Addictions Counseling Essentials

ADDICTIONS COUNSELING ESSENTIALS

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ABOUT THIS BOOK

This book is a collaboration between a group of educators with extensive experience in the addictions field. We aim 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. Many behaviors 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.

Before 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 disorders.

PREFACE

This textbook and ancillary materials were created as part of the Illinois Support for the Creation of Open Educational Resources (SCOERs) project, facilitated by the Consortium of Academic and Research Libraries in Illinois (CARLI) and funded by a $2 million Open Textbooks Pilot Program grant from the Department of Education and the Fund for the Improvement of Post-Secondary Education.[1]

Illinois SCOERs is a true statewide enterprise fundamentally changing the open educational resources landscape in Illinois by providing a new holistic support model that promotes student success through OER awareness, implementation, growth, and adoption. This project features a collaboration between educational systems in Illinois, the library community, and workforce representatives. Developed OER course materials will be released under a license that permits their free use, reuse, modification, and sharing with others., the library community, and workforce representatives. Developed OER course materials will be released under a license that permits their free use, reuse, modification, and sharing with others.

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1. The contents of this publication were developed under a grant from the Fund for the Improvement of Postsecondary Education, (FIPSE), U.S. Department of Education. However, those contents do not necessarily represent the policy of the Department of Education, and you should not assume endorsement by the Federal Government.

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PART I.

UNIT ONE: CORE KNOWLEDGE

INTRODUCTION

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 as the 2060 law.

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 provides critical expectations for all counselors to be aware of.

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 (e.g., 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:

1. Complete the required documents for admission to the program.
2. Complete the required documents for program eligibility and appropriateness.
3. 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:

1. Provide an overview to the client by describing program goals and objectives for client care.
2. Provide an overview to the client by describing program rules and client obligations and rights.
3. 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:

1. Gather relevant history from client, including, but not limited to, alcohol and other drug abuse, using appropriate interview techniques.
2. Identify methods and procedures for obtaining corroborative information from significant secondary sources regarding client's alcohol and other drug abuse and psychosocial history.
3. Identify appropriate assessment tools.
4. Explain to the client the rationale for the use of assessment techniques in order to facilitate understanding.
5. 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:

1. Explain assessment results to the client in an understandable manner.
2. Identify and rank problems based on individual client needs in the written treatment plan.
3. Formulate agreed-upon immediate and long-term goals using behavioral terms in the written treatment plan.
4. 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 elaborates 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:

1. Select the counseling theory or theories that apply.
2. Apply technique(s) to assist the client, group, and/or family in exploring problems and ramifications.
3. 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.
4. Individualize counseling in accordance with cultural, gender, and lifestyle differences.
5. Interact with the client in an appropriate therapeutic manner.
6. Elicit solutions and decisions from the client.
7. 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:

1. Coordinate services for client care.
2. 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:

1. Recognize the elements of the client crisis.
2. Implement an immediate course of action appropriate to the crisis.
3. 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 (e.g., 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:

1. Present relevant alcohol and other drug use/abuse information to the client through formal and/or informal processes.
2. 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:

1. Identify need(s) and or problem(s) that the agency and/or counselor cannot meet.
2. Explain the rationale for the referral to the client.
3. Match client needs and/or problems to appropriate resources.
4. Adhere to applicable laws, regulations, and agency policies governing procedures related to the protection of the client's confidentiality.
5. 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 ongoing 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:

1. Prepare reports and relevant records integrating available information to facilitate the continuum of care.
2. Chart pertinent ongoing information pertaining to the client.
3. 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. It 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:

1. Recognize issues that are beyond the counselor's base of knowledge and/or skill.
2. Consult with appropriate resources to ensure the provision of effective treatment services.
3. Adhere to applicable laws, regulations, and agency policies governing the disclosure of client-identifying data.
4. 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[2] (called the ASAM Criteria) contain 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 describe 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.[3]

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 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

1. The ASAM information comes from a set of guidelines published by the Medicaid Innovation Accelerator Program.
2. 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.
3. 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.

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.

LEVELS OF CARE

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 non-addiction 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

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.

- 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: Clinically Managed Low-Intensity Residential Programs

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 and self-efficacy, and make connections to the community including work, education, and family systems.

- 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 populations 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 they are able to progress onto another level of care appropriate for their SUD treatment needs.

- Setting: Services are often provided in structured, therapeutic rehabilitation facilities 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 appropriately 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, 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 patient's 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, and clinical staff who are knowledgeable about biological and psychosocial dimensions of SUD and psychiatric conditions and 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 when those 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.

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[4]

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 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.

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

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 biopsychosocial 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.

Figure 1: Summary of ASAM 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 withdrawal; will enter detoxification if needed and responds to social support when com- bined with treatment.	Risk of severe but manageable withdrawal, or has failed detoxification at lower levels of care.	Risk of severe withdrawal; detoxification requires frequent monitoring.
Biomedical Conditions	None or noninterfering with treatment.	May interfere with treatment but patient does not require inpatient care.	Continued use means imminent danger, or complications or other illness requires medical monitoring.	Complications (e.g., recurrent 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 comprehension and participation.	Inability to maintain behavioral 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, extreme depression, thought disorder, or alcohol hallucinosis/psychosis.
Readiness to Change	Willing to cooperate and attend treatment; admits problem.	Attributes problems externally; 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 therapeutic contact.	Deteriorating during level I treatment, or will drink without 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 environment or motivated to obtain social support.	Current job environment disruptive, family/ support system nonsupportive, or lack of social contacts.	Environment disruptive to treatment, logistic impediments to outpatient care, or occupation places public at risk if patient continues to drink.	Any difficulties noted in levels I, II, or III.

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.

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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 acknowledges them but reiterates 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.

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https://cod.pressbooks.pub/addictionscounseling/?p=24#h5p-2

DSM-5 CRITERIA FOR SUBSTANCE USE DISORDER[2]

Note: A current diagnosis relates only to the criterion met 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.

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

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.

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 the 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:
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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

Subpart B: Licensure Requirements

Subpart C: Requirements – All Licenses

Subpart D: Requirements – Treatment Licenses

Subpart E: Requirements – Intervention Licenses

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

In Unit 2 we will examine various skills and duties of the addictions counselor. This includes such responsibilities as assessment, treatment planning, and report and record keeping and competencies related to individual and group counseling.

In addition, there will be an exploration of different models for treating addiction. It is important to note that there isn't a one-size-fits-all solution for treating addiction. Each individual seeking help has unique needs. Treatment needs to be tailored to the individual as opposed to the other way around. As a result, there are various treatment models available to meet the various needs.

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 procedure 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 include:

- 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 psychosocial 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 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.

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 is 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 status 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: TREATMENT IMPROVEMENT PROTOCOL (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 of known or unknown origin, poor impulse control, changes in mental status, or transient neuropsychiatric complications)
4. Treatment acceptance or resistance
5. Relapse potential or continued use potential
6. 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 in private, and patients must be assured that the 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 the chart *Key Elements in Assessment*. The chart 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, 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 its own version of a biopsychosocial; all of these gather the same information utilizing different formats.

Click here to see a sample biopsychosocial template

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 1, 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 that 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 given 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 a path to identify what needs to change and what to do differently 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 successfully 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

WHAT IS TREATMENT PLANNING?

Treatment planning is the process by which the therapist and client develop a treatment plan. Treatment plans are often referred to as the roadmap of the treatment process. They outline the steps both the client and counselor will take toward the client's successful completion of treatment. They also serve as a tool to measure client progress.

After an initial assessment has been conducted, the counselor will develop a treatment plan. Treatment planning should be done collaboratively with a client, helping both client and counselor to identify problems that need to be addressed and goals related to those problems. By definition, treatment planning is the process by which the counselor and the 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 for treatment planning include:

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

Treatment planning is to be individualized. That is, the treatment plan is to include problems, goals, objectives, and interventions specific to the client and their needs. Thus, no two treatment plans will be the same, as no two individuals have the exact same experience.

IDENTIFYING PROBLEMS

When identifying problems, it helps to look at the ASAM dimensions and the information that was gathered during the initial assessment. As mentioned in Unit 1, the six ASAM dimensions are:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional, behavioral, or cognitive conditions and complications
4. Readiness to change
5. Relapse, continued use or continued problem potential
6. Recovering/living environment

When a client is seeking treatment related to a substance use disorder, the first problem addressed on the treatment plan should be related to ASAM dimension 1 and the client's use. It is determined whether or not the client will require detoxification and, if so, this is to be included on the treatment plan. If not, the substance use disorder is still the first problem to be addressed, however, in a more global sense.

Examples of Common Problems Addressed on Treatment Plans

- History of a substance use disorder
- Medical conditions that will need to be addressed in treatment or continue to be monitored if the client is already receiving medical care
- Inadequate coping related to emotions/difficulty with emotional regulation
- Diagnosable mental health disorders
- History of trauma
- Unresolved grief
- Lack of adequate support
- Relationship issues
- Employment issues, including, but not limited to, lack of employment and/or employment that places the individual at high risk for relapse
- Inadequate housing and/or housing that places the individual at high risk for relapse
- Involvement with the legal system

COMPONENTS OF THE TREATMENT PLAN

There are various components of a treatment plan. Together, these outline the issues to be addressed, outcome goals related to the issues, the steps the client will take to reach the goal, and the interventions the counselor (or sometimes other members of the clinical team) will implement to assist the client in meeting the goal.

Problems

It is not uncommon that clients will discuss several issues they are encountering in their lives during the initial assessment. It is the counselor's responsibility to identify the most significant problems to address during the time the client is engaged in treatment. Counselors should attempt to choose problems that are going to bring about the most immediate relief. Problems should be stated in behavioral terms.

Goals

Goals are created as resolutions to the problems identified. Each problem listed on the treatment plan will have one corresponding goal. Goals are written in broad terms and identify the long-term desired

outcome the client has related to the problem (e.g., "Begin to resolve family conflict related to use while maintaining a lifestyle free of substance use.")

Objectives

Objectives identify what the client will do to achieve a goal. Objectives highlight the actions a client will take to reach the goal. Because there are often several behaviors clients can or will engage in to reach a goal, it is recommended that each goal identified on the treatment plan have a minimum of two objectives.

Objectives should be written using behaviorally measurable language. This means they should be SMART (specific, measurable, achievable/attainable, relevant, and time-bound).

Creating SMART Objectives

Specific

- What will the client specifically do to reach the goal? What specific actions will they take?

Measurable

- Can you count or otherwise quantify the steps the client will take? Could someone observe and determine the skill/action was completed? Can you measure progress through use of a screening tool or questionnaire?

Achievable/attainable

- Is it realistic, given the anticipated length of stay in treatment, that the client will be able to complete the objective?

Relevant

- Is the objective related to the assessment and problem statement?

Time-bound

- What is the timeline the client has for completing the objective? Is the completion date reasonable?

Suggested Tip: *If you can see the client doing something, it is an objective (e.g., "make a list of 5 negative consequences related to use"). If you can't see the client doing something, it is a goal (e.g., "reduce anxiety").*

Interventions

Each objective on a treatment plan should have a corresponding intervention. Interventions are the actions a counselor (or sometimes another member of the clinical team) will take to assist the client in completing objectives and ultimately in achieving the goal. They outline strategies or services, and similarly to objectives, should be stated in measurable terms.

Diagnosis

Any Substance Use Disorders as determined from the assessment are included on the treatment plan.

This section of the treatment plan may also include any mental health diagnosis/es. It is important to note that certain credentials are required to diagnose mental health disorders. In the state of Illinois, a Certified Alcohol and Other Drug Counselor (CADC) cannot diagnose mental health disorders.

Responsible Person

The responsible person is the member of the clinical team who is accountable for the intervention and making sure the objective is completed. Usually this is the client's primary counselor. However, it may also be the attending psychiatrist, a case manager, or even another counselor on the treatment team who will be providing a specialized treatment or service.

Dates

The treatment plan will be signed and dated by the individual who is responsible for creating it (usually the primary counselor), the client, and the attending physician or psychiatrist. However, this isn't the only date that will be on the treatment plan. There will be target dates and sometimes review dates for each objective. The target date is the expected date the objective is to be completed and will depend on the anticipated length of treatment. The review dates identify the dates when the plan is to be reviewed. In the state of Illinois, these review dates are determined by the level of care and are outlined in Illinois Part 2060. Please refer back to Unit 1: Illinois 2060 Law for more information.

CHAPTER 7.

REPORT AND RECORD KEEPING

REPORT AND RECORD KEEPING INTRODUCTION

As we learned in Unit 1, one of the 12 core functions of the addictions counselor is report and record keeping. Report and record keeping includes charting the results of the initial assessment and treatment plan; writing reports, progress notes, and discharge summaries; and documenting any additional client-related data. In this chapter we will be covering information on report and record keeping best practices.

WHY KEEP RECORDS?

If you didn't write it down, it didn't happen. One reason to keep records is to demonstrate "proof" that a client was provided with services. It helps with justification of billing for these services. When documenting services, it is important to include the client's name, the date and time services were provided, the duration of the services (e.g., 2 hours for a treatment group), the type of service, details regarding the service (e.g., what was said and/or done), and the signature of the team member making the entry.

Records provide communication. Records can provide information to clients, professionals (including members of the clinical team), and other interested parties. Keeping well-documented records can help with continuity of care, making sure that all involved parties are working collaboratively to provide quality care.

Informed consent. A client's record should include documentation for informed consent. Informed consent is the process by which a client is provided with the relevant and necessary information regarding treatment recommendations so they may make a well-considered decision as to whether or not they want to participate in treatment. If the client agrees to the treatment recommendation(s), they must sign an informed consent document, which states that the client understands potential risks and benefits of treatment and that they are making the autonomous yet collaborative decision to enter treatment.

Case conceptualization. Good and organized record keeping helps members of the interdisciplinary team with case conceptualization. It provides the information necessary for understanding a client's presenting issues and needs, which in turn can help with mapping out a plan and treatment interventions.

Client progress. Comprehensive record keeping helps track the client's progress. Tracking the client's progress arms the counselor with the knowledge needed to make informed treatment decisions. It presents the needed information to know what is working, what might not be working, and what needs to be changed. Thorough record keeping can help with justifying clinical decisions.

Protection. Sound record-keeping practices protect both the client and the provider. As previously mentioned, record keeping helps with continuity of care and ensuring the client is provided quality

care. This protects the client. But what about the counselor? In the case of a lawsuit or other challenge to the counselor's competence, record keeping can demonstrate proof that the treatment provided was appropriate to the client's needs and goals.

Tips for Clinical Documentation

- Avoid abbreviations as they can be unclear. Abbreviations that are common usage and would easily be recognized are acceptable (e.g., HIV)
- Entries should be written using objectivity and nonjudgmental language.
- When creating handwritten entries, if a mistake is made draw a single line through the error, add the date and time and initial.
- Handwritten entries need to be legible
- Professional, clinical language should be used. Avoid language that is too informal.
- When documenting information regarding client suicidality or homicidality, make sure to be thorough.
    - Complete a risk assessment and document the results
    - Describe any actions taken to ensure client safety or the safety of others and why those actions were taken
    - If taking specific actions isn't necessary, explain how and why you reached this conclusion

THE CHART

There are various record-keeping documents that are included in a client's chart. In this section we will cover those that are most commonly found.

Informed Consent

As mentioned previously, the informed consent document is the one in which the client agrees with the treatment to be provided and *consents* to treatment.

Intake Forms

There are various documents that are completed at the time that a client enters treatment. They include such information as the client's demographic information, emergency contact information, and method of payment information.

Release of Information

When collateral information is needed and/or there are other parties the counselor will need to maintain contact with regarding the client's treatment, a release of information must be signed and dated by the client. Without a written release of information, a counselor cannot discuss the client's involvement with or progress in treatment. A release of information must include *what* information

is to be shared and with whom. It isn't uncommon that releases of information are signed to allow the counselor to discuss a client's treatment with individuals such as client's family members/significant other(s), a client's primary care physician or psychiatrist, or representatives of the justice system, such as a client's probation officer.

Assessment

As mentioned in chapter 5, assessment is the process by which the counselor/program gathers a thorough client history and evaluates the client's strengths, weaknesses, problems, and needs. The assessment, including relevant findings, should be included in the clinical documentation. Often a narrative summary (a detailed summary of the information gathered for the assessment) accompanies the assessment, as does a clinical diagnosis and level of treatment recommendation.

Progress Notes

Progress notes provide information regarding personal communication, such as individual or group counseling sessions, case management services, etc. They will include such information as content of an interaction with the client, interventions used, client progress, etc. Progress notes should include detailed information, but only that which is relevant and necessary.

The most common formats for writing progress notes include DAP (Data, Assessment, Plan) and SOAP (Subjective, Objective, Assessment, Plan).

Treatment Plan

As mentioned in chapter 6, the treatment plan is the roadmap of the treatment process. Treatment plans include problem statements, goals related to problems, and the steps both the client and counselor will take to assist the client in reaching goals.

Continued Stay Review

As outlined in Illinois 2060, there needs to be ongoing assessment of a client's progress in treatment to determine if the client is appropriate to remain in the current level of care or needs a higher or lower level of care. The continued stay reviews are included in the client's chart.

Discharge Summary/Discharge Paperwork

When a client is no longer actively receiving treatment in, or no longer requires an ASAM level of care, discharge paperwork needs to be completed and included in the chart. This includes a continuing recovery plan and a discharge summary. The discharge summary needs to include the reason for discharge, the client's progress relative to the goals on the treatment plan, and a prognostic statement of the client's condition at the time of discharge.

CONFIDENTIALITY

The United States Health Insurance Portability and Accountability Act (HIPAA) outlines federal regulatory standards regarding the lawful use and disclosure of protected health information. Maintaining HIPAA compliance ensures that sensitive client information is protected and secured.

Protected Health Information (PHI)

Protected Health Information refers to individually identifiable health information. This information can be in electronic, paper, or oral form. PHI is in essence any information related to an individual's physical or mental health. PHI includes such items as a client's:

- Name
- Address
- Social security number
- Date of birth
- Contact information including email address and phone number
- Medical record or account numbers

Although there is a great deal more information regarding client confidentiality and HIPAA compliance, the bottom line is that patient records are confidential and it is imperative that action is taken to ensure client confidentiality. Hard copies of client records need to be kept in locked and secured cabinets in locked offices or storage rooms. Electronic records are to be protected using various technical safeguards, including, but not limited to, encryption tools and firewalls.

Records of HIV-Positive Clients

It is important to note that there are specific state and federal laws that protect confidentiality of HIV-related information. In addiction treatment settings, records regarding a client's +HIV status need to be kept in a separate medical chart. This information is only to be shared only with members of the medical team unless otherwise disclosed by the client themselves.

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CHAPTER 8.

INDIVIDUAL AND GROUP COUNSELING SKILLS

INDIVIDUAL COUNSELING SKILLS

COMPONENTS OF THE THERAPEUTIC ALLIANCE

Before we can move onto looking at some of the individual counseling skills themselves, it is important to identify components of a positive therapeutic alliance. There are literally dozens, if not hundreds, of characteristics that could be listed as elements of the positive therapeutic alliance, depending on who was asked. For the purposes of this book, we have identified what we feel are the most important.

Empathy

In order to develop a strong therapeutic connection, empathy is imperative. Empathy is the ability to listen to another's story, understand context, and take their perspective. This includes the ability to accurately identify the individual's thoughts and feelings and *feel with* them. It also involves being able to effectively communicate this with the other party.

Trust

Trust is a key component in the therapeutic relationship. It involves the ability of our clients to feel safe in sharing their experiences along with having confidence that we will not hurt or violate them. It's important to note that trust is developed and earned over time and is a two-way street. Just as our clients need to trust us, we need to trust that they have the ability to make effective changes in their lives.

Active Listening

Active listening is vital to the therapeutic relationship. Active listening means being with our clients in the moment and not only hearing what they are saying, but being able to hypothesize as to the message they are trying to convey. It means being able to pay attention to nonverbal cues and read between the lines. Active listening also includes listening with the goal of understanding.

Cultural Competence

Human beings are multifaceted individuals. As a result, they have different worldviews and needs, given the intersection of these facets and their experiences in the world. Being culturally competent is an important characteristic for counselors to possess. It assists counselors in choosing approaches and interventions that are aligned with and respectful of a client's culture. Demonstrating cultural competence helps clients to feel safe and acknowledges the importance of culture in the recovery process.

Flexibility and Adaptability

Treatment does not consist of a "one size fits all" approach. Thus, flexibility is a key component of the therapeutic relationship. Flexibility has many benefits, from being able to work with clients who have different backgrounds, experiences, personalities, problems, and needs, and tailoring interventions to best suit the individual, to knowing when it is appropriate to refer a client to another professional who can better help and meet their needs.

Adaptability is equally important. There is a saying that "nothing is constant but change." This includes the counseling profession as well. Adaptability means being able to embrace that change is inevitable. It includes being able to grow from change, getting out of our comfort zone, having backup plans when the original doesn't turn out the way we expected, and the willingness to grow as a professional through our commitment to being lifelong learners, including learning new skills.

Respect

The great humanistic psychologist Carl Rogers coined the term "unconditional positive regard". It is the technique of accepting and supporting clients as who and how they are without conditions. Unconditional positive regard is in many ways tied to respect. It is important that counselors demonstrate respect for their clients as they are. This includes respecting a client's thoughts, feelings, and decisions as their own, even when the counselor may not agree.

Boundaries

The importance of establishing and maintaining boundaries within the therapeutic relationship cannot be stressed enough. Boundaries are the parameters counselors establish that help ensure the therapeutic relationship remains effective and ethical.

TREATMENT IMPROVEMENT PROTOCOL 35: ENHANCING MOTIVATION FOR CHANGE IN SUBSTANCE USE DISORDER TREATMENT (ADAPTATION)

MOTIVATIONAL INTERVIEWING AS A COUNSELING STYLE

> *"Motivational interviewing is a person-centered counseling style for addressing the common problem of ambivalence about change."*
> Miller & Rollnick, 2013, p. 21

Introduction to MI

MI is a counseling style based on the following assumptions:

- Ambivalence about substance use and change is normal and is an important motivational barrier to substance use behavior change.
- Ambivalence can be resolved by exploring the client's intrinsic motivations and values.
- Your alliance with the client is a collaborative partnership to which you each bring important expertise.
- An empathic, supportive counseling style provides conditions under which change can occur.

You can use MI to effectively reduce or eliminate client substance use and other health-risk behaviors in many settings and across genders, ages, races, and ethnicities (DiClemente, Corno, Graydon, Wiprovnick, & Knoblach, 2017; Dillard, Zuniga, & Holstad, 2017; Lundahl et al., 2013). Analysis of more than 200 randomized clinical trials found significant efficacy of MI in the treatment of SUDs (Miller & Rollnick, 2014).

The MI counseling style helps clients resolve ambivalence that keeps them from reaching personal goals. MI builds on Carl Rogers's (1965) humanistic theories about people's capacity for exercising free choice and self-determination. Rogers identified the sufficient conditions for client change, which are now called "common factors" of therapy, including counselor empathy (Miller & Moyers, 2017).

As a counselor, your main goals in MI are to express empathy and elicit clients' reasons for and commitment to changing substance use behaviors (Miller & Rollnick, 2013). MI is particularly helpful when clients are in the Precontemplation and Contemplation stages of the Stages of Change (SOC), when readiness to change is low, but it can also be useful throughout the change cycle.

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=138#oembed-1

The Spirit of MI

Use an MI counseling style to support partnership with clients. Collaborative counselor–client relationships are the essence of MI, without which MI counseling techniques are ineffective. Counselor MI spirit is associated with positive client engagement behaviors (e.g., self-disclosure, cooperation) (Romano & Peters, 2016) and positive client outcomes in health-related behaviors (e.g., exercise, medication adherence) similar to those in addiction treatment (Copeland, McNamara, Kelson, & Simpson, 2015).

The spirit of MI (Miller & Rollnick, 2013) comprises the following elements:

- **Partnership** refers to an active collaboration between you and the client. A client is more willing to express concerns when you are empathetic and show genuine curiosity about the client's perspective. In this partnership, you are influential, but the client drives the conversation.
- **Acceptance** refers to your respect for and approval of the client. This doesn't mean agreeing with everything the client says but is a demonstration of your intention to understand the client's point of view and concerns. In the context of MI, there are four components of acceptance:
    - ***Absolute worth:*** Prizing the inherent worth and potential of the client
    - ***Accurate empathy:*** An active interest in, and an effort to understand, the client's internal perspective reflected by your genuine curiosity and reflective listening
    - ***Autonomy support:*** Honoring and respecting a client's right to and capacity for self-direction

    - ***Affirmation:*** Acknowledging the client's values and strengths
- **Compassion** refers to your active promotion of the client's welfare and prioritization of client needs.
- **Evocation** elicits and explores motivations, values, strengths, and resources the client already has.

To remember the four elements, use the acronym PACE (Stinson & Clark, 2017). The specific counseling strategies you use in your counseling approach should emphasize one or more of these elements.

Principles of Person-Centered Counseling

MI reflects a longstanding tradition of humanistic counseling and the person-centered approach of Carl Rogers. It is theoretically linked to his theory of the "critical conditions for change," which states that clients change when they are engaged in a therapeutic relationship in which the counselor is genuine and warm, expresses unconditional positive regard, and displays accurate empathy (Rogers, 1965).

MI adds another dimension in your efforts to provide person-centered counseling. In MI, the counselor follows the principles of person-centered counseling, but also guides the conversation toward a specific, client-driven change goal. MI is more directive than purely person-centered counseling; it is guided by the following broad person-centered counseling principles (Miller & Rollnick, 2013):

- SUD treatment services exist to help recipients. The needs of the client take precedence over the counselor's or organization's needs or goals.
- The client engages in a process of self-change. You facilitate the client's natural process of change.
- The client is the expert on his or her own life and has knowledge of what works and what doesn't.
- As the counselor, you **do not** make change happen.
- People have their own motivation, strengths, and resources. Counselors help activate those resources.
- You are not responsible for coming up with all the good ideas about change, and you probably don't have the best ideas for any particular client.
- Change requires a partnership and "collaboration of expertise."
- You must understand the client's perspectives on his or her problems and need to change.
- The counseling relationship is not a power struggle. Conversations about change should not become debates. Avoid arguing with or trying to persuade the client that your position is correct.
- Motivation for change is evoked from, not given to, the client.
- People make their own decisions about taking action. It is not a change goal until the client says so.

- The spirit of MI and client-centered counseling principles foster a sound therapeutic alliance.

Research on person-centered counseling approaches consistent with MI in treating alcohol use disorder (AUD) found that several sessions improved client outcomes, including readiness to change and reductions in alcohol use (Barrio & Gual, 2016).

What Is New in MI

Much has changed in MI since Miller and Rollnick's original (1991) and updated (2002) work. Exhibit 3.1 summarizes important changes to MI based on decades of research and clinical experience.

EXHIBIT 3.1. A Comparison of Original and Updated Versions of MI

ORIGINAL VERSION	UPDATED VERSION
Four principles as the basis for the MI approach: 1. **Express empathy:** Demonstrate empathy through reflective listening. 2. **Develop discrepancy:** Guide conversations to highlight the difference between clients' goals or values and their current behavior. 3. **Roll with resistance:** Avoid arguing against the status quo or arguing for change. 4. **Support self-efficacy:** Support clients' beliefs that change is possible. Although these general principles are still helpful, the new emphasis in MI is on **evoking change talk** and **commitment to change** as primary principles.	Four processes as the basis for the MI approach: 1. **Engaging** is the relational foundation. 2. **Focusing** identifies agenda and change goals. 3. **Evoking** uses MI core skills and strategies for moving toward a specific change goal. 4. **Planning** is the bridge to behavior change. The four processes replace Phase I and II stages in the original version of MI. Core skills and strategies of MI include asking open questions, affirming, using reflective listening, and summarizing; all are integrated into the four processes. The original four principles have been folded into the four processes as reflective listening or strategic responses to move conversations along.
Resistance is a characteristic of the client.	Resistance is an expression of sustain talk and the status quo side of ambivalence, arising out of counselor–client discord.
Rolling with resistance	Strategies to lessen sustain talk and counselor–client discord
Self-motivating statements	Change talk
Decisional balancing is a strategy to help clients move in one direction toward changing a behavior.	Decisional balancing is used to help clients make a decision without favoring a specific direction of change. It may be useful as a way to assess client readiness to change but also may increase ambivalence for clients who are contemplating change.

Source: Miller & Rollnick, 1991, 2002, 2013; Miller & Rose, 2013.

Exhibit 3.2 presents common misconceptions about MI and provides clarification of MI's underlying theoretical assumptions and counseling approach, which are described in the rest of this chapter.

EXHIBIT 3.2. Misconceptions and Clarifications About MI

MISCONCEPTION	CLARIFICATION
MI is a form of nondirective, Rogerian therapy.	MI shares many principles of the humanistic, person-centered approach pioneered by Rogers, but it is not Rogerian therapy. Characteristics that differentiate MI from Rogerian therapy include clearly identified target behaviors and change goals and differential evoking and strengthening of clients' motivation for changing target behavior. Unlike Rogerian therapy, MI has a strategic component that emphasizes helping clients move toward a specific behavioral change goal.
MI is a counseling technique.	Although there are specific MI counseling strategies, MI is not a counseling technique. It is a style of being with people that uses specific clinical skills to foster motivation to change.
MI is a "school" of counseling or psychotherapy.	Some psychological theories underlie the spirit and style of MI, but it was not meant to be a theory of change with a comprehensive set of associated clinical skills.
MI and the SOC approach are the same.	MI and the SOC were developed around the same time, and people confuse the two approaches. MI is not the SOC. MI is not an essential part of the SOC and vice versa. They are compatible and complementary. MI is also compatible with counseling approaches like cognitive–behavioral therapy (CBT).
MI always uses assessment feedback.	Assessment feedback delivered in the MI style was an adaptation of MI that became motivational enhancement therapy (MET). Although personalized feedback may be helpful to enhance motivation with clients who are on the lower end of the readiness to change spectrum, it is not a necessary part of MI.
Counselors can motivate clients to change.	You cannot manufacture motivation that is not already in clients. MI does not motive clients to change or to move toward a predetermined treatment goal. It is a collaborative partnership between you and clients to discover their motivation to change. It respects client autonomy and self-determination about goals for behavior change.

Sources: Miller & Rollnick, 2013, 2014; Moyers, 2014.

Ambivalence

A key concept in MI is ambivalence. It is normal for people to feels two ways about making an important change in their lives. **Frequently, client ambivalence is a roadblock to change, not a lack of knowledge or skills about how to change** (Forman & Moyers, 2019). Individuals with SUDs are often aware of the risks associated with their substance use, but continue to use substances anyway. They may need to stop using substances, but they continue to use. The tension between these feelings is ambivalence.

Ambivalence about changing substance use behaviors is natural. As clients move from Precontemplation to Contemplation, their feelings of conflict about change increase. This tension may help move people toward change, but often the tension of ambivalence leads people to avoid thinking about the problem. They may tell themselves things aren't so bad (Miller & Rollnick, 2013). **View ambivalence not as denial or resistance, but as a normal experience in the change process.** If you interpret ambivalence as denial or resistance, you are likely to evoke discord between you and clients, which is counterproductive.

Sustain Talk and Change Talk

Recognizing sustain talk and change talk in clients will help you better explore and address their ambivalence.

Sustain talk consists of client statements that support not changing a health-risk behavior, like substance misuse. Change talk consists of client statements that favor change (Miller & Rollnick, 2013). Sustain talk and change talk are expressions of both sides of ambivalence about change. Over time, MI has evolved in its understanding of what keeps clients stuck in ambivalence about change and what supports clients to move in the direction of changing substance use behaviors. Client stuck in ambivalence will engage in a lot of sustain talk, whereas clients who are more ready to change will engage in more change talk with stronger statements supporting change.

Greater frequency of client sustain talk in sessions is linked to poorer substance use treatment outcomes (Lindqvist, Forsberg, Enebrink, Andersson, & Rosendahl, 2017; Magill et al., 2014; Rodriguez, Walters, Houck, Ortiz, & Taxman, 2017). Conversely, MI-consistent counselor behavior focused on eliciting and reflecting change talk, more client change talk compared with sustain talk, and stronger commitment change talk are linked to better substance use outcomes (Barnett, Moyers, et al., 2014; Borsari et al., 2018; Houck, Manuel, & Moyers, 2018; Magill et al., 2014, 2018; Romano & Peters, 2016). Counselor empathy is also linked to eliciting client change talk (Pace et al., 2017).

Another development in MI is the delineation of different kinds of change talk. The acronym for change talk in MI is DARN-CAT (Miller & Rollnick, 2013):

> In MI, your main goal is to evoke change talk and minimize evoking or reinforcing sustain talk in counseling sessions.

- **D**esire to change: This is expressed in statements about wanting something different— "I want to find an Alcoholics Anonymous (AA) meeting" or "I hope to start going to AA."
- **A**bility to change: This is expressed in statements about self-perception of capability— "I could start going to AA."
- **R**easons to change: This is expressed as arguments for change—"I'd probably learn more about recovery if I went to AA" or "Going to AA would help me feel more supported."
- **N**eed to change: This is expressed in client statements about importance or urgency—"I have to stop drinking" or "I need to find a way to get my drinking under control."
- **C**ommitment: This is expressed as a promise to change—"I swear I will go to an AA meeting this year" or "I guarantee that I will start AA by next month."
- **A**ctivation: This is expressed in statements showing movement toward action—"I'm ready to go to my first AA meeting."
- **T**aking steps: This is expressed in statements indicating that the client has already done something to change—"I went to an AA meeting" or "I avoided a party where friends would be doing drugs."

Exhibit 3.3 depicts examples of change talk and sustain talk that correspond to DARN-CAT.

EXHIBIT 3.3. Examples of Change Talk and Sustain Talk

TYPE OF STATEMENT	EXAMPLES OF CHANGE TALK	EXAMPLES OF SUSTAIN TALK
Desire	"I want to cut down on my drinking."	"I love how cocaine makes me feel."
Ability	"I could cut back to 1 drink with dinner on weekends."	"I can manage my life just fine without giving up the drug."
Reasons	"I'll miss less time at work if I cut down."	"Getting high helps me feel energized."
Need	"I have to cut down. My doctor told me that the amount I am drinking puts my health at risk."	"I need to get high to keep me going every day."
Commitment	"I promise to cut back this weekend."	"I am going to keep snorting cocaine."
Activation	"I am ready to do something about the drinking."	"I am not ready to give up the cocaine."
Taking steps	"I only had one drink with dinner on Saturday."	"I am still snorting cocaine every day."

Source: Miller & Rollnick, 2013.

To make the best use of clients' change talk and sustain talk that arise in sessions, remember to:

- Recognize client expressions of change talk but don't worry about differentiating various kinds of change talk during a counseling session.
- Use reflective listening to reinforce and help clients elaborate on change talk.
- Use DARN-CAT in conversations with clients.
- Recognize sustain talk and use MI strategies to lessen the impact of sustain talk on clients' readiness to change (see discussion on responding to change talk and sustain talk in the next section).
- Be aware that both sides of ambivalence (change talk and sustain talk) will be present in your conversations with clients.

A New Look at Resistance

Understanding the role of resistance and how to respond to it can help you maintain good counselor–client rapport.

Resistance in SUD treatment has historically been considered a problem centered in the client. As MI has developed over the years, its understanding of resistance has changed. Instead of emphasizing resistance as a pathological defense mechanism, MI views resistance as a normal part of ambivalence and a client's reaction to the counselor's approach in the moment (Miller & Rollnick, 2013).

A client may express resistance in sustain talk that favors the "no change" side of ambivalence. The way you respond to sustain talk can contribute to the client becoming firmly planted in the status quo or help the client move toward contemplating change. For example, the client's show of ambivalence about change and your arguments for change can create discord in your therapeutic relationship.

Client sustain talk is often evoked by discord in the counseling relationship (Miller & Rollnick,

2013). **Resistance is a two-way street. If discord arises in conversation, change direction or listen more carefully.** This is an opportunity to respond in a new, perhaps surprising, way and to take advantage of the situation without being confrontational. This new way of looking at resistance is consistent with the principles of person-centered counseling described at the beginning of the chapter.

Here is an example of what MI is NOT:

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=138#oembed-2

Core Skills of MI: OARS

To remember the core counseling skills of MI, use the acronym OARS (Miller & Rollnick, 2013):

- Asking **O**pen questions
- **A**ffirming
- **R**eflective listening
- **S**ummarizing

These core skills are consistent with the principles of person-centered counseling and can be used throughout your work with clients. If you use these skills, you will more likely have greater success in engaging clients and less incidence of discord within the counselor–client relationship. These core skills are described below.

Asking Open Questions

Use open questions to invite clients to tell their story rather than closed questions, which merely elicit brief information. Open questions are questions that invite clients to reflect before answering and encourage them to elaborate. Asking open questions helps you understand their point of view. Open questions facilitate a dialog and do not require any particular response from you. They encourage clients to do most of the talking and keep the conversation moving forward. Closed questions evoke yes/no or short answers and sometimes make clients feel as if they have to come up with the right answer. One type of open question is actually a statement that begins with "Tell me about" or "Tell me more about." The "Tell me about" statement invites clients to tell a story and serves as an open question.

Examples

Examples of **closed** questions:

- "So you are here because you are concerned about your use of alcohol, correct?"
- "How many children do you have?"
- "Do you agree that it would be a good idea for you to go through detoxification?"
- "On a typical day, how much marijuana do you smoke?
- "Did your doctor tell you to quit smoking?"

Examples of **open** questions:

- "What is it that brings you here today?"
- "Tell me about your family."
- "What do you think about the possibility of going through detoxification?"
- "Tell me about your marijuana use on a typical day."
- "In what ways are you concerned about your use of amphetamines?"

There may be times when you must ask closed questions, for example, to gather information for a screening or assessment. However, if you use open questions—"Tell me about the last time you used methamphetamines"—you will often get the information you need and enhance the process of engagement. During assessment, avoid the question-and-answer trap, which can decrease rapport, become an obstacle to counselor–client engagement, and stall conversations.

MI involves maintaining a balance between asking questions and reflective listening (Miller & Rollnick, 2013). Ask one open question and follow it with two or more reflective listening responses.

Affirming

Affirming is a way to express your genuine appreciation and positive regard for clients (Miller & Rollnick, 2013). Affirming clients supports and promotes self-efficacy. By affirming, you are saying, "I see you, what you say matters, and I want to understand what you think and feel" (Miller & Rollnick, 2013). **Affirming can boost clients' confidence about taking action.** Using affirmations in conversations with clients consistently predicts positive client outcomes (Romano & Peters, 2016).

When affirming:

- Emphasize client strengths, past successes, and efforts to take steps, however small, to accomplish change goals.
- Do not confuse this type of feedback with praise, which can sometimes be a roadblock to effective listening.
- Frame your affirming statements with "you" instead of "I." For example, instead of saying "I am proud of you," which focuses more on you than on the client, try "You have worked really hard to get to where you are now in your life," which demonstrates your appreciation, but keeps the focus on the client (Miller & Rollnick, 2013).
- Use statements such as (Miller & Rollnick, 2013):

- "You took a big step in coming here "
- "You got discouraged last week, but kept going to your AA. You are persistent."
- "Although things didn't turn out the way you hoped, you tried really hard, and that means a lot."
- "That's a good idea for how you can avoid situations where you might be tempted to drink."

There may be ethnic, cultural, and even personal differences in how people respond to affirming statements. Be aware of verbal and nonverbal cues about how the client is reacting and be open to checking out the client's reaction with an open question—"How was that for you to hear?" Strategies for forming affirmations that account for cultural and personal differences include (Rosengren, 2018):

- Focusing on specific behaviors to affirm.
- Avoiding using "I."
- Emphasizing descriptions instead of evaluations.
- Emphasizing positive developments instead of continuing problems.
- Affirming interesting qualities and strengths of clients.
- Holding an awareness of client strengths instead of deficits as you formulate affirmations.

Reflective Listening

Reflective listening is the key component of expressing empathy. Reflective listening is fundamental to person-centered counseling in general and MI in particular (Miller & Rollnick, 2013). Reflective listening (Miller & Rollnick, 2013):

- Communicates respect for and acceptance of clients.
- Establishes trust and invites clients to explore their own perceptions, values, and feelings.
- Encourages a nonjudgmental, collaborative relationship.
- Allows you to be supportive without agreeing with specific client statements.

Reflective listening builds collaboration and a safe and open environment that is conducive to examining issues and eliciting the client's reasons for change. It is both an expression of empathy and a way to selectively reinforce change talk (Romano & Peters, 2016). Reflective listening demonstrates that you are genuinely interested in understanding the client's unique perspective, feelings, and values. Expressions of counselor empathy predict better substance use outcomes (Moyers, Houck, Rice, Longabaugh, & Miller, 2016). Your attitude should be one of acceptance, but not necessarily approval or agreement, recognizing that ambivalence about change is normal.

Consider ethnic and cultural differences when expressing empathy through reflective listening. These differences influence how both you and the client interpret verbal and nonverbal communications.

Reflective listening is not as easy as it sounds. It is not simply a matter of being quiet while the client is speaking. Reflective listening requires you to make a mental hypothesis about the underlying

meaning or feeling of client statements, then reflect that back to the client with your best guess about his or her meaning or feeling (Miller & Rollnick, 2013). Gordon (1970) called this "active listening" and identified 12 kinds of responses that people often give to others that are not active listening and can actually derail a conversation. Exhibit 3.5 describes these roadblocks to listening.

EXHIBIT 3.5. Gordon's 12 Roadblocks to Active Listening

1. **Ordering, directing, or commanding**	Direction is given with a voice of authority. The speaker may be in a position of power (e.g., parent, employer, counselor) or the words may simply be phrased and spoken in a way that communicates that the speaker is the expert.
2. **Warning, cautioning, or threatening**	These statements carry an overt or covert threat of negative consequences. For example, "If you don't stop drinking, you are going to die."
3. **Giving advice, making suggestions, or providing solutions prematurely or when unsolicited**	The message recommends a course of action based on your knowledge and personal experience. These recommendations often begin with phrases like "What I would do is."
4. **Persuading with logic, arguing, or lecturing**	The underlying assumption of these messages is that the client has not reasoned through the problem adequately and needs help to do so. Trying to persuade the client that your position is correct will most likely evoke a reaction and the client taking the opposite position.
5. **Moralizing, preaching, or telling people what they should do**	These statements contain such words as "should" or "ought," which imply or directly convey negative judgment.
6. **Judging, criticizing, disagreeing, or blaming**	These messages imply that something is wrong with the client or with what the client has said. Even simple disagreement may be interpreted as critical.

Continued

7. **Agreeing, approving, or praising**	Praise or approval can be an obstacle if the message sanctions or implies agreement with whatever the client has said or if the praise is given too often or in general terms, like "great job." This can lessen the impact on the person or simply disrupt the flow of the conversation.
8. **Shaming, ridiculing, or labeling**	These statements express disapproval and intent to correct a specific behavior or attitude. They can damage self-esteem and cause major disruptions in the counseling alliance.
9. **Interpreting or analyzing**	You may be tempted to impose your own interpretations on a client's statement and to find some hidden, analytical meaning. Interpretive statements might imply you know what the client's "real" problem is and puts you in a one-up position.
10. **Reassuring, sympathizing, or consoling**	Counselors often want to console the client. It is human nature to want to reassure someone who is in pain; however, sympathy is not the same as empathy. Such reassurance can interrupt the flow of communication and interfere with careful listening.
11. **Questioning or probing**	Do not mistake questioning for good listening. Although you may ask questions to learn more about the client, the underlying message is that you might find the right answer to all the client's problems if enough questions are asked. In fact, intensive questioning can disrupt communication, and sometimes the client feels as if he or she is being interrogated.
12. **Withdrawing, distracting, humoring, or changing the subject**	Although shifting the focus or using humor may be helpful at times, it can also be a distraction and disrupt the communication.

Source: Gordon, 1970.

If you engage in any of these 12 activities, you are talking and not listening. However well intentioned, these roadblocks to listening shift the focus of the conversation from the client to the counselor. They are not consistent with the principles of person-centered counseling.

Types of reflective listening

In MI, there are several kinds of reflective listening responses that range from simple (e.g., repeating or rephrasing a client statement) to complex (e.g., using different words to reflect the underlying meaning or feeling of a client statement). **Simple reflections engage clients and let them know that you're genuinely interested in understanding their perspective. Complex reflections invite clients to deepen their self-exploration** (Miller & Rollnick, 2013). In MI, there are special complex reflections that you can use in specific counseling situations, like using a double-sided reflection when clients are expressing ambivalence about changing a substance use behavior. Exhibit 3.6 provides examples of simple and complex reflective listening responses to client statements about substance use.

EXHIBIT 3.6. Types of Reflective Listening Responses

TYPE	CLIENT STATEMENT	COUNSELOR RESPONSE	PURPOSE	SPECIAL CONSIDERATIONS
Simple				
Repeat	"My wife is nagging me about my drinking."	"Your wife is nagging you about your drinking."	Builds rapport. Expresses empathy.	Avoid mimicking.
Rephrase	"My wife is nagging me about my drinking."	"Your wife is pressuring you about your drinking."	Expresses empathy. Highlights selected meaning or feeling.	Move the conversation along, but more slowly than complex reflections.
Complex				
Feeling	"I'd like to quit smoking marijuana so that the second-hand pot smoke won't worsen my daughter's asthma."	"You're afraid that your daughter's asthma will get worse if you continue smoking marijuana."	Highlights selected feeling. Highlights discrepancy between values and current behavior.	Selectively reinforce change talk. Avoid reinforcing sustain talk.
Meaning	"I'd like to quit smoking marijuana because I read that second-hand pot smoke can make asthma worse and I don't want that to happen to my daughter."	"You want to protect your daughter from the possibility that her asthma will get worse if you continue smoking marijuana."	Highlights selected meaning. Highlights discrepancy between values and current behavior.	Selectively reinforce change talk. Avoid reinforcing sustain talk.
Double-sided	"I know I should give up drinking, but I can't imagine life without it."	"Giving up drinking would be hard, **and** you recognize that it's time to stop."	Resolves ambivalence. Acknowledges sustain talk **and** emphasizes change talk.	Use "and" to join two reflections. Start with sustain talk reflection and end with change talk reflection.
Amplified	"I think my cocaine use is just not a problem for me."	"There are absolutely no negative consequences of using cocaine."	Intensifies sustain talk to evoke change talk.	Use sparingly. Avoid getting stuck in sustain talk.

Source: Miller & Rollnick, 2013.

Forming complex reflections

Simple reflections are fairly straightforward. You simply repeat or paraphrase what the client said. Complex reflections are more challenging. A statement could have many meanings. The first step in

making a complex reflection of meaning or feelings is to make a hypothesis in your mind about what the client is trying to say (Miller & Rollnick, 2013).

Use these steps to form a mental hypothesis about meaning or feelings:

1. If the client says, "I drink because I am lonely," think about the possible meanings of "lonely." Perhaps the client is saying, "I lost my spouse" or "It is hard for me to make friends" or "I can't think of anything to say when I am with my family."
2. Consider the larger conversational context. Has the client noted not having much of a social life?
3. Make your best guess about the meaning of the client's statement.
4. Offer a reflective listening response—"You drink because it is hard for you to make friends."
5. Wait for the client's response. The client will tell you either verbally or nonverbally if your guess is correct. If the client continues to talk and expands on the initial statement, you are on target.
6. Be open to being wrong. If you are, use client feedback to make another hypothesis about the client's meaning.

Remember that reflective listening is about refraining from making assumptions about the underlying message of client statements, making a hypothesis about the meaning or feeling of the statement, and then checking out your hypothesis by offering a reflective statement and listening carefully to the client's response (Miller & Rollnick, 2013). Reflective listening is basic to all four MI processes. **Follow open questions with at least one reflective listening response—but preferably two or three responses—before asking another question.** A higher ratio of reflections to questions consistently predicts positive client outcomes (Romano & Peters, 2016). It takes practice to become skillful, but the effort is worth it because careful reflective listening builds a therapeutic alliance and facilitates the client's self-exploration—two essential components of person-centered counseling (Miller & Rollnick, 2013). The key to expressing accurate empathy through reflective listening is your ability to shift gears from being an expert who gives advice to being an individual supporting the client's autonomy and expertise in making decisions about changing substance use behaviors (Moyers, 2014).

Summarizing

Summarizing is a form of reflective listening that distills the essence of several client statements and reflects them back to him or her. It is not simply a collection of statements. You intentionally select statements that may have particular meaning for the client and present them in a summary that paints a fuller picture of the client's experience than simply using reflections (Miller & Rollnick, 2013).

There are several types of summarization in MI (Miller & Rollnick, 2013):

- **Collecting summary:** Recalls a series of related client statements, creating a narrative to reflect on.
- **Linking summary:** Reflects a client statement; links it to an earlier statement.
- **Transitional summary:** Wraps up a conversation or task; moves the client along the change process.

- **Ambivalence summary:** Gathers client statements of sustain talk and change talk during a session. This summary should acknowledge sustain talk, but reinforce and highlight change talk.
- **Recapitulation summary:** Gathers all of the change talk of many conversations. It is useful during the transition from one stage to the next when making a change plan.

At the end of a summary, ask the client whether you left anything out. This opportunity lets the client correct or add more to the summary and often leads to further discussion. Summarizing encourages client self-reflection.

Summaries reinforce key statements of movement toward change. Clients hear change talk once when they make a statement, twice when the counselor reflects it, and again when the counselor summarizes the discussion.

Let's take a look at an effective example of MI in action:

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=138#oembed-3

Four Processes of MI

MI has moved away from the idea of phases of change to overlapping processes that more accurately describe how MI works in clinical practice. This change is a shift away from a linear, rigid model of change to a circular, fluid model of change within the context of the counseling relationship. This section reviews these MI processes, summarizes counseling strategies appropriate for each process, and integrates the four principles of MI from previous versions.

Engaging

Engaging clients is the first step in all counseling approaches. Specific counseling strategies or techniques will not be effective if you and the client haven't established a strong working relationship. MI is no exception to this. Miller and Rollnick (2013) define engaging in MI "as the process of establishing a mutually trusting and respectful helping relationship" (p. 40). Research supports the link between your ability to develop this kind of helping relationship and positive treatment outcomes such as reduced drinking (Moyers et al., 2016; Romano & Peters, 2016).

Opening strategies

Opening strategies promote engagement in MI by emphasizing OARS in the following ways:

- Ask open questions instead of closed questions.
- Offer affirmations of client self-efficacy, hope, and confidence in the client's ability to change.
- Emphasize reflective listening.
- Summarize to reinforce that you are listening and genuinely interested in the client's perspective.
- Determine the client's readiness to change or specific stage in the stages of change.
- Avoid prematurely focusing on taking action.
- Try not to identify the client's treatment goals until you have sufficiently explored the client's readiness. Then you can address the client's ambivalence.

These opening strategies ensure support for the client and help the client explore ambivalence in a safe setting. In the following initial conversation, the counselor uses OARS to establish rapport and address the client's drinking through reflective listening and asking open questions:

Counselor: Jerry, thanks for coming in. *(Affirmation)* What brings you here today? *(Open question)*

Client: My wife thinks I drink too much. She says that's why we argue all the time. She also thinks that my drinking is ruining my health.

Counselor: So your wife has some concerns about your drinking interfering with your relationship and harming your health. *(Reflection)*

Client: Yeah, she worries a lot.

Counselor: You wife worries a lot about the drinking. *(Reflection)* What concerns **you** about it? *(Open question)*

Client: I'm not sure I'm *concerned* about it, but I do wonder sometimes if I'm drinking too much.

Counselor: You are wondering about the drinking. *(Reflection)* Too much for…? *(Open question that invites the client to complete the sentence)*

Client: For my own good, I guess. I mean it's not like it's really serious, but sometimes when I wake up in the morning, I feel really awful, and I can't think straight most of the morning.

Counselor: It messes up your thinking, your concentration. *(Reflection)*

Client: Yeah, and sometimes I have trouble remembering things.

Counselor: And you wonder if these problems are related to drinking too much. *(Reflection)*

Client: Well, I know it is sometimes.

Counselor: You're certain that sometimes drinking too much hurts you. *(Reflection)* Tell me what it's like to lose concentration and have trouble remembering. *(Open question in the form of a statement)*

Client: It's kind of scary. I am way too young to have trouble with my memory. And now that I think about it, that's what usually causes the arguments with my wife. She'll ask me to pick up something from the store and when I forget to stop on my way home from work, she starts yelling at me.

Counselor: You're scared that drinking is starting to have some negative effects on

what's important to you, like your ability to think clearly and good communication with your wife. *(Reflection)*

Client: Yeah. But I don't think I'm an alcoholic or anything.

Counselor: You don't think you're that bad off, but you do wonder if maybe you're overdoing it and hurting yourself and your relationship with your wife. *(Reflection)*

Client: Yeah.

Counselor: You know, Jerry, it takes courage to come talk to a stranger about something that's scary to talk about. *(Affirmation)* What do you think? *(Open question)*

Client: I never thought of it like that. I guess it is important to figure out what to do about my drinking.

Counselor: So, Jerry, let's take a minute to review where we are today. Your wife is concerned about how much you drink. You have been having trouble concentrating and remembering things and are wondering if that has to do with how much you are drinking. You are now thinking that you need to figure out what to do about the drinking. Did I miss anything? *(Summary)*

Avoiding traps

Identify and avoid traps to help preserve client engagement. The above conversation shows use of core MI skills to engage the client and help him feel heard, understood, and respected while moving the conversation toward change. The counselor avoids common traps that increase disengagement.

Common traps to avoid include the following (Miller & Rollnick, 2013):

- **The Expert Trap:** People often see a professional, like a primary care physician or nurse practitioner, to get answers to questions and to help them make important decisions. But relying on another person (even a professional) to have all the answers is contrary to the spirit of MI and the principles of person-centered care. **Both you and the client have expertise.** You have knowledge and skills in listening and interviewing; the client has knowledge based on his or her life experience. In your conversations with a client, remember that you do not have to have all the answers, and trust that the client has knowledge about what is important to him or her, what needs to change, and what steps need to be taken to make those changes. Avoid falling into the expert trap by:
  - **Refraining from acting on the "righting reflex,"** the natural impulse to jump into action and direct the client toward a specific change. Such a directive style is likely to produce sustain talk and discord in the counseling relationship.
  - **Not arguing with the client.** If you try to prove a point, the client predictably takes the opposite side. Arguments with the client can rapidly degenerate into a power struggle and do not enhance motivation for change.
- **The Labeling Trap**: Diagnoses and labels like "alcoholic" or "addict" can evoke shame in clients. There is no evidence that forcing a client to accept a label is helpful; in fact, it usually evokes discord in the counseling relationship. In the conversation above, the counselor didn't argue with Jerry about whether he is an "alcoholic." If the counselor had done so, the outcome would likely have been different:

  Client: But I don't think I'm an alcoholic or anything.

Counselor: Well, based on what you've told me, I think we should do a comprehensive assessment to determine whether or not you are.

Client: Wait a minute. That's not what I came for. I don't think counseling is going to help me.

- **The Question-and-Answer Trap:** When your focus is on getting information from a client, particularly during an assessment, you and the client can easily fall into the question-and-answer trap. This can feel like an interrogation rather than a conversation. In addition, a pattern of asking closed questions and giving short answers sets you up in the expert role, and the client becomes a passive recipient of the treatment intervention instead of an active partner in the process. Remember to ask open questions, and follow them with reflective listening responses to avoid the question-and-answer trap.
- **The Premature Focus Trap:** You can fall into this trap when you focus on an agenda for change before the client is ready—for example, jumping into solving problems before developing a strong working alliance. When you focus on an issue that is important to **you** (e.g., admission to an inpatient treatment program), but not to the client, discord will occur. Remember that your approach should match where the client is with regard to his or her readiness to change.
- **The Blaming Trap:** Clients often enter treatment focused on who is to blame for their substance use problem. They may feel guarded and defensive, expecting you to judge them harshly as family, friends, coworkers, or others may have. Avoid the blame trap by immediately reassuring clients that you are uninterested in blaming anyone and that your role is to listen to what troubles them.

Focusing

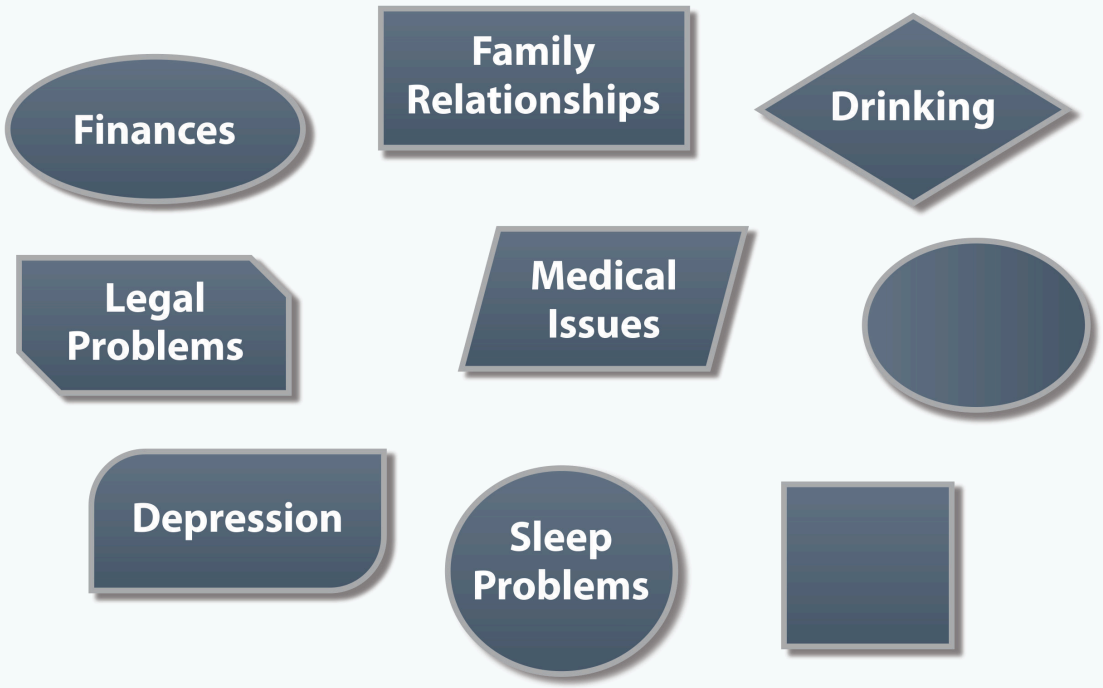
Once you have engaged the client, the next step in MI is to find a direction for the conversation and the counseling process as a whole. This is called focusing in MI. With the client, you develop a mutually agreed-on agenda that promotes change and then identify a specific target behavior to discuss. Without a clear focus, conversations about change can be unwieldy and unproductive (Miller & Rollnick, 2013).

Deciding on an agenda

MI is essentially a conversation you and the client have about change. The direction of the conversation is influenced by the client, the counselor, and the clinical setting (Miller & Rollnick, 2013). For example, a client walking through the door of an outpatient SUD treatment program understands that his or her use of alcohol and other drugs will be on the agenda.

Clients, however, may be mandated to treatment and may not see their substance use as a problem, or they may have multiple issues (e.g., child care, relational, financial, legal problems) that interfere with recovery and that need to be addressed. When clients bring multiple problems to the table or are confused or uncertain about the direction of the conversation, you can engage in agenda mapping, which is a process consistent with MI that helps you and clients decide on the counseling focus. Exhibit 3.7 displays the components in an agenda map.

EXHIBIT 3.7. Components in a Sample Agenda Map



Source: Miller & Rollnick, 2013.

