Addictions Counseling Essentials

ADDICTIONS COUNSELING ESSENTIALS

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CONTENTS

ABOUT THIS BOOK

This book is a collaboration between a group of educators with extensive experience in the addictions field. Our aim is to provide a meaningful resource for those who are training to become certified professionals in the field of addictions counseling and recovery.

A quick note about terminology: the term addiction will often be used interchangeably with substance use disorder. There are many behaviors that fit the description of addiction, but our focus in this book is on substances such as those described in the Diagnostic and Statistical Manual (DSM) under the rubric of Substance Use Disorder. We understand addiction to be a chronic illness of the brain marked by compulsion, loss of control, and continued use despite consequences. These three "Cs" highlight the key features of addiction and distinguish it from other problematic behaviors. Thus, the addiction treatment field incorporates its own distinctive methods.

The addictions counselor utilizes a unique skill set in the broad world of mental health. We believe it is important to recognize those unique attributes and prepare students for the specific environments they will work in. As identified by the Substance Abuse and Mental Health Services Administration (SAMSHA), counselors should enter the field with the appropriate knowledge, skills, and attitudes to assist those seeking recovery from substance use disorder.

Prior to reading this book, it is helpful to have an understanding of how to define addiction, theories of how addiction develops, basic drug pharmacology, and methods used to recover from addiction. The content of the book provides a further step toward becoming a certified counselor. We have divided the text into four primary units. Each unit encompasses a theme that is a fundamental function of people helping others to overcome substance use disorder.

PART I.

UNIT ONE: CORE KNOWLEDGE

In this unit, we explore the key areas of counselor knowledge. The chapters focus on information that is relevant to anyone working in addictions treatment and is foundational to good clinical practice.

Included are sections on the core functions of the addictions counselor, ASAM assessment and placement criteria, understanding diagnostic criteria, and becoming familiar with the Illinois administrative code governing treatment services – referred to at the 2060 law. Note that the information relating to the Illinois 2060 code is for the benefit of those seeking certification in the state of Illinois.

Being familiar with this content is important for all counselors to be successful in the field. The core functions encompass a group of fundamental aspects of the job, while assessment and diagnostic elements speak to the ways we establish a need for treatment and a path for working with an individual. The 2060 law outlines the requirements of all licensed treatment programs in the state of Illinois and provide critical expectations for all counselors to be aware of.

For many years, alcoholism treatment providers predominantly assumed that people with drinking problems[1] were a homogeneous group that could be treated optimally with only one treatment modality. This modality involved inpatient care with a fixed length of stay and a treatment approach based on the 12-step model of Alcoholics Anonymous. In recent years, however, both assumptions—that of patient homogeneity and treatment uniformity—have been abandoned. As the articles in this journal issue illustrate, researchers and clinicians now recognize that problem drinkers are a diverse group and differ substantially in the causes and manifestations of their alcohol-related problems. Furthermore, most researchers now believe that no single form of treatment is effective for all people presenting with alcohol-related problems (Hester and Miller 1989). Consequently, alcohol researchers now are conducting many studies designed to determine what types of interventions are most effective for what types of patients. This approach is founded on the "matching hypothesis," which states that an optimal matching of patients and treatments will produce the greatest overall treatment effectiveness.

The need to acknowledge formally the heterogeneity of treatment needs among people with alcohol-related problems recently has received additional impetus from a direction unanticipated when the subtyping of alcoholics first became popular—namely, from the proliferation of managed

1. In this article, the terms "people with drinking problems" and "problem drinkers" refer to all individuals whose alcohol consumption has caused them medical, psychological, or social problems. These overarching terms therefore encompass the more medical diagnoses of alcohol abuse and alcohol dependence as defined by the American Psychiatric Association.

care systems as a means of controlling health care costs (see sidebar, p. 38.). With the widespread use of managed care in treating alcohol and other drug (AOD) abuse in both the private and public sectors, the demand for specific types or levels of treatment (e.g., inpatient detoxification or residential rehabilitation) now depends on more than just the patient's wishes or the physician's perceptions of what the patient needs. Patients now must meet utilization review criteria set by the managed care providers in order to be eligible for treatment reimbursement. In addition to controlling costs, the development of such criteria will enable health care delivery systems to account for meaningful and valid differences among problem drinkers and to determine more accurately the mix of treatment services the patients need. Ultimately, the improved match between patient needs and the types of services avail able within the system will enhance the efficiency and effectiveness of the alcoholism treatment system. This matching process likely will focus on selecting specific treatment modalities rather than on the settings in which these modalities are provided.

The ASAM Criteria

The ASAM criteria were developed from numerous and widely disseminated drafts and revisions and were evaluated in field tests at 15 different sites (MeeLee 1993). The primary goal of the criteria was to provide a common language for both providers and payers when determining the severity of a patient's problems, the different levels or settings of the treatment modalities offered, and the criteria for patient placement within the continuum of AOD treatment. These criteria not only described patient characteristics that might warrant inpatient care but also provided guidelines for different types of outpatient treatment and outlined the process of moving across different levels of care.

The ASAM system is built around criteria dimensions that are used to place patients in one of four levels of care originally presented in an Institute of Medicine report (1990) describing transitions in the alcoholism treatment field. The four levels of care are as follows:

- *Level I: Outpatient treatment.*

Such settings include organized nonresidential services or office practices in permanent facilities with designated addiction treatment personnel who provide professionally directed evaluation, treatment, and recovery services to addicted patients. The services are provided in regularly scheduled sessions of usually fewer than 9 hours per week.

- *Level II: Intensive outpatient and partial hospitalization treatment.* In these settings, an organized service with designated addiction personnel provides a planned treatment regimen consisting of regularly scheduled sessions of at least 9 hours per week within a structured program. This level of care affords patients the opportunity to interact with the realworld environment while still benefiting from a programmatically structured therapeutic milieu.
- *Level III: Residential and medically monitored inpatient treatment.* These modalities, which are offered in permanent facilities with inpatient beds, include a planned regimen of roundtheclock professionally directed evaluation, care, and treatment for addicted patients provided by designated addiction personnel. The treatment is specific to AOD abuse and does not require the full resources of an acutecare general hospital.
- *Level IV: Medically managed inpatient treatment.* This level of care, which also is administered by designated addiction professionals, provides a roundtheclock planned regimen of medically directed

evaluation, care, and treatment for addicted clients in an acute care inpatient setting. Such a service requires permanent facilities that include, at a minimum, inpatient beds. A multidisciplinary staff and the full resources of a general hospital are available to provide treatment for clients with severe acute problems necessitating primary medical and nursing services. Treatment is specific to AOD-use disorders, although the available support services allow concurrent treatment of coexisting acute biomedical and emotional conditions.

Under ASAM guidelines, clients are assigned to one of the four levels of care after being evaluated along six criteria dimensions reflecting the severity of the client's problems. Each dimension contains several criteria, and the number of specific criteria that must be met depends on the level of care. These six dimensions are described in the following paragraphs.

Dimension 1: Acute Intoxication and/or Withdrawal Potential. The ASAM criteria assume that a person who is acutely intoxicated cannot be monitored adequately as an outpatient and should receive more intensive care. When assessing withdrawal potential, one of the most important considerations is whether the client is at risk of experiencing lifethreatening withdrawal symptoms or requires medication or other support services to cope with or reduce the discomfort of withdrawal, which otherwise might cause him or her to terminate treatment.

Dimension 2: Biomedical Conditions or Complications. Higher levels of care are indicated when continued AOD use would put the client in danger of health complications. For example, an alcohol-dependent woman who is pregnant might benefit from a higher level of care. Similarly, problem drinkers with cardiovascular, liver, or gastrointestinal diseases requiring medical monitoring or treatment should receive a higher level of care.

Dimension 3: Cognitive, Emotional, and Behavioral Conditions and Complications. A wide range of emotional and behavioral conditions and com plications exist in problem drinkers, either as manifestations of alcohol abuse or as independent, coexisting psychiatric disorders. These conditions (e.g., debilitating anxiety, guilt, or depression) deserve special attention during treatment and therefore may necessitate a higher level of clinical care. Moreover, problem drinkers exhibiting signs of an imminent risk of harming themselves (e.g., attempting suicide) or others may require 24-hour monitoring, thus justifying a higher level of clinical care. The same holds true for problem drinkers whose mental status does not allow them to understand the nature of the disorder or the treatment process.

Dimension 4: Readiness to Change. Clients in SUD treatment vary greatly in their willingness to comply with treatment regimens. Clients who seek treatment and cooperate by following clinical instructions typically require a lower level of care. However, alcohol dependence often compromises a person's capacity to cooperate with treatment protocols. Clients often present for treatment with some level of understanding that alcohol is responsible for their alcohol problems but are still unwilling to participate in the clinical process. Other clients may deny that they have a drinking problem. Thus, some problem drinkers may be unlikely to enter the treatment system without first receiving some form of therapeutic preparation directed at addressing their denial and their resistance to treatment. Under these conditions, a high level of clinical care may be appropriate.

Dimension 5: Relapse/Continued Use Potential. Because drug-related problems involve recurrent patterns of behavior, relapse is a frequent and integral part of the natural history of the disorder. Two major sets of factors that derive from the client's personal (i.e., psychological and biological) background and social environment contribute to relapse potential. This dimension addresses the

personal factors that influence the extent to which people can control their environments (environmental factors are addressed in dimension 6). Accordingly, when these elements impede a client's control over his or her behavior in the current environment, a higher level of care (e.g., a halfway house rather than outpatient care) may be justified to minimize the relapse risk. For example, if a client experiences marked and persistent cravings for alcohol and thus has higher relapse potential, treatment success may be less likely in an outpatient than in an inpatient setting.

Dimension 6: Recovery Environment. The client's environment can facilitate recovery or increase the risk of relapse. When the social setting is supportive (e.g., family members and friends agree with and encourage recovery) or the client seeks out social surroundings that discourage alcohol abusing behavior patterns, a lower level of clinical care may be justified. However, when a recovering person's social setting is compromised—for example, by inadequate transportation to the treatment provider, a higher level of family stress, or friends and coworkers who regularly use alcohol—a higher level of care may be required.

Key Takeaways

- Clients are assigned to the four levels of care after being evaluated along six criteria dimensions.
- Greater severity of issues corresponds to a higher level of care on the continuum.

Table 1 summarizes the correlations between the treatment settings and criteria dimensions specified by the ASAM guidelines. The actual criteria for placing an individual into a given level of care vary according to the care level, and placement ultimately depends on the combination of client characteristics in the six assessment dimensions.

For example, treatment in an outpatient setting (i.e., level I) requires that the patient meets level I criteria in all six assessment dimensions, whereas treatment in an inpatient setting (i.e., level III or IV) requires that the client meets the corresponding severity criteria in at least two of the six dimensions. Furthermore, not all dimensions are relevant to all placement decisions. For example, readiness to change, relapse potential, and recovery environment are not used to distinguish between clients requiring level III and level IV care.

Table 1 Summary of the ASAM1 Criteria Dimensions of Assessment

Criteria Dimension	Level I: Outpatient Treatment	Level II: Intensive Outpatient or Partial Hospitalization Treatment	Level III: Medically Monitored Inpatient (Residential) Treatment	Level IV: Medically Managed Inpatient Treatment
Acute Intoxication/ Withdrawal Potential	Minimal to no risk of severe withdrawal; will enter detoxification if needed.	Minimal risk of severe with- drawal; will enter detoxifica- tion if needed and responds to social support when com- bined with treatment.	Risk of severe but manage- able withdrawal, or has failed detoxification at lower levels of care.	Risk of severe withdrawal; detoxification requires fre- quent monitoring.
Biomedical Conditions	None or noninterfering with treatment.	May interfere with treatment but client does not require inpatient care.	Continued use means imminent danger, or complications or other illness requires medical monitoring.	Complications (e.g., recur- rent seizures or disulfiram reactions) that require medical management.
Cognitive/ Emotional/ Behavioral Conditions	Some anxiety, guilt, or depression related to abuse, but no risk of harm to self or others. Mental status permits treatment comprehen- sion and participation.	Inability to maintain behav- ioral stability, abuse/neglect of family, or mild risk of harm to self or others.	Symptoms require structured environment, moderate risk of harm to self or others, or history of violence during intoxication.	Uncontrolled behavior, confusion/ disorientation, ex- treme depression, thought disorder, or alcohol hallucinosis/ psychosis.
Readiness to Change	Willing to cooperate and attend treatment; admits problem.	Attributes problems exter- nally; not severely resistant.	Does not accept severity of problems despite serious consequences.	Any difficulties noted in levels I, II, or III.
Relapse Potential	Able to achieve goals with support and ther- apeutic contact.	Deteriorating during level I treatment, or will drink with- out close monitoring and support.	Deteriorating and in crisis during outpatient care, or at- tempts to control drinking without success.	Any difficulties noted in levels I, II, or III.
Recovery Environment	Supportive social en- vironment or motivated to obtain social support.	Current job environment dis- ruptive, family/support sys- tem nonsupportive, or lack of social contacts.	Environment disruptive to treatment, logistic impedi- ments to outpatient care, or occupation places public at risk if client continues to drink.	Any difficulties noted in levels I, II, or III.

1ASAM = American Society of Addiction Medicine.

INTRODUCTION TO UNIT ONE

INTRODUCTION

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CHAPTER 1.

CORE FUNCTIONS

In the 1980s, a consortium of states developed the core functions during a time when the field was undergoing a push toward standardized education and training. This was an important era in terms of recognizing the need for professional standards in this unique and growing field. The global criteria, which provide essential guidance for how to fulfill the criteria, were added over time and reflect current standards for counselors in the field.

The 12 core functions are fundamental to understanding the work of the addictions counselor and their integral role in the field. They outline the duties performed by substance use disorder counselors, while also detailing a roadmap of how the functions work in a treatment setting. Each function is described below, followed by the global criteria that define the function and an explanation of how they work in practice.

TWELVE CORE FUNCTIONS OF THE ALCOHOL AND OTHER DRUG ABUSE COUNSELOR

I. SCREENING: THE PROCESS BY WHICH THE CLIENT IS DETERMINED APPROPRIATE AND ELIGIBLE FOR ADMISSION TO A PARTICULAR PROGRAM.

Global Criteria:

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

Explanation:

This function requires the counselor to consider a variety of factors before deciding whether or not to admit the potential client for treatment. It is imperative that the counselor use appropriate diagnostic criteria to determine whether the applicant's alcohol or other drug use constitutes abuse. All counselors must be able to describe the criteria they use and demonstrate their competence by presenting specific examples of how the use of alcohol and other drugs has become dysfunctional for a particular client. The determination of a particular client's appropriateness for a program requires

the counselor's judgment and skill and is influenced by the program's environment and modality (i.e., inpatient, outpatient, residential, pharmacotherapy, detoxification, or daycare). Important factors include the nature of the substance abuse, the physical condition of the client, the psychological functioning of the client, outside support/ resources, previous treatment efforts, motivation, and the philosophy of the program. The eligibility criteria are generally determined by focus, target population, and funding requirements of the counselor's program or agency. Many of the criteria are easily ascertained. These may include the client's age, gender, place of residence, legal status, veteran status, income level, and the referral source. Making a reference to agency policy is a minimally acceptable statement. If the client is found ineligible or inappropriate for this program, the counselor should be able to suggest an alternative.

II. INTAKE: THE ADMINISTRATIVE AND INITIAL ASSESSMENT PROCEDURES FOR ADMISSION TO A PROGRAM.

Global Criteria:

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

Explanation:

The intake usually becomes an extension of the screening, when the decision to formally admit is documented. Much of the intake process includes the completion of various forms. Typically, the client and counselor fill out an admission or intake sheet, document the initial assessment, complete appropriate releases of information, collect financial data, sign a consent for treatment, and assign the primary counselor.

III. ORIENTATION: DESCRIBING TO THE CLIENT THE FOLLOWING: GENERAL NATURE AND GOALS OF THE PROGRAM; RULES GOVERNING CLIENT CONDUCT AND INFRACTIONS THAT CAN LEAD TO DISCIPLINARY ACTION OR DISCHARGE FROM THE PROGRAM; IN A NON-RESIDENTIAL PROGRAM, THE HOURS DURING WHICH SERVICES ARE AVAILABLE; TREATMENT COSTS TO BE BORNE BY THE CLIENT, IF ANY; AND CLIENT RIGHTS.

Global Criteria:

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

Explanation:

The orientation may be provided before, during, and/or after the client's screening and intake. It

can be conducted in an individual, group, or family context. Portions of the orientation may include other personnel for certain specific aspects of treatment, such as medication.

IV. ASSESSMENT: THE PROCEDURES BY WHICH A COUNSELOR/ PROGRAM IDENTIFIES AND EVALUATES AN INDIVIDUAL'S STRENGTHS, WEAKNESSES, PROBLEMS, AND NEEDS FOR THE DEVELOPMENT OF A TREATMENT PLAN.

Global Criteria:

12. Gather relevant history from client, including but not limited to, alcohol and other drug abuse using appropriate interview techniques.
13. Identify methods and procedures for obtaining corroborative information from significant secondary sources regarding client's alcohol and other drug abuse and psycho-social history.
14. Identify appropriate assessment tools.
15. Explain to the client the rationale for the use of assessment techniques in order to facilitate understanding.
16. Develop a diagnostic evaluation of the client's substance abuse and any coexisting conditions based on the results of all assessments in order to provide an integrated approach to treatment planning based on the client's strengths, weaknesses, and identified problems and needs.

Explanation:

Although assessment is a continuing process, it is generally emphasized early in treatment. It usually results from a combination of focused interviews, testing, and/or record reviews. The counselor evaluates major life areas (i.e., physical health vocational development, social adaptation, legal involvement, and psychological functioning) and assesses the extent to which alcohol or drug use has interfered with the client's functioning in each of these areas. The results of this assessment should suggest the focus of treatment.

V. TREATMENT PLANNING: THE PROCESS BY WHICH THE COUNSELOR AND CLIENT IDENTIFY AND RANK PROBLEMS NEEDING RESOLUTION; ESTABLISH AGREED UPON IMMEDIATE AND LONG-TERM GOALS; AND DECIDE UPON A TREATMENT PROCESS AND THE RESOURCES TO BE UTILIZED.

Global Criteria:

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

Explanation:

The treatment contract is based on the assessment and is a product of negotiation between the client and counselor to be sure the plan is tailored to the individual's needs. The language of the problem, goal, and strategy statements should be specific, intelligible to the client, and expressed in behavioral terms. The statement of the problem concisely on a client need identified previously. The goal statements refer specifically to the identified problem and may include one objective or set of objectives ultimately intended to solve or mitigate the problem. The goals must be expressed in behavioral terms in order for the counselor and client to determine progress in treatment. Both immediate and long-term goals should be established. The plan or strategy is a specific activity that links the problem with the goal. It describes the services, who will provide them, when they will be provided, and at what frequency. Treatment planning is a dynamic process and the contracts must be regularly reviewed and modified as appropriate.

VI. COUNSELING: (INDIVIDUAL, GROUP, AND SIGNIFICANT OTHERS): THE UTILIZATION OF SPECIAL SKILLS TO ASSIST INDIVIDUALS, FAMILIES, OR GROUPS IN ACHIEVING OBJECTIVES THROUGH EXPLORATION OF A PROBLEM AND ITS RAMIFICATIONS, EXAMINATION OF ATTITUDES AND FEELINGS; CONSIDERATION OF ALTERNATIVE SOLUTIONS; AND DECISION-MAKING.

Global Criteria:

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

Explanation:

Counseling is basically a relationship in which the counselor helps the client mobilize resources to resolve his or her problem and/or modify attitudes and values. The counselor must be able to demonstrate a working knowledge of various counseling approaches. These methods may include Reality Therapy, Motivational Interviewing, Strategic Family Therapy, Client-Centered Therapy, etc. Further, the counselor must be able to explain the rationale for using a specific approach for the particular client. For example, a behavioral approach might be suggested for clients who are resistant and manipulative or have difficulty anticipating consequences and regulating impulses. On the other hand, a cognitive approach may be appropriate for a client who is depressed, yet insightful and articulate. Also, the counselor should explain his or her rationale for choosing a counseling approach

in an individual, group, or family context. Finally, the counselor should be able to explain why a counseling approach or context changed during treatment.

VII. CASE MANAGEMENT: ACTIVITIES THAT 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.

Global Criteria:

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

Explanation:

Case management is the coordination of a multiple services plan. Case management decisions must be explained to the client. By the time many alcohol and other drug abusers enter treatment, they tend to manifest dysfunction in a variety of areas. For example, a heroin addict may have hepatitis, lack job skills, and have a pending criminal charge. In this case, the counselor might monitor his medical treatment, make a referral to a vocational rehabilitation program and communicate with representatives of the criminal justice system. The client may also be receiving other treatment services such as family therapy and pharmacotherapy, within the same agency. These activities must be integrated into the treatment plan and communication must be maintained with the appropriate personnel.

VIII. CRISIS INTERVENTION: THOSE SERVICES WHICH RESPOND TO AN ALCOHOL AND/OR OTHER DRUG ABUSER'S NEEDS DURING ACUTE EMOTIONAL AND/OR PHYSICAL DISTRESS.

Global Criteria:

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

Explanation:

A crisis is a decisive, crucial event in the course of treatment that threatens to compromise or destroy the rehabilitation effort. These crises may be directly related to alcohol or drug use (i.e., overdose or relapse) or indirectly related. The latter might include the death of a significant other, separation/divorce, arrest, suicidal gestures, a psychotic episode or outside pressure to terminate treatment. If no specific crisis is presented in the written case, rely on and describe a past experience with a client. Describe the overall picture–before, during and after the crisis. It is imperative that the counselor be able to identify the crises when they surface, attempt to mitigate or resolve the immediate problem and use negative events to enhance the treatment efforts, if possible.

IX. CLIENT EDUCATION: PROVISION OF INFORMATION TO INDIVIDUALS AND GROUPS CONCERNING ALCOHOL AND OTHER

DRUG ABUSE AND THE AVAILABLE SERVICES AND RESOURCES.

Global Criteria:

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

Explanation:

Client education is provided in a variety of ways. In certain inpatient and residential programs, for example, a sequence of formal classes may be conducted using a didactic format with reading materials and films. On the other hand, an outpatient counselor may provide relevant information to the client individually or informally. In addition to alcohol and drug information, client education may include a description of self-help groups and other resources that are available to the clients and their families. The applicant must be competent in providing specific examples of the type of education provided to the client and the relevance to the case.

X. REFERRAL: IDENTIFYING THE NEEDS OF A CLIENT THAT CANNOT BE MET BY THE COUNSELOR OR AGENCY AND ASSISTING THE CLIENT TO UTILIZE THE SUPPORT SYSTEMS AND COMMUNITY RESOURCES AVAILABLE.

Global Criteria:

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

Explanation:

In order to be competent in this function, the counselor must be familiar with community resources, both alcohol and drug and others, and should be aware of the limitations of each service and if the limitations could adversely impact the client. In addition, the counselor must be able to demonstrate a working knowledge of the referral process, including confidentiality requirements and outcomes of the referral. Referral is obviously closely related to case management when integrated into the initial and on-going treatment plan. It also includes, however, aftercare of discharge planning referrals that take into account the continuum of care.

XI. REPORT AND RECORD KEEPING: CHARTING THE RESULTS OF THE ASSESSMENT AND TREATMENT PLAN, WRITING REPORTS, PROGRESS NOTES, DISCHARGE SUMMARIES AND OTHER CLIENT-RELATED DATA.

Global Criteria:

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

Explanation:

The report and record-keeping function is important. It benefits the counselor by documenting the client's progress in achieving his or her goals. It facilitates adequate communication between co-workers. Is assists the counselor's supervisor in providing timely feedback. It is valuable to other programs that may provide services to the client at a later date. It can enhance the accountability of the program to its licensing/funding sources. Ultimately, if performed properly, it enhances the client's entire treatment experience. The applicant must prove personal action in regard to the report and record-keeping function.

XII. CONSULTATION: RELATING WITH IN-HOUSE STAFF OR OUTSIDE PROFESSIONALS TO ASSURE COMPREHENSIVE, QUALITY CARE FOR THE CLIENT.

Global Criteria:

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

Explanation:

Consultation is meetings for discussion, decision-making, and planning. The most common consultation is the regular in-house staffing in which client cases are reviewed with other members of the treatment team. Consultations may also be conducted in individual sessions with the supervisor, other counselors, psychologists, physicians, probation officers, and other service providers connected to the client's case.

VIDEO ON THE 12 CORE FUNCTIONS

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://cod.pressbooks.pub/addictionscounseling/?p=22#oembed-1

CHAPTER 2.

ASAM DIMENSIONS AND LEVELS OF CARE

ASAM CRITERIA[1]

The ASAM Criteria: Treatment Criteria for Addictive Substance-Related and Co-Occurring Conditions 6 (called the ASAM Criteria) contains the most recent set of industry guidelines released on the treatment of SUDs. This resource provides a brief overview of the key provider competencies described in the ASAM Criteria. The Medicaid IAP appreciates the informal review, edits and contributions provided by ASAM to the clinical summaries included below.

The content included in this document is an abbreviation of the full principles, concepts, and process described within the ASAM Criteria. Furthermore, the summary information in this document is based on the latest science available at the time of its release.

The ASAM Criteria describes five broad levels of care (Levels 0.5–4) with specific service and recommended provider requirements to meet those needs. These levels of care (Levels 0.5–4) span a continuum of care that represent various levels of care. A full list of the levels of care is provided in Figure 1, with more in-depth descriptions following this section.7

6 Mee-Lee D, ed. The ASAM Criteria: Treatment Criteria for Addictive Substance-Related, and Co-Occurring Conditions. Chevy Chase, MD: American Society of Addiction Medicine; 2013. http://www.asam.org/quality- practice/guidelines-and-consensus-documents/the-asam-criteria/text. Accessed March 18, 2016.

7 The ASAM Criteria discuss their application to adolescents in some detail, although they are not specified completely for adolescents as a separate population. The book includes a matrix for matching adolescent severity and level of function with type and intensity of service.

DEFINITION OF TREATMENT TERMS

Throughout the ASAM Criteria, the following treatment terms are used to describe services within a specified level of care:

- **Clinically managed services** are directed by nonphysician addiction specialists rather than medical personnel. They are appropriate for individuals whose primary problems involve emotional, behavioral, cognitive, readiness to change, relapse, or recovery environment concerns. Intoxication, withdrawal, and biomedical concerns, if present, are safely

1. The ASAM information comes from a set of guidelines published by the Medicaid Innovation Accelerator Program.

manageable in a clinically managed service. This type of care is described under Level 3.1, 3.3 and 3.5 residential programs.

- **Medically monitored services** are provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists, or other health and technical personnel under the direction of a licensed physician. Medical monitoring is provided through an appropriate mix of direct patient contact, review of records, team meetings, 24-hour coverage by a physician, 24-hour nursing and a quality assurance program. This type of care is described under Level 3.7 inpatient programs.

- **Medically managed services** involve daily medical care and 24-hour nursing. An appropriately trained and licensed physician provides diagnostic and treatment services directly, manages the provision of those services, or both. This type of care is described under Level 4 medically managed intensive inpatient programs.

LEVEL 0.5: EARLY INTERVENTION

Professional services targeting individuals who are at risk of developing a substance-related problem but may not have a diagnosed SUD are provided in Level 0.5. These early intervention services—including individual or group counseling, motivational interventions, and Screening, Brief Intervention, and Referral to Treatment (SBIRT)—seek to identify substance-related risk factors to help individuals recognize the potentially harmful consequences of high-risk behaviors. These services may be coverable under Medicaid as stand-alone direct services or may also be coverable as component services of a program such as driving under the influence or driving while intoxicated programs and Employee Assistance Programs (EAPs). Length of service may vary from 15 to 60 minutes of SBIRT, provided once or over five brief motivational sessions, to several weeks of services provided in programs. Medicaid coverage of services and component services, whether provided directly or through programs, must comport with all applicable rules, such as state plan benefit requirements.

- Setting: Early intervention services are often provided in nonspecialty settings including primary care medical clinics, hospital emergency departments, community centers, worksites, or an individual's home. SBIRT may be conducted in a primary care physician's office, mental health practice, trauma center, emergency department, school setting, or other nonaddiction treatment environments.

Provider Type: Appropriately credentialed and/or licensed treatment professionals, including addiction counselors, social workers, or health educators may offer early intervention services. SBIRT activities are often provided by generalist health care professionals or addiction counselors who are knowledgeable about substance use and addictive disorders, motivational counseling, and the legal and personal consequences of high-risk behavior.

- Treatment Goal: Individual, group, or family counseling and SBIRT services should educate individuals about the risks of substance use and help them avoid such behavior. SBIRT services aim to intervene early, linking individuals with SUDs to appropriate formal treatment programs.

LEVEL 1: OUTPATIENT SERVICES

Level 1 is appropriate in many situations as an initial level of care for patients with less severe disorders; for those who are in early stages of change, as a "step down" from more intensive services; or for those who are stable and for whom ongoing monitoring or disease management is appropriate. Adult services for Level 1 programs are provided less than 9 hours weekly, and adolescents' services are provided less than 6 hours weekly; individuals recommended for more intensive levels of care may receive more intensive services.

- Setting: Outpatient services are often delivered in a wide variety of settings such as offices, clinics, school-based clinics, primary care clinics, and other facilities offering additional treatment or mental health programs.
- Provider Type: Appropriately credentialed and/or licensed treatment professionals, including counselors, social workers, psychologists, and physicians (whether addiction- credentialed or generalist) deliver outpatient services, including medication and disease management services.
- Treatment Goal: Outpatient services are designed to help patients achieve changes in alcohol and/or drug use and addictive behaviors and often address issues that have the potential to undermine the patient's ability to cope with life tasks without the addictive use of alcohol, other drugs, or both.
- Therapies: Level 1 outpatient services may offer several therapies and service components, including individual and group counseling, motivational enhancement, family therapy, educational groups, occupational and recreational therapy, psychotherapy, MAT, or other skilled treatment services.

LEVEL 2: INTENSIVE OUTPATIENT AND PARTIAL HOSPITALIZATION PROGRAMS

Level 2 programs provide essential addiction education and treatment components and have two gradations of intensity. Level 2.1 intensive outpatient programs provide 9–19 hours of weekly structured programming for adults or 6–19 hours of weekly structured programming for adolescents. Programs may occur during the day or evening, on the weekend, or after school for adolescents.
Level 2.1: Intensive Outpatient Programs

- Setting: Intensive outpatient programs are primarily delivered by substance use disorder outpatient specialty providers, but may be delivered in any appropriate setting that meets state licensure or certification requirements. These programs have direct affiliation with programs offering more and less intensive levels of care as well as supportive housing services.
- Provider Type: Interdisciplinary team of appropriately credentialed addiction treatment professionals including counselors, psychologists, social workers, addiction-credentialed physicians, and program staff, many of whom have cross-training to aid in interpreting mental disorders and deliver intensive outpatient services.
- Treatment Goal: At a minimum, this level of care provides a support system including

medical, psychological, psychiatric, laboratory, and toxicology services within 24 hours by telephone or within 72 hours in person. Emergency services are available at all times, and the program should have direct affiliation with more or less intensive care levels and supportive housing.

- Therapies: Level 2.1 intensive outpatient services include individual and group counseling, educational groups, occupational and recreational therapy, psychotherapy, MAT, motivational interviewing, enhancement and engagement strategies, family therapy, or other skilled treatment services.

LEVEL 2.5: PARTIAL HOSPITALIZATION PROGRAMS

Level 2.5 partial hospital programs differ from Level 2.1 intensive outpatient programs in the intensity of clinical services that are directly provided by the program, including psychiatric, medical and laboratory services. Partial hospitalization programs are appropriate for patients who are living with unstable medical and psychiatric conditions. Partial hospitalization programs are able to provide 20 hours or more of clinically intensive programming each week to support patients who need daily monitoring and management in a structured outpatient setting.

- Setting: Structured outpatient setting that offers direct access to psychiatric, medical and laboratory services. Such programs may be freestanding or located within a larger healthcare system so long as the partial hospitalization unit is distinctly organized from the rest of the available programs. These programs have direct affiliation with programs offering more and less intensive levels of care as well as supportive housing services.
- Provider Type: Similar to Level 2.1, partial hospitalization services are delivered by an interdisciplinary team of providers, with some cross-training to identify mental disorders and potential issues related to prescribed psychotropic drug treatment in populations with SUD. Additionally, these programs must support access to more and less intensive programs as well as supportive housing services. One major distinction from Level 2.1 is the requirement for qualified practitioners in partial hospitalization programs to provide medical, psychological, psychiatric, laboratory, toxicology and emergency services.
- Treatment Goal: At a minimum, this level of care meets the same treatment goals as described for Level 2.1, with psychiatric and other medical consultation services available within 8 hours by telephone or within 48 hours in person.

Therapies: Level 2.5 intensive outpatient services include individual and group counseling, educational groups, occupational and recreational therapy, psychotherapy, MAT, motivational interviewing, motivational enhancement and engagement strategies, family therapy, or other skilled treatment services.

LEVEL 3: RESIDENTIAL OR INPATIENT PROGRAMS

Level 3 programs include four sublevels that represent a range of intensities of service. The uniting feature is that these services all are provided in a structured, residential setting that is staffed 24 hours daily and are clinically managed (see definition of terms above). Residential levels of care provide

a safe, stable environment that is critical to individuals as they begin their recovery process. Level 3.1 programs are appropriate for patients whose recovery is aided by a time spent living in a stable, structured environment where they can practice coping skills, self-efficacy, and make connections to the community including work, education and family systems.
Level 3.1: Clinically Managed Low-Intensity Residential Programs

- Setting: Services are provided in a 24-hour environment, such as a group home. Both clinic-based services and community-based recovery services are provided. Clinically, Level 3.1 requires at least 5 hours of low-intensity treatment services per week, including medication management, recovery skills, relapse prevention, and other similar services. In Level 3.1, the 5 or more hours of clinical services may be provided onsite or in collaboration with an outpatient services agency.
- Provider Type: Team of appropriately credentialed medical, addiction, and mental health professionals provide clinical services. Allied health professional staff including counselors and group living workers and some clinical staff knowledgeable about biological and psychosocial dimensions of SUD and psychiatric conditions support the recovery residence component of care.
- Treatment Goal: Patients receive individual, group, or family therapy, or some combination thereof; medication management; and psychoeducation to develop recovery, relapse prevention, and emotional coping techniques. Treatment should promote personal responsibility and reintegrate the patient to work, school, and family environments. At a minimum, this level of care provides telephone and in-person physician and emergency services 24-hours daily, offers direct affiliations with other levels of care, and is able to arrange necessary lab or pharmacotherapy procedures.
- Therapies: Level 3.1 clinically managed low-intensity residential services are designed to improve the patient's ability to structure and organize the tasks of daily living, stabilize and maintain the stability of the individual's substance use disorder symptoms, and to help them develop and apply recovery skills. The skilled treatment services include individual, group and family therapy; medication management and medication education; mental health evaluation and treatment; motivational enhancement and engagement strategies; recovery support services; counseling and clinical monitoring; MAT; and intensive case management, medication management and/or psychotherapy for individuals with co-occurring mental illness.

LEVEL 3.3: CLINICALLY MANAGED POPULATION-SPECIFIC HIGH-INTENSITY RESIDENTIAL PROGRAMS (SPECIFIED FOR ADULTS ONLY)

This gradation of residential treatment is specifically designed for specific population of adult patients with significant cognitive impairments resulting from substance use or other co-occurring disorders. This level of care is appropriate when an individual's temporary or permanent cognitive limitations make it unlikely for them to benefit from other residential levels of care that offer group therapy and other cognitive-based relapse prevention strategies. These cognitive impairments may be seen in individuals who suffer from an organic brain syndrome as a result of substance use, who suffer from chronic brain syndrome, who have experienced a traumatic brain injury, who have

developmental disabilities, or are older adults with age and substance-related cognitive limitations. Individuals with temporary limitations receive slower paced, repetitive treatment until the impairment subsides and s/he is able to progress onto another level of care appropriate for her/his SUD treatment needs.

- Setting: Services are often provided in a structured, therapeutic rehabilitation facility and traumatic brain injury programs located within a community setting, or in specialty units located within licensed healthcare facilities where high-intensity clinical services are provided in a manner that meets the functional limitations of patients. Such programs have direct affiliation with more or less intensive levels of care as well as supportive services related to employment, literacy training and adult education.
- Provider Type: Physicians, physician extenders, and appropriate credentialed mental health professionals lead treatment. On-site 24-hour allied health professional staff supervise the residential component with access to clinicians competent in SUD treatment. Clinical staff knowledgeable about biological and psychosocial dimensions of SUD and psychiatric conditions who have specialized training in behavior management support care. Patients have access to additional medical, laboratory, toxicology, psychiatric and psychological services through consultations and referrals.
- Treatment Goal: Specialized services are provided at a slower pace and in a repetitive manner to overcome comprehension and coping challenges. This level of care is appropriate until the cognitive impairment subsides, enabling the patient to engage in motivational relapse prevention strategies delivered in other levels of care.
- Therapies: Level 3.3 clinically managed population-specific high-intensity residential services may be provided in a deliberately repetitive fashion to address the special needs of individuals for whom a Level 3.3 program is considered medically necessary. Daily clinical services designed to improve the patient's ability to structure and organize the tasks of daily living and recovery, to stabilize and maintain the stability of the individual's substance use disorder symptoms, and to help them develop and apply recovery skills are provided. The skilled treatment services include a range of cognitive, behavioral and other therapies administered on an individual and group basis; medication management and medication education; counseling and clinical monitoring; educational groups; occupational and recreational therapies; art, music or movement therapies; physical therapy; clinical and didactic motivational interventions; and related services directed exclusively toward the benefit of the Medicaid-eligible individual.

LEVEL 3.5: CLINICALLY MANAGED RESIDENTIAL PROGRAMS (HIGH INTENSITY FOR ADULTS, MEDIUM INTENSITY FOR ADOLESCENTS)

This gradation of residential programming is appropriate for individuals in some imminent danger with functional limitations who cannot safely be treated outside of a 24-hour stable living environment that promotes recovery skill development and deters relapse. Patients receiving this level of care have severe social and psychological conditions. This level of care is appropriate for adolescents with patterns of maladaptive behavior, temperament extremes and/or cognitive disability related to mental health disorders.

- Setting: Services are often provided in freestanding, licensed facilities located in a community setting or a specialty unit within a licensed health care facility. Such programs rely on the treatment community as a therapeutic agent.
- Provider Type: Interdisciplinary team is made up of appropriately credentialed clinical staff including addictions counselors, social workers, and licensed professional counselors, and allied health professionals who provide residential oversight. Telephone or in-person consultation with a physician is a required support, but -on-site physicians are not required.
- Treatment Goal: Comprehensive, multifaceted treatment is provided to individuals with psychological problems, and chaotic or unsupportive interpersonal relationships, criminal justice histories, and antisocial value systems. The level of current instability is of such severity that the individual is in imminent danger if not in a 24-hour treatment setting. Treatment promotes abstinence from substance use, arrest, and other negative behaviors to effect change in the patients' lifestyle, attitudes, and values, and focuses on stabilizing current severity and preparation to continue treatment in less intensive levels of care.
- Therapies: Level 3.5 clinically managed residential services are designed to improve the patient's ability to structure and organize the tasks of daily living, stabilize and maintain the stability of the individual's substance use disorder symptoms, to help them develop and apply sufficient recovery skills, and to develop and practice prosocial behaviors such that immediate or imminent return to substance use upon transfer to a less intensive level is avoided. The skilled treatment services include a range of cognitive, behavioral and other therapies administered on an individual and group basis; medication management and medication education; counseling and clinical monitoring; random drug screening; planned clinical activities and professional services to develop and apply recovery skills; family therapy; educational groups; occupational and recreational therapies; art, music or movement therapies; physical therapy; and related services directed exclusively toward the benefit of the Medicaid-eligible individual.

LEVEL 3.7: MEDICALLY MONITORED INPATIENT PROGRAMS (INTENSIVE FOR ADULTS, HIGH-INTENSITY FOR ADOLESCENTS)

This level of care is appropriate for patients with biomedical, emotional, behavioral and/or cognitive conditions that require highly structured 24-hour services including direct evaluation, observation, and medically monitored addiction treatment. Medically monitored treatment is provided through a combination of direct patient contact, record review, team meetings and quality assurance programming. These services are differentiated from Level 4.0 in that the population served does not have conditions severe enough to warrant medically managed inpatient services or acute care in a general hospital where daily treatment decisions are managed by a physician.
Level 3.7 is appropriate for adolescents with co-occurring psychiatric disorders or symptoms that hinder their ability to successfully engage in SUD treatment in other settings. Services in this program are meant to orient or re-orient patients to daily life structures outside of substance use.

- Setting: Services are provided in freestanding, appropriately licensed facilities located in a community setting or a specialty unit in a general or psychiatric hospital or other licensed health care facility.

- Provider Type: Interdisciplinary team is made up of physicians credentialed in addiction who are available on-site 24 hours daily, registered nurses, and additional appropriately credentialed nurses, addiction counselors, behavioral health specialists, clinical staff who are knowledgeable about biological and psychosocial dimensions of SUD and psychiatric conditions who have specialized training in behavior management techniques and evidence-based practices.
- Treatment Goal: Patients with greater severity of withdrawal, biomedical conditions, and emotional, behavioral, or cognitive complications receive stabilizing care including directed evaluation, observation, medical monitoring, 24-hour nursing care and addiction treatment.
- Therapies: Daily clinical services, which may involve medical and 24-hour nursing services, individual, group, family and activity services; pharmacological, cognitive, behavioral or other therapies; counseling and clinical monitoring; random drug screening; health education services; evidence-based practices, such as motivational enhancement strategies; medication monitoring; daily treatment services to manage acute symptoms of the medical or behavioral condition; and related services directed exclusively toward the benefit of the Medicaid-eligible individual.

LEVEL 4: MEDICALLY MANAGED INTENSIVE INPATIENT PROGRAMS

This level of care is appropriate for patients with biomedical, emotional, behavioral and/or cognitive conditions severe enough to warrant primary medical care and nursing care. Services offered at this level differ from Level 3.7 services in that patients receive daily direct care from a licensed physician who is responsible for making shared treatment decisions with the patient (i.e. medically managed care). These services are provided in a hospital-based setting and include medically directed evaluation and treatment.

- Setting: Services may be provided in an acute care general hospital, an acute psychiatric hospital, or a psychiatric unit within an acute care general hospital, or through a licensed addiction treatment specialty hospital.
- Provider Type: Interdisciplinary team is made up of appropriately credentialed clinical staff including addiction-credentialed physicians who are available 24 hours daily, nurse practitioners, physicians' assistants, nurses, counselors, psychologists, and social workers. Some staff are cross-trained to identify and treat signs of comorbid mental disorders.
- Treatment Goal: Addiction services including medically directed acute withdrawal management are provided in conjunction with intensive medical and psychiatric services to alleviate patients' acute emotional, behavioral, and cognitive distresses associated with the SUD whose acute medical, emotional, behavioral and cognitive problems are so severe that they require primary medical and 24-hour nursing care. Because the length of stay in a Level 4 program typically is sufficient only to stabilize the individual's acute signs and symptoms, a primary focus of the treatment plan is case management and coordination of care to ensure a smooth transition to continuing treatment at another level of care.
    - Therapies: Cognitive, behavioral, motivational, pharmacologic and other therapies

provided on an individual or group basis; physical health interventions; health education services; planned clinical interventions; and services for the patient's family, guardian or significant others.

