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Application to Practice

Introduction

This course will provide education and information on understanding the diagnostic criteria for addiction treatment and placement, providing the appropriate treatment in consideration of a client's personal and cultural background situation, and familiarity with the acceptable range of medical and pharmacological resources available for treatment.
In addition, there will be a chapter dedicated to working with special populations which includes: aging individuals; individuals with co-occurring disorders (e.g. alcoholism and mental illness); individuals with post-traumatic stress disorder (PTSD); individuals with disabilities; diverse populations; individuals with cultural differences; individuals on probation / parole, etc.

Several of these topics have been covered to some extent in other courses. In this course they will be covered more in-depth.

Review and discuss terms related to:

- Standards of practice
- Professional ethics
- Substance Use Disorders
- Mental Disorders
- Clients
- Treatment
- Programs
- Systems

Instructor Note: All of these topics and more are areas you will need to provide professional addiction services. The main purpose of this course is to help you string together the various topics, issues, techniques etc., that you have learned to your actual clinical practice. Understanding how to utilize the many concepts and tools you have studied and relate them to addiction treatment and clinical practices is what guides you as a professional and helps you to help your clients.

In other words, putting into practice all you have been learning in a comprehensive, complete and applicable manner. Often being a student requires gathering information, memorizing information, understanding information but until you begin to utilize the information,

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incorporate the information into your daily work practices the information can seem overwhelming and not quite clear.

While this course will help you to make sense of much of what you have learned ultimately the true clarification will begin when you put all of these practices into use.

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Professional Practice Foundations

Chapter 1

This chapter presents an overview of the foundations of counseling practice. These foundations of practice are covered in many ways in several of the courses in the CAP program, and rightly so. Like in anything else a solid foundation is necessary to create stability, consistency and safety. This most certainly holds true in the field of addiction treatment. These foundations apply not just to the individual counselor but to facilities and governing bodies as well.

Instructor Note: As an addiction professional, whether you have your CAP or not, you are bound to know and comply with the Florida Certification Board Code of Ethics and Professional Conduct and Disciplinary Procedures. You can find the complete FCB Code of Ethics, glossary and disciplinary actions at: http://flcertificationboard.org/assets/uploads/Code-of-Ethics-April-2014.pdf

For the purposes of this course the information will be kept concise and to the point. You have the opportunity to learn in greater detail in the course Professional and Ethical Responsibilities.

ETHICS

General Definition: Consistent, objectively defined but essentially idealistic standards of behavior that tell us how human beings ought to act in their various personal and professional roles. Ethics are legal guidelines for professional behavior that are developed to protect the profession, the professional, the client and society

LEGAL

Definition: Those things which are codified in laws or regulations. Minimum level of acceptable practice in a profession. A good system of laws can incorporate ethical standards, but laws can be corrupted. Laws may also be based on ―culturally accepted norms‖ which may or may not be ethical.

MORALS

Beliefs about right and wrong conduct. They are often based on sociological conditions and learned behavior. They do not require reason or consistency or thorough analysis in their initial shaping or practical application.

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VALUES

The beliefs of an individual or culture which has an emotional investment attached. A set of values may be placed into the notion of a value system. Values are considered subjective and vary across peoples and cultures.

CRITICAL POINTS TO REMEMBER

- There is a difference between personal values, morals and religious convictions and our Professional Ethical Standards.
- Ethical dilemmas that arise in the course of our work must be resolved by following the guidelines of our professional ethical standards or principles rather than our own personal standards or religious convictions
- Ethical dilemmas can be addressed in different ways

SOME BASIC ASSUMPTIONS

- Ethics is a continuous, active process
- Standards are not a rote cookbook. They tell us what to do, not always how
- Each situation is unique
- Counseling\Therapy is done by fallible beings
- Sometimes answers are elusive

Four Common Pitfalls

The following are four common pitfalls committed by addiction counselors that can lead to ethical dilemmas.

- Conflicted Agendas
- Confused Roles
- Clinician Burnout
- Cutting Corners

FOUR KEYS to an ETHICAL PRACTICE

- Recognize your strengths and limitations
- Respect the Tiers of Ethics
- Seek Continuous Learning

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- Make the Rule

CONFIDENTIALITY

Confidentiality must be assured

Client personal information must be kept confidential

The limits of confidentiality prevents reference to, or discussion about a client, except as professionally appropriate, and then only with clients consent. Any breach of confidence will damage any trust that may have been built.

Professional Addiction Counselors are legally obligated to follow all the rules set forth in both:

1. 42 CFR – For a full description please go this website: http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2
2. HIPAA - - For a full description please go to this website: http://health.state.tn.us/hipaa/

Another part of being an addiction professional is knowing, understanding and applying the regulations and standards for practice set forth by the Florida Department of Children & Families (DCF). All agencies applying licensure with DCF and all those who receive licensure must comply with all regulation set forth in 65D-30 in order to maintain and renew licensure.

These regulations include:

Substance Abuse Program

65D-30.001Title

65D-30.002Definitions

65D-30.003Department Licensing and Regulatory Standards

65D-30.004Common Licensing Standards

65D-30.005Standards for Addictions Receiving Facilities

65D-30.006Standards for Detoxification

65D-30.0061Standards for Intensive Inpatient Treatment

65D-30.007Standards for Residential Treatment

65D-30.0081Standards for Day or Night Treatment with Community Housing

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65D-30.009Standards for Day or Night Treatment

65D-30.0091Standards for Intensive Outpatient Treatment

65D-30.010Standards for Outpatient Treatment

65D-30.011Standards for Aftercare

65D-30.012Standards for Intervention

65D-30.013Standards for Prevention

65D-30.014Standards for Medication and Methadone Maintenance Treatment

To read these standards of practice go to:

http://www.dcf.state.fl.us/programs/samh/SubstanceAbuse/docs/rule65d-30.pdf

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Practical Application of Diagnostics and Placement Criteria in Addiction Treatment Services - Chapter 2

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

Instructor Note: Once you begin working as an addiction professional you may be asked to perform several functions within your scope of practice. One of those functions might be to conduct clinical assessments on new or potential clients. The information gathered from the assessment provides the basis for the assessing counselor to make an initial diagnosis (DSM 5), determine which placement criteria is met (ASAM), matching client needs to treatment placement and formulation of treatment recommendations.

The following are summarized definitions and applications of those diagnostic and placement tools.

The goal of the diagnostic presentation is to give both the client and family members with *an overwhelming and undeniable argument that the client is suffering from the diagnosed disorders*, that recovery is possible, and that a comprehensive treatment plan needs to bring implemented that addresses the chronic and persistent symptoms of these disorders. The diagnostic presentation describes in no-nonsense language exactly what is wrong, what the painful problems are the client and significant others are experiencing, and then explains that recovery is possible and that these problems can be either resolved or effectively managed in ways that significantly reduces pain and dysfunction.

The process of preparing for a diagnostic presentation involves:

1. organizing the identified disorders and symptoms in a way that shows that logical connections to the clients Motivational Crisis and shows how all problems and symptoms relate to one another to create the motivational crisis
2. Listing the prioritized problems in preparation to formulate the treatment recommendations (which includes level of care/treatment modality), then the treatment plan.

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The Assessment Profile

The assessment profile is organized summary of the significant results of the assessment. This normally consists of the following:

- **Profile of Disorders:** The profile of disorders is a listing of all of the coexisting disorders that were identified during the assessment. The disorders are organized as Substance Use Disorders (specified by drugs of choice), Mental Disordered, Personality Disorders, and severe situational problems requiring counseling (DSM V-codes). It is important the profile of disorders have a brief no-nonsense explanation of each disorder and a simple plain-English title for the disorder.
- **Symptom Profile:** The symptom profile is a comprehensive list of the specific symptoms of substance use disorders and coexisting mental and personality disorders. A symptom is described as an area of dysfunction related to the identified disorders. The symptom profile is developed by working with clients to complete symptom checklists for substance use disorders and the common coexisting mental disorders, personality disorders, and lifestyle problems. A biopsychosocial is used to identify the relationship between biological, psychological, and social symptom clusters. When the symptoms of all disorders are identified and organized together, two types of symptoms can be identified: (1) *Holistic Symptoms*: The common symptoms that relate across all identified disorders; and (2) *Disorder-specific Symptoms*: Symptoms that are associated with only one disorder and are not shared by the other disorders.
- **Personality Profile:** The personality profile describes the essential characteristics of the client's habitual way of relating to self, others, and the world.
- **Life Style Profile:** The lifestyle profile describes the common habitual structures of the client's normal way of living and identified the lifestyle components that are centered around and support addiction and coexisting disorders and those that support sobriety, responsibility, and normal functioning.

The Diagnostic and Statistical Manual of Mental Disorders – DSM 5

- Produced by the American Psychiatric Association (APA).
- Establishes criteria for diagnosing specific disorders.
- Used by the medical and mental health fields as a reference for diagnosing substance use and mental health disorders.

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- Provides for a common language for communicating about disorders.

DSM-5 Chapters

- Neurodevelopmental Disorders
- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma-and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom Disorders
- Feeding and Eating Disorders
- Elimination Disorders
- Sleep-Wake Disorders
- Sexual Dysfunctions
- Gender Dysphoria
- Disruptive, Impulse Control and Conduct Disorders
- Substance Use and Addictive Disorders
- Neurocognitive Disorders
- Personality Disorders
- Paraphilic Disorders Other Disorders

Terms Related to Substance Use

In the new DSM 5 Substance Abuse Disorders will no longer separate out "abuse" versus "dependence" as these disorders occur on a continuum. The categories are described as "substance use disorders" with criteria for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders.

- New criterion of craving or strong desire or urge to use
- Recurrent legal problems criterion has been deleted

Substance Use Disorder (SUD) Criteria:

Substance use disorder is defined by the following criteria in DSM-5:

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A. A problematic pattern of substance use leading to clinically significant impairment or distress as manifested by at least two of the following occurring in a 12-month period:

1. Use in larger amounts or longer than intended
2. Desire or unsuccessful effort to cut down
3. Great deal of time using or recovering
4. Craving or strong urge to use
5. Role obligation failure
6. Continued use despite social/interpersonal problems
7. Sacrificing activities to use or because of use
8. Use in situations where it is hazardous
9. Continued use despite knowledge of having physical or psychological problem caused or exacerbated by use
10. Tolerance
11. Withdrawal

SUD CRITERIA PRIMARILY IN SEVERE DESIGNATION ONLY

The "Big Five" - Norman G. Hoffmann, Ph.D. President, Evince Clinical Assessments

- Wanting to cut down/unable to do so
- Craving with compulsion to use
- Sacrifice activities to use
- Failure at role fulfillment due to use
- Withdrawal symptoms

CRITERIA PREVALENT IN MILD & MODERATE GROUPS

- Unplanned use
- Time spent using
- Medical/psych. consequences of use
- Use where impairment is dangerous
- Interpersonal conflicts
- Legal problems and use to relieve emotional distress similar in distribution to these

Norman G. Hoffmann, Ph.D. President, Evince Clinical Assessments

CLINICAL IMPLICATIONS

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- Most of those in the "mild" designation can probably benefit from moderation and related harm reduction strategies
- Those in the "severe" designation will require more intensive and extended services where abstinence is essential to recovery
- The "moderate" group may contain cases that fit the mild or severe characteristics

- Persons in the severe designation with positive "Big Five" findings will require a more intensive and longer continuum of care to achieved treatment effectiveness
- Persons in the mild designation typically will benefit from brief interventions to achieve treatment efficiency
- Each treatment plan can be informed by prior empirical outcome data on comparable cases and modified based on the individual's treatment response

Severity Scale DSM-5

The Severity of each Substance Use Disorder is based on:

- 0 criteria or 1 criterion: No diagnosis
- 2-3 criteria: Mild Substance Use Disorder
- 4-5 criteria: Moderate Substance Use Disorder
- 6 or more criteria: Severe Substance Use Disorder

Assessing for substance use disorder

In assessing for substance use disorder, one initially attempts to determine whether the patient's substance use is causing negative consequences. If such consequences are significant and recurrent in a 12 month-period, then diagnosis of substance use disorder is warranted.

Assessing for substance-induced disorders

Even if client does not meet criteria for substance use disorder, there may be substance-induced withdrawal or intoxication; or variety of substance-induced disorders including anxiety, depression, psychosis, sleep disorder or sexual dysfunction.