Identifying a target behavior

Once you and the client agree on a general direction, focus on a specific behavior the client is ready to discuss. Change talk links to a specific behavior change target (Miller & Rollnick, 2010); you can't evoke change talk until you identify a target behavior. For example, if the client is ready to discuss drinking, guide the conversation toward details specific to that concern. A sample of such a conversation follows:

> **Counselor:** Marla, you said you'd like to talk about your drinking. It would help if you'd give me a sense of what your specific concerns are about drinking. *(Open question in the form of a statement)*
>
> **Client:** Well, after work I go home to my apartment and I am so tired; I don't want to do anything but watch TV, microwave a meal, and drink till I fall asleep. Then I wake up with a big hangover in the morning and have a hard time getting to work on time. My supervisor has given me a warning.
>
> **Counselor:** You're worried that the amount you drink affects your sleep and ability to get to work on time. *(Reflection)* What do you think you'd like to change about the drinking? *(Open question)*
>
> **Client:** I think I need to stop drinking completely for a while, so I can get into a healthy sleep pattern.
>
> **Counselor:** So I'd like to put stop drinking for a while on the map, is that okay? *[Asks permission. Pauses. Waits for permission.]* Let's focus our conversations on that goal.

Notice that this client is already expressing change talk about her alcohol use. By narrowing the focus from drinking as a general concern to stopping drinking as a possible target behavior, the counselor moved into the MI process of evoking.

Evoking

Evoking elicits client motivations for change. It shapes conversations in ways that encourage clients, not counselors, to argue for change. Evoking is the core of MI and differentiates it from other counseling methods (Miller & Rollnick, 2013). The following sections explore evoking change talk, responding to change talk and sustain talk, developing discrepancy, evoking hope and confidence to support self-efficacy, recognizing signs of readiness to change, and asking key questions.

Evoking change talk

Engaging the client in the process of change is the fundamental task of MI. Rather than identifying the problem and promoting ways to solve it, your task is to help clients recognize that their use of substances may be contributing to their distress and that they have a choice about how to move forward in life in ways that enhance their health and well-being. **One signal that clients' ambivalence about change is decreasing is when they start to express change talk.**

The first step to evoking change talk is to ask open questions. There are seven kinds of change talk, reflected in the DARN acronym. DARN questions can help you generate open questions that evoke change talk. Exhibit 3.8 provides examples of open questions that elicit change talk in preparation for taking steps to change.

Examples of Open Questions to Evoke Change Talk

DESIRE

- "How would you like for things to change?"
- "What do you hope our work together will accomplish?" "What don't you like about how things are now?"
- "What don't you like about the effects of drinking or drug use?" "What do you wish for your relationship with _____?"
- "How do you want your life to be different a year from now?" "What are you looking for from this program?"

ABILITY

- "If you decided to quit drinking, how could you do it?" "What do you think you might be able to change?" "What ideas do you have for how you could ?"
- "What encourages you that you could change if you decided to?"
- "How confident are you that you could if you made up your mind?"
- "Of the different options you've considered, what seems most possible?"
- "How likely are you to be able to ?"

REASONS

- "What are some of the reasons you have for making this change?"
- "Why would you want to stop or cut back on your use of _____?"

- "What's the downside of the way things are now?"
- "What might be the good things about quitting _____?"
- "What would make it worthwhile for you to _____?"
- "What might be some of the advantages of _____?"
- "What might be the three best reasons for _____ ?"

NEED

- "What needs to happen?"
- "How important is it for you to _____?"
- "What makes you think that you might need to make a change?"
- "How serious or urgent does this feel to you?"
- "What do you think has to change?"

Source: Miller & Rollnick, 2013. Motivational Interviewing: Helping People Change (3rd ed.), pp. 171-173. Adapted with permission from Guilford Press.

Other strategies for evoking change talk (Miller & Rollnick, 2013) include:

- **Eliciting importance of change.** Ask an open question that elicits "Need" change talk (Exhibit 3.8): "How important is it for you to [name the change in the target behavior, such as cutting back on drinking]?" You can also use scaling questions such as those in the Importance Ruler in Exhibit 3.9 to help the client explore change talk about need more fully.

EXHIBIT 3.9. The Importance Ruler

Not Important **Extremely Important**

- Initial question: "On a scale of 0 to 10, how important is it for you to change *[name the target behavior, like how much the client drinks]* if you decided to?"
- Follow-up question 1: "How are you at a *[fill in the number on the scale]* instead of a *[choose a lower number on the scale]*?" When you use a lower number, you are inviting the client to reflect on how he or she is already considering change. If you use a higher number, it will likely evoke sustain talk (Miller & Rollnick, 2013). Notice the difference in the following examples:

Lower number

- **Counselor:** You mention that you are at a 6 on the importance of quitting drinking. How are you at a 6 instead of a 3?
- **Client:** I'm realizing that drinking causes more problems in my life now than when I was younger.

Higher number

- **Counselor:** You mention that you are at a 6 on the importance of quitting drinking. How are you at a 6 instead of a 9?
- **Client:** Well, I am just not ready to quit right this second.

In the higher number example, the counselor evokes sustain talk, but it is still useful information and can be the beginning of a deep conversation about the client's readiness to change.

- Follow-up question 2: "What would help move from a *[fill in the number on the scale]* to a [*choose a slightly higher number on the scale]*?" This question invites the client to reflect on reasons to increase readiness to change.

- **Exploring extremes.** Ask the client to identify the extremes of the problem; this enhances his or her motivation. For example: "What concerns you the most about [name the target behavior, like using cocaine]?"
- **Looking back.** To point out discrepancies and evoke change talk, ask the client about what it was like before experiencing substance use problems, and compare that response with what it is like now. For example: "What was it like before you started using heroin?"
- **Looking forward.** Ask the client to envision what he or she would like for the future. This can elicit change talk and identify goals to work toward. For example: "If you decided to [describe the change in target behavior, such as quit smoking], how do you think your life would be different a month, a year, or 5 years from now?"

Reinforce change talk by reflecting it back verbally, nodding, or making approving facial expressions and affirming statements. Encourage the client to continue exploring the possibility of change by asking for elaboration, explicit examples, or details about remaining concerns. Questions that begin with "What else" effectively invite elaboration.

Your task is to evoke change talk and selectively reinforce it via reflective listening. The amount of change talk versus sustain talk is linked to client behavior change and positive substance use outcomes (Houck et al., 2018; Lindqvist et al., 2017; Magill et al., 2014).

Your focus should be on evoking change talk and minimizing sustain talk. Sustain talk expresses the side of ambivalence that favors continuing one's pattern of substance use. Don't argue with the client's sustain talk, and don't try to persuade the client to take the change side of ambivalence.

There are many ways to respond to sustain talk that acknowledge it without getting stuck in it. You can use (Miller & Rollnick, 2013):

- **Simple reflections**. Acknowledge sustain talk with a simple reflective listening response. This validates what the client has said and sometimes elicits change talk. Give the client an opportunity to respond before moving on.

  Client: I don't plan to quit drinking anytime soon.
  Counselor: You don't think that abstinence would work for you right now.

- **Amplified reflections**. Accurately reflect the client's statement, but with emphasis (and without sarcasm). An amplified reflection overstates the client's point of view, which can nudge the client to take the other side of ambivalence (i.e., change talk).

  Client: But I can't quit smoking pot. All my friends smoke pot.
  Counselor: So you really can't quit because you'd be too different from your friends.

- **Double-sided reflections**. A double-sided reflection acknowledges sustain talk, then pairs it with change talk either in the same client statement or in a previous statement. It acknowledges the client's ambivalence yet selectively reinforces change talk. Use "and" to join the two statements and make change talk the second statement (see Counselor Response in Exhibit 3.6).

  Client: I know I should quit smoking now that I am pregnant. But I tried to go cold turkey before, and it was just too hard.
  Counselor: You're worried that you won't be able to quit all at once, and you want your baby to be born healthy.

- **Agreements with a twist.** A subtle strategy is to agree, but with a slight twist or change of direction that moves the discussion forward. The twist should be said without emphasis or sarcasm.

  Client: I can't imagine what I would do if I stopped drinking. It's part of who I am. How could I go to the bar and hang out with my friends?
  Counselor: You just wouldn't be you without drinking. You have to keep drinking no matter how it affects your health.

- **Reframing**. Reframing acknowledges the client's experience yet suggests alternative meanings. It invites the client to consider a different perspective (Barnett, Spruijt-Metz, et al., 2014). Reframing is also a way to refocus the conversation from emphasizing sustain talk to eliciting change talk (Barnett, Spruijt-Metz, et al., 2014).

Client: My husband always nags me about my drinking and calls me an alcoholic. It bugs me.

Counselor: Although your husband expresses it in a way that frustrates you, he really cares and is concerned about the drinking.

- **A shift in focus**. Defuse discord and tension by shifting the conversational focus.

  Client: The way you're talking, you think I'm an alcoholic, don't you?

  Counselor: Labels aren't important to me. What I care about is how to best help you.

- **Emphasis on personal autonomy**. Emphasizing that people have choices (even if all the choices have a downside) reinforces personal autonomy and opens up the possibility for clients to choose change instead of the status quo. When you make these statements, remember to use a neutral, nonjudgmental tone, without sarcasm. A dismissive tone can evoke strong reactions from the client.

  Client: I am really not interested in giving up drinking completely.

  Counselor: It's really up to you. No one can make that decision for you.

All of these strategies have one thing in common: They are delivered in the spirit of MI.

Developing discrepancy: A values conversation

Developing discrepancy has been a key element of MI since its inception. It was originally one of the four principles of MI. In the current version, exploring the discrepancy between clients' values and their substance use behavior has been folded into the evoking process. When clients recognize discrepancies in their values, goals, and hopes for the future, their motivation to change increases.

Your task is to help clients focus on how their behavior conflicts with their values and goals. The focus is on intrinsic motivation. MI doesn't work if you focus only on how clients' substance use behavior is in conflict with external pressure (e.g., family, an employer, the court) (Miller & Rollnick, 2013).

To facilitate discrepancy, have a values conversation to explore what is important to the client (e.g., good heath, positive relationships with family, being a responsible member of the community, preventing another hospitalization, staying out of jail), then highlight the conflict the client feels between his or her substance use behaviors and those values. Client experience of discrepancy between values and substance use behavior is related to better client outcomes (Apodaca & Longabaugh, 2009).

This process can raise uncomfortable feelings like guilt or shame. Frame the conversation by conveying acceptance, compassion, and affirmation. The paradox of acceptance is that it helps people tolerate more discrepancy and, instead of avoiding that tension, propels them toward change (Miller & Rollnick, 2013). However, too much discrepancy may overwhelm the client and cause him or her to think change is not possible (Miller & Rollnick, 2013).

To help a client perceive discrepancy, you can use what is sometimes termed the "Columbo approach." Initially developed by Kanfer & Schefft (1988), this approach remains a staple of MI and is particularly useful with a client who is in the Precontemplation stage and needs to be in charge of the conversation. Essentially, the counselor expresses understanding and continuously seeks clarification of the client's problem, but appears unable to perceive any solution.

In addition to providing personalized feedback, **you can facilitate discrepancy by** (Miller & Rollnick, 2013):

- **Identifying personal values.** For clients to feel discrepancy between their values and actions, they need to recognize what those values are. Some clients may have only a vague understanding of their values or goals. A tool to help you and clients explore values is the Values Card Sort.
    - Print different values like "Achievement—to have important accomplishments" (Miller & Rollnick, 2013, p. 80) on individual cards.
    - Invite clients to sort the cards into piles by importance; those that are most important are placed in one pile, and those that are least important are in another pile.
    - Ask clients to pick up to 10 cards from the most important pile; converse about each one.
    - Use OARS to facilitate the conversations.
    - Pay attention to statements about discrepancy between these important values and clients' substance use behaviors, and reinforce these statements.
    - A downloadable, public domain version of the Value Card Sort activity is available online (www.motivationalinterviewing.org/sites/default/fles/valuescardsort_0.pdf).
- **Providing information.** Avoid being the expert and treating clients as passive recipients when giving information about the negative physical, emotional, mental, social, or spiritual effects or consequences of substance misuse. Instead, engage the client in a process of mutual exchange. This process is called Elicit-Provide-Elicit (EPE) and has three steps (Miller & Rollnick, 2013):
    - **Elicit readiness or interest in the information.** Don't assume that clients are interested in hearing the information you want to offer; start by asking permission. For example: "Would it be okay if I shared some information with you about the health risks of using heroin?" Don't assume that clients lack this knowledge. Ask what they already know about the risks of using heroin. For example: "What would you most like to know about the health risks of heroin use?"
    - **Provide information neutrally (i.e., without judgement).** Prioritize what clients have said they would most like to know. Fill in knowledge gaps. Present the information clearly and in small chunks. Too much information can overwhelm clients. Invite them to ask more questions about the information you're providing.
    - **Elicit clients' understanding of the information.** Don't assume that you know how clients will react to the information you have provided. Ask questions:

        "So, what do you make of this information?"
        "What do you think about that?"

"How does this information impact the way you might be thinking about *[name the substance use behavior, such as drinking]?"*

Allow clients plenty of time to consider and reflect on the information you presented. Invite them to ask questions for clarification. Follow clients' responses to your open questions with reflective listening statements that emphasize change talk whenever you hear it. **EPE is an MI strategy to facilitate identifying discrepancy and is an effective and respectful way to give advice to clients about behavior change strategies during the planning process.**

- Exploring others' concerns. Another way to build discrepancy is to explore the clients' understanding of the concerns other people have expressed about their substance use. This differs from focusing on the external pressure that a family member, an employer, or the criminal justice system may be putting on clients to reduce or abstain from substance use. The purpose is to invite clients to explore the impact of substance use behaviors on the people with whom they are emotionally connected in a nonthreatening way. Approach this conversation from a place of genuine curiosity and even a bit of confusion (Miller & Rollnick, 2013). Here is a brief example of what this conversation might look like using an open question about a significant other's concern, where reflecting sustain talk actually has the effect of eliciting change talk:

  Counselor: You mentioned that your husband is concerned about your drinking. What do you think concerns him? *(Open question)*

  Client: He worries about everything. The other day, he got really upset because I drove a block home from a friend's house after a party. He shouldn't worry so much. *(Sustain talk)*

  Counselor: He's worried that you could crash and hurt yourself or someone else or get arrested for driving under the influence. But you think his concern is overblown. *(Complex reflection)*

  Client: I can see he may have a point. I really shouldn't drive after drinking. *(Change talk)*

Evoking hope and confidence to support self-efficacy

Many clients do not have a well-developed sense of self-efficacy. They find it hard to believe that they can begin or maintain behavior change. Improving self-efficacy requires eliciting confidence, hope, and optimism that change, in general, is possible and that clients, specifically, **can change.** This positive impact on self-efficacy may be one of the ways MI promotes behavior change (Chariyeva et al., 2013).

One of the most consistent predictors of positive client behavior change is "ability" change talk (Romano & Peters, 2016). Unless a client believes change is possible, the perceived discrepancy between desire for change and feelings of hopelessness about accomplishing change is likely to result in continued sustain talk and no change. When clients express confidence in their ability to change, they are more likely to engage in behavior change (Romano & Peters, 2016).

Because self-efficacy is a critical component of behavior change, it is crucial that you also believe in clients' capacity to reach their goals. You can help clients strengthen hope and confidence in MI

by evoking confidence talk. Here are two strategies for evoking confidence talk (Miller & Rollnick, 2013):

Use the Confidence Ruler (Exhibit 3.10) and scaling questions to assess clients' confidence level and evoke confidence talk.

EXHIBIT 3.10. The Confidence Ruler

Not Confident **Extremely Confident**

- Initial question: "On a scale of 0 to 10, how confident are you that you could change *[name the target behavior, like stop drinking]* if you decided to?"
- Follow-up questions:
  - "How are you at a *[fill in the number on the scale]* instead of a *[choose a lower number on the scale]*?" Using a lower number helps clients reflect on how far they've come on the confidence scale. Using a higher number with this question may discourage clients, which can elicit sustain talk. If that should happen, use strategies discussed previously for responding to sustain talk.
  - "What would help you get from a *[fill in the number on the scale]* to a *[choose a slightly higher number on the scale]*?" This open question invites clients to reflect on strategies to build confidence. Don't jump to a much higher number, which can overwhelm clients and lower confidence.

Whatever the client's response to these scaling questions, use it as an opportunity to begin a conversation about his or her confidence or perceived ability to move forward in the change process.

COUNSELOR NOTE: SELF-EFFICACY

Self-efficacy is a person's confidence in his or her ability to change a behavior (Miller & Rollnick, 2013), such as a behavior that risks one's health. Research has found that MI is effective in enhancing a client's self-efficacy and positive outcomes including treatment completion, lower substance use at the end of treatment, greater desire to quit cannabis use, and reductions in risky sexual behavior for someone with HIV (Caviness et al., 2013; Chariyeva et al., 2013; Dufett, & Ward, 2015; Moore, Flamez,, & Szirony, 2017).

Ask open questions that evoke client strengths and abilities. Follow the open questions with reflective listening responses. Here are some examples of open questions that elicit confidence talk:

- "Knowing yourself as well as you do, how do you think you could [name the target behavior change, like cutting back on smoking marijuana]?"
- "How have you made difficult changes in the past?"
- "How could you apply what you learned then to this situation?"
- "What gives you confidence that you could [name the target behavior change, like stopping

cocaine use]?"

In addition, you can help enhance clients' hope and confidence about change by:

- Exploring clients' strengths and brainstorming how to apply those strengths to the current situation.
- Giving information via EPE about the efficacy of treatment to increase clients' sense of self-efficacy.
- Discussing what worked and didn't work in previous treatment episodes and offering change options based on what worked before.
- Describing how people in similar situations have successfully changed their behavior. Other clients in treatment can serve as role models and offer encouragement.
- Offering some cognitive tools, like the AA slogan "One day at a time" or "Keep it simple" to break down an overwhelming task into smaller changes that may be more manageable.
- Educating clients about the biology of addiction and the medical effects of substance use to alleviate shame and instill hope that recovery is possible.

Engaging, focusing, and evoking set the stage for mobilizing action to change. During these MI processes, your task is to evoke DARN change talk. This moves the client along toward taking action to change substance use behaviors. At this point, your task is to evoke and respond to CAT change talk.

Recognizing signs of readiness to change

As you evoke and respond to DARN change talk, you will begin to observe these signs of readiness to change in the client's statements (Miller & Rollnick, 2013):

- **Increased change talk:** As DARN change talk increases, commitment and activation change talk begin to be expressed. The client may show optimism about change and an intention to change.
- **Decreased sustain talk:** As change talk increases, sustain talk decreases. When change talk overtakes sustain talk, it is a sign that the client is moving toward change.
- **Resolve:** The client seems more relaxed. The client talks less about the problem, and sometimes expresses a sense of resolution.
- **Questions about change:** The client asks what to do about the problem, how people change if they want to, and so forth. For example: "What do people do to get off pain pills?"
- **Envisioning:** The client begins to talk about life after a change, anticipate difficulties, or discuss the advantages of change. Envisioning requires imagining something different—not necessarily how to get to that something different, but simply imagining how things could be different.
- **Taking steps:** The client begins to experiment with small steps toward change (e.g., going to an AA meeting, going without drinking for a few days, reading a self-help book). Affirming small change steps helps the client build self-efficacy and confidence.

When you notice these signs of readiness to change, it is a good time to offer the client a recapitulation summary in which you restate his or her change talk and minimize reflections of sustain talk. **The recapitulation summary is a good way to transition into asking key questions** (Miller & Rollnick, 2013).

Asking key questions

To help a client move from preparing to mobilizing for change, ask key questions (Miller & Rollnick, 2013):

- "What do you think you will do about your drinking?"
- "After reviewing the situation, what's the next step for you?"
- "What do you want to do about your drug use?"
- "What can you do about your smoking?"
- "Where do you go from here?"
- "What might you do next?"

When the client responds with change talk (e.g., "I intend to stop using heroin"), you can move forward to the planning process. If the client responds with sustain talk (e.g., "It would be too hard for me to quit using heroin right now"), you should go back to the evoking process. Remember that change is not a linear process for most people.

Do not jump into the planning process if the client expresses enough sustain talk to indicate not being ready to take the next step. The ambivalence about taking the next step may be uncertainty about giving up the substance use behavior or a lack of confidence about being able to make the change.

Planning

Your task in the process is to help the client develop a change plan that is acceptable, accessible, and appropriate. Once a client decides to change a substance use behavior, he or she may already have ideas about how to make that change. For example, a client may have previously stopped smoking cannabis and already knows what worked in the past. Your task is to simply reinforce the client's plan.

Don't assume that all clients need a structured method to develop a change plan. Many people can make significant lifestyle changes and initiate recovery from SUDs without formal assistance (Kelly, Bergman, Hoeppner, Vilsaint, & White, 2017). **For clients who need help developing a change plan**, remember to continue using MI techniques and OARS to move the process **from why change and what to change to *how* to change** (Miller & Rollnick, 2013). A change plan is like a treatment plan, but broader (e.g., going to an addiction treatment program may be part of a change plan), and the client, rather than you or the treatment program, is the driver of the planning process (Miller & Rollnick, 2013).

Identifying a change goal

Part of planning is working with the client to identify or clarify a change goal. At this point, the client may have identified a change goal. For example, when you ask a key question such as "What do

you want to do about the drinking?" the client might say, "I want to cut back to two drinks a day on weekends." In this situation, the focus shifts to developing a plan with specific steps the client might take to reach the change goal. If the client is vague about a change goal and says, "I really need to do something about my drinking," the first step is to help the client clarify the change goal.

Here is an example of a dialog that helps the client get more specific:

> **Counselor:** You are committed to making some changes to your drinking. *(Reflection)* What would that look like? *(Open question)*
>
> **Client:** Well, I tried to cut back to one drink a day, but all I could think about was going to the bar and getting drunk. I cut back for 2 days but did end up back at the bar, and then it just got worse from there. At this point, I don't think I can just cut back.
>
> **Counselor:** You made a good-faith effort to control the drinking and learned a lot from that experiment. *(Affirmation)* You now think that cutting back is probably not a good strategy for you. *(Reflection)*
>
> **Client:** Yeah. It's time to quit. But I'm not sure I can do that on my own.
>
> **Counselor:** You're ready to quit drinking completely and realize that you could use some help with making that kind of change. *(Reflection)*
>
> **Client:** Yeah. It's time to give it up.
>
> **Counselor:** Let's review the conversation, *(Summarization)* and then talk about next steps.

The counselor uses OARS to help the client clarify the change goal. The counselor also hears that the client lacks confidence that he or she can achieve the change goal and reinforces the client's desire for some help in making the change. The next step with this client is to develop a change plan.

Developing a change plan

Begin with the change goal identified by the client, then explore specific steps the client can take to achieve it. In the planning process, use OARS and pay attention to CAT change talk. As you proceed, carefully note the shift from change talk that is more general to change talk that is specific to the change plan (Miller & Rollnick, 2013). Some evidence shows that change talk is related to the completion of a change plan (Roman & Peters, 2016).

Here are some strategies for helping clients develop a change plan (Miller & Rollnick, 2013):

- **Confirm the change goal**. Make sure that you and the client agree on what substance use behavior the client wants to change and what the ultimate goal is (e.g., to cut back or to abstain). This goal might change as the client takes steps to achieve it. For example, a client who tries to cut back on cannabis use may find that that it is not a workable plan and may decide to abstain completely.
- **Elicit the client's ideas about how to change**. There may be many different pathways to achieve the desired goal. For example, a client whose goal is to stop drinking may go to AA or SMART Recovery meetings for support, get a prescription for naltrexone (a medication that reduces craving and the pleasurable effects of alcohol [Substance Abuse and Mental Health Services Administration & National Institute on Alcohol Abuse and Alcoholism, 2015]) from a primary care provider, enter an intensive outpatient treatment program, or try some combination of these. Before you jump in with your ideas, elicit the client's ideas about

strategies to make the change. Explore pros and cons of the client's ideas; determine which appeals to the client most and is most appropriate for this client.

- **Offer a menu of options.** Use the EPE process (see the section "Developing discrepancy: A values conversation" above) to ask permission to offer suggestions about accessible treatment options, provide information about those options, and elicit the client's understanding of options and which ones seem acceptable.
- **Summarize the change plan.** Once you and the client have a clear plan, summarize the plan and the specific steps or pathways the client has identified. Listen for CAT change talk and reinforce it through reflective listening.
- **Explore obstacles**. Once the client applies the change plan to his or her life, there will inevitably be setbacks. Try to anticipate potential obstacles and how the client might respond to them before the client takes steps to implement the plan. Then reevaluate the change plan, and help the client tweak it using the information about what did and didn't work from prior attempts.

Strengthening Commitment to Change

The planning process is just the beginning of change. Clients must commit to the plan and show that commitment by taking action. There is some evidence that client commitment change talk is associated with positive AUD outcomes (Romano & Peters, 2016). One study found that counselor efforts to elicit client commitment to change alcohol use is associated with reduced alcohol consumption and increased abstinence for clients in outpatient treatment (Magill, Stout, & Apodoaca, 2013).

Usually, people express an intention to make a change before they make a firm commitment to taking action. You can evoke the client's intention to take action by asking open questions: "What are you **willing** to do this week?" or "What specific steps of the change plan are you **ready** to take?" (Miller & Rollnick, 2013). Remember that the client may have an end goal (e.g., to quit drinking) and intermediate action steps to achieving that goal (e.g., filling a naltrexone prescription, going to an AA meeting).

Once the client has expressed an intention to change, elicit commitment change talk. Try asking an open question that invites the client to explore his or her commitment more clearly: "What would help you strengthen your commitment to _____ [name the step or ultimate goal for change, for example, getting that prescription from your doctor for naltrexone]?" (Miller & Rollnick, 2013).

Other strategies to strengthen commitment to action steps and change goals include (Miller & Rollnick, 2013):

- Exploring any ambivalence clients have about change goals or specific elements of change plans.
- Reinforcing CAT change talk through reflective listening.
- Inviting clients to state their commitment to their significant others.
- Asking clients to self-monitor by recording progress toward change goals (e.g., with a drinking log).
- Exploring, with clients' consent, whether supportive significant others can help with

medication adherence or other activities that reinforce commitment (e.g., getting to AA meetings).

The change plan process lends itself to using other counseling methods like CBT and MET. For example, you can encourage clients to monitor their thoughts and feelings in high-risk situations where they are more likely to return to substance use or misuse. No matter what counseling strategies you use, keep to the spirit of MI by working with clients and honoring and respecting their right to and capacity for self-direction.

Benefits of MI in Treating SUDs

The number of research studies on MI has doubled about every 3 years from 1999 to 2013 (Miller & Rollnick, 2013). Many studies were randomized clinical trials reflecting a range of clinical populations, types of problems, provider settings, types of SUDs, and co-occurring substance use and mental disorders (Smedslund et al., 2011).

Although some studies report mixed results, the overall scientific evidence suggests that MI is associated with small to strong (and significant) effects for positive substance use behavioral outcomes compared with no treatment. MI is as effective as other counseling approaches (DiClemente et al., 2017). A research review found strong, significant support for MI and combined MI/MET in client outcomes for alcohol, tobacco, and cannabis, and some support for its use in treating cocaine and combined illicit drug use disorders (DiClemente et al., 2017). Positive outcomes included reduced alcohol, tobacco, and cannabis use; fewer alcohol-related problems; and improved client engagement and retention (DiClemente et al., 2017). MI and combined MI/MET were effective with adolescents, young adults, college students, adults, and pregnant women.

Counselor adherence to MI skills is important for producing client outcomes (Apodaca et al., 2016; Magill et al., 2013). For instance, using open questions, simple and complex reflective listening responses, and affirmations is associated with change talk (Apodaca et al., 2016; Romano & Peters, 2016). Open questions and reflective listening responses can elicit sustain talk when counselors explore ambivalence with clients (Apodaca et al., 2016). However, growing evidence suggests that the amount and strength of client change talk versus sustain talk in counseling sessions are key components of MI associated with behavior change (Gaume et al., 2016; Houck et al., 2018; Lindqvist et al., 2017; Magill et al., 2014).

Other benefits of MI include (Miller & Rollnick, 2013):

- **Cost effectiveness.** MI can be delivered in brief interventions like SBIRT (screening, brief intervention, and referral to treatment) and FRAMES (**F**eedback, **R**esponsibility, **A**dvice, **M**enu of options, **E**mpathy, and **S**elf-efficacy), which makes it cost effective. In addition, including significant others in MI interventions is also cost effective (Shepard et al., 2016).
- **Ease of use.** MI has been adapted and integrated into many settings, including primary care facilities, emergency departments, behavioral health centers, and criminal justice and social service agencies. It is useful anywhere that focuses on helping people manage substance misuse and SUDs.
- **Broad dissemination.** MI has been disseminated throughout the United States and internationally.
- **Applicability to diverse health and behavioral health problems.** Beyond substance use

behaviors, MI has demonstrated benefits across a wide range of behavior change goals.

- **Effectiveness.** Positive effects from MI counseling occur across a range of real-life clinical settings.
- **Ability to complement other treatment approaches.** MI fits well with other counseling approaches, such as CBT. It can enhance client motivation to engage in specialized addiction treatment services and stay in and adhere to treatment.
- **Ease of adoption by a range of providers.** MI can be implemented by primary care and behavioral health professionals, peer providers, criminal justice personnel, and various other professionals.
- **Role in mobilizing client resources.** MI is based on person-centered counseling principles. It focuses on mobilizing the client's own resources for change. It is consistent with the healthcare model of helping people learn to self-manage chronic illnesses like diabetes and heart disease.

Conclusion

MI is a directed, person-centered counseling style that is effective in helping clients change their substance use behaviors. When delivered in the spirit of MI, the core skills of asking open questions, affirming, using reflective listening, and summarizing enhance client motivation and readiness to change. Counselor empathy, shown through reflective listening and evoking change talk, is another important element of MI's effectiveness and is associated with positive client outcomes. MI has been adapted for use in brief interventions and across a wide range of clinical settings and client populations. It is compatible with other counseling models and theories of change, including CBT and the SOC.

Substance Abuse and Mental Health Services Administration. *Enhancing Motivation for Change in Substance Use Disorder Treatment*. Treatment Improvement Protocol (TIP) Series No. SAMHSA Publication No. PEP19-02-01-003. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019.

GROUP COUNSELING SKILLS

Although not every client will be appropriate for group counseling, it remains the modality of choice for treating addiction. Group counseling has many benefits including, but not limited to, the following:

- Cost-effectiveness
- Peer-support and sense of community
- Development of social and interpersonal skills
- Ability to learn effective confrontation skills
- Ability to receive feedback from various perspectives

Given the importance of group counseling in treating addiction, it is imperative that counselors working in the field learn and develop the skills necessary to effectively facilitate various types of

groups used in treatment settings. Therapeutic groups used in the treatment of addiction include (*Substance Abuse Treatment: Group Therapy,* 2015):

- Psychoeducational groups, which teach about substance abuse
- Skills development groups, which hone the skills necessary to break free of addiction
- Cognitive-behavioral groups, which rearrange patterns of thinking and action that lead to addiction
- Support groups, which comprise a forum where members can debunk each other's excuses and support constructive change
- Interpersonal process group psychotherapy (often referred to as "therapy groups"), which enable clients to recreate their pasts in the here-and-now of group and rethink the relational and other life problems that they have previously fled by means of addictive substances

TREATMENT IMPROVEMENT PROTOCOL 41 / SUBSTANCE ABUSE TREATMENT: GROUP THERAPY (ADAPTATION)

THE GROUP LEADER

Personal Qualities

Although the attributes of an effective interpersonal process group leader treating substance abuse are not strikingly different from traits needed to work successfully with other client populations, some of the variations in approach make a big difference. Clients, for example, will respond to a warm, empathic, and life-affirming manner. Flores (1997) states that "many therapists do not fully appreciate the impact of their personalities or values on addicts or alcoholics who are struggling to identify some viable alternative lifestyle that will allow them to fill up the emptiness or deadness within them" (p. 456). For this reason, it is important for group leaders to communicate and share the joy of being alive. This life-affirming attitude carries the unspoken message that a full and vibrant life is possible without alcohol or drugs.

In addition, because many clients with substance abuse histories have grown up in homes that provided little protection, safety, and support, the leader should be responsive and affirming, rather than distant or judgmental. The leader should recognize that group members have a high level of vulnerability and are in need of support, particularly in the early stage of treatment. A discussion of other essential characteristics for a group leader follows. Above all, it is important for the leader of any group to understand that he or she is responsible for making a series of choices as the group progresses. The leader chooses how much leadership to exercise, how to structure the group, when to intervene, how to effect a successful intervention, how to manage the group's collective anxiety, and the means of resolving numerous other issues. It is essential for any group leader to be aware of the choices made and to remember that all choices concerning the group's structure and her leadership will have consequences (Pollack and Slan 1995).

Constancy

An environment with small, infrequent changes is helpful to clients living in the emotionally turbulent world of recovery. Group facilitators can emphasize the reality of constancy and security through

a variety of specific behaviors. For example, group leaders always should sit in the same place in the group. Leaders also need to respond consistently to particular behaviors. They should maintain clear and consistent boundaries, such as specific start and end times, standards for comportment, and ground rules for speaking. Even dress matters. The setting and type of group will help determine appropriate dress, but whatever the group leader chooses to wear, some predictability is desirable throughout the group experience. The group leader should not come dressed in a suit and tie one day and in blue jeans the next.

Active Listening

Excellent listening skills are the keystone of any effective therapy. Therapeutic interventions require the clinician to perceive and to understand both verbal and nonverbal cues to meaning and metaphorical levels of meaning. In addition, leaders need to pay attention to the context from which meanings come. Does it pertain to the here-and-now of what is occurring in the group or the then--and-there history of the specific client?

Firm Identify

A firm sense of their own identities, together with clear reflection on experiences in group, enables leaders to understand and manage their own emotional lives. For example, therapists who are aware of their own capacities and tendencies can recognize their own defenses as they come into play in the group. They might need to ask questions such as: "Am I cutting off discussions that could lead to verbal expression of anger because I am uncomfortable with anger? Have I blamed clients for the group's failure to make progress?"

Group work can be extremely intense emotionally. Leaders who are not in control of their own emotional reactions can do significant harm—particularly if they are unable to admit a mistake and apologize for it. The leader also should monitor the process and avoid being seduced by content issues that arouse anger and could result in a loss of the required professional stance or distance. A group leader also should be emotionally healthy and keenly aware of personal emotional problems, lest they become confused with the urgent issues faced by the group as a whole. The leader should be aware of the boundary between personal and group issues (Pollack and Slan 1995).

Confidence

Effective group leaders operate between the certain and the uncertain. In that zone, they cannot rely on formulas or supply easy answers to clients' complex problems. Instead, leaders have to model the consistency that comes from self-knowledge and clarity of intent, while remaining attentive to each client's experience and the unpredictable unfolding of each session's work. This secure grounding enables the leader to model stability for the group.

Spontaneity

Good leaders are creative and flexible. For instance, they know when and how to admit a mistake, instead of trying to preserve an image of perfection. When a leader admits error appropriately, group members learn that no one has to be perfect, that they––and others––can make and admit mistakes yet retain positive relationships with others.

Integrity

Largely due to the nature of the material group members are sharing in process groups, it is all but inevitable that ethical issues will arise. Leaders should be familiar with their institution's policies and with pertinent laws and regulations. Leaders also need to be anchored by clear internalized standards of conduct and able to maintain the ethical parameters of their profession.

Trust

Group leaders should be able to trust others. Without this capacity, it is difficult to accomplish a key aim of the group: restoration of group members' faith and trust in themselves and their fellow human beings (Flores 1997).

Humor

The therapist needs to be able to use humor appropriately, which means that it is used only in support of therapeutic goals and never is used to disguise hostility or wound anyone.

Empathy

Empathy, one of the cornerstones of successful group treatment for substance abuse, is the ability to identify someone else's feelings while remaining aware that the feelings of others are distinct from one's own. Through these "transient identifications" we make with others, we feel less alone. "Identification is the antidote to loneliness, to the feeling of estrangement that seems inherent in the human condition" (Ormont 1992, p. 147).

For the counselor, the ability to project empathy is an essential skill. Without it, little can be accomplished. Empathic listening requires close attention to everything a client says and the formation of hypotheses about the underlying meaning of statements (Miller and Rollnick 1991). An empathic substance abuse counselor:

- Communicates respect for and acceptance of clients and their feelings
- Encourages a nonjudgmental, collaborative relationship
- Is supportive and knowledgeable
- Sincerely compliments rather than denigrates or diminishes another person
- Tells less and listens more
- Gently persuades, while understanding that the decision to change is the client's
- Provides support throughout the recovery process (Center for Substance Abuse Treatment [CSAT] 1999*b*, p. 41)

One of the great benefits of group therapy is that as clients interact, they learn from one another. For interpersonal interaction to be beneficial, it should be guided, for the most part, by empathy. The group leader should be able to model empathic interaction for group members, especially since people with substance use disorders often cannot identify and communicate their feelings, let alone appreciate the emotive world of others. The group leader teaches group members to understand one another's subjective worlds, enabling clients to develop empathy for each other (Shapiro 1991).

The therapist promotes growth in this area simply by asking group members to say what they think someone else is feeling and by pointing out cues that indicate what another person may be feeling.

One of the feelings that the group leader needs to be able to empathize with is shame, which is common among people with substance abuse histories. Shame is so powerful that it should be addressed whenever it becomes an issue. When shame is felt, the group leader should look for it and recognize it (Gans and Weber 2000). The leader also should be able to empathize with it, avoid arousing more shame, and help group members identify and process this painful feeling.

Leading Groups

Group therapy with clients who have histories of substance abuse or dependence requires active, responsive leaders who keep the group lively and on task and ensure that members are engaged continuously and meaningfully with each other. Leaders, however, should not make themselves the center of attention. The leader should be aware of the differing personalities of the group members, while always searching for common themes in the group. Themes to focus on, for example, might include loss, abandonment, and self-value (Pollack and Slan 1995).

Leaders vary therapeutic styles with the needs of clients

Group leaders should modify their styles to meet clients' needs at different times. During the early and middle stages of treatment, the therapist is more active, becoming less so in the late stage. Moreover, during the late stage of treatment, the therapist should offer less support and gratification. This keeps the group at an "optimal level of anxiety," one that would be intolerable and counterproductive in the early or middle stages of treatment (Flores 1997). To determine the type of leadership required to support a client in treatment, the clinician should consider the client's capacity to manage affect, level of functioning, social supports, and stability, since these factors have some bearing upon alcohol or illicit drug use. These considerations are essential to determine the type of group best suited to meet the client's needs. For example, a client at the beginning stage of treatment who is high functioning and used to working in groups generally will require a less active therapist and less structure. On the other hand, a lower functioning client who has little or no group experience and is just beginning treatment would best be placed in a structured, task-oriented group. Such a person also would benefit from a clinician who more actively expresses warmth and acceptance, thus helping to engage the client.

Leaders model behavior

It is more useful for the therapist to model group-appropriate behaviors than to assume the role of mentor, showing how to "do recovery." For example, the therapist can model the way to listen actively, give accurate feedback, and display curiosity about apparent discrepancies in behavior and intent. Therapists should be aware that self-disclosure is always going on, whether consciously or unconsciously. They intentionally should use self-disclosure only to meet the task-related needs of the group, and then only after thoughtful consideration, perhaps including a discussion with a supervisor.

Both therapists and their institutions should have a thoughtful policy about self-disclosure, including disclosure of a therapist's past experiences with substance abuse or addiction. Too often, self-disclosure occurs to meet the therapist's own needs (for example, for affiliation and approval) or to gratify clients. When personal questions are asked, group leaders need to consider the motivation

behind the question. Often clients are simply seeking assurance that the therapist is able to understand and assist them (Flores 1997).

Leaders can be cotherapists

Cotherapy is an effective way to blend the diverse skills, resources, and therapeutic perspectives that two therapists can bring to a group. In addition, cotherapy is beneficial because, if properly carried out, it can provide:

- The opportunity to watch "functional, adaptive behavior in the coleader pair"
- Additional opportunities for family transferences when the leaders are of different genders
- An opportunity for "two sets of eyes to view the situation" (Vannicelli 1992, p. 238)

Cotherapy, also called coleadership, is extremely powerful when carried out skillfully. A male–female cotherapy team may be especially helpful, for a number of reasons. It allows clients to explore their conscious and subconscious reactions to the presence of a parental dyad, or pair. It shows people of opposite sexes engaging in a healthy, nonexploitative relationship. It presents two different gender role models. It demonstrates role flexibility, as clients observe the variety of roles possible for a male or a female in a relationship. It provides an opportunity for clients to discover and work through their gender distortions (Kahn 1996).

Leaders are sensitive to ethical issues

Group therapy by nature is a powerful type of intervention. As the group process unfolds, the group leader needs to be alert, always ready to perceive and resolve issues with ethical dimensions. Some typical situations with ethical concerns follow.

Leaders improve motivation

Client motivation is a vital factor in the success of treatment for substance use disorders. Motivation-boosting techniques have been shown to increase both treatment participation and outcomes (Chappel 1994; Easton et al. 2000; Foote et al. 1999). Motivation generally improves when:

- Clients are engaged at the appropriate stage of change.
- Clients receive support for change efforts.
- The therapist explores choices and their consequences with the client.
- The therapist honestly and openly communicates care and concern for group members.
- The therapist points out the client's competencies.
- Steps toward positive change are noted within the group and further encouragement is provided.

The therapist helps clients enjoy their triumphs with questions such as, "What's it like, Bill, to communicate your thoughts so clearly to Claire and to have her understand you so well?" or "What was it like to be able to communicate your frustration so directly?"

One effective motivational tool is the FRAMES approach, which uses the six key elements of Feedback, Responsibility, Advice, Menus (of change options), Empathic therapy, and Self efficacy

(Miller and Sanchez 1994). This approach engages clients in their own treatment and motivates them to change in ways that are the least likely to trigger resistance.

When this kind of supportive technique is employed, however, a client's stage of change should be taken into account. Techniques to enhance motivation that are appropriate at one stage of change may not be useful at another stage and may even trigger treatment resistance or noncompliance (CSAT 1999*b*). For example, clients in the contemplation stage are weighing the pros and cons of continued substance abuse. An intervention for the action stage is appropriate for a client who has already made a commitment to change. If such an intervention is used too early, the client understandably may fail to cooperate.

Leaders overcome resistance

Resistance is especially strong among clients referred by the courts. It generally arises as a defense against the pain that therapy and examining one's own behavior usually brings. In group therapy, resistance appears at both the individual and the group level. The group leader should have a repertoire of means to overcome the resistance that prevents successful substance abuse treatment in groups (Milgram and Rubin 1992).

The group therapist should be prepared to work effectively against intense resistance to "experiencing, expressing, and understanding emotions" (Cohen 1997, p. 443). In order to overcome resistance to the experience of emotion, "the group members should experience feelings at a level of arousal wherein feelings are undeniable, but not to the extent that the group member is overcome" (Cohen 1997, p. 445).

Leaders defend limits

Providing a safe, therapeutic frame for clients and maintaining firm boundaries are among the most important functions of the group leader. For many group members, a properly conducted group will be the first opportunity to interact with others in a safe, supportive, and substance-free environment. The boundaries established should be mutually agreed upon in a specific contract. When leaders point out boundaries and boundary violations, they should do so in a nonshaming, nonjudgmental, matter-of-fact way. Some possible ways of dealing with this situation might be:

"This is a hard place to end, but . . ."

"I know how angry you're feeling, but we have agreed . . ."

When boundary violations occur, group members should be reminded of agreements and given an opportunity to discuss the meaning and implication of the limit-breaking behavior as they see it. For example, if three group members are coming in late, the leader might say, "It's interesting that although everyone who joined the group agreed to arrive on time, many members are having a difficult time meeting this agreement." Or the leader might ask, "How would this group be different if everyone came on time?"

The group members may respond, for example, that they would not be obliged to repeat what already has been said to help latecomers catch up and, thus, get more out of each session.

This group involvement in limit setting is crucial. It transmits power and responsibility to the group, and the leader avoids the isolated role of enforcer. While leaders inevitably will be regarded as authority figures, they certainly want to avoid creating the image of an insensitive, punitive authority.

Leaders maintain a safe therapeutic setting

Emotional aspects of safety

Group members should learn to interact in positive ways. In the process, leaders should expect that people with substance abuse histories will have learned an extensive repertoire of intimidating, shaming, and other harmful behaviors. Because such conduct can make group members feel unsafe, the leader should use interventions that deflect the offensive behavior without shaming the shamer.

The group needs to feel safe without blaming or scapegoating an individual member. If a member makes an openly hostile comment, the leader's response should state clearly what has happened and set a firm boundary for the group that makes clear that group members are not to be attacked. Sometimes, the leader simply may need to state what has occurred in a factual manner: "Debby, you may not have intended this effect, but that last remark came across as really hurtful."

When group members' responses lack empathy or treat one group member as a scapegoat, this targeted individual represents "a disowned part of other members of the group." Members may fault Sally repeatedly for her critical nature and lack of openness. The leader may intervene with a comment such as, "We've taken up time dealing with Sally's problems. My guess is that part of the reason the group is so focused on this is that it's something everybody in here knows a little about and that this issue has a lot of meaning for the group. Perhaps the group is trying to kick this characteristic down and beat it out because it's too close to home and simply cannot be ignored" (Vannicelli 1992, p. 125).

When individual group members are verbally abusive and other group members are too intimidated to name the problem, the leader should find a way to provide "a safe environment in which such interactions can be productively processed and understood—not only by the attacking group member but also by the other members (who need to understand what is motivating their reluctance to respond)" (Vannicelli 1992, p. 165). To accomplish this goal, the leader may intervene with statements such as:

- To the group as a whole: "John has been pretty forthright with some of his feelings this evening. It seems as if others in here are having more difficulty sharing their feelings. Perhaps we can understand what it is about what John has shared or the way in which he shared it that makes it hard to respond" (Vannicelli 1992, p. 165).
- To John: "John, how do you suppose Mary might be feeling just now about your response to her?" or "If you had just received the kind of feedback that you gave to Mary, how do you suppose you'd be feeling right now?" (Vannicelli 1992, pp. 165–166).

Whatever intervention is used should show the group "that it is appropriate to let people know how you feel, and that people can learn in the group how to do this in a way that doesn't push others away" (Vannicelli 1992, p. 166). A client can be severely damaged by emotional overstimulation. It is the therapist's responsibility to maintain the appropriate level of emotion and stimulation in the group. This will "prevent a too sudden or too intense mobilization of feeling that cannot be adequately expressed in language" (Rosenthal 1999a, p. 159). The therapist can achieve this control by warning potential group members of the emotional hazards of revealing their feelings to a group of strangers and by helping new members regulate the amount of their self-disclosure.

Substance Use

In a group of people trying to maintain abstinence, the presence of someone in the group who is

intoxicated or actively using illicit drugs is a powerful reality that will upset many members. In this situation, the leader should intervene decisively. The leader will make it as easy as possible for the person who has relapsed to seek treatment, but a disruptive member should leave the group for the present. The leader also will help group members explore their feelings about the relapse and reaffirm the primary importance of members' agreement to remain abstinent. Some suggestions follow for situations involving relapse:

- If clients come to sessions under the influence of alcohol or drugs, the leader should ensure that the individual does not drive home. Even a person walking home sometimes should be escorted to prevent falls, pedestrian accidents, and so on.
- If a client obviously is intoxicated at the beginning of the group, that person should be asked to leave and return for the next session in a condition appropriate for participation (Vannicelli 1992).

Boundaries and Physical Contact

When physical boundaries are breached in the group, and no one in the group raises the issue, the leader should call the behavior to the group's attention. The leader should remind members of the terms of agreement, call attention to the questionable behavior in a straightforward, factual way, and invite group input with a comment such as, "Joe, you appear to be communicating something nonverbally by putting your hand on Mary's shoulder. Could you please put your actions into words?"

Most agencies have policies related to violent behavior; all group leaders should know what they are. In groups, threatening behavior should be intercepted decisively. If necessary, the leader may have to stand in front of a group member being physically threatened. Some situations require help, so a lone leader should never conduct a group session without other staff nearby. On occasion, police intervention may be necessary, which could be expected to disrupt the group experience completely.

The leader should not suggest touching, holding hands, or group hugs without first discussing this topic in group. This tactic will convey the message that strong feelings should be talked about, not avoided. In general, though, group members should be encouraged to put their thoughts and feelings into words, not actions. Whenever the therapist invites the group to participate in any form of physical contact (for example, in psychodrama or dance therapy), individuals should be allowed to opt out without any negative perceptions within the group. All members uncomfortable with physical contact should be assured of permission to refrain from touching or having anyone touch them.

Leaders also should make sure that suggestions to touch are intended to serve the clients' best interests and not the needs of the therapist. Under no circumstances should a counselor ask for or initiate physical contact.

Like their clients, counselors need to learn that such impulses affect them as well. Nothing is wrong with feeling attracted to a client. It is wrong, however, for group leaders to allow these feelings to dictate or influence their behavior.

Leaders help cool down affect

Group leaders carefully monitor the level of emotional intensity in the group, recognizing that too much too fast can bring on extremely uncomfortable feelings that will interfere with progress—especially for those in the earlier stages of recovery. When emotionally loaded topics (such

as sexual abuse or trauma) come up and members begin to share the details of their experiences, the level of emotion may rapidly rise to a degree some group members are unable to tolerate.

At this point, the leader should give the group the opportunity to pause and determine whether or not to proceed. The leader might ask, "Something very powerful is going on right now. What is happening? How does it feel? Do we want to go further at this time?"

At times, when a client floods the room with emotional information, the therapist should mute the disturbing line of discussion. The leader should not express discomfort with the level of emotion or indicate a wish to avoid hearing what was being said. Leaders can say something such as:

- "As I ask you to stop, there's a danger that what you hear is, 'I don't want to hear you.' It's not that. It's just that for now, I'm concerned that you may come to feel as if you have shared more than you might wish."
- "I'm wondering how useful it would be for you to continue with what you're doing right now." This intervention teaches individuals how to regulate their expression of emotions and provides an opportunity for the group to comment.
- "Let's pause for a moment and every few minutes from now. How are you feeling right now? Let me know when you're ready to move on."

A distinction needs to be made whether the strong feelings are related to there-and-then material or to here-and-now conduct. It is far less unsettling for someone to express anger—even rage—at a father who abused her 20 years ago than it is to have a client raging at and threatening to kill another group member. Also, the amount of appropriate affect will differ according to the group's purpose. Much stronger emotions are appropriate in psychodrama or gestalt groups than in psychoeducational or support groups.

For people who have had violence in their lives, strong negative emotions like anger can be terrifying. When a group member's rage adversely affects the group process, the leader may use an intervention such as:

- "Bill, stop for a moment and hear how what you're doing is affecting other people."
- "Bill, maybe it would be helpful for you to hear what other people have been thinking while you've been speaking."
- "Bill, as you've been talking, have you noticed what's been happening in the group?"

The thrust of such interventions is to modulate the expression of intense rage and encourage the angry person and others affected by the anger to pay attention to what has happened. Vannicelli (1992) suggests two other ways to modulate a highly charged situation:

- Switch from emotion to cognition. The leader can introduce a cognitive element by asking clients about their thoughts or observations or about what has been taking place.
- Move in time, from a present to a past focus or from past to present.

When intervening to control runaway affect, the leader always should be careful to support the genuine expressions of emotion that are appropriate for the group and the individual's stage of change.

Leaders encourage communication within the group

In support and interpersonal process groups, the leader's primary task is stimulating communication among group members, rather than between individual members and the leader.

This function also may be important on some occasions in psychoeducational and skills-building groups. Some of the many appropriate interventions used to help members engage in meaningful dialog with each other are:

- Praising good communication when it happens.
- Noticing a member's body language, and without shaming, asking that person to express the feeling out loud.
- Building bridges between members with remarks such as, "It sounds as if both you and Maria have something in common…"
- Helping the group complete unfinished business with questions such as, "At the end of our session last time, Sally and Joan were sharing some very important observations. Do you want to go back and explore those further?"
- When someone has difficulty expressing a thought, putting the idea in words and asking, "Have I got it right?"
- Helping members with difficulty verbalizing know that their contributions are valuable and putting them in charge of requesting assistance. The leader might ask, "I can see that you are struggling, Bert. My guess is that you are carrying a truth that's important for the group. Do you have any sense of how they can help you say it?"

In general, group leaders should speak often, but briefly, especially in time-limited groups. In group, the best interventions usually are the ones that are short and simple. Effective leadership demands the ability to make short, simple, cogent remarks.

Concepts, Techniques, and Considerations

Interventions

Interventions may be directed to an individual or the group as a whole. They can be used to clarify what is going on or to make it more explicit, redirect energy, stop a process that is not helpful, or help the group make a choice about what should be done. A well-timed, appropriate intervention has the power to:

- Help a client recognize blocks to connection with other people
- Discover connections between the use of substances and inner thoughts and feelings
- Understand attempts to regulate feeling states and relationships
- Build coping skills
- Perceive the effect of substance abuse on one's life
- Notice meaningful inconsistencies among thoughts, feelings, and behavior
- Perceive discrepancies between stated goals and what is actually being done

Any verbal intervention may carry important nonverbal elements. For example, different people would ascribe a variety of meanings to the words, "I am afraid that you have used again," and the interpretation will vary further with the speaker's tone of voice and body language. Leaders should therefore be careful to avoid conveying an observation in a tone of voice that could create a barrier to understanding or response in the mind of the listener.

Avoiding a leader-centered group

Generally a counselor leads several kinds of groups. Leadership duties may include a psychoeducational group, in which a leader usually takes charge and teaches content, and then a process group, in which the leader's role and responsibilities should shift dramatically. A process group that remains leader-focused limits the potential for learning and growth, yet all too often, interventions place the leader at the center of the group. For example, a common sight in a leader--centered group is a series of one-on-one interactions between the leader and individual group members. These sequential interventions do not use the full power of the group to support experiential change, and especially to build authentic, supportive interpersonal relationships. Some ways for a leader to move away from center stage:

- In addition to using one's own skills, build skills in participants. Avoid doing for the group what it can do for itself.
- Encourage the group to learn the skills necessary to support and encourage one another, because too much or too frequent support from the clinician can lead to approval seeking, which blocks growth and independence. Supporting each other, of course, is a skill that should develop through group phases. Thus, in earlier phases of treatment, the leader may need to model ways of communicating support. Later, if a client is experiencing loss and grief, for example, the leader does not rush in to assure the client that all will soon be well. Instead, the leader would invite group members to empathize with each other's struggles, saying something like, "Joanne, my guess is at least six other people here are experts on this type of feeling. What does this bring up for others here?"
- Refrain from taking on the responsibility to repair anything in the life of the clients. To a certain extent, they should be allowed to struggle with what is facing them. It would be appropriate, however, for the leader to access resources that will help clients resolve problems.

Confrontation

Confrontation is one form of intervention. In the past, therapists have used confrontation aggressively to challenge clients' defenses of their substance abuse and related untoward behaviors. In recent years, however, clinicians have come to recognize that when "confrontation" is equivalent to "attack," it can have an adverse effect on the therapeutic alliance and process, ultimately leading to failure. Trying to force the client to share the clinician's view of a situation accomplishes no therapeutic purpose and can get in the way of the work.

A more useful way to think about confrontation is "pointing out inconsistencies," such as disconnects between behaviors and stated goals. William R. Miller explains:

> The linguistic roots of the verb "to confront" mean to come face-to-face. When you think about it that way,

> confrontation is precisely what we are trying to accomplish: to allow our clients to come face-to-face with a difficult and often threatening reality, to "let it in" rather than "block it out," and to allow this reality to change them. That makes confrontation a goal of counseling rather than a particular style or technique. . . [T]hen the question becomes, What is the best way to achieve that goal?
>
> Evidence is strong that direct, forceful, aggressive approaches are perhaps the least effective way to help people consider new information and change their perceptions (CSAT 1999*b*, p. 10).

Confrontation in this light is a part of the change process, and therefore part of the helping process. Its purpose is to help clients see and accept reality so they can change accordingly (Miller and Rollnick 1991). With this broader understanding of what interventions that "confront" the client really mean, it is not useful to divide therapy into "supportive" and "confrontative" categories.

Transference and Countertransference

Transference means that people project parts of important relationships from the past into relationships in the present. For example, Heather may find that Juan reminds her of her judgmental father. When Juan voices his suspicion that she has been drinking, Heather feels the same feelings she felt when her father criticized all her supposed failings. Within the microcosm of the group, this type of incident not only relates the here-and-now to the past, but also offers Heather an opportunity to learn a different, more self-respecting way of responding to a remark that she perceives as criticism.

The emotion inherent in groups is not limited to clients. The groups inevitably stir up strong feelings in leaders. The therapist's emotional response to a group member's transference is referred to as countertransference. Vannicelli (2001) describes three forms of countertransference:

- *Feelings of having been there.* Leaders with family or personal histories with substance abuse have a treasure in their extraordinary ability to empathize with clients who abuse substances. If that empathy is not adequately understood and controlled, however, it can become a problem, particularly if the therapist tries to act as a role model or sponsor or discloses too much personal information.
- *Feelings of helplessness when the therapist is more invested in the treatment than the client is.* Treating highly resistant populations, such as clients referred to treatment by the courts, can cause leaders to feel powerless, demoralized, or even angry. The best way to deal with this type of countertransference may be to use the energy of the resistance to fuel the session. (See "Resistance in Group," next section.)
- *Feelings of incompetence due to unfamiliarity with culture and jargon.* It is helpful for leaders to be familiar with 12-Step programs, cultures, and languages. If a group member uses unfamiliar terms, however, the leader should ask the client to explain what the term means to that person, using a question like, "'Letting go' means something a bit different to each person. Can you say a little more about how this relates to your situation?" (Vannicelli 2001, p. 58).

When countertransference occurs, the clinician needs to bring all feelings associated with it to awareness and manage them appropriately. Good supervision can be really helpful. Countertransference is not bad. It is inevitable, and with the help of supervision, the group leader can use countertransference to support the group process (Vannicelli 2001).

Resistance In Group

Resistance arises as an often unconscious defense to protect the client from the pain of self--examination. These processes within the client or group impede the open expression of thoughts and feelings or block the progress of an individual or group. The effective leader will neither ignore resistance nor attempt to override it. Instead, the leader helps the individual and group understand what is getting in the way, welcoming the resistance as an opportunity to understand something important going on for the client or the group. Further, resistance may be viewed as energy that can be harnessed and used in a variety of ways, once the therapist has helped the client and group understand what is happening and what the resistant person or persons actually want (Vannicelli 2001).

In groups that are mandated to enter treatment, members often have little interest in being present, so strong resistance is to be expected. Even this resistance, however, can be incorporated into treatment. For example, the leader may invite the group members to talk about the difficulties experienced in coming to the session or to express their outrage at having been required to come. The leader can respond to this anger by saying, "I am impressed by how open people have been in sharing their feelings this evening and in being so forthcoming about really speaking up. My hope is that people will continue to be able to talk in this open way to make our time together as useful as possible" (Vannicelli 2001, p. 55).

Leaders should recognize that clients are not always aware that their reasons for nonattendance or lateness may be resistance. The most helpful attitude on the clinician's part is curiosity and an interest in exploring what is happening and what can be learned from it. Leaders need not battle resistance. It is not the enemy. Indeed, it is usually the necessary precursor to change.

It would be a serious mistake, however, to imagine that resistance always melts away once someone calls attention to it. "Resistance is always there for a reason, and the group members should not be expected to give it up until the emotional forces held in check by it are sufficiently discharged or converted, so that they are no longer a danger to the safety of the group or its members" (Flores 1997, p. 538).

When a group (rather than an individual) is resistant, the leader may have contributed to the creation of this phenomenon and efforts need to be made to understand the leader's role in the problem. Sometimes, "resistance can be induced by leaders who are passive, hostile, ineffective, guarded, weak, or in need of constant admiration and excessive friendliness" (Flores 1997, p. 538).

Confidentiality

For the group leader, strict adherence to confidentiality regulations builds trust. If the bounds of confidentiality are broken, grave legal and personal consequences may result. All group leaders should be thoroughly familiar with federal laws on confidentiality (42 C.F.R. Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records) and relevant agency policies. Confidentiality is recognized as "a central tenet of the practice of psychotherapy" (Parker et al. 1997, p. 157), yet a vast majority of states either have vague statutes dealing with confidentiality in group therapy or have no statutes at all. Even where a privilege of confidentiality does exist in law, enforcement of the law that protects it is often difficult (Parker et al. 1997). Clinicians should be aware of this legal problem and should warn clients that what they say in group may not be kept strictly confidential. Some studies indicate that a significant number of therapists do not advise group members that confidentiality has limits (Parker et al. 1997).

