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Certified Behavioral Health Technician

Thank you for your interest in training to becoming a Certified Behavioral Health Technician (CBHT). As a CBHT you will most often assist counselors and therapists by providing critical support services to clients who are receiving drug rehab, substance abuse or mental health treatment in a variety of treatment settings. With this certification you will be taking a huge step forward in your career in the addiction industry. Here at the Academy for Addiction Professionals you'll learn the skills and knowledge necessary for receiving a designation from the Florida Certification Board (FCB) that will open up doors in the recovery industry.

- Clinical Competence – 8 hours
- Ethics and Professional Conduct – 4 hours
- Documentation & Patient Confidentiality – 4 hours
- Maintaining Client and Personal Safety – 4 hours
- Electives - 10 hours
 - Suicide & Self-harm – 2 hours
 - Understanding Co-Occurring Disorders – 2 hours
 - Incident Reporting – 1 Hour
 - Infection Control – 1 Hour
 - Co-occurring Disorders – 2 hours
 - HIV – 1 hour
 - Domestic Violence – 1 hour



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Understanding Addiction

So many people entering the field of addiction treatment come with the mindset of “I have personal experience and that is enough to help others” or “I want to help others and I have clinical knowledge of therapy and that is enough”. While these experiences and knowledge will add to your coaching experience it will not be enough to frame your whole scope.

Most of society has some level of knowledge and understanding of drug and alcohol use and abuse. There are articles, books, TV shows, movies etc. Of course, most have some level of personal experience with addiction. Does this mean you have an understanding of addiction, how it happens, how it progresses, how it effects our brains, our bodies, our psyche??? The answer is NO.

This course covers a significant amount of information to help you see the whole picture of addiction, a picture that goes beyond what our client’s use, how much and how long. To work in addictions your level of knowledge and understanding of addiction will help you work clients on a different level. You will be able to assist the client in seeing themselves as a whole person, not just an addict. You will have the tools to educate, guide and answer questions posed by your client’s with confidence and clarity.

Let’s start by defining addiction.

Definition of Addiction

American Society of Addiction Medicine (ASAM)

Public Policy Statement: Definition of Addiction

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, and craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.



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Dictionary.com

The state of being enslaved to a habit or practice or to something that is psychologically or physically habit-forming, as narcotics, to such an extent that its cessation causes severe trauma.

Merriam-Webster Dictionary

1. (Noun) The quality or state of being addicted <*addiction* to reading>. An unusually great interest in something or a need to do or have something.
2. A strong and harmful need to regularly have something (such as a drug) or do something (such as gamble).
3. (Medical Definition) Compulsive need for and use of a habit-forming substance (as heroin, nicotine, or alcohol) characterized by tolerance and by well-defined physiological symptoms upon withdrawal; broadly: persistent compulsive use of a substance known by the user to be harmful.

Wikipedia

Addiction is a state characterized by compulsive engagement in rewarding stimuli, despite adverse consequences. It can be thought of as a disease or biological process leading to such behaviors. The two properties that characterize all addictive stimuli are that they are (positively) reinforcing (i.e., they increase the likelihood that a person will seek repeated exposure to them) and intrinsically rewarding (i.e., they activate the brain's "reward pathways", and are therefore perceived as being something positive or desirable).

Psychology Today

Addiction is a condition that results when a person ingests a substance (e.g., alcohol, cocaine, nicotine) or engages in an activity (e.g., gambling, sex, shopping) that can be pleasurable but the continued use/act of which becomes compulsive and interferes with ordinary life responsibilities, such as work, relationships, or health. Users may not be aware that their behavior is out of control and causing problems for themselves and others.

National Institute on Drug Abuse (NIDA)



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Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain; they change its structure and how it works. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors.

What is the Medical Definition of Addiction

1. **Tolerance.** Do you use more alcohol or drugs over time?
2. **Withdrawal.** Have you experienced physical or emotional withdrawal when you have stopped using? Have you experienced anxiety, irritability, shakes, sweats, nausea, or vomiting? Emotional withdrawal is just as significant as physical withdrawal.
3. **Limited control.** Do you sometimes drink or use drugs more than you would like? Do you sometimes drink to get drunk? Does one drink lead to more drinks sometimes? Do you ever regret how much you used the day before?
4. **Negative consequences.** Have you continued to use even though there have been negative consequences to your mood, self-esteem, health, job, or family?
5. **Neglected or postponed activities.** Have you ever put off or reduced social, recreational, work, or household activities because of your use?
6. **Significant time or energy spent.** Have you spent a significant amount of time obtaining, using, concealing, planning, or recovering from your use? Have you spend a lot of time thinking about using? Have you ever concealed or minimized your use? Have you ever thought of schemes to avoid getting caught?
7. **Desire to cut down.** Have you sometimes thought about cutting down or controlling your use? Have you ever made unsuccessful attempts to cut down or control your use?

Illegal Drugs in America – A Modern History

Since the 19th century when Americans first discovered new wonder drugs like morphine, heroin, and cocaine, our society has confronted the problem of drug abuse and addiction. Drug abuse and addiction has been a social problem in America for nearly a century. What may be surprising is that many of these illegal drugs were first introduced by doctors as legal over-the-counter and prescription



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medications. Here's more about the history of illegal drugs in America.

When the 20th century began, the United States--grappling with its first drug epidemic--gradually instituted effective restrictions: at home through domestic law enforcement and overseas by spearheading a world movement to limit opium and coca crops. By World War II, American drug use had become so rare, it was seen as a marginal social problem. The first epidemic was forgotten.

During the 1960s, drugs like marijuana, amphetamines, and psychedelics came on the scene, and a new generation embraced drugs. With the drug culture exploding, our government developed new laws and agencies to address the problem. In 1973, the U.S. Drug Enforcement Administration was created to enforce federal drug laws. In the 1970s, cocaine reappeared. Then, a decade later, crack appeared, spreading addiction and violence at epidemic levels.

Today, the DEA's biggest challenge is the dramatic change in organized crime. While American criminals once controlled drug trafficking on U.S. soil, today sophisticated and powerful criminal groups headquartered in foreign countries control the drug trade in the United States.

History of Marijuana in America

Perhaps one of the oldest drugs in American history is marijuana, which was grown by the Jamestown settlers around 1600. Before the Civil War marijuana was a major source of revenue for the U.S., and marijuana plantations flourished during the 19th century. Marijuana was widely used as a medicinal drug from 1850 to 1937 and could even be purchased over the counter in pharmacies and general stores. Marijuana became an attractive alternative to alcohol after the price of alcohol was raised in 1920.

In the 1930s, studies began to emerge that linked marijuana use by lower class communities to crime and violence, leading to the eventual banning of marijuana in 1937. In the 1960s, marijuana use became a popular drug of choice among white Beatniks, and stricter penalties for marijuana offenses were passed under the Comprehensive Drug Abuse Prevention and Control Act of 1970. Since then, citizens and politicians alike have pushed to have marijuana decriminalized, but it remains an illegal drug in the U.S. Marijuana was, however, legalized for medical use in California in 1966 for people with serious illnesses, and medical marijuana still remains legal in some states.

History of Methamphetamine in America

The stimulant amphetamine first became popular in the medical community in the 1920s, where it was used for stimulating the central nervous system, raising blood pressure, and enlarging nasal passages.



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Amphetamines were widely distributed to soldiers during World War II to combat fatigue and improve endurance and mood, and were prescribed by doctors after the war to help fight depression.

Amphetamine abuse began during the 1930s when it became an over-the-counter inhalant drug marketed under the name Benzedrine. As more and more people legally used amphetamines, an illegal black market began to emerge. Illegal amphetamines were used commonly by truck drivers who wanted to stay alert on long commutes and athletes looking to improve their performance. Students also began taking illicit amphetamines to help them study.

The practice of injecting amphetamines gained popularity in the 1960s, which led the emergence of underground labs that were mainly controlled by outlaw motorcycle groups. During the 1970s, amphetamine use began to decline due to increased public awareness of its dangers and remained on a decline until the 1990s when crystal methamphetamine, a smokable form of methamphetamine, emerged. Since then, crystal meth has remained a popular drug of choice for three main types of users: high school and college students; blue-collar Caucasians; and unemployed persons in their 20s and 30s.

History of Cocaine in America

Cocaine was a popular medical drug in Europe for decades before it became popular in America. In 1886, “Coca-Cola” was introduced and contained syrup derived from coca leaves. That same year the Surgeon-General of the United States Army endorsed medical use of cocaine. Over the next few decades various unregulated medicinal “tonics” were sold in the U.S. containing cocaine, and hundreds of Hollywood silent movies depicted scenes of cocaine use. By 1902 there were an estimated 200,000 cocaine addicts in the U.S.

Cocaine was finally outlawed in 1914 and declined in usage over the decades until it regained popularity in the 1970s as a recreational, glamorized drug, eventually reaching its peak in 1982 with 10.4 million users. Some U.S. media declared cocaine as non-addictive and it was viewed as a relatively harmless drug until the emergence of crack in 1985.

History of Crack Cocaine in America

Crack, a form of cocaine that is sold as “rocks” and smoked, first appeared in large U.S. cities around 1985. Crack became a popular alternative to cocaine in urban and working-class areas because it was much cheaper than cocaine. This led to a dramatic increase in crack use known as the “Crack Epidemic of the 1980s.” A major crackdown on crack abuse was launched, leading to its eventual decline in usage.



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History of LSD in America

LSD first emerged on the American scene during the 1950s, when the U.S. military and CIA researched the use of LSD as a “truth drug” that could be used to make prisoners talk. This led the psychiatric community to become interested in LSD for its possible therapeutic capabilities for depressed, psychotic and epileptic patients.

Illegal use of LSD began to escalate during the late 1950s and 1960s as mental health professionals and research study participants began to distribute the drug among their friends. LSD was only available through connections to the medical field until 1962, when a black market for LSD emerged in America. LSD was made illegal in 1966 and, soon after, an LSD black market emerged. Users began experiencing growing problems with the “new” LSD, which was contaminated and of a poorer quality than the medical-grade LSD they were used to. Despite its poorer quality, LSD was a popular drug of choice for “hippies” during the mid- to late-1960s. LSD use declined in the 1970s and 1980s, but reemerged in the 1990s in the rave subculture along with other hallucinogens.

History of Heroin in America

Opiates were popular in the United States throughout the 19th century, particularly among upper- and middle-class women who were prescribed tonics and elixirs containing opium to cure “female problems.” The practice of smoking opium was introduced in the 1850s and 1860s by Chinese laborers who came to the U.S. to work on railroads.

The opiate-based drug morphine was created in 1803 and widely used during the American Civil War as an injectable pain reliever, leading to the first wave of morphine addiction. Interestingly, the drug heroin was created in 1895 and marketed three years later as a potential solution to the increasing problem of morphine addiction. The charitable St. James Society even mailed free samples of heroin to morphine addicts as part of a campaign against morphine addiction. As a result, heroin addiction began to take root and grow.

The second major wave of opiate addiction in America began in the 1930s and 1940s Harlem jazz scene, and again during the Beatnik subculture of the 1950s. During the Vietnam War, heroin abuse became rampant among U.S. soldiers stationed abroad, with an estimated 10% to 15% of servicemen addicted to heroin. Heroin users began smoking and snorting heroin after improvements were made in the purity of street heroin in the 1980s and 1990s. As a result, heroin usage rose significantly in the 1990s.

Brief Overview of Addiction – The Basics



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Why study drug abuse and addiction?

Abuse of and addiction to alcohol, nicotine, and illicit and prescription drugs cost Americans more than \$700 billion a year in increased health care costs, crime, and lost productivity. Every year, illicit and prescription drugs and alcohol contribute to the death of more than 90,000 Americans, while tobacco is linked to an estimated 480,000 deaths per year.

How are drug disorders categorized?

NIDA continues to use the term “addiction” to describe compulsive drug seeking despite negative consequences. However, “addiction” is not considered a specific diagnosis in the fifth edition of The Diagnostic and Statistical Manual of Mental Disorders (DSM-5)—a diagnostic manual used by clinicians that contains descriptions and symptoms of all mental disorders classified by the American Psychiatric Association (APA).

In 2013, APA updated the DSM, replacing the categories of substance abuse and substance dependence with a single category: substance use disorder. The symptoms associated with a substance use disorder fall into four major groupings: impaired control, social impairment, risky use, and pharmacological criteria (i.e., tolerance and withdrawal).

What is the difference between physical dependence, dependence, and addiction?

Physical dependence is not equivalent to dependence or addiction, and may occur with the regular (daily or almost daily) use of any substance, legal or illegal, even when taken as prescribed. It occurs because the body naturally adapts to regular exposure to a substance (e.g., caffeine or a prescription drug). When that substance is taken away, symptoms can emerge while the body re-adjusts to the loss of the substance. Physical dependence can lead to craving the drug to relieve the withdrawal symptoms. Drug dependence and addiction refer to substance use disorders, which may include physical dependence but must also meet additional criteria.

How do drugs work in the brain to produce pleasure?

Nearly all addictive drugs directly or indirectly target the brain’s reward system by flooding the circuit with dopamine. Dopamine is a neurotransmitter present in regions of the brain that regulate movement, emotion, cognition, motivation, and feelings of pleasure. The overstimulation of this system, which rewards our natural behaviors, produces the euphoric effects sought by people who use



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drugs and teaches them to repeat the behavior.

Is drug abuse a voluntary behavior?

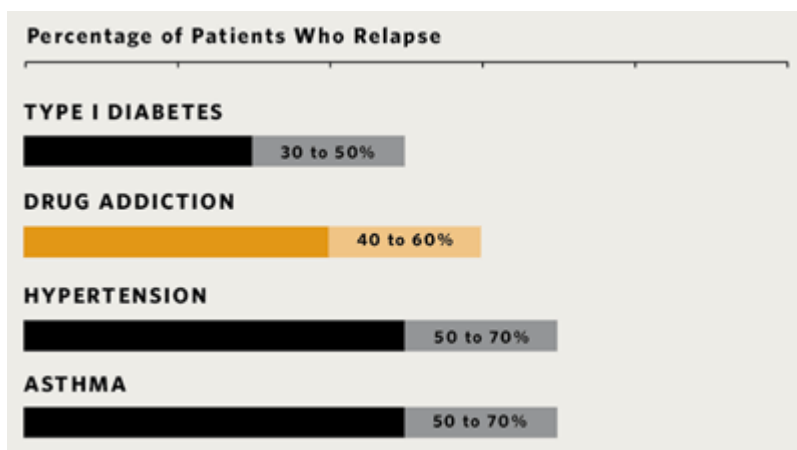
The initial decision to take drugs is mostly voluntary. However, when addiction takes over, a person's ability to exert self-control can become seriously impaired. Brain-imaging studies from people addicted to drugs show physical changes in areas of the brain that are critical for judgment, decision-making, learning, memory, and behavior control. Scientists believe that these changes alter the way the brain works and may help explain the compulsive and destructive behaviors of an addicted person.

Can addiction be treated successfully?

Yes. Addiction is a treatable, chronic disease that can be managed successfully. Research shows that combining behavioral therapy with medications, where available, is the best way to ensure success for most patients. Treatment approaches must be tailored to address each patient's drug use patterns and drug-related medical, psychiatric, and social problems.

How many people die from drug use?

The Centers for Disease Control and Prevention (CDC) report that there were more than 40,000 unintentional drug overdose deaths in the United States in 2011, a 118-percent increase since 1999. More than 22,000 people die every year from prescription drug abuse, more than heroin and cocaine combined.





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Relapse rates for drug-addicted patients are compared with those suffering from diabetes, hypertension, and asthma. Relapse is common and similar across these illnesses (as is adherence to medication). Thus, drug addiction should be treated like any other chronic illness, with relapse serving as a trigger for renewed intervention.

Source: McLellan et al., JAMA, 284:1689-1695, 2000.

How Common is Drug or Alcohol Addiction

Approximately 10% of any population is addicted to drugs or alcohol. **Addiction is more common than diabetes**, which occurs in approximately 7% of the population.

Addiction crosses all socio-economic boundaries. 10% of teachers, 10% of plumbers, and 10% of CEOs have an addiction.

The terms alcohol addiction, alcoholism, and alcohol dependence are all equivalent. The same is true for the terms drug addiction and drug dependence.

The Cost of Addiction

The dollars and cents cost of addiction is mind boggling. At least twice as many people die from alcoholism in the US every year as die from motor vehicle accidents.

Alcohol intoxication is associated with 40-50% of traffic fatalities, 25-35% of nonfatal motor vehicle injuries, and 64% of fires. Alcohol is present in nearly 50% of homicides, either in the victim or the perpetrator.

Alcohol intoxication is involved in 31% of fatal injuries, and 23% of completed suicides.

One study found that 86 % of homicide offenders, 37 % of assault offenders, and 57 % of men and 27 % of women involved in marital violence were drinking at the time of their offense.

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Five Things to Know about Alcohol

1. Almost one in 10 people in the United States experience alcohol dependence at some time during their lives.

Alcoholism occurs in both sexes, all ethnic and racial groups, and in people from all walks of life. It develops when someone drinks too much too often. Drinking more than three drinks a day if you are a woman or four drinks if you are a man increases health risks, including risk for alcohol dependence.

2. Alcoholism usually starts in the late teens or early twenties, yet most people don't seek help until 15- 20 years later.

Earlier treatment is more successful and results in far less destruction to individuals and their families.

3. Only about one in 10 people with alcoholism ever receives professional treatment.

Recent research suggests that newer medications are effective treatments for alcohol dependence when combined with brief counseling by a health professional. This means that many more people can receive treatment from their family, or primary care, doctor. Specialized alcohol counseling also works well, and all approaches (12-step, cognitive and motivational) are about equally effective. Some people will need more intensive programs.

4. Whatever treatment a person receives, the most important thing is they stick with it. The longer a person stays in treatment, the more likely they are to succeed.

If a person has a relapse, recognize that this is a chronic disease, and try to help them get back on track as quickly as possible. If they are taking medication for alcohol dependence, be sure to check they are taking it as prescribed. Encourage them not discontinue it even if they don't notice feeling any different. The medicine is working if they are not drinking, or if they are drinking much less.

5. Twelve-step and other support programs really do work! Recovering people who attend groups on a regular basis do better than those who do not.

If the recovering person is taking medication for alcohol dependence, allay worries about whether it is a "crutch." Medication can improve recovery rates by 20-40% in the first three months after stopping. Also, it's fine to take medication and to attend support groups or alcohol counseling.



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Instructor Note: There are many, many more statistics and trends now, research has grown by leaps and bounds in the area of addiction and because of that we know so much more than ever before. Which in turn finally arms us with the ability to answer some of our clients baffling yet heartfelt questions about why they do what they do.

This Is Your Brain On Drugs: Understanding Addiction from the Inside out

People experiment with drugs for many different reasons. Many first try drugs out of curiosity, to have a good time, because friends are doing it, or in an effort to improve athletic performance or ease another problem, such as stress, anxiety, or depression. Use doesn't automatically lead to abuse, and there is no specific level at which drug use moves from casual to problematic. It varies by individual.

Why do some drug users become addicted, while others don't?

As with many other conditions and diseases, vulnerability to addiction differs from person to person. Your genes, mental health, family and social environment all play a role in addiction. Risk factors that increase your vulnerability include:

- Family history of addiction
- Abuse, neglect, or other traumatic experiences in childhood
- Mental disorders such as depression and anxiety
- Early use of drugs
- Method of administration—smoking or injecting a drug may increase its addictive potential

Substance Addiction and the Brain

Addiction is a complex disorder characterized by compulsive drug use. While each drug produces different physical effects, all abused substances share one thing in common: repeated use can alter the way the brain looks and functions.

- Taking a recreational drug causes a surge in levels of dopamine in your brain, which trigger feelings of pleasure. Your brain remembers these feelings and wants them repeated.
- If you become addicted, the substance takes on the same significance as other survival behaviors, such as eating and drinking.
- Changes in your brain interfere with your ability to think clearly, exercise good judgment, control your behavior, and feel normal without drugs.



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- Whether you're addicted to inhalants, heroin, Xanax, speed, or Vicodin, the uncontrollable craving to use grows more important than anything else, including family, friends, career, and even your own health and happiness.
- The urge to use is so strong that your mind finds many ways to deny or rationalize the addiction. You may drastically underestimate the quantity of drugs you're taking, how much it impacts your life, and the level of control you have over your drug use.

How Substance Addiction Can Develop

People who experiment with drugs continue to use them because the substance either makes them feel good, or stops them from feeling bad. In many cases, however, there is a fine line between regular use and drug abuse and addiction. Very few addicts are able to recognize when they have crossed that line.

How does Addiction Feel?

An addictive substance feels good because it stimulates the pleasure center of the brain through neurotransmitters such as dopamine and GABA. If you have a genetic predisposition, addictive substances don't just feel good. They feel so good that you will want to chase after them.

This is where addiction comes in. If you have a genetic predisposition, addictive substances feel so good that you are willing to suffer negative consequences in order to get more and to continue to feel the high.

Addictive substances feel different inside an addict's brain than they do to a non-addict. This is why the two sides have difficulty understanding each other. In someone who is not addicted, drugs and alcohol only produce a mild high. Therefore, a non-addict cannot understand why the addict would go to such lengths, when it is clearly destroying their life.

The Genetics of Addiction

The Role of Family History

Addiction is due 50 percent to genetic predisposition and 50 percent to poor coping skills. This has been confirmed by numerous studies. One study looked at 861 identical twin pairs and 653 fraternal (non-identical) twin pairs. When one identical twin was addicted to alcohol, the other twin had a high probability of being addicted. But when one non-identical twin was addicted to alcohol, the other twin



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did not necessarily have an addiction. Based on the differences between the identical and non-identical twins, the study showed 50-60% of addiction is due to genetic factors. Those numbers have been confirmed by other studies.

The children of addicts are 8 times more likely to develop an addiction.

One study looked at 231 people who were diagnosed with drug or alcohol addiction, and compared them to 61 people who did not have an addiction. Then it looked at the first-degree relatives (parents, siblings, or children) of those people. It discovered that if a parent has a drug or alcohol addiction, the child had an 8 times greater chance of developing an addiction.

Why are there genes for addiction?

We all have the genetic predisposition for addiction because there is an evolutionary advantage to that. When an animal eats a certain food that it likes, there is an advantage to associating pleasure with that food so that the animal will look for that food in the future. In other words the potential for addiction is hardwired into our brain. Everyone has eaten too much of their favorite food even though they knew it wasn't good for them.

Although everyone has the potential for addiction, some people are more predisposed to addiction than others. Some people drink alcoholically from the beginning. Other people start out as a moderate drinker and then become alcoholics later on.

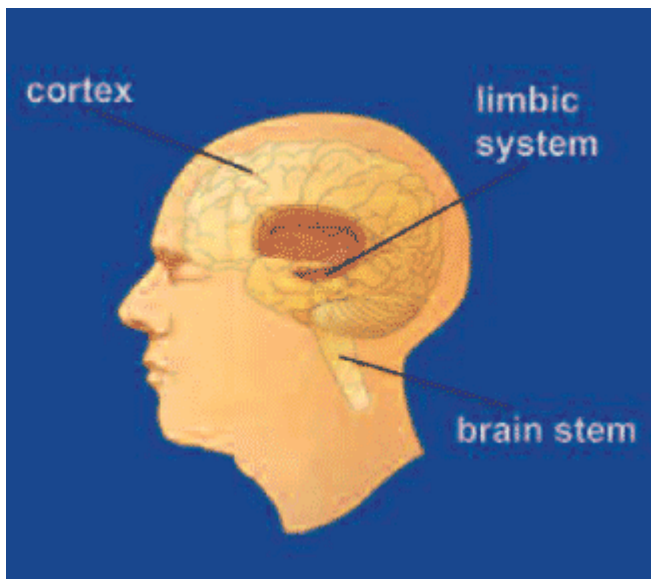
Repeatedly abusing drugs or alcohol permanently rewires your brain.

If you start out with a low genetic predisposition for addiction, you can still end up with an addiction. If you repeatedly abuse drugs or alcohol because of poor coping skills, then you'll permanently rewire your brain. Every time you abuse alcohol, you'll strengthen the wiring associated with drinking, and you'll chase that buzz even more. The more you chase the effect of alcohol, the greater your chance of eventually developing an addiction.

Genes are not your destiny. The 50% of addiction that is caused by poor coping skills is where you can make a difference. Lots of people have come from addicted families but managed to overcome their family history and live happy lives.

Let's Look Inside the Brain☺

The brain is made up of many parts that all work together as a team. Different parts of the brain are responsible for coordinating and performing specific functions. Drugs can alter important brain areas that are necessary for life-sustaining functions and can drive the compulsive drug abuse that marks addiction. Brain areas affected by drug abuse include:



- **The brain stem**, which controls basic functions critical to life, such as heart rate, breathing, and sleeping.
- **The cerebral cortex**, which is divided into areas that control specific functions. Different areas process information from our senses, enabling us to see, feel, hear, and taste. The front part of the cortex, the frontal cortex or forebrain, is the thinking center of the brain; it powers our ability to think, plan, solve problems, and make decisions.
- **The limbic system**, which contains the brain's reward circuit. It links together a number of brain structures that control and regulate our ability to feel pleasure. Feeling pleasure motivates us to repeat behaviors that are critical to our existence. The limbic system is activated by healthy, life-sustaining activities such as eating and socializing—but it is also activated by drugs of abuse. In



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addition, the limbic system is responsible for our perception of other emotions, both positive and negative, which explains the mood-altering properties of many drugs.

Cocaine, Marijuana and Heroin in your Brain

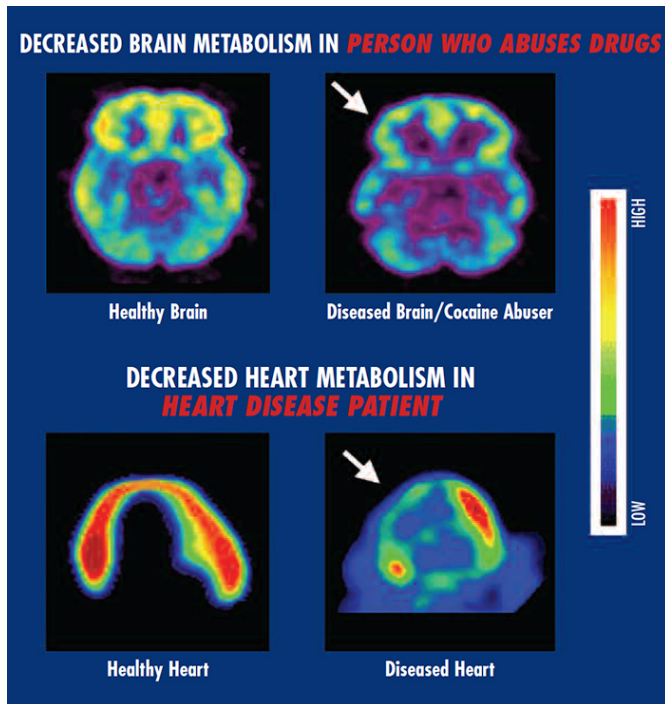
Drugs are chemicals that affect the brain by tapping into its communication system and interfering with the way neurons normally send, receive, and process information. Some drugs, such as marijuana and heroin, can activate neurons because their chemical structure mimics that of a natural neurotransmitter. This similarity in structure “fools” receptors and allows the drugs to attach onto and activate the neurons. Although these drugs mimic the brain’s own chemicals, they don’t activate neurons in the same way as a natural neurotransmitter, and they lead to abnormal messages being transmitted through the network.

Other drugs, such as amphetamine or cocaine, can cause the neurons to release abnormally large amounts of natural neurotransmitters or prevent the normal recycling of these brain chemicals. This disruption produces a greatly amplified message, ultimately disrupting communication channels.

Deeper in the Brain

We know addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain—they change its structure and how it works.

Check out the pictures of the brain impacted by substances below.



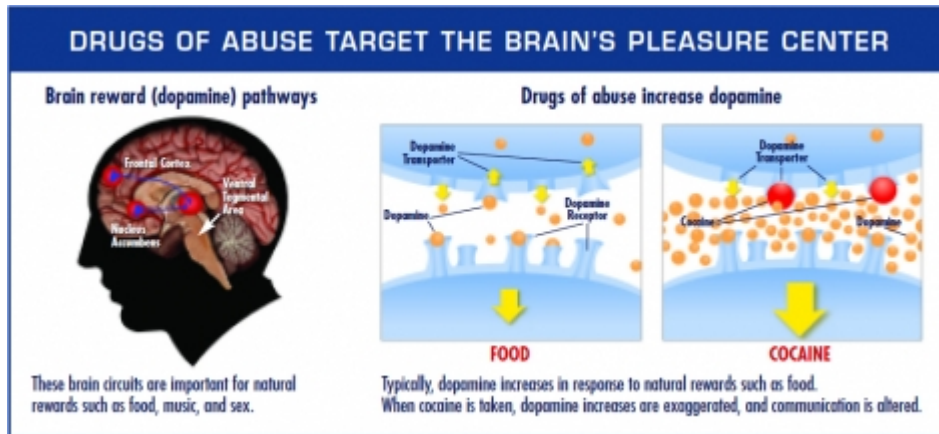
Source: From the laboratories of Drs. N. Volkow and H. Schelbert

Addiction is a lot like other diseases, such as heart disease. Both disrupt the normal, healthy functioning of the underlying organ, have serious harmful consequences, and are preventable and treatable, but if left untreated, can last a lifetime.

How do drugs work in the brain to produce pleasure?

Most drugs of abuse directly or indirectly target the brain's reward system by flooding the circuit with dopamine. Dopamine is a neurotransmitter present in regions of the brain that regulate movement, emotion, motivation, and feelings of pleasure. When activated at normal levels, this system rewards our natural behaviors. Over stimulating the system with drugs, however, produces euphoric effects, which strongly reinforce the behavior of drug use—teaching the user to repeat it.

Most drugs of abuse target the brain's reward system by flooding it with dopamine.



How does stimulation of the brain's pleasure circuit teach us to keep taking drugs?

Our brains are wired to ensure that we will repeat life-sustaining activities by associating those activities with pleasure or reward. Whenever this reward circuit is activated, the brain notes that something important is happening that needs to be remembered, and teaches us to do it again and again without thinking about it. Because drugs of abuse stimulate the same circuit, we learn to abuse drugs in the same way.

Why are drugs more addictive than natural rewards?

When some drugs of abuse are taken, they can release 2 to 10 times the amount of dopamine that natural rewards such as eating and sex do. In some cases, this occurs almost immediately (as when drugs are smoked or injected), and the effects can last much longer than those produced by natural rewards. The resulting effects on the brain's pleasure circuit dwarf those produced by naturally rewarding behaviors. The effect of such a powerful reward strongly motivates people to take drugs again and again. This is why scientists sometimes say that drug abuse is something we learn to do very, very well.



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Motivation for Drug Use

The motivation for taking substances is to achieve a desired effect in a reasonably short period of time. This effect or altered mood state is brought about by the effects drugs have on the brain and neurotransmitter systems. The effects on the neurotransmitter systems include action on the levels of the neurotransmitters (i.e., the chemical messengers) and the receptor sites (i.e., the sites where the specific chemical messengers have their effects). The use of drugs may prevent a neurotransmitter from breaking down, leading to a build-up of the neurotransmitter; it can block the reuptake of the neurotransmitter by the sending cell thus making more of the neurotransmitter available to the receiving cell.

Drugs can prevent a neurotransmitter from being produced at the normal level, or may block the receptor sites preventing the neurotransmitter from having its normal effects. Also, drugs can have an effect on the nerve cells in general as a toxin or just making them function slower than normal (Ray & Ksir, 2004; Carroll, 2000).

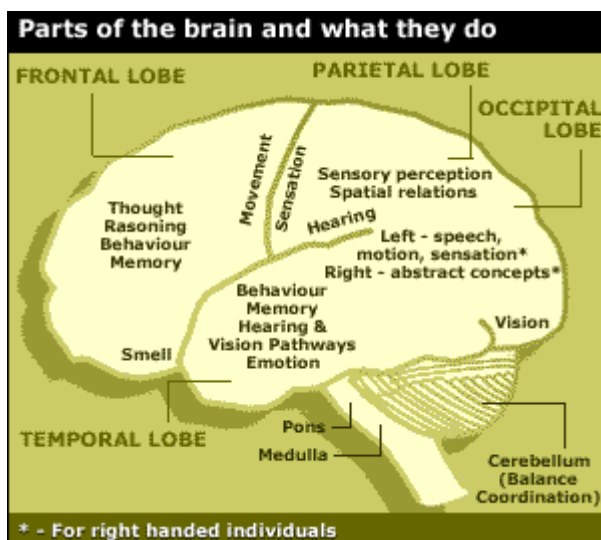
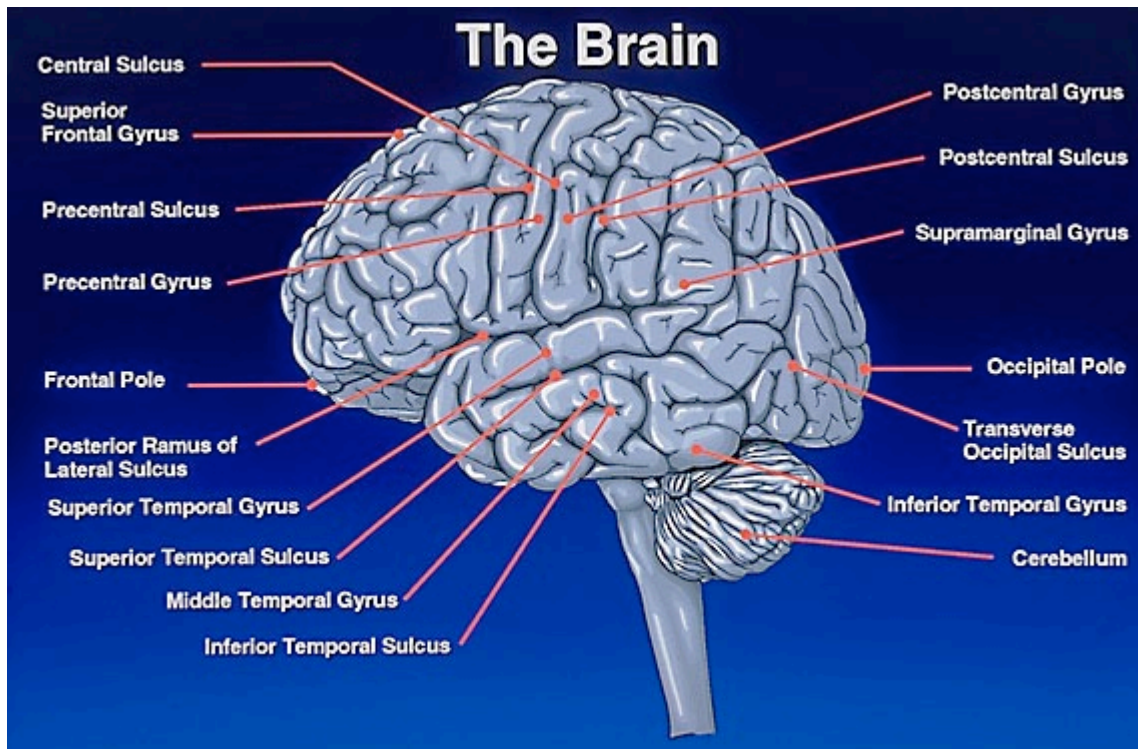
Neurotransmitters, the chemical messengers, are: GABA relates to inhibitory factors and slows communication. Norepinephrine usually associated with arousal reactions and moods. Dopamine usually associated with feeling of pleasure, Serotonin, usually associated with feelings of anxiety, depression, and aggressiveness, and Acetylcholine, which may be associated with arousal reactions or inhibitory factors (Ray & Ksir, 2004; Carroll, 2000).

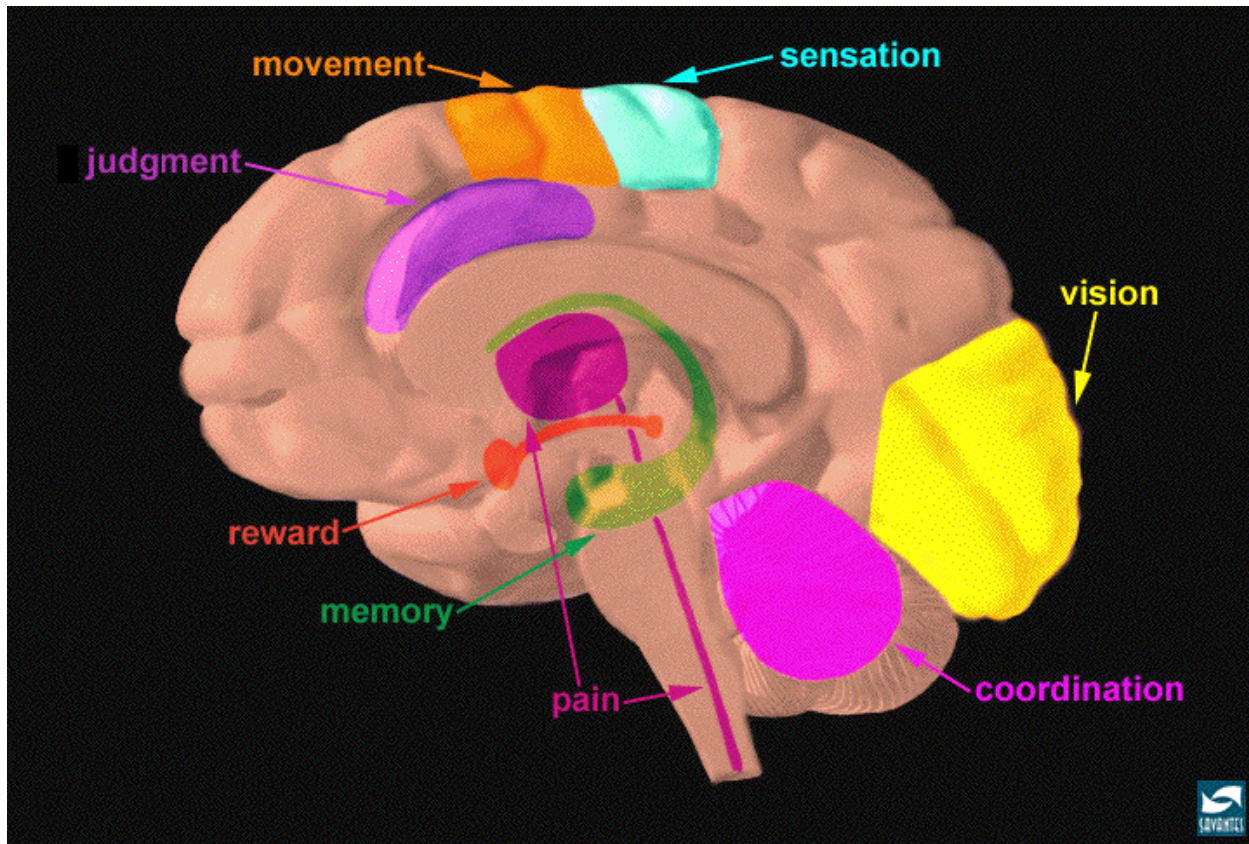
Drugs also activate the pleasure/reward center of the brain, which is made up of the ventral tegmental area (VTA), and the nucleus accumbens and other structures of the brain. These are two structures of the brain that are involved in the reward system for all drugs, although other mechanisms might be involved for specific drugs (Inaba, et al., 1997; Carroll, 2000).

How a drug is distributed throughout the body, where it is stored, and how long it is stored are determined by whether the drug is fat or water-soluble. Fat-soluble drugs store in the fatty areas of the body can have longer lasting traces in the body that water-soluble drugs do not (Ray & Ksir, 2004; Carroll, 2000).

Abuse potential is generally related to the drug's speed of action and how long the effects last. Drugs such as cocaine and nicotine with effects that are felt quickly and also wear off quickly have a high abuse potential. Abuse potential is a pharmacological term based on the effects of a drug; however, there are social factors that may influence it such as social acceptance of use, and opportunity for use (Ray & Ksir, 2004; Carroll, 2000).

Mountain West ATTC. (2005). *The Brain: Understanding Neurobiology Through the Study of Addiction*. Reno, NV: Author.





Addictions' Effect on the Cerebral Cortex: Impaired Decision-making, Impulsivity, and Compulsivity

The cerebral cortex is the outer most layer of the brain. The cerebral cortex is further divided into four areas. These four areas are: the frontal lobe (or frontal cortex), parietal lobes (left and right), temporal lobes (left and right), and occipital lobes (left and right). Each area is associated with certain brain functions: One area of the frontal cortex is called the prefrontal cortex. It has a vital role in higher-order functions. These functions include language, spatial learning, conscious thought, judgment, and decision-making. The process of addiction can negatively affect this area and alter its functioning.

The prefrontal cortex enables us to make rational, sound decisions. It also helps us to override impulsive urges. If acted upon, these impulsive urges can cause us to act without thinking. This is usually not in our best interest. For instance, suppose I've had a bad day at work. I may have an impulsive urge to tell my boss exactly what I think of her. To act on this impulse is not in my best interest. Fortunately, my prefrontal cortex is functioning quite well. I still have my job!



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Obviously, this ability to inhibit impulses is very helpful. It enables us to function well in society. It protects us from harm by allowing us to consider the consequences of our actions. However, when the pre-frontal cortex is not functioning correctly, the opposite occurs. Addiction causes changes to the prefrontal cortex. These changes account for two characteristics of addiction: impulsivity and compulsivity.

Impulsivity is the inclination to act upon sudden urges or desires without considering potential consequences. Sometimes people describe impulsivity as living in the present moment without regard to the future. Compulsivity is a behavior that an individual feels driven to perform to relieve anxiety. Once a person performs the compulsive behavior, the anxiety goes away and restores comfort. Thus, the presence of these behavioral characteristics in addicted persons indicates that changes to the prefrontal cortex have occurred. Unfortunately, these changes also make the discontinuation of drug use more difficult.

Addiction is a process that coordinates the transition from impulsive to compulsive behavior. Impulsivity occurs during the early stages of addiction. During this phase, people impulsively act on powerful urges to experience the pleasure of their addiction. Anxiety is not associated with the urges during these early stages. Instead, addiction reflects acting on impulsive desire to receive immediate pleasure from the drug or activity. People are not considering the future consequences.

As addiction progresses a shift begins to occur. At this point, the compulsive aspect of addiction takes hold. When this shift occurs, people are no longer pursuing their addiction solely for pleasure. The compulsions compel them to participate in their addiction to relieve anxious, uncomfortable feelings. These may arise at the mere thought of stopping the addiction for any reason (supply shortages, lack of opportunity, etc.). At this later compulsive stage, "pleasure" comes in the form of relief from these anxious, uncomfortable feelings. Thus, despite the negative consequences of addiction, the addictive behavior continues in a compulsive manner.

Another way to describe the pre-frontal cortex is to think of it as a braking system. The pre-frontal cortex acts as the brain's brakes. It sends out signals to inhibit particular behaviors or actions. When addiction damages this brain area, it limits the brain's ability to control other behavioral systems as well. Imagine how difficult it would be to operate a car without brakes. At this point, we might say the brain is "high-jacked" by the addiction. The prefrontal cortex also projects to other brain regions associated with addictive problems. These include the reward system; memory and emotion; and stress regulation centers of the brain. Therefore, damage to the prefrontal cortex may further interfere with the functioning of these other brain regions as well.



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Although addiction damages the brain's brakes (pre-frontal cortex) this is not to say there is a complete loss of control. We are not slaves to our biology. We have a tremendous amount of control over our actions. This is true even when impulsive and compulsive forces are operating. This recognition is vitally important if someone wishes to recover from addiction. When a person consciously decides the costs of addiction outweigh its benefits, they become motivated and able to stop. This allows them to actively counter the effects of addiction on the frontal cortex and other brain regions.

Unfortunately, people's addictions limit their ability to use rational thought. This is due in part to the damage to the prefrontal cortex. They may incorrectly tally the costs and benefits of their addiction; over-estimating the benefits, while minimizing the costs. The addict is often told, "You're in denial." This is incorrect. When people use this phrase, they are applying it improperly. Denial refers to a psychological defense, or justification for a negative behavior. This is quite different than a loss of rational brain functioning that occurs with addiction. This is where addiction treatment professionals can be very helpful. They can guide addicted persons to make an accurate assessment of the costs and benefits. This more accurate assessment often leads to the motivation to change. Once someone decides it is time to change, they have taken the first step toward recovery.

The addiction process relies on learning and memory to drive the addiction cycle forward. Addiction chemically alters the system. However, people can learn how to counteract these changes. There are specific techniques that people can learn to oppose powerful urges. As people become more skillful, the wonderfully adaptive brain makes adjustments and corrections. This in turn leads to lasting recovery from addiction. In some cases, pharmacological intervention may also be beneficial.

Addictions' Effect on the Amygdala: Habit Formation, Craving, Withdrawal, and Relapse Triggers

People often describe addiction as a habit, and one that is difficult to break. This is because when people attempt to discontinue an addictive behavior (drug use or addictive activities) they experience withdrawal. Because withdrawal is such an unpleasant experience, it serves as a powerful motivator to resume the addictive behavior. Eventually, the relief from withdrawal (by resuming use) becomes pleasurable in and of itself. To illustrate how this occurs, go ahead and pinch yourself on the arm for one full minute. Not too hard, just enough to cause some discomfort. Then stop. Notice the sudden absence of pain has become pleasurable. This is the same way that the removal of withdrawal effects (via return to addiction) becomes pleasurable. Because it is pleasurable, it is rewarding. Because it is rewarding, it will be repeated. Some drugs, such as alcohol and opiates, have withdrawal effects that are both physical and emotional. Other drugs or addictive activities may primarily involve emotional symptoms. This characteristic of addiction occurs because of several changes in the brain.



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As drug use or addictive activity escalates, the involvement of various brain regions associated with our emotional state also increases. The brain region most often associated with our emotional state is the extended amygdala. Scientists think this brain region plays an important role in addiction because of its association with emotions and stress.

The amygdala affects emotions and memory. We all have both "good" memories and "bad" memories about various events in our lives. What makes a memory "good" as opposed to "bad" are the emotional states that occurred during those events. When the brain forms these memories, it stores the memory of the event along with the emotions that accompanied it. When I smell the sea air, feel the ocean breeze, and hear the seagulls, I have a pleasant memory and emotional experience. This is because these things have been repeatedly associated with relaxing and enjoyable times. The memory of the sea is stored along with a pleasant emotional state. So I can merely think of the sea, without actually being there, and I will experience a pleasant emotional state. Likewise, an addicted person may only need to think about engaging in their addiction and they will experience pleasure. The memory of engaging in the addiction is stored with a pleasant emotional state. Thus, the pleasing memories of engaging with an addiction can lead to repeating those behaviors and a habit forms.

Emotional memory has another role in the development of addiction, called **cue anticipation**. Cue anticipation refers to environmental cues that can initiate or elevate craving. Cravings often lead to relapse. For this reason, these cues are often called *relapse triggers*. Therefore, a successful recovery plan will include a strategy for coping with cues (relapse triggers).

These environmental cues (relapse triggers) can be anything that is associated with the addiction. It could be a certain time of day, a place, a person, or an activity. For instance, suppose a man is addicted to pornography use. He usually gets online after his wife goes to bed. The mere act of his wife *getting ready* to go to bed serves as a cue that prompts powerful cravings. Later, even his own *anticipation* of his wife going to bed will serve as a powerful cue. The amygdala's role in emotional memory is responsible for these cues taking root. The brain forms an association between pleasant memories of drug use or addictive activities, and the cues. The more a person repeats this cycle, the more it strengthens the emotional memory circuits associated with these cues. Eventually, this leads to a complete pre-occupation with the addiction.

So far, we've been discussing the role of the amygdala and positive emotional memories. The brain may also form an association between unpleasant emotions and a memory (forming a "bad" memory). These negative emotional memories play an important role in withdrawal. The negative emotional memory of anxiety becomes associated with the physical signs of withdrawal. As withdrawal begins, the symptoms trigger an unpleasant emotional memory. This increases the negative experience of withdrawal. Withdrawal avoidance (via returning to the addiction) often becomes the cornerstone of



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the addiction in the later stages. Thus, in the earlier stages of addiction the pleasurable experience of the drug motivates a repetition of that behavior. In the later stages, relief of withdrawal symptoms (physical and/or emotional discomfort) achieves pleasure. This pleasurable relief from withdrawal symptoms continues to motivate the repetition of that behavior.

Stress Regulation and Withdrawal: Addictions' Effect on the Hypothalamus

Addiction affects another area of the brain called the hypothalamus. The hypothalamus has many duties. It controls body temperature, hunger, thirst, and sleep. The hypothalamus plays a key role in our response to stress. Stress regulation is highly relevant to our understanding of addiction. When an individual experiences stress, the hypothalamus releases chemicals called hormones. These hormones allow the brain and the body to respond to that stress. Unlike neurotransmitters (which are chemicals limited to the brain) hormones travel throughout the body via the blood system. Therefore, hormones can exert an effect on other body systems as well. When these chemical hormones operate in the brain, we refer to them as neuromodulators. These hormones (neuromodulators) can act just like neurotransmitters in the brain. Like neurotransmitters, they have their own receptors associated with them.

Stress is a well-known relapse trigger. It can prompt powerful cravings in addicted persons. Many of us know someone who tried to quit smoking but ultimately relapsed when they became "stressed out." Unfortunately, during the initial period of recovery withdrawal symptoms create stress. This creates an unfortunate cycle. Stress prompts addictive use, while efforts to discontinue use prompt stress. During withdrawal, these stress hormones are elevated. Even though stress levels are high, the brain's anti-stress neuromodulators appear to decrease, as do dopamine and serotonin in the nucleus accumbens. This suggests that withdrawal affected the reward system (evidenced by decreasing dopamine and serotonin). At the same time, withdrawal activates the stress and anxiety systems. This "1-2 punch" heightens the negative experience of withdrawal. This prompts people to seek relief via the addictive substance or activity (i.e., relapse).

In summary, the neurotransmitter pathways associated with the amygdala and the hypothalamus play a crucial role in sustaining the addiction process. This occurs thorough:

- The negative emotional memory that is associated with drug withdrawal.
- The positive emotional memory that is associated with drug cues.
- The disruption that occurs to stress regulation.
- The pleasurable relief from withdrawal symptoms that occurs by resuming drug use or addictive activities.



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The High-jacked Brain

We do not yet know all the relevant mechanisms, but the evidence suggests that those long-lasting brain changes are responsible for the distortions of cognitive and emotional functioning that characterize addicts, particularly including the compulsion to use drugs that is the essence of addiction.

This brain-based view of addiction has generated substantial controversy, particularly among people who seem able to think only in polarized ways.

Many people erroneously still believe that biological and behavioral explanations are alternative or competing ways to understand phenomena, when in fact they are complementary and integrative.

Modern science has taught that it is much too simplistic to set biology in opposition to behavior or to pit willpower against brain chemistry.

Addiction involves inseparable biological and behavioral components. It is the **quintessential bio-behavioral disorder**.

Many people also erroneously still believe that drug addiction is simply a failure of will or of strength of character. Research contradicts that position.

The Brain Also Helps to Reverse Addiction

There's no question. Addiction wreaks havoc on the brain. Addiction causes significant chemical, structural, and molecular changes that quite literally hijack the brain. However, treatment can reverse or counteract these effects. Moreover, as the recovery process proceeds, the brain continues to heal.