Terms Related to Mental Disorders

Personality Disorders

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The DSM 5 captures these differences between healthy and unhealthy personalities that we have been discussing. According to the definition of personality disorders in DMS-5 (APA 2013), the key elements of a personality disorder are:

1. A personality disorder is enduring pattern of inner experience and behavior. This pattern manifests in two or more of the following areas:
    a. Thinking
    b. Feeling
    c. Interpersonal relationships
    d. Impulse control
2. This pattern deviates markedly from cultural norms and expectations.
3. This pattern is pervasive and inflexible.
4. It is stable over time.
5. It leads to distress or impairment

The Four Core Features of Personality Disorders

The DSM-5 (APA, 2013) identifies and describes ten specific personality disorders. These ten diagnoses represent ten specific enduring patterns of thoughts, feelings, and behavior. However, each of these ten patterns can be distilled down to four core features of personality disorders:

1. 1. Rigid, extreme and distorted thinking patterns (thoughts)
    2. Problematic emotional response patterns (feelings)
    3. Impulse control problems (behavior)
    4. Significant interpersonal problems (behavior)

In fact, in order to diagnose a personality, disorder a person must exhibit at least two of these four core features.

Cluster A: Paranoid, Schizoid, and Schizotypal Personality Disorders

- Cluster A is called the odd, eccentric cluster. The common features of the personality disorders in this cluster are social awkwardness and social withdrawal. These disorders are dominated by distorted thinking.

Cluster B: Borderline Personality Disorder, Narcissistic Personality Disorder, Histrionic Personality Disorder, and Antisocial Personality Disorder.

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- Cluster B is called the dramatic, emotional, and erratic cluster. Disorders in this cluster share problems with impulse control and emotional regulation.

Cluster C: Avoidant, Dependent, and Obsessive-Compulsive Personality Disorders.

- Cluster C is called the anxious, fearful cluster. These three personality disorders share a high level of anxiety.

Psychotic Disorders

Schizophrenia Spectrum - These clients constitute what is commonly referred to as the serious and persistent mentally ill population.

Key Features in this group of disorders:

- Delusions
- Hallucinations
- Disorganized Thinking (Speech)
- Grossly Disorganized or Abnormal Motor Behavior (including Catatonia)
- Negative Symptoms

The DSM 5 eliminated the subtypes for schizophrenia. They were: Paranoid type, Disorganized type, Catatonic type, Undifferentiated type and Residual type. The rationale for doing away with these subtypes is they are not stable conditions, and have not afforded significant clinical utility nor scientific validity and reliability.

Mood Disorders

The DSM 5 separated Bipolar and related disorders from Depressive disorders as it was listed in the DSM IV-TR.

Bipolar and Related Disorders include:

Bipolar I disorder – The classic Manic-Depressive criteria

Bipolar II disorder – Criteria requires lifetime experience of at least one episode of major depression and one hypomanic episode. Typically this disorder is accompanied by serious impairment in work and social functioning.

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Cyclothymic disorder – Adults who have experienced at least two years (for children one year) of both hypomanic and depressive periods without ever fulfilling the criteria for an episode of mania, hypomania or major depression.

Depressive Disorders include:

Disruptive mood dysregulation disorder – (children up the age of 12 only) Persistent irritability and frequent episodes of extreme behavioral dyscontrol.

Major depressive disorder – Characterized by discrete episodes of at least two weeks duration involving clear-cut changes in affect, cognition, and neurovegetative functions and inter-episode remissions.

Persistent depressive disorder (dysthymia) – Diagnosed when mood disturbance continues for at least 2 years in adults or 1 year in children.

Anxiety Disorders

Anxiety disorders include disorders that share features of excessive fear and anxiety and related behavioral disturbances. Fear is the emotional response to real or perceived imminent threat, whereas anxiety is anticipation of future threat. Obviously, these two states overlap, but they also differ, with fear more associated with surges of autonomic arousal necessary for fight or flight, thoughts of immediate danger, and escape behaviors, and anxiety more associated with muscle tension and vigilance in preparation for future danger and cautious or avoidant behavior.

Instructor Note: The DSM 5 include many other sections for various other mental disorders (please refer to the chapter list earlier in this chapter). Remember that you will be using the DSM primarily to determine whether a potential client\client you have completed an assessment on meets the DSM 5 criteria for a substance use disorder and if so which severity applies. With your CAP you will not be called upon to diagnosis other mental health disorders, despite this, you will still need to be very familiar with characteristics\symptoms of many of the mental health disorders designated in the DSM 5.

Terms Related to Clients

Person-centered terminology – move away from labeling and negative connotations.

Terms for co-occurring disorders – utilize language that does NOT stigmatize clients.

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Diagnosis vs. symptoms – you may not need to diagnose clients but you WILL need to recognize and assess various mental health symptoms.

ASAM – The American Society of Addiction Medicine

The ASAM Criteria is a comprehensive, evidence-based set of guidelines that describes the continuum of addiction health services. The criteria guide professionals through the process of assessment, service planning, placement, continued stay and transfer/discharge of patients.

Goal of the ASAM criteria: To unify the addiction field around a single set of criteria

ASAM's NEW 2013 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, 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.

The updated ASAM offers:

Updated diagnostic criteria admission to be consistent with DSM-5

- Section on gambling disorders
- Section on tobacco use disorders
- Update opioid treatment section

Underlying Concepts of The ASAM Criteria: Individualized, Clinically-driven Treatment

Patient\Participant Assessment

BIOPSYCHOSOCIAL

Dimensions

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Progress

Severity of Illness\LOF

Problems\Priorities

Severity of Illness\LOF

Plan

Intensity of Service –

Modalities and Levels of Service

<u>Broad Treatment Levels of Service: A Description of the Continuum of Care</u>

Level of care and description

- Level 0.5- Early Intervention
  - Assessment and education for individual who do not meet diagnostic criteria for substance use disorder
- Level 1- Outpatient
  - Less than 9 hours of service per week for recovery or motivational enhancement therapies
- Level 2.1- Intensive Outpatient
  - 9 or more hours of service per week to treat multidimensional instability
- Level 2.5- Partial Hospitalization Services
  - 20 or more hours of service per week for multidimensional instability not requiring 24-hour care
- Level 3.1- Clinically managed low-intensity residential services
  - 24-hour structure with available trained personnel; at least 5 hours of clinical service per week
- Level 3.3- Clinically managed population-specific high-intensity residential services
  - 24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments.
- Level 3.5- Clinically managed high-intensity residential services

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- 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community

- Level 3.7- Medically monitored intensive inpatient services
  - 24-hour care with physician availability for significant problems in dimensions 1, 2, or 3. 16 hour per day counselor availability
- Level 4- Medically managed intensive inpatient services
  - 24-hours nursing care and daily physician care for severe, unstable problems in dimensions 1,2, or 3. Counseling available to engage patient in treatment
- OPT- Opioid Treatment program (outpatient)
  - Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with sever opioid use disorder

Adolescent Treatment Levels of Care

Level 0.5	Intervention
Level I	Outpatient
Level II.1	Intensive Outpatient
Level II.5	Day/Night
Level III.5	Level I & II Residential
Level III.2-D	Addiction Receiving Facilities
Level III.7-D	Detoxification

Through this strength-based multidimensional assessment the ASAM Criteria addresses the patient's needs, obstacles and liabilities, as well as the patient's strengths, assets, resources and support structure.

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ASAM	Dimension 1 Intoxication and/or Withdrawal Potential	Dimension 2 Bio-medical Conditions and Complications	Dimension 3 Emotional, Behavioral or Cognitive Conditions	Dimension 4 Readiness to Change	Dimension 5 Relapse, Continued Use or continued Problem Potential	Dimension 6 Recovery Environment
Level II.5 Partial Hospitalization	None or moderate risk of severe WD	None or not a dstraction from treatment	Mild to moderate, with potential to distract from recovery, needs stabilization	Poor engagement of Tx, significant ambivalence or lack of awareness or problems requires near-daily structured program or intensive engagement in svc.s to promote progress through the stages of change	Intensification of addiction or MH symptoms despite active participation in < LOC, indicates high likelihood of relapse w/o near daily monitoring	Eviroment not supportive but, with structure and support and relief form home life client can cope
Level III. Residential Treatment	From no WD to Level III-2D (Clinically Managed Residential Detox)	None or stable or receiving concurrent medical monitoring	Repeated inability to control impulses or personality DO that reqires structure to shape behavior or other fuctional defecits that require 24 hour setting to teach coping skills	Marked difficulty with or opposition to treatment, with dangerous consequences	No recognition of the skills needed to prevent continued use, w/ imminently dangerous consequences	Environment is dangerous and lacks skills to cope outside a highly structured 24-hour setting
Level IV Medically Managed Intensive Inpatient Treatment	High risk of W/D and requires a liscenced hospital	Requires 24-medical monitoring but not intensive treatment	Because of severe and unstable problems the patient requires 24-hour psychiatric care	Resistance is ↑ and poor impulse control, despite (-) consequences, requires motivating strageties only available in 24-hour setting	Unable to control use, w/ immenently dangerous consequences, despite participation in < LOC	Environment is dangerous and lacks skills to cope outside a highly structured 24-hour setting

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Instructor Note: In some ways this chapter is written with the end process first. I say this because in order to gain the information necessary to make a diagnosis for a client a thorough assessment\evaluation needs to be completed in its entirety. Whether that assessment is taken via a bio-psychosocial, an ASI, GAIN or some other measurement tool used in substance abuse treatment, the more information you can obtain the more accurate a diagnosis you will make. This will also guide you in assessing placement criteria\level of care and of course, helping the client create a pertinent, realistic treatment plan. The following are the highlights of the evaluation process. In the course "Clinical Evaluation" you will learn in step by step detail how to conduct the various elements of a clinical evaluation.

Clinical Evaluation is the systematic approach to screening and assessment.

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Screening - The process through which counselor, client, and available significant others determine the most appropriate initial course of action, given the client's needs and characteristics, and the available resources within the community.

Assessment is an ongoing process through which the counselor collaborates with the client and others to gather and interpret information necessary for planning treatment and evaluating client progress.

During the screening, what four things should the counselor do:

Establish rapport - including management of crisis situation and determination of need for additional professional assistance.

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

Screen - for psychoactive substance toxicity, intoxication, and withdrawal symptoms; aggression or danger to others; potential for self-inflicted harm or suicide; and co-existing mental health problems.

Assist the client in identifying the impact of substance use on his or her current life - problems and the effects of continued harmful use or abuse

Evaluation

- Initial Screening – eligibility and appropriateness
- Assessment – identify specific types of services and intensity of treatment
- Goals of Initial Interview
  - Establish trust, rapport and effective communication
  - Exploring client's problems and expectations
  - Determine whether further assessment is needed

Building Relationships

- **Communication Techniques**
  - Active Listening
  - Reflecting

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- Clarifying
- Focusing
- Summarizing
- Questioning – use questions to clarify or pursue a specific topic
- Observing – see information that is conveyed non-verbally

Once the clinical assessment\evaluation has been completed, using either a facility approved screening tool and\or a bio-psychosocial assessment, the assessor\counselor will document their findings in an Integrated Summary. An integrated Summary is summarized account of all the findings from the clinical assessment including: client demographics, family history, mental health history, alcohol and other drug history, all psychosocial areas of the clients life, client perceived strengths and weaknesses, ending with the counselors clinical "take" on the client, client's stage of change\readiness for treatment and readiness for recovery, counselor recommendations for treatment level and treatment plan. This clinical conclusion will also include a current brief mental status presentation of the client and DSM 5 diagnosis.

Instructor Note: The following section is a detailed description of what a mental status exam is, what is involved and the definition of each section of the exam. After you obtain your CAP you will be permitted (by 65D-30 regulations and some insurance company standards) to conduct a brief mental status exam. Typically in substance abuse treatment settings only a brief mental status exam is needed or required. However, learning about the complete mental status exam can only broaden your understanding and your clinical observation skills.

<u>The Mental Status Examination (MSE):</u>

The MSE is an integral portion of the psychiatric interview. It serves as a "snapshot" of the person you are evaluating. It should include all of the pertinent observations and findings you accomplish during your encounter with the patient. Not only is it important for describing the "state" of the patient, it is an important tool that can help substantiate a diagnosis, convey information to another provider, and assist in determining most appropriate step in treatment.

Based on the following sections, the mental status examination may appear quite involved and complicated. This is not the case. As you will see, much of the information for the mental status examination is obtained from the natural course of the interview.

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It is important to state that the goal is not pinpoint the absolute correct term to describe an observation. The beauty of the mental status examination is, even if you do not know the specific term, you can use your own words and observations.

APPEARANCE Yes, this is as straightforward as it sounds – this section describes how the patient looks, smells, behaves, speaks, establishes eye contact, etc. If this section is thorough enough, a reader of your mental status exam should be able to pick out the person out of a room. The mental status exam starts when you first set eyes on the patient.