One set of confidentiality issues has to do with the use of personal information in a group session.

Group leaders have many sources of information on a client, including the names of the client's employer and spouse, as well as any ties to the court system. A group leader should be clear about how information from these sources may and may not be used in group.

Clinicians consider the bounds of confidentiality as existing around the treatment enterprise, not around a particular treatment group. Clients should know that everyone on the treatment team has access to relevant information. In addition, clinicians should make it clear to clients that confidentiality cannot be used to conceal continued substance abuse, and the therapist will not be drawn into colluding with the client to hide substance use infractions. Clinicians also should advise clients of the exact circumstances under which therapists are legally required to break confidentiality.

A second set of confidentiality issues has to do with the group leader's relationships with clients and clients with one another. When counseling a client in both individual therapy and a group context, for example, the leader should know exactly how information learned in individual therapy may be used in the group context. In almost every case, it is more beneficial for the client to divulge such information than for the clinician to reveal it. In an individual session, the therapist and the client can plan how the issue will be brought up in group. This preparation gives clients ample time to decide what to say and what they want from the group. The therapist can prompt clients to share information in the group with a comment like, "I wonder if the group understands what a hard time you've been having over the last 2 weeks?" On the other hand, therapists should reserve the right to determine what information will be discussed in group. A leader may say firmly, "Understand that whatever you tell me may or may not be introduced in group. I will not keep important information from the group, if I feel that with holding the information will impede your progress or interfere with your recovery."

Still other confidentiality issues arise when clients discuss information from the group beyond its bounds. Violations of confidentiality among members should be managed in the same way as other boundary violations; that is, empathic joining with those involved followed by a factual reiteration of the agreement that has been broken and an invitation to group members to discuss their perceptions and feelings. In some cases,when this boundary is violated, the group may feel a need for additional clarification or addenda to the group agreement. The leader may ask, both at the beginning of the group or when issues arise, whether the group feels it needs additional agreements in order to work safely. Such amendments, however, should not seek to renegotiate the terms of the original group agreement.

Management of the Group

Handling conflict in group

Conflict in group therapy is normal, healthy, and unavoidable. When it occurs, the therapist's task is to make the most of it as a learning opportunity. Conflict can present opportunities for group members to find meaningful connections with each other and within their own lives.

Handling anger, developing empathy for a different viewpoint, managing emotions, and working through disagreements respectfully are all major and worthwhile tasks for recovering clients. The leader's judgment and management are crucial as these tasks are handled. It is just as unhelpful to clients to let the conflict go too far as it is to shut down a conflict before it gets worked through. The therapist must gauge the verbal and nonverbal reactions of every group member to ensure that every one can manage the emotional level of the conflict.

The clinician also facilitates interactions between members in conflict and calls attention to subtle, sometimes unhealthy patterns. For example, a group may have a member, Mary, who frequently

disagrees with others. Group peers regard Mary as a source of conflict, and some of them have even asked Mary (the scapegoat) to leave so that they can get on with group work. In such a situation, the therapist might ask, "Do you think this group would learn more about handling this type of situation if Mary left the group or stayed in the group?" An alternative tack would be, "I think the group members are avoiding a unique opportunity to learn something about yourselves. Giving in to the fantasy of getting rid of Mary would rob each of you of the chance to understand yourself better. It would also prevent you from learning how to deal with people who upset you."

Conflicts within groups may be overt or covert. The therapist helps the group to label covert conflicts and bring them into the open. The observation that a conflict exists and that the group needs to pay attention to it actually makes group members feel safer. The therapist is not responsible, however, for resolving conflicts. Once the conflict is observed, the decision to explore it further is made based on whether such inquiry would be productive for the group as a whole. In reaching this decision, the therapist should consider the function the conflict is serving for the group. It actually may be the most useful current opportunity for growth in the group.

On the other hand, as Vannicelli (1992) points out, conflicts can be repetitive and predictable. When two members are embroiled in an endless loop of conflict, Vannicelli suggests that the leader may handle the situation by asking, "John, did you know what Sally was likely to say when you said X?" and "Sally, did you know what John was likely to say when you said Y?" "Since both participants are likely to answer, 'Yes, of course,' the therapist would then inquire what use it might serve for them to engage in this dialogue when the expected outcome is so apparent to both of them (as well as to other members of the group). This kind of distraction activity or defensive maneuver should come to signal to group members that something important is being avoided. It is the leader's task to help the group figure out what that might be and then to move on" (Vannicelli 1992, p. 121).

Group leaders also should be aware that many conflicts that appear to scapegoat a group member are actually displaced anger that a member feels toward the therapist. When the therapist suspects this kind of situation, the possibility should be forthrightly presented to the group with a comment such as, "I notice, Joe, that you have been upset with Jean quite a bit lately. I also know that you have been a little annoyed with me since a couple weeks ago about the way I handled that phone call from your boss. Do you think some of your anger belongs with me?"

Individual responses to particular conflicts can be complex and may resonate powerfully according to a client's personal values and beliefs, family, and culture. Therefore, after a conflict, it is important for the group leader to speak privately with group members and see how each is feeling. Leaders also often use the last 5 minutes of a session in which a conflict has occurred to give group members an opportunity to express their concerns.

Subgroup management

In any group, subgroups inevitably will form. Individuals always will feel more affinity and more potential for alliance with some members than with others. One key role for the therapist in such cases is to make covert alliances overt. The therapist can involve the group in identifying subgroups by saying, "I notice Jill and Mike are finding they have a good deal in common. Who else is in Jill and Mike's subgroup?"

Subgroups can sometimes provoke anxiety, especially when a therapy group is made up of individuals acquainted before becoming group members. Group members may have used drugs together, slept together, worked together, or experienced residential substance abuse treatment

together. Obviously, such connections are potentially disruptive, so when groups are formed, group leaders should consider whether subgroups would exist.

When subgroups somehow stymie full participation in the group, the therapist may be able to reframe what the subgroup is doing. At other times, a change in the room arrangement may be able to reconfigure undesirable combinations. On occasion, however, subtle approaches fail. For instance, adolescents talking among themselves or making obscene gestures during the session should be told factually and firmly that what they are doing is not permissible. The group leader might say, "We can't do our work with distractions going on. Your behavior is disrespectful and it attempts to shame others in the group. I won't tolerate any abuse of members in this group."

Subgroups are not always negative. The leader, for example, may intentionally foster a subgroup that helps marginally connected clients move into the life of the group. This gambit might involve a question like, "Juanita, do you think it might help Joe if you talked some about your experience with this issue?" Further, to build helpful connections between group members, a group member might be asked, "Bob, who else in this group do you think might know something about what you've just said?"

Responding to disruptive behavior

Clients who cannot stop talking

When a client talks on and on, he or she may not know what is expected in a therapy group. The group leader might ask the verbose client, "Bob, what are you hoping the group will learn from what you have been sharing?" If Bob's answer is, "Huh, well nothing really," it might be time to ask more experienced group members to give Bob a sense of how the group works. At other times, clients tend to talk more than their share because they are not sure what else to do. It may come as a relief to have their monolog interrupted (Vannicelli 1992, p. 167).

If group members exhibit no interest in stopping a perpetually filibustering client, it may be appropriate to examine this silent cooperation. The group may be all too willing to allow the talker to ramble on, to avoid examining their own past failed patterns of substance abuse and forge a more productive future. When this motive is suspected, the leader should explore what group members have and have not done to signal the speaker that it is time to yield the floor. It also may be advisable to help the talker find a more effective strategy for being heard and understood (Vannicelli 1992).

Clients who interrupt

Interruptions disrupt the flow of discussion in the group, with frustrating results. The client who interrupts is often someone new to the group and not yet accustomed to its norms and rhythms. The leader may invite the group to comment by saying, "What just happened?" If the group observes, "Jim seemed real anxious to get in right now," the leader might intervene with, "You know, Jim, my hunch is that you don't know us well enough yet to be certain that the group will pay adequate attention to your issues; thus, at this point, you feel quite a lot of pressure to be heard and understood. My guess is that when other people are speaking you are often so distracted by your worries that it may even be hard to completely follow what is going on" (Vannicelli 1992, p. 170).

Clients who flee a session

Clients who run out of a session often are acting on an impulse that others share. It would be productive in such instances to discuss these feelings with the group and to determine what members can do to talk about these feelings when they arise. The leader should stress the point that no matter

what is going on in the group, the therapeutic work requires members to remain in the room and talk about problems instead of attempting to escape them (Vannicelli 1992). If a member is unable to meet this requirement, reevaluation of that person's placement in the group is indicated.

Coming late or missing sessions

Sometimes, addiction counselors view the client who comes to group late as a person who, in some sense, is behaving badly. It is more productive to see this kind of boundary violation as a message to be deciphered. Sometimes this attempt will fail, and the clinician may decide the behavior interferes with the group work too much to be tolerated.

Silence

A group member who is silent is conveying a message as clearly as one who speaks. Silent messages should be heard and understood, since nonresponsiveness may provide clues to clients' difficulties in connecting with their own inner lives or with others (Vannicelli 1992).

Special consideration is sometimes necessary for clients who speak English as a second language (ESL). Such clients may be silent, or respond only after a delay, because they need time to translate what has just been said into their first language. Experiences involving strong feelings can be especially hard to translate, so the delay can be longer. Further, when feelings are running high, even fluent ESL speakers may not be able to find the right words to say what they mean or may be unable to understand what another group member is saying about an intense experience.

Tuning out

When the group is in progress and clients seem present in body but not in mind, it helps to tune into them just as they are tuning out. The leader should explore what was happening as an individual became inattentive. Perhaps the person was escaping from specific difficult material or was having more general difficulties connecting with other people. It may be helpful to involve the group in giving feedback to clients whose attention falters. It also is possible, however, that the group as a whole is sidestepping matters that have to do with connectedness. The member who tunes out might be carrying this message for the group (Vannicelli 1992).

Participating only around the issues of others

Even when group members are disclosing little about themselves, they may be gaining a great deal from the group experience, remaining engaged around issues that others bring up. To encourage a member to share more, however, a leader might introduce the topic of how well members know each other and how well they want to be known. This topic could be explored in terms of percentages. For instance, a man might estimate that group members know about 35 percent about him, and he would eventually like them to know 75 percent. Such a discussion would yield important information about how much individuals wish to be known by others (Vannicelli 1992).

Fear of losing control

As Vannicelli (1992) notes, sometimes clients avoid opening up because they are afraid they might break down in front of others—a fear particularly common in the initial phases of groups. When this restraint becomes a barrier to clients feeling acute pain, the therapist should help them remember ways that they have handled strong feelings in the past.

For example, if a female client says she might "cry forever" once she begins, the leader might gently

inquire, "Did that ever happen?" Clients are often surprised to realize that tears generally do not last very long. The therapist can further assist this client by asking, "How were you able to stop?" (Vannicelli 1992, p. 152). When a client's fears of breaking down or becoming unable to function may be founded in reality (for example, when a client has recently been hospitalized), the therapist should validate the feelings of fear, and should concentrate on the strength of the person's adaptive abilities (Vannicelli 1992).

Fragile clients with psychological emergencies

Since clients know that the group leader is contractually bound to end the group's work on time, they often wait intentionally until the last few minutes of group to share emotionally charged information. They may reveal something particularly sad or difficult for them to deal with. It is important for the leader to recognize they have deliberately chosen this time to share this information. The timing is the client's way of limiting the group's responses and avoiding an onslaught of interest. All the same, the group members or leader should point out this self-defeating behavior and encourage the client to change it.

Near the end of a session, for example, a group leader has an exchange with a group member named Lan, who has been silent throughout the session:

> **Leader:** Lan, you've been pretty quiet today. I hope we will hear more about what is happening with you next week.
>
> **Lan:** I don't think you'll see me next week.

Further exploration reveals that Lan intends to kill herself that night. In view of the approaching time boundary, what should the leader do?

In such a situation, the group leader has dual responsibilities. First, the leader should respond to Lan's crisis. Second, the incident should be handled in a way that reassures other group members and preserves the integrity of the group. Group members will have a high level of anxiety about such a situation.

Because of their concern, some group leaders are willing to extend the time boundary for that session only, provided that all members are willing and able to stay. Others feel strongly that the time boundary should be maintained and that the leader should pledge to work with Lan individually right after the session. Whatever the decision and subsequent action, the leader should not simply drift casually and quietly over the time boundary. The important message is that boundaries should be honored and that Lan will get the help she needs. The group leader can say explicitly that Lan's needs will be addressed after group.

Anxiety and resistance after self-disclosure

Clients may feel great anxiety after disclosing something important, such as the fact that they are gay or incest victims. Often, they wonder about two possibilities: "Does this mean that I have to keep talking about it? Does this mean that if new people come into the group, I have to tell them too?" (Vannicelli 1992, p. 160).

To the first question, the therapist can respond with the assurance, "People disclose in here when they are ready." To the second, the member who has made the disclosure can be assured of not having to reiterate the disclosure when new clients enter. Further, the disclosing member is now at a different stage of development, so the group leader could say, "Perhaps the fact that you have opened up the secret a little bit suggests that you are not feeling that it is so important to hide it anymore. My guess

is that this, itself, will have some bearing on how you conduct yourself with new members who come into the group" (Vannicelli 1992, p. 160 & p. 161).

Center for Substance Abuse Treatment. *Substance Abuse Treatment: Group Therapy*. Treatment Improvement Protocol (TIP) Series, No. 41. HHS Publication No. (SMA) 15-3991. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

CHAPTER 9.

TREATMENT MODELS

Imagine that every restaurant you went to only served one item: a hot dog with ketchup. The same item at every restaurant, everywhere no matter where you went. Just a hot dog with ketchup. Nothing else. No modifications to the hot dog allowed whatsoever. No fries or beverages available. Just a hot dog with ketchup. Some of you reading this think, "Great! I love hot dogs with ketchup!" However, the chances are good that you would get bored with having only this option and would eventually have a taste for something else. What about the people who don't like hot dogs? Or don't like ketchup on hot dogs? What about vegans and vegetarians? Could you imagine how drab and unfair it would be if every time you went out to eat this was the only option?

Now imagine you are seeking treatment for addiction. There is only one option available. No matter what your needs, addiction, lifestyle, learning style, etc., there is ONE option. That's it, that's all. And although it doesn't quite fit and it isn't likely to help as a result, it's the only one you can choose. Talk about unfair!

Addiction is complex and so are the various treatment needs of the individuals who are looking for help. As a result, there needs to be a menu of options available when it comes to treating addiction. In this chapter we will be exploring various treatment models used in treating addiction.

PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE (ADAPTATION)

Evidence-Based Approaches to Drug Addiction Treatment

This section presents examples of treatment approaches and components that have an evidence base supporting their use. Each approach is designed to address certain aspects of drug addiction and its consequences for the individual, family, and society. Some of the approaches are intended to supplement or enhance existing treatment programs, and others are fairly comprehensive in and of themselves.

The following section is broken down into Pharmacotherapies, Behavioral Therapies, and Behavioral Therapies Primarily for Adolescents. They are further subdivided according to particular substance use disorders. This list is not exhaustive, and new treatments are continually under development.

Pharmacotherapies

Opioid Addiction

Methadone

Methadone is a long-acting synthetic opioid agonist medication that can prevent withdrawal symptoms and reduce craving in opioid-addicted individuals. It can also block the effects of illicit

opioids. It has a long history of use in treatment of opioid dependence in adults and is taken orally. Methadone maintenance treatment is available in all but three states through specially licensed opioid treatment programs or methadone maintenance programs.

Combined with behavioral treatment

Research has shown that methadone maintenance is more effective when it includes individual and/or group counseling, with even better outcomes when patients are provided with, or referred to, other needed medical/psychiatric, psychological, and social services (e.g., employment or family services).

Buprenorphine

Buprenorphine is a synthetic opioid medication that acts as a partial agonist at opioid receptors—it does not produce the euphoria and sedation caused by heroin or other opioids, but is able to reduce or eliminate withdrawal symptoms associated with opioid dependence and carries a low risk of overdose.

Buprenorphine is currently available in two formulations that are taken sublingually: (1) a pure form of the drug and (2) a more commonly prescribed formulation called Suboxone, which combines buprenorphine with the drug naloxone, an antagonist (or blocker) at opioid receptors. Naloxone has no effect when Suboxone is taken as prescribed, but if an addicted individual attempts to inject Suboxone, the naloxone will produce severe withdrawal symptoms. Thus, this formulation lessens the likelihood that the drug will be abused or diverted to others.

Buprenorphine treatment for detoxification and/or maintenance can be provided in office-based settings by qualified physicians who have received a waiver from the Drug Enforcement Administration (DEA) allowing them to prescribe it. The availability of office-based treatment for opioid addiction is a cost-effective approach that increases the reach of treatment and the options available to patients.

Naltrexone

Naltrexone is a synthetic opioid antagonist—it blocks opioids from binding to their receptors and thereby prevents their euphoric and other effects. It has been used for many years to reverse opioid overdose and is also approved for treating opioid addiction. The theory behind this treatment is that the repeated absence of the desired effects and the perceived futility of abusing opioids will gradually diminish craving and addiction. Naltrexone itself has no subjective effects following detoxification (that is, a person does not perceive any particular drug effect), it has no potential for abuse, and it is not addictive.

Naltrexone as a treatment for opioid addiction is usually prescribed in outpatient medical settings, although the treatment should begin *after* medical detoxification in a residential setting in order to prevent withdrawal symptoms.

Naltrexone must be taken orally—either daily or three times a week—but noncompliance with treatment is a common problem. Many experienced clinicians have found naltrexone best suited for highly motivated, recently detoxified patients who desire total abstinence because of external circumstances—for instance, professionals or parolees. Recently, a long-acting injectable version of naltrexone, called Vivitrol, was approved to treat opioid addiction. Because it only needs to be delivered once a month, this version of the drug can facilitate compliance and offers an alternative for those who do not wish to be placed on agonist/partial agonist medications.

Naltrexone

Naltrexone blocks opioid receptors that are involved in the rewarding effects of drinking and the craving for alcohol. It has been shown to reduce relapse to problem drinking in some patients. An extended release version, Vivitrol—administered once a month by injection—is also FDA-approved for treating alcoholism, and may offer benefits regarding compliance.

Acamprosate

Acamprosate (Campral®) acts on the gamma-aminobutyric acid (GABA) and glutamate neurotransmitter systems and is thought to reduce symptoms of protracted withdrawal, such as insomnia, anxiety, restlessness, and dysphoria.

Acamprosate has been shown to help dependent drinkers maintain abstinence for several weeks to months, and it may be more effective in patients with severe dependence.

Disulfiram

Disulfiram (Antabuse®) interferes with degradation of alcohol, resulting in the accumulation of acetaldehyde, which, in turn, produces a very unpleasant reaction that includes flushing, nausea, and palpitations if a person drinks alcohol. The utility and effectiveness of disulfiram are considered limited because compliance is generally poor. However, among patients who are highly motivated, disulfiram can be effective, and some patients use it episodically for high-risk situations, such as social occasions where alcohol is present. It can also be administered in a monitored fashion, such as in a clinic or by a spouse, improving its efficacy.

Topiramate

Topiramate is thought to work by increasing inhibitory (GABA) neurotransmission and reducing stimulatory (glutamate) neurotransmission, although its precise mechanism of action is not known. Although topiramate has not yet received FDA approval for treating alcohol addiction, it is sometimes used off-label for this purpose. Topiramate has been shown in studies to significantly improve multiple drinking outcomes, compared with a placebo.

Combined with Behavioral Treatment

While a number of behavioral treatments have been shown to be effective in the treatment of alcohol addiction, it does not appear that an additive effect exists between behavioral treatments and pharmacotherapy. Studies have shown that just getting help is one of the most important factors in treating alcohol addiction; the precise type of treatment received is not as important.

Behavioral Therapies

Behavioral approaches help engage people in drug abuse treatment, provide incentives for them to remain abstinent, modify their attitudes and behaviors related to drug abuse, and increase their life skills to handle stressful circumstances and environmental cues that may trigger intense craving for drugs and prompt another cycle of compulsive abuse. Below are a number of behavioral therapies shown to be effective in addressing substance abuse (effectiveness with particular drugs of abuse is denoted in parentheses).

Cognitive-Behavioral Therapy

Cognitive-Behavioral Therapy (CBT) was developed as a method to prevent relapse when treating problem drinking, and later it was adapted for cocaine-addicted individuals. Cognitive-behavioral strategies are based on the theory that in the development of maladaptive behavioral patterns like substance abuse, learning processes play a critical role. Individuals in CBT learn to identify and correct problematic behaviors by applying a range of different skills that can be used to stop drug abuse and to address a range of other problems that often co-occur with it.

A central element of CBT is anticipating likely problems and enhancing patients' self-control by helping them develop effective coping strategies. Specific techniques include exploring the positive and negative consequences of continued drug use, self-monitoring to recognize cravings early and identify situations that might put one at risk for use, and developing strategies for coping with cravings and avoiding those high-risk situations.

Research indicates that the skills individuals learn through cognitive-behavioral approaches remain after the completion of treatment. Current research focuses on how to produce even more powerful effects by combining CBT with medications for drug abuse and with other types of behavioral therapies. A computer-based CBT system has also been developed and has been shown to be effective in helping reduce drug use following standard drug abuse treatment.

Contingency Management Interventions / Motivational Incentives

Research has demonstrated the effectiveness of treatment approaches using contingency management (CM) principles, which involve giving patients tangible rewards to reinforce positive behaviors such as abstinence. Studies conducted in both methadone programs and psychosocial counseling treatment programs demonstrate that incentive-based interventions are highly effective in increasing treatment retention and promoting abstinence from drugs.

Voucher-Based Reinforcement (VBR) augments other community-based treatments for adults who primarily abuse opioids (especially heroin) or stimulants (especially cocaine) or both. In VBR, the patient receives a voucher for every drug-free urine sample provided. The voucher has monetary value that can be exchanged for food items, movie passes, or other goods or services that are consistent with a drug-free lifestyle. The voucher values are low at first but increase as the number of consecutive drug-free urine samples increases; positive urine samples reset the value of the vouchers to the initial low value. VBR has been shown to be effective in promoting abstinence from opioids and cocaine in patients undergoing methadone detoxification.

Prize Incentives CM applies similar principles as VBR, but uses chances to win cash prizes instead of vouchers. Over the course of the program (at least 3 months, one or more times weekly), participants supplying drug-negative urine or breath tests draw from a bowl for the chance to win a prize worth between $1 and $100. Participants may also receive draws for attending counseling sessions and completing weekly goal-related activities. The number of draws starts at one and increases with consecutive negative drug tests and/or counseling sessions attended, but resets to one with any drug-positive sample or unexcused absence. The practitioner community has raised concerns that this intervention could promote gambling—as it contains an element of chance—and that pathological gambling and substance use disorders can be comorbid. However, studies examining this concern found that Prize Incentives CM did not promote gambling behavior.

Community Reinforcement Approach Plus Vouchers

Community Reinforcement Approach (CRA) Plus Vouchers is an intensive 24-week outpatient therapy for treating people addicted to cocaine and alcohol. It uses a range of recreational, familial, social, and vocational reinforcers, along with material incentives, to make a non-drug-using lifestyle more rewarding than substance use. The treatment goals are twofold:

- To maintain abstinence long enough for patients to learn new life skills to help sustain it; and
- To reduce alcohol consumption for patients whose drinking is associated with cocaine use

Patients attend one or two individual counseling sessions each week, where they focus on improving family relations, learn a variety of skills to minimize drug use, receive vocational counseling, and develop new recreational activities and social networks. Those who also abuse alcohol receive clinic-monitored disulfiram (Antabuse) therapy. Patients submit urine samples two or three times each week and receive vouchers for cocaine-negative samples. As in VBR, the value of the vouchers increases with consecutive clean samples, and the vouchers may be exchanged for retail goods that are consistent with a drug-free lifestyle. Studies in both urban and rural areas have found that this approach facilitates patients' engagement in treatment and successfully aids them in gaining substantial periods of cocaine abstinence.

A computer-based version of CRA Plus Vouchers called the Therapeutic Education System (TES) was found to be nearly as effective as treatment administered by a therapist in promoting abstinence from opioids and cocaine among opioid-dependent individuals in outpatient treatment. A version of CRA for adolescents addresses problem-solving, coping, and communication skills and encourages active participation in positive social and recreational activities.

Motivational Enhancement Therapy

Motivational Enhancement Therapy (MET) is a counseling approach that helps individuals resolve their ambivalence about engaging in treatment and stopping their drug use. This approach aims to evoke rapid and internally motivated change, rather than guide the patient stepwise through the recovery process. This therapy consists of an initial assessment battery session, followed by two to four individual treatment sessions with a therapist. In the first treatment session, the therapist provides feedback to the initial assessment, stimulating discussion about personal substance use and eliciting self-motivational statements. Motivational interviewing principles are used to strengthen motivation and build a plan for change. Coping strategies for high-risk situations are suggested and discussed with the patient. In subsequent sessions, the therapist monitors change, reviews cessation strategies being used, and continues to encourage commitment to change or sustained abstinence. Patients sometimes are encouraged to bring a significant other to sessions.

Research on MET suggests that its effects depend on the type of drug used by participants and on the goal of the intervention. This approach has been used successfully with people addicted to alcohol to both improve their engagement in treatment and reduce their problem drinking. MET has also been used successfully with marijuana-dependent adults when combined with cognitive-behavioral therapy, constituting a more comprehensive treatment approach. The results of MET are mixed for people abusing other drugs (e.g., heroin, cocaine, nicotine) and for adolescents who tend to use multiple drugs. In general, MET seems to be more effective for engaging drug abusers in treatment than for producing changes in drug use.

The Matrix Model

The Matrix Model provides a framework for engaging stimulant (e.g., methamphetamine and cocaine) abusers in treatment and helping them achieve abstinence. Patients learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, and become familiar with self-help programs. Patients are monitored for drug use through urine testing.

The therapist functions simultaneously as teacher and coach, fostering a positive, encouraging relationship with the patient and using that relationship to reinforce positive behavior change. The interaction between the therapist and the patient is authentic and direct, but not confrontational or parental. Therapists are trained to conduct treatment sessions in a way that promotes the patient's self-esteem, dignity, and self-worth. A positive relationship between patient and therapist is critical to patient retention.

Treatment materials draw heavily on other tested treatment approaches and, thus, include elements of relapse prevention, family and group therapies, drug education, and self-help participation. Detailed treatment manuals contain worksheets for individual sessions; other components include family education groups, early recovery skills groups, relapse prevention groups, combined sessions, urine tests, 12-step programs, relapse analysis, and social support groups.

A number of studies have demonstrated that participants treated using the Matrix Model show statistically significant reductions in drug and alcohol use, improvements in psychological indicators, and reduced risky sexual behaviors associated with HIV transmission.

12-Step Facilitation Therapy

Twelve-step facilitation therapy is an active engagement strategy designed to increase the likelihood of a substance abuser becoming affiliated with and actively involved in 12-step self-help groups, thereby promoting abstinence. Three key ideas predominate: (1) acceptance, which includes the realization that drug addiction is a chronic, progressive disease over which one has no control, that life has become unmanageable because of drugs, that willpower alone is insufficient to overcome the problem, and that abstinence is the only alternative; (2) surrender, which involves giving oneself over to a higher power, accepting the fellowship and support structure of other recovering addicted individuals, and following the recovery activities laid out by the 12-step program; and (3) active involvement in 12-step meetings and related activities. While the efficacy of 12-step programs (and 12-step facilitation) in treating alcohol dependence has been established, the research on its usefulness for other forms of substance abuse is more preliminary, but the treatment appears promising for helping drug abusers sustain recovery.

Family Behavior Therapy

Family Behavior Therapy (FBT), which has demonstrated positive results in both adults and adolescents, is aimed at addressing not only substance use problems, but other co-occurring problems as well, such as conduct disorders, child mistreatment, depression, family conflict, and unemployment. FBT combines behavioral contracting with contingency management.

FBT involves the patient along with at least one significant other, such as a cohabiting partner or a parent (in the case of adolescents). Therapists seek to engage families in applying the behavioral strategies taught in sessions and in acquiring new skills to improve the home environment. Patients are encouraged to develop behavioral goals for preventing substance use and HIV infection, which are anchored to a contingency management system. Substance-abusing parents are prompted to set goals

related to effective parenting behaviors. During each session, the behavioral goals are reviewed, with rewards provided by significant others when goals are accomplished. Patients participate in treatment planning, choosing specific interventions from a menu of evidence-based treatment options. In a series of comparisons involving adolescents with and without conduct disorder, FBT was found to be more effective than supportive counseling.

Behavioral Therapies Primarily for Adolescents

Drug-abusing and addicted adolescents have unique treatment needs. Research has shown that treatments designed for and tested in adult populations often need to be modified to be effective in adolescents. Family involvement is a particularly important component for interventions targeting youth. Below are examples of behavioral interventions that employ these principles and have shown efficacy for treating addiction in youth.

Multisystemic Therapy

Multisystemic Therapy (MST) addresses the factors associated with serious antisocial behavior in children and adolescents who abuse alcohol and other drugs. These factors include characteristics of the child or adolescent (e.g., favorable attitudes toward drug use), the family (poor discipline, family conflict, parental drug abuse), peers (positive attitudes toward drug use), school (dropout, poor performance), and neighborhood (criminal subculture). By participating in intensive treatment in natural environments (homes, schools, and neighborhood settings), most youths and families complete a full course of treatment. MST significantly reduces adolescent drug use during treatment and for at least 6 months after treatment. Fewer incarcerations and out-of-home juvenile placements offset the cost of providing this intensive service and maintaining the clinicians' low caseloads.

Multidimensional Family Therapy

Multidimensional Family Therapy (MDFT) for adolescents is an outpatient, family-based treatment for teenagers who abuse alcohol or other drugs. MDFT views adolescent drug use in terms of a network of influences (individual, family, peer, community) and suggests that reducing unwanted behavior and increasing desirable behavior occur in multiple ways in different settings. Treatment includes individual and family sessions held in the clinic, in the home, or with family members at the family court, school, or other community locations.

During individual sessions, the therapist and adolescent work on important developmental tasks, such as developing decision-making, negotiation, and problem-solving skills. Teenagers acquire vocational skills and skills in communicating their thoughts and feelings to deal better with life stressors. Parallel sessions are held with family members. Parents examine their particular parenting styles, learning to distinguish influence from control and to have a positive and developmentally appropriate influence on their children.

Brief Strategic Family Therapy

Brief Strategic Family Therapy (BSFT) targets family interactions that are thought to maintain or exacerbate adolescent drug abuse and other co-occurring problem behaviors. Such problem behaviors include conduct problems at home and at school, oppositional behavior, delinquency, associating with antisocial peers, aggressive and violent behavior, and risky sexual behavior. BSFT is based on a family systems approach to treatment, in which family members' behaviors are assumed

to be interdependent such that the symptoms of one member (the drug-abusing adolescent, for example) are indicative, at least in part, of what else is occurring in the family system. The role of the BSFT counselor is to identify the patterns of family interaction that are associated with the adolescent's behavior problems and to assist in changing those problem-maintaining family patterns. BSFT is meant to be a flexible approach that can be adapted to a broad range of family situations in various settings (mental health clinics, drug abuse treatment programs, other social service settings, and families' homes) and in various treatment modalities (as a primary outpatient intervention, in combination with residential or day treatment, and as an aftercare/continuing-care service following residential treatment).

Functional Family Therapy

Functional Family Therapy (FFT) is another treatment based on a family systems approach, in which an adolescent's behavior problems are seen as being created or maintained by a family's dysfunctional interaction patterns. FFT aims to reduce problem behaviors by improving communication, problem-solving, conflict resolution, and parenting skills. The intervention always includes the adolescent and at least one family member in each session. Principal treatment tactics include (1) engaging families in the treatment process and enhancing their motivation for change, and (2) bringing about changes in family members' behavior using contingency management techniques, communication and problem-solving, behavioral contracts, and other behavioral interventions.

Adolescent Community Reinforcement Approach and Assertive Continuing Care

The Adolescent Community Reinforcement Approach (A-CRA) is another comprehensive substance abuse treatment intervention that involves the adolescent and his or her family. It seeks to support the individual's recovery by increasing family, social, and educational/vocational reinforcers. After assessing the adolescent's needs and levels of functioning, the therapist chooses from among 17 A-CRA procedures to address problem-solving, coping, and communication skills and to encourage active participation in positive social and recreational activities. A-CRA skills training involves role-playing and behavioral rehearsal.

Assertive Continuing Care (ACC) is a home-based continuing-care approach to preventing relapse. Weekly home visits take place over a 12- to 14-week period after an adolescent is discharged from residential, intensive outpatient, or regular outpatient treatment. Using positive and negative reinforcement to shape behaviors, along with training in problem-solving and communication skills, ACC combines A-CRA and assertive case management services (e.g., use of a multidisciplinary team of professionals, round-the-clock coverage, assertive outreach) to help adolescents and their caregivers acquire the skills to engage in positive social activities.

National Institute on Drug Abuse. *Principles of Drug Addiction Treatment: A Research-Based Guide.* NIH Publications No. 12-4180. National Institute of Health / U.S. Department of Health and Human Services 2012.

HARM REDUCTION (ADAPTATION FROM THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION)

Harm reduction is a public health approach to managing drug-related issues. The main focus of harm reduction is to reduce the negative consequences of drug use as opposed to eliminating it. Abstinence is the *ideal* goal as opposed to the *expected* goal. The premise with harm reduction is that

illicit drug use will always exist and there will always be individuals who are unwilling or unable to commit to abstinence. These individuals can still benefit from intervention despite their difficulties in committing to quit entirely.

Harm reduction is an evidence-based approach that is critical to engaging with people who use drugs and equipping them with life-saving tools and information to create positive change in their lives and potentially save their lives. Harm reduction is a key pillar in the U.S. Department of Health and Human Services' Overdose Prevention Strategy.

Harm reduction is a practical and transformative approach that incorporates community-driven public health strategies—including prevention, risk reduction, and health promotion—to empower people who use drugs (and their families) with the choice to live healthy, self-directed, and purpose-filled lives. Harm reduction centers the lived and living experience of people who use drugs, especially those in underserved communities, in these strategies and the practices that flow from them.

Harm reduction emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission; improve physical, mental, and social wellbeing; and offer low-barrier options for accessing health care services, including substance use and mental health disorder treatment.

Organizations who practice harm reduction incorporate a spectrum of strategies that meet people where they are—on their own terms—and may serve as a pathway to additional health and social services, including additional prevention, treatment, and recovery services.

Harm reduction works by addressing broader health and social issues through improved policies, programs, and practices.

Why are harm reduction services needed?

The U.S. is experiencing the most significant substance use and overdose epidemic it has ever faced, exacerbated by the recent worldwide pandemic, and driven by the proliferation of highly potent synthetic opioids (containing fentanyl or fentanyl analogs) and animal tranquilizers (like xylazine) into many types of drugs (including stimulants and counterfeit prescription pills).

There were more than 100,000 drug-involved overdose deaths in 2022.

Harm reduction offers an opportunity to reach people who aren't otherwise accessing healthcare services to offer them naloxone to reverse an overdose and help connect them to other needed services. As an example, treatment services (such as medications for opioid use disorder) can be co-located with harm reduction services and offered as an option.

This potential connection to treatment is critical when the data show that:

- Only around one out of ten people with a substance use disorder have received treatment.
- Nearly all people with a substance use disorder who didn't get treatment at a specialty facility didn't think they needed treatment.

Harm reduction organizations can fill that gap by providing services that people do feel they need, in order to make positive change.

Harm reduction services save lives by being available and accessible in a manner that emphasizes the need for humility and compassion toward people who use drugs. Harm reduction plays a significant role in preventing drug-related deaths and increasing access to healthcare, social services, and treatment. These services decrease overdose fatalities, acute life-threatening infections related to unsterile drug injection, and chronic diseases (such as HIV and hepatitis C).

It is ideal to implement overdose education and naloxone delivery (OEND) programs at syringe services programs. Naloxone distribution at syringe services sites has been found to significantly reduce death rates. Scaling these efforts is a priority strategy to achieving adequate availability of (and access to) naloxone.

Harm reduction's place in and among prevention, treatment, and recovery

Harm reduction is part of a comprehensive prevention strategy and the continuum of care. Harm reduction approaches have proven to prevent death, injury, disease, overdose, and substance misuse. Harm reduction is effective in addressing the public health epidemic involving substance use as well as infectious disease and other harms associated with drug use.

As an approach, harm reduction emphasizes kindness and autonomy in the engagement of people who use drugs. It also increases the number of touchpoints (and opportunities) that peers and/or service providers have with people who use drugs.

Specifically, harm reduction services can:

- Connect individuals to overdose education, counseling, and referral to treatment for infectious diseases and substance use disorders.
- Distribute opioid overdose reversal medications (e.g., naloxone) to individuals at risk of overdose, or to those who are likely to respond to an overdose.
- Lessen harms associated with drug use and related behaviors that increase the risk of infectious diseases, including HIV, viral hepatitis, and bacterial and fungal infections.
- Reduce infectious disease transmission among people who use drugs (including those who inject drugs) by equipping them with sterile supplies and accurate information and facilitating referrals to resources.
- Reduce overdose deaths, promote linkages to care, and facilitate co-location of services as part of a comprehensive, integrated approach.
- Reduce stigma associated with substance use and co-occurring disorders.
- Promote a philosophy of hope and healing by employing people with living and lived experience in leadership and in the planning, implementation, and evaluation of services. People with lived experience can also model for their peers what meaningful change can look like in their lives.
- Build community and increase protective factors for people who use drugs and their families.

Harm Reduction Programs

(Highlights of some of the work observed during SAMHSA site visits.)

- Build trust by:
    - Being consistent and reliable to those seeking support.
    - Increasing access to person-centered services by reducing access barriers.

    - Employing staff that reflect the community's culture, languages, and who have lived experience relevant to the population of focus (people who use drugs, people who have experienced homelessness, people who have been incarcerated, people in recovery, etc.).
- Involve people with lived experience in the design, implementation, and evaluation of programs.
- Infuse trauma-informed care into organizational structure.
- Receive and incorporate ongoing feedback from participants.
- Regularly conduct outreach in the community with humility, fostering relationships.
- Build and leverage community partnerships.
- Provide an array of services and resources that support a multitude of needs.
- Address psychosocial needs.
- Co-locate medical and social services with harm reduction programs.
- Nimble mobile units meet participants wherever they're located to provide services.
- Provide harm reduction resources and supplies (and support policies) to reduce infectious disease and overdose.

Harm reduction. SAMHSA. (n.d.). https://www.samhsa.gov/find-help/harm-reduction

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=141#oembed-1

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 factors 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 in 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

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 cravings 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 rehabilitation industry and large pharmaceutical companies, 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.[2][3][4]

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 remission 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. 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. National Institute on Alcohol Abuse and Alcoholism (NIAAA) 2006. National epidemiologic survey on alcohol and related conditions. Alcohol: Research & Health 29:2
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.

Finally, investigators who approach 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 sometimes considered rational in the short run—as when the pleasure or relief derived from drugs temporarily outweighs 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[7][8]. 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[9][10][11]. 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[12].

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[13][14][15], which, although valuable, provide only global neural arguments, without attention to key structures or processes. Maia Szalavitz[16] 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, alternatives to the disease model may lack the scientific traction they need. My book, *The Biology of Desire* [17], 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

5. Heyman, Gene M. 2009. Addiction: a disorder of choice. Cambridge: Harvard University Press.
6. Hart, Carl. 2013. High price: a neuroscientist's journey of self-discovery that challenges everything you know about drugs and society. New York: HarperCollins.
7. Hart, Carl. 2013. High price: a neuroscientist's journey of self-discovery that challenges everything you know about drugs and society. New York: HarperCollins.
8. Alexander, Bruce. 2008. The globalization of addiction: a study in poverty of the spirit. Oxford: Oxford University Press.
9. Brady, Kathleen T., and Rajita Sinha. 2005. Co-occurring mental and substance use disorders: the neurobiological effects of chronic stress. American Journal of Psychiatry. doi:10.1176/appi.ajp.162.8.1483.
10. Al'Absi, Mustafa. 2006. Stress in addiction: biological and psychological mechanisms. Amsterdam: Academic Press.
11. Szalavitz, Maia. Unbroken brain: a revolutionary new way of understanding addiction. New York: St. Martin's Press.
12. Szalavitz, Maia. Unbroken brain: a revolutionary new way of understanding addiction. New York: St. Martin's Press.
13. Maté, Gabor. 2008. In the realm of hungry ghosts. Toronto: Vintage Canada.
14. Levy, Neil. 2013. Addiction is not a brain disease (and it matters). Frontiers in Psychiatry 4:24. doi:10.3389/fpsyt.2013.00024.
15. Hall, Wayne, Adrian Carter, and Cynthia Forlini. 2015. The brain disease model of addiction: is it supported by the evidence and has it delivered on its promises? The Lancet Psychiatry. doi:10.1016/S2215-0366(14)00126-6.
16. Szalavitz, Maia. Unbroken brain: a revolutionary new way of understanding addiction. New York: St. Martin's Press.
17. Lewis, Marc. 2015. *The biology of desire: why addiction is not a disease.* New York: PublicAffairs.

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, "Addiction 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 "neuromodulator") for motivating, directing, and rewarding goal-directed behavior and focusing 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 networks—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[18][19]. 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[20] 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 "hijacked 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 currently heads NIDA, points to "tissue damage" in the brain as indisputable support for the disease model[21]. 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[22] 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,

18. Robinson, T.E., and K.C. Berridge. 2000. The psychology and neurobiology of addiction: an incentive-sensitization view. Addiction 95: 91–117. doi:10.1046/j.1360-0443.95.8 s2.19.x.

19. Kalivas, Peter W., and Jane Stewart. 1991. Dopamine transmission in the initiation and expression of drug- and stress-induced sensitization of motor activity. Brain Research Reviews. doi:10.1016/0165-0173(91)90007-U.

20. Kalivas, P.W., and J.E. Alesdatter. 1993. Involvement of N-methyl-D-aspartate receptor stimulation in the ventral tegmental area and amygdala in behavioral sensitization to cocaine. The Journal of Pharmacology and Experimental Therapeutics 267: 486–495.

21. Volkow, Nora D., George F. Koob, and A. Thomas McLellan. 2016. Neurobiologic advances from the brain disease model of addiction. New England Journal of Medicine 374: 363–371. doi:10.1056/NEJMra1511480.

22. Berridge, Kent C., and Terry E. Robinson. 1998. What is the role of dopamine in reward: hedonic impact, reward learning, or incentive salience? Brain Research Reviews. doi:10.1016/S0165-0173(98)00019-8.

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 "frenzied" quality to drug-seeking behavior[23].

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[24]. 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 Pavlovian 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, remembering, 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 comprising the motivational core of the brain[25,26]. 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[27,28]. They dub the resulting cognitive dysfunction "impaired 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 as a disease?

23. Robinson, Terry E., and Kent C. Berridge. 2003. Addiction. Annual Review of Psychology 54: 25–53. doi:10.1146/annurev.psych.54.101601.145237.

24. Everitt, Barry J, and Trevor W. Robbins. 2013. From the ventral to the dorsal striatum: devolving views of their roles in drug addiction. Neuroscience and Biobehavioral Reviews 37. doi:10.1016/j.neubiorev.2013.02.010. Elsevier Ltd: 1946–1954.

25. Goldstein, R.Z., and N.D. Volkow. 2002. Drug addiction and its underlying neurobiological basis: neuroimaging evidence for the involvement of the frontal cortex. The American Journal of Psychiatry 159: 1642–1652.

26. Goldstein, Rita Z., and Nora D. Volkow. 2011. Dysfunction of the prefrontal cortex in addiction: neuroimaging findings and clinical implications. Nature Reviews. Neuroscience 12: 652–669. doi:10.1038/nrn3119.

27. Goldstein, R.Z., and N.D. Volkow. 2002. Drug addiction and its underlying neurobiological basis: neuroimaging evidence for the involvement of the frontal cortex. The American Journal of Psychiatry 159: 1642–1652.

28. Volkow, N.D., and J.S. Fowler. 2000. Addiction, a disease of compulsion and drive: involvement of the orbitofrontal cortex. Cerebral Cortex 10: 318–325. doi:10.1093/cercor/10.3.318.

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[29]. 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 *isms*), or a conscious memory. Thus the mind and the brain shape each other. And ordinary classroom learning is just one version of this more general phenomenon—a brain that changes itself (a phrase borrowed from Norman Doidge[30]).

The brain would be useless if it wasn't highly changeable 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 pathways 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 "learning."

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

29. Greenough, W.T., J.E. Black, and C.S. Wallace. 1987. Experience and brain development. Child Development 58: 539–559. doi:10.2307/1130197.

30. Doidge, Norman. 2007. The brain that changes itself. Stories of personal triumph from the frontiers of brain science. London: Penguin.

its plasticity[31]. 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 "Look! 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 persuasively shows how early emotional disturbances steer us toward an intense desire for the relief provided by drugs[32], and Maia Szalavitz vividly portrays her experience as a late adolescent trying to brighten her depression with cocaine and ease her anxiety with heroin[33]. 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 described 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,

31. Doidge, Norman. 2007. The brain that changes itself. Stories of personal triumph from the frontiers of brain science. London: Penguin.

32. Maté, Gabor. 2008. In the realm of hungry ghosts. Toronto: Vintage Canada.

33. Szalavitz, Maia. Unbroken brain: a revolutionary new way of understanding addiction. New York: St. Martin's Press.

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[34] as a result of normal learning. In fact pruning is considered the primary mechanism by which learning occurs. Third, pruning in the prefrontal cortex increases efficiency in the processing and organizing of information—the essence of cognitive development from puberty onward[35]. 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[36]. 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 immediate 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)[37]—a crucial step in the development of emotion regulation. Addicts are known to be excessively now-oriented[38], consistent with their tendency to favor what Heyman calls the local choice[39]. 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[404142]. 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).

34. Edelman, Gerald. 1978. The mindful brain: cortical organization and the group-selective theory of higher brain function. Cambridge: MIT Press.

35. Blakemore, Sarah-Jayne, and Suparna Choudhury. 2006. Development of the adolescent brain: implications for executive function and social cognition. Journal of Child Psychology and Psychiatry, and Allied Disciplines 47: 296–312. doi:10.1111/j.1469-7610.2006.01611.x.

36. Kober, Hedy, Peter Mendesiedlecki, Ethan F. Kross, Jochen Weber, Walter Mischel, Carl L. Hart, and Kevin N. Ochsner. 2010. Prefrontal-striatal pathway underlies cognitive regulation of craving. Proceedings of the National Academy of Sciences of the United States of America 107: 14811–14816. doi:10.1073/pnas.1007779107.

37. Mischel, W., E.B. Ebbesen, and A.R. Zeiss. 1972. Cognitive and attentional mechanisms in delay of gratification. Journal of Personality and Social Psychology 21: 204–218.

38. Marsch, L.A., and W.K. Bickel. 2001. Toward a behavioral economic understanding of drug dependence: delay discounting processes. Addiction. doi:10.1046/j.1360-0443.2001.961736.x.

39. Heyman, Gene M. 2009. Addiction: a disorder of choice. Cambridge: Harvard University Press.

40. Kober, Hedy, Peter Mende-siedlecki, Ethan F. Kross, Jochen Weber, Walter Mischel, Carl L. Hart, and Kevin N. Ochsner. 2010. Prefrontal-striatal pathway underlies cognitive regulation of craving. Proceedings of the National Academy of Sciences of the United States of America 107: 14811–14816. doi:10.1073/pnas.1007779107.

41. McClure, S.M., D.I. Laibson, G.F. Loewenstein, and J.D. Cohen. 2004. Separate neural systems value immediate and delayed monetary rewards. Science 306: 503–507. doi:10.1126/science.1100907.

42. Bjork, James M., Reza Momenan, and Daniel W. Hommer. 2009. Delay discounting correlates with proportional lateral frontal cortex volumes. Biological Psychiatry 65: 710–713. doi:10.1016/j.biopsych.2008.11.023.

WHY ADDICTION IS NOT A DISEASE

In its contemporary form[43], 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 response 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[44]. So how do we know which urges, attractions, and desires to label "disease" 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. "Addiction" 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 response to a stimulus[45]. Once a person has reached this state, the brain is no longer functioning as it did. Yet, according to Everitt and Robbins, the acknowledged

43. Volkow, Nora D., George F. Koob, and A. Thomas McLellan. 2016. Neurobiologic advances from the brain disease model of addiction. New England Journal of Medicine 374: 363–371. doi:10.1056/NEJMra1511480.

44. Foddy, Bennett, and Julian Savulescu. 2010. A liberal account of addiction. Philosophy, Psychiatry, & Psychology 17: 1–22.

45. Everitt, Barry J, and Trevor W. Robbins. 2013. From the ventral to the dorsal striatum: devolving views of their roles in drug addiction. Neuroscience and Biobehavioral Reviews 37. doi:10.1016/j.neubiorev.2013.02.010. Elsevier Ltd: 1946–1954.

experts on the ventral-to-dorsal shift, "there is nothing aberrant or unusual about devolving behavioural 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 association between a particular smell (and other gustatory cues) and the act of biting? "Automatization of behaviour 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 "disorders" characterized by too much of any of the above show brain activation patterns that are nearly identical to those shown in drug addiction[46]. 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 eating. 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 description can cover anything from spending sprees to helicopter 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 thinking about future repercussions. Romantic love (but also parent–child love, and even perverse forms of love including fetishism, sadomasochism, etc.) can easily become compulsive, difficult to control, and overly focused 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 "increased levels of central dopamine contribute to the lover's focused attention on the beloved and the lover's tendency to regard the beloved as unique."[47] In fact, several researchers have examined the love-and-addiction link directly. Burkett and Young reviewed much of this work.[48] In their words, "mesolimbic 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 dopamine system provides a "common currency of wanting"

46. Brewer, Judson A., and Marc N. Potenza. 2008. The neurobiology and genetics of impulse control disorders: relationships to drug addictions. Biochemical Pharmacology 75: 63–75. doi:10.1016/j.bcp.2007.06.043.

47. Fisher, Helen E., Arthur Aron, Debra Mashek, Haifang Li, and Lucy L. Brown. 2002. Defining the brain systems of lust, romantic attraction, and attachment. Archives of Sexual Behavior 31: 413–419. doi:10.1023/A:1019888024255.

48. Burkett, James P., and Larry J. Young. 2012. The behavioral, anatomical and pharmacological parallels between social attachment, love and addiction. Psychopharmacology. doi:10.1007/s00213-012-2794-x.

in the pursuit of financial gains, drugs, and sexual partners.[49] He notes that the nucleus accumbens is involved in motivating the individual to overcome obstacles in order to reach such goals[50] and that dopamine metabolism biases decision making in favor of immediate gains.[51] With regard to romantic pairing, Burkett and Young conclude that "[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."[52] 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 substances and some eating disorders (including binge eating), the dorsolateral PFC becomes partially disconnected 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 addiction 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 reported 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 maturation of the dorsolateral PFC.[53] Not surprisingly, adults also overcome delay discounting by activating the dlPFC,[54] 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 favor of immediate rewards was consistently reversed by exposing participants to images of their future selves.[55] To examine such

49. Toates, Frederick. 2014. How sexual desire works. Cambridge: Cambridge University Press.

50. Salamone, J.D., M. Correa, A. Farrar, and S.M. Mingote. 2007. Effort-related functions of nucleus accumbens dopamine and associated forebrain circuits. Psychopharmacology. doi:10.1007 /s00213-006-0668-9.

51. Assadi, Seyed M., Murat Yucel, and Christos Pantelis. 2009. Dopamine modulates neural networks involved in effort-based decision-making. Neuroscience and Biobehavioral Reviews. doi:10.1016/j.neubiorev.2008.10.010.

52. Burkett, James P., and Larry J. Young. 2012. The behavioral, anatomical and pharmacological parallels between social attachment, love and addiction. Psychopharmacology. doi:10.1007/s00213-012-2794-x.

53. Steinbeis, N., J. Haushofer, E. Fehr, and T. Singer. 2014. Development of behavioral control and associated vmPFC-DLPFC connectivity explains Children's increased resistance to temptation in intertemporal choice. Cerebral Cortex: 32–42. doi:10.1093/cercor/bhu167.

54. McClure, S.M., D.I. Laibson, G.F. Loewenstein, and J.D. Cohen. 2004. Separate neural systems value immediate and delayed monetary rewards. Science 306: 503–507. doi:10.1126/science.1100907.

55. Hershfield, Hal E., Daniel G. Goldstein, William F. Sharpe, Jesse Fox, Leo Yeykelis, Laura L. Carstensen, and Jeremy N.

changes at the neural level, Figner applied transcranial magnetic stimulation (TMS), a procedure that can temporarily disrupt activity in the cortex, while participants were engaged in a delay discounting task.[56] Participants chose immediate rewards of lower 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.[57]

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 previously, synaptic pruning is a normal developmental process. In fact, research shows that, when the same inputs are encountered repeatedly, connections are depleted to improve overall efficiency,[58] 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 cortical 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.[59] 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.[60] 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.[61] 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 correspond with variations in

Bailenson. 2011. Increasing saving behavior through age-progressed renderings of the future self. Journal of Marketing Research 48: S23–S37. doi:10.1509/jmkr.48. SPL.S23.

56. Figner, Bernd, Daria Knoch, Eric J. Johnson, Amy R. Krosch, Sarah H. Lisanby, Ernst Fehr, and Elke U. Weber. 2010. Lateral prefrontal cortex and self-control in intertemporal choice. Nature Neuroscience 13: 538–539. doi:10.1038/nn.2516.

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58. Tian, Xing, and David E. Huber. 2013. Playing "duck duck goose" with neurons: change detection through connectivity reduction. Psychological Science 24: 819–827. doi:10.1177/0956797612459765.

59. Low, Lawrence K., and Hwai-Jong Cheng. 2006. Axon pruning: an essential step underlying the developmental plasticity of neuronal connections. Philosophical Transactions of the Royal Society of London. Series B, Biological Sciences 361:1531–1544. doi:10.1098/rstb.2006.1883.

60. Connolly, Colm G., Ryan P. Bell, John J. Foxe, and Hugh Garavan. 2013. Dissociated grey matter changes with prolonged addiction and extended abstinence in cocaine users. PLoS ONE: 8. doi:10.1371/journal.pone.0059645.

61. Morales, Angelica M., Buyean Lee, Gerhard Hellemann, Joseph O'Neill, and Edythe D. London. 2012. Gray-matter volume in methamphetamine dependence: cigarette smoking and changes with abstinence from methamphetamine. Drug and Alcohol Dependence 125: 230–238. doi:10.1016/j.drugalcdep.2012.02.017.

experience, not disease. Recurrent episodes of automatic responding reduce synaptic 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.[62] And from epidemiological reports the story is clear: most addicts recover,[63] and most of those recover without treatment.[646566] 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 addiction 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[6768], but it also underpins second language learning[69] 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

62. Flanagan, Owen. 2013. The shame of addiction. Frontiers in Psychiatry 4: 1–11.

63. 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 remission 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.

64. 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.

65. National Institute on Alcohol Abuse and Alcoholism (NIAAA) 2006. National epidemiologic survey on alcohol and related conditions. Alcohol: Research & Health 29:2

66. 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.

67. Doidge, Norman. 2007. The brain that changes itself. Stories of personal triumph from the frontiers of brain science. London: Penguin.

68. Doidge, Norman. 2015. The brain's way of healing. London: Viking.

69. Li, Ping, Jennifer Legault, and Kaitlyn A. Litcofsky. 2014. Neuroplasticity as a function of second language learning: anatomical changes in the human brain. Cortex. doi:10.1016 /j.cortex.2014.05.001.

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 attractive goals. There are many reasons why this cycle of goal pursuit, accompanied by the fade-out of alternative goals, becomes tighter and more invariant over time. Some are social and cultural, others societal and economical. The reasons I have highlighted in this article have more to do with the cascading nature of developmental constraints—the narrowing of possibilities into probabilities, states into traits.[70] 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, attraction, attention, memory, and cognitive reflection and control.[71][72]

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 addiction that makes it so difficult to overcome. In fact, there seem to be at least three specific mechanisms that accelerate 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. Immediate goals are available goals, and striatal networks surge with dopamine whenever those goals are cued by associated 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 attention. 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 concept of *intertemporal cooperation.*[73] 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 cooperation in place—until the addict can recreate it at will. The second mechanism is the motivational *amplification* 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 determines not only the frequency of repetition across occasions, but also the resilience or purity of attention within occasions.) 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

70. Lewis, Marc D. 1997. Personality self-organization: cascading constraints on cognition-emotion interaction. Dynamics and Interdeterminism in Developmental and Social Processes 193–216.

71. Lewis, Marc D. 2010. Desire, dopamine, and conceptual development. Child Development at the Intersection of Emotion and Cognition: 175–199. doi:10.1037/12059-010.

72. Lewis, Marc D., and Rebecca M. Todd. 2007. The self-regulating brain: cortical-subcortical feedback and the development of intelligent action. Cognitive Development 22: 406–430. doi:10.1016/j.cogdev.2007.08.004.

73. Ainslie, George. 2001. Breakdown of will. Cambridge: Cambridge University Press.

frustration, loss, and often depression in their wake. Moreover, because they are universally perceived as selfish and indulgent, they unleash great gouts of shame.[74] Because shame is such a painful emotion, it exacerbates the need for resolution, regulation, or escape.

In a nutshell, addictive rewards pack a double whammy. 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 withdrawal 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 learning 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 converges with other habits consolidating within one's personality, 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, focused 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 repeatedly 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 compelling 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 addictive 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 development 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 schizophrenia. In fact, defining a category at the intersection of pathology and development is the stated goal of the burgeoning field of "developmental psychopathology."[75] As with depression and anxiety disorders, the delineation 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

74. Flanagan, Owen. 2013. The shame of addiction. Frontiers in Psychiatry 4: 1–11.

75. Cicchetti, Dante, and Donald J. Cohen. 2006. Developmental psychopathology, Vol 3: Risk, disorder, and adaptation (2nd ed.). In Developmental psychopathology, Vol 2: Developmental neuroscience, xvi, 944.

understanding of addiction can be seen as advancing through three broad stages (a somewhat similar model has recently been proposed).[76] 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 solution to addiction is to be found in the realm of medicine. Specifically, addicts should be urged (convinced or compelled) to follow the advice handed down by medical 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 authority, 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,[77] 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 consolidates in habitual patterns of thinking and feeling. This view of addiction admits the potency of social factors, like isolation and dislocation.[78] It makes sense of the impact of adversity in early development, as demonstrated 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*.[79] And finally, it builds on our advancing knowledge of the neurobiology of individual differences in development.[8081]

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

76. Pickard, Hanna, S.H. Ahmed, and Bennett Foddy. 2015. Introduction: alternative models of addiction. Lausanne: Frontiers Media.

77. Pickard, Hanna, S.H. Ahmed, and Bennett Foddy. 2015. Introduction: alternative models of addiction. Lausanne: Frontiers Media.

78. Alexander, Bruce K., Robert B. Coambs, and Patricia F. Hadaway. 1978. The effect of housing and gender on morphine self-administration in rats. Psychopharmacology 58: 175–179.

79. Pickard, Hanna, Serge H. Ahmed, and Bennett Foddy. 2015. Alternative models of addiction. Frontiers in Psychiatry. doi:10.3389/fpsyt.2015.00020.

80. Cicchetti, Dante, and Donald J. Cohen. 2006. Developmental psychopathology, Vol 3: Risk, disorder, and adaptation (2nd ed.). In Developmental psychopathology, Vol 2: Developmental neuroscience, xvi, 944.

81. CA, Nelson Charles A., J.P.P. Joseph, P. McCleery, and C.A. Nelson 3rd. 2008. Use of event-related potentials in the study of typical and atypical development. Journal of the American Academy of Child & Adolescent Psychiatry 47: 1252–1261. doi:10.1097/CHI.0b013e318185a6d8.Use

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 developmental 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 perspectives, 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 addiction, 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 "neuronormativity." In contrast, the developmental-learning model embodies our advancing conception of *neuroplasticity.* A project focused 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.[8283]

Thus, both models borrow something from neuroscience—a detailed breakdown of the biological landscape underlying addiction. But they are fundamentally different 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 experience 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 authorities 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.

