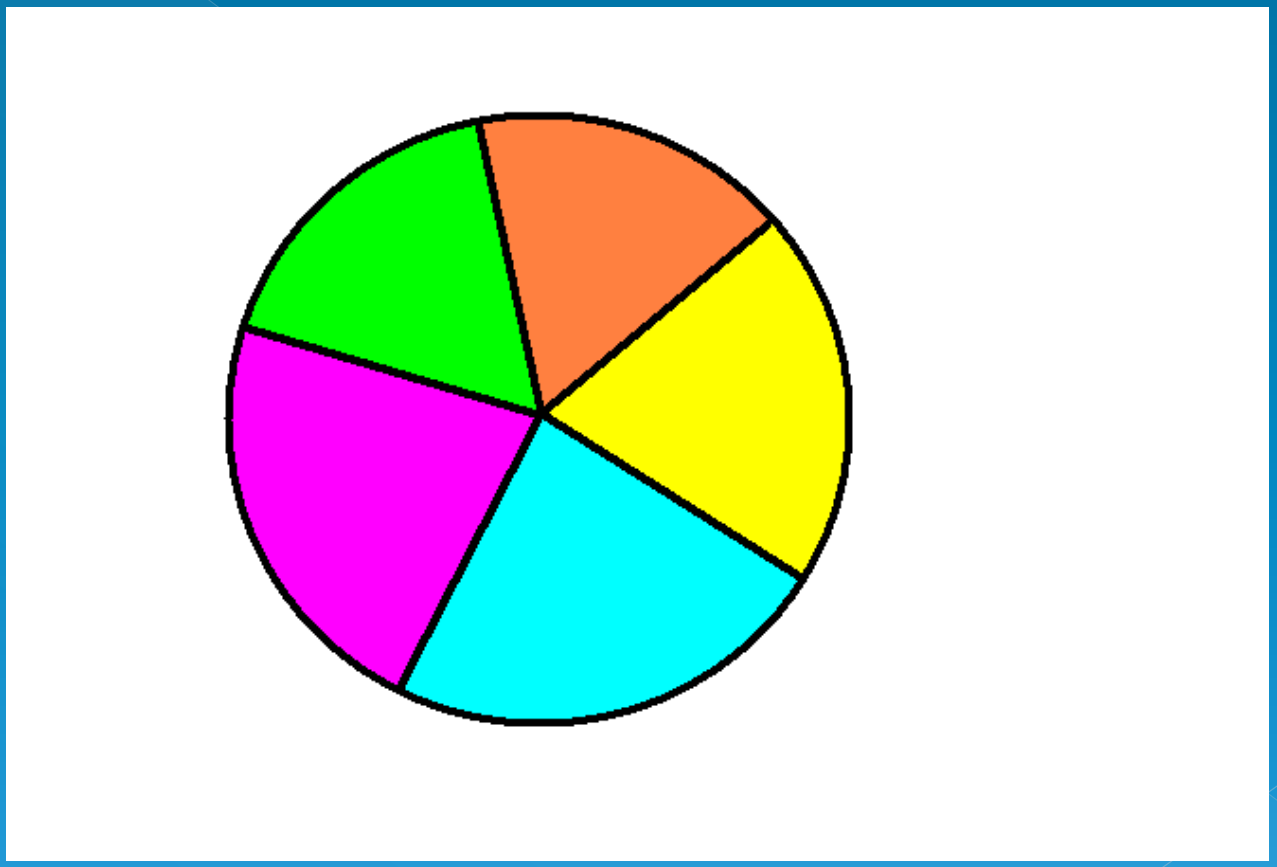
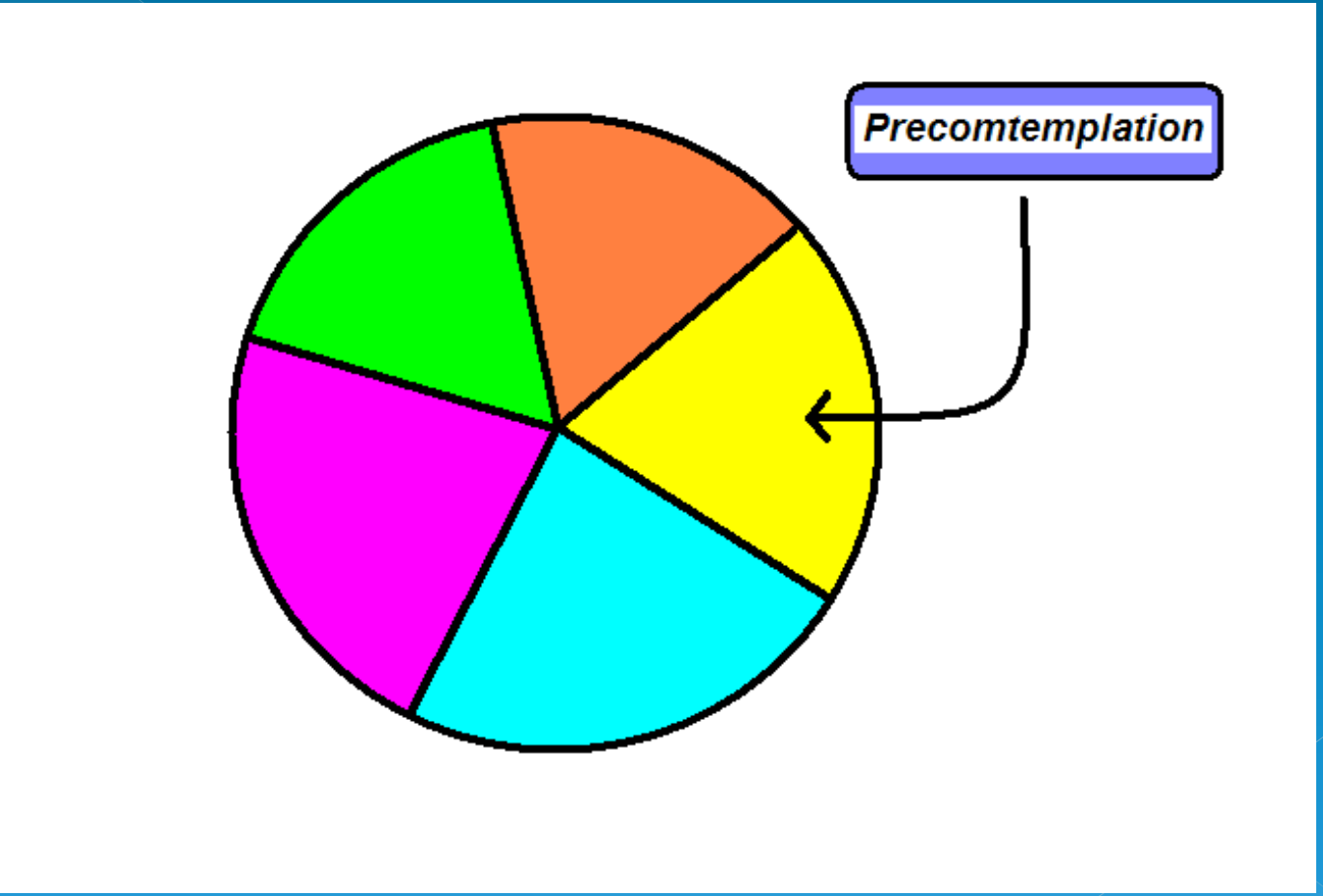
Prochaska and DiClemente's Stages of Change "Wheel"

The stages describe a person's motivational readiness or progress towards modifying the problem behavior



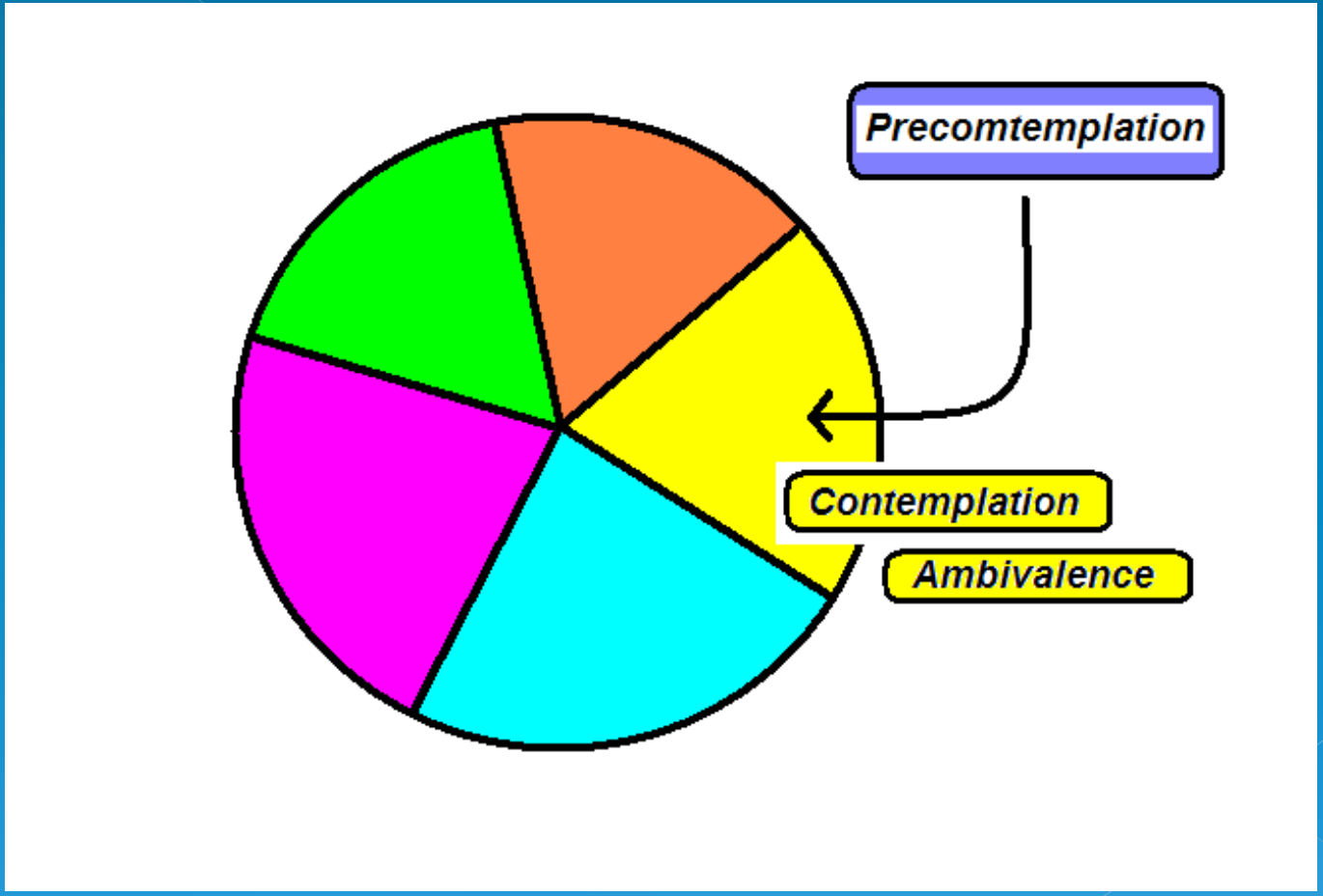
Precontemplation:

Not considering quitting in the next 6 months



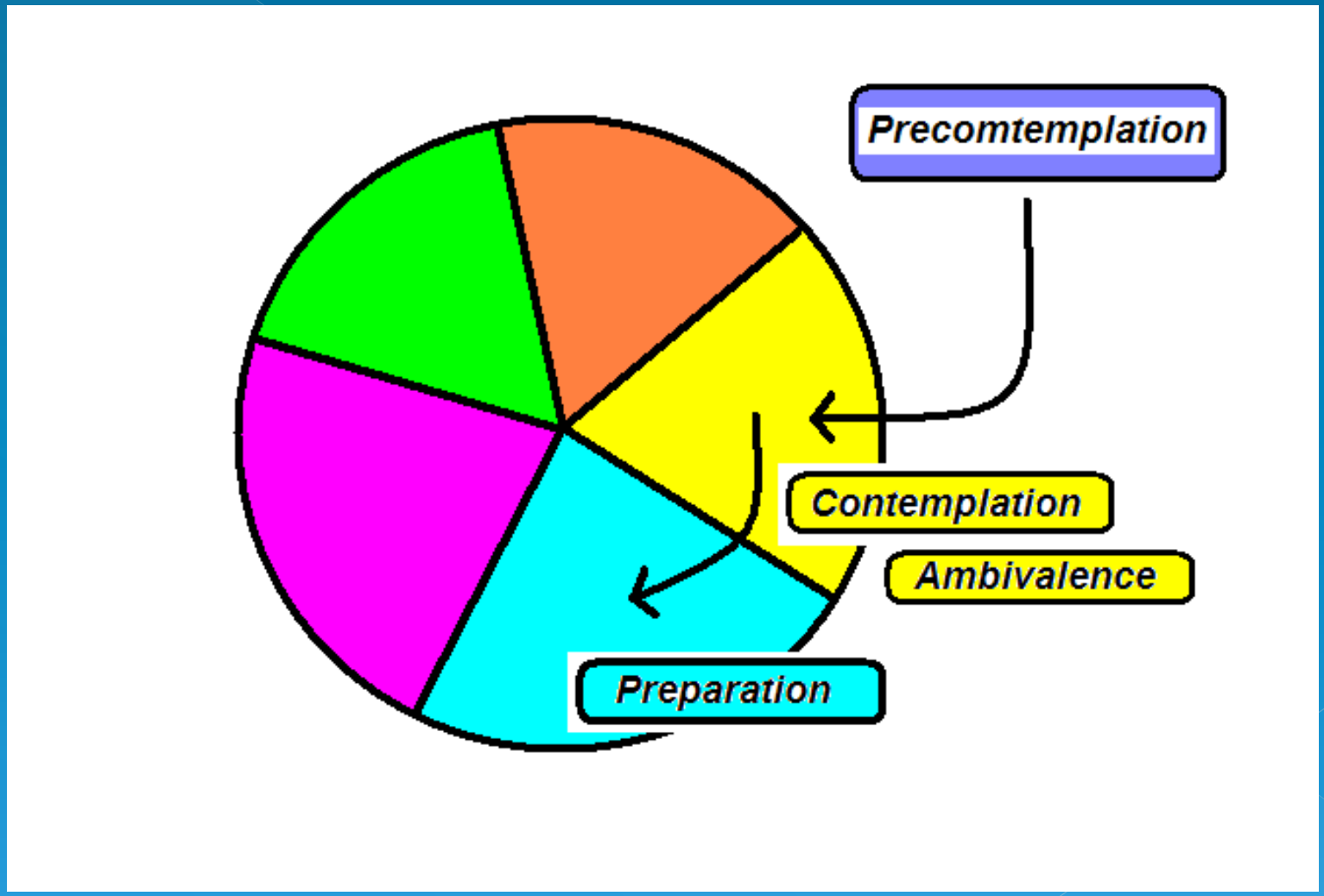
Contemplation: ambivalence

Seriously considering quitting in the next 6 months



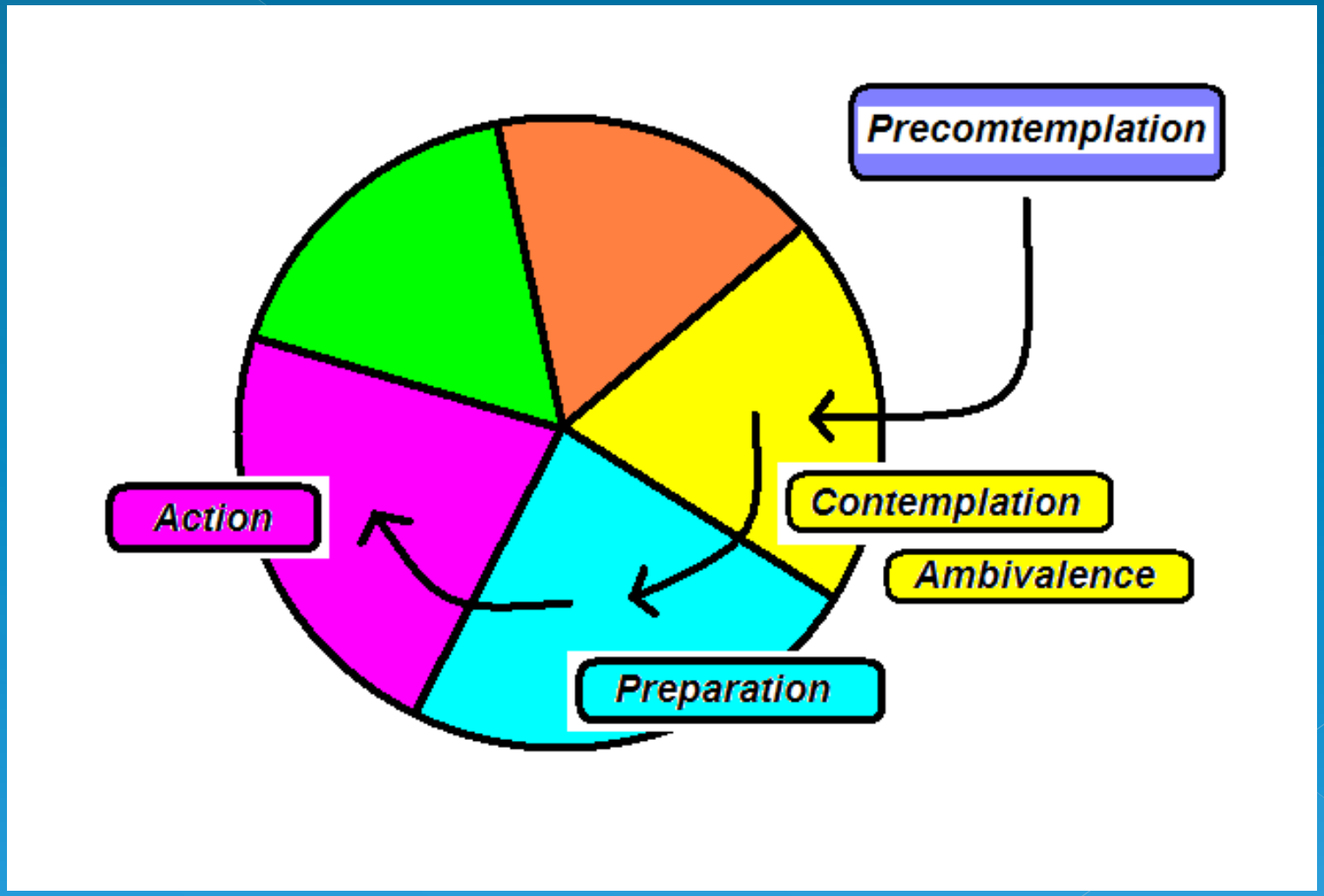
Preparation: readiness increases

Planning to quit in the next 30 days



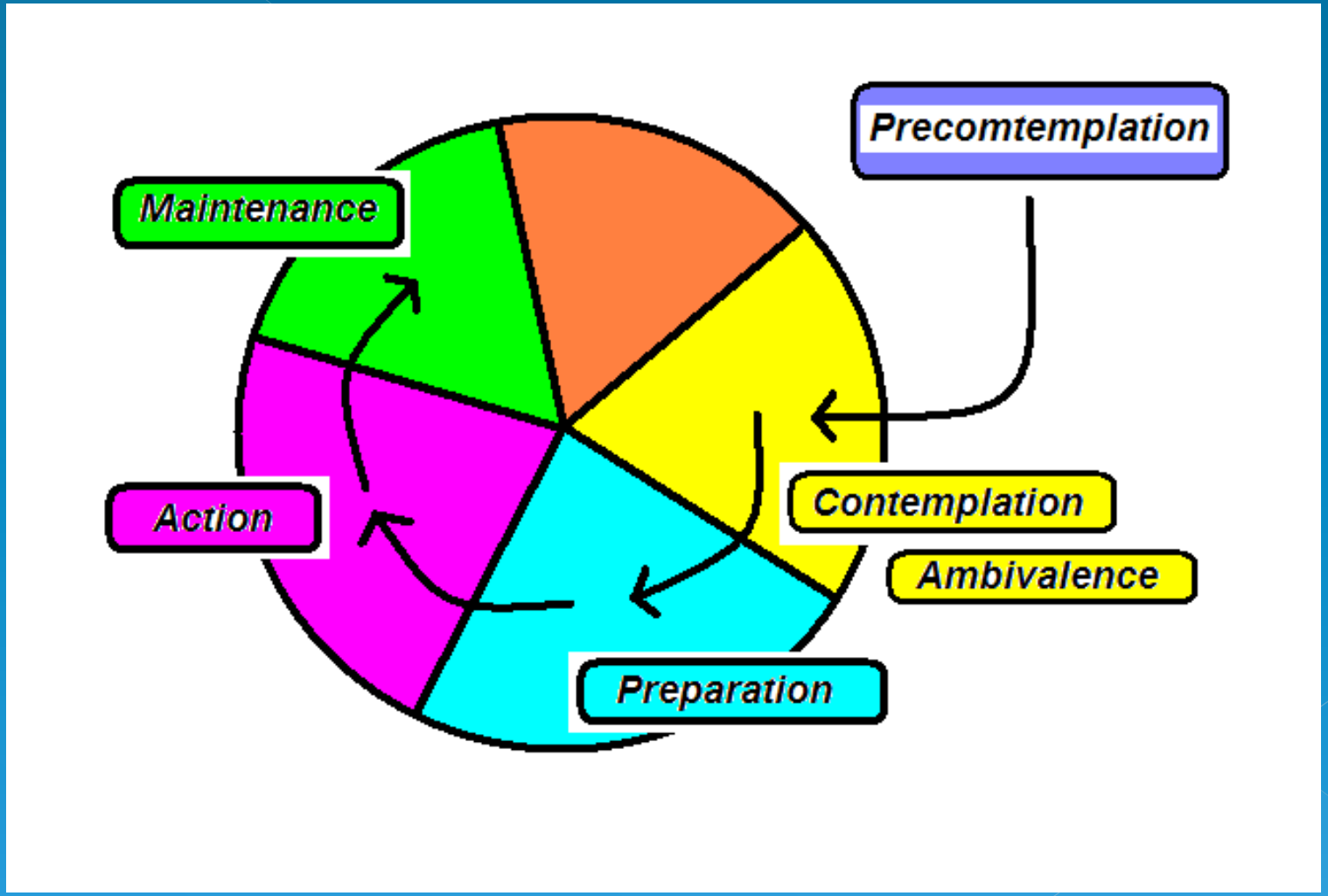
Action: change underway

The first 6 months of staying quit

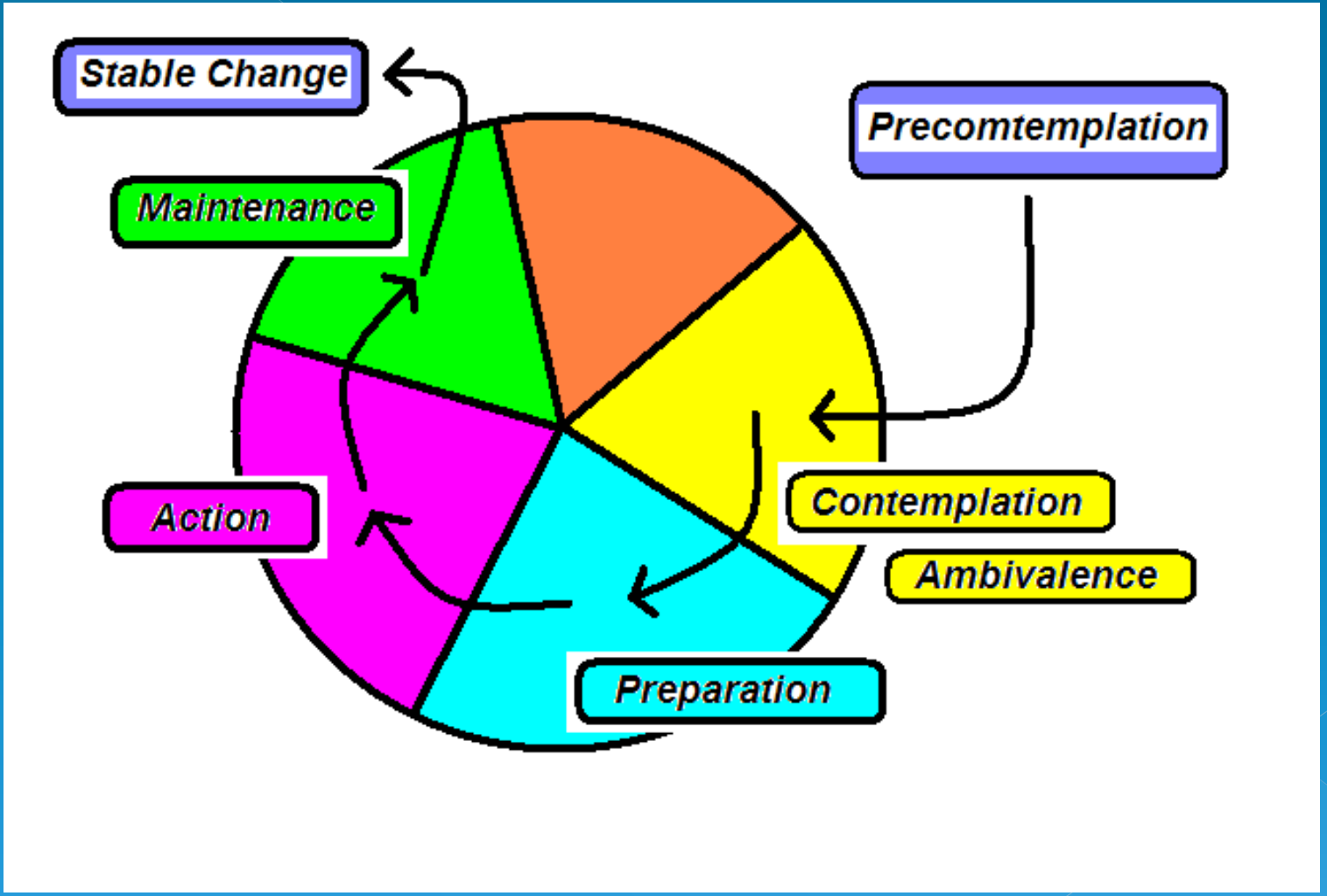


Maintenance: relapse prevention

Staying quit for more than 6 months

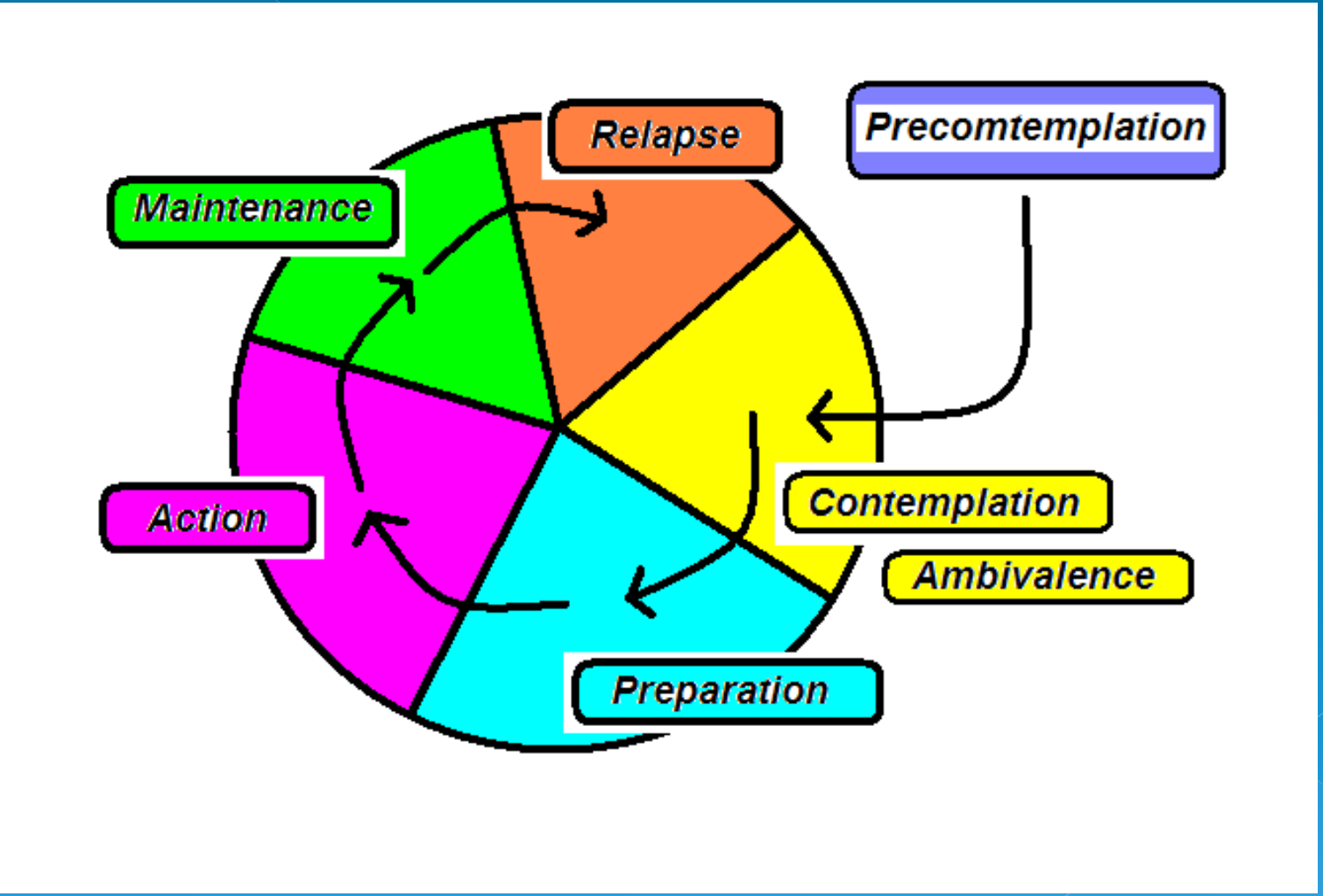


Stable Change (aka Termination):

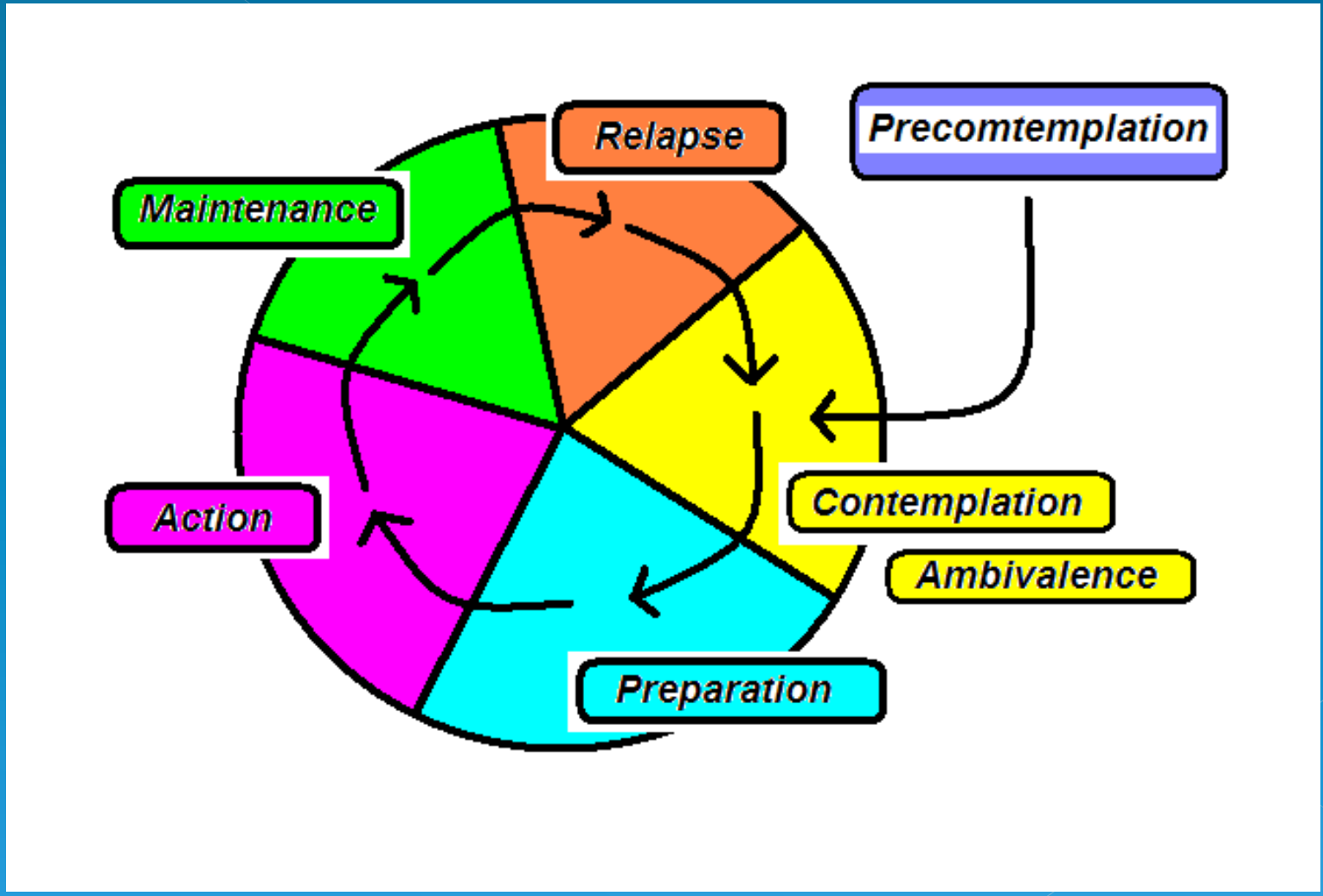


Relapse: ("Do Not Panic!")

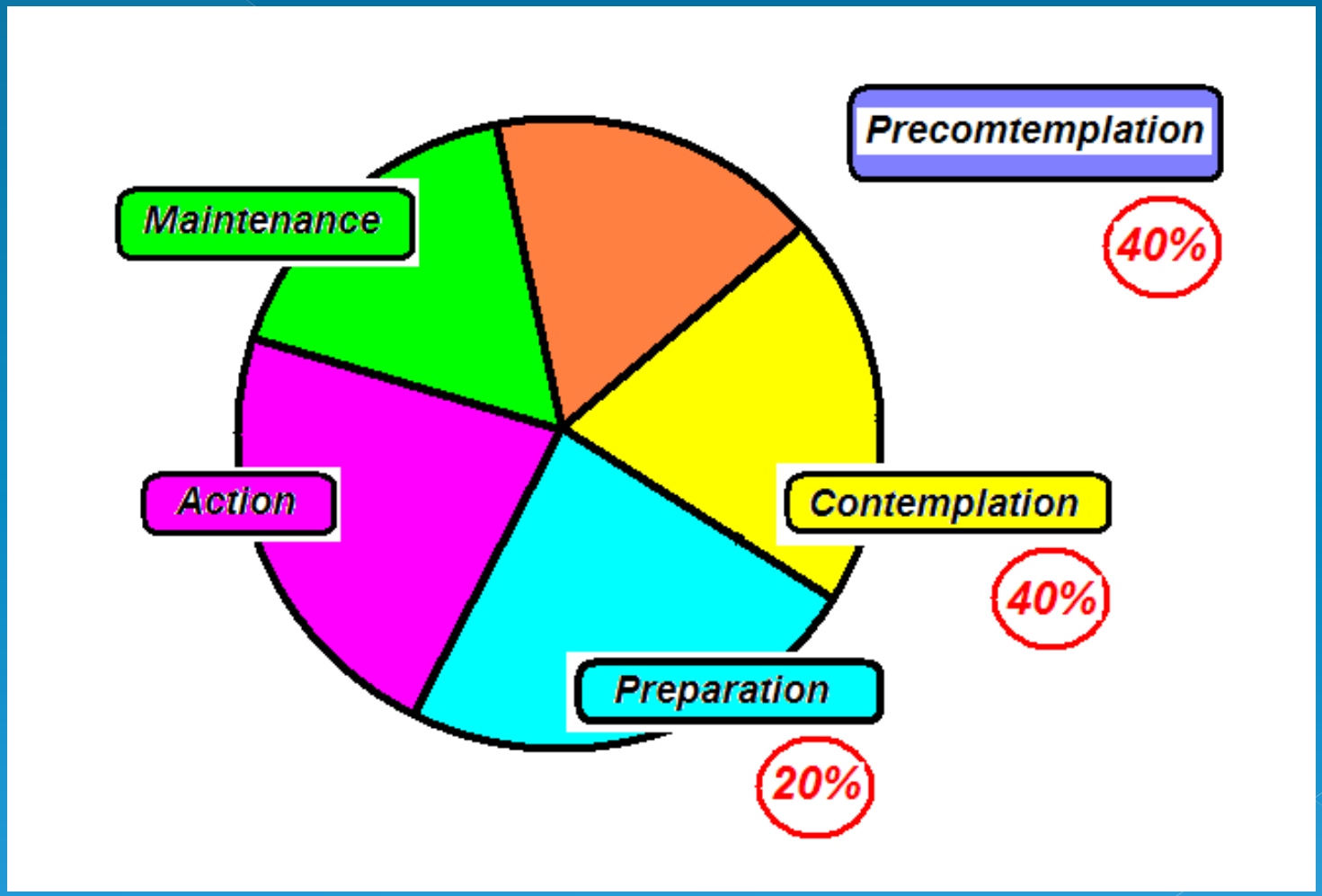
Transition to an earlier stage



Relapse: rapid re-entry to change



Stage of Change Distribution:



Competency 12

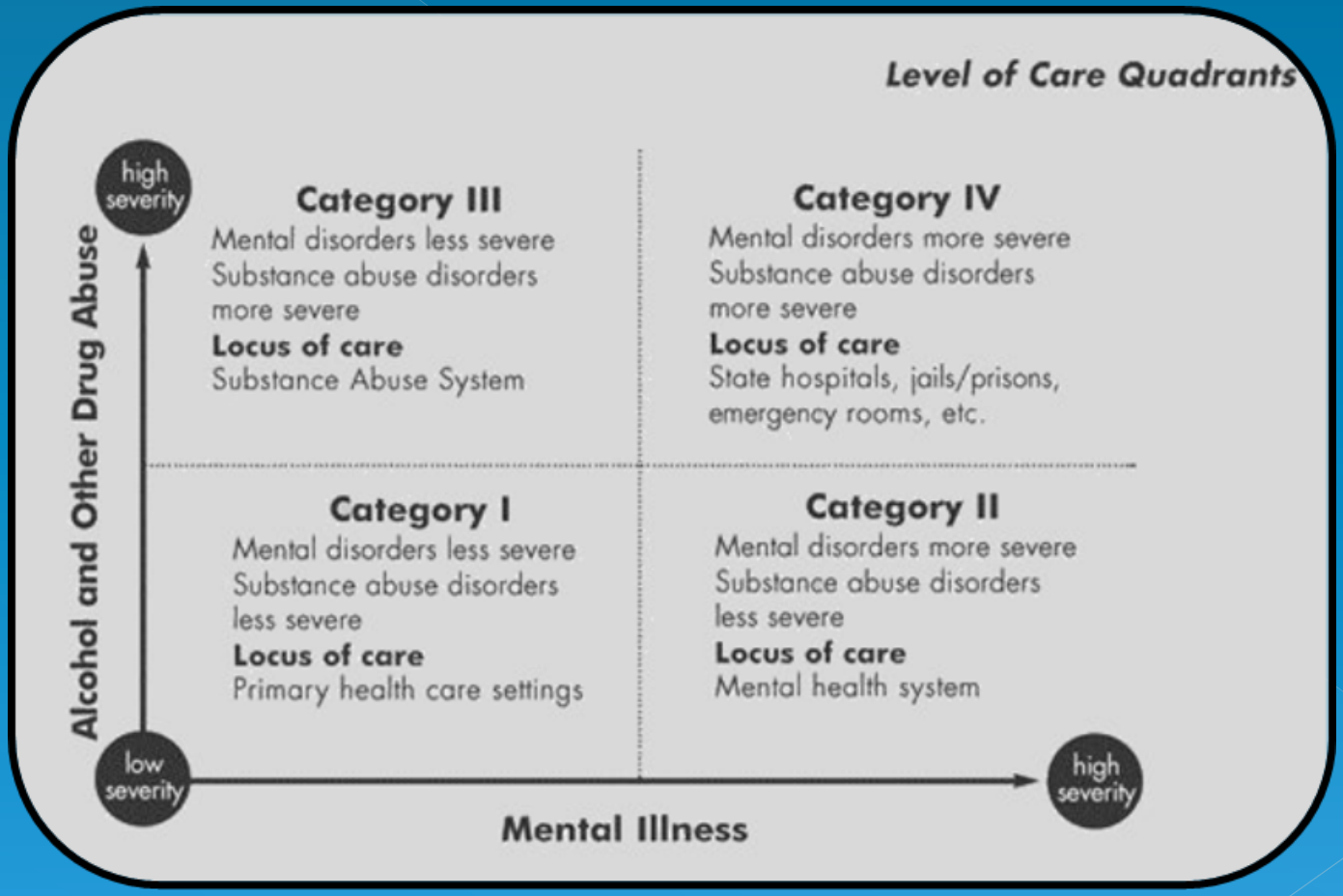
- *Provide treatment services appropriate to the client's personal and cultural identity and language.*

Culturally Appropriate Treatment

- Cultural factors include:
  - Heritage, history and experience, beliefs, traditions, values, customs
- Cultural competence may be viewed on a continuum:
  - *Cultural sensitivity*
  - *Cultural competence*
  - *Cultural proficiency*

Competency 13

- *Adapt practice to the range of treatment settings and modalities*



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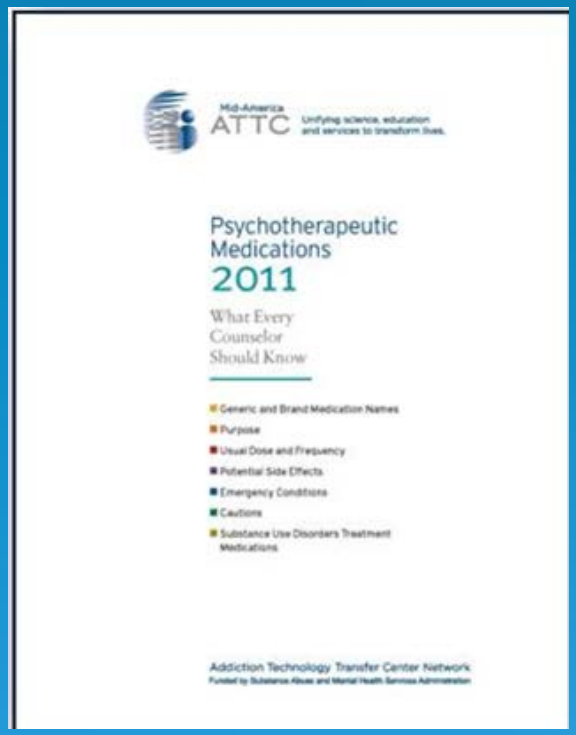
Competency 14

- *Be familiar with medical and pharmacological resources in the treatment of substance use disorders.*



Psychotherapeutic Medications 2011: What Every Counselor Should Know
http://www.findrxinformation.org/pdf/Psychomeds_2011.pdf

Searchable Rx database online
http://www.findrxinformation.org/

Competency 15

Understand the variety of insurance and health maintenance options available and the importance of helping clients access those benefits.

- **Federal Parity Law**
  - requires group health insurance plans (with 50 or more insured employees) *that offer coverage for mental illness and substance use disorders* to provide those benefits in a way that is no more restrictive than all other medical and surgical procedures covered by the plan.

Competency 16

Recognize that crisis may indicate an underlying substance use disorder and may be a window of opportunity for change.

- ***Brief Interventions***
  - *Short, problem-specific approaches*
  - *Used from risk to dependence*
  - *Help clients reduce or stop abuse*

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Knowledge and Skills for Brief Interventions

- Overall attitude of understanding and acceptance
- Counseling skills such as active listening and helping clients explore and resolve ambivalence
- A focus on intermediate goals
- Working knowledge of the stages-of-change model

Three Steps In Active Listening

1. *Listen* to what the client says.
2. *Form a reflective statement.* To reflect your understanding, repeat in your own words what the client said.
3. *Test the accuracy of your reflective statement.* Watch, listen, and/or ask the client to verify the accuracy of the content, feeling, and/or meaning of the statement.

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Competency 17

Understand the need for and use of methods for measuring treatment outcome

- Effective, Evidence-Based Substance Abuse Services
  - Demonstrable, positive outcomes in terms of lowering recidivism, increasing victim satisfaction, or decreasing expenditures
- Critical to improving outcomes, maximizing investment, and building support for further expansion of services

Internet Resources

- **The Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT** http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345
- **DSM-5:** www.dsm5.org/
  - http://www.psychiatry.org/dsm5
- SAMHSA's **National Registry of Evidence Based Programs and Practices** http://nrepp.samhsa.gov/

Videos/Webcasts

- **Addiction by Prescription** http://store.samhsa.gov/product/Addiction-by-Prescription-DVD-/DVD182
- **Co-Occurring Disorders** (introductory video) http://youtu.be/nLseAvC8Heo
- ***Methadonia*** http://youtu.be/M7P-QZqbr8

Exercises/Activities

- From TIP 35, *Brief Interventions and Brief Therapies for Substance Abuse*. Appendix D – Health Promotion Workbook http://www.ncbi.nlm.nih.gov/books/NBK64955/

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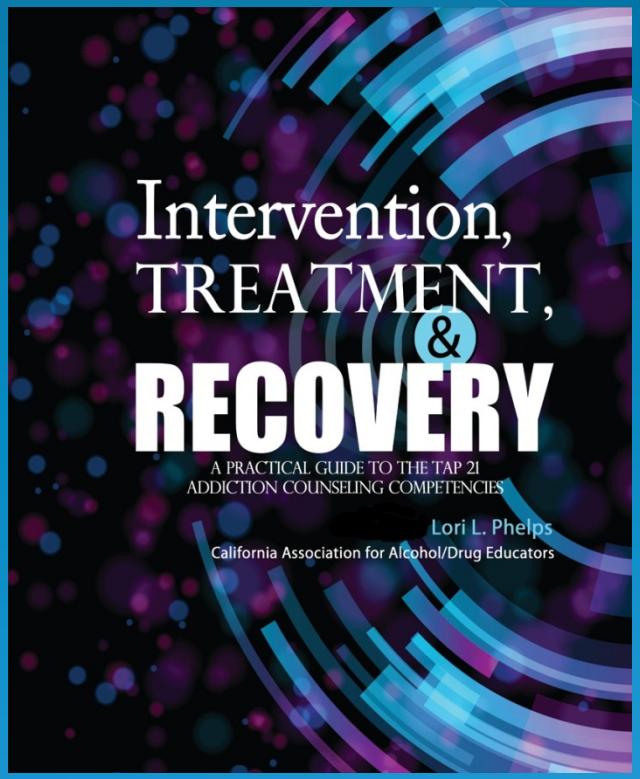

Chapter 5
TRANSDISCIPLINARY FOUNDATION IV: PROFESSIONAL READINESS

Contributors: Jack Kearney, Lori Phelps

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California Association for Alcohol/Drug Educators, 2013

What is Professional Readiness?

- Academic performance is crucial
- Other interpersonal and professional skills are equally important
- The competencies outlined in chapter 5 provide a framework for counselors and offer the student a range of professional readiness indicators to consider when assessing their own readiness to practice.

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Competency 18:

Understand diverse cultures and incorporate the relevant needs of culturally diverse groups as well as people with disabilities into clinical practice.

Cultural Competence

- A set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups

Competency 19

Understand the importance of self-awareness in one's personal, professional, and cultural life.

- **Self-Care and Stress Management**
  - Stress is an elevation in a person's state of arousal or readiness, caused by some stimulus or demand.

Common Stress Reactions

- Behavioral
- Physical
- Psychological/Emotional
- Thinking
- Social

Behavioral Stress Reactions

- Increase or decrease in activity level
- Substance use or abuse (alcohol or drugs)
- Difficulty communicating or listening
- Irritability, outbursts of anger, frequent arguments
- Inability to rest or relax
- Decline in job performance; absenteeism
- Frequent crying
- Hyper-vigilance or excessive worry
- Avoidance of activities or places that trigger memories
- Accident-prone

Physical Stress Reactions

- Gastrointestinal problems
- Headaches, other aches and pains
- Visual disturbances
- Weight loss or gain
- Sweating or chills
- Tremors or muscle twitching
- Being easily startled
- Chronic fatigue or sleep disturbances
- Immune system disorders

Psychological/Emotional Stress Reactions

- Feeling heroic, euphoric, or invulnerable
- Denial
- Anxiety or fear
- Depression
- Guilt
- Apathy
- Grief

Thinking Stress Reactions

- Memory problems
- Disorientation and confusion
- Slow thought processes; lack of concentration
- Difficulty setting priorities or making decisions
- Loss of objectivity

Social Stress Reactions

- Isolation
- Blaming
- Difficulty giving or accepting support or help
- Inability to experience pleasure

Competency 20

- *Understand the addiction professional's obligations to adhere to ethical and behavioral standards of conduct in the helping relationship.*

Ethical Standards for Addiction Counselors--Foundations

- **Autonomy:** To allow others the freedom to choose their own destiny
- **Obedience:** The responsibility to observe and obey legal and ethical directives
- **Conscientious Refusal:** The responsibility to refuse to carry out directives that are illegal and/or unethical
- **Beneficence:** To help others

- **Gratitude:** To pass along the good that we receive to others
- **Competence:** To possess the necessary skills and knowledge to treat the clientele in a chosen discipline and to remain current with treatment modalities, theories, and techniques
- **Justice:** Fair and equal treatment, to treat others in a just manner
- **Stewardship:** To use available resources in a judicious and conscientious manner, to give back

- **Honesty and Candor:** To tell the truth in all dealing with clients, colleagues, business associates, and the community
- **Fidelity:** To be true to your word, keeping promises and commitments
- **Loyalty:** The responsibility to not abandon those with whom you work
- **Diligence:** To work hard in the chosen profession, to be mindful, careful, and thorough in the services delivered
- **Discretion:** Use of good judgment, honoring confidentiality and the privacy of others

- **Self-improvement:** To work on professional and personal growth to be the best you can be
- **Nonmalfeasance:** To do no harm to the interests of the client
- **Restitution:** When necessary, make amends to those who have been harmed or injured
- **Self-interest:** To protect yourself and your personal interests

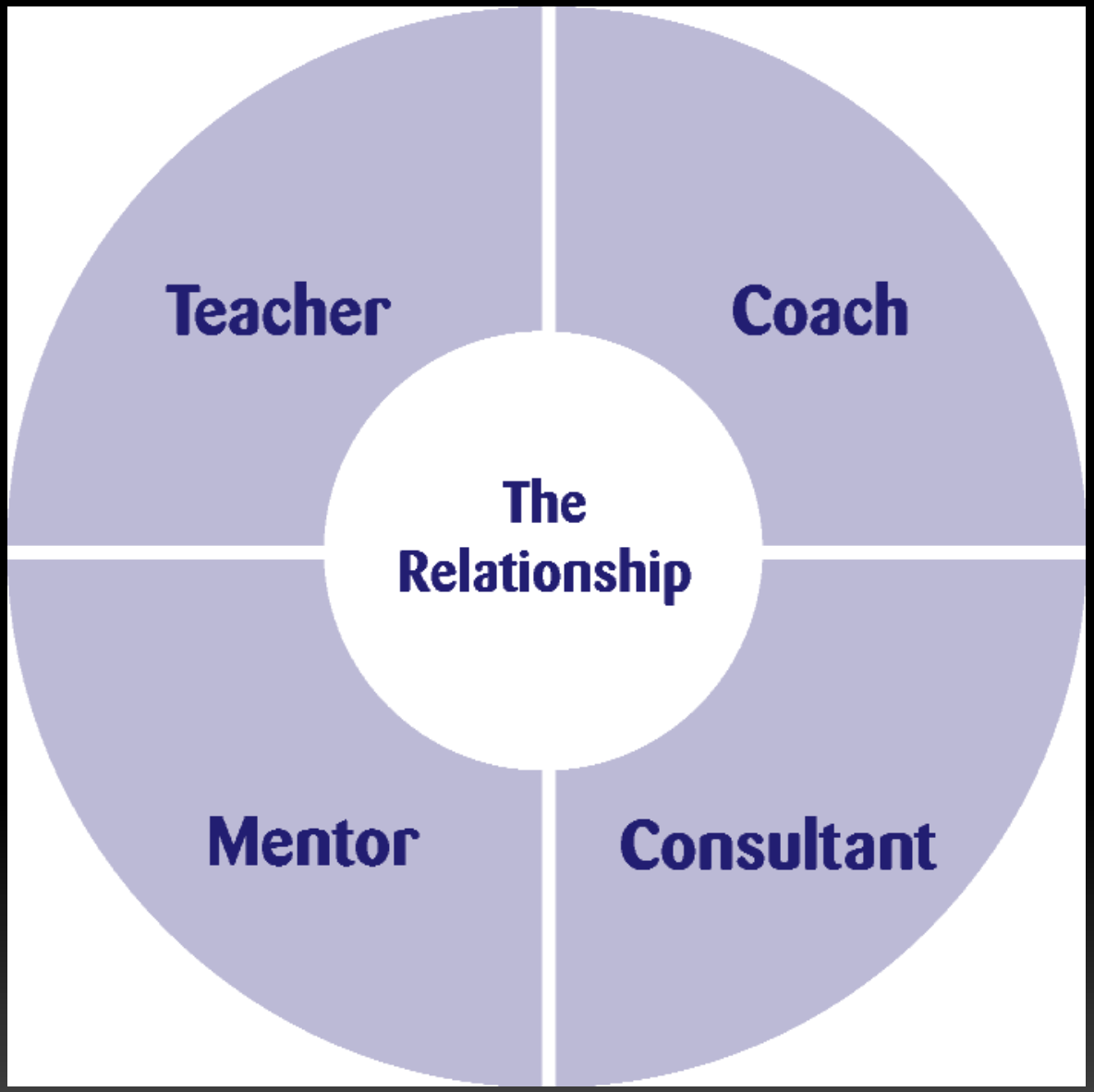
Variations in Ethical Codes

- Professional organizations develop their own unique codes of ethical behavior
- Uniform Code of Conduct in California (minimum ethical standards to be met by all certifying organizations in the state)
- Licensed professionals (MFTs, LCSWs, LPCCs, psychologists) have similar but different codes
- Dual relationship standards differ

Competency 21

- *Understand the importance of ongoing supervision and continuing education in the delivery of client services*
- A new development in the substance abuse field
- Necessary to improve client care, develop professionalism, impart and maintain ethical standards

ROLES OF THE CLINICAL SUPERVISOR



Source: CSAT (2009)

Competency 22:

Understand the obligation of the addiction professional to participate in prevention and treatment activities.

Competency 23:

Understand and apply setting-specific policies and procedures for handling crisis or dangerous situations, including safety measures for clients and staff.

Internet Resources

- *NAADAC: The Association for Addiction Professionals*: Code of Ethics http://www.naadac.org/resources/codeofethics
- *National Organization for Human Services*: Code of ethics http://www.nationalhumanservices.org/index.php?option=com_content&view=article&id=43

Videos/Webcasts

- **Embracing Diversity: Crossing Barriers to Deliver Treatment to Everyone**
  http://www.recoverymonth.gov/Resources-Catalog/2010/Webcast/Aug-Embracing-Diversity-Crossing-Barriers-To-Deliver-Treatment-to-Everyone.aspx
- **Recovery and the Media: Addiction and Treatment in Entertainment and News**
  http://store.samhsa.gov/product/Recovery-and-the-Media-Addiction-and-Treatment-in-Entertainment-and-News/SMA10-4496

Exercises/Activities

- **The Slippery Slope: Violating the Ultimate Therapeutic Taboo** http://www.psychotherapynetworker.org/populartopics/ethics/505-the-slippery-slope
- **Professional Ethics** (White, 2004). http://www.williamwhitepapers.com/pr/2004ProfessionalEthics.pdf

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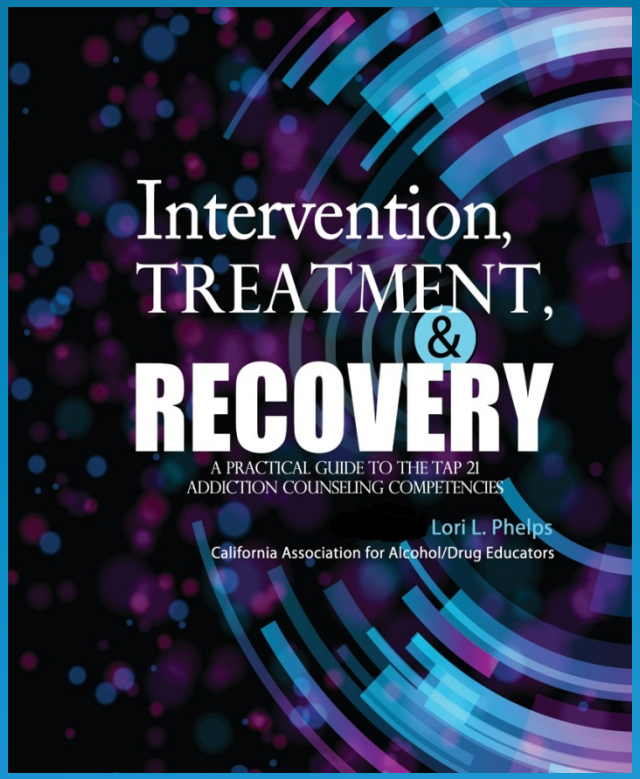

Chapter 6

PRACTICE DIMENSION I: CLINICAL EVALUATION

Contributor: Lori Phelps

Kendall Hunt publishing company

Competency 24

***Establish rapport, including management of a crisis situation and determination of need for additional professional assistance*.**

- **Strategies for Establishing Rapport**
  - Consider stages of Change
  - 80% of substance abusers are currently in pre-contemplation or contemplation
  - Offer relevant information in a supportive and empathetic manner

Raising the Topic

- Opening Sessions
  - Establish rapport and trust
  - Explore events that precipitated treatment entry
  - Commend clients for coming
- **Motivational** Approach

Establish Rapport and Trust

- First to ask the client for permission to address the topic of change
  - Shows respect for client's ***autonomy***
- Explain how you and/or your program operates
  - Try not to overwhelm
  - Explain assessments
  - Confidentiality
  - Let client do most of the talking (feelings and hopes)

5 Principles of Motivational Interviewing (Miller & Rollnick)

- Express empathy through reflective listening.
- Develop discrepancy between clients' goals or values and their current behavior.
- Avoid argument and direct confrontation.
- Adjust to client resistance rather than opposing it directly.
- Support self-efficacy and optimism.