- The following is a sample of items that should be included in the APPEARANCE section: Ethnicity
- Apparent age (younger, older, or appeared stated age)
- Sex
- Coordination/gait/notable movements
- Adherence to social conventions (i.e., shakes hands, military bearing)
- Build (Average, underweight, emaciated, petite, thin, obese, muscular)
- Grooming (Good, poor, adequate, immaculate, neglected)
- Dress (Casual, stylish, mismatched items, formal, tattered, appropriate for particular setting) Psychomotor activity (Described as increased in the case of agitation; decreased in cases of depression or catatonia)

A description of how the patient relates to the interviewer is a necessary component of the APPEARANCE section. This is sometimes also described as the “interpersonal style.”

- Congenial
- Guarded
- Open/candid
- Cooperative
- Withdrawn
- Distant
- Annoyed/Irritable
- Hostile
- Shy
- Relaxed
- Cautious
- Defensive
- Resistant

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Speech is something you can also comment on in the APPEARANCE section. Some patients will speak volumes, while others will say only a few words. Some patients will speak very fast, and others will not make any sense. A good speech section of the mental status examination comments on the rate, rhythm, volume, and spontaneity. Some ways to help describe speech patterns are:

Clear	Impoverished	Confabulation
Coherent	Monotone	Impressionistic/little detail
Normal rate	Mumbled	No speech
Pressured (fast)	Animated/Excited	Poor articulation
Soft-spoken	Difficulty finding words	Spontaneous speech
Stuttering	Slurred	Includes profanity

In describing speech, it would be appropriate to comment on "what" was said. This can also be deferred to the **THOUGHT** content section; however, if there are prominent themes – there should be a brief comment describing them.

Eye contact is also described in the **APPEARANCE** section. Usually is described with one or more of the following:

- Good
- Fleeting
- Avoided
- Intense/unwavering
- None
- Sporadic

Examples of appearance section:

Vicky is a 65-year-old obese African American woman who appeared older than her stated age. She was dressed in a wrinkled, dirty (riddled with food stains), and obviously expensive red business suit with matching red bonnet, which made her appear overdressed for the intake interview. Her hair was immaculately cut and styled; she also had copious amounts of make-up applied as well as dirty fingernails and mismatched earrings. She was noted to be quite gregarious, cooperative, and overly familiar with the interviewer, commenting on several occasions that the interviewer looked like her grandson, Dwayne. She had obvious, low, rhythmic motions of her lower jaw and tongue, as well as a slow tremor in her hands bilaterally

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– these appeared not to bother her. Eye contact was noted to be intense and, at times, unwavering as she looked at the interviewer with wide eyes. Her manner of speech was noted to be quite loud accompanied with a pressured rate, rhythm, and spontaneity with overvalued content around "hogs not being pigs."

Johnny appeared to be his stated age of 30. He was a fairly tall, thin, and slightly balding Caucasian male. While he greeted the interviewer appropriately with a handshake, his palm was notably sweaty. He nervously and sheepishly apologized for this. Throughout the course of the interview, he tapped his fingers on his knees, looked around the room frequently, and smiled nervously every few seconds. He was well-groomed, dressed in well-maintained in his Class B uniform, cooperative, and interactive throughout the entire interview. Eye contact was sporadic. Speech was of normal rate, rhythm, volume, and spontaneity; speech content was overrepresented with themes of worry. For example, these included worry whether he locked his car door or not and if he said "hello" to his boss this morning.

MOOD and AFFECT

Mood describes the subjective state of the patient. This can be directly asked (i.e., "What would you say your mood is right now?" "How do you feel right now?"). Even if it is not asked, it can be thought of as the predominant or average feeling state during the interview. Some mood examples are:

- Euthymic (normal)
- Anxious
- Depressed Elated/euphoric
- Calm
- Irritated
- Alexithymic
- Dysphoric

If mood is the subjective portion, affect describes the objective portion (i.e., what you see and observe). Affect can be described in terms of four variables: Range, Intensity, Lability, and Appropriateness to mood/context.

- **Range** refers to the amount of variation in behavior/emotion during the interview (such as enthusiasm that fluctuates with sadness). There is a normal amount of variation patients will display during an interview, usually equivalent to those seen in every day conversations with associates, friends, significant others, etc. If the patient

demonstrates more variation in affect than is usual, this is considered an increased range of affect. For example, if a patient expresses euphoria and then changes, within the same interview, to a deep, non-responsive depressed appearance, this would be increased range. Likewise, if another patient were to present with extreme, sustained euphoria – this might be described as expansive. The other presentation may also be seen – decreased range of affect (**also described as restricted, constricted, blunted, or limited range**). An example of this is often seen in depressed individuals. They will most likely be confined to a depressed range of affect, with little indication of joy, hope, or smiling. Finally, when there is absolutely no change in affect (as seen in negative symptoms of psychosis), this can be described as **flat**.

- **Intensity** can be thought of as the emotional amplitude and power is coming forth from the patient.
- **Lability** can be thought of as of rapid, extreme, brief swings of emotion followed by a quick return to normal. A presentation of labile affect would a be patient who appears depressed and solemn, breaks into sudden laughter with little prompting for one minute, followed by crying for another minute, and then back to appearing depressed again.
- **Appropriateness** of affect refers to whether the emotion is expected for the patient's current expressed thought. For example, a patient who laughs uncontrollably while recalling a tragic event is demonstrating an inappropriate affect. It is also important to examine if the affect is **congruent** to mood (which is another area to assess appropriateness). For example, if a patient states he is "deeply depressed" and laughs, jokes, and smiles throughout the entire interview – this would demonstrate an affect that is **not congruent** with mood.

Examples of Mood and Affect section:

Valarie stated her mood as being, "okay … no, actually it is really good." Her range of affect was expansive and of increased intensity; she often gestured wildly with her hands and appeared as if she were on the brink of moving toward the interviewer. Her affect was noted to be labile, as she would be happy and elated one moment which would quickly change to tears with a return to being extremely happy. Her affect was not appropriate to given context, as she was extremely emotional while relating even the trivial portions of her account.

Ernest stated his mood to be "pretty depressed." His affect was restricted to the depressed range and was noted to be quite blunted, with very little change even while discussing

potentially happy content. His affect was not labile and was appropriate to given context and congruent with his stated mood.

SENSORIUM

The patient's orientation is described in this section. Areas of orientation are person, place, time, and situation. Remote/immediate memory can also be commented in this section as well.

Examples of Sensorium:

She was oriented to person, place, time, and situation.

Bobby was oriented to person and place; however, he was not oriented to time (a couple of days off and noted it to be the incorrect year) and was not entirely sure of why he was in the emergency room giving the reason, "They just want to look at my stuff."

COGNITIVE FUNCTIONING

Closely tied to intellectual functioning are elements of cognitive functioning. Cognitive functioning would be especially important to test if a patient is consistently not able to accurately follow instructions within the interview or has a chief complaint of memory problems. **Abstraction** can be tested with proverbs (i.e., "What does the proverb, 'Don't cry over spelled milk mean?'") or similarities (i.e., "How are a banana and apple alike?") might be able to elicit problems with thought processes by revealing concrete thinking, which might suggest a thought disorder. **Memory** can also be tested with the recall components within the mini-mental status examination, or by asking the patient the order of the past presidents, what he/she had for breakfast, recent significant national events, etc. Example of cognitive functioning:

Trent was easily able to follow the instructions and questions of the interview. His memory for recent events was intact. He had difficulty with abstraction. For example, when asked what "Every dark cloud has a silver lining" meant, he paused, smiled, and stated, "It means that behind that dark cloud is Mr. Ziebius who is tormenting me and has always done so. There is no silver, but just the darkening of other metals." When asked what "Don't cry over spilled milk" meant – he stated, "It means if you spill the milk on the floor, really you shouldn't cry."

THOUGHT SECTION

Thought Process involves the flow and organization of thought.

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- Coherence – Is the patient's thoughts organized well enough that they make sense to the listener?
- Logical – Are the conclusions a patient reaches based on sound or flawed logic? Remember that coherence and logic are two separate variables. For example, a patient may give a coherent account, but not necessarily logical (such as a person with delusions).
- Goal directedness – **Does the patient get to the point in a direct manner?** Non-goal-directed thought patterns include **circumstantiality** (i.e., patient makes numerous detours with non-essential details, but eventually does reach the goal of the original thought or posed question). **Tangentiality** is also another non-goal-directed thought pattern describes a patient who never gets to the point and does not reach the goal of the original thought or posed question.
- Associations – How well connected are the thoughts? Disordered associations include **loose associations** (i.e., examiner cannot discern connection between ideas), **blocking** (i.e., train of thought either fails to begin or stops usually in mid-sentence – sometimes seen in thought disorders, like schizophrenia), and **flight of ideas** (i.e., thoughts jump rapidly from one idea to the next, but obvious connection to each is preserved).

Thought Content involves actual statements, themes, and beliefs presented by the patient

- **Perceptions** – False perceptions include **hallucinations** (i.e., auditory, visual, or other sensory experiences in the absence of external stimuli), **illusions** (misinterpretation of actual sensory stimuli), **depersonalization** (feelings of unreality or strangeness concerning one's self), **derealization** (feeling that the external world is foreign or strange), and **distortion of body image** (erroneous self-assessment that one's physique is flawed).
- **Delusions** – Fixed, false beliefs. Many of the types that belong here are somatic, persecution, jealousy, grandiosity, etc. **Delusion/Ideas of reference or delusions of control** are also part of this category. There is also **thought broadcasting** (feeling that one's thought are being "put out there" for all to see/hear), **thought withdrawal** (feeling that others can remove thoughts from them), and **thought insertion** (others can put thoughts into one's head).
- **Dangerousness** –This should **always** be a part of your mental status examination. In this section, it is paramount to place any suicidal and/or homicidal ideation, intent, and/or plan here. It would also be helpful here to be as specific as possible with regard to intent and plan.

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- **Other items** included in the content section are:
  - Overvalued ideas (differs from delusions in that the belief is less firmly held, is less bizarre, and is not systematized).
  - Obsession themes
  - Phobias

Additional components of Thought

- **Judgment** – This is the ability to make good decisions concerning the appropriate thing to do in various situations.
- **Insight** – This is related to correct understanding of presence, nature, cause, and significance of any mental or emotional problem.
- **Impulse Control** – this is an estimate of the patient's ability to control their actions (and thinking about them prior to acting on them). This can be seen during the interview – for example, physically attacking the interviewer or copious swearing might indicate poor impulse control. This also might be estimated through immediate history, such as fights (might indicate being quick to provocation), sexual behavior, and drug usage.
- **Abstract reasoning** – Please see "Intellectual function and Cognitive Functioning" section. Abstract reasoning is sometimes placed in this section.

Example of Thought section:

While Thomas' thought processes were coherent and goal directed, his conclusions that the young lady he just met was in love with him was illogical. He believed that her calling the police, calling his Command, striking him, and being arrested and thrown in jail as "Testaments of her love …" and that she was testing him. He did not demonstrate looseness of associations, thought blocking, or flight of ideas. In regard to thought content, prominent delusions were apparent, as he believed, despite evidence to the contrary, that this woman was for him and that all of these activities were a "test" he must pass. He exhibited ideas of reference, as demonstrated by interpreting her wearing pink on Monday and waiting by Bus Stop number 5 as definite signs that he must pursue her. He denied auditory and visual hallucinations, paranoia, thought broadcasting, thought insertion, thought withdrawal, and suicidal ideation. Although he denied specific homicidal ideations, he mentioned that if "I can't have her … then I will make it so no one does." His insight was noted to be poor; his judgment was also poor. Impulse control was noted to be poor, as he continued to pursue this young lady despite many

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warnings not to do so. His abstraction ability, as demonstrated by discussing the meaning of certain proverbs, was intact.

George's thought processes were coherent, logical, and goal directed. While he denied auditory hallucination, visual hallucination, and delusions, his thought content was significant for near obsessive quality themes of worthlessness and how those around him would be "better off without me." He endorsed present suicidal ideation, intent, and plan stating that he "did not want to live this way anymore," and considered using his revolver in order to "end it all in the most definite and fastest way possible." He denied homicidal ideation. Insight and judgment were poor, as he was brought in by the police after waving his revolver at his apartment complex and does not see that he has a problem. His impulse control was considered poor, based on his activities at his apartment complex and other self-harming behavior preceding this event.

Closing Considerations

Taken in its entirety, a properly done mental status examination describes quite a bit about the patient. A frequently asked question is, "Will I have to document such a complete exam on each client I assess" The answer is "Yes and no." While at most facilities\treatment centers, your mental status examinations will likely be succinct while still containing the pertinent mental status presentation information along with all the alcohol and other drug information and all psychosocial information supplied by your client.