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=265#h5p-8

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CHAPTER 11.

THE NEUROBIOLOGY OF SUBSTANCE USE, MISUSE, AND ADDICTION

PREVIEW

A substantial body of research has accumulated over several decades and transformed our understanding of substance use and its effects on the brain. This knowledge has opened the door to new ways of thinking about prevention and treatment of substance use disorders.

This chapter describes the neurobiological framework underlying substance use and why some people transition from using or misusing alcohol or drugs to a substance use disorder—including its most severe form, addiction. The chapter explains how these substances produce changes in brain structure and function that promote and sustain addiction and contribute to relapse. The chapter also addresses similarities and differences in how the various classes of addictive substances affect the brain and behavior and provides a brief overview of key factors that influence risk for substance use disorders.

AN EVOLVING UNDERSTANDING OF SUBSTANCE USE DISORDERS

Scientific breakthroughs have revolutionized the understanding of substance use disorders. For example, severe substance use disorders, commonly called addictions, were once viewed largely as a moral failing or character flaw, but are now understood to be chronic illnesses characterized by clinically significant impairments in health, social function, and voluntary control over substance use. [3] Although the mechanisms may be different, addiction has many features in common with disorders such as diabetes, asthma, and hypertension. All of these disorders are chronic, subject to relapse, and influenced by genetic, developmental, behavioral, social, and environmental factors. In all of these disorders, affected individuals may have difficulty in complying with the prescribed treatment. [4]

This evolving understanding of substance use disorders as medical conditions has had important implications for prevention and treatment. Research demonstrating that addiction is driven by changes in the brain has helped to reduce the negative attitudes associated with substance use disorders and provided support for integrating treatment for substance use disorders into mainstream health care.

Key Findings

- Well-supported* scientific evidence shows that addiction to alcohol or drugs is a chronic brain disease that has potential for recurrence and recovery.

- Well-supported evidence suggests that the addiction process involves a three-stage cycle: binge/intoxication, withdrawal/negative affect, and preoccupation/anticipation. This cycle becomes more severe as a person continues substance use and as it produces dramatic changes in brain function that reduce a person's ability to control his or her substance use.
- Well-supported scientific evidence shows that disruptions in three areas of the brain are particularly important in the onset, development, and maintenance of substance use disorders: the basal ganglia, the extended amygdala, and the prefrontal cortex. These disruptions: (1) enable substance-associated cues to trigger substance seeking (i.e., they increase incentive salience); (2) reduce sensitivity of brain systems involved in the experience of pleasure or reward, and heighten activation of brain stress systems; and (3) reduce functioning of brain executive control systems, which are involved in the ability to make decisions and regulate one's actions, emotions, and impulses.
- Supported** scientific evidence shows that these changes in the brain persist long after substance use stops. It is not yet known how much these changes may be reversed or how long that process may take.
- Well-supported scientific evidence shows that adolescence is a critical "at-risk period" for substance use and addiction. All addictive drugs, including alcohol and marijuana, have especially harmful effects on the adolescent brain, which is still undergoing significant development.

* Well-supported: when evidence is derived from multiple rigorous human and nonhuman studies

** Supported: when evidence is derived from rigorous but fewer human and nonhuman studies.

Moreover, research on the basic neurobiology of addiction has already resulted in several effective medications for the treatment of alcohol, opioid, and nicotine use disorders, and clinical trials are ongoing to test other potential new treatments. [5]

All addictive substances have powerful effects on the brain. These effects account for the euphoric or intensely pleasurable feelings that people experience during their initial use of alcohol or other substances, and these feelings motivate people to use those substances again and again, despite the risks for significant harms.

As individuals continue to misuse alcohol or other substances, progressive changes, called *neuroadaptations*, occur in the structure and function of the brain. These neuroadaptations compromise brain function and also drive the transition from controlled, occasional substance use to chronic misuse, which can be difficult to control. Moreover, these brain changes endure long after an individual stops using substances. They may produce continued, periodic craving for the substance that can lead to relapse: more than 60 percent of people treated for a substance use disorder experience relapse within the first year after they are discharged from treatment, [4, 6] and a person can remain at increased risk of relapse for many years. [7,8]

However, addiction is not an inevitable consequence of substance use. Whether an individual ever uses alcohol or another substance, and whether that initial use progresses to a substance use disorder of any severity, depends on a number of factors. These include: a person's genetic makeup and other individual biological factors; the age when use begins; psychological factors related to a person's unique history and personality; and environmental factors, such as the availability of drugs, family and peer dynamics, financial resources, cultural norms, exposure to stress, and access to social support. [9] Some of these factors increase risk for substance use, misuse, and use disorders, whereas

other factors provide buffers against those risks. Nonetheless, specific combinations of factors can drive the emergence and continuation of substance misuse and the progression to a disorder or an addiction.

CONDUCTING RESEARCH ON THE NEUROBIOLOGY OF SUBSTANCE USE, MISUSE, AND ADDICTION

Until recently, much of our knowledge about the **neurobiology** of substance use, misuse, and addiction came from the study of laboratory animals. Although no animal model fully reflects the human experience, animal studies let researchers investigate addiction under highly controlled conditions that may not be possible or ethical to replicate in humans. These types of studies have greatly helped to answer questions about how particular genes, developmental processes, and environmental factors, such as stressors, affect substance-taking behavior.

Neurobiology studies in animals have historically focused on what happens in the brain right after taking an addictive substance (this is called the acute impact), but research has shifted to the study of how ongoing, long-term (or chronic) substance use changes the brain. One of the main goals of this research is to understand at the most basic level the mechanisms through which substance use alters brain structure and function and drives the transition from occasional use to misuse, addiction, and relapse. [10]

A growing body of substance use research conducted with humans is complementing the work in animals. For example, human studies have benefited greatly from the use of brain-imaging technologies, such as magnetic resonance imaging (MRI) and positron emission tomography (PET) scans. These technologies allow researchers to "see" inside the living human brain so that they can investigate and characterize the biochemical, functional, and structural changes in the brain that result from alcohol and drug use. The technologies also allow them to understand how differences in brain structure and function may contribute to substance use, misuse, and addiction.

Animal and human studies build on and inform each other, and in combination provide a more complete picture of the neurobiology of addiction. The rest of this chapter weaves together the most compelling data from both types of studies to describe a neurobiological framework for addiction.

A BASIC PRIMER ON THE HUMAN BRAIN

To understand how addictive substances affect the brain, it is important to first understand the basic biology of healthy brain function. The brain is an amazingly complex organ that is constantly at work. Within the brain, a mix of chemical and electrical processes controls the body's most basic functions, like breathing and digestion. These processes also control how people react to the multitudes of sounds, smells, and other sensory stimuli around them, and they organize and direct individuals' highest thinking and emotive powers so that they can interact with other people, carry out daily activities, and make complex decisions.

The brain is made of an estimated 86 billion nerve cells—called neurons—as well as other cell types. Each neuron has a cell body, an axon, and dendrites (Figure 11.1). The **cell body** and its nucleus control the neuron's activities. The **axon** extends out from the cell body and transmits

messages to other neurons. **Dendrites** branch out from the cell body and receive messages from the axons of other neurons.

Neurons communicate with one another through chemical messengers called **neurotransmitters**. The neurotransmitters cross a tiny gap, or **synapse**, between neurons and attach to receptors on the receiving neuron. Some neurotransmitters are inhibitory—they make it less likely that the receiving neuron will carry out some action. Others are excitatory, meaning that they stimulate neuronal function, priming it to send signals to other neurons.

Neurons are organized in clusters that perform specific functions (described as networks or circuits). For example, some networks are involved with thinking, learning, emotions, and memory. Other networks communicate with muscles, stimulating them into action. Still others receive and interpret stimuli from the sensory organs, such as the eyes and ears, or the skin. The addiction cycle disrupts the normal functions of some of these neuronal networks.

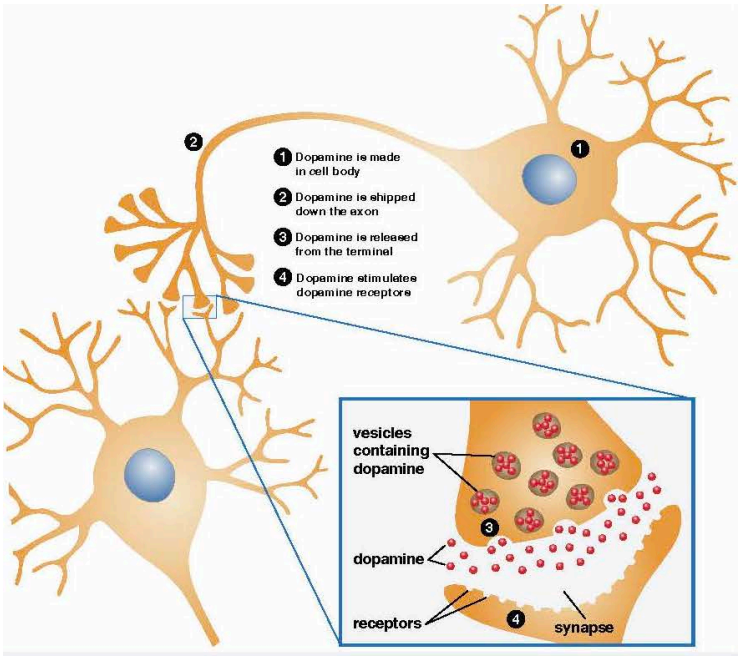

Figure 11.1: A Neuron and its Parts

THE PRIMARY BRAIN REGIONS INVOLVED IN SUBSTANCE USE DISORDERS

The brain has many regions that are interconnected with one another, forming dynamic networks that are responsible for specific functions, such as attention, self-regulation, perception, language, reward, emotion, and movement, along with many other functions. This chapter focuses on three regions that are the key components of networks that are intimately involved in the development and persistence of substance use disorders: the **basal ganglia**, the **extended amygdala**, and the **prefrontal cortex** (Figure 11.2). The basal ganglia control the rewarding, or pleasurable, effects of substance use and are also responsible for the formation of habitual substance taking. The extended amygdala is involved in stress and the feelings of unease, anxiety, and irritability that typically accompany

substance withdrawal. The prefrontal cortex is involved in executive function (i.e., the ability to organize thoughts and activities, prioritize tasks, manage time, and make decisions), including exerting control over substance taking.

These brain areas and their associated networks are not solely involved in substance use disorders. Indeed, these systems are broadly integrated and serve many critical roles in helping humans and other animals survive. For example, when people engage in certain activities, such as consuming food or having sex, chemicals within the basal ganglia produce feelings of pleasure. This reward motivates individuals to continue to engage in these activities, thereby ensuring the survival of the species.

Likewise, in the face of danger, activation of the brain's stress systems within the extended amygdala drives "fight or flight" responses. These responses, too, are critical for survival. As described in more detail below, these and other survival systems are "hijacked" by addictive substances.

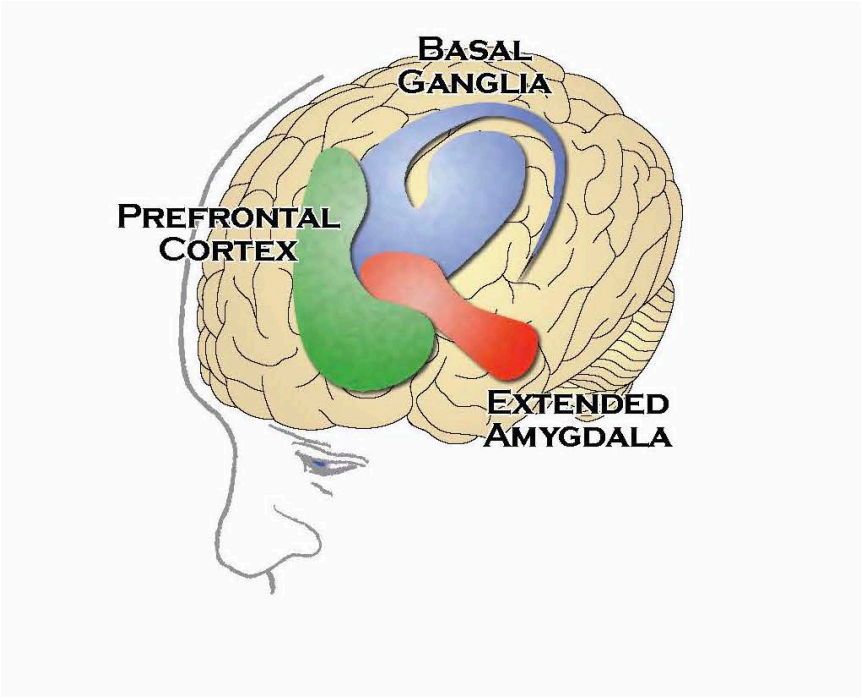

Figure 11.2: Areas of the human brain that are especially important in addiction

The Basal Ganglia

The basal ganglia are a group of structures located deep within the brain that play an important role in keeping body movements smooth and coordinated. They are also involved in learning routine behaviors and forming habits. Two sub-regions of the basal ganglia are particularly important in substance use disorders:

- The nucleus accumbens, which is involved in motivation and the experience of reward, and
- The dorsal striatum, which is involved in forming habits and other routine behaviors. [11]

The Extended Amygdala

The extended amygdala and its sub-regions, located beneath the basal ganglia, regulate the brain's reactions to stress—including behavioral responses like "fight or flight" and negative emotions like unease, anxiety, and irritability. This region also interacts with the hypothalamus, an area of the brain

that controls activity of multiple hormone-producing glands, such as the pituitary gland at the base of the brain and the adrenal glands at the top of each kidney. These glands, in turn, control reactions to stress and regulate many other bodily processes. [12]

The Prefrontal Cortex

The prefrontal cortex is located at the very front of the brain, over the eyes, and is responsible for complex cognitive processes described as "executive function." Executive function is the ability to organize thoughts and activities, prioritize tasks, manage time, make decisions, and regulate one's actions, emotions, and impulses. [13]

THE ADDICTION CYCLE

Addiction can be described as a repeating cycle with three stages. Each stage is particularly associated with one of the brain regions described above—basal ganglia, extended amygdala, and prefrontal cortex (Figure 11.3). [10] This three-stage model draws on decades of human and animal research and provides a useful way to understand the symptoms of addiction, how it can be prevented and treated, and how people can recover from it. [14] The three stages of addiction are:

- **Binge/Intoxication**, the stage at which an individual consumes an intoxicating substance and experiences its rewarding or pleasurable effects;
- Withdrawal/Negative Affect, the stage at which an individual experiences a negative emotional state in the absence of the substance; and
- Preoccupation/Anticipation, the stage at which one seeks substances again after a period of abstinence.

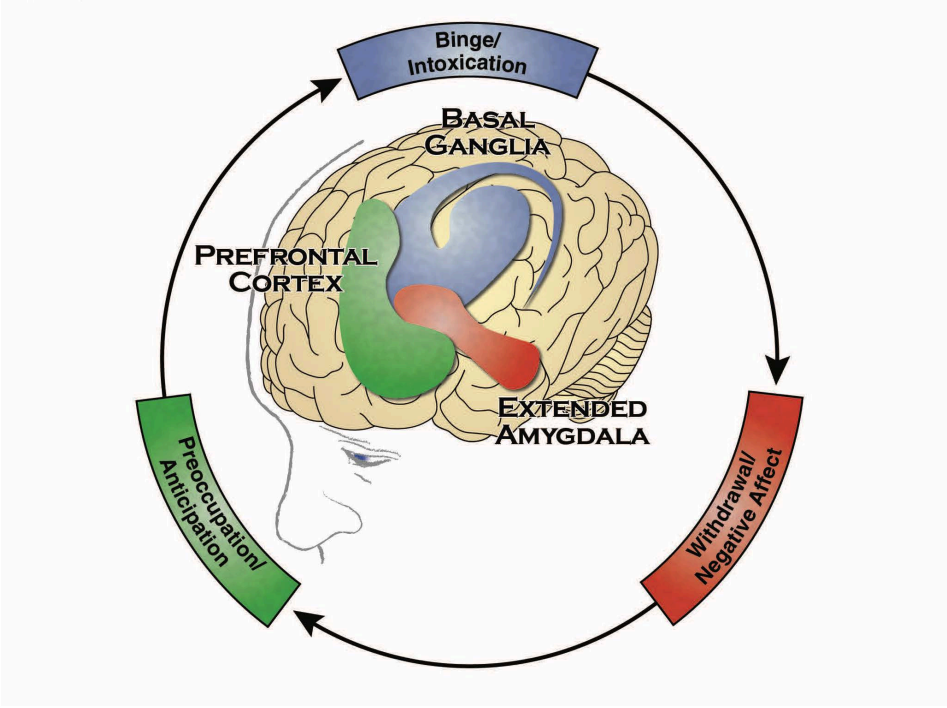

Figure 11.3: The three stages of the addiction cycle and the brain regions associated with them

The three stages are linked to and feed on each other, but they also involve different brain regions, circuits (or networks), and neurotransmitters and result in specific kinds of changes in the brain. A person may go through this three-stage cycle over the course of weeks or months or progress through it several times in a day. There may be variation in how people progress through the cycle and the intensity with which they experience each of the stages. Nonetheless, the addiction cycle tends to intensify over time, leading to greater physical and psychological harm. [10]

The following sections describe each of the stages in more detail. But first, it is necessary to explain four behaviors that are central to the addiction cycle: impulsivity, positive reinforcement, negative reinforcement, and compulsivity.

For many people, initial substance use involves an element of **impulsivity**, or acting without foresight or regard for the consequences. For example, an adolescent may impulsively take a first drink, smoke a cigarette, begin experimenting with marijuana, or succumb to peer pressure to try a party drug. If the experience is pleasurable, this feeling positively reinforces the substance use, making the person more likely to take the substance again.

Another person may take a substance to relieve negative feelings such as stress, anxiety, or depression. In this case, the temporary relief the substance brings from the negative feelings negatively reinforces substance use, increasing the likelihood that the person will use again. Importantly, positive and negative reinforcement need not be driven solely by the effects of the drugs. Many other environmental and social stimuli can reinforce a behavior. For example, the approval of peers positively reinforces substance use for some people. Likewise, if drinking or using drugs with others provides relief from social isolation, substance use behavior could be negatively reinforced.

The positively reinforcing effects of substances tend to diminish with repeated use. This is called tolerance and may lead to use of the substance in greater amounts and/or more frequently in an attempt to experience the initial level of reinforcement. Eventually, in the absence of the substance, a person may experience negative emotions such as stress, anxiety, or depression, or feel physically ill. This is called withdrawal, which often leads the person to use the substance again to relieve the withdrawal symptoms.

As use becomes an ingrained behavior, impulsivity shifts to **compulsivity**, and the primary drivers of repeated substance use shift from **positive reinforcement** (feeling pleasure) to **negative reinforcement** (feeling relief), as the person seeks to stop the negative feelings and physical illness that accompany withdrawal. [15] Eventually, the person begins taking the substance not to get "high," but rather to escape the "low" feelings to which, ironically, chronic drug use has contributed. Compulsive substance seeking is a key characteristic of addiction, as is the loss of control over use. Compulsivity helps to explain why many people with addiction experience relapses after attempting to abstain from or reduce use.

The following sections provide more detail about each of the three stages—binge/intoxication, withdrawal/negative affect, and preoccupation/anticipation—and the neurobiological processes underlying them.

BINGE/INTOXICATION STAGE: BASAL GANGLIA

The binge/intoxication stage of the addiction cycle is the stage at which an individual consumes the substance of choice. This stage heavily involves the basal ganglia (Figure 11.4) and its two key brain

sub-regions, the nucleus accumbens and the dorsal striatum. In this stage, substances affect the brain in several ways.

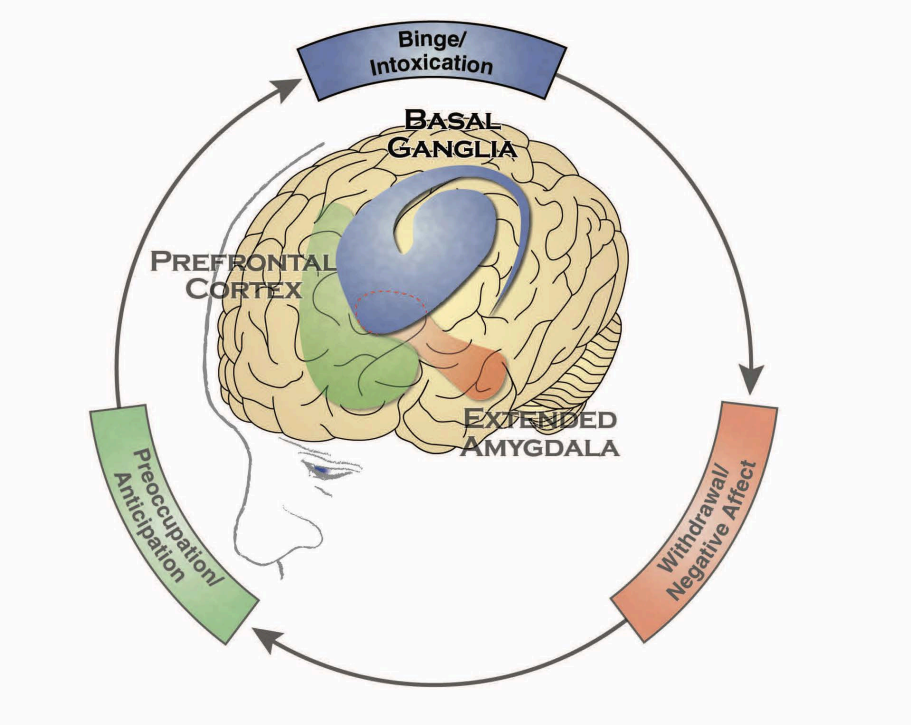

Figure 11.4: The binge/intoxication stage and the basal ganglia

Addictive Substances "Hijack" Brain Reward Systems

All addictive substances produce feelings of pleasure. These "rewarding effects" positively reinforce their use and increase the likelihood of repeated use. The rewarding effects of substances involve activity in the nucleus accumbens, including activation of the brain's dopamine and opioid signaling system. Many studies have shown that neurons that release dopamine are activated, either directly or indirectly, by all addictive substances, but particularly by stimulants such as cocaine, amphetamines, and nicotine (Figure 11.5). [16] In addition, the brain's opioid system, which includes naturally occurring opioid molecules (i.e., endorphins, enkephalins, and dynorphins) and three types of opioid receptors (i.e., mu, delta, and kappa), plays a key role in mediating the rewarding effects of other addictive substances, including opioids and alcohol. Activation of the opioid system by these substances stimulates the nucleus accumbens directly or indirectly through the dopamine system. Brain imaging studies in humans show activation of dopamine and opioid neurotransmitters during alcohol and other substance use (including nicotine). [10, 17] Other studies show that antagonists, or inhibitors, of dopamine and opioid receptors can block drug and alcohol seeking in both animals and humans. [14, 18, 19]

Cannabinoids such as delta-9-tetrahydrocannabinol (THC), the primary psychoactive component of marijuana, target the brain's internal or endogenous cannabinoid system. This system also contributes to reward by affecting the function of dopamine neurons and the release of dopamine in the nucleus accumbens.

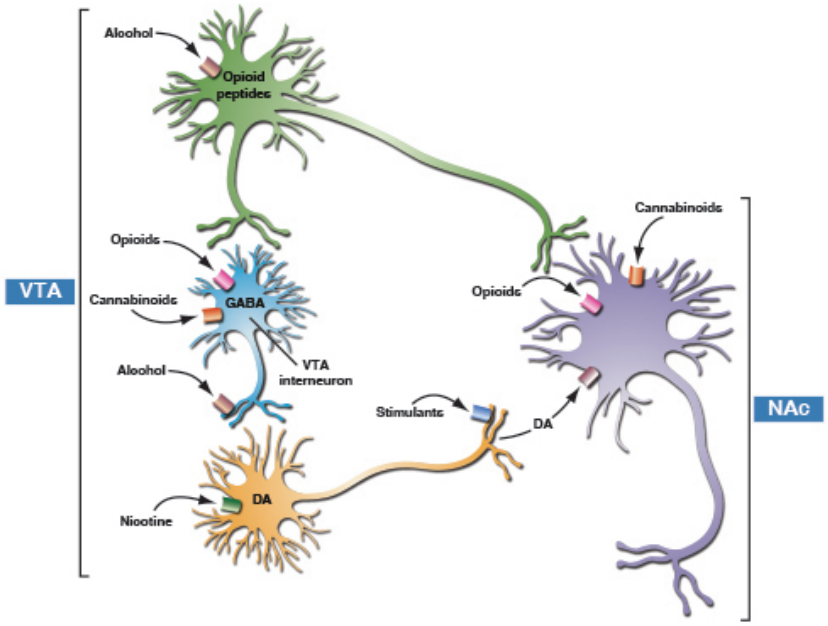

Figure 11.5: Actions of addictive substances on the brain. Modified with permission from Nestler, 2005.

Notes: Figure 11.5 is a simplified schematic of converging acute rewarding actions of addictive substances on the nucleus accumbens (NAc). Dopamine neurons that originate in the ventral tegmental area (VTA) project to the NAc. Opioid peptides act both in the VTA and NAc. Despite diverse initial actions, addictive substances produce some common effects on the VTA and NAc. Stimulants directly increase dopamine (DA) transmission in the NAc. Opioids, alcohol, and inhalants (e.g., the solvent toluene) do the same indirectly. Alcohol also activates the release of opioid peptides. Heroin and prescribed opioid pain relievers directly activate opioid peptide receptors. Nicotine activates dopamine neurons in the VTA. Cannabinoids may act in the VTA to activate dopamine neurons but also act on NAc neurons themselves.

Stimuli Associated with Addictive Substances Can Trigger Substance Use

Activation of the brain's reward system by alcohol and drugs not only generates the pleasurable feelings associated with those substances, it also ultimately triggers changes in the way a person responds to stimuli associated with the use of those substances. A person learns to associate the stimuli present while using a substance—including people, places, drug paraphernalia, and even internal states, such as mood—with the substance's rewarding effects. Over time, these stimuli can activate the dopamine system on their own and trigger powerful urges to take the substance. These "wanting" urges are called incentive salience and they can persist even after the rewarding effects of the substance have diminished. As a result, exposure to people, places, or things previously associated with substance use can serve as "triggers" or cues that promote substance seeking and taking, even in people who are in recovery.

Figure 11.6 shows the major neurotransmitter systems involved in the binge/intoxication stage of addiction. In this stage, the neurons in the basal ganglia contribute to the rewarding effects of addictive substances and to incentive salience through the release of dopamine and the brain's natural opioids.

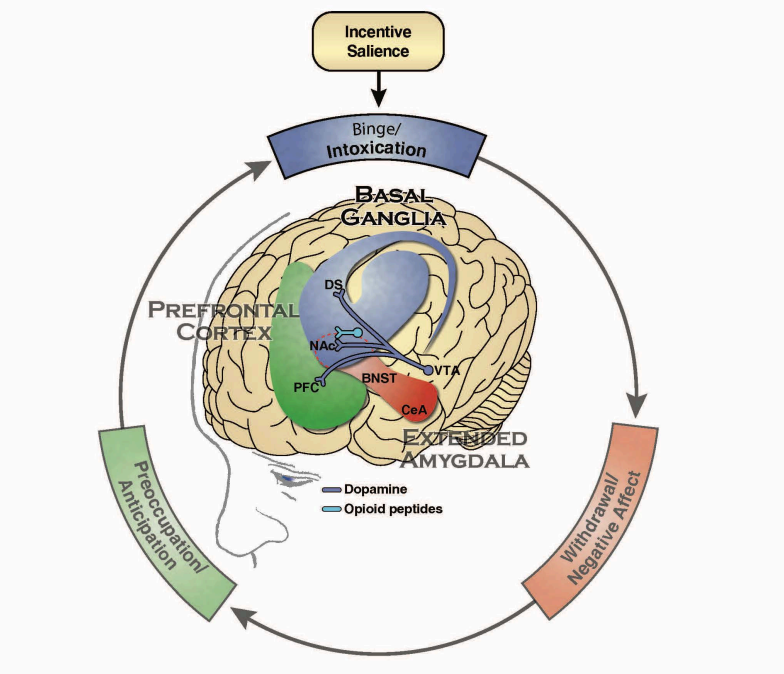

Figure 11.6: Major neurotransmitter systems implicated in the neuroadaptations associated with the binge/intoxication Stage of addiction. Modified with permission from Koob & Volkow, 2010.

Notes: Blue represents the basal ganglia involved in the binge/intoxication stage. Red represents the extended amygdala involved in the negative Affect/withdrawal stage. Green represents the prefrontal cortex involved in the preoccupation/anticipation stage.

Abbreviations: PFC—prefrontal cortex, DS—dorsal striatum, NAc—nucleus accumbens, BNST—bed nucleus of the stria terminalis, CeA—central nucleus of the amygdala, VTA—ventral tegmental area

Early studies in animals demonstrated how incentive salience works. For example, after researchers repeatedly gave an animal a stimulant drug (e.g., cocaine) along with a previously neutral stimulus, such as a light or a sound, they found that the neutral stimulus by itself caused the animal to engage in drug-seeking behavior, and it also resulted in dopamine release that had previously occurred only in response to the drug. [20] Even more compelling results were seen when scientists recorded the electrical activity of dopamine-transmitting neurons in animals that had been exposed multiple times to a neutral (non-drug) stimulus followed by a drug. At first, the neurons responded only when they were exposed to the drug. However, over time, the neurons stopped firing in response to the drug and instead fired when they were exposed to the neutral stimulus associated with it. This means that the animals associated the stimulus with the substance and, in anticipation of getting the substance, their brains began releasing dopamine, resulting in a strong motivation to seek the drug. [21, 22] Imaging studies in humans have shown similar results. For example, dopamine is released in the brains of people addicted to cocaine when they are exposed to cues they have come to associate with cocaine. [23, 24] This effect occurs even though cocaine itself causes less dopamine to be released in these individuals compared to those who are not addicted to cocaine (an effect also seen with other substances). [25]

Together, these studies indicate that stimuli associated with addictive drugs can, by themselves, produce drug-like effects on the brain and trigger drug use. These findings help to explain why individuals with substance use disorders who are trying to maintain abstinence are at increased risk

of relapse if they continue to have contact with the people they previously used drugs with or the places where they used drugs.

Substances Stimulate Areas of the Brain Involved in Habit Formation

A second sub-region of the basal ganglia, the dorsal striatum, is involved in another critical component of the binge/intoxication stage: habit formation. The release of dopamine (along with activation of brain opioid systems) and release of glutamate (an excitatory neurotransmitter) can eventually trigger changes in the dorsal striatum. [2, 26] These changes strengthen substance-seeking and substance-taking habits as addiction progresses, ultimately contributing to compulsive use.

In Summary: The Binge/Intoxication Stage and the Basal Ganglia

The "reward circuitry" of the basal ganglia (i.e., the nucleus accumbens), along with dopamine and naturally occurring opioids, play a key role in the rewarding effects of alcohol and other substances and the ability of stimuli, or cues, associated with that substance use to trigger craving, substance seeking, and use.

As alcohol or substance use progresses, repeated activation of the "habit circuitry" of the basal ganglia (i.e., the dorsal striatum) contributes to the compulsive substance seeking and taking that are associated with addiction.

The involvement of these reward and habit neurocircuits helps explain the intense desire for the substance (craving) and the compulsive substance seeking that occurs when actively or previously addicted individuals are exposed to alcohol and/or drug cues in their surroundings.

WITHDRAWAL/NEGATIVE AFFECT STAGE: EXTENDED AMYGDALA

The withdrawal/negative affect stage of addiction follows the binge/intoxication stage, and, in turn, sets up future rounds of binge/intoxication. During this stage, a person who has been using alcohol or drugs experiences withdrawal symptoms, which include negative emotions and, sometimes, symptoms of physical illness, when they stop taking the substance. Symptoms of withdrawal may occur with all addictive substances, including marijuana, though they vary in intensity and duration depending on both the type of substance and the severity of use. The negative feelings associated with withdrawal are thought to come from two sources: diminished activation in the reward circuitry of the basal ganglia [14] and activation of the brain's stress systems in the extended amygdala (Figure 11.7).

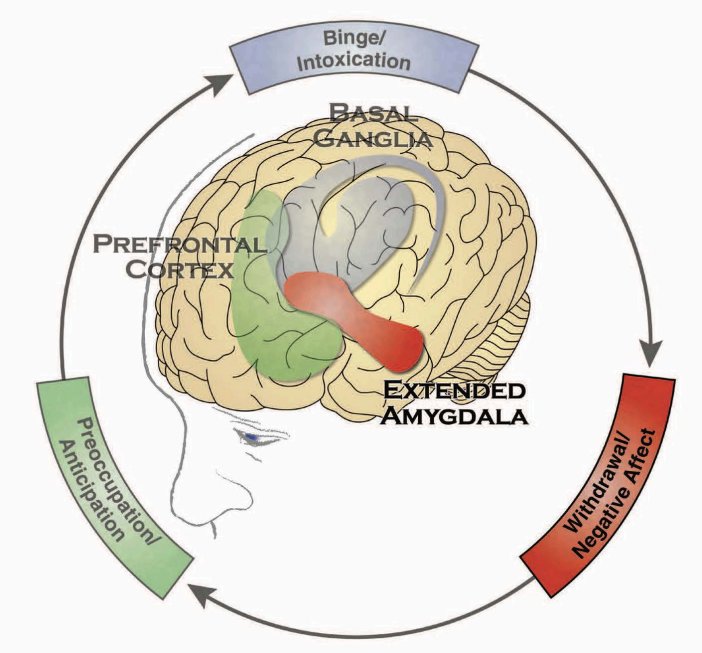

Figure 11.7: The withdrawal/negative affect stage and the extended amygdala

When used over the long term, all substances of abuse cause dysfunction in the brain's dopamine reward system. [27] For example, brain imaging studies in humans with addiction have consistently shown long-lasting decreases in a particular type of dopamine receptor, the D2 receptor, compared with non-addicted individuals (Figure 11.8). [25, 28] Decreases in the activity of the dopamine system have been observed during withdrawal from stimulants, opioids, nicotine, and alcohol. Other studies also show that when an addicted person is given a stimulant, it causes a smaller release of dopamine than when the same dose is given to a person who is not addicted.

These findings suggest that people addicted to substances experience an overall reduction in the sensitivity of the brain's reward system (especially the brain circuits involving dopamine), both to addictive substances and also to natural reinforcers, such as food and sex. This is because natural reinforcers also depend upon the same reward system and circuits. This impairment explains why those who develop a substance use disorder often do not derive the same level of satisfaction or pleasure from once-pleasurable activities.

This general loss of reward sensitivity may also account for the compulsive escalation of substance use as addicted individuals attempt to regain the pleasurable feelings the reward system once provided. [15]

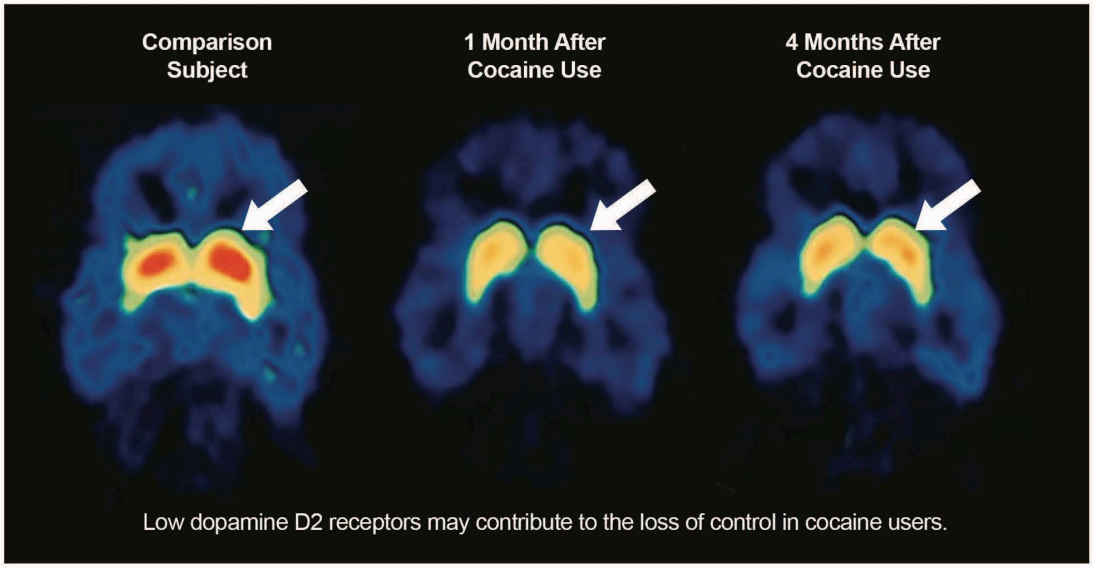

Figure 11.8: Time-related decrease in dopamine released in the brain of a cocaine user. Modified with permission from Volkow et al., 1993.

Notes: These fMRI images compare the brain of an individual with a history of cocaine use disorder (middle and right) to the brain of an individual without a history of cocaine use (left). The person who has had a cocaine use disorder has lower levels of the D2 dopamine receptor (depicted in red) in the striatum one month (middle) and four months (right) after stopping cocaine use compared to the non-user. The level of dopamine receptors in the brain of the cocaine user are higher at the 4-month mark (right), but have not returned to the levels observed in the non-user (left).

At the same time, a second process occurs during the withdrawal stage: activation of stress neurotransmitters in the extended amygdala. These stress neurotransmitters include corticotropin-releasing factor (CRF), norepinephrine, and dynorphin (Figure 11.9). [30]

Studies suggest that these neurotransmitters play a key role in the negative feelings associated with withdrawal and in stress-triggered substance use. In animal and human studies, when researchers use special chemicals called antagonists to block activation of the stress neurotransmitter systems, it has the effect of reducing substance intake in response to withdrawal and stress. For example, blocking the activation of stress receptors in the brain reduced alcohol consumption in both alcohol-dependent rats and humans with an alcohol use disorder. [31] Thus, it may be that an additional motivation for drug- and alcohol-seeking among individuals with substance use disorders is to suppress overactive brain stress systems that produce negative emotions or feelings. Recent research also suggests that **neuroadaptations** in the endogenous cannabinoid system within the extended amygdala contribute to increased stress reactivity and negative emotional states in addiction. [32]

The desire to remove the negative feelings that accompany withdrawal can be a strong motivator of continued substance use. As noted previously, this motivation is strengthened through negative reinforcement, because taking the substance relieves the negative feelings associated with withdrawal, at least temporarily. Of course, this process is a vicious cycle: taking drugs or alcohol to lessen the symptoms of withdrawal that occur during a period of abstinence actually causes those symptoms to be even worse the next time a person stops taking the substance, making it even harder to maintain abstinence.

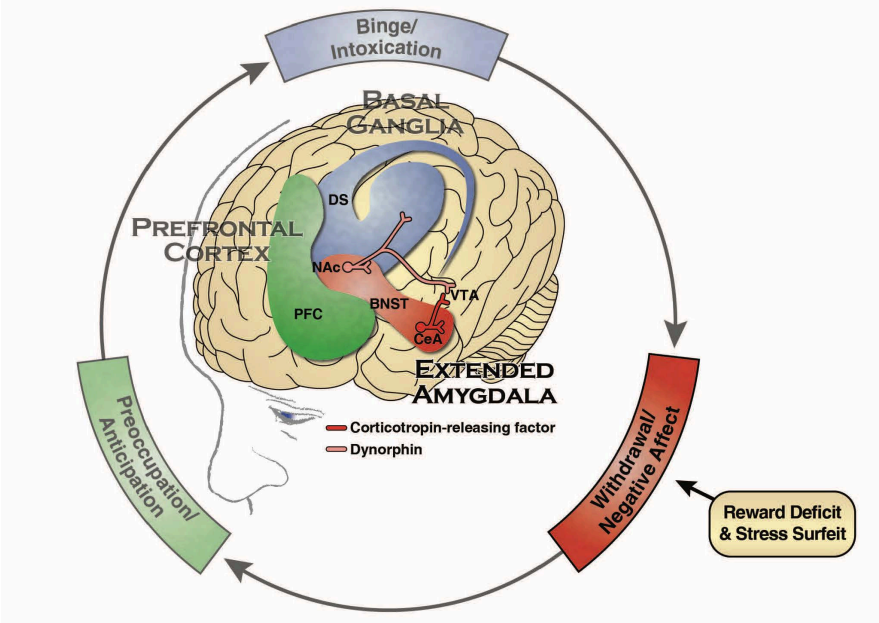

Figure 11.9: Major neurotransmitter systems implicated in the neuroadaptations associated with the withdrawal/negative affect Stage of addiction. Modified with permission from Koob & Volkow, 2010.

Notes: Not shown is the neurotransmitter norepinephrine which is also activated in the extended amygdala during withdrawal.

Abbreviations: PFC—prefrontal cortex, DS—dorsal striatum, NAc—nucleus accumbens, BNST—bed nucleus of the stria terminalis, CeA—central nucleus of the amygdala, VTA—ventral tegmental area.

In Summary: The Withdrawal/Negative Affect Stage and the Extended Amygdala

This stage of addiction involves a decrease in the function of the brain reward systems and an activation of stress neurotransmitters, such as CRF and dynorphin, in the extended amygdala. Together, these phenomena provide a powerful neurochemical basis for the negative emotional state associated with withdrawal. The drive to alleviate these negative feelings negatively reinforces alcohol or drug use and drives compulsive substance taking.

PREOCCUPATION/ANTICIPATION STAGE: PREFRONTAL CORTEX

The preoccupation/anticipation stage of the addiction cycle is the stage in which a person may begin to seek substances again after a period of abstinence. In people with severe substance use disorders, that period of abstinence may be quite short (hours). In this stage, an addicted person becomes preoccupied with using substances again. This is commonly called "craving." Craving has been difficult to measure in human studies and often does not directly link with relapse.

This stage of addiction involves the brain's prefrontal cortex (Figure 11.10), the region that controls executive function: the ability to organize thoughts and activities, prioritize tasks, manage time, make decisions, and regulate one's own actions, emotions, and impulses. Executive function is essential for a person to make appropriate choices about whether or not to use a substance and to

override often strong urges to use, especially when the person experiences triggers, such as stimuli associated with that substance (e.g., being at a party where alcohol is served or where people are smoking) or stressful experiences.

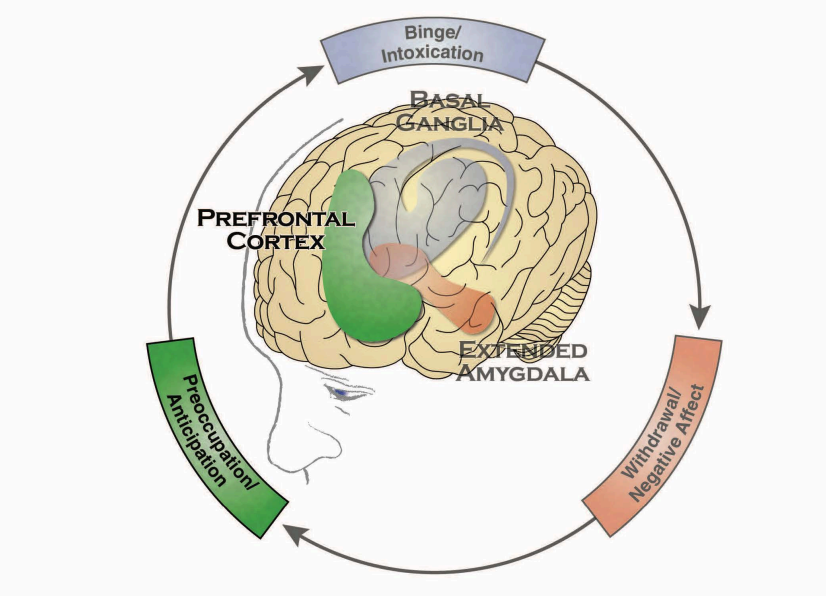

Figure 11.10: The preoccupation/anticipation stage and the prefrontal cortex

To help explain how the prefrontal cortex is involved in addiction, some scientists divide the functions of this brain region into a "Go system" and an opposing "Stop system." [33] The Go system helps people make decisions, particularly those that require significant attention and those involved with planning. People also engage the Go system when they begin behaviors that help them achieve goals. Indeed, research shows that when substance-seeking behavior is triggered by substance-associated environmental cues (incentive salience), activity in the Go circuits of the prefrontal cortex increases dramatically. This increased activity stimulates the nucleus accumbens to release glutamate, the main excitatory neurotransmitter in the brain. This release, in turn, promotes incentive salience, which creates a powerful urge to use the substance in the presence of drug-associated cues.

The Go system also engages habit-response systems in the dorsal striatum, and it contributes to the impulsivity associated with substance seeking. Habitual responding can occur automatically and subconsciously, meaning a person may not even be aware that they are engaging in such behaviors. The neurons in the Go circuits of the prefrontal cortex stimulate the habit systems of the dorsal striatum through connections that use glutamate (Figure 11.11).

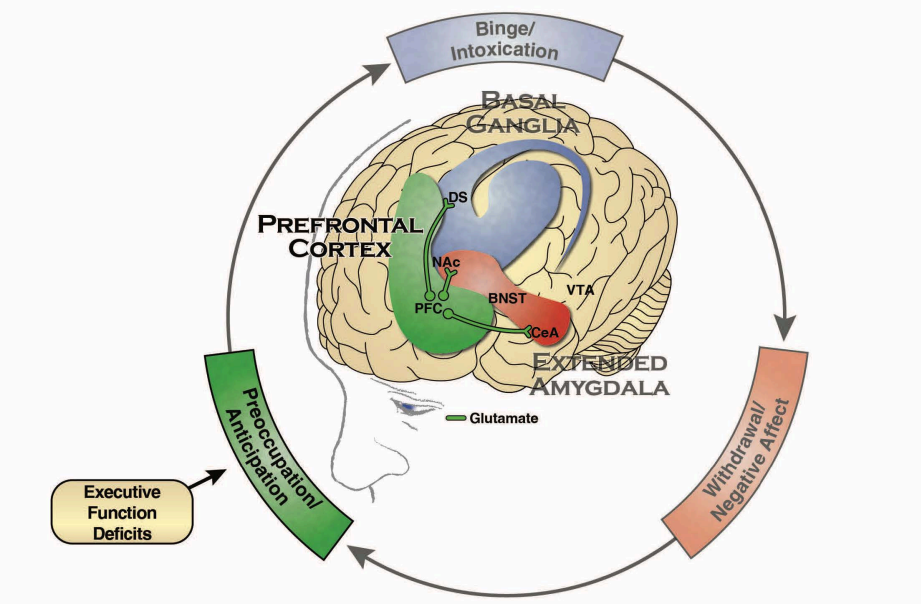

Figure 11.11: Major neurotransmitter systems implicated in the neuroadaptations associated with the preoccupation/anticipation stage of addiction. Modified with permission from Koob & Volkow, 2010.

Abbreviations: PFC—prefrontal cortex, DS—dorsal striatum, NAc—nucleus accumbens, BNST—bed nucleus of the stria terminalis, CeA—central nucleus of the amygdala, VTA—ventral tegmental area.

The Stop system inhibits the activity of the Go system. Especially relevant to its role in addiction, this system controls the dorsal striatum and the nucleus accumbens, the areas of the basal ganglia that are involved in the binge/intoxication stage of addiction. Specifically, the Stop system controls habit responses driven by the dorsal striatum, and scientists think that it plays a role in reducing the ability of substance-associated stimuli to trigger relapse—in other words, it inhibits incentive salience. [34]

The Stop system also controls the brain's stress and emotional systems, and plays an important role in relapse triggered by stressful life events or circumstances. Stress-induced relapse is driven by activation of neurotransmitters such as CRF, dynorphin, and norepinephrine in the extended amygdala. As described above, these neurotransmitters are activated during prolonged abstinence during the withdrawal/negative affect stage of addiction. More recent work in animals also implicates disruptions in the brain's cannabinoid system, which also regulates the stress systems in the extended amygdala, in relapse. Studies show that lower activity in the Stop component of the prefrontal cortex is associated with increased activity of stress circuitry involving the extended amygdala, and this increased activity drives substance-taking behavior and relapse. [37]

Brain imaging studies in people with addiction show disruptions in the function of both the Go and Stop circuits. [35-37] For example, people with alcohol, cocaine, or opioid use disorders show impairments in executive function, including disruption of decision-making and behavioral inhibition. These executive function deficits parallel changes in the prefrontal cortex and suggest decreased activity in the Stop system and greater reactivity of the Go system in response to substance-related stimuli.>

Indeed, a smaller volume of the prefrontal cortex in abstinent, previously addicted individuals predicts a shorter time to relapse. [38] Studies also show that diminished prefrontal cortex control over the extended amygdala is particularly prominent in humans with post-traumatic stress disorder

(PTSD), a condition that is frequently accompanied by drug and alcohol use disorders. [39] These findings bolster support for the role of the prefrontal cortex–extended amygdala circuit in stress-induced relapse, and suggest that strengthening prefrontal cortex circuits could aid substance use disorder treatment.

In Summary: The Preoccupation/Anticipation Stage and the Prefrontal Cortex

This stage of the addiction cycle is characterized by a disruption of executive function caused by a compromised prefrontal cortex. The activity of the neurotransmitter glutamate is increased, which drives substance use habits associated with craving, and disrupts how dopamine influences the frontal cortex. [2] The over-activation of the Go system in the prefrontal cortex promotes habit-like substance seeking, and the under-activation of the Stop system of the prefrontal cortex promotes impulsive and compulsive substance seeking.

To recap, addiction involves a three-stage cycle—binge/intoxication, withdrawal/negative affect, and preoccupation/anticipation—that worsens over time and involves dramatic changes in the brain's reward, stress, and executive function systems. Progression through this cycle involves three major regions of the brain: the basal ganglia, the extended amygdala, and the prefrontal cortex, as well as multiple neurotransmitter systems (Figure 11.12). The power of addictive substances to produce positive feelings and relieve negative feelings fuels the development of compulsive use of substances. The combination of increased incentive salience (binge/intoxication stage), decreased reward sensitivity and increased stress sensitivity (withdrawal/negative affect stage), and compromised executive function (preoccupation/ anticipation stage) provides an often overwhelming drive for substance seeking that can be unrelenting.

DIFFERENT CLASSES OF SUBSTANCES AFFECT THE BRAIN AND BEHAVIOR IN DIFFERENT WAYS

Although the three stages of addiction generally apply to all addictive substances, different substances affect the brain and behavior in different ways during each stage of the addiction cycle. Differences in the pharmacokinetics of various substances determine the duration of their effects on the body and partly account for the differences in their patterns of use. For example, nicotine has a short half-life, which means smokers need to smoke often to maintain the effect. In contrast, THC, the primary psychoactive compound in marijuana, has a much longer half-life. As a result, marijuana smokers do not typically smoke as frequently as tobacco smokers. [40] Typical patterns of use are described below for the major classes of addictive substances. However, people often use these substances in combination. [41] Additional research is needed to understand how using more than one substance affects the brain and the development and progression of addiction, as well as how use of one substance affects the use of others.

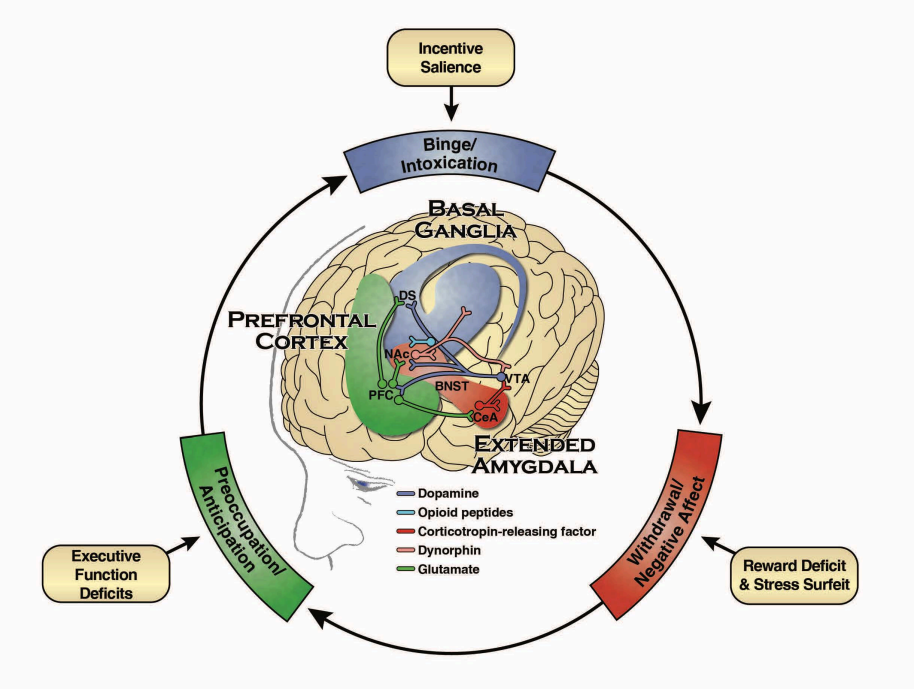

Figure 11.12: The primary brain regions and neurotransmitter systems involved in each of the three stages of the addiction cycle

Opioids

>Opioids attach to opioid receptors in the brain, which leads to a release of dopamine in the nucleus accumbens, causing euphoria (the high), drowsiness, and slowed breathing, as well as reduced pain signaling (which is why they are frequently prescribed as pain relievers). Opioid addiction typically involves a pattern of: (1) intense intoxication, (2) the development of tolerance, (3) escalation in use, and (4) withdrawal signs that include profound negative emotions and physical symptoms, such as bodily discomfort, pain, sweating, and intestinal distress and, in the most severe cases, seizures. As use progresses, the opioid must be taken to avoid the severe negative effects that occur during withdrawal. With repeated exposure to opioids, stimuli associated with the pleasant effects of the substances (e.g., places, persons, moods, and paraphernalia) and with the negative mental and physical effects of withdrawal can trigger intense craving or preoccupation with use.

Alcohol

When alcohol is consumed it interacts with several neurotransmitter systems in the brain, including the inhibitory neurotransmitter GABA, glutamate, and others that produce euphoria as well as the sedating, motor-impairing, and anxiety-reducing effects of alcohol intoxication. Alcohol addiction often involves a similar pattern as opioid addiction, characterized by periods of binge or heavy drinking followed by withdrawal. As with opioids, addiction to alcohol is characterized by intense craving that is often driven by negative emotional states, positive emotional states, and stimuli that have been associated with drinking, as well as a severe emotional and physical withdrawal syndrome. Many people with severe alcohol use disorder engage in patterns of binge drinking followed by withdrawal for extended periods of time. Extreme patterns of use may evolve into an opioid-like use pattern in which alcohol must be available at all times to avoid the negative consequences of withdrawal.

Stimulants

Stimulants increase the amount of dopamine in the reward circuit (causing the euphoric high) either by directly stimulating the release of dopamine or by temporarily inhibiting the removal of dopamine from synapses, the gaps between neurons. These drugs also boost dopamine levels in brain regions responsible for attention and focus on tasks (which is why stimulants like methylphenidate [Ritalin®] or dextroamphetamine [Adderall®] are often prescribed for people with attention deficit hyperactivity disorder). Stimulants also cause the release of norepinephrine, a neurotransmitter that affects autonomic functions like heart rate, causing a user to feel energized.

Addiction to stimulants, such as cocaine and amphetamines (including methamphetamine), typically follows a pattern that emphasizes the binge/intoxication stage. A person will take the stimulant repeatedly during a concentrated period of time lasting for hours or days (these episodes are called binges). The binge is often followed by a crash, characterized by negative emotions, fatigue, and inactivity. Intense craving then follows, which is driven by environmental cues associated with the availability of the substance, as well as by a person's internal state, such as their emotions or mood.

Marijuana (Cannabis)

Like other drugs, marijuana (also called cannabis) leads to increased dopamine in the basal ganglia, producing the pleasurable high. It also interacts with a wide variety of other systems and circuits in the brain that contain receptors for the body's natural cannabinoid neurotransmitters. Effects can be different from user to user, but often include distortions in motor coordination and time perception. Cannabis addiction follows a pattern similar to opioids. This pattern involves a significant binge/intoxication stage characterized by episodes of using the substance to the point of intoxication. Over time, individuals begin to use the substance throughout the day and show chronic intoxication during waking hours. Withdrawal is characterized by negative emotions, irritability, and sleep disturbances. [40] Although the craving associated with cannabis [42] has been less studied than for other substances, it is most likely linked to both environmental and internal states, similar to that of other addictive substances. [43, 44]

Synthetic Drugs

Different classes of chemically synthesized (hence the term synthetic) drugs have been developed, each used in different ways and having different effects in the brain. Synthetic cathinones, more commonly known as "bath salts," target the release of dopamine in a similar manner as the stimulant drugs described above. To a lesser extent, they also activate the serotonin neurotransmitter system, which can affect perception. Synthetic cannabinoids, sometimes referred to as "K2," "Spice," or "herbal incense," somewhat mimic the effects of marijuana but are often much more powerful. Drugs such as MDMA (ecstasy) and lysergic acid diethylamide (LSD) also act on the serotonin neurotransmitter system to produce changes in perception. Fentanyl is a synthetic opioid medication that is used for severe pain management and is considerably more potent than heroin. Prescription fentanyl, as well as illicitly manufactured fentanyl and related synthetic opioids, are often mixed with heroin but are also increasingly used alone or sold on the street as counterfeit pills made to look like prescription opioids or sedatives.

FACTORS THAT INCREASE RISK FOR SUBSTANCE USE, MISUSE, AND ADDICTION

Not all people use substances, and even among those who use them, not all are equally likely to become addicted. Many factors influence the development of substance use disorders, including developmental, environmental, social, and genetic factors, as well as co-occurring mental disorders. Other factors protect people from developing a substance use disorder or addiction. The relative influence of these risk and protective factors varies across individuals and the lifespan. The following sections discuss some of these factors.

Early Life Experiences

The experiences a person has early in childhood and in adolescence can set the stage for future substance use and, sometimes, escalation to a substance use disorder or addiction. Early life stressors can include physical, emotional, and sexual abuse; neglect; household instability (such as parental substance use and conflict, mental illness, or incarceration of household members); [45] and poverty. [46] Research suggests that the stress caused by these risk factors may act on the same stress circuits in the brain as addictive substances, which may explain why they increase addiction risk. [47]

Adolescence is a critical period in the vulnerability to substance use and use disorders, because a hallmark of this developmental period is risk-taking and experimentation, which for some young people includes trying alcohol, marijuana, or other drugs. In addition, the brain undergoes significant changes during this life stage, making it particularly vulnerable to substance exposure. [48] Importantly, the frontal cortex—a region in the front part of the brain that includes the prefrontal cortex—does not fully develop until the early- to mid-20s, and research shows that heavy drinking and drug use during adolescence affects development of this critical area of the brain. [49]

About three quarters (74 percent) of 18- to 30-year-olds admitted to treatment programs began using substances at the age of 17 or younger. [50] Individuals who start using substances during adolescence often experience more chronic and intensive use, and they are at greater risk of developing a substance use disorder compared with those who begin use at an older age. In other words, the earlier the exposure, the greater the risk. [51]

Not all adolescents who experiment with alcohol, cigarettes, or other substances go on to develop a substance use disorder, but research suggests that those who do progress to more harmful use may have pre-existing differences in their brains. For example, a brain imaging study of adolescents revealed that the volume of the frontal cortex was smaller in youth who transitioned from no or minimal drinking to heavy drinking over the course of adolescence than it was in youth who did not drink during adolescence. [49] Additional research can shed light on how these differences contribute to the progression from use to a disorder, as well as how changes caused by substance use affect brain function and behavior and whether they can be reversed.