Competency 25:

Gather data systematically from the client and other available collateral sources, using screening instruments and other methods that are sensitive to age, developmental level, culture, and gender. At a minimum, data should include current and historic substance use; health, mental health, and substance-related treatment histories; mental and functional statuses; and current social, environmental, and/or economic constraints.

Element: Screening

- A process by which the counselor, the client, and available significant others review the current situation, symptoms, and other available information to determine the most appropriate initial course of action, given the client's needs and characteristics and the available resources within the community (CSAT, 2006a, p. 39)

Integrating Treatment

- National Survey on Drug Use and Health (NSDUH) 2009
  - only 7.4 percent of people with co-occurring disorders receive treatment for both substance use disorders (SUDs) and mental illness (MI).
  - People with co-occurring disorders are far more likely to get treatment for MI than for SUDs.
- People with severe mental illness (SMI) are more likely than those with mild MI to have an SUD

Screening

- a formal process of testing to determine whether a client does or does not warrant further attention
- The screening process for COD seeks to answer a Yes or No question: Does the substance abuse (or mental health) client being screened show signs of a possible mental health (or substance abuse) problem?

Screening for COD

- Does not necessarily identify what kind of problem the person might have or how serious it might be
- Determines whether or not further assessment is warranted
- Can be conducted by counselors using their basic counseling skills.
- Seldom any legal or professional restraints on who can be trained to conduct a screening.

Suicide Assessment

- Suicide is a leading cause of death among people who abuse alcohol and drugs (Wilcox, Conner, & Caine, 2004).
  - Individuals treated for alcohol abuse or dependence are at about 10 times greater risk to eventually die by suicide (than general population)
  - people who inject drugs are at about 14 times greater risk for eventual suicide
- Individuals with substance use disorders are also at elevated risk for suicidal ideation and suicide attempts

GATE: Procedures for Substance Abuse Counselors

- **For Suicide Assessment**
- **G**ather information
  Access supervision
  Take responsible action
  Extend the action
- Document all actions you take
  - what information you obtained
  - when and what actions were taken
  - how you followed up

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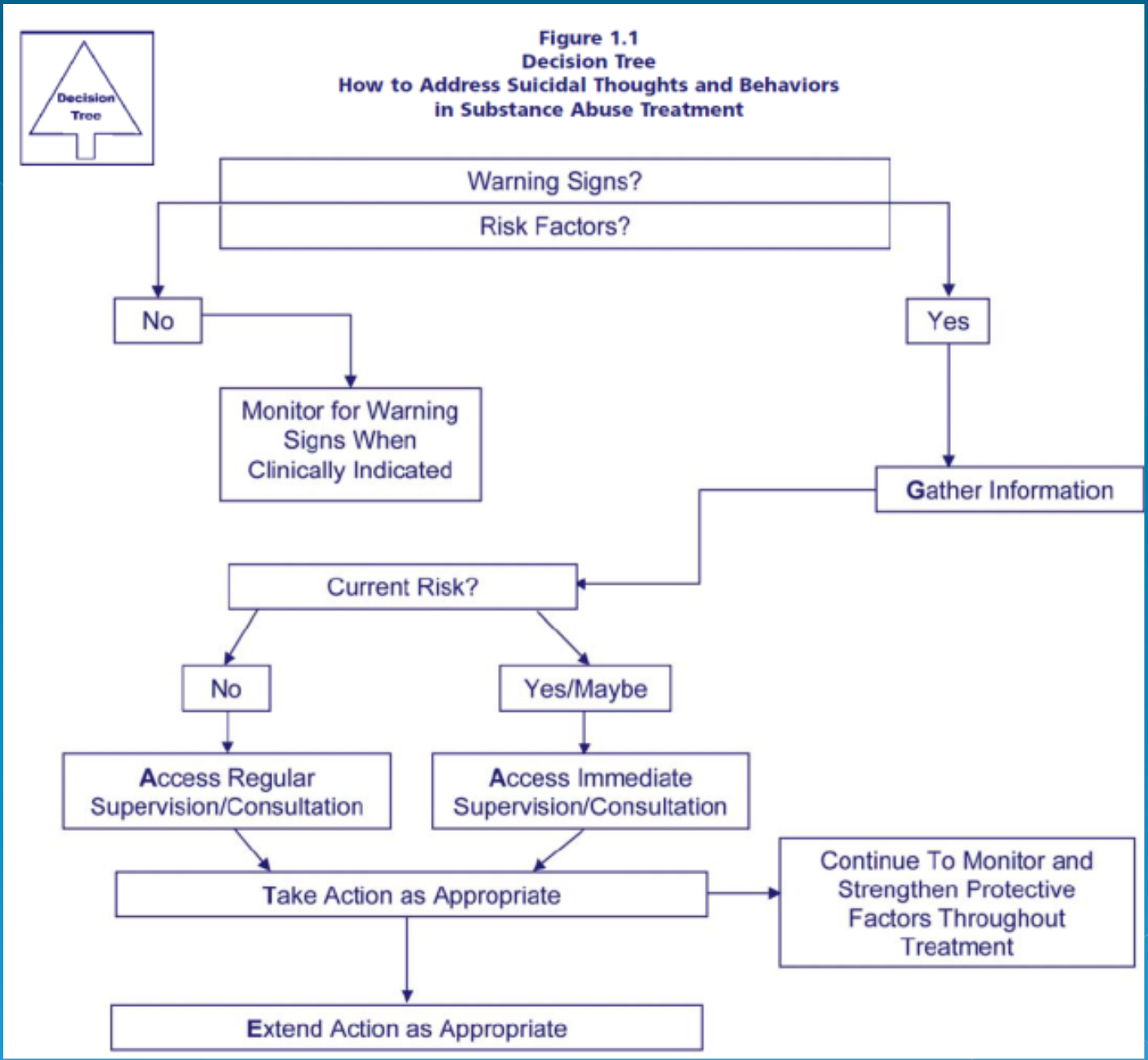

Sample Screening Questions

- *Introducing the topic*
  - I have a few questions to ask you about suicidal thoughts and behaviors.
- *Screening for suicidal thoughts*
  - Have you ever thought about carrying out suicide?
- *Screening for suicide attempts*
  - Have you ever tried to take your own life?

Element: Assessment

- *Understand the addiction professional's obligations to adhere to ethical and behavioral standards of conduct in the helping relationship.*

Competency 33

- Select and use a comprehensive assessment process that is sensitive to age, gender, racial, and ethnic culture, and disabilities that includes but is not limited to:
  - History of alcohol and drug use
  - Physical health, mental health, and addiction treatment histories
  - Family issues
  - Work history and career issues
  - History of criminality
  - Psychological, emotional, and worldview concerns . . . continued

Competency 33 cont'd

- Current status of physical health, mental health, and substance use
- Spiritual concerns of the client
- Education and basic life skills
- Socioeconomic characteristics, lifestyle, and current legal status
- Use of community resources
- Treatment readiness
- Level of cognitive and behavioral functioning

Assessment

- An ongoing process through which the counselor collaborates with the client and others to gather and interpret information necessary for planning treatment and evaluating client progress.
  - Screening is a process for evaluating the possible presence of a particular problem.
  - Assessment is a process for defining the nature of that problem and developing specific treatment recommendations for addressing the problem.

Screening	Determines the likelihood that a client has co-occurring substance use and mental disorders or that his or her presenting signs, symptoms, or behaviors may be influenced by co-occurring issues. The purpose is not to establish the presence or specific type of such a disorder, but to establish the need for an in-depth assessment. Screening is a formal process that typically is brief and occurs soon after the client presents for services.
Assessment	Gathers information and engages in a process with the client that enables the provider to establish (or rule out) the presence or absence of a co-occurring disorder. Determines the client's readiness for change, identifies client strengths or problem areas that may affect the processes of treatment and recovery, and engages the client in the development of an appropriate treatment relationship.
Treatment Planning	Develops a comprehensive set of staged, integrated program placements and treatment interventions for each disorder that is adjusted as needed to take into account issues related to the other disorder. The plan is matched to the individual needs, readiness, preferences, and personal goals of the client.
Integrated Screening, Assessment, and Treatment Planning	Screening, assessment, and treatment planning that address both mental health and substance abuse, each in the context of the other disorder.

Internet Resources

- **Project CORK:** http://www.projectcork.org/clinical_tools/index.html
- **Substance Use Screening & Assessment Instruments Database:** http://lib.adai.washington.edu/instruments/

Videos/Webcasts

- **Alcohol and Drug Use Screening, Intervention, and Referral: Changing the Nation's Approach to Comprehensive Healthcare**
  http://store.samhsa.gov/product/Alcohol-and-Drug-Use-Screening-Intervention-and-Referral-Changing-the-Nation-s-Approach-to-Comprehensive-Healthcare-DVD-/DVD183

Exercises/Activities

- **Project CORK**: http://www.projectcork.org/clinical_tools/index.html

AUDIT (Alcohol Use Disorder Identification Test)	**MAST** (Michigan Alcoholism Screening Test)
AUDIT-C (Consumption)	MAST-G (Geriatric)
AUDIT-PC (Primary Care)	Brief MAST
CAGE	Short MAST
CRAFFT	Short MAST-G
DAST (Drug Abuse Screening Test)	T-Ace
Fagerstrom Test for Nicotine Dependence	Trauma Index
	TWEAK

Exercises/Activities

- Simple Screening Instrument for Substance Abuse (SSI-SA)
- Mental Health Screening Form-III

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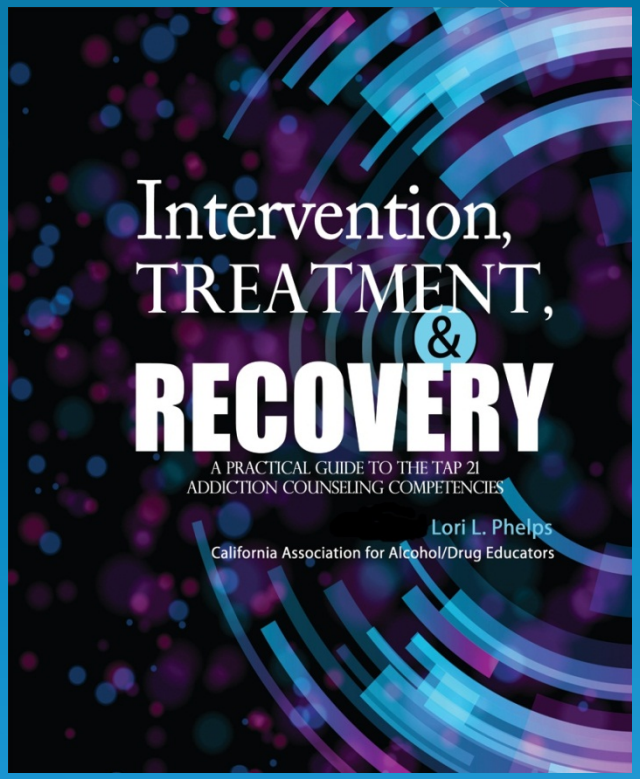


Chapter 7
PRACTICE DIMENSION II: TREATMENT PLANNING

Contributor: Ben Eiland

Kendall Hunt publishing company

Competencies 37-48

- **Competency 37**:
  - *Use relevant assessment information to guide the treatment planning process.*
- **Competency 38**:
  - *Explain assessment findings to the client and significant others.*
- **Competency 39**:
  - *Provide the client and significant others with clarification and additional information as needed.*

Competencies 37-48

- **Competency 40:**
  - *Examine treatment options in collaboration with the client and significant others.*
- **Competency 41:**
  - *Consider the readiness of the client and significant others to participate in treatment.*
- **Competency 42:**
  - *Prioritize the client's needs in the order they will be addressed in treatment.*

Competencies

- **Competency 43:**
  - *Formulate mutually agreed-on and measurable treatment goals and objectives.*
- **Competency 44:**
  - *Identify appropriate strategies for each treatment goal.*
- **Competency 45:**
  - *Coordinate treatment activities and community resources in a manner consistent with the client's diagnosis and existing placement criteria.*

Competencies

- **Competency 46:**
  - *Develop with the client a mutually acceptable treatment plan and method for monitoring and evaluating progress.*
- **Competency 47:**
  - *Inform the client of confidentiality rights, program procedures that safeguard them, and the exceptions imposed by regulations.*
- **Competency 48:**
  - *Reassess the treatment plan at regular intervals or when indicated by changing circumstances.*

Treatment Planning

- *A collaborative process in which professionals and the client develop a written document that identifies important treatment goals; describes measurable, time-sensitive action steps toward achieving those goals with expected outcomes; and reflects a verbal agreement between a counselor and client.*
  - (CSAT, 2006a, p. 55)

The Treatment Plan

- Includes:
  - the identified substance use disorder(s)
  - issues related to treatment progress including
    - Relationships with family and significant others
    - Potential mental conditions
    - Employment
    - Education
    - Spirituality
    - Health concerns
    - Social and legal needs.

Screening and Assessment

- Treatment planning depends on screening and assessment
- **Screening**
  - CAGE, MAST, DAST, SASSI, SBIRT
- **Assessment**
  - Addiction Severity Index
- Screening and assessment should engage the client, identify key collaterals (with contact information), identify strengths

Screening and Assessment

- Determine these key factors:
  - severity of mental and substance use disorders;
  - the appropriate care setting (e.g., inpatient, outpatient, day-treatment);
  - an appropriate diagnosis;
  - the level of disability and functional impairment;
  - readiness for change;
  - cultural and linguistic needs and supports;
  - additional problem areas(e.g., physical health, housing, vocational, educational, social, spiritual, cognitive, etc.).

Assessment

- Determine the extent and severity of the AOD abuse problem;
- Determine the level of maturity and readiness for treatment;
- Ascertain concomitant problems such as mental illness;
- Determine the type of intervention necessary to address the problems;
- Evaluate the resources available to help solve the problem. Typical resources include family support, social support, educational and vocational attainment, and personal qualities such as motivation that the client brings to treatment;
- Engage the client in the treatment process.

Some Treatment Options

- **Biopsychosocial**
- **Continuum of care:** interlinked treatment modalities and services; individuals' changing needs will be met as they move through the treatment and recovery process.
- **Dual Diagnosis** (Co-Occurring Disorders)
- **Eligibility criteria**: financial status, insurance coverage, age, severity of illness, geographic location, special needs
- **Intensity of Service**
- **Level of care (ASAM)**

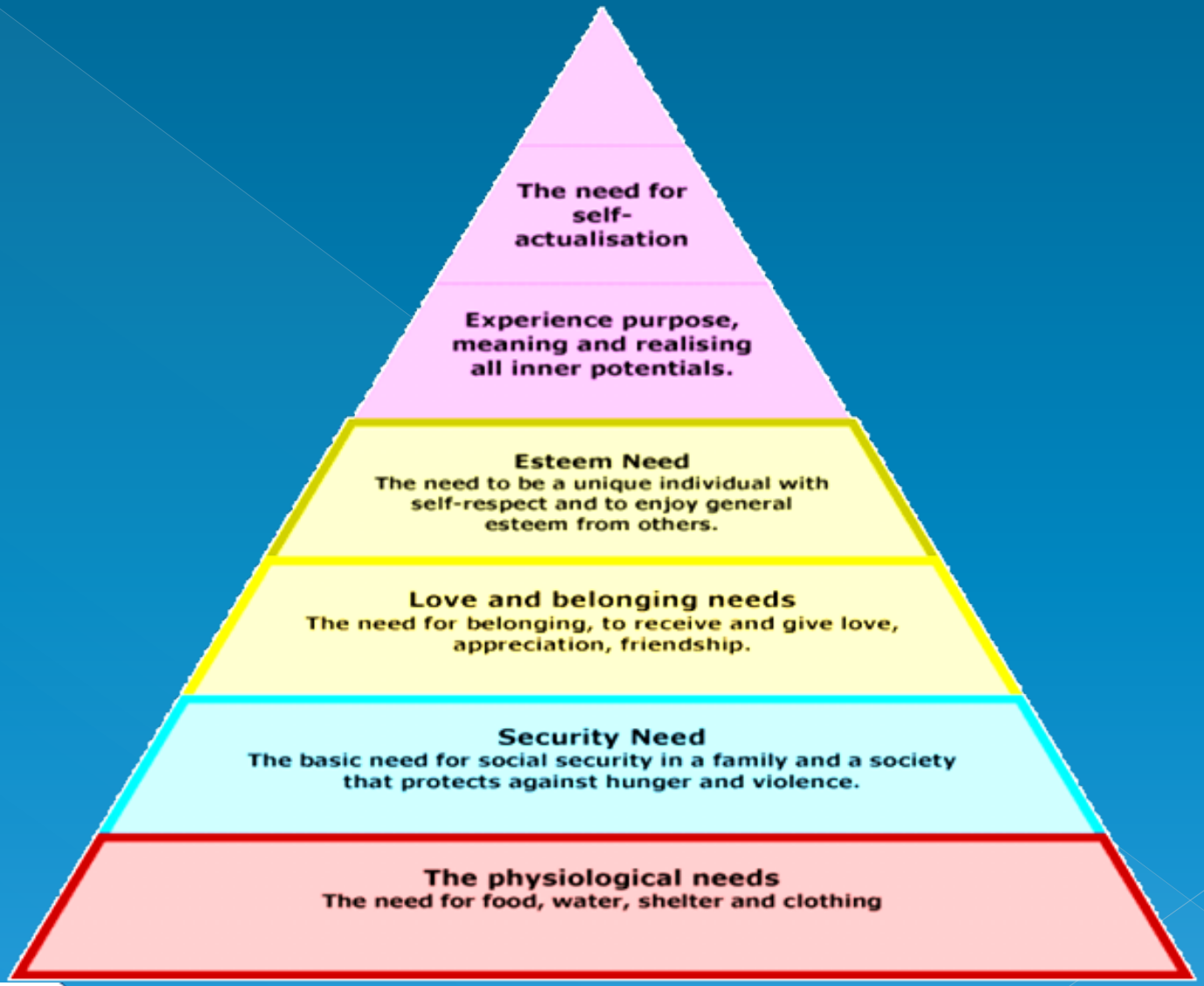
Levels of Care

- Medically monitored detox
- Social model detox
- Day treatment
- Intensive outpatient programs (IOP, usually 9–12 hours weekly)
- Outpatient program (usually 3–6 hours weekly)
- Medical model treatment (usually 28 days)
- Residential treatment:
- Therapeutic community (TC);
- Social model treatment (usually 12-step based)

Readiness for Treatment

Precontemplation	Not thinking about change May be resigned Feeling of no control Denial: does not believe it applies to self Believes consequences are not serious
Contemplation	Weighing benefits and costs of behavior, proposed change
Preparation	Experimenting with small changes
Action	Taking a definitive action to change
Maintenance	Maintaining new behavior over time
Relapse	Experiencing normal part of process of change Usually feels demoralized

Prioritizing Client's Needs



Treatment Planning MATRS

- **M**easurable—*Objectives are measurable so that the client and counselor can document change.*
- **A**ttainable—*Goals, objectives, and interventions should be achievable in the active treatment phase.*
- **T**ime-Limited—*Focus on time-limited or short-term goals and objectives*
- **R**ealistic—*Client can realistically complete objectives within specific time period*
- **S**pecific—*Objectives and interventions are specific and goal-focused*

Internet Resources

- **Project Cork (MAST, DAST, CAGE, ASI)** http://www.projectcork.org/clinical_tools/index.html
- ***Treatment Planning M.A.T.R.S.: Utilizing the Addiction Severity Index (ASI) to Make Required Data Collection Useful*** http://www.attcnetwork.org/explore/priorityareas/science/blendinginitiative/txplanningmatrs/

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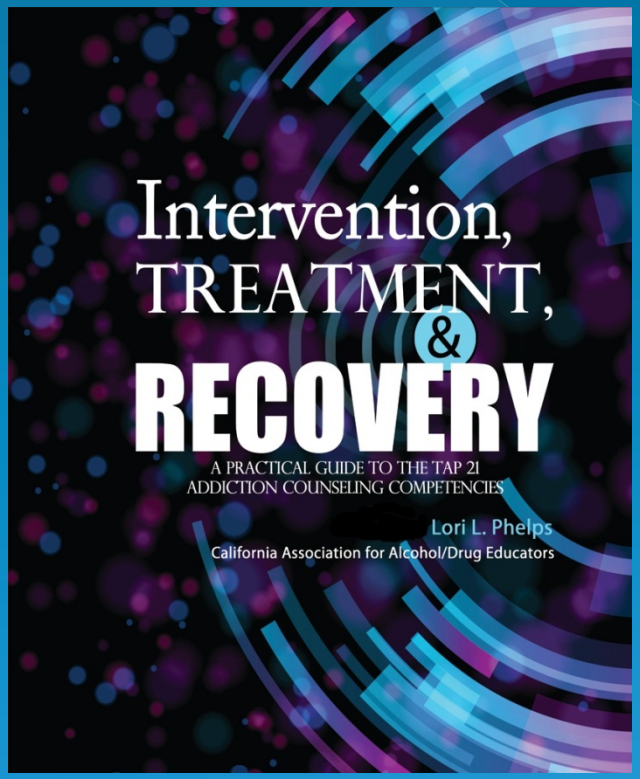

Chapter 8

PRACTICE DIMENSION III: REFERRAL

Contributors: Jack Kearney, Dennis Wade

Kendall Hunt publishing company

Lori L. Phelps
California Association for Alcohol/Drug Educators, 2013

Competencies 49 - 55

49: Establish and maintain relationships with civic groups, agencies, other professionals, governmental entities, and the community at large to ensure appropriate referrals, identify service gaps, expand community resources, and address unmet needs.