WITHDRAWAL MANAGEMENT LEVELS OF CARE

The ASAM Criteria includes five levels of withdrawal management services, which are described as if they were provided separately from the aforementioned level-of-care services available to manage SUDs. However, these services are routinely provided concurrently with other addiction services, by the same clinical staff, and in the same treatment setting. A brief description of withdrawal management services is provided below.

Withdrawal Management Levels of Care

Level 1-WM: Ambulatory Withdrawal Management Without Extended On-Site Monitoring

- Organized outpatient services delivered in a physician's office, addiction treatment facility, or patient's home
- Services provided in regularly scheduled sessions
- Services include individual assessment, medication/nonmedication withdrawal management, education, clinical support, and discharge planning

Level 2-WM: Ambulatory Withdrawal Management With Extended On-Site Monitoring

- Organized outpatient services delivered in a physician's office, general/mental health care facility, or addiction treatment facility
- Services are provided in regularly scheduled sessions on a daily basis with extended on-site services
- Services are identical to those provided in Level 1

Level 3.2-WM: Clinically Managed Residential Withdrawal Management

- Organized services are delivered in a social setting with an emphasis on peer support
- Services provide 24-hour structure and support
- Services include daily therapies to assess progress, medical services, individual and group therapy, withdrawal support, and health education services

Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management

- Services are delivered in a freestanding withdrawal management center with inpatient beds
- Services are provided daily with observation, monitoring, and treatment
- Services include specialized clinical consultation; supervision for cognitive, biomedical, emotional, and behavioral problems; medical nursing care; and direct affiliation with other levels of care

Level 4-WM: Medically Managed Intensive Inpatient Withdrawal Management

- Services are provided in an acute care or psychiatric hospital inpatient unit
- Services are provided 24 hours daily with observation, monitoring, and treatment
- Services include specialized medical consultation, full medical acute services, and intensive care

Key Takeaways

Withdrawal Management

- Withdrawal management can occur at all levels of care
- Withdrawal management is not confined to hospital-based programs and should be based on individual client needs

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://cod.pressbooks.pub/addictionscounseling/?p=5#h5p-5

PATIENT PLACEMENT CRITERIA[2]

For many years, addiction treatment providers predominantly assumed that people with drinking problems were a homogeneous group that could be treated optimally with only one treatment modality. This modality involved inpatient care with a fixed length of stay and a treatment approach based on the 12-step model of Alcoholics Anonymous. In recent years, however, both assumptions – that of patient homogeneity and treatment uniformity – have been abandoned. Researchers and clinicians now recognize that those with substance use disorder (SUD) are a diverse group and differ substantially in the causes and manifestations of their problems. Furthermore, most researchers now believe that no single form of treatment is effective for all people presenting with alcohol or drug-related problems (Hester and Miller, 1989). Consequently, researchers now are conducting many studies designed to determine what types of interventions are most effective for what types of patients. This approach is founded on the "matching hypothesis," which states that an optimal matching of patients and treatments will produce the greatest overall treatment effectiveness.

The need to formally acknowledge the unique treatment needs among people with addiction-related problems recently has received additional support from the proliferation of managed care systems that seek to control healthcare costs. With the widespread use of managed care in treating alcohol and other drug (AOD) abuse in both the private and public sectors, the demand for specific types or levels of treatment (ex: outpatient or residential) now depends on more than just the patient's wishes or the physician's perceptions of what the patient needs. Patients now must meet utilization

2. Morey, L. (1996). ASAM Patient Placement Criteria: Linking typologies to managed care. Alcohol Health and Research World, 36-44.

review criteria set by the managed care providers in order to be eligible for treatment reimbursement. In addition to controlling costs, the development of such criteria will enable healthcare delivery systems to account for meaningful and valid differences among problem drinkers and to determine more accurately the mix of treatment services the patients need. Ultimately, the improved match between patient needs and the types of services available within the system will enhance the efficiency and effectiveness of the alcoholism treatment system. This matching process likely will focus on selecting specific treatment modalities rather than on the settings in which these modalities are provided.

ASAM CRITERIA

The ASAM criteria were developed from numerous and widely disseminated drafts and revisions and were evaluated in field tests at 15 different sites (MeeLee, 1993). The primary goal of the criteria was to provide a common language for both providers and payers when determining the severity of a patient's problems, the different levels or settings of the treatment modalities offered, and the criteria for patient placement within the continuum of AOD treatment. These criteria not only described patient characteristics that might warrant inpatient care but also provided guidelines for different types of outpatient treatment and outlined the process of moving across different levels of care.

The ASAM system is built around criteria dimensions that are used to place patients in one of four levels of care originally presented in an Institute of Medicine report (1990) describing transitions in the alcoholism treatment field. The **levels of care** are as follows:

- Level 0.5: Early Intervention
- Level I: Outpatient Treatment
- Level II: Intensive Outpatient and Partial Hospitalization Treatment
- Level III: Residential and Medically Monitored Inpatient Treatment
- Level IV: Medically Managed Inpatient Treatment

ASSESSMENT DIMENSIONS

Under ASAM guidelines, patients are assigned to one of the four levels of care after being evaluated along six criteria dimensions reflecting the severity of the patient's problems. Each dimension contains several criteria, and the number of specific criteria that must be met depends on the level of care. These six dimensions are described in the following paragraphs.

Dimension 1: Acute Intoxication and/or Withdrawal Potential.

The ASAM criteria assume that a person who is acutely intoxicated cannot be monitored adequately as an outpatient and should receive more intensive care. When assessing withdrawal

potential, one of the most important considerations is whether the patient is at risk of experiencing lifethreatening withdrawal symptoms or requires medication or other support services to cope with or reduce the discomfort of withdrawal, which otherwise might cause him or her to terminate treatment.

Dimension 2: Biomedical Conditions or Complications.

Higher levels of care are indicated when continued AOD use would put the patient in danger of health complications. For example, an alcohol dependent woman who is pregnant might benefit from a higher level of care. Similarly, problem drinkers with cardiovascular, liver, or gastrointestinal diseases requiring medical monitoring or treatment should receive a higher level of care.

Dimension 3: Cognitive, Emotional, and Behavioral Conditions and Complications.

A wide range of emotional and behavioral conditions and complications exist in problem drinkers, either as manifestations of alcohol abuse or as independent, coexisting psychiatric disorders. These conditions (e.g., debilitating anxiety, guilt, or depression) deserve special attention during treatment and therefore may necessitate a higher level of clinical care. Moreover, problem drinkers exhibiting signs of an imminent risk of harming themselves (e.g., attempting suicide) or others may require 24-hour monitoring, thus justifying a higher level of clinical care. The same holds true for problem drinkers whose mental status does not allow them to understand the nature of the disorder or the treatment process.

Dimension 4: Readiness to Change.

Patients in addiction treatment vary greatly in their willingness to comply with treatment regimens. Patients who seek treatment and cooperate by following clinical instructions typically require a lower level of care. However, alcohol dependence often compromises a person's capacity to cooperate with treatment protocols. Patients often present for treatment with some level of understanding that AOD are responsible for their problems but are still unwilling to participate in the clinical process. Other patients may deny that they have a alcohol or drug problem. Thus, some may be unlikely to enter the treatment system without first receiving some form of therapeutic preparation directed at addressing their denial and their resistance to treatment. Under these conditions, a high level of clinical care may be appropriate.

Dimension 5: Relapse/Continued Use Potential.

Because drug-related problems involve recurrent patterns of behavior, relapse is a frequent and integral part of the natural history of the disorder. Two major sets of factors that derive from the patient's personal (i.e., psychological and biological) background and social environment contribute to relapse potential. This dimension addresses the personal factors that influence the extent to which people can control their environments (environmental factors are addressed in dimension 6). Accordingly, when these elements impede a patient's control over his or her behavior in the current environment, a higher level of care (e.g., a halfway house rather than out patient care) may be justified to minimize the relapse risk. For example, if a patient experiences marked and persistent cravings for alcohol and thus has higher relapse potential, treatment success may be less likely in an outpatient than in an inpatient setting.

Dimension 6: Recovery Environment.

The patient's environment can facilitate recovery or increase the risk of relapse. When the social setting is supportive (e.g., family members and friends agree with and encourage recovery) or the patient seeks out social surroundings that discourage alcohol abusing behavior patterns, a lower level of clinical care may be justified. However, when a recovering person's social setting is

compromised—for example, by inadequate transportation to the treatment provider, a higher level of family stress, or friends and coworkers who regularly use alcohol—a higher level of care may be required.

Key Takeaways

- Patients are assigned to one four levels of care after being evaluated along six criteria dimensions.
- Greater severity of problems corresponds to higher levels of care.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://cod.pressbooks.pub/addictionscounseling/?p=5#h5p-3

LINKING ASSESSMENT AND PLACEMENT

Once the counselor has completed a thorough bio-psycho-social assessment following the ASAM dimensions, the next step is to recommend placement in a level of care. One of the most important guidelines provided by ASAM is that counselors should recommend the least restrictive effective level of care. In general, this means that for a person without medical necessity for level III or IV treatment, and who has not had previous treatment, we would recommend a lower level of care such as outpatient or intensive outpatient. As always, the counselor must consider the full picture that includes biological, psychological, and social issues.

The table below summarizes the correlations between the treatment settings and criteria dimensions specified by the ASAM guidelines. The actual criteria for placing an individual into a given level of care vary according to the care level, and placement ultimately depends on the combination of patient characteristics in the six assessment dimensions.

For example, treatment in an outpatient setting (i.e., level I) requires that the patient meets level I criteria in all six assessment dimensions, whereas treatment in an inpatient setting (i.e., level III or IV) requires that the patient meets the corresponding severity criteria in at least two of the six dimensions. Furthermore, not all dimensions are relevant to all placement decisions. For example, treatment resistance, relapse potential, and recovery environment are not used to distinguish between patients requiring level III and level IV care.

Summary of ASAM Criteria Dimensions of Assessment

Criteria Dimension	Level I: Outpatient Treatment	Level II: Intensive Outpatient or Partial Hospitalization Treatment	Level III: Med Inpatient (Res
Acute Intoxication/ Withdrawal Potential	Minimal to no risk of severe withdrawal; will enter detoxification if needed.	Minimal risk of severe withdrawal; will enter detoxification if needed and responds to social support when com- bined with treatment.	Risk of severe withdrawal, or lower levels of
Biomedical Conditions	None or noninterfering with treatment.	May interfere with treatment but patient does not require inpatient care.	Continued use or complicatio medical monit
Cognitive/Emotional/ Behavioral Conditions	Some anxiety, guilt, or depression related to abuse, but no risk of harm to self or others. Mental status permits treatment comprehension and participation.	Inability to maintain behavioral stability, abuse/neglect of family, or mild risk of harm to self or others.	Symptoms req environment, self or others, during intoxic
Readiness to Change	Willing to cooperate and attend treatment; admits problem.	Attributes problems externally; not severely resistant.	Does not accep despite seriou
Relapse Potential	Able to achieve goals with support and therapeutic contact.	Deteriorating during level I treatment, or will drink without close monitoring and support.	Deteriorating outpatient car drinking with
Recovery Environment	Supportive social environment or motivated to obtain social support.	Current job environment disruptive, family/support system nonsupportive, or lack of social contacts.	Environment logistic imped or occupation patient contin

ASAM = American Society of Addiction Medicine

The video below summarizes key elements of the ASAM criteria for counselors.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://cod.pressbooks.pub/addictionscounseling/?p=5#oembed-1

CHAPTER 3.

DIAGNOSTIC CRITERIA

Although not all addictions counselors will provide formal diagnoses of clients, it is imperative that they understand the criteria used to develop a diagnosis of Substance Use Disorder (SUD). Addiction is a relatively new field, and our understanding and research of this problem are still in their infancy. As we better grasp the nature of addiction, definitions can be updated to reflect that new knowledge.

The American Psychiatric Association has been the center of the diagnostic world in the United States since the release of the first Diagnostic and Statistical Manual (DSM) in 1952. The first mention of addiction appeared in the original DSM and was used to describe someone with a Sociopathic Personality Disturbance[1]

In 1980, DSM-III incorporated Substance Dependence and Substance Abuse as two distinct categories of problematic substance use. These categories remained until 2013 when DSM-5 combined them into one category called Substance Use Disorder with 11 defining criteria that encompass physical dependence, risky use, and social problems associated with using.

Future paradigms around diagnosis and treatment will reflect both the current body of knowledge and the advances that are yet to come. Counselors in the addiction field will need to be aware of the historical foundations of diagnosis, current ways of describing addiction, and ongoing developments that will continue to shape treatment.

The following video highlights key terminology from the DSM related to Substance Use Disorder.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://cod.pressbooks.pub/addictionscounseling/?p=24#oembed-1

CASE STUDY

Exercise: Case Study of Marie

Background

Marie is a 57 year-old Latina woman who has been married for 30 years. She and her partner have two adult children, aged 26 and 28, and three grandchildren. Marie taught elementary school for 32 years and has not worked since retiring two years ago.

1. Michael A. Norko and W. Lawrence Fitch Journal of the American Academy of Psychiatry and the Law Online December 2014, 42 (4) 443-452.

She sees her family doctor for control of asthma and high blood pressure and takes medication for both. The same family doctor has treated the client for nearly 20 years.

Her mother suffered with hypertension and died of a stroke 10 years ago at age 77. Her father died after a heart attack more than 20 years ago at age 62. She has two younger sisters who are in good health.

For much of the time she has known Marie, the family doctor has been aware of the client's problems with alcohol. Marie reports that her drinking began in the early 1990s after she was involved in a lawsuit initiated by a parent of one of her students. Although the school supported her, and the case was eventually resolved in her favor, she remembers that time as one of constant fear and uncertainty.

She recalls subsequently experiencing blackout spells when she drank. On three separate occasions, she was hospitalized for detoxification, and brief periods of sobriety ensued. Her doctor inquires regularly about her alcohol use and believes that Marie is truthful about her bouts of drinking and times of abstinence.

One week ago, Marie's husband and one of her daughters called the doctor to express their concern about her. The husband related that his wife had resumed daily drinking of vodka three months ago. At times, he noticed that she slurred her words. Her daughter has become fearful of leaving the grandchildren with Marie. When her family each spoke with her, Marie denied drinking too much and thought they made "more of the problem than there was."

The doctor contacted Marie and told her that her husband and daughter had spoken with him, and she agreed to come in for an appointment. The doctor pointed out that the problem was not new, that it was causing marital and family consequences for her, that she had made several unsuccessful attempts to deal with it in the past, and that she felt it was time to take a definitive step to resolve the problem. After seeing the doctor, Marie agreed to accept a referral to a treatment center for an assessment and any follow-up recommendations.

Counseling Assessment

Marie presents to Bluebird Counseling for an evaluation. She is quiet but cooperative during her interview. She also signed a release of information so that your agency can communicate with her doctor about treatment.

She acknowledges that her drinking has become more intense lately and that it might be affecting her relationship with her family. When asked about her family's concerns, Marie acknowledged them but reiterated that she thinks they are overstating how much she drinks.

She states that her last drink was yesterday evening, about 12 hours ago, and that she had "maybe 4-5 mixed drinks with vodka." She reports that she occasionally feels shaky in the morning when she wakes up and will take a drink to "steady myself for the day."

She says that she drinks most days of the week, usually between 3-5 drinks but sometimes less and sometimes more. Her primary drink is vodka mixed with some kind of juice. She has noticed that the number of drinks she needs to "feel better" has gone up recently.

She denies use of any other types of alcohol and denies any other current drug use.

Client says she previously used cannabis in the form of joints, smoking once or twice a month when she was in her 20s, but denies using "since my children were born."

Marie's doctor noted that her medical tests indicated elevated liver enzymes, a possible indication of liver functioning problems.

Marie says she is willing to participate in a treatment program, although she is hopeful it will not be "somewhere I have to stay."

Marie denies driving her car when she drinks, and she has a valid license and access to a car.

Marie says she has never been in a formal treatment setting, aside from detoxification, although she has attended Alcoholics Anonymous meetings on two occasions, saying "I didn't feel like I fit in there."

Marie reports that her Catholic faith is important to her, although she does not attend church as often as she used to.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://cod.pressbooks.pub/addictionscounseling/?p=24#h5p-2

DSM-5 CRITERIA FOR SUBSTANCE USE DISORDER

Note: Current diagnosis relates to behavior within the past 12 months

The phrase 'As evidenced by' is a way of documenting the specific behavioral examples that fulfill the category or criterion. For example, a client might report that they have had a prior treatment episode or had made efforts to reduce or quit their use. These experiences would meet the criterion for unsuccessful efforts to quit or cut down on use.

The table below provides a way for counselors in training to practice identifying criteria presented by a client's assessment using the exact language of the DSM and linking a certain criterion to observed or reported client behavior.

Check if Applies	DSM Criterion	As Evidenced By
	The drug is often taken in larger amounts or over a longer period of time than intended.	
	There is a persistent desire or unsuccessful efforts to cut down or control drug use.	
	A great deal of time is spent in activities necessary to obtain the drug, use the drug, or recover from its effects.	
	Craving, or a strong desire to use the drug.	
	Recurrent use resulting in failure to fulfill major role obligations at work, school, or home.	
	Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the drug.	
	Important social, occupational, or recreational activities are given up or reduced because of use.	
	Recurrent use in situations in which it is physically hazardous.	
	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by using.	
	*Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of the drug to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of the drug	
	*Withdrawal, as manifested by either of the following: (a) the characteristic withdrawal syndrome for the drug (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms	

**Tolerance and withdrawal criteria are not considered to be met if the individual is taking opioids solely under appropriate medical supervision.*

Severity can be evaluated as follows: **Mild**: 2-3 symptoms. **Moderate**: 4-5 symptoms. **Severe**: 6 or more symptoms

American Psychiatric Association (2022). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision. Washington, D C. American Psychiatric Association.

Exercise: Applying DSM Criteria

Based on DSM criteria, what is your diagnostic impression of Marie?

1. Provide a diagnostic impression
2. List supporting criteria from the DSM

Exercise: Clinical Evaluation

Identify relevant issues for Marie in each of the six ASAM criteria.

Dimension 1: Acute Intoxication & Withdrawal Potential

(Exploring past and current experiences of substance use and withdrawal)

Dimension 2: Biomedical Conditions and Complications

(Health history and current physical condition)

Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications

(Thoughts, emotions, and mental health issues)

Dimension 4: Readiness to Change

(Readiness and interest in changing; stage of change)

Dimension 5: Relapse, Continued Use, or Continued Problem Potential

(What are the issues or barriers related to risk of relapsing or continuing use?)

Dimension 6: Recovery/Living Environment

(Recovery or living situation & surrounding people, places, and things)

Exercise: Treatment Referral

What ASAM level of care do you recommend for Marie and why do you think that's the best match? Keep in mind ASAM's guideline that we provide the *least restrictive effective setting* for treatment.

Level 1 = Outpatient

Level 2.1 = Intensive Outpatient

Level 2.5 = Partial Hospitalization

Level 3.1 = Low-intensity residential (halfway house)

Level 3.5 = High-intensity residential

Level 4 = Medically managed inpatient

Rationale:

Exercise: Initial Treatment Plan / Master Problem-Goal List

A master problem-goal list can be used to identify primary client concerns and create a working list of issues that will be addressed over time. The counselor or clinician can then return to this list throughout a client's treatment to continue developing treatment goals with the client.

Based on Marie's assessment, what are the primary problems to address on her treatment plan?

CHAPTER 4.

ILLINOIS 2060 LAW

This chapter contains the full written text known as Illinois Part 2060. This law describes in detail the requirements for licensed treatment providers throughout the state. The Illinois Department of Human Services licenses treatment providers through a division known as Substance Use Prevention and Recovery (SUPR). All licensees must adhere to the 2060 regulations.

To be frank, this information may seem dry. It is included here because all agencies in Illinois must adhere to these rules, and knowing thee rules gives counselors in the field a tremendous edge. It's important for even brand-new counselors to remember that one day in the not-too-distant future they may be managing the very programs they are working for now.

While we recommend being familiar with the overall code, there are some sections that will be of particular significance to counselors, and these are highlighted in the video below.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://cod.pressbooks.pub/addictionscounseling/?p=43#oembed-1

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://cod.pressbooks.pub/addictionscounseling/?p=43#h5p-4

ILLINOIS ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER X: DEPARTMENT OF HUMAN SERVICES
SUBCHAPTER D: LICENSURE
PART 2060 ALCOHOLISM AND SUBSTANCE ABUSE TREATMENT AND INTERVENTION LICENSES

Click to jump to a specific subpart.

SUBPART A: GENERAL REQUIREMENTS

Section 2060.101 Applicability

This Part shall apply to all persons engaged in substance abuse treatment and intervention as defined in Section 301/15-5 of the Illinois Alcoholism and Other Drug Abuse and Dependency Act [20 ILCS 301/15-5] and further defined in this Part.

Section 2060.103 Incorporation by Reference and Definitions

"Act" means the Alcoholism and Other Drug Abuse and Dependency Act [20 ILCS 301].

"Admission" means what occurs after a patient has completed an assessment, received placement into a level of care, and been accepted for and begins such treatment.

"Adolescent" means a person who is at least 12 years of age and under 18 years of age.

"Adult" means a person who is 18 years of age or older.

"Alcohol and Drug Evaluation Report Summary" means the form, developed by the Office of the Secretary of State and required for use by the Illinois courts when granting judicial driving privileges, as defined in Section 6-201 of the Illinois Driver Licensing Law [625 ILCS 5/6-201].

"Alcohol and Drug Evaluation Uniform Report" means the form, mandated by the Department and produced from the DUI Services Reporting System (DSRS), that is required to report a summary of the DUI evaluation to the circuit court or the Office of the Secretary of State.

"Americans with Disabilities Act of 1990 (ADA)", 42 USC 12101, is the federal law requiring that public accommodations offer their services equally to persons without discrimination based on disabilities. An organization may not deny its services, offer unequal services or separate services, or have policies and procedures that have a discriminatory effect based on a disability, and shall remove barriers where possible and provide alternatives where not possible.

"ASAM Patient Placement Criteria" means the American Society of Addiction Medicine's Patient

Placement Criteria for the Treatment of Substance-Related Disorders, Fourth Edition (ASAMPPC-2R), 4601 North Park Avenue, Upper Arcade Suite 101, Chevy Chase MD 20815 (2001, no later amendments or editions included).

"Assessment" means the process of collecting and professionally interpreting data and information from an individual and/or collateral sources, with the individual's permission, about alcohol and other drug use and its consequences as a basis for establishing a diagnosis of a substance use disorder, determining the severity of the disorder and comorbid conditions and identifying the appropriate level and intensity of substance abuse treatment, as well as needs for other services.

"Associate Director" means the Associate Director of the Department of Human Services Office of Alcoholism and Substance Abuse (OASA).

"Authorized Prescriber" means a physician licensed to practice medicine in all its branches pursuant to the Medical Practice Act of 1987 [225 ILCS 60] or a physician under federal authority who issues prescriptions pursuant to 21 CFR 1301.25 (2000).

"Authorized Organization Representative" means the individual in whom authority is vested for the management, control and operation of all services at a facility and for communication with the Department regarding the status of the organization's licenses at that facility.

"CDC Tuberculosis Guidelines" means "Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities", MMWR 1994 (no. RR13).

"Case Management" means the provision, coordination, or arrangement of ancillary services designed to support a specific patient's substance abuse treatment with the goal of improving clinical outcomes.

"Chemical Test" means, in the context of intervention services, a breath, blood or urine test that measures the blood alcohol concentration (BAC) and/or drug concentration.

"Client" means a person who receives intervention services as defined in this Part.

"Clinical Services" means substance abuse assessment, individual or group counseling, and discharge planning. The organization may also determine that other specified activities require the services of a professional staff member.

"Continuing Recovery Plan" means a plan developed with the patient prior to discharge that identifies recommended activities, support groups, referrals and any other necessary follow-up activities that will support and enhance patient progress, to date.

"Continuum of Care" means a structure of interlinked treatment services (either offered by one organization or through linkage agreements with other organizations) that is designed so a patient's changing needs will be met as that individual moves through the treatment and recovery process.

"Controlled Substance" means a drug or substance, or immediate precursor, that is enumerated in the Schedules of Article II of the Illinois Controlled Substances Act [720 ILCS 570] and in the Cannabis Control Act [720 ILCS 550]

"Department" means the Department of Human Services.

"Detoxification" means the process of withdrawing a person from a specific psychoactive substance in a safe and effective manner.

"Discharge" means the point at which the patient's treatment is terminated either by successful completion or by some other action initiated by the patient and/or the organization.

"Drunk and Drugged Driving Prevention Fund" means a special fund in the State Treasury created by Section 50-20 of the Alcoholism and Other Drug Abuse and Dependency Act out of which the Department may provide reimbursement for DUI evaluation and risk education services to indigent

DUI offenders pursuant to this Part, and that it may also use to enhance and support its regulatory inspections and investigations.

"DUI" means driving while under the influence of alcohol, other drugs or combination thereof as defined in the Illinois Vehicle Title and Registration Law [625 ILCS 5/Ch. 2-5] or a similar provision of a local ordinance.

"DUI Evaluation" means the services provided to a person relative to a DUI offense in order to determine the nature and extent of the use of alcohol or other drugs as required by the Unified Code of Corrections [730 ILCS 5] and Section 6-206.1 of the Illinois Driver Licensing Law [625 ILCS 5/6-206.1].

"DUI Service Reporting System (DSRS)" means the computer software that shall be utilized to summarize all evaluation and risk education services statistics semi-annually and to produce the "Alcohol and Drug Evaluation Uniform Report" and other associated forms.

"Early Intervention" means services that are sub-clinical or pre-treatment and are designed to explore and address problems or risk factors that appear to be related to substance use and/or to assist individuals in recognizing the harmful consequences of inappropriate substance abuse.

"Facility" means the building or premises that are used for treatment and intervention services as specified in this Part.

"Good Cause" means conditions that would prevent a reasonable licensee from meeting one or more of the requirements of this Part.

"HIPAA" means the Health Insurance Portability and Accountability Act, 42 USC 1320(d) et seq. and the regulations promulgated thereunder at 45 CFR 160, 162 and 164 (Privacy and Security).

"Incident" means any action by staff or patients that led, or is likely to lead, to adverse effects on patient services.

"Indigent DUI Offender" means anyone who has proven inability to pay the full cost of the DUI evaluation or risk education service as determined through criteria established by the U.S. Department of Health and Human Services and published in the Federal Register and whose costs for such DUI services may be reimbursed from the Drunk and Drugged Driving Prevention Fund, subject to availability of such funds.

"Individual Counseling" means a therapeutic interaction between a patient and professional staff that includes but is not limited to the following: assessment of the patient's needs; development of a treatment plan to meet those identified needs; continual assessment of patient progress toward identified treatment plan goals and objectives; referral, if necessary; and discharge planning.

"Informed Consent" means a legally valid written consent by an individual or legal guardian that authorizes treatment, intervention or other services or the release of information about the individual, and that gives appropriate information to the individual so that he or she can authorize the service or disclosure with understanding of the consequences.

"Intervention" means activities or services that assist persons and their significant others in coping with the immediate problems of substance abuse or dependence and in reducing their substance use. Such services facilitate emotional and social stability and involve referring persons for treatment, as needed.

"Investigational New Drugs" means those substances that require approval by the U.S. Food and Drug Administration for trials with human subjects pursuant to 21 CFR 312 (2002).

"LAAM" means levo-alpha-acetyl-methadol that is a synthetic opioid agonist whose opioid effect

is slower in onset and longer in duration (72 hours) than methadone and that is used in opioid maintenance therapy.

"Life Safety Code of 2000" means the National Fire Protection Association's Life Safety Code of 2000, National Fire Protection Association, 1 N. Batterymarch Park, Quincy MA 02269 (2000, no later amendments or editions included).

"Linkage Agreement" means a written agreement with an external organization to supplement existing levels of care and to arrange for other specialty services not directly provided by the organization.

"Methadone" means a synthetic narcotic analgesic drug (4,4-diphenyl-6-dimethylamino-heptanone-3-hydrochloride) that is used in opioid maintenance therapy.

"Mission Statement" means the reason for existence for the organization and/or specific setting or service.

"Opioid Maintenance Therapy (OMT)" means the medical prescription, medical monitoring and dispensing of opioid compounds (such as Methadone and LAAM) as a medical adjunct to substance abuse treatment.

"Off-Site Delivery of Services" means licensable services that are delivered at a location separate from the licensed facility.

"Organization" means any public or private agency, corporation, unit of State or local government or other legal entity acting individually or as a group that seeks licensure or is licensed to operate one or more substance abuse treatment or intervention services.

"Patient" means a person who receives substance abuse treatment services as defined in this Part from an organization licensed under this Part.

"Person" means any individual, firm, group, association, partnership, corporation, trust, government or governmental subdivision or agency.

"Physician" means a person who is licensed to practice medicine in all its branches pursuant to the Medical Practice Act of 1987 [225 ILCS 60].

"Practitioner" means a physician, dentist, podiatrist, veterinarian, scientific investigator, pharmacist, licensed practical nurse, registered nurse, hospital, laboratory, or pharmacy, or other person licensed, registered, or otherwise permitted by the United States pursuant to 21 CFR 1301.21 and this State to distribute or dispense in accordance with Section 312 of the Illinois Controlled Substances Act [720 ILCS 510], conduct research with respect to, administer or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research.

"Professional Staff" means any person who provides clinical services or who delivers intervention services as defined in this Part.

"Protected Health Information" means the health information governed by HIPAA privacy and security requirements set forth in 45 CFR 164.501.

"Psychiatrist" means a physician licensed to practice medicine in all its branches pursuant to the Medical Practice Act of 1987 [225 ILCS 60] and who meets the requirements of the Mental Health and Developmental Disabilities Code [405 ILCS 5].

"Recovery Home" means alcohol and drug free housing authorized by an intervention license issued by the Department, whose rules, peer-led groups, staff activities and/or other structured operations are directed toward maintenance of sobriety for persons in early recovery from substance abuse or who recently have completed substance abuse treatment services or who may still be receiving such treatment services at another licensed facility.

"Relapse" means a process manifested by a progressive pattern of behavior that reactivates the symptoms of a disease or creates debilitating conditions in an individual who has experienced remission from addiction.

"Residential Extended Care" (formerly halfway house) means residential clinical services for adults (17 year olds may be admitted provided that their assessment includes justification based on their behavior and life experience) or adolescents provided by professional staff in a 24 hour structured and supervised treatment environment. This type of service is primarily designed to provide residents with a safe and stable living environment in order to develop sufficient recovery skills.

"Revocation" means the termination of a treatment or intervention license, or any portion thereof, by the Department.

"Risk" means, in the context of intervention services, the designation (minimal, moderate, significant, or high) assigned to a person who has completed a substance abuse evaluation as a result of a charge for DUI that describes the person's probability of continuing to operate a motor vehicle in an unsafe manner. This assignment is based upon the following factors: the nature and extent of the person's substance use; chemical testing results; prior dispositions for DUI, statutory summary suspensions or reckless driving convictions reduced from a DUI; and any other significant dysfunction resulting from substance abuse or dependence.

"Secretary" means the Secretary of the Department of Human Services or his or her designee.

"Significant Incident" means any occurrence at a licensed facility that requires the services of the coroner and/or that renders the facility inoperable.

"Significant Other" means the spouse, immediate family member, other relative or individual who interacts most frequently with the patient in a variety of settings and who may also receive substance abuse services.

"Substance Abuse or Dependence" means maladaptive patterns of substance use leading to a clinically significant impairment or distress as defined in the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV), 1400 K Street NW, Washington, DC 20005 (1994, no later amendments or editions included).

"Support Staff" means any staff who do not deliver clinical or intervention services.

"Transfer" means the process that occurs when a patient can no longer receive services at an organization because the appropriate level of care is not available, or the movement of the patient from one level of care to another within an organization's continuum of care.

"Treatment" means a continuum of care provided to persons addicted to or abusing alcohol or other drugs that is designed to identify and change patterns of behavior that are maladaptive, destructive and/or injurious to health; or to restore appropriate levels of physical, psychological, and/or social functioning.

"Treatment Plan" means an individually written plan for a patient that identifies the treatment goals and objectives based upon a clinical assessment of the patient's individual problems, needs, strengths and weaknesses.

"Tuberculosis Services" means counseling the person regarding tuberculosis; testing to determine whether the person has been infected with mycobacteria tuberculosis to determine the appropriate form of treatment; and providing for or referring the infected person for appropriate medical evaluation and treatment.

"U.S. Drug Enforcement Administration rules and regulations pertaining to medical dispensary services" means 21 CFR 1301.71-1301.76, 1304, and 1307.2 (2000).

"Universal Precautions" means the following guidelines published by the U.S. Centers for Disease Control and Prevention:

"Recommendations for Prevention of HIV Transmission in Health Care Settings", MMWR 1987; 36 (2s); and

"Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and other Bloodborne Pathogens in Health Care Settings, MMWR 1988; 37 (no. 24).

"Utilization Review" means a quality protective function that attempts to ensure that the patient is receiving an appropriate level of services, in accordance with assessed clinical conditions. Utilization review activities focus primarily in four major areas:

- the appropriateness and clinical necessity of admitting a patient to a level of care;
- the appropriateness and clinical necessity of continuation of the initiated level of care;
- the initiation and completion of timely discharge planning; and
- the appropriateness and clinical necessity and timelines of support services.

SUBPART B: LICENSURE REQUIREMENTS

Section 2060.201 Types of Licenses

Substance abuse treatment and intervention services as specified in Section 2060.101 of this Part shall be licensed by the Department. An organization may apply for an intervention and a treatment license at the same facility and all services authorized by both an intervention and a treatment license shall be authorized by a single license issued to that facility. Consistent with rules herein, services may be provided to adults as well as adolescents. The license certificate for the facility shall specify all levels of care and a designation of adult and or adolescent services. Individuals who are 16 and 17 may be admitted as adults and individuals who are 18, 19 and 20 may be admitted as adolescents provided that the assessment of such individuals includes justification based on the person's behavior and life experience.

a) Treatment

A treatment license issued by the Department may authorize substance abuse services as established in the ASAM Patient Placement Criteria. The level of care and category (adolescent/adult) shall be specified on the license application or, after licensure, on any application to add an additional level of care and/or category (adolescent/adult).

b) Intervention

1) DUI Evaluation

An intervention license issued by the Department may authorize the following services:

Substance abuse evaluation services for persons who are charged with driving under the influence (DUI) offenses pursuant to the Illinois Vehicle Code [625 ILCS 5/11-501] or similar local ordinances that determine the offender's risk to public safety and make a subsequent corresponding recommendation for intervention to the Illinois courts or the Office of the Secretary of State.

2) DUI Risk Education

Substance abuse risk education services for persons who are charged with driving under the influence (DUI) offenses pursuant to the Illinois Vehicle Code [625 ILCS 5/11-501] or similar local ordinances.

3) Designated Program

A program designated by the Department to provide screening, assessment, referral and tracking services pursuant to Article 40 of the Act.

4) Recovery Homes

Alcohol and drug free housing with rules, peer-led groups, staff activities and/or other structured operations which are directed toward maintenance of sobriety for persons in early recovery from substance abuse or persons who have completed substance abuse treatment services or who may still be receiving such treatment at another licensed facility.

Section 2060.203 Off-Site Delivery of Services

a) Licensure shall be facility specific; however, treatment or intervention services may be offered off-site when good cause is established by the organization for an exception to be granted by the Department in accordance with Section 2060.303 of this Part and the criteria outlined in subsection (d) of this Section.

b) The exception process for off-site delivery of services shall not be required for:

1) patient or client emergency situations;

2) services delivered in schools, hospitals or facilities or offices owned or operated by the State of Illinois or any local governmental entity, with the exception of Illinois Department of Corrections facilities and city or county operated jails and detention centers;

3) court ordered service to an individual in jail;

4) early intervention services; or

5) case management services.

However, in such cases, the rationale and location for the provision of the off-site service shall be documented in the patient record and any patient record utilized or stored at the off-site location shall be done so in accordance with the provisions specified in Section 2060.319 of this Part.

c) In order to receive an exception for off-site services the licensed organization shall submit a request to the Department at least 30 calendar days prior to the anticipated provision of such services. The request shall include the following:

1) the legal name, address and telephone number of the off-site location;

2) the services that will be provided at the off-site location;

3) the days of the week and hours when each service will be provided;

4) the legal name, address, telephone number and license number of the organization that will operate and provide supervision for the services;

5) the names of professional staff who will provide the services;

6) the reason for the provision of services at the off-site location; and

7) the numbers of individuals to be served.

d) In determining whether the provision of off-site service shall be allowed, the Department shall consider, but not be limited to, appropriate factors such as:

1) the ability to provide the environment required for the level of care;

2) the gravity of the reason that service at the licensed location is not acceptable (transportation requirements, sickness, etc.);

3) availability of necessary support functions at the off-site location;

4) ability to provide professional environment at the off-site location;

5) physical safety of the patient; and

6) compliance with applicable State and federal regulations.

e) The Department shall also be notified of any change in the provision of off-site services at least 10 calendar days prior to any change in such services.

f) Failure to report such information to the Department shall result in the unlicensed practice of services at such locations.

Section 2060.205 Unlicensed Practice

a) Whenever the Department determines that an unlicensed organization or person is engaging in activities that require licensure, pursuant to the specifications in Section 2060.101 of this Part, it shall issue an order to that organization or person to cease and desist from engaging in the activity. The order shall specify the particular services that require licensure, and shall include citation of relevant Sections of the Act and this Part.

b) The Department's order shall be accompanied by a notice that instructs the recipient that written documentation may be submitted to the Department within 10 calendar days to support a claim that licensure is not required, or that the recipient is properly authorized to conduct the services.

c) After the expiration of the 10 day period, if the Department believes that the organization or unlicensed person is continuing to provide services that require licensure, the matter shall be referred to the appropriate State's Attorney or to the Office of the Attorney General for prosecution.

Section 2060.207 Organization Representative

a) At each facility, one individual shall be designated by the organization as the authority for the management, control, and operation of all services relative to that facility and for communication with the Department regarding the status of the license for that facility. This person shall be known as the organization representative.

b) The Department shall be notified, in writing, within ten calendar days, when there is a new designation of an organization representative.

Section 2060.209 Ownership Disclosure

a) At the time of application for licensure, the names and addresses of all owners or controlling parties of the organization (whether they are individuals, partnerships, corporate bodies, or subdivisions of other bodies, such as public agencies or religious, fraternal, or other charitable organizations) shall be fully disclosed.

b) In the case of corporations, the names and addresses of all officers, directors, and stockholders owning five percent or more of the stock of the corporation, either beneficial or of record, shall be disclosed.

Section 2060.211 License Application Forms

a) An application for a license, an application to renew a license, an application to relocate a facility or an application to add an additional level of care or category (adolescent/adult) shall be made on forms specified by the Department. The organization shall provide any and all information requested on the application forms.

b) Such forms may be obtained in person or by writing to:

Illinois Department of Human Services

Office of Alcoholism and Substance Abuse
100 W. Randolph St., Suite 5-600
Chicago, Illinois 60601
Attention: Division of Licensing and Certification

c) An application for a license shall be signed and dated by the organization representative, and at least two of the corporate officers in the case of a corporate applicant, or by all partners or associates in the case of a partnership or association.

Section 2060.213 License Application Fees

a) Application fees are due upon application for each facility license. Application fees are not refundable. Payment shall be made by check or money order made payable to the Department of Human Services. Payment shall not be in the form of U.S. currency, foreign currency, or stamps. A separate check or money order shall be submitted with each application.

b) The application fee is $200.00 for each facility license.

c) Relocation of a facility requires submission of a relocation application and payment of the application fee.

d) No application fee shall be required of any unit of local, State, or federal government.

Section 2060.215 Period of Licensure

a) Each license issued by the Department shall be effective for a period of three years.

b) At any time during this licensure cycle, an additional treatment or intervention service may be added at a facility at no extra cost.

Section 2060.217 License Processing/Review Requirements

a) All licensure applications are deemed received by the Department on the postmarked date.

b) The Department shall notify the organization regarding any error or omission found after review of the application. The organization shall submit all requested information within 90 calendar days after the date of the Department's notification. If the organization fails to submit all required information within this 90 day period, the entire application will be returned and the process will be terminated. To re-initiate the process after this 90 day period, the organization shall re-submit the corrected application and another application fee.

c) The Department may verify the data furnished in any application for licensure. Submission of an application carries implied consent to permit inquiry into the data furnished when an examination of submitted information discloses an anomaly or disparity in the information in comparison to that on file with the Department or other data submitted by other organizations, or information about the organization, facility, staff and/or board of directors received by the Department.

d) The Department may, either before or after the issuance of a license, request the cooperation of the State Fire Marshal, county health departments, or local boards of health to make investigations if the Department is unable through its own resources to ascertain compliance with this Part.

e) Prior to issuance or renewal of a license and upon receipt by the Department of evidence to the contrary, the Department may seek to verify that the physical, mental and professional capability and integrity of management, control and/or ownership personnel is sufficient to assure that the applicant can perform anticipated services with reasonable judgement, skill and safety. In determining such capability and integrity the Department may consider, but is not limited to, the following:

1) the accuracy of materials and information maintained and/or submitted in the course of the establishment or operation of the services;

2) prior criminal conduct by personnel;

3) prior violations of this Part or any other Department Rule by the organization or by personnel either as current employees of the organization applying for licensure or as employees of any other organization that has held or holds a license from the Department;

4) competent evidence of emotional, psychological and/or physical impairment which may substantially interfere with the provision of services as licensed; or

5) the timeliness of responses to the Department's reasonable requests for information from such personnel.

f) The Department may investigate the background of staff members, if deemed necessary, to assure that these individuals satisfy applicable professional requirements and/or standards referenced in Sections 2060.309 and 2060.313 of this Part.

Section 2060.219 Renewal Of Licensure

a) The Department shall send a license renewal application to each organization at least 60 calendar days prior to expiration of the license. The organization shall notify the Department if the license renewal application is not received.

b) The Department shall receive the license renewal application at least 30 calendar days prior to expiration of the license in order to guarantee that the renewal process is complete prior to expiration.

Section 2060.221 Change of Ownership/Management

a) Each license issued by the Department shall be valid only for the premises and persons named in the application. Licensure is not transferrable. A license shall become null and void when:

1) a change in ownership involving more than 25% of the aggregate ownership interest within a one year period or a significant change in management; or

2) a change of 50% or more in the board of directors of a not-for-profit corporation within a one year period.

b) In order to obtain a new license reflective of the change in ownership the licensee shall submit to the Department:

1) written notification at least ten calendar days prior to any of the above referenced changes in ownership; and

2) an application for initial licensure and the license application fee of $200 per license.

c) Failure to notify the Department within ten calendar days relative to the above referenced changes in ownership will result in the imposition of a license fee of $1000 for each affected license.