It is true that many changes occur in the brain after addiction takes hold. But, we must also remember that the brain is a dynamic and ever-changing system. Changes to the brain's neuronal circuits, chemistry, and structures powerfully drive the addiction forward. However, a strong motivation to change, can just as powerfully counter these changes. People can learn new coping skills. They can practice behavioral modification techniques. These efforts will counter those damaging changes. Professional assistance can be enormously helpful as someone learns to overcome addiction's effect on the brain.

Abstinence from addictive substances or activities can lead to a reversal of many physical changes that occurred during addiction. Combination therapies (medications plus psychotherapy) help the recovery



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process by managing the physiological effects of addiction and withdrawal. Cognitive-behavioral treatments work to mend and repair the psychological impact of addiction.

Instructor Note: WOW! Our brain is truly amazing. It has the capacity to control its own physiology and is highly adaptive. Each behavioral step we make forward has a beneficial physiological effect on the brain. A sincere effort to change behavior is a powerful tool that mends the damaged brain.

When we change our behavior and find healthy outlets for satisfying cravings, we correct damaged brain function. These positive changes form new memory and behavioral circuits in the brain that strengthen and reinforce recovery efforts. Yes, the brain has changed because of the addictive process. Nevertheless, even people with severe addiction problems succeed in overcoming their addictions. Motivation is the key.

Signs and Symptoms of Addiction

Although different drugs have different physical effects, the symptoms of addiction are similar. See if you recognize yourself in the following signs and symptoms of substance abuse and addiction.

Physical warning signs of drug abuse

- Bloodshot eyes, pupils larger or smaller than usual
- Changes in appetite or sleep patterns. Sudden weight loss or weight gain
- Deterioration of physical appearance, personal grooming habits
- Unusual smells on breath, body, or clothing
- Tremors, slurred speech, or impaired coordination

Behavioral signs of drug abuse

- Drop in attendance and performance at work or school
- Unexplained need for money or financial problems. May borrow or steal to get it.
- Engaging in secretive or suspicious behaviors
- Sudden change in friends, favorite hangouts, and hobbies
- Frequently getting into trouble (fights, accidents, illegal activities)

Psychological warning signs of drug abuse

- Unexplained change in personality or attitude



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- Sudden mood swings, irritability, or angry outbursts
- Periods of unusual hyperactivity, agitation, or giddiness
- Lack of motivation; appears lethargic or “spaced out”
- Appears fearful, anxious, or paranoid, with no reason

Key Components of Addiction

- Compulsion
- Continued use despite negative consequences
- Craving
- Denial

Warning Signs of Commonly Abused Drugs

Marijuana: Glassy, red eyes; loud talking, inappropriate laughter followed by sleepiness; loss of interest, motivation; weight gain or loss.

Depressants (including Xanax, Valium, GHB): Contracted pupils; drunk-like; difficulty concentrating; clumsiness; poor judgment; slurred speech; sleepiness.

Stimulants (including amphetamines, cocaine, crystal meth): Dilated pupils; hyperactivity; euphoria; irritability; anxiety; excessive talking followed by depression or excessive sleeping at odd times; may go long periods of time without eating or sleeping; weight loss; dry mouth and nose.

Inhalants (glues, aerosols, vapors): Watery eyes; impaired vision, memory and thought; secretions from the nose or rashes around the nose and mouth; headaches and nausea; appearance of intoxication; drowsiness; poor muscle control; changes in appetite; anxiety; irritability; lots of cans/aerosols in the trash.

Hallucinogens (LSD, PCP): Dilated pupils; bizarre and irrational behavior including paranoia, aggression, hallucinations; mood swings; detachment from people; absorption with self or other objects, slurred speech; confusion.

Heroin: Contracted pupils; no response of pupils to light; needle marks; sleeping at unusual times; sweating; vomiting; coughing, sniffing; twitching; loss of appetite.

Warning signs of teen drug abuse



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While experimenting with drugs doesn't automatically lead to drug abuse, early use is a risk factor for developing more serious drug abuse and addiction. Risk of drug abuse also increases greatly during times of transition, such as changing schools, moving, or divorce. The challenge for parents is to distinguish between the normal, often volatile, ups and downs of the teen years and the red flags of substance abuse. These include:

- Having bloodshot eyes or dilated pupils; using eye drops to try to mask these signs
- Skipping class; declining grades; suddenly getting into trouble at school
- Missing money, valuables, or prescriptions
- Acting uncharacteristically isolated, withdrawn, angry, or depressed
- Dropping one group of friends for another; being secretive about the new peer group
- Lying about new interests and activities

Does drug abuse cause mental disorders, or vice versa?

Drug abuse and mental illness often co-exist. In some cases, mental disorders such as anxiety, depression, or schizophrenia may precede addiction; in other cases, drug abuse may trigger or exacerbate those mental disorders, particularly in people with specific vulnerabilities.\

Damage due to Addiction

Regardless of the drug abused, addiction leads to

- Physical deterioration
- Psychiatric problems
- Intellectual impairment
- Personality deterioration
- Increased risk of accidents and higher susceptibility to high risk behavior in the form of unprotected sex or use of unsterile needles
- Legal risks

But when a drug is taken for reasons other than medical, in an amount, strength, frequency or manner that causes damage to the physical or mental functioning of an individual, it becomes 'drug abuse'. Any type of drug can be abused; drugs with medical uses can also be abused.



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Tolerance refers to a condition where the user needs more and more of the drug to experience the same effect. Smaller quantities, which were sufficient earlier, are no longer effective and the user is forced to increase the amount of drug intake.

Slowly, drug dependence develops. Some drugs produce only psychological dependence while others produce both physical and psychological dependence.

Psychological dependence is a state characterized by emotional and mental preoccupation with the effects of the drug and a persistent craving for it. As psychological dependence develops, the user gets mentally 'hooked' on to the drug.

When physical dependence develops, the user's body becomes totally dependent on the drug. With prolonged use, the body becomes so used to functioning under the influence of the drug that it is able to function normally only if the drug is present.

Alcohol / drug abuse causes general physical deterioration in addition to affecting at least a few organs in particular. Mental health status is also affected. Safety risks are also another issue for concern. Moreover, drug abusers generally eat poorly, have irregular sleep patterns and do not seek timely medical help which only further worsen the situation.

Medical and psychiatric complications can be studied under four major heads.

- a. Problems due to intoxication
- b. Problems due to withdrawal
- c. Psychiatric disorders associated with substance abuse
- d. Systemic disorders associated with substance abuse

Continuum of Alcohol and Drug Use

The continuum of substance abuse is a term that is used to refer to the stages of substance use and abuse. The use of a drug can be only labeled drug abuse when the user becomes dysfunctional as a result of their use. If a person can maintain healthy relationships, does not suffer financial hardships, does not become unwell or is harmed from the use of the substance, then the use is maintained as drug use and not abuse. However, if a person begins to exhibit adverse reactions from a drug, has



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considerable problems with relationships with others, acts in a harmful, dangerous or reckless manner and begins to use significant amounts of energy acquiring and using a drug, then it can be considered that the individual has a drug abuse problem.

The theory of a continuum of drug use can be used to assess where a person is at in terms of their drug use and evaluate the type of treatment that may be appropriate, if any. Policymakers may also use the continuum to make decisions on education, harm minimization and policing. Some stages in the continuum, such as experimental or occasional use, can be considered as relatively harm free. Others such as regular or dependent use may require some intervention to alleviate or prevent further harm from occurring.

4 Stages of Addiction – In Brief

- **Use – Socially accepted/medically approved**
- **Misuse – Regular use of illegal drugs/Higher quantities than prescribed**
- **Abuse – Continued use of substances despite negative consequence**
- **Addiction – Compulsive using, negative consequences, tolerance, withdrawal potential**

Risk and Protective Factors

Why do some people become addicted to drugs, while others do not?

As with any other disease, vulnerability to addiction differs from person to person, and no single factor determines whether a person will become addicted to drugs. In general, the more *risk factors* a person has, the greater the chance that taking drugs will lead to abuse and addiction. *Protective factors*, on the other hand, reduce a person's risk of developing addiction. Risk and protective factors may be either environmental (such as conditions at home, at school, and in the neighborhood) or biological (for instance, a person's genes, their stage of development, and even their gender or ethnicity).



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Risk and Protective Factors for Drug Abuse and Addiction

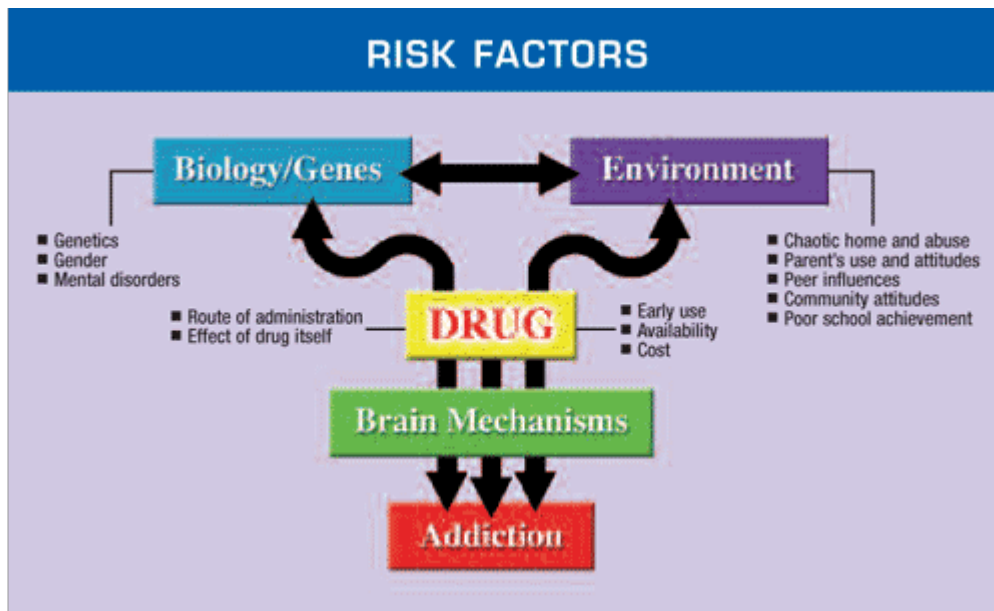
Risk Factors	Protective Factors
Aggressive behavior in childhood	Good self-control
Lack of parental supervision	Parental monitoring and support
Poor social skills	Positive relationships
Drug experimentation	Academic Competence
Availability of drugs at school	School anti-drug policies
Community poverty	Neighborhood pride

What environmental factors increase the risk of addiction?

- **Home and Family.** The influence of the home environment, especially during childhood, is a very important factor. Parents or older family members who abuse alcohol or drugs, or who engage in criminal behavior, can increase children's risks of developing their own drug problems.
- **Peer and School.** Friends and acquaintances can have an increasingly strong influence during adolescence. Drug-using peers can sway even those without risk factors to try drugs for the first time. Academic failure or poor social skills can put a child at further risk for using or becoming addicted to drugs.

What biological factors increase risk of addiction?

Scientists estimate that genetic factors account for between 40 and 60 percent of a person's vulnerability to addiction; this includes the effects of environmental factors on the function and expression of a person's genes. A person's stage of development and other medical conditions they may have are also factors. Adolescents and people with mental disorders are at greater risk of drug abuse and addiction than the general population.



Children's earliest interactions within the family are crucial to their healthy development and risk for drug abuse.

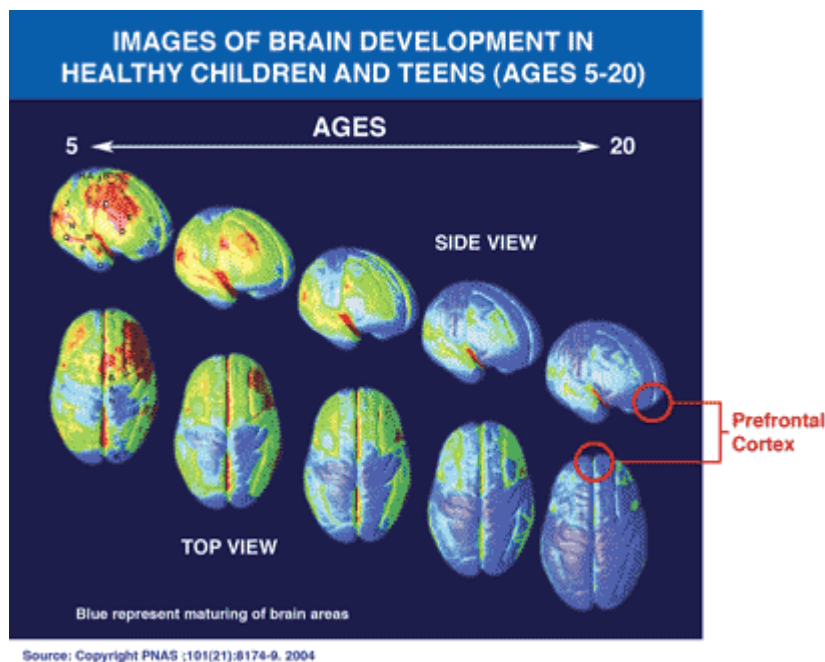
What other factors increase the risk of addiction?

- **Early Use.** Although taking drugs at any age can lead to addiction, research shows that the earlier a person begins to use drugs, the more likely he or she is to develop serious problems. This may reflect the harmful effect that drugs can have on the developing brain; it also may result from a mix of early social and biological vulnerability factors, including unstable family relationships, exposure to physical or sexual abuse, genetic susceptibility, or mental illness. Still, the fact remains that early use is a strong indicator of problems ahead, including addiction.

- **Method of Administration.** Smoking a drug or injecting it into a vein increases its addictive potential. Both smoked and injected drugs enter the brain within seconds, producing a powerful rush of pleasure. However, this intense “high” can fade within a few minutes, taking the abuser down to lower, more normal levels. Scientists believe this starkly felt contrast drives some people to repeated drug taking in an attempt to recapture the fleeting pleasurable state.

Addiction is a developmental disease—it typically begins in childhood or adolescence. The brain continues to develop into adulthood and undergoes dramatic changes during adolescence

One of the brain areas still maturing during adolescence is the prefrontal cortex—the part of the brain that enables us to assess situations, make sound decisions, and keep our emotions and desires under control. The fact that this critical part of an adolescent’s brain is still a work in progress puts them at increased risk for making poor decisions (such as trying drugs or continuing to take them). Also, introducing drugs during this period of development may cause brain changes that have profound and long-lasting consequences.



Instructor Note: Prevention is the best form of medicine. That old saying is still around because at it's heart is the truth. Recognizing risk factors, warning signs and symptoms of potential for substance



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use and misuse helps us to intervene BEFORE the person increases their use and with that all the potential health risks that come along with addiction.

Physical Health Risks Associated With Alcohol/Drug Use

Physical health risks from the use of alcohol can be associated with the amount used, duration of use, and the condition of the individual using. Because of the potential for fetal alcohol syndrome and fetal alcohol effect, it is suggested that women who think they might be pregnant should not drink alcohol. Those with other medical conditions such as diabetes, seizure disorders, gastric ulcers, various skin conditions, and osteoporosis should not drink alcohol.

The chronic use of alcohol can affect all systems of the body and can have definite visible signs as well as have physical effects. Physical signs and symptoms of chronic alcohol use can include a weakened overall appearance, hyper-pigmented, jaundiced skin or a yellowish pigment to the whites of the eyes. There may be hoarseness in the voice; ataxia, a wide spaced unsteady gate; the appearance of spider veins; and dilated capillaries and acne-like lesions on the face and body. The nose may be enlarged and bulbous (Kinney, 2003).

The chronic use of alcohol affects the internal systems of the body as well as the outward appearance. The irritation caused by the alcohol may cause inflammation, abdominal pain, and bleeding of the esophagus and stomach (Kinney, 2003). Chronic alcohol use is many times associated with acute pancreatitis

Alcoholic hepatitis often follows a heavy or extended bout of alcohol use and can occur in non-alcohol dependent persons. There is inflammation of the liver, metabolism is disrupted, jaundice, the yellowing of the skin and whites of the eyes, as well as other symptoms present with alcoholic hepatitis. Alcoholic hepatitis may be completely reversible in some people if they stop alcohol consumption and receive proper medical care (Kinney, 2003).

Cirrhosis is caused when there is permanent, widespread destruction of liver cells, which are replaced with nonfunctioning scar tissue. The liver cells are unable to perform their necessary functions and while progression may possibly be slowed down by stopping the consumption of alcohol, it is irreversible and fatal if alcohol is continued to be consumed (Kinney, 2003).

Anemia is the most common red blood cell related problem in chronic alcohol users. Alcohol use can negatively affect one's ability to achieve good, restful sleep (Kinney, 2003).



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Heavy alcohol consumption can lead to a blackout which is an amnesia-like state in which the individual may appear to be functioning normally yet later has no memory of what transpired. Blackouts are usually associated with alcohol dependence and are related to the dose taken. However, blackouts can occur in nondependent individuals as a result of a heavier than normal drinking episode in those who drank to the point of intoxication.

Is there a difference between physical dependence and addiction?

Yes. Addiction—or compulsive drug use despite harmful consequences—is characterized by an inability to stop using a drug; failure to meet work, social, or family obligations; and, sometimes (depending on the drug), tolerance and withdrawal. The latter reflect physical dependence in which the body adapts to the drug, requiring more of it to achieve a certain effect (tolerance) and eliciting drug-specific physical or mental symptoms if drug use is abruptly ceased (withdrawal). Physical dependence can happen with the chronic use of many drugs—including many prescription drugs, even if taken as instructed. Thus, physical dependence in and of itself does not constitute addiction, but it often accompanies addiction. This distinction can be difficult to discern, particularly with prescribed pain medications, for which the need for increasing dosages can represent tolerance or a worsening underlying problem, as opposed to the beginning of abuse or addiction.

Does drug abuse cause mental disorders, or vice versa?

Drug abuse and mental illness often co-exist. In some cases, mental disorders such as anxiety, depression, or schizophrenia may precede addiction; in other cases, drug abuse may trigger or exacerbate those mental disorders, particularly in people with specific vulnerabilities.

Five Things to Know about Adolescents' Brain Development and Use

1. The brain's "front end," the part above the eyes, exists to slow us down or stop our impulsive behaviors. It considers the risks and benefits of our actions, and it helps us "hit the brakes" when we consider doing things that are too risky.
2. This front part of the brain is still developing connections to the rest of the brain until adulthood, so adolescents' brains lack some of the "wiring" that carries "brake" or "stop" messages to the rest of the brain.



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3. Drugs of abuse are often available to adolescents. These drugs feel good, but they can be very harmful. Lacking some of the wiring for the "stop" message, adolescents' brains may not fully weigh the risks of drug use.
4. The two drugs that cause the most death are also the most available drugs: tobacco and alcohol. Late adolescence, before the brain is fully matured, is the peak time for developing dependence on these (and other) drugs.
5. Heavy drug use during times of critical brain development may cause permanent changes in the way the brain works and responds to rewards and consequences. Therefore, it is important to begin to address a developing substance use problem as early as possible.

Concerning Behaviors to look for in an Adolescent Who Might be Using Drugs

- Changes in school performance (falling grades, skipping school, tardiness)
- Changes in peer group (hanging out with drug-using, antisocial, older friends)
- Breaking rules at home, school, in the community
- Extreme mood swings, depression, irritability, anger, negative attitude
- Sudden increases or decreases in activity level
- Withdrawal from the family; keeping secrets
- Changes in physical appearance (weight loss, lack of cleanliness, strange smells)
- Red, watery, glassy eyes or runny nose not due to allergies or cold
- Changes in eating or sleeping habits
- Lack of motivation or interest in things other teenagers enjoy (hobbies, sports)
- Lying, stealing, hiding things
- Using street or drug language or possession of drug paraphernalia/items
- Cigarette smoking

What Adolescents Are Using

By a wide margin, teenagers abuse alcohol more than any other substance. It is legal and widely available. Nationwide, teens with alcohol dependency are the majority of adolescents admitted for treatment. Each year, the federal government conducts a survey to determine Americans' patterns of using alcohol and other drugs. This survey, the National Survey of Drug Use and Health (NSDUH), provides vital information on a wide array of topics. The survey showed that in 2005, the illicit substances that 12- to-17-year olds reported that they had used the most were, in this order:

- **marijuana**



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- **prescription drugs including stimulants, tranquilizers, sedatives, and pain relievers such as OxyContin and Vicodin**
- **inhalants**

Marijuana use among adolescents is second only to alcohol. Many believe marijuana is harmless, the brain shows that is simply not true.

Early Onset Alcoholism

Alcohol dependence, or alcoholism, can begin very early, even as early as 12 or 13 years old. Most teens obtain alcohol first from their parents; alcoholic beverages should be kept locked away. Prevention educates parents and guardians, the first thing parents and guardians need to know is if they believe their teen is beginning to drink, they need to talk about it, and be clear that they do not approve and that they expect different behavior. Parents/guardians need to keep track of where their teen is, and with whom.

FIVE WARNING SIGNS

1. Heavy drinking and alcoholism are more likely to occur when a parent has a similar problem. A family history of alcohol dependence increases risk of alcohol dependence four-fold.
2. Other early risk factors include serious childhood behavior problems requiring treatment, such as attention deficit hyperactivity disorder (ADHD), depression or anxiety, and health problems such as asthma. Parents/guardians need to talk about this with their teens and let them know how important it is not to drink. Let them know help is available if they need assistance.
3. Often, early onset alcoholism results in serious problems such as emergency room visits, injuries, fights or declining school performance. These serious problems may occur very early, even the first time teens drink on their own. If these occur an evaluation from a professional needs to be obtained.
4. If drinking problems develop early, be sure that any treatment includes a thorough evaluation of other possible disorders such as ADHD, depression or anxiety. Treatment of coexisting disorders helps with recovery from alcoholism. Also, teens that drink heavily often use other drugs, especially marijuana. Be sure to have this evaluated as well.
5. If an older child begins drinking a lot, younger siblings are more likely to do so as well. Be especially vigilant as your younger children grow.



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8 Myths about Drug Abuse and Addiction

- MYTH 1: Overcoming addiction is a simply a matter of willpower. You can stop using drugs if you really want to. Prolonged exposure to drugs alters the brain in ways that result in powerful cravings and a compulsion to use. These brain changes make it extremely difficult to quit by sheer force of will.
- MYTH 2: Addiction is a disease; there's nothing you can do about it. Most experts agree that addiction is a brain disease, but that doesn't mean you're a helpless victim. The brain changes associated with addiction can be treated and reversed through therapy, medication, exercise, and other treatments.
- MYTH 3: Addicts have to hit rock bottom before they can get better. Recovery can begin at any point in the addiction process—and the earlier, the better. The longer drug abuse continues, the stronger the addiction becomes and the harder it is to treat. Don't wait to intervene until the addict has lost it all.
- MYTH 4: You can't force someone into treatment; they have to want help. Treatment doesn't have to be voluntary to be successful. People who are pressured into treatment by their family, employer, or the legal system are just as likely to benefit as those who choose to enter treatment on their own. As they sober up and their thinking clears, many formerly resistant addicts decide they want to change.
- MYTH 5: Treatment didn't work before, so there's no point trying again. Recovery from drug addiction is a long process that often involves setbacks. Relapse doesn't mean that treatment has failed or that you're a lost cause. Rather, it's a signal to get back on track, either by going back to treatment or adjusting the treatment approach.
- MYTH 6: Addicts should be punished, not treated, for using drugs. Science is demonstrating that addicts have a brain disease that causes them to have impaired control over their use of drugs. Addicts need treatment for their neuro-chemically driven brain pathology.
- MYTH 7: Addicts cannot be treated with medications. Actually, addicts are medically detoxified in hospitals, when appropriate, all the time. But can they be treated with medications after detox? New pharmacotherapies (medicines) are being developed to help patients who have already become abstinent to further curb their craving for addicting drugs. These medications reduce the chances of relapse and enhance the effectiveness of existing behavioral (talk) therapies.
- MYTH 8: Addicts are bad, crazy, or stupid. Evolving research is demonstrating that addicts are not bad people who need to get good, crazy people who need to get sane, or stupid people who need education. Addicts have a brain disease that goes beyond their use of drugs.



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The Latest View in Understanding Addiction

Instructor Note: We have presented a lot of information in this chapter about the science of addiction, how substances impact various areas of the brain and how, in turn, addiction develops from voluntary, experimental use. The following is a newer, updated viewpoint and explanation of addiction. Not all is new but enough to warrant it's inclusion in this chapter.

The Essence of Addiction

The entire concept of addiction has suffered greatly from imprecision and misconception. In fact, if it were possible, it would be best to start all over with some new, more neutral term.

The confusion comes about in part because of a now **archaic distinction between whether specific drugs are “physically” or “psychologically” “addicting.”**

The distinction historically revolved around whether or not dramatic physical withdrawal symptoms occur when an individual stops taking a drug; what we in the field now call “physical dependence.”

- However, 20 years of scientific research has taught that focusing on this physical versus psychological distinction is off the mark and a distraction from the real issues.
- From both clinical and policy perspectives, it actually does not matter very much what physical withdrawal symptoms occur.
- Physical dependence is not that important, because even the dramatic withdrawal symptoms of heroin and alcohol addiction can now be easily managed with appropriate medications.
- Even more important, many of the most dangerous and addicting drugs, including methamphetamine and crack cocaine, do not produce very severe physical dependence symptoms upon withdrawal.
- What really matters most is whether or not a drug causes what we now know to be the essence of addiction, namely
- **The uncontrollable, compulsive drug craving, seeking, and use, even in the face of negative health and social consequences.**

This is the crux of how the Institute of Medicine, the American Psychiatric Association, and the American Medical Association define addiction and how we all should use the term.



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It is really only this compulsive quality of addiction that matters in the long run to the addict and to his or her family and that should matter to society as a whole.

Thus, the majority of the biomedical community now considers addiction, in its essence, to be a brain disease:

A condition caused by persistent changes in brain structure and function.

This results in compulsive craving that overwhelms all other motivations and is the root cause of the massive health and social problems associated with drug addiction.

Updating the Definition of Addiction

In updating our national discourse on drug abuse, we should keep in mind this simple definition:

Addiction is a brain disease expressed in the form of compulsive behavior.

Both developing and recovering from it depend on biology, behavior, and social context.

It is also important to correct the common misimpression that drug use, abuse and addiction are points on a single continuum along which one slides back and forth over time, moving from user to addict, then back to occasional user, then back to addict.

Clinical observation and more formal research studies support the view that, once addicted, the individual has moved into a different state of being.

Very few people appear able to successfully return to occasional use after having been truly addicted.

The Altered Brain

Unfortunately, we do not yet have a clear biological or behavioral marker of that transition from voluntary drug use to addiction.

However, a body of scientific evidence is rapidly developing that points to an array of cellular and molecular changes in specific brain circuits. Moreover, many of these brain changes are common to all chemical addictions, and some also are typical of other compulsive behaviors such as pathological overeating.

The complexity of this brain disease is not atypical, because virtually no brain diseases are simply biological in nature and expression. All, including stroke, Alzheimer's disease, schizophrenia, and clinical depression, include some behavioral and social aspects.



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What may make addiction seem unique among brain diseases, however, is that it does begin with a clearly voluntary behavior- the initial decision to use drugs. As previously stated, not everyone who ever uses drugs goes on to become addicted.

Individuals differ substantially in how easily and quickly they become addicted and in their preferences for particular substances.

In fact, estimates are that between 50 and 70 percent of the variability in susceptibility to becoming addicted can be accounted for by genetic factors. Although genetic characteristics may predispose individuals to be more or less susceptible to becoming addicted, genes do not doom one to become an addict.

Over time the addict loses substantial control over his or her initially voluntary behavior, and it becomes compulsive. For many people these behaviors are truly uncontrollable, just like the behavioral expression of any other brain disease.

Environmental Cues

Addictive behaviors do have special characteristics related to the social contexts in which they originate.

- All of the environmental cues surrounding initial drug use and development of the addiction actually become “conditioned” to that drug use and are thus critical to the development and expression of addiction.
- Environmental cues are paired in time with an individual’s initial drug use experiences and, through classical conditioning, take on conditioned stimulus properties.
- When those cues are present at a later time, they elicit anticipation of a drug experience and thus generate tremendous drug craving.

Cue-induced craving is one of the most frequent causes of drug use relapses, even after long periods of abstinence, independently of whether drugs are available.

The significance of environmental or contextual cues helps explain why reentry to one’s community can be so difficult for addicts leaving the controlled environments of treatment or correctional settings and why aftercare is so essential to successful recovery.

- The person who became addicted in the home environment is constantly exposed to the cues conditioned to his or her initial drug use, such as the neighborhood where he or she hung out, drug-using buddies, or the lamppost where he or she bought drugs.
- Simple exposure to those cues automatically triggers craving and can lead rapidly to relapses.



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This is one reason why someone who apparently overcame drug cravings while in prison or residential treatment could quickly revert to drug use upon returning home.

- One of the major goals of drug addiction treatment is to teach addicts how to deal with the cravings caused by inevitable exposure to these conditioned cues.
- It is no wonder addicts cannot simply quit on their own.
- People often assume that because addiction begins with a voluntary behavior and is expressed in the form of excess behavior, people should just be able to quit by force of will alone.
- However, it is essential to understand when dealing with addicts that we are dealing with individuals whose brains have been altered by drug use.

Instructor Note: Finally, let's look briefly at relapse. We will discuss relapse both here and in the Treatment and Recovery chapter. Here we look at relapse from the various perspectives presented throughout this chapter. Later, we look at relapse as it pertains to recovery and treatment. Both perspectives are equally important in understanding addiction.

What is Relapse?

Relapse is a cardinal feature of addiction, and one of the most painful.

Most people who struggle with addiction will have one or more relapses - the return to drug use after a drug-free period - during their ongoing attempts to recover. This can be extremely frustrating for patients and for families, as they have already experienced great pain.

What leads to relapse?

Multiple - and often interactive - factors can increase the likelihood of relapse. These are some of the commonly cited precursors:

- drug-related "reminder" cues (sights, sounds, smells, drug thoughts or drug dreams) tightly linked to use of the preferred drug(s) can trigger craving and drug seeking
- negative mood states or stress
- positive mood states or celebrations
- sampling the drug itself, even in very small amounts

The motivation to seek a drug, once triggered, can feel overwhelming and sometimes leads to very poor decision-making: the user will pursue the drug, despite potentially disastrous future negative consequences (and many past negative consequences).



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Individuals have different brain circuitry

Brain-imaging is helping us to understand the paradox of the decision to pursue a drug reward despite such consequences. For example, very recent imaging research shows that visual drug cues as short as 33 milliseconds can activate the ancient reward ("go") circuitry, and that this process does not require conscious processing - it can begin outside awareness.

By the time the motivation does reach awareness, and is recognized and labeled, the reward circuit has a strong head start. This head start means the frontal brain regions may be less effective. This area of the brain is responsible for weighing the consequences of a decision and for helping to "stop" or inhibit the impulses toward drug reward.

Imaging research also shows that some individuals have less effective "stop" circuitry. For these people, the job of managing the powerful impulses toward drug reward may be even more difficult.

When it comes to the vulnerability to relapse, and to addiction itself, we are not all created equal. We differ both in our brain response to drug rewards and in our ability to manage the powerful impulses toward drug reward.

Hope through research

Relapse is a long-term vulnerability, but intensive ongoing research is targeting the problem. The tools of brain imaging and genetics promise to help us understand our vulnerabilities - and our strengths - to help us realize more effective relapse prevention. Many different clinical research trials are underway, and new anti-relapse interventions (behavioral or medication-based) may be available in a location close to you.

Stuck Points in Recovery

Although some patients progress through the stages of recovery without complications, most chemically dependent people do not. They typically get stuck somewhere. A "stuck point" can occur during any period of recovery. Usually it is caused either by lack of skills or lack of confidence in one's ability to complete a recovery task. Other problems occur when the recovering person encounters a problem (physical, psychological, or social) that interferes with his or her ability to use recovery supports.

When recovering people encounter stuck points, they either recognize they have a problem and take action, or they lapse into the familiar coping skill of denial that a problem exists. Without specific relapse prevention skills to identify and interrupt denial, stress begins to build. Eventually, the stress will cause the patient to cope less and less well. This will result in relapse.



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Symptoms of Becoming Stuck in Recovery

When people become stuck they may experience symptoms such as:

- An increase in negative thinking. The individual may feel disappointed with life in recovery because it has not lived up to their expectations. They are likely to feel pessimistic about the future.
- Anger outbursts and feelings of resentment
- Problems at work, home, or with friends. When people become stuck in recovery it usually means that relationships will suffer.
- The individual can begin to isolate. They stop talking about their problems and concerns with other people.
- They may begin to romance the drink or drug. This is when they remember the days when substance abuse seemed to help them.

The Dangers of Becoming Stuck in Recovery

Recovery from an addiction is a process. This means that the individual needs to be progressing all the time or else they begin to backslide. The dangers of becoming stuck in recovery include:

- It causes people to become dissatisfied with life away from addiction. It can take a long time before people manage to build a good life in sobriety. If people become stuck then they may lose hope of ever achieving such happiness.
- If people are stuck they will usually experience a great deal of stress. They may turn to new maladaptive behaviors to deal with this discomfort. This could include becoming a workaholic, a fitness fanatic, or turning to other forms of substance abuse. Addiction substitution is just more avoidance and can ultimately only lead to further pain
- Becoming stuck is the first stage of the relapse process
- People become sober because they want to improve their life. When they are stuck in recovery it just delays them reaching that day when they will experience true peace and contentment. Life is short so it is probably best to avoid wasting time.
- Those individuals who become stuck in recovery may develop into dry drunks. Such individuals might manage to remain sober, but life away from their addiction will not be full of happiness. Instead it is more likely to feel like a prison sentence. The dry drunk tends to not only make their own life miserable but also the lives of those close to them. Such an individual may no longer be using alcohol or drugs but in many ways it is still business as usual.



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Becoming Stuck and the Relapse Process

Those individuals who return to alcohol or drug abuse will often pass through a number of stages before reaching that point. This is known as the relapse process and involves:

- Becoming stuck in recovery
- The individual tries to ignore the fact that they are stuck
- They turn to negative coping strategies to deal with the discomfort of being stuck. This increases their level of internal suffering.
- A trigger event occurs and this causes the internal suffering to become far more obvious
- The individual experiences a great deal of emotional turmoil
- The inner turmoil is now impossible to ignore
- The individual feels like they are out of control
- They return to alcohol or drug abuse in order to escape the pain

History of Drug and Alcohol Treatment in America – Timeline of Notable Events

The phrase, **drug treatment**, is currently used to refer to treatment for problems with a wide array of substances including both illegal drugs and prescription medications. From the 1950's through the 1970's, however, drug treatment programs focused primarily on heroin and other opiates and were operated separately from programs focusing on alcohol. This division is reflected to this day in the fact that the federal government still maintains a National Institute on Drugs (NIDA) separate from the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Significant Events in the History of Addiction Treatment and Recovery in America

1750 to Early 1800s Alcoholic mutual aid societies (sobriety "Circles") are formed within various Native American tribes. Some are part of, or evolve into, abstinence-based Native American cultural revitalization movements and temperance organizations.

1784 Dr. Benjamin Rush's Inquiry into the Effects of Ardent Spirits on the Human Mind and Body catalogues the consequence of chronic drunkenness and argues that this condition is a disease that physicians should be treating. Rush's writing marks beginning of American temperance movement.

1810 Dr. Benjamin Rush calls for creation of a "Sober House" for the care of the confirmed drunkard.



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1844 – 1845 Lodging Homes and later (1857) a Home for the Fallen are opened in Boston -- marking the roots of the 19th century inebriate home. As inebriate homes spread, they will spawn several alcoholic mutual aid societies such as the Godwin Association.

1845 Frederick Douglass (having earlier acknowledged a period of intemperance in his life) signs a pledge of abstinence and becomes involved in promoting temperance among African American people. His call for abstinence as a foundation of the drive to abolish slavery and prepare Black people for full citizenship anticipated modern Afrocentric models of addiction recovery.

1849 The Swedish physician Magnus Huss describes a disease resulting from chronic alcohol consumption and christens it Alcoholismus chronicus. This marks the introduction of the term alcoholism.

1864 The New York State Inebriate Asylum, the first in the country, is opened in Binghamton, NY. A growing network of inebriate asylums will treat alcoholism and addiction to a growing list of other drugs: opium, morphine, cocaine, chloral, ether, and chloroform.

1867 The opening of the Martha Washington Home in Chicago marks the first institution in America that specialized in the treatment of inebriate women.

1870 The American Association for the Cure of Inebriety founded under the principle "Inebriety is a disease." The Association's Journal of Inebriety is published from 1876-1914.

1870's New alcoholic mutual aid societies - the Ribbon Reform Clubs -- begin in the Northeast and spread throughout the U.S. over the next two decades. They are named for their members' practice of wearing a colored ribbon on their clothing so that they could recognize one another and convey a message of hope about recovery to the larger community.

1879 Dr. Leslie Keeley announces that "Drunkenness is a disease and I can cure it." He opens more than 120 Keeley Institutes across the U.S., marking the beginning of franchised, private, for-profit addiction treatment institutes/sanatoria in America.

1880's Cocaine is recommended by Sigmund Freud and a number of American physicians in the treatment of alcoholism and morphine addiction. Bottled home cures for the alcohol and drug habits abound; most will be later exposed to contain alcohol, opium, morphine, cocaine and cannabis.



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1891-1892 Keeley League (a Keeley Institute patient mutual aid society) founded. Keeley League members meet under the banner, "The Law Must Recognize a Leading Fact: Medical Not Penal Treatment Reforms the Drunkard." As inebriate homes and asylums close, alcoholics are relegated to city "drunk tanks," "cells" in "foul wards" of public hospitals, and the backwards of aging "insane asylums." Wealthy alcoholics/addicts will continue to seek discrete detoxification in private sanatoria know as "jitter joints," "jag farms" or "dip shops."

1901 The Charles B. Towns Hospital for Drug and Alcoholic Addictions in New York City marks the beginning of a new type of private "drying out" hospital for affluent alcoholics and addicts.

1906 The Emmanuel Clinic in Boston begins the practice of lay therapy in the treatment of alcoholism. The Clinic will generate a number of noted lay therapists (Baylor, Chambers, Peabody) who will exert enormous influence on alcoholism treatment for several decades. The Jacoby Club serves as the Clinic's mutual aid society.

1919 – 1924 Forty-four communities establish morphine maintenance clinics (run by public health departments or police departments) to care for incurable and medically infirm addicts. All eventually close under threat of federal indictment. Treatment for narcotic addiction virtually disappears for all but the most affluent Americans.

1920's Most inebriate homes, inebriate asylums and private addiction cure institutes collapse between 1910 and 1925. The Journal of Inebriety ceases publication in 1914 and its parent association collapses in the early 1920s.

1935 The opening of Shadel Sanatorium marks the introduction of aversive conditioning in an institutional alcoholism treatment setting.

The first federal "narcotics farm" (U.S. Public Health Prison Hospital) opens in Lexington, Kentucky. The second facility opens in Fort Worth, Texas in 1938. This marks the beginning of federal involvement in addiction research and addiction treatment.

The meeting of Bill W. and Dr. Bob S. (and Dr. Bob's last drink) mark the beginning of Alcoholics Anonymous (AA).

1939 The book, Alcoholics Anonymous, is published.



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1940- 1945 Recovered alcoholics in AA are recruited at Remington Arms, DuPont, Kaiser Shipyards, and North American Aviation to work in the first modern industrial alcoholism programs -- forerunners of today's employee assistance programs (EAPS).

1943 Yale Center of Alcohol studies initiates a significant research program, the Summer School of Alcohol Studies, the Yale Plan Outpatient Clinics, and the Yale Plan for Business and Industry. The Center will move to Rutgers in 1962.

1944 Marty Mann founds the National Committee for Education on Alcoholism (today the National Council on Alcoholism and Drug Dependence) around the following propositions:

1. Alcoholism is a disease.
2. The alcoholic, therefore, is a sick person.
3. The alcoholic can be helped.
4. The alcoholic is worth helping.
5. Alcoholism is our No. 4 public health problem, and our public responsibility.

Mann calls for a five-prong approach to be achieved by local NCEA affiliates:

1. Launching local public education campaigns on alcoholism.
2. Encouraging hospitals to admit alcoholics for acute detoxification.
3. Establishing local alcohol information centers.
4. Establishing local clinics for the diagnosis and treatment of alcoholism.
5. Establishing "rest centers" for the long-term care of alcoholics.

The first state alcoholism commissions are founded. They support fledgling efforts at local community education and treatment.

1947 An Addicts Anonymous group begins meeting at U.S. Public Health Hospital in Lexington, Kentucky. Meetings begin outside the institution in New York City under the name Narcotics Anonymous (NA) in 1949 but dissipate over time. The roots of today's NA can be traced to groups that began in California in 1953. International Doctors in AA founded.

1948 Alcoholics Victorious is founded within the Chicago Christian Industrial League and spreads as a Christian, recovery support group within many of the nation's urban missions.



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1948 – 1950 The "Minnesota Model" of chemical dependency treatment emerges in the synergy between three institutions: Pioneer House, Hazelden, and Willmar State Hospital. (Antabuse) introduced as an adjunct in the treatment of alcoholism in the U.S. Other drugs used in the treatment of alcoholism during this period include barbiturates, amphetamines (Benzedrine), and LSD.

1950 The Twelve Traditions are formally adopted to govern the group life of AA. The National Institute of Mental Health establishes a special division on alcoholism Marty Mann's Primer on Alcoholism is published. American Medical Association (AMA) resolves to create a special committee to develop a program for "medicine's aggressive participation in the work of solving the problems of alcoholism."

Early 1950's AA membership surpasses 90,000 as America (and Hollywood) becomes interested in the subject of alcoholism. Cinema portrayal of alcoholism includes such noted films as Lost Weekend, Days of Wine and Roses, and Come Back, Little Sheba.

1950's The halfway house movement culminates in the founding (1958) of the Association of Halfway House Alcoholism Programs of North America.

1951 Lois W. and Anne B. start a Clearing House for the growing number of Family Groups that have grown in tandem with AA through the 1940s. The opening of the Clearing House marks the formal organization of these groups into Al-Anon Family Groups.

1952 American Medical Association first defines alcoholism. R. Brinkley Smithers establishes the Christopher D. Smithers Foundation, a charitable organization that focuses its primary mission on the support of alcoholism education and treatment efforts. This focus followed Smithers' own recovery from alcoholism and his participation in the Yale Summer School of Alcohol Studies. By the mid-1990s, the Foundation and the Smithers family had donated more than \$37 million to support alcoholism-related projects.

1954 Ruth Fox, MD establishes the New York City Medical Society on Alcoholism, today known as the American Society of Addiction Medicine (ASAM). The Minnesota State Civil Service Commission becomes the first such body in the United States to approve a state job classification position for "Recovery Coach on Alcoholism."

1956 The American Medical Association stops short of declaring alcoholism a disease but does recognize alcoholics as legitimate patients: "Hospitals should be urged to consider admission of such



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patients with a diagnosis of alcoholism based upon the condition of the individual patient, rather than a general objection to all such patients."

1957 The Veteran's Health Administration begins developing alcoholism treatment units within its national network of VA hospitals. American Hospital Association passes resolution to help prevent discrimination against alcoholics. Fordham University School of Social Services offers first full university course on alcoholism for credit.

1958 The first ex-addict-directed therapeutic community - Synanon -- is founded by Charles Dederich. It will be widely replicated in the 1960s and 1970s.

1960 E.M. Jellinek publishes The Disease Concept of Alcoholism.

Early 1960's Several states initiate civil commitment programs for narcotic addicts.

1963 American Public Health Association adopts an official statement on alcoholism, identifying it as a treatable illness. Dr. Vincent Dole, an endocrinologist, and Dr. Marie Nyswander, a psychiatrist specializing in addiction, introduce methadone blockade therapy in the treatment of narcotic addiction.

1964 – 1975 The insurance industry begins to reimburse the treatment of alcoholism on par with the treatment of other illnesses. This leads to a dramatic expansion in private and hospital-based inpatient treatment programs.

1966 Two federal Appeals Court decisions support the disease concept of alcoholism. President Johnson appoints first National Advisory Committee on Alcoholism and becomes the first President to address the country about alcoholism. He proclaims: "The alcoholic suffers from a disease which will yield eventually to scientific research and adequate treatment."

The National Center for the Prevention and Control of Alcoholism is created within the National Institute on Mental Health.

The Narcotic Addict Rehabilitation Act (NARA) marks a milestone of increased federal involvement in supporting development of local addiction treatment services.

The New York Medical Society alters its mission to become the American Society on Addiction Medicine.



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1967 – 1971 Special alcoholism Recovery Coaching/treatment initiatives begin within all major branches of the U.S. Armed Forces.

1970 Congress passes the "Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act," known as the Hughes Act for its sponsor in the Senate, Harold E. Hughes. The legislation establishes the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Those testifying in support of the legislation include Marty Mann of NCA and Bill Wilson, Co-founder of AA.

1972 The Joint Commission on Accreditation of Hospitals develops accreditation standards for alcoholism treatment programs.

The Alcoholism Report, the first newsletter devoted exclusively to the field of alcoholism, begins publication.

The National Association of Alcoholism Recovery Coaches and Trainers is founded at a meeting of Organization for Economic Opportunity regional alcoholism programs. It will evolve into the National Association of Alcoholism and Drug Abuse Recovery Coaches (NAADAC).

The Food and Drug Administration approves use of methadone for treating heroin addiction.

The Drug Abuse Treatment Act of 1972 creates the Special Action Office for Drug Abuse Prevention that will lay the groundwork for the creation of the National Institute on Drug Abuse in 1974.

TASC (Treatment Alternatives to Street Crime) is created by the Drug Abuse and Treatment Act to screen addicts in the criminal justice system and then to link and manage their involvement in treatment services.

1973 U.S. investigators first describe fetal alcohol syndrome (FAS), a pattern of birth defects observed in children born to alcoholic mothers.

Vernon Johnson's book, I'll Quit Tomorrow, introduces intervention technologies that will be widely used to reach alcoholics and addicts before they "hit bottom."

1974 The first of a series of studies on credentialing of Recovery Coaches working in alcohol and drug treatment programs marks the beginning of a sustained process of certification and licensure of addiction Recovery Coaches.



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1978 First Lady Betty Ford speaks to the nation about entering recovery from addiction to alcohol and other drugs.

1980 President Carter appoints the National Commission on Alcoholism and Other Alcohol Related Problems chaired by Senator Harold Hughes. It only meets once.

Mothers Against Drunk Driving, a powerful grassroots advocacy group, is formed.

1981 The U.S. Postal Service issues a first-class stamp imprinted with "Alcoholism. You can beat it!"

Nancy Reagan's "Just Say No" anti-drug campaign is launched within a broader "zero tolerance" campaign that will reduce federal support for treatment and mark the beginning of the dramatic rise in the number of drug users incarcerated. The growth of addicted offenders in the 1980s will lead to the demand for drug courts and in-prison treatment in the 1990s.

1982 The federal Block Grant Program transfers responsibility for the delivery of treatment and prevention services to the states.

Former First Lady Betty Ford lends her name to a treatment center for alcoholism and other drug addictions.

Cocaine Anonymous is founded.

1982 – 1992 The number of women-only treatment units triple as NIAAA and NIDA focus attention on the special needs of addicted women.

1983 First certification exam for addiction medicine specialty is offered in California. National Association for Children of Alcoholics is founded.

1985 First appearance of crack cocaine focuses enormous public attention on the illegal drug problem. Concerns about cocaine-exposed infants lead to expansion of treatment resources for women and specialized programs to treat women involved in the child protection system.

American Academy of Psychiatrists in Alcoholism and Addictions is founded.

1985 – 1990 Addiction treatment becomes increasingly concerned about "special populations" and launches specialized treatment tracks for women, adolescents, the elderly, gays and lesbians, and the



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"dually diagnosed." As the challenges of treating new patterns of cocaine addiction grow, relapse tracks also become a common treatment innovation.

1987 President Reagan formally announces a renewed "War on Drugs"; the shift away from treatment toward punishment and incarceration intensifies.

American Medical Association calls all drug dependencies diseases whose treatment is a legitimate part of medical practice.

1989 The publication of Stanton Peele's *Diseasing of America: Addiction Treatment Out of Control* marks the full emergence of a movement whose primary mission is opposition to Twelve Step programs and Twelve Step-oriented addiction treatment.

The first specialized "drug court" is started by Miami Judge Stanley Goldstein. It will spur a national movement to link addicted, non-violent offenders to treatment as an alternative to incarceration.

1989 – 1994 Following an erosion of alcoholism treatment reimbursement benefits by insurance carriers, an aggressive system of managed care all but eliminates the 28-day inpatient treatment program in hospitals and private, free-standing centers. The downsizing and closure of hospital-based treatment units sparks a trend toward the integration of many psychiatric and addiction treatment units and a renewed community trend of incorporating addiction treatment services under the umbrella of mental health or "behavioral health" services. Most inpatient treatment programs shift their emphasis toward outpatient and intensive outpatient services. The loss of residential services adds fuel to a growing recovery home movement.

1991 The American Society of Addiction Medicine publishes its ASAM Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders. The ASAM criteria shift treatment toward a "levels of care" system rather than a single modality indiscriminately applied to all those entering treatment.

1992 The Center for Substance Abuse Treatment created to expand the availability and quality of addiction treatment.

The Americans With Disabilities Acts extends job protection (except in safety-sensitive positions) to alcoholics and recovering drug addicts in the private sector.



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1995 U.S. Food and Drug Administration approves prescription use of naltrexone in treatment for alcoholism. Naltrexone marks the emergence of a new generation of pharmacological adjuncts in the treatment of alcoholism and other addictions.

2000 In a milestone article in the Journal of the American Medical Association, Drs. McLellan, Lewis, O'Brien, and Kleber call for the re-conceptualization and treatment of addiction as a chronic medical illness.



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Ethics and Professional Conduct

Section Outline: This course will cover the ethical and professional mandates of the addiction counselor as they pertain to: Ethical standards of conduct, client confidentiality, client records confidentiality, professional clinical practices, boundaries, assessing crisis, and the importance of continuing professional development.

Section Objectives:

1. Student will be able to demonstrate ethical and professional behavior.
2. Student will learn and understand the Florida Certification Board Code of Ethics and Disciplinary Actions
3. Student will be able to define and recognize boundary issues between client and counselor.
4. Student will be able to define, implement and practice client rights.
5. Student will be able to define and implement culturally aware clinical practices.
6. Student will understand the benefits of professional associations.
7. Student will be able to assess risk factors for self-harm and implement crisis interventions.
8. Student will learn to adapt therapeutic strategies to client needs.
9. Student will learn the ethical and professional benefits of clinical supervision.
10. Student will be able to identify and professionally resolve transference and counter-transference issues.
11. Student will accept the responsibility of continuing personal and professional growth.
12. Student will learn to practice self-evaluations for the purpose of professional and personal growth.
13. Student will learn to assess signs of potential professional burn out and implement strategies for self-care.



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Introduction

Instructor Note: You all may be asking yourselves “Why another course about ethics and professionalism? Aren’t there more important or practical things we could be learning about?” Truthfully, from my point of view there is a short answer to these questions....No, there isn’t anything more important, useful, purposeful or practical. The reason I give this is answer is simple and basic. As a student you can read more books or articles, as a staff person you can attend trainings, sit for webinars and take part in clinical rounds, all to enhance your working knowledge of addiction and the counseling process, your clinical tool belt, and your style/techniques in working with clients. However, understanding the importance of being ethical and professional is something you must FEEL & BELIEVE is mandatory. The understanding that being responsible for helping other human beings and having those human beings trust you to enter into their lives allowing you to see their frailties and vulnerabilities requires without hesitation, without devaluing the commitment to the highest standards of quality, earnest, ethical and professional care.