Genetic and Molecular Factors

Genetic factors are thought to account for 40 to 70 percent of individual differences in risk for addiction. [52, 53] Although multiple genes are likely involved in the development of addiction, only a few specific gene variants have been identified that either predispose to or protect against addiction. Some of these variants have been associated with the metabolism of alcohol and nicotine, while others involve receptors and other proteins associated with key neurotransmitters and molecules involved in all parts of the addiction cycle. [54] Genes involved in strengthening the connections between

neurons and in forming drug memories have also been associated with addiction risk. [55, 56] Like other chronic health conditions, substance use disorders are influenced by the complex interplay between a person's genes and environment. Additional research on the mechanisms underlying gene–environment interactions is expected to provide insight into how substance use disorders develop and how they can be prevented and treated.

USE OF MULTIPLE SUBSTANCES AND CO-OCCURRING MENTAL HEALTH CONDITIONS

Many individuals with a substance use disorder also have a mental disorder, [57, 58] and some have multiple substance use disorders. For example, according to the 2015 National Survey on Drug Use and Health (NSDUH), of the 20.8 million people aged 12 or older who had a substance use disorder during the past year, about 2.7 million (13 percent) had both an alcohol use and an illicit drug use disorder, and 41.2 percent also had a mental illness. [59] Particularly striking is the three- to four-fold higher rate of tobacco smoking among patients with schizophrenia and the high prevalence of co-existing alcohol use disorder in those meeting criteria for PTSD. It is estimated that 30-60 percent of patients seeking treatment for alcohol use disorder meet criteria for PTSD, [60, 61] and approximately one third of individuals who have experienced PTSD have also experienced alcohol dependence at some point in their lives. [60]

The reasons why substance use disorders and mental disorders often occur together are not clear, and establishing the relationships between these conditions is difficult. Still, three possible explanations deserve attention. One reason for the overlap may be that having a mental disorder increases vulnerability to substance use disorders because certain substances may, at least temporarily, be able to reduce mental disorder symptoms and thus are particularly negatively reinforcing in these individuals. Second, substance use disorders may increase vulnerability for mental disorders, [62-64] meaning that the use of certain substances might trigger a mental disorder that otherwise would have not occurred. For example, research suggests that alcohol use increases risk for PTSD by altering the brain's ability to recover from traumatic experiences. [65, 66] Similarly, the use of marijuana, particularly marijuana with a high THC content, might contribute to schizophrenia in those who have specific genetic vulnerabilities. [67] Third, it is also possible that both substance use disorders and mental disorders are caused by shared, overlapping factors, such as particular genes, neurobiological deficits, and exposure to traumatic or stressful life experiences. As these possibilities are not mutually exclusive, the relationship between substance use disorders and mental disorders may result from a combination of these processes.

Regardless of which one might influence the development of the other, mental and substance use disorders have overlapping symptoms, making diagnosis and treatment planning particularly difficult. For example, people who use methamphetamine for a long time may experience paranoia, hallucinations, and delusions that may be mistaken for symptoms of schizophrenia. The psychological symptoms that accompany withdrawal, such as depression and anxiety, may be mistaken as simply part of withdrawal instead of an underlying mood disorder that requires independent treatment in its own right. Given the prevalence of co-occurring substance use and mental disorders, it is critical to continue to advance research on the genetic, neurobiological, and environmental factors that contribute to co-occurring disorders and to develop interventions to prevent and treat them.

BIOLOGICAL FACTORS CONTRIBUTING TO POPULATION-BASED DIFFERENCES IN

SUBSTANCE MISUSE AND SUBSTANCE USE DISORDERS

Differences Based on Sex

Some groups of people are also more vulnerable to substance misuse and substance use disorders. For example, men tend to drink more than women and they are at higher risk for alcohol use disorder, although the gender differences in alcohol use are declining. [68] Men are also more likely to have other substance use disorders. [69] However, clinical reports suggest that women who use cocaine, opioids, or alcohol progress from initial use to a disorder at a faster rate than do men (called "telescoping"). [70-72] Compared with men, women also exhibit greater symptoms of withdrawal from some drugs, such as nicotine. They also report worse negative affects during withdrawal and have higher levels of the stress hormone cortisol. [73]

Sex differences in reaction to addictive substances are not particular to humans. Female rats, in general, learn to self-administer drugs and alcohol more rapidly, escalate their drug taking more quickly, show greater symptoms of withdrawal, and are more likely to resume drug seeking in response to drugs, drug-related cues, or stressors. The one exception is that female rats show fewer withdrawal symptoms related to alcohol use. [74] Researchers are investigating the neurobiological bases for these differences.

Differences Based on Race and Ethnicity

Research on the neurobiological factors contributing to differential rates of substance use and substance use disorders in particular racial and ethnic groups is much more limited. A study using functional magnetic resonance imaging (fMRI) found that African American smokers showed greater activation of the prefrontal cortex upon exposure to smoking-related cues than did White smokers, an effect that may partly contribute to the lower smoking-cessation success rates observed among African Americans. [75]

Alcohol research with racial and ethnic groups has shown that approximately 36 percent of East Asians carry a gene variant that alters the rate at which members of that racial group metabolize alcohol, causing a buildup of acetaldehyde, a toxic byproduct of alcohol metabolism that produces symptoms such as flushing, nausea, and rapid heartbeat. Although these effects may protect some individuals of East Asian descent from alcohol use disorder, those who drink despite the effects are at increased risk for esophageal [76] and head and neck cancers. [77] Another study found that even low levels of alcohol consumption by Japanese Americans may result in adverse effects on the brain, a finding that may be related to the differences in alcohol metabolism described above. [78] Additional research will help to clarify the interactions between race, ethnicity, and the neuroadaptations that underlie substance misuse and addiction. This work may inform the development of more precise preventive and treatment interventions.

RECOMMENDATIONS FOR RESEARCH

Decades of research demonstrate that chronic substance misuse leads to profound disruptions of brain circuits involved in the experience of pleasure or reward, habit formation, stress, and decision-making. This work has paved the way for the development of a variety of therapies that effectively help people reduce or abstain from alcohol and drug misuse and regain control over their lives. In spite of this progress, our understanding of how substance use affects the brain and behavior is far from complete. Four research areas are specifically emphasized in the text below.

Effects of Substance Use on Brain Circuits and Functions

Continued research is necessary to more thoroughly explain how substance use affects the brain at the molecular, cellular, and circuit levels. Such research has the potential to identify common neurobiological mechanisms underlying substance use disorders, as well as other related mental disorders. This research is expected to reveal new neurobiological targets, leading to new medications and non-pharmacological treatments—such as transcranial magnetic stimulation or vaccines—for the treatment of substance use disorders. A better understanding of the neurobiological mechanisms underlying substance use disorders could also help to inform behavioral interventions. Therefore, basic research that further elucidates the neurobiological framework of substance use disorders and co-occurring mental disorders, as well as research leading to the development of new medications and other therapeutics to treat the underlying neurobiological mechanisms of substance use disorders, should be accelerated.

As with other diseases, individuals vary in the development and progression of substance use disorders. Not only are some people more likely to use and misuse substances than are others, and to progress from initial use to addiction differently, individuals also differ in their vulnerability to relapse and in how they respond to treatments. For example, some people with substance use disorders are particularly vulnerable to stress-induced relapse, but others may be more likely to resume substance use after being exposed to drug-related cues. Developing a thorough understanding of how neurobiological differences account for variation among individuals and groups will guide the development of more effective, personalized prevention and treatment interventions. Additionally, determining how neurobiological factors contribute to differences in substance misuse and addiction between women and men and among racial and ethnic groups is critical.

Continued advances in neuroscience research will further enhance our understanding of substance use disorders and accelerate the development of new interventions. Data gathered through the National Institutes of Health's Adolescent Brain Cognitive Development study, the largest long-term study of cognitive and brain development in children across the United States, is expected to yield unprecedented information about how substance use affects adolescent brain development. The Human Connectome Project and the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) initiative are poised to spur an explosion of knowledge about the structure and function of brain circuits and how the brain affects behavior. Technologies that can alter the activity of dysfunctional circuits are being explored as possible treatments. Moreover, continued advances in genomics, along with President Obama's Precision Medicine Initiative, a national effort to better understand how individual variability in genes, environment, and lifestyle contribute to disease, are expected to bring us closer to developing individually-tailored preventive and treatment interventions for substance-related conditions.

Neurobiological Effects of Recovery

Little is known about the factors that facilitate or inhibit long-term recovery from substance use disorders or how the brain changes over the course of recovery. Developing a better understanding of the recovery process, and the neurobiological mechanisms that enable people to maintain changes in their substance use behavior and promote resilience to relapse, will inform the development of additional effective treatment and recovery support interventions. Therefore, an investigation of the neurobiological processes that underlie recovery and contribute to improvements in social, educational, and professional functioning is necessary.

Adolescence, Brain Change, and Vulnerability to Substance Use Disorders

Although young people are particularly vulnerable to the adverse effects of substance use, not all adolescents who experiment with alcohol or drugs go on to develop a substance use disorder. Prospective, longitudinal studies are needed to investigate whether pre-existing neurobiological factors contribute to adolescent substance use and the development of substance use disorders, how adolescent substance use affects brain structure and function, and whether the changes in brain structure and function that accompany chronic substance use can recover over time. Studies that follow groups of adolescents over time to learn about the developing human brain should be conducted. These studies should investigate how pre-existing neurobiological factors contribute to substance use, misuse, and addiction, and how adolescent substance use affects brain function and behavior.

Neurobiological Effects of Polysubstance Use and Emerging Drug Products

Patterns of alcohol and drug use change over time. New drugs or drug combinations, delivery systems, and routes of administration emerge, and with them new questions for public health. For example, concern is growing that increasing use of marijuana extracts with extremely high amounts of THC could lead to higher rates of addiction among marijuana users. Concerns also are emerging about how new products about which little is known, such as synthetic cannabinoids and synthetic cathinones, affect the brain. Additional research is needed to better understand how such products—as well as emerging addictive substances—affect brain function and behavior, and contribute to addiction.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
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LICENSE AND ATTRIBUTION

CHAPTER 12.

THE BEST EXPLANATION OF ADDICTION I'VE EVER HEARD

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CHAPTER 13.

CHANGING THE STIGMA OF MENTAL HEALTH AND ADDICTION

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CHAPTER 14.

STIGMA AND ADDICTION

WORDS MATTER: PREFERRED LANGUAGE FOR TALKING ABOUT ADDICTION

Addiction is a chronic but treatable medical condition. Often unintentionally, many people still talk about addiction in ways that are stigmatizing—meaning they use words that can portray someone with a substance use disorder (SUD) in a shameful or negative way and may prevent them from seeking treatment.[9] With simple changes in language, harmful stigma and negativity around SUD can be reduced or avoided. Read on to learn more about what stigma is, how it affects people with SUD, and how you can help make a change.

STIGMA AND ADDICTION

What is stigma?

Stigma is a discrimination against an identifiable group of people, a place, or a nation. Stigma about people with substance use disorders might include inaccurate or unfounded thoughts like: they are dangerous, incapable of managing treatment, or at fault for their condition.

Where does stigma come from?

Stigma around addiction may come from old and inaccurate ideas, or fear of things that are different or misunderstood. Today, we know that addiction is a chronic, treatable medical condition. We also know that people can recover and continue to lead healthy lives.

How does it affect people with SUD?

- Feeling stigmatized can make people with SUD less willing to seek treatment.[1,2]
- Negative stereotypes about people with SUD can make others feel pity, fear, and even anger.[2]

How can we make a change?

- When talking to or about people with SUD, make sure to use words that aren't stigmatizing. See the table below for some helpful tips to get started.
- Use person-first language, which focuses on the person—not their illness. It focuses on removing words that define a person by their condition or have negative meanings.[4] For example, "person with a substance use disorder" has a neutral tone and separates the person from his or her disorder.[5]
- Let people choose how they are described.[3] If you're not sure what words to use, just ask! Check in with friends or loved ones about how they refer to themselves and how they would like others to refer to them.

TERMS TO USE, TERMS TO AVOID, AND WHY

The chart below can help you choose words to reduce stigma and use person-first language when talking about addiction.

Talking About Yourself or Others with Substance Use Disorder

Use…	Instead of…	Because…
• **Person with a substance use disorder**[10] • **Person with an opioid use disorder (OUD) or person with opioid addiction**	• Addict • User • Substance or drug abuser • Junkie	• Using person-first language shows that SUD is an illness. • Using these words shows that a person with a SUD "has" a problem/illness, rather than "is" the problem.[6] • The terms avoid elicit negative associations, punitive attitudes, and individual blame.[6]
• **Person with alcohol use disorder** • **Person who misuses alcohol/engages in unhealthy/hazardous alcohol use**	• Alcoholic • Drunk	
• **Person in recovery or long-term recovery/person who previously used drugs**	• Former addict • Reformed addict	
• **Testing positive (on a drug screen)**	• Dirty • Failing a drug test	• Use medically accurate terminology the same way it would be used for other medical conditions.[8] • These terms may decrease a person's sense of hope and self-efficacy for change.[6]

Talking about Using Substances

Use…	Instead of…	Because…
• **Substance use disorder** • **Drug addiction**	• Habit	• "Habit" implies that a person is *choosing* to use substances or can *choose* to stop. This implication is inaccurate.[5] • Describing SUD as a habit makes the illness seem less serious than it is.
• **Use** (for illicit drugs) • **Misuse** (for prescription medications used other than prescribed)	• Abuse	• The term "abuse" was found to have a high association with negative judgments and punishment.[7] • Use outside of the parameters of how medications were prescribed is misuse.

Talking about Recovery and Treatment

Use...	Instead of...	Because...
• **Medication treatment for OUD** • **Medications for OUD** • **Opioid agonist therapy** • **Pharmacotherapy** • **Medication for a substance use disorder**	• Opioid substitution • Replacement therapy • Medication-assisted treatment (MAT)	• It is a misconception that medications merely "substitute" one drug or "one addiction" for another.[5] • The term MAT implies that medication should have a supplemental or temporary role in treatment. Using "MOUD" aligns with the way other psychiatric medications are understood (e.g., antidepressants, antipsychotics), as critical tools that are central to a patient's treatment plan.
• **Being in remission or recovery** • **Abstinent from drugs** • **Not drinking or taking drugs** • **Testing negative** (on a drug screen)	• Clean	• Use of medical terminology (the same way you would for other illnesses) can help reduce stigma.[8]

Talking about Babies Born to Parents Who Used Drugs

Use...	Instead of...	Because...
• **Baby born to a parent who used drugs while pregnant** • **Baby with signs of withdrawal from prenatal drug exposure** • **Newborn exposed to substances** • **Baby with neonatal abstinence syndrome**	• Addicted baby	• Babies cannot be born with addiction because addiction is a behavioral disorder. • Using person-first language can reduce stigma. • Use of medical terminology (the same way you would for other illnesses) can help reduce stigma.[8]

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CHAPTER 15.

CASE MANAGEMENT

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 resources—a case manager—or 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 below). 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 inhabit—the 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). 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 therapy—substance 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 recovery—and 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.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
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LICENSE AND ATTRIBUTION

REFERENCE LIST

Appendix A: Reference List.

CHAPTER 16.

COMPREHENSIVE CASE MANAGEMENT FOR SUBSTANCE USE DISORDER TREATMENT

The definition of case management varies by setting, but in general terms it is a coordinated, individualized approach that links patients[1] with appropriate services to address their specific needs and help them achieve their stated goals. Case management for patients with substance use disorders (SUDs) has been found to be effective because it helps them stay in treatment and recovery. Also, by concurrently addressing other needs, it allows patients to focus on SUD treatment. The types of settings offering SUD case management include specialty treatment programs, federally qualified health centers, rural health centers, community mental health centers, veterans' health programs, and integrated primary care practices.

This Advisory is based on the Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Improvement Protocol (TIP) 27, Comprehensive Case Management for Substance Abuse Treatment. It surveys the underlying principles and models of case management, discusses reasons SUD treatment providers might consider implementing or expanding the use of case management, and lists some case management-related resources and tools.

Key Messages

- Case management is framed around screening to identify a patient's medical, psychosocial, behavioral, and functional needs, and then working directly and/or through community resources to address these needs while the SUD is treated.
- Case management is increasingly used to support treatment engagement and retention while reducing the impact of SUDs on the community.
- The SUD treatment program can select a case management model that matches its treatment approach and best suits its patients and the service setting.
- In any type of case management model employed, all care team members should contribute to and endorse the patient's treatment plan, and effectively communicate with each other as the plan is implemented.

CASE MANAGEMENT OVERVIEW

The percentage of U.S. SUD treatment programs using case management has risen since 2000, from

1. This publication uses only the term "patients" to describe recipients or potential recipients of case management services. In practice, depending on the setting and the context, the terms "clients" or "participants" are also frequently used.

66 percent of the 13,418 facilities then in operation to 83 percent of the 15,961 facilities operating in 2019 (SAMHSA, 2020c; SAMHSA, Office of Applied Studies, 2002).

Definitive statements about the overall effectiveness of case management cannot be made, because studies vary in their definitions of the term, methodology, study populations, intervention designs, and outcome measures. However, multiple analyses (Joo & Huber, 2015; Kirk et al., 2013; Penzenstadler et al., 2017; Rapp et al., 2014; Regis et al., 2020) have found positive outcomes for one or more measures, such as treatment adherence, overall functioning, costs, decreases in substance use, reductions in acute care episodes, and increased engagement in nonacute services. A 2019 meta-analysis comparing case management with treatment as usual showed a small yet statistically significant positive effect, which was greater for treatment-related tasks than for personal functioning outcomes such as improved health status and family relations and reductions in substance use and legal involvement (Vanderplasschen et al., 2019).

Principles of case management

It offers the patient a single point of contact with the health and social services system. The case manager assumes responsibility for coordinating the care of patients who receive services from multiple agencies. This replaces a haphazard process of referrals with a single, more well-structured service.

It is patient centered. Each patient's right to self-determination is emphasized. The case manager is familiar with the patient's experiences and world, and uses this understanding to identify psychosocial stressors and anticipate needs. The case manager works with the patient to set reasonable goals (see box) and helps the patient access the chosen services.

It is community based. The case manager helps the patient access and integrate formalized and informal care services, overcome barriers to services, and transition between services. Case managers vary in how much they are directly involved with community services (e.g., whether they make warm handoffs or accompany patients to meetings).

It is equity driven. Typically, the case manager begins by addressing a patient's urgent and tangible needs, such as stable and safe housing, food, childcare, or income. The case manager does this work recognizing that when viewed through a social determinants of health (SDOH) lens (see box), some populations disproportionately lack such life-enhancing resources—and that for some patients, access to one or more of these resources may be a prerequisite for focusing on treatment.

It involves advocacy. The case manager promotes the patient's best interests. This can include educating service providers, negotiating for services, and recommending actions (e.g., using sanctions instead of jail time for patients involved with the justice system). Advocacy can also involve speaking out and acting on behalf of a patient who is refused services (e.g., because of discriminatory attitudes toward people with SUDs) or who requires assistance with meeting basic needs.

It is culturally sensitive and nonstigmatizing. The case manager is knowledgeable and nonjudgmental about the patient's culture. This enables the case manager to effectively connect with the patient and service providers in the patient's community. Another key function of the case manager is to model nonstigmatizing language, attitudes, and actions for other service providers (Volkow, 2020).

It is pragmatic. The case manager may also teach skills helpful to recovery (e.g., assertive communication, collaboration with a team of providers, day-to-day skills for living in the

community). These pragmatic skills may be taught explicitly, or simply modeled during interactions between the case manager and client.

Social Determinants of Health

SDOH have been defined as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (U.S. Department of Health and Human Services, n.d.), including risk for substance misuse and related health consequences (Office of the Surgeon General, 2016). Case managers can play a central role in assessing SDOH and in assisting to develop a plan that effectively takes them into account (Fink-Samnick, 2018).

Care management versus case management

"Care management" refers to services that help a patient manage one or more chronic diseases, such as diabetes or cardiovascular disease. Case management is usually more limited in scope and time commitment (Ahmed, 2016; Centers for Medicare & Medicaid Services, 2019). For example, a case manager may be involved in a patient's care for only one or a few specific needs, such as transportation to treatment or help in applying for Medicaid (Case Management Society of America, 2020; Treiger, 2020). However, a patient with an SUD may need the kind of sustained help that is more like care management. Assistance from a case manager may be offered along the full continuum of care, and for as long as it benefits the patient.

Models of case management

Variations in the case manager's role are illustrated in the "Models of Case Management" table, which compares four case management models across 11 activities. (See TIP 27, Introduction, pp. 9–11, for descriptions of each model.) Whichever model is used, all members of the care team should contribute to and endorse a shared care plan for the patient, and effectively communicate with each other as the plan is implemented (van Dongen et al., 2016). It is important to note that certification programs exist for case managers, but not all case managers are required to be certified by the relevant authorities (e.g., state Medicaid authorities and/or state mental health authorities).

Models of Case Management

Primary Case Management Activities	**Broker/Generalist**	**Strengths Perspective**	**Assertive Community Treatment**	**Clinical/ Rehabilitation**
Conducts outreach and case finding	Not usually	Depends on agency mission & structure	Depends on agency mission & structure	Depends on agency mission & structure
Provides assessment and ongoing reassessment	Specific to immediate resource acquisition needs	Strengths-based; applicable to any of a patient's life areas	Broad-based; part of a comprehensive (biopsychosocial) assessment	Broad-based; part of a comprehensive (biopsychosocial) assessment
Assists in goal planning	Generally brief; related to acquiring resources, possibly informal	Patient-centered; teaches how to set goals and objectives; goals may include any of a patient's life areas	Comprehensive; goals may include any of a patient's life areas	Comprehensive; goals may include any of a patient's life areas
Makes referrals to needed resources	Initiates contact or patient may contact on own	Contacts resource or accompanies a patient, or patient may contact on own	Multiple resources, as needed, are integrated into a broad package of case management services	Contacts resource or accompanies a patient, or patient may contact on own
Monitors referrals	Makes follow-up checks	Closely involved in ongoing relationship between patient and resource	Closely involved in ongoing relationship between patient and resource	Closely involved in ongoing relationship between patient and resource
Provides therapeutic services beyond resource acquisition (e.g., therapy, skills teaching)	Provides referral to other sources for these services if requested	Usually limited to answering patient questions about treatment, helping management services	Provides many services within a unified package of treatment/case management services	Provides therapeutic activities central to the model
Helps develop informal support systems	No	Develops informal resources—neighbors, places of worship, family—a key principle of the model	Through implementation of drop-in centers and shelters	Stresses family & mutual-help support via therapeutic activities
Responds to crises	Responds to crises related to resource needs such as housing	Responds to crises related to mental health and resource needs; active in stabilization and then referral	Responds to crises related to mental health and resource needs; active in stabilization and then referral	Responds to crises related to mental health and resource needs; stabilizes situation, provides further therapeutic intervention
Engages in advocacy on behalf of individual patients	Usually only at level of line staff	Assertively advocates for patients' needs with multiple systems, including agencies, families, legal systems, and legislative bodies	Assertively advocates for patients' needs with multiple systems, including agencies, families, legal systems, and legislative bodies	Assertively advocates for patients' needs with multiple systems, including agencies, families, legal systems, and legislative bodies

Engages in advocacy in support of resource development	Not usually	Usually in the context of specific patient needs	Advocates for needed resources or may create resources	Usually in the context of specific patient needs
Provides direct services related to resource acquisition (e.g., drop-in center, employment counseling)	Provides referral to resources that provide direct services	Helps prepare patient to acquire resources (e.g., by role-playing, accompanying patient to interviews)	Provides many direct services within a unified package of treatment/case management	Provides services that are part of a rehabilitation services plan; offers skill teaching

FACTORS UNDERLYING THE INCREASED USE OF CASE MANAGEMENT FOR PATIENTS WITH SUD

Reasons behind the increasing use of case managers in SUD treatment programs include the following:

Many patients with SUDs have co-occurring mental disorders and comorbid conditions that providers recognize need concurrent treatment. For example, in 2019, 9.5 million adults had both an SUD and a co-occurring mental illness, and of these individuals 3.6 million had a serious mental illness (SAMHSA, 2020b). Common comorbid diseases include cardiovascular disease, hepatitis, and HIV/AIDS (National Institute on Drug Abuse, 2020). The services of a case manager become especially important for patients with an SUD who must navigate complex health systems to obtain treatment for all their psychiatric and medical care needs or who must adhere to a medication regimen that may involve multiple prescriptions from one or more care providers. In such an instance, the case manager must be familiar with the patient's full medication regimen (National Council for Behavioral Health, 2020).

Programs increasingly recognize that helping patients address basic needs, as determined by a comprehensive SDOH assessment, is essential to treatment (American Public Health Association, 2014). For example, based on needs identified in the comprehensive SDOH assessment, case managers may help patients apply for Medicare, obtain transportation vouchers, or receive housing assistance so that they are better positioned to engage in and benefit from treatment. (See Chapter 5 of TIP 27 for strategies on assisting special needs populations.)

The rate of acute health crises related to drug use continues to increase. Since 1999, U.S. deaths from opioid, other drug, and polysubstance use have trended upward (Centers for Disease Control and Prevention [CDC], 2019), increasing by 10 percent from March 2019 to March 2020 (Ahmad et al., 2020). The numbers of nonfatal overdoses, hospitalizations, and emergency department visits have also increased considerably (AHRQ, 2019, 2020; Vivolo-Kantor et al., 2020; Weiss et al., 2017). For people who enter the health system through emergency services for an SUD-related crisis, case managers can help access follow-up services and care (Sortedahl et al., 2018). For example, a hospital case manager can help coordinate a drug transition plan for a patient with pain seen in the emergency department for prescription opioid overdose. Often, peer recovery support specialists are embedded in these medical settings to help assist with the initial case management needs of patients with an SUD. These specialists have lived experience with recovery and are trained to help patients with SUDs engage in treatment and enter long-term recovery.

Multiple developments in healthcare and behavioral health services are expanding the use of case management (Ahmed, 2016). These include:

- More emphasis on medical and behavioral health integration, which creates a need for coordination of services—a need that case managers can fulfill.
- Greater use of screening, brief intervention, and referral to treatment (SBIRT) tools in care settings, which can involve case managers in implementation, follow-up, and coordination of care.
- Growing adoption of reimbursement for chronic care management and value-based care by Medicare and other insurers; case managers may be involved in monitoring, measuring, and evaluating outcomes achieved by the care team (Tahan et al., 2020).
- The development of health information technology solutions that facilitate care coordination and patient-centered care.
- Increased use of peer recovery support specialists, who can cost effectively extend the services of case managers by guiding people in SUD treatment on their journey through recovery-oriented systems of care (prevention, intervention, treatment, post-treatment).
- Recent changes to the federal regulations governing the confidentiality of SUD patient records that make it easier to use information in such records for case management and care coordination activities (SAMHSA, 2020a).
- The movement of health systems toward a population-based approach to behavioral health care and a systems-wide focus on health equity, cultural competence, and cultural responsiveness. Case managers may participate in community health assessments (CDC, n.d.), and they may also help educate the treatment team about how addressing SDOH can contribute to greater health equity and therefore better health.

Case management services can benefit the individual who needs short-term help in connecting to SUD treatment, or some specific ancillary service that facilitates access to treatment (e.g., transportation, child care). However, case management is especially helpful for people with complex or chronic health and social services needs. Ideally, case management supports the philosophy of "no wrong door." This means that however people enter the healthcare and social services system (whether through the emergency department, a law enforcement encounter, hospitalization, a prevention program, an initial visit to a treatment program, a primary care visit, a shelter stay, or some other entry point), a case manager links them with the range of services they want or need.

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CHAPTER 17.

FINDING QUALITY TREATMENT FOR SUBSTANCE USE DISORDERS

This fact sheet, published by the Substance Abuse and Mental Health Services Administration, serves as a guide for individuals seeking behavioral health treatment. It provides three necessary steps to complete prior to utilizing a treatment center and the five signs of a quality treatment center, which include a review of the accreditation, medication, evidence-based practices, position on the role of families, and support networks.

THREE STEPS TO ACCESSING CARE

1. **If you have insurance:** Contact your insurer. Ask about your coverage and whether they have a network of preferred providers for you to use.
   If you don't have insurance: Each state has funding to provide treatment for people without insurance coverage. Find where to call for information about payment for services at: samhsa.gov/sites/default/files/ssa-directory.pdf
2. Review the websites of the providers and see if they have the **five signs of quality treatment detailed below.**
3. Call for an appointment. If they can't see you or your family member **within 48 hours**, find another provider. One indicator of quality is the ability to get an appointment quickly. Many programs offer walk-in services. Look for programs that can get you or a family member into treatment quickly.

TREATMENT LOCATORS

Substance Use and Mental Health Treatment Locator:

findtreatment.samhsa.gov

1-800-662-HELP (4357)

1-800-487-4899 (TTY)

Alcohol Treatment Navigator:

alcoholtreatment.niaaa.nih.gov

FIVE SIGNS OF QUALITY TREATMENT

You can use these questions to help decide about the quality of a treatment provider and the types

of services offered. Quality programs should offer a full range of services accepted as effective in treatment and recovery from substance use disorders and should be matched to a person's needs.

1. **Accreditation:** Has the program been licensed or certified by the state? Is the program currently in good standing in the state? Are the staff qualified? Good quality programs will have a good inspection record and both the program and the staff should have received training in treatment of substance use and mental disorders and be licensed or registered in the state. Does the program conduct satisfaction surveys? Can they show you how people using their services have rated them?
2. **Medication:** Does the program offer FDA-approved medication for recovery from alcohol and opioid use disorders? At this point in time, there are no FDA-approved medications to help to prevent relapse from other problem substances.
3. **Evidence-Based Practices:** Does the program offer treatments that have been proven to be effective in treating substance use disorders, including medication management therapies, motivational therapy, cognitive behavioral therapy, drug and alcohol counseling, education about the risks of drug and alcohol use, and peer support? Does the program either provide or help to obtain medical care for physical health issues?
4. **Families:** Does the program include family members in the treatment process? Family members have an important role in understanding the impact of addiction on families and providing support.
5. **Supports:** Does the program provide ongoing treatment and supports beyond just treating the substance issues? For many people, addiction is a chronic condition and requires ongoing medication and supports. Quality programs provide treatment for the long term, which may include ongoing counseling or recovery coaching and support, and helps in meeting other basic needs like sober housing, employment supports, and continued family involvement.

FOR A DRUG OR ALCOHOL USE EMERGENCY, CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM

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=278#h5p-13

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Substance Abuse and Mental Health Services Administration. (2018). Finding Quality Treatment for Substance Use Disorders. Fact Sheet.

CHAPTER 18.

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 19.

CLINICAL SUPERVISION AND PROFESSIONAL DEVELOPMENT OF THE SUBSTANCE ABUSE COUNSELOR

INTRODUCTION

Clinical supervision is emerging as the crucible in which counselors acquire knowledge and skills for the substance abuse treatment profession, providing a bridge between the classroom and the clinic. Supervision is necessary in the substance abuse treatment field to improve client care, develop the professionalism of clinical personnel, and impart and maintain ethical standards in the field. In recent years, especially in the substance abuse field, clinical supervision has become the cornerstone of quality improvement and assurance.

Your role and skill set as a clinical supervisor are distinct from those of counselor and administrator. Quality clinical supervision is founded on a positive supervisor–supervisee relationship that promotes client welfare and the professional development of the supervisee. You are a teacher, coach, consultant, mentor, evaluator, and administrator; you provide support, encouragement, and education to staff while addressing an array of psychological, interpersonal, physical, and spiritual issues of clients. Ultimately, effective clinical supervision ensures that clients are competently served. Supervision ensures that counselors continue to increase their skills, which in turn increases treatment effectiveness, client retention, and staff satisfaction. The clinical supervisor also serves as liaison between administrative and clinical staff.

This TIP focuses primarily on the teaching, coaching, consulting, and mentoring functions of clinical supervisors. Supervision, like substance abuse counseling, is a profession in its own right, with its own theories, practices, and standards. The profession requires knowledgeable, competent, and skillful individuals who are appropriately credentialed both as counselors and supervisors.

Definitions

This document builds on and makes frequent reference to CSAT's Technical Assistance Publication (TAP), *Competencies for Substance Abuse Treatment Clinical Supervisors* (TAP 21-A; CSAT, 2007). The clinical supervision competencies identify those responsibilities and activities that define the work of the clinical supervisor. This TIP provides guidelines and tools for the effective delivery of clinical supervision in substance abuse treatment settings. TAP 21-A is a companion volume to TAP 21, *Addiction Counseling Competencies* (CSAT, 2006), which is another useful tool in supervision.

The perspective of this TIP is informed by the following two definitions of supervision:

- "Supervision is a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical, and supportive" (Powell & Brodsky, 2004, p. 11). "Supervision is an intervention provided by a senior member of a profession to a more junior member or members. … This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional

functioning of the more junior person(s); monitoring the quality of professional services offered to the clients that she, he, or they see; and serving as a gatekeeper of those who are to enter the particular profession" (Bernard & Goodyear, 2004, p. 8).

- Supervision is "a social influence process that occurs over time, in which the supervisor participates with supervisees to ensure quality of clinical care. Effective supervisors observe, mentor, coach, evaluate, inspire, and create an atmosphere that promotes self-motivation, learning, and professional development. They build teams, create cohesion, resolve conflict, and shape agency culture, while attending to ethical and diversity issues in all aspects of the process. Such supervision is key to both quality improvement and the successful implementation of consensus- and evidence-based practices" (CSAT, 2007, p. 3).

Rationale

For hundreds of years, many professions have relied on more senior colleagues to guide less experienced professionals in their crafts. This is a new development in the substance abuse field, as clinical supervision was only recently acknowledged as a discrete process with its own concepts and approaches.

As a supervisor to the client, counselor, and organization, the significance of your position is apparent in the following statements:

- Organizations have an obligation to ensure quality care and quality improvement of all personnel. The first aim of clinical supervision is to ensure quality services and to protect the welfare of clients.
- Supervision is the right of all employees and has a direct impact on workforce development and staff and client retention.
- You oversee the clinical functions of staff and have a legal and ethical responsibility to ensure quality care to clients, the professional development of counselors, and maintenance of program policies and procedures.
- Clinical supervision is how counselors in the field learn. In concert with classroom education, clinical skills are acquired through practice, observation, feedback, and implementation of the recommendations derived from clinical supervision.

Functions of a Clinical Supervisor

You, the clinical supervisor, wear several important "hats." You facilitate the integration of counselor self-awareness, theoretical grounding, and development of clinical knowledge and skills; and you improve functional skills and professional practices. These roles often overlap and are fluid within the context of the supervisory relationship. Hence, the supervisor is in a unique position as an advocate for the agency, the counselor, and the client. You are the primary link between administration and front line staff, interpreting and monitoring compliance with agency goals, policies, and procedures and communicating staff and client needs to administrators. Central to the supervisor's function is the alliance between the supervisor and supervisee (Rigazio-DiGilio, 1997).

As shown in Figure 19.1, your roles as a clinical supervisor in the context of the supervisory relationship include:

- **Teacher**: Assist in the development of counseling knowledge and skills by identifying learning needs, determining counselor strengths, promoting self-awareness, and transmitting knowledge for practical use and professional growth. Supervisors are teachers, trainers, and professional role models.
- **Consultant**: Bernard and Goodyear (2004) incorporate the supervisory consulting role of case consultation and review, monitoring performance, counseling the counselor regarding job performance, and assessing counselors. In this role, supervisors also provide alternative case conceptualizations, oversight of counselor work to achieve mutually agreed upon goals, and professional gatekeeping for the organization and discipline (e.g., recognizing and addressing counselor impairment).
- **Coach**: In this supportive role, supervisors provide morale building, assess strengths and needs, suggest varying clinical approaches, model, cheerlead, and prevent burnout. For entry-level counselors, the supportive function is critical.
- **Mentor/Role Model**: The experienced supervisor mentors and teaches the supervisee through role modeling, facilitates the counselor's overall professional development and sense of professional identity, and trains the next generation of supervisors.

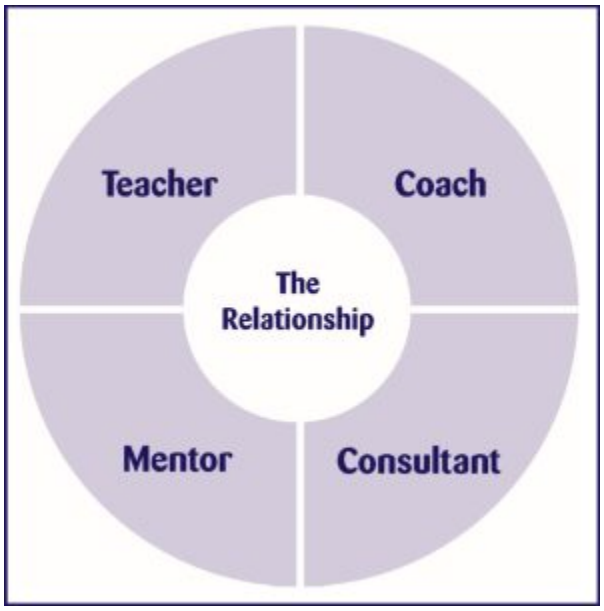

Figure 19.1. Roles of the Clinical Supervisor.

CENTRAL PRINCIPLES OF CLINICAL SUPERVISION

The Consensus Panel for this TIP has identified central principles of clinical supervision. Although the Panel recognizes that clinical supervision can initially be a costly undertaking for many financially strapped programs, the Panel believes that ultimately clinical supervision is a cost-saving process. Clinical supervision enhances the quality of client care; improves efficiency of counselors in direct and indirect services; increases workforce satisfaction, professionalization, and retention; and ensures that services provided to the public uphold legal mandates and ethical standards of the profession.

The central principles identified by the Consensus Panel are:

1. **Clinical supervision is an essential part of all clinical programs.**Clinical supervision is a central organizing activity that integrates the program mission, goals, and treatment philosophy with clinical theory and evidence-based practices (EBPs). The primary reasons for clinical supervision are to ensure (1) quality client care, and (2) clinical staff continue professional development in a systematic and planned manner. In substance abuse treatment, clinical supervision is the primary means of determining the quality of care provided.
2. **Clinical supervision enhances staff retention and morale.** Staff turnover and workforce development are major concerns in the substance abuse treatment field. Clinical supervision is a primary means of improving workforce retention and job satisfaction (see, for example, Roche, Todd, & O'Connor, 2007).
3. **Every clinician, regardless of level of skill and experience, needs and has a right to clinical supervision. In addition, supervisors need and have a right to supervision of their supervision.** Supervision needs to be tailored to the knowledge base, skills, experience, and assignment of each counselor. All staff need supervision, but the frequency and intensity of the oversight and training will depend on the role, skill level, and competence of the individual. The benefits that come with years of experience are enhanced by quality clinical supervision.
4. **Clinical supervision needs the full support of agency administrators.**Just as treatment programs want clients to be in an atmosphere of growth and openness to new ideas, counselors should be in an environment where learning and professional development and opportunities are valued and provided for all staff.
5. **The supervisory relationship is the crucible in which ethical practice is developed and reinforced.** The supervisor needs to model sound ethical and legal practice in the supervisory relationship. This is where issues of ethical practice arise and can be addressed. This is where ethical practice is translated from a concept to a set of behaviors. Through supervision, clinicians can develop a process of ethical decision-making and use this process as they encounter new situations.
6. **Clinical supervision is a skill in and of itself that has to be developed.** Good counselors tend to be promoted into supervisory positions with the assumption that they have the requisite skills to provide professional clinical supervision. However, clinical supervisors need a different role orientation toward both program and client goals and a knowledge base to complement a new set of skills. Programs need to increase their capacity to develop good supervisors.
7. **Clinical supervision in substance abuse treatment most often requires balancing administrative and clinical supervision tasks.** Sometimes these roles are complementary and sometimes they conflict. Often the supervisor feels caught between the two roles. Administrators need to support the integration and differentiation of the roles to promote the efficacy of the clinical supervisor.
8. **Culture and other contextual variables influence the supervision process; supervisors need to continually strive for cultural competence.** Supervisors require cultural competence at several levels. Cultural competence involves the counselor's response to clients, the supervisor's response to counselors, and the program's response to the cultural needs of

the diverse community it serves. Since supervisors are in a position to serve as catalysts for change, they need to develop proficiency in addressing the needs of diverse clients and personnel.

9. **Successful implementation of EBPs requires ongoing supervision.** Supervisors have a role in determining which specific EBPs are relevant for an organization's clients (Lindbloom, Ten Eyck, & Gallon, 2005). Supervisors ensure that EBPs are successfully integrated into ongoing programmatic activities by training, encouraging, and monitoring counselors. Excellence in clinical supervision should provide greater adherence to the EBP model. Because state funding agencies now often require substance abuse treatment organizations to provide EBPs, supervision becomes even more important.
10. **Supervisors have the responsibility to be gatekeepers for the profession.** Supervisors are responsible for maintaining professional standards, recognizing and addressing impairment, and safeguarding the welfare of clients. More than anyone else in an agency, supervisors can observe counselor behavior and respond promptly to potential problems, including counseling some individuals out of the field because they are ill-suited to the profession. This "gatekeeping" function is especially important for supervisors who act as field evaluators for practicum students prior to their entering the profession. Finally, supervisors also fulfill a gatekeeper role in performance evaluation and in providing formal recommendations to training institutions and credentialing bodies.
11. **Clinical supervision should involve direct observation methods.** Direct observation should be the standard in the field because it is one of the most effective ways of building skills, monitoring counselor performance, and ensuring quality care. Supervisors require training in methods of direct observation, and administrators need to provide resources for implementing direct observation. Although small substance abuse agencies might not have the resources for one-way mirrors or videotaping equipment, other direct observation methods can be employed (see the section on methods of observation, below).

GUIDELINES FOR NEW SUPERVISORS

Congratulations on your appointment as a supervisor! By now you might be asking yourself a few questions: What have I done? Was this a good career decision? There are many changes ahead. If you have been promoted from within, you'll encounter even more hurdles and issues. First, it is important to face that your life has changed. You might experience the loss of friendship of peers. You might feel that you knew what to do as a counselor, but feel totally lost with your new responsibilities. You might feel less effective in your new role. Supervision can be an emotionally draining experience, as you now have to work with more staff-related interpersonal and human resources issues.

Before your promotion to clinical supervisor, you might have felt confidence in your clinical skills. Now you might feel unprepared and wonder if you need a training course for your new role. If you feel this way, you're right. Although you are a good counselor, you do not necessarily possess all the skills needed to be a good supervisor. Your new role requires a new body of knowledge and different skills, along with the ability to use your clinical skills in a different way. Be confident that you will acquire these skills over time and that you made the right decision to accept your new position.

Suggestions for new supervisors:

- Quickly learn the organization's policies and procedures and human resources procedures (e.g., hiring and firing, affirmative action requirements, format for conducting meetings, giving feedback, and making evaluations). Seek out this information as soon as possible through the human resources department or other resources within the organization.
- Ask for a period of 3 months to allow you to learn about your new role. During this period, do not make any changes in policies and procedures but use this time to find your managerial voice and decision-making style.
- Take time to learn about your supervisees, their career goals, interests, developmental objectives, and perceived strengths.
- Work to establish a contractual relationship with supervisees, with clear goals and methods of supervision.
- Learn methods to help staff reduce stress, address competing priorities, resolve staff conflict, and other interpersonal issues in the workplace.
- Obtain training in supervisory procedures and methods.
- Find a mentor, either internal or external to the organization.
- Shadow a supervisor you respect who can help you learn the ropes of your new job.
- Ask often and as many people as possible, "How am I doing?" and "How can I improve my performance as a clinical supervisor?"
- Ask for regular, weekly meetings with your administrator for training and instruction.
- Seek supervision of your supervision.

Problems and Resources

As a supervisor, you may encounter a broad array of issues and concerns, ranging from working within a system that does not fully support clinical supervision to working with resistant staff. A comment often heard in supervision training sessions is "My boss should be here to learn what is expected in supervision," or "This will never work in my agency's bureaucracy. They only support billable activities." The work setting is where you apply the principles and practices of supervision and where organizations are driven by demands, such as financial solvency, profit, census, accreditation, and concerns over litigation. Therefore, you will need to be practical when beginning your new role as a supervisor: determine how you can make this work within your unique work environment.

Working With Staff Who Are Resistant to Supervision

Some of your supervisees may have been in the field longer than you have and see no need for supervision. Other counselors, having completed their graduate training, do not believe they need further supervision, especially not from a supervisor who might have less formal academic education than they have. Other resistance might come from ageism, sexism, racism, or classism. Particular to the field of substance abuse treatment may be the tension between those who believe that recovery from substance abuse is necessary for this counseling work and those who do not believe this to be true.

In addressing resistance, you must be clear regarding what your supervision program entails

and must consistently communicate your goals and expectations to staff. To resolve defensiveness and engage your supervisees, you must also honor the resistance and acknowledge their concerns. Abandon trying to push the supervisee too far, too fast. Resistance is an expression of ambivalence about change and not a personality defect of the counselor. Instead of arguing with or exhorting staff, sympathize with their concerns, saying, "I understand this is difficult. How are we going to resolve these issues?"

When counselors respond defensively or reject directions from you, try to understand the origins of their defensiveness and to address their resistance. Self-disclosure by the supervisor about experiences as a supervisee, when appropriately used, may be helpful in dealing with defensive, anxious, fearful, or resistant staff. Work to establish a healthy, positive supervisory alliance with staff. Because many substance abuse counselors have not been exposed to clinical supervision, you may need to train and orient the staff to the concept and why it is important for your agency.

Things a New Supervisor Should Know

Eight truths a beginning supervisor should commit to memory are listed below:

1. The reason for supervision is to ensure quality client care. As stated throughout this TIP, the primary goal of clinical supervision is to protect the welfare of the client and ensure the integrity of clinical services.>
2. Supervision is all about the relationship. As in counseling, developing the alliance between the counselor and the supervisor is the key to good supervision.
3. Culture and ethics influence all supervisory interactions. Contextual factors, culture, race, and ethnicity all affect the nature of the supervisory relationship. Some models of supervision (e.g., Holloway, 1995) have been built primarily around the role of context and culture in shaping supervision.
4. Be human and have a sense of humor. As role models, you need to show that everyone makes mistakes and can admit to and learn from these mistakes.
5. Rely first on direct observation of your counselors and give specific feedback. The best way to determine a counselor's skills is to observe him or her and to receive input from the clients about their perceptions of the counseling relationship.
6. Have and practice a model of counseling and of supervision; have a sense of purpose. Before you can teach a supervisee knowledge and skills, you must first know the philosophical and theoretical foundations on which you, as a supervisor, stand. Counselors need to know what they are going to learn from you, based on your model of counseling and supervision.
7. Make time to take care of yourself spiritually, emotionally, mentally, and physically. Again, as role models, counselors are watching your behavior. Do you "walk the talk" of self-care?
8. You have a unique position as an advocate for the agency, the counselor, and the client. As a supervisor, you have a wonderful opportunity to assist in the skill and professional development of your staff, advocating for the best interests of the supervisee, the client, and your organization.

MODELS OF CLINICAL SUPERVISION

You may never have thought about your model of supervision. However, it is a fundamental premise of this TIP that you need to work from a defined model of supervision and have a sense of purpose in your oversight role. Four supervisory orientations seem particularly relevant. They include:

- Competency-based models.
- Treatment-based models.
- Developmental approaches.
- Integrated models.

Competency-based models (e.g., microtraining, the Discrimination Model [Bernard & Goodyear, 2004], and the Task-Oriented Model [Mead, 1990], focus primarily on the skills and learning needs of the supervisee and on setting goals that are **s**pecific, **m**easurable, **a**ttainable, **r**ealistic, and **t**imely (SMART). They construct and implement strategies to accomplish these goals. The key strategies of competency-based models include applying social learning principles (e.g., modeling role reversal, role playing, and practice), using demonstrations, and using various supervisory functions (teaching, consulting, and counseling).

Treatment-based supervision models train to a particular theoretical approach to counseling, incorporating EBPs into supervision and seeking fidelity and adaptation to the theoretical model. Motivational interviewing, cognitive–behavioral therapy, and psychodynamic psychotherapy are three examples. These models emphasize the counselor's strengths, seek the supervisee's understanding of the theory and model taught, and incorporate the approaches and techniques of the model. The majority of these models begin with articulating their treatment approach and describing their supervision model, based upon that approach.

Developmental models, such as Stoltenberg and Delworth (1987), understand that each counselor goes through different stages of development and recognize that movement through these stages is not always linear and can be affected by changes in assignment, setting, and population served. (The developmental stages of counselors and supervisors are described in detail below).

Integrated models, including the Blended Model, begin with the style of leadership and articulate a model of treatment, incorporate descriptive dimensions of supervision (see below), and address contextual and developmental dimensions into supervision. They address both skill and competency development and affective issues, based on the unique needs of the supervisee and supervisor. Finally, integrated models seek to incorporate EBPs into counseling and supervision.

In all models of supervision, it is helpful to identify culturally or contextually centered models or approaches and find ways of tailoring the models to specific cultural and diversity factors. Issues to consider are:

- Explicitly addressing diversity of supervisees (e.g., race, ethnicity, gender, age, sexual orientation) and the specific factors associated with these types of diversity;
- Explicitly involving supervisees' concerns related to particular client diversity (e.g., those whose culture, gender, sexual orientation, and other attributes differ from those of the supervisee) and addressing specific factors associated with these types of diversity; and
- Explicitly addressing supervisees' issues related to effectively navigating services in

intercultural communities and effectively networking with agencies and institutions.

It is important to identify your model of counseling and your beliefs about change, and to articulate a workable approach to supervision that fits the model of counseling you use. Theories are conceptual frameworks that enable you to make sense of and organize your counseling and supervision and to focus on the most salient aspects of a counselor's practice. You may find some of the questions below to be relevant to both supervision and counseling. The answers to these questions influence both how you supervise and how the counselors you supervise work:

- What are your beliefs about how people change in both treatment and clinical supervision?
- What factors are important in treatment and clinical supervision?
- What universal principles apply in supervision and counseling and which are unique to clinical supervision?
- What conceptual frameworks of counseling do you use (for instance, cognitive–behavioral therapy, 12-Step facilitation, psychodynamic, behavioral)?
- What are the key variables that affect outcomes? (Campbell, 2000)

According to Bernard and Goodyear (2004) and Powell and Brodsky (2004), the qualities of a good model of clinical supervision are:

- Rooted in the individual, beginning with the supervisor's self, style, and approach to leadership
- Precise, clear, and consistent.
- Comprehensive, using current scientific and evidence-based practices.
- Operational and practical, providing specific concepts and practices in clear, useful, and measurable terms.
- Outcome-oriented to improve counselor competence; make work manageable; create a sense of mastery and growth for the counselor; and address the needs of the organization, the supervisor, the supervisee, and the client.

Finally, it is imperative to recognize that, whatever model you adopt, it needs to be rooted in the learning and developmental needs of the supervisee, the specific needs of the clients they serve, the goals of the agency in which you work, and in the ethical and legal boundaries of practice. These four variables define the context in which effective supervision can take place.

DEVELOPMENTAL STAGES OF COUNSELORS

Counselors are at different stages of professional development. Thus, regardless of the model of supervision you choose, you must take into account the supervisee's level of training, experience, and proficiency. Different supervisory approaches are appropriate for counselors at different stages of development. An understanding of the supervisee's (and supervisor's) developmental needs is an essential ingredient for any model of supervision.

Various paradigms or classifications of developmental stages of clinicians have been developed (Ivey, 1997; Rigazio-DiGilio, 1997; Skolvolt & Ronnestrand, 1992; Todd and Storn, 1997). This TIP

has adopted the Integrated Developmental Model (IDM) of Stoltenberg, McNeill, and Delworth (1998). This schema uses a three-stage approach. The three stages of development have different characteristics and appropriate supervisory methods. Further application of the IDM to the substance abuse field is needed. (For additional information, see Anderson, 2001.)

Figure 19.2. Counselor Development Model

Developmental Level	Characteristics	Supervision Skills Development Needs	Techniques
Level 1	• Focuses on self • Anxious, uncertain • Preoccupied with performing the right way • Overconfident of skills • Overgeneralizes • Overuses a skill • Gap between conceptualization, goals, and interventions • Ethics underdeveloped	• Provide structure and minimize anxiety • Supportive, address strengths first, then weaknesses • Suggest approaches • Start connecting theory to treatment	• Observation • Skills training • Role playing • Readings • Group supervision • Closely monitor clients
Level 2	• Focuses less on self and more on client • Confused, frustrated with complexity of counseling • Overidentifies with client • Challenges authority • Lacks integration with theoretical base • Overburdened • Ethics better understood	• Less structure provided, more autonomy encouraged • Supportive • Periodic suggestion of approaches • Confront discrepancies • Introduce more alternative views • Process comments, highlight countertransference • Affective reactions to client and/or supervisor	• Observation • Role playing • Interpret dynamics • Group supervision • Reading
Level 3	• Focuses intently on client • High degree of empathic skill • Objective third person perspective • Integrative thinking and approach • Highly responsible and ethical counselor	• Supervisee directed • Focus on personal-professional integration and career • SupportiveChange agent	• Peer supervision • Group supervision • Reading

Source: Stoltenberg, Delworth, & McNeil, 1998

It is important to keep in mind several general cautions and principles about counselor development, including:

- There is a beginning but not an end point for learning clinical skills; be careful of counselors who think they "know it all."
- Take into account the individual learning styles and personalities of your supervisees and fit the supervisory approach to the developmental stage of each counselor.
- There is a logical sequence to development, although it is not always predictable or rigid; some counselors may have been in the field for years, but remain at an early stage of professional development, whereas others may progress quickly through the stages.
- Counselors at an advanced developmental level have different learning needs and require different supervisory approaches from those at Level 1; and
- The developmental level can be applied for different aspects of a counselor's overall competence (e.g., Level 2 mastery for individual counseling and Level 1 for couples counseling).

DEVELOPMENTAL STAGES OF SUPERVISORS

Just as counselors go through stages of development, so do supervisors. The developmental model presented in figure 19.3 provides a framework to explain why supervisors act as they do, depending on their developmental stage. It would be expected that someone new to supervision would be at a Level 1 as a supervisor. However, supervisors should be at least at the second or third stage of counselor development. If a newly appointed supervisor is still at Level 1 as a counselor, he or she will have little to offer to more seasoned supervisees.

Figure 19.3. Supervisor Development Model

Developmental Level	Characteristics	To Increase Supervision Competence
Level 1	• Is anxious regarding role • Is näive about assuming the role of supervisor • Is focused on doing the "right" thing • May overly respond as an "expert" • Is uncomfortable providing direct feedback	• Follow structure and formats • Design systems to increase organization of supervision • Assign Level I counselors
Level 2	• Shows confusion and conflict • Sees supervision as complex and multidimensional • Needs support to maintain motivation • Overfocused on counselor's deficits and perceived resistance • May fall back to being a therapist with the counselor	• Provide active supervision of the supervision • Assign Level 1 counselors
Level 3	• Is highly motivated • Can provide an honest self-appraisal of strengths and weaknesses as supervisor • Is comfortable with evaluation process • Provides thorough, objective feedback	• Comfortable with all levels

CULTURAL AND CONTEXTUAL FACTORS

Culture is one of the major contextual factors that influence supervisory interactions. Other contextual variables include race, ethnicity, age, gender, discipline, academic background, religious and spiritual practices, sexual orientation, disability, and recovery versus non-recovery status. The relevant variables in the supervisory relationship occur in the context of the supervisor, supervisee, client, and the setting in which supervision occurs. More care should be taken to:

- Identify the competencies necessary for substance abuse counselors to work with diverse individuals and navigate intercultural communities.
- Identify methods for supervisors to assist counselors in developing these competencies.
- Provide evaluation criteria for supervisors to determine whether their supervisees have met minimal competency standards for effective and relevant practice.

Models of supervision have been strongly influenced by contextual variables and their influence on the supervisory relationship and process, such as Holloway's Systems Model (1995) and Constantine's Multicultural Model (2003).

The competencies listed in TAP 21-A reflect the importance of culture in supervision (CSAT, 2007). The Counselor Development domain encourages self-examination of attitudes toward culture and other contextual variables. The Supervisory Alliance domain promotes attention to these variables in the supervisory relationship. (See also the TIP, *Improving Cultural Competence in Substance Abuse Counseling* [CSAT, 2014].)

Cultural competence "refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a commitment and is achieved over time" (U.S. Department of Health and Human Services, 2003, p. 12). Culture shapes belief systems, particularly concerning issues related to mental health and substance abuse, as well as the manifestation of symptoms, relational styles, and coping patterns.

There are three levels of cultural consideration for the supervisory process: the issue of the culture of the client being served and the culture of the counselor in supervision. Holloway (1995) emphasizes the cultural issues of the agency, the geographic environment of the organization, and many other contextual factors. Specifically, there are three important areas in which cultural and contextual factors play a key role in supervision: in building the supervisory relationship or working alliance, in addressing the specific needs of the client, and in building supervisee competence and ability. It is your responsibility to address your supervisees' beliefs, attitudes, and biases about cultural and contextual variables to advance their professional development and promote quality client care.

Becoming culturally competent and able to integrate other contextual variables into supervision is a complex, long-term process. Cross (1989) has identified several stages on a continuum of becoming culturally competent (see figure 19.4).

Figure 19.4. Continuum of Cultural Competence

Cultural Destructiveness

Superiority of dominant culture and inferiority of other cultures; active discrimination

Cultural Incapacity

Separate but equal treatment; passive discrimination

Cultural Blindness

Sees all cultures and people as alike and equal; discrimination by ignoring culture

Cultural Openness (Sensitivity)

Basic understanding and appreciation of importance of sociocultural factors in work with minority populations

Cultural Competence

Capacity to work with more complex issues and cultural nuances

Cultural Proficiency

Highest capacity for work with minority populations; a commitment to excellence and proactive effort

Source: Cross, 1989.

Although you may never have had specialized training in multicultural counseling, some of your supervisees may have (see Constantine, 2003). Regardless, it is your responsibility to help supervisees build on the cultural competence skills they possess as well as to focus on their cultural competence deficits. It is important to initiate discussion of issues of culture, race, gender, sexual orientation, and

the like in supervision to model the kinds of discussion you would like counselors to have with their clients. If these issues are not addressed in supervision, counselors may come to believe that it is inappropriate to discuss them with clients and have no idea how such dialog might proceed. These discussions prevent misunderstandings with supervisees based on cultural or other factors. Another benefit from these discussions is that counselors will eventually achieve some level of comfort in talking about culture, race, ethnicity, and diversity issues.

If you haven't done it as a counselor, early in your tenure as a supervisor you will want to examine your culturally influenced values, attitudes, experiences, and practices and to consider what effects they have on your dealings with supervisees and clients. Counselors should undergo a similar review as preparation for when they have clients of a culture different from their own. Some questions to keep in mind are:

- What did you think when you saw the supervisee's last name?
- What did you think when the supervisee said his or her culture is X, when yours is Y?
- How did you feel about this difference?
- What did you do in response to this difference?

Constantine (2003) suggests that supervisors can use the following questions with supervisees:

- What demographic variables do you use to identify yourself?
- What worldviews (e.g., values, assumptions, and biases) do you bring to supervision based on your cultural identities?
- What struggles and challenges have you faced working with clients who were from different cultures than your own?

Beyond self-examination, supervisors will want continuing education classes, workshops, and conferences that address cultural competence and other contextual factors. Community resources, such as community leaders, elders, and healers, can contribute to your understanding of the culture your organization serves. Finally, supervisors (and counselors) should participate in multicultural activities, such as community events, discussion groups, religious festivals, and other ceremonies.

The supervisory relationship includes an inherent power differential, and it is important to pay attention to this disparity, particularly when the supervisee and the supervisor are from different cultural groups. A potential for the misuse of that power exists at all times but especially when working with supervisees and clients within multicultural contexts. When the supervisee is from a minority population and the supervisor is from a majority population, the differential can be exaggerated. You will want to prevent institutional discrimination from affecting the quality of supervision. The same is true when the supervisee is gay and the supervisor is heterosexual, or the counselor is non-degreed and the supervisor has an advanced degree, or a female supervisee with a male supervisor, and so on. In the reverse situations, where the supervisor is from the minority group and the supervisee from the majority group, the difference should be discussed as well.