Brief MSE Checklist – This is typically what a CAP will be expected to utilize with all clients receiving services in a treatment facility at any level of care

Mental Status Examination Reports

A good report is brief, clear, concise, and addresses the areas below:

1. Appearance
2. Behavior/psychomotor activity
3. Attitude toward examiner (interviewer)
4. Affect and mood
5. Speech and thought
6. Perceptual disturbances
7. Orientation and consciousness
8. Memory and intelligence
9. Reliability, judgment, and insight

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Instructor Note: At the end of this booklet is helpful terminology for use in mental status exams and progress notes. See Appendix A

Treatment: Applying Stages of Addiction, Change and Recovery to Levels of Care - Chapter 3

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

Alcohol/Drug Treatment Programs

Regardless of a program's length in weeks or months, support and long-term follow-up are crucial to recovery. A quality treatment program not only addresses the drug abuse, it also addresses the emotional pain and other life problems that contribute to addiction.

Important criteria for substance abuse treatment programs

- **Program accreditation and licensing.** Make sure the treatment program is accredited by the state it's in. Also check to ensure that the program is run by licensed, well-trained mental health professionals and addiction specialists.
- **The effectiveness of the program's treatment methods**. Treatment centers should have at least some statistics on their success rates, preferably from an objective outside agency.
- **Type of aftercare services to prevent relapse.** Is there a well-run aftercare program? Does it provide referrals to other recovery services and support groups in the community? Also make sure that staff collaborate with the client and their families to create a discharge plan before you leave the program.

An overview of substance abuse treatment programs

Residential treatment – Residential treatment involves living at a treatment facility while undergoing intensive treatment during the day. Residential treatment normally lasts from 30-90 days.

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Day Treatment with community housing – Day long programming 6 days a week with clients sleeping off site under monitoring by behavioral techs.

Partial hospitalization – Partial hospitalization is for people who require ongoing medical monitoring but have a stable living situation. These treatment programs usually meet at the hospital for 3-5 days a week, 4-6 hours per day.

Intensive outpatient program (IOP) – Not a live-in treatment program, but it still requires a major time commitment. Intensive outpatient programs usually meet at least 3 days a week for 2-4 hours a day or more. The major focus is relapse prevention. These outpatient programs are often scheduled around work or school.

Counseling (Individual, Group, or Family) – Works best in conjunction with other types of treatment or as follow-up support. Therapy can help identify the root causes of alcohol/drug use, repair relationships, and learn healthier coping skills.

The Stages of Drug Addiction

Stage 1: Experimentation

Experimentation is defined as the voluntary use of drugs without experiencing any negative social or legal consequences. For many, experimenting may occur once or several times as a way to "have fun" or even to help the individual cope with a problem. For many, experimentation can occur without any desire to continue using the drug. For others, it can start to become a problem when it moves into the next stage of addiction: regular use.

Stage 2: Regular Use

Some people will be able to enter the stage of regular use without developing a dependence or addiction. These people will be able to stop the drug use on their own. The problem with regular use is that the risk for substance abuse greatly increases during this stage. It also increases risky behaviors such as driving under the influence, unexplained violence, and symptoms of depression and anxiety.

Stage 3: Risky Use/Abuse

The line between regular use and risky use/abuse is a very thin one, but is usually defined as continued use of drugs in spite of severe social and legal consequences. What might have begun as a temporary form of escape can quickly lead to more serious problems. This is the

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stage where the warning signs of addiction will begin to appear: craving, preoccupation with the drug, and symptoms of depression, irritability and fatigue if the drug is not used.

Stage 4: Drug Addiction and Dependency

Physical dependence on a drug is often intertwined with addiction. Characteristics of dependence and drug addiction include withdrawal symptoms and compulsive use of the drug despite severe negative consequences to his or her relationships, physical and mental health, personal finances, job security and criminal record.

The 5 Stages of Addiction Recovery

Addiction can take hold in as little as one or two uses, or can develop over a period of years, but recovery from addiction is always a long-term process. The person you are at the beginning of your recovery effort will be very different from the person you become as you get more grounded in your recovery.

There is no one "right" way to recover from addiction, but people generally work through five stages, many of which occur during drug rehab.

1. Awareness and Early Acknowledgement

This stage is marked by a growing awareness that there is a problem, often because of prompting from family, friends or co-workers, or health, financial, work or legal problems. Awareness gradually turns into an acknowledgement that action is needed, shifting from denial to a willingness to make a change. Although the addict is still engaging in addictive behaviors and hasn't made any measurable progress toward recovery, this first stage is critical in paving the way for the rest of the recovery process.

2. Consideration

In this stage, the addict is ready to take the first step toward recovery, often in the form of learning more about addiction and the impact it is having on their life and the lives of the people they care about.

3. Exploring Recovery

Some would say that true recovery begins here. Moving past denial, the addict is motivated to overcome their addiction and is taking small steps such as exploring the concepts of moderation and abstinence. This is also when some addicts make the critical decision to begin addiction treatment.

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4. Early Recovery

The addict officially enters recovery, but is still in the early stages. Those in early recovery are vulnerable but are beginning to build the foundation for a new life. Some of the most important steps taken during Stage Four are developing new coping skills and healthy habits and rebuilding damaged relationships.

5. Active Recovery and Maintenance

Welcome to recovery! The addict has worked hard to get here, and will continue to work hard for the rest of their life to guard their sobriety against relapse (or return to sobriety after relapsing). This will require active monitoring of their thoughts and behaviors, ongoing practice of new skills, maintaining a support system, and staying alert to triggers and temptations to use. Although recovery is never easy, in this stage the addict is living the life they could only have imagined at the start of this journey.

Recovery is about much more than overcoming an addiction to drugs or alcohol it is a full mind, body and spirit transformation. While some individuals can progress through the stages of recovery with just the support of friends and family, most will require education and new skills from a drug rehab program.

Instructor Note: So now you have read about both the stages of addiction and recovery. Now the million dollar question is how do we, counselors that is, help motivate and help the client maintain motivation so as to help the client achieve their goals of moving from active addiction to recovery? As we know addiction recovery is not easy or quick and during the treatment process our clients will struggle with many things. One of the most potentially defeating struggles is the one of change. Human beings by nature do not like change, we are creatures of habit, change makes us nervous, hesitant, anxious and ambivalent. It is that ambivalence that fills our heads with questions – "Is this right for me?", "What if I am making the wrong choice?" etc. Well the same process occurs for people trying to decide whether or not they want to stop using. At times it seems like a good idea, at times it seems do-able, and at times it seems pointless (don't forget that there are times when the clients don't want to change at all, they are in treatment strictly due to external forces like legal requirements)this is known as ambivalence.

As professional counselors you will be expected to recognize what stage of change\treatment readiness your client is in and know what interventions to employ to help either support their change efforts or to motivate your client to move along the stage of change continuum.

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The following is a list of the Stages of Change and some suggested interventions\techniques counselors can use to motivate clients.

Prochaska and DiClemente's Stages of Change Model

Stage of Change	Characteristics	Techniques
Pre-contemplation	**Not currently considering change: "Ignorance is bliss"**	**Validate lack of readiness** **Clarify: decision is theirs** **Encourage re-evaluation of current behavior** **Encourage self-exploration, not action** **Explain and personalize the risk**
Contemplation	**Ambivalent about change: "Sitting on the fence"** **Not considering change within the next month**	**Validate lack of readiness** **Clarify: decision is theirs** **Encourage evaluation of pros and cons of behavior change** **Identify and promote new, positive outcome expectations**
Preparation	**Some experience with change and are trying to change: "Testing the waters"** **Planning to act within 1month**	**Identify and assist in problem solving re: obstacles** **Help patient identify social support** **Verify that patient has underlying**

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		skills for behavior change **Encourage small initial steps**
Action	**Practicing new behavior for** **3-6 months**	**Focus on restructuring cues and social support** **Bolster self-efficacy for dealing with obstacles** **Combat feelings of loss and reiterate long-term benefits**
Maintenance	**Continued commitment to sustaining new behavior** **Post-6 months to 5 years**	**Plan for follow-up support** **Reinforce internal rewards** **Discuss coping with relapse**
Relapse	**Resumption of old behaviors: "Fall from grace"**	**Evaluate trigger for relapse** **Reassess motivation and barriers** **Plan stronger coping strategies**

Instructor Note: is much more information available online and it is worth researching since the stages of changes is used in conjunction with Motivational Interviewing (MI) and MI is now one of the most currently utilized and accepted addiction treatment interventions and therapeutic practices.

The following section offers more information regarding therapeutic interventions for the treatment of substance addiction.

Competency: Describe a variety of helping strategies for reducing the negative effects of substance misuse.

Pharmacological treatments - Pharmacological treatments are beneficial for selected patients with specific substance use disorders. The categories of pharmacological treatments are: medications to treat intoxication and withdrawal states

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- Medications to decrease the reinforcing effects of abused substances
- Agonist maintenance therapies
- Antagonist therapies
- Abstinence-promoting and relapse prevention therapies
- Medications to treat comorbid psychiatric conditions.

Psychosocial treatments

Psychosocial treatments are essential components of a comprehensive treatment program. Evidence-based psychosocial treatments include:

Cognitive-behavioral therapies (CBTs, e.g., relapse prevention, social skills training), Motivational enhancement therapy (MET), behavioral therapies (e.g., community reinforcement, contingency management)

- 12-step facilitation (TSF)
- Psychodynamic therapy/interpersonal therapy (IPT)
- Self-help manual
- Behavioral self-control
- Brief interventions
- Case management
- Group, marital, and family therapies

There is evidence to support the efficacy of integrated treatment for patients with a co-occurring substance use and psychiatric disorder; such treatment includes blending psychosocial therapies used to treat specific substance use disorders with psychosocial treatment approaches for other psychiatric diagnoses (e.g., CBT for depression).

Effective Treatment Approaches

Medication and behavioral therapy, especially when combined, are important elements of an overall therapeutic process that often begins with detoxification, followed by treatment and relapse prevention. Easing withdrawal symptoms can be important in the initiation of treatment; preventing relapse is necessary for maintaining its effects.

And sometimes, as with other chronic conditions, episodes of relapse may require a return to prior treatment components. A continuum of care that includes a customized treatment regimen—addressing all aspects of an individual's life, including medical and mental health services—and

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follow-up options (e.g., community- or family-based recovery support systems) can be crucial to a person's success in achieving and maintaining a drug-free lifestyle.

Sober living – Normally follows intensive treatment like residential treatment. Clients live with other recovering addicts in a supportive drug-free environment. Sober living facilities are useful if clients have nowhere to go or there is a worry that returning home too soon will lead to relapse.

Brief intervention – Only appropriate for those at risk for drug abuse or drug addiction, not those who have already developed a serious problem. Consists of several visits to a healthcare professional to discuss the harmful effects of drug abuse and strategies for cutting back.

Matching Treatment Services – Individualized Treatment and Interventions

The goal of drug abuse treatment is to stop drug use and allow people to lead active lives in the family, workplace, and community. One continual challenge, however, is keeping clients in treatment long enough for them to achieve this goal. That is why finding the right treatment for a person's specific needs is critical. Drug abuse treatment is not "one size fits all." Treatment outcomes depend on the:

- extent and nature of the person's problems
- appropriateness of treatment
- availability of additional services
- quality of interaction between the person and his or her treatment provider

Importance in Treatment programming to be Evidence-based

Effective drug abuse treatments can include behavioral therapy, medications, or, ideally, their combination.

Behavioral therapies vary in focus and may involve:

- addressing a client's motivation to change
- providing incentives to stop taking drugs
- building skills to resist drug use
- replacing drug-using activities with constructive and rewarding activities
- improving problem-solving skills

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- building better personal relationships

Examples of Behavioral Therapies:

Cognitive Behavioral Therapy. Seeks to help clients recognize, avoid, and cope with the situations in which they are most likely to abuse drugs.

Motivational Incentives. Uses positive reinforcement such as providing rewards or privileges for remaining drug free, for participating in counseling sessions, or for taking treatment medications as prescribed.

Motivational Interviewing. Uses strategies to encourage rapid and self-driven behavior change to stop drug use and help a patient enter treatment.

Solution Focused Therapy. Uses a goal-directed collaborative approach to change that is conducted through direct observation of clients' responses to a series of precisely constructed questions. SFT focuses on addressing what clients want to achieve exploring the history and origin of their problem(s). SF therapy sessions typically focus on the present and future, focusing on the past only to the degree necessary for communicating empathy and accurate understanding of the clients concerns

Motivational enhancement therapy (MET). Seeks to evoke from clients their own motivation for change and to consolidate a personal decision and plan for change. The approach is largely client centered, although planned and directed.

Group Therapy. Helps patients face their drug abuse realistically, come to terms with its harmful consequences, and boost their motivation to stay drug free. Patients learn how to resolve their emotional and personal problems without abusing drugs.

Medications are an important part of treatment for many patients, especially when combined with counseling and other behavioral therapies. Different types of medications may be useful at different stages of treatment: to stop drug abuse, to stay in treatment, and to avoid relapse.