As an addiction counselor (certified or not) or behavioral health tech you are required to know, understand and adhere to the Florida Certification Board standards of Ethical Practices, Rules of Conduct and Standards of Care.

Please, **on your own**, go to the following links to read these required readings:

1. <http://flcertificationboard.org/ethics/>
2. http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr2_main_02.tpl
3. <https://www.flrules.org/gateway/ChapterHome.asp?Chapter=65D-30>

All counselor’ and behavioral health techs will not only be held to the standards and rules of behavior and practice but they will also be subject to the ramifications of non-compliance as stated in the Florida Certification Board guidelines of ethics and professional practices.

For additional information on what is expected of you as an addiction professional. Please go to the following link:

<http://store.samhsa.gov/product/TAP-21-Addiction-Counseling-Competencies/SMA14-4171>



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In addition to following all of the professional standards, ethical guidelines, codes of conduct and scope of practice listed above, you must also have a full and complete working knowledge and understanding of client rights and responsibilities, confidentiality rules and regulations, appropriate boundaries, biases – personal & otherwise, multicultural awareness and sensitivity, trauma awareness and sensitivity and a thorough understanding of the difference between the role of the professional counselor and that of a peer counselor or sponsor.

Finally, of course, there is the clinical work, the expectation of the professional addiction counselor to be knowledgeable in a variety of intervention techniques, counseling methods, and psychoactive substance use research in order to improve client care and enhance your professional growth.

As a professional addiction counselor you will be faced with many challenges and uncertainties even with knowledge and practice. For this there are two things you, the addiction professional must do:

1. Take part in and seek out ongoing clinical supervision and consultation.
2. Develop and implement a personal self-care plan to maintain your physical and mental health.

For this class we will be examining the roles of transference, counter-transference, boundary guidelines and violations, counselor burn-out, risk assessment and management, crisis assessment and management, the potential influence of counselor personal values and biases and the counselor's personal recovery issues impact on job performance and client interactions.



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Scope of Practice, Ethical Practice, Confidentiality and Informed Consent

The ability to recognize and respond appropriately to ethical dilemmas encountered while treating addictive disorders is a complex task that cannot be taken for granted by even experienced counselors. Full caseloads and busy schedules provide few opportunities for in-depth examinations of ethical dilemmas that often demand an on-the-spot decision. This article sets forth a pragmatic set of principles that can help counselors to evaluate ethically challenging situations. While these ethical principles are relevant to almost any counseling situation, this article focuses on how they apply to the treatment of substance and behavioral addictions.

Numerous written codes of ethical conduct exist to guide the many different counseling professions. These documents may be more useful for giving clients and the public an assurance of the ethical parameters of professional behavior than in providing counselors with a useful frame of reference for dealing with day-to-day dilemmas. There is also an important difference between merely abiding by rules of conduct and embodying the ideals contained within them (Coale, 1998; Tjeltvelt, 1999). A set of common principles derived from these various codes must be sufficiently broad enough to take into account the rich variety of practice settings, counseling theories and treatment approaches in which addiction counselors operate. Any less inclusive formula for determining whether a counselor's behavior is ethically appropriate requires knowledge of the context in which it occurs. For example, vigorously challenging a client's beliefs or behaviors may be ethically justifiable under one set of circumstances but not another (Tjeltvelt, 1999). Similarly, different counselors may respond to an identical ethical dilemma in very distinct yet equally justifiable ways.

Informed Consent

Instructor Note: The Informed Consent form is typically provided to the client to read and sign during the initial intake process. This form is provided to client with stack of other important forms. I have sadly seen many counselors, intake workers and admission specialists simply lay the form down in front of the client and say “here is your informed consent and this says you give us permission to treat you and work with you” etc. etc., then “just sign and date”. What is wrong with this picture?? Is this how we look out for our clients, our clients who trust that we have their best interest in mind; that we are going to help them and care for them? No, this is lazy, unprofessional and completely unethical practice! Working in addictions treatment requires professionalism, high standards of clinical and conduct practices and care and concern for the well-being of your clients. It is a betrayal of the client, the facility and ethics to do anything less. The information in this chapter details many



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areas that you will be expected to learn, understand and ultimately practice. Be the best you can be always.

Informed consent is the fundamental bedrock of ethical practice, because it helps to assure the client's autonomy in matters that affect the entire course and direction of counseling. Counselors may not always fully appreciate the lengths they must go in order to insure that important decisions about treatment issues are truly made from a basis of informed choice. Rather than being a one-time event, informed consent is an on-going collaborative effort between client and counselor for establishing and continuously monitoring the goals and strategies of counseling as well as the roles, rights and responsibilities of all parties. (Tjeltveit, 1999)

A client has a right to know which treatment modalities an addiction counselor typically recommends, such as group therapy, couples therapy, family therapy, and medication, support group attendance, and so forth. Counselors often don't take the time to explicitly discuss the expected benefits and potential risks of their services, as well as any alternative treatment approaches that may be available to the client. Informed consent also includes information about the anticipated duration of treatment and any situations that could result in a counselor prematurely terminating services. In addition, clients should know the policy for resolving disputes as well as all pertinent financial aspects of the counseling relationship; counselors should also be open to discussing their background and theoretical orientation (Houston-Vega and Nuehring, 1997). This is so much information that a counselor may choose to convey it by a combination of verbal and written means.

A client's informed consent is not in itself sufficient to determine whether a counselor's behavior is ethical. It's conceivable that clients might be willing to give their approval to any number of ethically inappropriate behaviors, so a counselor needs other core principles to guide the ethical decision-making process.

Competence and Established Theory

A counselor has an ethical responsibility to practice only within the scope of his or her professional competence. Some typical indicators of competence include education, experience, training, and certification (Pope and Vasquez, 1998). Competence in one clinical area doesn't necessarily translate to another. Counselors with extensive experience treating general psychiatric disorders aren't necessarily competent to meet the specific needs of addicted clients, just as addiction counselors without advanced training don't always adequately recognize signs of psychiatric disorders. Cross-referral between such specialists is necessary in such situations.

One often-overlooked component of competency is a counselor's ability to clearly describe the theoretical basis for providing a particular clinical service. Just because a client's case turned out all



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right doesn't necessarily justify a counselor's actions if they otherwise lack adequate theoretical support. It is important to do the right thing for the right reason, not just for the right result. Counselors operating without the benefit of a clear theory are likely to rely too much on a combination of intuition, habit, consensus and personal preference (Herring, 2001, Tjeltveit, 1999, Corey, Corey and Callanan, 1998). Clients deserve the knowledge and right to accept or reject treatment that represents a particular theoretical orientation. In the absence of information to the contrary, clients will assume that whatever form of counseling they are receiving is the only available or appropriate choice.

Confidentiality

Another core ethical principle is for a counselor to vigilantly guard against unauthorized disclosure of client information. The assurance of confidentiality is a fundamental guarantee, but it is not an absolute one.

Several ethical dilemmas involving confidentiality commonly arise in the treatment of addictive disorders:

Duty to Warn/Protect

It is widely accepted that counselors have a general obligation to warn or protect people whom a client places in imminent harm. The right to confidential treatment is therefore balanced by the need to insure the safety of others. The beginning of the counseling relationship is the most appropriate time for a client to learn about these limits on confidentiality as well as any safeguards necessary to protect others, such as policies on notifying law enforcement personnel if a habitual DUI offender drives to a counseling appointment while intoxicated.

Clients who inject drugs or engage in sexually risky behavior while chemically impaired may expose others to the risk of HIV infection. Courts have not generally applied duty-to-warn standards to these situations (Houston-Vega and Nuehring, 1997). Balancing the counselor-client relationship with the protection of at-risk populations is a very complex and emotionally charged situation. Counselors should inform clients about their policy for dealing with HIV-related confidentiality issues, educate clients about the health risks of their specific sex and drug practices, communicate any concerns that arise during the course of treatment, offer to help communicate information to partners, and consult with colleagues as appropriate.

Minors and Families

All states require counselors to report situations in which minors are in danger of harm, although specific state statutes differ (Corey, Corey and Callanan, 1998). As most counselors



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know, it can be difficult to distinguish potential from probable risk. For instance, a client who admits to blackouts may deny that she places her children in any danger. A counselor who decides not to notify the designated reporting agency in such a situation should document the basis for this decision in the clinical record. Consultation in these situations is again extremely valuable in helping a counselor maintain much-needed clinical objectivity.

Counselors who treat minors for substance use disorders need to clearly establish the extent to which parents have the right to information that is disclosed by their children. A minor may be reluctant to talk honestly if confidentiality boundaries are not clear, and the therapeutic alliance may be crippled if a counselor who is unclear on the limits of confidentiality later provides information to parents. Counselors should be familiar with federal law on confidentiality of alcohol and drug abuse records for minor clients (Confidentiality of Alcohol and Drug Abuse Patient Records, 1998) as well as any applicable state laws, and should seek professional consultation whenever questions arise.

A major ethical concern that arises when counseling couples or families is how to deal with the emergence of secrets that so often accompany addictive disorders. For example, consider the situation that could arise when providing marital counseling to a couple if a husband who attends a session by himself announces that he's relapsed on cocaine but is unwilling to admit this to his wife. A counselor who keeps this information secret is not fostering a climate of honesty. On the other hand, revealing information that a client reasonably presumed would remain confidential will damage that client's trust, while threatening to summarily end treatment if the client isn't honest with his spouse is a form of coercion and potential abandonment. This again points to the necessity of informed consent: whatever approach a counselor takes in response to these types of situations needs to be thoroughly discussed at the beginning of the counseling relationship so that all clients are aware of the consequences of disclosure (Corey, Corey and Callanan, 1998; Herring, 2001).

Maintaining Appropriate Boundaries

The next core concept of ethical counseling involves the complex area of maintaining appropriate professional boundaries. Most counselors know that there are ethical risks to developing relationships outside of the therapeutic role, such as counseling a friend or pursuing business or social interactions with clients. These types of dual relationships can impair a counselor's objectivity or unintentionally exploit a client's dependence (Pope and Vasquez, 1998). Yet some subtle boundary issues present ethical dilemmas that are neither obvious nor easily avoidable.

Counselor Self-Disclosure



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In order to maintain appropriate clarity of roles, a counselor should only reveal intimate personal information when doing so is clearly relevant to the client's treatment goals, carefully tailoring this information to the client and paying close attention to how such sharing affects the clinical relationship (Bloomgarden, 2000). Consultation with colleagues and supervisors can help insure that the true purpose for disclosing personal information is to meet the emotional needs of the client rather than the counselor. One helpful guideline is for a counselor to reveal information about a personal life problem only well after it has been resolved, and not while it is an ongoing issue (Hunter and Struve, 1998).

Touch

Since a significant proportion of clients with addictive disorders have a history of childhood trauma (Briere, 1992), even a simple act of touch can convey a variety of ethically ambiguous messages. The history of addiction support is replete with reassuring hugs. It's very important for a counselor who engages in any form of physical contact with clients to have a highly developed sense of boundaries and an astute awareness of the clinical implications of this behavior. The initial stages of the therapeutic relationship may not provide sufficient emotional safety to insure that a client can discuss any uncomfortable feelings involving counselor touch (Hunter and Struve, 1998).

Sexual Attraction

Sexual involvement with a client constitutes a profound ethical violation with severe emotional consequences. However, occasional sexual feelings are not in themselves either unethical or even particularly abnormal in the context of an intimate therapeutic relationship (Pope and Vasquez, 1998). Counselors must acknowledge and appropriately process the existence of these feelings when they emerge in order to successfully understand and redirect them. The presence of intense preoccupation or sexual fantasies involving client's needs to be forthrightly discussed in consultation and supervision.

Recovery Boundaries

Counselors who have successfully dealt with addictive disorders in their own lives can often relate to their clients with profound understanding, empathy and clarity. However, they may also be overly devoted to the treatment approach they personally found successful (Johnson, 2000). For instance, counselors who are strongly 12-step oriented may discount non-abstinence models for addressing substance abuse, such as risk reduction strategies, which threatens to place clients into a one-size-fits-all philosophy of care.



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A counselor who is candid about being "in recovery" may give clients hope and reduce the shame that inevitably accompanies addiction. However, too much disclosure can be intrusive and distracting for some clients, and can even inadvertently generate unrealistic expectations or a sense of inadequacy (Bloomgarden, 2000). Counselors should therefore carefully reveal information about their personal addiction experience only in as much detail as is necessary to meet a compelling and clearly defined clinical need.

A counselor who is treating clients with substance use disorders should not be unsuccessfully fighting the same battle. Sustained abstinence from addictive behavior is an inescapable ethical responsibility for anybody working in this field. Counselors with less than several years of recovery time may easily lose objectivity when dealing with clients whose clinical picture mirrors their own personal experience. Heightened levels of consultation and supervision are highly advisable in such circumstances.

Nobody is immune to relapse, regardless of the length of time in recovery. A counselor who reverts to a previous pattern of addictive behavior must face the ethical dilemma of whether to limit, suspend or terminate clinical duties. Abruptly withdrawing services from a client due to this (or any other) form of counselor impairment is likely to be deeply disruptive to the client's healing process (Bissell and Royce, 1994). Clients in such situations must be given the opportunity to continue counseling with another provider. There is no one answer to the problem of counselor relapse that is completely satisfying. In this regard the difference between a temporary "slip" that can result in increased self-awareness and an unrestrained relapse may be useful in determining a counselor's overall level of clinical impairment. These decisions should be made in a process of supervision and consultation so that the counselor is not relying on his or her personal judgment which may be impaired.

All counselors who are in recovery from addictive behavior must establish whatever safeguards are necessary to insure the maintenance of a personal program of sobriety. This may include establishing boundaries around support group meetings that clients are asked not to attend. It is not ethically appropriate for counselors in 12-step recovery to sponsor their own patients or chair meetings where they are employed (Bissell and Royce, 1994).

Supervision

The next core ethical concept is for counselors to have a structured process for discussing formulations, interventions, reactions and inevitable difficulties with supervisors and colleagues. There is a heightened need for supervision and consultation for counselors who are working on the outer limits of either personal competence or established theory (Corey, Corey and Callanan,



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1998). For example, a counselor attempting to implement a new technique should utilize close supervision until it becomes fully integrated into his or her set of skills.

It's an unfortunate reality that not all clinical supervisors have adequate experience or knowledge in the treatment of addictive disorders. In such cases a counselor needs to seek out additional sources for case consultation. One solution is to set up and utilize informal telephone and e-mail networks which can be established fairly easily with colleagues and contacts made through professional affiliations. When consultation is not available for discussing a clinical or ethical dilemma, a counselor should document in the clinical record a summary of the relevant issues as well as any action taken in response to it.

Honoring Diverse Values

All of the preceding ethical principles involve some specific actions for a counselor to take. However, the ethical dimension of counseling goes far beyond merely abiding by a procedural checklist. An ethical counselor consistently demonstrates respect for the client as a person by honoring diversity and appreciating the degree to which his or her personal values influence the entire process of counseling. Since counselors are in the business of helping clients change some aspect of their lives, the great ethical challenge is to effectively guide the process and direction of this change without undermining the client's autonomy. This ethical use of a counselor's influence is a skill that cannot be taught as much as developed.

Since every person's view of the world represents a unique combination of diverse personal and cultural perspectives, it is inevitable that counselors will sometimes hold views that are very different from their clients. No counselor is ethically justified in assuming that the way he or she views life is the way everybody else does, is the right way, or is the only way. However, some counselors act as if the way to avoid imposing their personal values is to simply not talk about them. But biases don't lose their influence just because they're not discussed; in fact they often become less amenable to change. It is often more ethically beneficial for a counselor to invite discussion about his or her personal values while conveying an ability to respect and work with many alternative positions. A counselor doesn't need to be neutral about his or her values in order to be nonjudgmental (Coale, 1998; Tjeltveit, 1999).

When a client and a counselor hold fundamentally incompatible value orientations, the counselor should either refer the case or strive to help the client achieve the goals of counseling within the context of the client's value system rather than attempting to change those values. If a counselor finds it necessary to attempt to modify a client's values, this should be done to no more extent than is necessary to address that client's particular focus of treatment.



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Counselors often avoid initiating discussion with clients about the ethical dimensions of clinical issues. Sometimes this reluctance stems from the fear of appearing moralistic, but it also reflects a general tendency of the counseling profession to be ethically inarticulate. It takes considerable effort and skill to engage in thoughtful dialogue about the ethical aspects of life, but doing can have great benefit for clients whose history of addiction is marked by diminished personal integrity. While this does not guarantee a positive clinical outcome, it does foster the kind of therapeutic environment for a client to utilize the counseling experience to its fullest potential.

These guidelines are not an exhaustive review of every ethical issue related to addictions counseling and they cannot substitute for a counselor's knowledge of his or her professional code of conduct. Many clinical situations require a more detailed examination of the ethical issues involved or compliance with specific codified procedures, such as guidelines for research involving human subjects. Although counselors almost always operate within ethical parameters, these principles can serve as a helpful reminder of some of the important points to consider when evaluating the proper ethical stance to take when dealing with the many complexities of addictions counseling.

FYI

Most Frequent Claims to Ethics Boards

1. Sexual/dual relationship— 35%
2. Unprofessional, negligence— 29%
3. Fraudulent acts—10%
4. Conviction of crimes—9%
5. Inadequate/improper supervision—5%
6. Impairment—4%
7. Improper record keeping—3%
8. Fraud in applying for credential—2%

Instructor Note: As mentioned in the introduction, there are Federal and state guidelines specific to confidentiality; the keeping and managing of client records including computer, email and faxing;



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release of information; protecting client's personal health records; grievance procedures and disciplinary actions for violations. As part of this course you will be presented with three power point presentations, one of those presentations will cover all of these guidelines, rules, procedures etc. in detail.

The Addiction Professional

TAP 21 Competency: Recognize the importance of individual differences that influence client behavior, and apply this understanding to clinical practice

Professional Responsibility

The addiction professional espouses objectivity and integrity and maintains the highest standards in the services provided. The addiction professional recognizes that effectiveness in his/her profession is based on the ability to be worthy of trust. The professional has taken time to reflect on the ethical implications of clinical decisions and behavior using competent authority as a guide. Further, the addiction professional recognizes that those who assume the role of assisting others to live a more responsible life take on the ethical responsibility of living a life that is more than ordinarily responsible. The addiction professional recognizes that even in a life well-lived, harm might be done to others by words and actions. When he/she becomes aware that any work or action has done harm, he/she admits the error and does what is possible to repair or ameliorate the harm except when to do so would cause greater harm. Professionals recognize the many ways in which they influence clients and others within the community and take this fact into consideration as they make decisions in their personal conduct.

Professional Counselor Attributes

1. The addiction professional, as an educator, has a primary obligation to help others acquire knowledge and skills in treating the disease of substance use disorders.
2. The addiction professional practices honesty and congruency in all aspects of practice including accurate billing for services, accurate accounting of expenses, faithful and accurate reporting of interactions with clients and accurate reporting of professional activities.
3. When work involves addressing the needs of potentially violent clients, the addiction professional will ensure that adequate safeguards are in place to protect clients and staff from harm.



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4. Addiction professionals shall continually seek out new and effective approaches to enhance their professional abilities including continuing education research, and participation in activities with professionals in other disciplines.
5. Addiction professionals have a commitment to lifelong learning and continued education and skills to better serve clients and the community.
6. The addiction professional respects the differing perspectives that might arise from professional training and experience other than his/her own. In this regard, common ground is sought rather than striving for ascendance of one opinion over another.
7. Addiction professionals, whether they profess to be in recovery or not, must be cognizant of ways in which their use of psychoactive chemicals in public or in private might adversely affect the opinion of the public at large, the recovery community, other members of the addiction professional community or, most particularly, vulnerable individuals seeking treatment for their own problematic use of psychoactive chemicals. Addiction professionals who profess to be in recovery will avoid impairment in their professional or personal lives due to psychoactive chemicals. If impairment occurs, they are expected to immediately report their impairment, to take immediate action to discontinue professional practice and to take immediate steps to address their impairment through professional assistance.

The Professional Counseling Relationship

It is the responsibility of the addiction professional to safeguard the integrity of the counseling relationship and to ensure that the client is provided with services that are most beneficial. The client will be provided access to effective treatment and referral giving consideration to individual educational, legal and financial resources needs. Addiction professionals also recognize their responsibility to the larger society and any specific legal obligations that may, on limited occasions, supersede loyalty to clients. The addiction professional shall provide the client and/or guardian with accurate and complete information regarding the extent of the potential professional relationship. In all areas of function, the addiction professional is likely to encounter individuals who are vulnerable and exploitable. In such relationships he/she seeks to nurture and support the development of a relationship of equals rather than to take unfair advantage. In personal relationships, the addiction professional seeks to foster self-sufficiency and healthy self-esteem in others. In relationships with clients he/she provides only that level and length of care that is necessary and acceptable.

Identifying, Assessing Risk/ Self-harm



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One of the tasks that addiction counselors are often required to perform is a suicide risk assessment. Substance abuse counseling involves the knowledge of co-occurring disorders and the people who have them. Even if your client does not have a mental health issue it is not at all unusual for clients in addiction treatment to have thoughts, ideas, plans of harming themselves or someone else. To be a professional addiction counselor means to be educated, trained and practiced in recognizing the signs, symptoms and risk factors for self-harm behaviors or violent behaviors in individual clients.

Did You Know?

- ✚ Suicide is a leading cause of death among people who abuse alcohol and drugs (Wilcox, Conner, & Caine, 2004).
- ✚ Compared to the general population, individuals treated for alcohol abuse or dependence are at about 10 times greater risk to eventually die by suicide compared with the general population, and people who inject drugs are at about 14 times greater risk for eventual suicide (Wilcox et al., 2004).
- ✚ Individuals with substance use disorders are also at elevated risk for suicidal ideation and suicide attempts (Kessler, Borges, & Walters, 1999).
- ✚ People with substance use disorders who are in treatment are at especially high risk of suicidal behavior for many reasons, including:
 - They enter treatment at a point when their substance abuse is out of control, increasing a variety of risk factors for suicide (Ross, Teesson, Darke, Lynskey, Ali, Ritter, et al., 2005).
 - They enter treatment when a number of co-occurring life crises may be occurring (e.g., marital, legal, job) (Ross et al., 2005).
 - They enter treatment at peaks in depressive symptoms (Ross et al., 2005).
 - Mental health problems (e.g., depression, posttraumatic stress disorder [PTSD], anxiety disorders, some personality disorders) associated with suicidality often co-occur among people who have been treated for substance use disorders.
 - Crises that are known to increase suicide risk sometimes occur during treatment (e.g., relapse and treatment transitions).

You Can Do This!

Your clinical training in substance abuse counseling puts you in a solid position to perform the tasks outlined. As you will learn, the first step in addressing suicidality is to “gather information,” or to



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perform exactly the same kind of information-gathering tasks you do every day. For example, if a client were having trouble with craving, you would first want to know more about it. Think about the types of questions you would ask. They might include “Tell me about your craving. How often do you have it? How strong is it? What makes it worse?” These questions are precisely the type you would ask about suicidal thoughts: “Tell me about your suicidal thoughts. How often do you have them? How strong are they? What makes them worse?” In other words, even though some content areas may be less familiar to you, your training and experience in substance abuse counseling provides you with the foundation you need to address suicidal behaviors with your clients.

You will be a trained substance abuse treatment professional who works with persons with co-occurring substance use and mental disorders, but most likely, your background will not include detailed training in addressing your clients' suicidal thoughts and behaviors. The information provided here is designed to begin to fill that gap and increase your understanding of relevant mental disorders. There is tons of information available and it is your responsibility, as an addiction professional or professional of any kind for that matter, to research, read, and stay abreast of all new information related to the field of addiction counseling.

The following are recommended for professional addiction counselors:

- ✚ Clients in substance abuse treatment should be screened for suicidal thoughts and behaviors routinely at intake and at specific points in the course of treatment. Screening for clients with high risk factors should occur regularly throughout treatment.
- ✚ Counselors should be prepared to develop and implement a treatment plan to address suicidality and coordinate the plan with other providers.
- ✚ If a referral is made, counselors should check that referral appointments are kept and continue to monitor clients after crises have passed, through ongoing coordination with mental health providers and other practitioners, family members, and community resources, as appropriate.
- ✚ Counselors should acquire basic knowledge about the role of warning signs, risk factors, and protective factors as they relate to suicide risk.
- ✚ Counselors should be empathic and nonjudgmental with people who experience suicidal thoughts and behaviors.
- ✚ Counselors should understand the impact of their own attitudes and experiences with suicidality on their counseling work with clients.



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- ✚ Substance abuse counselors should understand the ethical and legal principles and potential areas of conflict that exist in working with clients who have suicidal thoughts and behaviors.

Preparing to Assess for Suicidality/Self-harm

It is important for you to be comfortable and competent when asking your clients questions about suicidal ideation and behavior. It may be challenging to balance your own comfort level with your need to obtain accurate and clear information in order to best help the client. Here are some suggestions to ease the process follow.

Be Direct

Talking with clients about their thoughts of suicide and death is uncomfortable. However, you must overcome this discomfort, as it may lead a counselor to ask a guaranteed conversation-ending question, such as “You don't have thoughts about killing yourself, do you?” Discomfort can also lead counselors to avoid asking directly about suicidality, which may convey uneasiness to the patient, imply that the topic is taboo, or result in confusion or lack of clarity.

Increase Your Knowledge about Suicidality

One of the best ways to become more comfortable with any topic is to learn more about it. Suicide is no exception. Knowing some of the circumstances in which people become suicidal, how suicidality manifests, what warning signs might indicate possible suicidal behavior, what questions to ask to identify suicidality, and, perhaps most important, what the effective interventions are, can increase your competence, and as a result, your comfort in addressing this issue with clients.

Do What You Already Do Well

Good counselors are empathic, warm, and supportive, and trust their experience and intuition. However, on encountering suicidal thoughts and behaviors, counselors sometimes unwittingly employ counter-therapeutic practices, such as aggressively questioning the client about his or her thoughts and feelings, demanding assurance of safety when a client cannot provide such assurance, becoming autocratic and failing to collaborate with the client, and/or avoiding sensitive topics so as not to engender sadness. These counter-therapeutic practices can be the consequence of anxiety and unfamiliarity with the issue, along with fear of litigation if the client does make a suicidal act. Given



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these fears and issues, it is easy to see how otherwise highly skilled counselors can fall into the trap of becoming “the suicide interrogator.” Your option? Deliberately choose another path. Stay grounded and make use of your therapeutic skills when dealing with suicidal behaviors, as that is the most important time to fall back on (and not veer away from) your therapeutic abilities, experience, and training. Collect objective data, just as you would collect objective data about a client's substance use, but don't lose your empathy or concern in the process.

Practice, Practice, Practice

Nothing reduces anxiety more than practice. The same holds true about talking with your clients about suicidal thoughts and behaviors. If you need to reduce your initial discomfort on the topic, practice with another counselor or your clinical supervisor. You may also consider attending a workshop or getting additional training specific to the topic of suicidality.

Get Good Clinical Supervision and Consultation

Getting clinical supervision is a great way to learn and practice new skills.

Work Collaboratively With Suicidal Clients

Just as you involve clients in developing a treatment plan for recovery, so too should you involve them in suicide prevention planning. You will be most effective if you ask them about suicide with concern (but not alarm), just as you would with any other area of concern. Explain the reason(s) for your concern and any action(s) that you take, elicit their input as to what may help them be safe, and (with your supervisor), consider their input as much as possible in determining the actions that you take.

Realize Limitations of Confidentiality and Be Open with Your Clients About Such Limits

You should understand existing ethical and legal principles and potential areas of conflict (including the possible limits of confidentiality) because safety and protection of the client trumps confidentiality in certain crisis situations. When you first meet clients and as appropriate during the course of treatment, explain that, in the event of suicide risk, you may take steps to promote the client's safety (including the potential for breaking confidentiality, arranging for an emergency evaluation over the client's objections, and involving emergency personnel). Clients should not be given the false impression that everything is confidential or that all types of treatment are always voluntary.



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Maintain Positive Attitudes

Before working with clients who are suicidal, counselors are advised to conduct their own suicidal attitude inventory. The goal of the inventory is not to change your views but rather to help you understand what your views are and how those views can positively or negatively affect your interactions with clients. Some of the items you might consider in an inventory include:

- ✚ What is my personal and family history with suicidal thoughts and behaviors?
- ✚ What personal experiences do I have with suicide or suicide attempts, and how do they affect my work with suicidal clients?
- ✚ What is my emotional reaction to clients who are suicidal?
- ✚ How do I feel when talking to clients about their suicidal thoughts and behaviors?
- ✚ What did I learn about suicide in my formative years?
- ✚ How does what I learned then affect how I relate today to people who are suicidal, and how do I feel about clients who are suicidal?
- ✚ What beliefs and attitudes do I hold today that might limit me in working with people who are suicidal?

These views may also need to be further clarified by consultation with your clinical supervisor or with your peers.

As noted, your attitudes about suicide are strongly influenced by your life experiences with suicide and similar events. Needless to say, your responses to suicide and to people who are suicidal are highly susceptible to attitudinal influence, and these attitudes play a critical role in work with people who are suicidal. An empathic attitude can assist you in engaging and understanding people in a suicidal crisis. A negative attitude can cause you to miss opportunities to offer hope and help or to overreact to people in a suicidal crisis.

Below are some attitudinal issues to consider in working with people who are suicidal:

Positive Attitude and Behavior 1: People in substance abuse treatment settings often need additional services to ensure their safety

Positive Attitude and Behavior 2: All clients should be screened for suicidal thoughts and behaviors as a matter of routine.



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Positive Attitude and Behavior 3: All expressions of suicidality indicate significant distress and heightened vulnerability that require further questioning and action.

Positive Attitude and Behavior 4: Warning signs for suicide can be indirect; you need to develop a heightened sensitivity to these cues.




Positive Attitude and Behavior 5: Talking about a client's past suicidal behavior can provide information about triggers for suicidal behavior.

Positive Attitude and Behavior 6: You should give clients who are at risk of suicide the telephone number of a suicide hotline; it does no harm and could actually save a life.

***Instructor Note:** It is extremely important to remember that even when you believe a client is “manipulating or attention seeking” by stating they are experiencing suicidal thoughts, of desire to hurt themselves in some way, you **MUST** take them seriously. Counselors need to realize that even in rare circumstances where clients appear to be purposefully using reports of suicidal thoughts or plans to manipulate their treatment regimen, expressions of suicidality must be taken seriously. Thus, when clients appear to “use” suicidality, it should be recognized as a very limited approach to coping. Indeed, there is often more than one reason for an act of suicide (e.g., one may simultaneously want to die and elicit attention). You must address clients “where they are” and not impose your own agenda. If suicidal thoughts or behaviors occur, addressing suicidality must be a priority. Even if a client really does not want to die, if his or her reports of suicidal ideation are not taken seriously, the client may act on them to “save face.”*

Warning Signs for Suicide

Warning signs are defined as acute indications of elevated risk. In other words, they signal potential risk for suicidal behavior in the near future. Warning signs may be evident at intake or may arise during the course of treatment. Warning signs always require asking follow-up; warning signs can be direct or indirect. **Direct** indications of acute suicidality are given the highest priority. They are:

-  **Suicidal communication:** Someone threatening to hurt or kill him- or herself or talking of wanting to hurt or kill him- or herself.
-  **Seeking access to a method:** Someone looking for ways to kill him- or herself by seeking access to firearms, available pills, or other means.
-  **Making preparations:** Someone talking or writing about death, dying, or suicide, when these actions are out of the ordinary for the person.



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Warning signs are often in evidence following acute stressful life events. Among people who abuse substances, break-up of a partner relationship is most common. It is also important to look for warning signs in your clients when relapse occurs and during acute intoxication.

Stressful life events include:

- ✚ Break-up of a partner relationship.
- ✚ Experience of trauma.
- ✚ Legal event.
- ✚ Job loss or other major employment setback.
- ✚ Financial crisis.
- ✚ Family conflict or disruption.
- ✚ Relapse.
- ✚ Intoxication.

Each of the **direct** warning signs indicates potential for suicidal behavior in its own right, and, if present, requires rigorous follow-up. The **indirect** warning signs may or may not signal risk for acute suicidal behavior (for example, “substance abuse” is the norm among your clients). In all cases, they require further follow-up questions to determine if they may indeed indicate acute suicidality.

Risk Factors

Risk factors are defined as indicators of long-term (or ongoing) risk. They are different from warning signs, which signal immediate risk. Risk factors for suicidal thoughts and behaviors among individuals with substance use disorders have been well researched (Conner, Beautrais, & Conwell, 2003; Conner et al., 2007; Darke & Ross, 2002; Ilgen et al., 2007; Murphy et al., 1992; Preuss et al., 2002; Roy, 2001; Schneider et al., 2006). The list below, although not exhaustive, is informed by these studies.

Risk factors for suicidal thoughts and behaviors include:

- ✚ Prior history of suicide attempts (most potent risk factor, although it should be remembered that about half of all deaths by suicide are first-time attempts).
- ✚ Family history of suicide.
- ✚ Severe substance use (e.g., dependence on multiple substances, early onset of dependence).
- ✚ Co-occurring mental disorder:



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- Depression (including substance-induced depression).
- Anxiety disorders (especially PTSD).
- Severe mental illness (schizophrenia, bipolar disorder).
- Personality disorder (best researched are borderline and antisocial personality disorders).
- Anorexia nervosa.
- ✚ History of childhood abuse (especially sexual abuse).
- ✚ Stressful life circumstances:
 - Unemployment and low level of education, job loss, especially when nearing retirement.
 - Divorce or separation.
 - Legal difficulties.
 - Major and sudden financial losses.
 - Social isolation, low social support.
 - Conflicted relationships.
- ✚ Personality traits:
 - Proneness to negative affect (sadness, anxiety, anger).
 - Aggression and/or impulsive traits.
- ✚ Firearm ownership or access to a firearm.
- ✚ Probable risk factors (although greater certainty requires more research in people with substance use disorders):
 - Inflexible/rigid personality characteristics.
 - Sexual orientation (lesbian, gay, or bisexual).
 - Chronic pain.

Protective Factors

Protective factors are defined as buffers that lower long-term risk. Unlike risk factors, factors that are protective against suicidal behavior are not well researched (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). Fewer protective factors than risk factors have been identified among people who abuse substances and other populations. Reasons for living are perhaps the best researched protective factors in the literature (Linehan Goodstein, Nielsen, & Chiles, 1983; Oquendo Dragasti et al., 2005).

The following are known and likely protective factors:



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- ✚ Reasons for living.
- ✚ Being clean and sober.
- ✚ Attendance at 12-Step support groups.
- ✚ Religious attendance and/or internalized spiritual teachings against suicide.
- ✚ Presence of a child in the home and/or childrearing responsibilities.
- ✚ Intact marriage.
- ✚ Trusting relationship with a counselor, physician, or other service provider.
- ✚ Employment.
- ✚ Trait optimism (a tendency to look at the positive side of life).

A caution about protective factors: If acute suicide warning signs and/or multiple risk factors are in evidence, the presence of protective factors does not change the bottom-line assessment that preventive actions are necessary, and should not give you a false sense of security. Although protective factors may sustain someone showing ongoing signs of risk (e.g., due to chronic depression), they do not immunize clients from suicidal behavior and may afford no protection in acute crises.

Protective factors vary with cultural values. For example, in cultures where extended families are closely knit, family support can act as a protective factor. Others include a strong affiliation with a clan, tribe, or ethnic community; faith in and reliance on traditional healing methods; strong spiritual values shared among community members; and absence of cultural trauma such as that of families of Holocaust survivors and American Indians who were sent unwillingly to boarding schools to be acculturated.

Definition of Professional Counselor Characteristics

- ✚ Empathy - the ability to identify with and understand another person's feelings or difficulties.
- ✚ Genuineness - honest and open in relationships with others.
- ✚ Respect - a feeling or attitude of admiration and deference toward somebody or something
- ✚ Warmth - affection and kindness, fond or tender feeling toward somebody or something
- ✚ Immediacy - moving away from the contents of the sharer's problems and placing the emphasis on the process going on in the moment between the helper and the one seeking help.



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- ✚ Concreteness - certain and specific rather than vague or general
- ✚ Potency - successful, especially in producing a strong or favorable impression on people
- ✚ Self-actualization - the successful development and use of personal talents and abilities
- ✚ Understanding - a sympathetic, empathetic, or tolerant recognition of somebody else's nature or situation
- ✚ Transparent - completely open and frank about things
- ✚ Tolerant - accepting the differing views of others
- ✚ Patient - able to endure waiting or delay without becoming annoyed or upset or to persevere calmly when faced with difficulties
- ✚ Validating - to provide somebody with moral support, or inspire somebody with confidence
- ✚ Flexible - able to change or be changed according to circumstances
- ✚ Curious - eager to know about something or to get information
- ✚ Open-minded - free from prejudice and receptive to new ideas
- ✚ Clarification - to make something clearer by explaining it in greater detail
- ✚ Paraphrasing - to restate something using other words, especially in order to make it simpler or shorter
- ✚ Reflection - careful thought, especially the process of reconsidering previous actions, events, or decisions
- ✚ Neutral - not possessing any particular quality or revealing a particular attitude or feeling

Try to Avoid

- ✚ Assumptions - something that is believed to be true without proof, the tendency to expect too much
- ✚ Preconceived Ideas - formed in the mind in advance, especially if based on little or no information or experience and reflecting personal prejudices
- ✚ Biases - an unfair preference for or dislike of something

Advice for the Professional Counselor

Tips to Avoid Increasing Resistance



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Behaviors to avoid as they damage rapport, increase resistance, and create conflict between client and counselor.

- ✚ Arguing for change
- ✚ Assuming the expert role
- ✚ Criticizing, shaming, or blaming
- ✚ Labeling the client's behavior
- ✚ Being in a hurry
- ✚ Claiming to know what is best

What a Professional Counselor Needs To Know

Show your Professionalism

- ✚ Express empathy
- ✚ Develop discrepancy
- ✚ Avoid argumentation and direct confrontation
- ✚ Roll with resistance
- ✚ Support self-efficacy and optimism

Professional Counselor Presentation

- ✚ Attending Behavior
- ✚ Encourages client talk
- ✚ Active Listening
- ✚ Eye contact: interested, alert, awake, processing
- ✚ Cultural differences: Be aware & sensitive
- ✚ Attentive body language
- ✚ Vocal qualities – even, soothing
- ✚ Verbal tracking—keep to the client's topic
- ✚ Silence



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Attitudes and Values

TAP 21 Competency: Conduct self-evaluations of professional performance applying ethical, legal and professional standards to enhance self-awareness and performance.

TAP 21 Competency: Recognize the importance of individual differences that influence client behavior, and apply this understanding to clinical practice.

Clarification of Values

Individually, we work within standards of care to support our professional role in the helping professions.

We may ask ourselves:

- ✚ Where is my knowledge and skills best used?
- ✚ Am I getting the support I need to help the people we serve? Am I getting the support I need to help the people we serve?
- ✚ Do my individual practice standards/values conflict the organization's expectations?
- ✚ What is our overall agency mission and goals?
- ✚ Who's needs are being met? Ours or the clients'?
- ✚ How can we improve upon our services to meet the clients' needs?
- ✚ Commitment to Clients
- ✚ Promote the well-being of clients. In general, clients' interests are primary.
- ✚ Self-Determination
- ✚ Respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals.

Definition of Culture:

The word 'culture' describes the integrated pattern of human behavior(s) that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group.

Some General Cultural Considerations:



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- ✚ Lack of confidentiality (trust)
- ✚ Lack of social services (rural/reservation/poorly developed area)
- ✚ Limited access to comprehensive health care
- ✚ Unresolved trauma(s): historical or otherwise (ex Urban Unresolved trauma(s): historical or otherwise (ex. Urban relocation program, history of abuse –sexual or otherwise)
- ✚ Racism – Homophobia – Xenophobia

Cultural Humility:

- ✚ Incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician patient dynamic.
- ✚ Acknowledges that we can never become truly competent in another's culture
- ✚ Requires simultaneous process of ongoing self-reflection and commitment to lifelong learning

Building Trust:

- ✚ Foundation for any and all that we work with...
- ✚ Non-judgmental: No “right or wrong” – setting aside biases.
- ✚ Strengths-based: Identifying behaviors that support healthy lifestyle (ex. scheduling an appointment).
- ✚ Authenticity: Personal connection helps build the therapeutic relationship:
- ✚ Important to take time to establish a connection before work can be done, specific with Native clients.
- ✚ Introductions are important.
- ✚ Make no assumptions regarding sexual behavior (ageism).
- ✚ Make no assumptions regarding sexual orientation (straight vs. gay identified).

Engagement:

- ✚ Can be as simple as offering a glass of water
- ✚ Meeting at a place of their choice (creating ease for the client) Consider outdoors/park, client home
- ✚ Offer extended hours to meet
- ✚ If possible rearrange the furniture (remove any barriers to open communication).
- ✚ Professional use of self: ex. humor.



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- ✚ Utilizing supportive family/connections.
- ✚ Accessing cultural knowledge and spiritual practices.

Service providers work from a positive-service delivery model:

- ✚ Strengths-based approach: collaborate, identify and exemplify strengths as a way to empower.
- ✚ Convey authentic/real interest (mindfulness)
- ✚ Acknowledge and provide support for positive steps already made! Ex. scheduling an intake appointment (support)

Instructor Note: In my classroom I have the students complete a few different self-evaluations that take a look at their feeling about clients, various populations they may serve, their own values, biases and judgments. These exercises always turn out to be the highlight of the course. When the student is honest in answering the self-evaluations they are able to discover things about themselves that set them up to explore these thoughts and feelings and how they may help or hinder their work with clients. As an instructor it is a joy for me to watch students come to different realizations about themselves and how they see things. I suggest that you do a search on the internet, there are plenty of counselor self-evaluations to be printed out and completed. See what you can learn and what that learning provides for you and your idea of counseling. Go on, explore, learn, and grow.

Know Thyself: Boundaries and Burn Out

TAP 21 Competency: Develop and use strategies to maintain one's physical and mental health.

TAP 21 Competency: Use a range of supervisory options to process personal feelings and concerns about your clients

Understanding Transference and Counter-transference

What do the terms transference and counter-transference mean?

Transference refers to clients' placement of feelings originally directed towards significant others in their life onto the counselor (Wallin, 2007). For example, clients might project feelings related to their mother or father figure onto the counselor. In some cases this may lead to a belief that the counselor is



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nurturing and loving; in other situations feelings of anger and mistrust may arise. In the clients' mind the counselor may also come to represent their ideal partner or friend; this may lead to platonic, romantic, or sexual attraction.

Due to the clients' complicated thoughts, beliefs, and emotions entangled with the issue of transference developing ways to guide a counselor to work with these issues will be discussed so that clients may gain deeper insight and to preserve the therapeutic relationship.

Counter-transference - occurs when counselors' emotions, beliefs, and biases are projected onto their client; as with transference this is typically related to the counselor's life history. Counter-transference involves an emotional connection with the client beyond what other counselors would deem as appropriate within the therapeutic relationship. The counselor's acceptance of the client's transference is another example of counter-transference (Gelso & Hayes, 2007). For example, when clients project feelings related to their parental figure onto their counselors, the counselors may find themselves wanting to protect the clients and reach beyond their boundaries to assist the clients. In such cases it is important to explore issues of both transference and counter-transference in order to rebalance the therapeutic relationship, re-establish boundaries, and promote client growth. Again, there are many ways to recognize and respond to counter-transference during individual and group supervision. When not addressed, counter-transference can lead to violations of boundaries and potential harm to clients.

Although these are issues which are present in every form of counseling and therapy, some areas are more influential regarding the level of transference and counter-transference experienced in particular by developing Alcohol and Drug Counselors. Two of these areas include a higher potentiality for the client to have similar life experiences as the counselor (i.e., history of alcohol and other drug (AOD) use, treatment history, legal issues, etc) and the degree of confidence the counselor feels working with co-occurring issues (depending on education, training, and experience). As with all other developing counselors, it is imperative to acknowledge what stage the individual counselors are in regarding their professional development and base the intensity of supervision and oversight on their level of development.



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Maintaining awareness

Management of transference and counter-transference is critical to effective counseling and the prevention of compassion fatigue and ultimately burnout. The intensity of my reaction to a client serves as my personal trigger for counter-transference awareness. When I really like and enjoy (or dislike and don't enjoy) a client, I realize that this is most likely a counter-transference reaction. Experience has taught me to seek supervision when I suspect that counter-transference is percolating in the therapeutic relationship.

Ongoing clinical supervision that allows counselor honesty offers the best method for addressing counter-transference. Counter-transference is an inevitable and desired component of the therapeutic relationship and often serves as the vehicle for professional and personal growth for both recovering and non-recovering counselors. However, these reactions must be addressed, because if they are ignored, they usually reappear more intensely. Unaddressed counter-transference can have a destructive impact on the client, the counselor, and the therapeutic relationship. Some-times a resolution of the situation requires a break from working with the population that is causing the counter-transference. Giving counter-transference prominence in a burnout prevention plan is critical to counselor survival.

Counter-transference that is not managed via supervision and personal therapy can be acted out in ways that never help the therapeutic process. When the counselor becomes the good parent and tries to rescue the client or is overprotective, mothering/smothering, and enmeshed, the therapeutic relationship is compromised and the client is encouraged to stay dependent. When the counselor forms an alliance with the client, he/she demonstrates counter-transference by avoiding negative feelings and protecting the client from confrontation; this ultimately can divide staff members. Whichever way counter-transference plays out, it has gone too far and never will encourage client growth.

The recovering counselor is particularly vulnerable to counter-transference reactions, compassion fatigue, and burnout because of the double-edged sword of personal experience. Counselors in recovery have the strength of knowing that addiction can be managed by significant lifestyle and philosophic changes. However, heightened sensitivity to the issues surrounding addiction can occasionally pierce the protective shell of even the best-trained professional. Because 12-Step programs suggest we are equal and can learn from honest sharing, recovering counselors must establish firm role boundaries for themselves. Hyper-vigilance to personal reactions to the stories and issues of clients helps counselors improve quality of care.



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Boundaries

Boundary - Edge of appropriate behavior at a given moment in a relationship between patient/provider, governed by the therapeutic context & contract.

Boundary crossing - Benign deviations from standard practice, harmless, non-exploitative, may advance therapy goals, i.e., helping a falling patient, giving patient ride home in a blizzard.

Boundary violation - Significant deviations from standard practice, harmful, exploitative, takes therapist out of professional role.

Why are Boundary Issues Important?

- ✚ Blurred boundaries distort therapy bond
- ✚ Can impair counselor's judgment
- ✚ Conflict of interest
- ✚ Exploitation of client

Codes to Practice By:

- ✚ The responsibility for setting & maintaining boundaries always belongs to the counselor.
- ✚ The patient should not be blamed or stigmatized for violating a boundary.

Touch

- ✚ 59% of counselors hugged, kissed, or affectionately touched clients
- ✚ When we touch all patients the same then we know it is therapeutically supportive
- ✚ Do nothing in private that you wouldn't do in public

Dual Relationships

Dual or multiple relationships occur when professionals assume two or more roles at the same time or sequentially with a client.

The addiction professional understands that the goal of treatment services is to nurture and support the development of a relationship of equals of individuals to ensure protection and fairness of all parties. Addiction professionals will provide services to clients only in the context of a professional setting.



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1. Because a relationship begins with a power differential, the addiction professional will not exploit relationships with current or former clients, current or former supervisees or colleagues for personal gain, including social or business relationships.
2. The addiction professional avoids situations that might appear to be or could be interpreted as a conflict of interest. Gifts from clients, other treatment organizations or the providers of materials or services used in the addiction professional's practice will not be accepted, except when refusal of such gift would cause irreparable harm to the client relationship. Gifts of value over \$25 will not be accepted under any circumstances.
3. The addiction professional will not engage in professional relationships or commitments that conflict with family members, friends, close associates or others whose welfare might be jeopardized by such a dual relationship.
4. The addiction professional will not, under any circumstances, engage in sexual behavior with current or former clients.
5. The addiction professional will not accept as clients anyone with whom they have engaged in romantic or sexual relationships.
6. The addiction professional makes no request of clients that does not directly pertain to treatment (giving testimonials about the program or participating in interviews with reporters or students).
7. The addiction professional recognizes that there are situations in which dual relationships are difficult to avoid. Rural areas, small communities and other situations necessitate discussion of the counseling relationship and take steps to distinguish the counseling relationship from other interactions.
8. When the addiction professional works for an agency such as department of corrections, military, an HMO or as an employee of the client's employer, the obligations to external individuals and organizations are disclosed prior to delivering any services.
9. The addiction professional recognizes the challenges resulting from increased role of the criminal justice system in making referrals for addiction treatment. Consequently he/she strives to remove coercive elements of such referrals as quickly as possible to encourage engagement in the treatment and recovery process.
10. The addiction professional encourages self-sufficiency among clients in making daily choices related to the recovery process and self-care.
11. The addiction professional shall avoid any action that might appear to impose on others' acceptance of their religious/spiritual, political or other personal beliefs while also encouraging and supporting participation in recovery support groups.



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Examples of Dual Relationships

- ✚ Counselor and friend
- ✚ Counselor and business partner
- ✚ Bartering therapy for goods and / or services
- ✚ Providing therapy to a relative or a friend's relative.
- ✚ Socializing outside of therapy sessions
- ✚ Combining the roles of supervisor and therapist
- ✚ Becoming emotionally involved with a client or former client.
- ✚ Becoming sexually involved with a client or former client

Counselor Self-Disclosure

During your CAP courses there has been a lot of discussion clients' disclosure, but what about counselors' disclosure?

The counselor should avoid too much self-disclosure. While occasional appropriate self-disclosure can help the client to open up or motivate the client by providing a role model, too much self-disclosure removes the focus from the client's recovery. A good rule regarding self-disclosure, if the counselor is so inclined, is that the counselor first has a clear purpose or goal for the intervention and then think about why he or she is choosing self-disclosure at this time.

The counselor should be aware of when his or her own issues are stimulated by a client's problems and therefore refrain from responding to the client out of his or her own dynamics. For example, if a counselor in recovery feels it extremely important to break ties with addicted peers, but a particular client with an addicted spouse or partner cannot break free of the relationship, it is imperative that the counselor respond flexibly and creatively to the client's perception of the situation and not rigidly adhere to the notion that breaking ties with all addicts is the only way to recovery.

Research summations have indicated cautions on counselor disclosure. The conclusions generally indicate that counselor self-disclosure is rarely associated with counseling outcomes, and when it was, the influence was often negative. However, a fine distinction has been made between disclosing (information that is associated with a counselor's past) versus self-involvement, which is associated with the current counseling situation (e.g. how you, the counselor, feel the counseling is proceeding; and your feelings about the client and process). The latter is associated more with positive outcomes, and rates higher with clients.



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In terms of strict counselor disclosure, it would appear that too much is not a good idea. If repeatedly used as a mainstay of counseling, the client may begin to think, “Who has the problems here?” Yet, utilizing self-involved statements may bring about benefits of rapport and warmth.