Section 2060.223 Dissolution of the Corporation

a) A license shall become null, void and of no further effect when there is any dissolution of the corporation. Written notification shall be given to the Department within ten calendar days after such dissolution.

b) A license issued to a corporation which is subsequently dissolved shall not be reactivated upon reinstatement of the corporation and the license is also subject to sanctions provided herein. Such corporation shall reapply for licensure.

c) In order to obtain a new license relative to reinstatement of a corporation, an application for initial licensure and the license application fee of $200 per license shall be submitted to the Department. If the Department was not notified within ten calendar days relative to the dissolution of the corporation the license fee will be $1000 for each affected license.

Section 2060.225 Relocation of Facility

a) Notification shall be given to the Department at least 30 calendar days prior to the relocation of any facility.

b) An application shall be completed by the organization relative to each relocation.

c) A relocation fee of $200 per application is required unless proper notification, as referenced in subsection (a), was not given, in which case the relocation fee will be $1000 per application.

Section 2060.227 License Certificate Requirements

a) A license certificate shall be issued by the Department for each facility that reflects the type of license and the levels of care and category (adolescent/adult) authorized for that facility.

b) The license certificate shall remain the property of the Department and shall be returned to the Department if there is a change in ownership, management, or location, or if the license is suspended, revoked or modified.

c) The license certificate issued by the Department shall contain the name and address of the facility, license number, all levels of care and the category (adolescent/adult) authorized by that license and expiration date.

d) The most current license certificate issued by the Department shall be displayed in the facility at all times in a location that is visible to all patients.

SUBPART C: REQUIREMENTS – ALL LICENSES

Section 2060.301 Federal, State and Local Regulations and Court Rules

All organizations shall attest to compliance, on the license application, and shall comply with all applicable provisions of State and federal constitutions, laws, regulations, court rules or judicial orders, including but not limited to:

a) The Illinois Human Rights Act [775 ILCS 5]. The licensee shall also take affirmative action to ensure that no unlawful discrimination is committed;

b) The Americans with Disabilities Act of 1990 (42 USC 12101) and the regulations and guidelines;

c) The Environmental Barriers Act [410 ILCS 25] and The Illinois Accessibility Code (71 Ill Adm Code 400);

d) The Age Discrimination Act of 1975 [42 USC 3001]; and

e) The 1991 Civil Rights Act [42 USC 1981].

Section 2060.303 Rule Exception Request Process

a) Requests for exceptions to any Section in this Part that is not statutorily mandated may be submitted to the Department. Requests shall be made by the Authorized Organization Representative to the Associate Director in writing, indicating the specific basis, rationale and need for the exception. Requests for exceptions may be made by any Department staff or provider.

b) In order to maintain uniformity to the greatest extent feasible, the Department will endeavor to keep exceptions to a minimum. Prior to granting any exception, the Department shall consider, but not be limited to, the following factors: the organization's patient or client population and size; type of services; geographic location; client or patient well-being if the exception is granted; the specific geographic location of the organization; and the accreditation status of the organization, as applicable.

c) Exceptions are at the sole discretion of the Department and the decision of the Associate Director is final.

d) The Department may revoke any exception granted when the circumstances that gave rise to the exception no longer exist or when any conditions imposed by the granting of the exception are not implemented by the provider or are subsequently prohibited by State or federal statute. The provider shall notify the Department in writing within 10 calendar days when the circumstances that gave rise to the exception no longer exist.

e) An exception to any Sections shall be valid only for the term of the license under which it was granted unless a different time period or permanent variance is specified by the Department. At the point of license renewal, reapplication for the exception shall be made.

f) Any licensed organization may be granted deemed status, in accordance with the provisions specified in Section 2060.229 of this Part.

Section 2060.305 Facility Requirements

a) At the time of application for initial or renewal licensure, all organizations, with the exception of Recovery Homes that are subject to the provisions specified in Section 2060.509 of this Part, shall, on a form supplied by the Department, document full compliance with all applicable provisions specified in this Section and, specifically, with the following:

1) all local and State health, safety, sanitation, building and zoning codes;

2) all applicable sections, as specified in this Section, of the National Fire Protection Association's (NFPA) Life Safety Code of 2000;

3) the facility requirements specified in the Environmental Barriers Act [410 ILCS 25] and the Illinois Accessibility Code (71 Ill. Adm. Code 400); and

4) the facility requirements specified in Section 12181 of the Americans with Disabilities Act of 1990 (42 USC 12181).

b) The days and hours of operation shall be posted at each facility where treatment or intervention services are provided. This information shall be displayed in a location that is visible to all persons.

c) Each facility shall also:

1) have a written emergency preparedness plan that ensures appropriate disaster preparedness and continuation of services, if possible, after a disaster. This plan shall contain provisions for a tornado and fire drill at least annually, identify the role of the facility in a community-wide disaster and have an emergency evacuation plan, including provisions for disabled persons; and

2) have areas for confidential interviewing, counseling, and administration and public reception and waiting areas.

d) Residential extended care facilities shall comply with the provisions specified in Chapter 26 (Lodging or Rooming Houses) of the National Fire Protection Association's (NFPA) Life Safety Code of 2000 for any building housing 16 or fewer residents and with the provisions specified in Chapter

29 (Existing Hotels and Dormitories) of the NFPA Life Safety Code of 2000 for any building housing 17 residents or more.

e) Inpatient treatment facilities shall comply with the provisions specified in Chapter 28 (New Hotels and Dormitories) of the NFPA Life Safety Code of 2000.

f) All existing outpatient treatment facilities shall comply with Chapter 39 (Existing Business Occupancies) of the NFPA Life Safety Code of 2000. Any outpatient treatment facility constructed after promulgation of this Part shall comply with Chapter 38 (New Business Occupancies) of the NFPA Life Safety Code of 2000.

g) Organizations shall also ensure, as applicable:

1) that each bedroom is kept clean and organized;

2) that each bedroom is occupied only by those of the same sex, except in situations where children are in residence with a parent in treatment;

3) a separate bedroom is provided for any 16 or 17 year old patient admitted to an adult inpatient service or any patient 17 years old or younger admitted to medically monitored detoxification services;

4) a minimum of 80 square feet is provided in a single bedroom and 60 square feet per bed in a multi-bed room with no more than four beds per room;

5) at least three feet of space is provided at the foot or head and one side of each bed and at least three feet between each bed;

6) that bunk beds will not be used for any detoxification patient and all other beds shall be non-folding, at least 36 inches wide and have flame retardant mattresses;

7) that each inpatient bedroom is an outside room with not less than the equivalent of ten percent of its floor area devoted to windows, which shall be covered with curtains, blinds, or shades;

8) that no inpatient bedroom opens into the kitchen or necessitates passing through the kitchen to reach any other part of the facility;

9) that no bedroom is in an attic or in an area with a floor more than three feet below the adjacent ground level;

10) that each inpatient has a wardrobe, locker, or closet;

11) that each bedroom has a swinging door no less than 32 inches in width that opens directly into a corridor or to the outside;

12) that doors in inpatient facilities that lead to corridors shall not be lockable from the inside;

13) that each bathroom contains a toilet and sink and that each tub or shower is enclosed with space for drying and dressing (the sink may be omitted from a bathroom that serves two adjacent bedrooms if each of these rooms contains a sink);

14) that a bathroom is accessible to each central bathing area and that a minimum of one toilet, one sink and one bathtub or shower for each sex shall be provided on each inpatient floor occupied by both sexes;

15) that one sink, one toilet and one bathtub or shower is provided for each eight beds on each floor where bathrooms are not adjacent to bedrooms;

16) that all bathrooms are well lighted and vented to the outside, either by means of a window that can be opened or by an exhaust fan; that no bathroom, other than for employees, shall open directly into a kitchen, pantry, food preparation area or food storage room;

17) that, in inpatient facilities with a capacity to serve more than 20 patients, a separate enclosed room is available for group counseling, other than the one used for recreation or dining;

18) that any facility that provides 24 hour care or that provides any meals shall do so under the direction, as an employee or through a contractual agreement, of a licensed dietician (LD) or a licensed nutrition counselor (LNC);

19) that the dietitian or licensed nutrition counselor shall develop a written plan for the provision of food services that describes either the organization of the food service and the delivery of food services or the arrangements for the provision of such services to patients;

20) that all nutritional aspects of patient care, including any specific dietary patient needs, shall be under the direction of the licensed dietitian, the licensed nutrition counselor or other persons who are supervised by the licensed dietitian or the licensed nutrition counselor;

21) that the dining area is supervised and staffed to provide assistance to the patients when needed, shall be sized and equipped to accommodate the age and number of patients served and shall be separate from the kitchen area;

22) that the preparation or cooking of regularly scheduled hot meals is restricted to kitchen areas that shall be designed and equipped to meet the requirements of the services provided, including provisions for food receiving, storage, and preparation, dish and pot washing, and waste disposal;

23) that there is access to a handwashing sink and toilet and that all equipment and appliances are installed to permit thorough cleaning of all equipment, walls, baseboards, and non-absorbent floor material and that each kitchen has an Underwriters Laboratories (U.L.) approved five pound class B:C dry chemical fire extinguisher; and

24) that if laundry is done at the facility, space for soiled linen sorting, laundry equipment, including washers and dryers, and clean linen storage space is provided. If laundry is done outside the facility, a soiled linen storage room or area shall be provided.

Section 2060.307 Service Termination/Record Retention

a) The Department shall be notified at least 30 calendar days prior to the date on which cessation of any service is scheduled to occur. If involuntary termination occurs due to inability to operate (from damage to the facility, loss of staff, change in management, corporate dissolution or any other cause) the licensee shall notify the Department upon termination even though the 30 day notice has not occurred.

b) All patients receiving such services shall be apprised of the pending cessation and the needs of such patients shall be met by alternative means. The Department shall be notified within ten calendar days prior to closure of any case in which it is anticipated that a patient's needs cannot be met by existing systems of treatment.

c) When notified by an organization of its intention to cease operations at a location, the Department, if necessary, will schedule an inspection to ensure that the controlled substances inventory is transferred or destroyed in accordance with the Drug Enforcement Administration (DEA) requirements set forth at 21 CFR 1307.14 and 1301.21 (1987), respectively.

d) When an organization ceases operation of any service, all records (patient, personnel, financial) relative to that service shall be maintained as follows:

1) If the organization has a current license issued by the Department for any other treatment or intervention service, the organization may maintain the records from the service that has ceased operation.

2) If the organization has no other current license issued by the Department for any other treatment or intervention service, all records shall be transferred for maintenance and storage to a

treatment or intervention service currently licensed by the Department or to a person specifically exempted from such licensure in Section 15-5 of the Act.

e) The Department shall be notified regarding the location where records will be maintained and stored within ten calendar days after cessation of service.

f) Such records shall be stored and maintained for a period of five years from the date of cessation of service, if the organization is required to document disclosures of the record pursuant to the provisions of 45 CFR 164.528, for such documentation shall be maintained six years from the date of its creation or the date when it last was in effect, whichever is later.

g) Upon cessation of operations, the license shall automatically become null and void, and all documentation of licensure shall be immediately surrendered to the Department.

Section 2060.311 Staff Training Requirements

a) All organizations shall provide an initial employee orientation to all staff within the first seven days after employment that shall include, at a minimum, the following information:

1) An overview of all organization operations, including the specific duties assigned to the employee; emergencies and disaster drills; familiarization with existing staff backup and support; and all required training.

2) An overview of this Part for all staff.

3) Information on bloodborne pathogens and universal precautions (as those terms are defined in the regulations set forth in Section 2060.413 of this Part) and the importance of tuberculosis control and personal hygiene, the responsibilities of all staff with regard to infection control and an overview of the fundamentals of HIV, AIDS and tuberculosis control.

4) Information on HIV and AIDS relative to the etiology and transmission of HIV infection and associated risk behaviors, the symptomatology and clinical progression of HIV infection and AIDS and their relationship to substance abuse behavior, the purposes, uses and meaning of available testing and test results, relapse prevention and sensitivity to the issues of an HIV infected patient.

5) An overview of the principles of patient confidentiality, all related federal and State statutes and all record keeping requirements regarding confidential information.

b) Within the first six months after employment, any and all staff providing a DUI evaluation service shall attend one complete DUI Orientation training session offered or approved by the Department.

c) Within the first 12 months after employment, any and all staff providing a DUI risk education intervention service shall attend the first day of a DUI Orientation training session offered or approved by the Department.

d) In addition to mandatory training specified in subsections (b) and (c) of this Section, each DUI evaluator or Risk Education instructor shall obtain additional hours of substance abuse training annually consistent with the requirements of their professional staff credential.

Section 2060.313 Personnel Requirements and Procedures

a) All professional staff:

1) shall be at least 18 years of age; and

2) cannot have been convicted of any felony or had any subsequent incarceration for at least two years prior to the date of employment.

b) Verification of the requirements specified in subsection (a) above shall be documented on

the Department's Schedule L at the time of employment and this form shall be maintained in the employee's personnel file. Prior to employment a copy of the Schedule L, along with a letter requesting an exception for employment, shall be sent to the Department relative to any person that indicates a felony conviction within the time period specified above.

c) In addition, any staff providing DUI evaluation or risk education services shall not have a suspension or revocation of driving privileges for an alcohol or drug related driving offense for at least two years prior to the date of employment.

d) Any staff providing clinical services to or any other supportive services for a child or adolescent who is receiving treatment at a facility, or is receiving child care at a facility, or is residing at a facility with a parent who is in treatment shall consent to a background check to determine whether they have been indicated as a perpetrator of child abuse or neglect in the Child Abuse and Neglect Tracking System (CANTS), maintained by the Department of Children and Family Services as authorized by the Abused and Neglected Child Reporting Act [325 ILCS 5/11.1(15)]. The organization shall have a procedure that precludes hiring of indicated perpetrators based on the reasons set forth in 89 Ill. Adm. Code 385.30(a) and procedures wherein exceptions will be made consistent with 89 Ill. Adm. Code 385.30(e) and procedures for record keeping consistent with 89 Ill. Adm. Code 385.60.

e) The organization shall ensure that treatment services for special populations (gender, youth, criminal justice, HIV, etc.) are delivered by appropriate professional staff as clinical needs indicate.

f) The organization shall have written personnel procedures approved by the management or, if applicable, the board of directors. Such procedures shall apply to all full and part-time employees and shall include the process for:

1) recruiting, selecting, promoting and terminating staff;

2) verifying applicant or employee information;

3) protecting the privacy of personnel records;

4) performance appraisals, and review and update of job descriptions, for all positions in the organization;

5) disciplinary action, including suspension and termination;

6) employee grievances;

7) employment related accident or injury;

8) handling instances of suspected or confirmed patient/client abuse and/or neglect by staff, whether paid or volunteer;

9) handling instances of suspected or confirmed alcohol and other drug abuse by staff; and

10) documentation that the personnel procedures, and any changes in procedures, have been distributed to employees and are available on request.

g) The organization shall provide documentation that all personnel procedures have been reviewed and approved at least annually by the Authorized Organization Representative or, if applicable, the board of directors.

h) A personnel file shall be maintained for each employee that contains:

1) the employee's name, address, telephone number, social security number, emergency contact and telephone number;

2) resume and evidence of qualifications;

3) documentation of the Schedule L and any relevant background checks and/or exception request;

4) unless otherwise kept in a training file, documentation of required training and continuing

education received while employed by the organization (as indicated by a certificate of completion or the title, date and location of the training and the signature of the staff member who attended the training);

5) a copy of any professional certification, current license and/or registration, and date of employment and/or termination from the organization;

6) a copy of the signed applicable professional code of ethics as referenced in Part 2060.309(e)(4) of this Part; and

7) documentation of annual review of the organization's policy and procedures manual by all staff during their first year of employment and, annually thereafter, any updated sections that pertain to each staff member.

i) Each personnel file shall be maintained for a period of five years from the date of employee termination.

Section 2060.314 COVID-19 Vaccination of Organization Staff

a) For the purposes of this Section,

1) "Organization" means any organization certified as a Substance Use Prevention Treatment program under this Part.

2) "Staff" or "staff person" means any person who:

A) is employed by, volunteers for, or is contracted to provide services for a facility, or is employed by an organization that is contracted to provide services to a facility; and

B) is in close contact (fewer than 6 feet) with other persons in the organization for more than 15 minutes at least once a week on a regular basis as determined by the entity. The term "staff" or "staff person" does not include any person who is present at the organization for only a short period of time and whose moments of close physical proximity to others on site are fleeting (e.g., contractors making deliveries to a site where they remain physically distanced from others or briefly entering a site to pick up a shipment).

3) "COVID-19 vaccine" means a vaccine for COVID-19 that has been authorized for emergency use, licensed, or otherwise approved by the U.S. Food and Drug Administration (FDA).

4) An individual is "fully vaccinated against COVID-19" two weeks after receiving the second dose in a two-dose series of a COVID-19 vaccine or two weeks after receiving a single-dose COVID-19 vaccine.

b) Each organization shall require all staff to be fully vaccinated against COVID-19 or be tested in a manner consistent with the requirements of subsection (c).

1) Each organization shall require staff who are not fully vaccinated against COVID-19 to have, at a minimum, the first dose of a two-dose vaccination series or a single-dose vaccination by September 19, 2021, and if applicable, the second dose of a two-dose COVID-19 vaccination series within 30 days after administration of their first dose, or be tested consistent with the requirements of subsection (c).

2) Each organization shall require staff who are fully vaccinated against COVID-19 to submit proof of full vaccination against COVID-19. Proof of vaccination may be met by providing to the organization one of the following:

A) a Centers for Disease Control and Prevention (CDC) COVID-19 vaccination record card or photo of the card;

B) documentation of vaccination from a health care provider or electronic health record; or

C) state immunization records.

3) Each organization shall make available opportunities for staff to be fully vaccinated against COVID-19, either directly at the organization or indirectly, such as through an arrangement with a pharmacy partner, local health department, or other appropriate health entity.

4) Each organization shall exempt individual staff members from the requirement that all staff be fully vaccinated against COVID-19 if:

A) vaccination is medically contraindicated, including any individual staff member who is entitled to an accommodation under the Americans with Disabilities Act (42 U.S.C. 12101) or any other law applicable to a disability-related reasonable accommodation; or

B) vaccination would require the individual staff member to violate or forgo a sincerely held religious belief, practice, or observance.

5) Staff that fall within the exemptions of subsection (b)(4) shall undergo the testing requirements set forth in Subsection (c).

6) Organizations may adopt more stringent policies requiring all staff to be vaccinated. Nothing in this Section supersedes or modifies the date such policies are designated by the organization to take effect.

c) By September 19, 2021, each organization shall require its staff who are not fully vaccinated against COVID-19 to undergo testing for COVID-19, weekly, at a minimum. If staff who are not fully vaccinated against COVID-19 are not tested as required by this subsection, the staff shall not be permitted to enter or work at the organization in their healthcare provider roles.

1) The COVID-19 test must either have Emergency Use Authorization by the FDA or be operated pursuant to the Laboratory Developed Test requirements by the U.S. Centers for Medicare and Medicaid Services.

2) Such testing must be conducted on-site at the organization or the organization must obtain proof or confirmation from the staff person of the negative test result obtained elsewhere.

3) Each organization shall make COVID-19 tests available to its staff consistent with the requirements of this Section, or consistent with any more stringent requirements for testing adopted by the organization.

4) If a staff person tests positive for COVID-19, the organization shall exclude the staff person from the organization, consistent with federal, State, and local health guidance, recommendations and regulations.

5) Staff who are not fully vaccinated may be permitted to enter or work at the organization while they are waiting to receive the results of their weekly test.

d) Each entity shall post conspicuous signage throughout the organization, including at points of entry and exit and each hallway, notifying staff that the organization makes available opportunities for staff to be fully vaccinated against COVID-19. The signs shall be on 8.5 by 11-inch white paper, with text in Calibri (body) font and 26-point type in black letters.

e) Each organization shall maintain a record of fully vaccinated staff, unvaccinated staff, and weekly testing. The record shall include a weekly count of how many staff are fully vaccinated; how many are not fully vaccinated; and how many (vaccinated or unvaccinated) have tested positive for COVID-19.

f) The organization shall maintain documentation in each staff person's confidential medical

file, in accordance with federal and state privacy laws, regarding COVID-19 vaccinations and tests, including the following:

1) Proof of vaccination for the staff person, or
2) Written declination of the vaccination if offered by the organization; and
3) The results of any COVID-19 tests for the staff person.

g) Each organization shall verify that staff have been provided education on the benefits and potential risks associated with the COVID-19 vaccine.

h) Failure to comply with any of the requirements set forth in this Section creates a substantial probability of risk of death or serious mental or physical harm and shall result in the imposition of sanctions against the organization's license as defined and further specified in Section 2060.339.

Section 2060.315 Quality Improvement

a) The licensee shall design and utilize a quality improvement plan. Such plan shall be written and shall contain, at a minimum, a method of evaluation to assess achievement of the organization's mission and the functioning of the organization and its service delivery systems and utilization review process.

b) The quality improvement plan shall be approved by management or, if applicable, the board of directors of the organization and annually reviewed and revised as necessary.

c) The evaluation shall contain, at a minimum:

1) a mission statement for the organization;

2) specific and measurable goals, objectives, activities and outcome standards that are utilized by the organization to achieve its missions and projected results;

3) a description of how the organization will review and implement needed changes based on the results of the evaluation;

4) a method to review use of medication in any level of care;

5) a method of risk management that, at a minimum, includes:

A) review and analysis of any incident or significant incident reports as referenced in Section 2060.331 of this Part; and

B) design and implementation of necessary procedures to address both proactively and reactively any identified risks; and

6) a method of utilization review to measure appropriate patient placement.

d) The method of organization evaluation shall be submitted with the application for licensure. The results of the evaluation shall also be available for inspection by the Department and submitted at the time of application for renewal of licensure.

e) Utilization Review

1) For treatment licensees, utilization review shall be conducted at least quarterly and shall be conducted on a minimum 15% sample. If random sampling at 15% indicates problems, the organization will develop a specific remediation plan to correct the identified problems. Utilization review shall be conducted in accordance with continued stay and discharge criteria as established in the ASAM Patient Placement Criteria.

2) For DUI evaluation or designated program intervention licensees, utilization review shall:

A) be conducted at least quarterly on randomly selected cases consisting of at least 15% (but no less than five and no more than 20) of persons receiving each service; and

B) be based on the established criteria specified in this Part for the applicable category of intervention license relative to the substance abuse assessment or evaluation and subsequent intervention or referral.

f) All organizations required to conduct utilization review shall also:

1) specify all staff participating in utilization review;

2) specify how conflict of interest shall be addressed in any small organization where professional staff cannot always avoid reviewing their own cases; and

3) issue a report of finding from utilization review at least quarterly and make such report available to all professional staff.

g) Treatment licensees who are not otherwise required to report data electronically to the Department shall maintain statistics that, at a minimum, determine the total number of assessments, admissions, and discharges per patient by type of discharge and the average length of stay in each level of care.

h) DUI risk education services shall not be subject to utilization review as specified in subsection (e).

i) All treatment and intervention licensees shall develop and maintain a written policy and procedures manual that describes the operation of the organization. At a minimum, the manual shall explain how the organization will comply with all federal and State regulatory and contractual requirements, any additional requirements from independent accrediting bodies, and any other organizational policies and procedures. The manual shall be approved by the board of directors of the organization or, if not applicable, the organization representative and annually reviewed and revised as necessary. The manual shall be submitted to the Department at the time of licensure and upon request from Department staff. The manual shall also be reviewed during the first year of employment by all staff. Annually thereafter, the organization shall ensure that all staff shall review updated sections pertinent to such staff.

Section 2060.317 Service Fees

a) A fee schedule shall be established that specifies the fee charged for all treatment and intervention services and any other related services and that also specifies or estimates the amount for which the individual might be responsible based upon the anticipated length of stay in treatment or the type of intervention service.

b) Each person shall be given a fee schedule prior to the beginning of any treatment or intervention service for which the organization intends to seek reimbursement from the individual, indicating the amount that he or she will be responsible to pay along with any relevant payment schedule for each service.

Section 2060.318 Reimbursement Rates and Rate Modification Methodology

a) Reimbursement rates for Department funding and/or for services reimbursed through Medicaid are or have been developed through the application of Department approved formal methodologies specific to each reimbursable service. Unique to each service, a mean is then established and a standardized rate adopted with the exception of provider specific rates for certain residential and withdrawal management levels of care.

b) When an increase to an appropriation is made specifically for a cost of living adjustment (COLA) to Department established rates, the Department will increase all treatment provider service

rates by the same percent and all contract awards by the same corresponding percent using the increased funds available, unless the appropriation results in an increase of 1 percent or less to each individual provider, or an increase of 1 percent or less for each category of service. If this occurs, increases to established rates and awards will be made to one or more specific categories of funded treatment/recovery service providers using the increased appropriations available. All funded providers that deliver the selected service or services will receive a uniform rate/award increase within their category of service. Services targeted for increased rates or awards will be selected based on the following criteria:

1) The amount of increase to appropriated funds;

2) The need for provider capacity enhancement or expansion;

3) Analysis of the impact of the rate increase on other State agencies that fund substance use disorder services;

4) Analysis of prior State fiscal year earnings posted by vendor or location;

5) Based upon the analysis of earnings and appropriated funds, a determination of the total value of the rate increase in order to keep earnings liabilities within the available appropriation; and

6) The ability of the Department to continue the rate increase into future fiscal years if budget requests are approved.

c) A general increase in an appropriation that is not specified as a COLA shall be awarded according to the legislative direction associated with the increase or by language in the budget implementation plan for that State fiscal year. Increases of this nature may be directed to a provider, a program, or another purpose by the General Assembly. If a general appropriation increase exceeds the 1 percent parameters specified in subsection (b) and the General Assembly provides no direction on how the Department shall allocate the increase, the Department will modify all rates and contract awards by the same percent.

d) All rates or rate modifications are effective only after approval by the Department and, for covered services reimbursed through Medicaid, the Illinois Department of Healthcare and Family Services (HFS) in its capacity as the Medicaid single state agency.

e) Licensed/certified organizations and the public shall be informed of any changes in the methods and standards of determining reimbursement rates for services funded under this Part pursuant to 42 CFR 447.205 (2003).

Section 2060.319 Confidentiality – Patient Information

a) The organization shall have written policies and procedures controlling access to and use of records and information that are governed by the Confidentiality of Alcohol and Drug Abuse Patient Records regulations (42 CFR 2 (1987)) of the Alcohol, Drug Abuse, and Mental Health Administration of the Public Health Service of the United States Department of Health and Human Services effective August 10, 1987 and Article 30 of the Act [20 ILCS 301/Art. 30], and access to and use of protected health information governed by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC 1320 et seq., and the regulations promulgated thereunder at 45 CFR 160, 162 and 164. The policies and procedures shall be consistent with said regulations and statutes. The organization shall comply with said regulations and statutes. However, nothing in this Part shall be construed as having the effect of imposing HIPAA requirements on a provider to whom HIPAA does not apply.

b) This Section shall not prohibit:

1) disclosure of information about a crime committed by a patient at the organization, or a threat to commit such crime;

2) disclosure of information about suspected child abuse or neglect, as allowed by, required by and consistent with State law;

3) disclosure of a patient's own records to the patient, or as consented to in writing by the patient;

4) communications of information between or among personnel having a need for the information in connection with their duties either within the organization or with an entity having direct administrative control over the services;

5) disclosure of information to medical personnel if necessary in a medical emergency;

6) disclosure of information as authorized by an appropriate court order upon showing of good cause, after appropriate procedure and notice, and with appropriate safeguards against unauthorized disclosure contained in the order as set forth in 42 CFR 2.61-2.67 (1987);

7) disclosure of information to qualified personnel for the purpose of conducting scientific research as set forth in 42 CFR 2.52 (1987) (if such disclosure is in compliance with HIPAA regulations, 45 CFR 160, 162 and 164);

8) disclosure of information to qualified personnel who are authorized by law or who provide financial assistance for the purpose of conducting audit or evaluation activity (services review or evaluation, quality review, financial or management audits, etc., as set forth in 42 CFR 2.53 (1987)).

This Section shall also not prohibit any other disclosure not precluded by the regulations and statute cited in subsection (a), nor by any other applicable law, provided that any and all of the above disclosure is done consistent with the regulations and laws in subsection (a), is made only to the extent allowed, for the purposes allowed and that appropriate safeguards as required therein are provided.

c) Patient records and any other information which is subject to any laws and rules cited in this Section shall be maintained in a secure room, locked file cabinet, safe or other similar container when not in use. If patient information is stored in electronic or other types of automated information systems, security measures shall be in place to prevent inadvertent or unauthorized access to such information.

d) Except as authorized by an appropriate court order granted pursuant to the regulations and statutes cited in this Section, no record referred to by said laws may be used to initiate or substantiate any charges against a patient or to conduct any investigation of a patient.

e) The prohibitions cited in this Section apply to records concerning any individual who has been a patient, regardless of whether or when he or she ceases to be a patient.

f) When the Department requests a record or information which is subject to the regulations and statutes cited in this Section for audit, evaluation, research or other authorized purposes, it shall, in writing:

1) indicate the purpose for obtaining the information;

2) agree to maintain the information in accordance with security requirements of said laws;

3) agree to comply with limitations on disclosures in said laws;

4) agree to destroy all the information upon completion of its use; and

5) indicate the authorized personnel to whom such information is to be submitted.

g) Organizations providing a DUI evaluation or risk education intervention service shall disclose offender information as allowed by law. The informed consent form and procedures as referenced in

Section 2060.503(d) and (e) of this Part shall be utilized to allow for the disclosure of evaluation and risk education information to Illinois court officials, the Illinois Office of the Secretary of State and the Department for the purpose of adjudicating and court monitoring of DUI cases, drivers license issues and for monitoring licensed services.

h) Organizations shall have policies and procedures to comply with HIPAA and its regulations as set forth more specifically in Sections 2060.323(e) and 2060.325(u) of this Part, if the organization is required to comply with HIPAA.

Section 2060.321 Confidentiality – HIV Antibody/AIDS Status

a) The organization shall have written policies and procedures controlling access to records and information governed by the AIDS Confidentiality Act [410 ILCS 305] (AIDS Act), and the AIDS Confidentiality and Testing Code (77 Ill Adm Code 697) (AIDS Code).

b) The confidentiality of the following information is protected by the AIDS Act and AIDS Code:

1) the identity of a person upon whom a test for HIV is performed; and

2) the results of a test for HIV for an individual.

c) This Section shall not apply to HIV and/or AIDS risk reduction education and/or counseling, or other HIV and/or AIDS education which is provided to all persons but shall apply to information regarding individual requests for or participation in HIV pre-test and/or post-test counseling.

d) When dealing with information governed by the AIDS Confidentiality Act and AIDS Code, this Section shall control, notwithstanding any other provisions of this Part to the contrary.

e) An HIV antibody or AIDS test cannot be required as a condition of treatment, and an individual cannot be required to disclose or to sign an authorization for release of information concerning his or her HIV antibody test or HIV or AIDS status as a condition of treatment.

f) An individual who wishes to be tested for HIV antibodies shall be informed that he or she may undergo testing on an anonymous basis.

g) Unless disclosure is otherwise authorized by statute and rule, no information governed by the AIDS Confidentiality Act and the AIDS Code shall be released by an organization, or by any member of its staff, to other staff members, including but not limited to the executive director, and/or to the medical director, and/or to any other person or entity, unless there is a legally effective consent or another exception in accordance with the statute and rule. Release of information which is allowed by consent or by statute and rule shall be done only to the extent provided therein.

h) Records which document the above confidential information shall be maintained in a separate portion of the file and be accessible only in accordance with the AIDS Confidentiality Act and Section 697.140(c) of the AIDS Code.

i) The organization shall have a policy regarding how and what shall be recorded if a person self-discloses HIV status during the course of treatment or if the person requires the administration of medications or other services by staff related to AIDS treatment. The policy shall protect the confidentiality of the person and protect his or her right to give consent prior to disclosure of HIV status, and shall limit disclosure to only what is necessary to accomplish the purpose of the disclosure.

j) Any HIV and/or AIDS counseling or testing service which is operated within the facility is considered a separate service and shall maintain separate records. Organization staff shall not have access to such counseling and testing records unless otherwise authorized in writing by the patient's informed consent.

Section 2060.323 Patient Rights

a) A written statement shall be provided to any patient at the time of acceptance for an intervention service or admission to a treatment service which describes the rights of all patients as specified in Article 30 of the Act as follows:

1) access to services will not be denied on the basis of race, religion, ethnicity, disability, sexual orientation or HIV status;

2) services will be provided in the least restrictive environment available;

3) confidentiality of HIV/AIDS status and testing and anonymous testing as specified in Section 2060.321 of this Part;

4) the right to nondiscriminatory access to services as specified in the American's With Disabilities Act of 1990 (42 USC 12101);

5) the right to give or withhold informed consent regarding treatment and regarding confidential information about the patient;

6) a description of the route of appeal available when a person disagrees with an organization's decision or policies;

7) confidentiality of patient records as specified in Section 2060.319 of this Part;

8) the right to refuse treatment or any specific treatment procedure and a right to be informed of the consequences resulting from such refusal.

b) The patient will attest by signature that he or she has received a copy of the written statement of patient rights and this signatory document shall be maintained in the patient record.

c) The statement of patient rights shall be posted in an area accessible to patients at all times.

d) Each patient shall be given the statement of patient rights. If a patient is unable to read such written statement, it shall be read to the patient in a language the patient understands.

e) If the organization is required to comply with HIPAA, the patient shall also be given written notice of the uses and disclosures of protected health information that will be collected and maintained, and the rights provided by HIPAA with respect to such information as set forth in 45 CFR 164.520 and referenced in part in Sections 2060.319 and 2060.325(u) of this Part.

Section 2060.325 Patient/Client Records

a) Licensees shall maintain a written record for each patient or client. Such record may also be maintained electronically on a computer but shall be made available in hard copy upon request for review by the Department.

b) Any written entry on the record shall be in ink and shall be dated and shall meet all other signatory requirements for professional staff as specified in Sections 2060.421 and 2060.423 of this Part.

c) Written signatures or initials and electronic signature or computer-generated signature codes and corresponding dates are acceptable as authentication to identify the author of the record entry by that author and to confirm that the contents are what the author intended. Signature or initial stamps shall not be utilized.

d) All signatures or initials, whether written, electronic, or computer-generated, shall include the initials of the signer's credentials.

e) In order to utilize electronic signature or computer-generated signature codes and dates, the organization shall adopt a policy that permits use and authentication by electronic or computer-generated signature and dates and shall, at a minimum:

1) identify which staff are authorized to authenticate records using electronic or computer-generated signatures and dates;

2) ensure that each user is assigned a unique identifier that is generated through a confidential access code;

3) certify in writing that each identifier is kept confidential; and

4) have each user certify in writing that he or she is the only person with user access to the identifier and the only person authorized to use the signature code.

f) Records maintained on computer shall have a back-up system to safeguard the records in the event of operator or equipment failure.

g) Any document or entry made on a document in the record that is in any other language than English shall have an accompanying English language translation.

h) All records shall be protected in a locked room, locked file, safe or similar container or in computer records with secure, limited access.

i) The record shall document any service provided by the organization at any facility. Additionally, if the organization provides multiple services that are licensed by the Department at any facility, one record can document all of such services.

j) The record shall contain the signatory document that indicates the patient/client has been informed of his or her rights.

k) The record shall contain documentation indicating the consent of the patient, and any other family members or guardians, for any service.

l) The record shall contain, on a standardized format, the following information:

1) name;

2) home address;

3) home and work telephone number;

4) date of birth;

5) sex;

6) race or ethnic origin and/or language preference;

7) emergency contact;

8) education;

9) religion;

10) marital status;

11) type and place of employment;

12) physical or mental disability, if any;

13) social security number, if requested;

14) drivers license number, county of residence and county of arrest (required only for DUI evaluation or risk education services);

15) annual household income, if applicable to any subsidized or reduced fee for service, unless this information is kept in a separate financial record; and

16) documentation of any disclosures of protected health information to the extent required by HIPAA (see Section 2060.325(u)(3) of this Part).

m) The record shall contain dates of any admission, change in level of care or discharge.

n) The record shall contain a dated service fee statement and proof, if applicable, of any qualifying documents relative to fee subsidization, including the "Qualification for DUI Services as an Indigent" form, unless this information is kept in a separate financial record.

o) The record shall be kept for a period of five years from the date of discharge, except that required accounting of disclosures of HIPAA protected health information must be kept for six years. While organizations may elect to keep records past this five year period, if the option to delete records is exercised, it shall be done by one of the following methods:

1) burning or shredding; or

2) erasure from all computer files.

p) The record shall contain the following information or documents for any treatment service:

1) documentation of the treatment assessment and patient placement process;

2) documentation of the diagnostic impression and physician confirmed diagnosis;

3) documentation of laboratory and/or other diagnostic procedures/results and reports that the organization directly provided (except for HIV testing unless the patient has given written informed consent) and documentation of the tuberculin skin test results, the date given and date read, if applicable;

4) the treatment plan and documentation of all required signatures and dates;

5) progress notes that document all treatment services, any subsequent treatment plan reviews and on-going assessment and documentation of all required signatures and dates;

6) documentation of completion of patient education specified in Section 2060.409 of this Part;

7) documentation of any correspondence or telephone calls received or made relevant to treatment services; and

8) a copy of the discharge summary unless the patient left prior to receiving any of these services.

q) The record shall contain copies of all referenced forms in Subpart E for any offender receiving a DUI evaluation or risk education service.

r) A staff member shall be designated who will have responsibility to ensure that all records are in compliance with this Part. This staff member shall review, at least annually, the record system to ensure that the system meets all requirements specified in this Part.

s) Records shall be kept in the facility where the patient/client is receiving services (or in accordance with Section 2060.203(b) of this Part, in specific relation to off-site services) and shall be directly accessible to the professional staff providing those services.

t) Information in the record may be used for training, research and quality improvement provided that the information is collected in accordance with any relevant confidentiality requirements.

u) Licensees who are covered by HIPAA shall have procedures to comply with HIPAA Privacy and Security provisions (45 CFR 160 and 164), including the following:

1) procedure to access the patient's record as set forth in 45 CFR 164.524;

2) procedure to request amendment to his or her record as set forth in 45 CFR 164.526;

3) procedure to request an accounting of disclosures of his or her medical records or portions thereof for the previous six years as set forth in 45 CFR 164.528; and

4) procedure to file a complaint with the licensee and with the U.S. Department of Health and Human Services, Office of Civil Rights in connection with an alleged violation of the HIPAA Privacy provisions set forth in 45 CFR 160.306.

Section 2060.327 Emergency Patient Care

a) A written plan shall be submitted at the time of application for licensure which specifies the manner in which emergency patient care is provided, either by the organization or through a linkage agreement with another facility or both, in the event of unforeseen interruption of services to current patients.

b) The plan should specify staff who are authorized to provide emergency care, the method for exchange of patient records when necessary, the name, location and contact person who is part of the emergency patient care plan, the method of transfer of any patients, if applicable, to another facility and the method of notification of patient families concerning the emergency and any subsequent transfer of the patients.

Section 2060.329 Referral Procedure

a) Written procedures shall be established for the referral of patients to other providers for services that are not available within the organization and/or that are requested by the patient. These procedures shall include the following:

1) the method of obtaining any necessary written consent from the patient for transfer of any relevant portion of the patient record and for communication regarding patient services with that provider;

2) the method for ensuring continuity of patient care which shall include a written referral document that indicates the reason for the referral, provides information about any service received to date and any additional services needed or requested, specifies any necessary continued coordination between the providers and the time frame for any necessary follow-up reports; and

3) the method by which a patient may request a referral.

b) Each organization shall have a written linkage agreement, specifying the above provisions, with any other provider that it routinely utilizes for referrals unless otherwise required by the Department.

c) All referrals made for treatment or intervention services as defined in this Part shall only be made to organizations licensed under this Part, to those individuals or organizations that are specifically exempted from licensure as specified in Section 15-5 of the Act or to similarly licensed and regulated organizations in other states.

Section 2060.331 Incident and Significant Incident Reporting

a) An incident is any action by staff or patients that led to, or is likely to lead to, an adverse effect on patient services because of a deviation from established patient care procedures.

b) Such incidents shall be documented immediately, in writing, by staff and such report shall be maintained at the facility for review by Department staff as necessary or during inspection.

c) A significant incident is any occurrence at the facility which requires the services of the coroner and/or which renders the facility inoperable.

d) A verbal report of any significant incident shall be given to the Department's Division of Licensing and Monitoring within 24 hours after its occurrence.

e) A written report of any significant incident shall be submitted within ten calendar days after the occurrence and, if applicable, a copy of any coroner's report shall be submitted within five calendar days after receipt of the written report.

Section 2060.333 Complaints

a) A complaint shall be filed with this Department whenever evidence is discovered that indicates non-compliance with this Part by any other organization providing services licensed under this Part or about any person suspected of providing unlicensed services. An individual may also file a complaint with the Department relative to any service. In all cases, complaints shall be directed to the Department as follows:

1) complaints may be received verbally but shall be documented in writing by the complainant before any official Department action is undertaken;

2) any supporting documentation relative to the complaint shall also be submitted to the Department; and

3) the Department shall notify the organization of any complaints that it receives relative to any service provided within the organization.

b) The complaint procedure poster furnished by the Department shall be posted in an area accessible to persons at all times.

Section 2060.335 Inspections

a) The Department shall conduct inspections of services licensed under this Part to enforce compliance with this Part.

b) Such inspections shall be routinely scheduled but may also occur at any reasonable time. Employees of the Department shall be authorized to enter the facility and shall be permitted access to all areas and records.

c) If consent to inspect is not given, the Department will seek access pursuant to Section 45-5 of the Act.

Section 2060.337 Investigations

a) The Department may on its own motion, and shall upon the sworn complaint in writing of any person setting forth charges which, if proved, indicate criminal activity and/or would constitute grounds for sanction pursuant to the Act, conduct its own investigation and/or refer the matter for investigation.

b) The Department may also refer such matters for investigation to the appropriate legal authority.

Section 2060.339 License Sanctions

a) Prior to initiating a formal action to sanction a license, the Department will allow an organization an opportunity to take corrective action to eliminate or ameliorate a violation of the Act or this Part, except in cases in which the Department determines that emergency action is necessary to protect the public interest, safety or welfare.

b) The Department shall issue written notice to an organization determined to be in non-compliance. The Department's notice shall specify the particular activities deemed to violate the Act and/or this Part. The Department's notice shall require such corrective action as it deems necessary for compliance and shall establish a time period within which the corrective action is to be completed.

c) In determining whether to initiate formal action the Department shall consider whether the organization made an effort to comply with the Department's notice of corrective action, whether

compliance with the Act and this Part was achieved within the designated time frame and the potential for harm to a patient as a result of the failure to comply.

d) Nothing contained herein shall preclude the Department from initiating formal action against an organization who has complied with the Department's notice of corrective action. In such case, the factors enumerated above shall be considered by the Department in determining whether and to what extent the following sanctions should be imposed:

1) Administrative Warning – A written warning issued by the Department which specifies rule violations and a corrective time period and that also warns that any additional violation of this Part may result in a more severe sanction.