50: Continuously assess and evaluate referral sources to determine their appropriateness.

Competencies

51: Differentiate between situations in which it is most appropriate for the client to self-refer to a resource and situations requiring counselor referral.

52: Arrange referrals to other professionals, agencies, community programs, or appropriate resources to meet the client needs.

Competencies

53: Explain in clear and specific language the necessity for and process of referral to increase the likelihood of client understanding and follow-through.

54: Exchange relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality rules and regulations and generally accepted professional standards of care.

55: Evaluate the outcome of the referral.

Agencies' Resources And Services Needed By Clients While They Are Receiving Substance Abuse Treatment

- City, county and state-operated vocational rehabilitation (VR) services;
- Public and private employment and job placement services;
- Public and private employers in the community;
- Vocational-technical colleges;
- Community colleges;
- Privately owned VR facilities;
- Criminal justice vocational training programs;
- Economic development centers(one-stop or workforce development centers);

Agencies' Resources and Services (continued):

- Shelters for survivors of domestic violence;
- Mental health agencies;
- Homeless shelters;
- Child welfare agencies;
- Child care services;
- Family services;
- Housing authorities;
- Evening adult education programs;
- Alternative education programs;
- Literacy programs;
- Adult basic education programs and general equivalency diploma (GED) programs;

Agencies' Resources and Services (continued):

- Young Men's Christian Associations (YMCAs), Young Women's Christian Associations (YWCAs), Young Men's Hebrew Associations (YMHAs), and Young Women's Hebrew Association (YWHAs);
- Social service organizations;
- HIV/AIDS programs;
- Independent living centers;
- Religious groups;
- Self-help meetings;
- Accessible meetings.

Agencies' Resources and Services

All collaborators, including those providing treatment for substance abuse disorders, should be aware that their efforts are likely to be ineffective unless all the client's life areas are addressed.

Elements of Effective Referrals

An authentically connected referral network is composed of a set of defined relationships formed as clients' needs dictate, using sound principles of case management and building in flexibility and adaptability to meet the needs of individual clients.

Mechanism for Information Dissemination

The authentically connected model calls for a communication mechanism that allows the timely dissemination of information to all agencies and stakeholders.

An authentically connected network includes continually updated information about available resources.

Focus on Communitywide Outcomes

- *Set priorities based on client populations in individual communities.*
- *Encourage responsiveness on the part of the community and the network as a whole, rather than from the agency only.*

Vision-Driven Service Provision

- *Client needs are the primary focus of the agencies' existence.*
- *Emphasis is on shared purpose while acknowledging the organizational "cultures" among collaborating agencies.*

Provider Credibility and Consistency

- *Mutual provider credibility and trust are the core of the referral relationship.*
- *A sense of uniformity and cooperation is fostered by effective referrals.*

Case Management is Client Driven and Driven by Client Need

- Focus on identifying psychosocial issues and anticipating and helping the client obtain resources.
- Aim of case management is to provide least restrictive level of care necessary so client's life is disrupted as little as possible.
- Case management must be flexible.

Goal of Case Management is For Clients to Learn How to Obtain Social Services

Assess Client 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 service agencies;
- Skill in accessing mental health and substance abuse treatment services.

Discuss Issues With Client If You Suspect Substance Abuse and Referral to Addiction Treatment Is Warranted

Explain to clients and significant others that:

- Addiction is a treatable chronic disease.
- You want to give them the best treatment and so you are referring them to a specialist much like you would do for other chronic diseases.
- When stabilized, patients may return to the primary care provider for ongoing care.

Sensitive Interviewing Techniques

"Ask-Tell-Ask" Approach:

1. Ask permission to discuss something with them.
2. Tell them your concerns.
3. Ask what they thought about what you said.

Sensitive Interviewing Techniques (Continued)

- Explain that you need to discuss drug use because you are concerned about their health and why you are recommending a referral.
- Point out the direct relationship between their drug use and any health or social consequences they might have experienced.
- Provide as much information as possible about the provider/clinic where you are referring the client.
- Maintain client's privacy.

Know Your Limitations

Referral of a patient is called for if the care is beyond the scope of your own training or if the necessary care cannot be provided.

Note: Consent of client must be obtained before the release of confidential information to any third party. Release of information to non-health care workers requires the full written consent of the client(with limited exceptions).

Evaluate the Outcome of the Referral

- Referral Forms:
  - Who – Identify the client and counselor who made the referral.
  - What – Types of issues that led to referral.
  - How – Describe consequence of referral or how client was dealt with.

Guidelines For Referrals
Establishing Referral Networks
(American Health Counselors Association 1992)

a. Referrals may be made to a range of community services and resources.
b. 12-step program is the first referral.
c. Alcohol and other drug treatment and rehabilitation services.
d. Counselors, psychiatrists, psychologists, and social workers in private practice.
e. Community mental health facilities.
f. Community social service and welfare agencies.
g. Hospital outpatient departments.
h. Community public school systems.
i. Court and probation systems.

Guidelines For Referrals
Criteria for Evaluating Referral Resource
(American Health Counselors Association 1992)

a. The program's record and success rate.
b. Attitudes of program staff.
c. Education and training of program staff.
d. Licensure and accreditation of the program.
e. Treatment of alcohol and drug dependence as primary disorders.
f. Patients free of drugs early in the recovery process.
g. Adequate provision for care of acute medical problems.
h. Extent to which the program will help expedite the client's entry into treatment.

Guidelines For Referrals
Criteria for Evaluating Referral Resource
(American Health Counselors Association 1992)

i. Use of a comprehensive treatment approach.
j. Encouragement of families to participate in the treatment process.
k. Active preparation of clients against relapse.
l. Development of a plan of continuing care.
m. Ability to respond to special issues and needs.
n. Reasonable cost.

Guidelines For Referrals
Preparing the Client
(American Health Counselors Association 1992)

a. Give rationale for referral.
b. Describe the referral resource.
c. Provide emotional and logistical support.
d. Provide name and number of contact person.
e. Discuss monitoring and follow-up plans.

Lori L. Phelps
California Association for Alcohol/Drug Educators, 2013

Making Effective Referrals

A. Treatment Planning and Use of Referral Network by Stage of Illness.
B. Importance of Follow-up and Monitoring.
   1. Client may find referral unsatisfactory and require new referral.
   2. Client may drop out of specialized treatment and need help in returning.
   3. Referral of family and significant others to support groups.
C. Managing Treatment Problems Posed by Concurrent Treatment Modalities.
D. Discharging Clients Before Completion of Program.
   1. Make a reasonable effort to place in a suitable program.

Integrating Substance Abuse Treatment and Vocational Services
Steps For Establishing an Authentically Connected Referral Network

1. Determine the services available in the local area by developing an updated inventory and by resource mapping.
2. Hold discussions with agencies identified as potential collaborators.
3. Develop working agreements between collaborators to organize information sharing and communicate respective roles.
4. Determine the agency's criteria for accepting clients.
5. If warranted, establish a partnership with the agency and draft agreements regarding the flow of information and feedback between the agencies to ensure provider accountability.

Integrating Substance Abuse Treatment and Vocational Services
Characteristics of Authentically Connected Referral Networks

- Multiple agencies work as equal partners with each other and with the client. Referring agencies make the initial contact to the referral source and keep abreast of client progress.
- Clients and agencies have mutual responsibility and trust. Interagency accountability and data sharing exists.
- Communication mechanisms for timely information dissemination are accessible to all agencies and stakeholders.

Integrating Substance Abuse Treatment and Vocational Services
Characteristics of Authentically Connected Referral Networks
(CSAT 2000)

- The full range of stakeholders is identified, including local community services, and feedback is elicited from all of them.
- Relationships among providers are collaborative and flexible in the assumption of multiple job tasks related to client needs.
- The network is client, vision and mission driven.
- Change and growth of the referring organization are demonstrated as a result of the referral process.

Integrating Substance Abuse Treatment and Vocational Services
Characteristics of Authentically Connected Referral Networks (CSAT 2000)

- The network is open to new paradigms, approaches, use of technology on behalf of clients, and individualization of client treatment plans and services.
- There is ongoing provider training and involvement in continuing education and staff development.
- Shared assessment of network effectiveness is ongoing.
- Cross-training of staff among collaborating agencies is ongoing.

Integrating Substance Abuse Treatment and Vocational Services Characteristics of Authentically Connected Referral Networks (CSAT 2000)

- Accountability is results and progress based, with interagency negotiation of shared outcomes.
- The referral process is concurrent.

Internet Resources

- Performance Assessment Rubrics for the Addiction Counseling Competencies: http://www.nattc.org/regcenters/index_northwestfrontier.asp

Exercises/Activities

- **Self-Assessment of Your Skills With Competencies**

  Go to the *Performance Assessment Rubrics for Addiction Counseling Competencies* and asses your skills with competencies 49-55.

- **Assess Community Resources**

  Practice assessing referral needs and referral resources in your community.

- **Identify Community Resources**

  Make a list of substance abuse, mental health, and other relevant resources in your community.

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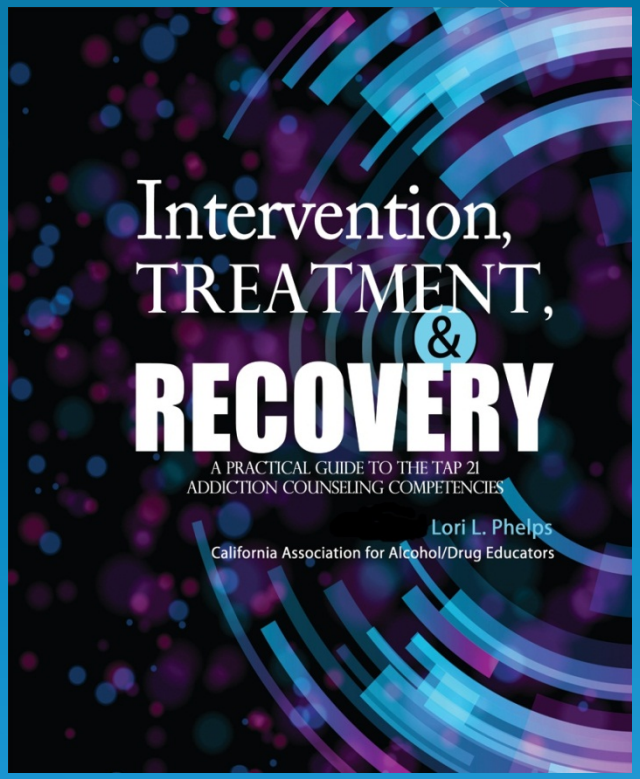

Chapter 9
PRACTICE DIMENSION IV: SERVICE COORDINATION

Contributors: Melinda Moneymaker, Angela Stocker

Kendall Hunt publishing company

Element:
Implementing the Treatment Plan
Competencies 56- 61

56: Initiate collaboration with the referral source.

57: Obtain, review, and interpret all relevant screening, assessment, and initial treatment planning information.

Competencies 56- 61 (continued)

58: Confirm the client's eligibility for admission and continued readiness for treatment and change.

59: Complete necessary administrative procedures for admission to treatment.

Competencies 56- 61 (continued)

60: Establish accurate treatment and recovery expectations with the client and involved significant others, including but not limited to:

- The nature of services
- Program goals
- Program procedures
- Rues regarding client conduct
- The schedule of treatment activities
- Costs of treatment
- Factors affecting duration of care
- Clients' rights and responsibilities
- The effect of treatment and recovery on significant others.

Competencies 56- 61 (continued)

61: Coordinate all treatment activities with services provided to the client by other resources.

Service Coordination

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.

Definitions of Case Management:

"planning and coordinating a package of health and social services that is individualized to meet a particular client's needs"

(Moore, 1990, p.444)

Definitions of Case Management:

"[a] process or method for ensuring that consumers are provided with whatever services they need in a coordinated, effective, and efficient manner."

(Intagliata, 1981)

Definitions of Case Management:

"helping people whose lives are unsatisfying or unproductive due to the presence of many problems which require assistance from several helpers at once"

(Ballew & Mink, 1996, p.3)

Definitions of Case Management:

"monitoring, tracking, and providing support to a client, throughout the course of his/her treatment and after."

(Ogborne & Rush, 1983, p.136)

Definitions of Case Management:

"assisting the patient in re-establishing an awareness of internal resources such as intelligence, competence, and problem solving abilities; establishing and negotiating lines of operation and communication between the patient and external resources; and advocating with those external resources in order to enhance the continuity, accessibility, accountability, and efficiency of those resources."

(Rapp, Siegal & Fisher, 1992, p.83)

Definitions of Case Management:

"assess[ing] the needs of the client and the client's family, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client's complex needs."

(National Association of Social Workers, 1992, p.5 in CSAT, 1998)

Case Management and Service Coordination

- *Link among treatment providers and mental health agencies are crucial if the two programs are to understand each other's activities.*

- *A case summary should be developed that lists the key issues that need to be addressed in other settings.*

Sample Consent Form

Source: CSAT(1998)

Sample Consent Form
Consent for the Release of Confidential Information
I, _____, authorize XYZ Clinic to receive **(name of client or participant)**
from/disclose to _____ **(name of person and organization)**
for the purpose of _____ **(need for disclosure)**
the following information _____ **(nature of the disclosure)**
I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically on _____ unless otherwise specified below. **(date, condition, or event)**
Other expiration specifications:
_____ **Date executed**
_____ **Signature of client**
_____ **Signature of parent or guardian, where required**

Element: Consulting Competencies 62- 66

62: Summarize the client's personal and cultural background, treatment plan, recovery progress, and problems inhibiting progress to ensure quality of care, gain, feedback, and plan changes in the course of treatment.

63: Understand the terminology, procedures, and roles of other disciplines related to the treatment of substance use disorders.

Competencies 62 – 66 (continued)

64: Contribute as part of a multi-disciplinary treatment team.

65: Apply confidentiality rules and regulation appropriately.

66: Demonstrate respect and nonjudgmental attitudes toward clients in all contacts with community professionals and agencies.

SERVICE COORDINATION

Service Coordination Form

When working with client / patient service coordination needs the use of gathered information from treatment plans, assessment tools, progress notes, and presenting problems lists can help to determine what services are needed, what goals to set and action steps to be taken, and dates of follow up until the need is met. The following sample progress note gives out some information about the client. Goal #1 reflects one issue regarding client's substance abuse. What other services could be addressed with the information you have on this client? What other information could be useful in helping you to determine other needs?

Goal	Strength / Need	Resource	Action Step	Date Addressed	Follow Up	Problem / Need
#1 Client to remain clean and sober, and start to identify relationship between problems and drug use.	*Ct has transportation* *Ct needs to work on motivation*	*Treatment team, including counselor and peers*	*Attend scheduled groups, and individual sessions and bring in presenting problem list to review*	*2/27*	*Will meet again on 3/3*	*Unmet at this time*

Using evidenced based practices such as motivational interviewing the competent counselor can help identify financial, legal, social supports needed, or evaluate resources and motivation that the client may have already in the way of strengths.

Service coordination integrates intervention, treatment and recovery

For a client community centered approach.

Sharing Information With an Outside Agency Qualified Service Organization Agreement (QSOA)

- *A Qualified Service Organization Agreement (QSOA) is a written agreement between a program and a person (or agency) providing services to the program, in which that person (or agency):*
  - *Acknowledges that in receiving, storing, processing, or otherwise dealing with any client records from the program, that person (or agency) is fully bound by federal confidentiality regulations.*
  - *Promises that, if necessary, that person (or agency) will resist in judicial proceedings any efforts to obtain access to client records except as permitted by these regulations [§§2.11, 2.129 (c) (4)]*

Sample Qualified Service Organization Agreement *(CSAT, 1998)*

Qualified Service Organization Agreement

XYZ Service Center ("the Center") and the _____
(name of the program)

("the Program") hereby enter into a qualified service organization agreement, whereby the Center agrees to provide
_____
(nature of services to be provided)

Furthermore, the Center:
(1) acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the Program about the clients in the Program, it is fully bound by the provisions of the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 C.F.R. Part 2; and

(2) undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to clients otherwise than as expressly provided for in the Federal Confidentiality Regulations, 42 C.F.R. Part 2.

Executed this _____ day of _____, 20_____

_____
President
XYZ Service Center
[address]

_____
Program Director
[name of program]
[address]

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

- *Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders as well as those who are at risk of developing these disorders.*

Opportunities for Early Intervention with At-Risk Substance Abusers

- *Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.*

- *Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.*

Element: Continuing Assessment and Treatment Planning (Competencies 67- 74)

67: Maintain ongoing contact with the client and involved significant others to ensure adherence to the treatment plan.

68: Understand and recognize stages of change and other signs of treatment progress.

Competencies 67- 74 (continued)

- **69**: Assess treatment and recovery progress and, in consultation with the client and significant others, make appropriate changes to the treatment plan to ensure progress toward treatment goals.
- **70**: Describe and document the treatment process, progress, and outcome.
- **71**: Use accepted treatment outcome measures.

Competencies 67- 74 (continued)

- **72**: Conduct continuing care, relapse prevention, and discharge planning with the client and involved significant others.
- **73**: Document service coordination activities throughout the continuum of care.
- **74**: Apply placement, continued stay, and discharge criteria for each modality on the continuum of care.

COSSR Task Force Principles for an Effective Continuum of alcohol and Other Drug Treatment.