Kottler (1991) outlined the following questions for the counselor to consider prior to any disclosure:

- What will this accomplish?
- Is there another way to make my point?
- Is the timing right?
- Am I trying to meet some of my own needs?
- How can the client personalize and use what I share?

Stress Management & it's Relationship to Professional Burn Out

Bio-Psycho-Social Stress:

Biological: Brain, muscles, skin, limbic—emotions, endocrine—glands/hormones, autonomic nervous—expending and conserving energy, cardiovascular, gastrointestinal

Psychological: Thoughts and feelings

Sociological: Surrounding environment

Stress Symptoms:

- ✚ Diminished or over-stimulated sense of humor.
- ✚ Skipping rest and food breaks
- ✚ Binge eating
- ✚ Increased overtime and no vacation
- ✚ Increased physical complaints
- ✚ Social withdrawal: church, family, friends
- ✚ Changed job performance
- ✚ Increase in time away from work (illness, family, and environment)
- ✚ Self-medication
- ✚ Sleep: too much or lack of
- ✚ Emotional Changes (low self-esteem, depression, anxiety, irritation, anger)



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- ✚ Physiological Changes (Hypertension--high blood pressure, ulcers, migraine or chronic tension headaches, ulcers, acid reflux, skin irritations)

Stress ➡ **Burnout**

Recognize that you can take action in managing your stress and prevent burn-out:

1. Is your efficiency at work declining?
2. Do you have frequently changing or depressing moods?
3. Have you lost some of your initiative at work?
4. Are you easy to anger?
5. Have you lost interest in your work?
6. Do you get frustrated easily?
7. Does work stress get to you more than it used to?
8. Are you more suspicious than you used to be?
9. Do you feel fatigued or run-down?
10. Do you feel more helpless than you used to?
11. Do you get headaches, stomach aches or back aches?
12. Are you using too many mood altering drugs (sleep aids, alcohol...)
13. Have you lost or gained weight recently?
14. Are you becoming more inflexible?
15. Do you find yourself eating to replace emotion?
16. Are you becoming more critical of your own and others' competencies?
17. Do you have trouble sleeping?
18. Are you working more but feeling that you are getting less done?
19. Do you experience shortness of breath?
20. Have you lost some of your sense of humor

Compassion Fatigue, Burnout and Vicarious Trauma are all terms that are used within the helping profession. Often Compassion Fatigue is confused with Burnout and it's important that helping professionals understand the difference.

Burnout: Burnout refers to the physical and emotional exhaustion that comes from prolonged stress and frustration. When we feel we have too many demands, and not enough resources, we begin to feel powerless to reach our goals. This can lead to a reduced feeling of personal accomplishment and



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diminished self-care. Burnout can happen in any field/job. It results in significant negative impacts on health and outlook on life.

Vicarious Trauma: When a person is continuously exposed to other people's traumatic experiences through witnessing and/or hearing others' stories, vicarious trauma can be experienced. Vicarious trauma (VT) means that you have not been the direct victim of a trauma, but you have experienced it second hand from clients through their stories of pain. Clinicians may begin to experience posttraumatic stress symptoms similar to the person who experienced it. This can include intrusive imagery (images of trauma popping into your head) dreaming about the traumatic situation or avoiding certain activities and so on.

Ongoing vicarious trauma can result in a shift in the helper's world view and sense of meaning, for example, someone who may regularly feel safe can begin to doubt their safety if they work with victims of crime and hear numerous stories of crimes and trauma. If a helper has a previous history of trauma (and many have as more than 70% of the population has experienced one or more event significant enough to be traumatic) that is unresolved, then you are more likely to experience VT. Vicarious trauma is something that people experience on a continuum, you may leave the job but you will still have that foundation of VT within you.

Compassion Fatigue: Compassion Fatigue is applied to people who suffer as a result of being in the helping profession. If helpers experience both burnout and VT they are more vulnerable to developing Compassion Fatigue (CF). Compassion Fatigue is when someone who regularly hears/witnesses very difficult and traumatic stories begins to lose their ability to feel empathy for their clients, loved ones and co-workers. This deep physical and emotional exhaustion has been described as "having nothing left to give" and "an occupational hazard". Compassion Fatigue can show as a variety of symptoms presenting behaviorally, emotionally, relationally, physically and spiritually. Sometimes CF is misdiagnosed as depression.

Compassion Fatigue is developed because of the helper's strong ability to care for their clients in the first place. It is the most caring individuals who are most likely to develop CF. The best helping professionals are able to connect with their clients because of their strong ability to empathize with them. It is this gift of empathy that can also lead them to develop CF. By learning about CF and



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developing ways to manage it, these helpers can continue to do the work they love, and are good at, while still being able to thrive personally. Simply leaving one helping job and moving into another will not reduce one's CF.

So how do we remain in the helping profession while limiting our Compassion Fatigue? One strategy is to **Empathize With Care!** One way to manage Compassion Fatigue is to be aware of the effects of empathizing. We empathize with our clients so that we can connect with them and help them in their suffering and struggles. In her book, *Help for the Helper*, Babette Rothschild explains the neuroscience behind empathy and discusses emotional contagion. In order to do our jobs well, we need to be able to maintain awareness of what feelings are ours and what feelings belong to the people we are working with.

One way to ensure we maintain awareness is to be mindful about our own internal experiences while we are hearing our client's stories. We can do this by picking up on sensations in our bodies, noticing images or sounds that come into our minds, note our breath and muscle tension, as well as any emotions that arise or any thoughts that occur. This will enable us to ensure that we engage in conscious empathy, thereby, allowing us to empathize while still caring for ourselves, managing our own internal experience and being the best helper we can be. The next time you are working with a client who is sharing a difficult story, take a moment to check in with your whole self and ensure you are empathizing with care!

More on Burn Out

- ✚ An emotional exhaustion in which the professional no longer has any positive feelings, sympathy, or respect for clients.
- ✚ An adverse work stress reaction with psychological, physiological, and behavioral components often associate with:
 - stress
 - fatigue
 - frustration
 - apathy (an absence of emotion or enthusiasm)

Stages of Burnout Development:



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Stage One: the honeymoon – satisfied with the job

Stage Two: fuel shortage – fatigue sets in

Stage Three: chronic symptoms – physical effects

Stage Four: crisis – actual illness can develop

Stage Five: hitting the wall – physical and psychological problems can become severe enough to cause illness that is life-threatening.

Burn-Out Simply Put:

Sustained, unmanageable, painful stress.

Your response is your responsibility.

- ✚ Burnout has implications for ethical practice.
- ✚ Burnout compromises your physical and mental health and social relationships (work, family and friends).

Interventions:

- ✚ Seek help!
- ✚ Set limits
- ✚ Manage symptoms
- ✚ Seek deeper meaning in your work
- ✚ Ex. new interests, new areas, new challenges
- ✚ Implications of burnout for ethical practice
- ✚ Your response is your responsibility

Stress Management

Interventions or activities designed to block a stressor from resulting in negative consequences such as illness or disease.

Stress management consists of the use of interventions (diet, exercise, activities, laughter, reading, medication, music, etc.).



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- ✚ Humor
- ✚ Time management – Too little occupational stress is almost as unhealthy as too much
- ✚ Meditation
- ✚ Prayer/Spirituality
- ✚ Volunteer
- ✚ Setting goals, prioritizing, scheduling, saying “no”, maximize your rewards, delegate, evaluate, limit interruptions
- ✚ Volunteer
- ✚ Progressive Relaxation Techniques – nerve/muscle
- ✚ Exercise – make it fun!

Instructor Note: Recognizing, following and respecting these guidelines creates your clinical and professional foundation for a healthy, ethical, successful, clinical practice. Understanding the impact of countertransference and taking care of any unresolved issues you may have is of the utmost importance if you want to help clients, do no harm to your clients and work in this field for a long, long time without burning out and without compromising your ethics or your clinical judgment.

Professional Growth

TAP 21 Competency: Obtain appropriate continuing professional education

TAP 21 Competency: Interpret and apply information from current counseling and psychoactive use research literature to improve client care and enhance professional growth.

So, you have completed all your coursework, you have amassed all of your direct practice hours, you filed your application, you took the CAP exam and YES!!!! YOU DID IT!! YOU PASSED!! Now what?

Well hopefully you find a great job as a counselor in a facility you are proud to work for with clients you care about. You are also ethically and professionally bound to continue your professional and clinical growth. Part of this continuing education is mandated by the Florida Certification Board as part of your recertification process. But that is not the only reason/purpose to continually challenge yourself.



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Attending professional trainings, watching webinars, staying on top of articles related to the newest research in addiction treatment, understanding addiction, new street drugs, new therapeutic techniques etc. makes you prepared, professional, clinically astute and an asset to your clients.

Just as in any other behavioral health discipline addiction professionals have their own association that you can become a member of and take part in all they have to offer in the form of education, research, professional information, trainings etc.

NAADAC, the Association for Addiction Professionals, is the largest national organization for addiction-focused health care professionals with 8,000 members. NAADAC is dedicated to the professional growth and development of addiction specialists.

Credential Maintenance and Renewal

Maintaining a credential in good standing is very important. To further our mission of public safety, the FCB maintains a public-access database allowing verification of an individual's certification status and ethical history. To remain in good standing, certified professionals must:

1. Actively participate in annual continuing education to maintain a current knowledge and skill base.
2. Follow the FCB Code of Ethical and Professional Conduct.
3. Complete the renewal process in a timely manner, every June.

Please carefully read this section to ensure you understand maintenance and renewal requirements.

Continuing Education Requirement:

Certified Addiction Professionals must complete 20 hours of continuing education units (CEUs) per year. One CEU is equal to 50 minutes of instruction.

Training content must be related to at least one of the Transdisciplinary Foundations and CEU hours must be non-repetitive (i.e., the same course cannot be claimed more than one time during each credentialed period, even if the course was taken annually.)

Continuing education units must be earned from a FCB recognized or approved CEU training provider: some training providers hold approval from other entities that is recognized by the FCB, other training providers apply for and hold FCB Training Provider Status.



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FCB Recognized Education and Training Providers: The FCB will honor CEUs issued by any of the following providers:

1. FCB approved training providers
2. International Certification and Reciprocity Consortium (IC&RC) member board approved providers
3. College or university coursework offered by institutions holding Federal Department of Education and/or Council of Higher Education Accreditation (CHEA) recognized accreditation.
4. Training providers approved to offer CEUs by other state or national professional licensing or certification boards. FCB Approved Education and Training Providers: The FCB will award FCB Education and Training Provider status and a number to approved applicants.

A list of approved FCB Education and Training Providers is maintained on our webpage at www.flcertificationboard.org.

Credential Renewal Requirement:

The Certified Addiction Professional (CAP) credential and the IC&RC Alcohol and Drug Counselor (ADC) credentials each must be renewed annually, no later than June 30 of the renewal year.

Renewal Notice Process:

The FCB will send out renewal notices in April and May of the renewal year. Renewal fees must be paid and, if audited, CEU documentation must be approved no later than June 30th of the renewal year.

Individuals who DO NOT meet renewal requirements by June 30th may pay the renewal fee, a \$30 late fee and must submit CEU (regardless of audit status) no later than July 31st of the renewal year.

Individuals who DO NOT meet renewal requirements by August 1st of the renewal year will be automatically placed in inactive status and must complete the FCB Reinstatement Process to recertify.

Instructor Note: DO NOT rest on your laurels, do not be satisfied you know enough. Find what interests you, what sparks your mind to thinking and research it, learn it and practice it. You and your clients will benefit.



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Conclusion

As an addiction counselor you will be called upon to help many people in deep distress during your career. These people will count on you to have some answers, some care and concern, empathy, clinical knowledge and more. But the most important things you can be is ethical and professional.

Your sense of professional moral responsibility to those you serve is what will guide through a long and successful career. Standing solidly on ethical and professional ground keeps you on a path of growth, clinically and personally.

Never mind the others around you, you stick to your ethical and professional guns and feel pride and self-fulfillment.

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Documentation Section

Section Outline - This course will provide the information necessary to enable counselors to document a complete client treatment episode from initial phone screening to discharge utilizing legal, ethical and clinical practice standards.

Course Objectives:



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1. Student will understand the purpose of documentation.
2. Student will learn the benefits of clinical documentation.
3. Student will learn the documentation process and requirements for the client's assessment.
4. Student will learn the documentation process and requirements for writing an Integrated Summary.
5. Student will learn the documentation process and requirements for the client's treatment plan.
6. Student will learn the documentation process and requirements for progress notes.
7. Student will learn the documentation process and requirements for group and family sessions.
8. Student will learn the documentation process and requirements for client discharge.
9. Student will learn the legal standards set for documentation, release of information and maintenance of client records.

Documentation

Introduction

TAP 21 Definition of Documentation: The recording of the screening and intake process, assessment, treatment plan, clinical reports, clinical progress notes, discharge summaries, and other client-related data.

Clinical documentation and recordkeeping requirements, often viewed as a chore, yet another burden heaped upon behavioral health care practitioners, are a familiar part of agency practice. The clinical record has an important place in assuring the quality of health and behavioral health services.

Professional practice standards require that treatment must be based on a proper diagnostic assessment and must be implemented in a planned manner, which is reviewed periodically, with identified goals, methods, time frames, and criteria to measure its efficacy and appropriateness. The clinical record should document compliance with these basic practice standards.

Documentation, the primary focus of clinical chart audits, is scrutinized by regulatory bodies. Among other things, chart audits assess for medical necessity to determine whether or not the treatment is necessary and/or effective. Documentation that does not support medically necessary treatment potentially results in a recoupment of disbursements and, in extreme cases, a loss of clinical licensure. Whether in an agency or private practice setting, all practicing behavioral health providers are required



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to meet regulatory standards of practice, and under healthcare reform, these standards are increasingly stringent. To meet the demands of these standards, clinicians must have a working knowledge of the process and an understating of the standards and requirements to which they are expected to adhere.

Charting the results of the assessment and treatment plan, writing reports, progress notes, discharge summaries and other client-related data are of the utmost importance and needed in most, if not all, levels of care and various treatment facilities, whether privately funded or not for profit.

Instructor Note: This course is relatively brief, but don't let that fool you! Learning how to document a client's entire treatment episode is important for the client's treatment process, the agencies' standards and the counselor's ability to provide individualized up to the moment clinical interventions. Becoming a good clinical writer is what sets apart one average counselor from an excellent counselor. This course is short but integral in your professional education.

CLINICAL DOCUMENTATION AND RECORDKEEPING

TAP 21 Competency: Demonstrate knowledge of accepted principles of client record management.

Instructor Note: I have set up this chapter in a bullet point fashion to help your learning process and to help with studying. When it comes to documentation there can be some differences from treatment center to treatment center or agency to agency but some things do NOT change, HIPAA and 42 CFR standards never change, these are written in stone and need to followed to the letter in order to maintain professional ethics, agency standards, auditing need and of course, client protection.

Purposes of Clinical Documentation

The seven key purposes of clinical documentation which, at times, overlap with each other, are:

- 1) Document professional work:
 - to record what was done, by whom, with, to, for, and/or on behalf of whom, when, where, why, and with what results
 - to document assessment and differential diagnosis, treatment and other services provided, the client's clinical course and clinical decision making (including assessment- based treatment and service planning and periodic reviews and modifications of the treatment/service plan)



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- 2) Serve as the basis for organization and continuity of care of the client by the practitioner:
 - to record clinically meaningful information that the practitioner can later rely on to refresh his or her memory of crucial events in treatment, the patient's response to treatment and other services, problems experienced in treatment, key historical facts and details of substantive collateral contacts
 - to create a longitudinal record of the history of the client's complaints, symptoms, co-morbidities, assessments, diagnoses, treatment and other services provided, clinical course, and response to treatment and other services so that the treating practitioner and other practitioners who are, or who later become involved in working with the client can use this information to identify potential trends, guide their assessment and guide their development and implementation of their treatment/service plans
 - to provide a basis for practitioner reflection and self-supervision on the client's evaluation, diagnoses, treatment and services, assessment-based treatment/service plan, clinical course and progress
- 3) Serve as the basis for subsequent continuity of care of the client by recording for use by other practitioners who may serve the client in the future clinically meaningful data regarding the client's:
 - assessment, diagnoses, treatment and other services provided, clinical course, progress and response to treatment and other services
 - assessment-based treatment and service plans and the periodic reviews and modifications of those plans
 - trends, crises and problems in treatment, so that they may have sufficient data based upon which they can provide meaningfully clinically informed continuity of care to the patient
- 4) Risk management purposes to protect against malpractice lawsuits and professional discipline complaints, and to aid in defending effectively against any such lawsuits or complaints; (in this regard, be aware that if you didn't document something of importance contemporaneously in the client's clinical record and that becomes the subject of contention in a legal or disciplinary proceeding against you, it can be treated by a court or administrative body as if it did not happen or you missed it or you ignored it or you did not address it, etc., all of which may well ensure to your detriment in such proceedings)
 - Document informed consent (i.e., for treatment, disclosure of information) and the nature and extent of the professional relationship and of duty owed with regard to the patient



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- Explain, detail and justify professional decision-making, problems encountered in working with the patient, and the professional response to crises and other special or problem situations
 - Record the details of supervision/consultation obtained in relation to the assessment and treatment of the patient, particularly with regard to crises or other special or problematic situations that arise
 - Supervisors (who are legally professionally responsible and accountable for the professional services provided by their supervisees) to document each of their supervisory sessions, each of their contacts with the patients whose care they are supervising, and their oversight of the assessments, treatment and other services rendered by their supervisees under their supervision in order to enable them to defend the quality and appropriateness of their supervision and the quality of their supervisee's professional work against any malpractice lawsuit or professional discipline complaint alleging negligent supervision or malpractice by them or their supervisee
 - Record information that will support the adequacy of the clinical assessment, the appropriateness of the treatment/service plan and the application of professional skills and knowledge in the provision of professional services
 - Substantiate the treatment/services provided and the results of such treatment/services
- 5) Comply with legal, regulatory and institutional requirements
- Assure compliance with clinical documentation and recordkeeping requirements imposed by federal and state (including licensing boards) laws, regulations and rules
 - Assure compliance with clinical documentation and recordkeeping standards set by specific accreditation programs (i.e., JCAHO) and by health care institutions, facilities and agencies
 - Fulfill clinical documentation and recordkeeping requirements of various third-party payers (i.e. Medicare, Workmen's Compensation, Medicaid, insurance, managed care plans)
- 6) Facilitate quality assurance and utilization review
- Record professional activities, the process and substance of assessment, differential diagnosis, treatment and service planning, clinical decision-making and the results of treatments and other services provided
 - Document the appropriateness, clinical necessity and effectiveness of treatments and other services provided
 - Substantiate the need for further assessment, testing, treatment and/or other services, or to support changes in or termination of treatment and/or services



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- Facilitate supervision, consultation and staff/professional development
 - to help improve the quality of services by identifying problems with service delivery by providing data based upon which effective preventative or corrective actions can be undertaken to improve and assure the quality of care
 - Provide data for use in planning educational and professional development activities, policy development, program planning and research in agency setting
 - Provide data to guide choices of continuing professional education programs to attend, ongoing review and revision of the organization and operation of the practitioner's professional practice and research in private practice settings
- 7) Facilitate coordination of professional efforts by fostering communication and collaboration between members of the treatment team
- Assure coordinated rather than fragmented treatment/service delivery
 - Assure appropriate utilization of team members from multiple disciplines in order to bring to bear collaboratively in an interdisciplinary/transdisciplinary manner the particular competencies of team members from various disciplines and/or who have specific specialties to maximize the quality of services to clients.

The Role of Clinical Documentation in Quality Assurance

Writing up appropriate initial assessments and proper progress/session notes requires thought and reflection. Having to prepare proper clinical documentation serves an important role of helping assure quality client care by making practitioners think about their clients, review and reflect on their therapeutic interventions, consider the efficacy of their clinical work and weigh alternative approaches to the care of their clients. The capacity for professional self-reflection and self-appraisal of one's professional work is essential to a practitioner's professional development, to the maintenance of his or her professional skills and to the provision of high quality clinical services. Rather than viewing clinical documentation as a meaningless chore that consumes precious time, practitioners should view it in this light, as a form of self-supervision that is an essential element of their professional practice and of their provision of quality clinical services.

Good Clinical Documentation

TAP 21 Competency: Prepare accurate and concise screening, intake and assessment reports.



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TAP 21 Competency: Record treatment and continuing care plans that are consistent with agency standards and comply with applicable administrative rules.

What is good clinical documentation? Who decides? What needs to be included? What does not need to be included?

Elements of Good Clinical Documentation

Clinical documentation should be recorded and organized as follows:

1. Each page of a client record should have the client's name clearly printed or typewritten on the top.
2. ALL entries in the client record should be signed (either in handwritten form or electronic form) by the practitioner making the entry.
3. Entries in the client record should be written contemporaneously (in the present) with the events they are documenting.
4. Each entry in a client record should be dated the day it is written.
5. If an entry in a client record documents an interview, therapy session, missed session, any follow-up of the missed session, assessment or other substantive client related collateral contact (i.e.; with another treating practitioner, with a family member, with the parents of a child who is in treatment) that took place earlier than the day the entry is written, the entry should include clear documentation of the day the activity being documented occurred.
6. Any materials or information received regarding a client which are entered in the clinical record should be dated and initialed on the day the information or material is initially reviewed and placed in the client record. Additionally, a progress note should be written to document the review of the material or information and any action taken as a result of that review.
7. All substantive collateral contacts with others relating to the client and all referrals made relating to the client should be documented contemporaneously in the client's clinical record. Timely follow-up on any referral made should be documented in the client's clinical record.
8. The record should be kept neatly, in date order for each section, in at least the following sections:
 - a) basic contact and demographic information about the client,
 - b) intake information including demographic and contact information about the client,
 - c) progress notes, initial and interval updates of treatment plans and closing/termination summary,



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- d) referrals made, tests requested, and the reports of consultations, referrals or test results which are received,
- e) communications with other practitioners received or sent relating to the client,
- f) non-professional correspondence to or from the client or from non-professional collateral contacts,
- g) documents relating to HIPAA compliance, informed consent for treatment documents, consents and authorizations for use and/or disclosure of clinical information and records, etc.

Elements of Good Clinical Documentation - Writing

Clinical documentation should be written (typed) in a manner that is well organized and that allows rapid location, recovery and utilization of clinical and other information about the patient. Writing good, useful clinical documentation requires thinking about and reflecting on the event(s) being documented in the context of the client's history and condition, the treatment and services being provided, and the client's treatment plan.

Good clinical documentation:

- 1) provides relevant information in appropriate detail
- 2) is organized with appropriate headings and logical progression
- 3) is thoughtful, reflecting the application of professional knowledge, skills and judgment in the treatment/services provided
- 4) is appropriately concise
- 5) serves the purposes of clinical documentation (as outlined above) that are applicable to a given situation
- 6) uses relevant direct quotes from the client and from other sources identified as such by utilizing quotation marks
- 7) distinguishes clearly between facts, observations, hard data and opinions
- 8) states the source(s) of the facts, observations, hard data, opinions and other information being relied upon, and provides an assessment of the reliability of that material
- 9) is internally consistent
- 10) is written in the present tense, as appropriate.

Documenting Elements of an Appropriate Initial Intake and Assessment.



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An initial diagnostic assessment, which may be abbreviated or elongated depending on the circumstances of a particular case, provides the basis for the development and implementation of the treatment plan. In clinical practice the lack of a proper clinical assessment is likely to result in less than optimal and, perhaps inadequate or inappropriate treatment. The failure to conduct an appropriate differential diagnostic assessment or to develop an appropriate treatment plan is a serious deviation from the standard of care owed by a clinician to a client. The conduct and documentation of a proper initial assessment, and the development of the initial treatment plan includes:

- 1) identification of the referral source(s), gathering information about the background and reasons for the referral and assessing the client's response to and expectations with regard to the referral
- 2) defining the presenting problem(s) and what the patient wants to accomplish in treatment, both in the client's own words using appropriate quotes (identified by using quotation marks), as well as in terms of the practitioner's perception of the presenting problem(s) and needs of the patient
- 3) detailing the history and clinical course of presenting problem(s) and the details of treatment or services the client has sought or received to deal with those problems in the past (either in the long term or in the immediate past)
- 4) gathering and documenting relevant history from the client and from collateral sources, in appropriate detail, by topic, identifying the sources of such historical information and assessing the reliability of the information, regarding:
 - a) family history including a list of family members in families of origin and procreation and basic demographic information about them (i.e., age, birthplace, education, occupation, age, and cause of death if applicable), a brief description about their relationship with the client, marital history, and any family history of mental, neurological, substance abuse/alcoholism or serious medical problems
 - b) medical history including details of serious or chronic ailments, hospitalizations, serious physical trauma and/or surgery, allergies or adverse drug reactions; any physical disabilities and how the client has and/or is coping with them; any chronic medications and all current medications including OTC drugs, supplements, herbs and other alternative treatments, and information about their relationships and feelings about past and current treating practitioners
 - c) psychiatric history including details of mental health symptoms, diagnoses and treatments, hospitalizations (including whether voluntary or not), what precipitated or triggered the symptoms, treatment or hospitalization, and the client's response to prior mental health treatment (including response to and side effects of particular psychotropic medications that



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have been prescribed), prior psychotherapy and/or psychopharmacotherapy and the client's response to and feelings about psychotherapy and/or psychopharmacotherapy; history of treatment compliance and non-compliance (if patient left treatment, why he or she did so and with what results), details of the degree of the client's mental disability and how the patient is coping with this; and information about their relationships and feelings about past and current treating mental health practitioners;

- d) history of alcohol and other substance abuse and alcoholism and substance abuse treatment including, for each substance of abuse, including alcohol, the substance, the first and most recent use of the substance, the route(s) of use, the amount used/time period (i.e., \$10 of crack/day, five 40oz cans of beer/weekend), the frequency of use (i.e., steady on a daily basis, binging once every three of four weeks for one to three days) the duration of use, any significant periods of abstinence (including how these were achieved and why they ended), the social context of the substance abuse (i.e., alone, sharing with others, only at parties), identified triggers for the substance abuse, treatment programs attended (which ones, when and for how long, what the patient liked and disliked about the program, what the client felt that he or she accomplished and did not accomplish in the program, and whether the patient completed the program successfully, if not, why), and the bio-psychosocial impact of the substance abuse on the client and his or her significant others
- e) child and adolescent developmental history including family and peer group relationships, home life, socio-economic status, schooling, parenting and discipline, type of neighborhood and housing, learning disabilities and other developmental delays (in children and young adolescents a more detailed developmental history is usually indicated)
- f) educational history including level of academic achievement, academic strengths weaknesses, relationships with teachers, history of being denied regular promotion, placement in special education or other special educational programs, school behavior including any suspensions, expulsions or school transfers
- g) history of occupational training/skills and work history including significant employment, work related difficulties, how the client views his or her work, the client's career goals, general salary information and adult economic status
- h) history of interpersonal relationships including the nature and extent of peer group relationships, marriages and other close relationships over the life span, what has kept or keeps these relationships functioning, why and how these relationships end, the client's reactions and



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feelings about the end of close interpersonal relationships, the nature and type of any significant interpersonal problems the patient has had or is having

- i) history of past and current social support systems including the nature and impact of these or the lack of these on the client's development and functioning
 - j) juvenile and criminal justice history including the nature of any arrests, convictions and any sentences imposed, and history of patterns of antisocial behavior
 - k) history of sexual relationships, issues including sexual orientation issues and any sexual dysfunction
 - l) history of religious affiliation and practices and issues relating to religion
 - m) spirituality (aside from religion) including the values, thoughts, emotions, motivations, needs, dreams, experiences, assumptions and relationships that make the person a unique individual, and provide him or her with the vitality, drive and determination to develop and function as a fully actualized person
 - n) social issues his or her functioning in relation to other persons and his or her environment including, but not limited to interpersonal and social relatedness, skills and capacity; behavioral responses to environmental, mental and emotional events and stimuli; responsiveness to the environment and to other persons; adaptive functioning and behavior; stress and frustration tolerance and impulse control; linguistic and communicative functioning; social judgment; and the influences of age, culture, customs, disability, discrimination, economic factors, gender, geographic and other environmental factors, health status, illness, injury, loss, national origin, pain and suffering, politics, race and religion his or her development and functioning
 - o) history of physical, emotional or sexual abuse or other victimization including where and when these occurred, the patient's view of the impact of these on his or her life, whom the client told about these events and the response of people who learned about these occurrences.
- 5) describing the counselor's observations of the client and the results of a mental status examination which generally includes an assessment (which may be abbreviated depending on the client's presentation) of the following:
- sensorium (attention, concentration, orientation, memory, intelligence, cognition and learning)
 - appearance, eye contact with practitioner, and psychomotor functioning
 - the form, nature and quality of speech and other communication;
 - mood, feelings, affect and emotions, suicidality and violence potential;
 - the form, nature, process and content of thought, and perception;
 - attitudes, motivations and behavior;



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- stress and frustration tolerance and impulse control;
 - ego functioning and ego defenses;
 - adaptive functioning and behavior;
 - sense of self, autonomy and competence;
 - interpersonal and social relatedness, skills and capacity (object relations);
 - client's self-assessment of his or her strengths and weaknesses; and
 - reality testing; insight, and judgment.
- 6) gathering information about the client's current/recent general physical health (including any current or recent symptoms or health problems and any current or recent health care treatment)
 - 7) detailing prior clinical services, the background and reasons for which those services were sought and provided, the results of such services and the reason(s) for termination of those services
 - 8) making a substance related diagnosis using the DSM 5 and an assessment of the patient in functional as well as diagnostic terms, which distinguishes between observations, hard data and opinions, sets forth the support for generalizations and conclusions in the assessment, and makes a determination about the practitioner's degree of confidence in the assessment
 - 9) developing an initial differential treatment/service plan with identified short-term goals and longer-term objectives, methods to be used, time frames and standards to measure treatment progress in functional terms, with a rationale for prioritizing of treatment goals and for the choice from among various treatment alternatives and strategies; the plan may include services from other providers, in which case these should be identified by function and/or name, and the services to be provided by them specified
 - 10) an assessment of prognosis with supporting rationale
 - 11) describing the client's response to the assessment and to the proposed treatment plan and, if the patient agrees to proceed with that plan, documenting informed consent for implementation of that plan.

Elements of Documentation of a Treatment Session

The ongoing provision of clinical services should be documented, keeping in mind the seven key purposes of clinical documentation and the ten elements of good clinical documentation discussed above. Depending on the changing circumstances of each case, certain purposes of documentation will be more crucial than others at various points in treatment. For instance, if a client's mental status deteriorates and he or she becomes threatening, the purpose of carefully documenting the



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practitioner's professional response and clinical decision-making and the purpose of risk management/malpractice protection will predominate. In a case where a client who has significant medical, family and mental health problems is being served by several different practitioners, documentation dealing with coordination of the professional efforts of the various practitioners will predominate. A proper progress note, which need not be particularly extensive, in most cases merely several sentences, should include:

1. the date and length of the contact
2. the specific services provided, including CPT [Current Procedural Terminology] descriptions and codes; in the case of other non-clinical services (i.e., case management, advocacy, referral, etc.) indicate the service(s) in words
3. description of the type of contact (i.e.; in person, telephone, mail)
4. indication of who initiated the contact (i.e.; regularly scheduled session, client showed up without appointment, phone call by client, phone call by patient's family who put client on the phone, inquiry from another practitioner/service provider who is with the client in the emergency room and puts the client on the phone)
5. statement of where the contact took place (i.e.; office, if a home visit - the address visited, if by phone - the phone number called)
6. indication of who, besides the patient, was involved in the contact (i.e.; client, family, other practitioner, friend)
7. a description of the themes of the session, in generic terms, addressing particular symptoms, feelings, thinking, beliefs or behaviors (i.e., pain, anxiety, dysphoria, suspiciousness, avoidance, etc.) or relating to specific relationships or situations (i.e.; work problems, interpersonal relationships, parent-child problems, marital relationship, school problems, the effects of chronic physical illness)
8. an assessment of the client's mental status during the session, relating this to the client's baseline mental status and the client's mental status in the recent past
9. notation of any symptoms or complaints that may indicate a physical health problem (i.e., side effects of psychotropic medication, sleep problems, confusion)
10. description of any new significant history obtained
11. description of relevant problems newly identified



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12. description of relevant significant new events (i.e., changes in medication, results of tests, exacerbation of a concurrent physical ailment, break-up of a relationship, beginning new relationship)
13. description of therapeutic interventions with clinical justification and reasoning to support these in relation to the treatment plan and clinical circumstances, particularly when in response to crisis situations or special/markedly changed circumstances
14. statement of what was accomplished in the session
15. statement of what wasn't accomplished in the session that needs to be followed up on
16. details of obstacles to progress in treatment, if any, and a plan to address these
17. a description of a plan for further care or follow-up (including date and time of next appointment), changes in diagnosis and/or treatment plan/goals, if any, and reasoning to support these changes (particularly when in response to crisis situations or special/markedly changed circumstances) and any referrals made or testing ordered (including the nature of the referral, to whom the referral is made, the reason for the referral, tests ordered and the reason they were ordered, and the patient's response to the referral and/or ordering of tests).

Progress Notes

Instructor Note: Right up front I am going to state this is the area where many a counselor fall down ☹️ Counselors are busy with very full caseloads and a lot of groups and meetings, and I have heard many say, "I'll catch up on my notes later". Well late either never comes and that counselor ends up out of compliance on most or all of their cases or they write a bunch of notes at one go and forget most of the clinical details necessary to meet standards and provide assistance in the client's treatment process. To be professional and maintain ethical standards and practice guidelines counselors have to have great organizational skills and excellent time management. Excelling in these two areas allows the counselor to complete all of their required tasks in a timely manner and in a clinically proficient style. Don't fall into this trap, if you find yourself falling behind speak to your clinical supervisor right away; get tips on how to tighten up your time management and organizational skills or to get help with a problem related to a specific client that may be taking up extra time.

Progress notes are vital to good clinical treatment. Counselors often see progress notes as "busywork" and consequently write them in ways that don't enhance the client's treatment episode. Carefully documenting the treatment process can be time consuming, and often tedious, but it is critical to



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quality treatment. The written record supplies the details of how the client utilized their treatment plan. It is similar to drawing a map, in that it charts the client's journey through the continuum of care.

A quick review of progress notes is the best way to refresh your memory when you sit with your clinical team to discuss your client's progress. It is common to have case conferences with social workers, mental health case managers, PO's, and other related professionals. Life-changing decisions are often made in those meetings and it is essential that the counselor is able to give a complete picture of their client's progress and/or lack of progress. Remember that the purpose of progress notes is not to satisfy supervisors and auditors; the primary purpose is to improve and enhance the treatment process by helping the counselor track the client's progress in treatment while staying focused on the treatment plan. Good progress notes also assist other program staff to participate intelligently in the client's treatment process. If the primary counselor is not available to provide support to the client, the chance that another counselor will be able to provide meaningful assistance may be dependent on the quality of documentation in the progress notes. A series of notes that only reports the client's attendance and indicating that they had "good participation" are clinically useless

Progress Notes – a different description & break down

Progress notes are the threads that tie treatment together. A good progress note addresses progress of current treatment goals, identifies new goals, assesses the client's response to treatment, includes new information not previously identified in the mental health assessment, notes changes in diagnoses, and ultimately represents evidence of treatment. As with the mental health assessment, progress notes should include the client's demographic information, date of service (with start and end time), description of services, and location of service (e.g., office, school, hospital). In the event documentation occurs at a time other than at the time of service delivery, include a notation of the late entry (including entry date/time) along with the date service occurred. Organizing a progress note can be done in several ways. One way is using the Data, Assessment, and Plan (DAP) format.

The first step is recording the subjective and objective data about the client. Subjective information is what the clients says or feels. As a general rule, incorporate specific statements made by the client into every note. Objective data is what is observable by the therapist (e.g., behaviors, actions, and emotions), notations about progress of presenting problems, review of client homework when given, and a summary of the content and process of the session.



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The assessment step involves analysis of what is going on in or outside of treatment that is impacting the client. The clinician should describe which interventions are working or not working and include a working hypothesis that may lead to further interventions or a change in goals.

Finally, the note should describe the next steps. This includes homework assignments, date of the next session, and any topics to be addressed at the next session.

Another common format used in a clinical setting is Subjective, Objective, Assessment, and Plan (SOAP). The content areas of the SOAP note are very similar to DAP, and depending on the treatment setting and clinician preference, either format is a generally acceptable.

Another less common format used in a clinical setting is BIRP – Behavior, Intervention, Response and Plan. Behavior is the counselor observations and client statements; Intervention is counselor’s methods used to address goals and objectives, observation and client statements; Response is client’s response to intervention and progress made toward treatment plan goals and objectives; and Plan is documenting what is going to happen next.

The premise of having a set format is to guide the content of the note. More importantly, the content areas should adhere to the documentation standards required by the clinician's regulatory body. In most cases, additional content includes diagnosis, MSE results, risk assessment, referrals, medications, and unresolved issues from past session. If a client misses a session, a progress note should document the missed appointment; any attempted contact with client, and/or if contact was received from the client. If non-billable services are performed, these should also be documented in a progress note as such.

The Process of Change

Progress notes should contain three specific elements: 1) The Counselor’s Interventions, 2) The Client’s Response to those interventions and, 3) The Process of Change. Think of it as a simple formula: The Counselor’s Interventions X The Client’s Response = The Client’s Process of Change.

Chart documentation includes the expectation that progress notes include details that elaborate on how the client actually responded and/or related to a particular intervention, assignment, topic, discussion, film, etc. during counseling activities (individual, group, psycho-ed, etc.) In addition, progress notes should always connect the various aspects and interventions in treatment back to the primary purpose of providing substance use treatment services.



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The Counselor's Interventions

Clinical interventions are creative methods and techniques counselors use to help the client make progress. In short, they are the action steps used on treatment plans to assist clients in reaching their goals. The progress notes should reflect which of the interventions (action steps) you are referring to. Describe specifically what the client is working on and what they have discovered or accomplished up to this point.

Client Responses

Suppose the intervention asked for the client to interview others in recovery and get suggestions for what to do if they have a craving to use. Be brief but specific about what information they were given. In other words, don't simply say, "Client reports he asked three men in his support group for recovery ideas." Document what he learned and/or experienced: "Client was given phone numbers and told to call if needed. Client felt hopeful that people cared." Or, "It was suggested to client for him to volunteer for service, because having a commitment helps people when they feel like using. Client is ambivalent about making that commitment at this point." As treatment progresses, continue to follow up with the client and enquire what they are following through with and document that progress in the notes. This is a relevant indicator of the client's process of change.

At the same time, don't feel like you have to report everything the client tells you. If the client got lost and was ten minutes late to the meeting – that would not be relevant to the treatment plan assignment.

Lack of Progress

There are times when clients do not follow through with the interventions on their treatment plans. Try to catch this as early as possible because it may be an indication that the client does not have a "buy-in" on the treatment plan. Or it could be that a new issue has surfaced that is more immediate for the client. Sometimes the client is confused about what they agreed to do and needs additional clarification or help organizing her/his plan.

When there appears to be lack of progress, be sure and document the particular issue in the notes along with how you are helping the client work through it. Always update changes in the client's SOC along with their progress or lack thereof.



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The progress notes are the record of your client's treatment experience. Progress notes tell the story of the treatment episode. As with any story, there must be enough detail to make the client come to life as a unique individual that is struggling to save his/her life.

Documenting Group/ Family Therapy

Even when a client is being seen in group or family, the client must have his or her own client record. The practice of writing one note for each group or family session and then placing a copy of that note in the chart of each client who participated in the session is not appropriate, even if each client is referred to only by his or her initials in the one note. Additionally, notes of group or family therapy that are placed in a client's record should be kept separate from, and written on a separate page than any notes relating to individual therapy sessions. In this manner, if a client's clinical record must be disclosed, this can be accomplished easily without disclosing information about other persons with whom he or she is receiving group or family therapy.

For documentation of a group or family therapy session, a note which reflects the information that should be documented in a general progress note as indicated above should be written and should be supplemented by addition of comments about the client's functioning in the group/family/couple session and his or her reactions and responses in the context of the group/family/couple process. **The progress/session note for each person in the group or family therapy, should focus on that individual's mental status, behavior, participation and functioning in the session, and their reactions and responses to the themes and processes that arose during the session. It should avoid, to the extent possible, mentioning any identifiable material from or about other particular members of the group, couple or family, unless this is necessary for clarity. In writing an individual group therapy note for each group member, only the name of the individual group member whose note is being written should appear in that note.**

In this regard, in the case of group therapy the number of clients attending the group session should be documented in the progress/session note, along with the initials of the other clients who attended. A separate attendance list of the clients in each group, by session (date of service) should be filed in a group therapy record folder so that there is a record of which clients attended which group and when.

Counselors have a tendency to just note that the client attended a group or watched a film or was part of the discussion of a particular topic. Phrases like "good participation", "participated actively", "attended and participated appropriately", etc. do not document progress or lack of progress, only that



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the client was there and apparently talking. Even a statement that the client “shared her triggers with the group” does not provide enough detail to evaluate progress or lack of progress. A far better note would state “Client demonstrated an understanding of her relapse triggers by sharing that rainy days and Mondays (or whatever) always bring her down and makes her feel like using.

Counselors may need to make a shift in order to accommodate each client and their specific treatment plan during group. One really good way to do that is to remind clients to consider how the group topic relates to their treatment plan and invite them to discuss that.

In addition to recording treatment plan progress based on individual and group sessions, it is also important to note significant clinical observations. Make sure to distinguish between observations and personal opinions or judgments.

Here is an example of a clinical observation: “Client appeared extremely angry in group; sat with fists clenched and rigid posture. When asked to talk, client refused.” An opinion or judgment by the counselor would be, “Client was hostile toward others and looked like he was ready to hit someone. Client probably drank last night.” Documenting clinical observations is important – documenting opinions and judgments is inappropriate.

Documenting the Treatment Plan

Instructor Note: Just a few words.....once the master treatment plan is formulated between you, the counselor and your client, ALL ROADS (NOTES) SHOULD LEAD BACK TO THE TREATMENT PLAN.

Treatment planning begins at the first encounter with the client. During the initial assessment and diagnostic formulation, identifying symptoms and a focus for treatment emerges. The treatment plan is a written document that identifies the target problem (the problem that will be the central focus of the current treatment efforts), the goal (the outcome that needs to be achieved to resolve the target problem, and an action plan (the specific steps that will be taken to resolve the problem and achieve the stated goal, an outcome evaluation that measures the level of completion of step of the action plan and the overall level of achievement of the stated goal.

Components of a treatment plan

Information gathered through a comprehensive assessment should be used to guide the negotiation of a treatment plan with the client. Problem areas and strengths should be clearly identified.



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The treatment plan should specifically address how each problem area will be managed. For each problem area, the treatment plan should specify the specific nature of the problem(s), the desired change (short- and long-term goals) and the means by which the goals will be achieved. It should also describe how the problem will be managed, including the type of treatment (e.g., group vs. individual counselling, the frequency of treatment contact, the provider(s) responsible for the treatment service and the time frame for re-evaluating treatment progress).

The treatment plan should prioritize problems requiring immediate focus and those of less urgency.

All major problems, once formulated, regardless of whether or not they will be addressed, should be documented in a formal treatment plan. If a decision is made not to address a major problem, the justification for this decision should be explained in the treatment plan.

Treatment planning as a collaborative process

Treatment plans should take into account the client's motivation to engage in counselling. Clients and counsellors need to collaboratively develop a treatment plan.

To foster a sense of individual responsibility, clients need to feel they control decisions about their treatment. This will also help clients to feel that their concerns are being addressed and help reduce client resistance to the counsellor's interventions.

- **Client goals:** State client goals, preferably in their own words. Clients may not be able to identify the specific issue and may state they just want to feel better. In these cases, attempt to assist the client in clarifying what would need to happen or change in order to meet the goal of "feeling better."
- **Recovery/Wellness goals/objectives:** From the identified symptoms and diagnostic formulation, specify the clinical goals/objectives for specific symptoms. For example, if a client presents with a history of relapse with untreated anxiety as an underlying cause, the goal is to reduce intensity and frequency of anxious feelings. This is where measurement of symptoms plays into the treatment plan. If the client reports feeling anxious 6 times per day at least 5 times per week at an intensity level of 5/6, the goal may be to reduce the frequency to 3 times per day not more than 3 times per week and to reduce intensity to not more than a 3.
- **Interventions and their focus:** How the clinician plans to reduce symptoms should be noted. Using the example of anxiety, interventions might include teaching stress-reduction techniques, identifying situation-specific triggers, and developing a mindfulness practice. If indicated, additional interventions may include referrals to external providers, such as a psychiatrist.
- **Duration and frequency of treatment/interventions:** Delineate a general plan for how often the client is expected to attend therapy, the duration of treatment required to address the



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symptoms, and issues in the treatment plan. This is usually assessed based on acuity, level of functioning, and specific client needs.

- Coordination of care: When other providers are directly involved in the care team or treatment of a client, document the names, agencies, contact information, and reason for coordination of care in the treatment plan. This may include a case manager at an outside agency, a psychiatrist or other prescriber, or a school therapist.
- Termination/discharge/transition plan: Planning for the achievement of treatment goals is an essential part of the overall conceptualization of treatment planning. Early focus on this part of the process supports a sense of purpose in the therapy and identifies the next steps, resulting in a feeling of progress and growth for the client.
- Additional notes: The signature and licensure of the clinician engaged in the treatment plan should be included at the end of the document along with the date of completion. The client should review and sign and date the plan as evidence of his or her participation, and a copy should be given to the client as well. If indicated, note any referrals given and include copies of signed and dated releases of information if collateral information will be requested from an outside provider, such as in coordination of care.
- Updates: When updates are made, include these changes in the treatment plan. This could include changes to diagnoses, new risk behaviors/situations, client strengths and resources, overall response to treatment, and modifications to measurable goals.

Documenting Client Discharges

Elements of an Appropriate Closing/Termination Summary

A closing/termination summary, which may be abbreviated or elongated depending on the circumstances of a particular case, documents the practitioner's thoughtful reflection on the clinical course of the client's treatment (to date in relation to an interval summary, or with regard to the entire period of treatment in relation to a closing/termination summary). Such summaries can be useful if the client later seeks treatment from another practitioner and requests that a summary be sent to that practitioner.

The documentation of a proper closing/termination summary includes:



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1. the dates the client was referred, first contacted the practitioner and was first seen, the referral source, and the time period covered by the summary (if this is a closing/termination summary, the date the client was last seen and the last contact with the client)
2. a synopsis of the initial reason for and background circumstance of the referral, the presenting problem(s) from the client's perspective at intake, the client's initial clinical presentation, and the initial assessment, including the initial diagnoses and initial identified problems as identified by the practitioner
3. a review of the problem areas and symptoms addressed in treatment, the treatment modalities used, of the client's clinical course in treatment during the treatment period in question (noting changes, if any, in the patient's symptoms, thinking, emotions, beliefs, behaviors and other areas of bio-psychosocial functioning), and of the extent that the identified symptoms/problems were resolved and the treatment goals established were achieved during the treatment period in question; a brief assessment of the client's condition at the end of the time period in question; and, if this is an interval summary, a notation explaining any changes in diagnosis, prognosis, or the treatment/service plan
4. a summary of any concurrent treatments, including the provider(s) of such treatments, the names and dosages of medications prescribed, other treatments rendered or any other relevant assessments performed; the steps taken to coordinate care with other practitioners (including the extent and success of achieving collaboration, or any problems that interfered with collaborative efforts), the results of any referrals made or testing ordered, and the impact/results of the other concurrent treatments
5. if this is a closing/termination summary, a statement regarding the circumstances of the termination of treatment (precipitants, was it planned or unplanned?, was it mutually agreed upon by client and the practitioner?, did the client stop coming and, if so, what steps were taken to address this and with what results)
6. if this is a closing/termination summary include final diagnoses and a statement as to the client's functioning, as well a statement as to which, if any, of the concurrent treatments (including medication) the client is receiving the client intends to continue whom and to what extent) and does not intend to continue (if so, what are the client's reasons for discontinuation of those services)
7. if this is a closing/termination summary include a statement detailing any referrals or recommendations provided to the client regarding further care, and the client's response to such referrals and recommendations



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8. if this is a closing/termination summary include a statement of whether the client poses a risk of decompensation, suicidality, assaultiveness, homicidality, relapse back to alcoholism or substance abuse, inability to care for himself or herself, of being victimized, of victimizing others, or is at any other serious risk at the time of termination/closing, the basis of the risk assessment, details of the steps taken to address any of these risks, and the results of such steps.

Discharge Summary – different description.....

As treatment comes to a close, the client will have met all of his or her goals and be moving on to either another level of care or no longer engaging in treatment. Although it gets little recognition as part of the overall treatment record, the discharge summary is the book end that supports all the documentation that has come before.

Generally, the format of the discharge summary will include the client's demographics, date of discontinuation of treatment, reason for discontinuation of treatment, a summary of treatment provided and the client's overall response (with specific reference to treatment goals), and notation about whether goals were met and to what degree. If treatment goals were not met, this should also be noted. Include any change to diagnoses and medications being taken at the time of discontinuation of treatment. Finally, include details about referrals made and any aftercare plans that were discussed and are part of the client's plan of action post-treatment.

Clinical Documentation Through the Eye of HIPAA

Instructor Note: LEARN IT, LIVE IT, PRACTICE IT!! Nothing else to say😊

The General Medical/Clinical Record Contrasted with Counseling Notes

HIPAA does not alter the requirements for clinical documentation and recordkeeping established by Florida State law, regulation and court decisions, as well as by federal statutes and regulations which govern the operation of certain federal health care benefit programs. The elements of clinical documentation noted above remain the standard for information that, consistent with the type of case, should be collected and recorded by behavioral health practitioners. However, HIPAA has made provisions for the way that some mental health related material may be recorded and organized in order to provide greater protection for the privacy and confidentiality of some of the material obtained during counseling sessions.



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The passage of HIPAA and the promulgation of the HIPAA Privacy Regulations have impacted on how some mental health information may be recorded and how mental health records may be organized. In this regard, HIPAA provided that counseling notes, “are held to a higher standard of protection because they are not part of the medical record and are never intended to be shared with anyone else.” Counseling notes are defined in the HIPAA Privacy Regulations as, “notes recorded [in any medium] by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Counseling notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.”

HIPAA does not require mental health practitioners to keep “psychotherapy notes,” as defined above. It merely provides that if a mental health practitioner maintains notes of the information covered in the definition of “psychotherapy notes,” and maintains those notes physically separate from the patient’s general medical/clinical record [which general medical/clinical record is required to be maintained under Florida State laws and regulations and the regulations governing various federal health care benefit programs], those notes are subject to special confidentiality protections.

Under HIPAA regulations, a behavioral health provider who is a covered entity under HIPAA must obtain an authorization for any use or disclosure of counseling notes, to carry out treatment, payment or health care operations,

except for.....

(a) use by the originator of the counseling notes [the treating therapist who created the notes] for treatment,

(b) use or disclosure by the covered entity for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or

(c) use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the patient.



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Also, a health plan may not condition the enrollment of the client in the plan or a client's eligibility for plan benefits on receiving an authorization from the client for disclosure to the plan of the client's counseling notes.