2) Probation – Probation of the license for a specified period of time during which action shall be taken, as necessary, to achieve compliance with all licensure standards. When the probationary period has expired, the Department shall terminate the probationary status. If the Department determines that the organization still does not meet licensure standards or has continued violations, the Department may suspend the license or extend the probationary period, if such extension would likely result in correction.

3) Restricted License – A restriction placed on a license which limits operation to specified services after a Department finding that one or more services has not met licensure standards.

4) Financial Penalty – A financial penalty imposed upon a finding of violation of any one or combination of the provisions of Section 15-25 of the Act. A financial penalty may not be paid with public funds. In determining an appropriate financial penalty the Department may consider the deterrent effect of the penalty on the organization and on other providers, the nature of the violation, the degree to which the violation resulted in a benefit to the organization and/or harm to the public and any other relevant factor to be examined in mitigation or aggravation of the organization's conduct. The financial penalty may be imposed in conjunction with other sanctions or separately.

5) Summary Suspension – An immediate suspension of the license ordered if the Department finds that the public interest, safety, or welfare imperatively requires emergency action.

A) A petition for summary suspension shall state the statutory basis for the action petitioned, alleged facts, supported by evidence or affidavit, sufficient to demonstrate a need for emergency action, be signed by the Department's chief legal counsel and be presented to the Secretary either in person or by telephone and in the presence of a court reporter.

B) An order for summary suspension shall contain findings of fact sufficient to support imposition of a summary suspension, recite the statutory basis for the action, appoint a hearing officer, demand immediate surrender of the license and be signed by the Secretary.

C) A notice of summary suspension shall accompany the order and shall set a date for commencement of a hearing within 14 calendar days after the date on which the order takes effect. The notice of summary suspension shall also identify the hearing officer who will conduct the hearing and include a copy of the Department's rule pertaining to hearings.

D) If the parties agree to a prehearing conference, such conference shall constitute the commencement of the hearing. The hearing shall determine whether the summary suspension shall remain in effect until conclusion of a formal hearing on the merits.

6) Suspension – Suspension of the license is a temporary withdrawal, by formal action, of a license for a period of time specified by the Department during which corrective action is taken

to rectify problem areas that led to the suspension. When the corrective action has been taken, the Department will determine if such action meets Department standards and either reinstate or revoke the license.

7) Revocation – Revocation of the license is withdrawal by formal action of a license to provide treatment or intervention services. The termination shall be in effect until such time as the license is reinstated or an application for a new license has been made and approved by the Department.

e) The Department may reinstate a license, after a period of suspension or revocation, providing the organization proves full compliance with licensure standards.

f) The Department shall deny a license application for failure to comply with the Act and this Part.

Section 2060.341 License Hearings

a) Hearings conducted pursuant to Sections 45-20 and 45-25 [20 ILCS 301/45-20 and 45-25] of the Act shall follow the procedures set forth in 89 Ill. Adm. Code 508 and this Section.

b) Any organization receiving a "Notice of an Opportunity for Hearing" shall file a request for such hearing within 30 calendar days after the date of notice or the hearing rights afforded under this Act shall be deemed waived.

c) Both the burden of going forward with evidence and the burden of proof rest with the party requesting a hearing. The burden of proof is to show by preponderance of the evidence that the Department's decision is contrary to the evidence on the record when taken as a whole.

d) Hearing Officer Report

1) Within 30 calendar days after the conclusion of the hearing, the hearing officer shall deliver a report of the hearing to the Secretary.

2) All exhibits, pleadings, documents, or other material made a part of the record will accompany the report.

3) The report will summarize the testimony presented at the hearing and the hearing officer's opinion about the reliability of the witnesses.

SUBPART D: REQUIREMENTS – TREATMENT LICENSES

Section 2060.401 Levels of Care

Substance abuse treatment shall be offered in varying degrees of intensity based on the level of care in which the patient is placed and the subsequent treatment plan developed for that patient. The level of care provided shall be in accordance with that specified in the ASAM Patient Placement Criteria and with the following:

a) Level 0.5: Early Intervention

An organized service, delivered in a wide variety of settings, for individuals (adult or adolescent) who, for a known reason, are at risk of developing substance-related problems. Early intervention services are considered sub-clinical or pre-treatment and are designed to explore and address problems or risk factors that appear to be related to substance use and to assist the individual in recognizing the harmful consequences of inappropriate substance use. The length of such service varies according to the individual's ability to comprehend the information provided and to use that information to make behavior changes to avoid problems related to substance use or the appearance of new problems that require treatment at another level of care. Early intervention services are for

individuals whose problems and risk factors appear to be related to substance use but do not appear to meet any diagnostic criteria for substance related disorders. Examples of individuals who might receive early intervention are at-risk individuals (i.e., family members of an individual who is in treatment or in need of treatment) or DUI offenders classified at a moderate risk level.

b) Level I: Outpatient

Non-residential substance abuse treatment consisting of face-to-face clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on patient need but shall be a planned regimen of regularly scheduled sessions that average less than nine hours per week.

c) Level II: Intensive Outpatient/Partial Hospitalization

Non-residential substance abuse treatment consisting of face-to-face clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on patient need but shall be a planned regimen of scheduled sessions for a minimum of nine hours per week.

d) Level III: Inpatient Subacute/Residential

Residential substance abuse treatment consisting of clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on patient need but shall, except in residential extended care as defined in this Part, include a planned regimen of clinical services for a minimum of 25 hours per week. Inpatient care, with the exception of residential extended care as defined in this Part, shall require staff that are on duty and awake, 24 hours a day, seven days per week. During any work period, if professional staff as defined in Section 2060.309(a) of this Part are not on duty, such staff shall be available on call for consultation relative to any aspect of patient care. Residential extended care shall require staff on duty 24 hours a day, seven days per week and that low intensity treatment services be offered at least five hours per week. Any staff providing clinical services shall meet the requirements for professional staff as defined in Section 2060.309(a) of this Part. Individuals who have been in residence for at least three months without relapse may be used to fulfill any remaining staff requirements.

e) Level IV: Medically Managed Intensive Inpatient

Inpatient subacute residential substance abuse treatment for patients whose acute bio/medical/emotional/behavioral problems are severe enough to require primary medical and nursing care services. Such services are for adults or adolescents and require 24 hours medically directed evaluation, care and treatment and that a physician see the patient daily.

Section 2060.403 Court Mandated Treatment

Any organization providing treatment to any individual under a specific court order that mandates such treatment shall:

a) Have the organization's medical director develop admission criteria and any necessary associated clinical protocol that will allow physician confirmation for admission and initial placement in a level of care without a diagnosis of substance abuse or dependence for an individual under a court order for treatment. Such criteria and protocol shall be in accordance with all other provisions specified in Section 2060.417 of this Part; and

b) Deliver such treatment in accordance with the provisions specified in the court order as long as there is clinical justification (as specified in Section 2060.419 and 2060.423) for the intensity and duration of such treatment; and

c) Upon admission to treatment, require all necessary patient signatures authorizing the release of information, in accordance with Section 2060.319, in order to ensure effective communication

with the court relative to progress in treatment, any recommended change in duration and intensity of treatment, unsuccessful or successful discharge from treatment and information about the individual's continuing care plan.

Section 2060.405 Detoxification

The medical director, as referenced in Section 2060.413 of this Part, shall develop protocols and authorize procedures for the medical supervision of and the staffing pattern for any patient receiving ambulatory or clinically managed residential detoxification as specified in the ASAM Patient Placement Criteria. All other detoxification shall be medically monitored or managed by a physician according the specifications contained in the ASAM Patient Placement Criteria and as follows:

a) Medically Monitored (Level III.7-D)

Medically monitored detoxification is for adults and adolescents. At least two staff persons shall provide 24 hour observation, monitoring and treatment, one of whom shall meet the staff qualifications specified in Section 2060.309(c) of this Part.

b) Medically Managed (Level IV-D)

Medically managed detoxification is for adults and adolescents. However, medically managed opioid maintenance therapy shall only be used for adolescents age 16 and 17. At least two staff persons shall provide 24 hour observation, monitoring and treatment, one of whom shall meet the staff qualifications specified in Section 2060.309(c) of this Part. Medically managed detoxification also requires that a physician see the patient daily.

- Please note that the most updated ASAM guidelines have removed the use of the word detoxification and replaced it with term withdrawal management.

Section 2060.407 Group Treatment

Group treatment shall consist of didactic and counseling groups as follows:

a) Didactic groups are, but are not limited to, a therapeutic activity the primary purpose of which is to educate patients and their significant others on a specific treatment related topic in a group setting. All didactic groups shall be led or supervised by professional staff or by other professionals with credentials specific to the subject matter of the didactic group following a lesson plan or outline approved by the organization. Justification for all patients who attend any didactic group needs to be documented. Didactic groups should not exceed an average of 24 people.

b) Counseling groups are, but are not limited to, a therapeutic activity the primary purpose of which is to allow patients or their significant others an opportunity to process issues related to their treatment in a group setting. Counseling groups can have a specific focus (i.e., women, relapse, cocaine, etc.) but are generally less educational and more process oriented than didactic groups. All counseling groups shall be facilitated by professional staff. Justification for all patients who attend any counseling group needs to be documented as an assessed need. Counseling groups at no time shall exceed 16 patients per group.

Section 2060.409 Patient Education

All organizations shall develop a patient education plan that specifies all patient education that is available at the facility and ensures that all patients are informed about this plan and the mandatory elements of it (as specified in this Section) prior to or during the development of the treatment plan.

Patient education may be provided individually or in a group in accordance with the group size specifications contained in Section 2060.407 of this Part. Such education shall be provided to each patient at least once and documented as such in the patient record. Upon subsequent admissions, the need for such education may be determined by the organization. At a minimum, the patient education plan shall include the following:

a) Information about the benefits and risks of all medications prescribed by the organization's medical director or physician working under his/her supervision/direction, laboratory tests performed by the organization's medical director or physician working under their supervision/direction, treatment protocol, all rules relative to patient conduct and patient rights, and all organization rules relative to confidential patient information as referenced in Section 2060.319 of this Part.

b) Initial AIDS risk reduction counseling and education services and tuberculosis information consisting of the following components:

1) Education relative to infectious disease control and HIV/AIDS that shall provide information about the etiology and transmission of HIV infection and associated risk behaviors, symptomatology and clinical progression of HIV infection and AIDS and their relationship to substance abuse behavior, prevention of transmission and risk reduction (including information about needle sharing, sexual transmission, transmission to infants, etc.), the availability of counseling and testing services, the confidentiality rights of the patient regarding counseling, testing and HIV status and relapse prevention.

2) Education relative to infectious disease control and tuberculosis that shall include information about its transmission and prevention, the importance of diagnosis, the requirement for skin testing and the interpretation of skin test results, the importance of x-rays for positive test results and HIV infected persons, the importance of treatment regimens and the basic symptoms associated with tuberculosis.

c) Upon completion of any mandatory education specified in this Section, documentation shall be placed in the patient record. That documentation shall specify the type of education received and the date received, and shall be signed by the patient if the documentation is maintained separately from the treatment plan.

Section 2060.411 Recreational Activities

Recreational activities may be provided to patients if they:

a) are identified in the treatment plan as an assessed need; and

b) are conducted under the supervision of staff. Recreational activities shall not average more than one-fourth of the treatment services received for any patient in any ASAM level of care.

Section 2060.415 Infectious Disease Control

a) Licensees shall be in compliance with:

1) guidelines issued by the U.S. Centers for Disease Control and Prevention in "Recommendations for Prevention of HIV Transmission in Health Care Settings": and "Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and other Bloodborne Pathogens in Healthcare Settings", both known as "Universal Precautions"; and

2) the U.S. Department of Labor rules for Occupational Exposure to Bloodborne Pathogens, 29 CRF 1910.1030 (2000).

b) Tuberculosis Control and Services

1) Any organization providing treatment services shall have its medical director or other designated staff be responsible for developing, reviewing annually and evaluating the effectiveness of a tuberculosis infection control plan based on a tuberculosis risk assessment of the facility following the protocol for conducting a tuberculosis (TB) risk assessment in a health care facility in "Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities", referred to as CDC Tuberculosis Guidelines, which should, at a minimum, include:

A) a medical screening of each patient for infectious, communicable tuberculosis as required in Section 2060.413(b) of this Part;

B) identification of patients at increased risk of being infected with tuberculosis, using a standardized screening tool, and provision of tuberculosis services, either directly or through referral with other public, nonprofit or private entities;

C) procedures for the immediate reporting of patients with, or suspected of having, active, infectious tuberculosis to the local tuberculosis control agency and a process for isolation of such patients from the general population until the patient is determined to be non-infectious. Provisions shall be made for respiratory isolation (by linkage with other health care providers and the local tuberculosis control agency) for substance abuse treatment if and when possible and appropriate;

D) procedures for providing prompt and appropriate curative therapy directly by the organization or by referral. Such medical care provided shall be consistent with standards specified by the Centers for Disease Control and Prevention, Treatment of Tuberculosis and Tuberculosis Infection in Adults and Children (American Thoracic Society, Medical Society of the American Lung Association and U.S. Department of Health and Human Services). Am. J. Respir. Crit. Care Med. vol. 149, pp. 1359-1374, 1994 (no later amendments or editions included);

E) procedures (by way of linkage with other health care providers and with the local health department) for isolation of patients who may have active infectious tuberculosis;

F) procedures for lessening the risk of environmental transmission within the facility; and

G) procedures for meeting State reporting requirements while adhering to confidentiality requirements specified in Section 2060.319 of this Part and in 42 CFR 2.

2) Employee Skin Testing and Management

A) All staff shall have a tuberculin skin test using the Mantoux method (5TU, PPD) when hired, annually and as indicated in the CDC Tuberculosis Guidelines (or authentic documentation of a skin test within the past three months, or of completion of previous medical treatment of the disease, or of preventive therapy). The test shall be read within 48 to 72 hours by personnel trained in accordance with guidance from the local tuberculosis agency.

B) The organization shall establish procedures requiring medical evaluation for personnel with positive skin tests or with signs and symptoms of active tuberculosis disease; requiring preventive therapy for personnel with tuberculosis infection, unless medically contraindicated; and requiring leave and/or restriction from the patient population as necessary in cases of active infectious tuberculosis.

C) Staff who have an initial negative skin test result but who have not had a documented

negative skin test result during the 12 preceding months shall be retested using the Mantoux method within one to three weeks after the initial test. If the second test is positive, the person should be considered previously infected.

D) Staff with negative tests shall be retested at least every 12 months and upon a known or suspected exposure to tuberculosis.

E) The organization shall document and have available for review by the Department the results of all staff tuberculin testing.

3) Patient Skin Testing and Management

A) The medical director of any organization providing treatment services shall develop a tuberculosis skin testing policy and procedure based on the tuberculosis risk assessment and tuberculosis infection control plan required in subsection (b)(1) of this Section.

B) Patient Testing

i) Each organization providing inpatient services (except for residential extended care) and/or providing opioid maintenance therapy shall either directly or through arrangements with other public, nonprofit or private entities, provide each patient with medical tuberculosis screening services including at a minimum a PPD skin test (5TU, PPD), placed within seven calendar days after admission and read within 48 to 72 hours after placement by personnel trained in accordance with guidance from the local tuberculosis agency. If a patient is known to be immunosuppressed, a chest x-ray, energy battery, sputum smear and/or sputum culture/sensitivity study for tuberculosis may be used instead of a PPD skin test.

ii) Patients with prior positive skin tests or diagnoses who have not completed treatment or prevention therapy shall be medically evaluated for symptoms of infectious tuberculosis.

C) The result of the Mantoux skin test in mm of induration, the date given and the date read shall be recorded in the patient's medical file.

D) Patients who have a positive reaction of 5 mm or more to the skin test or who have signs and symptoms compatible with tuberculosis disease shall be medically evaluated for tuberculosis or shall be referred for such evaluation. Admission of patients with symptoms of active tuberculosis may be delayed until there is adequate documentation that the person is not infectious.

E) Organizations shall follow the CDC Tuberculosis Guidelines regarding appropriate testing after the initial test (i.e., in determining appropriate retesting, the need for anergy testing, testing required upon exposure and additional considerations for interpreting test results). Patients with negative reactions to the initial tuberculin test shall be retested using the Mantoux method (5TU PPD) at least annually or after any known exposure to infectious tuberculosis.

F) Procedures shall be established for providing prompt and appropriate curative and preventive therapy directly by the organization or by referral. Medical care provided shall be consistent with the CDC's Treatment of Tuberculosis and Tuberculosis Infection in Adults and Children.

4) Facility Environment-Transmission Prevention

A) An organization that provides respiratory isolation at a facility shall assure that it has consulted engineers or other professionals with expertise in ventilation engineering to ensure that its facility ventilation systems meet applicable federal, State and local standards.

B) Persons with suspected or known infectious tuberculosis shall not be allowed to enter living or work areas of a treatment facility. The process for handling persons prior to and while screening for infectious tuberculosis shall be done as to avoid environmental exposure to other patients and staff.

Section 2060.417 Assessment for Patient Placement

An assessment shall be conducted prior to admission to any level of care. This assessment shall be an individual face-to-face service and shall include collection of demographic data as referenced in Section 2060.325(1) of this Part and:

a) For admission to Level 0.5, Early Intervention:

1) review of any specific conditions of court supervision or probation including any prior substance abuse screenings or evaluations conducted prior to admission (i.e., DUI); and

2) sufficient assessment to screen for, or rule out, substance related disorders.

b) For admission to Levels I-IV care:

1) an evaluation of the severity of the six dimensions established in the ASAM Patient Placement Criteria;

2) a recommendation for placement in Levels I-IV care as established in the ASAM Patient Placement Criteria;

3) a diagnostic impression of substance abuse and/or dependence as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) that shall be confirmed as a diagnosis by a physician.

c) Physician confirmation of diagnosis and initial patient placement:

1) the medical director shall define protocols and authorize procedures for confirmation of diagnosis or admission without diagnosis as specified in Section 2060.403(a) of this Part and initial patient placement in Levels I-IV care.

2) confirmation of diagnosis may be made by telephone or facsimile transmission if so authorized by procedure.

3) confirmation shall occur no later than 24 hours after admission for Level IV care, no later than 72 hours after admission for Level III care, and no later than 7 working days after admission for Level I and II care.

4) confirmation of diagnosis and admission is not necessary for Level 0.5 Early Intervention.

d) Prior to admission, or in the case of an intoxicated patient, as soon as stabilization occurs, basic information about treatment services shall also be provided and shall include the following:

1) the procedures and treatment services the patient will receive;

2) if possible, an introduction to the professional staff members who serve as the primary contact with the facility for the client;

3) the hours during which services are available;

4) the risks, side effects, and benefits of all medications prescribed by the organization's medical director or physicians working under his/her supervision or direction and experimental treatment procedures to be used;

5) the cost, itemized when possible, of services to be rendered;

6) any limitations placed on duration of services; and

7) the rules and regulations of the facility applicable to the patient's conduct.

e) A written, dated, and signed informed consent form shall be obtained from the patient, or the patient's legal guardian, and from family members who also participate, for use or performance of the following activities:

1) experimental medications;
2) hazardous on experimental assessment procedures;
3) recording on audiovisual equipment;
4) participation of the patient in research projects; and
5) testing for Human Immunodeficiency Virus (HIV).

Section 2060.419 Assessment for Treatment Planning

Upon admission and initial placement in Levels I-IV of care, the clinical assessment of the patient shall continue in order to develop the treatment plan. Patient needs shall be determined through specific inquiry and analysis in the six dimensions established in the ASAM Patient Placement Criteria and include but not be limited to:

a) a review of the medical screening, any subsequent physician referrals or changes in the patient's health, including a determination of acute intoxication and/or withdrawal potential, the current substance use or abuse pattern and medication use, and history of prior treatment for substance abuse or dependence and number of relapses, if applicable;

b) any previous emotional or behavioral problems and treatment and the patient's current emotional and behavioral functioning, including any history of previous or on-going physical, emotional or sexual abuse, in order to detect problems that may be life threatening or indicative of severe personality disorganization or that may seriously affect the patient's progress in treatment;

c) an analysis of the patient's home and/or living environment including child care needs, religion, childhood, military service history, education and vocational history, financial status, social or peer group, family constellation and history of substance abuse and a determination of the need for participation of any family members or significant others in the patient's treatment, information on pending criminal or misdemeanor charges or any specific conditions of court supervision, probation or parole including any prior substance abuse evaluations conducted in specific reference to an offense of DUI.

Section 2060.421 Treatment Plans

a) At a minimum, the initial patient treatment plan shall be based on the patient's presenting concerns as evidenced from the biomedical and emotional/behavioral assessment. Such treatment plan shall be developed within 24 hours after admission for any patient in Level IV care, seven calendar days after admission for any patient in Level III or II care and 14 calendar days after admission for any patient in Level I care.

b) The initial treatment plan shall be confirmed by the medical director or physician according to established protocol (i.e., in person, by telephone, facsimile transmission, standing order), in accordance with the time frames established in subsection (a) of this Section. Such confirmation shall be documented in the patient record by date and signature of the physician making such confirmation. The treatment plan shall also be signed and dated by the patient, indicating participation in the development of the plan, and by the professional staff member assigned primary responsibility for services to the patient.

c) The treatment plan shall be written, gender and culturally appropriate and individual to each patient.

d) The treatment plan shall list problems (e.g., an injury, dysfunction or loss), goals (a statement to guide resolution or reduction of the problem), objectives (observable and measurable signposts on the way to achieving the goals), methods (the treatment services to be provided, the site of those services, the intensity and duration of those services) and a time table for achieving the goals and objectives of treatment that are within the time frame of the patient's expected participation.

e) The treatment plan shall describe and include the frequency of all activities, referrals and consultations planned for the patient and/or any family members or significant others and shall designate all professional staff members assigned to provide or coordinate referrals for such services. Referrals or consultations for other needed services not directly provided may include, but not be limited to, prenatal care, other medical care, child care services or any other appropriate legal, financial, social or mental health service.

Section 2060.423 Continued Stay Review

a) Ongoing assessment of the patient's progress in treatment shall occur in order to determine continued stay in the level of care in which the patient was placed or the need to move to another level of care or to discharge. The assessment shall be accomplished using the ASAM "continued stay" or "discharge" criteria." As the patient moves through treatment, progress shall be continually assessed and recorded in progress notes. At a minimum, a continued stay review shall include a review of the ASAM continued stay or discharge criteria, the current treatment plan, and all subsequent progress notes. Continued stay reviews shall be measured through hours or days. The type of measurement (hours or days) must be specified in the initial and each subsequent treatment plan and this measurement must remain unchanged until the next continued stay review. Continued stay review shall occur as follows:

1) upon movement to any other level of care based on any change in the level of patient functioning; or

2) every 60 calendar days or after every 10 hours of treatment for patients receiving Level I or residential extended care, every 30 calendar days or after every 27 hours of treatment for patients receiving Level II care, every 14 calendar days for patients receiving Level III care, and every 24 hours for patients receiving Level IV care;

3) prior to planned discharge;

4) every 30 days for patients in opioid maintenance therapy during the first 90 days of treatment and every 90 days thereafter for patients who demonstrate 90 days of stable participation and for whom no change has occurred in the ASAM Biomedical Conditions and Complications dimension.

b) Documentation of the continued stay review shall:

1) be by progress note in the patient record;

2) include the participation of the patient;

3) be initialed and dated by the patient;

4) be initialed and dated by the professional staff member conducting the review; and

5) be authorized as evidenced by a progress note in the patient record written and dated and initialed by the medical director or a physician working under his or her supervision if there is a change in the ASAM Biomedical Conditions and Complications dimension.

Section 2060.425 Progress Notes and Documentation of Service Delivery

a) Progress notes shall reflect patient progress and shall be consistent with the clinical assessment, level of care and expectation of progress. Progress notes can include a summary of services delivered prior to each continued stay review. Progress notes shall be summarized a minimum of every 14 calendar days for patients in Level II care, daily for patients in Level III care, and upon each continued stay review for patients in Level I and Residential Extended Care. Progress notes shall be entered in the patient record and include the following:

1) chronological documentation of the patient's progress in treatment;

2) documentation of any change in the patient's behavior; and

3) descriptions of the patient's response to treatments, the outcome of treatment, and the response of significant others to events in the course of treatment.

b) Documentation of service delivery in the patient record shall specify the name and credentials of the individual who provided the service and be signed or initialed and dated in ink by the individual making the entry or in accordance with the provisions for electronic signature specified in 2060.325(c)-(e) of this Part.

c) Any entry that includes a subjective interpretation of the patient's progress shall include a description of the actual behavior observed.

d) Each service delivered shall be documented in the patient record and include the specific type of service delivered, location of service delivery, date, time and duration of each service rendered to the patient (with the exception of HIV counseling and testing). Clinical notes, clinical checklists and clinical rating scales may also be included with this documentation.

Section 2060.427 Continuing Recovery Planning and Discharge

a) Organizations shall develop a continuing recovery plan for patients who are no longer actively receiving treatment in, or no longer require, an ASAM level of care.

b) The continuing recovery plan shall contain the following information as appropriate for individual patients:

1) a relapse prevention plan for patients who have obtained abstinence that also identifies actions to be taken if relapse should occur;

2) actions planned by the organization to support continuing recovery or reinitiation of active treatment services;

3) specific and measurable patient involvement in the event that accountability by the patient is required for any case management or monitoring organization (i.e., circuit courts, offices of probation, Office of the Illinois Secretary of State, parole officers, employers, etc.); and

4) community recovery support services that will maintain, support and enhance progress made in treatment.

The continuing recovery plan shall be completed prior to the patient discharge from all ASAM levels of care within the organization for any patient no longer meeting the criteria for continued active treatment.

c) Organizations shall develop discharge and exclusionary criteria consistent with customary clinical standards accepted within the community. After the patient is discharged from all treatment, a discharge summary shall be entered in the patient record within 15 days. This summary shall include:

1) the reason for discharge and the progress of the patient relative to each goal and objective in the treatment plan;

2) a prognostic statement of the patient's condition at discharge, including any continued use of prescribed medications; and

3) the patient's continuing recovery plan.

SUBPART E: REQUIREMENTS – INTERVENTION LICENSES

Section 2060.501 General Requirements

In addition to the provisions specified in this Subpart, all DUI evaluation, DUI risk education and designated program services shall meet all applicable provisions specified in Subparts A, B, and C of this Part. Recovery Homes shall meet all applicable provisions specified in Subparts A and B, as well as all provisions specified in Section 2060.509 of this Part.

Section 2060.503 DUI Evaluation

a) The purpose of a DUI evaluation is to conduct an initial screening to obtain significant and relevant information from a DUI offender about the nature and extent of the use of alcohol or other drugs in order to:

1) identify the offender's risk to public safety for the circuit court of venue or the Office of the Secretary of State; and

2) recommend an initial intervention to the DUI offender and to the circuit court of venue or the Office of the Secretary of State.

b) DUI evaluation services shall be provided to any offender under the same terms and conditions regardless of ability to pay.

1) If an offender provides proof of indigence, in accordance with poverty guidelines established by the U.S. Department of Health and Human Services and contained in the Department's annual Drunk and Drugged Driving Prevention Fund (DDDPF) billing manual, the organization providing the evaluation may bill for reimbursement for the DUI evaluation from the DDDPF. All such reimbursement shall be via a rate established by the Department and in accordance with the Department's most current fiscal year DDDPF billing manual.

2) Additionally, all reimbursement from the DDDPF is subject to availability of funds. Organizations shall have an alternative fee assessment and collection procedure for use should DDDPF funding not be available. However, if the reimbursement from the DDDPF or any additional fee assessed to the offender, as specified in subsection (b)(3) of this Section, has not been received by the completion of services, the evaluation shall still be released to the appropriate circuit court of venue or the Office of the Secretary of State in accordance with this Section.

3) The organization may also assess a fee for the evaluation to an indigent DUI offender when the organization's standard fee charged for an evaluation to a non-indigent DUI offender exceeds the rate of reimbursement provided by the Department. In such cases, the amount assessed to the offender shall not exceed the difference between the organization's standard fee and the Department's rate.

4) Any organization choosing not to submit reimbursement claims shall still provide services to indigent offenders in accordance with this Part.

c) All evaluations shall consist of a face-to-face individual interview. The evaluation shall be conducted at the facility unless otherwise specified in this Part or by court rule.

d) Each DUI offender shall be given a copy of the Department's Informed Consent form and a copy of the Department's brochure that explains the DUI evaluation process.

1) This brochure shall be read by or to the offender prior to the provision of the evaluation.

2) The Informed Consent specifies that any information provided by the DUI offender will be released to the circuit court of venue, the Office of the Secretary of State and/or the Department and explains that the consent of the offender is not required for this disclosure.

3) The Informed Consent also requires the offender to specify where he or she underwent any previous evaluations as a result of the most current DUI offense and to provide a copy of those evaluations, if completed, to the current DUI evaluator.

4) Each DUI offender shall sign the Informed Consent form indicating his or her understanding of the DUI evaluation process and disclosure requirements or initial the Informed Consent form indicating refusal to proceed with the evaluation. A copy of this form shall be placed in the DUI offender record.

5) If the offender refuses to sign, or refuses to present copies of other evaluations completed, written notice of that refusal shall be sent to the circuit court of venue or the Office of the Secretary of State and the evaluation will be terminated.

e) Written policies and procedures shall be established that protect the non-disclosure privilege of DUI offenders that, at a minimum, shall include provisions to ensure that no evaluation information shall be released to any party other than the DUI offender, the Illinois circuit court of venue or its court officials as specified by local court rules, the Office of the Secretary of State or the Department without the written consent of the DUI offender. Any release of information relative to alcohol and drug treatment received by the DUI offender requires the written consent of the offender.

f) The evaluation shall be structured and scheduled in order to ensure that, prior to its completion, the following occurs:

1) collection of a comprehensive chronological history of substance use from first use to present, including alcohol, prescription and non-prescription drugs, and exposure to intoxicating compounds and illegal drugs, that specifies the frequency and patterns of use, type and amount of substance used and any change in the use or abuse pattern and the reason for the change;

2) a determination of the extent to which the substance use has caused marital, family, legal, social, emotional, vocational, physical and/or economic impairment;

3) an analysis of the offender's verbal description of:

A) alcohol and drug related legal history, driving history (all offenses), and any related substance use or chemical test results (blood alcohol concentration – BAC) and all substances used that resulted in all arrests, including the most recent DUI arrest;

B) past history of substance abuse evaluations, alcohol or drug treatment and/or self-help group involvement;

C) family history of substance abuse.

4) an analysis of:

A) objective test results from either the Driver Risk Inventory (DRI) or Mortimer/Filkens test;

B) the offender's current driving record as documented on the Alcohol/Drug Related Driving Offenses summary form from the Office of the Secretary of State or a copy of the

actual Court Purposes driving abstract supplied to the circuit court of venue by the Office of the Secretary of State; and

C) the Law Enforcement Sworn Report (issued to the offender at the time of the arrest for DUI) that identifies the chemical test result BAC or the refusal to submit to chemical testing relative to the most current DUI arrest.

g) All information obtained during the evaluation shall be analyzed and the offender's risk to public safety shall be determined. However, such determination shall be considered an initial finding that may be subject to change when more comprehensive and definitive information is obtained from the offender during participation in any recommended intervention. The determination of risk shall be minimal, moderate, significant, or high as follows:

1) Minimal Risk

The offender has:

A) no prior conviction or court ordered supervisions for DUI, no prior statutory summary suspensions, and no prior reckless driving conviction reduced from DUI; and

B) a BAC of less than .15 as a result of the most current arrest for DUI; and

C) no other symptoms of substance abuse or dependence.

2) Moderate Risk

The offender has:

A) no prior conviction or court ordered supervisions for DUI, no prior statutory summary suspensions, and no prior reckless driving conviction reduced from DUI; and

B) a BAC of .15 to .19 or a refusal of chemical testing as a result of the most current arrest for DUI; and

C) no other symptoms of substance abuse or dependence.

3) Significant Risk

The offender has:

A) one prior conviction or court ordered supervision for DUI, or one prior statutory summary suspension, or one prior reckless driving conviction reduced from DUI; and/or

B) a BAC of .20 or higher as a result of the most current arrest for DUI; and/or

C) other symptoms of substance abuse.

4) High Risk

The offender has:

A) symptoms of substance dependence (regardless of driving record); and/or

B) within the 10 year period prior to the date of the most current (third or subsequent) arrest, any combination of two prior convictions or court ordered supervisions for DUI, or prior statutory summary suspensions, or prior reckless driving convictions reduced from DUI, resulting from separate incidents.

h) After the determination of risk, a corresponding intervention shall be recommended. However, that recommendation shall be viewed as the minimum necessary and, as such, not the determinate intervention. Any subsequent information relevant to the offender's substance use or arrest history discovered during the offender's participation in risk education, early intervention and/or treatment shall be considered pertinent in formulating a recommendation for further services necessary to reduce the offender's risk to public safety. Initially, the following interventions for each designation of risk shall be selected and recommended:

1) Minimal Risk

Successful completion of a minimum of 10 hours of DUI risk education as defined in Section 2060.505 of this Part.

2) Moderate Risk

Successful completion of a minimum of 10 hours of DUI risk education as defined in this Part; a minimum of 12 hours of early intervention as defined in Section 2060.401(a) provided over a minimum of four weeks with no more than three hours per day in any seven consecutive days; subsequent completion of any and all necessary treatment; and, after discharge, active ongoing participation in all activities specified in the continuing care plan, if so recommended following completion of the early intervention. This early intervention and any subsequent treatment shall be as specified in the ASAM Patient Placement Criteria and shall be conducted by an organization meeting the requirements specified in subsection (j) of this Section and Section 2060.401 of this Part.

3) Significant Risk

Successful completion of a minimum of 10 hours of DUI risk education as defined in this Part; a minimum of 20 hours of substance abuse treatment; and, upon completion of any and all necessary treatment, and, after discharge, active on-going participation in all activities specified in the continuing care plan. This treatment shall be as specified in the ASAM Patient Placement Criteria and shall be conducted by an organization meeting the requirements specified in subsection (j) of this Section and Section 2060.401 of this Part.

4) High Risk

Successful completion of a minimum of 75 hours of substance abuse treatment; and upon completion of any and all necessary treatment, and, after discharge, active on-going participation in all activities specified in the continuing care plan. This treatment shall be as specified in the ASAM Patient Placement Criteria and shall be conducted by an organization meeting the requirements specified in subsection (j) of this Section and Section 2060.401 of this Part.

i) A summary of the DUI evaluation, the assigned risk and the corresponding intervention shall be documented on the Department's Alcohol and Drug Evaluation Uniform Report, which is produced by the DUI Service Reporting System (DSRS). All sections of this form shall be complete and it shall be signed by the offender at the facility.

j) Upon completion of the evaluation, all offenders:

1) who need substance abuse treatment shall be referred for appropriate services to organizations licensed pursuant to the Act or to individuals who are otherwise licensed in Illinois or any other state to provide such services.

2) who need DUI risk education as defined in this Part shall be referred to such services licensed by the Department.

3) shall verify that they have been shown, prior to referral, a listing of organizations as specified in subsection (j)(1) and (2) of this Section, unless an alternative process is established by court rule. The verification shall be on the Department's Referral List Verification Form.

k) The evaluation is complete when all of the above referenced information is obtained and the Alcohol and Drug Evaluation Uniform Report is signed by the offender.

1) The Alcohol and Drug Evaluation Uniform Report shall be provided directly to the circuit court of venue, unless another court repository is specified by court rule. A copy shall also be given to the DUI offender upon completion of payment or as otherwise specified in subsection (b)(2) of this Section.

2) If the offender will be requesting a judicial driving permit from the circuit court of venue, an Alcohol and Drug Evaluation Report Summary shall also be completed. This form is supplied by the Office of the Secretary of State and required by Section 6-201 of the Illinois Driver Licensing Law [625 ILCS 5/6-201] and should be sent directly to the circuit court of venue, unless another court repository is specified by court rule.

l) Evaluations shall be scheduled and completed so that the Alcohol and Drug Evaluation Uniform Report can be sent directly to the circuit court of venue at least five calendar days prior to the offender's court date, unless otherwise specified by court rule.

m) The evaluator shall be available to provide testimony relative to the DUI evaluation when summoned by the circuit court of venue, the Office of the Secretary of State or the DUI offender.

n) The circuit court of venue or the Office of the Secretary of State, whichever is applicable, shall be notified, within five calendar days, when a DUI offender does not complete an evaluation or refuses to sign the evaluation. Such notification shall also be made, within five calendar days, when an offender does not return to sign the evaluation after 30 calendar days from the last face-to-face contact. The information needed to complete the evaluation shall be communicated using the Department's Notice of Incomplete/Refused DUI Evaluation form.

o) In addition to meeting the provisions specified in Section 2060.325 of this Part, the following documents shall also be contained in the DUI offender's record:

1) a copy of the offender's Alcohol and Drug Evaluation Uniform Report and narrative information to support the conclusions summarized in this report and a copy of the Alcohol and Drug Evaluation Report Summary if the offender requested judicial driving privileges;

2) a copy of the Driver Risk Inventory (DRI) report or Mortimer/Filkens test;

3) documentation to support any subsequent change in risk assignment or intervention;

4) a copy of the Informed Consent Release form;

5) documentation of the offender's driving record and chemical tests results;

6) a copy of Notification of Incomplete or Refused Evaluation form, if applicable; and

7) a copy of the Referral List Verification form.

Section 2060.505 DUI Risk Education

a) The purpose of DUI risk education is to provide orientation to offenders regarding the impact of alcohol and other drug use on individual behavior and driving skills and to allow offenders to further explore the personal ramifications of their own substance use and abuse.

b) DUI risk education services shall be provided to any offender under the same terms and conditions regardless of ability to pay.

1) If an offender provides proof of indigence, in accordance with poverty guidelines established by the U.S. Department of Health and Human Services and published in the Department's annual Drunk and Drugged Driving Prevention Fund (DDDPF) billing manual, the organization providing the risk education may bill for reimbursement for such evaluation from the DDDPF. All such reimbursement shall be via a rate established by the Department and in accordance with the Department's most current fiscal year DDDPF billing manual.

2) Additionally, all reimbursement from the DDDPF is subject to availability of funds. Organizations shall have an alternative fee assessment and collection procedure for use should DDDPF funding not be available. However, if the reimbursement from the DDDPF or any additional fee assessed to the offender, as specified in subsection (b)(3) of this Section, has not been received by the completion of services, documentation of successful completion of risk education shall still be released to the appropriate circuit court of venue or the Office of the Secretary of State in accordance with this Section.

3) The organization may also assess a fee for the risk education to an indigent DUI offender when the organization's standard fee charged for risk education to a non-indigent DUI offender exceeds the rate of reimbursement provided by the Department. In such cases, the amount assessed to the offender shall not exceed the difference between the organization's standard fee and the Department's rate.

4) Any organization choosing not to submit reimbursement claims shall still provide services to indigent offenders in accordance with this Part.

c) The risk education curriculum shall include:

1) information on alcohol as a drug;

2) physiological and pharmacological effects of alcohol and other drugs, including their residual impairment on normal levels of driving performance;

3) other drugs, legal and illegal, and their effects on driving when used separately and/or in combination with alcohol;

4) substance abuse/dependence and the effect on individuals and families;

5) blood alcohol concentration (BAC) level and its effect on driving performance;

6) information about Illinois driving under the influence laws and associated penalties;

7) factors that influence the formation of patterns of alcohol and drug abuse; and

8) information about referrals for services that can address any identified problem that may increase the risk for future alcohol/drug-related difficulty.

d) Risk education courses shall include a minimum of 10 hours of classroom instruction, divided into at least four sessions held on different days. No session shall exceed three hours in length.

e) A pre-test and post-test shall be designed and administered to offenders to assess the effectiveness of the service and any increase in knowledge in the curriculum areas. The pre-test and post-test shall be submitted for review by the Department at the time of application for licensure or license renewal.

f) In order to successfully complete risk education, the offender shall attend each session in its entirety and in proper sequence and achieve a score on the post-test of at least 75%.

g) Upon successful completion, a DUI Risk Education Certificate of Completion shall be issued to each offender. The certificate is produced by the DUI Service Reporting System (DSRS). All sections of this form shall be complete and it shall be signed by the DUI Risk Education Instructor.

h) Audio-visual presentations shall not comprise more than 25% of the total class time.

i) No more than 24 participants shall be permitted in any one class session.

j) Written rules shall be developed and provided to each DUI offender upon enrollment, which address the following:

1) criteria for admission;

2) criteria for disqualification;

3) responsibilities of the DUI offender;

4) sobriety and drug-free requirements during class; and

5) course outline, content and class schedule.

k) Prior to enrollment in risk education classes, the DUI offender shall provide a copy of his or her completed Alcohol and Drug Evaluation Uniform Report indicating that risk education has been recommended.

l) The organization that provided the evaluation or, if applicable, treatment service shall be notified in the event that information is discovered or disclosed while the offender is in risk education that indicates the offender was not correctly evaluated and is in need of additional services. The notification shall also be made to the circuit court of venue or the Office of the Secretary of State, if applicable.

m) The circuit court of venue or the Office of the Secretary of State, whichever is applicable, shall be notified, within five calendar days, when a DUI offender is involuntarily terminated from risk education. This information shall be communicated by using the Department's Notice of Involuntary Termination from DUI Risk Education form.

n) Each risk education instructor shall be available to provide testimony relative to the offender's participation in risk education when summoned by the circuit court of venue, the Office of the Secretary of State or the DUI offender.

o) In addition to meeting the provisions specified in Section 2060.325 of this Part, the following documents shall also be contained in the DUI offender's record:

1) a copy of the Alcohol and Drug Evaluation Uniform Report;

2) the pre- and post-test specifying percentage scores;

3) a copy of the DUI Risk Education Certificate of Completion;

4) a copy of Notice of Involuntary Termination from DUI Risk Education form, if applicable; and

5) a copy of any notification regarding a change in the risk level assignment and intervention.

Section 2060.507 Designated Program

a) The Department shall designate an organization (hereafter referred to as the designated program) to provide assessment and case management services for the Illinois courts. Such services are subject to the exemptions specified in Section 40-5 of the Act and are for any substance abuser who is charged with or convicted of a crime and who may elect treatment as an alternative to incarceration under the supervision of such organization pursuant to the provisions of Article 40 of the Act.

b) The designated program shall provide the services specified in this Section in a uniform manner to districts or circuits of the Illinois courts throughout the State either directly or by subcontract or referral.

c) The designated program shall have a written agreement with the Chief Judge of each circuit court receiving services from the program that identifies such services and specifies how they will be provided in relation to the operation of that specific court.

d) Assessment

1) The designated program shall conduct an assessment, in accordance with the provisions specified in Section 2060.417 of this Part, to determine if the offender is likely to be rehabilitated through substance abuse treatment.