Tailoring treatment to the needs of each client

No single treatment is right for everyone. The best treatment addresses a person's various needs, not just his or her drug abuse.

Matching treatment settings, programs, and services to a person's unique problems and level of need is key to his or her ultimate success in returning to a productive life. It is important for the

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treatment approach to be broad in scope, taking into account a person's age, gender, ethnicity, and culture. The severity of addiction and previous efforts to stop using drugs can also influence a treatment approach.

The best programs provide a combination of therapies and other services to meet a client's needs. In addition to drug abuse treatment, a client may require other medical services, family therapy, parenting support, job training, and social and legal services.

Finally, because addictive disorders and other mental disorders often occur together, a person with one of these conditions should be assessed for the other. And when these problems co-occur, treatment should address both (or all conditions), including use of medications, as appropriate.

***Medical detoxification is a necessary first step in the treatment of certain addictions, but by itself does little to change long-term drug use.

The Continuum of Care

Individual treatment and service plans must be assessed and modified as needed to meet changing needs.

A person in treatment may require varying combinations of services during its course, including ongoing assessment. For instance, the program should build in drug monitoring so the treatment plan can be adjusted if relapse occurs. For most people, a continuing care approach provides the best results, with treatment level adapted to a person's changing needs.

A patient's needs for support services, such as day care or transportation, should also be met.

Please refer to chart below for an idea of what a continuum of services may look like.

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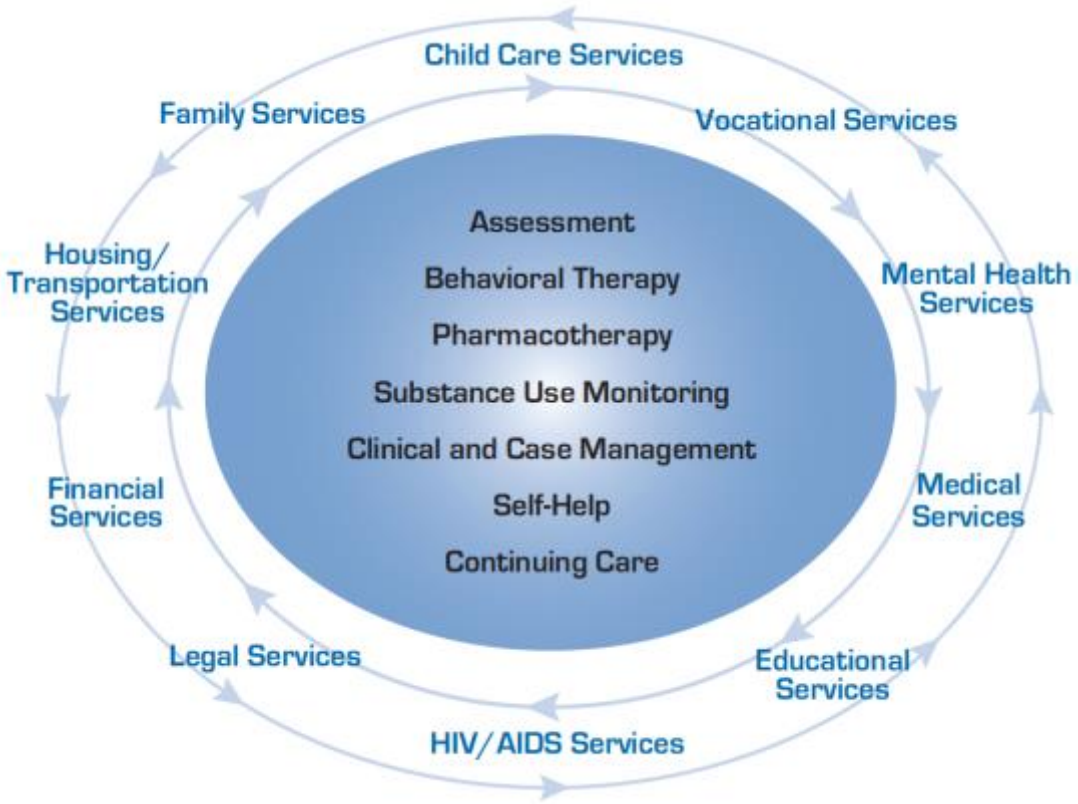

Duration of treatment

Remaining in treatment for the right period of time is critical.

Appropriate time in treatment depends on the type and degree of a person's problems and needs. Research tells us that most addicted people need at least three months in treatment to really reduce or stop their drug use and that longer treatment times result in better outcomes. The best programs will measure progress and suggest plans for maintaining recovery. Recovery from drug addiction is a long-term process that often requires several episodes of treatment and ongoing support from family or community.

How do 12-step or similar recovery programs fit into drug addiction treatment?

Self-help groups can complement and extend the effects of professional treatment.

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The most well-known programs are Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA), all of which are based on the 12-step model. This group therapy model draws on the social support offered by peer discussion to help promote and sustain drug-free lifestyles.

Most drug addiction treatment programs encourage patients to participate in group therapy during and after formal treatment. These groups offer an added layer of community-level social support to help people in recovery with abstinence and other healthy lifestyle goals.

Benefits of Peer Support Groups

12-Step Support Groups

Since its founding in the 1930s, the 12-Step program has become one of the most widely used approaches to treat substance abuse and other addictions and compulsions. With a worldwide membership in the millions, and meetings located in most communities throughout the world, 12-Step support groups are free, easily accessible and highly effective for some.

Other benefits of 12-Step support groups include:

- Access to a sober peer support system
- Emphasis on personal accountability and a spiritual connection
- Twelve-Step groups can be found almost anywhere at least a few times a week
- Twelve-Step groups can be used in conjunction with other treatments

There are also 12-Step support groups specifically geared toward families of those with addictions and compulsions, such as Al-Anon, Nar-Anon and Alateen. These groups provide free education and support to help loved ones care for themselves and support their family member in recovery.

12-Step Alternatives

The 12-Step program works for many people in recovery, but not all. Others may prefer to get involved in 12-Step alternatives such as SMART Recovery or LifeRing, some of which place less emphasis on spirituality (or involve a different kind of spirituality), encourage moderation rather than complete abstinence, and make other key variations to the 12-Step principles.

Competency: Be familiar with medical and pharmacological resources in the treatment of substance use disorders.

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Pharmacotherapy

Definition: In the context of substance abuse treatment, pharmacotherapy is the treatment of drug or alcohol dependence with medication to achieve one of three ends: detoxification, relapse prevention, or opioid maintenance.

Medication-Assisted Treatment (MAT)

Medication-Assisted Treatment (MAT) is a form of pharmacotherapy and refers to any treatment for a substance use disorder that includes a pharmacologic intervention as part of a comprehensive substance abuse treatment plan with an ultimate goal of patient recovery with full social function.

Pharmacotherapy is utilized in various stages of treatment of substance addictions. General considerations for SUD pharmacotherapy:

- Alcohol
  - Acute withdrawal
  - Relapse prevention (ongoing pharmacotherapy)
- Opiates
  - Acute withdrawal
  - Relapse prevention
- Co-Occurring mental illness and psych medications

Phases of Substance Use that are Targets for Pharmacotherapy

- intoxication/overdose
- withdrawal/detoxification
- abstinence initiation/use reduction
- relapse prevention
- Substance-related psychiatric symptoms (psychosis, agitation, etc.)

Some Pharmacological Treatment Strategies for Substance Use Disorders (SUDs)

- agonist (replacement/substitution)
- antagonist (blockade)
- aversive (negative reinforcement)
- correction of underlying/associated disorders (such as depression, etc.)

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Substances for which Pharmacotherapy is Available

- Opioids
- Alcohol
- Benzodiazepines
- Tobacco (nicotine dependence)

Substances for which Pharmacotherapy is Not Available

- Cocaine
- Methamphetamine
- Hallucinogens
- Cannabis
- Solvents/Inhalants

Why Use Psychiatric Medications in Patients with Co-occurring SUD?

- To treat psychiatric disorders
- To attempt to treat substance use disorders
    - directly or indirectly

Medication Uses - Specifically

Medications can be used to help with different aspects of the treatment process.

Withdrawal

Medications offer help in suppressing withdrawal symptoms during detoxification. However, medically assisted detoxification is not in itself "treatment"—it is only the first step in the treatment process. Patients who go through medically assisted withdrawal but do not receive any further treatment show drug abuse patterns similar to those who were never treated.

Treatment

Medications can be used to help reestablish normal brain function and to prevent relapse and diminish cravings. Currently, we have medications for opioids (heroin, morphine), tobacco (nicotine), and alcohol addiction and are developing others for treating stimulant (cocaine, methamphetamine) and cannabis (marijuana) addiction. Most people with severe addiction

problems, however, are users of more than one drug and will require treatment for all of the substances that they abuse.

- Opioids: Methadone, buprenorphine and, for some individuals, naltrexone are effective medications for the treatment of opiate addiction. Acting on the same targets in the brain as heroin and morphine, methadone and buprenorphine suppress withdrawal symptoms and relieve cravings. (brand names Revia or Vivitrol) works by blocking the effects of heroin or other opioids at their receptor sites and should only be used in patients who have already been detoxified. Because of compliance issues, naltrexone is not as widely used as the other medications. All medications help patients disengage from drug seeking and related criminal behavior and become more receptive to behavioral treatments.

- Tobacco: A variety of formulations of nicotine replacement therapies now exist—including the patch, spray, gum, and lozenges—that are available over the counter. In addition, two prescription medications have been FDA-approved for tobacco addiction: bupropion (classified as an anti-depressant) and varenicline (brand name Chantrix). They have different mechanisms of action in the brain, but both help prevent relapse in people trying to quit. Each of the above medications is recommended for use in combination with behavioral treatments, including group and individual therapies, as well as telephone quit-lines.

Alcohol: Three medications have been FDA-approved for treating alcohol dependence: naltrexone, Acamprosate (brand name Campral), and Disulfiram (brand name Antabuse). A fourth, Topiramate (brand name Topomax – classified as an anti-epileptic), is showing encouraging results in clinical trials.

Naltrexone blocks opioid receptors that are involved in the rewarding effects of drinking and in the craving for alcohol. It reduces relapse to heavy drinking and is highly effective in some but not all patients—this is likely related to genetic differences.

Acamprosate is thought to reduce symptoms of protracted withdrawal, such as insomnia, anxiety, restlessness, and dysphoria (an unpleasant or uncomfortable emotional state, such as depression, anxiety, or irritability). It may be more effective in patients with severe dependence.

Disulfiram interferes with the degradation of alcohol, resulting in the accumulation of acetaldehyde, which, in turn, produces a very unpleasant reaction that includes flushing,

nausea, and palpitations if the patient drinks alcohol. Compliance can be a problem, but among patients who are highly motivated, Disulfiram can be very effective.

Nalmefene

This medication is currently used in anesthesia to reverse the effects of narcotic pain relievers. A recent study shows that nalmefene, an opioid antagonist, is effective in reducing cravings and preventing relapse to heavy drinking in alcohol-dependent patients. Studies found that patients who received nalmefene were 2.4 times less likely to relapse to heavy drinking that those who received a placebo. Nalmephene is a "universal" opioid antagonist that works on all opioid receptors. It appears to last longer and be more potent in blocking dopamine than naltrexone.

Buprenorphine

Buprenorphine will be approved by the FDA for use in the United States as an opiate detoxification and opiate maintenance agent. There will be two forms of the medication:

- Sublingual (under the tongue) tablet called Subutex®
- Buprenorphine combined with Naloxone called Suboxone®

Buprenorphine combined with naloxone is called Suboxone® and prevents intravenous use of the tablet after crushing. The user would get an antagonist effect of the naloxone, or at the least, a diminished opiate effect.

Clonidine

Clonidine is an agonist. Originally used solely for treatment of hypertension, Clonidine decreases norepinephrine release, thus reducing the heart rate and relaxes and dilates blood vessels, resulting in a lowered blood pressure. Studies have found that clonidine is useful in treating opiate withdrawal, alcohol withdrawal and nicotine dependence, though it is said to be ineffective in benzodiazepine detoxification. Its major side effects are a decrease in blood pressure, dry mouth and sedation. When used for opiate detoxification, symptoms such as lethargy, restlessness, insomnia and craving are not well relieved.

A study by Glassman et al, showed that clonidine reduced the intensity of craving for tobacco. Overall, it tends to ameliorate signs and symptoms of withdrawal, although its does not alter the time course of withdrawal. Regimens for detoxification have been tested with both tablets and longer-acting patches.

Gabapentin

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Gabapentin is an anticonvulsant sold under the name Neurontin®. It is being used for pain management and anxiety, though some of the more interesting work is in the field of insomnia, a problem that is very common among alcohol - dependent patients. Dr. Kirk Brown is studying its use in alcohol-dependent patients and has had good results in ameliorating the insomnia when increasing this medication, as needed and up to 1500 mg per day.