1. *Services must be comprehensive, integrated, and high quality, with demonstrated effectiveness.*

2. *Services must share the following characteristics: accessible, affordable, individual and community centered, culturally and gender appropriate, and responsive to individual and family needs and differences.*

COSSR Task Force Principles (continued)

3. *Delivering quality and effective care requires outcome and data-based planning for California's prevention, treatment, and recovery systems.*

4. *Potential problems can be prevented by reducing risk factors and increasing protective factors in both communities and individuals.*

COSSR Task Force Principles (continued)

5. *Transient or nondependent alcohol or other drug problems can be resolved through acute care, including brief intervention and brief treatment services.*

6. *Recovery from severe and persistent problems can be achieved through continuing and comprehensive alcohol and other drug treatment services.*

(ADP, 2006)

Internet Resources

- Case Management Society of America: www.cmsa.org

- Internet Resources Institute for Research, Education and Training in Addictions: http://www.ireta.org/sbirt/

Internet Resources (Continued)

- Office of National Drug Control Policy: Screening, Brief Intervention, Referral & Treatment: http://www.whitehousedrugpolicy.gov/treat/screen_brief_intv.html
- SAMHSA SBIRT: http://www.samhsa.gov/prevention/SBIRT/index.aspx

Internet Resources (Continued)

Recovery Resource **Website from William White**

williamwhitepapers.com contains the full text of more than 200 articles, 5 monographs, 30+ recovery tools, 9 book chapters, 3 books, and links to an additional 12 books written by White and co-authors over the past four decades. Of interest for service coordination are the following articles on integrating mental health and substance abuse services, written by William White.

1. The Concept of Recovery as an Organizing Principle for Integrating Mental Health and Addiction Services
2. Recovery: A Common Vision for the Fields of Mental Health and Addictions
3. Recovery from Addiction and Recovery from Mental Illness: Shared and Contrasting Lessons
4. Recovery: A Conceptual Bridge Between the Mental Health and Addictions Fields

http://www.williamwhitepapers.com/

Videos/Webcasts

Military Families: Access to Care for Active Duty, National Guard, Reserve, Veterans, Their Families and Those Close to Them:

http://store.samhsa.gov/product/Military-Families-Access-to-Care-for-Active-Duty-National-Guard-Reserve-Veterans-Their-Families-and-Those-Close-to-Them/SMA11-4621DVD

Providing a Continuum of Care: Improving Collaboration Among Services: Recovery Month Webcast: May 2009:

http://store.samhsa.gov/product/Providing-a-Continuum-of-Care-Improving-Collaboration-Among-Services-DVD-/SMA09-4388

Videos/Webcasts
(Continued)

Substance Abuse Treatment & Recovery Approaches for Women:

http://youtu.be/tK87pHEkIno

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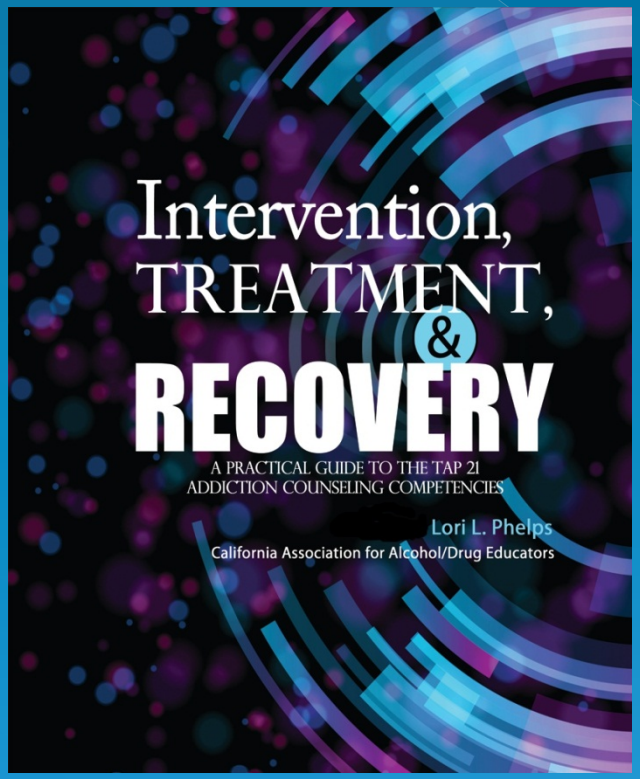

Chapter 10
PRACTICE DIMENSION V: SERVICE COORDINATION

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Lori L. Phelps
California Association for Alcohol/Drug Educators, 2013

Element:
Individual Counseling Competencies 75 - 87

75: Establish a helping relationship with the client characterized by warmth respect, genuiness, concreteness, and empathy.

76: Facilitate the client's engagement in the treatment and recovery process.

Lori L. Phelps
California Association for Alcohol/Drug Educators, 2013

Competencies 75 -87 (continued)

77: Work with the client to establish realistic achievable goals consistent with achieving and maintaining recovery.

78: Promote client knowledge, skills, and attitudes that contribute to a positive change in substance use behaviors.

Competencies 75 -87 (continued)

79: Encourage and reinforce client actions determined to be beneficial in progressing towards treatment goals.

80: Work appropriately with the client to recognize and discourage all behaviors inconsistent with progress towards treatment goals.

Competencies 75 -87 (continued)

81: Recognize how, when, and why to involve the client's significant others in enhancing or supporting the treatment plan.

82: Promote client knowledge, skills, and attitudes consistent with the maintenance of health and prevention of HIV/AIDS, tuberculosis, sexually transmitted diseases, hepatitis C, and other infectious diseases.

Competencies 75 -87 (continued)

83: Facilitate the development of basic and life skills associated with recovery.

84: Adapt counseling strategies to the individual characteristics of the client, including but not limited to disability, gender, sexual orientation, development level, culture, ethnicity, age and health status.

Competencies 75 -87 (continued)

85: Make constructive therapeutic responses when the client's behavior is inconsistent with stated recovery goals.

86: Apply crisis prevention and management skills.

Competencies 75 -87 (continued)

87: Facilitate the client's identification, selection, and practice of strategies that help sustain the knowledge, skills and attitudes needed for maintaining treatment progress and preventing relapse.

Definition of Counseling:

"a collaborative process that facilitates the client's progress towards a mutually determined treatment goals and objectives"

Counseling Methods:

Counseling includes methods that are sensitive to individual client characteristics and to influence of significant others, as well as the client's cultural and social content.

Competence in Counseling:

Competence in counseling is built on an understanding of, appreciation of, and ability to apply modalities of care for individuals, groups, families, couples, and significant others.

Traits of a Successful Counselor

- *The ability to be empathetic with the client, yet maintain healthy boundaries.*
- *Information, skills and knowledge delivered with compassion.*

Carl Rogers (1902-1987) Humanist

"if one is able to get to the core of an individual, then one finds a trustworthy, positive center. People are trustworthy, resourceful, and capable of self understanding and self-direction."

Basic Therapy Tools

- ***Congruence***

  Genuiness or realness

- ***Unconditional Positive Regard***

  Acceptance and Caring

- ***Accurate Empathetic Understanding***

  An ability to deeply understand the subjective world of the client

Basic Therapy Tools

- *The skills of congruence, unconditional positive regard, and accurate empathetic understanding can be developed through the application of*
  - *appropriate language and paralanguage*
  - *the practice of active listening*
  - *advanced active listening*
- *Advanced active listening*
  - *Intuiting* how a client really feels and confirming that with the client

Competence in Counseling

- ***It is imperative that the counselor not let his or her judgment or morals get in the way of being empathetic toward the client.***

Body Language

- *Understanding the body language of the counselor as well as the client is as fundamental as understanding the spoken word.*

Body Language

- *Listening with your eyes is as important as listening with your ears.*

- *Up to 50% of information conveyed is communicated through the body.*

Body Language

- ***Proximity***
  - *The counselor should be seated between two and four feet away from the client.*
  - *The counselor and client should be in similar chairs with no barriers such as a desk between them.*
- *The counselor should*
  - *lean forward*
  - *open posture*
  - *legs uncrossed*
  - *arms uncrossed*
  - *hands open for appropriate hand movement.*

Recovery is a Slow Process: Counselor Responsibilities

- *your positive intentions and your responsibility to do no harm must be conveyed in all interactions with the client.*

Recovery is a Slow Process: Counselor Responsibilities

- *Making certain that a client is fully aware of any program rules or regulations in which he or she is participating*
  - *helps the client understand the healthy boundaries that are often nonexistent on substance abuse families.*

Counselor Responsibilities

- *Creating a safe environment for clients to identify and express feelings.*
- *Formulating and stating treatment goals.*
- *Motivating and monitoring success.*
- *Providing education, consultation and referral services.*

Theoretical Foundations

- *Examples of counseling therapies and evidence based approaches in substance abuse:*
  - *Motivational Interviewing (MI)*
  - *Cognitive Behavioral Therapy (CBT)*
  - *12-Step Facilitation Therapy*

See SAMHSA's National Registry of Evidence-Based Programs: http://nrepp.samhsa.gov/

Motivation for Change: Client Readiness

- *Self motivation can be assessed by hearing, observing and understanding client's emotional and physical pain.*
- *Self-motivation may happen when client recognizes the need for help with sobriety, or the family has reached a breaking point and requests help for the addict.*
- *Sometimes achieved through intervention conducted by a skilled counselor.*

Intervention:

"presenting reality in a caring receivable way"

(Vernon E. Johnson, 1990)

Final Step of Intervention:

- ***Appropriate treatment plan consisting of:***
  - *Break through denial*
  - *Acknowledge the problem*
  - *Set attainable goals*
  - *Set timelines*
  - *Prepare methods for evaluating progress*

Involve the Family in Treatment

- *The involvement of family members or significant others at appropriate times must always be a part of the treatment program.*

Counseling – Involve the Family:

- *The family need to know that their own recovery is as important as the client's treatment program.*
- *Make referrals to*
  - *Family therapists*
  - *Al-Anon*
  - *other support groups that provide positive support social support for the addicted families.*

Skills Enhancement

- *Assessing basic skill deficits as well as educational and career needs should be done early in the treatment.*
- *Coaching, mentoring, and validating*
- *Recognize and address ambivalence*
- *Educate the client about life skills*
- *Make an inventory of those needs and create a plan to learn and practice new life skills.*

Past, Present & Future

- *Knowledge of the client's history, both positive and negative, is helpful for:*
  - *developing the treatment plan*
  - *evaluating progress*
  - *making appropriate changes.*
- *Recognize co-occurring disorders*
- *Make referrals*
  - *medical*
  - *educational*
  - *psychological*

Past, Present & Future

- *Have the client research, make contacts and set-up interviews regarding sober living, recovery homes, and resource centers.*
- *Encourage the family to support healthy decisions made by the client and allow the adult client to take care of his or her own needs.*
- *Let the family members know what is and what is not their responsibility.*
- *Educate the family about relapse*

Sexually Transmitted Diseases

- *Educate the client about health maintenance and prevention of*
  - *HIV/AIDS*
  - *Tuberculosis*
  - *sexually transmitted diseases (STDs)*
  - *hepatitis C, and other infectious diseases.*
- *Refer to doctors and other appropriate health care workers who are trained in addiction*

Healthy Schedules

- *A consistent healthy schedule maintained at an inpatient or recovery home routine includes:*
  - *Early wake-up*
  - *Fixed meal times*
  - *Clean-up*
  - *Meditation*
  - *Group time*
  - *Fixed bedtimes*

Healthy Practices

- *Life skills :*
  - *Personal hygiene*
  - *Communication skills*
  - *Budgeting*
  - *Assertiveness training*
  - *Self-esteem*
  - *Interviewing skills*
  - *Anger management*

Healthy Thinking

- *Recognition of drinking and using patterns, triggers, and relapse signs important.*
- *Recognize the people, places, and things that contribute to substance abuse*
- *Recognize the people, places, and things that contribute to a healthy lifestyle.*

Cultural Awareness

- *Be educated and aware of issues related to:*
  - *Gender*
  - *Sexual orientation*
  - *Development level*
  - *Ethicnicity*
  - *Age*
  - *Health status.*

Recognize and Redirect Inappropriate Behavior

- The client may regress to old, familiar dysfunctional behaviors which may be inconsistent with the recovery goals.
- Know the client's strengths and weaknesses
- Recognize stressors and crisis situations
- Teach the client to identify and talk about his or her feelings

Crisis Prevention

- Informed consent
- Suicide contracts
- Code of Federal Regulation (CFR) Title 42 Part 2
- Health Insurance Portability and Accountability (HIPAA) laws

Relapse

- Common!
- Does not have to be permanent
- Teach clients the medical and emotional consequences of relapse
- Relapse can be both emotional and physical
- Recognize the signs
- Practice relapse prevention strategies.

Lori L. Phelps
California Association for Alcohol/Drug Educators, 2013

Internet Resources

- Alcoholics Anonymous: http://www.AA.org
- CNS Productions (*Uppers Downers All Arounders*): http://www.cnsproductions.com
- FMS Productions (treatment films): http://www.fmsproductions.com
- Hazelden (books, films for recovery): http://www.hazelden.org
- Motivational Interviewing: http://www.motivationalinterview.org/

Videos/Webcasts

Bill W: http://www.page124.com/

The only documentary about the co-founder of Alcoholics Anonymous

Watch *Bill W.* Online

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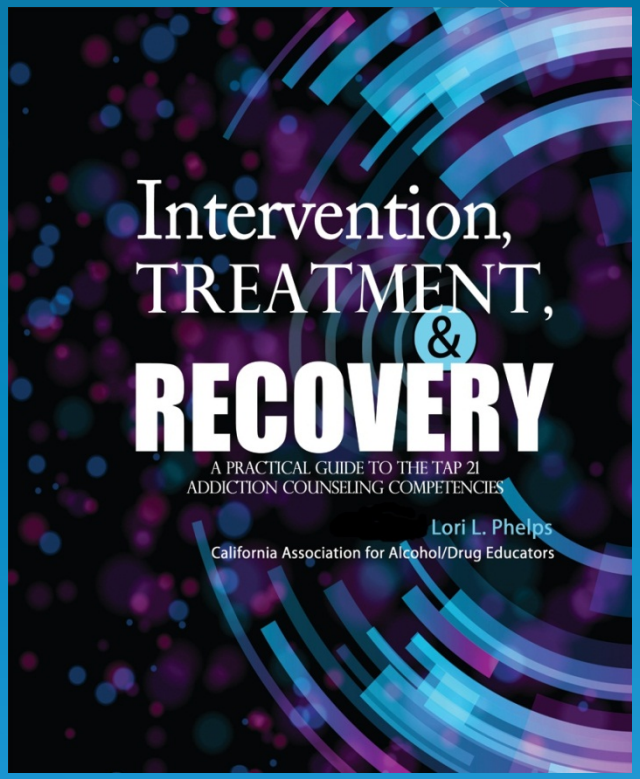

Chapter 11

PRACTICE DIMENSION V: COUNSELING (ELEMENT: GROUP)

Contributors: Greg Granderson, Dick Wilson, Lori Phelps

Kendall Hunt publishing company

Competencies 88-93

88: Describe, select, and appropriately use strategies from accepted and culturally appropriate models for group counseling with clients with substance use disorders.

89: Carry out the actions necessary to form a group, including but not limited to determining group type, purpose, size, and leadership; recruiting and selecting members; establishing group goals and clarifying behavioral ground rules for participating; identifying outcomes; and determining criteria and methods for termination or graduation from the group.

Competencies

90: Facilitate the entry of new members and the transition of exiting members.

91: Facilitate group growth within the established ground rules and movement toward group and individual goals by using methods consistent with group type.

92: Understand the concepts of process and content, and shift the focus of the group when such a shift will help the group move toward its goals.

Groups and Substance Abuse Treatment

- Modifying Group Therapy to Treat Substance Abuse
  - Specific training and education needed
  - Individual therapy is not equivalent to group therapy
  - Group therapy is not equivalent to 12-step program practices
- Group therapy, properly conducted, is difficult.
  - Addicted populations pose unique problems

Five Group Models

- **Psychoeducational Groups**
  - Structured content using video, audio, lecture
- **Skills Development Groups**
  - Coping skills training groups
- **Cognitive-Behavioral Groups**
- **Support Groups**
  - Manage emotions, develop interpersonal skills
- **Interpersonal Process Group Psychotherapy**

Specialized Groups

- Relapse prevention treatment groups
- Communal and culturally specific treatment groups
- Expressive groups (art therapy, dance, psychodrama)

Criteria for Placement

- The client's characteristics, needs, preferences, and stage of recovery
- The program's resources
- The nature of the group or groups available

Goals and Effectiveness of Treatment

- Reducing substance abuse or achieving a substance-free life
- Maximizing multiple aspects of life functioning
- Preventing or reducing the frequency and severity of relapse

Stages of Recovery

- ***Early recovery:*** One month to one year. Clients are fragile and particularly vulnerable to relapse.
- ***Middle recovery****:* The client will begin to make significant lifestyle changes and will begin to change personality traits. This stage generally will take at least a year to complete, but can last indefinitely.
- ***Late recovery/maintenance:*** Clients work to maintain abstinence while continuing to make changes unrelated to substance abuse in their attitudes and responsive behavior. This phase has no end.

Group Stages

Forming: Development of attraction bonds. Exchange of information. Orientation toward others.
Storming: Dissatisfaction, competition, disagreement
Norming: Development of structure, cohesiveness, harmony, establishment of roles and relationships
Performing: Focus on achievements, task orientation, performance and productivity
Adjourning: Termination of duties, reduction of dependency, task completion

Characteristics in the Stages

- **Forming:** Tentative, polite, concern about how to fit in
- **Storming:** Ideas are criticized, speakers interrupted, poor attendance, hostility
- **Norming:** Agreement on rules, consensus seeking, feeling of support, "We" feeling
- **Performing:** Problem solving, increased cooperation
- **Adjourning:** Regret, increased emotionality, disintegration

Extensional Groups

- Self-disclosure
- Authentic behavior
- Personal risk taking
- Personal privacy and risk

Internet Resources

- Johari Window: http://www.noogenesis.com/game_theory/johari/johari_window.html
- All About Psychology
  - http://www.all-about-psychology.com/
- Psychotherapy.net
  - http://www.psychotherapy.net

Videos/Webcasts

- The Therapeutic Benefits of Group Therapy http://sereneconnections.com/video_detail.php?VideoID=1
- Irvin Yalom Inpatient Group Psychotherapy Video http://youtu.be/05Elmr65RDg
- Tip 41- Substance Abuse Treatment and Group Therapy
  - http://youtu.be/EcU4dG-l_70
- Cesar Milan: Power of the Pack
  - http://youtu.be/_2fs7Qdt61k

Exercises/Activities

- **Who Am I?**
  Write a full page or two in answer to the question, Who am I?
- **Animal Game**
  Go around the group and have each member answer this question: If I came back in another life as an animal, what kind of animal would I be? Each member explains in a few words why they have chosen a particular animal (its characteristics, color, strengths, weaknesses, abilities, etc.).
- **Pinto Bean Identity Exercise**

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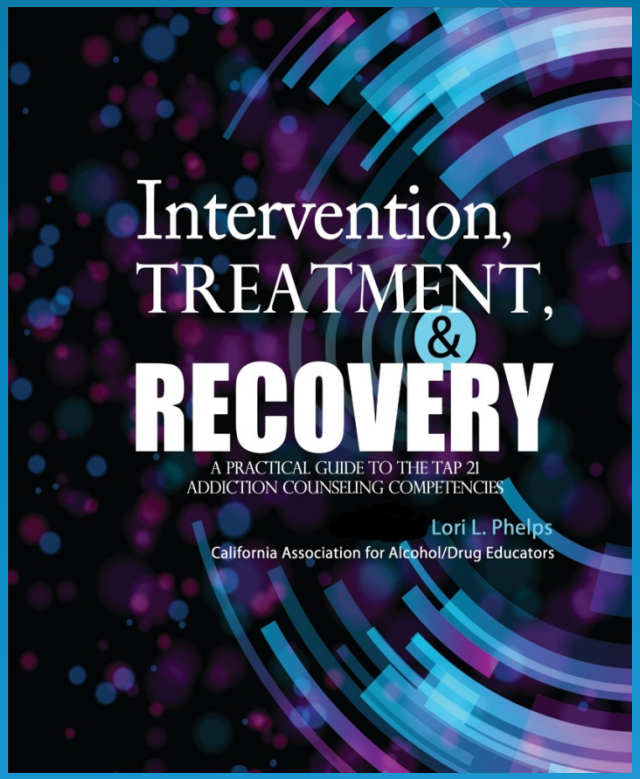


Chapter 12

Practice Dimension V: Counseling (Element: Counseling Families, Couples, and Significant Others)

Contributors: Lynn Delvaux, Lori Phelps

Kendall Hunt publishing company

Competencies 94-98

94: Understand the characteristics and dynamics of families, couples, and significant others affected by substance use.