The HIPAA dichotomy between the general medical/clinical record and psychotherapy notes is not inconsistent with Florida State's recordkeeping and clinical documentation requirements for health care providers. The information that is kept in the general medical/clinical record, is material that is necessary to assure continuity of care if the provider is not or will no longer be available, and to fully document the extent of care, services and supplies furnished. This includes: diagnoses (including the details of the client's history, clinical course, symptoms and functioning needed to support the diagnoses); details regarding the client's history, symptoms and functioning needed to document the client's clinical course during treatment; the therapeutic interventions used and the client's response to them; the identified problems that are the focus of the treatment plan; the evolving short-term goals and long-term objectives of treatment in terms of improving mental, emotional, behavioral, and physical functioning, addressing and resolving bio-psychosocial issues, symptoms and dysfunction, and addressing the impact of and resolving various types of events in the client's life history; and, prognosis (including the details of the client's history, clinical course symptoms and functioning that support the prognosis). Additionally, the general medical/clinical record includes results of tests and consultations, clinical information obtained from other providers, and material gained through collateral contacts.

Counseling notes document the actual detailed, highly personal and private material elicited in the therapy or counseling session, which information the client never intended to be shared with anyone else, and the therapist's analysis of that material. This material is often helpful to the therapist in treating the client over time, but is not necessary to assure continuity of care in the absence of the counselor/therapist. This material is also not necessary to document adequately the client's diagnosis and prognosis and the basis of those assessments, the evaluation and treatment of the client, the services provided, the necessity of those services, and the treatment plan, all of which can be accomplished using the information contained in the general medical/clinical record.

Organizing the Client Record

The client record should be organized into various sections. This has been and remains the manner in which records are kept in hospitals, clinics and other health care agencies, as contrasted with the



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manner in which records have been kept in individual practices, particularly by behavioral health practitioners.

With the introduction of electronic records some of the following information will not pertain to everyone. Those counselors who work for facilities that have electronic health records must follow all the same documentation standards, requirements etc. Regarding keeping these electronic records safe – the counselor must lock their computer when they leave their office or walk away from their desks even for a “minute”. This ensures no one can access personal health information (PHI) of any client, even if they work for the same agency. Disclosure of client information is always on a need to know basis.

The information in the following paragraph will not apply to electronic client records.

The practice of maintaining patient records in spiral notebooks, loose-leaf binders, or composition [bound] notebooks, either one for each client, or combining client records on various pages of the same notebook is inappropriate. Each client should have his or her own record maintained in a file folder (preferably one which has fasteners) exclusively for that client. The reason for using folders is that the clinical record should be arranged in sections and can be easily secured in a locked filing cabinet. Using spiral or bound notebooks makes it difficult to keep materials received in the client’s clinical record.

42 CFR Part 2

TAP 21 Competency: Protect client rights to privacy and confidentiality in the preparation and handling of records, especially in relation to the communication of client information with third parties.

Instructor Note: LEARN IT, LIVE IT, PRACTICE IT!! Nothing else to say☺ AGAIN!

Just about anyone who has ever received medical care has heard of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the law that regulates the use and disclosure of Protected Health Information (PHI) held by "covered entities" such as health plans. But far fewer are familiar with the special privacy protections afforded to alcohol and drug abuse patient records by 42 Code of Federal Regulations (“CFR”) Part 2.



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The privacy provisions in 42 CFR Part 2 were motivated by the understanding that stigma and fear of prosecution might dissuade persons with substance use disorders from seeking treatment. To add an extra layer of protection on these records, the regulations outline under what limited circumstances information about a patient's treatment may be disclosed with and without the patient's consent. Who and what are covered can be confusing, though.

The Legal Action Center has developed some handy-dandy FAQ's for the [Substance Abuse and Mental Health Services Administration](#). Here is the summary of them:

- 42 CFR Part 2 applies to any individual or entity that is federally assisted and holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment (42 CFR § 2.11). Most drug and alcohol treatment programs are federally assisted. For-profit programs and private practitioners that do not receive federal assistance of any kind would not be subject to the requirements of 42 CFR Part 2 unless the State licensing or certification agency requires them to comply. However, any clinician who uses a controlled substance for detoxification or maintenance treatment of a substance use disorder requires a federal DEA registration and becomes subject to the regulations through the DEA license.
- The regulations restrict 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 apply to any information disclosed by a covered program that "would identify a patient as an alcohol or drug abuser ..." (42 CFR §2.12(a) (1)). In laymen's terms, the information protected by 42 CFR Part 2 is any information disclosed by a covered program that identifies an individual directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a covered program.
- With limited exceptions, 42 CFR Part 2 requires patient consent for disclosures of protected health information even for the purposes of treatment, payment, or health care operations. Consent for disclosure must be in writing.

Concluding Instructor Note

*Understanding the basic function and purpose of clinical documentation is important. However, learning to write quality clinical notes is an **ART** that takes time and practice. Becoming adept at this art puts you ahead of the game, **EVERYONE** benefits from a counselor who is really good at forming clinical observations and then accurately documenting those observations for the treatment team to*



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read and use in providing clients with best, strength-based, focused individualized treatment possible.

Clinical notes are, however, more than a mere jotting of information derived from clinical sessions. They are structured legal documents with a basis in state and federal law, a legal record of treatment, and a reference point for treatment interventions and progress validating the need for treatment.

Developing quality clinical documents involves determining local, state, and federal laws that apply to your specific practice setting and developing standardized forms that adhere to the applicable laws and guidelines. Clinicians should keep clinical content concise, neutral, and specific (e.g., measurement of symptoms) and adhere to level-of-care guidelines (medical necessity). It is important to ensure continuity of content between documents throughout the assessment and treatment process.

Remember, like anything else in life that is new.....practice makes perfect. Find practice case studies and write mock progress notes, treatment plans, integrated summaries, group notes and discharge summaries. The more you practice the better and more effective you will be.

Happy documenting ☺

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Aggression Management & Verbal De-Escalation

Overview And Objectives

The ability to effectively handle aggression is a crucial skill for someone working in Behavioral Health. Self-management and assertive communication are two key components to verbal deescalation.

This course will explore identifying, preventing and managing aggressive behavior through the use of verbal de-escalation interventions.

Introduction

Aggression

In psychology, the term aggression refers to “a range of behaviors that may result in both physical and psychological harm to oneself, others or objects in the environment.” The expression of aggression may occur in a variety of ways including verbally, mentally and physically. (Cherry, K. (n.d.) aboutpsychology.com)

Verbal De-escalation

Verbal de-escalation is a targeted, non-physical, intervention used with clients to diffuse, redirect, or de-escalate a conflict situation. The technique of verbal de-escalation uses calm language, along with other communication skills during a potentially threatening or dangerous situation in order to prevent an individual from causing harm to self, others, or the environment.

Aggression and Behavioral Health

As behavioral health workers, we interact closely with clients and their families. On many occasions, these interactions occur under difficult circumstances, possibly due to the client’s illness, personal issues, medication, or history of violent behavior. Violent and/or aggressive behavior from a client is common in the behavioral health field and staff members are often required to diffuse crisis situations. The ultimate goal is to provide an environment that is safe for both clients and staff members.

It is important to remember that the client’s interests and needs always come first. As behavioral health workers, we need to recognize that the aggressor is often feeling threatened, anxious, or fearful, and will respond even more aggressively if he/she feels threatened.



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When the need to manage aggression arises, keep in mind it is beneficial to be genuine and authentic in order to build rapport with a client. The way we treat the client will influence how they respond to our de-escalation strategies. The majority of potentially violent situations can be diffused successfully through the use of effective communication techniques. Our goal as behavioral health workers is to remain calm and confident in our interactions with the escalated client, with hopes that he/she will respond positively to our respectful, assertive techniques.

Signs of Aggression

Possible signs of aggression to watch out for include:

- Easily or often angered
- Making threats of violence
- Intimidating others
- Drastic change in personality
- Red/flushed face/perspiring
- Standing tall
- Clenched fists
- Rapid breathing/pacing
- Direct, prolonged eye contact
- Exaggerated gestures
- Narrowing of the gaze
- Tight jaw/facial muscles
- Raised voice

Possible reasons clients become aggressive include:

- Frustration
- Immaturity
- Humiliation
- Excitement
- Learned Behavior
- A means to an end
- To assert dominance
- To intimidate or threaten
- To express possession



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- Unfairness (perceived or real)

When dealing with an aggressive client, consider the factors that may be contributing to the individual's aggression (risk factors) such as:

- Is the person facing a high level of stress? (e.g. recent bereavement, pending court issues)
- Is the person under the influence of substances or coming off substances?
- Does the person have a history of violence?
- Does the person have a history of psychiatric illness?
- Does the person have a history of violence or verbal abuse toward staff in the past?
- Has the person suffered a significant loss or frustration (e.g. losing a pass or parental rights)
- Has the person received a warning about their behavior?
- Does the person believe they have been treated disrespectfully?
- Has the person failed to receive a privilege they expected or counted on?
- Does the person have a hostile relationship with another client?

Effective Verbal De-Escalation

According to John Lundholm (2007), effective verbal de-escalation of aggression is built on five key strategies:

1. Self-management
2. Situational awareness (managing the stages of conflict)
3. Non-verbal communication
4. Listening (active and empathetic)
5. Assertive verbal communication

Self-management

In terms of managing our clients and their aggression, we need to first look at ourselves and the way we manage and express our emotions. Behavioral Health can be a very challenging and overwhelming environment to work in. At times, stressful situations arise in the workplace and how you choose to handle these situations is of the utmost importance. The choices we make in managing our emotions and responding to situations greatly influence the workplace environment. Most importantly, our choices and our behavior influence our relationships and rapport with clients.

“Everything can be taken from a man but the last of human freedoms – the ability to choose one's



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attitude in a given set of circumstances, to choose one's way." – Viktor Frankl, "Man's Search for Meaning."

When working with our clients, we must strive to:

- Appear calm
- Be present
- Have relaxed muscles
- Look confident
- Be open and receptive
- Abstain from judgment
- Use a calm monotonous voice
- Be respectful and assertive

Situational Awareness

Situational awareness involves being aware of what is happening around you in order to understand how information, events, and one's own actions will impact goals and objectives, both immediately and in the near future. ("Situational awareness". (n.d.), para. 2, In Wikipedia) It is important to be aware of factors in the environment, in the client, and in the staff that can escalate the risk of violence. Awareness allows you to predict what is likely to happen next and what action you need to take. The more awareness you bring to a situation, the better equipped you will be to make smart and safe decisions. It is important to take responsibility for your own safety and security, as well as that of your peers. Listen to your gut and your intuition at all times, even when you are busy or distracted.

In a crisis situation, ask yourself the following questions to perform a quick self-assessment:

- Do I need to call for help from co-workers?
- Can I avoid criticizing and finding fault with the angry person?
- Can I avoid being judgmental?
- Can I keep myself removed from conflict?
- Can I see the situation from the angry person's point of view or understand the need he/she is trying to satisfy?
- Can I remember that my job is to keep the peace and protect the client and staff?

Non-verbal Communication



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It is important to recognize that a large part of communication is non-verbal; therefore, our facial expressions, gestures, eye contact, posture, and tone of voice can speak the loudest. In order to be an effective communicator it is essential to be aware of your own non-verbal signals and body language. Below are some descriptions and tips for non-verbal communication:

- **Space and Positioning**—It is important to remember that the amount of space required to feel comfortable differs based on gender, familiarity, culture, mood, etc. We all have our comfort level when it comes to personal space. Space can be used to communicate aggression or dominance. Standing too close to an angry individual can make him/her feel unsafe and, in turn, make YOU unsafe. Always position yourself to be at the same eye level as the client—if they are sitting, you sit—if they are standing, you stand. When standing, stand at angle from the individual—if you stand directly in front of a client they may feel more threatened and boxed in. Avoid standing too close to the person—a “kickdistance” is an appropriate gauge. Never turn your back to the client, as this can communicate that you don’t care what the person has to say or you can get hurt because you will not be aware of your surroundings. Position yourself closer to the room entrance than the escalated client—do not physically back yourself into a corner.
- **Facial Expressions**—Be aware of your facial expressions. Your facial expressions and non-verbal signals can affect how a client will respond to you and their willingness to trust you. Be careful not to smile or laugh when re-directing a client as this will most likely escalate the client further.
- **Eye Contact**—The way we look at a person can communicate many different things such as anger, affection, and sadness. Staring at someone can cause them to feel anxious or uncomfortable. However, we need to use our eyes to express interest in what people are saying and communicating, so it is important to keep good eye contact without appearing confrontational. We must also keep in mind cultural differences when it comes to eye contact. Knowing a culture’s norms can help you sharpen your non-verbal communication skills by teaching you to pick up on or use different facial or body language signals.
- **Voice Tone**—Certain voice tones can disturb some people and cause their aggression levels to rise. Pay attention to your tone and inflection—it’s not what you say it’s how you say it. Keep your voice calm and even, do not sneer, scowl, yell or sigh in exasperation.
- **Body Movements and Gesture**—Be aware of your own body language; keep an open stance, with your arms down at your side. Try to keep movements slow and calm. Be aware of your hand and arm movements as to not make gestures that could be perceived as threatening. Keep your hands out of your pockets and where they can be seen at all times—keep them in front of you, open and relaxed. Do not cross your arms or point your finger at the individual.



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Listening

Active listening is the primary strategy for diffusing anger and aggression. Most people prefer to resolve conflict through communication and cooperation, rather than through aggression. People desperately need to be heard, and active listening keeps the lines of communication open. Active listening involves supporting positive conversation, acknowledging the other person's point of view, repeating back what they said in your own words, and showing empathy. Sometimes all an angry person needs is for someone to take the time to allow them to vent his/her anger and frustrations. Active listening is attempting to hear, acknowledge and understand what a person is saying (listening not only to words, but also to the underlying emotion as well as to body language). The objective of active listening is to build trust, collect relevant information, and diffuse any anger.

Steps to Active Listening

In order to actively listen to others take the following steps:

- Sit or stand with a receptive posture (do not slump your shoulders, be open with posture, do not cross arms in front of our chest as this will display a closed off approach).
- Look at the speaker—this will show that you are listening to them and not looking at your cell phone or distractions around you. Nod to let the client know you are acknowledging them.
- Let the speaker know you are listening (facial and verbal). Smile if appropriate to show them you are listening; be conscious of your facial expressions. Do not roll your eyes.
- Paraphrase, summarize and repeat back what you've heard for accuracy—this will allow you to repeat what the client said and understand what they are telling you. This will help prevent miscommunication.
- Ask for more information if needed —ask questions as this can be encouraging to the client and you can get a clarification of their point of view and what happened.
- Allow the speaker to confirm accuracy—wait for the client to confirm that you understood what they stated.
- Allow silence —although you may find the silence unbearable, sometimes the escalated person may need time to reflect or think. We need to allow the other person silent time to reflect and collect their thoughts, and often they come up with their own solutions!
- Agree —frequently, when people are angry about something, there is at least some truth in what they are saying. When attempting to diffuse a client's anger, it is important to find that truth and validate their feelings.
- Apologize —sincerely apologizing for anything in the situation that was unjust or unfair



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allows for a client to feel heard and validated and can assist in de-escalation.

Invite criticism —simply ask the escalated person to voice his/her concerns of the listener

(What am I doing wrong that makes you so angry at me? Tell me, I want to hear everything you are angry about.)

Assertive Verbal Communication

There are major differences between aggressive and assertive communication.

- Aggressive Communication is based on winning and initiating hostility. Aggression is acting without regard for the rights, needs, feelings, or desires of others. An individual with an aggressive style of communication may be perceived as a bully who disregards the needs, feelings, and opinions of others. Very aggressive people humiliate and intimidate others and can be physically threatening.
- Assertive Communication is based on balance and mutual respect. It requires being forthright about your wants and needs while still considering the rights, needs, and wants of others. Being assertive means being confident, direct and respectful. Guidelines for assertive communication include:
 - Use “I” statements—such as, “I feel”, “I want”, “I would like” – this shows that the speaker is taking responsibility for their own feelings.
 - Be empathetic—recognize what the person may be experiencing, “I understand you’re having a tough time...”
 - Give choices—give choices so the client still can feel they have control.
 - Broken record technique—repeat the request if needed in the same way every time until they understand.
 - Be clear and set reasonable limits.
 - Describe to the client the nature of the interaction you are having in a non-positional way. For example: “I am noticing that we are both getting a little tired and frustrated. I am not sure how we can move on or resolve this. What do you think?”
 - Be aware of your body language, tone of voice and words, as you don’t want to sound confrontational. While it is important to communicate your viewpoint, it is important to do so in a way that refrains from personal attack. When we speak in a nonaggressive manner/tone, we encourage others to shift their behavior and do the same.

Staff Preparedness

All staff need to be prepared to manage aggression. Tips to remember include:



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- Recognize early warning signs of aggressive behavior
- Take all threats seriously
- Report abnormal client behavior to other staff members
- Follow established rules and procedures
- Treat all clients equally—do not show favoritism
- Always treat clients with respect
- Do not speak in a loud or aggressive tone of voice
- Validate client requests, frustrations, and angry feelings

When faced with an aggressive situation seek to:

- Do a quick self-assessment and assessment of situation.
- Call other staff for assistance if needed.
- Appear confident and calm and don't take things personally.
- Create some space and check your surroundings for any potential objects that could be used as weapons.
- Avoid audiences when possible. When someone is acting up, ask the other clients to leave the area or, if possible, ask the agitated client to move to another location where they can express themselves without their peer involvement.
- Show that you are listening.
- Be careful of your assumptions about the escalated client.
- Speak slowly, gently, and clearly—lower your voice tone.
- Avoid staring, arguing, or confrontation.
- Calm the person and assure he/she feels heard before trying to solve the problem.
- Keep both hands visible so the client doesn't misinterpret your actions.
- Avoid sudden movements that may startle or be perceived as an attack.
- Avoid threats and, instead, explain your purpose or intention.
- Move towards a safer place (avoid being trapped in a corner).
- Never touch the client as they may take this as an aggressive action.
- Be aware of transference and counter-transference reactions.

Have a plan ready for when you need it. Think about options and actions you could take before such a circumstance occurs. Decisions made before a crisis occurs are more likely to be effective than those thought of “on the fly”. There may be occasions, particularly with the mentally ill, when the listener is unsuccessful. Your safety and the safety of others should always be your primary concern.



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De-escalation is a very difficult and humbling skill. You must maintain self-awareness. You must be able to control your own anger. You must be able to see the bigger picture. You must be willing to practice what you've learned.

Barriers to Effective Communication

In order to minimize communication problems:

- Use language appropriate to the person (use interpreter when necessary)
- Take time to communicate
- Confirm that you are understood
- Encourage and give feedback
- Communicate at an appropriate time and place (whenever possible)

There are many barriers to effective communication the most common of which include:

- Noise—it is hard to hold a conversation against a noisy background.
- Language—be careful of using jargon and avoid emotive language (words used deliberately to create an emotional impact or response). Express yourself in a direct manner. If there is a language barrier, seek assistance from other staff members or an interpreter.
- Perception and prejudice—everybody has a unique background and history with influences and experiences that form our way of looking at the world. Recognize your prejudices and work around prejudices of others. Maintain a professional attitude (do not allow our perceptions, personal opinions or prejudices to get in the way of duties and responsibilities to others).
- Intrusion of personal space—have you ever felt uncomfortable when someone stands a little too close? Remember that everyone has different preferences for personal space that a person needs to feel comfortable which can sometimes depend on one's culture and personal history. Be aware that being inappropriately far apart can also be uncomfortable.
- Power struggles—avoid getting into power struggles with clients. Work together with the person, not against them.
- Cultural Sensitivity—Culture can be defined as behaviors, beliefs, and values that are shared by a group of people. Each culture has its own unique rules, customs and ways of living life. Therefore, language is not always interpreted the same way for everyone. We need to be careful of our beliefs and personal assumptions when interacting with clients.



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- Culture affects many aspects of a person's life. For example, the way conflict is dealt with can be determined by one's culture/belief system. Mental health providers need to be aware of the influence that culture has on mental illness and communication.
- According to Saldaña, D. (2001), The following issues are to be considered when working with a diverse group of people:
- Don't assume the individual is proficient in the English language. The individual may interpret your words or phrases differently.
- In the United States it is common for people to stand about 3 feet apart when having a personal conversation. In other cultures, people may typically stand closer, which may feel awkward to someone unfamiliar with this style.
- In the United States, individuals are encouraged to look each other directly in the eye. In other countries or cultures, people may show respect by not looking directly into someone's eyes when communicating.
- Most Americans expect a conversation to take turns, but in other cultures it may be typical for several people to talk at once.
- Hand and arm gestures can be interpreted differently with various cultures.
- Facial Expressions – Can vary with different cultures so don't assume you know what someone is feeling based on their facial expressions.
- Silence – Some cultures may use silence often during a conversation.
- Touching – Varies from culture to culture, can be viewed as intrusive for one culture or viewed as aloof by another culture if you don't touch when speaking to someone. (Saldana, D., 2001)

Stages of Crisis Management

Danskin, E.(2013) defines the following as the four stages of Crisis Management:

1---Anxiety Level

During this stage you may notice a change in the client's behavior or energy. The recommended response to the client at this stage is one of support and empathy. It is important you demonstrate active listening and abstain from judgment.

2—Defensive Level

At the defensive stage the client experiences loss of rationality. The client will give cues both verbal and non-verbal indicating they are beginning to lose control and may challenge



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you and push buttons. They may not respond to words, but will be paying attention to your tone, posture and position.

The recommended response to an escalated client during this stage is “assertive and directive.” You must set clear behavioral limits, be directive, professional and respectful at all times. The limits you set must be clear, simple and enforceable. Inform the client of the potential positive or negative consequences of his compliance/non-compliance with your direction and empower him/her to make a wise behavioral choice. It is important to remember you are there to enforce the consequences of the individual’s choice, not to make the person choose one option or the other.

According to The Provincial Violence Prevention Curriculum, Effective Limits are:

- Specific
- Achievable
- Realistic
- Enforceable

In order to effectively set limits:

- Validate the client’s concerns
- Describe the behavior you want to change
- Explain why you want the behavior to change
- Describe the benefits of changing their behavior
- Describe the negative consequences of continuing their behavior
- Whatever they decide to do—your role is to follow-through on the benefits or negative consequences in a realistic timeframe.

Limit setting may not always work but you need to try it. This makes the client aware of the consequence before you enforce it and gives them the power to choose.

Example: “I know you are really upset right now, if you could lower your voice we can take a walk and talk about what happened.” “If you continue to yell, and disrupt the clients in group therapy and I will have to call for help.”

3—Acting Out

During the acting out stage the client loses control and verbal aggression turns into physical assault or



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damage to property. As the professional, it is important that you know your company's safety policy and procedure to be used when a client loses control.

4—Tension Reduction

At this stage, the client comes down from the peak of energy output, often going from explosive to withdrawn. The client may feel remorseful, fearful, or ashamed. This is the start of control or regaining rationality. The act of "going out of control" is even more frightening to the individual than to the staff. At this point the staff needs to use therapeutic skills, communicate and build rapport, assisting the client to gain equilibrium. (Danskin, E., 2013)

Summary

Verbal de-escalation is used when we need to calm a person down as we come face to face with someone who is frustrated and/or angry. The methods used are non-physical, instead we utilize effective communication skills. The goal is to prevent the situation from becoming worse or lead into aggressive/physical behavior. Effective communication will improve trust between clients and staff, increase safety and improve overall morale.

As a professional in Behavioral Health, know your limits. Sometimes the best thing for you and the client is for someone else to take over the intervention. Look out for your peers and be a supportive member of the team by assisting a co-worker in an intervention when necessary. Remember to debrief with co-workers and supervisors after an incident occurs. Discussing the incident that occurred, why it occurred and any improvements that could be made with the intervention, helps to plan for future incidents and improves staff communication and cohesion.

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Suicide and Self-Harm Training

What you will learn:

- The difference between suicide and self-harm
- The similarities between suicide and self-harm
- Are the risks increased for suicide when someone has a history of self-harm?
- The correlation between suicide and mental health diagnosis
- The correlation between self-harm and mental health diagnosis
- Suicide, Self-Harm and Eating Disorders
- Statistics about current suicide rates according to age, race, gender, etc.
- Correlation between self-harm and addiction
- Correlation between suicide and addiction
- How to we make a difference
- How to do a good assessment for suicide
- How to prevent suicide
- How to treat suicidality
- How to assess for self-harm
- How to treat self-harm
- What time of the day do the most suicides occur?
- What month of the year do most suicides occur?

Introduction

“The beeper next to my bed went off at 1:30 a.m. When I called the number, my supervisor said that my client was trying to kill herself. She was on the Canadian side of the Niagara Falls where she deliberately climbed over a railing, walked down a few feet and stood there, 100 feet above the Niagara River. Police cars, firefighters, ambulances, and a crowd of people stood in the dark, watching to see what happens. Does somebody save her? Is she willing to jump? Will she climb back up? She was a librarian, intelligent, with a dark sense of humor colored by an unrelenting, depressive episode lasting over a decade. Before I started my car, I received a phone call that first line responders talked her off the ledge. She would attempt suicide two other times before I left the clinic and moved to another state. Every once in a while those of us who worked at the clinic run into each other and when her name is mentioned, there is agreement that she is probably dead.”



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Nearly everyone at some time in his or her life thinks about suicide. Most everyone decides to live because they come to realize that the crisis is temporary, but death is not. On the other hand, people in the midst of a crisis often perceive their dilemma as inescapable and feel an utter loss of control.

Frequently, they:

- Can't stop the pain.
- Can't think clearly
- Can't make decisions.
- Can't see any way out.
- Can't sleep, eat, or work.
- Can't get out of the depression.
- Can't make the sadness go away.
- Can't see the possibility of change.
- Can't see themselves as worthwhile.
- Can't get someone's attention.
- Can't seem to get control.

Suicide is newsworthy because life is precious. In 1993, a 6-year old girl living in Florida stepped in front of a train. She left a note saying that she "wanted to be with her mother" who recently died from a terminal illness. This is the power of the human mind. A girl in Kindergarten thinks of the past and imagines a future that is so bleak, so devoid of meaningful moments without her mom, that she takes her own life. The same mental tools that distinguish us from other animals, the same mental tools that allow us to solve problems and produce creative works that give us symbolic immortality are the same tools that allow a 6-year old to contemplate a future that is terrible enough to physically leap into an oncoming train. If a 6-year old has the cognitive capacity to kill herself, then we need to step up our efforts to understand and prevent it from happening. **So, what do we do? What helps? What doesn't help?**

History teaches us that sometimes that it is the small things that make a big difference

In Great Britain Suicides were reduced rate dropped by one third after removing coal gas in favor of natural gas. How can this be? After all, if the impulse to suicide is primarily rooted in mental illness and that illness goes untreated, how does merely closing off one means of self-destruction have any lasting effect? At least a partial answer is that many of those who asphyxiated themselves did so impulsively. In a moment of deep despair or rage or sadness, they turned to what was easy and quick and deadly — "the execution chamber in everyone's kitchen," as one psychologist described it — and



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that instrument allowed little time for second thoughts. Remove it, and the process slowed down; it allowed time for the dark passion to pass. **The British gas conversion proved that the incidence of suicide across an entire society could be radically reduced, upending the conventional wisdom about suicide in the process.**

In Northwest Washington stands a pretty neoclassical-style bridge named for one of the city's most famous native sons, Duke Ellington, Running perpendicular to the Ellington, a stone's throw away, is another bridge, the Taft. Both span Rock Creek, and even though they have virtually identical drops into the gorge below — about 125 feet — it is the Ellington that has always been notorious as Washington's "suicide bridge." By the 1980s, the four people who, on average, leapt from its stone balustrades each year accounted for half of all jumping suicides in the nation's capital. The adjacent Taft, by contrast, averaged less than two.

After three people leapt from the Ellington in a single 10-day period in 1985, a consortium of civic groups lobbied for a suicide barrier to be erected on the span. Many argued that barriers really don't work. In the Ellington's case, opponents had the added ammunition of pointing to the equally lethal Taft standing just yards away: if a barrier were placed on the Ellington, it was not at all hard to see exactly where thwarted jumpers would head. Except that they were wrong. A study conducted five years after the Ellington barrier went up showed that while suicides at the Ellington were eliminated completely, the rate at the Taft barely changed, inching up from 1.7 to 2 deaths per year. What's more, over the same five-year span, **the total number of jumping suicides in Washington had decreased by 50 percent**, or the precise percentage the Ellington once accounted for.

Impulsivity

What makes looking at jumping suicides potentially instructive is that it is a method associated with a very high degree of impulsivity, and its victims often display few of the classic warning signs associated with suicidal behavior. In fact, jumpers have a lower history of prior suicide attempts, diagnosed mental illness (with the exception of schizophrenia) or drug and alcohol abuse than is found among those who die by less lethal methods, like taking pills or poison. **Instead, many who choose this method seem to be drawn by a set of environmental cues that, together, offer three crucial ingredients: ease, speed and the certainty of death.** The difference between the two bridges was simple. The concrete railing the Taft Bridge stands chest-high while the pre-barrier on the Ellington Bridge came to just above the waist. Jumping from either would be lethal, but one required a few more seconds of thought a just a little bit more time and effort.

Richard Seiden, a professor emeritus and clinical psychologist at the University of California at Berkeley School of Public Health, is probably best known for his pioneering work on the study of suicide. Seiden set out to test the notion of inevitability in jumping suicides. Obtaining a Police Department list of all



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would-be jumpers who were thwarted from leaping off the Golden Gate between 1937 and 1971 — an astonishing 515 individuals in all — he painstakingly culled death-certificate records to see how many had subsequently “completed.” His report, “Where Are They Now?” remains a landmark in the study of suicide, for what he found was that just 6 percent of those pulled off the bridge went on to kill themselves. Even allowing for suicides that might have been mislabeled as accidents only raised the total to 10 percent. “That’s still a lot higher than the general population, of course. **But, the more significant fact is that 90 percent of them got past it. They were having an acute temporary crisis, they passed through it and, coming out the other side, they got on with their lives.**”

A crucial factor in suicide is that it boils down to the issue of time. In the case of people who attempt suicide impulsively, cutting off or slowing down their means to act allows time for the impulse to pass — perhaps even blocks the impulse from being triggered to begin with. What is remarkable, though, is that it appears that the same holds true for the non-impulsive, with people who may have been contemplating the act for days or weeks.

What this means to us as Clinicians and Professionals in the field is that slowing down, limiting access to means, interrupting the process somehow, actually prevents suicide. If 90% of the people who were “interrupted” from their suicide attempt by jumping off of the Golden Gate Bridge and then did not make another attempt, then installing a couple of minutes maybe even hours or days between the thought and the attempt, can and does save lives.

“At the risk of stating the obvious,” Seiden said, “people who attempt suicide aren’t thinking clearly. They might have a Plan A, but there’s no Plan B. They get fixated. They don’t say, ‘Well, I can’t jump, so now I’m going to go shoot myself.’ And that fixation extends to whatever method they’ve chosen. They decide they’re going to jump off a particular spot on a particular bridge, or maybe they decide that when they get there, but if they discover the bridge is closed for renovations or the railing is higher than they thought, most of them don’t look around for another place to do it. They just retreat.” Seiden cited a particularly striking example of this, a young man he interviewed over the course of his Golden Gate research. The man was grabbed on the eastern promenade of the bridge after passers-by noticed him pacing and growing increasingly despondent. What was the reason? He had picked out a spot on the western promenade that he wanted to jump from, but separated by six lanes of traffic, he was afraid of getting hit by a car on his way there.”

In a therapeutic setting, it is vital that we engage clients quickly, build a solid rapport, get to truly know them and evaluate for risk factors. We know that substance abuse has a high correlation with suicidality and that substance abuse is the ultimate in self-harm and



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is often suicidal in nature. We must use our treatment and medical team resources effectively and promptly whenever we have a client who has a prior history of suicide attempts or intent. This is also true for those who self-harm.

Despite our best efforts at suicide assessment and treatment, suicides can and do occur in clinical practice. Approximately 12,000-14,000 suicides occur per year while in treatment.

Facing the Facts

- In 2009, 36,909 people in the United States died by suicide. About every 14.2 minutes someone in this country intentionally ends his/her life.
- Although the suicide rate fell from 1992 (12 per 100,000) to 2000 (10.4 per 100,000), it has been fluctuating slightly since 2000 – despite all of our new treatments.
- Suicide is considered to be the second leading cause of death among college students.
- Suicide is the second leading cause of death for people aged 25-34.
- Suicide is the third leading cause of death for people aged 10-24.
- Suicide is the fourth leading cause of death for adults between the ages of 18 and 65.
- Suicide is highest in white males over 85.
- The suicide rate was 12.0/100,000 in 2009.
- It greatly exceeds the rate of homicide. (5.5/100,000)
- From 1981-2009, 901,180 people died by suicide, whereas 463,942 died from AIDS and HIV-related diseases.

Death by Suicide and Psychiatric Diagnosis Psychological autopsy studies done in various countries over almost 50 years report the same outcomes: 90% of people who die by suicide are suffering from one or more psychiatric disorders:

- Major Depressive Disorder
- Bipolar Disorder, Depressive phase
- **Eating Disorders**
- Alcohol or Substance Abuse* *Primary diagnoses in youth suicides.
- Schizophrenia
- Personality Disorders such as Borderline BPD
- 42% had 2 or more Axis I Diagnosis
- 31% had Axis I and Axis II Diagnosis
- 50% had Axis I and at least one Axis III Diagnosis

Eating Disorders and Suicide

Suicide is one of the major causes of premature death in eating disordered (ED) patients (Berkman et al, 2007; Bulik et al, 2008; Foulon et al, 2007; Pompili et al, 2006) and the dominant cause of death among ED patients who die from non-natural causes (Møller-Madsen et al, 1996). Harris and Barraclough (1997) reported the suicide mortality rate among both anorexics and bulimics to be 23 times higher than that of the general population, placing the rate of suicide among ED patients among the highest of all psychiatric disorders.

Sullivan (1995) derived a crude rate of mortality (5.9%) due to all causes of death for individuals with Anorexia Nervosa (AN). This author analyzed 38 studies in which the cause of death was specified (N=164), and found that 89 (54%) of the deaths could be attributed to complications of the eating disorder, 44 (27%) to suicide, and 31 (19%) to unknown or other causes. The suicide mortality rate in people with AN is one of the highest of all psychiatric illnesses (Holm-Denoma et al, 2008; Kaye, 2008; Keel et al., 2003) with the risk of death by suicide in AN subjects calculated as high as 57 to 58 times the expected rate in similar age and gender populations (Herzog et al, 2000; Keel et al., 2003; Pompili et al, 2006). Because of this extremely high rate of suicide, suicide is a more likely cause of death in a current AN sufferer than are complications from the disorder.

Nonfatal suicidal behaviors (suicide attempts), as one might expect, also occur at significantly elevated rates among these patients, with the lifetime prevalence of suicide attempt found to be as high as 26% (3-20% of AN patients and 25-35% of Bulimia Nervosa [BN] patients: Franko et al, 2006; Milos et al, 2004). In an earlier report Favaro et al (1997) found the rate of attempt to be lower, 13%. Bulik et al (2008) found that 16.9% of 432 AN patients (mean age = 30.4) had a history of suicide attempts with attempts being more common among purging AN patients (26.1%), binge eating patients (24.3%) and mixed AN/BN patients (21.2%) than among restricting subtypes (7.4%). Franko et al (2004) conducted a prospective study over 8.6 years and reported that 22% of AN and 11% of BN patients made a suicide attempt in this follow-up period. In a recent Belgian study (Vervaeke et al, 2008) of 342 AN



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patients, 38% were found to have suicide ideation and 10% to have histories of suicide attempt by the median age of 23 years, 7 months. The majority (62%) of patients reporting prior attempts reported making more than one. A history of suicide attempt is a significant risk factor for later completed suicide.

Domestic Violence and Suicide

Of the 34,000 Americans who lose their lives each year to suicide, all too often violence, including domestic violence, is woven through their lives. Women who experience intimate partner violence are 12 times more likely to end their lives by suicide than those who have not. And it is not just victims who are at risk; research indicates a two to five fold increase in suicidal behavior for children exposed to domestic violence. A growing body of research focuses on this link and offers us hope that better outcomes can be found.

Warning signs and implications; most people with thoughts of suicide are ambivalent about death; a part of them wants to die, but a part of them wants to live. Suicide is the means they identify to escape searing emotional pain and they see no other way out.

The American Association of Suicidology has developed a mnemonic to help identify the warning signs of suicide:

IS PATH WARM? The letters represent:

- Ideation • Substance abuse***
- Purposelessness • Anxiety • Trapped • Hopelessness***
- Withdrawal • Anger • Recklessness and • Mood change***

A history of trauma presents a significant risk factor for suicide, which may be evidenced by the above warning signs. Counselors who see one or more of these signs should consider the possibility that the person may be having thoughts of suicide. However, the only way to know for sure is to ask. Thus, when screening victims, counselors should be alert to suicidal risk and ask directly if the victim is having thoughts of suicide and assess for potential risk. If the person is having thoughts of suicide, there must be a full assessment and it must be taken seriously.

WHO [World Health Organization] reports that 1.5% of all deaths worldwide are due to suicide. Suicide is estimated to be the eighth leading cause of death in all age groups. The mean age for successfully completed suicide is reported to be 40 years. Although globally, more women attempt



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suicide, more men die from suicide by a factor of 4.5:1. Evidence is mounting that an increase in the number of suicides in some communities may represent only the tip of the iceberg of an epidemic of self-injurious behaviors and suicidal ideation.

The risk factors for suicide include female gender, low socioeconomic status, lack of education, unemployment, increasing age, being married, not working outside of the home, and domestic violence. As the literature reports, women known to be exposed to a violent intimate relationship were significantly more likely to be hospitalized with a psychiatric diagnosis, injury and poisoning diagnoses, and diagnoses of assault or attempted suicide. As WHO's recently released World Report on Violence and Health notes: "One of the most common forms of violence against women is that performed by a husband or male partner." The result is that half of humanity is vulnerable to a risk factor with profound implications for health, but one which is nevertheless often ignored.

Facts about Suicide

Suicide Is Not Predictable in Individuals

- In a study of 4,800 hospitalized vets, it was not possible to identify who would die by suicide — too many false-negatives, false-positives.
- Individuals of all races, creeds, incomes and educational levels die by suicide. There is no typical suicide victim.

Suicide Communications Are Often Not Made to Professionals

- In one psychological autopsy study, only 18% told professionals of intentions*
- In a study of suicidal deaths in hospitals: 77% denied intent on last communication
- 28% had “no suicide” contracts with their caregivers” **
- Research does not support the use of no-harm contracts (NHC) as a method of preventing suicide, nor from protecting clinicians from malpractice litigation in the event of a client suicide***

Suicide Communications ARE Made to Others

- In adolescents, 50% communicated their intent to family members*
- In elderly, 58% communicated their intent to the primary care doctor**

Research shows that during our lifetime:

- 20% of us will have a suicide within our immediate family.
- 60% of us will personally know someone who dies by suicide.



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Understanding Motivation

Some studies have made a dent into understanding suicide. **Researchers looked at 20 suicide notes by people who had attempted and successfully killed themselves. *The five dimensions included the sense of burden, the level of emotional pain and how much suffering there is their lives, escaping negative feelings and using death as an answer to ending pain, poor social relations and the belief that death is the answer to their troublesome relationships and most importantly a sense of hopelessness and the belief that life is not going to get any better.***

The most noted aspect of the notes of suicide completer's included a lot of detail about how much they were a burden on others and society at large. In fact, this sense of burden was the main dimension that distinguished suicide letters between attempts and successes. People do not commit suicide because they are in pain, they commit suicide because they don't believe there is a reason to live and the world would be better off without them.

Components of a good Suicide Assessment:

- *Ask directly about suicide, be specific in your inquiry*
- *Determine level of suicide risk; low, moderate or high*
- *Intensity and Frequency of thoughts, intent, active plan in place*
- *Determine detail of plan and access to means*
- *Prior attempts, means used and prior hospitalizations or interventions for suicide prevention*
- *Prior attempts increase possibility of successful suicide*
- *Suicide attempts both actual and aborted (get detailed information and document)*
- *Intent – subjective expectation and desire for a self-destructive act to end in death*
- *Medications, what they are currently taking, what they have taken in the past and what did or did not work*
- *Family history of suicide increases the risk exponentially*
- *Suicide attempters are usually more impulsive and aggressive regardless of psychiatric diagnosis.*
- *Protective Factors; family relations, positive therapeutic relation, religion/spirituality, belief system around taking of own life, employment, positive support system, pets, children, anything that connects them to life is relevant.*
- *Document EVERYTHING!*
- *Seek SUPERVISION*



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What is it that enables a person to be strong enough to follow through and swallow an entire bottle of pills, ingest poison, or push the chair out so that they dangle from a rope tied to the ceiling? It might be controversial to use the word courage or strength in this context. Nevertheless, a suicidal person often must overcome intense emotional distress to commit the final act. Leading suicide researchers speculated that a sense of burden is necessary but insufficient to understand who kills themselves.

A person might also require the capacity to harm themselves. A person must be highly tolerant of pain and conflict to make room for the uncomfortable thoughts and feelings that arise when working toward the goal of ending life. This tolerance of distress must be acquired somewhere along the way. Researchers continue to find support for the notion that the greatest suicidal risk exists for people that believe they are a burden on society AND possess a history where they acquired the capacity to harm themselves.

If you remain unconvinced about the importance of an acquired capacity to tolerate pain and distress, consider these sobering figures. **One in 25 people who sought health care services at a hospital because of self-harm or self-injurious behavior will kill themselves in the next 5 years.**

Prevention may be a matter of a caring person with the right knowledge being available in the right place at the right time.

Because the two most prevalent risk factors associated with suicide are mental health disorders and substance abuse, it is vital to understand these risks and take steps to manage addictions in order to save lives.

How are substance abuse and suicide linked?

Both substance use and addiction are associated with suicide attempts. One large study carried out across 12 states by the National Violent Death Reporting System showed that **alcohol was found in the bloodstreams of 33% of people who died from suicide, and opiates like heroin and prescription pain killers were present in the systems of almost 25% of people who committed suicide.**

Not all of these people were necessarily addicted to alcohol or opiates, although alcohol addiction is strongly associated with suicide. **According to the American Society for Addiction Medicine, 1 in 6 alcoholics will die from suicide, and 1 in 6 people who die from suicide have alcohol addiction. Experts estimate that 85% of the people who die from suicide suffer from major depressive disorder, alcohol addiction, or both.**



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Intoxication itself puts people at a higher risk for suicide because it makes it more likely that individuals will engage in impulsive behaviors that can harm themselves or others, whether accidentally or intentionally. Alcohol and other sedatives alter a person's judgment, aggressiveness, and impulsivity. The crash that follows a cocaine or methamphetamine high can precipitate suicide attempts due to intense feelings of disappointment and self-loathing, as well as the neurochemical changes caused by cocaine and speed. Stimulants can also trigger manic episodes in people with latent bipolar disorder, and other drugs can sometimes cause psychotic episodes.

In addition, addictions can contribute to mental health disorders. The regular use of alcohol and other sedatives as well as habitual opioid-induced narcosis (unconsciousness) can lead to a form of depression called substance-induced mood disorder. The consequences of addiction in a person's life, including broken relationships, lost financial security, the potential for lost freedom through imprisonment, and poor health, can also contribute to situational depression and make it more likely that a person may attempt to take their own life.

Suicide by intentional overdose is yet another danger linked to addiction. Drugs of abuse should be considered to be potentially lethal means in the hands of a depressed person.

Do behavioral addictions increase a person's risk of suicide?

Yes, there is some evidence that indicates that a behavioral addiction like internet pornography, sexual addiction or compulsive gambling can increase a person's risk of attempting suicide. For example, people with the eating disorder anorexia are at a particularly high risk for suicide attempts.

Myths versus Facts

- **MYTH:** People who talk about suicide don't complete suicide.
- **FACT:** Many people who die by suicide have given definite warnings to family and friends of their intentions. Always take any comment about suicide seriously.
- **MYTH:** Suicide happens without warning.
- **FACT:** Most suicidal people give clues and signs regarding their suicidal intentions.
- **MYTH:** Suicidal people are fully intent on dying.
- **FACT:** Most suicidal people are undecided about living or dying, which is called "suicidal ambivalence." A part of them wants to live; however, death seems like the only way out of their pain and suffering. They may allow themselves to "gamble with death," leaving it up to others to save them.



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- **MYTH:** Men are more likely to be suicidal.
- **FACT:** Men are four times more likely to kill themselves than women. *Women attempt suicide three times more often than men do.*
- **MYTH:** Asking a depressed person about suicide will push him/her to complete suicide.
- **FACT:** Studies have shown that patients with depression have these ideas and talking about them does not increase the risk of them taking their own life.
- **MYTH:** Improvement following a suicide attempt or crisis means that the risk is over.
- **FACT:** Most suicides occur within days or weeks of "improvement," when the individual has the energy and motivation to actually follow through with his/her suicidal thoughts. **The highest suicide rates are immediately after a hospitalization for a suicide attempt.**
- **MYTH:** Once a person attempts suicide, the pain and shame they experience afterward will keep them from trying again.
- **FACT:** The most common psychiatric illness that ends in suicide is Major Depression, a recurring illness. Every time a patient gets depressed, the risk of suicide returns.
- **MYTH:** Sometimes a bad event can push a person to complete suicide.
- **FACT:** Suicide results from having a serious psychiatric disorder. A single event may just be "the last straw."
- **MYTH:** Suicide occurs in great numbers around holidays in November and December.
- **FACT:** Highest rates of suicide are in May or June, while the lowest rates are in December.

Other psychiatric risk factors with potential to result in suicide (*account for significantly fewer suicides than Depression*):

- Post-Traumatic Stress Disorder (PTSD)
- Eating disorders
- Borderline personality disorder
- Antisocial personality disorder

Past suicide attempt

- After a suicide attempt that is seen in the ER about 1% per year take their own life, up to approximately 10% within 10 years.



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- More recent research followed attempters for 22 years and saw 7% die by suicide.

Symptom Risk Factors during Depressive Episode:

- Desperation
- Hopelessness
- Anxiety and panic attacks
- Aggressive or impulsive personality
- Has made preparations for a potentially serious suicide attempt* or has rehearsed a plan during a previous episode
- Recent hospitalization for depression
- Psychotic symptoms (especially in hospitalized depression)
- Major physical illness, especially recent
- Chronic physical pain
- History of childhood trauma or abuse, or of being bullied
- Family history of death by suicide
- Drinking/Drug use
- Being a smoker

Socio-demographic Risk Factors

- Male
- Over age 65
- White
- Separated, widowed or divorced
- Living alone
- Being unemployed or retired
- Occupation: health-related occupations higher (dentists, doctors, nurses, social workers) especially high in women physicians

Educational Tools

- Depression and suicide among college students: *The Truth About Suicide: Real Stories of Depression in College* (2004) Comes with accompanying facilitator's guide
- Depression and suicide among physicians and medical students:
 - *Struggling in Silence: Physician Depression and Suicide* (54 minutes)*
 - *Struggling in Silence: Community Resource Version* (16 minutes)
 - *Out of the Silence: Medical Student Depression and Suicide* (15 minutes)



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- Both shorter films are packaged together and include PPT presentations on the DVD's
- Depression and suicide among teenagers:
- *More Than Sad: Teen Depression* (2009)**
 - Comes with facilitator's guide and additional resources
- Suicide Prevention Education for Teachers and Other School Personnel (2010)
 - Includes new film, *More Than Sad: Preventing Teen Suicide*, *More Than Sad: Teen Depression*, facilitator's guide, a curriculum manual and additional resources

The ISP is an anonymous, web-based, interactive screen for individuals (students, faculty, and employees) with depression and other mental disorders that put them at risk for suicide. ISP connects at-risk individuals to a counselor who provides personalized online support to get them engaged to come in for an evaluation. Based on evaluation findings, ISP was included in the Suicide Prevention Resource Center's Best Practice Registry in 2009. It is currently in place in 16 colleges, including four medical schools.

Preventing Suicide

Antidepressants and Adequate prescription treatment and monitoring. Only 20% of medicated depressed patients are adequately treated with antidepressants – possibly due to:

- Side effects or Lack of improvement
 - High anxiety not treated
 - Fear of drug dependency
 - Concomitant substance use
 - Didn't combine with psychotherapy
 - Dose not high enough
 - Didn't add adjunct therapy such as lithium or other medication(s)
 - Didn't explore all options including: ECT or other somatic treatment

Psychotherapy

- Research shows that when it comes to treating depression, all therapy is NOT created equal.
 - *Study shows applying correct techniques reduce suicide attempts by 50% over 18 month period*
 - **To be effective, psychotherapy must be:**
 - Specifically designed to treat depression
 - Relatively short-term (10-16 weeks)



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- Structured (therapist should be able to give step-by-step treatment instructions that any other therapist can easily follow)
- **Examples:** Cognitive Behavior Therapy (CBT), Interpersonal Therapy (IPT), Dialectical Behavior Therapy (DBT)
- **Implement teaching of these techniques**

Means Restrictions

- Firearm safety
- Construction of barriers at jumping sites
- Detoxification of domestic gas
- Improvements in the use of catalytic converters in motor vehicles
- Restrictions on pesticides
- Reduce lethality or toxicity of prescriptions
 - Use of lower toxicity antidepressants
 - Change packaging of medications to blister packs
 - Restrict sales of lethal hypnotics

Media

- **Guidelines Media Considerations**
- **Consider how suicide is portrayed in the media**
 - TV
 - Movies
 - Advertisements
- **The Internet danger**
 - Suicide chat rooms
 - Instructions on methods
 - Solicitations for suicide pacts.

Warning Signs

- **Observable signs of serious depression**
 - Unrelenting low mood
 - Pessimism
 - Hopelessness
 - Desperation
 - Anxiety, psychic pain, inner tension
 - Withdrawal



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- Sleep problems
- **Increased alcohol and/or other drug use**
- **Recent impulsiveness and taking unnecessary risks**
- **Threatening suicide or expressing strong wish to die**
- **Making a plan**
 - Giving away prized possessions
 - Purchasing a firearm
 - Obtaining other means of killing oneself
- **Unexpected rage or anger**

Intervention

Three Basic Steps:

- ***Show you care***
- ***Ask about suicide***
- ***Get help***
 - ***Intervention: Step One***
 - *Show You Care*
 - *Be Genuine*
 - ***Show you care***
 - ***Take ALL talk of suicide seriously***
 - *If you are concerned that someone may take their life, trust your judgment!*
 - ***Listen Carefully***
 - ***Reflect what you hear***
 - ***Use language appropriate for age of person involved***
 - *Do not worry about doing or saying exactly the "right" thing. Your genuine interest is what is most important.*
 - ***Be Genuine***
 - ***Let the person know you really care. Talk about your feelings and ask about his or hers.***
 - *"I'm concerned about you... how do you feel?"*
 - *"Tell me about your pain."*
 - *"You mean a lot to me and I want to help."*
 - *"I care about you, about how you're holding up."*



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- *"I'm on your side...we'll get through this."*
- **Intervention: Step Two**
 - *Ask About Suicide*
 - *Be direct but non-confrontational*
 - *Talking with people about suicide won't put the idea in their heads. Chances are, if you've observed any of the warning signs, they're already thinking about it. Be direct in a caring, non-confrontational way. Get the conversation started.*
- *You do not need to solve all of the person's problems – **just engage them.***
- *Questions to ask:*
 - *Are you thinking about suicide?*
 - *What thoughts or plans do you have?*
 - *Are you thinking about harming yourself, ending your life?*
 - *How long have you been thinking about suicide?*
 - *Have you thought about how you would do it?*
 - *Do you have ___? (Insert the lethal means they have mentioned)*
 - *Do you really want to die? Or do you want the pain to go away?*
- *Ask about treatment:*
 - *Are you taking your medications?*
- **Intervention: Step Three**
 - *Get help, but do NOT leave the person alone*
 - *Communicate with your TEAM!*
 - *Contact Medical Staff*
 - *Know referral resources*
 - *Reassure the person*
 - *Encourage the person to participate in helping process*
 - *Outline safety plan*
- **Know Referral Resources**
- **Resource sheet**
- **Hotlines**
 - **Hotlines**
- **National Suicide Prevention Lifeline**



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- **1-800-273-TALK**
- **www.suicidepreventionlifeline.org**
- **911 - In an acute crisis, call 911**
 - **Reassure the person that help is available and that you will help them get help:**
 - “Together I know we can figure something out to make you feel better.”
 - “I know where we can get some help.”
 - “I can go with you to where we can get help.”
 - “Let's talk to someone who can help . . . Let's call the crisis line now.”