Methadone

Methadone is a synthetic narcotic that was developed in Germany during WWII. In 1963, Drs. Dole and Nyswander treated opiate addicts with methadone to control craving. In 1972, it was approved by the FDA for the treatment of narcotic dependence. It is a highly regulated medication that can only be prescribed by a licensed clinic or, on an emergency basis, in a general hospital for addiction treatment. It can be ordered by a licensed physician for the treatment of pain as an outpatient. With a very favorable side effect profile, it is an extremely effective and safe medication. Of extra benefit, there is blood - level testing that can help to individualize treatment.

Zyban® (bupropion hydrochloride, Wellbutrin SR®)

This is the first non-nicotine medication approved for smoking cessation. The medication works on cravings and withdrawal at the brain level through dopaminergic and noradrenergic pathways. It is successfully used alone or in combination with nicotine-replacement medications (patches, gum). The most common side effect is dry mouth and insomnia. It cannot be used in patients with seizure disorders, bulimia, anorexia, pregnancy, allergy to bupropion or those already treated with Wellbutrin®.

Competency: Adapt practice to the range of treatment settings and modalities.

Quadrants of Care

The quadrants of care are a conceptual framework that classifies clients in four basic groups based on relative symptom severity, not diagnosis.

- Category I: Less severe mental disorder/ less severe substance disorder
- Category II: More severe mental disorder/ less severe substance disorder
- Category III: Less severe mental disorder/ more severe substance disorder
- Category IV: More severe mental disorder/ more severe substance disorder

Matching Quadrants to Treatment

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- **Quadrant 1**
  - People with low-severity substance abuse and low-severity mental illness can be treated:
  - Within the primary healthcare system (such as by your physician).
  - From either intermediate outpatient addiction treatment or intermediate outpatient mental health programs (for example, intensive outpatient programs).
  - In some cases, people in this quadrant might benefit from some integration of services between mental health and addiction treatment providers.
- Quadrant 2
  - People with serious mental illness and milder substance use disorders are best served within the metal health system.
  - You can access the mental health system through outpatient mental health centers (such as clinics) or more intensive residential or inpatient programs. Many mental health providers will also offer some addiction treatment, such as motivational interviewing or skills training. To find mental health services in your area, visit SAMHSA's Behavioral Health Locator Tool.
- Quadrant 3
  - People with more serious substance use disorders and less serious mental health disorders should receive substance abuse treatment as the primary focus of care.
  - The types of treatment facilities capable of providing care for people in this quadrant are often referred to as dual diagnosis capable (DDC) or dual diagnosis enhanced (DDE). See below for more information on these types of specialty programs.

- Quadrant 4
  - Serious mental illness and substance use disorders are typically treated in:
  - Psychiatric hospitals
  - Hospital emergency rooms
  - Specialized long-term residential substance treatment programs, such as modified therapeutic communities (sometimes within the criminal justice system).

The following is a brief list of therapeutic interventions and their matching treatment levels and modalities. This is by no means a comprehensive list.

Cognitive Behavioral Therapy (CBT) – is well suited to all levels of care and in both individual and group counseling.

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Motivational Interviewing (MI) – is well suited to all levels of care and works particularly well during the screening and assessment processes. In addition, MI is helpful during the early/initial phases of substance abuse treatment.

Motivational Enhancement Therapy (MET) – adapts to all levels of care and works well in individual, group and family sessions. MET also works very well in conjunction with behavioral and medication therapies.

Solution Focused Therapy (SFT) – Originally conceived to work with alcohol misusers and alcoholics but has now been adapted to work with alcohol and other drugs (AOD). SFT can e adapted to brief models of addiction treatment and works well in individual and group modalities.

Systems Therapy – Mostly used in counseling work with clients and their families. Systems therapy can be utilized in residential and all levels of outpatient treatment which incorporate family and significant others in the treatment process.

Contingency Management – Most effectively used in residential and day treatment programs. This model is typically used in conjunction with other therapeutic interventions. Contingency Management can be used on adults and adolescents and studies have shown this model to be effective with involuntary clients.

Instructor Note: As stated earlier in this chapter there are many therapeutic interventions beyond what are described here. Research them on your own, many are evidence-based and shown to have positive outcomes, and some are not recommended. It is your professional duty to have, at a minimum, a basic awareness of multiple therapeutic interventions, whether you will be practicing them or not.

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Addiction Treatment Services and Cultural Competent Practices

Chapter 4

Competency: Provide treatment services appropriate to the personal and cultural identity and language of the client.

Cultural Competence Defined:

"A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable the system, agency, or professionals to work effectively in cross-cultural situations" (Cross, et al., pg. 13 1989).

The Office of Minority Health (OMH 2000) merged several existing definitions to conclude that:

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (p. 28)

In addition to race, ethnicity and culture the aspects of client values, beliefs, and behaviors also must be taken into account in cultural competent practices.

Cultural factors include:

- Heritage, history and experience, beliefs, traditions, values, customs

Cultural competence may be viewed on a continuum:

- Cultural sensitivity
- Cultural competence

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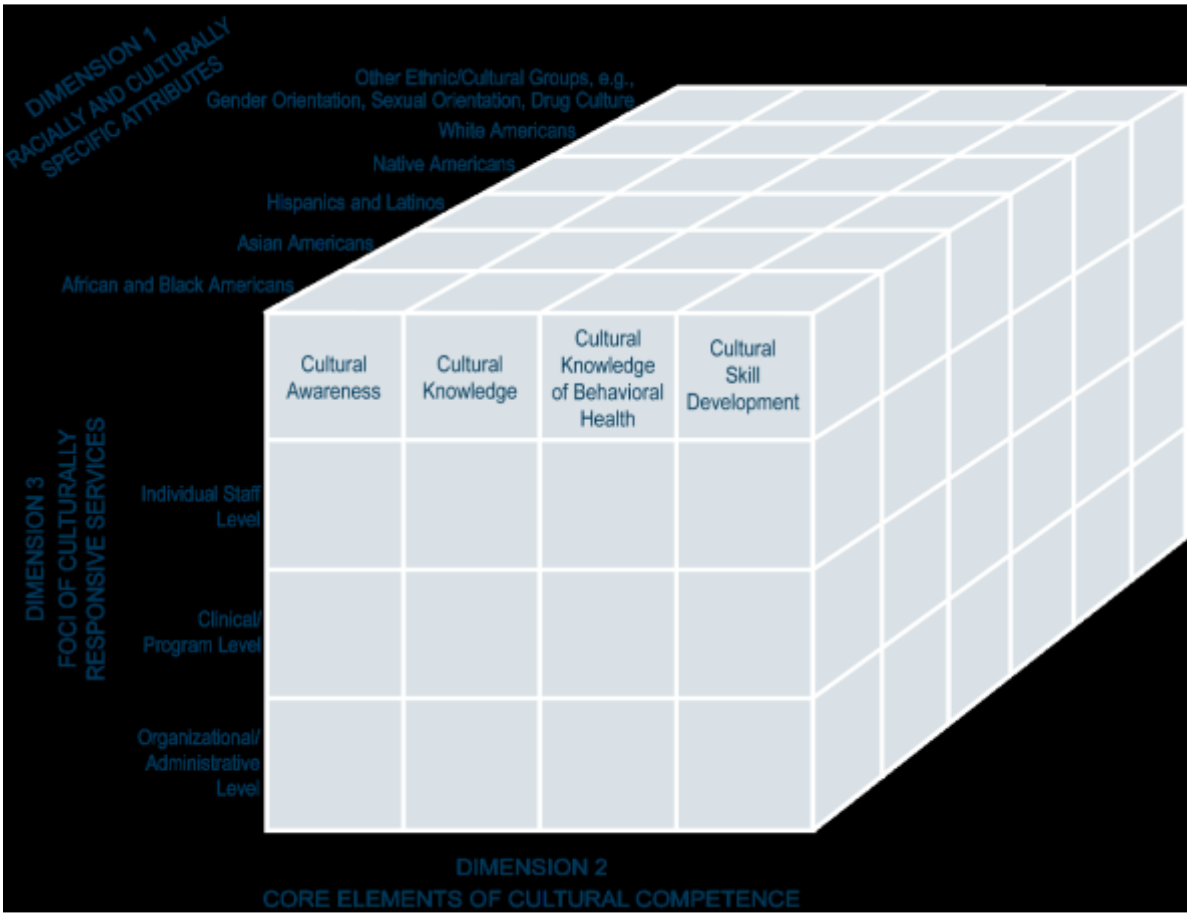
- Cultural proficiency



To provide culturally responsive treatment services, counselors, other clinical staff, and organizations need to become aware of their own attitudes, beliefs, biases, and assumptions about others. Providers need to invest in gaining cultural knowledge of the populations that they serve and obtaining specific cultural knowledge as it relates to help-seeking, treatment, and recovery.

<u>What Are Health Disparities?</u>

A health disparity is a particular type of health difference closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who

have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual or gender orientation; geographic location; or other characteristics historically tied to discrimination or exclusion.

Source: U.S. Department of Health and Human Services (HHS) 2011a.

Perspectives on Health, Illness, and Healing

Beliefs, attitudes, and behaviors related to health, illness, and healing vary across racial, ethnic, and cultural groups. Many cultural groups hold views that differ significantly from those of Western medical practice and thus can affect treatment (Sussman 2004). Much has been written about the range of cultural beliefs concerning health and healing. In general, cultural groups differ in how they define and determine health and illness; who is able to diagnosis and treat an illness; their beliefs about the causes of illness; and their remedies (including the use of Western medicines), treatments, and healing practices for illness (Bhugra and Gupta 2010; Comas-Diaz 2012). In addition, there are complex rules about which members of a community or family can make decisions about health care across cultural groups (Sussman 2004).

With respect to mental health, providers should be aware that any mental disorder or symptom is only considered a disorder or problem by comparison with a socially defined norm. For instance, in some societies, someone who hears voices can be considered to have greater access to the spirit world and to be blessed in some way. Furthermore, there are mental disorders that only present in a specific cultural group or locality; these are called cultural concepts of distress. The DSM-5 describes cultural concepts of distress.

Counselor Self-Knowledge

Counselors with a strong belief in evidence-based treatment methods can find it hard to relate to clients who prefer traditional healing methods. Conversely, counselors with strong trust in traditional healers and culturally accepted methods can fail to understand clients who seek scientific explanations of, and solutions to, their substance abuse and mental health problems. To become culturally competent, counselors should begin by exploring their own cultural heritage and identifying how it shapes their perceptions of normality, abnormality, and the counseling process. Counselors who understand themselves and their own cultural groups and perceptions are better equipped to respect clients with diverse belief systems.

Trust and power

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Counselors need to understand the impact of their role and status within the client–counselor relationship. Client perceptions of counselors' influence, power, and control vary in diverse cultural contexts. In some contexts, counselors can be seen as all-knowing professionals, but in others, they can be viewed as representatives of an unjust system. Counselors need to explore how these dynamics affect the counseling process with clients from diverse backgrounds. Do client perceptions inhibit or facilitate the process? How do they affect the level of trust in the client–counselor relationship? These issues should be identified and addressed early in the counseling process. Clients should have opportunities to talk about and process their perceptions, past experiences, and current needs.

Culturally Responsive Client Evaluations and Treatment Planning

To provide culturally responsive evaluation and treatment planning, counselors and programs must understand and incorporate relevant cultural factors into the process while avoiding a stereotypical or "one-size-fits-all" approach to treatment. Cultural responsiveness in planning and evaluation entails being open minded, asking the right questions, selecting appropriate screening and assessment instruments, and choosing effective treatment providers and modalities for each client. Moreover, it involves identifying culturally relevant concerns and issues that should be addressed to improve the client's recovery process.

Most clients are unfamiliar with the evaluation and treatment planning process and how they can participate in it. Some clients may view the initial interview and evaluation as or if the content is a source of family dishonor or shame. Other clients may resist or distrust the process based on a long history of racism and oppression. Still others feel inhibited from actively participating because they view the counselor as the authority or sole expert.

The counselor can help decrease the influence of these issues in the interview process through a collaborative approach that allows time to discuss the expectations of both counselor and client; to explain interview, intake, and treatment planning processes; and to establish ways for the client to seek clarification of his or her assessment results (Mohatt et al. 2008a). The counselor can encourage collaboration by emphasizing the importance of clients' input and interpretations. Client feedback is integral in interpreting results and can identify cultural issues that may affect intake and evaluation (Acevedo-Polakovich et al. 2007). Collaboration should extend to client preferences and desires regarding inclusion of family and community members in evaluation and treatment planning.