95: Be familiar with and appropriately use models of diagnosis and intervention for families, couples, and significant others, including extended, kinship, or tribal family structures.

96: Facilitate the engagement of selected members of the family or significant others in the treatment and recovery process.

Competencies 94-98

97: Assist families, couples, and significant others in understanding the interaction between the family system and substance use behaviors.

98: Assist families, couples, and significant others in adopting strategies and behaviors that sustain recovery and maintain healthy relationships.

Impact of Substance Abuse on Families

- *Negativism*
- *Parental inconsistency*
- *Parental denial*
- *Miscarried expression of anger*
- *Self-medication*
- *Unrealistic parental expectations*

Family Intervention

- **Johnson Intervention**
  - a method for mobilizing, coaching, and rehearsing with family members, friends, and associates
  - Element of surprise
- **Unilateral Family Therapy**
  - applied with spouses (usually wives) of uncooperative family members who are abusing substances (typically alcohol)
  - "programmed confrontation"

Family Intervention (cont'd)

- **Community Reinforcement Training (CRT)**
  - *Includes a number of sessions with the spouse*
  - *Attempts to take advantage of a moment when the person is motivated to get treatment by immediately calling a meeting at the clinic with the counselor, even in the middle of the night*
- **A Relational Intervention Sequence for Engagement (ARISE)**
  - *an invitational intervention method with the family conducting most of the intervention*

Goals and Outcomes of Family Services

- *Increase family support for the client's recovery*
- *Identify and support change of family patterns that work against recovery*
- *Prepare family members for what to expect in early recovery*
- *Educate the family about relapse warning signs*

Goals and Outcomes of Family Services (cont'd)

- *Help family members understand the causes and effects of substance use disorders from a family perspective*
- *Take advantage of family strengths*
- *Encourage family members to obtain long-term support*

Outcomes of Family Involvement

- The client is encouraged to enter treatment.
- The client is motivated to remain in treatment.
- Relapses are minimized.
- A supportive and healthy environment for recovery is provided.
- Other family members who may need treatment or other services are identified and treated.
- Changes in the family's longstanding dysfunctional patterns of communication, behavior, and emotional expression may protect other family members from abusing substances.

Strategies to Engage the Family in Treatment

- *Include family members in the intake session*
- *Use client-initiated engagement efforts*
- *Written invitations*
- *Incentives (refreshments, transportation, child care, etc.)*
- *Picnics or dinners for families*
- *Community reinforcement training (CRT) interventions (improve retention and outcomes)*

Overcoming Barriers

- **Use the resources of the program**
  - Flexible hours
  - Large offices
  - Safe toys
- **Provide a safe, welcoming environment**
  - A safe, clean, cheerful meeting space
  - well-marked and well-maintained exterior, comfortable furniture
  - Ice-breaking activities, simple games, and role-play activities

Techniques to Help Families Attain Sobriety

- Motivate the family
- Contract with the family for abstinence
- Al-Anon, spousal support groups, and multifamily support groups
- Use the network (courts, parole officers, employer, team staff, licensing boards, child protective services, social services, lawyers, schools, etc.)
- Reduce anxiety
- Create genograms

Techniques to Help Families Adjust to Sobriety

- Restructure family roles
- Realign subsystems/generational boundaries
- Teach relapse prevention
- Teach communication and conflict resolution skills
- Use communication skills and negotiation skills training.
- Employ conflict resolution techniques
- Use AA, Al-Anon, Alateen, and Families Anonymous as part of the network

Internet Resources

- **Adult Children of Alcoholics (ACOA)** www.adultchildren.org
- **Al-Anon Family Groups** www.al-anon.org
- **Families Anonymous (FA)** www.familiesanonymous.org
- **Nar-Anon Family Groups** www.naranon.com
- **National Asian Pacific American Families Against Substance Abuse** www.napafasa.org

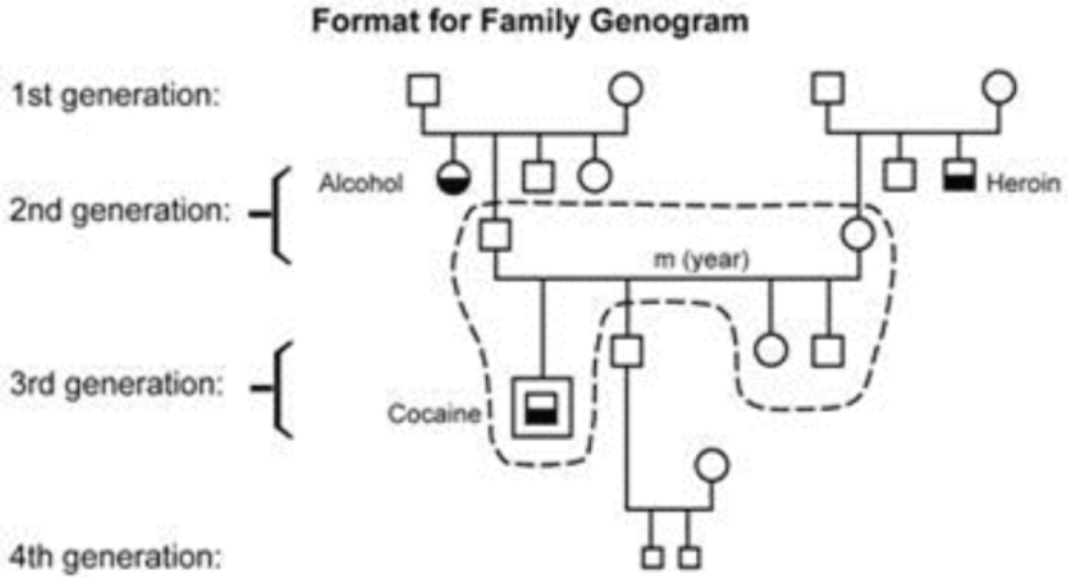
Matrix Manuals

- Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders: Counselor's Family Education Manual w/CD
  http://store.samhsa.gov/product/Matrix-Intensive-Outpatient-Treatment-for-People-with-Stimulant-Use-Disorders-Counselor-s-Family-Education-Manual-w-CD/SMA12-4153

Videos/Webcasts

- **A&E Intervention**
  http://www.aetv.com/intervention/index.jsp
- **Moyers on Addiction: Close to Home**
  www.pbs.org/wnet/closetohome
- Matrix Family Education Videos **(Free CD from SAMHSA) http://store.samhsa.gov/product/Matrix-Family-Education-Videos/SMA11-4637**
- **When Love Is Not Enough: The Lois Wilson Story**
  - **http://youtu.be/jVCYeL8Uv8s**

Exercises/Activities

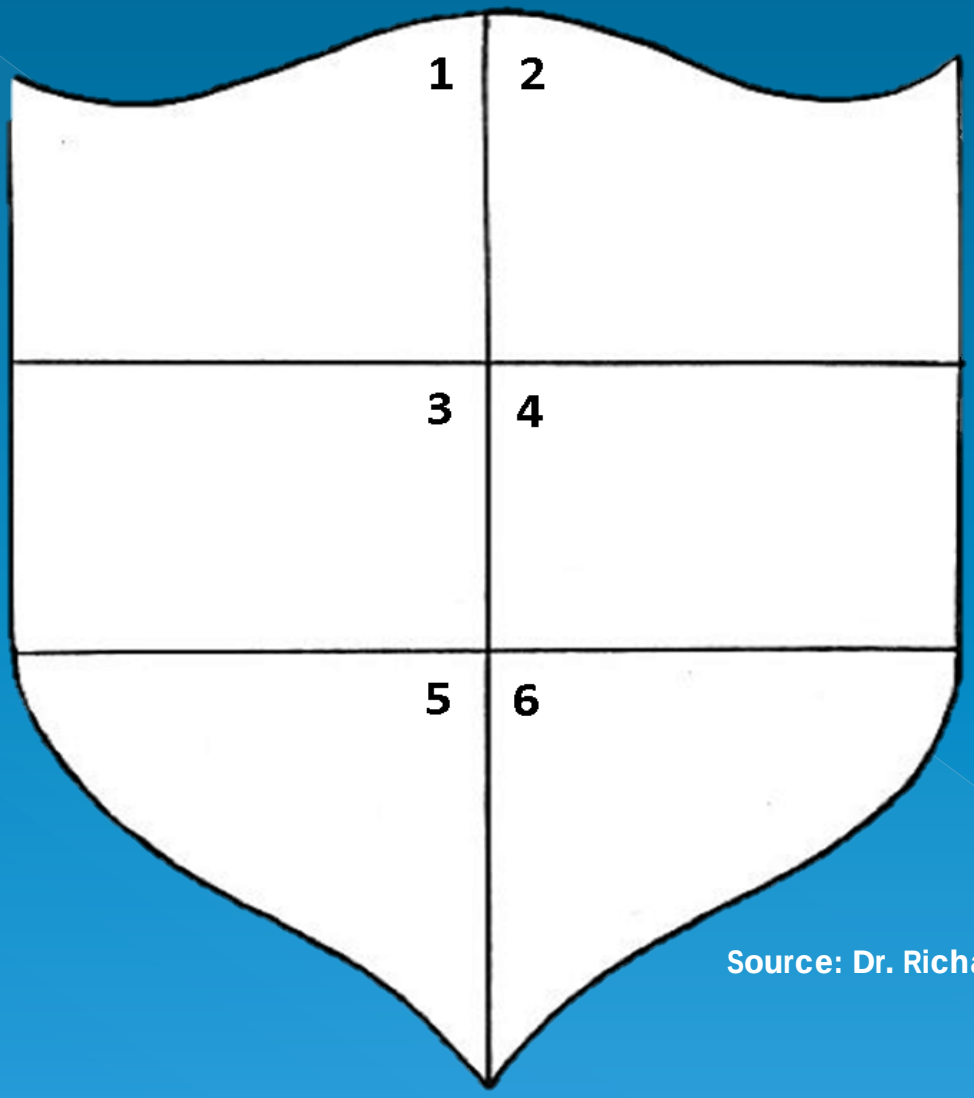


The Family Table

Each participant is asked to sketch a design of their own family by describing the place where he or she was located at that table

- What did my place at that table tell me about my role in that family group? For example:
- Was I an active or passive participant?
- How did I get attention? By rebelling, being funny, etc.
- Who was my friend at that table, a parent, older or younger sibling or perhaps a grandparent?
- What role did I play? A scapegoat, or my value as a person was discounted or my opinions were respected.
- When I had a problem whom did I talk to?
- And as I look back on that table scene do I play the same roles today? Am I a leader or a follower, am I more or less assertive, am I outgoing or pretty much into self?

Personal Coat of Arms



Source: Dr. Richard Wilson

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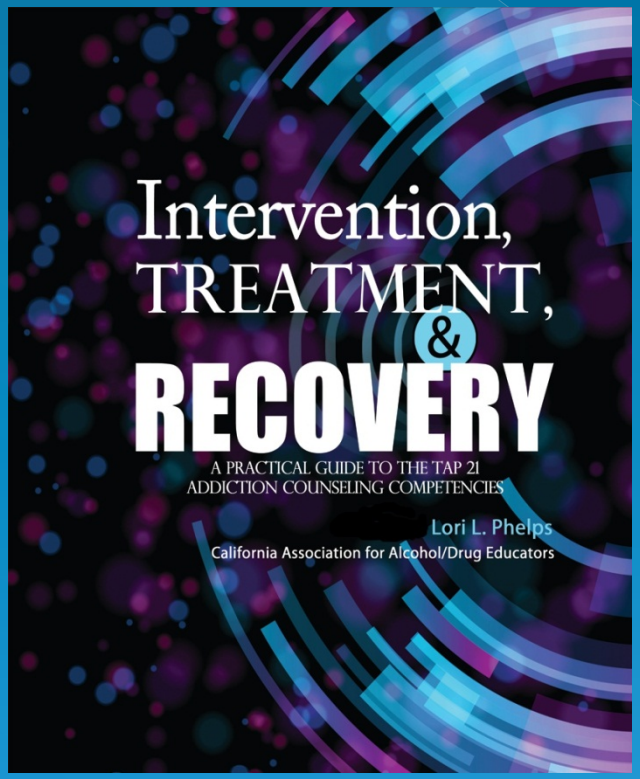


Chapter 13

PRACTICE DIMENSION VI:
CLIENT, FAMILY, AND COMMUNITY EDUCATION

Contributors:
Carlton Blanton, Tandy Iles, Lori Phelps

Kendall Hunt publishing company

Client, Family, and Community Education

- *Client, family, and community education* is defined as "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, 2006c, p. 123)

Competencies 99-107

- **The Addictions Counselor Should**:

99. Provide culturally relevant formal and informal education programs that raise awareness and support substance abuse prevention and the recovery process.

100. Describe factors that increase the likelihood for an individual, community, or group to be at risk for or resilient to psychoactive substance use disorders.

101. Sensitize others to issues of cultural identity, ethnic background, age, and gender in prevention, treatment, and recovery.

102. Describe warning signs, symptoms, and the course of substance use disorders.

Competencies 99-107

103. Describe how substance use disorders affect families and concerned others.

104. Describe the continuum of care and resources available to the family and concerned others.

105. Describe the principles and philosophy of prevention, treatment, and recovery.

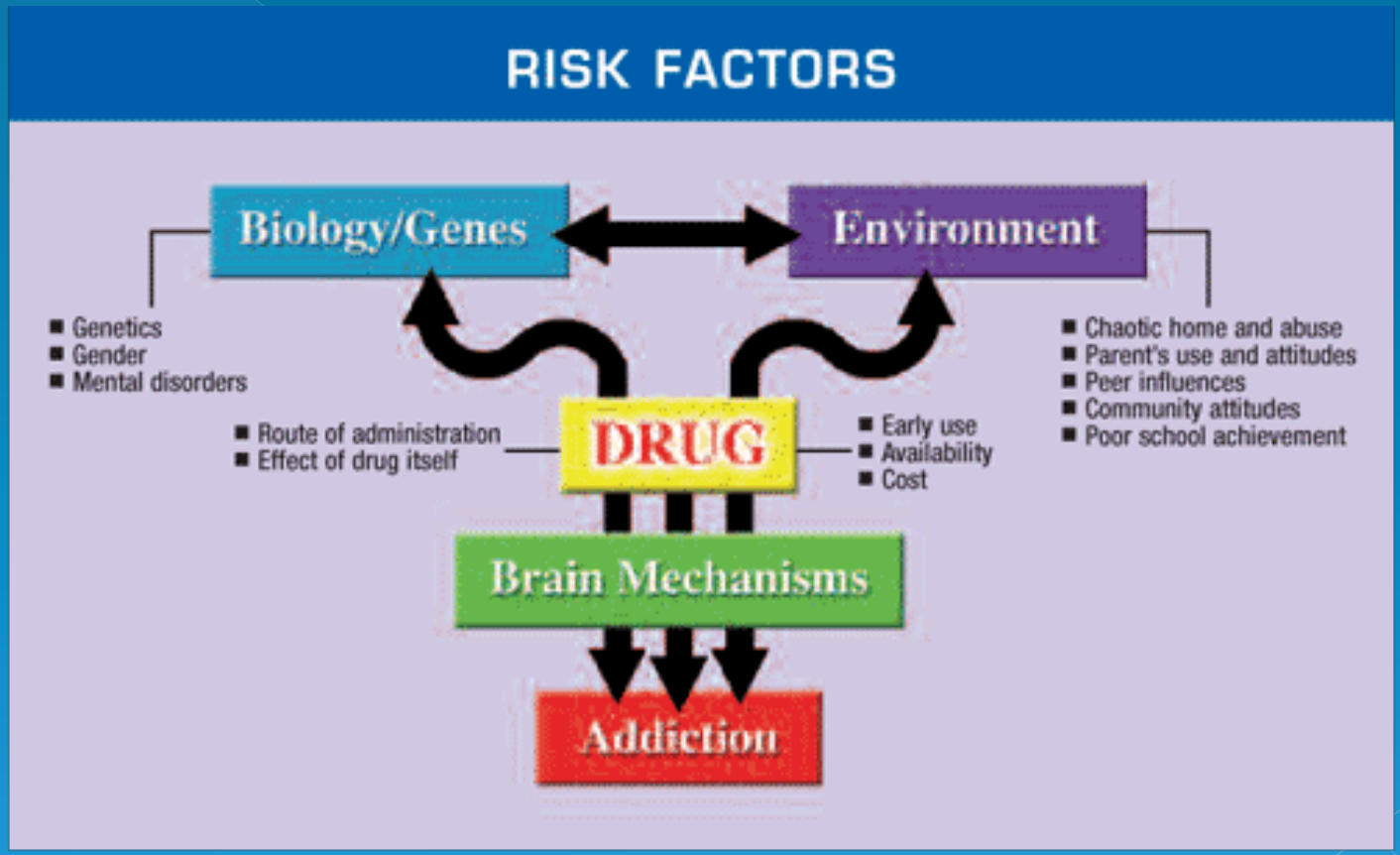
106. Understand and describe the health and behavior problems related to substance use, including transmission and prevention of HIV/AIDS, tuberculosis, sexually transmitted diseases, hepatitis C, and other infectious diseases.

107. Teach life skills including but not limited to stress management, relaxation, communication, assertiveness, and refusal skills.

Cultural Competence

- Outcome studies suggest that tailoring services to the specific needs of cultural and ethnic groups improves outcomes
- Meeting the needs of diverse clients involves two components:
  - (1) understanding how to work with persons from different cultures, and
  - (2) understanding the specific culture of the person being served .
- Cultural competence means being a responsible, caring clinician who treats clients with respect, expresses genuine interest in clients as individuals, keeps an open mind, asks questions of clients and other providers, and is willing to learn.

Risk and Protective Factors for ATOD Problems



Risk Factors

- Vulnerability to addiction is 40-60% genetic
- **Community Environment** (unemployment, inadequate housing, crime, drug use
- **Minority Status** (discrimination, level of assimilation, language barriers, low education levels
- **Family** (parental addiction, abuse, mental illness), stress, unemployment, violence
- **Early behavior prob**lems
- **Adolescence**: negative behavior/experiences

Protective Factors

- **Community** (low unemployment, adequate housing, low crime)
- **Family** (adequate income, structure and nurturing, attention during first year of life)
- **Constitutional Strengths** (intelligence, physically robust, no impairments)
- **Personality** (easy temperament, adaptable, positive, healthy expectations, self-discipline, problem-solving skills)

Resilience (Wolin, 1993)

- **Insight -** asking tough questions and giving honest answers.
- **Independence -** distancing emotionally and physically from the sources of trouble in one's life.
- **Relationships -** making fulfilling connections to other people.
- **Initiative -** taking charge of problems.
- **Creativity -** using imagination and expressing oneself in art forms.
- **Humor -** finding the comic in the tragic.
- **Morality -** acting on the basis of an informed conscience.