2) The designated program shall obtain the offender's informed consent prior to the provision of services.

3) The assessment shall include, at a minimum, collection of demographic data as specified in Section 2060.325(l) of this Part.

A) If it is determined that the offender has had a previous sentence of probation, the designated program shall request a statement from the relevant probation department.

B) This statement shall, at a minimum, summarize the offender's probation record, including, when available, known history of substance use, the identity of any treatment program utilized by the offender and any record of compliance with court ordered conditions.

4) Upon completion of the assessment, the designated program shall make a recommendation to the court relative to the offender's substance use and/or abuse and the likelihood of the offender's rehabilitation through substance abuse treatment.

A) Such notification to the court shall be made to the probation department during the offender's pre-sentence investigation, unless otherwise ordered by the court.

B) The designated program shall send written notification to the offender regarding the result of the assessment and its subsequent recommendation.

e) Case Management

1) The designated program shall provide case management services which will assist the offender with admission to treatment, assist the court in final dispositions, and assist treatment providers in identifying any special treatment needs the offender may have. At a minimum, such services shall include:

A) written notification to the court regarding the offender's initial or subsequent admission to treatment which shall include identification of the treatment program; address and telephone number; the name of the professional treatment staff assigned to the case; the name, address and telephone number of the designated program staff assigned to the case; and the date of the admission to treatment;

B) written monthly reports to the court relative to the offender's status in treatment; and

C) a written report summarizing the offender's treatment and rehabilitation upon discharge from the designated program.

f) The designated program shall have mutual linkage agreements with any treatment program utilized for referrals that ensures communication and documentation of offender progress in treatment.

g) The designated program shall identify all criteria that the offender shall meet in order to participate in the program and how such criteria will be used to measure the offender's progress in treatment.

h) The designated program shall specify the method that will be utilized to intervene with an offender should such offender fail to comply with the program's criteria or those specified in the offender's treatment plan.

i) The designated program shall conduct all chemical test services in accordance with the provisions specified in Section 2060.415(a) of this Part.

j) The designated program shall document all court appearances, including any status or violation hearing and all decisions of the court and any subsequent required actions. Procedures shall be established to specify the activities required before, during and after any hearing and the staff responsible for such.

k) The designated program shall maintain offender records in accordance with the provisions specified in Section 2060.325 of this Part. In addition, each offender record shall include:

1) documentation of the offender's informed consent and any other consent to release information form;

2) the document which contains the results of the assessment, including psychological evaluation reports and prior treatment information that determined the offender's substance abuse problem and readiness for treatment;

3) a copy of the notification of assessment results and recommendations to the offender and the court;

4) copies of any other correspondence, court order or record of judicial proceedings related to the assessment or any other case management service;

5) documentation of admission to treatment and a copy of the notification to the court of such admission;

6) documentation of any chemical test results;

7) documentation of all court appearances;

8) written reports from the treatment provider relative to the offender's progress in treatment;

9) copies of any warning letters and/or jeopardy meeting reports;

10) copies of any case conference meeting report; and

11) copies of all documents related to the offender's discharge from the designated program.

l) Offender Discharge

1) The designated program shall establish standardized procedures for discharge of the offender from the designated program. Such procedures shall include, at a minimum:

A) the process for review of offender progress in treatment to determine if a change in status is justified;

B) the specific instances that would lead to a change in offender status and the procedure to be followed when such determination is made;

C) the process that will be followed when there is a judicial request to reassess a discharge offender; and

D) a process to ensure that proper notice is given to the courts and the offender prior to and upon successful or unsuccessful discharge.

2) The designated program shall send written reports of successful discharge to the court within ten calendar days after discharge. Such reports shall contain the offender's intended residency, if known, summary of treatment progress, and recommendations for any further treatment.

3) The designated program shall send written reports of unsuccessful discharge to the courts within three calendar days after discharge. Such reports shall contain the offender's intended residency, if known, instructions for continued contact between the designated program and the courts, and the specific reasons for the unsuccessful discharge.

Section 2060.509 Recovery Homes

Recovery Homes are alcohol and drug free housing components whose rules, peer-led groups, staff activities and/or other structured operations are directed toward maintenance of sobriety for persons who exhibit treatment resistance, relapse potential and/or lack of suitable recovery living environments or who recently have completed substance abuse treatment services or who may be receiving such treatment services at another licensed facility. In order to be called a Recovery Home, the home shall:

a) provide a structured alcohol and drug free environment for congregate living that shall

offer regularly scheduled peer-led or community gatherings (self-help groups, etc.) that are held a minimum of five days per week and provide recovery education groups weekly;

b) have written linkage agreements with substance abuse providers in accordance with the provisions specified in Section 2060.329 of this Part;

c) establish a referral network to be utilized by residents for any necessary medical, mental health, substance abuse, vocational or employment resources, and maintain the confidentiality of client identifying information in accordance with 42 CFR 2 (Confidentiality of alcohol and drug abuse patient records);

d) establish a budget that specifies monthly operating expenses and demonstrates sufficient income to meet these expenses plus emergency reserve by providing documentation of access to a minimum sum equivalent to the total of two months of operating expenses;

e) comply with all applicable zoning and local building ordinances and the provisions specified in Chapter 26 (Lodging or Rooming Houses) of the National Fire Protection Association's (NFPA) Life Safety Code of 2000 (no later amendments or editions included) for any building housing 16 or fewer residents and with the provisions specified in Chapter 29 (Existing Hotels and Dormitories) of the NFPA Life Safety Code of 2000 (no later amendments or editions included) for any building housing 17 or more residents;

f) maintain fire, hazard, liability and other insurance coverages appropriate to the administration of a recovery home;

g) employ at least one full-time Recovery Home Operator who is responsible for the daily operations at the Recovery Home (i.e., fiscal, personnel, rule compliance, etc.) who shall:

1) either:

A) hold clinical certification from IAODAPCA or receive that certification within two years after the date of employment; or

B) hold certification as a National Certified Recovery Specialist (NCRS) as specified by the Association of Halfway House Alcohol Programs (AHHAP), RR 2 Box 415, Kerhonkson NY 12446

C) have a minimum of 2000 hours of work experience or 4000 hours of volunteer experience in the field of substance abuse of which 1500 hours shall have been in direct Recovery Support Systems Services (i.e., Residential Extended Care Facility or Recovery Home); and

2) provide three letters of recommendation from substance abuse professional staff as defined in Section 2060.309 of this Part; and

3) provide a signed and dated acceptance of the Code of Ethics as established by the Illinois Association of Residential Extended Care Programs, Box 269180, Chicago, Illinois 60626, website: AHHAP.org; and

h) have on-site at least one Recovery Home Manager who oversees all Recovery Home activities under the direction of the Recovery Home Operator. Recovery Home Managers shall:

1) hold certification as a National Certified Recovery Specialist (NCRS) as specified by the Association of Halfway House Alcoholism Programs of North America, Inc. (AHHAP), RR2 Box 415 Kerhonkson NY 12446, or receive such certification within two years after the date of employment; or

2) hold certification from IAODAPCA or receive the certification within two years after the date of employment; or

3) have a minimum of 1000 hours of work experience or 2000 hours of volunteer experience in the field of substance abuse of which 750 hours shall have been in direct Recovery Support Systems Services (i.e., Residential Extended Care Facility or Recovery Home) and provide a signed and dated acceptance of the Code of Ethics as established by the Illinois Association of Residential Extended Care, Box 269180, Chicago, Illinois, 60626, website: AHHAP.org.

The Recovery Home Operator may also function as the Recovery Home Manager as long as the requirements for both positions are met.

PART II.

UNIT TWO: CORE SKILLS

INTRODUCTION TO UNIT TWO

CHAPTER 5.

ASSESSMENT

WHAT IS ASSESSMENT?

Although all the core functions substance abuse counselors carry out are important, assessment is particularly significant. Assessment is the procedures by which a counselor/program identifies and evaluates an individual's strengths, weaknesses, problems and needs for the development of a treatment plan. Global criteria for assessment includes:

- Gather relevant history from client including but not limited to alcohol and other drug abuse using appropriate interview techniques.
- Identify methods and procedures for obtaining corroborative information from significant secondary sources regarding client's alcohol and other drug abuse and psycho-social history.
- Identify appropriate assessment tools.
- Explain to the client the rationale for the use of assessment techniques in order to facilitate understanding.
- Develop a diagnostic evaluation of the client's substance abuse and any co-existing conditions based on the results of all assessments in order to provide an integrated approach to treatment planning based on the client's strengths, weaknesses, and identified problems and needs.

The initial assessment occurs at the beginning of the client's treatment journey and it usually takes place during the initial visit. However, it's important to note that assessment in an ongoing process that helps us in evaluating client progress. During the initial assessment the counselor gathers a thorough client history that includes but is not limited to:

- Current status of and history related to alcohol and drug use including any previous treatment
- Current state of and history related to physical health including any hospitalizations
- Current status of and history related to mental health including any previous treatment
- Family relationships including possible issues
- Employment history and career issues
- Current legal status and history of involvement with the legal system
- Emotional and behavioral issues
- Spiritual beliefs, practices, and concerns of the client
- Education and basic life skills

- Strengths the client possesses
- Access to and use of familial and social support
- Access to and use of community resources
- Treatment readiness
- Level of cognitive and behavioral functioning

RESOURCE: TIP 24 A GUIDE TO SUBSTANCE ABUSE SERVICES FOR PRIMARY CARE CLINICIANS

Information gained through an assessment will clarify the type and extent of the problem and will help determine the appropriate treatment response. Assessment:

- Examines problems related to use (e.g., medical, behavioral, social, and financial)
- Provides data for a formal diagnosis of a possible problem
- Establishes the severity of an identified problem (i.e., mild, moderate, intermediate, or severe stage)
- Helps to determine appropriate level of care
- Guides treatment planning (e.g., whether specialized care is needed, components of an appropriate referral, and eligibility for services)
- Defines a baseline of the patient's status to which future conditions can be compared (National Institute on Alcohol Abuse and Alcoholism, 1995a)

If one thinks of screening as triage, then assessment is acquiring the information needed to direct a patient to appropriate treatment. At a minimum, patients must be assessed for:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral conditions (e.g., psychiatric conditions, psychological or emotional/ behavioral complications
4. of known or unknown origin, poor impulse control, changes in mental status, or transient neuropsychiatric complications)
5. Treatment acceptance or resistance
6. Relapse potential or continued use potential
7. Recovery/living environment (American Society of Addiction Medicine, 1996, p. 6)

Assessing along these dimensions helps the assessor confirm that a substance abuse problem exists and recommend an appropriate level of care.

Through a combination of clinical interview, personal history-taking, and self-reports, supplemented by laboratory testing and collateral reports as appropriate, the assessment process identifies patients' health problems, interest in and readiness for treatment, and feasible treatment

options. It also provides information on a patient's familial, educational, social, and vocational supports and deficits.

Understanding the Impact of Culture and Gender

Clinicians performing in-depth assessments should also understand how patients' gender and cultural background bear on the characteristics and severity of the disease (Spector, 1996). For example, more males than females abuse alcohol and drugs, and older women are more likely than older men to abuse prescription drugs. Culture and gender also may influence patients' recognition of their problems (e.g., local cultural norms may condone or accept male drunkenness) and their reaction to the assessment process and recommended treatment interventions (e.g., substantial stigma may be associated with substance abuse treatment, especially for women and older patients of either sex).

Assessors also should be aware of the influence of their own gender and cultural background on their response to patients with suspected substance abuse problems and on their interpretation of the information provided through the assessment process. While an understanding of "typical" patterns is useful in anticipating problem areas, experienced assessors resist the temptation to stereotype patients and subsume them within broad categories based on language, ethnicity, age, education, and appearance. An oft-repeated anecdote illustrating the dangers of stereotyping concerns a well-dressed, middle-aged woman and her disheveled teenage son seen in an emergency room following a car accident. The young man was screened for substance abuse; the mother was not. Several hours after admission, the woman went into alcohol withdrawal.

When referring patients for assessment, primary care clinicians should consider whether a particular patient will relate more readily to a male or female assessor of similar cultural background or if a patient who speaks English as a second language will respond more easily to questions posed in his native tongue (Spector, 1996).

Knowledge of Comorbid Mental Disorders

The relationship between mental disorders and substance use disorders is variable and complicated. The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that, in the general population, 4.7 to 13.7 percent of individuals between the ages of 15 and 54 may have both a mental disorder and a substance abuse or dependence problem (Substance Abuse and Mental Health Services Administration, 1995). Intoxication with a drug can produce psychiatric symptoms that subside with abstinence, but for those with a mental illness, substance use may mask, exacerbate, or be used to ameliorate psychiatric symptoms; precipitate psychological decompensation; or increase the frequency with which individuals require hospitalization. Because substance abuse disorders often manifest symptoms similar to those of mental health disorders, misdiagnosis may occur.

Inadvertent bias may affect the assessment process when performed by addiction specialists who do not recognize or accept the role of mental disorders in prompting or sustaining substance use or who have no experience with dually diagnosed patients. Conversely, some mental health practitioners dismiss substance abuse as merely symptomatic of underlying mental health disorders and do not acknowledge it as a problem requiring specific attention. While screening results, per se, do little to illuminate comorbid mental health disorders, information gleaned through a patient's history or inability to respond to brief intervention may suggest a mental health problem. If possible, primary care clinicians should refer patients to assessors who understand and are trained in mental health as well as substance abuse assessment and who are willing and able to expand the assessment process as

needed to identify the multiple dimensions that may be contributing to a patient's problems (Institute of Medicine, 1990).

Whether referring for or conducting intensive assessments themselves, primary care clinicians also should be alert to the possibility of conflict of interest when assessors are linked to a program or practice providing substance abuse services. There may be financial incentives (e.g., fee-for-service arrangements) or ideological pressure to interpret assessment results in such a way as to steer patients to a particular program or treatment provider (Institute of Medicine, 1990). Aside from insisting on an independent assessment source, which may be impractical, clinicians have few options for ensuring objective assessments (Institute of Medicine, 1990). However, primary care providers who understand the purposes of assessment and are familiar with its components will be in a better position to identify and subsequently avoid biased assessors.

The Assessment Setting

Like screening, assessments must be conducted inprivate,andpatientsmustbeassuredthatthe information they provide is confidential. Patients often will not reveal information about drug or alcohol use because they fear that information will be shared with their family members or employers or be used against them by law enforcement agencies or health insurance organizations.Prior to conducting an assessment, assessors should review current legal protections with the patient and discuss the limitations that apply to sharing information.

Assessment Components

Assessment comprises a medical and psychological history along with family, social, sexual, and drug use histories. In its 1990 report, *Broadening the Base of Treatment for Alcohol Problems*, the Institute of Medicine recommended conducting "sequential" and "multidimensional" assessments for alcohol problems (Institute of Medicine, 1990). The Consensus Panel recommends the same approach when assessing for other drug-related problems. Essentially, *sequential* assessment entails separating "the process of assessment into a series of stages, each of which may or may not lead into the next stage" (Institute of Medicine, 1990, p. 249; Skinner, 1981) depending on the information obtained previously. In this model, a broad- based assessment is conducted first. If the information compiled suggests that other problems may be present, such as a psychiatric disorder, then a series of progressively more intense procedures would be initiated to confirm and characterize that finding. This approach not only provides information needed for treatment planning, it saves both patient and assessor time. Moreover, by ensuring that "further information is necessary [it also] justifies its increased cost" (adapted from Skinner, 1981, in Institute of Medicine, 1990, p. 250).

A *multidimensional* approach to assessment ensures that the variety of factors that impinge on an individual's substance abuse (level, pattern, and history of use; signs and symptoms of use; and consequences of use) are considered when evaluating individual patient problems and recommending treatment (Institute of Medicine, 1990). Detailed characterization not only helps assessors match patients to appropriate available services, it also provides information useful in anticipating relapse triggers and planning for relapse management. A number of assessment instruments elicit similar information and specialized substance abuse treatment assessors may use one or more with patients.

Administering an assessment can take from 90 minutes to 2 hours, depending on the instrument(s) being used. Training is frequently required, and costs for purchase and required staff time can be substantial. Based on members' clinical experience, the Consensus Panel recommends that an

assessment include at least the components presented in Figure 4-1. The figure also includes additional questions on certain sensitive topics for situations in which primary care clinicians cannot refer for specialized assessment and require additional information in order to make a reasonable decision about the need for formal substance abuse treatment. In addition to the elements listed under the Mental Health History component in Figure 4-1, primary care clinicians contemplating a possible referral for treatment should evaluate level of cognition because it is such an important measure of a patient's ability to participate in treatment. Results of a mental status examination can support diagnoses of intoxication, withdrawal, depression, and suicidal tendencies and signal the possibility of psychosis and organic states such as dementia.

Assessment Instruments

Assessment instruments assist in gathering consistent information, clarifying and elaborating on information obtained through the patient history and physical examination, and establishing a baseline against which patient progress can be monitored. Instruments are not a substitute for clinical judgment, but the uniformity they introduce to the assessment process helps to ensure that key areas are not overlooked (Institute of Medicine, 1990).

Standardized tools have already been tested for reliability and validity and offer assessors ready-made and carefully sequenced questions that are easy to use in patient interviews and relatively simple to score (National Institute on Drug Abuse, 1994). Some instruments can be self- administered, are available in multiple languages, are computerized, and are in the public domain. However, many require that those administering them be trained in their use.

> *The most common "tool" used in assessment is called the biopsychosocial. Typically, each agency has their own version of a biopsychosocial, all of which gather the same information utilizing different formats.*

Supplementing Assessment Results

Collateral Reports

Collateral reports and laboratory tests are tools used to supplement and, in some cases, augment the information obtained during the intensive assessment.

Collateral reporting (information supplied by family and friends) can help a clinician validate substance use because patients do not always reply honestly to assessment questions, especially those concerning illicit drug use. In addition, some patients cannot recall information accurately because of cognitive impairments. Collateral reports can be useful in determining or confirming the following:

- Which substances a patient used
- Age at first use
- Frequency of use
- Quantities used per occasion
- Duration of periods of abstinence

- Concurrent or sequential choice of substances
- Dysfunctional or inappropriate use of alcohol or prescription drugs (e.g., using anxiolytics or alcohol to induce sleep or sedatives to reduce anxiety)

However, before a clinician can obtain information from family members and significant others, the patient must give consent. In some cases, permission may be denied or family members will refuse to cooperate or cannot be contacted. While less than ideal, assessors in this situation may ask the patient, "Has anybody told you that you're doing this too often?" or "Has anybody complained about your behavior when you use?" Because people with substance use disorders are often "in denial," responses that provide a perspective that differs from the patient's account of his use and its consequences frequently suggest a problem. Sometimes, patients' explanations for why their interpretation conflicts with those of family and friends also can be useful in gauging a patient's understanding of his situation and readiness to change: "My wife is so rigid, drinking just loosens me up. When I'm uninhibited, she gets nervous." Or, "I just smoke pot to relax. What my mom really doesn't like are my friends."

Supporting Laboratory Tests

Common laboratory tests for direct measures of recent alcohol use include blood alcohol content (BAC) levels, urine, Breathalyzers™, and recheck Breathalyzers™. These tests measure current use and are used for the most part by law enforcement and hospital emergency room personnel (National Institute on Alcohol Abuse and Alcoholism, 1993). Drug tests include analysis of urine, hair, and saliva, though the latter two are not commonly used. Because of the limitations of self-reporting and of under-reporting due to the stigma associated with problem drinking, many assessors use laboratory testing to:

- Confirm recent use (prior to recommending methadone, for example)
- Validate suspicions about recent use
- Support findings from the assessment pointing to chronic use
- Provide information about alcohol- and other drug-related physical problems (e.g., liver damage)

Making the Diagnosis

The categorical classification of "Substance Use Disorders" in the DSM-5-TR provides the standard against which a formal diagnosis is made. Once an assessor has made a diagnosis, the next critical step is to work with the patient in determining the level and type of services that the patient needs. Over the past several years, the substance abuse treatment field, led by the American Society of Addiction Medicine (ASAM), has been grappling with the concept and implementation of patient placement criteria that identify both major problem areas that should be considered in designing an individual treatment plan and the array of services most likely to address those problems. ASAM's *Patient Placement Criteria for the Treatment of Substance-Related Disorders*, Second Edition (ASAM PPC-2) offers guidelines that are consistent with the DSM-IV to help assessors and other clinicians evaluate the "severity and intensity of service required" (American Society of Addiction Medicine, 1996, p. 14). See TIP 13, *The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders*, for more on patient placement criteria (CSAT, 1995a).

Central to this evolving model of patient placement is that level of care and service mix may change as patient needs dictate. When selecting the level of care, the goal should be the least restrictive treatment that is effective. ASAM's criteria help focus attention on an individual's needs (American Society of Addiction Medicine, 1996). Rather than forcing a fit between a patient and a single program, those criteria provide information that frees assessors and patients to critically evaluate assessment results, investigate various options in the community, and construct a plan that incorporates needed services from a variety of resources. The realities of service availability and insurance coverage, however, ultimately affect both the level and type of service a patient receives.

KEY ELEMENTS FOR INCLUSION IN ASSESSMENT

STANDARD MEDICAL HISTORY AND PHYSICAL EXAM, WITH PARTICULAR ATTENTION TO THE FOLLOWING:

- Inability to focus (both visually and mentally)
- Nicotine stains
- Dental caries
- Disrupted menstrual cycle
- Frontal lobe release reflexes (e.g., snout reflex, palmomental reflex)
- Slurred, incoherent, or too rapid speech
- Unsteady gait (staggering, off balance)
- Tremors
- Red facies
- Dilated or constricted pupils
- Blackouts or other periods of memory loss
- Gingivitis
- Perforated septum
- "Nodding off" (dozing or falling asleep)
- Agitation
- Scratching
- Needle track marks
- Skin abscesses, burns on inside of lips (from smoking crack or heroin)
- Angiomas
- Swollen hands or feet
- Swollen parotid glands
- Leukoplakia in mouth

- Insomnia or other sleep disturbances
- Withdrawal symptoms including delirium tremens
- Seizures
- Physical injuries (If yes, consider using ***Skinner Trauma History:*** A score of two or more positive responses indicates a high probability of problem drinking)

ALCOHOL AND OTHER DRUG USE HISTORY

- Use of alcohol and other drugs (begin with legal drugs first)
- Mode of use with drugs (e.g., smoking, snorting, inhaling, chewing, injecting)
- Quantity used
- Frequency of use
- Pattern of use: date of last drink or drug used, duration of sobriety, longest abstinence from substance of choice (When did it end?)
- Alcohol/drug combinations used
- Legal complications or consequences of drug use (selling, trafficking)
- Craving (as manifested in dreams, thoughts, desires)

FAMILY/SOCIAL HISTORY

- Marital/cohabiting status
- Legal status (minor, in custody, immigration status)
- Alcohol or drug use by parents, siblings, relatives, children, spouse/partner (Probe for type of alcohol or drug use by family members since this is frequently an important problem indicator: "Would you say they had a drinking problem? Can you tell me something about it?")
- Alienation from family
- Alcohol or drug use by friends
- Domestic violence history, child abuse, battering (Many survivors and perpetrators of violence abuse drugs and alcohol.)
- Other abuse history (physical, emotional, verbal, sexual)
- Educational level
- Occupation/work history (Probe for sources of financial support that may be linked to addiction or drug-related activities such as participation in commercial sex industry.)
- Interruptions in work or school history (Ask for explanation)
- Arrest/citation history (e.g., DUI, legal infractions, incarceration, probation)

SEXUAL HISTORY

- Sexual preference—"Are your sexual partners of the same sex? Opposite sex? Both?"
- Number of relationships—"How many sex partners have you had within the past 6 months? Year?"
- Types of sexual activity engaged in; problems with interest, performance, or satisfaction—"Do you have any problems feeling sexually excited? Achieving orgasm? Are you worried about your sexual functioning? Your ability to function as a spouse or partner? Do you think drugs or alcohol are affecting your sex life?" (A variety of drugs may be used or abused in efforts to improve sexual performance and increase sexual satisfaction; likewise, prescription and illicit drug use and alcohol use can diminish libido, sexual performance, and achievement of orgasm.)
- Whether the patient practices safe sex; frequency of use of condoms (Research indicates that substance abuse is linked with unsafe sexual practices and exposure to HIV.)
- Women's reproductive health history/pregnancy outcomes (In addition to obtaining information, this item offers an opportunity to provide some counseling about the effects of alcohol and drugs on fetal and maternal health.)

MENTAL HEALTH HISTORY

- Mood disorders—"Have you ever felt depressed or anxious or suffered from panic attacks? How long did these feelings last? Does anyone else in your family suffer from similar problems?" (If yes, do they receive medication for it?)
- Other mental health disorders—"Have you ever been treated by a psychiatrist, psychologist, or other mental health professional? Has anyone in your family been treated? Can you tell me what they were treated for? Were they given medication?"
- Self-destructive or suicidal thoughts or actions—"Have you ever thought about committing suicide?" (If yes: "Have you ever made an attempt to kill yourself? Have you been thinking about suicide recently? Do you have a plan?" [If yes, "What means would you use?"] Depending on the patient's response and the clinician's judgment, a mental health assessment tool like the Beck Depression Inventory or the Beck Hopelessness Scale may be used to obtain additional information, or the clinician may opt to implement his/her own predefined procedures for addressing potentially serious mental health issues.)

Substance Abuse and Mental Health Services Administration. (1997). *Treatment Improvement Protocol (TIP) Series 24: A Guide to Substance Abuse Services for Primary Care Clinicians* (DHHS Publication No. (SMA) 08-4075. Rockville, MD

ASSESSING FOR STAGE OF CHANGE

Looking back to Unit I, we discussed the American Society of Addiction Medicine (ASAM) patient placement criteria. Dimension 4 helps identify a client's readiness to change. Questions to consider for dimension 4 include, but are not limited to:

- Is the client seeking treatment on their own or are they being "mandated" by an external source (e.g. spouse, child, employer, legal system, etc.)?
- Does the client believe their behavior (use) is a problem?
- How ready or committed is the client to change?
- Has the client already taken steps toward change?
- What stage of change do you believe the client is in?

To understand what is meant by "stage of change", it's important for us to look at the Transtheoretical Model of Stages of Change (often referred to as the Stages of Change Model) of health behavior change developed by James Prochaska and Roberto DiClemente. While working with individuals who were at various stages in their attempts at smoking cessation, Prochaska and DiClemente posited there are 6 identifiable stages an individual works through when attempting to achieve behavior change. These stages of change are:

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse

The precontemplation stage of change is one in which an individual doesn't recognize their behavior is problematic. You may have heard the phrase "He's/she's in denial!" Most people interpret this to mean the individual is oblivious for the need to change their behavior. It's important to note many professionals in the addictions field are steering away from using the term "denial" due to its judgmental connotation and agree that sometimes people simply aren't ready for change.

The second stage of change is contemplation. In the contemplation stage of change the individual feels two ways about the need for change. In other words, they are ambivalent about change. On one hand they can see that perhaps their behavior does yield some consequences, but they're not quite sure if they are ready to change, may not feel their behavior is "that bad", and/or still justify and defend their problematic behavior.

While in the preparation stage of change, the individual starts to take steps toward behavior change. The smoker buys nicotine patches but doesn't set a quit date. The dieter starts looking up healthier recipes but doesn't start to make them. In other words the person starts to *prepare* for behavior change even though they may not yet be ready to totally commit.

In the action stage of change, there is a commitment to change, and the individual starts to engage in the new desired behavior and eliminate the old, ineffective one. For someone with a substance use disorder, action can take many forms. Some will commit to total abstinence. Others may decide to limit their use as opposed to stopping altogether. What is important to note is that is that each individual has the autonomy to choose their own goal and meeting clients where they're at tends to strengthen the therapeutic relationship and increase the chances of better outcomes for treatment.

In the maintenance stage of change individuals are *maintaining* their change. They engage in

activities and use supports and other tools to help them maintain their new behavior. For those recovering from addiction that may include things such as participating in community based self-help meetings and other recovery support groups, avoiding people, places, and things that trigger urges and cravings and a possible return to old behavior, the use of medication (e.g. Antabuse, Suboxone, etc.), and continued treatment.

The final stage of change Prochaska and DiClemente proposed was relapse. Relapse is a return to problematic behavior after a period of improvement. Relapse has a negative connotation which is understandable particularly with addiction. It's difficult to see someone return to a problematic pattern of use and encounter unpleasant consequences. It's also concerning with the risk for overdose with certain substances. However, if we can normalize relapse as something that doesn't *have* to happen but more often than not *does,* we can use it as path to identify what needs to change and what to do different the next time. Think of your own journey while attempting a behavior change. Perhaps you tried to eat healthier. Or maybe you tried to or quit smoking. Most people who attempt to change a behavior will experience a return to the behavior they are trying to change. Thus relapse doesn't equate to failure. Instead, it can be a learning experience.

CHAPTER 6.

TREATMENT PLANNING

CHAPTER 7.

REPORT AND RECORD KEEPING

CHAPTER 8.

INDIVIDUAL AND GROUP COUNSELING SKILLS

JULIE TRYTEK

CHAPTER 9.

TREATMENT MODELS

PART III.

UNIT THREE: CORE ATTITUDES

In Unit 3, we will look at core attitudes necessary to succeed in being an addiction counselor. First, we need to understand the neurobiological mechanisms of addiction and how the repetition of particular experiences (including trauma) modifies synaptic networks. The biopsychosocial model of addiction which drives treatment approaches, considers the biological, psychological and sociocultural factor that contribute to addiction. The unit then moves to a discussion of how society's tolerance of negative norms sets the precedent for stigma, which is the cultural context within which treatment is provided.

Next, we examine the case management model for SUDS treatment because it has been found to be effective helping clients focus on treatment and remain in recovery.

Finally, we look at the role supervision plays in developing successful addiction counselors. The unit concludes by discussing ethics and confidentiality. This is important because the counselor has an ethical obligation to benefit the client, avoid harm and respect the client's values and preferences.

CHAPTER 10.

ADDICTION AND THE BRAIN: DEVELOPMENT, NOT DISEASE

CITATION

The harm done by addicts to themselves and those around them has riveted public attention in recent years. It has become essential to discard outdated perceptions of addiction and replace them with coherent models based on scientific principles. Toward this end, doctors, psychiatrists, medical researchers and treatment providers have come to define addiction as a brain disease. Specifically, addiction is characterized by changes in brain systems that mediate the experience and anticipation of reward, systems responsible for perception and memory, and higher-order executive systems underlying cognitive control. The disease model stipulates that these changes are caused by exposure to drugs of abuse, and they are difficult if not impossible to reverse.

By looking at changes in the function and structure of the nervous system, the disease model helps explain why it is so difficult to achieve abstinence through the exercise of willpower. It makes sense of individual differences in vulnerability to addiction, based on dispositional factors and environmental stressors. The disease model provides a knowledge base and research agenda for developing pharmaceuticals that can be useful for reducing craving and easing withdrawal symptoms. And it has countered the perception that addicts are morally deficient or self-indulgent, arguably reducing the stress and isolation they and their families experience.

Given these achievements, it isn't surprising that the disease model of addiction is accepted—in fact nearly unchallenged—by the medical community, the psychiatric community, research funding bodies, and governments themselves, as reflected by a mountain of articles and posts by the National Institute on Drug Abuse (NIDA), the National Institutes of Health (NIH), the American Medical Association (AMA), and the American Society of Addiction Medicine (ASAM). Yet there are reasons to question the validity of the disease perspective. First, this perspective clashes with the experience of many former addicts, who do not feel they were ever sick or have now been cured. Second, the strongest endorsements of the disease model come from the rehab industry and Big Pharma, both of which profit from the belief that addicts need long-term medical treatment. Rather, most alcoholics and addicts recover,[1] and most of those do so without treatment of any kind, a finding that is difficult to reconcile with the idea that addiction is a chronic disease.[234] Finally, investigators who approach

1. 1. Lopez-Quintero, Catalina, Deborah S. Hasin, José Pérez De Los Cobos, Abigail Pines, Shuai Wang, Bridget F. Grant, and Carlos Blanco. 2011. Probability and predictors of re- mission from life-time nicotine, alcohol, cannabis or cocaine dependence: results from the National Epidemiologic Survey on alcohol and related conditions. Addiction 106: 657–669. doi:10.1111/j.1360-0443.2010.03194.x.
2. 2. Dawson, Deborah A., Bridget F. Grant, Frederick S. Stinson, and Patricia S. Chou. 2006. Maturing out of alcohol dependence: the impact of transitional life events. Journal of Studies on Alcohol 67: 195–203.
3. 3. National Institute on Alcohol Abuse and Alcoholism (NIAAA) 2006. National epidemiologic survey on alcohol and related conditions. Alcohol: Research & Health 29:2
4. 4. Heyman, Gene M. 2013. Quitting drugs: quantitative and qualitative features. Annual Review of Clinical Psychology 9: 29–59. doi:10.1146/annurev-clinpsy-032511-143041.

addiction as a disease are far more likely to get their work funded, thus minimizing the volume and impact of discrepant findings.

For these and other reasons, the disease model of addiction has been heatedly challenged, and alternative models have been proposed in its place. Addiction may be viewed as a choice rather than a pathology. While few people imagine that addiction is a good choice, it is some- times considered rational in the short run—as when the pleasure or relief derived from drugs temporarily out- weighs the alternatives [5, 6]. Addiction may be a natural response to environmental or economic conditions beyond the addict's control, including poverty and social alienation [6, 7]. Addiction can be viewed as a form of self- medication that works against psychological suffering. Trauma—whether physical, psychological, or sexual—is often considered the root cause of long-term anxiety and depression; and post-traumatic stress disorder (PTSD) is highly correlated with substance use [8–10]. A framework that encompasses all these approaches views addiction as a product of cognitive and emotional development, predisposed by constitutional factors but consolidated through learning over childhood and adolescence [10].

These alternatives to the disease model of addiction may be compelling, but they lack one important ingredient. They have little or nothing to say about the brain. (There are notable exceptions [11–13], which, although valuable, provide only global neural arguments, without attention to key structures or processes. Maia Szalavitz [10] is the only author I'm aware of who backs a learning account of addiction with detailed neuroscientific explanation.) In this era of scientific acceleration, brain science has become a gold standard for conclusive explanations of human phenomena. Without detailed neurobiological analysis, alter- natives to the disease model may lack the scientific traction they need. My book, *The Biology of Desire* [14], was intended to fill in the neural level of analysis in a developmental-learning model of addiction, integrate that level of explanation with experiential accounts of addiction and recovery, and demonstrate that the disease model has outlived both its credibility and its usefulness. In the following sections, I summarize these arguments and connect them to the larger debate on how to understand and combat addiction. I end by showing that the ethos of the disease model makes it difficult to reconcile with a developmental-learning orientation.

The Core Tenets of the Disease Model

According to NIDA, BAddiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences.^ A key observation underlying this depiction is that dopamine transmission and reception are altered over time: increasingly, it is only the user's substance of choice that reliably impacts on dopaminergic activity. Dopamine is a crucial neurotransmitter (or Bneuromodulator^) for motivating, directing, and rewarding goal-directed behavior and focus- ing attention and memory. Because the action of dopamine enhances the formation of new synapses (and the corresponding loss of older ones), changes in dopamine metabolism bring about structural changes in synaptic net- works—the basic wiring diagram of the brain. A critical locus of dopamine reception and synaptic restructuring is the striatum, the area responsible for pursuing rewards, but other targets include the amygdala, which mediates emotional salience, the hippocampus, which directs memory encoding and retrieval, and several regions of the prefrontal cortex, responsible for a variety of cognitive functions. Indeed, starting in the 1980s and 1990s, researchers began to show synaptic changes in these regions in laboratory animals exposed to cocaine, amphetamine, morphine, alcohol, and other drugs, corresponding with behavioral sensitization in addicted animals and humans [15, 16]. For example, dopamine activation of the striatum was found to go up and down with drug availability—and not much else. The receptors

that absorb and use dopamine were also found to change in structure or efficiency [17] increasingly over months and years of use. The message seemed clear: drug use messes up brain wiring. These brain changes were seen as direct evidence that an insidious force—namely drugs—had Bhijacked the brain,^ a phrase first uttered by Bill Moyers on a popular PBS television series, but quick to catch on in addiction debates everywhere.

Nora Volkow M.D., the firebrand scientist who current- ly heads NIDA, points to Btissue damage^ in the brain as indisputable support for the disease model [18]. In her view, this damage is specifically caused by drug use, and it corresponds with reduced capacity to engage cognitive control, increased compulsivity in drug seeking, and emotional blunting in response to rewards more generally. The *nucleus accumbens* describes one of the most ventral (lower) regions of the striatum, and it is the brain part most often referred to when it comes to addiction. Berridge and Robinson [19] coined the phrase *incentive sensitization* to describe the increasing specificity with which dopamine flows from the ventral tegmental area (VTA) in the mid- brain to the accumbens in response to drug cues. In fact, even secondary and tertiary drug-related cues were found to trigger dopamine release, which then increased activation in the accumbens and induced a more driven, even Bfrenzied^ quality to drug-seeking behavior [20, 21].

The ventral striatum or accumbens is associated with impulsive drug seeking and use, but the dorsal striatum becomes increasingly important for addiction with the passage of time. As the period of addiction stretches over months and years, activation shifts from the ventral to the dorsal striatum in response to drug-associated cues, while drug-seeking behavior becomes more compulsive and less impulsive in character. Trevor Robbins and his colleagues at Cambridge have been studying the shift from impulsive to compulsive drug seeking for many years [22]. They see the compulsive phase as true addiction, as do many others in the field. Now, according to Volkow, Koob, and others, the addictive urge is truly out of control. Whether the addict actually desires the addictive reward, he or she is compelled to go after it, based on a stimulus-response (S- R) association acquired and strengthened through Pavlov- ian conditioning. The stimulus simply elicits a response, without the need for a reinforcing outcome.

According to Volkow and other scientists, not only the brain regions underlying goal-seeking but also those responsible for self-control are physically modified by drugs. An example can be seen in the dorsolateral prefrontal cortex (dlPFC), which is critical for reasoning, remember- ing, planning, and self-control. The dlPFC becomes hyperactivated in the early stages of addiction, as it does in some eating disorders, perhaps when people try to control or maintain the rewardingness of this new experience. But over time, this region and other prefrontal control centers start to disengage (i.e., lose functional connectivity) from the striatum, the amygdala, and other areas compris- ing the motivational core of the brain [23, 24]. Volkow and colleagues have carried out two decades of research into cortical changes underlying addiction. They conclude that prefrontal regions responsible for judging options and selecting among them lose grey matter volume (reduced synaptic density) and become partially dysfunctional over the course of addiction [23, 25]. They dub the resulting cognitive dysfunction Bimpaired response inhibition.^

This cluster of changes in the function and structure of the brain has led many authorities to view addiction as a disease, and because these changes seem to endure long beyond the cessation of drug-taking, it is considered a chronic disease. According to Steven Hyman, previous director of the National Institute of Mental Health, addiction is a condition that changes the way the brain works, just like diabetes changes the way the pancreas works. Then why shouldn't it be viewed asa disease?

Development and the Brain

One of the key premises of the disease model is that addiction changes the brain. Yet brains are supposed to change. They are designed to change. In fact the stages of child and adolescent development, and the learning that goes on throughout adulthood, are all underpinned by changes in the cortex and limbic regions. Given the realities of brain change in normal development and learning, neuroscientists who endorse the disease model must view the brain changes resulting from addiction as extreme or pathological. In fact, they would have to show that the *kind* (or extent or location) of brain change characteristic of addiction is nothing like what we see in normal learning and development. How then should we characterize brain changes that occur naturally?

First of all, brains grow and shape themselves, not by following pre-specified guidelines, but by a process of *self-organization*. They organize themselves, changing their own structure as they go. Such changes build on themselves over time, such that the products (synaptic changes) of one learning episode set the conditions for subsequent learning episodes. Of course there are some species-specific constraints on the timing of neural development, and there are certainly constraints on the kinds of information human beings can access and manipulate. Moreover, social norms help guide neural development along pathways consistent with particular cultural environments. Yet neural development is in no way programmed. It results almost entirely from synaptic activation patterns that both result from and give rise to experience itself.

One way to conceptualize this kind of self-perpetuating growth is to see it as a feedback loop between experience and brain change. The way we experience things changes synaptic configurations, and those changes shape the way we experience things subsequently. In other words, experience-dependent changes in brain structure make a particular way of experiencing things more probable on future occasions [26]. This can take the form of a self- perpetuating perception (as in language learning), an expectancy, a budding interpretation (as in judgments of individuals or groups), a recurring wish, a familiar emotional reaction (as in anxiety regarding perceived threats), an emergent belief (as in religious ideas and corresponding *ism*s), or a conscious memory. Thus the mind and the brain shape each other. And ordi- nary classroom learning is just one version of this more general phenomenon—a brain that changes it- self (a phrase borrowed from Norman Doidge [27]). The brain would be useless if it wasn't highly change- able and highly sensitive to events in the world. But since we need stability in our percepts, concepts, and actions, brain changes almost always settle into habits. And once formed, habits—even minor habits—remain in place, sometimes for the rest of our lives. Examples range from idiosyncratic patterns like nail-biting and suspiciousness to cultural norms like politeness and sexual stereotyping. New synaptic pathways, and corresponding patterns of thought and behavior, start off tentative and fluctuating. But after they've been activated repeatedly, fledgling path- ways get more entrenched, more concretized. As Donald Hebb made famous in the 1940s, *cells that fire together wire together.* Change and stabilization—novelty and habit formation—work together in the mind and in the brain. In a word, that's Blearning^.

Another helpful concept is *neuroplasticity.* Neuroplasticity simply describes brain changeability and

elevates it to a first principle. Indeed, there's nothing more fundamental to the human brain than its plasticity [27]. Yet neuroscientists who study addiction seem to have missed the point. When the brains of addicts (following years of drug taking) are compared to those of drug-naive controls, these scientists can be heard to say BLook! Their brains have changed!^ Yet if neuroplasticity is the rule, not the exception, then they're actually not saying much at all. The brain is supposed to change with new experiences. And those changes are supposed to stabilize and consolidate the more that experience is repeated.

When our experience of the world produces strong emotions—whether of desire, threat, pleasure, or relief— brain change takes on extra momentum. Emotions focus our attention and our thinking, partly through connections between the amygdala and a variety of cortical structures and partly through the wash of neuromodulators (including dopamine) released from the brain stem (including the VTA) in response to salient inputs. When those emotions recur over and over, in response to a particular event, perception, thought, memory, or need, then attention directs memory consolidation systematically. Our recurrently-focused brains inevitably self-organize in a particular direction, entrenching particular interpretations and emotional associations. Most relevant to addiction, the feeling of *desire* for something shapes synaptic configurations that become increasingly sensitive to cues associated with whatever is desired—since those cues are processed repeatedly in our efforts to acquire it.