Conducting Strength-Based Culturally Sensitive Interviews

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By nature, initial interviews and evaluations can overemphasize presenting problems and concerns while underplaying client strengths and supports. This list, although not exhaustive, reminds clinicians to acknowledge client strengths and supports from the outset.

Strengths and supports:

- Pride and participation in one's culture
- Social skills, traditions, knowledge, and practical skills specific to the client's culture
- Bilingual or multilingual skills
- Traditional, religious, or spiritual practices, beliefs, and faith
- Generational wisdom
- Extended families and non-blood kinships
- Ability to maintain cultural heritage and practices
- Perseverance in coping with racism and oppression
- Culturally specific ways of coping
- Community involvement and support

Source: Hays 2008

Eliciting Client Views on Presenting Problems

Some clients do not see their presenting physical, psychological, and/or behavioral difficulties as problems. Instead, they may view their presenting difficulties as the result of stress or another issue, thus defining or labeling the presenting problem as something other than a physical or mental disorder. In such cases, word the following questions using the clients' terminology rather than using the word "problem." These questions help explore how clients view their behavioral health concerns:

- I know that clients and counselors some-times have different ideas about illness and diseases, so can you tell me more about your idea of your problem?
- Do you consider your use of alcohol and/or drugs a problem?
- How do you label your problem? Do you think it is a serious problem?
- What do you think caused your problem?
- Why do you think it started when it did?
- What is going on in your body as a result of this problem?
- How has this problem affected your life?

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- What frightens or concerns you most about this problem and its treatment?
- How is your problem viewed in your family? Is it acceptable?
- How is your problem viewed in your com-munity? Is it acceptable? Is it considered a disease?
- Do you know others who have had this problem? How did they treat the problem?
- How does your problem affect your stature in the community?
- What kinds of treatment do you think will help or heal you?
- How have you treated your drug and/or alcohol problem or emotional distress?
- What has been your experience with treatment programs?

Sources: Lynch and Hanson 2011; Tang and Bigby 1996; Taylor 2002

Instructor Note: Important to note is that the Stages of Change and Motivational Interviewing with Motivational Enhancement techniques work well in culturally competent practice, so feel free to utilize these interventions engage, collaborate and treat your clients. All of these interventions and clinical applications will serve you well in helping your clients in their recovery efforts. If you truly believe that treatment is individualized and that no single treatment modality or intervention work for everyone then you are well on your way to understanding how to incorporate cultural awareness and sensitivity to your daily work with your clients.

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Understanding Health Insurance Options for Addiction Treatment

Chapter 5

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

Insurance

Major Insurance Companies

Blue Cross Blue Shield, Cigna, United Healthcare, Aetna, Value Options and many many more.

Some others are:

Humana, Vista, AvMed

In time we begin to recognize a policy simply by the characteristics of its member identification number.

- **Blue Cross Blue Shield** - is separated by State, (example BCBS of FL or BCBS of CA) sometimes a BCBS may also have a name attached to like Horizon BCBS of NJ or Empire BCBS of NY. BCBS also uses a three letter alpha-prefix for different policies. For instance most FL policies start with "XJB", NJ's start "NJX" or "YHA", PA is "QCB". All federal employees, with BCBS insurance, start with a single letter "R". This is known as an FEP (Federal Employee Program) policy.
- **UHC** – member numbers are always 9 numerical digits.
- **Aetna –** approximately 50% of the ID numbers start with a "W".

The benefit of knowing this information is to be able to make an educated guess on if the place you work for can accept the policy, or if not where you could possibly refer the client. The other

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benefit is to save time. If someone calls and gives a member ID for UHC that is only 8 digits, it is obvious red flag they do not have the correct information. This will save the time of having to make multiple calls. When we are trying to help someone get into to treatment time is always of the essence.

It is important to reiterate, this information is only to make an educated guess.

The most important thing to understand is nothing is definite, every policy could be different. NOTHING IS DEFINATE. This is why no matter what, the best practice is to always call and verify the benefits.

Some Insurance Company Lingo

In Network Providers have a contract with between Provider and Insurance Company. The client will need to pay any deductible and copay.

Out of Network Providers do not have a contract with the Insurance Company. The Insurance Company charges a higher deductible and pays only a percentage of the cost.

Deductible - is the amount client must pay before the insurance will pay anything.

Co- pay - is a daily amount in dollars, this is the client's responsibility. (Usually HMO)

Co-insurance - is a percentage the insurance company will pay the, client is responsible to pay the rest.

(ex. 70/30% or 60/30%)

Out of Pocket – is the most money a client will be responsible for in a calendar before the insurance company pays 100% of bill.

Types of Policies:

- **HMO** (Health Maintenance Organization) – with this type of plan, the policy holder can only go to "in-network" providers
- **PPO** (Preferred Provider Organization) – with this type of a plan, the policy holder can go to "in-network" or providers
- **POS** (Point of Service) – Similar to PPO
- **EPO** (Exclusive Provider Organization) – Similar to HMO

Verification of benefits

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There is usually a number on the back of the card specific to Mental Health and Substance Abuse, if possible always call this number first. Calling any insurance company is time consuming and usually frustrating. Most often there are prompts to follow and information needed before you ever get to actually talk to a human being. This is why getting accurate information the first time is so important.

The following information is needed before calling:

- **Insurance company phone number**
- **Your companies Tax ID** (this verifies you can be given the clients information)
  - Most often they will ask you to verify your address and phone number.
- **Client's Name**
- **Client date of birth**
- **Member identification number**
- **(Sometimes they may ask you to verify client address or phone number)**
- **It is good practice to also know the Subscribers name and date of birth.**

The following is the information you will need to ask:

- **You will need to know if you are in or out of network with the insurance company you are calling.**
- **You will need to know what levels of care will be needed.**

Pre-certification

First phone call to insurance company after the client is assessed for level of care. In this phone call the provider gives clinical information to insurance company, criteria on why this level of care is needed. ASAM

Utilization Review

This pertains to follow up calls for continued stay, again to meet criteria.

Pre-existing Clause – to prevent people from buying insurance after they realize they have a problem. If the client knows they have an existing condition prior to insurance they may have to wait a period of time (6 mos. to a 1 year) before the insurance company will pay for treatment of condition.

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The Mental Health Parity Act (MHPA) - is legislation signed into United States law on September 26, 1996 that requires that annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. MHPA was largely superseded by the Paul Wellstone and Pete Domenici's Mental Health Parity and Addiction Equity Act (MHPAEA), which the 110th United States Congress passed as rider legislation on the Troubled Asset Relief Program (TARP), signed into law by President George W. Bush in October 2008. Prior to MHPA and similar legislation, insurers were not required to cover mental health care and as a result access to treatment was limited, underscoring the importance of the act.

Health Parity and Addiction Equity Act

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted in October of 2008. The main purpose of MHPAEA was to fill the loopholes left by the MHPA. The act requires health insurers as well as group health plans to guarantee that financial requirements on benefits, including co-pays, deductibles, and out-of-pocket maximums, and limitations on treatment benefits such as caps on visits with a provider or days in a hospital visit, for mental health or substance use disorders are not more restrictive than the insurer's requirements and restrictions for medical and surgical benefits. MHPAEA only applies to insurance plans for public and private sector employers with over 50 employees. Similar to MHPA, MHPAEA requires parity in terms of total annual dollar limits, as well as aggregate lifetime benefits. It is important to note however, that MHPAEA does not explicitly require that any insurance plan offer benefits for mental health and substance abuse disorders. Instead, it enacts parity rules for plans that choose to offer both medical and surgical benefits as well as mental health and substance abuse disorder benefits. This includes out-of-network benefits. If plans choose to offer both types of benefits, MHPAEA mandates that insurers define and make available specific criteria for medical necessity when it comes to mental health and substance abuse disorder benefits. In addition, MHPAEA also requires that insurers provide specific information and reasons in the event that reimbursement or payment for treatment is denied.

CONFIDENTIALITY AND MANAGED CARE

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Confidentiality is one of the basic principles of mental health and substance abuse treatment. In the course of therapy, clients reveal personal, highly sensitive information about themselves that they may not reveal to anyone else. Clients trust that the information they reveal in the course of treatment will be kept confidential by the clinician, subject to the patient-doctor/therapist/counselor privilege. However, when clients request reimbursement from a third-party payer, the payer has a right to know that the services being requested are appropriate. To pursue that knowledge, the payer may request that the clinician provide information about the client's symptoms, diagnosis, treatment and progress.

Understanding and Recognizing Client Crisis

Chapter 6

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

CRISIS INTERVENTION: Those services which respond to an alcohol and/or other drug abuser's needs during acute emotional and/or physical distress.

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

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

Features of a Crisis

Family Disruption - In most cases the family has endured the brunt of the consequences for the loved one's addiction, including the stress of worry financial costs and life adjustments made to

accommodate the addicted person's lifestyle. Once a family or significant other begin to care for themselves and begin to withdraw help, assistance, money etc. from the active addict the addict may experience some level of crisis, particularly if they lose housing and financial ability to purchase alcohol and/or other drugs.

Social and/or legal consequences – Much in the same way the loss/withdrawal of healthy friends or healthy romantic relationships can also generate a crisis state for the active addict as isolation begins to take hold.

Many addicts experience legal consequences related to active addiction, while for some addicts the first brush with the law ignites a crisis of character or confusion and for others maybe a particular arrest or type of crime will prompt a crisis state.

Physical and psychological – For active addicts a medical diagnosis can prompt significant levels of a crisis response. Medical diseases like Hepatitis C, HIV/AIDS, Cirrhosis, heart disease etc. can lead to fear and at times panic prompting a full-blown crisis state.

The same can be true if an addict experiences sever, life-disrupting psychiatric symptoms directly related to their alcohol or drug use.

Panic States – The process of addiction and its effects on a person's body, brain and psyche can eventually take its toll. Sometimes this effect begins with higher levels of stress than previously experienced, as this progresses with addict's fear of the anxiety and the inability of substances to quell this anxiety the symptoms of anxiety exacerbate until pre-panic or panic states ensue. The pre-panic or panic can often be a catalyst for the addict to seek treatment, not necessarily recovery but, initially treatment for the crisis.

Physical Dysfunction – This occurs as the addict's body becomes more fragile and vulnerable to illness and physical deterioration. When physical deterioration persists or increases this can stimulate a crisis in the addict and prompt the addict to seek treatment.

Characteristics of Post-traumatic Stress Disorder (PTSD)

Currently, diagnosis of PTSD is based on 8 criteria from the DSM-5.

The first DSM criterion has 4 components, as follows:

- Directly experiencing the traumatic event(s)
- Witnessing, in person, the event(s) as it occurred to others
- Learning that the traumatic event(s) occurred to a close family member or friend

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- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s); this does not apply to exposure through media such as television, movies, or pictures

The second criterion involves the persistent re-experiencing of the event in 1 of several ways:

- Thoughts or perception
- Images
- Dreams
- Illusions or hallucinations
- Dissociative flashback episodes
- Intense psychological distress or reactivity to cues that symbolize some aspect of the event

The third criterion involves avoidance of stimuli that are associated with the trauma and numbing of general responsiveness, as determined by the presence of 1 or both of the following:

- Avoidance of thoughts, feelings, or conversations associated with the event
- Avoidance of people, places, or activities that may trigger recollections of the event

The fourth criterion is 2 or more of the following symptoms of negative alterations in cognitions and mood associated with the traumatic event(s):

- Inability to remember an important aspect of the event(s)
- Persistent and exaggerated negative beliefs about oneself, others, or the world
- Persistent, distorted cognitions about the cause or consequences of the event(s)
- Persistent negative emotional state
- Markedly diminished interest or participation in significant activities
- Feelings of detachment or estrangement from others
- Persistent inability to experience positive emotions

The fifth criterion is marked alterations in arousal and reactivity, as evidenced by 2 or more of the following:

- Irritable behavior and angry outbursts
- Reckless or self-destructive behavior

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- Hypervigilance
- Exaggerated startle response
- Concentration problems
- Sleep disturbance
- The remaining 3 criteria are as follows:
- The duration of symptoms is more than 1 month
- The disturbance causes clinically significant distress or impairment in functioning
- The disturbance is not attributable to the physiological effects of a substance or other medical condition

Critical Incident Debriefing

A "critical incident" is any event that has the potential of causing an unusually strong, intense, or lasting emotional reaction. The severity of this event is such that its impact may interfere with one's ability to cope or function after the incident.

Critical Incident Stress Debriefing (CISD) is a specific intervention designed to assist those impacted by a critical incident. The CISD assists all impacted by the critical incident process the event and work toward coping strategies that are more likely to be helpful and healthy for the individual and the company/organization.

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Outcomes of Alcohol/Other Drug Dependency Treatment - Chapter 7

Competency: Understand the need for and the use of methods for measuring treatment outcome.