What to do

- ***Utilize Suicide Assessment Tools.***
- ***Follow Policy and Procedure of your Employer.***
- ***Ask your Supervisor for assistance.***
- ***Notify Medical Staff.***
- ***Many facilities Baker Act clients who present with moderate to high risk for suicide. A Baker Act is a 72 hour hold in a psychiatric hospital for evaluation and stabilization.***
- ***Increase monitoring of client with any suicidal ideation by placing them in a location where staff can observe more frequently. Contracting for safety is not believed to reduce suicide attempts, but it certainly makes the client acutely aware that staff is now paying close attention.***
- ***Reduce access to lethal means; i.e. remove all sharps from area in which the client is housed***

Self-Harm

*Self-Harm is an act in which people attempt to deal with deep distress and emotional pain by harming yourself with acts such as cutting, burning, sticking objects in your skin, or intentionally preventing wounds from healing, **you are becoming increasingly capable of suicide.***

One of the odd things about this line of research is that in any other context, high pain tolerance is strength, a gift, a form of emotional agility that allows a person to be more successful and satisfied with life. This is why we are bringing this research up. Look at the motives behind people's actions because what we might view as an admirable strength in another context is a fatal risk factor.

Clinical guidelines for the management of self-harm highlight the need for primary and secondary care services to provide a thorough assessment of mental health and social needs, precipitating factors and



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the risk of further self-harm or suicide among self-harming clients who we come into contact with. Appropriate treatment responses will be sensitive to differences between self-harm clients such as "diverse populations and diverse service needs".

Repetitive self-harm places a heavy burden on health and social services and society as a whole. **Up to half of hospital admissions following self-harm are repeat episodes, and a history of repetitive self-harm is a key risk factor for suicide. A single previous episode of self-harm is associated with high suicidal intent in a subsequent episode**

The experience of psychiatric illness emerged as a recurring theme with cutters. This was not based on any independent or third-party diagnosis of illness, but patients' own reports of **Depression, Borderline Personality Disorder and Bipolar Disorder, as well as Anxiety and Agoraphobia. There is also a significant correlation between Eating Disorders and Substance Abuse.**

Consistent with the well-documented relationship between psychiatric illness and repetitive self-harm it was not surprising that the experience of **psychiatric illness was interwoven with their accounts of self-harm**, and that their self-harm was seen as inextricably part, or symptomatic, of their illness. Self-harm is also highly correlated to substance abuse. As in the study by Sinclair and Green, they viewed their self-harm as a consequence of illness.

"When they told me I had depression, I could think, that's why I do it (self-harm). It sounds stupid, but that made me feel better" [female, aged 35 years].

"I've got this borderline personality disorder, and that's who I am, you know, it's my personality, so that's why it [self-harm] will never stop. What do they want me to do? Change my personality?"

A recent study showed that clients described their self-harm as a means to get support and attention, because of frustration about not receiving support for their illness, with self-harm a "*sure thing*" for being admitted to hospital. They also reported sometimes feeling a strong desire to be admitted, to escape the overwhelming and often uncontrollable emotions leading to self-harm.

Self-Harm and Suicidality

PTSD and Self-Harm



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- Childhood abuse results in patterns of neglect in which the child's body, mind and emotions are available to be exploited by adults and it should therefore not surprise use that children who have been impacted in this way, might become adults who in turn abuse themselves and use their bodies to remove or relieve tension or act out impulses.
- Their experience is that a body is a vehicle for tension and has no other real value.
- To make matters worse, abused children are also deprived of the normal experiences of tension relief they don't have any way out except to self-harm.
- When distressed, children who have not been abused seek connections with others, preferably adults, to find soothing, reassurance, or comfort.
- Children who have experienced neglect or abuse have learned to avoid connection, rather than seek it, and to rely almost exclusively on their own resources.

********The most common mistake made by therapists is the assumption that self-harm and suicidality cause pain, rather than relieve it. If we assume that self-harm induces pain, then we will interpret it as masochism or self-punishment or a cry for help. ********

And if we do that, we will miss the core issue in self-harm of mastery and relief-seeking. Because to interpret it as self-punishment usually leads the patient right into her feelings of shame and worthlessness, and she responds by thinking or saying, "But I am bad—I do deserve to be punished—and since I'll never feel anything but hate for myself, I'll never stop my self-harm." Or, "Since I will never be able to help myself, my only hope is to keep crying for help."

If, on the other hand, we go to the heart of the matter (to the fact that hurting the body, or planning to, brings welcome relief and is in fact an ingenious attempt to cope with overwhelming distress and tension), the patient will feel understood, and the therapist will be able to share the dilemma with her. If we acknowledge that self-harm and suicidality work in a paradoxical way and that the patient currently has no better way to soothe herself, we can begin to talk with her about why self-harm works and what other ways of achieving tension release could fulfill the same needs.

- Let us go back to the fact that the body has become the expected vehicle for tension relief and that accessing help or support is not an option because connection with others has always been more dangerous than helpful.
- Let us also remember what we know about the psychobiological effects of trauma: that the patient has become accustomed, perhaps even addicted, to adrenaline.



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- She has learned that adrenaline is calming, that dissociation is calming, and that pain can increase the production of endorphins inducing an analgesic effect.
- And all of these ways of calming the body are completely under her control: she does not have to depend on anyone to achieve relief from distress through any of these avenues.
- Thus, self-harm of any sort "makes sense": all forms of self-harm either induce adrenaline responses, dissociation, or an increase in endorphin production.
- And the self-harm "doesn't matter" because the body doesn't matter.
- No wonder our patients are surprised and sometimes even annoyed that their self-harm and suicidality matter so much to us!
- In fact, they may even interpret our interventions to prevent or reduce suicidality as our not caring about how they feel.

Childhood abuse can alter brain structure

Interestingly, research has reported that physical, emotional, and/or sexual abuse in childhood can actually alter neural structures that involve dopamine and serotonin. This is thought to happen indirectly through stress hormones released in the body due to the traumatic experience in childhood. These stress hormones are thought to interact with chemicals in the body to "trigger" different genes, such as the serotonin transporter gene, which then tells the body to develop its neurons in the brain a particular way.

Studies have shown that negligent parent-child interactions (including minimal touch, talk, and play) actually might alter neurons that process dopamine in the brain, leading to a condition known as "dopamine receptor supersensitivity" or "dopamine deficiency". Studies have shown that people who are super sensitive to dopamine are more prone to anxiety and impulsivity.

For example, numerous studies have recently shown that people with Parkinson's disease, who are known to have dopamine receptor supersensitivity, displayed impulsive behaviors such as gambling and shopping when given dopamine agonists (medications that increase dopamine in the brain). These individuals also reported high rates of anxiety when given these medications.

In the case of self-harm, studies have suggested that dopamine receptor supersensitivity may be involved in the expression of different forms of self-harm. Some studies using Positron Electron Tomography (PET) scans showed that individuals who self-injured showed dopamine receptor



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supersensitivity in their brains. This makes sense considering that anxiety and different forms of abuse have been associated with both self-harm and dopamine receptor supersensitivity.

Since research on stressful early parent-child relationships has demonstrated increased sensitivity to anxiety in adulthood by way of altered dopaminergic and serotonergic systems, it is questioned what type of effect caffeine might have on a person who has supersensitive dopamine receptors. This question arises because caffeine affects both dopamine and serotonin levels in the brain.

Self-Harm and Alcohol/Drug Dependence

Patient accounts highlighted the significance of alcohol and drug use in their history of self-harm.

One patient was presently abstinent, while alcohol had been involved in the most recent self-harm of the others. For some of these patients, self-harm was frequently the culmination of a binge drinking session which could last several days. Their drinking habit, which was often traced back to adolescence, served as an outlet for escaping problems and painful emotions. Cutting is another easily accessed outlet for escaping problems and painful emotions.

Feelings of hopelessness and low self-esteem associated with alcohol and drug dependency were common among these patients. Their chaotic lifestyles, as evidenced by difficulties in securing and keeping jobs and living in temporary accommodation, also contributed significantly to their self-harm. Several patients described losing contact with, or the support of, friends and family through their addiction or alcoholism. Relationships with their 'drinking and using buddies' were superficial and not mutually supportive.

All surveyed patients described the pressures of overcoming an alcohol and addiction as a factor contributing to their self-harm, yet viewed abstinence as the route to managing or prevailing over the behavior. In discussing the role of alcoholism and addiction on self-harm, some patients considered their excessive drinking and drug use as self-harming.

Responses to interventions included;

"It's pointless, there's nothing they can do, and you can't stop a self-harmer"

"Everything I've ever been given is useless, the whole thing's bugged up"

Borderline Personality Disorder and Self-Harm



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What we do know is that there is a high correlation between self-harming behaviors and Borderline Personality Disorder. Borderline personality disorder is a disturbance in personality disorder which goes back and forth between self-blame and blame of others, and which almost always include both severe emotional highs and severe emotional lows. The jury is still out on how exactly this works and what's going on in the neural circuitry of people with BPD, but right now what we know is that they appear to have a lot of trouble regulating their emotions.

Of course, you might say. But it's not as simple as just telling someone to calm down. What appears to be going on in **Borderline Personality Disorder patients is that they have an over-functioning of the limbic system of the brain, which is a group of brain areas associated with things like fear, emotion, and other behaviors. So if you have an over-functioning in these areas, you might expect greater emotional highs and lows.**

But the limbic system is restrained in part by input from the prefrontal cortex, that big area in the front of your brain which is devoted to what we like to call "higher function" and which is often responsible for inhibiting impulsive behaviors and emotions.

The prefrontal cortex is the stop system or if you like, the brakes. People with BPD have a dysfunction in this area, in particular what appears to be a hypo-functional system. So this means they are getting too much emotion from the limbic system, and too little reigning in from the prefrontal cortex. The result is a very dysregulated emotional state, with really high highs, and very low lows. And one of the ways that people with BPD often attempt to deal with their excess emotion is through self-injurious behavior.

Why is that?

With Borderline Personality Disorder self-injury, it may not be a relief of the emotions, rather than just a distraction, which in turn decreases the activation in the brain and provides some relief. This doesn't mean that self-injury is a good thing, far from it. But it does mean that, if this hypothesis turns out to be true and distraction works very well to help people with BPD that we could come up with behavioral treatments to help combat their episodes of severe emotion. Things that they have to do which will distract them and then help them to deal with emotional surges, and possibly stop the cycle of self-and-other blame that can make them very difficult to identify and treat.

- **Intentional and often repetitive self-injurious behavior is exhibited by approximately 1-2 million people the in United States.**



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- The typical self-injurer is female (women are 1.5-3 times more likely than men to self-injure), adolescent or young adult, single, middle to upper-middle class, and intelligent.

Though it is often conceptualized as a "derivation of suicide", the primary objective in approximately 85% of self-injurious events is tension relief opposed to suicide.

The nature of self-injurious events into four categories:

- 1) Stereotypic
- 2) Major
- 3) Compulsive
- 4) Impulsive.

Stereotypic self-harm is primarily exhibited by individuals with developmental disabilities and occurs without regard for social context or without thought and feeling.

Major self-harm is very dramatic and occurs as an isolated event whereas compulsive self-harm occurs repetitively, sometimes multiple times a day.

Impulsive self-harm is episodic, buffered by periods where no self-harm occurs. Generally, self-harm is accomplished in the absence of pain due to disassociation the individual achieves and is followed by a feeling of relief or normalcy which continues until the cycle begins again..

According to the current definition of self-harm in which it is described as "the destruction or alteration of body tissue that occurs in the absence of conscious suicidal intent" , an exhaustive list of self-harm includes tattooing, piercing, surgical implants, scarification, pigmentation changes, radical dieting, hunger striking, fasting, cutting, and burning.

Because self-harm varies etiologically over a continuum, it is impossible to assign a definitive causal argument which becomes problematic in attempting treatment.

An important question that arises in the treatment of self-harm is whether the behavior is in response to neurochemical stimuli or whether there is something that is being communicated by the individual who is exhibiting self-injurious behavior. If there is something that the self-harming client is nonverbally articulating, what follows is whether the individual is aware of this and how they themselves interpret their behavior.



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To address these nuances, motivating factors behind self-harm have been categorized as either interpersonal, in which attempts are made to effect change in the interpersonal environment, or intrapersonal, in which attempts are made to "quell intra-physic distress"

Neurochemistry and Self-Harm

At the biological level, self-harm is attributed to abnormal neurochemistry involving the neurotransmission of serotonin, dopamine, and endorphins. Serotonergic deficits, or decreased serotonin levels, have been observed in self-harming individuals by analyzing the breakdown products (metabolites) of serotonin in spinal fluid. Serotonogenic deficits, determined by imipramine binding sites on platelets was linked to aggression and impulsiveness by Stoffetal (1987) and Birmaher et al (1990) **which suggests that self-harm is akin to impulse disorders like kleptomania and trichotillomania and also correlates to theory that self-harm is yet another impulse control disorder.**

Another neurochemical explanation of self-harm is that the body becomes addicted to endorphins, pain-relieving neurotransmitters derived from opium, released by self-mutilation. Individuals with self-harming behaviors have abnormal endogenous opiod systems which may be congenital or a result of neurochemical responses to events in early childhood. **This correlates further with high self-harm rate and PTSD.**

Those who were unwilling to engage with services were more likely to have been harming themselves over a long period. In line with this, patients spoke of feeling they were "beyond help" or "defeated"

The unwillingness to seek support for self-harm was most strongly expressed by patients whose accounts were characterized by traumatic life events (especially in childhood) or chronic life problems (including coping with the consequences of childhood trauma, a series of traumatic events), although not exclusively.

Some patients voiced a greater degree of willingness to engage with a variety of services, sharing an aspiration to minimize their self-harming behavior, and were more likely to remain in long-term contact with services.

"I badly want to ... stop ... I've been asking for help, I'm willing to try anything"

Clients who reported a longer commitment to a particular intervention tended to recount feeling satisfied with this service. In contrast, experience of a large number of different interventions was associated with less commitment to, or perseverance with, any particular intervention.



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Some patients (all female) felt that they were not in a position to feel or demonstrate any dissatisfaction, and dwelled on feelings of guilt, linked to the self-inflicted nature of their injuries:

"You feel like a fraud ... [there are] wards full of people who are not well, and you want to punish yourself even more because ... there is other people who need the space more than you"

When looking at self-harm and suicide we assume some similarities due to the methods involved. This is both true and not true at the same time. Some of what needs to be understood is the patterns of repetition, to look at the correlation between self-harm and suicide as well as past traumatic experiences.

Signs of self-harm include;

- many cuts/burns on the wrists, arms, legs, back, hips or stomach,
- wearing baggy or loose clothing such as wearing hoodies or long sleeves during hot days to conceal the wounds,
- always making excuses for having cuts, marks, or wounds on the body,
- finding razors, scissors, lighters or knives in strange places,
- spending long periods locked in the bedroom or in the bathroom, isolation and avoiding social situations.

Why do people self-harm?

- *They do it to escape their feelings, to cope with stressors, to express their pain and to punish themselves.*
- *Some mutilate their bodies for what is happening in their lives, they lack the appropriate coping skills, suffer from low self-esteem and they feel that they deserve what they are doing to themselves, to feel euphoria (it's true that when we get hurt endorphins are released into the blood stream resulting in a natural high or feeling of euphoria).*

Self-harm is addictive and habit forming.

Self-injury, self-inflicted violence, self-injurious behavior or self-mutilation is defined as a deliberate, intentional injury to one's own body that causes tissue damage or leaves marks for more than a few minutes which is done to cope with an overwhelming or distressing situation. Statistics show that self-harm is more common amongst girls who begin this addiction in their early teens and may continue into their adulthood. But there are guys that have been known to inflict self-injury.



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Common Ways of Self-injury

Cutting this type of self-injury involves making cuts or scratches on your body with any sharp object including knives, needles, razor blades or even fingernails. The arms, legs and front of the torso are most commonly cut because they are easily reached and easily hidden under clothing.

Cutting can be habit forming. It can become a compulsive behavior — *meaning that the more a person does it, the more he or she feels the need to do it.*

The brain starts to connect the false sense of relief from bad feelings to the act of cutting, and it craves this relief the next time tension builds.

When cutting becomes a compulsive behavior, it can seem impossible to stop.

It's easy to see how cutting can become an addiction, where the urge to cut can seem too hard to resist.

A behavior that starts as an attempt to feel more in control can end up controlling you.

Hair-pulling (trichotillomania) this is an impulse control disorder which at times seems to resemble a habit, an addiction, or an obsessive-compulsive disorder. The person has an irresistible urge to pull out hair from any part of their body. Hair pulling from the scalp often leaves patchy bald spots on their head which they hide by wearing hats, scarves and wigs. Abnormal levels of serotonin or dopamine may play a role in this disorder.

The combined treatment of using an anti-depressant such as Anafranil and cognitive behavioral therapy (CBT) has been effective in treating this disorder. CBT teaches you to become more aware of when you're pulling, helps you identify your pulling habits, and teaches you about what emotions and triggers are involved in hair pulling. When you gain awareness of pulling, you can learn to substitute healthier behaviors instead.

Other Forms

- Branding – burning self with a hot object
- Friction burn – rubbing a pencil eraser on your skin
- Picking at skin or re-opening wounds (dermatillomania) – an impulse control disorder characterized by the repeated urge to pick at one's own skin, often to the extent that damage is caused which relieves stress or is gratifying



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- Many compulsive skin picking causes are emotional or mental. Emotional trauma can lead to feelings of helplessness and insecurity. When a child is being traumatized and bullied, he or she loses the feeling of being in control of their environment.
- Hitting (with hammer or other object)
- Bone breaking
- Punching
- Head-banging (more often seen with autism or severe mental retardation)
- Multiple piercing or tattooing – may also be a type of self-injury, especially if pain or stress relief is a factor
- Drinking harmful chemicals
- *From a study which was conducted with 60 clients who were receiving drug treatment it was revealed that 65% of the clients had a history of self-harm.*
- *Cutting is the most common method of self-harm with 72% utilizing this method.*
- *The other forms of self-harm include head banging 15% and picking 13% which other unnamed methods being 10%.*
- The most common feeling experienced before these acts of deliberate self-harm is emotional pain which was described by 64% of the sample.
- The most common feeling afterward is regret fullness with 41% endorsing this emotion. Alcohol and drugs were frequently implicated in the episodes and were perceived to have aggravated the self-mutilation.
- Almost half of the sample had made a previous suicide attempt and 82% of the sample had a history of traumatic experiences.

As unlikely as it seems, deliberate self-harm has been reported to be an addiction and falls under the realm of addictive behavior (process addictions include a variety of behaviors such as gambling, sex addiction, food, internet, gaming, etc.)

The neurotransmitters of addictive behaviors (process addictions) utilize similar neuropathways as substance use does. With self-harm there is said to be an alleged addiction to endogenous opioids.

Self-harm is actually a “coping mechanism” and as destructive as it is, it is still a mechanism that works and this is part of the addictive quality of this behavior.

There is a significant amount of repetition with deliberate self-harm.

- Risk factors include prior episodes, psychiatric history, and alcohol and drug use.
- Antisocial Personality Disorder and Borderline Personality Disorder are also highly correlated to self-harm.



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- Major self-harm such as castration of limbs and enucleating of eyes is usually associated with psychosis.

Superficial or moderate self-harm, which is the most common form, including cutting, burning, scratching, skin-picking, hair-pulling, bone-breaking, hitting, interference with wound injuries and deliberate overdosing.

Deliberate Self-Harm and Suicide Deliberate Self-Harm is distinct from suicide; the basic understanding is that a person who truly attempts suicide seeks to end all feelings where as a person self-harm seeks to feel better.

- In fact self-harm can actually be a life saver. Suicide is not reported to provide relieve as self-harm does and it is repeated less frequently.
- Although self-harm is not the same as suicidal behavior, there is a strong association between the two.
- Suicide risk with self-harm is increased a hundred times than the general population.
- Completed suicide is associated with major depressive disorder, severe bipolar disorder, alcohol/drug abuse and a past history of suicidal acts.
- Although the two may blur, the meaning does not and this is focused on whether or not the person intends to die.
- The mean age of first self-harm is 23.2 years with a standard deviation of 6.5.
- Common places where self-harm occurs includes; wrist, abdomen, anterior left chest in the region of the heart, arm and thigh. Other methods include hanging, inhaling car fumes and drinking fuel.
- Beyond regret, other emotions include feeling stupid, selfish and desperate. Other categories include family problems and thinking of past trauma and difficulties.
- More than 50% of those who carry out self-harm were under the influence of alcohol and drugs.
- Science sheds new light into self-injurious behavior, the brain, and early childhood experiences.

Self-harm or self-injury has generally been defined as self-destructive behavior without the intention to die. Although the behaviors that are classified under this definition have not yet been clearly defined, it has been generally accepted that the different and dynamic forms of self-harm lie along a continuum. This continuum ranges from mild forms of self-harm such as nail biting to more severe forms such as cutting and head banging. In between this spectrum lie impulse control disorders



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such as obsessive hair pulling (Trichotillomania) and obsessive skin picking (Dermatillomania).

Anxiety and physical and emotional abuse have been shown to be prevalent among people who self-harm (including skin-picking and hair-pulling). People who self-harm are often found to have higher rates of anxiety than those who do not and research has reported that most people who self-injure have a diagnosable anxiety disorder. Research has also reported that people who self-injure have reported higher rates of physical and emotional abuse in childhood than those who do not.

Caffeine is known to raise dopamine levels and produce stress and anxiety in certain individuals logically suggesting that individuals who have dopaminergic receptor sensitivity might be more vulnerable to anxiety and increase risk for self-injuring.

As strange as it may sound, some individuals hurt themselves to obtain relief from emotional stress. Actions such as cutting or burning oneself are behaviors displayed by people who compulsively hurt themselves.

This behavior is sometimes evident among individuals with borderline personality disorder (BPD). BPD is a condition that often leads to intense emotions among individuals who have difficulty regulating their emotions.

Accordingly, this group of people displays high prevalence rates of self-injurious behavior, which may help them to reduce negative emotional states.

Researchers have studied the effects of emotional stimuli and a thermal stimulus in people either with or without borderline personality disorder.

They conducted a brain imaging study using picture stimuli to induce negative, positive, or neutral affect and thermal stimuli to induce heat pain or warmth perception. The painful heat stimuli were administered at an individually-set temperature threshold for each subject.

In patients with Borderline Personality Disorder, they found evidence of heightened activation of limbic circuitry in response to pictures evocative of positive and negative emotions, consistent with their reported emotion regulation problems. Amygdala activation also correlated with self-reported deficits



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in emotion regulation. However, the thermal stimuli inhibited the activation of the amygdala in these patients and also in healthy controls, presumably suppressing emotional reactivity.

Dr. John Krystal, editor of *Biological Psychiatry*, commented, “These data are consistent with the hypothesis that physically painful stimuli provide some relief from emotional distress for some patients with Borderline Personality Disorder because they paradoxically inhibit brain regions involved in emotion. This process may help them to compensate for deficient emotional regulation mechanisms.

Most of the clients did not seek any medical treatment after the self-harm and 64.1% of the clients had never been referred to psychiatrist and 74.4% had never been followed up by general psychiatrist or any other medical professional.

When asked if they wanted to stop harming 92% reported that they needed to stop self-harming and gave different reasons such as to live, it is mad to keep hurting myself, it leads to scars and it doesn’t look good, for the sake of the children, it can lead to infection and it is stupid..

Things that prevented and reduced the feeling or need to self-harm included being drug free and having family support were the main reasons.

How do they know when to stop self-harm? Some said they did not know, when it hurts, realizing that I did it when I was mad, when my heart pumps fast, and when getting consciousness back.

The feelings prior to self-harm are emptiness, frustration, fear, agitation, anger and emotional pain. The feelings reported after self-harm are relaxed, euphoria, angry, and regretful.

Interventions should include;

- Self-Harm Safety Contract which can include an agreement not to harm for a certain amount of time or they can contract to speak with staff before they self-harm. Any interruption in the process can slow the client down enough, perhaps engage the prefrontal lobe and improve the client’s chances of refraining from further self-harm.
- Utilize tools such as a Body Map of Cuts, Burns, Picking upon admission and when seen by medical staff. This can be done with photos as well as an outline of the human body on which staff records all current scars, cuts, etc. This provides a baseline of all self-injuries and will therefore assist with identifying if further cutting/self-harm occurs.



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- Have client's journal about their feelings throughout the day and indicate when there are urges or cravings to cut. This may provide insight into particular moods or events that trigger self-harm and there is now a therapeutic opportunity to address these feelings and situations.
- A simple tool is to ask them to write one page of feelings or thoughts in their journal each time that they have a craving to cut.
- Another method is to provide them with a red marker and ask them to write with the red marker on their body whenever they have a craving/urge to cut. After the urge has passed ask them to wash the red marker off with soap and water.
- Another intervention is to ask them to paint/draw/make a collage of their pain. After they have completed the assignment ask them if you can hold it for them for a day. At the end of the day ask them if they would like it back and ask them to explain why. Ask them why they need their pain, how it serves them and what would happen if they let it go. After about 5 days of this, ask them to create a similar art assignment in which they create their life without pain and/or freedom and joy. After this is completed, ask them to keep them both for a few days and then ask them which one they would like to give away. This changes the way that the brain interacts with self-harm and increases their ability to ask for help and deeply consider their choices. .
- For pickers and people who pull their hair, sometimes simply asking them to wear gloves for the day. Don't tell them that they cannot pick, simply ask them to wear the gloves. Again, this provides a "pause" button in between the obsession and the compulsion and sometimes this is enough to see great improvement.

Although there are limited medications that have been specifically identified to reduce urges for self-harm, there are medications that assist with impulsivity and obsessive compulsive disorders.

Medications that work with Obsessive Compulsive Disorder may be helpful with Self-Harm

- Clomipramine (Anafranil)
- Fluvoxamine (Luvox CR)
- **Fluoxetine (Prozac)**
- Paroxetine (Paxil, Pexeva)
- **Sertraline (Zoloft)**

Medications that work with Impulse Control Disorders and could assist with Self-Harm;



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- **Antidepressants.** Selective serotonin reuptake inhibitors (SSRIs) are commonly used to treat kleptomania. These include fluoxetine (**Prozac**, Prozac Weekly), paroxetine (Paxil, Paxil CR), fluvoxamine (Luvox, Luvox CR) and others.
- **Mood stabilizers.** These medications are meant to even out your mood so that you don't have rapid or uneven changes that may trigger urges to self-harm. One mood stabilizer used to treat impulse control disorders is lithium (Lithobid) and **Risperdal (Risperidone)** has also been found to be helpful.
- **Anti-seizure medications.** Although originally intended for seizure disorders, these medications have shown benefits in certain mental health disorders, possibly including impulse control disorders. Examples include topiramate (Topamax) and valproic acid (Depakene, Stavzor).
- **Addiction medications.** **Naltrexone** (Revia, Vivitrol), known technically as an opioid antagonist, blocks the part of your brain that feels pleasure with certain addictive behaviors. It may reduce the urges and pleasure associated with self-harm.

Again, follow your employer's policy regarding self-harm behavior, communicate with your supervisor, notify appropriate staff, and speak with medical/psychiatric staff and DOCUMENT.



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Understanding Co-occurring Disorders (2 CEUs)

Course Description

Prevalence rates show that individuals with co-occurring disorders are common in both the substance abuse and mental health treatment systems. This course will provide participants with an understanding of the concept and term: co-occurring disorders. Participants will become familiar with the assessment, symptoms, and treatment of co-occurring disorders, and will be provided with an example of a special population that exists within the realm of co-occurring disorders.

Course Objectives

On completion of this course, participants will be able to identify/demonstrate familiarity with:

1. The definition and terms related to co-occurring disorders.
2. The assessment of co-occurring disorders and common symptoms.
3. The relationship between substance abuse and mental health concerns.
4. The symptoms of specific co-occurring disorders.
5. Available treatments for clients with co-occurring disorders.
6. A special population example and co-occurring disorders.

Introduction

Formerly known as dual diagnosis or dual disorder, the term co-occurring disorders describes the presence of two or more disorders at the same time. For example, a person may suffer with substance use disorder, as well as bipolar disorder. For the purpose of this training, the terms co-occurring and dual-diagnosis may be used interchangeably.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines cooccurring disorders as:

“The term co-occurring disorders (COD) refers to co-occurring substance-related and mental disorders. Clients said to have COD have one or more substance-related disorder as well as one or more mental disorder.”

According to SAMHSA, a 2002 report to Congress estimated that seven to ten million individuals



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in the United States have at least one mental disorder as well as a substance use disorder. In the 2012 SAMHSA's National Survey on Drug Use and Health (NSDUH) it was reported that an estimated 43.7 million (18.6%) Americans ages 18 and up experienced some form of mental illness. In the past year, 20.7 million adults (8.8%) had a substance use disorder. Of these, 8.4 million people had both a mental disorder and substance use disorder, also known as co-occurring mental and substance use disorders.

Terminology

As the field of treatment for substance use and mental disorders is evolving to become more precise, so too is the terminology used to describe people with both substance use and mental disorders. The term co-occurring disorders has been integrated as a term that will be more encompassing than the terms dual disorder or dual diagnosis. These latter terms, though used commonly to refer to the combination of substance use and mental disorders, are confusing in that they also refer to other combinations of disorders (such as mental disorders and mental retardation). Furthermore, the terms suggest that there are only two disorders occurring at the same time, when in fact there may be more. Clients with COD have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders. A diagnosis of co-occurring disorders occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder.

Understanding Co-occurring Disorders

Both mental health issues and substance use disorders have their own unique symptoms that may get in the way of one's ability to function, handle life's difficulties, and relate to others. To make the situation more complicated, the co-occurring disorders also affect and interact with one another. When a mental health problem goes untreated, the substance abuse problem usually gets worse as well, and when alcohol or drug abuse increases, mental health problems usually increase too.

Common examples of co-occurring disorders include the combinations of:

- Major depression with cocaine addiction.
- Alcohol use disorder with panic disorder.
- Alcoholism and poly-drug addiction with schizophrenia.
- Borderline personality disorder with episodic poly-drug abuse.
- Substance use disorder and eating disorder.

Combinations of COD problems and psychiatric disorders vary along dimensions such as:



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- Severity,
- Chronicity,
- Disability, and
- Degree of impairment in functioning.

For example, two disorders may each be severe or mild, or one may be more severe than the other, and the severity of both disorders may change over time. Levels of disability and impairment in functioning may also vary. There is no single combination of dual disorders, as there is great variability among them. However, clients with similar combinations of dual disorders are often encountered in certain treatment settings. For example, adults with severe mental illness who are further impaired by substance use disorders (abuse or dependence related to alcohol or other drugs) would often be receiving treatment at a dual-diagnosis/co-occurring disorders treatment center. Patients with dual disorders often experience more severe and chronic medical, social, and emotional problems compared to patients who have a mental health disorder or a substance use disorder alone. Because they have two disorders, they are vulnerable to relapsing and a worsening of the psychiatric disorder. Further, addiction relapse often leads to psychiatric decompensation, and worsening of psychiatric problems often leads to addiction relapse.

A mental health disorder complicates and compounds the challenges in overcoming an addiction to drugs or alcohol. Also, many times people who have an undiagnosed mental illness may try to treat their symptoms by self-medicating with drugs or alcohol, with alcohol being the most common choice. This self-medicating to numb symptoms can unfortunately cause side effects and worsen the very symptoms they were trying to relieve. Some common symptoms that people seek relief from by self-medicating include anxiety, depression, or paranoia. Down the road, if an individual is a chronic drug abuser, they can acquire mental illness from years of heavy use. Therefore, relapse prevention must be specially designed for patients with dual disorders. Compared with patients who have a single disorder, patients with dual disorders often require longer treatment, have more crises, and progress more gradually in treatment.

Psychiatric disorders most prevalent among dually diagnosed patients include mood disorders, anxiety disorders, personality disorders, and psychotic disorders. Antisocial personality disorders have a 15.5 percent abuse rate; Bipolar disorder is next at 14.5 percent, while anxiety disorders have a 4.3 percent abuse rate.

Source: <http://drugbuse.com/library/mental-health-and-drug-abuse>.

The relationship between substance use disorder and mental health concerns
Addiction is common within people who are also facing mental health problems. Although



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substance abuse and mental health disorders, like depression and anxiety, are closely linked, one does not directly cause the other in a linear fashion. In other words, the presence of a mental health problem does not necessarily mean that a client is also going to develop or have a substance use problem. Although, one can easily see how an increase in depression or anxiety could lead a person to using substances as an attempt to solve their symptoms of depression or anxiety. It is also quite plausible to see how a person who has a substance use problem could have an increase in depression or anxiety symptoms. Duration and intensity of symptoms helps to distinguish what problems may need the most attention. In order to expand on the relational aspect between substance abuse and mental health problems, think about the following ideas:

- Alcohol or drugs are often used to self-medicate the symptoms of depression or anxiety. Unfortunately, substance abuse causes side effects and in the long run worsens the very symptoms they initially numbed or relieved.
- Alcohol and drug abuse can increase underlying risk for mental disorders. Mental disorders are caused by a complex interplay of genetics, the environment, and other outside factors. If you are at risk for a mental disorder, drug or alcohol abuse may push you over the edge.
- Alcohol and drug abuse can make symptoms of a mental health problem worse. Substance abuse may sharply increase symptoms of mental illness or trigger new symptoms. Alcohol and drug abuse also interact with medications such as antidepressants, anti-anxiety pills, and mood stabilizers, making them less effective.

According to reports published in the Journal of the American Medical Association:

- Roughly 50% of individuals with severe mental disorders are affected by substance abuse.
- 37 percent of alcohol abusers and 53 percent of drug abusers also have at least one serious
- mental illness.
- Of all people diagnosed as mentally ill, 29 percent abuse either alcohol or drugs.

Source: National Alliance on Mental Illness

Recognizing co-occurring disorders or dual diagnosis

It can be difficult to diagnose a substance abuse problem and a co-occurring mental health disorder such as depression, anxiety, or bipolar disorder. It takes time to tease out what might be a mental disorder and what might be a drug or alcohol problem. Often chronic alcohol abuse and withdrawal can imitate symptoms of psychiatric disorders, such as anxiety, mood changes, and cognitive impairment.



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Complicating the issue is denial. Denial is common in substance abuse. The term "denial" refers to the process by which people with addictions pretend (to themselves and/or to other people) that they do not have an addiction, when in fact they do, or that their addictive behavior is not problematic, when in fact it is. Denial says that if the problem is not acknowledged, it doesn't exist. It's hard to admit how dependent you are on alcohol or drugs or how much they affect your life. Denial frequently occurs in mental disorders as well. The symptoms of depression or anxiety can be frightening, so you may ignore them and hope they go away. Or you may be ashamed or afraid of being viewed as weak if you admit the problem.

To assist you in recognizing a dual diagnosis or co-occurring disorders:

- Consider family history. If people in one's family have grappled with either a mental disorder such as depression or alcohol abuse or drug addiction, they have a higher risk of developing these problems. Children of alcoholics are 50 to 60 percent more likely to develop alcohol use disorders than people in the general population. Children of parents who abuse illicit drugs may be 45 to 79 percent more likely to do so themselves than the general public. <http://pubs.niaaa.nih.gov/publications/AA76/AA76.htm>.
- Consider sensitivity to alcohol or drugs. Is a client highly sensitive to the effects of alcohol or drugs? Have they noticed a relationship between their substance use and their mental health? For example, do they get depressed when they drink?
- Look at and explore symptoms when clients are sober. While some depression or anxiety is normal after people have stopped drinking or doing drugs, if the symptoms persist after one has achieved sobriety, clients may be dealing with a mental health problem.
- Review treatment history. Has your client been treated before for either an addiction or mental health problem? Did the substance abuse treatment fail because of complications from mental health issues or vice versa?
- Helping clients to think about the role that alcohol and other drugs play in their lives. Clients benefit when they are able to explore the larger picture of how substances came into their lives. Having conversations that allow for clients to better understand how the use of drugs was most likely an attempt to solve another problem will also allow them to think about what they wanted drugs/alcohol to do for them. When clients begin to make connections such as this, they often gain more insight into their behaviors/thoughts. Along with this insight, one can increase their ability to make conscious changes and improvements to their lives.
- Offering a chance to learn more about alcohol/drug interactions with medications Educating your clients about how medications they might be taking for their mental health symptoms interact with drugs and alcohol is one more way of helping clients to see the larger picture of how to best manage co-occurring disorders.



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- Helping clients identify and develop their own recovery goals. One of the most useful and important components of therapy is the client's formation of treatment goals. This allows for a direction in therapy and is also a way of tracking progress.

Signs and symptoms of alcohol abuse or substance abuse

If you're wondering whether your client has a substance abuse problem, the following questions may help them and you as the therapist to better understand the role that substances may have in their life. The more "yes" answers, the more likely that drinking or drug use is a problem.

- Have you ever felt you should cut down on your drinking or drug use?
- Have you tried to cut back, but couldn't?
- Do you ever lie about how much or how often you drink or use drugs?
- Have your friends or family members expressed concern about your alcohol or drug use?
- Do you ever felt bad, guilty, or ashamed about your drinking or drug use?
- On more than one occasion, have you done or said something while drunk or high that you later regretted?
- Have you ever blacked out from drinking or drug use?
- Has your alcohol or drug use caused problems in your relationships?
- Has your alcohol or drug use gotten you into trouble at work or with the law?

Signs and symptoms of common co-occurring disorders

The mental health problems that most commonly co-occur with substance abuse are depression, anxiety disorders, bipolar disorder, obsessive compulsive disorder and eating disorders.

Listed below are common signs and symptoms of depression:

- Feelings of helplessness and hopelessness
- Loss of interest in daily activities
- Inability to experience pleasure
- Appetite or weight changes
- Sleep changes
- Loss of energy
- Strong feelings of worthlessness or guilt
- Concentration problems
- Anger, physical pain, and reckless behavior (especially in men)



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Listed below are common signs and symptoms of mania in bipolar disorder:

- Feelings of euphoria or extreme irritability
- Unrealistic, grandiose beliefs
- Decreased need for sleep
- Increased energy
- Rapid speech and racing thoughts
- Impaired judgment and impulsivity
- Hyperactivity
- Anger or rage

Listed below are common signs and symptoms of anxiety:

- Excessive tension and worry
- Feeling restless or jumpy
- Irritability or feeling “on edge”
- Racing heart or shortness of breath
- Nausea, trembling, or dizziness
- Muscle tension, headaches
- Trouble concentrating
- Insomnia

Listed below are common signs and symptoms of obsessive compulsive disorder:

- Examples of obsession signs and symptoms include
 - Fear of being contaminated by shaking hands or by touching objects others have touched
 - Doubts that you've locked the door or turned off the stove
 - Intense stress when objects aren't orderly or facing a certain way
 - Images of hurting yourself or someone else
 - Avoidance of situations that can trigger obsessions, such as shaking hands
 - Distress about unpleasant sexual images repeating in your mind
- Examples of compulsion signs and symptoms include
 - Hand-washing until your skin becomes raw
 - Checking doors repeatedly to make sure they're locked
 - Checking the stove repeatedly to make sure it's off
 - Counting in certain patterns



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- Arranging your canned goods to face the same way

Listed below are common signs and symptoms of eating disorders:

- · Anorexia Nervosa
 - Inadequate food intake leading to a weight that is clearly too low.
 - Intense fear of weight gain, obsession with weight and persistent behavior to prevent weight gain.
 - Self-esteem overly related to body image.
 - Inability to appreciate the severity of the situation
- · Binge Eating Disorder
 - Frequent episodes of consuming very large amounts of food but without behaviors to prevent weight gain, such as self-induced vomiting.
 - A feeling of being out of control during the binge eating episodes.
 - Feelings of strong shame or guilt regarding the binge eating.
 - Indications that the binge eating is out of control, such as eating when not hungry, eating to the point of discomfort, or eating alone because of shame about the behavior.
- · Bulimia Nervosa
 - Frequent episodes of consuming very large amount of food followed by behaviors to prevent weight gain, such as self-induced vomiting.
 - A feeling of being out of control during the binge-eating episodes.
 - Self-esteem overly related to body image.

Treatment for co-occurring disorders or dual diagnosis

Clients with co-occurring disorders have historically received substance abuse treatment services in isolation from mental health treatment services. As more research on co-occurring disorders began to be conducted, the many limitations this approach places on the client and his or her success in treatment began to surface. There are various models of treatment of co-occurring disorders including:

- Single model of care - It was believed that once the “primary disorder” was treated effectively, the client’s substance use problem would resolve itself because drugs and/or alcohol were no longer needed to cope.
- Sequential model of treatment - acknowledges the presence of co-occurring disorders but treats them one at a time.



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- Parallel model of treatment - mental health disorders are treated at the same time as co-occurring substance use disorders, only by separate treatment professionals and often at separate treatment facilities.
- Integrated model of treatment – an approach to treating co-occurring disorders that utilizes one competent treatment team at the same facility to recognize and address all mental health and substance use disorders at the same time.

According to SAMSHA, the best treatment for co-occurring disorders is an integrated approach, where both the substance abuse problem and the mental disorder are treated simultaneously. Whether your mental health or substance abuse problem came first, recovery depends on treating both disorders simultaneously. This approach often lowers the cost of treatment and creates better outcomes including:

- Reduced substance use
- Improved psychiatric symptoms and functioning
- Decreased hospitalization
- Increased housing stability
- Fewer arrests
- Improved quality of life

Without integrated treatment, one or both disorders may not be addressed properly. Successful treatment requires:

- An integrated screening and assessment processes
- An integrated treatment plan
- Integrated or coordinated treatment
- Collaboration across all disciplines on the treatment team
- Integrated continued care plan
- Trained staff that will recognize the needs of patients with co-occurring disorder.

There are various levels of treatment depending on the severity and type of symptoms a person is experiencing. Some levels of care include daily therapy and close monitoring while people learn to gain a better sense of managing their symptoms, such care may include a residential component, where one receives treatment while they also reside at a facility that specializes in co-occurring disorders. Other levels of care, such as an outpatient therapy program could include a client attending group/individual sessions 3-4 times per week while residing at home.



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A comprehensive continuum of care for people requiring treatment for COD may include:

- Detoxification
- In-patient hospitalization
- Residential treatment
- Day-time or night-time treatment
- Intensive outpatient treatment
- Outpatient treatment

The best ways to determine the needed level of care is to consult with a psychiatrist, therapist, and/or co-occurring disorder treatment center, complete an integrated assessment.

Special Populations Example

Treatment programs for veterans with co-occurring disorders

When working with clients who have co-occurring disorders, some people also fall into a special category, which often means that within the population other sensitivity concerns are also necessary to address and/or keep in mind. Some examples of special populations include: LGBTQ clients, geriatric clients, clients with eating disorders, and Veterans to name a few. To further expand on this concept; let's think about some of the additional challenges that Veterans might have when it comes to co-occurring disorders. The pressures of deployment or combat can exacerbate underlying mental disorders, and substance abuse is a common way of coping with unpleasant feelings or memories. Often, these problems take a while to show up after a vet returns home, and may be initially mistaken for readjustment. Untreated co-occurring disorders can lead to major problems at home and work, so it's important to seek help. The U.S. Department of Veterans Affairs indicates that more than 2 out of 10 veterans who suffer from post-traumatic stress disorder (PTSD) concurrently have a substance abuse disorder. Veterans often benefit from treatment and support from specialized programs that address the unique stresses veterans face.

Group support for co-occurring disorders or dual diagnosis

As with other addictions, groups are very helpful, not only in maintaining sobriety, but also as a safe place to get support and discuss challenges. Sometimes treatment programs for co-occurring disorders provide groups that continue to meet on an aftercare basis. If you are treating a client who has a co-occurring disorder for individual therapy, it might be very useful to also refer them to a group for people with co-occurring disorders.



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While it's often best to join a group that addresses both substance abuse and mental health disorders, twelve-step groups for substance abuse can also be helpful—plus they're more common and often easy to locate. These free programs, facilitated by peers, use group support and a set of guided principles—the twelve steps—to obtain and maintain sobriety.

Find a group that is accepting of the idea of co-occurring disorders and psychiatric medication. Some people in these groups, although well meaning, may mistake taking psychiatric medication as another form of addiction. Clients need a place to feel safe, not pressured.

Self-help for co-occurring disorders or dual diagnosis

Getting sober is often the first, yet most important step for clients to make. Continued recovery depends on ongoing mental health treatment, learning healthier coping strategies, and making better decisions when dealing with life's challenges. Listed below are simple, yet valuable recovery tips that are often shared throughout the therapeutic community, and can be especially helpful for clients who are trying to better manage co-occurring disorders:

Recovery tip 1: Recognize and manage overwhelming stress and emotions

- Learn how to manage stress. Stress is inevitable, so it's important to have healthy coping skills so one can deal with stress without turning to alcohol or drugs. Stress management skills go a long way towards preventing relapse and keeping symptoms at bay.
- Know personal triggers and have an action plan. While coping with a mental disorder as well as a substance abuse disorder, it's especially important to know the signs that challenging symptoms are beginning to flare up. Common causes include stressful events, big life changes, or unhealthy sleeping or eating. At these times, having a plan in place is essential to preventing drug relapse. Who will you talk to? What do you need to do?

Recovery tip 2: Stay connected

- Get therapy or stay involved in a support group. One's chances of staying sober improve if they are participating in a social support group like Alcoholics Anonymous or Narcotics Anonymous or if you are seeking therapy.
- Follow doctor's orders. Once you are sober and you feel better, you might think you no longer need medication or treatment. But arbitrarily stopping medication or treatment is a common reason for relapse in people with co-occurring disorders. Always talk with your doctor before making any changes to your medication or treatment routine.



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Recovery tip 3: Make healthy lifestyle changes

- Practice relaxation techniques. When practiced regularly, relaxation techniques such as mindfulness meditation, progressive muscle relaxation, and deep breathing can reduce symptoms of stress, anxiety, and depression, and increase feelings of relaxation and emotional well-being.
- Adopt healthy eating habits. Start the day right with breakfast, and continue with frequent small meals throughout the day. Going too long without eating leads to low blood sugar, which can make you feel more stressed or anxious.
- Exercise regularly. Exercise is a natural way to bust stress, relieve anxiety, and improve your mood and outlook. To achieve the maximum benefit, aim for at least 30 minutes of aerobic exercise on most days.
- Get enough sleep. A lack of sleep can exacerbate stress, anxiety, and depression, so try to get 7 to 9 hours of quality sleep a night.

Conclusion

Although in the past, mental health disorders and addiction problems were often treated separately, we now know that co-occurring mental health and substance use disorders impact one another and must be treated together. Treating just one disorder will not cause the other to automatically improve. And separate, parallel care for the disorders does not result in one, effective treatment plan. To be effective, both disorders must be treated at the same time, in the same place, by the same treatment team. This integrated approach to treatment has provided not only hope, but real improvements to those who are learning how to better manage their co-occurring disorders.

Resources

- Drugabuse.com: <http://drugabuse.com/library/mental-health-and-drug-abuse/>
- NIH: <http://pubs.niaaa.nih.gov/publications/AA76/AA76.htm>
- SAMHSA: <http://www.samhsa.gov/disorders>
- The National Alliance on Mental Health



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Incident & Abuse Reporting

Introduction

In accordance with Florida Statute (FS) 397.419 (2) (f) and Chapter 65D-30 of the Florida Administrative Code (F.A.C.) public or private substance abuse service providers, licensed by The Department of Children and Families, must create and maintain an internal quality improvement program which includes policies and procedures for Incident Reporting.

Chapter 65D-30 FAC states:

“Incident Reporting Pursuant to paragraph 397.419(2)(f), F.S. is required of all providers and shall be conducted in accordance with Children and Families Operating Procedure 215-6.”

Florida Statute 397.419 (2) (f) requires incident reporting policies and procedures be created and:

“...include verification of corrective action, provision for reporting to the department within a time period prescribed by rule, documentation that incident reporting is the affirmative duty of all staff, and a provision that specifies that a person who files an incident report may not be subjected to any civil action by virtue of that incident report.”

Internal Incident Reporting

All DCF Licensed substance abuse providers are required to develop internal procedures regarding reporting incidents to their Incident Coordinator or assigned representative (IC/AR). All staff members are required to document unusual events/incidents that occur involving a patient and/or staff member on an Incident Report Form (IRF) and to notify a supervisor immediately. Unusual events/incidents include, but are not limited to, the following:

- Altercation/verbal between either two patients
- and/or a patient and a staff member
- Violent threat to self or others
- Violent action toward self or others
- Property loss / stolen property / damage
- Vehicular accident
- Medical problem / seizure
- Employee injury
- Self destructive behavior
- Psychiatric emergency (Baker Act)



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- Abuse / neglect
- Altercation/physical between either two
- patients and/or a patient and a staff member
- Procedure break
- Weapon
- Contraband
- Alcohol / drug use
- Bio-hazardous material
- Patient leaving against clinical advice
- Rule violation
- AWOL
- Medication error

Internal Reporting Procedure

Please consult your organization's Incident Reporting Policy and Procedure manual for the organization-specific course of action to be taken.

A standard (sample) procedure is outlined below:

- The staff member most immediately involved in and/or observing a particular incident shall complete an IRF as soon as possible and no later than 24 hours from the occurrence of the incident and give the completed IRF to their supervisor immediately.
- The supervisor shall immediately review the IRF and submit a copy to the IC/AR.
- The supervisor shall complete the investigation portion of the IRF within 24 hours of receipt of the form and forward the IRF to the IC/AR.
- The IC/AR shall complete the "Corrective Action/Follow-up" portion of the IRF within 24 hours of receipt of the form.
- The IC/AR will review the completed IRF and ensure all information was obtained and documented accurately and that all follow-up and corrective action has been completed.
- The IC/AR will forward the IRF to the appropriate outside agencies, if required.
- The IC/AR shall maintain all IRFs and subsequent investigation in a confidential file.
- While any event involving a patient needs to be described in their chart, an IRF is NEVER to be made a part of any patient's medical record.
- Appointed staff will notify patient of any adverse outcomes and note this in the IRF.
- In an unusual incident involves a patient with an appointed guardian, the guardian is to be notified of the unusual incident by appointed staff member within 24 hours.
- Data from the IRF will be entered into a database for tracking and trending purposes.