Importantly, it's not just attraction or desire that fuels feedback loops and promotes neural habits. Depression and anxiety also develop through feedback. The more we think sad or fearful thoughts, the more synapses get strung together to generate scenarios of loneliness or danger, and the more likely we are to practice strategies—often unconsciously—for dealing with those scenarios. Neural patterns forged by desire can complement and merge with those born of depression or anxiety. In fact, that's a lynchpin in the self-medication model of addiction. Gabor Maté per- suasively shows how early emotional disturbances steer us toward an intense desire for the relief provided by drugs [11], and Maia Szalavitz vividly portrays her experience as a late adolescent trying to brighten her depression with cocaine and ease her anxiety with heroin [10]. So, when we examine the correlation between addiction and depression or anxiety, we should recognize that addiction is often a partner or even an extension of a developmental pattern already set in motion, not simply a newcomer who happened to show up one day.

Thus, repeated experiences establish patterns, forming habits, and those habits link with other habits that also evolve with repeated experiences. But here's the main point when it comes to addiction. We don't need an external cause like *disease* to explain the growth of bad habits, or even a set of interlocking bad habits (like being a drug addict and a criminal and a liar). Bad habits self-organize like any other habits. Addiction has been de- scribed as a habit for many decades, across various cultural contexts and societal conversations. Is that all it is? Like other habits, addiction may simply grow and stabilize, in brain tissue that is designed (by evolution) to change and stabilize. Yet addiction belongs to a subset of habits: those which are most difficult to extinguish. If we conceptualize addiction as an outcome of normal learning, we still have to explain why it is such an extreme outcome, so destructive and so difficult to reverse.

My outline of the principles of brain development highlighted individual trajectories. However, brain development also incorporates normative tendencies that are crucial for understanding addiction. First, brain development always balances the formation of new synapses—synaptogenesis—with synaptic loss or pruning. Second, and perhaps counterintuitively,

synaptic pruning far outweighs synaptogenesis over the years of childhood and adolescence. The infant brain has an overabundance of synapses, roughly one-third of which are pruned through competition [28] as a result of normal learning. In fact pruning is considered the primary mechanism by which learning occurs. Third, pruning in the pre- frontal cortex increases efficiency in the processing and organizing of information—the essence of cognitive development from puberty onward [29]. Fourth, emotion regulation skills, which continue to advance through childhood and adolescence, involve two-way communication between prefrontal control centers and subcortical (e.g., striatal) regions that mediate emotions and impulses [30]. It can be assumed that both synaptogenesis and pruning play significant roles in this crucial developmental achievement.

A closer look at the nature of impulsive responding will help us understand not only the development of emotion regulation but addiction as well. All mammals and certainly human children tend to overvalue imme- diate rewards at the expense of long-term gains. This proclivity, called delay discounting, must be tamed in order for children to advance from a preoccupation with whatever is presently available (e.g., one marshmallow in the famous marshmallow test) to a capacity to wait for long-term gains (e.g., two marshmallows, a few minutes later) [31]—a crucial step in the development of emo- tion regulation. Addicts are known to be excessively now-oriented [32], consistent with their tendency to favor what Heyman calls the local choice [5]. Moreover, delay discounting has been shown to correspond to activation of the ventral striatum, the villain when it comes to addictive behavior, while the capacity to delay gratification taps activation of the dlPFC [30, 33, 34]. In other words, the neural picture in both delay discounting and addiction features striatal activation that is underregulated by the dlPFC (and other regions of the PFC).

Why Addiction Is Not a Disease

In its contemporary form [18], the disease model of addiction asserts that addiction is a chronic, relapsing brain disease. This disease is evidenced by changes in the brain, especially alterations in the striatum, brought about by the repeated uptake of dopamine in response to drugs and other substances. But it is also characterized by changes in the prefrontal cortex, where regions responsible for cognitive control become partially disconnected from the striatum and sometimes lose a portion of their synapses as the addiction progresses. These are big changes, they can't be brushed aside, and so far the disease model is the only model of addiction that actually tries to explain them. So why should we look further?

Self-Perpetuating Attractions Do Not a Disease Make

The brain changes with all learning experiences, and it changes more rapidly and more radically in re- sponse to experiences with high motivational impact. Every experience that is repeated enough times because of its motivational appeal will change synaptic networks in the striatum and related regions (e.g., the amygdala and orbitofrontal cortex) while adjusting the flow and uptake of dopamine to all these regions. Such changes lead to the formation of habits—neural and behavioral habits—habits that become self-perpetuating and self- stabilizing. Yet we wouldn't want to call the excitement we feel about summer vacation, meeting our lover, or cheering for our favorite team a disease. As we anticipate and live through these experiences, the corresponding network of synapses is strengthened and refined; so the uptake of dopamine gets more selective as rewards are identified and habits established. This is simply learning, motivated by desire.

Even if addictive habits are more deeply entrenched than other habits, there is no clear dividing line between addiction and the repeated pursuit of other attractive goals, either in experience or in brain function [35]. So how do we know which urges, attractions, and desires to label Bdisease^ and

which to consider aspects of normal experience and brain change? Some authorities apply the disease label when the pursuit of a drug, drink, or activity seriously interferes with one's life. But again, where should we draw the line? The lover we can't help but desire may be abusive, may be involved in another relationship, or may be forbidden for familial or cultural reasons. And sports fans have been known to beat each other up, get arrested, and ignore their familial responsibilities when the excitement runs high. BAddiction^ doesn't fit a unique physiological stamp. It simply describes the repeated pursuit of highly attractive goals and the brain changes that condense this cycle of thought and behavior into a well-learned habit. Brain change, even more extreme brain change, does not imply that something is wrong with the brain.

My review of the disease model highlighted the shift in activation from the ventral to the dorsal striatum as addictive behavior becomes increasingly compulsive. This change has been well documented: it consists of the growth of fibers from the VTA to the dorsal striatum as the addictive behavior becomes an automatic re- sponse to a stimulus [22]. Once a person has reached this state, the brain is no longer functioning as it did. Yet, according to Everitt and Robbins [22], the acknowledged experts on the ventral-to-dorsal shift, Bthere is nothing aberrant or unusual about devolving behaviour- al control to a dorsal striatal S-R habit mechanism.^ These authors remind us that this neural restructuring is to be expected in many aspects of our lives, including eating and other normal activities. Do we bite down on that piece of pizza because of an anticipated reward, or because a great many trials have established an associ- ation between a particular smell (and other gustatory cues) and the act of biting? BAutomatization of behav- iour frees up cognitive processes,^ these authors continue. That would explain why we can talk, eat, drive, and listen to music all at the same time. We need habits in order to free our minds for other things. Unfortunately, in addiction, this perfectly natural developmental mechanism often leads to suffering.

Addiction without Substances

One of the greatest blows to the current notion of addiction as a disease is the fact that behavioral addictions can be just as severe as substance addictions. However, the party line of NIDA, the AMA, and ASAM remains what it has been for decades: addiction is primarily caused by substance abuse. If that were so, how would we explain addictions to porn, sex, internet games, food, and gambling? In a comprehensive review, Brewer and Potenza conclude that Bdisorders^ characterized by too much of any of the above show brain activation patterns that are nearly identical to those shown in drug addiction [36]. According to these authors, even the ventral-to-dorsal shift in striatal activation, and the corresponding increase in compulsive responding, show up in behavioral addictions just as they do in substance addictions. This is exemplified in compulsive gambling and binge eat- ing. It is interesting that, despite widespread acceptance of neural and behavioral parallels between substance and behavioral addictions, the promoters of the disease model have never retracted their claim that drugs cause the brain changes underlying addiction.

People pursue certain activities repeatedly, often with little control, because those activities start off as highly rewarding and end up as behavioral habits. That descrip- tion can cover anything from spending sprees to heli- copter parenting to jihadism. But there is one very normal human endeavor that most of us recognize as the epitome of blind desire and recurrent pursuit: falling in love. Lovers think obsessively about their love object, exaggerate his or her positive qualities and avoid think- ing about future repercussions. Romantic love (but also parent-child love, and even perverse forms of love in- cluding fetishism, sadomasochism, etc.) can easily be- come compulsive, difficult to control, and overly fo- cused on the immediate, with little regard for the long- range forecast.

A look at the neuroscience of love reveals some remarkable similarities with addiction. It is generally agreed that Bincreased levels of central dopa- mine contribute to the lover's focused attention on the beloved and the lover's tendency to regard the beloved as unique^ [37]. In fact, several researchers have examined the love-and-addiction link directly. Burkett and Young reviewed much of this work [38]. In their words, Bmesolimbic dopamine is a major contributor to the formation of pair bonds in prairie voles and particularly in the nucleus accumbens region.^ In a comprehensive new book, Toates summarizes research showing that the dopa- mine system provides a Bcommon currency of wanting^ in the pursuit of financial gains, drugs, and sexual partners [39]. He notes that the nucleus accumbens is involved in motivating the individual to overcome obstacles in order to reach such goals [40] and that dopamine metabolism biases decision making in favor of immediate gains [41]. With regard to romantic pairing, Burkett and Young con- clude that B[w]hen these early interactions with the object of addiction produce rewarding outcomes, dopamine is released in the nucleus accumbens, which acts to increase the salience of incentive cues that predict the reward^ [38]. If addiction is a disease, then so apparently is love.

Alternative Explanations of Cortical Change

So far, I've argued that addictions are consolidated patterns of attraction and pursuit that cultivate distinct synaptic configurations in the motivational core of the brain (the striatum and related regions). But the disease model also stipulates cortical changes: most seriously the loss of functional coupling between the PFC and the striatum and, perhaps as a result, the eventual loss of synapses in the PFC, both of which contribute to a loss of self- control. Indeed, after a while, with a variety of sub- stances and some eating disorders (including binge eat- ing), the dorsolateral PFC becomes partially disconnect- ed from the striatum. The reasons for this disconnection are complex and not fully understood. But suffice it to say that dopamine signaling in the cortex is partly under the control of striatal outputs, and with long-term addic- tion striatal habits no longer send signals to the PFC eliciting control. Functional connections are lost, which means some of the synaptic pathways get pruned and eventually disappear. Now structural connections are lost. This explains the loss of grey matter volume re- ported with long-term addiction. Can these changes be seen as anything but the ravages of a disease?

From a functional perspective, the interplay between prefrontally mediated control and striatal goal-pursuit is never permanently fixed in the brain. Children's ability to overcome delay discounting (and other impulsive tendencies) improves with age from middle childhood to middle adolescence, due at least in part to the matu- ration of the dorsolateral PFC [42]. Not surprisingly, adults also overcome delay discounting by activating the dlPFC [33], yet this avenue of control isn't carved in stone. Adults fall prey to delay discounting regularly, suggesting functional rather than structural variability in prefrontal control. And they can reverse this tendency in response to novel environmental inputs. In one set of studies, the tendency to discount future gains in favour of immediate rewards was consistently reversed by ex- posing participants to images of their future selves [43]. To examine such changes at the neural level, Figner applied transcranial magnetic stimulation (TMS), a pro- cedure that can temporarily disrupt activity in the cortex, while participants were engaged in a delay discounting task [44]. Participants chose immediate rewards of low- er value more frequently when the TMS machine was placed over their dorsolateral PFC, but their discounting rate went back to normal immediately afterward. There are more natural (and less expensive) ways to disrupt dlPFC activation and facilitate impulsive responding. Drug or alcohol use, especially during the sensitive developmental period of adolescence, is clearly one such way [45].

Yet the loss of cortical control is thought to be long- lasting, even permanent, in long-term addiction. This implies structural changes, which are often conflated with the notion of disease. However, as noted previous- ly, synaptic pruning is a normal developmental process. In fact, research shows that, when the same inputs are encountered repeatedly, connections are depleted to im- prove overall efficiency [46], and addiction certainly exemplifies repeated inputs. In the sequel to Hebb's famous maxim, not only do cells that fire together wire together but cells that fire apart wire apart. In other words, changes in behavior and experience naturally deplete synaptic connections, not only functionally but, over time, structurally as well. As addicts pursue the same rewards every day, it appears that they no longer rely on reflective judgment to curtail the feelings and behaviors to which they've grown accustomed. Then it should not be surprising, nor should it imply the presence of disease, if their neural configurations readjust by pruning the underused synapses.

This account of cortical decoupling and loss of cor- tical synapses doesn't quite close Pandora's Box. It isn't easy to determine which patterns of synaptic pruning are normal and which are not [47]. Yet, in a seminal study, Connolly and colleagues showed that the reduction of grey matter volume in specific regions of the prefrontal cortex (and the anterior cingulate, a closely related structure), induced by years of addiction, can reverse over several months of abstinence [48]. These authors reported that grey matter volume returned to a normal (population) baseline level within six months to a year of abstinence (from heroin, cocaine, and alcohol), and similar results have been found by others [e.g. 49]. Of even greater interest, Connolly and colleagues observed an increase in grey matter volume *beyond* the population baseline in participants who remained abstinent for a year or more. These findings jibe with the idea that synaptic loss and synaptic growth in these regions cor- respond with variations in experience, not disease. Re- current episodes of automatic responding reduce synap- tic activity in the PFC, but new modes of experiencing the world and new means for regulating one's emotions and behaviors can just as easily build new synaptic connections in the same (or nearby) regions.

From subjective reports we know that most addicts never feel that they have lost all control over their impulses. Rather, most addicts report that control has become more difficult because it is buffeted by a variety of psychological and social factors: it has become less automatic—more nuanced but less reliable [50]. And from epidemiological reports the story is clear: most addicts recover [1], and most of those recover without treatment [2–4]. This would seem impossible if regions of the PFC responsible for self-control did not remain highly plastic.

In fact, a detailed understanding of neuroplasticity is the best antidote to the disease model of addiction. Yes, the prefrontal cortex is malleable. Yes, it can undergo major changes in synaptic organization in response to drug taking. But it can and must undergo synaptic reorganization anyway, and it does so throughout a lifetime of learning. Spontaneous recovery from addic- tion is common, it has been studied in depth, and it certainly must embody cortical plasticity, though in a direction opposite to that highlighted by disease model advocates. Neuroplasticity (e.g., synaptogenesis) is the norm when people recover from medical problems like strokes or concussions [27, 51], but it also underpins second language learning [52] and the acquisition of new skills in adulthood. People *learn* addiction through neuroplasticity, which is how they learn everything. They maintain their addiction because they lose some of that plasticity. Then, when they recover, with or without treatment, their neuroplasticity returns. Their brains start changing again. With the onset of addiction, plasticity is devoted to new means for acquiring pleasure or relief. With recovery, plasticity is devoted to goals with far-reaching personal value and the skills necessary to attain them.

If it's Not a Disease, then What Is it?

In an earlier section, I outlined a number of processes by which brains change as people (and their habits, and their personalities) develop. The repetition of particular experiences modifies synaptic networks. This creates a feedback cycle between experience and brain change, each one shaping the other. New patterns of synaptic connections perpetuate themselves like the ruts carved by rainwater in the garden. Thus, brain changes that result from repeated learning experiences naturally settle into brain habits—which lock in mental habits. And the experiences that get repeated most often, most reliably, are those that are most compelling. In fact, *desire* is evolution's premier agent for getting us to pursue goals repeatedly. Thus, intense and/or recurrent desires will naturally change the *rate* and *depth* of learning by augmenting the feedback cycle between experience and brain change.

In this sense, I would say that addiction is an outcome of learning, but learning that has been accelerated and/or entrenched through the recurrent pursuit of highly at- tractive goals. There are many reasons why this cycle of goal pursuit, accompanied by the fadeout of alternative goals, becomes tighter and more invariant over time. Some are social and cultural, others societal and eco- nomical. The reasons I have highlighted in this article have more to do with the cascading nature of develop- mental constraints—the narrowing of possibilities into probabilities, states into traits [53]. Looked at from a biological perspective, this tendency is embodied in the reconfiguration, self-perpetuation, and consolidation of synaptic networks in structures that mediate desire, at- traction, attention, memory, and cognitive reflection and control [54, 55].

Desire is at the top of the list when it comes to emotional states that propel learning. And while this standard feature of the psychological repertoire can explain the locking in of habitual attractions, we must still ask whether there is something special about addic- tion that makes it so difficult to overcome. In fact, there seem to be at least three specific mechanisms that ac- celerate our attraction to addictive rewards and entrench addictive activities—without making it a disease.

The first is the tendency toward delay discounting, which creates a narrowed beam of attention toward imminent rewards. That is precisely the state addicts find themselves in time after time. One of dopamine's chief functions is to highlight available goals. Immedi- ate goals are available goals, and striatal networks surge with dopamine whenever those goals are cued by asso- ciated stimuli or memories. Another function of striatal dopamine is to inhibit awareness of competing goals (e.g., going out on a date, finding a movie to watch). In fact, that's how the striatum narrows the beam of atten- tion. As a result, addicts become stuck in a bleak here- and-now, nearly identical from one day to the next. It is this entrapment in the immediate that calls for treatment approaches that might help addicts stretch their sense of personal time, consistent with Ainslie's powerful con- cept of *intertemporal cooperation* [56]. Movement in this direction can be facilitated by some form of interpersonal scaffolding (e.g., targeted dialogue in group or individual therapy) intended to hold this coop- eration in place—until the addict can recreate it at will. The second mechanism is the motivational *amplifica- tion* caused by addictive rewards. We know that synaptic patterns get reinforced with each repetition of the same kind of experience, whether it's playing the piano, baking bread, or smoking crack. And we know that repetition boosted by strong motivation is the most effective driver of synaptic shaping. (Actually, strong motivation deter- mines not only the frequency of repetition across occasions but also the resilience or purity of attention within occa- sions.) Then imagine the impact of a longed-for reward that only lasts a few hours, or maybe just a few minutes. Drugs wear off, drinking sedates, the money's spent, or sexual pyrotechnics become boring. Addictive rewards whet the appetite and leave frustration, loss, and often depression in their wake. Moreover,

because they are universally perceived as selfish and indulgent, they unleash great gouts of shame [50]. Because shame is such a painful emotion, it exacerbates the need for resolution, regulation, or escape.

In a nutshell, addictive rewards pack a double wham- my. Desire flares again after only a few hours, a day at most, and brings with it a host of other compelling emotions. Physiological consequences, including with- drawal symptoms with certain drugs, make it a triple whammy. The cycle of acquisition and loss then recurs with increasing frequency, the same neural passages get dredged again and again, and the trajectory of learning is progressively reinforced.

The third mechanism that enhances addictive learn- ing is the fusion between personality development and the consolidation of addictive habits. Not only desire but also negative emotions, like anxiety and shame, fuel synaptic configurations that strengthen themselves over development, as in the crystallization of depressive or anxious personality traits. The addictive habit thus con- verges with other habits consolidating within one's per- sonality, such that addiction complements or reinforces preexisting tendencies. Synaptic networks are not only self-reinforcing but also mutually reinforcing, in a brain that likes to conserve structure and resources, as do all living things. The mechanics of this process involve multiple brain regions, interlaced to form a web that holds the addiction in place—as part of one's personality structure. Thus, intense emotions, fo- cused attention, and cognitive habits harness one another, and together they gouge deep ruts in the neural underpinnings of the self.

So, what exactly is addiction? It's a habit that grows and self-perpetuates relatively quickly, when we repeat- edly pursue the same highly attractive goal. Or, in a phrase, *motivated repetition that gives rise to deep learning.* Addictive patterns grow more quickly and become more deeply entrenched than other, less com- pelling habits, because of the intensity of the attraction that motivates us to repeat them, especially when they leave us gasping for more. Often, emotional turmoil during childhood or adolescence initiates patterns of personality development that anchor the search for ad- dictive rewards, serving as sources of relief and comfort. But there are other points of entry too, based on various intersections of dispositional and environmental factors. However it is entered, and however it is eventually left, addiction is a condition of recurrent desire for a single goal, but also an aspect or phase of personality devel- opment that leaves enduring footprints in neural tissue.

Why can't we just Get along?

Will a developmental-learning model of addiction ever make peace with the disease model? That would provide one kind of happy ending. It would encourage proponents of the disease model and those who study the development of addiction to talk with each other, share data and ideas, and derive higher-order explanations. Yet I don't think this is in the cards. Not because the disease model is so far off base scientifically. Some of the brain changes observed in addiction may be sufficiently ominous to exemplify both pathology and learning, as is the case in autism and schizo- phrenia. In fact, defining a category at the intersection of pathology and development is the stated goal of the burgeoning field of Bdevelopmental psychopathology^ [57]. As with depression and anxiety disorders, the delin- eation between learning and pathology is not a line but a zone.

Yet the baggage accompanying the disease model may preclude a happy marriage. Society's understanding of addiction can be seen as advancing through three broad stages (a somewhat similar model has recently been pro- posed [58]). First, beginning in the Victorian era, addicts were considered morally flawed and indulgent, sinners by choice or by happenstance. The appropriate response to addiction was to punish the addict through scorn, isolation, disenfranchisement, or incarceration. The proper resolution to the problem of addiction was to shame and punish the

addict who might, with luck, go back to being good. This set of beliefs and attitudes was gradually overwritten by the disease model of addiction in the middle of the twentieth century. This change was driven by the emphasis on helplessness in Alcoholics Anonymous, beginning in the 30s, and the evolution of residential treatment centers that stressed obedience to therapeutic regimes, beginning in the 50s. Finally, the proliferation of neuroscience in the 80s and 90s sealed the deal by specifying the substrate of the disease, namely the brain. Now specific neural changes could be pinpointed as the source of addiction, and the disease model reached its zenith.

According to the disease model, the appropriate so- lution to addiction is to be found in the realm of medi- cine. Specifically, addicts should be urged (convinced or compelled) to follow the advice handed down by med- ical practitioners. As emphasized by Nora Volkow in dozens of policy statements, the solution to addiction isn't shame. Rather than confess to being immoral, addicts are advised to confess to being incapable. The only hope to control addiction is to accept a regime imposed from outside, from the halls of medical author- ity, in order to subdue a problem located on the inside, in the mind itself (an approach to the treatment of mental disorders that has governed psychiatry throughout its history—with some unfortunate consequences). It is this baggage that seems destined to clash with the ethos of a third, more progressive view of addiction.

What I see as the third stage in our understanding of addiction is not restricted to reinterpreting the role of choice [58], though that's part of the package. Rather, it's a developmental model of the kind outlined in this article, highlighting a learning trajectory that consoli- dates in habitual patterns of thinking and feeling. This view of addiction admits the potency of social factors, like isolation and dislocation [59]. It makes sense of the impact of adversity in early development, as demon- strated by large epidemiological studies from the 80s to the present. It is consistent with a far more nuanced view of addiction, embodying personal, philosophical, and societal factors, as elaborated in a recent special issue of *Frontiers in Psychiatry* [60]. And finally, it builds on our advancing knowledge of the neurobiology of indi- vidual differences in development [57, 61].

According to a developmental-learning conceptualization, the appropriate response to addiction is neither shame and isolation nor submission to a therapeutic regime. Rather, it is further growth. The cure for addiction can't be a medical regime that returns the addict to some previous level of stability or homeostasis. Rather, growth beyond addiction exemplifies develop- mental progress, powered by one's own efforts. In this light, addiction can be viewed as a stage of individual development, and it must therefore be addressed through individual strivings based on individual per- spectives, goals, and capacities. A developmental- learning model of addiction suggests that positive change must be conceived and pursued from within.

The final two stages in our understanding of addic- tion, the disease model and the developmental-learning model, achieve some of their plausibility on the basis of brain research. But the role of neuroscience in these two stages of conceptualization could not be more different. Neuroscience helped shore up the disease model by identifying deviations from what is considered standard neural architecture. Although it's never been made clear exactly how this standard could be determined, we could say that the project of the brain disease model draws on the principle of Bneuronormativity.^ In con- trast, the developmental-learning model embodies our advancing conception of *neuroplasticity.* A project fo- cused on neuroplasticity replaces the search for norms with an emphasis on the brain's capacity to change, and it confirms our intuition that there are many different ways to move forward [10, 14].

Thus, both models borrow something from neurosci- ence—a detailed breakdown of the biological

landscape underlying addiction. But they are fundamentally differ- ent in their perception of that landscape. The brain is either a normative thing that can go wrong and then be repaired, or it is an open system that can develop in a multitude of directions, integrating the meaning of ex- perience according to its own proclivities. No doubt this process of integration can be greatly facilitated by the cognitive scaffolding and emotional support provided by other people. Yet, neither the spirit nor the specifics of change can be dictated, either by professional author- ities or by society in general. Since addiction is viewed as a phase of individual development, so is the pathway most of us find for moving beyond addiction.

CHAPTER 11.

THE NEUROBIOLOGY OF SUBSTANCE USE, MISUSE, AND ADDICTION

CITATION

U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016. https://www.ncbi.nlm.nih.gov/books/NBK424849/

CHAPTER 12.

THE BEST EXPLANATION OF ADDICTION I'VE EVER HEARD

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://cod.pressbooks.pub/addictionscounseling/?p=270#oembed-1

CHAPTER 13.

DISEASES ASSOCIATED WITH STIGMA: A REVIEW

CITATION

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CHAPTER 14.

CHANGING THE STIGMA OF MENTAL HEALTH AND ADDICTION

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CHAPTER 15.

CASE MANAGEMENT

The following information appears in the Substance Abuse and Mental Health Service Administration's Treatment Improvement Protocol (TIP) Series.

Center for Substance Abuse Treatment. (2015). *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series, Number 27. HHS Publication No. (SMA) 08-4215. Rockville, MD: Substance Abuse and Mental Health Services Administration.

SUBSTANCE ABUSE AND CASE MANAGEMENT: AN INTRODUCTION

The term *case management* has appeared in social services literature more than 600 times in the last 30 years, referring to everything from the routing of court dockets through the judicial system to the medical management of a hospitalized patient's care. This TIP uses the term to refer to interventions designed to help substance abusers access needed social services.

Support for the use of case management in this setting developed from both clinical practice and empirical observation suggesting that substance abusers who seek treatment have significant problems in addition to using psychoactive substances. Alcohol or other drug use often damages many aspects of an individual's life, including housing, employment, and relationships (Oppenheimer et al., 1988; Westermeyer, 1989). Clients in substance abuse treatment programs, particularly publicly funded treatment programs, present a variety of associated problems. Many use multiple substances and may be poly-addicted. Many suffer from related health disorders, either caused by their substance abuse—such as liver disease and organic brain disorders—or exacerbated by neglect of health and lack of preventive health care. In addition, some diseases—including HIV/AIDS, tuberculosis, and some strains of hepatitis—are transmitted by substance abuse, either directly or indirectly.

Substance abusers also have a higher incidence of mental health disorders than the general population. Up to 70 percent of individuals treated for substance abuse have a lifetime history of depression (Mirin et al., 1988). Between 23 and 56 percent of individuals with diagnosable Axis I mental disorders also have a substance abuse or dependence disorder (Regier et al., 1990).

Substance abuse clients often arrive in treatment programs with numerous social problems as well. Many are unemployed or under-employed, lacking job skills or work experience. Many in publicly funded treatment programs do not have a high school diploma. Some are homeless, and those who have been incarcerated may face significant barriers in accessing safe and affordable housing. Many substance abuse clients have alienated their families and friends or have peer affiliations only with other substance abusers. Women in treatment have often been victims of domestic violence, including sexual abuse; some women in treatment may be living with an abuser. Achieving and maintaining abstinence and recovery nearly always requires forming new, healthy peer associations.

A significant number of clients in treatment are also under some form of control

by the criminal justice system. Criminal justice substance abuse clients represent more than half of all clients in treatment in many state and local jurisdictions. Although those afflicted by chemical addiction are found among all socioeconomic groups, persons already plagued by poverty, disease, and unemployment are over-represented (CSAT, 1994). Particularly in publicly funded treatment programs, substance abuse clients have limited resources and may lack health insurance. Many are eligible for publicly supported health and social benefits, including Medicare, food stamps, or welfare.

Data suggest that substance abusers who receive professional attention for these additional problems will see improvements in occupational and family functioning and a lessening of psychiatric symptoms (McLellan et al., 1993; McLellan et al., 1982; Moos et al., 1990; Siegal et al., 1995). Clinicians who develop a "helping alliance" with substance abusers have been shown to produce better treatment outcomes than those who do not (Luborsky et al., 1985).

WHY CASE MANAGEMENT

Because addiction affects so many facets of the addicted person's life, a comprehensive continuum of services promotes recovery and enables the substance abuse client to fully integrate into society as a healthy, substance-free individual. The continuum must be designed to provide engagement and motivation, primary treatment services at the appropriate intensity and level, and support services that will enable the individual to maintain long-term sobriety while managing life in the community.

Treatment must be structured to ensure smooth transitions to the next level of care, avoid gaps in service, and respond rapidly to the threat of relapse. Case management can help accomplish all of the above.

Case management is needed because, in most jurisdictions, services are fragmented and inadequate to meet the needs of the substance-abusing population. This lack of coordinated services results from a variety of factors, including:

- Different funding streams. Substance abuse treatment is funded from a variety of sources—block grants, competitive grants, state and local funding, criminal justice funding, and others. The different requirements or goals of these sources can result in a piecemeal approach to programming
- A focus on program funding rather than system funding
- Funding focused on single modalities rather than a continuum of care
- Inadequate funding created by missing pieces in the continuum
- Waiting lists caused by inadequate funding
- Barriers between systems (e.g., mental health vs. substance abuse, criminal justice vs. mental health and substance abuse)
- Lack of incentives geared to client outcome; programs rewarded for process measures, not outcome measures
- Eligibility/admission criteria that exclude certain clients
- Lack of agreement on priority for admission/treatment

- Lack of incentives for programs to work together

Due to the fragmentation of services, the accompanying inefficiency, and a growing scarcity of resources, some form of case management is used with virtually every population that routinely seeks social services. The variability in social services system configurations has led to many different implementations of case management, resulting in conceptual disagreements about case management and difficulty in assessing its value. Inevitably, many of the same issues will arise in the substance abuse setting. This TIP is designed to establish a common starting point for case management work with substance abusers. To address at least some of those conceptual disagreements, the TIP makes several assumptions, including:

1. Case management is a set of social service *functions* that helps clients access the resources they need to recover from a substance abuse problem. The functions that comprise case management—assessment, planning, linkage, monitoring, and advocacy—must always be adapted to fit the particular needs of a treatment or agency setting. The resources an individual seeks may be external in nature (e.g., housing and education) or internal (e.g., identifying and developing skills).
2. Advocacy is one of case management's hallmarks. While a professional conducting therapy may speak out on behalf of a client, case management is dedicated to making services fit clients, rather than making clients fit services.
3. Case management may be implemented by an individual dedicated solely to helping the client access needed resources¾a case manager¾or by a professional who has this responsibility along with therapeutic or counseling functions. This TIP stresses the *intervention* rather than the intervener's *profession.*
4. The primary difference between case management and therapy is that the former stresses resource acquisition, while the latter focuses on facilitating intra- and interpersonal change. However, case management and therapy are not incompatible. Indeed, both are generally called for in addressing the needs of a majority of substance abuse clients.
5. When implemented to its fullest, case management challenges the addiction treatment continuum of pretreatment, primary treatment, and aftercare (discussed further in Chapter 2). This occurs because of the advocacy function of case management; the need for case managers to be flexible, community-based, and community-oriented; and the need for case managers to be the primary figures in planning work with the client.

These assumptions are all affected by the setting in which case management is practiced. Practitioners who work with substance abusers do so in methadone maintenance clinics, hospital- and community-based addiction programs, local social service departments, family preservation programs, and storefront community outreach programs. These physical settings are in turn influenced by numerous other factors, including the source(s) of an agency's funding; the agency's mission; staff orientation, education, and training; the agency's treatment philosophy; and the makeup of other social services in a particular geographical area.

Complicating the implementation of case management with substance abusers are three trends that will alter the current manner in which substance abuse treatment and case management are implemented: Managed care, treatment provided in the criminal justice system, and diminishing social services and resources. Managed care uses case management to *restrict* access to services as well as to *facilitate* access to services. In addition to the issue of cost containment, the movement of a

great deal of substance abuse treatment (and thereby case management) into criminal justice venues is significant. The potential conflicts between coerced involvement in treatment and case management will test the limits of advocacy and client-driven aspects of the intervention.

Finally, unlike the early period of case management, clients and professionals practicing case management now negotiate a drastically *constricted* menu of services. Each of these contemporary conditions makes implementation and evaluation an increasingly difficult task.

CASE MANAGEMENT – A BRIEF HISTORY

In the early 1900s, when Mary Richmond envisioned a cadre of "friendly neighbors" helping others in their struggles with real world needs (Richmond, 1922), she created not only the field of social work, but case management as well. While she applied the term *social casework* to the activities that affected the adjustment between an individual and the social environment, she could well have been describing the key functions that now comprise case management.

One of the first legislative embodiments of case management occurred in the 1963 Federal Community Mental Health Center Act (Intagliata, 1982) in anticipation of deinstitutionalization, in which persons in long term psychiatric care were moved into community settings. The expectation that these individuals would need services previously provided in the institution led to the rapid expansion of community-based social services. Unfortunately, these services were often created independently of one another and, coupled with the categorical nature of the eligibility for services, led to difficulties for persons used to having these services provided in institutions.

The Community Support System developed by the National Institutes of Mental Health in 1977 envisioned case management as a mechanism for helping clients navigate this fragmented social service system. Accessing these resources would thus enable them to live and function adequately in their communities (Intagliata, 1982; Stein and Test, 1980; Test, 1981; Turner and TenHoor, 1978).

Substance abusers historically were never institutionalized as often as were persons with chronic mental illness and so were not directly impacted by deinstitutionalization legislation. Substance abusers were not generally targeted for the development of categorical systems of service delivery and were not generally recipients of case management services.

However, case management-like services were provided to substance abusers under other titles, such as "mission work," and frequently delivered by the clergy or others in skid row missions, detoxification centers, and ad hoc halfway houses. Jails and county work farms were generally the institutions of choice in dealing with this population. Only after substance abuse began to be decriminalized and defined as a disease were substance abusers referred to various social services.

Policymakers in Canada were among the first to translate many generic case management functions into the field of substance abuse treatment, outlining the essential elements of a union of case management and substance abuse treatment (Graham and Birchmore-Timney, 1990; Ogborne and Rush, 1983; Rush and Ekdahl, 1990). Case management for substance abusers initially gained attention in the United States through the Treatment Alternatives for Safe Communities (TASC) program (formerly known as Treatment Alternatives to Street Crime), which began linking the criminal justice system with the drug abuse treatment system in 1972 and has grown to over 185 programs (Cook, 1992) today.

A 1987 National Institute of Mental Health initiative funded 13 demonstration projects targeted at young adults with coexisting mental health and substance use problems. Of these 13 projects, 10

identified some form of case management as a primary service and provided a general description of the case management intervention (Teague et al., 1990). Initiatives undertaken by both the National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA) resulted in numerous projects that used case management to enhance treatment (Bonham et al., 1990; Conrad et al., 1993; Cox et al., 1993; Inciardi et al., 1993; Fletcher et al., 1994; Mejta et al., 1994). Case management in these projects was designed to increase retention in the treatment continuum and to improve treatment outcomes.

DEFINITIONS AND FUNCTIONS

Any definition of case management today is inevitably contextual, based on the needs of a particular organizational structure, environmental reality, and prior training of the individuals who are implementing it, whether they are social workers, nurses, or case management specialists. Nonetheless, there is relatively widespread agreement on the basic definition, as shown below:

Case management is…

- "planning and coordinating a package of health and social services that is individualized to meet a particular client's needs" (Moore, 1990, p. 444)
- "a process or method for ensuring that consumers are provided with whatever services they need in a coordinated, effective, and efficient manner" (Intagliata, 1981)
- "helping people whose lives are unsatisfying or unproductive due to the presence of many problems which require assistance from several helpers at once" (Ballew and Mink, 1996, p. 3)
- "monitoring, tracking and providing support to a client, throughout the course of his/her treatment and after" (Ogborne and Rush, 1983, p. 136)
- "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 et al., 1992, p. 83)
- "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)

While definitions are useful in guiding general discussions, *functions* are a more helpful way to approach case management as it is actually practiced. As with definitions, there is a high degree of consensus about a core group of functions. One widely accepted set of functions comprises (1) assessment, (2) planning, (3) linkage, (4) monitoring, and (5) advocacy (Joint Commission on Accreditation of Healthcare Organizations, 1979). The National Association of Social Workers' standards for social work case management include assessing, arranging, coordinating, monitoring, evaluating, and advocacy (National Association of Social Workers, 1992).

There is also general agreement about case management functions in the

specific context of substance abuse treatment. Case management is one of eight counseling skills identified by the National Association of Alcoholism and Drug Abuse Counselors (National Association of Alcoholism and Drug Abuse Counselors, 1986) and one of five performance domains developed in the Role Delineation Study (International Certification and Reciprocity Consortium, 1993).

Another framework is supplied by the Addiction Technology Transfer Centers (ATTCs), established by CSAT to transmit current information on treatment to providers in the field. The essential elements of case management are laid out in their publication *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (CSAT, 1998). That document has been endorsed by many leading addiction organizations.

Referral and service coordination are two of eight practice dimensions the ATTCs deem essential to the effective practice of addiction counseling. Activities considered part of those two dimensions include engagement; assessment; planning, goal-setting, and implementation; linking, monitoring, and advocacy; and disengagement. The document defines service coordination as:

"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. Service coordination, which includes case management and client advocacy, establishes a framework of action for the client to achieve specified goals. It involves collaboration with the client and significant others, coordination of treatment and referral services, liaison activities with community resources and managed care systems, client advocacy, and ongoing evaluation of treatment progress and client needs" (CSAT, 1998, p. 53).

MODELS OF CASE MANAGEMENT WITH SUBSTANCE ABUSERS

Case management models, like the definitions of case management, vary with the context. Some models focus on delivering social services, others on coordinating the delivery of services by other providers. Some provide both. The models result as much from the needs of specific client populations and service settings as they do from distinct theoretical differences about what case management should be. Four models from the mental illness field have been adapted for the field of substance abuse treatment. Each of these models—broker/generalist, strengths-based, assertive community treatment, and clinical/rehabilitation—has proved valuable in treating substance abusers in a particular setting.

For example, the strengths-based approach was adapted to work with crack cocaine users. This approach was chosen not only for its focus on resource acquisition but also because it helps clients see their own assets as a valuable part of recovery (Siegal and Rapp, 1996). Assertive community treatment was implemented to provide parolees a wide range of integrated services, including drug treatment, skills building, and resource acquisition. Implementation of these case management models may vary among populations and from setting to setting.

Brokerage/Generalist

Brokerage/generalist models seek to identify clients' needs and help clients access identified

resources. Planning may be limited to the client's early contacts with the case manager rather than an intensive long-term relationship. Ongoing monitoring, if provided at all, is relatively brief and does not include active advocacy.

Brokerage/generalist models are sometimes disparaged in discussions of case management because of the limited nature of the client–case manager relationship and the absence of advocacy. Nonetheless, this approach shares the basic foundations of case management and has proved useful in selected situations. The relatively limited nature of the relationship in this model allows the case manager to provide services to more clients. This approach is also appropriate in instances where treatment and social services in a particular area are relatively integrated and the need for monitoring and advocacy is minimal. The model works best with clients who are not economically deprived, who have significant intent and sufficient resources, or who are not in late-stage addiction. Small agencies or agencies that offer narrowly defined services may be in an ideal position to offer brokerage-only services.

Two creative uses of a brokerage model involved clients who were infected with the human immunodeficiency virus (HIV) or who were at significant risk of acquiring HIV. In one program, case managers also served as educators, delivering cognitive, behaviorally oriented, educational sessions focusing on substance abuse and high-risk behaviors (Falck et al., 1992). The mixing of the educator and case manager roles was intended to increase clients' receptivity to HIV prevention messages by reducing barriers to services that would address problems that might divert attention from those messages. In another variation of the brokerage model, case managers in a large

metropolitan area conducted extensive assessments with HIV-infected clients, generally making at least two referrals during the initial session. This "quick response" approach was intended to provide immediate results to clients and to link them with agencies or services that would provide ongoing services (Lidz et al., 1992).

Generalist approaches to working with substance-abusing clients have taken several forms. Case managers in the central intake facility of a large metropolitan area performed the core functions of case management, linking clients with area substance abuse treatment and other human service providers. These case managers had access to funds for purchasing treatment services, thereby drastically reducing waiting periods for these services (Bokos et al., 1993). Another example of a generalist model is Providence, Rhode Island's Project Connect, a family-centered, community-based intervention program designed to address the problems of substance abuse among high-risk families in the child welfare system. Staff members provide intensive home-based counseling services and work with families to obtain other services they may need, including safe and affordable housing and adequate health care.

Assertive Community Treatment

The Program of Assertive Community Treatment (PACT) model, originally developed in Wisconsin (Stein and Test, 1980), emphasizes the following components

- Making contact with clients in their homes and natural settings
- Focusing on the practical problems of daily living
- Assertive advocacy
- Manageable caseload sizes

- Frequent contact between a case manager and client
- Team approach with shared caseloads
- Long-term commitment to clients

Willenbring and his colleagues were among the first to adapt a mental health model for persons with substance abuse problems, specifically chronic public inebriates (Willenbring et al., 1990). Following the tenets of PACT, an individual case manager was closely supported by a core services team that together carried the responsibility for providing services. The model deviated from the usual approach to dealing with substance abuse clients in two ways. First, instead of expecting clients to come to services when they "hit bottom," case managers sought out clients through a process known as "enforced contact." Second, case managers and the services team acknowledged the chronic nature of the client's condition and sought to modify the course of the condition and to alleviate suffering. The clients were not required to pledge a goal of abstinence.

A derivation of PACT, the Assertive Community Treatment (ACT) model, was used with parolees who had histories of injecting drugs (Martin and Scarpitti, 1993). In this implementation, case managers provided direct counseling services and worked with clients to develop the skills necessary to function successfully in the community. Case management staff also provided family consultations and crisis intervention services and functioned as group facilitators to provide skills training in areas such as work skills, relapse prevention, and education about HIV/AIDS. Departing from the mental health tenets of the PACT model, ACT had time limits and success goals rather than the continuous care envisioned for the mentally ill.

Achievement of protracted periods of abstinence and graduation from treatment continuum components were expected of clients (Martin and Scarpitti, 1993). Assertive Community Treatment has been implemented alone and in conjunction with a therapeutic community (Martin et al., 1993).

Strengths-Based Perspective

The strengths-based perspective of case management was originally developed at the University of Kansas School of Social Welfare to help a population of persons with persistent mental illness make the transition from institutionalized care to independent living (Rapp and Chamberlain, 1985). The foremost two principles on which the model rests are (1) providing clients support for asserting direct control over their search for resources, such as housing and employment, and (2) examining clients' own strengths and assets as the vehicle for resource acquisition. To help clients take control and find their strengths, this model of case management encourages use of informal helping networks (as opposed to institutional networks); promotes the primacy of the client-case manager relationship; and provides an active, aggressive form of outreach to clients.