ETHICAL AND LEGAL ISSUES

You are the organization's gatekeeper for ethical and legal issues. First, you are responsible for

upholding the highest standards of ethical, legal, and moral practices and for serving as a model of practice to staff. Further, you should be aware of and respond to ethical concerns. Part of your job is to help integrate solutions to everyday legal and ethical issues into clinical practice.

Some of the underlying assumptions of incorporating ethical issues into clinical supervision include:

- Ethical decision-making is a continuous, active process.
- Ethical standards are not a cookbook. They tell you what to do, not always how.
- Each situation is unique. Therefore, it is imperative that all personnel learn how to "think ethically" and how to make sound legal and ethical decisions.
- The most complex ethical issues arise in the context of two ethical behaviors that conflict; for instance, when a counselor wants to respect the privacy and confidentiality of a client, but it is in the client's best interest for the counselor to contact someone else about his or her care.
- Therapy is conducted by fallible beings; people make mistakes—hopefully, minor ones.
- Sometimes the answers to ethical and legal questions are elusive. Ask a dozen people, and you'll likely get twelve different points of view.

Helpful resources on legal and ethical issues for supervisors include Beauchamp and Childress (2001); Falvey (2002*b*); Gutheil and Brodsky (2008); Pope, Sonne, and Greene (2006); and Reamer (2006).

Legal and ethical issues that are critical to clinical supervisors include (1) vicarious liability (or respondeat superior), (2) dual relationships and boundary concerns, (4) informed consent, (5) confidentiality, and (6) supervisor ethics.

Direct Versus Vicarious Liability

An important distinction needs to be made between direct and vicarious liability. Direct liability of the supervisor might include dereliction of supervisory responsibility, such as "not making a reasonable effort to supervise" (defined below).

In vicarious liability, a supervisor can be held liable for damages incurred as a result of negligence in the supervision process. Examples of negligence include providing inappropriate advice to a counselor about a client (for instance, discouraging a counselor from conducting a suicide screen on a depressed client), failure to listen carefully to a supervisee's comments about a client, and the assignment of clinical tasks to inadequately trained counselors. The key legal question is: "Did the supervisor conduct him- or herself in a way that would be reasonable for someone in his position?" or "Did the supervisor make a reasonable effort to supervise?" A generally accepted time standard for a "reasonable effort to supervise" in the behavioral health field is 1 hour of supervision for every 20–40 hours of clinical services. Of course, other variables (such as the quality and content of clinical supervision sessions) also play a role in a reasonable effort to supervise.

Supervisory vulnerability increases when the counselor has been assigned too many clients, when there is no direct observation of a counselor's clinical work, when staff are inexperienced or poorly trained for assigned tasks, and when a supervisor is not involved or not available to aid the clinical staff. In legal texts, vicarious liability is referred to as "respondeat superior."

Dual Relationships and Boundary Issues

Dual relationships can occur at two levels: between supervisors and supervisees and between counselors and clients. You have a mandate to help your supervisees recognize and manage boundary issues. A dual relationship occurs in supervision when a supervisor has a primary professional role with a supervisee and, at an earlier time, simultaneously or later, engages in another relationship with the supervisee that transcends the professional relationship. Examples of dual relationships in supervision include providing therapy for a current or former supervisee, developing an emotional relationship with a supervisee or former supervisee, and becoming an Alcoholics Anonymous sponsor for a former supervisee. Obviously, there are varying degrees of harm or potential harm that might occur as a result of dual relationships, and some negative effects of dual relationships might not be apparent until later.

Therefore, firm, always-or-never rules aren't applicable. You have the responsibility of weighing with the counselor the anticipated and unanticipated effects of dual relationships, helping the supervisee's self-reflective awareness when boundaries become blurred, when he or she is getting close to a dual relationship, or when he or she is crossing the line in the clinical relationship.

Exploring dual relationship issues with counselors in clinical supervision can raise its own professional dilemmas. For instance, clinical supervision involves unequal status, power, and expertise between a supervisor and supervisee. Being the evaluator of a counselor's performance and gatekeeper for training programs or credentialing bodies also might involve a dual relationship. Further, supervision can have therapy-like qualities as you explore countertransferential issues with supervisees, and there is an expectation of professional growth and self-exploration. What makes a dual relationship unethical in supervision is the abusive use of power by either party, the likelihood that the relationship will impair or injure the supervisor's or supervisee's judgment, and the risk of exploitation.

The most common basis for legal action against counselors (20 percent of claims) and the most frequently heard complaint by certification boards against counselors (35 percent) is some form of boundary violation or sexual impropriety (Falvey, 2002*b*).

Codes of ethics for most professions clearly advise that dual relationships between counselors and clients should be avoided. Dual relationships between counselors and supervisors are also a concern and are addressed in the substance abuse counselor codes and those of other professions as well. Problematic dual relationships between supervisees and supervisors might include intimate relationships (sexual and non-sexual) and therapeutic relationships, wherein the supervisor becomes the counselor's therapist. Sexual involvement between the supervisor and supervisee can include sexual attraction, harassment, consensual (but hidden) sexual relationships, or intimate romantic relationships. Other common boundary issues include asking the supervisee to do favors, providing preferential treatment, socializing outside the work setting, and using emotional abuse to enforce power.

It is imperative that all parties understand what constitutes a dual relationship between supervisor and supervisee and avoid these dual relationships. Sexual relationships between supervisors and supervisees and counselors and clients occur far more frequently than one might realize (Falvey, 2002*b*). In many states, they constitute a legal transgression as well as an ethical violation.

Informed Consent

Informed consent is key to protecting the counselor and/or supervisor from legal concerns, requiring

the recipient of any service or intervention to be sufficiently aware of what is to happen, and of the potential risks and alternative approaches, so that the person can make an informed and intelligent decision about participating in that service. The supervisor must inform the supervisee about the process of supervision, the feedback and evaluation criteria, and other expectations of supervision. The supervision contract should clearly spell out these issues. Supervisors must ensure that the supervisee has informed the client about the parameters of counseling and supervision (such as the use of live observation or video- or audiotaping). A sample template for informed consent is provided in Part 2, chapter 2 (p. 106).

Confidentiality

In supervision, regardless of whether there is a written or verbal contract between the supervisor and supervisee, there is an implied contract and duty of care because of the supervisor's vicarious liability. Informed consent and concerns for confidentiality should occur at three levels: client consent to treatment, client consent to supervision of the case, and supervisee consent to supervision (Bernard & Goodyear, 2004). In addition, there is an implied consent and commitment to confidentiality by supervisors to assume their supervisory responsibilities and institutional consent to comply with legal and ethical parameters of supervision. (See also the Code of Ethics of the Association for Counselor Education and Supervision [ACES], available online at http://www.acesonline.net/members/supervision/.)

With informed consent and confidentiality comes a duty not to disclose certain relational communication. Limits of confidentiality of supervision session content should be stated in all organizational contracts with training institutions and credentialing bodies. Criteria for waiving client and supervisee privilege should be stated in institutional policies and discipline-specific codes of ethics and clarified by advice of legal counsel and the courts. Because standards of confidentiality are determined by state legal and legislative systems, it is prudent for supervisors to consult with an attorney to determine the state codes of confidentiality and clinical privileging.

In the substance abuse treatment field, confidentiality for clients is clearly defined by federal law: 42 CFR, Part 2 and the Health Insurance Portability and Accountability Act (HIPAA). Key information is available at http://www.hhs.gov/ocr/privacy/. Supervisors need to train counselors in confidentiality regulations and to adequately document their supervision, including discussions and directives, especially relating to duty-to-warn situations. Supervisors need to ensure that counselors provide clients with appropriate duty-to-warn information early in the counseling process and inform clients of the limits of confidentiality as part of the agency's informed consent procedures.

Under duty-to-warn requirements (e.g., child abuse, suicidal or homicidal ideation), supervisors need to be aware of and take action as soon as possible in situations in which confidentiality may need to be waived. Organizations should have a policy stating how clinical crises will be handled (Falvey, 2002*b*). What mechanisms are in place for responding to crises? In what timeframe will a supervisor be notified of a crisis situation? Supervisors must document all discussions with counselors concerning duty-to-warn and crises. At the onset of supervision, supervisors should ask counselors if there are any duty-to-warn issues of which the supervisor should be informed.

New technology brings new confidentiality concerns. Websites now dispense information about substance abuse treatment and provide counseling services. With the growth in online counseling and supervision, the following concerns emerge: (a) how to maintain confidentiality of information, (b) how to ensure the competence and qualifications of counselors providing online services, and (c) how

to establish reporting requirements and duty to warn when services are conducted across State and international boundaries. New standards will need to be written to address these issues. (The National Board for Certified Counselors has guidelines for counseling by Internet at https://www.matrc.org/wp-content/uploads/2023/09/NBCC-Policy-Regarding-Practice-of-Distance-Professional-Services-2016.pdf.)

Supervisor Ethics

In general, supervisors adhere to the same standards and ethics as substance abuse counselors with regard to dual relationship and other boundary violations. Supervisors will:

- Uphold the highest professional standards of the field.
- Seek professional help (outside the work setting) when personal issues interfere with their clinical and/or supervisory functioning.
- Conduct themselves in a manner that models and sets an example for agency mission, vision, philosophy, wellness, recovery, and consumer satisfaction.
- Reinforce zero tolerance for interactions that are not professional, courteous, and compassionate.
- Treat supervisees, colleagues, peers, and clients with dignity, respect, and honesty.
- Adhere to the standards and regulations of confidentiality as dictated by the field. This applies to the supervisory as well as the counseling relationship.

MONITORING PERFORMANCE

The goal of supervision is to ensure quality care for the client, which entails monitoring the clinical performance of staff. Your first step is to educate supervisees in what to expect from clinical supervision. Once the functions of supervision are clear, you should regularly evaluate the counselor's progress in meeting organizational and clinical goals as set forth in an Individual Development Plan (IDP) (see the section on IDPs below). As clients have an individual treatment plan, counselors also need a plan to promote skill development.

Behavioral Contracting in Supervision

Among the first tasks in supervision is to establish a contract for supervision that outlines realistic accountability for both yourself and your supervisee. The contract should be in writing and should include the purpose, goals, and objectives of supervision; the context in which supervision is provided; ethical and institutional policies that guide supervision and clinical practices; the criteria and methods of evaluation and outcome measures; the duties and responsibilities of the supervisor and supervisee; procedural considerations (including the format for taping and opportunities for live observation); and the supervisee's scope of practice and competence. The contract for supervision should state the rewards for fulfillment of the contract (such as clinical privileges or increased compensation), the length of supervision sessions, and sanctions for noncompliance by either the supervisee or supervisor. The agreement should be compatible with the developmental needs of the supervisee and address the obstacles to progress (lack of time, performance anxiety, resource limitations). Once a behavioral contract has been established, the next step is to develop an IDP.

Individual Development Plan

The IDP is a detailed plan for supervision that includes the goals that you and the counselor wish to address over a certain time period (perhaps 3 months). Each of you should sign and keep a copy of the IDP for your records. The goals are normally stated in terms of skills the counselor wishes to build or professional resources the counselor wishes to develop. These skills and resources are generally oriented to the counselor's job in the program or activities that would help the counselor develop professionally. The IDP should specify the timelines for change, the observation methods that will be employed, expectations for the supervisee and the supervisor, the evaluation procedures that will be employed, and the activities that will be expected to improve knowledge and skills. An example of an IDP is provided in Part 2, chapter 2 (p. 122).

As a supervisor, you should have your own IDP, based on the supervisory competencies listed in TAP 21-A (CSAT, 2007), that addresses your training goals. This IDP can be developed in cooperation with your supervisor, or in external supervision, peer input, academic advisement, or mentorship.

Evaluation of Counselors

Supervision inherently involves evaluation, building on a collaborative relationship between you and the counselor. Evaluation may not be easy for some supervisors. Although everyone wants to know how they are doing, counselors are not always comfortable asking for feedback. And, as most supervisors prefer to be liked, you may have difficulty giving clear, concise, and accurate evaluations to staff.

The two types of evaluation are formative and summative. A formative evaluation is an ongoing status report of the counselor's skill development, exploring the questions "Are we addressing the skills or competencies you want to focus on?" and "How do we assess your current knowledge and skills and areas for growth and development?"

Summative evaluation is a more formal rating of the counselor's overall job performance, fitness for the job, and job rating. It answers the question, "How does the counselor measure up?" Typically, summative evaluations are done annually and focus on the counselor's overall strengths, limitations, and areas for future improvement.

It should be acknowledged that supervision is inherently an unequal relationship. In most cases, the supervisor has positional power over the counselor. Therefore, it is important to establish clarity of purpose and a positive context for evaluation. Procedures should be spelled out in advance, and the evaluation process should be mutual, flexible, and continuous. The evaluation process inevitably brings up supervisee anxiety and defensiveness that need to be addressed openly. It is also important to note that each individual counselor will react differently to feedback; some will be more open to the process than others.

There has been considerable research on supervisory evaluation, with these findings:

- The supervisee's confidence and efficacy are correlated with the quality and quantity of feedback the supervisor gives to the supervisee (Bernard & Goodyear, 2004).
- Ratings of skills are highly variable between supervisors, and often the supervisor's and supervisee's ratings differ or conflict (Eby, 2007).
- Good feedback is provided frequently, clearly, and consistently and is SMART (specific, measurable, attainable, realistic, and timely) (Powell & Brodsky, 2004).

Direct observation of the counselor's work is the desired form of input for the supervisor. Although direct observation has historically been the exception in substance abuse counseling, ethical and legal considerations and evidence support that direct observation as preferable. The least desirable feedback is unannounced observation by supervisors followed by vague, perfunctory, indirect, or hurtful delivery (Powell & Brodsky, 2004).

Clients are often the best assessors of the skills of the counselor. Supervisors should routinely seek input from the clients as to the outcome of treatment. The method of seeking input should be discussed in the initial supervisory sessions and be part of the supervision contract. In a residential substance abuse treatment program, you might regularly meet with clients after sessions to discuss how they are doing, how effective the counseling is, and the quality of the therapeutic alliance with the counselor. (For examples of client satisfaction or input forms, search for Client-Directed Outcome-Informed Treatment and Training Materials at http://www.goodtherapy.org/client-directed-outcome-informed-therapy.html)

Before formative evaluations begin, methods of evaluating performance should be discussed, clarified in the initial sessions, and included in the initial contract so that there will be no surprises. Formative evaluations should focus on changeable behavior and, whenever possible, be separate from the overall annual performance appraisal process. To determine the counselor's skill development, you should use written competency tools, direct observation, counselor self-assessments, client evaluations, work samples (files and charts), and peer assessments. Examples of work samples and peer assessments can be found in Bernard and Goodyear (2004), Powell and Brodsky (2004), and Campbell (2000). It is important to acknowledge that counselor evaluation is essentially a subjective process involving supervisors' opinions of the counselors' competence.

Addressing Burnout and Compassion Fatigue

Did you ever hear a counselor say, "I came into counseling for the right reasons. At first I loved seeing clients. But the longer I stay in the field, the harder it is to care. The joy seems to have gone out of my job. Should I get out of counseling as many of my colleagues are doing?" Most substance abuse counselors come into the field with a strong sense of calling and the desire to be of service to others, with a strong pull to use their gifts and make themselves instruments of service and healing. The substance abuse treatment field risks losing many skilled and compassionate healers when the life goes out of their work. Some counselors simply withdraw, care less, or get out of the field entirely. Most just complain or suffer in silence. Given the caring and dedication that brings counselors into the field, it is important for you to help them address their questions and doubts. (See Lambie, 2006, and Shoptaw, Stein, & Rawson, 2000.)

You can help counselors with self-care; help them look within; become resilient again; and rediscover what gives them joy, meaning, and hope in their work. Counselors need time for reflection, to listen again deeply and authentically. You can help them redevelop their innate capacity for compassion, to be an openhearted presence for others.

You can help counselors develop a life that does not revolve around work. This has to be supported by the organization's culture and policies that allow for appropriate use of time off and self-care without punishment. Aid them by encouraging them to take earned leave and to take "mental health" days when they are feeling tired and burned out. Remind staff to spend time with family and friends, exercise, relax, read, or pursue other life-giving interests.

It is important for the clinical supervisor to normalize the counselor's reactions to stress and

compassion fatigue in the workplace as a natural part of being an empathic and compassionate person and not an individual failing or pathology. (See Burke, Carruth, & Prichard, 2006.)

Rest is good; self-care is important. Everyone needs times of relaxation and recreation. Often, a month after a refreshing vacation you lose whatever gain you made. Instead, longer-term gain comes from finding what brings you peace and joy. It is not enough for you to help counselors understand "how" to counsel, you can also help them with the "why." Why are they in this field? What gives them meaning and purpose at work? When all is said and done, when counselors have seen their last client, how do they want to be remembered? What do they want said about them as counselors? Usually, counselors' responses to this question are fairly simple: "I want to be thought of as a caring, compassionate person, a skilled helper." These are important spiritual questions that you can discuss with your supervisees.

Other suggestions include:

- Help staff identify what is happening within the organization that might be contributing to their stress and learn how to address the situation in a way that is productive to the client, the counselor, and the organization.
- Get training in identifying the signs of primary stress reactions, secondary trauma, compassion fatigue, vicarious traumatization, and burnout. Help staff match up self-care tools to specifically address each of these experiences.
- Support staff in advocating for organizational change when appropriate and feasible as part of your role as liaison between administration and clinical staff.
- Assist staff in adopting lifestyle changes to increase their emotional resilience by reconnecting to their world (family, friends, sponsors, mentors), spending time alone for self-reflection, and forming habits that re-energize them.
- Help them eliminate the "what ifs" and negative self-talk. Help them let go of their idealism that they can save the world.
- If possible in the current work environment, set parameters on their work by helping them adhere to scheduled time off, keep lunch time personal, set reasonable deadlines for work completion, and keep work away from personal time.
- Teach and support generally positive work habits. Some counselors lack basic organizational, teamwork, phone, and time management skills (ending sessions on time and scheduling to allow for documentation). The development of these skills helps to reduce the daily wear that erodes well-being and contributes to burnout.
- Ask them, "When was the last time you had fun?" "When was the last time you felt fully alive?" Suggest they write a list of things about their job about which they are grateful. List five people they care about and love. List five accomplishments in their professional life. Ask, "Where do you want to be in your professional life in 5 years?"

You have a fiduciary responsibility given you by clients to ensure counselors are healthy and whole. It is your responsibility to aid counselors in addressing their fatigue and burnout.

Gatekeeping Functions

In monitoring counselor performance, an important and often difficult supervisory task is managing problem staff or those individuals who should not be counselors. This is the gatekeeping function. Part of the dilemma is that most likely you were first trained as a counselor, and your values lie within that domain. You were taught to acknowledge and work with individual limitations, always respecting the individual's goals and needs. However, you also carry a responsibility to maintain the quality of the profession and to protect the welfare of clients. Thus, you are charged with the task of assessing the counselor for fitness for duty and have an obligation to uphold the standards of the profession.

Experience, credentials, and academic performance are not the same as clinical competence. In addition to technical counseling skills, many important therapeutic qualities affect the outcome of counseling, including insight, respect, genuineness, concreteness, and empathy. Research consistently demonstrates that personal characteristics of counselors are highly predictive of client outcome (Herman, 1993, Hubble, Duncan & Miller, 1999). The essential questions are: Who should or should not be a counselor? What behaviors or attitudes are unacceptable? How would a clinical supervisor address these issues in supervision?

Unacceptable behavior might include actions hurtful to the client, boundary violations with clients or program standards, illegal behavior, significant psychiatric impairment, consistent lack of self-awareness, inability to adhere to professional codes of ethics, or consistent demonstration of attitudes that are not conducive to work with clients in substance abuse treatment. You will want to have a model and policies and procedures in place when disciplinary action is undertaken with an impaired counselor. For example, progressive disciplinary policies clearly state the procedures to follow when impairment is identified. Consultation with the organization's attorney and familiarity with state case law are important. It is advisable for the agency to be familiar with and have contact with your state impaired counselor organization, if it exists.

How impaired must a counselor be before disciplinary action is needed? Clear job descriptions and statements of scope of practice and competence are important when facing an impaired counselor. How tired or distressed can a counselor be before a supervisor takes the counselor off-line for these or similar reasons? You need administrative support with such interventions and to identify approaches to managing worn-out counselors. The Consensus Panel recommends that your organization have an employee assistance program (EAP) in place so you can refer staff outside the agency. It is also important for you to learn the distinction between a supervisory referral and a self-referral. Self-referral may include a recommendation by the supervisor, whereas a supervisory referral usually occurs with a job performance problem.

You will need to provide verbal and written evaluations of the counselor's performance and actions to ensure that the staff member is aware of the behaviors that need to be addressed. Treat all supervisees the same, following agency procedures and timelines. Follow the organization's progressive disciplinary steps and document carefully what is said, how the person responds, and what actions are recommended. You can discuss organizational issues or barriers to action with the supervisee (such as personnel policies that might be exacerbating the employee's issues). Finally, it may be necessary for you to take the action that is in the best interest of the clients and the profession, which might involve counseling your supervisee out of the field.

Remember that the number one goal of a clinical supervisor is to protect the welfare of the client, which, at times, can mean enforcing the gatekeeping function of supervision.

METHODS OF OBSERVATION

It is important to observe counselors frequently over an extended period of time. Supervisors in the substance abuse treatment field have traditionally relied on indirect methods of supervision (process recordings, case notes, verbal reports by the supervisees, and verbatims). However, the Consensus Panel recommends that supervisors use direct observation of counselors through recording devices (such as video and audio taping) and live observation of counseling sessions, including one-way mirrors. Indirect methods have significant drawbacks, including:

- A counselor will recall a session as he or she experienced it. If a counselor experiences a session positively or negatively, the report to the supervisor will reflect that. The report is also affected by the counselor's level of skill and experience.
- The counselor's report is affected by his or her biases and distortions (both conscious and unconscious). The report does not provide a thorough sense of what really happened in the session because it relies too heavily on the counselor's recall.
- Indirect methods include a time delay in reporting.
- The supervisee may withhold clinical information due to evaluation anxiety or naiveté.

Your understanding of the session will be improved by direct observation of the counselor. Direct observation is much easier today, as a variety of technological tools are available, including audio and videotaping, remote audio devices, interactive videos, live feeds, and even supervision through web-based cameras.

Guidelines that apply to all methods of direct observation in supervision include:

- Simply by observing a counseling session, the dynamics will change. You may change how both the client and counselor act. You get a snapshot of the sessions. Counselors will say, "it was not a representative session." Typically, if you observe the counselor frequently, you will get a fairly accurate picture of the counselor's competencies.
- You and your supervisee must agree on procedures for observation to determine why, when, and how direct methods of observation will be used.
- The counselor should provide a context for the session.
- The client should give written consent for observation and/or taping at intake, before beginning counseling. Clients must know all the conditions of their treatment before they consent to counseling. Additionally, clients need to be notified of an upcoming observation by a supervisor before the observation occurs.
- Observations should be selected for review (including a variety of sessions and clients, challenges, and successes) because they provide teaching moments. You should ask the supervisee to select what cases he or she wishes you to observe and explain why those cases were chosen. Direct observation should not be a weapon for criticism but a constructive tool for learning: an opportunity for the counselor to do things right and well, so that positive feedback follows.
- When observing a session, you gain a wealth of information about the counselor. Use this

information wisely, and provide gradual feedback, not a litany of judgments and directives. Ask the salient question, "What is the most important issue here for us to address in supervision?"

- A supervisee might claim client resistance to direct observation, saying, "It will make the client nervous. The client does not want to be taped." However, "client resistance" is more likely to be reported when the counselor is anxious about being taped. It is important for you to gently and respectfully address the supervisee's resistance while maintaining the position that direct observation is an integral component of his or her supervision.
- Given the nature of the issues in drug and alcohol counseling, you and your supervisee need to be sensitive to increased client anxiety about direct observation because of the client's fears about job or legal repercussions, legal actions, criminal behaviors, violence and abuse situations, and the like.
- Ideally, the supervisee should know at the outset of employment that observation and/or taping will be required as part of informed consent to supervision.

In instances where there is overwhelming anxiety regarding observation, you should pace the observation to reduce the anxiety, giving the counselor adequate time for preparation. Often enough, counselors will feel more comfortable with observation equipment (such as a video camera or recording device) rather than direct observation with the supervisor in the room.

The choice of observation methods in a particular situation will depend on the need for an accurate sense of counseling, the availability of equipment, the context in which the supervision is provided, and the counselor's and your skill levels. A key factor in the choice of methods might be the resistance of the counselor to being observed. For some supervisors, direct observation also puts the supervisor's skills on the line too, as they might be required to demonstrate or model their clinical competencies.

Recorded Observation

Audiotaped supervision has traditionally been a primary medium for supervisors and remains a vital resource for therapy models such as motivational interviewing. On the other hand, videotape supervision (VTS) is the primary method of direct observation in both the marriage and family therapy and social work fields (Munson, 1993; Nichols, Nichols, & Hardy, 1990). Video cameras are increasingly commonplace in professional settings. VTS is easy, accessible, and inexpensive. However, it is also a complex, powerful and dynamic tool, and one that can be challenging, threatening, anxiety-provoking, and humbling. Several issues related to VTS are unique to the substance abuse field:

- Many substance abuse counselors "grew up" in the field without taping and may be resistant to the medium;
- Many agencies operate on limited budgets and administrators may see the expensive equipment as prohibitive and unnecessary; and
- Many substance abuse supervisors have not been trained in the use of videotape equipment or in VTS.

Yet, VTS offers nearly unlimited potential for creative use in staff development. To that end, you need training in how to use VTS effectively. The following are guidelines for VTS:

- Clients must sign releases before taping. Most programs have a release form that the client signs on admission. The supervisee informs the client that videotaping will occur and reminds the client about the signed release form. The release should specify that the taping will be done exclusively for training purposes and will be reviewed only by the counselor, the supervisor, and other supervisees in group supervision. Permission will most likely be granted if the request is made in a sensitive and appropriate manner. It is critical to note that even if permission is initially given by the client, this permission can be withdrawn. You cannot force compliance.
- The use and rationale for taping needs to be clearly explained to clients. This will forestall a client's questioning as to why a particular session is being taped.
- Risk-management considerations in today's litigious climate necessitate that tapes be erased after the supervision session. Tapes can be admissible as evidence in court as part of the clinical record. Since all tapes should be erased after supervision, this must be stated in agency policies. If there are exceptions, those need to be described.
- Too often, supervisors watch long, uninterrupted segments of tape with little direction or purpose. To avoid this, you may want to ask your supervisee to cue the tape to the segment he or she wishes to address in supervision, focusing on the goals established in the IDP. Having said this, listening only to segments selected by the counselor can create some of the same disadvantages as self-report: the counselor chooses selectively, even if not consciously. The supervisor may occasionally choose to watch entire sessions.
- You need to evaluate session flow, pacing, and how counselors begin and end sessions.

Some clients may not be comfortable being videotaped but may be more comfortable with audio taping. Videotaping is not permitted in most prison settings and EAP services. Videotaping may not be advisable when treating patients with some diagnoses, such as paranoia or some schizophrenic illnesses. In such cases, either live observation or less intrusive measures, such as audio taping, may be preferred.

Live Observation

With live observation you actually sit in on a counseling session with the supervisee and observe the session first hand. The client will need to provide informed consent before being observed. Although one-way mirrors are not readily available at most agencies, they are an alternative to actually sitting in on the session. A videotape may also be used either from behind the one-way mirror (with someone else operating the videotaping equipment) or physically located in the counseling room, with the supervisor sitting in the session. This combination of mirror, videotaping, and live observation may be the best of all worlds, allowing for unobtrusive observation of a session, immediate feedback to the supervisee, modeling by the supervisor (if appropriate), and a record of the session for subsequent review in supervision. Live supervision may involve some intervention by the supervisor during the session.

Live observation is effective for the following reasons:

- It allows you to get a true picture of the counselor in action.
- It gives you an opportunity to model techniques during an actual session, thus serving as a

role model for both the counselor and the client.

- Should a session become countertherapeutic, you can intervene for the well-being of the client.
- Counselors often say they feel supported when a supervisor joins the session, and clients periodically say, "This is great! I got two for the price of one."
- It allows for specific and focused feedback.
- It is more efficient for understanding the counseling process.
- It helps connect the IDP to supervision.

To maximize the effectiveness of live observation, supervisors must stay primarily in an observer role so as to not usurp the leadership or undercut the credibility and authority of the counselor.

Live observation has some disadvantages:

- It is time consuming.
- It can be intrusive and alter the dynamics of the counseling session.
- It can be anxiety-provoking for all involved.

Some mandated clients may be particularly sensitive to live observation. This becomes essentially a clinical issue to be addressed by the counselor with the client. Where is this anxiety coming from, how does it relate to other anxieties and concerns, and how can it best be addressed in counseling?

Supervisors differ on where they should sit in a live observation session. Some suggest that the supervisor sit so as to not interrupt or be involved in the session. Others suggest that the supervisor sit in a position that allows for inclusion in the counseling process.

Here are some guidelines for conducting live observation:

- The counselor should always begin with informed consent to remind the client about confidentiality. Periodically, the counselor should begin the session with a statement of confidentiality, reiterating the limits of confidentiality and the duty to warn, to ensure that the client is reminded of what is reportable by the supervisor and/or counselor.
- While sitting outside the group (or an individual session between counselor and client) may undermine the group process, it is a method selected by some. Position yourself in a way that doesn't interrupt the counseling process. Sitting outside the group undermines the human connection between you, the counselor, and the client(s) and makes it more awkward for you to make a comment, if you have not been part of the process until then. For individual or family sessions, it is also recommended that the supervisor sit beside the counselor to fully observe what is occurring in the counseling session.
- The client should be informed about the process of supervision and the supervisor's role and goals, essentially that the supervisor is there to observe the counselor's skills and not necessarily the client.
- As preparation, the supervisor and supervisee should briefly discuss the background of the session, the salient issues the supervisee wishes to focus on, and the plans for the session. The role of the supervisor should be clearly stated and agreed on before the session.

- You and the counselor may create criteria for observation, so that specific feedback is provided for specific areas of the session.
- Your comments during the session should be limited to lessen the risk of disrupting the flow or taking control of the session. Intervene only to protect the welfare of the client (should something adverse occur in the session) or if a moment critical to client welfare arises. In deciding to intervene or not, consider these questions: What are the consequences if I don't intervene? What is the probability that the supervisee will make the intervention on his or her own or that my comments will be successful? Will I create an undue dependence on the part of clients or supervisee?
- Provide feedback to the counselor as soon as possible after the session. Ideally, the supervisor and supervisee(s) should meet privately immediately afterward, outlining the key points for discussion and the agenda for the next supervision session, based on the observation. Specific feedback is essential; "You did a fine job" is not sufficient. Instead, the supervisor might respond by saying, "I particularly liked your comment about …" or "What I observed about your behavior was …" or "Keep doing more of …"

PRACTICAL ISSUES IN CLINICAL SUPERVISION

Distinguishing Between Supervision and Therapy

In facilitating professional development, one of the critical issues is understanding and differentiating between counseling the counselor and providing supervision. In ensuring quality client care and facilitating professional counselor development, the process of clinical supervision sometimes encroaches on personal issues. The dividing line between therapy and supervision is how the supervisee's personal issues and problems affect their work. The goal of clinical supervision must always be to assist counselors in becoming better clinicians, not seeking to resolve their personal issues. Some of the major differences between supervision and counseling are summarized in figure 19.6.

Figure 19.6. Differences Between Supervision and Counseling

	Clinical Supervision	Administrative Supervision	Counseling
Purpose	Improved client care Improved job performance	Ensure compliance with agency and regulatory body's policies and procedures	Personal growth Behavior changes Better self-understanding
Outcome	Enhanced proficiency in knowledge, skills, and attitudes essential to effective job performance	Consistent use of approved formats, policies, and procedures	Open-ended, based on client needs
Timeframe	Short-term and ongoing	Short-term and ongoing	Based on client needs
Agenda	Based on agency mission and counselor needs	Based on agency needs	Based on client needs
Basic Process	Teaching/learning specific skills, evaluating job performance, negotiating learning objectives	Clarifying agency expectations, policies and procedures, ensuring compliance	Behavioral, cognitive, and affective process including listening, exploring, teaching

Source: Adapted from Dixon, 2004

The boundary between counseling and clinical supervision may not always be clearly marked, for it is necessary, at times, to explore supervisees' limitations as they deliver services to their clients. Address counselors' personal issues only insofar as they create barriers or affect their performance. When personal issues emerge, the key question you should ask the supervisee is, how does this affect the delivery of quality client care? What is the impact of this issue on the client? What resources are you using to resolve this issue outside of the counseling dyad? When personal issues emerge that might interfere with quality care, your role may be to transfer the case to a different counselor. Most important, you should make a strong case that the supervisee should seek outside counseling or therapy.

Problems related to countertransference (projecting unresolved personal issues onto a client or supervisee) often make for difficult therapeutic relationships. The following are signs of countertransference to look for:

- A feeling of loathing, anxiety, or dread at the prospect of seeing a specific client or supervisee.
- Unexplained anger or rage at a particular client.
- Distaste for a particular client.
- Mistakes in scheduling clients, missed appointments.

- Forgetting client's name, history.
- Drowsiness during a session or sessions ending abruptly.
- Billing mistakes.
- Excessive socializing.

When countertransferential issues between counselor and client arise, some of the important questions you, as a supervisor, might explore with the counselor include:

- How is this client affecting you? What feelings does this client bring out in you? What is your behavior toward the client in response to these feelings? What is it about the substance abuse behavior of this client that brings out a response in you?
- What is happening now in your life, but more particularly between you and the client, that might be contributing to these feelings, and how does this affect your counseling?
- In what ways can you address these issues in your counseling?
- What strategies and coping skills can assist you in your work with this client?

Transference and countertransference also occur in the relationship between supervisee and supervisor. Examples of supervisee transference include:

- The supervisee's idealization of the supervisor.
- Distorted reactions to the supervisor based on the supervisee's reaction to the power dynamics of the relationship.
- The supervisee's need for acceptance by or approval from an authority figure.
- The supervisee's reaction to the supervisor's establishing professional and social boundaries with the supervisee.

Supervisor countertransference with supervisees is another issue that needs to be considered. Categories of supervisor countertransference include:

- The need for approval and acceptance as a knowledgeable and competent supervisor.
- Unresolved personal conflicts of the supervisor activated by the supervisory relationship.
- Reactions to individual supervisees, such as dislike or even disdain, whether the negative response is "legitimate" or not. In a similar vein, aggrandizing and idealizing some supervisees (again, whether or not warranted) in comparison to other supervisees.
- Sexual or romantic attraction to certain supervisees.
- Cultural countertransference, such as catering to or withdrawing from individuals of a specific cultural background in a way that hinders the professional development of the counselor.

To understand these countertransference reactions means recognizing clues (such as dislike of a supervisee or romantic attraction), doing careful self-examination, personal counseling, and receiving supervision of your supervision. In some cases, it may be necessary for you to request a transfer

of supervisees with whom you are experiencing countertransference, if that countertransference hinders the counselor's professional development.

Finally, counselors will be more open to addressing difficulties such as countertransference and compassion fatigue with you if you communicate understanding and awareness that these experiences are a normal part of being a counselor. Counselors should be rewarded in performance evaluations for raising these issues in supervision and demonstrating a willingness to work on them as part of their professional development.

Balancing Clinical and Administrative Functions

In the typical substance abuse treatment agency, the clinical supervisor may also be the administrative supervisor, responsible for overseeing managerial functions of the organization. Many organizations cannot afford to hire two individuals for these tasks. Hence, it is essential that you are aware of what role you are playing and how to exercise the authority given you by the administration. Texts on supervision sometimes overlook the supervisor's administrative tasks, but supervisors structure staff work; evaluate personnel for pay and promotions; define the scope of clinical competence; perform tasks involving planning, organizing, coordinating, and delegating work; select, hire, and fire personnel; and manage the organization. Clinical supervisors are often responsible for overseeing the quality assurance and improvement aspects of the agency and may also carry a caseload. For most of you, juggling administrative and clinical functions is a significant balancing act. Tips for juggling these functions include:

- Try to be clear about the "hat you are wearing." Are you speaking from an administrative or clinical perspective?
- Be aware of your own biases and values that may be affecting your administrative opinions.
- Delegate the administrative functions that you need not necessarily perform, such as human resources, financial, or legal functions.
- Get input from others to be sure of your objectivity and your perspective.

There may be some inherent problems with performing both functions, such as dual relationships. Counselors may be cautious about acknowledging difficulties they face in counseling because these may affect their performance evaluation or salary raises.

On the other hand, having separate clinical and administrative supervisors can lead to inconsistent messages about priorities, and the clinical supervisor is not in the chain of command for disciplinary purposes.

Finding the Time To Do Clinical Supervision

Having read this far, you may be wondering, "Where do I find the time to conduct clinical supervision as described here? How can I do direct observation of counselors within my limited time schedule?" Or, "I work in an underfunded program with substance abuse clients. I have way too many tasks to also observe staff in counseling."

One suggestion is to begin an implementation process that involves adding components of a supervision model one at a time. For example, scheduling supervisory meetings with each counselor is a beginning step. It is important to meet with each counselor on a regular, scheduled basis to develop learning plans and review professional development. Observations of counselors in their work might

be added next. Another component might involve group supervision. In group supervision, time can be maximized by teaching and training counselors who have common skill development needs.

As you develop a positive relationship with supervisees based on cooperation and collaboration, the anxiety associated with observation will decrease. Counselors frequently enjoy the feedback and support so much that they request observation of their work. Observation can be brief. Rather than sitting in on a full hour of group, spend 20 minutes in the observation and an additional 20 providing feedback to the counselor.

Your choice of modality (individual, group, peer, etc.) is influenced by several factors: supervisees' learning goals, their experience and developmental levels, their learning styles, your goals for supervisees, your theoretical orientation, and your own learning goals for the supervisory process. To select a modality of supervision (within your time constraints and those of your supervisee), first pinpoint the immediate function of supervision, as different modalities fit different functions. For example, a supervisor might wish to conduct group supervision when the team is intact and functioning well, and individual supervision when specific skill development or countertransferential issues need additional attention. Given the variety of treatment environments in substance abuse treatment (e.g., therapeutic communities, intensive outpatient services, transitional living settings, correctional facilities) and varying time constraints on supervisors, several alternatives to structure supervision are available.

Peer supervision is not hierarchical and does not include a formal evaluation procedure, but offers a means of accountability for counselors that they might not have in other forms of supervision. Peer supervision may be particularly significant among well-trained, highly educated, and competent counselors. Peer supervision is a growing medium, given the clinical supervisors' duties. Although peer supervision has received limited attention in literature, the Consensus Panel believes it is a particularly effective method, especially for small group practices and agencies with limited funding for supervision. Peer supervision groups can evolve from supervisor-led groups or individual sessions to peer groups, or can begin as peer supervision. For peer supervision groups offered within an agency, there may be some history to overcome among the group members, such as political entanglements, competitiveness, or personality concerns. (Bernard and Goodyear [2004] has an extensive review of the process and the advantages and disadvantages of peer supervision.)

Triadic supervision is a tutorial and mentoring relationship among three counselors. This model of supervision involves three counselors who, on a rotating basis, assume the roles of the supervisee, the commentator, and the supervision session facilitator. Spice and Spice (1976) describe peer supervision with three supervisees getting together. In current counseling literature, triadic supervision involves two counselors with one supervisor. There is very little empirical or conceptual literature on this arrangement.

Individual supervision, where a supervisor works with the supervisee in a one-to-one relationship, is considered the cornerstone of professional skill development. Individual supervision is the most labor-intensive and time-consuming method for supervision. Credentialing requirements in a particular discipline or graduate studies may mandate individual supervision with a supervisor from the same discipline.

Intensive supervision with selected counselors is helpful in working with a difficult client (such as one with a history of violence), a client using substances unfamiliar to the counselor, or a highly resistant client. Because of a variety of factors (credentialing requirements, skill deficits of some counselors, the need for close clinical supervision), you may opt to focus, for concentrated periods of

time, on the needs of one or two counselors as others participate in peer supervision. Although this is not necessarily a long-term solution to the time constraints of a supervisor, intensive supervision provides an opportunity to address specific staffing needs while still providing a "reasonable effort to supervise" all personnel.

Group clinical supervision is a frequently used and efficient format for supervision, team building, and staff growth. One supervisor assists counselor development in a group of supervisee peers. The recommended group size is four to six persons to allow for frequent case presentations by each group member. With this number of counselors, each person can present a case every other month—an ideal situation, especially when combined with individual and/or peer supervision. The benefits of group supervision are that it is cost-effective, members can test their perceptions through peer validation, learning is enhanced by the diversity of the group, it creates a working alliance and improves teamwork, and it provides a microcosm of group process for participants. Group supervision gives counselors a sense of commonality with others in the same situation. Because the formats and goals differ, it is helpful to think through why you are using a particular format. (Examples of group formats with different goals can be found in Borders and Brown, 2005, and Bernard & Goodyear, 2004.)

Given the realities of the substance abuse treatment field (limited funding, priorities competing for time, counselors and supervisors without advanced academic training, and clients with pressing needs in a brief-treatment environment), the plan described below may be a useful structure for supervision. It is based on a scenario where a supervisor oversees one to five counselors. This plan is based on several principles:

- All counselors, regardless of years of experience or academic training, will receive at least 1 hour of supervision for every 20 to 40 hours of clinical practice.
- Direct observation is the backbone of a solid clinical supervision model.
- Group supervision is a viable means of engaging all staff in dialog, sharing ideas, and promoting team cohesion.

With the formula diagramed below, each counselor receives a minimum of 1 hour of group clinical supervision per week. Each week you will have 1 hour of observation, 1 hour of individual supervision with one of your supervisees, and 1 hour of group supervision with five supervisees. Each week, one counselor will be observed in an actual counseling session, followed by an individual supervision session with you. If the session is videotaped, the supervisee can be asked to cue the tape to the segment of the session he or she wishes to discuss with you. Afterwards, the observed counselor presents this session in group clinical supervision.

When it is a counselor's week to be observed or taped and meet for individual supervision, he or she will receive 3 hours of supervision: 1 hour of direct observation, 1 hour of individual/one-on-one supervision, and 1 hour of group supervision when he or she presents a case to the group. Over the course of months, with vacation, holiday, and sick time, it should average out to approximately 1 hour of supervision per counselor per week. Figure 7 shows this schedule.

Figure 7. Sample Clinical Supervision Schedule

Counselor	Week 1	Week 2	Week 3	Week 4	Week 5
A	1 hour direct observation 1 hour individual supervision 1 hour group supervision of A's case (3 hours)	1 hour group	1 hour group	1 hour group	1 hour group
B	1 hour group	3 hour group	1 hour group	1 hour group	1 hour group
C	1 hour group	1 hour group	3 hour group	1 hour group	1 hour group
D	1 hour group	1 hour group	1 hour group	3 hour group	1 hour group
E	1 hour group	1 hour group	1 hour group	1 hour group	3 hour group

When you are working with a counselor who needs special attention or who is functioning under specific requirements for training or credentialing, 1 additional hour per week can be allocated for this counselor, increasing the total hours for clinical supervision to 4, still a manageable amount of time.

Documenting Clinical Supervision

Correct documentation and recordkeeping are essential aspects of supervision. Mechanisms must be in place to demonstrate the accountability of your role. (See Tools 10–12 in Part 2, chapter 2.) These systems should document:

- Informal and formal evaluation procedures.
- Frequency of supervision, issues discussed, and the content and outcome of sessions.
- Due process rights of supervisees (such as the right to confidentiality and privacy, to informed consent).
- Risk management issues (how to handle crises, duty-to-warn situations, breaches of confidentiality).

One comprehensive documentation system is Falvey's (2002*a*) Focused Risk Management Supervision System (FoRMSS), which provides templates to record emergency contact information, supervisee profiles, a logging sheet for supervision, an initial case review, supervision records, and a client termination form.

Supervisory documents and notes are open to management, administration, and human resources (HR) personnel for performance appraisal and merit pay increases and are admissible in court proceedings. Supervision notes, especially those related to work with clients, are kept separately and are intended for the supervisor's use in helping the counselor improve clinical skills and monitor client care. It is imperative to maintain accurate and complete notes on the supervision. However, as discussed above, documentation procedures for formative versus summative evaluation of staff may vary. Typically, HR accesses summative evaluations, and supervisory notes are maintained as formative evaluations.

An example of a formative note by a supervisor might be "The counselor responsibly discussed countertransferential issues occurring with a particular client and was willing to take supervisory direction," or "We worked out an action plan, and I will follow this closely." This wording avoids concerns by the supervisor and supervisee as to the confidentiality of supervisory notes. From a

legal perspective, the supervisor needs to be specific about what was agreed on and a timeframe for following up.

Structuring the Initial Supervision Sessions

As discussed earlier, your first tasks in clinical supervision are to establish a behavioral contract, get to know your supervisees, and outline the requirements of supervision. Before the initial session, you should send a supportive letter to the supervisee expressing the agency's desire to provide him or her with a quality clinical supervision experience. You might request that the counselor give some thought to what he or she would like to accomplish in supervision, what skills to work on, and which core functions used in the addiction counselor certification process he or she feels most comfortable performing.

In the first few sessions, helpful practices include:

- Briefly describe your role as both administrative and clinical supervisor (if appropriate) and discuss these distinctions with the counselor.
- Briefly describe your model of counseling and learn about the counselor's frameworks and models for her or his counseling practice. For beginning counselors this may mean helping them define their model.
- Describe your model of supervision.
- State that disclosure of one's supervisory training, experience, and model is an ethical duty of clinical supervisors.
- Discuss methods of supervision, the techniques to be used, and the resources available to the supervisee (e.g., agency in-service seminar, community workshops, professional association memberships, and professional development funds or training opportunities).
- Explore the counselor's goals for supervision and his or her particular interests (and perhaps some fears) in clinical supervision.
- Explain the differences between supervision and therapy, establishing clear boundaries in this relationship.
- Work to establish a climate of cooperation, collaboration, trust, and safety.
- Create an opportunity for rating the counselor's knowledge and skills based on the competencies in TAP 21 (CSAT, 2007).
- Explain the methods by which formative and summative evaluations will occur.
- Discuss the legal and ethical expectations and responsibilities of supervision.
- Take time to decrease the anxiety associated with being supervised and build a positive working relationship.

It is important to determine the knowledge and skills, learning style, and conceptual skills of your supervisees, along with their suitability for the work setting, motivation, self-awareness, and ability to function autonomously. A basic IDP for each supervisee should emerge from the initial supervision sessions. You and your supervisee need to assess the learning environment of supervision by determining:

- Is there sufficient challenge to keep the supervisee motivated?
- Are the theoretical differences between you and the supervisee manageable?
- Are there limitations in the supervisee's knowledge and skills, personal development, self-efficacy, self-esteem, and investment in the job that would limit the gains from supervision?
- Does the supervisee possess the affective qualities (empathy, respect, genuineness, concreteness, warmth) needed for the counseling profession?
- Are the goals, means of supervision, evaluation criteria, and feedback process clearly understood by the supervisee?
- Does the supervisory environment encourage and allow risk taking?

METHODS AND TECHNIQUES OF CLINICAL SUPERVISION

A number of methods and techniques are available for clinical supervision, regardless of the modality used. Methods include (as discussed previously) case consultation, written activities such as verbatims and process recordings, audio and videotaping, and live observation. Techniques include modeling, skill demonstrations, and role playing. (See descriptions of these and other methods and techniques in Bernard & Goodyear, 2004; Borders & Brown, 2005; Campbell, 2000; and Powell & Brodsky, 2004.) Figure 19.8 outlines some of the methods and techniques of supervision, as well as the advantages and disadvantages of each method.

Figure 19.8

	Description	Advantages	Disadvantages
Verbal Reports	• Verbal reports of clinical situations • Group discussion of clinical situations	• Informal • Time efficient • Often spontaneous in response to clinical situation • Can hear counselor's report, what he or she includes, thus learn of the counselor's awareness and perspective, what he or she wishes to report, contrasted with supervisory observations	• Sessions seen through eyes of beholder • Nonverbal cues missed • Can drift into case management, hence it is important to focus on the clinical nature of chart reviews, reports, etc., linking to the treatment plan and EBPs
Verbatim Reports	• Process recordings • Verbatim written record of a session or part of session • Declining method in the behavioral health field	• Helps track coordination and use of treatment plan with ongoing session • Enhances conceptualization and writing skills • Enhances recall and reflection skills • Provides written documentation of sessions	• Nonverbal cues missed • Self-report bias • Can be very tedious to write and to read
Written/File Review	• Review of the progress notes, charts, documentation	• An important task of a supervisor to ensure compliance with accreditation standards for documentation • Provides a method of quality control • Ensures consistency of records and files	• Time consuming • Notes often miss the overall quality and essence of the session • Can drift into case management rather than clinical skills development
Case Consultation/ Case Management	• Discussion of cases • Brief case reviews	• Helps organize information, conceptualize problems, and decide on clinical interventions • Examines issues (e.g., cross-cultural issues), integrates theory and technique, and promotes greater self-awareness • An essential component of treatment planning	• The validity of self-report is dependent on counselor developmental level and the supervisor's insightfulness • Does not reflect broad range of clinical skills of the counselor
Direct Observation	• The supervisor watches the session and may provide periodic but limited comments and/or suggestions to the clinician	• Allows teaching of basic skills while protecting quality of care • Counselor can see and experience positive change in session direction in the moment • Allows supervisor to intervene when needed to protect the welfare of the client, if the session is not effective or is destructive to the client	• May create anxiety • Requires supervisor caution in intervening so as to not take over the session or to create undue dependence for the counselor or client • Can be seen as intrusive to the clinical process • Time consuming

Audiotaping	• Audiotaping and review of a counseling session	• Technically easy and inexpensive • Can explore general rapport, pace, and interventions • Examines important relationship issues • Unobtrusive medium • Can be listened to in clinical or team meetings	• Counselor may feel anxious • Misses nonverbal cues • Poor sound quality often occurs due to limits of technology
Videotaping	• Videotaping and review of a counseling session	• A rich medium to review verbal and nonverbal information • Provides documentation of clinical skills • Can be viewed by the treatment team during group clinical supervision session • Uses time efficiently • Can be used in conjunction with direct observation • Can be used to suggest different interventions • Allows for review of content, affective and cognitive aspects, process relationship issues in the present	• Can be seen as intrusive to the clinical process • Counselor may feel anxious and self-conscious, although this subsides with experience • Technically more complicated • Requires training before using • Can become part of the clinical record and can be subpoenaed (should be destroyed after review)
Webcam	• Internet supervision, synchronistic and asynchronistic • Teleconferencing	• Can be accessed from any computer • Especially useful for remote and satellite facilities and locations • Uses time efficiently • Modest installation and operation costs • Can be stored or downloaded on a variety of media, watched in any office, then erased	• Concerns about anonymity and confidentiality • Can be viewed as invasive to the clinical process • May increase client or counselor anxiety or self-consciousness • Technically more complicated • Requires assurance that downloads will be erased and unavailable to unauthorized staff

Cofacilitation and Modeling	• Supervisor and counselor jointly run a counseling session • Supervisor demonstrates a specific technique while the counselor observes • This may be followed by roleplay with the counselor practicing the skill with time to process learning and application	• Allows the supervisor to model techniques while observing the counselor • Can be useful to the client ("two counselors for the price of one") • Supervisor must demonstrate proficiency in the skill and help the counselor incrementally integrate the learning • Counselor sees how the supervisor might respond • Supervisor incrementally shapes the counselor's skill acquisition and monitors skill mastery • Allows supervisor to aid counselor with difficult clients	• Supervisor must demonstrate proficiency in the skill and help the counselor incrementally integrate the learning • The client may perceive counselor as less skilled than the supervisor • Time consuming
Role Playing	• Role play a clinical situation	• Enlivens the learning process • Provides the supervisor with direct observation of skills • Helps counselor gain a different perspective • Creates a safe environment for the counselor to try new skills	• Counselor can be anxious • Supervisor must be mindful of not overwhelming the counselor with information

Source: Adapted from Mattel, 2007.

The context in which supervision is provided affects how it is carried out. A critical issue is how to manage your supervisory workload and make a reasonable effort to supervise. The contextual issues that shape the techniques and methods of supervision include:

- The allocation of time for supervision. If the 20:1 rule of client hours to supervision time is followed, you will want to allocate sufficient time for supervision each week so that it is a high priority, regularly scheduled activity.
- The unique conditions, limitations, and requirements of the agency. Some organizations may lack the physical facilities or hardware to use videotaping or to observe sessions. Some organizations may be limited by confidentiality requirements, such as working within a criminal justice system where taping may be prohibited.
- The number of supervisees reporting to a supervisor. It is difficult to provide the scope of supervision discussed in this TIP if a supervisor has more than ten supervisees. In such a case, another supervisor could be named or peer supervision could be used for advanced staff.
- Clinical and management responsibilities of a supervisor. Supervisors have varied responsibilities, including administrative tasks, limiting the amount of time available for clinical supervision.

ADMINISTRATIVE SUPERVISION

As noted above, clinical and administrative supervision overlap in the real world. Most clinical

supervisors also have administrative responsibilities, including team building, time management, addressing agency policies and procedures, recordkeeping, human resources management (hiring, firing, disciplining), performance appraisal, meeting management, oversight of accreditation, maintenance of legal and ethical standards, compliance with state and federal regulations, communications, overseeing staff cultural competence issues, quality control and improvement, budgetary and financial issues, problem solving, and documentation. Keeping up with these duties is not an easy task!

This TIP addresses two of the most frequently voiced concerns of supervisors: documentation and time management. Supervisors say, "We are drowning in paperwork. I don't have the time to adequately document my supervision as well," and "How do I manage my time so I can provide quality clinical supervision?"

Documentation for Administrative Purposes

One of the most important administrative tasks of a supervisor is that of documentation and recordkeeping, especially of clinical supervision sessions. Unquestionably, documentation is a crucial risk-management tool. Supervisory documentation can help promote the growth and professional development of the counselor (Munson, 1993). However, adequate documentation is not a high priority in some organizations. For example, when disciplinary action is needed with an employee, your organization's attorney or human resources department will ask for the paper trail, or documentation of prior performance issues. If appropriate documentation to justify disciplinary action is missing from the employee's record, it may prove more difficult to conduct the appropriate disciplinary action (see Falvey, 2002; Powell & Brodsky, 2004).

Documentation is no longer an option for supervisors. It is a critical link between work performance and service delivery. You have a legal and ethical requirement to evaluate and document counselor performance. A complete record is a useful and necessary part of supervision. Records of supervision sessions should include:

- The supervisor–supervisee contract, signed by both parties.>
- A brief summary of the supervisee's experience, training, and learning needs.
- The current IDP.
- A summary of all performance evaluations.
- Notations of all supervision sessions, including cases discussed and significant decisions made.
- Notation of cancelled or missed supervision sessions.
- Progressive discipline steps taken.
- Significant problems encountered in supervision and how they were resolved.
- Supervisor's clinical recommendations provided to supervisees.
- Relevant case notes and impressions.

The following should not be included in a supervision record:

- Disparaging remarks about staff or clients.

- Extraneous or sensitive supervisee information.
- Alterations in the record after the fact or premature destruction of supervision records.
- Illegible information and nonstandard abbreviations.

Several authors have proposed a standardized format for documentation of supervision, including Falvey (2002*b*), Glenn and Serovich (1994), and Williams (1994).

Time Management

By some estimates, people waste about two hours every day doing tasks that are not of high priority. In your busy job, you may find yourself at the end of the week with unfinished tasks or matters that have not been tended to. Your choices? Stop performing some tasks (often training or supervision) or take work home and work longer days. In the long run, neither of these choices is healthy or effective for your organization. Yet, being successful does not make you manage your time well. Managing your time well makes you successful. Ask yourself these questions about your priorities:

- Why am I doing this? What is the goal of this activity?
- How can I best accomplish this task in the least amount of time?
- What will happen if I choose not to do this?

It is wise to develop systems for managing time-wasters such as endless meetings held without notes or minutes, playing telephone or email tag, junk mail, and so on. Effective supervisors find their times in the day when they are most productive. Time management is essential if you are to set time aside and dedicate it to supervisory tasks.

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LICENSE AND ATTRIBUTION

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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

CHAPTER 21.

FREQUENTLY ASKED QUESTIONS: APPLYING THE SUBSTANCE ABUSE CONFIDENTIALITY REGULATIONS TO HEALTH INFORMATION EXCHANGE (HIE)

In 2010, the HHS Substance Abuse and Mental Health Services Administration (SAMHSA) and the HHS Office of the National Coordinator (ONC) published FAQs "Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE)." The 2010 FAQs are available at Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE) (PDF | 381 KB).

This document is an educational document from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the U.S. Department of Health and Human Services. It was prepared by SAMHSA staff, in collaboration with staff from the Office of the National Coordinator for Health Information Technology, and contractors and should not be considered legal advice.

FREQUENTLY ASKED QUESTIONS

Q1. Does the federal law that protects the confidentiality of alcohol and drug abuse patient records allow information about patients with substance use disorders to be included in electronic health information exchange systems?[1]

A1. Yes. The federal confidentiality law and regulations (codified as 42 U.S.C. § 290dd-2 and 42 CFR Part 2 ["Part 2"]), enacted almost three decades ago after Congress recognized that the stigma associated with substance abuse and fear of prosecution deterred people from entering treatment, has been a cornerstone practice for substance abuse treatment programs across the country. Part 2 permits patient information to be disclosed to Health Information Organizations (HIOs)[2] and other health information exchange (HIE) systems; however, the regulation contains certain requirements for the disclosure of information by substance abuse treatment programs; most notably, patient consent is required for disclosures, with some exceptions.[3]

This consent requirement is often perceived as a barrier to the electronic exchange of health

1. Health Information Exchange is a generic term that refers to a number of methods and mechanisms through which information can be exchanged electronically.
2. As used in this paper, the term "HIO" means an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards. See The National Alliance for Health Information Technology, Report to the Office of the National Coordinator for Health Information Technology on Defining Key Health Information Technology Terms, April 28, 2008, found at http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_10741_848133_0_0_18/10_2_hit_terms.pdf. While the majority of these FAQs relate to HIOs, the principles for applying the Part 2 regulations apply to other methods of health information exchange as well.
3. Most substance abuse treatment programs are also subject to the HIPAA Privacy Rule. In 2004, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a guidance that summarizes variance between the two rules and implementation solutions. That guidance can be found at http://www.hipaa.samhsa.gov/download2/SAMHSAPart2-HIPAAComparison2004.pdf.

information. However, as explained in other FAQs, it is possible to electronically exchange drug and alcohol treatment information while also meeting the requirements of Part 2.

Q2. What types of providers are covered programs under 42 CFR Part 2 ("Part 2")?

A2. To be a "program" that falls under 42 CFR Part 2, an individual or entity must be federally assisted and hold itself out as providing, and provide, alcohol or drug abuse diagnosis, treatment or referral for treatment (42 CFR § 2.11). A program is "federally assisted" if it is:

1. authorized, licensed, certified, or registered by the federal government;
2. receives federal funds in any form, even if the funds do not directly pay for the alcohol or drug abuse services; or
3. is assisted by the Internal Revenue Service through a grant of tax exempt status or allowance of tax deductions for contributions; or
4. is authorized to conduct business by the federal government (e.g., certified as a Medicare provider, authorized to conduct methadone maintenance treatment, or registered with the Drug Enforcement Agency [DEA] to dispense a controlled substance used in the treatment of alcohol or drug abuse); or
5. is conducted directly by the federal government.

A different definition of a "program" applies when services are provided by a specialized unit or staff within a general medical facility (or "mixed use" facility—see FAQ #15). A general medical facility has a Part 2 program if:

1. there is "an identified unit within a medical facility which holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment"; or
2. there are "medical personnel or other staff in a general medical facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral for treatment and who are identified as such providers." (42 CFR § 2.11 [b], [c])

Most drug and alcohol treatment programs are federally assisted. However, there are for-profit programs and private practitioners that may not receive federal assistance of any kind. These programs and practitioners only see clients who have private health insurance or self-pay. Unless the state licensing or certification agency requires those programs or private practitioners to comply with Part 2, they are not subject to the requirements of 42 CFR Part 2, because they are not federally assisted. States may, however, enact laws requiring compliance with Part 2, and programs should refer to their state laws in these situations. Clinicians who use a controlled substance (e.g., benzodiazepines, methadone, or buprenorphine) for detoxification or maintenance treatment of a substance use disorder require a federal DEA registration and become subject to Part 2 through the DEA license. In contrast, a physician who does not use a controlled substance for treatment, such as Naltrexone, and does not otherwise meet the definition of a Part 2 program is not subject to Part 2.