Diverse Client Populations

- **Competency 101**: *Sensitize others to issues of cultural identity, ethnic background, age, and gender in prevention, treatment, and recovery.*

- **Hispanics/Latinos**
- **African Americans**
- **Native Americans**
- **Asian Americans and Pacific Islanders**
- **Persons with HIV/AIDS**
- **Lesbian, Gay, Bisexual, and Transgender (LGBT) Clients**
- **Persons with Physical and Cognitive Disabilities**
- **Rural Populations**
- **Homeless Populations**
- **Older Adults**

Preventing Drug Abuse

- **Adolescence is a critical time**
  - Early use of drugs increases the chance for more serious drug abuse and addiction
  - Drugs change the brain
- **Science-validated Programs**
  - can significantly reduce early use of tobacco, alcohol and illicit drugs
- ***Universal programs*** address risk and protective factors common to all children in a given setting, such as a school or community.
- ***Selective programs*** target groups of children and teens who have factors that further increase their risk of drug abuse.
- ***Indicated programs*** are designed for youth who have already begun abusing drugs.

Health and Behavior Problems Related to Substance Use

- Mental and substance use disorders are among the top conditions for disability, burden of disease, and cost to families, employers, and publicly funded health systems
- By 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide.

Find Current Data on Alcohol and Drug Abuse in the US

- **Monitoring the Future Survey**
  http://www.drugabuse.gov/DrugPages/MTF.html

- **National Survey on Drug Use and Health**
  http://oas.samhsa.gov/nsduh.htm

Illness Management and Recovery EBP Kit

- **Practitioner Guides and Handouts**

http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463

- **IMR curriculum**
  - Recovery strategies
  - Practical facts about mental illnesses
  - Stress-Vulnerability Model and treatment strategies
  - Building social support

IMR Curriculum (cont'd)

- Using medication effectively
- Drug and alcohol use
- Reducing relapses
- Coping with stress
- Coping with problems and persistent symptoms
- Getting your needs met by the mental health system

Internet Resources

- Central Center for the Application of Prevention Technologies (CAPT). http://www.ccapt.org/
- SAMHSA's National Registry of Evidence-Based Programs and Practices. http://nrepp.samhsa.gov/
- *NIDA for teens: The science behind drug abuse*. http://teens.drugabuse.gov/
- *Project Resilience* www.projectresilience.com

Videos/Webcasts

- **Prevention and Early Intervention for Substance Use and Mental Disorders: What's Working, What's Needed?** http://www.recoverymonth.gov/Resources-Catalog/2011/Webcast/04-Prevention-and-Early-Intervention.aspx
- **Survivor's Pride: An Introduction to Resiliency** http://projectresilience.com/spvideo.htm
- **Youth and College Drinking: Breaking the Patterns** **http://store.samhsa.gov/product/Youth-and-College-Drinking-Breaking-the-Patterns/DVD253**

Exercises/Activities

- **What are some reasons that you use substances (or have used them in the past)?**
- **Prevention Program Research Project**
- **Reframe Your Own Life**
  - make a *summary statement* that includes the powerful abilities you have developed from adversity—a statement of your *survivor's pride*.

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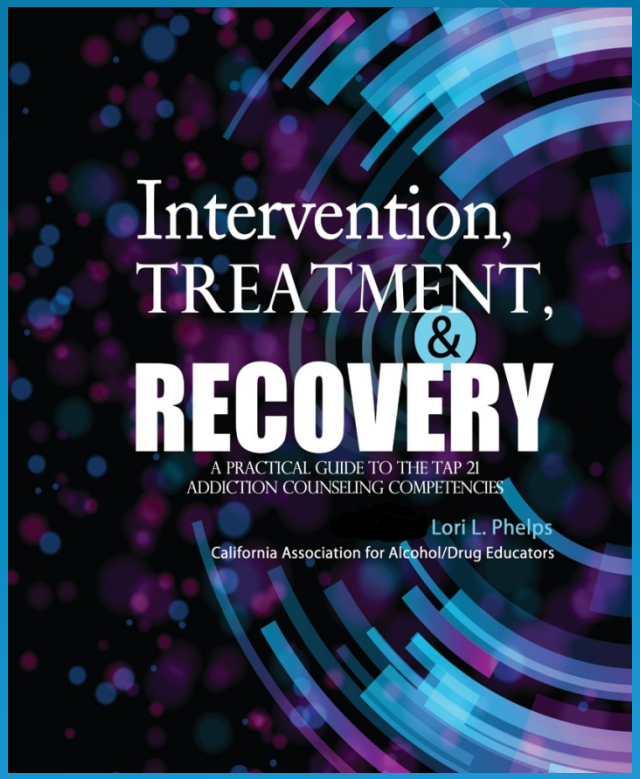


Chapter 14
PRACTICE DIMENSION VII: DOCUMENTATION

Contributors:
Carlton Blanton, Lou Hughes, Patrick Hughes

Kendall Hunt publishing company

Competencies 108-114

- **Competency 108**:
  - *Demonstrate knowledge of accepted principles of client record management.*
- **Competency 109:**
  - *Protect client rights to privacy and confidentiality in the preparation and handling of records, especially in relation to the communication of client information with third parties.*
- **Competency 110**:
  - *Prepare accurate and concise screening, intake, and assessment reports.*

Competencies 108-114

- **Competency 111:**
  - *Record treatment and continuing care plans that are consistent with agency standards and comply with applicable administrative rules.*
- **Competency 112:**
  - *Record progress of client in relation to treatment goals and objectives.*
- **Competency 113:**
  - *Prepare accurate and concise discharge summaries.*
- **Competency 114:**
  - *Document treatment outcome, using accepted methods and instruments.*

Client Record Management

- Selecting and recording the appropriate treatment/recovery options for clients
- Assuring your agency remains in fiscal compliance with its funding agencies.
- **Important Forms:**
  - Release of information
  - Assessments
  - Treatment/recovery plans
  - Progress notes
  - Discharge summaries/continuing care plans.

Essential Counselor Skills

- Writing legibly, clearly, concisely
- Understanding state and county standards, policies, and procedures
- Proper recording of treatment/recovery plan information is critical
- **Key Elements include:**
  - listing AOD-related problems including medical, family, vocational, and social issues
  - developing short-term and long-term objectives
  - preparing a plan of action to meet objectives
  - tracking client progress toward meeting objectives
  - writing a discharge summary/continuing care plan

Progress Notes

- The Treatment plan is the blueprint for recovery (the big picture)
- Progress notes record the details of what does or does not happen during actual treatment
  - any treatment/recovery plan changes
  - changes in client's status, behavior, and functioning levels.
- Counselors must know clinical terminology
- Counseling sessions must be documented within 14 days.

Discharge Summary & Continuing Care Plan

Discharge Summary	Continuing Care Plan
• Client's profile and demographics • Client's presenting symptoms • Selected interventions • Critical incidents • Progress toward meeting treatment goals • Discharge recommendations (e.g., further treatment, options for housing, education, training, family, legal)	• Aftercare options based on client's success in treatment program • Contacting appropriate and needed resources to determine availability (e.g., further treatment, options for housing, education, training, family, legal) • Scheduling AA meetings, meeting legal obligations, and attending alumni meetings

Documenting Treatment Outcome

- **TWO KEY EVALUATION TERMS**
- **Process**
  - includes recording individual and group sessions attended, session topics, number and results of urinalysis testing, and treatment plans prepared and modified
- **Outcome**
  - documents for individual clients if primary program goals were achieved (did recovery happen? was sobriety maintained? were educational, vocational, behavioral, social, and family goals achieved?)

Charting and Documentation

- **Charting**
  - reflects what actually happened; e.g., completion of program, dirty drug test, client left against staff advice
  - a legal/ethical responsibility
  - Counselors must document before leaving their shifts
- Under current law, HIV status may ***not*** be listed on a regular chart (such info is stored separately in a secure chart).
  - Use phrases such as “special medical needs” for regular chart

Protect Your Client

- The criminal justice system sometimes finds ways to get charts and use the information to penalize or prosecute patients.
- **Do not record** information that could come back to harm your client;
  - use language that would identify the issue for staff but is vague enough that non-staff could not use it against the client.

Areas Requiring Documentation

- Medical
- Employment
- Alcohol/Drug
- Legal
- Family
- Social
- Psychiatric

Treatment Plan Documentation Notes

- The client and the counselor prepare the treatment plan together.
- Client agrees to outline a recovery plan of action for the next 89 days (treatment plan must be updated within 90 days).
- Client and counselor sign and date treatment plan.
- Supervisor and medical director sign and date treatment plan.
- Treatment plans must be updated if major treatment changes occur (e.g., failed UA tests, not attending AA meetings, missing group sessions).

Treatment Plan Terms

- Modality: Type of service programs
  - Residential
  - Outpatient
  - Day care
  - Narcotic treatment
  - Perinatal
- DSM
  - *Diagnostic and Statistical Manual of Mental Disorders*
- ST/LT: Short term/Long term goals
- TX: Treatment

Progress Notes

- Objective reporting of client's attitudes, behavior, and progress (or lack of progress) toward meeting short- and long-term objectives
- Good example:
  - *Client decided to leave program against staff advice. He was given referrals to other programs as well as program referral list. He left with his wife at 5:20 pm. He took all his belongings including his prescribed medications.*
- Poor example:
  - *Client decided to leave program against staff advice. He was given referrals to other programs as well as program referral list. He left with his wife at 5:20 pm. He took all his belongings including his prescribed medications.*

Progress Notes Points to Remember

- The chart is a legal document and counselors are accountable for everything in it.
- Always sign your name, highest academic degree if applicable, license certification and your job title (service coordinator, counselor, intern, LCSW, MFT, MD).
- Every page in the chart must have the participant's name
- All notes should be written in **black ink**.
- Participants should not sign a blank Release of Information form.
- Do not speak to anyone regarding a participant without a signed **Release of Information** form.
- Mistakes: Cross out with one line and write the word Error, date, and initial above it. **Do not erase or use white-out**!

More Points to Remember

- Identify only the participant in the document. Use mother, father, friend, etc., to name others. Do not use a specific name. In a group, write group participant by first name or initials. Do not use full name of any participant in another participant's chart.
- All notes, including telephone calls, must reflect interventions and participant response to intervention.
- Progress notes must reflect either the plan goal or the stated goal for the session.
- Charts are never to leave the facility except for audit purposes.
- There should be no blank space/pages in the chart.
- Draw a diagonal line through unused space.
- Transportation is not a billable service. Accompanying a participant to an appointment and providing intervention while in transit and at the appointment are billable.

Useful Words/Phrases for Charting Staff Interventions

Acknowledged	Facilitated	Introduced	Reframed
Clarified	Helped improve	Modeled	Reinforced
Demonstrated	Implemented	Prompted	Role-modeled
Directed	Impressed	Recommended	Suggested
Educated	Informed	Redefined	Supported
Encouraged	Initiated	Redirected	Urged
Engaged	Inquired	Referred	Validated
Established	Intervened	Reflected	

Discharge/Summary Statement

- **Vital**
- **Correct Documentation**
  - Participant continues to experience difficulty in [XXX identify goal] due to lack of [XXX be specific and give behavioral examples, e.g., skills development, low self-esteem, lack of motivation, hearing voices, poor skills in [XXX], ongoing depression, etc.].
  - Participant has shown growth in the area(s) of [XXX] and has been given praise and recognition.
- **Incorrect Documentation**
  - Participant has improved. Participant no longer has [XXX]. Participant has no need for further [XXX].

Internet Resources

- Behavenet.com (DSM overview)
- Sample Substance Use Disorder Program Discharge Summary http://www.ncbi.nlm.nih.gov/books/NBK64383/#A54389

Videos/Webcasts

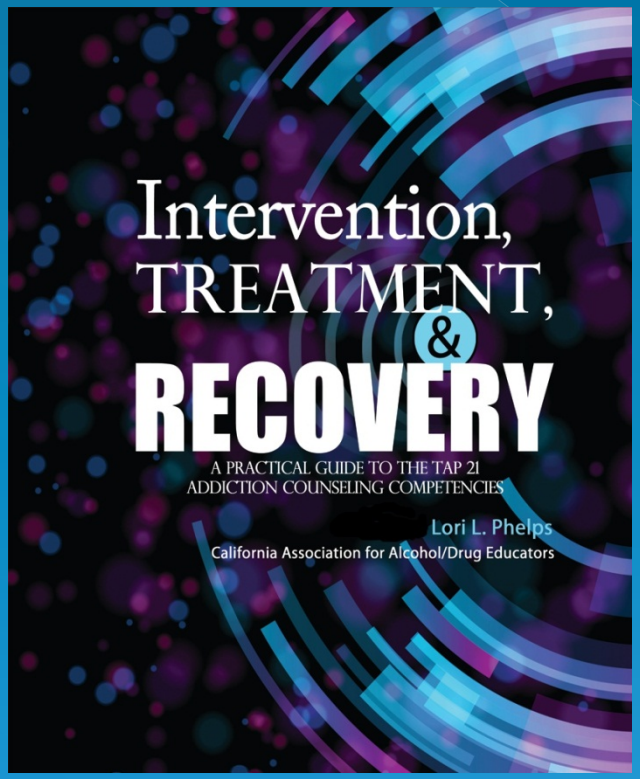
- Medication Treatment, Evaluation, and Management (MedTEAM) http://www.youtube.com/watch?v=S5UCp9HHglE

Exercises/Activities

- *Illness management and recovery: Practitioner guides and handouts* **http://store.samhsa.gov/shin/content//SMA09-4463/PractitionerGuidesandHandouts.pdf**

Intervention, TREATMENT, & RECOVERY

First Edition



Chapter 15
Practice Dimension VIII: Professional and Ethical Responsibilities

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Kendall Hunt publishing company

Competency 115:
Adhere to established professional codes of ethics that define the professional context within which the counselor works to maintain professional standards and safeguard the client.

Competency 116:
Adhere to federal and state laws and agency regulations regarding the treatment of substance use disorders.

Competency 117:
Interpret and apply information from current counseling and psychoactive substance use research literature to improve client care and enhance professional growth.

Competency 118:
Recognize the importance of individual differences that influence client behavior, and apply this understanding to clinical practice.

Competency 119:
Use a range of supervisory options to process personal feelings and concerns about clients.

Competency 120:
Conduct self-evaluations of professional performance applying ethical, legal, and professional standards to enhance self-awareness and performance.

Competency 121:
Obtain appropriate continuing professional education.

Competency 122:
Participate in ongoing supervision and consultation.

Competency 123:
Develop and use strategies to maintain one's physical and mental health.

Professional and Ethical Responsibilities

- Defined as "the obligations of an addiction counselor to adhere to accepted ethical and behavioral standards of conduct and continuing professional development" (CSAT, 2006a, p. 141).

CFR 42 Part 2

- **Code of Federal Regulations: Confidentiality of Alcohol and Drug Abuse Patient Records**
- restricts the disclosure of records or other information concerning any patient in a federally assisted alcohol or drug program, except under certain specified conditions

Intent of 42 CFR Part 2

- to ensure that an alcohol or drug abuse patient is not made more vulnerable by reason of the availability of his or her patient record than an individual who has an alcohol or drug problem and who does not seek treatment.
- 1970s

CFR 42 Part 2 and HIPAA

- Health Insurance Portability and Accountability Act (HIPAA) (1996)
- Substance abuse treatment programs already complying with Part 2 in December 2000 would not have had a difficult time complying with the Privacy Rule, as it parallels the requirements of Part 2 in many areas

Licensing and Certification in California

- The California Department of Health Care Services (DHCS) licenses and certifies treatment agencies only (not counselors)
- There is no license for addiction counselors in California, only certification (MFTs, LCSWs, psychologists, MDs may treat addiction)
- Currently five certifying organizations
- DHCS handles ethical violations (agencies and counselors)

Fundamental Ethical Principles

- **Beneficence** (client welfare)
- **Autonomy** (self-determination)
- **Nonmalfeasance** (*"First do no harm"*)
- **Justice** (fairness, equality)
- **Fidelity** (loyalty, faithfulness, honoring commitments)

Competency 119

- *Use a range of supervisory options to process personal feelings and concerns about clients.*
- Counselors will need the competent guidance and support of clinical supervisors
- Supervision standards protect the supervisor, the counselor and the client

The Competencies for Clinical Supervisors

- TAP 21-A: Competencies for Substance Abuse Treatment Clinical Supervisors (CSAT, 2008)
- Available from http://store.samhsa.gov/product/TAP-21A-Competencies-for-Substance-Abuse-Treatment-Clinical-Supervisors/SMA08-4243

Competency 120

- *Conduct self-evaluations of professional performance applying ethical, legal, and professional standards to enhance self-awareness and performance.*
- **Performance Assessment Rubrics**
  - Developed for assessing competency in the 8 practice dimensions
- **Ratings**
  - Awareness (1), Initial Application (2), Competent Practice (3) and Mastery (4).

Competency 121

- *Obtain appropriate continuing professional education*

- **Continuing Education and Training**
- Professional development
- California regulations require counselors to obtain 40 hours of continuing education every 2 years

Therapeutic Issues for Counselors

- **Competency 122:**
  - *Participate in ongoing supervision and consultation*
- **Competency 123:**
  - *Develop and use strategies to maintain one's physical and mental health.*

The Client-Counselor Relationship

- A crucial component of all therapy
- **Transference**
  - client transfers or projects onto counselor
- **Countertransference**
  - range of counselor responses to client
- Transference/countertransference are normal, expected
- Can be healthy or unhealthy

Secondary Traumatization

- The counselor who is repeatedly confronted by disclosures of victimization and exploitation may experience symptoms of trauma:
  - disturbing dreams, free-floating anxiety, increased difficulties in personal relationships
- May experience anger or helplessness
- May seem unaffected until strong emotions emerge—seemingly out of nowhere
- The stress and burnout can produce symptoms similar to those of posttraumatic stress disorder (PTSD)
  - anhedonia, restricted range of affect, diminished interest, irritability, difficulty concentrating, and insomnia

Burnout

- The pressures can erode a counselor's spirit and outlook, and begin to interfere with personal life
- *Compassion fatigue*
  - Secondary trauma responses
- Can shorten the counselor's professional life
- Seeing too many clients
- Inadequate support or supervision
- Failure to closely monitor reactions to clients
- Failure to maintain a healthy personal lifestyle

Establishing the Treatment Frame

- **Treatment Frame**
  - those conditions necessary to support a professional relationship
- **Boundaries**
  - Making regular appointment times, specified in advance
  - Enforcing set starting and ending times for each session
  - Declining to give out a home phone number or address
  - Canceling sessions if the client arrives under the influence of alcohol or psychoactive drugs
  - Not having contact outside the therapy session
  - Having no sexual contact
  - Terminating counseling if threats are made or acts of violence are committed against the counselor

Treatment Frame and Special Issues

- Establish and enforce a clear policy in regard to payment
- Build Trust
- When the client falls in love with the counselor
  - Maintain boundaries
  - Bring the matter to the attention of a colleague
  - Can be a "teachable moment"

Dealing With Disruptive Or Dangerous Behavior

- It is the program's responsibility to be aware of and inform counselors of any client's history of violence
- Counselors should have a personal safety plan
  - Policies should require them to call law enforcement and press charges if they are threatened.
- Create and maintain a safe environment for clients
- Avoid rescuing
- Recognize professional limitations
- It is the agency's responsibility to support the counselor

Internet Resources

- *Recovering your mental health—A self-help guide* http://store.samhsa.gov/product/Recovering-Your-Mental-Health-A-Self-Help-Guide/SMA-3504
- **Legal Action Center (Alcohol and Drug Sample Forms for free download)** http://lac.org/index.php/lac/alcohol_drug_publications#forms

Case Law

- **Tarasoff v. Regents of the University of California**
  http://www.adoctorm.com/docs/tarasoff.htm
- **Ewing v. Goldstein**
  http://www.apa.org/about/offices/ogc/amicus/ewing.aspx
- **Tarasoff reconsidered after Goldstein:**
  http://www.apa.org/monitor/julaug05/jn.aspx
- **Hedlund v. Superior Court of Orange County**
  http://www.apa.org/about/offices/ogc/amicus/hedlund.aspx