A strengths perspective of case management has been selected for work with substance abusers for three reasons. First is case management's usefulness in helping them access the resources they need to support recovery. Second, the strong advocacy component that characterizes the strengths approach counters the widespread belief that substance abusers are in denial or morally deficient—perhaps

unworthy of needed services (Bander et al., 1987; Ross and Darke, 1992). Last, the emphasis on helping clients identify their strengths, assets, and abilities supplements treatment models that focus on pathology and disease. Strengths-based case management has been implemented with both female (Brindis and Theidon, 1997) and male substance abusers (Rapp, 1997; Siegal et al., 1995).

Because of the advocacy component and client-driven goal planning, a strengths-based approach can at times cause stress between a case manager and other members of the treatment team (Rapp et al., 1994). Despite this, there is evidence that the approach can be integrated with the disease model of treatment and that its presence leads to improved outcomes for clients. The improved outcomes include employability, retention in treatment, and (through retention in treatment) reduced drug use (Rapp et al., in press; Siegal et al., 1996; Siegal et al., 1997).

Clinical/Rehabilitation

Clinical/rehabilitation approaches to case management are those in which clinical (therapy) and resource acquisition (case management) activities are joined together and addressed by the case manager. It has been suggested that the separation of these two activities is not feasible over an extended period of time and that the case manager must be trained to respond to client-focused, as opposed to solely environmental issues (Kanter, 1996).

Client-focused services could include providing psychotherapy to clients, teaching specific skills, and family therapy. Beyond the usual repertoire of case management functions (e.g., monitoring), the case manager should be aware of numerous issues including transference, countertransference, how clients internalize what they observe, and theories of ego functioning (Harris and Bergman, 1987; Kanter, 1996).

Many substance abuse treatment programs use a clinical model in which the same treatment professional provides, or at least coordinates, both therapy and case management activities. Such an approach is frequently driven by staffing considerations: It is more economical to have one treatment professional provide all services than to have separate clinical and case managers deliver them.

One example of combining clinical and case management activities is found in a program for women who have substance abuse problems (Markoff and Cawley, 1996). In Project Second Beginning, an emphasis on relationships and empowerment is used both to secure needed resources and to guide implementation of therapy activities. This approach is based on the belief that women have special needs in the treatment setting—needs that can most appropriately be addressed through a therapeutic relationship with a single caregiver. The clinical/rehabilitation approach has been widely used in the treatment of persons with diagnoses of both substance abuse and psychiatric problems (Anthony and Farkas, 1982; Drake et al., 1993; Drake and Noordsey, 1994; Lehman et al., 1993; Shilony et al., 1993).

APPLYING CASE MANAGEMENT TO SUBSTANCE ABUSE TREATMENT

Case management is almost infinitely adaptable, but several broad principles are true of almost every application. This chapter will discuss those principles, the competencies necessary to implement case management functions, and the relationship between those functions and the substance abuse

treatment continuum. For the purposes of discussion, case management and substance abuse treatment are presented as separate and distinct aspects of the treatment continuum, although in reality they are complementary and at times thoroughly blended.

CASE MANAGEMENT PRINCIPLES

Case management offers the client a single point of contact with the health and social services systems. The strongest rationale for case management may be that it consolidates to a single point responsibility for clients who receive services from multiple agencies. Case management replaces a haphazard process of referrals with a single, well-structured service. In doing so, it offers the client continuity. As the single point of contact, case managers have obligations not only to their clients but also to the members of the systems with whom they interact. Case managers must familiarize themselves with protocols and operating procedures observed by these other

professionals. The case manager must mobilize needed resources, which requires the ability to negotiate formal systems, to barter informally among service providers, and to consistently pursue informal networks. These include self-help groups and their members, halfway and three-quarter-way houses, neighbors, and numerous other resources that are sometimes not identified in formal service directories.

Case management is client-driven and driven by client need. Throughout models of case management, in the substance abuse field and elsewhere, there is an overriding belief that clients must take the lead in identifying needed resources. The case manager uses her expertise to identify options for the client, but the client's right of self-determination is emphasized. Once the client chooses from the options identified, the case manager's expertise comes into play again in helping the client access the chosen services. Case management is grounded in an understanding of clients' experiences and the world they inhabit¾the nature of addiction and the problems it causes, and other problems with which clients struggle (such as HIV infection, mental illness, or incarceration). This understanding forms the context for the case manager's work, which focuses on identifying psychosocial issues and anticipating and helping the client obtain resources. The aim of case management is to provide the least restrictive level of care necessary so that the client's life is disrupted as little as possible.

Case management involves advocacy. The paramount goal when dealing with substance abuse clients and diverse services with frequently contradictory requirements is the need to promote the client's best interests. Case managers need to advocate with many systems, including agencies, families, legal systems, and legislative bodies. The case manager can advocate by educating non-treatment service providers about substance abuse problems in general and about the specific needs of a given client. At times the case manager must negotiate an agency's rules in order to gain access or continued involvement on behalf of a client. Advocacy can be vigorous, such as when a case manager must force an agency to serve its clients as required by law or contract. For criminal justice clients, advocacy may entail the recommendation of sanctions to encourage client compliance and motivation.

Case management is community-based. All case management approaches can be considered community-based because they help the client negotiate with community agencies and seek to integrate formalized services with informal care resources such as family, friends, self-help groups, and church. However, the degree of direct community involvement by the case manager varies with

the agency. Some agencies mount aggressive community outreach efforts. In such programs, case managers accompany clients as they take buses or wait in lines to register for entitlements. This personal involvement validates clients' experiences in a way that other approaches cannot. It suits the subculture of addiction because it enables the case manager to understand the client's world better, to learn what streets are safe and where drug dealing takes place. This familiarity helps the professional appreciate the realities that clients face and set more appropriate treatment goals—and helps the client trust and respect the

case manager. Because it often transcends facility boundaries, and because the case manager is more involved in the community and the client's life, case management may be more successful in re-engaging the client in treatment and the community than agency-based efforts. For clients who are institutionalized, case management involves preparing the client for community-based treatment and living in the community. Case management can ensure that transitions are smooth and that obstacles to timely admissions into community-based programs are removed. Case management can also coordinate release dates to ensure that there are no gaps in service. The type of relationship described here is likely at times to stretch the more narrow boundaries of the traditional therapist-client relationship.

Case management is pragmatic. Case management begins "where the client is," by responding to such tangible needs as food, shelter, clothing, transportation, or child care. Entering treatment may not be a client priority; finding shelter, however, may be. Meeting these goals helps the case manager develop a relationship with and effectively engage the client. This client-centered perspective is maintained as the client moves through treatment. At the same time, however, the case manager must keep in mind the difficulty in achieving a balance between help that is positive and help that may impede treatment engagement. For example, the loss of housing may provide the impetus for residential treatment. Teaching clients the day-to-day skills necessary to live successfully and substance free in the community is an important part of case management. These pragmatic skills may be taught explicitly, or simply modeled during interactions between case manager and client.

Case management is anticipatory. Case management requires an ability to understand the natural course of addiction and recovery, to foresee a problem, to understand the options available to manage it, and to take appropriate action. In some instances, the case manager may intervene directly; in others, the case manager will take action to ensure that another person on the care team intervenes as needed. The case manager, working with the treatment team, lays the foundation for the next phase of treatment.

Case management must be flexible. Case management with substance abusers must be adaptable to variations occasioned by a wide range of factors, including co-occurring problems such as AIDS or mental health issues, agency structure, availability or lack of particular resources, degree of autonomy and power granted to the case manager, and many others. The need for flexibility is largely responsible for the numerous models of case management and difficulties in evaluating interventions.

Case management is culturally sensitive. Accommodation for diversity, race, gender, ethnicity, disability, sexual orientation, and life stage (for example, adolescence or old age), should be built into the case management process. Five elements are associated with becoming culturally competent: (1) valuing diversity, (2) making a cultural self-assessment, (3) understanding the dynamics of cultural

interaction, (4) incorporating cultural knowledge, and (5) adapting practices to the diversity present in a given setting (Cross et al., 1989).

CASE MANAGEMENT PRACTICE—KNOWLEDGE, SKILLS, AND ATTITUDES

All professionals who provide services to substance abusers, including those specializing in case management, should possess particular knowledge, skills, and attitudes, which prepare them to provide more treatment-specific services. The basic prerequisites of effective practice include the ability to establish rapport

quickly, an awareness of how to maintain appropriate boundaries in the fluid case management relationship, the willingness to be nonjudgmental toward clients, and certain "transdisciplinary foundations" created by the Addiction Technology Transfer Centers (ATTCs) (see page 6). These foundations— understanding addiction, treatment knowledge, application to practice, and professional readiness—are articulated in 23 competencies and 82 specific points of knowledge and attitude. Examples of competencies include

- Understanding a variety of models and theories of addiction and other problems related to substance use
- Ability to 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
- Recognizing the importance of family, social networks, and community systems in the treatment and recovery process
- Understanding the variety of insurance and health maintenance options available and the importance of helping clients access those benefits
- Understanding diverse cultures and incorporating the relevant needs of culturally diverse groups, as well as people with disabilities, into clinical practice
- Understanding the value of an interdisciplinary approach to addiction treatment (CSAT, 1998)

Even though case managers have not always enjoyed the same stature accorded other specialists in the substance abuse treatment continuum, they must possess an equally extensive body of knowledge and master a complex array of skills in order to provide optimal services to their clients. Case managers must not only have many of the same abilities as other professionals who work with substance abusers (such as counselors), they must also possess special abilities relating to such areas as interagency functioning, negotiating, and advocacy. In recognition of the specific competencies applicable to conducting case management functions, two of the eight core dimensions—referral and service coordination— provide critical knowledge, skills, and attitudes pertinent to case management. Below are the activities covered under those dimensions.

Referral

- Establish and maintain relations with civic groups, agencies, other professionals, governmental entities, and the community at large to ensure appropriate referrals, identify service gaps, expand community resources, and help to address unmet needs
- Continuously assess and evaluate referral resources to determine their appropriateness
- Differentiate between situations in which it is more appropriate for the client to self-refer to a resource and those in which counselor referral is required
- Arrange referrals to other professionals, agencies, community programs, or other appropriate resources to meet client needs
- Explain in clear and specific language the necessity for and process of referral to increase the likelihood of client understanding and follow-through
- Exchange relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality regulations and professional standards of care
- Evaluate the outcome of the referral

Service Coordination

Implement the treatment plan

- Initiate collaboration with referral source
- Obtain, review, and interpret all relevant screening, assessment, and initial treatment-planning information
- Confirm the client's eligibility for admission and continued readiness for treatment and change
- Complete necessary administrative procedures for admission to treatment
- Establish realistic treatment and recovery expectations with the client and involved significant others including, but not limited to
    - Nature of services
    - Program goals
    - Program procedures
    - Rules regarding client conduct
    - Schedule of treatment activities
    - Costs of treatment
    - Factors affecting duration of care
    - Client rights and responsibilities
- Coordinate all treatment activities with services provided to the client by other resources

Consulting

- Summarize the client's personal and cultural background, treatment plan, recovery progress, and problems inhibiting progress for purpose of ensuring quality of care, gaining feedback, and planning changes in the course of treatment
- Understand terminology, procedures, and roles of other disciplines related to the treatment of substance use disorders
- Contribute as part of a multidisciplinary treatment team
- Apply confidentiality regulations appropriately
- Demonstrate respect and nonjudgmental attitudes toward clients in all contacts with community professionals and agencies (CSAT, 1998)

Almost 200 specific knowledge items, skills, and attitudes are associated with these dimensions: They can be found in Appendix B.

THE SUBSTANCE ABUSE TREATMENT CONTINUUM AND FUNCTIONS OF CASE MANAGEMENT

Substance Abuse Continuum of Care

Substance abuse treatment can be characterized as a continuum arrayed along a particular measure, such as the gravity of the substance abuse problem, level of care—inpatient, residential, intermediate, or outpatient (Institute of Medicine, 1990)—or intensity of service (ASAM, 1997). The continuum in this TIP is arranged chronologically, moving from case finding and pretreatment through primary treatment, either residential or outpatient, and finally to aftercare. Inclusion of case finding and pretreatment acknowledges the wide variety of case management activities that take place before a client has actually become part of the formal treatment process.

While distinct goals and treatment activities are associated with each point on the continuum, clients' needs seldom fit neatly into any one area at a given time. For example, a client may need residential treatment for a serious substance abuse problem, but only be motivated to receive assistance for a housing problem. Case management is designed to span client needs and program structure.

Case finding and pretreatment

The case-finding aspect of treatment is generally of paramount concern to treatment programs because it generates the flow of clients into treatment. Pretreatment has changed enormously in the past five years as programs have closed, resources have dwindled, and services available under managed care plans have been severely curtailed. Many individuals identified as viable treatment candidates cannot get through the gate, and pretreatment may in fact constitute brief intervention therapy.

Treatment programs may undertake case-finding activities through formal liaisons with potential referral sources such as employers, law enforcement authorities, public welfare agencies, acute emergency medical care facilities, and managed care companies. Health maintenance organizations

and managed care companies often require case finding when hotlines are called. General media campaigns and word of mouth also lead substance abusers to contact treatment programs.

Some treatment programs operate aggressive outreach street programs to identify and engage clients. Outreach workers contact prospective clients and offer to facilitate their entry into treatment. Although treatment admission may be the foremost goal of the worker and the treatment program, prospective clients frequently have other requests before agreeing to participate. Much of the assistance offered by outreach workers resembles case management in that it is community-based, responds to an immediate client need, and is pragmatic.

A pretreatment period is frequently the result of waiting lists or client reluctance to become fully engaged in primary treatment. In a criminal justice setting, it may be a time to prepare clients who are not ready for primary treatment because they do not have support systems in place and lack homes, transportation, or necessary work and living skills. The pretreatment period may be when clients lose interest in treatment. When the appropriate services are provided, however, it may actually increase the commitment to treatment at a later time. Numerous interventions-role induction techniques, pretreatment groups, and case management-have been instituted to improve outcomes associated with the pretreatment period (Alterman et al., 1994; Gilbert, 1988; Stark and Kane, 1985; Zweben, 1981).

Primary treatment

Primary treatment is a broad term used to define the period in which substance abusers begin to examine the impact of substance use on various areas of their lives. The American Society of Addiction Medicine (ASAM) delineates five categories of primary treatment, characterized by the level of treatment intensity: early intervention, outpatient services, intensive outpatient or partial hospitalization, residential or inpatient services, and medically managed intensive inpatient services (ASAM, 1997).

Whatever the setting, an extensive biopsychosocial assessment is necessary. This assessment provides both the client and the treatment team the opportunity to determine clinical severity, client preference, coexisting diagnoses, prior treatment response, and other factors relevant to matching the client with the appropriate treatment modality and level of care. If not already established during the case finding/pretreatment phase, this assessment should also consider the client's needs for various resources that case management can help secure.

Aftercare

Aftercare, or continuing care, is the stage following discharge, when the client no longer requires services at the intensity required during primary treatment. A client is able to function using a self-directed plan, which includes minimal interaction with a counselor.

Counselor interaction takes on a monitoring function. Clients continue to reorient their behavior to the ongoing reality of a pro-social, sober lifestyle. Aftercare can occur in a variety of settings, such as periodic outpatient aftercare, relapse/recovery groups, 12-Step and self-help groups, and halfway houses. Whether individuals completed primary treatment in a residential or outpatient program, they have at least some of the skills to maintain sobriety and begin work on remediating various areas of their lives. Work is intrapersonal and interpersonal as well as environmental. Areas that relate to environmental issues, such as vocational rehabilitation, finding employment, and securing safe housing, fall within the purview of case management.

If different individuals perform case management and addictions counseling, they must

communicate constantly during aftercare about the implementation and progress of all service plans. Because case managers interact with the client in the community, they are in a unique position to see the results of work being done in aftercare groups and provide perspective about the client's functioning in the community. Recent findings suggest that the case management relationship may be as valuable to the client during this phase of recovery as that with the addictions counselor (Siegal et al., 1997; Godley et al., 1994).

Aftercare is important in completing treatment both from a funding standpoint (many funders refuse to pay for aftercare services), as well as from the client's perspective.

Case Management Functions and the Treatment Continuum

In this section, case management functions are presented against the backdrop of the substance abuse continuum of care to highlight the relationship between treatment and case management. The primary difference between the two is case management's focus on assisting the substance abuser in acquiring needed resources. Treatment focuses on activities that help substance abusers recognize the extent of their substance abuse problem, acquire the motivation and tools to stay sober, and use those tools. Case management functions mirror the stages of treatment and recovery. If properly implemented, case management supports the client as she moves through the continuum, encouraging participation, progress, retention, and positive outcomes. The implementation of the case management functions is shaped by many factors, including the client's place in the continuum and level of motivation to change, agency mission, staff training, configuration of the treatment or case management team, needs of the target population, and availability of resources. The fact that not all clients move through each phase of the treatment continuum or through a particular phase at the same pace adds to the variability inherent in case management.

Engagement

Case finding and pretreatment

Engagement during the case finding/pretreatment phase is particularly proactive. The case manager frequently needs to provide services in nontraditional ways, reaching out to the client instead of waiting for the client to seek help. Engagement is not just meeting clients and telling them that a particular resource exists. Engagement activities are intended to identify and *fulfill* the client's immediate needs, often with something as tangible as a pair of socks or a ride to the doctor.

This initial period is often difficult. Motivation may be fleeting and access to services limited. In many jurisdictions, there is a significant wait to schedule an orientation, assessment, or intake appointment. Third parties responsible for authorizing behavioral health benefits may be involved, and client persistence may be a key factor in accessing services.

Additional factors may come into play with clients referred from the criminal justice system. They may be angry about their treatment by the criminal justice system and may resent efforts to help them. Clients who begin treatment after serving time in jail or prison have significant life issues that must be addressed simultaneously (such as safe housing, money, and other subsistence issues) as well as resentment, resistance, and anger. Others may have active addictions or be engaged in criminal

activity. Requirements imposed by the criminal justice system must also be met; these can present conflicts with meeting other goals, including participation in substance abuse treatment.

Potential clients may be unfamiliar with the treatment process. Their expectations about treatment may not be realistic, and they may know very little about substance abuse and addiction. It is not uncommon for people at this stage to minimize the impact substance use or abuse has on their lives. These factors often manifest in client behaviors such as missing appointments, continued use, excuses, apathy, and an unwillingness to commit to change.

The goal of case management at this stage is to reduce barriers, both internal and external, that impede admission to treatment. Client reluctance to enter into services can be reduced by (1) motivational interviewing approaches; (2) basic education about addiction and recovery; (3) reminding clients of past and future consequences of continued substance abuse; (4) assistance in meeting the client's basic survival needs; and (5) commitment to developing the case manager-client relationship. Prescreening for program eligibility, coordinating referrals, and working to reduce any administrative barriers can facilitate access to services.

The process of motivating a client, beginning the education process, identifying essential needs, and forming a relationship can begin during a prescreening or screening interview. The motivational approaches suggested by Miller and Rollnick encourage client engagement through exploratory rather than confrontational means (Miller and Rollnick, 1991). Recognizing that not every client enters treatment with the same motivational levels, they build on Prochaska and DiClemente's stages of motivation for treatment. The stages move from the client's non-recognition of a problem (precontemplation) to contemplation of a need for treatment, to determination, to action, and finally, to the maintenance of attained goals (Prochaska and DiClemente, 1982). Case management can use this framework to engage the client with stage-appropriate services. This means that clients who have not decided to address their substance abuse can often be "hooked" into more intensive treatment by providing basic practical supports. Providing these supports can have the additional effect of reducing the perceived desirability of continued substance use and the lifestyles associated with it.

A structured interview provides the client the opportunity to discuss her drug use and history with the case manager and to explore the losses that may have resulted from that use. For some clients, this history may reveal a pattern of increasing loss of control (and perhaps loss of freedom). Review and discussion of losses can serve to motivate clients to proceed to treatment. Listening empathetically and showing genuine concern about a client's well-being can facilitate the beginning of a meaningful, supportive relationship between the client and the case manager and can serve to motivate the client as well. A good initial relationship between client and case manager can also be invaluable when the client experiences difficulties later on in treatment (Miller and Rollnick, 1991).

In addition to information regarding substance abuse and the treatment process, clients must be informed about requirements and obligations of the case manager or case management program, and about requirements they will be expected to meet once they are admitted to treatment. This type of discussion presents another opportunity to solidify the client's commitment to participate in treatment. Even at the earliest stages, clients should be reminded that permanent changes are necessary for recovery. Finally, any questions the client has should be addressed. This can be particularly important for clients referred by the criminal justice system, who may be somewhat

confused about that system's requirements, the consequences of noncompliance, and the difficulties they encounter in meeting those requirements.

While case management in the pretreatment phase may be intended to route clients to a particular program, engagement is not just a "come-on" to treatment. Many prospective clients will not formally enter treatment within an agency-defined period, but, within flexible limits, case management services should still be made available to these individuals. The transition from engagement to planning is a gradual one and does not lend itself to agency-created distinctions such as "pretreatment" and "primary treatment."

Primary treatment

For clients who elect to enter treatment, engagement serves to orient the client to the program. Orientation involves explaining program rules and regulations in greater detail than was possible or necessary during pretreatment. The provider elicits the client's expectations of the program and describes what the program expects of the client. The person responsible for delivering case management to a particular client is in a unique position to assist in the match between individual and treatment. During primary treatment, the case manager can serve as one of the client's links with the outside world, assisting the client to resolve immediate concerns that may make it difficult to focus on dealing with the goal of primary treatment— coming to grips with a substance abuse problem.

In addition to orienting clients to treatment programs, case managers can orient treatment programs to the clients they refer. Sharing information gathered during the pretreatment phase can provide support for the treatment process that ensues upon program admission.

Aftercare

While in treatment, most of a client's time is spent dealing with substance use. Although discharge plans may have been considered, it is not until discharge that the day-to-day realities of living assume the most urgency. Because of their relationship with their clients and their community ties, case managers are well-positioned to help clients make this delicate transition. Case management serves to coordinate all aspects of the client's treatment. This coordination occurs within a given treatment program, between the program and other resources, and among these other resources. The extent of the case manager's ability to work on the client's behalf will be guided both by the formal authority vested in the individual by the service providers involved and by the individual's informal relationships.

The case manager's extensive knowledge of the client's real-world needs can help the client who is no longer using. Clients in aftercare have an array of needs, including housing, a safe and drug-free home environment, a source of income, marketable skills, and a support system. Many have postponed medical or dental care; in recovery, they may seek it for the first time in years. Once an individual is in recovery, physician-prescribed medication for pain management can become a major problem, an issue that may require coordination and advocacy.

Assessment

The primary difference between treatment and case management assessments lies in case management's focus on the client's need for community resources. The findings from the assessment, including specific skill deficits, basic support needs, level of functioning, and risk status, define the scope and focus of the service plan.

Case finding and pretreatment

Depending on the structure and mission of the program providing case management, assessment may begin when engagement begins. It is case management's role to explore client needs, wants, skills, strengths, and deficits and relate those attributes to a service plan designed to address those needs efficiently. If the client is not eligible for a particular case manager's program, the case manager links the client with appropriate external treatment resources. This process includes assessing the client's eligibility and appropriateness for both substance abuse and other services and for a specific level of care within those services. If the client is both eligible and appropriate for the program, the case manager's role is to engage the client in treatment.

Primary treatment

For clients who enter primary treatment, the case management assessment function, which is primarily oriented to the acquisition of needed resources, is merged with an assessment that focuses on problems amenable to therapy¾substance use, psychological problems, and family dysfunction. Ideally both assessments are integrated into a biopsychosocial assessment (Wallace, 1990).

This biopsychosocial assessment should, at a minimum, examine the client's situation in the life domains of housing, finances, physical health, mental health, vocational/educational, social supports, family relationships, recreation, transportation, and spiritual needs. Detailed information should be gathered on drug use, drug use history, health history, current medical issues, mental health status, and family drug and alcohol use. This assessment, used in conjunction with the needs assessment, assists the treatment team in developing a formal treatment plan to be presented to, modified, and approved by the client. Whether one person or several conduct these two assessments is largely irrelevant. Where a team approach exists, all members of the team, including the case manager or other professional identified in that role, should bring their expertise to the assessment. Discharge planning and long-range needs identification, particularly with current funding limitations, begins at treatment admission. Because of this, intensive case management for substance abuse clients, regardless of the level of care, is imperative.

As the individual responsible for coordinating diverse services, the case manager must take a broad view of client needs, look beyond primary therapy to the impact of the client's addiction on broader domains, and assess the impact of these domains on the client's recovery. He also must assess specific areas of functional skill deficits, including personal living skills, social or interpersonal skills, service procurement skills, and vocational skills. Individuals performing this function need to have strong knowledge of and experience in the field of substance abuse. The greater the number of problems the case manager can help the client identify and manage during primary treatment, the fewer problems the client must address during aftercare and ongoing recovery¾and the greater the chances for treatment success.

A case management assessment should include a review of the following functional areas (Harvey et al., 1997; Bellack et al., 1997). These items are not exhaustive, but demonstrate some of the major skill and service need areas that should be explored. The assessment of these areas of functioning gives evidence of the client's degree of impairment and barriers to the client's recovery. The case manager may have to perform many services on behalf of the client until skills can be mastered.

Service procurement skills

While the focus of case management is to assist clients in accessing social services, the goal is for clients to learn how to obtain those services. The client should therefore be assessed for:

- Ability to obtain and follow through on medical services
- Ability to apply for benefits
- Ability to obtain and maintain safe housing
- Skill in using social service agencies
- Skill in accessing mental health and substance abuse treatment services

Prevocational and vocation-related skills

In order to reach the ultimate goal of independence, clients must also have vocational skills and should therefore be assessed for:

- Basic reading and writing skills
- Skills in following instructions
- Transportation skills
- Manner of dealing with supervisors
- Timeliness, punctuality
- Telephone skills

The case management assessment should include a scan for indications of harm to self or others. The greater the deficits in social and interpersonal skills, the greater the likelihood of harm is to self and/or others, as well as endangerment from others. The case manager should also conduct an examination of criminal records. If the client is under the supervision of the criminal justice system, supervision officers should be contacted to determine whether or not there is a potential for violent behavior, and to elicit support should a crisis erupt.

Aftercare

The client's readiness to reintegrate into the community is a focus of case management assessment throughout the treatment continuum. Because the case manager is often out in the community with the client, she is in an excellent position to evaluate this important indicator. During aftercare, her assessment may reveal new, recurring, or unresolved problems the client must deal with before they interfere with recovery. The potential for relapse is a particularly significant challenge, and the client must be able to identify personal relapse triggers and learn how to cope with them. Because case managers are familiar with the community, clients, and substance abuse treatment issues, they can spot such triggers and intervene appropriately. If, for example, a case manager fears that a client's decision to return to a familiar neighborhood could result in contact with drug-using friends that could jeopardize sobriety, a new residence may be necessary.

Planning, goal-setting, and implementation

Flowing directly and logically from the assessment process, planning, goal-setting, and

implementation comprise the core of case management. Based on the biopsychosocial or case management assessment, the client and case manager identify goals in all relevant life domains, using the strengths, needs, and wants articulated in the assessment process. Service plan development and goal-setting are discussed in detail in numerous works on substance abuse and case management (Ballew and Mink, 1996; Rothman, 1994; Sullivan, 1991). These authors agree on several points: Each goal in service plans should be broken down into objectives and possibly into even smaller steps or strategies that are behaviorally specific, measurable, and tangible. Distinct, manageable objectives help keep clients from feeling overwhelmed and provide a benchmark against which to measure progress. Goals, objectives, and strategies should be developed in partnership with the client. They should be framed in a positive context—as something to be achieved rather than something to be avoided.

Time frames for completing the objectives and strategies should be identified. Abbreviated, user-friendly treatment planning templates make client participation in development of a service plan more likely. The availability of staff to assist in the planning, goal-setting, and implementation of the case management aspects of the treatment plan is crucial.

Successful completion of an objective should provide the client the satisfaction of gaining a needed resource and demonstrating success. Failure to complete an objective should be emphasized as an opportunity to reevaluate one's efforts. In the latter situation, the case manager should be prepared to help the client come up with alternative approaches or to begin an advocacy process.

A deliberate, carefully considered approach to identifying client goals offers benefits that go beyond the actual acquisition of needed resources. Clients benefit by:

- Learning a process for systematically setting goals
- Understanding how to achieve desired goals through the accomplishment of smaller objectives
- Gaining mastery of themselves and their environment through brainstorming ways around possible barriers to a particular goal or objective
- Experiencing the process of accessing and accepting assistance from others in goal-setting and goal attainment

These and other individually centered outcomes make the planning and goal-setting process as important as the final outcome in some cases. This is the action stage of case management, when the client participates in many new or foreign activities and may have multiple requirements imposed by multiple programs or systems. Many significant and stressful transitions may be involved—from substance use to abstinence, from institutionalization or residential placement to community reintegration, and from a drug- or alcohol-using peer group to new, abstinent friends. As clients struggle to stop using, many will relapse, sometimes after a significant period of abstinence. They may feel overwhelmed, and it is not uncommon for clients in recovery to experience feelings of isolation and depression as they develop new peer associations and lifestyle patterns, and come to grips with their losses. In addition, the very real pressures of finances, employment, housing, and perhaps reunifying with and caring for children can be very stressful.

Case finding and pretreatment

During the pretreatment phase, the planning function of case management focuses on supporting

clients in achieving immediate needs and facilitating their entry into treatment. Ideally, the professional implementing case management meets with the client to plan the goals and objectives for the service plan. While planning and goal setting are important in this early stage of treatment, it may be difficult to follow traditional approaches given the immediacy of clients' needs and the possibility that they are still using alcohol or other drugs. The case manager may decide to complete a formal plan after an action is undertaken and present it to the client as a summary of work that was accomplished. If a client's capacity is diminished by substance abuse and the presence of multiple, serious life problems, the case manager may have to delay teaching and modeling for the client, and instead trade on his own contacts, resources, and abilities. As the client progresses through the treatment continuum, the case manager can turn more and more of the responsibility for action over to the client.

Clients who are using addictive substances while receiving case management services present a significant dilemma for the case manager. On the one hand, the client may not be willing or able to participate in treatment; on the other, treatment providers normally expect some commitment to sobriety before clients begin the treatment process. As a result, the case manager frequently needs to negotiate common ground between client and program.

For example, a case manager might require the client to identify and make progress toward mutually understood goals pending entry into treatment. Structured correctly, such an approach fosters a win-win situation.

Attainment of these goals either eliminates the client's need for treatment or prepares him to accept treatment more willingly. Even if the client is unwilling or unable to achieve those goals, the case manager and treatment program have additional information to use in attempting to motivate the client to seek treatment.

Primary treatment

During primary treatment, the case manager and client develop a service plan that identifies and proposes strategies to meet the client's short- and medium-term needs. The case management plan should reflect the level and intensity of the service along with the client's specific objectives. Virtually all clients have multiple needs; consequently, the service plan should be structured to enable clients to focus on addressing their problems *while* they participate in treatment. The idea that one can put lack of housing, employment issues, or a child's illness aside to concentrate exclusively on addiction treatment and recovery is unrealistic and sets up both the treatment provider and the client for failure. At the same time, it is often necessary for the client and case manager to prioritize problems.

During primary treatment, the case manager must (1) continue to motivate the client to remain engaged and to progress in treatment; (2) organize the timing and application of services to facilitate client success; (3) provide support during transitions; (4) intervene to avoid or respond to crises; (5) promote independence; and (6) develop external support structures to facilitate sustained community integration. Case management techniques should be designed to reduce the client's internal barriers, as well as external barriers that may impede progress.

Providing ongoing motivation to clients is critical throughout the treatment continuum. Clients need encouragement to commit to entering treatment, to remain in treatment, and to continue to progress. The case manager must continually seek client-specific incentives.

Clients are encouraged by different factors, and the same client may respond differently depending on the situation. For instance, many clients referred by the criminal justice system will be initially

motivated to try treatment in order to avoid a jail sentence; they may be motivated to stay in treatment for very different reasons (e.g., they start to feel better, they hope to regain custody of children). The treatment process is difficult, and many clients become discouraged after their initial enthusiasm.

Recovery may require them to explore uncomfortable issues. Physical discomfort, as well as depression, can ensue. Case managers can provide support during these periods by supplying information on coping techniques such as exercise, diet, and leisure activities. If depression is significant, case managers can work with substance abuse counselors to have a mental health evaluation conducted, and, if appropriate, enable the client to seek additional therapeutic support for the depression. Continued empathetic caring can also motivate clients.

Disincentives may also be used. For example, the case manager might remind clients of the outcome of terminating treatment—for some, this might mean a return to prison, for others it might mean dealing with the health or safety consequences of addictive behaviors. For clients under the control of the criminal justice system, sanctions, including possible jail stays, may be necessary to regain commitment and motivation.

In criminal justice settings, particularly drug courts, regular "status hearings" before a judge may motivate the client. In status hearings, the judge is informed of the client's progress (or lack thereof), and engages the client in a dialogue. The judge can then apply rewards (encouragement, or reduction of criminal sanctions), adjust treatment requirements, or apply sanctions. Sanctions vary, but may include warnings, community service, short jail stays, or ultimately, termination from the program and incarceration.

Another fundamental role of case management during the active treatment phase is to coordinate the timing of various interventions to ensure that the client can achieve his goals. The case manager has to work with the client to balance competing interests, and to develop strategies so the client can meet basic survival needs while in treatment. For example, a case manager may have to negotiate between probation and treatment to ensure that the client can attend treatment sessions and meet with his probation officer. Some activities require staging to ensure that they are applied at the right time and in the correct order. Clients who are unemployed and lack employment skills, for instance, should begin job readiness and training activities after they are stabilized in treatment; they will need additional support for seeking and maintaining employment. It is not uncommon for clients to feel they can take on the world once they are stabilized in treatment. If this is the case, the job of the case manager is to encourage clients to go slowly and take on responsibility one step at a time. This can be particularly critical for women anxious to reconnect with their children. The financial and emotional responsibilities are great, and the case manager should work with the woman and child protective services to transition these responsibilities in manageable ways.

Transition among programs—from institutional programming to residential treatment; from residential treatment to outpatient; or to lower level services within an outpatient setting — is always stressful, and frequently triggers relapse. In order to avoid crises during transitions, case managers should intensify their contact with clients. Case managers should work to ensure that service is not interrupted. When possible, release dates should be coordinated to coincide with admission to the next program.

If the client is under the control of the criminal justice system, the case manager should work to ensure that supervision activities remain the same or increase when treatment activity decreases. Too frequently, a client completes a treatment program and is moved to a lower level of supervision at the same time. This pulls out support all at once. If possible, supervision and treatment activities should

be coordinated to promote gradual movement to independence in order to reduce the likelihood of relapse.

In addition to activities designed to avoid a crisis or relapse, the case manager should be available to respond to relapses and crises when they do occur. In many cases, the case manager leads the response effort. Case managers should be in frequent contact with the treatment program to check on client attendance and progress. Lapses in attendance and/or poor progress can signal an impending crisis, and a case conference should be held. The case conference can resolve problems and prevent the client's termination from the program.

While violence toward staff or other patients is obviously adequate grounds for immediate program termination, other infractions do not necessarily warrant expulsion. The case management team and client should work together to develop alternatives that will keep the client engaged in treatment. If removal from the program is absolutely necessary, it may be possible to have the client readmitted after he "adjusts his attitude" and re-commits to treatment and to obeying the rules.

The Treatment Alternatives for Safe Communities (TASC) Project has developed a special form of case conference, known as "jeopardy meetings" for treatment clients involved in the criminal justice system. These meetings are attended by the case manager, treatment counselor, probation officer, client, and anyone else involved in the case. The purpose of the meeting is to confront the client with the problem, and to discuss its resolution as a team. The client must agree to the proposed resolution in writing. The jeopardy meeting provides a clear warning to the client (three jeopardy meetings can result in client termination); reduces the "triangulation" or manipulation that can occur if all parties aren't working in a coordinated fashion; and brings together the skills and resources of multiple agencies and professionals. (For more on jeopardy meetings, including structure and format, see the *TASC Implementation Guide* (Bureau of Justice Assistance, 1988).

Aftercare

One of the anticipatory roles for case management during primary care is to plan for aftercare, discharge, and community reentry. During primary care and into aftercare, the case manager helps the client master basic skills needed to function independently in the community, including budgeting, parenting, and housekeeping. Short-term goals increasingly become supplanted by long-term goals of integrating the individual into a recovery lifestyle. When appropriate, service plans should reflect an ever-increasing emphasis on clients' accepting greater responsibility for their actions. The case management intervention may increase or decrease in intensity, depending on client response to independence and progress toward community reintegration.

Linking, monitoring, and advocacy

Some findings suggest that while persons with substance abuse problems are generally adept at accessing resources on their own without case management, they often have trouble using the services effectively (Ashery et al., 1995). This is where the linking, ongoing monitoring, and, in many cases, advocacy, of case management can be valuable. An additional crucial function of case management is coordinating all the various providers and plans and integrating them into a unified whole.

Linking goes beyond merely providing clients with a referral list of available resources. Case managers must work to develop a network of formal and informal resources and contacts to provide needed services for their clients.

Case finding and pretreatment

Case managers may be especially active in providing linking and advocacy during the pretreatment phase of the treatment continuum. As with each of the case management functions, the roots of linking begin much earlier, while conducting an assessment with the client and in creating goals in which the client is vested. The authors of one primer on case management identify five tasks related to linking that should be undertaken with the client before actual contact with a needed resource even occurs.

Case managers must (1) enhance the client's commitment to contacting the resource; (2) plan implementation of the contact; (3) analyze potential obstacles; (4) model and rehearse implementation; and (5) summarize the first four steps for the client (Ballew and Mink, 1996).

Primary treatment

After the linkage is made, the case manager moves on to monitoring the fit and relationship between client and resource. Monitoring client progress, and adjusting services plans as needed, is an essential function of case management. Coupled with monitoring is the need to share client information with relevant parties. For instance, if a client who is involved in the criminal justice system tests positive for drugs, both the treatment counselor and the probation officer may need to know. If the case manager is aware that the client is having problems at work, this information may need to be shared with the treatment provider, within the constraints of confidentiality regulations.

Case managers who are responsible for offenders in treatment may oversee regular drug testing. This is an effective way to obtain objective information on a client's drug use, as well as to structure boundaries for the client to help prevent relapse.

Monitoring may reveal that the case manager needs to take additional steps on the client's behalf. Simply put, *advocacy* is speaking out on behalf of clients. Advocacy can be precipitated by any one of a number of events, such as:

- A client being refused resources because of discrimination, whether discrimination is based on some intrinsic aspect of the client, such as gender or ethnicity, or on the nature of the client's problems, such as addiction
- A client being refused services despite meeting eligibility requirements
- A client being discharged from services for reasons outside the rules or guidelines of that service
- A client being refused services because they were previously accessed but not utilized
- The case manager's belief that a service can be broadened to include a client's needs without compromising the basic nature of the service

Advocacy on behalf of a client should always be direct and professional. Advocacy can take many forms, from a straightforward discussion with a landlord or an employer, to a letter to a judge or probation officer, to reassuring the community that the client's recovery is stable enough to permit re-entry. Advocacy often involves educating service providers to dispel myths they may believe about substance abusers, or ameliorating negative interactions that may have taken place between the client and the service provider. This is particularly important for certain groups with whom

some programs are reluctant to work, such as clients with AIDS/HIV or clients involved in the criminal justice system.

More complicated advocacy involves, for example, appealing a particular decision by a service staff member to progressively higher levels of authority in an organization. The highest, most involved levels of advocacy include organizing a community response to a particular situation or initiating a legal process. Modrcin and colleagues provide an advocacy strategy matrix that can help case managers systematically plan advocacy efforts (Modrcin et al., 1985). In this view of advocacy, the levels at which advocacy can be effected (individual, administrative, or policy) are weighed against varying approaches (positive, negative, or neutral). Three guidelines for advocating on behalf of a client are getting at least three "No's" before escalating the advocacy effort, understanding the point of view of the organization that is withholding service, and consulting with supervisory personnel regularly before moving to the next level of advocacy (Sullivan, 1991).

Client advocacy should always be geared toward achieving the goals established in the service plan. Advocacy does not mean that the client always gets what she wants. Particularly for clients whose continued drug use or cessation of treatment will present considerable negative consequences such as incarceration or death, advocacy may involve doing whatever it takes to keep them in treatment, even if that means recommending jail to get them stabilized. It is not uncommon, in fact, for clients to state their preference for jail when treatment gets difficult. Even when advocating for clients, the case manger must respect system boundaries.

For example, a case manager might negotiate hard to keep an offender client in community-based treatment, but agree to inform the probation office of positive drug tests or suspected criminal behavior. While advocacy for certain client populations is essential, concern for the client should not override goals of public safety. Effective, client-centered advocacy may put the case manager in a position of conflict with co-workers, program administrators, or even supervisors. Case managers who advocate for an extension of benefits for their clients may put themselves and their supervisors in jeopardy with funding sources. A coordinated infrastructure with existing policies and procedures for client-centered collaboration will help.

Disengagement

Disengagement in the case management setting, as with clinical termination, is not an event but a process. In some ways, the process begins during engagement. For both client and case manager, it entails physical as well as emotional separation, set in motion once the client has developed a sense of self-efficacy and is able to function independently. To a significant degree, this decision can be based on progress defined by the service plan. If the plan has truly been developed with the client's active involvement, there will be a great deal of objective information that will help both the case manager and client decide when disengagement is appropriate. It is preferable that disengagement be planned and deliberate rather than have the relationship end in a flurry of missed appointments, with no summary of what has been learned by the client and professional.

Formal disengagement gives clients the opportunity to explore what they learned about interacting with service providers and about setting and accomplishing goals. The case manager has a chance to hear from clients what they considered beneficial—or not beneficial— about the relationship. Reviewing and summarizing client progress can be an important aspect of consolidating clients' gains and encouraging their future ability to access resources on their own.

CHAPTER 16.

CASE MANAGEMENT AND COUNSELING ETHICS

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://cod.pressbooks.pub/addictionscounseling/?p=280#oembed-1

CHAPTER 17.

FINDING QUALITY TREATMENT FOR SUBSTANCE USE DISORDERS

CITATION

https://store.samhsa.gov/sites/default/files/d7/priv/pep18-treatment-loc.pdf

CHAPTER 18.

COMPREHENSIVE CASE MANAGEMENT FOR SUBSTANCE USE DISORDER TREATMENT

CITATION
MHSA_Digital_Download/PEP20-02-02-013.pdf

CHAPTER 19.

CLINICAL SUPERVISION AND PROFESSIONAL DEVELOPMENT OF THE SUBSTANCE ABUSE COUNSELOR

CITATION

https://www.ncbi.nlm.nih.gov/books/NBK64848/

CHAPTER 20.

NAVIGATING THE TREACHEROUS TERRITORY OF ADDICTION COUNSELOR SUPERVISION

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://cod.pressbooks.pub/addictionscounseling/?p=284#oembed-1

PART IV.