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Internal Documentation

- Each employee involved in, witness to, or informed of any unusual event/incident or occurrence
- involving a patient, visitor or other staff member has an affirmative duty to complete an IRF.
- If a staff member is uncertain as to whether an event should be documented and reported, the Supervisor or IC/AR can advise. If in doubt, an IRF SHOULD be completed.
- If more than one staff member is involved in or witnessed the unusual event, each staff member MUST complete a separate report and follow the organization's Incident

Reporting Procedure

- If more than one client is involved in the unusual event, a separate IRF for each client
- MUST be completed. Only one client is to be named on each report for confidentiality purposes. For example, if client John Doe was in an altercation with Joe Soap two separate
- Incident Reports would have to be completed. On John Doe's report it would state that
- John Doe was in an altercation with another client or peer. On Joe Soap's report it would state that Joe Soap was in an altercation with another client or peer.
- When entering narrative documentation on the form, only concise OBJECTIVE statements of fact are to be written. Avoid making personal assumptions and expressing personal opinions.
- Any area of the IRF not requiring a response specific to the incident must be marked as

"N/A" (Not applicable)

- IRFs are confidential reports and are NEVER part of a client's medical records.

External Reporting Procedure

The Department of Children and Families

In addition to documenting and reviewing/resolving incidents through an internal Quality Improvement Process, it is the responsibility of all DCF licensed substance abuse providers to promptly report within one business day all critical incidents in accordance with CFOP 215-6.

Each Department licensed or contracted service provider will designate one staff person to be the Incident Coordinator (IC) for the provider/agency. This person will manage the provider's/agency's incident notification process.

The Department of Children and Families has created an online incident reporting tool that enables the Department to collect and analyze information about critical incidents that occur in substance abuse



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and mental health facilities. This is called The Incident Reporting and Analysis System (IRAS). In some cases, critical incidents that occur outside of facilities, such as the death of an individual served, must also be reported.

Providers who must report critical incidents through IRAS include:

- Licensed Substance Abuse Providers—(including all providers who are licensed to provide substance abuse prevention and treatment under FS Chapter 397 and CH 65D-30 of the FAC.
- Private (non-contracted) substance abuse providers licensed by the Department are required to submit incident reports to IRAS directly. Private (non-contracted) designated receiving facilities are not required to report incidents to IRAS unless they are licensed by the
- Department as substance abuse providers.
- Managing Entities (MEs)—“The department contracts for behavioral health services through regional systems of care called Managing Entities (MEs).
- Private (non-contracted) designated receiving facilities are NOT required to submit incidents to IRAS unless they are licensed by the Department as substance abuse providers.
- State mental health treatment facilities are NOT required to submit incidents to IRAS
- According to CFOP 215-6 Critical Incidents to be reported include:
 - Child-on-Child Sexual Abuse
 - Child Arrest
 - Child Death
 - Adult Death
 - Elopement
 - Employee Arrest
 - Employee Misconduct
 - Escape
 - Missing Child
 - Security Incident – Unintentional
 - Significant Injury to Clients
 - Significant Injury to Staff
 - Suicide Attempt
 - Sexual Abuse/Sexual Battery

Please see CFOP 215-6 attached as Appendix A for full details on the above critical incidents.

CFOP 215-6—Guidelines for Reporting Incidents—Staff Discovery of Incident

Any employee of the licensed provider who discovers that a reportable critical incident (as outlined in



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CFOP 215-6) has taken place will take the following action:

- Ensure the health, safety, and welfare of all individual(s) involved.
- Ensure contacts are made for assistance as dictated by the needs of the individuals involved (911, law enforcement etc.) When the incident involves suspected abuse, neglect, or exploitation, the employee must call the Florida Abuse Hotline to report the incident. The employee must ensure that the client's guardian, representative or relative is notified, as applicable.
- Once the situation is stabilized the employee must report the incident to their supervisor and follow protocol. The supervisor will report to the IC/AR. Each service provider/agency will use their internal reporting process and timeframes for notifying provider/agency leadership of incidents. All critical incidents must be entered into IRAS within one business day of the incident occurring.

CFOP 215-6—Guidelines for Reporting Incidents—Actions to be taken by Provider's IC/AR

This person will manage the provider's/agency's incident notification process.

- When a supervisor is informed of a critical incident, that person shall verify what has occurred, confirm the known facts with the discovering employee, and ensure that internal reporting procedures and timeframes have been adhered to.
- If the incident qualifies as a critical incident in accordance with CFOP 215-6, the IC/AR will review for accuracy and forward the incident to the DCF via the IRAS.
- The licensed service provider will ensure timely notification of critical incidents is made to appropriate individuals or agencies such as emergency medical services (911), law enforcement, the Florida Abuse Hotline, the Agency for Health Care Administration (AHCA), or Center for Mental Health Services (for licensed mental health facilities), as required.

CFOP 215-6—Guidelines for Reporting Incidents—Actions to be taken by DCF

The actions to be taken by the DCF representative is outlined in CFOP 215-6 as follows:

“(1) The Department's Incident Coordinator or designee at the Circuit/Region level will review the incident information and clarify or obtain any necessary additional information from the applicable service provider and make revisions as necessary.

(2) The Department's Incident Coordinator or designee will make a determination regarding any required notifications that should be sent to Department leadership. The Department's



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Incident Coordinator or designee is responsible for ensuring appropriate notification is provided and serves as the contact person regarding the IRAS. In addition to Department's leadership staff, the Department's Incident Coordinator or designee will notify the Circuit/Region Public Information Officer within two (2) hours of any incident that may have Department impact or media coverage.

(3) The entry of the incident into IRAS does not substitute for a direct phone call to the Department's leadership staff when the incident type or severity of the incident warrants such contact. This determination is to be made by the Department's Incident Coordinator or designee in consultation with other Department leadership staff, as needed.

(4) The Department's Incident Coordinator or designee should submit incidents in IRAS even in cases where there is missing information not readily available. When the information is obtained, the Incident Coordinator or designee should submit an update in IRAS as soon as possible.

(5) The Department's Incident Coordinator or designee shall ensure all necessary information is entered into the IRAS in order to have a complete notification. The incident report is considered to be "complete" when the initial notifications have been made and sufficient information regarding the incident has been submitted. Additional information, such as from an autopsy or medical examiner report regarding an incident can be submitted into the IRAS after the incident has been determined to be "complete."

(6) Each Circuit/Region shall develop an internal process for reviewing and analyzing trends regarding critical incidents within their Circuit/Region across all Department program areas. Each service provider/agency including Managing Entities will establish a system for reviewing critical incidents to determine what actions need to be taken, if any, to prevent future occurrences and a follow-up process to assure such needed actions are implemented."

NOTE

The entry of the critical incident into IRAS DOES NOT substitute for a direct phone call to the Department's leadership staff when the incident type or severity of the incident warrants such contact. These incident reporting procedures do not replace exploitation reporting protocols, as required by law. Allegations of abuse, neglect, or exploitation must always be reported immediately to the Florida Abuse Hotline.

Abuse Reporting



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Patient Neglect And/Or Abuse

In addition to completing an Incident Report Form, Any incident of suspected abuse must immediately be reported.

Mandatory Reporting

- Any person, including professionally mandatory reports, should contact the Florida Abuse Hotline when they know or have reasonable cause to suspect that a child or vulnerable adult has been abused, abandoned, neglected, or exploited. The Hotline has counselors available 24 hours a day, 7 days a week.
- 39.201 Florida Statute - Mandatory reports of child abuse, abandonment, or neglect; mandatory reports of death;

By Florida Statute 39.201, a therapist or case manager “who knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare, shall report such knowledge or suspicion” to the DCF Abuse Hotline. As a mandated reporter, a therapist or case manager who fails to call in an abuse report is in violation of the law.

Definitions:

Vulnerable Adult - A person 18 years of age or older, whose ability to perform the normal activities of daily living, or to provide for his or her own care or protection is impaired due to a mental, emotional, long term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging.

Abuse - Any willful act or threatened act by a relative, caregiver, or household member which causes or is likely to cause significant impairment to a vulnerable adult's physical, mental, or emotional health. Abuse includes acts and omissions.

Exploitation - A person who stands in a position of trust and confidence with a vulnerable adult knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use, a vulnerable adult's funds, assets, or property with the intent to temporarily or permanently deprive a vulnerable adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the vulnerable adult.

OR



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That a person who knows or should know that the vulnerable adult lacks the capacity to consent, obtains or uses, or endeavors to obtain or use, the vulnerable adult's funds, assets, or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the vulnerable adult.

Neglect - Failure or omission on the part of the caregiver or vulnerable adult to provide the care, supervision, and services necessary to maintain the physical and mental health of a vulnerable adult, including but not limited to food, clothing, medicine, shelter, supervision and medical services, which a prudent person would consider essential for the well-being of a vulnerable adult. The term "neglect" also means the failure of a caregiver or vulnerable adult to make a reasonable effort to protect a vulnerable adult from abuse, neglect or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness, which produces or could reasonably be expected to result in serious physical or psychological injury, or a substantial risk of death.

Sexual Abuse - Acts of a sexual nature committed in the presence of a vulnerable adult without that person's informed consent. Sexual abuse includes, but is not limited to the acts defined in s. 94.011(1)(h), Florida Statutes, fondling, exposure of a vulnerable adult's sexual organs, or the use of a vulnerable adult to solicit for or engage in prostitution or sexual performance. Sexual abuse does not include any act intended for a valid medical purpose or any act that may reasonably be construed to be normal caregiving action or appropriate display of affection.

To Report Abuse:

Phone 80096ABUSE (22873) • TDD 8004535145

Fax 8009140004 URL <http://reportabuse.dcf.state.fl.us>



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INFECTION CONTROL (1 CEU)

Objective

Healthcare workers are required to participate in an annual training on infection prevention and control. At the end of this study guide participants will be able to:

1. Understand modes of transmission of bacteria and infections
2. Understand universal precautions
3. Practice proper hand washing techniques
4. Take action to prevention of the spread of disease in your workplace

Introduction

Infection prevention and control is essential to providing a quality and safe working environment for clients and for those that work in healthcare settings. Infection control also refers to the policies and procedures developed by an organization to minimize the risk of spreading infections and communicable diseases. Every health care worker plays a vital part in helping to minimize the risk of workplace infection. By applying standard precautions to all clients, then the risk of infection is minimized. Staff communication, managing accidents, and staff training/education are all important for infection prevention and control.

Please note that this manual contains basic infection control guidelines that are applicable to most workplace settings. Your organization may have additional guidelines and policies to follow specific to your work environment. Please consult with your designated representative before implementing any of the suggested infection control policies.

Infectious Disease

What is an Infectious Disease?

Infectious diseases are collectively a leading cause of death in the United States and around the world. From rare tropical variants to the common cold, infectious diseases are usually transmitted through being in contact with or near unsanitary conditions. Generally speaking, infectious disease is much more common in countries that do not have high quality medical care and do not offer sufficient educational resources about the transmission of disease.



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Biological Causes

Infectious diseases are caused by microorganisms - those that we cannot see with the naked eye. These organisms attack the body and without treatment can kill the human host. Infectious diseases are not only caused by viruses, but they can also be caused by parasites, bacteria or a fungus. While most of these organisms in our body are benign and actually quite helpful, some can be serious and even life-threatening.

Symptoms

The wide scope of infectious diseases means that symptoms can range from relatively mild to extremely virulent. Additionally, some infections are rare and may not have current forms of treatment developed to fight them. Infectious disease can range from flu to HIV and the symptoms that a person will experience can be as mild as a cold or deadly.

Modern society has developed ways of fighting most infectious diseases. Prevention is key, through vaccination and/or proper hygiene. Those who have contracted the disease can be treated quickly and effectively with antibiotics, antifungals or antivirals.

The few major infectious diseases that we have not been able to treat effectively are subject to a great deal of research and testing to find an appropriate treatment programs.

Transmission

Infectious diseases are transmitted from person to person and sometimes between animals and people. The transmission can occur through various forms, including blood to blood contact, bodily fluid contact and through casual contact depending on the organism and how it responds outside the host. Transmission can either be quite difficult or very easy. The infectious diseases transmitted through air, water and casual contact can be transmitted the most quickly, while those that are transmitted through bodily fluid or blood to blood contact tend to spread more slowly.

Routes of Transmission

Transmission of infectious agents within a healthcare setting requires three elements:

- a) A source of infectious agents
- b) A susceptible host with a portal of entry receptive to the agent
- c) A mode of transmission for the agent.



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Contact

Infections spread by direct or indirect contact with patients or the patient-care environment (e.g., Herpes Simplex Virus, MRSA, Scabies/Lice, Pink eye, Respiratory illness). Direct contact is skin to skin contact. Indirect contact occurs through touching contaminated surfaces such as doorknobs, sink faucets or soiled linens. This is the most frequent mode of transmission in the healthcare setting.

Droplet

Infections spread by large droplets generated by coughs, sneezes, talking, etc. (e.g., influenza, pneumonia, whooping cough). They can be propelled a short distance before settling quickly onto a surface. They can cause infection by being deposited directly onto a susceptible person's mucosal surface (e.g., eyes, mouth, nose, or breaks in skin) or onto nearby environmental surfaces, which can then be touched by a susceptible person who infects themselves.

Airborne

Infections that occur when bacteria or viruses travel on dust particles or on small respiratory droplets when people sneeze, cough, laugh, or exhale. They can remain infectious while suspended in the air (e.g., TB, chicken pox, measles). These germs may be inhaled by susceptible individuals who have not had face-to-face contact with an infected person.

Bloodborne Diseases: HIV/AIDS, Hepatitis B, Hepatitis C

The Centers for Disease Control and Prevention (CDC) estimates that 5.6 million workers in the health care industry and related occupations are at risk of occupational exposure to bloodborne pathogens, including Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), and others. All occupational exposure to blood or other potentially infectious materials (OPIM) place workers at risk for infection with bloodborne pathogens. (OSHA.gov)

The Occupational Safety and Health Administration (OSHA) defines Blood as human blood, human blood components and products made from human blood. OSHA defines Bloodborne Pathogens as pathogenic microorganisms that are present in human blood and can cause disease in humans.

According to the Occupational Safety and Health Administration (OSHA), Other Potentially Infectious Materials (OPIM) includes the following:



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- Semen
- Saliva in dental procedures
- Vaginal secretions
- Any body fluid visibly contaminated with blood
- Cerebrospinal fluid
- Fluids where it is difficult to differentiate the fluid
- Pleural fluid
- Amniotic fluid
- Pericardial fluid

According to the Red Cross; Bloodborne pathogens, such as bacteria and viruses, are present in blood and body fluids and can cause disease in humans. Bloodborne pathogens can be spread through direct contact, indirect contact, respiratory, and vector-borne transmission. Some infections that can be transmitted through contact with blood and body fluids include HIV, Hepatitis B, C, Staph and Strep infections, Pneumonia, TB, Syphilis, Measles, Chicken Pox, and Herpes. (Red Cross, 2011)

According to the Red Cross, bloodborne pathogens are spread through:

- Direct contact - caused by infected blood or body fluid from one person enters another person's body at a correct entry site, such as infected blood splashing in the eye.
- Indirect contact - such as when a person's skin touches an object that contains the blood or body fluid of an infected person, such as picking up soiled dressings contaminated with an infected person's blood or body fluid.
- Respiratory droplet transmission - a person inhales droplets from an infected person, such as through a cough or sneeze.
- Vector-borne transmission - A person's skin is penetrated by an infectious source, such as an insect bite.

Blood is the single most important source of exposure to HBV, HCV, and HIV in healthcare settings. Exposures by needlesticks and punctures or cuts with other sharp objects are most frequently sustained by those occupational groups that handle sharps.

Hepatitis B Virus

Hepatitis B is a virus that infects the liver and over time can damage the liver. It is spread by blood and body fluids of an infected person. Hepatitis B is found in semen and vaginal secretions. The virus can be transmitted during unprotected sexual intercourse and from mother to infant during birth. Saliva of people with Hepatitis B can contain the Hepatitis B virus, but in very low concentrations compared



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with blood. Punctures of the skin with blood-contaminated needles, lancets, scalpels, or other sharps can transmit Hepatitis B. Also, splashes to skin bearing minute scratches, abrasions, burns, or even minor rashes, splashes to mucous membranes in the mouth, nose, or eyes can transmit Hepatitis B. Hepatitis B is not transmitted by casual contact. For example, hospital employees who have no contact with blood, blood products, or blood contaminated fluids are at no greater risk than the general public. However, the virus can spread through intimate contact with carriers in a household setting. Why this happens is not completely understood. Somehow, the virus can find its way into the bloodstream of fellow family members possibly because of frequent physical contact with the small cuts or skin rashes. The virus can also spread through biting and possibly by the sharing of toothbrushes or razors. The virus is not spread through sneezing, coughing, hand holding, hugging, breastfeeding, sharing eating utensils, water or food. The virus can survive outside the body for at least 7 days and still able to cause infection. (Canadian Center for Occupational Health and Safety (CCOHS), 1997)

In mild cases, the signs and symptoms are those of a minor infection. In severe cases, they are extreme reactions resulting from liver failure. The extent of the illness depends on the original size of the dose of the virus, the route of exposure, and the specific response of the infected individual. More than half of Hepatitis B infections occur and pass without noticeable symptoms. Sometimes, only mild symptoms such as a general discomfort occur. Rarely is medical attention needed. Often, the infection disappears without treatment. In fact, laboratory testing is often the only way of determining whether someone has had Hepatitis B.

When symptoms develop, the earliest ones often include a general discomfort, joint pain, abdominal pain, fatigue, lack of appetite, skin rash or possibly nausea, vomiting or other flu-like symptoms.

In relatively few cases, these symptoms are followed by jaundice causing skin and white of eyes to yellow and urine to darken--typical signs of a malfunctioning liver. An accumulation of a waste product, called bilirubin, in the blood causes this yellowish color. Jaundice and other symptoms usually subside gradually within 3 to 4 weeks and most patients fully recover, becoming immune in the process.

People with serious cases of Hepatitis B require hospitalization. A very small proportion of these patients develop a critical form of the disease called "Fulminant" Hepatitis B. This condition results from a sudden breakdown of liver function. Fulminant Hepatitis B is extremely serious. Over half of the victims of fulminant Hepatitis B die from the disease. (CCOHS, 1997)

Hepatitis C Virus

Hepatitis C is an infectious liver disease caused by the Hepatitis C Virus (HCV). Infections of Hepatitis C occur only if the virus is able to enter the blood stream and reach the liver. For reasons that are not



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completely understood, about half of all people who develop Hepatitis C never fully recover and can carry the virus for the rest of their lives. These people have chronic Hepatitis C, and some may eventually develop cirrhosis of the liver and liver failure. (CCOHS, 1997)

The symptoms of Hepatitis C infection include fever, nausea and vomiting, loss of appetite, stomach pain, extreme fatigue, and yellowing of the skin and eyes (jaundice).

Some people who are infected with Hepatitis C virus have no symptoms and can infect others without knowing it. These persons are at risk of becoming ill at some time in the future.

It has been estimated that it may take up to 10 years to develop symptoms.

The Hepatitis C virus is spread primarily by exposure to blood. Some people who get Hepatitis C do not know how they were infected with the virus.

People may get Hepatitis C by sharing needles to inject drugs, through exposure to blood in the workplace, from unsterile equipment used for body piercing, tattoos or acupuncture, exposure to dental or medical practices with poor infection control practices or by sharing personal care items including nail clippers, razors, and scissors with infected people. The risk of getting this virus from a blood transfusion is minimal but still exists. All donated blood is now screened for the Hepatitis C virus.

Hepatitis C has been transmitted between sex partners and among household members. However, the degree of this risk still needs to be accurately defined. An infected mother can pass HCV to her child at birth.

There is no evidence that Hepatitis C virus is spread by casual contact. Sneezing, coughing and hugging do not pose the risk for Hepatitis C. In addition, there is no evidence that Hepatitis C virus is spread by food or water. (CCOHS, 1997)

There is currently no vaccine for Hepatitis C. The risk of Hepatitis C can be significantly reduced by implementing infection control guidelines suitable for the specific workplace.

Human Immunodeficiency Virus (HIV)

The Human Immunodeficiency Virus (HIV) is a virus that infects the immune system. Acquired Immune Deficiency Syndrome (AIDS) is the most advanced stage of the HIV infection. HIV causes the immune system to become vulnerable to other infections. There is presently no cure or vaccine for HIV. It takes, on average, 10 years for the initial HIV infection to progress to AIDS. (CCOHS 1997)



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HIV can pass from one person to another in the following ways:

- By unprotected sexual intercourse with infected persons
- By using contaminated needles
- Via transfusion of infected blood or blood products
- From an infected mother to her infant before or during birth
- Via organ transplant from an infected donor

HIV is not found in vomit, feces, nasal secretions, tears or urine unless these fluids are visibly contaminated with blood.

All workers who are in contact with contaminated blood or other body fluids are at risk.

Exposure to HIV in the workplace occurs through:

- skin and mucous membrane contact with blood and other body fluids of an infected person
- accidents with needles or other sharp instruments contaminated with the blood of an infected person (CCOHS, 1997)

Airborne Diseases

According to OSHA, airborne transmission occurs through very small particles or droplet nuclei that contain infectious agents and can remain suspended in air for extended periods of time. When they are inhaled by a susceptible individual, they enter the respiratory tract and can cause infection. Since air currents can disperse these particles or droplet nuclei over long distances, airborne transmission does not require face-to-face contact with an infected individual. Airborne transmission only occurs with infectious agents that are capable of surviving and retaining infectivity for relatively long periods of time in airborne particles or droplet nuclei. Only a limited number of diseases are transmissible via the airborne route. Two examples of airborne transmissible agents include *Mycobacterium tuberculosis* which causes tuberculosis (TB) and the rubella virus which causes measles. (OSHA.gov)

Some examples of airborne diseases include:

- Tuberculosis
- Chicken-pox
- Measles
- Shingles in a person whose immune system is weak



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- There are many ways to protect staff and other patients from airborne diseases.
- Patients who have airborne diseases will be discharged and/or transferred to another facility until there are free from the airborne disease.
- Staff will be notified of any airborne diseases to ensure proper care is given to individual.

Tuberculosis

According to the CDC, TB is a contagious and potentially life-threatening infectious disease caused by a bacterium called *Mycobacterium tuberculosis*. The TB bacteria are spread from person to person through the air. People with TB disease of the lungs or larynx release the bacteria into the surrounding area when they cough, sneeze, talk, or otherwise expel air, dispersing droplets that contain *M. tuberculosis*. These droplets can dry into tiny particles called droplet nuclei that remain suspended in air for long periods of time. Other people can breathe the infectious particles into their lungs and become infected. Infection usually requires prolonged sharing of airspace with a person actively spreading TB bacteria into the area. The risk of developing active TB disease is greatest in the first few years after infection, but some risk remains throughout life. TB is preventable and, in most cases, treatable. (CDC, 2012)

People with active TB disease feel tired and weak. They cough constantly, sometimes bringing up blood. They also suffer chest pain, night sweats, fever, and fatigue. They have no appetite, and lose weight. Many people become short of breath. Among older people, males typically experience worse symptoms than females. The incubation period for TB infection is about 4 to 12 weeks, after which a skin test will show positive or, in some cases, a lesion will appear on a Chest X-ray. (Worksafe BC)

http://www.worksafebc.com/publications/health_and_safety/by_topic/assets/pdf/bk129.pdf

Droplet Precautions

Droplet transmission can spread diseases when a person coughs, sneezes or through talking. The droplets travel about 3-6 feet before drying out or falling onto a surface. These droplets can be deposited on the host's nasal mucosa, conjunctivae or mouth.

Examples of conditions transmitted through droplets include:

- Bronchiolitis
- Meningitis
- Pneumonia
- Viral infections including influenza, mumps and rubella



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Droplet precautions include hand washing to keep everyone's hands clean and to avoid spreading germs through touching other people or objects in the patient's room, such as door knobs, light switches, or patient care equipment. Wearing a surgical mask when working with the client to protect yourself as well to keep droplets from getting into the nose or mouth.

Contact Precautions

Contact precautions apply to clients with any of the following conditions:

- Presence of stool incontinence
- Draining wounds
- Uncontrolled secretions
- Pressure ulcers,
- Bags/tubes draining fluids
- Presence of a rash.

Wear gloves if touching the patient or patient belongings/immediate environment. Wear a gown if substantial contact with client or their environment is anticipated. Make sure to perform proper hand hygiene, disinfect room accordingly and instruct client to use separate bathroom if available and client has infectious diarrhea.

Airborne Precautions

Airborne precautions applies clients with known or suspected infection that include but not limited to the following infections:

- Tuberculosis
- Measles
- Chickenpox (until lesions are crusted over)

Airborne Precautions are intended to prevent transmission of infectious agents that remain infectious over long distances when suspended in the air. In addition to Standard Precautions, Airborne precautions require respiratory protection, wear a fit-tested NIOSH-approved N95 or higher level respirator for protection when entering the room or home of a patient who is suspected or confirmed to have an airborne disease. If available, place patient in an isolation room, try to have them enter a separate entrance to avoid reception area. Provide a surgical face mask for client to place on themselves. Initiate protocol to transfer client to healthcare facility that can properly manage client.



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Once client leaves area, the room should remain vacant for at least one hour before anyone enters.

Safeguarding The Workplace—Standard Precautions

The CDC recommends Standard Precautions (formerly known as Universal Precautions) for the care of all patients, regardless of their diagnosis or presumed infection status. Always follow Standard Precautions because you cannot tell by looking at a person whether they have a contagious disease or not.

Standard Precautions apply to:

- 1) blood
- 2) all body fluids, secretions, and excretions, except sweat, regardless of whether or not they contain visible blood
- 3) non-intact skin
- 4) mucous membranes.

Standard precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in hospitals. Standard precautions include the use of: hand washing, appropriate personal protective equipment such as gloves, gowns, masks, whenever touching or exposure to patients' body fluids is anticipated. (CDC.gov)

Infection Control Measures to consider include:

- Early recognition and reporting any signs of infection to your supervisor
- Use hand washing guidelines
- PPE: use personal protective equipment (gloves, gowns, masks, goggles/eye protection)
- Cleaning and disinfection of your environment and equipment as well as patient environment
- Disposing of sharps in puncture-resistant, leak-proof, labeled containers
- Avoid touching eyes, nose or mouth
- Cover your nose/mouth with a tissue when you sneeze
- Cough/sneeze into your sleeve if you do not have a tissue
- Always clean your hands after you cough or sneeze

According to the CDC, when evaluating occupational exposures to fluids that might contain hepatitis B virus (HBV), hepatitis C virus (HCV), or human immunodeficiency virus (HIV), health care workers should consider that all blood, body fluids, secretions, and excretions except sweat, may contain transmissible infectious agents. (CDC.gov)



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Personal Protective Equipment

The CDC states that, Personal Protective Equipment (PPE) refers to wearable equipment that is intended to protect HCP from exposure to or contact with infectious agents. Examples include gloves, gowns, face masks, respirators, goggles and face shields. The selection of PPE is based on the nature of the patient interaction and potential for exposure to blood, body fluids or infectious agents. Examples of appropriate use of PPE for adherence to Standard Precautions include: use of gloves in situations involving possible contact with blood or body fluids, mucous membranes, nonintact skin or potentially infectious material; use of a gown to protect skin and clothing during procedures or activities where contact with blood or body fluids is anticipated; use of mouth, nose and eye protection during procedures that are likely to generate splashes or sprays of blood or other body fluids. Hand hygiene is always the final step after removing and disposing of PPE. (CDC.gov)

Environmental cleaning

Complete guidance for the cleaning and disinfection of environmental surfaces, including for cleaning blood or body substance spills, is available in the Guidelines for Environmental

Infection Control in Health-Care Facilities available at:

http://www.cdc.gov/hicpac/pdf/guidelines/eic_in_HCF_03.pdf

Guideline for Disinfection and Sterilization in Healthcare Facilities (available at:

http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf)

The CDC guide to Cleaning Spills of Blood and Body Substances as follows:

- Wear protective gloves and use appropriate PPE (e.g., use forceps to pick up any sharps and discard in sharps container).
- If the spill contains large amounts of blood or body fluids (e.g., >10 mL), clean the visible matter with disposable absorbent material and discard in appropriate containers for biohazardous waste.
- Decontaminate the area using an EPA-registered disinfectant with specific label claims for bloodborne pathogens (e.g., HIV, HBV, HCV) or a freshly diluted bleach-based product (preferably EPA-registered), in accordance with manufacturer's instructions, and allow the surface to dry.
- If a bleach-based product is used:



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- Use a 1:100 dilution to decontaminate nonporous surfaces
- If the spill involves large amounts of blood or body fluids, use a 1:10 dilution for first application of germicide before cleaning, then followed by cleaning and subsequent decontamination with 1:100 dilution application (CDC, 2011)

The CDC guide to Waste Disposal is as follows:

- Puncture-resistant, leak-proof sharps containers are located in designated patient-care area, (for example, exam room)
 - All sharps are disposed of in the designated sharps container; do not bend, recap, or break used syringe needles before discarding them into the container.
 - Filled sharps containers are disposed of in accordance with state regulated medical waste rules.
- Regular trash and regulated medical waste (e.g., biohazardous material and chemical hazardous waste are disposed of in their designated containers.
- All trash and waste containers are emptied at least daily by designated personnel
 - Wear appropriate PPE.
 - Handle, transport, and dispose regulated waste, including antineoplastic and hazardous drugs, in accordance with state and local regulations.
- Use biohazard bags to dispose of contaminated materials, such as used gloves and bandages
- Place all soiled clothing in marked plastic bags for disposal or cleaning.
- Biohazard warning labels are required on any container holding contaminated materials.
- (CDC, 2011)

What to do when an employee is exposed

- 1) Needle sticks
- 2) Splash in eye or mouth
- 3) Exposure to non-intact skin, or contact with unprotected hands

When an employee is exposed to blood or potentially infectious body fluids the employee should:

- Cleanse area and flush contaminated skin with antimicrobial soap and water immediately
- For exposure to eyes, nose, and/or mouth should be thoroughly flushed with a lot of tepid to warm water
- If splashed in or around the eyes, irrigate with clean water, saline or sterile irrigants for 20 minutes
- Remove all contaminated clothing as soon as possible



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- Report incident to supervisor immediately
- Consent for HIV and HBV infectivity will be needed
- Medical exam by workman's compensation physician

Hand Washing

Hand hygiene Recommendations Adapted from the Centers for Disease Control and Prevention

Hand washing is easy to do and it's one of the most effective ways to prevent the spread of many types of infection and illness in all settings—from your home and workplace to child care facilities and hospitals. Clean hands can stop germs from spreading from one person to another and throughout an entire community. (CDC.gov)

When should you wash your hands?

- Before, during, and after preparing food
- Before eating food
- Before and after caring for someone who is sick
- Before and after treating a cut or wound
- After using the toilet
- After changing diapers or cleaning up a child who has used the toilet
- After blowing your nose, coughing, or sneezing
- After touching an animal, animal feed, or animal waste
- After touching garbage
- After being in contact with any body fluids (blood, saliva, semen, urine, feces, vaginal secretions, mucous membranes, non-intact skin)

How should you wash your hands?

- Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
- Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails.
- Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
- Rinse your hands well under clean, running water.
- Dry your hands using a clean towel or air dry them. (CDC.gov)
- Other hand washing tips:
- Wash your hands before you apply gloves, after you take them off, and between contacts that



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might contaminate other surfaces.

- Wash your hands between patients.
- If soap and water are not available, use an alcohol-based antimicrobial agent or waterless antiseptics only in special circumstances.

According to the CDC, washing hands with soap and water is the best way to reduce the number of microbes on them in most situations. If soap and water are not available, use an alcohol-based hand sanitizer that contains at least 60% alcohol. Alcohol-based hand sanitizers can quickly reduce the number of microbes on hands in some situations, but sanitizers do not eliminate all types of germs.

Hand sanitizers are not as effective when hands are visibly dirty or greasy. How do you use hand sanitizers?

- Apply the product to the palm of one hand (read the label to learn the correct amount).
- Rub your hands together.
- Rub the product over all surfaces of your hands and fingers until your hands are dry.
(CDC.gov)

Summary

Infection control in the workplace begins by assuming that everyone is potentially infectious. Techniques that will assist in the spread of infection include routine hand washing or the use of alcohol hand gel/rub, and keeping the workplace environment clean. Personal protective equipment such as gloves, gowns, eye goggles and face shields should be provided if necessary. Employers should update their infection and control plan annually to reflect any changes to reduce or eliminate possible exposure for the staff and clients.

According to 65d-30, we must report communicable diseases to the Department of Health in accordance with Sections 381.0031 and 384.25, F.S.

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Understanding Co-occurring Disorders

Course Description

Prevalence rates show that individuals with co-occurring disorders are common in both the substance abuse and mental health treatment systems. This course will provide participants with an understanding of the concept and term: co-occurring disorders. Participants will become familiar with the assessment, symptoms, and treatment of co-occurring disorders, and will be provided with an example of a special population that exists within the realm of co-occurring disorders.

Course Objectives

On completion of this course, participants will be able to identify/demonstrate familiarity with:

1. The definition and terms related to co-occurring disorders.
2. The assessment of co-occurring disorders and common symptoms.
3. The relationship between substance abuse and mental health concerns.
4. The symptoms of specific co-occurring disorders.
5. Available treatments for clients with co-occurring disorders.
6. A special population example and co-occurring disorders.

Introduction

Formerly known as dual diagnosis or dual disorder, the term co-occurring disorders describes the presence of two or more disorders at the same time. For example, a person may suffer with substance use disorder, as well as bipolar disorder. For the purpose of this training, the terms co-occurring and dual-diagnosis may be used interchangeably.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines cooccurring disorders as:

“The term co-occurring disorders (COD) refers to co-occurring substance-related and mental disorders. Clients said to have COD have one or more substance-related disorder as well as one or more mental disorder.”

According to SAMHSA, a 2002 report to Congress estimated that seven to ten million individuals



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in the United States have at least one mental disorder as well as a substance use disorder. In the 2012 SAMHSA's National Survey on Drug Use and Health (NSDUH) it was reported that an estimated 43.7 million (18.6%) Americans ages 18 and up experienced some form of mental illness. In the past year, 20.7 million adults (8.8%) had a substance use disorder. Of these, 8.4 million people had both a mental disorder and substance use disorder, also known as co-occurring mental and substance use disorders.

Terminology

As the field of treatment for substance use and mental disorders is evolving to become more precise, so too is the terminology used to describe people with both substance use and mental disorders. The term co-occurring disorders has been integrated as a term that will be more encompassing than the terms dual disorder or dual diagnosis. These latter terms, though used commonly to refer to the combination of substance use and mental disorders, are confusing in that they also refer to other combinations of disorders (such as mental disorders and mental retardation). Furthermore, the terms suggest that there are only two disorders occurring at the same time, when in fact there may be more. Clients with COD have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders. A diagnosis of co-occurring disorders occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder.

Understanding Co-occurring Disorders

Both mental health issues and substance use disorders have their own unique symptoms that may get in the way of one's ability to function, handle life's difficulties, and relate to others. To make the situation more complicated, the co-occurring disorders also affect and interact with one another. When a mental health problem goes untreated, the substance abuse problem usually gets worse as well, and when alcohol or drug abuse increases, mental health problems usually increase too.

Common examples of co-occurring disorders include the combinations of:

- Major depression with cocaine addiction.
- Alcohol use disorder with panic disorder.
- Alcoholism and poly-drug addiction with schizophrenia.
- Borderline personality disorder with episodic poly-drug abuse.
- Substance use disorder and eating disorder.

Combinations of COD problems and psychiatric disorders vary along dimensions such as:



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- Severity,
- Chronicity,
- Disability, and
- Degree of impairment in functioning.

For example, two disorders may each be severe or mild, or one may be more severe than the other, and the severity of both disorders may change over time. Levels of disability and impairment in functioning may also vary. There is no single combination of dual disorders, as there is great variability among them. However, clients with similar combinations of dual disorders are often encountered in certain treatment settings. For example, adults with severe mental illness who are further impaired by substance use disorders (abuse or dependence related to alcohol or other drugs) would often be receiving treatment at a dual-diagnosis/co-occurring disorders treatment center. Patients with dual disorders often experience more severe and chronic medical, social, and emotional problems compared to patients who have a mental health disorder or a substance use disorder alone. Because they have two disorders, they are vulnerable to relapsing and a worsening of the psychiatric disorder. Further, addiction relapse often leads to psychiatric decompensation, and worsening of psychiatric problems often leads to addiction relapse.

A mental health disorder complicates and compounds the challenges in overcoming an addiction to drugs or alcohol. Also, many times people who have an undiagnosed mental illness may try to treat their symptoms by self-medicating with drugs or alcohol, with alcohol being the most common choice. This self-medicating to numb symptoms can unfortunately cause side effects and worsen the very symptoms they were trying to relieve. Some common symptoms that people seek relief from by self-medicating include anxiety, depression, or paranoia. Down the road, if an individual is a chronic drug abuser, they can acquire mental illness from years of heavy use. Therefore, relapse prevention must be specially designed for patients with dual disorders. Compared with patients who have a single disorder, patients with dual disorders often require longer treatment, have more crises, and progress more gradually in treatment.

Psychiatric disorders most prevalent among dually diagnosed patients include mood disorders, anxiety disorders, personality disorders, and psychotic disorders. Antisocial personality disorders have a 15.5 percent abuse rate; Bipolar disorder is next at 14.5 percent, while anxiety disorders have a 4.3 percent abuse rate.

Source: <http://drugbuse.com/library/mental-health-and-drug-abuse>

The relationship between substance use disorder and mental health concerns



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Addiction is common within people who are also facing mental health problems. Although substance abuse and mental health disorders, like depression and anxiety, are closely linked, one does not directly cause the other in a linear fashion. In other words, the presence of a mental health problem does not necessarily mean that a client is also going to develop or have a substance use problem. Although, one can easily see how an increase in depression or anxiety could lead a person to using substances as an attempt to solve their symptoms of depression or anxiety. It is also quite plausible to see how a person who has a substance use problem could have an increase in depression or anxiety symptoms. Duration and intensity of symptoms helps to distinguish what problems may need the most attention. In order to expand on the relational aspect between substance abuse and mental health problems, think about the following ideas:

- Alcohol or drugs are often used to self-medicate the symptoms of depression or anxiety. Unfortunately, substance abuse causes side effects and in the long run worsens the very symptoms they initially numbed or relieved.
- Alcohol and drug abuse can increase underlying risk for mental disorders. Mental disorders are caused by a complex interplay of genetics, the environment, and other outside factors. If you are at risk for a mental disorder, drug or alcohol abuse may push you over the edge.
- Alcohol and drug abuse can make symptoms of a mental health problem worse. Substance abuse may sharply increase symptoms of mental illness or trigger new symptoms. Alcohol and drug abuse also interact with medications such as antidepressants, anti-anxiety pills, and mood stabilizers, making them less effective.

According to reports published in the Journal of the American Medical Association:

- Roughly 50% of individuals with severe mental disorders are affected by substance abuse.
- 37 percent of alcohol abusers and 53 percent of drug abusers also have at least one serious mental illness.
- Of all people diagnosed as mentally ill, 29 percent abuse either alcohol or drugs.

Source: National Alliance on Mental Illness

Recognizing co-occurring disorders or dual diagnosis

It can be difficult to diagnose a substance abuse problem and a co-occurring mental health disorder such as depression, anxiety, or bipolar disorder. It takes time to tease out what might be a mental disorder and what might be a drug or alcohol problem. Often chronic alcohol abuse and withdrawal can imitate symptoms of psychiatric disorders, such as anxiety, mood changes, and cognitive



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impairment.

Complicating the issue is denial. Denial is common in substance abuse. The term "denial" refers to the process by which people with addictions pretend (to themselves and/or to other people) that they do not have an addiction, when in fact they do, or that their addictive behavior is not problematic, when in fact it is. Denial says that if the problem is not acknowledged, it doesn't exist. It's hard to admit how dependent you are on alcohol or drugs or how much they affect your life. Denial frequently occurs in mental disorders as well. The symptoms of depression or anxiety can be frightening, so you may ignore them and hope they go away. Or you may be ashamed or afraid of being viewed as weak if you admit the problem.

To assist you in recognizing a dual diagnosis or co-occurring disorders:

- Consider family history. If people in one's family have grappled with either a mental disorder such as depression or alcohol abuse or drug addiction, they have a higher risk of developing these problems. Children of alcoholics are 50 to 60 percent more likely to develop alcohol use disorders than people in the general population. Children of parents who abuse illicit drugs may be 45 to 79 percent more likely to do so themselves than the general public. <http://pubs.niaaa.nih.gov/publications/AA76/AA76.htm>. Consider sensitivity to alcohol or drugs. Is a client highly sensitive to the effects of alcohol or drugs? Have they noticed a relationship between their substance use and their mental health? For example, do they get depressed when they drink?
- Look at and explore symptoms when clients are sober. While some depression or anxiety is normal after people have stopped drinking or doing drugs, if the symptoms persist after one has achieved sobriety, clients may be dealing with a mental health problem.
- Review treatment history. Has your client been treated before for either an addiction or mental health problem? Did the substance abuse treatment fail because of complications from mental health issues or vice versa?
- Helping clients to think about the role that alcohol and other drugs play in their lives. Clients benefit when they are able to explore the larger picture of how substances came into their lives. Having conversations that allow for clients to better understand how the use of drugs was most likely an attempt to solve another problem will also allow them to think about what they wanted drugs/alcohol to do for them. When clients begin to make connections such as this, they often gain more insight into their behaviors/thoughts. Along with this insight, one can increase their ability to make conscious changes and improvements to their lives.
- Offering a chance to learn more about alcohol/drug interactions with medications Educating your clients about how medications they might be taking for their mental health symptoms



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interact with drugs and alcohol is one more way of helping clients to see the larger picture of how to best manage co-occurring disorders.

- Helping clients identify and develop their own recovery goals. One of the most useful and important components of therapy is the client's formation of treatment goals. This allows for a direction in therapy and is also a way of tracking progress.

Signs and symptoms of alcohol abuse or substance abuse

If you're wondering whether your client has a substance abuse problem, the following questions may help them and you as the therapist to better understand the role that substances may have in their life. The more "yes" answers, the more likely that drinking or drug use is a problem.

- Have you ever felt you should cut down on your drinking or drug use?
- Have you tried to cut back, but couldn't?
- Do you ever lie about how much or how often you drink or use drugs?
- Have your friends or family members expressed concern about your alcohol or drug use?
- Do you ever felt bad, guilty, or ashamed about your drinking or drug use?
- On more than one occasion, have you done or said something while drunk or high that you later regretted?
- Have you ever blacked out from drinking or drug use?
- Has your alcohol or drug use caused problems in your relationships?
- Has your alcohol or drug use gotten you into trouble at work or with the law?

Signs and symptoms of common co-occurring disorders

The mental health problems that most commonly co-occur with substance abuse are depression, anxiety disorders, bipolar disorder, obsessive compulsive disorder and eating disorders.

Listed below are common signs and symptoms of depression:

- Feelings of helplessness and hopelessness
- Loss of interest in daily activities
- Inability to experience pleasure
- Appetite or weight changes
- Sleep changes
- Loss of energy
- Strong feelings of worthlessness or guilt
- Concentration problems



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- Anger, physical pain, and reckless behavior (especially in men)

Listed below are common signs and symptoms of mania in bipolar disorder:

- Feelings of euphoria or extreme irritability
- Unrealistic, grandiose beliefs
- Decreased need for sleep
- Increased energy
- Rapid speech and racing thoughts
- Impaired judgment and impulsivity
- Hyperactivity
- Anger or rage

Listed below are common signs and symptoms of anxiety:

- Excessive tension and worry
- Feeling restless or jumpy
- Irritability or feeling “on edge”
- Racing heart or shortness of breath
- Nausea, trembling, or dizziness
- Muscle tension, headaches
- Trouble concentrating
- Insomnia

Listed below are common signs and symptoms of obsessive compulsive disorder:

- Examples of obsession signs and symptoms include
 - Fear of being contaminated by shaking hands or by touching objects others have touched
 - Doubts that you've locked the door or turned off the stove
 - Intense stress when objects aren't orderly or facing a certain way
 - Images of hurting yourself or someone else
 - Avoidance of situations that can trigger obsessions, such as shaking hands
 - Distress about unpleasant sexual images repeating in your mind
- Examples of compulsion signs and symptoms include
 - Hand-washing until your skin becomes raw
 - Checking doors repeatedly to make sure they're locked



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- Checking the stove repeatedly to make sure it's off
- Counting in certain patterns
- Arranging your canned goods to face the same way

Listed below are common signs and symptoms of eating disorders:

- Anorexia Nervosa
 - Inadequate food intake leading to a weight that is clearly too low.
 - Intense fear of weight gain, obsession with weight and persistent behavior to prevent weight gain.
 - Self-esteem overly related to body image.
 - Inability to appreciate the severity of the situation
- Binge Eating Disorder
 - Frequent episodes of consuming very large amounts of food but without behaviors to prevent weight gain, such as self-induced vomiting.
 - A feeling of being out of control during the binge eating episodes.
 - Feelings of strong shame or guilt regarding the binge eating.
 - Indications that the binge eating is out of control, such as eating when not hungry, eating to the point of discomfort, or eating alone because of shame about the behavior.
- Bulimia Nervosa
 - Frequent episodes of consuming very large amount of food followed by behaviors to prevent weight gain, such as self-induced vomiting.
 - A feeling of being out of control during the binge-eating episodes.
 - Self-esteem overly related to body image.

Treatment for co-occurring disorders or dual diagnosis

Clients with co-occurring disorders have historically received substance abuse treatment services in isolation from mental health treatment services. As more research on co-occurring disorders began to be conducted, the many limitations this approach places on the client and his or her success in treatment began to surface. There are various models of treatment of co-occurring disorders including:

- Single model of care - It was believed that once the “primary disorder” was treated effectively, the client’s substance use problem would resolve itself because drugs and/or alcohol were no longer needed to cope.
- Sequential model of treatment - acknowledges the presence of co-occurring disorders but treats them one at a time.



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- Parallel model of treatment - mental health disorders are treated at the same time as co-occurring substance use disorders, only by separate treatment professionals and often at separate treatment facilities.
- Integrated model of treatment – an approach to treating co-occurring disorders that utilizes one competent treatment team at the same facility to recognize and address all mental health and substance use disorders at the same time.

According to SAMSHA, the best treatment for co-occurring disorders is an integrated approach, where both the substance abuse problem and the mental disorder are treated simultaneously. Whether your mental health or substance abuse problem came first, recovery depends on treating both disorders simultaneously. This approach often lowers the cost of treatment and creates better outcomes including:

- Reduced substance use
- Improved psychiatric symptoms and functioning
- Decreased hospitalization
- Increased housing stability
- Fewer arrests
- Improved quality of life

Without integrated treatment, one or both disorders may not be addressed properly. Successful treatment requires:

- An integrated screening and assessment processes
- An integrated treatment plan
- Integrated or coordinated treatment
- Collaboration across all disciplines on the treatment team
- Integrated continued care plan
- Trained staff that will recognize the needs of patients with co-occurring disorder.

There are various levels of treatment depending on the severity and type of symptoms a person is experiencing. Some levels of care include daily therapy and close monitoring while people learn to gain a better sense of managing their symptoms, such care may include a residential component, where one receives treatment while they also reside at a facility that specializes in co-occurring disorders. Other levels of care, such as an outpatient therapy program could include a client attending group/individual sessions 3-4 times per week while residing at home.



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A comprehensive continuum of care for people requiring treatment for COD may include:

- Detoxification
- In-patient hospitalization
- Residential treatment
- Day-time or night-time treatment
- Intensive outpatient treatment
- Outpatient treatment

The best ways to determine the needed level of care is to consult with a psychiatrist, therapist, and/or co-occurring disorder treatment center, complete an integrated assessment.

Special Populations Example

Treatment programs for veterans with co-occurring disorders

When working with clients who have co-occurring disorders, some people also fall into a special category, which often means that within the population other sensitivity concerns are also necessary to address and/or keep in mind. Some examples of special populations include: LGBTQ clients, geriatric clients, clients with eating disorders, and Veterans to name a few. To further expand on this concept; let's think about some of the additional challenges that Veterans might have when it comes to co-occurring disorders. The pressures of deployment or combat can exacerbate underlying mental disorders, and substance abuse is a common way of coping with unpleasant feelings or memories. Often, these problems take a while to show up after a vet returns home, and may be initially mistaken for readjustment. Untreated co-occurring disorders can lead to major problems at home and work, so it's important to seek help. The U.S. Department of Veterans Affairs indicates that more than 2 out of 10 veterans who suffer from post-traumatic stress disorder (PTSD) concurrently have a substance abuse disorder. Veterans often benefit from treatment and support from specialized programs that address the unique stresses veterans face.

Group support for co-occurring disorders or dual diagnosis

As with other addictions, groups are very helpful, not only in maintaining sobriety, but also as a safe place to get support and discuss challenges. Sometimes treatment programs for co-occurring disorders provide groups that continue to meet on an aftercare basis. If you are treating a client who has a co-occurring disorder for individual therapy, it might be very useful to also refer them to a group for people with co-occurring disorders.



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While it's often best to join a group that addresses both substance abuse and mental health disorders, twelve-step groups for substance abuse can also be helpful—plus they're more common and often easy to locate. These free programs, facilitated by peers, use group support and a set of guided principles—the twelve steps—to obtain and maintain sobriety.

Find a group that is accepting of the idea of co-occurring disorders and psychiatric medication. Some people in these groups, although well meaning, may mistake taking psychiatric medication as another form of addiction. Clients need a place to feel safe, not pressured.

Self-help for co-occurring disorders or dual diagnosis

Getting sober is often the first, yet most important step for clients to make. Continued recovery depends on ongoing mental health treatment, learning healthier coping strategies, and making better decisions when dealing with life's challenges. Listed below are simple, yet valuable recovery tips that are often shared throughout the therapeutic community, and can be especially helpful for clients who are trying to better manage co-occurring disorders:

Recovery tip 1: Recognize and manage overwhelming stress and emotions

- Learn how to manage stress. Stress is inevitable, so it's important to have healthy coping skills so one can deal with stress without turning to alcohol or drugs. Stress management skills go a long way towards preventing relapse and keeping symptoms at bay.
- Know personal triggers and have an action plan. While coping with a mental disorder as well as a substance abuse disorder, it's especially important to know the signs that challenging symptoms are beginning to flare up. Common causes include stressful events, big life changes, or unhealthy sleeping or eating. At these times, having a plan in place is essential to preventing drug relapse. Who will you talk to? What do you need to do?

Recovery tip 2: Stay connected

- Get therapy or stay involved in a support group. One's chances of staying sober improve if they are participating in a social support group like Alcoholics Anonymous or Narcotics Anonymous or if you are seeking therapy.
- Follow doctor's orders. Once you are sober and you feel better, you might think you no longer need medication or treatment. But arbitrarily stopping medication or treatment is a common reason for relapse in people with co-occurring disorders. Always talk with your doctor before making any changes to your medication or treatment routine.



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Recovery tip 3: Make healthy lifestyle changes

- Practice relaxation techniques. When practiced regularly, relaxation techniques such as mindfulness meditation, progressive muscle relaxation, and deep breathing can reduce symptoms of stress, anxiety, and depression, and increase feelings of relaxation and emotional well-being.
- Adopt healthy eating habits. Start the day right with breakfast, and continue with frequent small meals throughout the day. Going too long without eating leads to low blood sugar, which can make you feel more stressed or anxious.
- Exercise regularly. Exercise is a natural way to bust stress, relieve anxiety, and improve your mood and outlook. To achieve the maximum benefit, aim for at least 30 minutes of aerobic exercise on most days.
- Get enough sleep. A lack of sleep can exacerbate stress, anxiety, and depression, so try to get 7 to 9 hours of quality sleep a night.