Q3. What patients, and which records and information, are protected by 42 C.F.R Part 2?

A3. The Part 2 regulations "impose restrictions upon the disclosure and use of alcohol and drug patient records which are maintained in connection with the performance of any federally assisted alcohol and drug abuse program." (42 CFR § 2.3[a]) The restrictions on disclosure apply to any

information disclosed by a Part 2 program that "would identify a patient as an alcohol or drug abuser …" (42 CFR §2.12[a][1])

Under 42 CFR § 2.11:

- "Patient" means "any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program."
- "Records" mean "any information, whether recorded or not, relating to a patient received or acquired by a federally assisted alcohol or drug program."
- "Disclose or disclosure" means the "communication of patient identifying information, the affirmative verification of another person's communication of patient identifying information, or the communication of any information from the records of a patient who has been identified."
- "Patient identifying information" means the "name, address, social security number, fingerprints, photographs of similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information."

In sum, the information protected by Part 2 is any information disclosed by a Part 2 program that identifies an individual directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a Part 2 program.

Q4. For the purposes of the applicability of 42 CFR Part 2, does it matter how HIOs are structured?

A4. No. HIOs may take any number of forms and perform a variety of functions on behalf of the health care providers and other entities participating in the HIO network.[4] Regardless of the functions performed by the HIO, 42 CFR Part 2 still applies. HIOs may:

- provide the infrastructure to exchange patients' health records among entities participating in the HIO network and facilitate the exchange of patients' electronic health information;
- serve as a data repository that holds or stores patient records supplied by entities participating in the HIO network, and then makes them available for exchange in response to participants' requests for such records;
- provide a record locator service for HIO participants and match individuals to their health records from different locations; or
- review and respond to requests for patient records from HIO participating providers.

Each of these scenarios involves the disclosure of Part 2 information. In some cases, the Part 2 program is disclosing protected information to the HIO, which stores it within the HIO system and then makes it available to HIO affiliated members on request. In other cases, the Part 2 program is disclosing protected information to the HIO, which does not keep it in a repository but rather passes the information along to HIO affiliated members. In either event, the disclosure of Part 2 protected

4. For purposes of these FAQs, entities that participate in an HIO network, including, but not limited to, participating health care providers, will be referred to as "HIO affiliated members." Participating health care providers may also be referred to as "HIO affiliated health care providers."

patient information to and through the HIO would only be permitted in ways authorized by Part 2. This means that in nonmedical emergency situations, either a patient consent or a Qualified Service Organization Agreement (defined in other FAQs) will need to be in place in order for the Part 2 program to disclose the information to the HIO, and patient consent will be needed to allow the HIO to redisclose the Part 2 information to other HIO affiliated members.

Q5. Does 42 CFR Part 2 permit the disclosure of information without a patient's consent for the purposes of treatment, payment, or health care operations?

A5. Unlike HIPAA, which generally permits the disclosure of protected health information without patient consent or authorization for the purposes of treatment, payment, or health care operations, Part 2, with limited exceptions (i.e., medical emergencies and audits and evaluations), requires patient consent for such disclosures (42 CFR §§ 2.3, 2.12, 2.13).[5] Some types of exchange, however, may take place without patient consent when a qualified service organization agreement (QSOA) exists or when exchange takes place between a Part 2 program and an entity with administrative control over that program.

A qualified service organization (QSO) means a person or organization that:

1. provides services to a Part 2 program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting or other professional services or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy, and
2. has entered into a written agreement with a program under which that person a) acknowledges that in receiving, storing, processing or otherwise dealing with any patient records from the programs, it is fully bound by these regulations; and b) if necessary, will resist in judicial proceedings any efforts to obtain access to patient records, except as permitted by these regulations.

Where a Part 2 program has entered into a QSOA with an entity that provides any of the covered services, and where the information exchanged is needed to provide the covered services, patient consent is not required. (42 CFR § 2.11)

In addition, patient consent is not required when information is exchanged within a Part 2 program or between a Part 2 program and an entity that has direct administrative control over the program. When a substance use disorder unit is a component of a larger behavioral health program or of a general health program, specific information about a patient arising out of that patient's diagnosis, treatment or referral to treatment can be exchanged without patient consent among the Part 2 program personnel and with administrative personnel who, in connection with their duties, need to know information (42 CFR § 2.12[c][3]). Patient information may not be exchanged among all of the programs and personnel that fall under the umbrella of the entity that has administrative control over the Part 2 program. A QSOA would be required to enable information exchange without patient consent in this situation.

Q6. Under Part 2, can a Qualified Service Organization Agreement (QSOA) be used to facilitate communication between a Part 2 program and an HIO?

A6. Yes. A QSOA under Part 2, which is similar but not identical to a business associate agreement

5. For a comparison of the HIPAA Privacy Rule and Part 2 provisions, see the SAMHSA guidance at: http://www.hipaa.samhsa.gov/download2/SAMHSAPart2-HIPAAComparison2004.pdf.

under §§ 164.314(a) and 164.504(e) of the HIPAA Security and Privacy Rules, is a mechanism that allows for disclosure of information between a Part 2 program and an organization that provides services to the program, such as an HIO. Examples of services that an HIO might provide include holding and storing patient data, receiving and reviewing requests for disclosures to third parties, and facilitating the electronic exchange of patients' information through the HIO network.

Before a Part 2 program can communicate with a Qualified Services Organization—in this case the HIO—it must enter into a two-way written agreement with the HIO. Once a QSOA is in place, Part 2 permits the program to freely communicate information from patients' records to the HIO as long as it is limited to that information needed by the HIO to provide services to the program. The HIO may also communicate with the Part 2 program and share information it receives from the program back with the program. Patient consent is not needed to authorize such communications between the HIO and Part 2 program when a QSOA is in place between the two.

Q7. May information protected by Part 2 be made available to an HIO for electronic exchange?

A7. Information protected by 42 CFR Part 2 may only be made available to an HIO for exchange if:

1. a patient signs a Part 2-compliant consent form authorizing the Part 2 program to disclose the information to the HIO, OR
2. a Qualified Service Organization Agreement (QSOA) is in place between the Part 2 program and the HIO.

Q8. If Part 2 information has been disclosed to the HIO, either pursuant to a Part 2-compliant consent form authorizing such disclosure or under a QSOA, may the HIO then make that Part 2 information available to HIO-affiliated members?

A8. An HIO may disclose Part 2 information that it has received from a Part 2 program to HIO affiliated members (other than the originating Part 2 program) only if the patient signs a Part 2-compliant consent form. Patient consent is not needed to authorize such communications between the HIO and Part 2 program when a QSOA is in place between the two.

Q9. How do different HIO patient choice models regarding whether general clinical health information may be disclosed to or through an HIO (e.g., no consent, opt in, or opt out) affect the requirements of 42 CFR Part 2?

A9. HIOs have adopted a number of different policies for making general clinical information available to participating members. Some HIOs have adopted a "no consent" model, under which a patient's health information may be disclosed to an HIO and subsequently disclosed by the HIO to its affiliated members for specified purposes without obtaining the patient's consent. Other HIOs have adopted an "opt in" model, in which the patient's information is disclosed to the HIO and subsequently disclosed by the HIO to affiliated members for specified purposes only if the patient has affirmatively agreed to such disclosures. Yet other HIOs have adopted an "opt out" model, in which the patient's information is disclosed to the HIO and subsequently disclosed by the HIO to affiliated members for specified purposes unless the patient has affirmatively declined to participate in such exchange.[6]

6. This discussion of patient choice models relies upon definitions presented in "Consumer Consent Options for Electronic Health Information Exchange: Policy Considerations and Analysis" found on the web page of the Office of the National Coordinator for Health Information Technology at http://healthit.hhs.gov/portal/server.pt?open=512&objID=1147&parentname=CommunityPage&parentid=10&mode=2&in_

Regardless of which model the HIO adopts for exchanging general clinical information, the HIO must still comply with the requirements of 42 CFR Part 2 with respect to Part 2 information. This means that even if an HIO adopts a "no consent" model for other information, the patient's Part 2-compliant consent must be obtained to disclose Part 2 information to or through the HIO. On the other hand, the HIO may impose requirements in addition to 42 CFR Part 2. For example, because an "opt in" model requires affirmative patient consent to participate in the HIO, a Part 2 program may need to obtain patient consent to disclose Part 2 information to an HIO even if the Part 2 program has a QSOA with the HIO.

Q10. If an HIO is holding or storing Part 2 patient data through a QSOA, can the HIO redisclose the data coming from the Part 2 program to a third party without patient consent?

A10. Only in very limited circumstances. An HIO may disclose the Part 2 information to a contract agent of the HIO, if it needs to do so in order to provide the services described in the QSOA, and as long as the agent only discloses the information back to the HIO or the Part 2 program from which the information originated. If a disclosure is made by the HIO to an agent acting on its behalf to perform the service, both the HIO and the agent are bound by Part 2, and neither organization can disclose the information except as permitted by Part 2.

The HIO would **not** be allowed to redisclose the information to third parties, including HIO affiliated members (except in a medical emergency, which will be discussed in other FAQs), because the HIO affiliated members are not acting as agents of the HIO, but rather are receiving services provided by the HIO. Consequently, if an HIO wants to redisclose the Part 2 program's records to a participating member, it would need the consent of the patient.

Q11. What are the required elements of a patient consent under Part 2?

A11. A written consent to a disclosure under the Part 2 regulations must be in writing and include all of the following items (42 CFR § 2.31):

1. the specific name or general designation of the program or person permitted to make the disclosure;
2. the name or title of the individual or the name of the organization to which disclosure is to be made;
3. the name of the patient;
4. the purpose of the disclosure;
5. how much and what kind of information is to be disclosed;
6. the signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient;
7. the date on which the consent is signed;
8. a statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to

hi_userid=11113&cached=true . There are variations on these general models, however, the principles with respect to 42 CFR Part 2 apply to all models.

disclose information to a third party payer; and

9. the date, event or condition upon which the consent will expire if not revoked before. This data, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

Q12. What must a Part 2 program do to notify the HIO, or any other recipient of Part 2 protected information, that it may not redisclose Part 2 information without patient consent?

A12. Part 2 requires each disclosure made with written patient consent to be accompanied by a written statement that the information disclosed is protected by federal law and that the recipient cannot make any further disclosure of it unless permitted by the regulations. Thus, when information is disclosed electronically, an accompanying notice explaining the prohibition on redisclosure must also be electronically sent. Under 42 CFR § 2.32, the statement must read:

"This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

Q13. Can a single consent form be used to authorize the disclosure of Part 2 information to an HIO, as well as authorize the redisclosure of that information to other identified parties, such as HIO affiliated members?

A13. Yes. Under Part 2, a single consent form can authorize a disclosure of information about a patient to one recipient, such as an HIO, and simultaneously authorize that recipient to redisclose that information to an additional entity or entities (such as other HIO affiliated health care providers identified in the consent form), provided that the purpose for the disclosure is the same. The required statement prohibiting redisclosure must accompany the information disclosed through consent, so that each subsequent recipient of that information is notified of the prohibitions on redisclosure.

Q14. Does Part 2 allow the use of multiple-party consent forms?

A14. Yes. A Part 2 consent form can authorize an exchange of information between multiple parties named in the consent form. The key is to make sure the consent form authorizes each party to disclose to the other ones the information specified and for the purpose specified, in the consent.

If patients want to authorize all or many members of the HIO to access their Part 2-protected record as well as to exchange information with one another, a multiple-party consent form must comply with all relevant requirements of Part 2, including a list of the names of each person or organization to whom disclosures are authorized, that the parties may disclose to each other, and for what purposes.

Q15. Does Part 2 require the use of original signed consents?

A15. No. While consent under Part 2 must be in writing and nonverbal, "wet" signatures—where the entity obtaining a patient's consent gets the consent form signed by the patient in-person and sends the original, signed consent form to the Part 2 provider—are not necessary. Part 2 does not require programs (or recipients named in the consent) to have a patient's "original" signed consent form in their possession to make disclosures. As long as the program or recipient of the consent acts with reasonable caution, it may accept a facsimile or a photocopy of a consent form. Some electronic health information systems may have, or may be developing, the capacity to obtain

electronic consents. An electronic signed consent form would be allowable as well, provided an electronic signature is valid under applicable law.

Q16. Under Part 2, may an HIO release demographic information about Part 2 patients without patient consent?

A16. Yes. However, one must be sure to be in compliance with Part 2, which prohibits the disclosure of patient-identifying information. (42 CFR § 2.11 and § 2.13) Therefore, releasing demographic information would only be allowed under Part 2 if the demographic information does not reveal any information that would identify the person, either directly or indirectly, as having a current or past drug or alcohol problem or as being a patient in a Part 2 program.[7]

Q17. Under Part 2, can an HIO reveal that a patient had an encounter at a mixed use facility (or "general medical" facility—see FAQ #2) as long as the HIO does not reveal that the patient was in the mixed use facility's Part 2 program? A mixed use facility can be defined as a service provider organization that provides substance abuse treatment services as well as other health services such as primary care, dental care, mental health services, social services, etc.

A17. Yes, such a disclosure would be permitted under Part 2 because no information protected under Part 2—any information that would identify the person, either directly or indirectly, as having a current or past drug or alcohol problem or as being a patient in a Part 2 program—is being disclosed. Part 2 explicitly permits "acknowledgement of the presence of an identified patient in a facility or part of a facility if the facility is not publicly identified as only an alcohol or drug abuse diagnosis, treatment, or referral facility, and if the acknowledgement does not reveal that the patient is an alcohol or drug abuser." (42 CFR § 2.13[c][1])

Q18. Under Part 2, can an HIO use a consent form that provides for disclosure to "HIO members" and refers to the HIO's website for a list of those members?

A18. No. 42 CFR Part 2, § 2.31(a)(2) states that consent forms must include the names of the individuals or organizations who will be the recipients of the Part 2 data. The purpose of this requirement is to ensure that patients are sufficiently informed about the disclosures that will be made under the consent. Many individuals throughout the country still do not have computers or access to the Internet, and many HIO affiliated health care providers do not have the resources to provide patients with access to the Internet at the HIO providers' offices. Thus, Part 2 consents should identify, by attachment if necessary, all the HIO affiliated members that are potential recipients of the Part 2 data.

Q19. Can an HIO use a consent form under Part 2 to allow for the disclosure of information to future HIO affiliated health care providers?

A19. No. If a health care provider joins the HIO after a consent is signed, and the patient later goes to that provider for care, Part 2 would require that the new HIO affiliated health care provider obtain the patient's consent for access to the patient's information. This is consistent with 42 CFR Part 2, §2.31(a)(2) that requires patient consent to include the names of the individuals or organizations that will be the recipients of the Part 2 data.

Q20. Can an HIO use a consent form under Part 2 to allow for the disclosure of information to health care providers who are providing on-call coverage for HIO affiliated health care providers or with whom those affiliated providers consult?

7. Additional information about patient-identifying information can be found in the 2004 Substance Abuse and Mental Health Services Administration (SAMHSA) guidance document at http://www.hipaa.samhsa.gov/download2/SAMHSAPart2-HIPAAComparison2004.pdf.

A20. Yes, if those providing on-call coverage and consultation for an HIO affiliated provider are listed on the consent form. (See 42 CFR § 2.31[a][2] requiring the specific name of the individual or organization to whom disclosure may be made to be included in the consent form.)

Q21. Can a Part 2 patient consent be used to enable multiple disclosures?

A21. Yes. Under a Part 2 patient consent, information may be disclosed multiple times, as long as the consent has not yet expired and the entities to whom the information is to be disclosed, the nature of the information, and the purpose for the disclosure specified in the consent form are still the same. A separate consent form does not need to be obtained each time a disclosure of Part 2 records is made.

Q22. Can a Part 2 program or HIO use a consent form that has no specific expiration date but rather states that disclosure is permitted until consent is revoked by the patient?

A22. No. Under 42 CFR § 2.31, a Part 2 consent form must list the date, event, or condition upon which the consent will expire, if not revoked before. Thus, it is not sufficient under Part 2 for a consent form to merely state that that disclosures will be permitted until the consent is revoked by the patient. It is, however, permissible for a consent form to specify the event or condition that will result in revocation, such as having its expiration date be "upon my death."

Q23. Is "treatment" a sufficient description of the intended purpose of a disclosure on a Part 2 consent?

A23. Yes, it is sufficient for "treatment" to be listed on a consent form as the intended purpose of a disclosure under Part 2. A consent authorizing Part 2 patient information to be included in, or exchanged through, an HIO's system for the purpose of "treatment" would not permit that information to be shared or used for other purposes, such as for payment, disease management, or quality improvement activities, among others.

Q24. Under Part 2, can any health care provider make the determination that a medical emergency exists, or must a Part 2 provider make that determination?

A24. Any health care provider who is treating the patient for a medical emergency can make that determination. Under the medical emergency provision in Part 2, §2.51, "patient identifying information may be disclosed to medical personnel who have a need for information about the patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention." (42 CFR § 2.51[a]) This provision does not require that the Part 2 program make that determination. Thus, any treating provider who determines that a condition which poses an immediate threat to the health of an individual exists can make the decision to "break the glass" (the term used when a health care provider, in the case of an emergency, gets access to a patient's records without the patient's consent) and gain access to Part 2 records. This includes HIO affiliated health care providers treating an individual in a medical emergency who might seek access to records about a patient that are held in, or made available through, an HIO.

Q25. May a computer system be used to automatically determine whether a medical emergency exists and whether a disclosure of Part 2 data can be made without the patient's consent?

A25. Automated electronic health information systems can be programmed to flag specific patient information for a provider to use in determining whether a medical emergency exists and may be programmed to provide alerts to authorized providers. However, one may not automate the determination of a medical emergency. Part 2 requires medical personnel treating an emergency (the treating provider) to use their professional judgment to determine whether the situation meets Part 2's definition of a medical emergency, defined as a particular condition that poses an immediate threat

to the health of any individual and requires medical intervention. Once a medical emergency has been determined, Part 2 information may be disclosed without the patient's consent. (42 CFR § 2.51[a])

Q26. If a medical emergency exists, can the entire Part 2 record be released?

A26. Yes. If there is a medical emergency, Part 2 would allow the entire record to be released through an HIO to a treating provider who indicates that he or she needs access to that information to treat a condition that poses an immediate threat to the health of any individual and requires immediate medical intervention.

Q27. For documentation purposes, if a medical emergency is present, would it be permissible under Part 2 to have treating providers simply check a drop down box signifying the existence of such a medical emergency?

A27. Under Part 2 it is permitted, but not sufficient, for treating providers in a medical emergency to merely check a drop down box to signify that they deem that a medical emergency exists under Part 2's definition. Part 2 requires that when a disclosure is made in connection with a medical emergency, the Part 2 program must document in the patient's record the name and affiliation of the medical personnel receiving the information, the name of the individual making the disclosure, the date and time of the disclosure, and the nature of the emergency. Thus, the same information must be recorded by treating providers in any medical emergency and conveyed to the Part 2 program. Automated electronic systems may be used to generate information necessary for a provider to make a determination of a medical emergency, to enable provider entry of emergency information, and/or to generate a report documenting the emergency. Other laws or legal requirements that are, or may be, applicable to HIO affiliated health care providers have similar requirements for audit trails to document the specifics of "break the glass" incidents, such that it enables review by the relevant privacy officer that such access was proper.

Q28. Under Part 2, may an HIO system make clinical decision support functions (such as showing a patient's medications to clinicians when they write prescriptions, automatically ordering medications, and/or alerting clinicians about potential drug interactions) available to HIO affiliated health care providers in a medical emergency?

A28. Yes. Access without patient consent is permitted for information protected by Part 2 in circumstances that meet Part 2's definition of a medical emergency (42 CFR § 2.51). When a treating provider determines that a true medical emergency exists, the system can show the physician the information that is needed to treat that medical emergency, including revealing Part 2 information. In circumstances not involving a medical emergency, the system could not disclose any Part 2 data to the treating physician in the absence of consent. The system could only tell the provider that a specific consent must be obtained, and it must be set up so that such a notice would not reveal the existence of protected Part 2 information.

Q29. Does the Part 2 definition of medical emergency also include mental health emergencies?

A29. Yes. Part 2 does not distinguish between physical and mental health emergencies. A medical emergency is simply defined as a health emergency affecting any individual that requires immediate medical intervention. (42 CFR § 2.51[a])

Q30. When the HIO keeps an electronic record of a medical emergency, does that fully meet Part 2's requirement to document disclosures made in a medical emergencies in the patient's record?

A30. No. Part 2 requires that when a disclosure is made in connection with a medical emergency, the Part 2 *program* (emphasis added) must document in the patient's record the name and affiliation

of the recipient of the information, the name of the individual making the disclosure, the date and time of the disclosure, and the nature of the emergency (42 CFR § 2.51[c]). Thus, data systems must be designed to ensure that the Part 2 program is notified when a "break the glass" disclosure occurs and Part 2 records are released pursuant to a medical emergency. The notification should include all the information that the Part 2 program is required to document in the patient's records. The information about emergency disclosures should also be kept in the HIO's electronic system.

Q31. If an HIO's electronic system makes a disclosure in a medical emergency, would documenting the name of the discloser as "electronically disclosed through the system administered by HIO" meet Part 2's requirement that the name of the person who made the disclosure be documented in the patient's record?

A31. No. Part 2 requires that all the circumstances surrounding a disclosure in a medical emergency situation be immediately documented in writing in order to ensure that all the circumstances surrounding a medical emergency disclosure can be investigated and individuals held accountable for their decisions. The HIO is the vehicle for the disclosure of the Part 2 record but not the decision-maker. Thus, documenting the disclosure as "electronically disclosed through the system administered by the HIO," while technically accurate, does not reveal the information that must be documented under Part 2—the identity of the individual who determined that the situation was in fact a medical emergency and determined that the patient's records should be released. The name of the person who makes the determination and documentation of disclosure made electronically through a system administered by the HIO should be recorded in the HIO's electronic system.

Q32. If an HIO's electronic system sends Part 2 data in a medical emergency to a printer or fax machine in the emergency room, can "the printer in the emergency department" meet Part 2's requirement to document in the patient's record the name of the person to whom the disclosure was made?

A32. No. Part 2 requires that "[t]he name of the medical personnel to whom disclosure was made and their affiliation with any health care facility" be recorded in order to ensure that all the recipients of the information were authorized to receive that information and used it appropriately. Therefore, the name(s) of the medical personnel who received the information and used it to treat the patient should be recorded. (42 CFR § 2.51[c])

Q33. Once Part 2 information is disclosed in a medical emergency, can that information be redisclosed without obtaining patient consent?

A33. Yes. In contrast to circumstances where information is disclosed through patient consent, if a medical emergency exists, Part 2 provisions do not prohibit the redisclosure of Part 2 information once it is released. Consequently, medical personnel treating a patient for a medical emergency who are HIO affiliated providers may download and include in their own records the information they obtained in treating the emergency, and may then redisclose that information to others without obtaining patient consent. However, all disclosures of information under the regulation must be limited to the information necessary to carry out the purpose of the disclosure (42 CFR § 2.13[a]).

Q35. Can an HIO disclose data for Disease Management purposes under Part 2 without patient consent?

A35. No. The HIO may not disclose protected Part 2 information for Disease Management purposes unless the patient specifically authorizes such a redisclosure for that purpose in a consent form that meets Part 2's requirements. It would be helpful for the consent form to explain the term "Disease Management" and even, perhaps, provide examples of how the information might be used.

If a Part 2 program discloses information to the HIO via a QSOA, the HIO would still need to obtain the patient's consent before redisclosing the protected information to any third parties for Disease Management purposes. A disclosure would be permitted in those rare situations where information disclosed by the HIO for Disease Management purposes does not implicitly or explicitly disclose the information protected by Part 2. An example would be when information is aggregated data that does not reveal that the patient has a drug or alcohol problem or the patient's status as a participant in alcohol or drug treatment.

Q36. Under Part 2, would an HIO be permitted to disclose to an HIO affiliated payer the data of several patients held by the HIO, which may include Part 2 data, in order for the payer to target where interventions could be made with particular patients to improve care and management of disease?

A36. No. An HIO would not be permitted to disclose information protected by Part 2 to payers for any reason, including Disease Management, without a Part 2 consent specifically authorizing disclosure for that purpose.

Q37. If an HIO affiliated health care provider wishes to gain access to a minor's Part 2 record held by the HIO, may the HIO or provider obtain only the consent of a parent or guardian, or must the minor's consent also be obtained?

A37. Under Part 2, the HIO affiliated provider and/or the HIO (acting for the provider and Part 2 program) must always obtain the minor's consent before the provider can gain access to the minor's Part 2 record (42 CFR § 2.14). Depending on state law, the provider might also need to obtain the parent's or guardian's consent as well. Parental consent for a disclosure is required in addition to the minor's only if the Part 2 program is required by state law to obtain parental consent before providing alcohol or drug treatment to the minor. In other words, if a state law gives a minor the legal authority to consent to treatment on his/her own, without a parent's or guardian's permission or knowledge, then only the minor's consent is required for the HIO to disclose the minor's information to the HIO affiliated health care provider under Part 2. If state law requires parental consent for the minor to be provided alcohol or drug treatment, then the consent of both the minor patient and the parent or guardian is required before the Part 2 program or HIO can make any disclosures. The minor's written consent must be obtained first in all cases.

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=429#h5p-11

LICENSE AND ATTRIBUTION

CHAPTER 22.

DISCLOSURE OF SUBSTANCE USE DISORDER PATIENT RECORDS: DOES PART 2 APPLY TO ME?

This fact sheet explains a 42 CFR Part 2 Program and how healthcare providers can determine how Part 2 applies to them.

INTRODUCTION

Title 42 of the Code of Federal Regulations (CFR) Part 2: Confidentiality of Substance Use Disorder Patient Records (Part 2) was first promulgated in 1975 to address concerns about the potential use of Substance Use Disorder (SUD) information in non-treatment based settings, such as administrative or criminal hearings related to the patient. Part 2 is intended to ensure that a patient receiving treatment for a SUD in a Part 2 Program does not face adverse consequences in relation to issues such as criminal proceedings and domestic proceedings, such as those related to child custody, divorce, or employment. Part 2 protects the confidentiality of SUD patient records by restricting the circumstances under which Part 2 Programs or other lawful holders[1] can disclose such records.

Part 2 Programs are federally assisted[2] programs.[3] In general, Part 2 Programs are prohibited from disclosing any information that would identify a person as having or having had a SUD unless that person provides written consent. Part 2 specifies a set of requirements for consent forms, including, but not limited to, the name of the patient, the names of individuals/entities that are permitted to disclose or receive patient-identifying information, the amount and kind of the information being disclosed, and the purpose of the disclosure (see §2.31).[4] In addition to Part 2, other privacy laws such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[5] have been enacted. HIPAA generally permits the disclosure of protected health information for certain purposes without patient authorization, including treatment, payment, or health care operations.

To help stakeholders understand their rights and obligations under Part 2, the Office of the

1. 1 A "lawful holder" is an individual or entity who has received patient identifying information as the result of a Part 2-compliant consent or as otherwise permitted under the Part 2 statute, regulations, or guidance.
2. "Federally assisted" (defined at § 2.12 [b]) encompasses a broad set of activities, including management by a federal office or agency, receipt of any federal funding, or registration to dispense controlled substances related to the treatment of SUDs. Many SUD treatment programs are federally assisted.
3. A "program" (defined at § 2.11) is an individual, entity (other than a general medical facility), or an identified unit in a general medical facility, that "holds itself out" as providing and provides diagnosis, treatment, or referral for treatment for a SUD. Medical personnel or other staff in a general medical facility who are identified as providers whose primary function is to provide diagnosis, treatment, or referral for treatment for a SUD are also Programs. "Holds itself out" means any activity that would lead one to reasonably conclude that the individual or entity provides substance use disorder diagnosis, treatment, or referral for treatment.
4. A full description of the requirements of a Part 2 consent form is available at: https://www.gpo.gov/fdsys/pkg/FR-2017-01-18/pdf/2017-00719.pdf.
5. State laws and regulations may also further restrict the disclosure of substance use disorder patient records.

National Coordinator for Health Information Technology (ONC) and the Substance Abuse and Mental Health Services Administration (SAMHSA) have released two fact sheets illustrating how Part 2 might apply in various settings. This fact sheet focuses on helping health care providers determine how Part 2 applies to them by depicting scenarios they might encounter when caring for patients. Each scenario illustrates whether Part 2 applies to a theoretical disclosure of patient health information, and if so, what a provider would need to do to properly disclose the information according to Part 2.[6]

SCENARIO 1: OPIOID TREATMENT PROGRAM

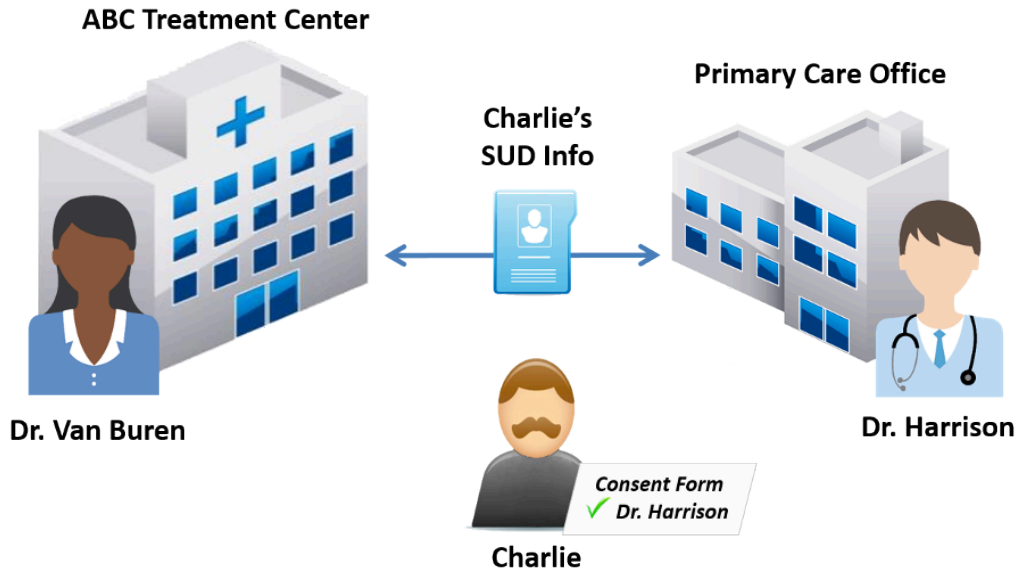

Figure 22.1

ABC Treatment Center (ABC) is a SAMHSA-certified Opioid Treatment Program that provides Medication-Assisted Treatment (MAT) for persons diagnosed with an opioid use disorder (OUD). ABC is accredited by a SAMHSA-approved accrediting body to dispense opioid treatment medications. Dr. Van Buren works at ABC and is registered with the Drug Enforcement Administration (DEA) to prescribe controlled substances for the treatment of OUD.

Charlie is a 33-year-old who hurt his back at work. He went to his primary care provider, Dr. Harrison, and was prescribed an opioid painkiller to manage his pain. Charlie became dependent on the painkiller and began illegally obtaining and using opioids after his prescription ran out. Charlie sought help from ABC and is now receiving methadone treatment for an OUD.

Charlie is seeing Dr. Harrison in two weeks to follow up about his back injury. Dr. Van Buren asked Charlie if he wanted his treatment information sent to his primary care provider, Dr. Harrison. Charlie agreed in a written consent to let Dr. Van Buren share his OUD treatment information with Dr. Harrison.

- Step 1: Is ABC covered? Does Part 2 apply? Yes. ABC meets the definition of a program

6. Note: All scenarios described in this fact sheet involve adult patients. Part 2 includes specific provisions for minor patients (see § 2.14) that are not presented in this fact sheet.

because it is an entity (other than a general medical facility) that holds itself out (e.g., through advertisements) as providing and provides SUD treatment services. Additionally, ABC is federally assisted because it has been certified by SAMHSA as an Opioid Treatment Program. Therefore, ABC meets the definition of a Part 2 Program.

- Step 2: Can ABC disclose patient-identifying information? If so, how? Yes. As a Part 2 Program, ABC can disclose patient-identifying information if it obtains written patient consent. Because ABC Treatment Center holds itself out as a facility that provides SUD diagnosis, treatment, or referral for treatment, any patient information coming from ABC could identify the patient as having or having had a SUD.

To share Charlie's record with Charlie's primary care provider, Dr. Van Buren would need to obtain written consent from Charlie. The consent form would need to comply with all of the requirements specified in §2.31 of the Part 2 regulations, including identifying the SUD information in the "Amount and Kind" section and stating the purpose of the disclosure. Charlie's information would also need to be accompanied by a notice of prohibition on redisclosure (described at §2.32) so that Dr. Harrison recognizes the information as Part 2-protected and does not further disclose the information without Charlie's consent. See Figure 22.1, above, for an illustration.

SCENARIO 2: MIXED-USE FACILITY

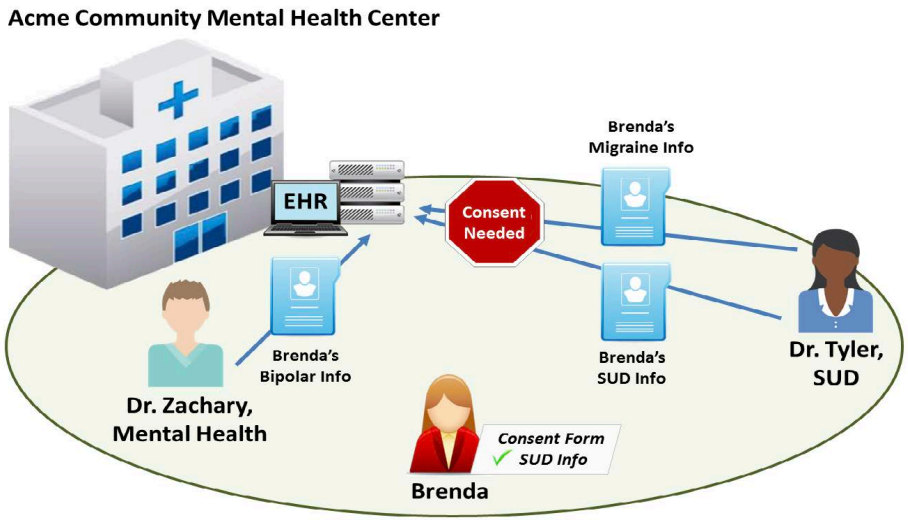

Figure 22.2

Acme Community Mental Health Center (Acme) provides both SUD treatment services and mental health services. Acme recently installed an Electronic Health Record (EHR) system for the entire health center.

Dr. Tyler, an addiction specialist at Acme, only treats patients with SUDs. Typically, Dr. Tyler uses controlled substances for detoxification or maintenance treatment of a patient's SUD.

Dr. Zachary, a psychiatrist at Acme, specializes in treating patients with mental disorders. Dr. Zachary does not treat patients for SUD.

Brenda has bipolar disorder and a SUD. She has been going to Acme for the past five years and sees Dr. Zachary for treatment of her bipolar disorder and Dr. Tyler for treatment of her SUD. At Brenda's

most recent visit, Dr. Tyler added to Brenda's record that Brenda was suffering from migraines and had relapsed in her recovery from her SUD.

- Step 1: Is Acme covered? Does Part 2 apply? Yes. Dr. Tyler meets the definition of a Part 2 Program because Dr. Tyler works at a general medical facility where her primary function is for the provision of diagnosis, treatment, or referral for treatment of patients with SUDs. Additionally, Dr. Tyler is considered federally assisted because she is registered with the DEA to prescribe controlled substances for detoxification or maintenance treatment of a SUD. Therefore, Dr. Tyler is considered a Part 2 Program.
- Step 2: Can Acme disclose patient-identifying information? If so, how? This scenario is complex, with three types of health information to consider: SUD, migraines, and bipolar disorder.
    - SUD: Because Dr. Tyler meets the definition of a Part 2 Program, she needs to obtain Brenda's consent to disclose information that would identify her as a patient with a SUD. This includes disclosures to other providers at Acme. Therefore, if Brenda's SUD patient records are available to other providers at Acme through the facility's EHR system, Brenda's consent form must name Acme or individual providers at Acme if she wants to share her records with them (see Figure 22.2 for an illustration). The consent form would need to comply with all of the requirements specified in §2.31 of the Part 2 regulations (i.e., identify the SUD information in the Amount and Kind section, identify the purpose of the disclosure, etc.). Brenda's information would also need to be accompanied by a notice of prohibition on re-disclosure (described at §2.32).
    - Migraines: In other circumstances, information about Brenda's migraines would not identify her as a patient with a SUD and could potentially be disclosed without her consent. However, in this scenario, Dr. Tyler is a Part 2 Program. She only treats patients with a SUD and is recognized as such. Therefore, any information disclosed by Dr. Tyler would identify a patient as having or having had a SUD. Dr. Tyler would need to obtain Brenda's consent to disclose any personally identifying information related to her care, even if that information would not otherwise indicate that she had a SUD.
    - Bipolar disorder: Dr. Zachary does not meet the definition of a Part 2 Program and Brenda's diagnosis of bipolar disorder would not identify her as a patient with a SUD. Therefore, Part 2 does not prohibit Dr. Zachary from disclosing information related to Brenda's treatment for bipolar disorder without her consent; however, state laws may restrict the disclosure of mental health information without patient consent or authorization.

Part 2 permits providers at Acme to acknowledge that Brenda is a patient at Acme without her consent. Because Acme is a mixed-use facility that provides services other than diagnosis, treatment, or referral for treatment for a SUD, acknowledging the presence of a patient at Acme would not necessarily identify that patient as having or having had a SUD. However, Acme providers could not disclose that Brenda is a patient of a Part 2 Program (e.g., that Brenda is a patient of Dr. Tyler's) without her consent because that would identify her as having or having had a SUD. See figure 22.2, above, for an illustration.

SCENARIO 3: ACCOUNTABLE CARE ORGANIZATION (ACO)

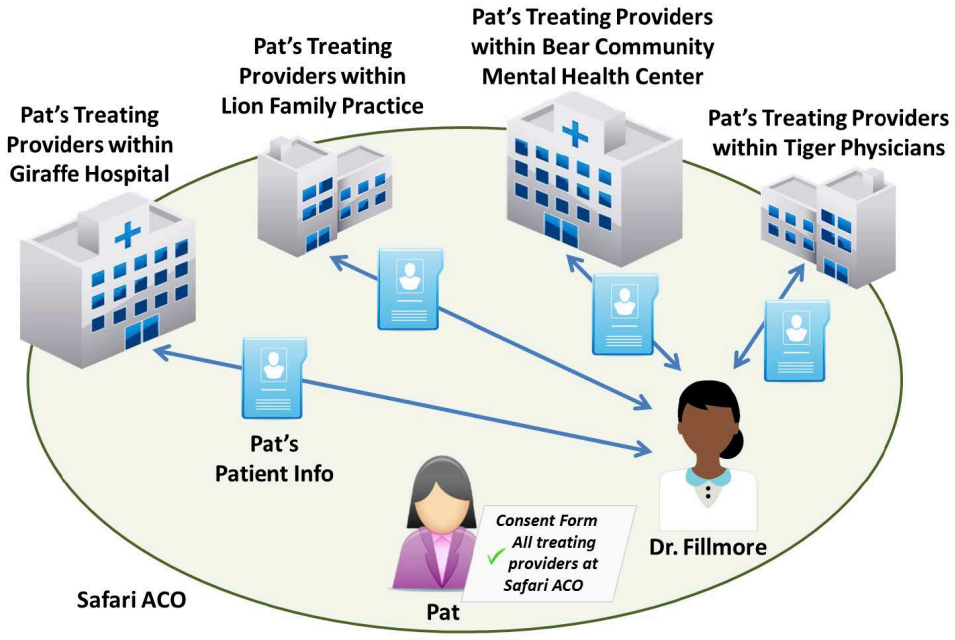

Figure 22.3

Accountable care organizations (ACOs) and other value-based payment arrangements create incentives for health care providers to work together to deliver high quality, coordinated care for patients. ACOs are often composed of a variety of different providers and care settings.

Safari ACO includes Lion Family Practice (Lions), Tiger Physicians Group (Tigers), Giraffe Hospital (Giraffes), and Bear Community Mental Health Center (Bears). Dr. Fillmore works at Bears, a mixed-use facility. She is recognized as the facility's lead SUD physician and primarily treats patients with SUDs. Dr. Fillmore often prescribes controlled substances for detoxification or maintenance treatment to his patients, including Pat.

- Step 1: Is Dr. Fillmore covered? Does Part 2 apply? Yes. Dr. Fillmore meets the definition of a Part 2 Program because she is identified as a provider at a general medical facility whose primary function is to treat patients with SUDs. Additionally, Dr. Fillmore is considered federally assisted because she is registered with the DEA to prescribe controlled substances for detoxification or maintenance treatment of a SUD. Therefore, Dr. Fillmore meets the definition of a Part 2 Program.
- Step 2: Can Dr. Fillmore disclose patient-identifying information to Pat's other providers in the ACO? If so, how? Dr. Fillmore would need to obtain written consent from Pat to disclose information about Pat's treatment for a SUD to any other of her treating providers from Lions, Tigers, Giraffes, or Bears. The consent form would need to comply with all of the requirements specified in §2.31 of the Part 2 regulations (i.e., specifically identify the SUD information in the "Amount and Kind" section, identify the purpose of the disclosure, etc.). Pat's information would also need to be accompanied by a notice of prohibition on re-disclosure (described at §2.32). Rather than naming each of her treating providers on the consent form, Pat could name Safari ACO and use a general designation (e.g., "all of my treating providers"). If Pat used a general designation, the consent form must include a

statement indicating that, upon request, Pat is entitled to receive a list of all entities that have received her information under the general designation. See Figure 22.3, above, for an illustration.

SCENARIO 4: INTEGRATED CARE SETTING

Today, many patients receive treatment for a SUD in a primary care or integrated care setting. These settings may provide both behavioral and physical health services, and individual providers may address all of a patient's behavioral or physical health needs. Depending on its particular characteristics, an integrated care setting may not have a Part 2 Program even if it provides some services for the diagnosis, treatment, or referral for treatment of a SUD.

Blue Mountain Physician Group is a group of providers that treats the whole person in an integrated care setting. Although Blue Mountain does not advertise that it provides SUD treatment services, its physicians have received waivers from SAMHSA to prescribe buprenorphine for the treatment of opioid use disorders.

Dr. Pierce is a provider at Blue Mountain and treats a diverse group of patients. Occasionally, Dr. Pierce encounters patients with an opioid dependency and provides MAT with buprenorphine. However, he does this only for a handful of patients and such services do not constitute his primary function at Blue Mountain.

One of his patients, Brooke, came to see him for a respiratory infection. Brooke had previously received treatment for an OUD at an inpatient treatment facility not affiliated with Blue Mountain, but recently relapsed. When Dr. Pierce saw Brooke for the respiratory infection, she mentioned that she was experiencing withdrawal symptoms from opioid use. Dr. Pierce prescribed an antibiotic for the infection and started MAT with buprenorphine.

- Step 1: Is Dr. Pierce covered? Does Part 2 apply? Dr. Pierce is federally assisted because he is registered with the DEA to prescribe controlled substances for the treatment of OUD and has received a physician waiver from SAMHSA to prescribe buprenorphine. However, Dr. Pierce practices at a general medical facility where his primary function is not providing diagnosis, treatment, or referral for treatment for a SUD. Therefore, Dr. Pierce does not meet the definition of a Part 2 Program.
- Step 2: Can Dr. Pierce disclose patient-identifying information? If so, how? In this case, Dr. Pierce is not a Part 2 Program and therefore is not subject to the disclosure restrictions of Part 2. However, before he discloses Brooke's information, Dr. Pierce still needs to consider privacy requirements under HIPAA and state privacy laws.

DISCLAIMER

The information in this fact sheet is not intended to serve as legal advice nor should it substitute for legal counsel. The fact sheet is not exhaustive, and readers are encouraged to seek additional technical guidance to supplement the illustrative information contained herein.

LICENSE AND ATTRIBUTION

Substance Abuse and Mental Health Services Administration. (2018). Disclosure of Substance Use Disorder Patient Records: Does Part 2 Apply to Me? Fact Sheet.

CHAPTER 23.

ETHICS RELATED TO MENTAL ILLNESSES AND ADDICTIONS

INTRODUCTION

Overview

The general public learns about mental illnesses and addictions primarily from mainstream media, including news reports, television programs, and movies. The stories presented usually center on sensationalism or danger, such as those about young women at life-threatening stages of anorexia nervosa or people labeled as "psychopaths." Or the stories appeal to our feelings of sympathy or empathy, such as those about people with untreated mental illnesses sleeping on subway vents during winter or a person with moderate dementia who finds greater companionship with someone other than their spouse. These reports and programs often oversimplify the ethical nature of these situations by dramatically pitting one value against another: self-determination versus life, public safety versus rehabilitation, quality of life versus non-abandonment, and happiness versus loyalty. Distilling situations down to one or two values can be motivated more by the ongoing competition for the public's attention and/or economics than by the demands of concise reporting.

However, mental illnesses and addictions are complex, as those who live with a mental health or addiction problem and their families can attest. The high incidence of mental health and addiction problems and their disruptive and lasting impact on people's lives, families' sustainability, communities' well-being, and employers' productivity are publicly acknowledged more often now. In recent years, more and more governments (civic, provincial/state, national) and employers have become interested in listening to those with first-hand experience of these conditions and to those who have developed holistic, integrative ways to diagnose and offer treatments and supports earlier and longer.

Ethical complexity is not limited to crises and strong emotions. It exists in everyday, seemingly routine questions, experiences, and situations. The cases in section 1.2, below, help illustrate the wide diversity of ethically complex, "real world" situations that those living with a mental health or addiction problem, their families and friends, professional healthcare workers, and their managers commonly face. Accordingly, the selected cases involve a variety of participants, interests, contexts, histories, health problems, options, and values. The healthcare ethics literature—which is quite extensive now—and educational workshops and courses encourage their readers and participants to increase their understanding of a particular situation or question and they offer various theories, concepts, and approaches to help make ethically defensible decisions. This chapter has similar objectives: first, to broaden and deepen readers' understanding of ethically relevant aspects in living with a mental health or addiction concern; second, to increase the understanding of ethically relevant aspects in offering, managing, and accessing healthcare services; and third, to increase readers' abilities to determine which options or responses to a particular issue or situation are and are not ethically sound.

With this said, though, it is not just "soundness" or basic justification that will be emphasized here. Too often decisions can be merely adequate ethically or minimally ethical. The appropriate goal is strongly ethical decisions and responses. Whether treating spina bifida, colitis or alcohol dependence, clinicians and healthcare organizations do not talk about providing merely adequate or merely acceptable therapies. In terms of the "technical" aspects of the programs and treatments they offer, their language is peppered with adjectives such as high quality, incomparable, excellent, leading, the best, and world-class. Why then settle for ethically "okay" or ethically adequate analyses and conclusions about these same interventions? A healthcare treatment or service cannot be described as first-rate or promulgated as "the standard of care" if its related ethical features have been simplified or minimized. The level of attention to and engagement with an intervention or service's ethical features directly and proportionately impacts its quality.

Two other considerations contribute to ethically strong health care practices and services. Health and healthcare are not about decisions and choices only. They are also and inescapably about human interactions, whether it is the person's interactions with her family, teachers, or employer, or her interactions with her healthcare team, or the interactions among her interprofessional and interagency workers. In his book, *Ethics and the Clinical Encounter* (2004), and as a philosopher who spends a lot of time in hospitals, Richard Zaner insightfully explores and questions the formal–informal and multivalent–ambiguous interactions that occur routinely between patients and professionals. "How" we are with one another matters a great deal ethically. Arthur Frank, a well-known sociologist whose scholarly interests include the meaning of illness and interactions with professionals and institutions, suggests, "We should speak less of ethics as some activity or substantive content that appears to stand alone and more of ethical relations" (2004, 357). Unethical language, tone, and demeanor can transform what seems, at the time, to be a good option—all things considered—into a poor and unpersuasive option.

Frank cautions against excessive emphasis on decision-making when he states that:

> "Being ethical… has less to do with making a single decision than with initiating a process—often a very slow process—of a person or persons coming to feel that how they acted was as good as it could have been, given the inherent impossibility of the situation (Ibid, 355-6).

Although "inherent impossibility" is meant to refer to healthcare situations typified by complicated machinery, invasive procedures, and life-threatening events (e.g., in intensive care units, in operating rooms, and in emergency departments), Frank's point holds true for long-term mental illnesses and substance use problems, too. Accordingly, this chapter's second noteworthy consideration is participants' characters or who they are, from both the perspectives of important people in their lives and from their own perspective. In modern bioethics discussions and analyses, virtue ethics as an ethical theory has tended to rely on Aristotle's Nicomachean Ethics (350 B.C.) and contemporary philosopher Alasdair MacIntyre's *After Virtue* (first published in 1981). More recently, philosopher Lisa Tessman has insightfully examined the durability and praiseworthiness of character virtues in progressively oppressive and harsh situations and societies. *Burdened Virtues: Virtue Ethics for Liberatory Struggles* (2005) is a welcome rehabilitation of virtue theory such that it is highly relevant for mental health and addictions settings, because unfortunately these settings can be restricting, stigmatizing, and marginalizing.

The remainder of this chapter describes ethically salient concepts and values for mental illnesses and addictions' questions, issues, and situations. Admittedly, some of these concepts are meaningful

for any illness, injury, or health condition. Nonetheless, certain ethical concepts are especially meaningful for serious mental health and addiction problems.

Daniel Sokol (2007) wrote a perceptive editorial piece in the BMJ describing his first days and weeks as an ethicist in a large general hospital in London. Surrounded by innumerable procedures, treatments, and appointments as he accompanies a nephrologist, Sokol observes that, "My proximity to the patients, instead of highlighting the ethical commitments, obscured them" (670). It took a while before he could see beyond what was urgent and close. With time, he began to see the underlying ethical quandaries, unasked questions, and troubling assumptions. His personal experience underscores an ability or skill that is critical for strong ethical analyses and responses: awareness or discernment (Holland, 1998; Nussbaum, 1985).

In this light, the section on ethical concepts and values is followed by four sections describing other considerations that bear significantly on what constitutes a strong ethically defensible decision or response for mental health and addictions issues and questions. These four sections cover clinical, legal, organizational, and systemic factors that cannot be ignored or dismissed by those endeavoring to understand and respond well ethically. In healthcare, ethics does not stand alone…. an unfortunate notion that can be reinforced when ethics specialists dramatically "parachute in" to meet briefly with a clinical team and the patient/family and leave just as quickly. Moreover, integrating all five aspects means that ethics never trumps everything else (Russell, 2008). It is both naïve and impractical for an ethicist to say, "Just do what is most ethical to do in this situation." Therefore this chapter's concluding section revisits the opening cases and identifies their ethical, clinical, legal, organizational, and systemic considerations and analyzes what qualifies as strongly ethical decisions and, as per Frank's wisdom, ethically strong interactions and characters.

Stylistic note: Many people consider the term "mental illness" to include addictions. In this chapter, however, they routinely will be referred to separately to ensure that addiction problems are not overlooked. Instead of "substance dependence, misuse, and abuse," the word "addiction" is used to help reduce this chapter's length. Ethical worries about the word will be discussed in the section "Stigma," below. Recently, however, various professionals have recommended "addiction" be used in the future DSM-V, the diagnostic manual of North American psychiatry. Different words are used to refer to those living with a mental health or addiction problem, such as patient, client, consumer, and survivor. "Client" will be used most often in this chapter because it portrays a reasonable balance in the power and interests between the individual and healthcare professionals and organizations and because most people with these health problems access treatments while living in the community.

FOUNDATIONAL ETHICAL CONSIDERATIONS

A familiar claim by those working as ethics specialists in hospitals and those teaching healthcare ethics is "It's ethics all the way down." Ethics involves what should matter or what should be valued and based on such values, what should be our aspirations, behaviors, and relationships. The word "should" is important here; in philosophical settings, "should" represents the normative element of ethics. There is a critical difference between what is valued and what should be valued. We must ask what the reasons are to value something and whether they are defensible or justified reasons. It is important to underscore that not all values are ethical, though everything that is ethical is based on values. This distinction is often disregarded in healthcare ethics.

Healthcare is informed by a host of values, including self-interest, economics (which can include efficiency and productivity measures), reputation, relationships, and politics (i.e., power). For

example, a decision to generate added revenue by charging to train community workers can be justified by economics. To justify it ethically, though, the added revenue would have to be used, for instance, to provide more recreational activities for clients' enjoyment and rehabilitation. If the additional monies were used to increase the agency's profile as the area's "go to" agency, then its justification would be focused on politics and/or reputation. Further examination would be required to determine if a better reputation will or will not contribute to achieving the agency's ethically defensible goals.

Being humane

It seems obvious that illnesses do not detract from being a human. Yet being a human, that is a member of the *homo sapiens* species, is not the same as being humane. "Being humane" typically means thinking, behaving, and interacting in certain ways. In the context of mental health and addictions programs and services, being humane warrants discussion because it may be what is first sacrificed when units are busy and staff levels are low.

Much has been written in the ethics literature and the nursing literature about the importance of caring and compassion: 21,246 articles and 1,285 articles respectively are listed when these key words are used with CINAHL, a primary nursing database. It is important, however, to distinguish between caring/compassion and respect because they are made manifest by different actions. If a close friend of someone unable to leave his home due to a relapse of his depression arranges an outing that will be as "easy" as possible to accept, this is an act of caring. Prior to deciding whether to go, if the depressed person listens carefully to what has been arranged and why specific arrangements have been made, this is an act of respect. If a case worker has a few toys in his office to occupy clients' children and does not keep clients waiting more than five minutes beyond their appointment time, he has been, respectively, caring and respectful. As Frank incisively points out, "Being ethical… is never anything that one has" (2004, 356). It is something one does or strives to do. Skillfulness is relevant to ethics, just as it is to nursing and case management, in terms of astutely discerning what is required and how it can best be accomplished. Ineptness should not be repeatedly forgiven simply because the person had good intentions.

Being humane should also include generosity and welcome, two qualities often overlooked in everyday interactions. Generosity is not about money. Instead it is a philanthropy of spirit and hope wherein people are pro-the Other. Yet this generosity does not equate to strident self-sacrifice and Puritanism. It involves giving but it can be in small, subtle ways. While generosity is a giving or contributing to, without expectation of return, welcome is a taking in wherein the presence of the Other is appreciated. The history of mental health and addictions work and settings includes far too little generosity and welcome. This constitutes an ongoing challenge for contexts in which police powers can be employed: how to once again be seen as generous and welcoming after a client has lost some basic civic rights and freedoms (e.g., involuntary hospitalization, use of a seclusion room)? Welcome and generosity can fade in the wake of efficiency measures, bed flow pressures, staff shortages, and management by statistics; operations may improve economically, but not ethically.

Finally, being humane means relationships are inescapably important, given that human beings are social creatures. In health care settings, ongoing attention must be paid to honoring and maintaining appropriate boundaries between clients and staff. This can be especially challenging because workers utilize various methods to examine and influence highly personal and intimate aspects of clients' behaviors. Moreover, clients may not have many affirming and reliable relationships, often due to

their illnesses' symptoms, which, in turn, cause family and friends to disengage. Healthcare workers may believe compassion justifies their filling this relational void by taking on the role of friend, family, or confidante. This erroneous belief increases the likelihood of enduring boundary crossings or repeated boundary violations. It is not surprising that medical and nursing books and curricula routinely discuss maintaining appropriate professional relationships and avoiding inappropriate personal relationships, boundary crossings, and boundary violations.

Being humane can be most challenging when staff work with individuals who are diagnosed as having a personality disorder. While the resulting behaviors seriously test the therapeutic alliance, too often the label of "difficult client" or "difficult patient" predetermines all activities and it becomes a self-fulfilling prophecy (Hilfiker, 1992; Knesper, 2007; Lauro et al., 2003). In the case of those diagnosed with sociopathy, public rhetoric has often labeled these people as "criminally insane." Since they appear not to be motivated by common morality, these individuals may be judged to be less than human. When working with clients with personality disorders, healthcare workers must avoid such moral judgments. Healthcare and health professions' mandate is to help preserve and restore health and well-being and alleviate suffering, irrespective of inferences about a person's goodness or badness (Pouncey & Lukens, 2010). With this said, though, employers must provide effective forums and measures to alleviate a worker's fear of a specific client and to prevent or address dislike of or negative feelings towards certain clients (e.g., someone convicted of infanticide). The concept of countertransference is well-known in the psychiatric and psychological fields. It is a professional's response to a client's behaviors or statements such that the professional shifts into an inappropriate role (e.g., parent, disciplinarian, rescuer). Psychiatry and psychology textbooks and courses teach ways to prepare for, recognize, and effectively address countertransference. Similar attention to the psychological responses of other allied health workers is needed because their negative (or sometimes unchecked positive) feelings and attitudes can obstruct clients' recovery.

Being a person

Personhood, or being a person, is a longstanding concept in academic communities, regardless of whether it is political science, sociology, theology, or moral theory. Much debate has been generated because of its political, legal, and ethical significance: those who legitimately qualify as "persons" must be accorded a certain level of attention, respect, and assistance, while "non-persons" can be accorded less. Various philosophers have developed different definitions of personhood. For instance, British philosopher John Locke held that a person was a being with a complex, psychological consciousness that continued over time. Focusing on consciousness, cognition, and affect meant that as time passed, people with progressive dementia would become different people compared to their former selves and, when certain defining abilities faded, non-persons. Alternative definitions have been offered; for example Rosfort and Stanghellini hold that personhood is "the identity of an embodied self, which is embedded in a coexistence with other selves through time" (2009, 286). Grant Gillett (2002) appeals to a cumulative and evolving narrative of "my life," while Bruce Jennings (2009) posits the "memorial person," wherein someone with advanced dementia remains a person and connected with her earlier years through the memories of those around her.

Farah and Heberlin (2007) present various theorists' definitions of personhood to demonstrate that consensus in defining such a potent concept still does not exist yet. In fact, Tom Beauchamp (1999) recommends discontinuing efforts to refine the moral or metaphysical attributes of personhood. He favors working on concepts that more directly capture the lived reality of daily life. In the case

of mental illnesses, clinician, family, employers, and the general public's interest can be focused on psychiatric diagnoses, impairing symptoms and behaviors so much that individuals are depersonalized. Hospital and governmental agencies' operational and administrative practices can depersonalize, too.

Depersonalization is ethically indefensible because the individual is not recognized as unique (Peterneliji-Taylor, 2004; Sierra et al., 2006). Instead, forms and computer programs can average or homogenize clients such that they become "another case of X" or as Flanagan et al. note, "the medical chart." Depersonalization silences such that the individual's unique perspective, lived history, and hard-won expertise are not sought or are ignored. Moreover, "othering occurs in relationships between the powerful and the powerless, where vulnerabilities are exploited and where domination and subordination prevail" (Peterneliji-Taylor, 133). French philosopher Emmanuel Levinas' work counters depersonalization by morally and positively privileging the Other and his presence-to-me (Burns, 2008; Nortvedt, 2003; Standish, 2001). Simply put, if I am in the presence of someone else, I am automatically and inarguably obliged to respond to him and respond in certain ways.

Respect is one of the most popular concepts employed to avoid depersonalization in mental health and addictions settings. Too often, however, determining what actually demonstrates respect in a particular situation with a particular person or group of people receives scant attention. Instead a kind of basic civility is considered sufficient. But it is not, especially when healthcare institutions and clinicians are expected to provide high quality treatment and care. Preventing depersonalization of individuals with mental health and addictions problems requires Levinas-ian active engagement with them and equal acceptance plus a kind of existential attention and presence. Processes for information disclosure, clinicians' truth-telling, and obtaining informed consent can dominate routine interactions with clients and their families such that little consideration is given to clinicians and staff being with clients and families. The effect is eroded personalization of clinicians and staff as well as of clients and families. In other words, healthcare workers also become interchangeable, "all the same," and regrettably for those they serve, forgettable.