UNIT FOUR: PROFESSIONAL DEVELOPMENT

CHAPTER 21.

ADDICTION COUNSELING COMPETENCIES

INTRODUCTION

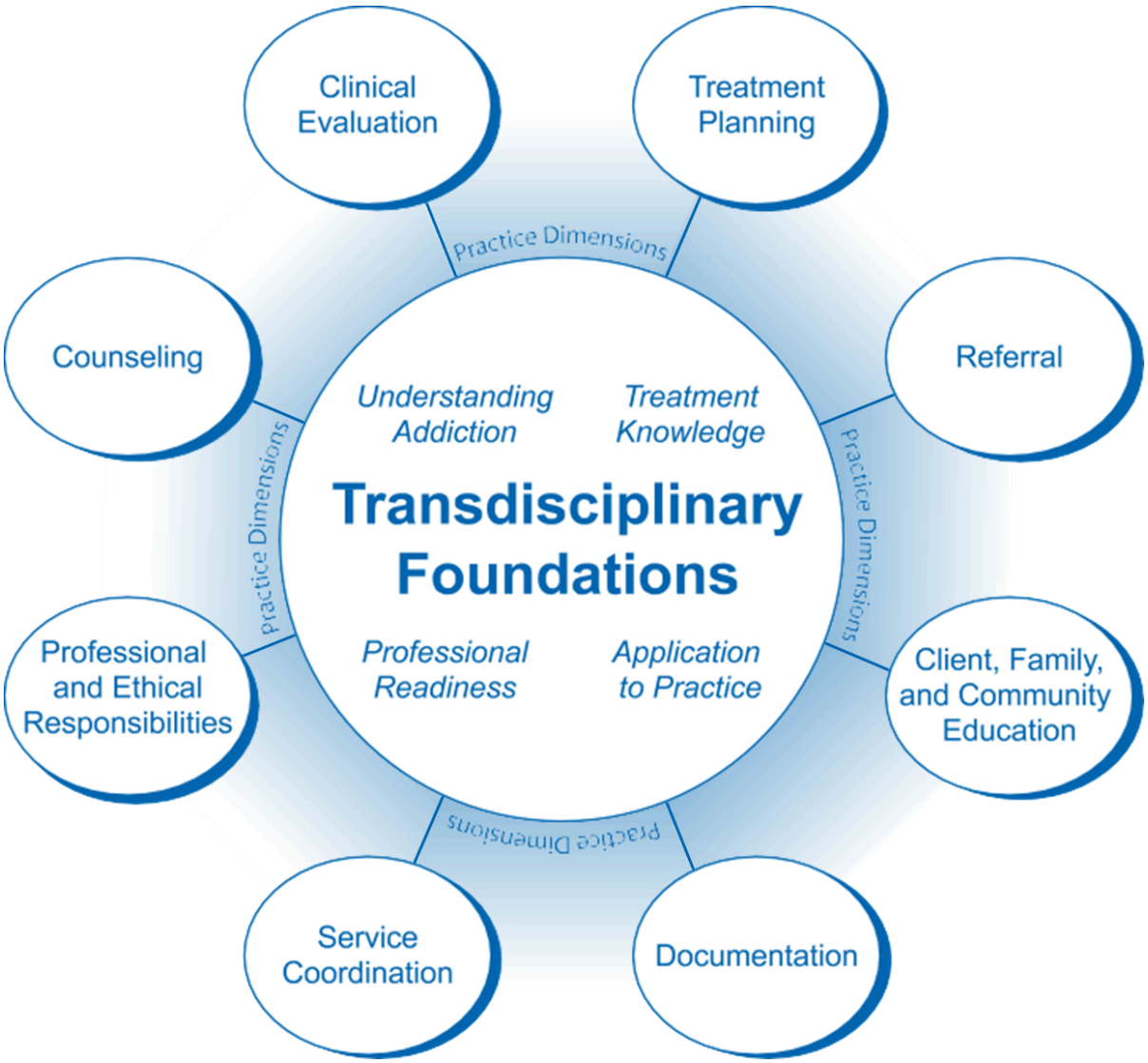
Counselors who treat people with substance use disorders do life-changing work on a daily basis, amid difficult circumstances that include staff shortages, high turnover, low salaries, and scant program funding. Counselors come to this important work by various paths and with vastly different skills and experience. The diversity of backgrounds and types of preparation can be a strength, provided there is a common foundation from which counselors work.

This chapter addresses the following questions: What professional standards should guide substance abuse treatment counselors? What is an appropriate scope of practice for the field? Which competencies are associated with positive outcomes? What knowledge, skills, and attitudes (KSAs) should all substance abuse treatment professionals have in common?

The Model

When creating *The Competencies*, the National Curriculum Committee recognized a need to emphasize three characteristics of competency: knowledge, skills, and attitudes. Many hours were spent conceptualizing a differentiated model when designing TAP 21—a model that could address general KSAs necessary for all practitioners dealing with substance use disorders while explaining the more specific needs of professional substance abuse treatment counselors.

The first section of the model addresses the generic KSAs. This section contains the trans-disciplinary foundations, comprising four discrete building blocks: understanding addiction, treatment knowledge, application to practice, and professional readiness. The term "trans-disciplinary" was selected to describe the knowledge and skills needed by all disciplines (e.g., medicine, social work, pastoral guidance, corrections, social welfare) that deal directly with individuals with substance use disorders.



Competencies Hub

The second section of the model specifically addresses the professional practice needs, or practice dimensions, of addiction counselors. Each practice dimension includes a set of com- petencies, and, within each competency, the KSAs necessary for effective addiction counseling are outlined. Many additional competencies may be desirable for counselors in specific settings. Education and experience affect the depth of the individual counselor's knowledge and skills; not all counselors will be experienced and proficient in all the compe- tencies discussed. The National Curriculum Committee's goal for the future is to help ensure that every addiction counselor possesses, to an appropriate degree, each competency listed, regardless of setting or treatment model.

The relationship of the components in the competencies model is conceptualized as a hub with eight spokes (see figure 1). The hub contains the four transdisciplinary foundations that are central to the work of all addiction profes- sionals. The eight spokes are the practice dimensions, each containing the competencies the addiction counselor should attain to master each practice dimension.

THE TRANSDISCIPLINARY FOUNDATIONS

Addiction professionals work in a broad variety of disciplines but share an understanding of the addictive process that goes beyond the narrow confines of any one specialty. Specific proficiencies, skills, levels of involvement with clients, and scope of practice vary widely among specializations. At their base, however, all addiction-focused disciplines are built on four common foundations.

This section focuses on four sets of competencies that are transdisciplinary in that they underlie the work not just of counselors but of all addiction professionals. The four areas of knowledge identified here serve as prerequisites to the development of competency in any of the addiction-focused disciplines.

The Four Transdisciplinary Foundations

- Understanding Addiction
- Treatment Knowledge
- Application to Practice
- Professional Readiness

Regardless of professional identity or discipline, each treatment provider must have a basic understanding of addiction that includes knowledge of current models and theories, appreciation of the multiple contexts within which substance use occurs, and awareness of the effects of psychoactive drug use. Each professional must be knowledgeable about the continuum of care and the social contexts affecting the treatment and recovery process.

Each addiction specialist must be able to identify a variety of helping strategies that can be tailored to meet the needs of individual clients. Each professional must be prepared to adapt to an everchanging set of challenges and constraints.

Although specific skills and applications vary across disciplines, the attitudinal components tend to remain constant. The development of effective practice in addiction counseling depends on the presence of attitudes reflecting openness to alternative approaches, appreciation of diversity, and willingness to change.

The following knowledge and attitudes are prerequisite to the development of competency in the professional treatment of substance use disorders. Such knowledge and attitudes form the basis of understanding on which discipline-specific proficiencies are built.

Competency 1: **Understand a variety of models and theories of addiction and other problems related to substance use.**	
Knowledge • Terms and concepts related to theory, etiology, research, and practice. • Scientific and theoretical basis of model from medicine, psychology, sociology, religious studies, and other disciplines. • Criteria and methods for evaluating models and theories. • Appropriate applications of models. • How to access addiction-related literature from multiple disciplines.	**Attitudes** • Openness to information that may differ from personally held views. • Appreciation of the complexity inherent in understanding addiction. • Valuing of diverse concepts, models, and theories. • Willingness to form personal concepts through critical thinking.

Competency 2: **Recognize the social, political, economic, and cultural context within which addiction and substance abuse exist, including risk and resiliency factors that characterize individuals and groups and their living environments.**	
Knowledge • Basic concepts of social, political, economic, and cultural systems and their impact on drug-taking activity. • The history of licit and illicit drug use. • Research reports and other literature identifying risk and resiliency factors for substance use. • Statistical information regarding the incidence and prevalence of substance use disorders in the general population and major demographic groups.	**Attitudes** • Recognition of the importance of contextual variables. • Appreciation for differences between and within cultures.

Competency 3: Describe the behavioral, psychological, physical health, and social effects of psychoactive substances on the person using and significant others.	
Knowledge • Fundamental concepts of pharmacological properties and effects of all psychoactive substances. • The continuum of drug use, such as initiation, intoxication, harmful use, abuse, dependence, withdrawal, craving, relapse, and recovery. • Behavioral, psychological, social, and health effects of psychoactive substances. • The effects of chronic substance use on clients, significant others, and communities within a social, political, cultural, and economic context. • The varying courses of addiction. • The relationship between infectious diseases and substance use.	**Attitudes** • Sensitivity to multiple influences in the developmental course of addiction. • Interest in scientific research findings.

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.	
Knowledge • Normal human growth and development. • Symptoms of substance use disorders that are similar to those of other medical and/ or mental health conditions and how these disorders interact. • The medical and mental health conditions that most commonly exist with addiction and substance use disorders. • Methods for differentiating substance use disorders from other medical or mental health conditions.	**Attitudes** • Willingness to reserve judgment until completion of a thorough clinical evaluation. • Willingness to work with people who might display and/or have mental health conditions. • Willingness to refer for treating conditions outside one's expertise. • Appreciation of the contribution of multiple disciplines to the evaluation process.

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.

Knowledge

- Generally accepted models, such as but not limited to:
  – pharmacotherapy
  – mutual help and self-help
  – behavioral self-control training
  – mental health
  – self-regulating community
  – psychotherapeutic
  – relapse prevention.
- The philosophy, practices, policies, and outcomes of the most generally accepted therapeutic models.
- Alternative therapeutic models that demonstrate potential.

Attitudes

- Acceptance of the validity of a variety of approaches and models.
- Openness to new, evidence-based treatment approaches, including pharmacological interventions.

Competency 6:

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

Knowledge

- The role of family, social networks, and community systems as assets or obstacles in treatment and recovery processes.
- Methods for incorporating family and social dynamics in treatment and recovery processes.

Attitudes

- Appreciation for the significance and complementary nature of various systems in facilitating treatment and recovery.

Competency 7:

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

Knowledge

- Research methods in the social and behavioral sciences.
- Sources of research literature relevant to the prevention and treatment of addiction.
- Specific research on epidemiology, etiology, and treatment efficacy.
- Benefits and limitations of research.

Attitudes

- Recognition of the importance of scientific research to the delivery of addiction treatment.
- Openness to new information.

Competency 8: Understand the value of an interdisciplinary approach to addiction treatment.	
Knowledge • Roles and contributions of multiple disciplines to treatment efficacy. • Terms and concepts necessary to communicate effectively across disciplines. • The importance of communication with other disciplines.	**Attitudes** • Desire to collaborate. • Respect for the contribution of multiple disciplines to the recovery process.

APPLICATION TO PRACTICE

Competency 9: Understand the established diagnostic criteria for substance use disorders, and describe treatment modalities and placement criteria within the continuum of care.	
Knowledge • Established diagnostic criteria, including but not limited to current *Diagnostic and Statistical Manual of Mental Disorders (DSM)* standards and current *International Classification of Diseases* (ICD) standards. • Established placement criteria developed by various States and professional organizations. • Strengths and limitations of various diagnostic and placement criteria. • Continuum of treatment services and activities.	**Attitudes** • Openness to a variety of treatment services based on client need. • Recognition of the value of research findings.

Competency 10: Describe a variety of helping strategies for reducing the negative effects of substance use, abuse, and dependence.	
Knowledge • A variety of helping strategies, including but not limited to: ◦ – evaluation methods and tools ◦ – stage-appropriate interventions ◦ – motivational interviewing ◦ – involvement of family and significant others ◦ – mutual-help and self-help programs ◦ – coerced and voluntary care models ◦ – brief and longer term	**Attitudes** • Openness to various approaches to recovery. • Appreciation that different approaches work for different people.

Competency 11: Tailor helping strategies and treatment modalities to the client's stage of dependence, change, or recovery.	
Knowledge • Strategies appropriate to the various stages of dependence, change, and recovery.	**Attitudes** • Flexibility in choice of treatment modalities. • Respect for the client's racial, cultural, economic, and sociopolitical backgrounds.

Competency 12: Provide treatment services appropriate to the personal and cultural identity and language of the client.	
Knowledge • Various cultural norms, values, beliefs, and behaviors. • Cultural differences in verbal and nonverbal communication. • Resources to develop individualized treatment plans.	**Attitudes** • Respect for individual differences within cultures. • Respect for differences between cultures.

Competency 13: Adapt practice to the range of treatment settings and modalities.	
Knowledge • The strengths and limitations of available treatment settings and modalities. • How to access and make referrals to available treatment settings and modalities.	**Attitudes** • Flexibility and creativity in practice application.

Competency 14: Be familiar with medical and pharmacological resources in the treatment of substance use disorders.	
Knowledge • Current literature regarding medical and pharmacological interventions. • Assets and liabilities of medical and pharmacological interventions. • Health practitioners in the community who are knowledgeable about addiction and addiction treatment. • The role that medical problems and complications can play in the intervention and treatment of addiction.	**Attitudes** • Open and flexible with respect to the potential risks and benefits of pharmacotherapies to the treatment and recovery process.

Competency 15: Understand the variety of insurance and health maintenance options available and the importance of helping clients access those benefits.	
Knowledge • Existing public and private payment plans including treatment orientation and coverage options. • Methods for gaining access to available payment plans. • Policies and procedures used by available payment plans. • Key personnel, roles, and positions within plans used by the client population.	**Attitudes** • Willingness to cooperate with payment providers. • Willingness to explore treatment alternatives. • Interest in promoting the most cost-effective, high-quality care.

Competency 16: Recognize that crisis may indicate an underlying substance use disorder and may be a window of opportunity for change.	
Knowledge • The features of crisis, which may include but are not limited to: ◦ – family disruption ◦ – social and legal consequences ◦ – physical and psychological ◦ – panic states ◦ – physical • Substance use screening and assessment methods. • Prevention and intervention principles and methods. • Principles of crisis case management. • Posttraumatic stress characteristics. • Critical incident debriefing methods. • Available resources for assistance in the management of crisis situations.	**Attitudes** • Willingness to respond and follow through in crisis situations. • Willingness to consult when necessary.

Competency 17: Understand the need for and the use of methods for measuring treatment outcome..	
Knowledge • Treatment outcome research literature. • Scientific process in applied research. • Appropriate measures of outcome. • Methods for measuring the multiple variables of treatment outcome.	**Attitudes** • Recognition of the importance of collecting and reporting on outcome data. • Interest in integrating research findings into ongoing treatment design.

USES OF THE COMPETENCIES

The Board of Directors of the Illinois Alcohol and Other Drug Abuse Professional Certification Association has endorsed and will be incorporating the knowledge, skills, and attitudes provided in *The Competencies* into all of its models for Certified Alcohol and Other Drug Abuse Counselors.

THE PRACTICE DIMENSIONS

Professional practice for addiction counselors is based on eight practice dimensions, each of which is necessary for effective performance of the counseling role. Several of the practice dimensions are subdivided into elements. The dimensions identified, along with the competencies that support them, form the heart of this section of *The Competencies.*

THE EIGHT PRACTICE DIMENSIONS OF ADDICTION COUNSELING

I. Clinical Evaluation

Screening

1. – Assessment

2. Treatment Planning

- Referral

1. Service Coordination

    - – Implementing the Treatment Plan
    - – Consulting
    - – Continuing Assessment and Treatment Planning

2. Counseling

    - – Individual Counseling
    - – Group Counseling
    - – Counseling Families, Couples, and Significant Others

3. Client, Family, and Community Education

- Documentation
- Professional and Ethical Responsibilities

A counselor's success in carrying out a **practice dimension** depends on his or her ability to attain the **competencies** underlying that component. Each **competency**, in turn, depends on its own set of knowledge, skills, and attitudes. For an addiction counselor to be truly effective, he or she should possess the knowledge, skills, and attitudes associated with each competency that are consistent with the counselor's training and professional responsibilities.

Center for Substance Abuse Treatment. Addiction Counseling Competencies: The Knowledge, Skills,

and Attitudes of Professional Practice. Technical Assistance Publication (TAP) Series 21. HHS Publication No. (SMA) 15-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration,- 2006.

CHAPTER 22.

CREDENTIALING

PREFACE

This chapter defines the role, purpose, functions and responsibilities of the certified alcohol and other drug counselor, and establishes a fair methodology for evaluation of competency. The credential defines minimum acceptable standards for the certified alcohol and other drug (AOD) counselor knowledge and skills to insure that the AOD counselor meets an acceptable standard of competency.

Competency Based – This professional, voluntary certification system is competency based, meaning that the minimum standards for AOD counselors are the knowledge and skill base identified for the profession. The competencies are specific to alcohol and other drug counseling, thus distinguishing this profession from other behavioral health/human services professions.

Experience Based – This certification system recognizes two ways to acquire the minimum AOD counselor competencies: paid work experience and/or supervised practicum/internship experience that is a part of a curriculum approved by the Illinois Certification Board (ICB).

PURPOSE

Mission – To protect the public by providing competency-based credentialing of Human Service Professionals.

- To establish standards and procedures for the voluntary, professional certification of AOD counselors
- To assure competent, professional counseling to persons suffering from substance use disorders and their family members
- To provide professional standards required for program licensing and accreditation and reimbursement
- To provide a respected credential of professional competency
- To provide a method for maintaining and updating professional standards

RATIONALE

ICB endorses the concept that the treatment of substance use disorders is a specialty field requiring performance by competent professionals. The standards for certification of these professionals are weighted on the side of proven experience and education.

ICB PHILOSOPHY STATEMENT

Substance use disorders result in many negative consequences, including loss of productivity,

deteriorating relationships, arrested emotional and physical development and in many cases death. Such consequences mandate that care be available to those suffering from substance use disorders. Treatment must be comprehensive in nature by treating the whole person and not just the symptoms.

Counselors seeking AOD counselor certification must be proficient in the performance domains and core functions in order to provide quality care. While these may be learned in a variety of settings, such knowledge and skills must be present regardless of how they were obtained.

ICB recognizes the disease model of substance use disorders as well as the bio-psycho-social-spiritual approach and other philosophies effective in promoting recovery. It supports ongoing research and technology and remains open to new techniques as they are proven to be effective. ICB is committed to the professional growth of counselors and to openness and enthusiasm about new information that allows AOD counselors to become more effective in their work. ICB recognizes the abstinence (from the use of mind-altering drugs unless under medical supervision) model in the treatment of persons who suffer from substance use disorders. ICB also recognizes the harm reduction model, specifically methadone maintenance, for those clients for whom this is appropriate.

INTRODUCTION

Alcohol and other drug (AOD) counselors fill a unique role among health and human service professionals. AOD counselors work in a variety of settings, use multidisciplinary treatment approaches and serve a client population that varies greatly in its needs. Recognizing the need to assure the provision of quality care to clients, AOD counselors created the Illinois Certification Board, Inc. (ICB), a voluntary credentialing system that evaluates counselor competency and grants recognition only to counselors who meet specific minimum standards.

AOD counselors in Illinois support such a credentialing process for other reasons besides quality client care. A growing professionalization of AOD counseling services is widely recognized largely in response to the need expressed by treatment facilities as well as third party payers. Such factors require insistence of specific standards for AOD counselors and can guide employers in hiring and promotion.

The credentialing system identifies the functions, responsibilities, knowledge and skill bases required by AOD counselors. The Illinois Model is the basic document that describes the rationale and competencies of the credentialing process. ICB recognizes that AOD counselors are educated in a wide range of disciplines, utilize many different therapeutic approaches and techniques and bring to the field diverse personal and professional experiences. The certification system is designed to accommodate and evaluate counselors regardless of treatment setting, academic preparation or professional training and orientation.

The AOD counselor is a professional who has the skills and knowledge to deal with the unique attitudes and behavior of individuals who suffer from alcohol and/or other drug problems. The AOD counselor also provides counseling services to the family members/significant others of persons with alcohol and other drug problems.

DEFINITION AND SETTING

The role of the AOD counselor generally includes:

1. Assisting clients in recognizing the need for help with alcohol/drug problems
2. Motivating clients to enter the counseling process

3. Providing professional counseling services to clients that helps them develop and/or maintain a responsible and functional recovering lifestyle
4. Providing professional counseling services to family members/significant others of persons with alcohol/drug problems
5. Recognizing limits of knowledge, skills and experience and in such cases, referring the client to other appropriate professional services

The knowledge and skill base of the AOD counselor is generally acquired through a combination of specialized training and education and supervised work experience.

HOW TO APPLY

Certification will be granted contingent upon documentation of eligibility, submission of all required application material, successful completion of the appropriate examinations and payment of all fees. The following outlines the application, review and approval process.

1. Read the entire Illinois Model thoroughly.
2. A valid email address is required to apply. The address must be written or typed legibly on the first page of the application where indicated. All correspondence regarding the application will be sent to the provided email address. If you do not have an email address, contact the ICB office for assistance.
3. Complete all parts of the application. Print legibly or type application.
4. Attach all required documentation to support employment and education (i.e., current job description, official transcripts, copies of training certificates, letters of attendance/ participation).
5. A current job description is required. Job descriptions must be on agency letterhead, dated and signed by the applicant and supervisor and must reflect the applicant's actual counseling duties and responsibilities.
6. Sign, date and notarize the Counselor's Code of Ethics. *Please submit page 17 of the application only.*
7. Verify the completeness of the application by using the "Application Checklist" included in the front of the application.
8. Completed application materials and the application fee must be mailed to, ICB, 401 East Sangamon Avenue, Springfield, IL 62702. **Applications will not be accepted by email**.
9. After the application is approved, the applicant has paid the exam fee and passed the exam, the applicant will be sent an invoice for the initial certification fee. Once the fee is paid and the applicant receives the certificate in the mail, he/she will be officially certified and will be required to renew the certification in two years.
10. Applicants have one year to complete the application process. The year time limit starts when ICB receives your application and fee.

Review of Materials

Upon receipt, the application and materials will be screened by ICB for completeness and correctness. The results may be one of the following:

Application Approved – The application meets all certification standards, and the applicant must pass the examination, if he or she has not already done so, in order to meet the requirements for certification.

Application Pending – Some materials need clarification, submission or resubmission of any part of the application. The applicant will be notified in writing by email of the problem(s). **Within one year of the application date, corrected materials must be submitted to ICB or the applicant will need to restart the application process.**

Fees (April 2023)

Application Fee …….. $ 85.00

Examination Fee ……..$175.00

Biennial Certification Fee……. $160.00

Inactive Status (Biennial) …….. $ 20.00

Retired Emeritus Status (Biennial) …….. $ 10.00

Extension Fee (maximum 6 months) (per month) ……... $ 10.00

Late Fee (maximum 6 months) (per month) ……. $ 15.00

Returned Check Fee …….. $ 50.00

Payment Plan Service Charge …….. $ 15.00

Certificate (replacement copy) …….. $ 25.00

All fees are non-refundable. The fee schedule is subject to change without notice

REQUIREMENTS FOR CERTIFICATION

Applicants must meet all requirements to obtain certification, including an approved application, passing an examination and payment of the appropriate fees (application fee, exam fee, and initial certification fee). The following chart details the minimum requirements for certification based on work experience, supervised practical experience and training/education:

Certification Level	Degree Requirement	Required Work Experience	Supervised Practical Experience	Training/ Education	Required Examinations
CADC	High School/GED	2 years (4,000 hours) of paid AOD qualified work experience in the past four years	150 Hours	**225 clock hours/CEU's** 100 hours – AOD Specific (examples on page 8 Category I/Counselor I) · 15 hours AOD Treatment Services for Women and/or their Families* · 15 hours AOD Treatment Services for Adolescents and/or their Families* 6 hours Professional Ethics and Responsibility 10 hours Race and Equity 109 hours *Performance Domains	CADC Illinois Examination

**Performance domains are defined as: 1. Clinical Evaluation 2. Treatment Planning 3. Counseling 4. Case Management and Referral 5.Documentation 6. Client, Family and Community Education 7. Professional and Ethical Responsibilities*

Work Experience

ICB defines qualified work experience as paid, supervised work experience in a position where at least ***51% of the applicant's time is spent providing direct, primary alcohol and other drug counseling.*** Volunteer work and unpaid internships are not applicable. The applicant minimally must have primary responsibility for providing drug and alcohol counseling to an individual and/or group, preparing treatment plans, documenting client progress and is clinically supervised by an individual who is knowledgeable in AOD counseling.

Waiving Work Experience –

- A **Bachelor's degree or higher** that is clinically focused from an accredited school of higher education with a course of study in behavioral sciences or relevant field (i.e., community counseling, mental health, social work, rehabilitation counseling, criminal justice, psychology, sociology), with at least twelve (12) semester, fifteen (15) trimester or eighteen (18) quarter credit hours of AOD specific topics, will substitute for one year (2,000 hours) of employment.
- An **Associate's degree** that is clinically focused from an accredited school of higher education with a course of study in behavioral sciences or relevant field (i.e., community counseling, mental health, social work, rehabilitation counseling, criminal justice, psychology, sociology), with at least twelve (12) semester, fifteen (15) trimester or eighteen (18) quarter credit hours of AOD specific topics, will substitute for six (6) months (1,000 hours) of employment.

Applicants must supply an official transcript indicating completion of the course of study and a copy of the award of the degree. ICB reserves the right to disqualify any course of study that does not meet the requirement of a behavioral science or relevant field.

Counseling of the adjuvant nature (i.e., life skills, recreation, music, etc.) does not meet the employment standard for counselor certification. Also, internships are not acceptable.

Supervision

Clinical supervision is the process of assuring the AOD counselor is provided monitoring and feedback to assure quality AOD services are being delivered. The applicant must submit documentation of on-the-job clinical supervision in the 12 core skill areas of counseling. No single core skill area is to be performed for fewer than ten (10) hours. Supervised hours are understood to be face-to-face supervision. Hours that the counselor spends providing AOD counseling services are NOT counted as supervision.

Realizing that supervision may take place in a variety of settings and have many faces, ICB determined not to place limiting criteria on qualifications of a supervisor. Rather, it was determined that supervision should be as broadly defined as in the Center for Substance Abuse Treatment/ Substance Abuse and Mental Health Services Administration's Technical Assistance Publication Number 21. TAP 21 defines supervision/clinical supervision as: the administrative, clinical and evaluative process of monitoring, assessing and enhancing counselor performance.

Education

- High School or GED
- Documentation that applicant has obtained a diploma, or a degree or certificate of completion from an institution accredited by the US Department of Education's Office of Post Secondary Education
- All required education may be alcohol and other drug specific as long as they include the specified number of hours of education pertaining to specialized alcohol and drug treatment services for women and adolescents
- Performance domains are defined as: Clinical Evaluation, Treatment Planning, Counseling, Case Management and Referral, Documentation, Client, Family and Community Education, and Professional and Ethical Responsibilities.
- Race and equity topic areas include, but are not limited to, a) self-knowledge, self-awareness, and reflective practice, b) culturally-specific strengths and resources that aid in recovery (including a discussion of recovery capital; awareness of and caution to not reinforce any stereotyping bias), c) culturally-specific barriers and risks – awareness and how to address (systemic/structural inequities; intersectionality; implicit bias and microaggressions; historical, intergenerational, collective, and migration trauma, including "war on drugs" failures), d) evidence-based culturally responsive care (evidence-based approaches tested with racially diverse populations; adapting evidence-based approaches to be responsive to individual, family, and community culture and context; model programs), and e) cultivating and sustaining diverse organizations (hiring, supporting, retaining, and promoting diverse teams).
- Sources of education are college courses, seminars, conferences, in-services and home study courses. Education does not have to be ICB approved for initial applications.

1 college semester hour = 15 clock hours, 1 college trimester hour = 12 clock hours, 1 college quarter hour = 10 clock hours. A 3 semester hour college course equals 45 clock hours/CEUs.

A thorough understanding of the 12-step fellowship philosophy and process is an essential tool for AOD counselors. ICB strongly encourages familiarity with the 12-step fellowship process to promote personal and professional growth.

When applicants question the results of the application review, question examination results or are subject to an action by ICB that they deem unjustified, they have the right to inquire and appeal. If, after having been provided an explanation or clarification of the action of ICB, the applicant (complainants) still thinks an action taken is unjustified, he or she may request an appeal. The complainant may appeal the decision within 30 days of receipt of the notice of denial or any other action deemed unjustified, by sending a certified letter to the Executive Director of ICB, 401 East Sangamon Avenue, Springfield, IL 62702.

APPEAL PROCESS

If applicants wish to appeal their examination scores, they must submit a written request to ICB within 30 days of the postmark of the examination score report. Applicants will be required to pay a fee to re- score the examination. Applicants should be aware that examination security and item banking procedures do not permit access to examination questions, answer keys or other secure materials by applicants.

The examination is computer based and scheduled by appointment only. Testing candidates will need to have a current email account in order to set the exam appointment. Walk-in examinations are not allowed.

CERTIFICATION EXAMINATION

CADC applicants may take the examination prior to approval of their application. However, applicants must have appropriate pieces of the application and a letter requesting to test in our office 60 days prior to the examination you wish to take.

The minimum application requirements to take the exam prior to approval include:

- the first two pages of the application that include general information about the applicant
- a signed and dated Assurance and Release form
- a signed, dated and notarized ICB Code of Ethics
- payment of the application fee
- a letter from the applicant requesting to take the examination prior to application approval as telephone requests are not accepted

ICB is not responsible for delays in your exam process if the proper forms are not submitted.

This information must be received prior to being eligible to test. Once the application has been processed, the applicant will receive an examination letter and pre-registration test code sheet via email. To be scheduled for the examination, the applicant must return a completed pre-registration test code sheet with payment of the non-refundable examination fee.

The Illinois Certification Board (ICB) utilizes a separate testing company to administer this exam. Upon ICB's receipt of this pre-registration form, and appropriate exam fee, your eligibility

information will be forwarded to our testing administrators. You will then receive an email directly from our testing administrators allowing you to set your exam appointment. The email will contain complete instructions on how to choose your exam date, time and location.

Individuals with disabilities and/or religious obligations that require modifications in examination administration must submit a written request for specific procedural changes to ICB no less than thirty days prior to the examination date. Official documentation of the disability or religious issue must be provided with the written request. With supportive documentation and proper notice for request, ICB will offer appropriate modifications.

CERTIFICATION TIME PERIOD

Once the application receives approval and the applicant has passed the examination, he or she will be invoiced for the biennial certification fee. Once payment is received certification will be issued. Only after receiving the official certificate in the mail can one be deemed certified.

ICB certification encompasses two calendar years starting on the date of successful completion of the certification process. Two dates (date of issue and expiration date) will appear on the counselor's certificate along with a certification number.

Certified counselors must display their certificates at their primary work site. Certified counselors are responsible for renewal of their certification.

CHAPTER 23.

CONTINUING EDUCATION

MAINTAINING YOUR CERTIFICATION – CERTIFIED AOD COUNSELOR

Certified Alcohol and Other Drug (AOD) counselors will follow the guidelines set forth in the Illinois Model for Counselor Certification. They are required to pay a biennial certification fee and submit continuing education units (CEUs).

To maintain the high standards of the professional practice and to assure continuing awareness of new knowledge in the field, ICB requires all certified AOD counselors to renew their certification every two years. Certified AOD counselors have the responsibility to maintain and renew their credential, and any failure to act is their responsibility. Counselors must notify ICB, in writing, of any change of address. They are required to pay a biennial certification fee and submit continuing education units (CEUs).

Certified AOD counselors will be notified that their certification is about to expire no fewer than 30 days prior to the expiration date. The renewal notice will come via email. They will submit their biennial certification fee and CEUs to the Illinois Certification Board (ICB) by their expiration date. Forms for the documentation of CEUs are available on the ICB's website, www.iaodapca.org, under Credentialing/Credentialing Forms/Counselor. The form must be completed, signed, and submitted with proof of attendance. CEUs should not be submitted until notification of expiration. **CEUs can be uploaded at time of payment.**

Certified AOD counselors may arrange a payment plan for the biennial certification fee by selecting a payment option on the fee statement provided to the counselor. Such requests must be received **PRIOR** to the expiration date. If 45 days have passed from the expiration date without payment of biennial certification fee and/or submission of continuing education units, that certification shall be terminated. A non-response to biennial notices will result in termination of certification.

CONTINUING EDUCATION POLICY

1. Forty (40) ICB approved continuing education units (CEUs) are required to maintain certification and must be earned within the two- year certification period. An average of 20 CEUs should be obtained each year. CEUs are not transferable to any other certification period. CEUs obtained prior to the certified counselor's initial date of certification are not eligible for maintaining certification. Certified AOD counselors may receive CEU credit only once for a training event, even if it is repeated during different certification periods. A CEU is equivalent to one clock hour. (Excluded is non-program time such as breaks, social hours, registration time, meal times). One college semester hour of credit is equivalent to 15 CEUs, one college trimester hour of credit is equivalent to 12 CEUs, and one college quarter hour of credit is equivalent to 10 CEUs.
2. All 40 CEUs required to maintain certification **must** be recognized or

petitioned for ICB CEUs. Continuing education is broken down into two categories with some education recognized by ICB for both categories.

CATEGORY I (Counselor I) – Minimum 15 CEUs of education **specific to AOD**.

Examples – pharmacology, the effects of alcohol or drugs on the human body, signs and symptoms of alcohol and other drugs use, dynamics of substance use disorders, medical treatment issues, detoxification/withdrawal, relapse, AOD rules and regulations, AOD special populations, history of AOD.

CATEGORY II (Counselor II) – Minimum 25 CEUs of education **specific to knowledge and skills/Performance Domains** related to the Core Functions of AOD counselors (refer to the Illinois Model for a list of core functions), but does not have to be AOD specific. This education covers counselor skills, competencies, and knowledge base.

Examples – theory/techniques of therapeutic approaches, human behavior/development, dysfunctional behavior, family dynamics, domestic violence, cultural issues, special populations, social services, confidentiality, legal systems, intervention/prevention strategies, health/safety, professional relationship dynamics, crisis intervention, psychology, clinical documentation.

CSADCs and CAADCs – six (6) of the 25 CEUs needed for Category II must be training received in how to provide clinical supervision.

3. CADCs who are also Licensed Private Practitioners, are required to **only** submit ten (10) Category I alcohol and other drug specific CEUs for recertification. Category II CEUs are **not** required. Recertification is contingent on continued good standing of the Illinois Department of Financial and Professional Regulation (IDFPR) license; therefore, proof of a current license is required and must be submitted with their biennial CADC renewal. **(This policy is applicable to CADCs only. CRADCs, CSADCs, and CAADCs are not eligible for this policy and therefore, must submit 40 CEUs at the time of recertification.)**

Licensed Private Practitioner means a health care practitioner who is one of the following:

- A physician licensed to practice medicine in all its branches pursuant to the Medical Practice Act of 1987
- An Advanced Practice Nurse with a psychiatric specialty licensed under the Nursing and Advanced Practice Nursing Act [225 ILCS 65]
- A clinical psychologist licensed under the Clinical Psychologist Licensing Act [225 ILCS 15]
- A licensed clinical social worker (LCSW) licensed under the Clinical Social Work and Social Work Practice Act [225 ILCS 20]
- A licensed clinical professional counselor (LCPC) licensed under the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107]
- A licensed marriage and family therapist (LMFT) licensed under the Marriage and Family Therapy Licensing Act [225 ILCS 55]

SOURCES OF CONTINUING EDUCATION UNITS

1. Recognized programs are training/education programs ICB has identified as fulfilling the criteria for CEU credit and have been awarded CEUs by ICB or are pre-recognized sources. The certificate of completion will contain the name of the participant, name and date of the

program, signature of instructor or sponsor, program number assigned by ICB, number of CEUs and the category designation.

2. Structured individual continuing education, such as the ICB Bibliocredit Reading Program and other home study programs, is available to certified AOD counselors with a maximum of 15 CEUs every two years.
3. Certified AOD counselors may receive up to 12 Category II CEUs every two years for volunteer time serving as a member of the Board of Directors, a member of a Board committee, or a member of another ICB committee.
4. Providing clinical supervision to an AOD practicum student enrolled in an ICB AOD Counselor Training Program qualifies for up to 15 CEUs in a two-year certification period.
5. Teaching and/or training other AOD Professionals in AOD knowledge or competency areas qualifies for up to a maximum of 15 CEUs in a two-year certification period. The number of CEUs awarded will be equal to the number of hours spent in actual training time. Patient education and public education lectures are not eligible for CEUs. Presentations for which the AOD counselor has previously received credit are also not eligible. Petitions must be submitted for any presentations that have not been awarded ICB CEUs.
6. Research papers accepted for publication, reading, or discussion at a professional meeting or conference, and professional publications in the AOD field qualifies for up to a maximum of 15 CEUs in a two-year certification period. The topic must pertain to alcohol and other drugs and address one of the core functions, performance domains or knowledge or skill area. The work can be counted only once, even though presented in more than one format or location. Petitions must be submitted for CEUs.

AGENCY IN-SERVICE EDUCATION PROGRAMS PROGRAMS

Of the 40 CEUs required biennially, 20 CEUs may be agency in-service training programs. Inservices not previously awarded CEU recognition by ICB must be petitioned for CEUs.

VALIDATION OF CONTINUING EDUCATION

Certified AOD counselors must document they have obtained CEUs and submit the appropriate validation for each educational experience.

1. Certificates or other proof of completion for ICB recognized or petitioned trainings.
2. Transcripts or other official grade reports for college or university courses.

PROCEDURES FOR COUNSELORS TO PETITION FOR CEUS

Not all educational experiences available to the certified AOD counselor will have been awarded CEUs by ICB, requiring the counselor to petition such education/training for CEU credit. Requests are to be submitted to ICB on the petition form with the following information:

- Documentation of attendance
- Goals and objectives of the program

- Date/length of program in clock hours
- Brochure describing program content
- Sponsor, location, instructor and target population
- Definition of the training type (publication, workshop, seminar)
- Identification of the AOD specific content and/or knowledge/skill related to the Core Functions
- Non-refundable petition fee

Requests will be reviewed within 30 days and the counselor will be notified of the results. If recognized, the counselor will be informed of the number of CEUs awarded.

EXTENSION OF CONTINUIN EDUCATION REQUIREMENTS

Certified AOD counselors unable to meet the continuing education requirements for recertification may request an extension, in writing. Extensions are $10.00 per month for up to six months from the expiration date. To request an extension, certified AOD counselors must include the biennial certification fee plus $10.00 per month with a written request. Extension will not be granted beyond six months. If at the end of six months of extensions certified AOD counselors have not met the requirements for recertification, their certification will be terminated. They will not be permitted to place their certification on inactive status. Reinstatement shall be through completing the full certification requirement.

NOTE: Certified AOD counselors should remember that process leaves only 18 months to obtain CEU credit for the current recertification period.

INACTIVE STATUS

Certified AOD counselors in good standing unable to meet the continuing education requirements for recertification maintenance due to health or extenuating personal reasons may place their certificate on inactive status if they meet the requirements. The process for reactivation from inactive status will then be followed when they wish to activate their certification.

CHAPTER 24.

SELF-CARE

THE IMPORTANCE OF A SELF-CARE PLAN

In a profession that seeks to improve the self-efficacy and health of others, it is vital that counselors have their own self-care plan that encompasses their self-help strategies. As there is no one size fits all plan, self-care refers to the activities and practices that are engaged in on a regular basis to maintain and enhance a person's health and well-being. Everyone encounters bumps in the road of life or the downward swings of the roller coaster experience we all experience. As these stressful events can lead to physical, emotional, and mental stress, a self-care plan is vital, especially in the realm of counseling.

Figure 4.1 Aspects of Self-Care

Because we are all have our own unique life history, face different circumstances, stressors, and challenges, all of us will need to develop our own self-care plan. However, "despite the uniqueness of our individual self-care needs, there are objectives common to almost all such plans: taking care of physical health, managing and reducing stress, honoring emotional and spiritual needs, nurturing

relationships, and finding balance in school and work life" (http://www.socialwork.buffalo.edu/students/self-care/developing-maintenance-plan). I have outlined my self-care plan below:

PHYSICAL HEALTH

- Participate in a recreational basketball league
- Attend Zumba classes 3 times each week
- Although I often struggle, I strive to make healthy food choices

MANAGING AND REDUCING STRESS

- Cardiovascular exercise
- Hiking/Walking trails
- Listening to relaxing music
- Using relaxation techniques such as deep breathing and meditation
- Striving to not procrastinate
- Be organized to reduce anxiety

EMOTIONAL AND SPIRITUAL NEEDS

- Attending church and bible study on a regular basis
- Praying
- Bible reading
- Not dwelling on past mistakes
- Not dwelling on issues related to previous relationships
- Realizing it is ok to cry. (As this is the body's way of releasing stress)

NURTURING RELATIONSHIPS

- Taking time to spend with friends, family to maintain trust and comfort
- Seeking to establish positive relationships with my students
- Striving to form meaningful, professional relationships with coworkers
- Spending time to talk to Christ to maintain the most important relationship I have.

FINDING BALANCE IN WORK, SCHOOL AND LIFE

- Although often difficult, I strive to not take work related stress home
- Striving to be organized and prepared so I do not have to spend a lot of time working or doing homework at home
- Forming positive relationships with students, classmates and professors so I can easily ask for assistance when needed. (This will relieve stress related to work and school.)

SELF CARE RESOURCES

Below are some links to valuable resources that can be used for one's own self-care plan and for helping others develop their own self-care strategies.

Tips and steps to get started:
http://www.socialwork.buffalo.edu/students/self-care/developing-maintenance-plan.asp

Lifestyle behavior assessment to see what strategies are needed:
http://www.socialwork.buffalo.edu/students/self-care/documents/plan/Lifestyle_Behaviors.pdf

Self-Care Assessment
http://www.socialwork.buffalo.edu/students/self-care/documents/plan/Self-Care_Assessment.pdf

Maintenance and self-care worksheet
http://www.socialwork.buffalo.edu/students/self-care/documents/plan/My_Maintenance_Self-Care_Worksheet.pdf

Developing Emergency Self-Care Plan
http://www.socialwork.buffalo.edu/students/self-care/developing-emergency-plan.asp

Self-Care plan questionnaire
http://www.cpt.org/files/PP%20-%20Self-Care%20Plan.pdf

This is where you can add appendices or other back matter.

FURTHER READING