Conclusion

Although in the past, mental health disorders and addiction problems were often treated separately, we now know that co-occurring mental health and substance use disorders impact one another and must be treated together. Treating just one disorder will not cause the other to automatically improve. And separate, parallel care for the disorders does not result in one, effective treatment plan. To be effective, both disorders must be treated at the same time, in the same place, by the same treatment team. This integrated approach to treatment has provided not only hope, but real improvements to those who are learning how to better manage their co-occurring disorders.

Resources

- Drugabuse.com: <http://drugabuse.com/library/mental-health-and-drug-abuse/>
- NIH: <http://pubs.niaaa.nih.gov/publications/AA76/AA76.htm>
- SAMHSA: <http://www.samhsa.gov/disorders>
- The National Alliance on Mental Health



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HIV/AIDS

About HIV – Human Immunodeficiency Virus

HIV is an acronym for human immunodeficiency virus and it is the disease that often leads to AIDS.

- Human – This particular virus can only infect human beings.
- Immunodeficiency – HIV weakens the immune system by destroying important cells.
- Virus – A virus can only reproduce itself by taking over a cell in the body of its host.

While there are two strains of HIV: HIV-1 and HIV-2; when most people discuss HIV they are referring to HIV-1. No matter which form of HIV that is contracted, the virus attacks particular white blood cells (T-Cells) which are the foundation for the immune system that allows the body to fight disease.

Unlike other viruses, such as the FLU or Common Cold, the human immune system cannot get rid of the HIV virus from the body. HIV attacks a key part of the immune system – the T-cells. The body has to have these cells to fight infection and disease. HIV invades these cells, uses them to replicate itself, and then destroys them. Over time the immune system becomes so badly damaged, the body cannot fight off infection or disease. When this happens HIV can lead to AIDS.

Acquired Immunodeficiency Syndrome

Acquired Immunodeficiency Syndrome is the final stage of HIV infection. People at this stage of HIV disease have badly damaged immune systems, which puts them at risk for opportunistic infections (OIs). There is no cure.

- Acquired – AIDS is acquired—it is not inherited.
- Immuno – The immune system includes all organs and cells that work to fight infection/disease.
- Deficiency – Individuals get AIDS when their immune system is "deficient."
- Syndrome – A syndrome is a collection of symptoms and signs of disease.

AIDS is a syndrome, rather than a single disease, because it is a complex illness with a wide range of complications and symptoms.

Risk Groups



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HIV/AIDS takes a heavy toll on people of all ethnicities, genders, ages, and income levels. However, some populations have been uniquely affected by the epidemic. These populations include men who have sex with men, injecting-drug users, women, and people of color. Three primary risk groups account for 75% of new HIV infections in the United States:

- Men who have sex with men (MSM)
- Injecting-drug users (IDUs)
- MSM who also use injection drugs

A History of AIDS

Scientists identified a type of chimpanzee in West Africa as the source of HIV infection in humans. They believe that the chimpanzee version of the immunodeficiency virus (called simian immunodeficiency virus, or SIV) most likely was transmitted to humans and mutated into HIV when humans hunted these chimpanzees for meat and came into contact with their infected blood. Studies show that HIV may have jumped from apes to humans as far back as the late 1800s. Over decades, the virus slowly spread across Africa and later into other parts of the world. We know that the virus has existed in the United States since at least the middle to late 1970's.

The world first became aware of AIDS in the early 1980's. Growing numbers of gay men in New York and California were developing rare types of pneumonia and cancer, and a wasting disease was spreading in Uganda. Doctors reported AIDS symptoms under different names, including "gay-related immune deficiency" and "slim," but by 1985, they reported them all over the world.

We now know that HIV existed long before it was identified as the cause of AIDS in 1984. Blood analysis reveals instances of the virus as early as the 1940s. While researchers aren't sure exactly when and how HIV developed, the most likely theories posit that HIV-1 (the most common strain of the virus) was transmitted to humans from chimpanzees sometime in the early to mid-20th century. In 2006, the number of AIDS-related deaths and new HIV infections fell for the first time since the epidemic began 25 years before. According to the most recent estimates (2012), about 35.3 million people are living with HIV today.

HIV is an equal opportunity virus. Newborn babies, women, seniors, teens and people of all races or nationalities can have HIV. The prevalence of the virus in different groups varies (as it does for other diseases), but it can affect anyone. Of HIV positive people worldwide, slightly more than half are women. Compared to older adults, sexually active teens and young adults are at higher risk for acquiring Sexually Transmitted Infections, due to a combination of behavioral, biological and cultural factors. Though they make up 25% of the sexually active population, they account for nearly half of



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new STI cases. Early diagnosis, prompt and continued care, and antiretroviral drug therapy are key to lowering the risk of illness and death among patients, and reducing transmission of HIV.

Fast Facts

According to the Centers for Disease Control and Prevention (CDC):

- HIV and AIDS are generally concentrated in urban areas in the United States.
- Gay, bisexual, and other men who have sex with men (MSM), particularly young black/African

American MSM, are most seriously affected by HIV.

- By race, blacks/African Americans face the highest incidence of HIV. Over 40% of new HIV diagnosis in the US is in the black community.
- The term AIDS applies to the most advanced stages of HIV infection, defined by the occurrence of any of more than 20 opportunistic infections or HIV-related cancers. In addition, the CDC defines AIDS on the basis of a CD4 positive T cell count of less than 200 per mm³ of blood.
- More than 1.2 million people in the United States are living with HIV infection, and almost 1 in 7 (14%) are unaware of their infection
- Globally, the number of HIV infections across the world is over 35 million and a significant percentage (close to 10%) of this is children. Close to 2 million new cases are reported every year.

Stage 1 – Primary

Short, flu-like illness, fever, and rash - occurs one to six weeks after infection and is your body's natural response to the virus.

- Not everyone develops symptoms or may feel ill after infection
- The infected person can infect other people

Stage 2 – Asymptomatic

- Lasts for an average of ten years
- This stage is free from symptoms
- There may be swollen glands
- The level of HIV in the blood drops to very low levels
- HIV antibodies are detectable in the blood



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Stage 3 – Symptomatic

- The symptoms are mild, may include unexplained chronic diarrhea, unexplained persistent fever, oral candidiasis leukoplakia, severe bacterial infections, inflammation in the mouth.
- The immune system deteriorates
- Emergence of opportunistic infections and cancers are likely

Stage 4 - HIV / AIDS

- The immune system weakens
- The illnesses become more severe leading to an AIDS diagnosis
- Once HIV progresses to AIDS, a person is more likely to die

Opportunistic Infections Associated with AIDS

- Bacterial
 - Tuberculosis (TB)
 - Strep pneumonia
- Viral
 - Kaposi Sarcoma (Is a cancer. The abnormal cells of KS form purple, red, or brown blotches or tumors on the skin. These affected areas are called lesions. The skin lesions of KS most often appear on the legs or face)
 - Herpes
 - Influenza (flu)
- Parasitic
 - Pneumocystis carinii pneumonia (classified as a fungal pneumonia)
- Fungal
 - Candida
 - Cryptococcus (potentially fatal fungal disease)

Modes of HIV/AIDS Transmission

Sexual Contact: HIV is most often spread through unsafe sexual contact and practices. This is most often associated with sexual contact with someone who is infected and unprotected sex (not using a latex condom). Those who practice anal sex are more susceptible to infection than those who practice vaginal sex resulting in high rates of HIV infection in the gay male community.



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Drug Use: Another source of the spread of HIV has been within the injecting drug user (IDU) community. IDUs who share needles and other drug paraphernalia facilitate blood to blood contact, in turn making it very likely that the disease will spread. Non-injecting drug users have a much lower incidence of HIV infection as there is no infected bodily fluid transmission.

Perinatal Transmission: Children born to a mother who is infected with HIV are likely to become infected themselves either during pregnancy or even breast-feeding. These children do not contract HIV from their genetics.

Other Sources: HIV is also spread through accidental means including accidental injection often in a medical setting, through saliva exchange including kissing or eating an infected persons already chewed food (if blood is present in the saliva) and biting. Rarely HIV is transmitted through wound to wound contact or tattooing and body piercing. We do hear of HIV contraction through receiving tainted blood during a transfusion or organ transplantation. While this is possible, it is relatively uncommon. Most blood banks screen the blood they collect for HIV and organs are almost always screened for HIV.

You do NOT get HIV from:

- Donating blood
- Mosquito bites or bites from other bugs
- Sneezes or coughs
- Touching, hugging or dry kissing a person with HIV
- The urine or sweat of an infected person
- Public restrooms, saunas, showers or pools
- Sharing towels or clothing
- Sharing eating utensils or drinks
- Being friends with a person who has HIV/AIDS

Testing Options for HIV

An HIV test is a test that reveals whether HIV is present in the body. Commonly-used HIV tests detect the antibodies produced by the immune system in response to HIV, as it is much easier (and cheaper) to detect antibodies than the virus itself. Antibodies are produced by the immune system in response to an infection. For most people, it takes three months for these antibodies to develop. In rare cases, it can take up to six months. During this “window period” of early infection a person is at their most infectious.



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Generally, it is recommended that you wait three months after possible exposure before being tested for HIV. Although HIV antibody tests are very sensitive, there is a 'window period' of 3 to 12 weeks, which is the period between infection with HIV and the appearance of detectable antibodies to the virus.

- Anonymous Testing - No name is used, test recipient is assigned a unique identifying number and results are only issued to the test recipient.
- Confidential Testing - Person's name is recorded along with HIV results. The name and positive results are reported to the State Department and the CDC. Results issued only to test recipient.

Administration of Tests

- Blood Detection Tests
 - Enzyme-Linked Immunosorbent Assay/Enzyme Immunoassay (ELISA/EIA)
 - Radio Immunoprecipitation Assay/Indirect Fluorescent Antibody Assay (RIP/IFA)
 - Polymerase Chain Reaction (PCR)
 - Western Blot Confirmatory test
- Urine Testing
 - Urine Western Blot – as sensitive as testing blood, safe way to screen for HIV, however can cause false positives in certain people at high risk for HIV.
 - Oral Testing
 - Orasure - The only FDA approved HIV antibody and is as accurate as blood testing. It draws blood-derived fluids from the gum tissue. It is NOT A SALIVA TEST!

Counseling

- Pre-test Counseling - Items that can be discussed during this counseling include transmission, prevention, risk factors, voluntary & confidential, and reportability of positive test results.
- Post-test Counseling - Items that can be discussed during this counseling include clarifying test results, discussing the need for additional testing, how to promote safe behavior and releasing of results.

Omnibus AIDS Act

In 1988, Florida became one of the first states with high rates of HIV infection to enact comprehensive legislation addressing the AIDS epidemic. In 1998, the Omnibus AIDS Act remains consistent with the



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recommendations of many national organizations that have carefully examined the issues. It is premised on the health policy judgment that this illness can best be controlled through an informed public that knows how to avoid contracting and transmitting the disease and that voluntarily agrees to be tested. (Hartog, 2013)

Informed Consent

In Florida, an HIV test subject must essentially understand (be "informed" about) and then explicitly agree ("consent") to the test. A "general consent" from a patient to draw blood and run unspecified tests on the sample is an insufficient basis for performing an HIV test. Except in the very few situations described below, the patient's informed consent specifically to the HIV test must be obtained. (Hartog, 2013)

Minors in Florida

Minors in Florida (unemancipated children under 18) are adults for the purposes of consenting to an HIV test. The general rule that parental consent is required prior to medical diagnosis or treatment of a minor does not apply when sexually transmitted diseases such as HIV infection are involved. Indeed, Florida specifically forbids telling parents the fact of the minor's HIV test or its results either directly or indirectly (such as by billing a parent without the child's permission). Infants and young children are treated as unable to make an informed decision and consent of their parents or legal guardian is required; however, for older children (such as teenagers), the provider must make an individual judgment whether the child has the cognitive and emotional capacity to understand the risks and benefits of the test or treatment to which child is being asked to consent. (Hartog, 2013)

Pregnancy

The Florida's AIDS law in 1996 requires every physician and midwife attending a woman for conditions related to pregnancy to offer HIV testing in conjunction with required blood tests. Florida Administrative Rule 64D-3.042, requires all pregnant women to be tested at their initial prenatal appointment, at 28 to 32 weeks, and at labor and delivery if there has not been an HIV test after 27 weeks gestation. Because these health care providers must take at least one blood sample during pregnancy, this law assures that during pregnancy a woman will be offered an HIV test. In addition, state legislation requires health care providers to counsel the woman, including discussing the availability of treatment if the woman tests HIV positive. Prior to any testing, practitioners are required to notify the woman which tests will be conducted and inform her of the right to refuse testing (opt-out testing). If the woman declines, the provider must take "reasonable steps" to obtain a signed statement from her objecting to the test and place the signed statement in her medical record.



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If such activity occurs, the provider is immune from liability should the infant contract HIV infection from the mother during pregnancy or at birth. (Hartog, 2013)

Exceptions to Informed Consent Requirements

The statute lists the very limited circumstances in which an HIV test may be performed without the test subject's informed consent. No provision permits testing for evidence of HIV infection in a general medical setting on a routine basis without informed consent. Permitted exceptions are as follows:

- A provider may test without consent in "bona fide medical emergencies," but only if the provider documents in the medical record that the test results are medically necessary in order to provide appropriate emergency care or treatment to the test subject and the test subject is unable to consent. This situation rarely arises. By the time a confirmed HIV test result can be secured (which usually takes in excess of 48 hours) the emergency medical condition would have passed. Because the inability to consent due to physical incapacity by itself does not mean that an HIV test is a medical emergency, the fact that a patient may be unconscious and unable to consent is not a basis for using this exception.
- The Act allows a "therapeutic privilege" to bypass informed consent requirements when the provider's medical record documents that obtaining informed consent would be detrimental to the health of a patient suffering from an acute illness and that the test results are necessary for medical diagnostic purposes to provide appropriate care or treatment to the patient. This same privilege applies to all medical procedures for which informed consent is required. The statute emphasizes that this provision provides no basis for routinely testing patients for HIV without their informed consent.
- State laws permit HIV testing on certain subjects, such as convicted prostitutes, and cadavers over which a medical examiner has asserted authority, without the consent of the test subject; federal laws authorize HIV testing of immigrants without consent in certain situations.
- Victims of criminal offenses that involve transmission of body fluids may require the person charged with or convicted of the offenses to be tested for HIV infection by requesting a court to order the test. Similarly, when a defendant, prosecuted for certain offenses where transmission might have occurred, has been ordered to or has voluntarily given a blood sample, the victim may request the sample be tested for evidence of HIV without the consent of the defendant.
- Other statutory provisions permit testing without informed consent in specifically identified specialty areas: certain blood and tissue donations the Act explicitly exempts from those requirements; autopsies to which consent to perform the autopsy was obtained; corneal removals and eye enucleation that Florida allows by law to be done without consent; and certain kinds of epidemiologic research that ensure test subject anonymity.
- When a licensed physician determines that it is medically indicated that a hospitalized infant



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have an HIV test, but the infant's parent(s) or legal guardian cannot be located after reasonable attempts, the test may be performed without consent. The reason why consent could not be obtained must be documented in the medical record, and the test result must be provided to the parent(s) or guardian once they are located.

- Under the limited circumstances discussed in Section VI of this booklet, the blood of the source of a significant exposure to medical personnel or others who rendered emergency medical assistance may be tested without informed consent.
- Repeated HIV testing either to monitor the clinical progress of a previously diagnosed HIV positive patient or for conversion from a significant exposure without renewed consents is authorized by the 1998 amendments.
- Finally, a court may order that an HIV test be performed without the individual's consent.

Confidentiality and HIV/AIDS

The results of HIV antibody tests are confidential and may not be publicly disclosed except with the resident's written permission or as otherwise provided in Chapter 384, Florida Statutes. All agencies are required to establish appropriate procedure to maintain these confidential medical records, including limiting access to persons authorized by statute and administrative rule to review or receive such records. Confidential medical information including HIV antibody test results may only be shared with those listed in section 64D-2.003 (2) F.A.C. This includes but is not limited to the following:

- The person tested
- Any person designated in a legally effective release of information executed by the client
- The Department of Health in accordance with rules for reporting and controlling the spread of disease, as otherwise provided in state law
- Any personnel who experience a significant exposure while performing emergency assistance
- Employees of the department and its authorized representatives who are responsible for the custody, medical care and treatment of persons served and who have a need to know such information.

Need to know is outlined in section 64D-.003 F.A.C. and includes but is not limited to: medical personnel involved with the diagnosis or treatment of the person tested; licensed medical professionals who regularly participate as part of an interdisciplinary team responsible for the care and treatment of the client; staff that handle body fluids or who have the potential of coming into contact with body fluids; personnel involved in utilization review, risk management or peer review activities; financial staff who compile or review medical records as part of routine billing activities.



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Voluntary Partner Notification

The person ordering the HIV test (or that person's designee), although under no liability exposure to the sexual or needle-sharing partners of their HIV-positive patients, is required to advise their patients with HIV positive test results of the importance of notifying partners who may have been exposed. §381.004(2) (c), F.S.

Practitioners are well advised also to tell the patient of the availability of voluntary partner notification services provided by the Department of Health.

Client medical records cannot be marked, coded or distinguished on the outside in any way that identifies HIV test results or that an HIV test was or was not performed. The written informed consent form or documentation of informed consent and HIV test results will be kept in the medical record. When a resident is transferred from one facility to another, the resident's medical records including HIV/AIDS data must be transferred in a sealed envelope marked confidential.

Treatment Options

Antiretroviral Drugs

- Nucleoside Reverse Transcriptase inhibitors - AZT (Zidovudine)
- Non-Nucleoside Transcriptase inhibitors - Viramune (Nevirapine)
- Protease inhibitors - Norvir (Ritonavir)

Opportunistic Infection Treatment

- OIT can be issued in an event where antiretroviral drugs are not available.

Protection

There are four ways to protect yourself from HIV/AIDS:

- Abstinence
- Monogamous Relationship with partners not infected with HIV/AIDS
- Protected Sex
- Sterile needles

Abstinence

- It is the only 100 % effective method of not acquiring HIV/AIDS.
- Refraining from sexual contact: oral, anal, or vaginal.



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- Refraining from intravenous drug use.

Monogamous relationship

- A mutually monogamous (only one sex partner) relationship with a person who is not infected with HIV. HIV testing before intercourse is necessary to prove your partner is not infected (antibodies may not be present in blood for 4-12 weeks, partners need follow-up testing after the necessary time lapse to ensure negative results).

Protected Sex

- Use condoms (female or male) every time you have sex (vaginal or anal)
- Always use latex or polyurethane condom (not a natural skin condom)
- Always use a latex barrier during oral sex

When using a condom remember to:

- Make sure the package is not expired
- Make sure to check the package for damages
- Do not open the package with your teeth for risk of tearing
- Never use the condom more than once
- Use water-based rather than oil-based condoms

Sterile Needles

If a needle/syringe or cooker is shared, it must be disinfected:

- Fill the syringe with undiluted bleach and wait at least 30 seconds. Thoroughly rinse with water.

Do this between each person's use.

Needle Exchange Programs

With Needle Exchange Programs, sterile needles are provided in exchange for contaminated ones. Legalization of needle exchange programs in Florida would be instituted to decrease transmission of HIV and blood-borne disease, reduce contaminated needles on streets and accidental needle sticks, and reduce taxpayer costs. Chapter 893 of the Florida Statutes currently forbids the transfer of a syringe to a person known to inject illegal drugs. HB 735 and SB 808 would remove this prohibition from law to allow for legal syringe exchange programs in Florida. This legislation is a non-partisan, public health issue.

Prevention Strategies In The Workplace



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Health care workers should assume that the blood and other body fluids from all patients are potentially infectious. They should therefore follow infection control precautions at all times.

These precautions include:

- Routinely using barriers when anticipating contact with blood or body fluids.
- Immediately washing hands and other skin surfaces after contact with blood or body fluids, and carefully handling and disposing of sharp instruments.

HIV/AIDS - Related Emotional Issues

There are many possible emotional issues associated with an HIV diagnoses. Along with the physical illness associated with HIV there are mental health conditions that may come up, such as depression and anxiety. It is important for behavioral health staff to be aware of and sensitive these conditions. What follows are some of the most common feelings associated with a diagnosis of HIV and suggestions on how to cope with these feelings. Clients may experience some, all, or none of these feelings, and they may experience them at different times.

Denial

People who find out that they are HIV positive often deal with the news by denying that it is true. You may believe that the HIV test was not accurate or that there was a mix-up with the result, even after confirmatory testing shows that it is a true positive. This is a natural and normal first reaction. At first, this denial may even be helpful, because it can give you time to get used to the idea of infection. However, if not dealt with, denial can be dangerous; you may fail to take certain precautions or reach out for the necessary help and medical support.

It is important that you talk out your feelings with your doctor, a therapist, or someone you trust. It is important to do this so that you can begin to receive the care and support you need.

Anger

Anger is another common and natural feeling related to being diagnosed with HIV. Many people are upset about how they got the virus or angry that they didn't know they had the virus.

Ways to deal with feelings of anger include the following:



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- Talk about your feelings with others, such as people in a support group, or with a counselor, friend, or social worker.
- Try to get some exercise (i.e. gardening, walking, or dancing) to relieve some of the tension and angry feelings you may be experiencing.
- Avoid situations involving certain people, places, and events that cause you to feel angry or stressed out. Using drugs or alcohol when you feel angry can be dangerous for you and lead to conflict or violence that might otherwise have been avoidable.

Sadness or depression

It is also normal to feel sad when you learn you have HIV. If, over time, you find that the sadness doesn't go away or is getting worse, talk with your doctor or someone else you trust. You may be depressed.

Symptoms of depression can include the following, especially if they last for more than 2 weeks:

- Feeling sad, anxious, irritable or hopeless
- Gaining or losing weight
- Sleeping more or less than usual
- Moving slower than usual or finding it hard to sit still
- Losing interest in the things you usually enjoy
- Feeling tired all the time
- Feeling worthless or guilty
- Having a hard time concentrating
- Thinking about death or giving up
- Persistent loss of libido or interest in sex

To deal with these symptoms, you may want to:

- Talk with your doctor about treatments for depression, such as therapy or medications
- Get involved with a support group
- Spend time with supportive people, such as family members and friends

If your mood swings or depression get very severe, or if you ever think about suicide, call your doctor right away. Your doctor can help you.

Fear and anxiety



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Fear and anxiety may be caused by not knowing what to expect after you've been diagnosed with HIV, or by not knowing how others will treat you if they find out you have HIV. You also may be afraid of telling people (friends, family members, and others) that you are HIV positive. Fear can make your heart beat faster or make it hard for you to sleep. Anxiety also can make you feel nervous or agitated. Fear and anxiety might make you sweat, feel dizzy, or feel short of breath. Ways to control your feelings of fear and anxiety include the following:

- Learn as much as you can about HIV. HIV infection is now a very treatable disease and most HIV-infected people can live long, healthy lives if they seek medical care and have healthy lifestyles. Current HIV medications can be very well tolerated and in general do not lead to the body changes that were seen with older treatments.
- Have your questions answered by your doctor.
- Talk with your friends, family members, and health care providers.
- Join a support group.
- Help others who are in the same situation, such as by volunteering at an HIV service organization. This may empower you and lessen your feelings of fear.
- Talk to your doctor about medication if the feelings don't lessen with time or increase.

Stress

If you are HIV infected, you and your loved ones constantly have to deal with stress. Stress is unique and personal to each of us. When stress does occur, it is important to recognize the fact and deal with it. Some ways to handle stress are discussed below. As you gain more understanding about how stress affects you, you will come up with your own ideas for coping with stress.

- Try physical activity. When you are nervous, angry, or upset, try exercise or some other kind of physical activity. Walking, yoga, and gardening are just some of the activities you might try to release your tension.
- Take care of yourself. Be sure you get enough rest and eat well. If you are irritable from lack of sleep or if you are not eating right, you will have less energy to deal with stressful situations. If stress keeps you from sleeping, you should ask your doctor for help.

AIDS dementia

HIV/AIDS and some medications for treating HIV may affect brain functioning. When HIV itself infects the brain, it can cause a condition known as AIDS Dementia Complex (ADC). Symptoms can include the following:



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- Forgetfulness
- Confusion
- Difficulty paying attention
- Slurred speech
- Sudden shifts in mood or behavior
- Muscle weakness
- Clumsiness

If you think you may have ADC:

- Don't be afraid to tell your doctor that you think something is wrong. These symptoms can be subtle in the beginning, and telling your care providers about your concerns can help them to diagnose and treat you early.
- Keep a notepad with you and write down details about your symptoms whenever they occur. This information can help your doctor to help you
- Build as much support as possible, including friends, family, and health care providers. Although it's possible to treat ADC successfully, it may take a while for some symptoms to go away.

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- <http://www.healthaim.com/9-relevant-facts-about-hiv-as-us-observes-national-black-hivaids-awarenessday/12560>
- <http://www.careresource.org/hivaids/statistics/>



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Understanding Domestic Violence

Course Description

This course is designed to assist the behavioral healthcare worker in understanding domestic violence and the mandates that involve behavioral healthcare workers. In addition to defining domestic violence, this course will review the effects of domestic violence, the cycle of violence, associated risk factors, safety planning, confidentiality and the legalities of domestic violence.

Course Objectives

Upon completion of this course the participant will:

- Be able to define domestic violence.
- Be able to discuss the statistics related to domestic violence.
- Develop an understanding of the impact and consequences of domestic violence on the victim from a health, psychological, and emotional perspective.
- Be able to assess, counsel and formulate safety plans for clients at risk of domestic violence or who are currently in a violence relationship.
- Be able to identify national and local domestic violence resources.

Introduction

Every year, on average, more than four people a day are murdered by their romantic partners in the United States. Men and women of all ages are at risk for domestic and sexual violence and its effects, which include: long-lasting pain, increased risk of substance abuse, depression, poor academic performance, suicidal ideation, and future violence. In addition, sexual and domestic violence are linked to a wide range of reproductive health issues including sexually transmitted disease and HIV transmission.

Defining the Problem

Domestic violence is a broad term that indicates violence in close or intimate interpersonal relationships. This violence is known by many names: intimate partner violence, wife abuse, wife battering, spousal abuse, woman abuse, etc. Some define the term domestic violence even broader to include child abuse, elder abuse, or any close interpersonal relationship. Put simply, domestic violence occurs when one person purposely causes either physical or mental harm to another when they are in a close personal relationship. These crimes occur in both heterosexual and same-sex relationships.



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Because the definition of domestic violence varies from agency to agency and state to state, obtaining accurate statistics is difficult. It is also important to remember that abuse rarely occurs in just one form; more frequently forms of abuse occur in combinations. A man who is physically abused is also likely isolated and controlled by his partner; a woman who is abused sexually may also be stalked and emotionally abused. Domestic violence is a serious, preventable public health problem affecting more than 32 million Americans (Tjaden & Thoennes, 2000a). It occurs on a continuum, ranging from one assault that may or may not significantly impact the victim, to chronic, repeated abuse which is also known as battering (CDC, 2008).

Definitions and Types of Abuse

Definitions

Domestic violence (also known as domestic abuse, spousal abuse, or intimate partner violence) occurs when a family member, partner or ex-partner attempts to physically or psychologically dominate another. Domestic violence often refers to violence between spouses, or spousal abuse but can also include cohabitants and non-married intimate partners. Domestic violence occurs in all cultures; people of all race, ethnicity, religion, sex and class can be perpetrators of domestic violence.

The following definition and examples are provided by domesticviolence.org –

Domestic violence and emotional abuse are behaviors used by one person in a relationship to control the other. Partners may be married or not married; heterosexual, gay, or lesbian; living together, separated or dating. Examples of abuse include:

- Name-calling or putdowns.
- Keeping a partner from contacting their family or friends.
- Withholding money.
- Stopping a partner from getting or keeping a job.
- Actual or threatened physical harm.
- Sexual assault.
- Stalking.
- Intimidation.

Violence can be criminal and may include physical assault (hitting, pushing, shoving, etc.), sexual abuse (unwanted or forced sexual activity), and stalking. Although emotional, psychological and financial abuses are not criminal behaviors, they are forms of abuse and can lead to criminal violence. The violence takes many forms and can happen all the time or once in a while.



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"Family or household member" means spouse, former spouse; persons related by blood or marriage, persons who are presently residing together as if they are a family or who have resided together in the past as if they are a family, and persons who are parents of a child in common regardless of whether they have been married. With the exception of persons who have a child in common, the family or household members must be currently residing or have in the past resided together in the same single dwelling unit.

The U.S. Office on Violence Against Women (OVW) defines domestic violence as a "pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner". The definition adds that domestic violence "can happen to anyone regardless of race, age, sexual orientation, religion, or gender", and that it can take many forms, including physical abuse, sexual abuse, emotional, economic, and psychological abuse.

The Florida Coalition Against Domestic Violence defines domestic violence as:

"A pattern of controlling behaviors – violence or threats of violence – that one person uses to establish power over an intimate partner in order to control that partner's actions and activities. Domestic violence is not a disagreement, a marital spat, or an anger management problem. Domestic violence is abusive, disrespectful, and hurtful behavior that one intimate partner chooses to use against the other partner."

Florida's legal definition of domestic violence is as follows:

"741.28 Domestic violence; definitions. --As used in ss. 741.28-741.31: "Department" means the Florida Department of Law Enforcement. "Domestic violence" means any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another family or household member.

"Law enforcement officer" means any person who is elected, appointed, or employed by any municipality or the state or any political subdivision thereof who meets the minimum qualifications established in s. 943.13 and is certified as a law enforcement officer under s. 943.1395."

Types Of Abuse

Physical Violence

Physical violence is the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to, scratching; pushing; shoving; throwing;



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grabbing; biting; choking; shaking; slapping; punching; burning; use of a weapon; and use of restraints or one's body, size, or strength against another person.

Sexual Violence

Sexual violence is divided into three categories: 1) use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed; 2) attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure; and 3) abusive sexual contact.

Threats of physical or sexual violence

Using words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm constitutes "threats of physical or sexual violence."

Psychological/Emotional Violence

Psychological/Emotional Violence involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources. It is considered psychological/emotional violence when there has been prior physical or sexual violence or prior threat of physical or sexual violence. In addition, stalking is often included among the types of domestic violence. Stalking generally refers to "harassing or threatening behavior that an individual engages in repeatedly, such as following a person, appearing at a person's home or place of business, making harassing phone calls, leaving written messages or objects, or vandalizing a person's property" (Tjaden & Thoennes 1998). Stalking is the unwanted pursuit of another person. By its nature, stalking is not a one-time event. The individual's actions must be considered in connection with other actions to determine if someone is being stalked.

Statistics and Costs

Statistics



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Approximately, 29% of women and 10% of men in the U.S. have experienced rape, physical violence, and/or stalking by an intimate partner and reported at least one measured impact related to these or other forms of violence in that relationship (Black et al., 2011). In general, victims of repeated violence over time experience more serious consequences than victims of one-time incidents (Johnson and Leone, 2005).

1 in 4 women (24.3%) and 1 in 7 men (13.8%) aged 18 and older in the United States have been the victim of severe physical violence by an intimate partner in their lifetime (Black et al., 2011).

Nearly, 15% of women (14.8%) and 4% of men have been injured as a result of domestic violence that included rape, physical violence, and/or stalking by an intimate partner in their lifetime (Black et al., 2011).

In 2010, 241 males and 1095 females were murdered by an intimate partner (U.S. Department of Justice, FBI, 2011).

More than one in three women and more than one in four men in the United States have experienced rape, physical violence and/or stalking by an intimate partner in their lifetime.

74% of all murder-suicides involved an intimate partner (spouse, common-law spouse, ex-spouse or boyfriend/girlfriend). Of these, 96 percent were women killed by their partners.

1 in 5 female high school students reports being physically and/or sexually abused by a dating partner. Interpersonal violence is the leading cause of female homicides and injury-related deaths during pregnancy.

The percentage of women who consider their mental health to be poor is almost three times higher among women with a history of violence than among those without.

Women with disabilities have a 40 percent greater risk of domestic violence, especially severe violence, than women without disabilities.

Nearly half of all women in the United States have experienced at least one form of psychological aggression by an intimate partner.

On average, more than 3 women are murdered by their husbands or boyfriends every day.

1 out of 3 women around the world has been beaten, coerced into sex or otherwise abused during her lifetime.



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These statistics come from The American Psychological Association

Costs to Society

Costs of domestic violence against women alone in 1995 exceeded an estimated \$5.8 billion. These costs included nearly \$4.1 billion in the direct costs of medical and mental health care and nearly \$1.8 billion in the indirect costs of lost productivity (CDC 2003). This is generally considered an underestimate because the costs associated with the criminal justice system were not included. In 2003 domestic violence costs exceeded \$8.3 billion, which included \$460 million for rape, \$6.2 billion for physical assault, \$461 million for stalking, and \$1.2 billion in the value of lost lives (Max et al. 2004).

The increased annual health care costs for victims of domestic violence can persist as much as 15 years after the cessation of abuse (Rivara et al., 2007).

Victims of severe domestic violence lose nearly 8 million days of paid work-the equivalent of more than 32,000 full-time jobs-and almost 5.6 million days of household productivity each year (CDC 2003). Women who experience severe aggression by men (e.g., not being allowed to go to work or school, or having their lives or their children's lives threatened) are more likely to have been unemployed in the past, have health problems, and be receiving public assistance (Lloyd and Taluc 1999).

Risk and Protective Factors

Risk factors are associated with a greater likelihood of domestic victimization or perpetration. They are contributing factors and may or may not be direct causes. Not everyone who is identified as "at risk" becomes involved in violence.

Some risk factors for domestic violence victimization and perpetration are the same. In addition, some risk factors for victimization and perpetration are associated with one another; for example, childhood physical or sexual victimization is a risk factor for future domestic violence perpetration and victimization.

A combination of individual, relational, community and societal factors contribute to the risk of becoming a victim or perpetrator of domestic violence. Understanding these multilevel factors can help identify various opportunities for prevention.



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Children in a Violent Home

Most children in violent homes know about the violence. Parents may think children do not know about the violence, but most of the time they do. They can feel helpless, scared and upset. They may also feel like the violence is their fault.

Violence in the home is dangerous for children. They are afraid for their parents and themselves. Children feel bad that they cannot stop the abuse. If they try to stop the fight, they can be hurt. They can also be hurt by things that are thrown or weapons that are used. Children live with scary noises, yelling and hitting. They are harmed just by seeing and hearing the violence. Children in violent homes may not get the care they need. A parent who is being abused may be in too much pain to take good care of their child. Children who live in violent homes can have many problems. They can have trouble sleeping. They can have trouble in school and getting along with others. They often feel sad and scared all the time. They may grow up feeling bad about themselves.

Victims, Abusers and the Cycle of Violence

Before establishing who the victims of abuse are and who the perpetrators are, let's look at what abuse is and define some examples of abuse.

Caution: As we look at what is known about those who perpetrate domestic violence it is essential to remain mindful of the dangers of generalizing. Here are some things to consider:

- How dangerous a particular batterer is cannot be determined on the basis of generalizations but must be determined by the survivor in the context of her or his actual knowledge and experience of the perpetrator.
- An individual survivor's decisions about what to do or not do about the violence is very much a function of what that survivor knows about the perpetrator and not what studies tell us about perpetrators in general.
- The empowerment model does not explicitly or implicitly point survivors toward leaving a violent partner. Instead, it points toward supporting each survivor to become clear about the safest and best path for her or him.

About Abuse

Many people who are being abused do not see themselves as victims. Also, abusers do not see themselves as being abusive. People often think of domestic violence as physical violence, such as



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hitting. However, domestic violence takes other forms, such as psychological, emotional, or sexual abuse.

The following is a brief list of patterns of controlling behavior:

- Pushing, hitting, slapping, choking, kicking, or biting.
- Threatening victim, their children, other family members or pets.
- Threatening suicide to get the victim to do something.
- Using or threatening to use a weapon.
- Keeping or taking the victims paychecks.
- Making statements with the intent of making the victim feel bad.
- Forcing sex or sexual acts the victim does not want or like.
- Keeping the victim from seeing friends, family or going to work.

Who Are The Victims?

Victims can be of any age, sex, race, culture, religion, education, employment or marital status. Although both men and women can be abused, most victims are women. Children in homes where there is domestic violence are more likely to be abused and/or neglected. Most children in these homes know about the violence. Even if a child is not physically harmed, they may have emotional and behavior problems. Anyone can be a victim—a lesbian, gay, or transgendered person; people of color; a physically or mentally challenged individual; the elderly; a male or female; children, adolescents, etc. A person can be a victim of abuse or at risk if they are dating someone who:

- Is very jealous and/or spies on you
- Will not let you break off the relations
- Hurts you in any way, is violent, or brags about hurting other people
- Puts you down or makes you feel bad
- Forces you to have sex or makes you afraid to say no to sex
- Abuses drugs or alcohol or pressures you to use drugs or alcohol
- Has a history of bad relationships and blames it on others

Who Are The Abusers?

Abusers are not easy to spot. There is no 'typical' abuser. In public, they may appear friendly and loving to their partner and family. They often only abuse behind closed doors. They also try to hide the abuse by causing injuries that can be hidden and do not need a doctor.



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Abuse is not an accident. It does not happen because someone was stressed-out, drinking, or using drugs. Abuse is an intentional act that one person uses in a relationship to control the other. Abusers have learned to abuse so that they can get what they want. The abuse may be physical, sexual, emotional, and psychological. Abusers often have low self-esteem. They do not take responsibility for their actions. They may even blame the victim for causing the violence. In most cases, men abuse female victims. It is important to remember that women can also be abusers and men can be victims. Risk Factors for Becoming an Abusive Partner

Why Don't People Leave Abusive Relationships?

Some of the many reasons people don't leave abusive relationships are listed below:

- Fear of retaliation against the victim, children, friends and/or family members.
- Partner may threaten to kill her or other family members if she leaves, threaten to kill himself or escalate his violence in an attempt to hold her in the relationship.
- Fear of losing children or placing the children in danger, either in a custody battle or because of partner's threats.
- Fear of an inadequate or harmful response by the criminal justice system and other institutions.
- Fear that no one will believe her. Batterers are often respected and popular members of the community who keep their violence and controlling behaviors secret from the public. The battered woman knows this and it increases her fear that no one will believe her. Because she believes many people will not understand the seriousness of the violence, they will not support her disruption of the family.
- Fear of being deported for undocumented persons who are victims of domestic violence.
- Fear of being blackmailed; partner may have threatened to reveal to the authorities any wrongdoing such as alcohol or drug abuse. In same sex relationships, the fear of job loss or losing one's children if the victim's sexual orientation is revealed.
- Fear of losing her support systems. In order to escape their partner's threats of retaliation, many battered women have to leave the community which provided them with support. This is especially difficult for women whose ethnic, racial and/or cultural heritage, language and experiences are affirmed by her community (i.e. Asian, African-American, Jewish, Latina and Native American).
- The batterer has literally isolated her. For example, a batterer may prohibit the battered woman from using the phone, may insist on transporting her to work, may read her mail, and may forbid her from seeing family and friends.
- Hope for change and that the batterer's treatment is successful. Battered Women are reluctant to leave when their partners are in treatment. They believe the treatment will motivate them to change and stop battering. Therefore, it is very important that battered women are referred



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by law enforcement to domestic violence programs so that they can be informed about treatment programs for batterers and evaluate whether these programs are likely to effect the change that will make life safe for them.

The Role of the Behavioral Healthcare Professional

Early Intervention

Behavioral Healthcare providers can help by screening for domestic violence. You can do this by documenting abuse in the medical record, safeguarding evidence, providing medical advice, referrals, safety planning, and showing empathy and compassion.

Early identification and intervention with victims of domestic violence can help prevent injuries and save lives (Nelson, et al, 2012; Decker, et al, 2012). Many victims of domestic violence seek assistance in healthcare settings, often repeatedly, but are only treated for symptoms and injuries. Unfortunately, healthcare professionals often fail to identify victims. Missed cases of domestic violence may be due to the screening method: depending on the screening tool that is being used, the rate of detection has been reported to range from 9.2% to 30.5% (Sprague, Madden, Dosanjh, et al, 2012). Missed cases may also be due to healthcare professionals simply not screening (Sprague, Madden, Simonovic, et al, 2012), and many nurses are not prepared to provide care to a woman who is a victim of violence from her partner (Sundborg, et al, 2012). There are many reasons nurses, physicians, and other healthcare professionals may not screen for domestic violence including:

- Lack of time.
- Lack of training.
- Lack of resource.
- Language barriers.
- Cultural barriers.
- Emotional discomfort.
- Behavior of the victim, e.g. uncooperative, unwilling to accept help. (Beynon, et al, 2012)

Behavioral healthcare providers see victims of domestic violence for suicide attempts, anxiety, and depression. Practitioners who specialize in chronic pain, such as headache or stomach disorders, also treat victims of abuse. Pediatricians who see abused children may also see abused women because child abuse and spousal abuse frequently co-exist (Harding, et al, 2013).



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Screening

Screening questions should always be asked in a private room, away from the batterer and preceded by assurances of strict confidentiality. The spouse or partner should be separated from the patient if they demand to accompany the patient into the examining room (Hancock, 2011). Victims of domestic violence may not discuss the violence unless they are asked directly (Beynon, et al, 2012; Morse, et al, 2012). However, many victims of domestic violence will talk about the abuse if they are asked in a direct, caring, and non-judgmental manner (Decker, et al, 2012;)

By acknowledging and addressing potential client barriers, behavioral healthcare staff may become effective advocates for their clients experiencing domestic violence. Client barriers include, but are not limited to, the following:

- Fear of disclosure—a client experiencing domestic violence may be reluctant to disclose her abuse fearing she or her children will be further harmed. A typical tactic of a batterer is to threaten harm, including murder, if a victim discloses. A client may also fear disclosure because she is humiliated by her experience, feels she is worthless, etc.
- Lack of trust in Behavioral Health staff—a client may not fully disclose or may minimize her abuse because she doesn't trust her counselor to understand her experience, to respect her autonomy, and / or to protect her confidentiality. Perpetrators typically will not disclose their abuse of partners.
- Lack of awareness—some patients, even those encountering extreme abuse, may believe that their experience is "normal". Many perpetrators don't acknowledge their behaviors as being violent, abusive or harmful to their partners.

Documentation

Documentation is critical, both for the protection of the patient and of the healthcare provider. When interacting with a client document all relevant history, including:

- Chief complaint or history of present illness.
- Record details of the abuse and its relationship to the presenting problem.
- Document any concurrent medical problems that may be related to the abuse.

For current victims, document a summary of past and current abuse including:

Social history, including relationship to abuser and abusers name if possible.

Patient's statement about what happened, not what lead up to the abuse—e.g. "boyfriend John Smith hit me in the face" not "we were arguing over money."



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- The date, time, and location of incidents where possible.
- Patients appearance and demeanor—e.g. "tearful, shirt ripped" not "distraught."
- Any objects or weapons used in an assault—e.g. knife, iron, closed or open fist.
- Patients account of any threats made or other psychological abuse.
- Names or descriptions of any witnesses to the abuse.

Document results of physical examination:

- Findings related neurological, gynecological, mental status exam if indicated.
- If there are injuries, (present or past) describe type, color, texture, size, and location
- Use a body map and/or photographs to supplement written description;
- Obtain a consent form prior to photographing patient. Include a label and date.

Document laboratory and other diagnostic procedures:

- Record the results of any lab tests, x-rays, or other diagnostic procedures and their relationship to current or past abuse

Document results of assessment, intervention and referral:

- Record information pertaining to the patient's health and safety assessment including your assessment of potential for serious harm, suicide and health impact of domestic violence.
- Document referrals made and options discussed.
- Document follow-up arrangements.
- If patient does not disclose domestic violence victimization document that assessment was conducted and the patient did not disclose abuse.
- If you suspect abuse, document your reasons for concerns i.e. "physical findings are not congruent with history or description," "patient presents with indications of abuse".
- Offer at least one follow-up appointment (or referral) with a healthcare provider, social worker or domestic violence advocate after disclosure of current or past abuse.

Safety Planning

Whenever social workers interact with families experiencing domestic violence, the worker's first concern should be the safety of both the children and the adult victims. To help increase safety for children and adult victims, social workers should partner with adult victims and children (if appropriate) to develop domestic violence safety plans. To help increase safety for children and adult victims:



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- Behavioral Health professionals should partner with adult domestic violence victims and children (if appropriate) to develop safety plans.
- Safety plans address risk to both the child and the adult victim.
- A safety plan should reflect the specific information the behavioral healthcare provider has gathered from the assessment.
- Behavioral healthcare providers should do safety planning whenever domestic violence is identified as an issue or when circumstances affecting safety have changed.
- Age-appropriate safety plans for children can increase their safety and support their resilience.

Domestic Violence safety planning typically covers:

- Immediate safety, as well as safety during assaults, stalking, or abuser attempting contact.
- Escape.
- Long-term safety.
- Safety for children.

Domestic Violence safety planning addresses a wide variety of issues, including:

- Increasing victim safety at home, commuting, at work, at school, and other public spaces.
- Identifying who should know about the danger that a perpetrator poses in these places.
- Identifying who can be a source of support or protection in each of these places.
- Identifying risks from the perpetrator, as well as other risks such as homelessness.

Typical Elements of a Safety Plan for immediate safety and safety during assaults include:

- Identifying a relatively safe room in the house to run to when abuse starts, such as a room with a locking door, a telephone, and access to the outside; moving away from the kitchen, the bathroom, or areas where weapons are stored during fights.
- Establishing a code or agreement with neighbors or children about when to call 911.
- If the perpetrator has guns, hiding or disposing of the ammunition and, whenever possible, making sure that the guns in the house or car are not loaded Planning for escape.
- Making copies of critical documents or moving the originals of those documents to a safe place, such as a friend's or family member's home or the victim's workplace. Critical documents include: - social security cards - school records, bank records - insurance, passports - medical information.
- Packing a small bag with clothes, a couple of toys, and any medicines taken regularly by the adult victim or the children and keeping it in a safe place outside the house, in the trunk, or with a trusted friend.



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- Changing the locks on the house, getting an unlisted number, getting caller ID, and blocking caller ID on calls from the victim's house.
- Asking neighbors, co-workers, and/or family to call 911 if they see the perpetrator.
- Finding out how to use technology (cell phones, email, and internet) safely and ensure the perpetrator cannot track movements via the victim's cell phone (information on this can be found at www.getmoneygetsafe.org/privacyandtechnology.cfm).
- Identifying who to talk to at work about the situation, what is necessary to increase safety at work (such as security, escort to and from car, locking office door), and how to arrive at and leave work safely.
- Knowing what to do and where to go if the perpetrator is following the victim (identify police stations close to routes to and from home/work/ school, don't stop, and call 911 on a cell phone).
- Plan for safety with children.
- Plan for emotional support.

Important Phone Numbers

- If you are in immediate danger, call 911
- National Domestic Violence Hotline at 1-800-799-SAFE (7233)
- National Sexual Assault Hotline at 1-800-656-4673

Documentation Reporting and Legal Requirements

Calling the police is not always in the best interest of a victim of domestic abuse. Some victims of domestic violence have learned to distrust the police or believe that law enforcement intervention will further endanger them. Immigrant victims may fear that calling the police will lead to deportation. Others are unwilling to use law enforcement intervention until a safety plan is in place. Each victim should be informed of their legal options and encouraged to make their own choices (Burnett, 2011; Hancock, 2011). The requirements for reporting incidents of domestic violence - what must be reported, how it must be reported and to whom, and who is responsible for the reporting – vary from state to state (Family Violence Prevention Fund, 2010).

Florida statute 790.24 requires healthcare providers to report gunshot or life-threatening wounds or injuries. This does not cover the majority of injuries sustained in domestic violence. Reports are to be made to the sheriff's department or the police department. Failing to report is a 1st degree misdemeanor and is punishable by up to a \$1,000 fine and up to one year in prison. Florida law also mandates the reporting of child abuse or neglect and elder abuse or abuse of the disabled.



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In Florida, a 24-hour domestic violence hotline is available for toll-free counseling and information. The number is 800-500-1119. The counselors answering the toll-free line may refer the victim to his or her local domestic violence center. A list of Florida certified domestic violence centers organized by county and city may also be found on the Florida Coalition Against Domestic Violence website at <http://www.fcadv.org/centers>. As of 2014, Florida had 42 certified domestic violence centers that provide information and referral services, counseling and case management services, a 24-hour hotline, temporary emergency shelter for more than 24 hours, educational services for community awareness relative to domestic violence, assessment and appropriate referral of resident children, and training for law enforcement personnel.

The Florida Domestic Violence Confidentiality and Privilege Laws—90.5036 Domestic violence advocate-victim privilege states:

“(1) for purposes of this section:

- A “domestic violence center” is any public or private agency that offers assistance to victims of domestic violence, as defined in s. 741.28, and their families.
- A “domestic violence advocate” means any employee or volunteer who has 30 hours of training in assisting victims of domestic violence and is an employee of or volunteer for a program for victims of domestic violence whose primary purpose is the rendering of advice, counseling, or assistance to victims of domestic violence.
- A “victim” is a person who consults a domestic violence advocate for the purpose of securing advice, counseling, or assistance concerning a mental, physical, or emotional condition caused by an act of domestic violence, an alleged act of domestic violence, or an attempted act of domestic violence.
- A communication between a domestic violence advocate and a victim is “confidential” if it relates to the incident of domestic violence for which the victim is seeking assistance and if it is not intended to be disclosed to third persons other than:
- Those persons present to further the interest of the victim in the consultation, assessment, or interview.
- Those persons to whom disclosure is reasonably necessary to accomplish the purpose for which the domestic violence advocate is consulted.
- A victim has a privilege to refuse to disclose, and to prevent any other person from disclosing, a confidential communication made by the victim to a domestic violence advocate or any record made in the course of advising, counseling, or assisting the victim. The privilege applies to confidential communications made between the victim and the domestic violence advocate and to records of those communications only if the advocate is registered under s. 39.905 at



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the time the communication is made. This privilege includes any advice given by the domestic violence advocate in the course of that relationship.

The privilege may be claimed by:

- The victim or the victim's attorney on behalf of the victim.
- A guardian or conservator of the victim.
- The personal representative of a deceased victim.
- The domestic violence advocate, but only on behalf of the victim. The authority of a domestic violence advocate to claim the privilege is presumed in the absence of evidence to the contrary."

Vulnerable Adult Abuse

Report suspected abuse of vulnerable adults to the Florida Abuse Hotline. All reports are confidential, including the name of the reporter. Abuse means any willful act or threatened act by a relative, caregiver, or household member which causes or is likely to cause significant impairment to a vulnerable adult's physical, mental, or emotional health. Abuse includes acts and omissions (415.102(1), F.S.)

If the abuse was perpetrated by the spouse/partner or other person known to the victim, it constitutes domestic violence. The National Center on Elder Abuse (2006) encourages health professionals not to try to answer, "Is this domestic violence?" or "Is this elder abuse?" Instead, efforts should be made to maximize both the domestic violence and aging networks services by partnering to meet the unique needs of older victims.

To be admissible in a court of law, medical documentation should include the following:

- Photographs of the injuries.
- Body maps, which document the extent and location of the injuries.
- Description of the patient's demeanor.
- A record of the patient's comments about how the injuries occurred. The patient's own words should be set off in quotation marks or identified by such phrases as "the patient states" or "the patient reports."

References



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