Being a member of a community

In mental health and addictions, considerable focus is paid to people's rights and freedoms. This makes sense because it is so common for others to intervene to limit individual freedoms and obstruct the exercise of rights. Ethics-related justification for such interference typically comes from safety concerns, either for the individual herself or for others. However, a hidden, but common, concern is the existence of double standards wherein those with suspected or diagnosed mental health problems are not permitted to do certain things while the rest of society are. Some examples help make this point. Restrictions on sexual and intimate activities between hospitalized clients are often excessive. The only permitted activities are those deemed socially responsible, such as not engaging in "casual sex" or "risking a pregnancy." And yet a common freedom is for people to decide how sexually active they will and will not be. Moreover, women are permitted in many countries to seek an abortion, especially before the third trimester, so it is discriminatory to summarily hold that women with mental health concerns must always act so that pregnancy is avoided. A more ordinary example of double standards involves medication regimens. Exercising, eating balanced meals, getting sufficient sleep, and drinking enough water contribute to feeling and performing well. Most people do not engage in such activities consistently. In general, people are non-compliant. Yet those who have mental health problems are expected to be highly compliant with their medications

and non-compliance is summarily often assumed to reflect abnormally impaired thinking abilities and motivations.

The notion of citizenship moves people with mental illnesses "beyond the mere allocation or management of financial or physical resources and implies instead a form of moral assistance that calls for their full participation" (Perron et al. 2010; 108). Rights and freedoms associated with citizenship are ethically very important. But what is often disregarded is whether a person belongs within general society and within different sub-groups that are meaningful to him. Belonging here emphasizes that the person is a valued and equal member such that if he is absent, he is missed and he owes other members certain things just as they owe him. He is accepted "as is," both in terms of recognizing inescapable human fallibility, inconsistency, strengths, aspirations, and all that has led him to be who he is here and now. This goes beyond emphasizing the provision of quality services to those with mental health and addiction worries. Citizenship and belonging focus on membership within a particular network of relationships. Discrimination and marginalization can result in the person being "not of us" and outside the community or relegated to its impoverished and lonely margins, both of which are existentially cruel.

Another often overlooked communal factor focuses on expectations. Too often the general public expects too much of people with mental illnesses and addictions, because they do not give adequate weight to the impact of the social determinants of health, stigma, and the often discouraging chronicity and relapse of these illnesses. On the other hand, society can be overly paternalistic and sympathetic such that too little is expected. Opportunities are not taken to encourage and applaud people's perseverance, kindnesses, resourcefulness, and lived expertise. Instead focus can be merely about psychological and behavioral symptoms of the illness and the prescribed therapies and treatments, not about the kind of person he is. He becomes defined by the illness. This ethically troubling reductionism explains why many eschew language such as "he is autistic…" or "schizophrenics are…" and instead speak about "those who are living with depression" or "he has a borderline personality disorder diagnosis or traits."

Being a caregiver/provider

There is empirical evidence that family and friends provide significant assistance and support for those with mental health and addiction problems. This often presents practical challenges if applicable legislation regarding personal health information prohibits disclosure to family members without the client's explicit consent. In most instances, mental illnesses are not yet curable; they are long-term health concerns. This means that family and friends are even more important in supporting someone through expected relapses. Some of these relapses can be highly damaging to these relationships: for instance, dementia often results in aggressive behaviors as well as disinhibition (e.g., undressing, frequent swearing, sexual remarks). Mental illnesses can result in frightening behaviors such as verbal, psychological, and physical aggression, loss of property (e.g., if a person has gambling problems or drives while impaired), and more. Therefore, family members may require emotional and psychological help to deal with their fears and distress as to the shared impact of the person's mental illness or addiction. Family members can become secondary "sufferers" of a particular illness or addiction.

The unique nature of psychiatrists' and therapists' work "[places] additional ethical demands on practice" (Radden & Sadler, 2010, 59). Meaningful therapeutic engagement requires entering into the inner lives of clients, examining and oftentimes challenging clients' interpretations, beliefs, self-

image, fears, and hopes. Clinicians may learn details that no other person in a client's life knows. In the name of safety, healthcare workers are permitted, often expected, to use governmental or police powers that will violate fundamental rights and freedoms. Accordingly, professionals' characters are very important. Radden and Sadler identify a considerable number of characterological virtues and offer detailed explanations as to why they are essential to the routine or everyday work of psychiatrists and therapists. The needed traits include trustworthiness, self-knowledge, integrity, empathy, warmth, sincerity, authenticity, unself-ing, "respect for the patient and the healing project," and more (Ibid, 136).

In forensic settings, a common concern is divided loyalties wherein professionals and healthcare teams are expected to prevent the individual from harming others and violating civil or criminal laws, and yet work with the person to build a therapeutic alliance to help recover from the illness or disorder. When clinicians are asked to assess a person for the court's purpose, it is essential that the person understand that the clinician is acting for the benefit of the court, not for her benefit. In this case, the overarching fiduciary responsibilities of physician–client or nurse–client are suspended to a certain extent. If the psychiatrist or therapist is unable to have a different relationship with the client in doing this assessment, it is ethically wise for him to decline to do the assessment. The general public often does not appreciate the inherent tensions between healthcare systems' and clinicians' roles and the judicial system and lawyers'/police roles, especially when the public's fears and biases are exploited by the media or by political interests. Yet the value conflict between these two systems is ethically necessary, as discussed in the sections below.

WHY DO SCIENCE, TECHNOLOGY, AND CLINICAL FACTORS MATTER ETHICALLY?

Compared to many physical medicine interventions and programs, mental health and addiction services and treatments face added challenges that have ethical import. The following three issues clarify these challenges.

Our knowledge about mental illnesses and addictions

As Schmidt et al. note, "Definitions of mental illness tend to contain two aspects: a normative element and a functional element. Normative definitions delimit abnormal behavior in light of what is typical, usual, or the norm…[while] maladaptation suggests some diminished capacity to function relative to the average" (2004, 10). Yet authoritative statements of knowledge and fact are fewer in psychiatry and psychology than in physical medicine. Individual experience and subjectivity still inform most psychiatric diagnoses. Scientific uncertainty continues, as illustrated by briefly describing the evolution of psychiatric classifications.

In 1948, the World Health Organization created the International Classification of Diseases (ICD). In 1952, the American Psychiatric Association (APA) published the Diagnostic and Statistical Manual of Mental Disorders (DSM), a short glossary of different psychiatric disorders based on psychoanalytic theory. This was considered a positive first step because various disorders were identified and publicized for the practice community's use. Yet the DSM-I was not widely embraced because the disorders were relatively broad, the descriptions quite brief, and many practitioners were not Freudians. Sixteen years later, DSM-II was published, but the changes did not significantly resolve the first version's limitations. However, DSM-III (1982) was different. It was reputedly not theoretically grounded. Instead, its diagnostic categories were based on observed and reported behavioral symptoms. It garnered praise from the psychiatric community because its multiple axes

of contributing problems represented the disorders' complexity more accurately. Moreover, the categories and diagnostic criteria had higher inter-rater reliability (Pincus & McQueen, 2002; Schmidt et al., 2004; Wilson & Skodol, 1994). DSM-III-R (1987) included various clarifications and corrections. While DSM-IV (1994) was much like its predecessor, how it was created was particularly noteworthy: expert teams' consensus about each disorder was augmented by input from the psychiatric community at large as well as those involved in revising the ICD. DSM-IV also was based on scientifically stronger empirical (as opposed to anecdotal) evidence. Although DSM-IV-TR (2000) reflected no major revisions, it did provide various clarifications.

During this period, an anti-psychiatric movement emerged in the United States. One of its best known proponents is the psychiatrist Thomas Szasz (2009; 1976; 1961). He contends that very few disorders are brain-based or organic. Instead, the majority of DSM-IV disorders reflect personal preferences that do not comply with social norms. As a result, these people experience difficulties in daily life. Those who feel that the harms of "mis-fitting societal norms" outweigh the benefits can, if they wish, seek assistance from other people to reduce or eliminate such difficulties. But since the maladies are not physiological, says Szasz, it makes no sense to seek physicians' and medical programs' assistance. The anti-psychiatry movement endures today. In fact, some individuals and advocacy groups embrace the term "madness" as one way to counter what they believe is psychiatry's and medical institutions' illegitimate and hegemonic power and authority (Foucault, 1988; Wilson & Beresford, 2002).

The epistemic process of typological knowledge creation is often called nosology, or medical classification/categorization. Nosology continues to be an issue in mental health and addictions work because the questions still remain: "What makes something a mental [or addictive] disorder? and, Does this something form a category?" (Schmidt et al.; 11). In 2012 or 2013, the APA will publish the DSM-V. It will include a new framework or approach: dimensions, rather than mainly categories. There will be two general kinds of dimensions. First, clinicians' diagnoses will take into account the severity of symptoms, rather than mainly their presence or absence. Second, there will be "cross-cutting" symptoms, such as anxiety and suicidality, which occur in many illnesses. As a result, some disorders are expected to be de-listed and some new ones listed. In other words, some people will no longer have a psychiatric diagnosis, some people's diagnoses will be refined, and some will be newly diagnosable. Professional debate about the advantages and disadvantages of this new approach has been pronounced (Banzato, 2004; Collier, 2010; Helzer et al., 2007; Kraemer, 2007).

A similar debate is in progress in addiction treatment and care. Is an addiction to alcohol, tobacco, illegal drugs, or prescription drugs some type of disease, or a personal choice, or something else? The most popular alternative to the disease paradigm considers addictions to be more complex: they are the combined result of biological, psychological, and sociological factors. Researchers and practitioners differ as to which paradigm they believe is most accurate. But the ethical implications of this difference are real. People who develop cancer, psoriasis, or glaucoma are generally not considered ethically culpable for the loss of important abilities or for requiring publicly funded health services. If alcoholism is deemed to be a disease, then the alcohol dependent person may not be blamed for "having it." This is a welcome correction to the traditional moral condemnation of people with drinking problems. If responsibility follows causation, then a biopsychosocial explanation presumes something different. People's physiology, psychology, and social environment are presumed to be self-controllable and modifiable, albeit not totally. They are also presumed to be modified by other people's actions and inactions. Accordingly, if there are negative consequences, culpability for

what could have been changed must be shared, rather than resting solely with the individual. The locus of responsibility relative to having an addiction matters ethically because it connects with the ethical concept of fairness. This concept of fairness, and more specifically equality and equity, helps determine the amount of publicly funded versus privately funded services individuals with an addiction problem should be able to access.

Treatment and care

Those who are not psychiatrists, psychologists, or addictions therapists may not realize how very diverse available treatments and therapies are. For instance, there are more than two hundred psychotherapies, clustered, for example, as cognitive behavior therapy, family therapy, mindfulness, art therapy, psychoanalysis, and more. This increases the uncertainty and complexity of finding the therapy that will benefit a particular person most or at least sufficiently. In the case of psychopharmacological treatments, they have had a checkered history. In the 1950s, new medications were hoped to provide effective and sustainable relief of illnesses' disabling symptoms…a promising change from the seeming unending-ness of psychotherapeutic counseling and from the irreversibility and extreme invasiveness of psychosurgeries. In addition to the physiochemical benefits, medications could also be administered without a client's cooperation or consent. This was not possible for psychotherapies. They could not be beneficial if the person was not in the appropriate stage of change and was not willingly engaged, irrespective of whether she or a substitute decision-maker had consented.

The first generation of antipsychotic medications or "typicals" unfortunately caused too many people very serious and irreversible side effects such as tardive dyskinesia. The next generation of antipsychotic medications, the "atypicals," were expected to cause fewer side effects. While second generation drugs have helped many people, the long-term effects are discouragingly negative. For instance, individuals diagnosed with schizophrenia may develop diabetes due to some of these medications (Amiel et al., 2008; Lowe & Lubos, 2008; Muench & Hamer, 2010). Yet it takes years and millions of dollars to develop a new pharmacological treatment that can offer meaningful improvements, not just in terms of biochemical or physiological measures, but in terms of quality of life measures as well. The negative effects of medications, such as significant weight gain, slowed thinking, and sluggishness, help explain in part why people discontinue using them, only to find that they relapse into a serious state that may require emergency or involuntary hospitalization.

From the outset, funding of research of mental illnesses and addictions has been disproportionately low compared to funding of research of physical illnesses. In 2004-2005, for example, the Canadian Institute of Health Research devoted 7.5% of its $700 million budget to mental health and addiction (Senate Standing Committee, 2008). Yet approximately 20% of Canadians have a mental health problem during their lives. In the same year, the U.K. spent 6% of its £950 million governmental health research funds on mental health (Kingdon & Nicholl, 2006). In 2011, the American National Institutes of Health will allocate only 4% of its budget to the National Institute of Mental Health (National Institutes of Health, 2010). Consequently, available treatments and therapies are often less reliable and less specific than those for various medical problems. Moreover, more research funds are spent on pharmacological interventions compared to psychotherapeutic or alternative interventions, in part because the pharmaceutical industry spends almost as much as governments on healthcare research (World Health Organization, 2004). This means that new or more effective psychotherapies are less

likely to be developed and that a proportion of research funds are used for economic purposes, namely improving a medication's competitive marketability and profitability.

Daily practice models

Different clinics and hospitals offer markedly different addiction and mental health treatments and programs (Finney & Moos, 2006; Futterman et al., 2004). For instance, one addictions program's work may be guided by harm reduction principles. Familiar examples of a harm reduction approach are safe injection sites and methadone maintenance programs for ex-heroin users. Another program's work, however, may be guided by an abstinence model of treatment. Furthermore, what counts as harm reduction can differ considerably among clinicians (Miller et al., 2008). They may calculate the benefits and harms of a particular activity differently, for instance, providing information about different settings for alcohol consumption and their relative risks. Just as importantly, though, clinicians' opinions may differ regarding the morality of said activity. For example, accepting a client's decision to begin taking taxis during weekend drinking binges as harm reduction may seem to condone the client's wilful drunkenness. Some clinicians believe this clearly violates their professional ethos; others do not (Miller; 2008).

Models of care for mental health settings are also diverse: for instance, strengths-based, empowerment-focused, recovery, trauma-informed, custodial, rehabilitative, and sanctuary. As a result, how clients are seen and engaged by clinicians and teams will vary. A strengths-based approach, not surprisingly, attends to clients' positive abilities to deal with and improve their health and circumstances. An empowerment approach emphasizes correcting historic and current power imbalances—typically profound imbalances—between people with a mental health or addiction problem and professional caregivers and their institutions or between these same people and society at large. The ethical concepts of agency, self-determination, voice, and liberation resonate with empowerment. A recovery approach focuses on a person's valuations, aspirations, interpretations, and pace and it adopts "the long-view," wherein recovery is acknowledged to be an ongoing and unfolding journey. As shown in Gagne et al. (2007) and Ontken et al. (2007) in relation to recovery, focal ethical values are narrative integrity, resilience, commitment, and fallibility.

It is ethically important to identify and understand the practice model relevant to a particular treatment situation because inherent ethical values can vary. In terms of a specific program's model of care, an ethics-related goal should be coherence among the model's foundational values, staff-client interactions, and the kinds of therapies and care offered. However, models can become outdated as more is learned about what helps clients maintain and regain important activities and relationships, as other programs and systems change, and as certainty increases regarding what qualifies as mental illnesses and effective interventions.

Psychiatry, psychology, and case management qualify as "forensic" when they are applied to and used in our justice system. These include scientific and theoretical analyses of criminal behavior, clinical and institutional/communal efforts to prevent or deter law-violating behavior, risk assessments and diagnoses for judicial proceedings, and police psychology. Ethically critical to this work is separating understanding why a person behaved in a certain way—in terms of "nature and nurture"—and morally judging him or her. Conflating nature and nurture or conflating biological processes and socializing processes typify anti-psychiatry's worries.

WHY LAW AND REGULATIONS MATTER ETHICALLY

It is sometimes said that mental health and addictions services and settings are dictated by laws and legal institutions, be they the courts, legislatures, regulatory agencies, prisons and jails, or the police. A common concern is that society uses its various powers for its collective interests to the detriment of individual or minority interests. This concern is historically accurate in many countries in terms of how they have responded to individuals with mental health or addiction problems. Too often, these responses were dictated by social norms for acceptable behaviors and appearances. If the behaviors or appearances violated these norms and rules, common responses were punishment, social expulsion, controlled quarantine, surgical interventions, and even death. However, there were often compassionate individuals and religious-based groups that countered societal edicts by offering agapic assistance and places of sanctuary to people seen as innocent sufferers of cravings or disordered thinking.

Rights and duties regarding decision-making and consent

Personal decision-making typically is one of the first ethical concerns in healthcare settings or issues, in large part due to the courts and legislatures. Today, healthcare involves many therapies and procedures, even in economically disadvantaged or developing nations. Most medical and nursing training programs now include seminars and discussions about clients' legally-protected rights to start, modify, or discontinue any intervention or service and the ensuing duties of professionals to honor such decisions. Valid consent—which authorizes a professional to act—is obtained when the person is informed about the particular intervention's benefits, risks, and burdens compared to other options, has the requisite capacity to make this decision, and is not being pressured, coerced or manipulated to decide.

These three components of the consent process can be obstructed or compromised by the nature or symptoms of mental illnesses and addictions. First, being informed. Healthcare workers frequently overlook this component when clients decline recommended treatments. This is why the consent process is shared: if a treatment is declined, the reason may be that personally irrelevant, non-meaningful, or unintelligible information has been unintentionally provided. Timely disclosure and intelligible explanations are among clinicians' routine duties. As per the clinical section above, our understanding of the nature and causes of mental health and addiction problems is relatively limited, though it is increasing. Accurate diagnoses can take considerable time and prognoses may be quite uncertain. Available therapies and treatments may be scientifically promising, but still lack sufficient high quality research studies to be able to provide highly reliable and nuanced details to patients. Consequently, clinicians can find it difficult to provide clients with individualized and useful information about their illness, prognoses, and personally beneficial treatments.

The second component of a valid consent process is having "enough" mental capacity to decide. When clients decline treatments, this component can garner disproportionately more attention from clinicians than the other two components. Governmental legislation often stipulates specific criteria that, if not met, mean the person lacks the legally required abilities to make his or her own health-related decisions. Two criteria often comprise legislated standards: (1) is the person able to understand the information, and (2) is he able to appreciate the consequences of having versus not having the intervention. These abilities can be undermined by mental illness or addiction. But no set of assessment questions or exercises qualifies yet as the validated set for accurate assessments. Consequently, different clinicians may assess a person differently in terms of having or not having

capacity for a particular decision. Importantly, however, legislation and court rulings typically hold that someone who has a mental health or addiction problem can still have the needed capacity to consent to or decline a recommended therapy. In other words, depression, mania, paranoia, or hallucinations do not, in and of themselves, void the needed abilities to make treatment or other health-related decisions.

The third component is voluntary-ness. Certain therapies and care can involve social, environmental, and bodily control (e.g., group counseling, behavior modification, protective devices). Coercion therefore is an ongoing possibility. Moreover, some mental health problems can result in a lack of self-control (i.e., mania, disinhibition) or in heightened fears (e.g., paranoid schizophrenia, having a history of trauma or abuse). This means that the invasiveness, demanding-ness or restrictiveness of certain treatments may be very unwelcome, even though they can benefit the person in other ways. Furthermore, despite an appropriate substitute decision-maker consenting to treatment on behalf of someone lacking capacity, it will still be traumatic and damaging to the therapeutic alliance whenever a treatment is administered against the person's will (e.g., with security staff present, by forced injection, by forced application of a protective device to prevent self-injury). Accordingly, before deciding whether an intervention fits with the person's prior expressed wishes and best interests, a substitute decision-maker must understand not just the type of treatment recommended, but also how it will be administered and what will be the individual's likely experience of "being treated."

Rights and duties regarding privacy and confidentiality

Governmental legislation about the collection, use, and sharing of personally identifiable health-related information is common today. These acts, statutes and regulations protect citizens' right to privacy regarding their health, minds, bodies, and related activities by delineating professionals' and organizations' duties to keep such information as confidential as possible and yet use it effectively and efficiently. To preserve clients' and families' trust, limits to confidentiality and any legally required duties to report should be discussed as early as possible by healthcare workers. Later in this chapter, stigma and discrimination will be discussed in detail, but suffice it to say that the need to protect mental health- and addictions-related information is especially important. The consequences of a person's employer and insurer learning that he or she has or has had a mental health or addiction problem can be significant and irreversible. This need to protect this information, however, can unintentionally frustrate, even damage, professionals' interactions and relationships with patients' families.

While many healthcare organizations include family-centeredness among their corporate values, this is more complex in mental health and addictions settings because family may have knowingly or more often, unknowingly, contributed to the person's poor health. Too often, family members emotionally, psychologically, and/or physically abuse one another. Yet research and testimonials show that people recover and sustain a good quality of life because of familial support. More strongly put, family support can be a protective factor (Cleveland et al. 2010; Ivanova & Israel, 2006; Korol 2008; Piko & Kovacs, 2010). Negotiating this quandary requires healthcare workers to have strong communication, interactive, and assessment skills. Clinicians and healthcare organizations must be proactive in instituting practices to safeguard clients' privacy and to balance the competing interests of clients and their families without losing their trust or compromising their relationships further.

Rights and duties regarding safety

The political philosophy concept of *parens patriae* means that a legitimate government serves much like a patriarchal parent or father to its citizens. It is thus responsible for their general well-being and safety, and at times must make decisions that contravene their immediate wishes. A citizen may be in danger of being harmed such that those formally delegated powers to fulfill the government's duty (e.g., police and medical professionals) are expected to intervene on his behalf. So too if the citizen is harming or posing a serious threat to another innocent citizen. Governmental representatives may act unilaterally to stop or prevent such harm, especially if the potential victims may lack the abilities or resources to protect themselves.

Mental illnesses and addictions can result in serious risks to the individual: suicide, self-neglect (e.g., poor hygiene), self-harm (e.g., cutting, pulling out hair, repetitive scratching). Governmental powers to hospitalize, restrain, seclude, or treat against a person's wishes, when her behaviors are due to mental illness, are often legally set out in mental health legislation. The same legislation will specify who is legally obligated to forcibly act against the person's wishes when other people could be harmed or at risk of harm by her due to the mental health problem. If there is no actual or suspected mental health problem, then the individual would be dealt with according to applicable civil or criminal laws. Questions about the kind (physical only or psychological too?), the probability, the urgency or imminence (within the next few days or longer?), the seriousness or significance (life-threatening, disabling, and/or dignity-threatening?) arise when such legislation is written or revised. While mental health legislation in most jurisdictions agrees that governmental intervention is warranted when death or serious physical harm is likely, there is disagreement as to whether other harms should be unilaterally and forcibly prevented. Similar questions arise in healthcare settings when healthcare workers, family members, and the police try to decide whether to invoke their government-delegated powers.

Governmental legislation should try to strike a balance between the safety of the individual and others and the magnitude and duration of restrictions imposed upon the individual. Which rights and freedoms enjoyed by other citizens will she lose and for how long? What are the least invasive and limiting options? These questions probe whether the response to her harmful behavior focuses on maintaining safety or on punishing undesirable behaviors.

Institutional mechanisms

Punishment is a worry for mental health facilities because their competing goals include keeping individual clients safe and keeping others safe. There are four theories of punishment: retributive theory, deterrence theory, rehabilitative theory, and restorative theory. The last three of these theories happen to resonate with various clinical paradigms. Such coherence can unintentionally link punishment with clinical interventions. It is crucial for clinicians and teams to focus on the behaviors and decisions that relate to the health problem for which the client is seeking therapeutic help. Interventions and accompanying interactions must not be punitive.

A recent judicial trend is the creation of "mental health courts" and "drug treatment courts." Their objective is to divert those who have been found guilty of violating certain laws, albeit as non-violent crimes, away from prisons and jails. The mitigating factor in this sentencing is that these people broke a particular law because of a mental illness or addiction. The fact that someone has a mental health or addiction problem does not mean that all his or her actions and choices are determined by the problem. To qualify for "medical diversion," the law-breaking actions have to be the result of the

health problem; for instance, the person's judgment was impaired because he or she was intoxicated or responding to paranoid thoughts or to threatening internal voices. Accordingly, a judge decides whether the person should be diverted to an appropriate health facility to receive treatment and care for the mental health or addiction problem. Historically, judicial systems have provided no or minimal mental health and addictions treatment because punishment and control were the priorities and funding was inadequate. Focused, integrated, and sustained treatment in hospitals' programs is expected to help these individuals return to the community more quickly and not re-offend. Those who are directed to mental health and drug treatment courts usually can choose to have their cases heard in "regular court" with the possibility that if found guilty, jail, prison or probation is next. However it has been found that those who agree to be diverted into the health system may be under its auspices longer than if they had been in jail or prison. It can seem that diversion is harsher and thus less fair. This harkens back to the lack of highly effective, of easily sustained therapies or of adequate community services to justify a conditional discharge.

Therapeutic jurisprudence is a concept first coined by David Wexler, a professor of law and psychology, in a 1987 NIH conference paper (Corvette, 2000). He held that judicial systems and processes can be beneficial or harmful to those who break civil or criminal laws. Being held responsible, treated fairly, assisted in exercising rights to a fair hearing, as well as others having duties to follow the impartial rule of law, are considered to be psychologically and existentially affirmative of the individual as an equal member of the community. Moreover, the judicial system can help mediate injustices experienced in the public realm: "Therapeutic jurisprudence is normative. It suggests that to the extent possible, consonant with due process and justice values and goals, undesirable effects should be avoided or minimized and positive effects should be maximized" (Ibid, 103). Therapeutic jurisprudence fits with mental health courts and drug treatment courts to a degree. These court settings bring together employees of two major societal endeavors: the judiciary and healthcare. Nevertheless, caution is warranted. Various legal scholars and academics worry that these employees' roles will illegitimately merge such that role boundaries are crossed. In other words, the judicial employees will weigh too far—beyond their knowledge and training—into the work of the healthcare employees and vice versa (Dickie, 2008; Moore, 2007; Nolan, 2003). Furthermore, benefits vary between women and men. This, in turn, warrants increased study as to different stakeholders' views about the meaning as well as the effects of these courts and their processes (Hunt et al., 2007; Moore, 2007; Shaffer et al., 2009).

Similar debates have arisen when legislatures have considered amending existing mental health laws to include community treatment orders. These orders, often called involuntary community treatment, are meant to organize a mixed set of supportive community services so that a person can leave the hospital and live safely in the community as a less restrictive option. If, however, the community providers and agencies do not fulfill their responsibilities and it is possible that the person will become unsafe as a result, then he can be forcibly re-hospitalized forthwith. At issue is how to ethically evaluate this option: solely on probable consequences (e.g., fewer urgent hospitalizations, shorter hospitalizations)? At present, not enough is known as to why community treatment orders are associated with certain positive outcomes. Are they due to the ongoing availability of comprehensive supports or is it due to the ever-present threat of the client being re-hospitalized against his will? (Burns & Dawson, 2009; Hunt et al., 2005).

Mental health and addictions settings encounter another challenge in the guise of advance directives. Advance directives have been discussed for years in the context of physical, acute care

medicine. Medical advance directives permit people to designate who will be their healthcare decision proxy and/or to provide guidelines for subsequent decisions when they no longer have the capacity to decide on their own behalf. Empirical evidence shows that psychiatric advance directives, or "crisis cards" in the U.K., reduce the frequency and length of emergency hospitalizations. They also increase clinician–client trust (Srebnik & Russo, 2008; Sutherby et al., 1999). Yet discussions about psychiatric advanced directives' usefulness often ignore a critical detail: can directives be invoked before persons satisfy legislated criteria to be deemed incapable? Or can they be invoked only after they are assessed as lacking capacity? The "after" scenario is not too ethically or legally controversial because the directive actually constitutes client participation in the care plan and establishes relevant "prior expressed wishes" (Bogdanoski, 2009; Srebnik et al., 2005; Swanson et al., 2006). Dubbed "a Ulysses contract" after the Greek fable about Ulysses, the "before" scenario is definitely controversial. If there are legislated standards and court rulings to protect decision-making by capable citizens, then it could prove difficult, perhaps legally impossible, for citizens to waive their right to such decisional protection.

WHY ORGANIZATIONAL CONTEXT MATTERS ETHICALLY

In the early decades of bioethics inquiry, academic and professional scrutiny and debate centered on the work of researchers using human subjects and "bedside" or "front line" practitioners. The issue that expanded this focus to include administrators, management and executives, and board members was, I believe, the galloping costs of healthcare services that were not adequately reimbursed by governmental and private insurance plans. In the United States, Medicare's and Medicaid's decision in the 1980s to shift from reimbursing as per diagnostic Related Diagnostic Groups and to capitated managed care costs confirmed the immense impact of management on client–professional relationships. Moreover, increasing annual deficits made the business of healthcare an issue for everyone, from patients, practitioners, hospitals, and commercial employers to governmental health ministers. All economically developed nations now experience demand exceeding healthcare supply, despite increasing budgets. Continued technological advances are typically more costly and citizens' confidence that "new" and "more" produces better health outcomes is often short-lived.

An "organization" will herein be defined as a designated group of specially trained or skilled people working towards a shared goal or purpose. As such, a rural adolescent drug counseling office consisting of three addictions workers and an office administrator constitutes an organization, as does each discrete unit within a psychiatric hospital, as does the hospital as a whole. Organizational considerations are not the concern or responsibility of only executive management; they are the responsibility of virtually all staff members.

Organizational factors

Organizational considerations in healthcare fall into four general categories, each of which warrants a brief explanation as to its relevance for ethical practice in mental health and addictions settings. One category is the ethics of the organization's mission or mandate. The purpose of an organization, irrespective of whether it has been formally and explicitly described or it is implicit in its regular activities, establishes to whom the organization is responsible and accountable and for what…and to whom it is not responsible. More simply put, a mandate sets out the groups of people to whom the organization must respond with "Yes, we can help you" and to whom it can respond legitimately with "You will have to look elsewhere for assistance." In contemporary healthcare, healthcare organizations

have often developed a set of values to guide how their mission and strategic goals are accomplished. A point in this chapter's introduction bears repeating here: some values are intrinsically ethical (e.g., being trustworthy, relieving suffering). Other values may be instrumentally ethical (e.g., financial stewardship so as to maximize number of clients served).

A second category is the ethics of how a healthcare organization is governed: what should be the guiding operational standards and according to whom? Governance will be both internal and external. Examples of external governance include accreditation standards, employment and occupational health regulations, applicable government legislation, funding regulations, professional colleges' codes of practice, and the organization's board of trustees/directors. Examples of internal governance include negotiated labor contracts, a code of employee conduct, quality–safety committee, any document that details patient rights, as well as the largest and most endemic "repository" of internal governance, written policies and procedures.

Another general organizational ethics category for healthcare settings is the ethics of resource acquisition, allocation, and disposal. Here, "resources" applies not just to money, but also to staff, beds, counseling sessions, equipment, physical space, and professionals' time. How resources are obtained is ethically important, as evidenced by debates about seeking funds from pharmaceutical and gaming corporations or about recruiting nurses and professionals from countries sorely lacking in qualified personnel. Allocation of resources, as mentioned earlier, is the most well known organizational ethics issue in health care: how to allocate resources fairly, even if there is just "soft" scarcity, is challenging and often is informed only by an implicit utilitarian calculus. Prioritizing access to and provision of inpatient or outpatient services occurs routinely and includes wide-ranging decisions such as which medications to include or exclude from a hospital formulary, how to respond to "VIP requests" for access, and how many times a hospitalized client or his substitute decision-maker can decline a community bed without consequence. Resource "disposal" first came to attention vis-à-vis discussions about the environmental impact of what was being discarded by tertiary, acute care hospitals. Yet closing or reducing services can mean staff layoffs and reduced hours. Refreshing all computer hardware can mean deciding whether to donate the replaced computers to a remote school or a community center serving people living with addictions problems. "Disposal" decisions involve ethics-related values such as who will be harmed versus benefited, who should help identify alternatives and applicable rationales, and who is responsible for making the final decision.

The last category is the ethics of an organization's culture and climate. Understanding what culture and climate are and their impact has been a favored topic in business ethics and business literature for some time. Culture is reflected in what is considered acceptable versus unacceptable behavior and interactions. It is so ingrained and presumed to be "right" that it does not need to be written anywhere. Culture will include norms for how hard staff should work, what counts as humor, what questions can and cannot be asked out loud, and how much is decided by committees versus individuals. Climate is a metaphoric word to capture the organization's current mood: is it optimistic, such that trying something new without administrative permission is a safe thing to do? Or is it suspicious, such that "not rocking the boat" is well advised? Or is it celebratory, such that being a little less productive for a while is acceptable?

In virtually all ethics-related questions involving clients, organizational considerations will implicitly or explicitly impact their treatment, care, and interactions with co-clients, staff, family members, and outside parties. In some instances, staff responses will be ethically weaker or stronger because of these considerations. Some everyday examples include practices and policies about

smoking restrictions, searching clients' belongings, hospitalized clients' intimate and sexual behaviors, clients' use of illegal substances during the therapy period, staff responses when clients may be driving impaired, staff obligations or lack thereof if a pregnant client uses illegal substances, and so on. Policies and practices must balance competing, often conflicting, interests and responsibilities. As noted by Winkler (2005), depending on how policies are developed and implemented, they can minimize the power and resource imbalances among staff as well as between clients and staff. Or they can exacerbate them. As memorably explained in Skorpen et al.'s (2008) article about smoking rooms in a psychiatric facility, clients can try to find ways to regain power and equal status. On a separate but related point, safety initiatives will be ethically grounded. However, safety can become the "sun" that blocks out all other considerations, or "a trump card" that silences all other interests and voices. Depending on a healthcare facility's culture and climate, it may be politically unwise to suggest that safety measures are causing more burdens and disadvantages than anticipated.

Busy clinics and hospitals may operate unintentionally in ways that traumatize or retraumatize clients. Many people who develop a mental health or addiction problem have experienced serious trauma, be it physical, emotional, and/or psychological abuse. If a medical office or health clinic's practices are impersonal, coercive, or disrespectful, the person may find them even more distressful and stressful because her past experiences of being silenced, pressured, or shamed are remembered and reinforced. Moreover, programs and units may operate with such allegiance to "the rules" that professional judgement and integrity fade. Having integrity requires some modicum of inner struggle, according to scholar Stephen Carter (1996). In other words, having integrity is praiseworthy because it is hard to achieve. Therefore if healthcare workers' motives for acting as they do come from "following the rules," then they might be commended as being capable rule followers, but this is divorced from being professional or having integrity. As noted in the introduction, reasons for acting may not be based on ethics-related values, but instead on other considerations such as self-interest, convenience, power, or fatigue.

Forensic programs and services

The ethical challenges and complexities of forensic healthcare programs and settings are numerous and significant, as reflected throughout this chapter. In the case of forensic services, care is needed to avoid unintentional "creep" of the police and prison system into the therapeutic system. Language is an obvious marker of such ingress: clients or patients have privileges that they can lose, regain, and exercise. Yet the word "privileges" evokes imperialism and parentalism because privileges are granted by one party to another. If an empowering or strengths-based approach is adopted instead, clinicians could refer to a client's "responsibilities" or "actions" as set out in the court or review board order. There would be consequences, positive and negative, if she fulfills or does not fulfill her responsibilities, rather than the moralizing or infantilizing rhetoric of "consequences to reward good behavior." To help balance the power relations more equitably, her clinical team and the program management would also have various responsibilities to fulfill. Another example is contraband, wherein clients are prohibited from having certain qualifying items with them in the hospital. But "contraband" is a familiar police and drug enforcement word related to smuggling. It does not belong in a healing environment (recall that the person was diverted from the prison or jail system). Alternative wording could be "unsafe items" or "prohibited items," which are accurate descriptions but far less polarizing. Ethics texts written for psychologists and psychiatrists usually include a chapter on ethically defensible ways to formally assess a person for court such that the person

does not mistakenly presume the clinician has her best interests in mind. As noted above, health workers may struggle to maintain the appropriate balance between offering therapy and following a court's legitimate demands. It is essential for programs to proactively and openly examine their routine practices. These forums will help support workers to deal with the to-be-expected moral distress of meeting competing commitments (Austin, 2001; Morse, 2008; Pouncey & Lukens, 2010). Moreover, understanding clients' actual experiences of these situations, rather than just working from assumptions, is important because the significant power differential between clinician and client can progressively erode professional commitments.

WHY SYSTEMIC FACTORS MATTER ETHICALLY

Since moving from a large tertiary, acute care hospital to working at a large mental health and addictions hospital, systemic factors have figured prominently in my ethical analyses and recommendations. Like Sokol, I gradually became aware of these factors' impact on the daily lives of clients, families, and healthcare workers alike as I listened to more and more personal stories: someone who can only afford substandard housing and worries bedbugs will soon infiltrate their belongings, a recreational therapist frustrated that clients are not welcome at a community gym, and rural parents whose employer-paid insurance plan caps psychotherapy for their behaviorally aggressive child at ten sessions per year. Systemic factors are implicit in a community or society's ongoing activities that occur just outside the walls of a private practice, clinic, or hospital. Three kinds of factors are particularly relevant to defensibly determining normative responses or, in other words, "what should happen." Moreover, these factors ground any health and healthcare decision in the reality of a particular society or community. Sidestepping these factors in ethics-related analyses can result in ineffective responses or assigning responsibilities disproportionately.

Stigma

The first ethically weighty factor is stigma. There are many definitions of stigma, but Jo Phelan and Bruce Link (2001) offer a nuanced characterization. They suggest that it has four components, which appropriately captures its complexity: (1) human differences are identified and labeled, (2) these differences are linked to negative qualities, (3) those who are different become "Them" as separate from "Us," and (4) the person's or group's social status declines and unfair discrimination occurs. Those who make up society's majority, captive to the seeming truth of "bell curve statistics," commonly presume that what is common constitutes what is "normal" and what is uncommon constitutes what is not just rare, but also what is morally abnormal. As described by historical accounts of societies' treatment of those whose thinking was unusual, this treatment has traditionally been fear-based and repressive. Furthermore, if people's thoughts were accompanied by behaviors and appearances that violated social etiquette and norms, the collective responses included dismissive marginalization, controlled quarantine, or forced treatment. Historically, mainly charitable or faith-based institutions endeavored to care for and about people with mental illnesses until the past fifty years or so in North America and Europe. Yet stigma remains a contemporary problem. For example, based on its 2006 Senate report on mental illnesses and addictions and available services, *Out of the Shadows at Last,* Canada's Mental Health Commission launched "Opening Minds," a ten-year anti-stigma/anti-discrimination initiative.

Social or communal stigmatization and discrimination—related to ethics concepts of dehumanization and injustice—help explain why most people are initially reluctant to seek

psychiatric and psychological testing because of the enduring harms of being labeled as having a mental health or addictions problem. Families, too, delay seeking information and help from clinicians and programs, often relying primarily on the Internet's anonymity and nonjudgmentalness. Keeping health problems secret limits access as well as limits offers of needed physical, psychological, relational, educational, and economic support. Yet stigma and discrimination go beyond the general public's response to those living with a mental health or addiction problem. Studies have also revealed that many mental health and addictions workers unconsciously and consciously stigmatize and discriminate against their own clients despite their day-to-day interactions with them (Flanagan et al., 2009; Liggins & Hatcher, 2005; Ross, 2009; Schulze, 2007). There is also evidence that mental health and addiction workers themselves are stigmatized by working in this field of healthcare (Gouthro, 2010; Halter, 2008; Stuhlmiller, 2005).

Discrimination of individuals with mental health and addictions problems can be more subtle, but can be just as unfair. It is important to examine whether double standards are being presumed or relied upon. Clinicians and teams may want to restrict client activities that would be permitted in general society. For example, a residential program may decide to permit residents to engage in consensual, non-exploitative intimate behaviors in their private rooms, but expect these behaviors to reflect "highly responsible" or "meaningful" activity. Or the program may have a search policy that presumes residents to be more dangerous and more devious than has been actually experienced. Media stories and mainstream television and movie companies sensationalize rare disorders and behaviors as well as behaviors that result in criminal charges or convictions. For instance, programs and healthcare workers' attention can be disproportionately directed to people's use of illegal drugs compared to their tobacco and alcohol use. Yet smoking and drinking alcohol cause more death and serious co-morbidities than marijuana, or even heroin.

Language is slow to change, too. Someone in treatment for, say, cocaine addiction is said to "test dirty" on a urine drug screen (Radcliffe & Stevens, 2008; Rose et al., 2005). Urine screens for people with diabetes, however, are described as "testing positive" or "negative." As "addicts," "schizophrenics," or "sex offenders," people are reduced to a particular illness or behavioral category. There has been a move within the addictions field to talk about substance dependence, misuse, and abuse…rather than always about addictions. Hofman et al's 2003 study of inner-city women who were IV-drug users and used outreach health services far less than male IV-drug users in the same area revealed the women's ongoing efforts to fulfill familial and communal responsibilities plus retain a sense of respectability. The criticism of healthcare workers' continued use of the demeaning and paternalistic terms "compliance" and "noncompliance" is about stigma as well (Acosta et al., 2009; Bissella et al., 2004; Proulx et al., 2007; Stewart & DeMarco, 2010). Because of stigma, discrimination, negative side effects, and human nature, it should not surprise us that people do not follow prescribed regimens at the high level of "compliance" needed. As noted by a systems and client advocate, those receiving health services do not set a personal goal of "being more compliant" with their treatment (Jennifer Chambers, 2010; personal communications). Instead, they set more meaningful goals such as getting sustainable employment, feeling well enough to help with a son's homework, or having more faith in one's hard-won wisdom.

Social determinants of health

Being healthy does not rely solely on physiology, genetics, and lifestyle choices. Social and cultural factors also have significant impact (Lauder et al., 2007). While the World Health Organization

(2003) identifies several social determinants, three are of particular ethical import for mental health and addictions contexts: housing, unemployment and poverty, and social isolation. The percentage of people who are homeless and have a mental illness, while difficult to accurately determine, is estimated to range from 20% to up to 50% in various studies of Canadian, U.K., and American cities (Hwang, 2001; Meltzer, 2008; National Coalition for the Homeless, 2009; Neale, 2008; Senate Standing Committee, 2006). The relationship between unstable and inadequate housing and mental illness and addictions is considered to be bi-directional. In other words, substandard housing contributes to onset or relapse just as mental illness and addictions contribute to loss of adequate and reliable housing. Reflective of continued discrimination, "NIMBY" or "not in my back yard" is a common community response, opposing governmental or private agency housing initiatives for people with persistent health concerns, such as mental illnesses and addictions.

People with mental health and addictions problems are at increased risk of living in poverty (Canadian Mental Health Association, 2007; Hudson, 2005; Wilton, 2004). Schizophrenia, for instance, usually manifests in late adolescence or young adulthood, which means educational efforts are disrupted. Lack of post-secondary education usually results in being less competitive in the job market. Stigma means that finding suitable employment is more difficult—even though many countries have legislation prohibiting discrimination based on health conditions—and once employed, people must often be diligent to keep their mental health or addictions history secret. Governments may offer financial assistance to those unable to work due to a physical or mental disability, but the amount of support typically provides for a low standard of living.

Psychiatric hospitals were once known as "asylums" because they were considered safe havens from the uncertainties and rigors of daily life. But too many became immense institutions of sturdy walls and high fences in which people with mental health problems lived out their lives separated from the community. Exclusion is anathema to human health and well-being. Moreover, some mental illnesses, such as autism, paranoia, and personality disorders, involve reduced abilities to understand or trust other people and this, in turn, undermines relationship-building. Add public prejudice and the consequences for many people with mental health problems are isolation and marginalization (Baum et al., 2010; Elisha et al., 2006; Morgan et al., 2008 and 2007; Smith & Hirdes 2009).

Health and social systems writ large

The third systemic factor that is ethically noteworthy is our social and health systems. Three issues help illustrate the tangible impact of these systems on the therapies available and the recovery realized. First, ethically worrisome conflicts of interest can exist. When a government sells alcohol and operates gambling venues (e.g., casinos, lotteries), this runs counter to its public health mandate (Andresen, 2006; Livingstone & Adams, 2011; Walker & Jackson; 2011). Even if a government only regulates commercial sales of these items and activities, their coffers receive immense sums of money from luxury taxes on alcohol, gambling, and cigarettes. As evidenced by the "Big Tobacco Settlement" in the United States, only a few of the 48 states in the class action suit directed a substantial part of their proportion of the $235 billion settlement to smoking prevention and treatment. The other states assigned their settlement portion to deficit reduction, infrastructure needs, and more general uses (Johnson, 2004).

Another systemic issue is the historic and continued unfair insurance coverage or reimbursement for non-physician and non-hospital therapies. For instance, Canadian provincial and territorial governments' health insurance plans tend to not reimburse psychotherapies or alternative treatments

provided by non-physicians in the community, but do reimburse physician-provided/prescribed and/or hospital-based treatments. In most cases, psychologist/therapist and psychological measures are either paid by employer insurance plans or out-of-pocket (Parker & Burke, 2005). These plans usually cap their coverage at low levels. In fact, the U.S. Congress passed the Mental Health Parity and Addiction Equity Act in 2008 to help address this inequity by requiring federal health plans to reimburse mental health services on par with medical health services.

Systemic considerations contribute to "revolving door situations," which are usually and unfairly identified as "revolving door patients." These situations center on health gains, made by someone while receiving the intensive and publicly provided services in a hospital, dissipating quickly once he returns to the community, which may lack certain services, or have insufficient services, or have services that are neither easily understood nor effective. Continuity of care and comprehensiveness of services falter. As a result, he soon requires rehospitalization to receive more intensive and comprehensive therapies. Returning to home may mean that the benefits prove unsustainable and rehospitalization is likely. This repetitive cycle is particularly concerning if the illness is such that it is not physiologically possible to return fully to the pre-crisis levels of functioning. Health system reform and social system reform appear on most countries' election platforms, but reform is difficult to achieve given the programs' immense complexity and the perpetual expectation of increased funding.

CONCLUSION

In summary, people and their communities are complex. Problems with our cognitive and emotional abilities have profound effects. Understanding and defining human cognition and emotions and their interconnections continues to evolve in psychiatry, psychology, neurology, and neuroscience. Moreover, recent research and clinical advances in neurology and neuroscience have led to the emergence of neuroethics, the newest field within bioethics and one focused on the human brain and nervous system. In a sense, science and what is traditionally known as the medical complex have—rightly or wrongly—not yet assumed in relation to mental health and addictions the authoritative position they have in physical medicine and acute care settings.

Foundational ethical commitments and values remain relevant: for instance, the person's own wisdom and perspective, the community's obligations to all its members, the duties and limits of the state's intervention in individual and familial lives, a holistic view of factors contributing to individual and group well-being, and the immense, lasting harms of discrimination and stigma. Therefore, ethical understanding, engagement, and assistance for people's mental health and addiction problems requires in-depth and broad analyses, multi-faceted and integrated responses, "the long view" and abiding commitment, non-replication of past power imbalances and moralization, and a defensible role or place for law and legislation.

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=457#h5p-12

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CHAPTER 24.

ADDICTION COUNSELOR ETHICS PART 1 & 2

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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=465#oembed-2

PART IV.

UNIT FOUR: PROFESSIONAL DEVELOPMENT

CHAPTER 25.

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 transdisciplinary foundations, comprising four discrete building blocks: understanding addiction, treatment knowledge, application to practice, and professional readiness. The term "transdisciplinary" 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.

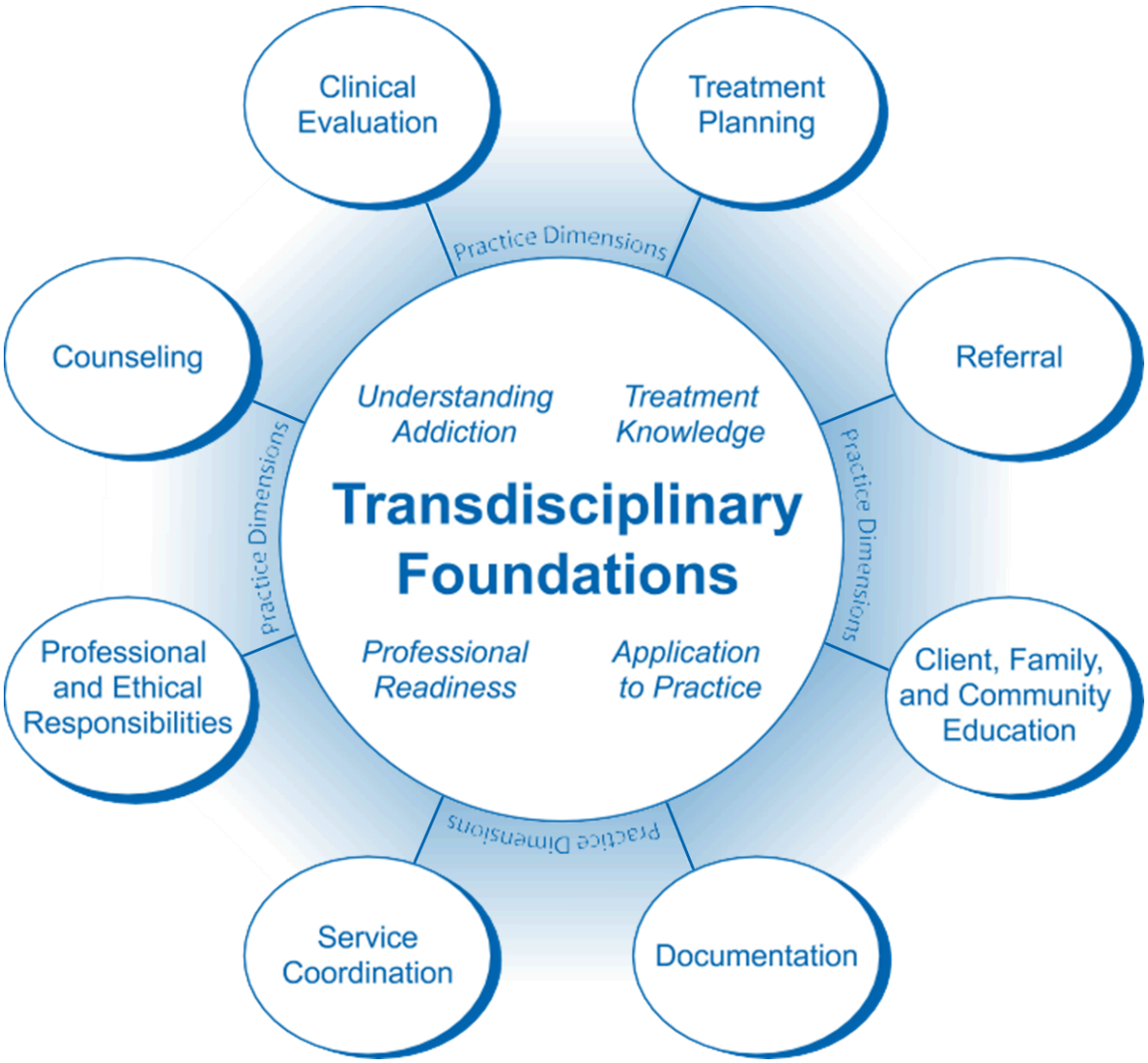

Figure 25.1: Competencies Hub

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 competencies, 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 competencies 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 25.1). The hub contains the four transdisciplinary foundations that are central to the work of all addiction professionals. 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 ever-changing 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.

Understanding Addiction

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.

Treatment Knowledge

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	Attitudes
• 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.	• 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	Attitudes
• 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.	• 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	Attitudes
• 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.	• 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	Attitudes
• 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.	• 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	Attitudes

• 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.
	• 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	Attitudes
• Treatment outcome research literature. • Scientific process in applied research. • Appropriate measures of outcome. • Methods for measuring the multiple variables of treatment outcome.	• 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
    1. Screening
    2. Assessment
II. Treatment Planning
III. Referral
IV. Service Coordination
    1. Implementing the Treatment Plan
    2. Consulting
    3. Continuing Assessment and Treatment Planning
V. Counseling
    1. Individual Counseling
    2. Group Counseling
    3. Counseling Families, Couples, and Significant Others
VI. Client, Family, and Community Education
VII. Documentation
VIII. 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.

LICENSE AND ATTRIBUTION

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 26.

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 biopsychosocial–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 on 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 of 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 help 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 (e.g., 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/CEUs: • 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, and 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 (e.g., 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 ensuring the AOD counselor is provided monitoring and feedback to ensure 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 Postsecondary 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 27.

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 ensure 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 qualify 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 AND TRAINING PROGRAMS

Of the 40 CEUs required biennially, 20 CEUs may be agency in-service training programs. In-services 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 CONTINUING 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 the 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 28.

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 downward swings of the roller coaster. 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 28.1: Aspects of Self-Care

Because we all have our own unique life history and 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 okay 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

BURNOUT AND SELF-CARE

Definition of Burnout: "The process of physical and emotional depletion resulting from conditions at work or, more concisely…prolonged job stress"*(Osborn, 2004).*

Professional burnout can be understood as both a syndrome and a process. There are degrees of burnout that can affect us over time, and this occurs on a continuum. Burnout can also describe a state where a professional has become impaired and can no longer function effectively.

The dimensions can include exhaustion, feelings of incompetence, an unhealthy work environment, devaluing the client, and deterioration of personal life. Below are symptoms of burnout in various categories.

Symptoms of Burnout: Physiological

- Sleep disturbance
- Headache
- Back pain
- Weight Change
- GI issues
- Prone to illness
- Fatigue

Symptoms of Burnout: Cognitive

- Poor concentration

- Increased irritability
- Boredom
- Lack of pleasure
- Restlessness
- Increased anxiety

Symptoms of Burnout: Behavioral

- Poor frustration tolerance
- Irritability
- Indecisiveness
- Procrastination
- Absenteeism
- Decreased quality of work
- Isolation from co-workers
- Increased substance abuse

Key Takeaways

Burnout has the potential to affect all helping professionals.

- Burnout is both a syndrome and a process
- There are symptoms of burnout that can affect us physiologically, cognitively, and behaviorally

When we fail to identify the early warning signs of burnout, the effects can be seen in many areas of our lives. The agencies where we work and the clients we serve are also impacted greatly by our lack of self-care.

Effects of Burnout on the Individual

- Decrease in physical health
- Loss of sleep, weight gain, weight loss, more prone to illness
- Increase in negative behaviors
- Irritability
- Apathy
- Family/Friends Consequences

- Alienation from loved ones

Effects of Burnout on the Organization:

- Lost productivity
- Negative work environment
- Counselors who are not invested in their work
- Dissatisfied clients

Effects of Burnout on the Client:

- Decreased quantity and quality of services
- Devaluation of the counselor who does not meet the client's needs
- A sense of frustration with the field of human services

Contributors to Burnout: Personality Factors

- Enter the field highly motivated with high expectations
- Rigid beliefs (Inflexible, Unable to adapt to change)
- Irrational beliefs (Perfectionism, personalization)
- Self-doubt
- Vicarious Trauma
    - A natural consequence when one person relates their traumatic experiences
- Expressing genuine empathy is draining
- Therapeutic alliance leaves the therapist traumatized

Contributors to Burnout: Environmental/Occupational Factors

- Large caseloads
- Financial insecurity
- Role conflict
- Role ambiguity
- Lack of supervision

Contributors to Burnout: Client factors

- Suicidal statements

- Client expression of anger/hostility
- Lack of perceptible progress
- Manipulative behaviors
- Expression of apathy
- Severe pathology

THERAPEUTIC RULES

There are so many things to do and not do that we experience stress just trying to remember them. Some examples, taken from Jeffrey Kotler's book *On Being a Therapist*:

Do NOT…

- Express personal opinions
- Take sides
- Be too passive
- Be too directive
- Let your attention wander
- Let your clients know how you really feel about them
- Have a vested interest in the direction the client chooses
- Ask closed questions
- Share too much of yourself
- Hide behind a personal mask

RECIPE FOR A RAGING CASE OF BURNOUT

- Work long hours, especially at night
- Don't take breaks between clients
- Don't use vacation time
- Personalize client decisions
- Judge yourself by your clients' reactions
- Stop attending workshops
- Stop paying attention to your own recovery or personal issues

IMPACT OF STRESS

- Stress hormones are intended to help us in a physical crisis
- Not intended to be prolonged, but modern human lifestyles create chronic release of stress

hormones

- Leads to increased blood pressure, higher rates of depression, storage of fat in the midsection, destruction of brain cells
- Need to shift our values: instead of praising the multi-tasker who works 12-hour days, what if we recognized the person who took breaks and used vacation time?

WHY DO WE DO IT?

Each individual has different motivations driving a desire to work in the helping field. It's important to occasionally pause and reflect on why you entered the field and why you continue doing it. Some possible reasons include:

- Altruism
- Personal growth
- Intimacy
- Reflection
- Legacy
- Power
- Creativity

Benefits of Self-Care

- If you don't take care of yourself, no one else will
- Stay healthy / fewer illnesses
- Able to function at a high level
- Longevity in the field
- Balance in all areas of functioning
- Greater enjoyment from work and personal life

Self-Care Strategies: Personal

- Maintain a personal life
- Rest and Play
- Attend to your physical health
- Use personal psychotherapy

- Identify healing activities
- Find and use humor
- Tend to spiritual needs

Self-Care Strategies: Professional

- Arrange for supervision
- Continued education and training
- Find an evidence-based approach you are comfortable with
- Develop professional connections
- Develop a balanced work-life
- Involve yourself in different work projects
- Keep work at work

Self-Care Strategies: Organizational

- Attend to your physical setting
- Arrange for adequate resources
- Create an atmosphere of respect
- Develop relationships with community resources

In Conclusion

- Draw energy from your successes
- It's serious work, but don't take it too seriously
- Be mindful of your emotional and physical well-being
- Although stress is a part of the job, there are strategies to manage it
- Remember the clients who make it worthwhile

GLOSSARY

axon
Projection of the nerve cell that extends out from the cell body and transmits messages to other neurons

basal ganglia
Located deep within the brain and one of the brain regions involved in the development and persistence of substance use disorders. This region is involved in learning routine behaviors and forming habits.

cell body
Core section of the neuron, which along with the nucleus controls the neuron's activities.

Clinically managed services
Services directed by nonphysician addiction specialists rather than medical personnel.

compulsivity
Repetitive behaviors in the face of adverse consequences, and repetitive behaviors that are inappropriate to a particular situation. People suffering from compulsions often recognize that the behaviors are harmful, but they nonetheless feel emotionally compelled to perform them. Doing so reduces tension, stress, or anxiety.

Dendrites
Extension of the nerve cell that receives messages from the axons of other neurons

extended amygdala
Located beneath the basal ganglia and regulates the brains reactions to stress -including behavioral responses like "fight or flight" and negative emotions like unease, anxiety, and irritability.

impulsivity
An inability to resist urges,
deficits in delaying gratification, and unreflective decision-making. It is a tendency to act without foresight or regard for consequences and to
prioritize immediate rewards over longterm goals.

levels of care
The various types of addiction treatment provided based on clinical needs.Higher levels are associated with greater intensity of services.

Medically managed services
Services requiring daily medical care and 24-hour nursing.

Medically monitored services

Services 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.

negative reinforcement

The process by which removal of a stimulus such as negative feelings or emotions increases the probability of a response like drug taking.

neuroadaptations

Progressive changes in the structure and function of the brain due to continued misuse of alcohol or other substances. This results in compromised brain function and moving from controlled, occasional substance use to chronic misuse.

neurobiology

The study of the anatomy, function, and diseases of the brain and nervous system.

neurotransmitters

Chemical messengers that provide communication between neurons, they can be excitatory (stimulate neuronal function) or inhibitory (prevents neuronal function)

positive reinforcement

The process by which presentation of a stimulus such as a drug increases the probability of a response like drug taking.

positively reinforces

The process by which presentation of a stimulus such as a drug increases the probability of a response like drug taking.

prefrontal cortex

Located at the very front of the brain, responsible for complex cognitive processes described as "executive function"

synapse

Gap between neurons where communication occurs between neurons