Performance measures: Definition

Evaluate how well health care practitioners' actions conform to practice guidelines, medical review criteria, or standards of quality, can be used to improve access to treatment and the quality of treatment for people with alcohol and other drug problems. This article examines different types of quality measures, how they fit within the continuum of care, and the types of data that can be used to arrive at these measures.

Outcome Measures: General definition

These measures generally are used to evaluate the state of a patient's health resulting from the health care services and interventions received. In general, outcomes can be considered both in terms of patient functioning and in terms of categories of symptom severity related to the patient's clinical problem. For Alcohol and Other Drugs (AOD) disorders, health outcomes can be expanded to include four areas: sustained reductions in AOD use, improvements in personal health, sustained improvements in functioning (e.g., employment), and sustained reductions in threats to public health and safety (McLellan et al. 2005).

Attributing improved patient outcomes to providers' specific actions can be difficult because outcome measures of quality reflect the cumulative impact of multiple factors such as the

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timeliness of services and the appropriateness of the type or amount of services for a person's substance abuse or dependence problem. Outcomes also are influenced by factors that depend on the patients themselves and are outside the health care system, such as the choices the patients make (e.g., to remain in treatment for the full course of recommended services); their living situation, income, and employment; or whether the patients have other medical conditions.

Without objective indicators of performance, it is difficult to know how effective a treatment program is, whether its performance is improving or worsening. Performance improvement and outcomes monitoring are becoming required elements in health service delivery. Outcomes monitoring has long been important to industry and health care because it provides an excellent and efficient mechanism for improving productivity and care (Mecca 1998). Performance improvement can increase revenues by improving service delivery, reducing costs, and increasing client satisfaction (Deming 1986).

Performance improvement has a critical mission: to use objective information to improve outcomes continually by

- Identifying opportunities for improvement
- Testing innovations
- Reporting the results to the relevant stakeholders

What are Successful Outcomes?

"Successful treatment outcomes can be defined in a number of ways. Many outcomes measures focus specifically on the quantity and frequency of substance use during a predefined period of time following discharge from alcohol or drug (AOD) treatment. However, other measures of life functioning can provide a more complete picture of treatment success. These measures include quality of life, level of functioning in one's career or job, level of involvement with the legal system, and the extent to which a person requires medical care or hospitalization for medical problems associated with alcohol or drug use". (Butler Center for Research, 2011)

According to The Butler Center for Research at Hazelden (BCR) they "conduct telephone interviews with patients at roughly 1, 6 and 12 months following discharge from Hazelden. Outcomes analyses are performed at each follow up and typically focus on two measures related to substance use: the percentage of patients who report being continuously abstinent from alcohol and drugs for the entire follow up period (continuous abstinence), and the

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percentage of days during the follow up period that patients remain abstinent from alcohol (PDA from alcohol)".

Increasing Importance of Outcomes Measures in Today's Funding Environment

As financial support from Federal and State sources, insurance companies, and managed care organizations (MCOs) has diminished, funding sources and taxpayers increasingly are demanding that money be spent only on the most effective programs.

Today, licensing and credentialing bodies and payers have prioritized performance improvement initiatives. The two major accreditation bodies in the addictions field—the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF)—have made performance and quality improvement initiatives a cornerstone of their accreditation processes. CARF expects agencies to measure efficiency, effectiveness, and client satisfaction. Both bodies have published manuals on performance improvement for behavioral programs (Joint Commission on Accreditation of Healthcare Organizations 1998; Wilkerson et al. 1998).

States are required by the Government Performance and Results Act of 1993 to implement procedures for funding public programs based on their performance. The Federal Government and the States are developing the indicators and procedures for a performance-based system.

Since the mid-1990s, the U.S. Department of Health and Human Services, particularly through the Center for Substance Abuse Treatment (CSAT), has sponsored and funded major initiatives and pilot studies designed to help States and the field develop substance abuse treatment performance indicators, databases, and information systems that can be used in outcomes monitoring and performance improvement. Some of these Federal initiatives include the Methadone Treatment Quality Assurance System (Phillips et al. 1995), National Treatment Outcomes Monitoring System (NTOMS), and Drug Evaluation Network System (Carise et al. 1999).

Programs can measure their efforts at helping clients achieve the desired outcomes by identifying specific performance indicators, measuring them regularly, and testing whether specific initiatives lead to improvements in those performance indicators.

There are many different areas that can be applied to performance measures. Some of these areas include:

- Client engagement rate

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- Clinic-wide engagement rate
- Counselor-specific engagement rate

- Retention rate
- Abstinence rate
- Quality of life indicators
  - Problem-specific monitoring
  - Support group participation
- Client Satisfaction
  - Client satisfaction with clinic services
  - Client satisfaction with the counselors
  - Confidential descriptive (demographic) information about the respondent

There are too many categories to state here, however it is important to understand that performance measures can and should go beyond abstinence measures. Programs might examine any performance measures that will provide meaningful and helpful information about how the clinic, individual clinicians, and clients are doing. Outcomes can be calculated based on drug of choice, referral source, funding source, housing status, gender, co-occurring conditions, or other factors.

Performance measures can also be implemented for monitoring purposes. Monitoring for specific program needs include:

- Monitoring New Treatment Interventions or Program Services
- Monitoring in Response to Program Difficulties
- Accreditation Issues

The rationale for performance monitoring should be clear. Collecting and analyzing performance data have a practical benefit for the program and will improve service to clients. All staff members should know that performance monitoring can identify needs for additional training, resources, policy changes, and staff support—improvements the organization needs to make as a *system*. It is important for staff members to understand that the objective measures are being implemented to improve treatment outcomes and, wherever possible, to make it easier for staff members to work efficiently and effectively. Management should make clear that the results of the monitoring will *not* be used to punish employees: The program is initiating monitoring to receive feedback that will enable staff members and managers to improve.

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Taking Action To Improve Performance

Once data have been collected and shared with staff as a whole, decisions can be made about how to improve. All staff members can be involved in identifying strategies or interventions for improvement. Staff should focus on:

- Resource allocation
- Conditions causing differences in therapist outcomes
- Factors that indicate program success
- Improvements in program structure
- A retrospective study

Using Performance Data to Promote the Program

In addition to providing information for making needed changes in the program, results of a performance improvement study can be used both as a fundraising and as a public relations tool. As Yates (1999) states, having solid reports of the effectiveness and cost-effectiveness of your program will assure donors that their contributions will have the maximum impact possible... If your program saves substantially more money than it consumes, it will be easier to defend as a form of social investment that may deserve more attention and additional funds. (pp. 1–2)

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Conclusion

Instructor's Note: During your CAP courses you have learned a lot of information and will learn still more. All of the things that are presented in your course work will, at some point, be applicable to a client you are working with, a situation you are dealing with, a group you are running, and individual session you are conducting, an assessment, a treatment plan, a discharge plan, a referral, and more. There are things you cannot and will not be able to predict, just know, the more you learn and keep learning the more prepared you will be to act appropriately to intervene, resolve and manage various situations as they present themselves.

This is what it means to be a professional clinical practitioner… And, for me, there is nothing better to be!

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Appendix A - Counselor's Thesaurus

AFFECT (Mood or Disposition)

APPROPRIATE - PROPER, CORRECT, LEGITIMITE
EMOTIONALLY LABILE - INSTABILITY, MOOD SWINGS
PLACID - PEACEFUL, RESTFUL, TRANQUIL
PREOCCUPIED - ABSORBED, ENGROSSED, LOST IN THOUGHT
PERSONABLE - FRIENDLY PLEASANT - AFFABLE, AGREEABLE, AMIABLE
PASSIVE - INACTIVE, INERT, UNRESISTANT
ENTHUSIASTIC - ENTHUSED, ARDENT, ZEALOUS
TEARFUL - WEEPY, TEARY
DEPRESSED - DEJECTED, DISPIRITED, DISHEARTENED
CONTROLLED - DETERMINED, REGIMENTED, DISCIPLINED
FLAT-SHALLOW, DULL, SPIRITLESS
BLUNTED-CURT, ABRUPT, BRUSQUE
DETACHED - INDIFFERENT, IMPERSONAL
EUPHORIC - BOUYANT
ELATED – JOYFUL
LIGHTHEARTED - CAREFREE

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CHEERFUL - HEARTY
OPTIMISTIC - SMILING
PLACID - QUIET
SOBER - SEDATE
SERIOUS - EARNEST
SOLEMN - GRIM
GRAVE - SOMBER
BROODY - MEDITATIVE
DEJECTED - DISHEARTENED
DESPONDENT - DISMAL
HOPELESS – DESPERATE

Attitude

INDIFFERENT - NONCHALANT, UNCONCERNED
APATHETIC - INERT, ABSENCE OF AFFECT
SUSPICIOUS - DISTRUSTFUL
BELLIGERENT - QUARRELSOME, DISAGREEABLE
ANXIOUS - FEARFUL, APPREHENSIVE
CHEERFUL – OPTIMISTIC

Behavior

1. IMPULSIVENESS (DETERMINATION)
RECKLESS – IRRESPONSIBLE RASH - IMPRUDENT
IMPETUOUS - IMPULSIVE
EXCITABLE - ROUSING
HASTY - HURRIED
ABRUPT - UNEXPECTANT
RESTLESS - UNEASY
SPONTANEOUS - IMMEDIATE
MOBILE - VARIABLE
SELF-POSSESSED - SERENE

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COOL-HEADED - LEVEL-HEADED
DELIBERATE - CAREFUL
CONTROLLABLE - REGULAR
RESTRAINABLE - REPRESSIBLE
OVER-CAUTIOUS - TOO CAREFUL
SLUGGISH - LETHARGIC

2. DOMINANCE

DICTATORIAL - DOMINATIVE
AUTOCRATIC - SELF-WILLED
HIGH-HANDED
MASTERFUL - SHOWING LEADERSHIP
FORCEFUL - EFFECTIVE
ASSERTIVE - CONFIDENT
DECISIVE - CONCLUSIVE
COOPERATIVE - CO-ACTIVE
CONFORMABLE - HARMONIOUS
COMPLIANT - YIELDING
COURTEOUS - POLITE
TIMID - FEARFUL
MEEK - SUBMISSIVE
SERVILE-TOO OBEDIENT

3. WORK HABITS

CONSISTENT-REGULAR
DELIBERATE-MASTERFUL, FORCEFUL
METICULOUT-NEAT
DEPENDABLE-RELIABLE
INITIATIVE-CREATIVE, SPONTANEOUS
ERRATIC-INCONSISTENT
NEEDS REASSURANCE
ORGANIZED
FOLLOWS-THROUGH
NEED FOR APPROVAL
REACTION TO CRITICISM
NEED FOR SUPERVISION OR INSTRUCTION

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COGNITION (THOUGHT PROCESS)

JUDGEMENT
PROBLEM SOLVING
DECISION MAKING
GOAL SETTING
COMPREHENSION
MEMORY

FLEXIBILITY (ACCOMODATION)

UNBENDING-UNYIELDING, RIGID
PERSERVING-TENACIOUS
STUBBORN-INFLEXIBLE, RESISTIVE
HABITUAL-REPEITITOUS
CONVENTIONAL-CUSTOMARY
ADAPTABLE-AMENABLE-SUGGESTIBLE
DOCILE-MANAGEABLE
YIELDING-SUBMISSIVE, PASSIVE
SPINELESS-NERVELESS

ORIENTATION

FORGETFUL-MEMORY LOSS
CONFUSED
DISORIENTED TO TIME, PLACE PERSON
ORIENTED
POOR MEMORY FOR RECENT EVENTS
WANDERS-ROAMS, PACES
EASILY DISTRACTIBLE
HALLUCINATIONE
DELUSIONS
DETACHED-DISTANT

PSYCHOMOTOR FUNCTIONING

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LETHARGIC
RESTLESS
HYPERACTIVE
GRIMACING
POSTURING
MANNERISMS
NERVOUS
AGGITATED
SEDUCTIVE
HOSTILE
RIGID
APATHETIC
IMPULSIVE
DESTRUCTIVE
HESITANT
COMPULSIVE
ANXIOUS
NERVOUS
SLOW
QUICK

SELF-ESTEEM

SELF-EXALTED - SELF-GLORIOUS

POMPOUS - OSTENTATIOUS

CONCEITED - VAIN, GLORIOUS

BOASTFUL - BRAGGING

VAIN-SELF- ADMIRABLE

COCKY - PERT

CONFIDENT - SELF-RELIANT

SELF-RESPECTIVE - SELF-ASSURABLE

MODEST - PROPER

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UNASSUMING - UNPRETENTIOUS

HUMBLE - UNASSUMING, MODEST

SELF-UNCERTAIN, SELF-DOUBTFUL

SELF-EFFACIVE - INCONSPICUOUS

FORLORN - MISERABLE

SOCIALIZATION (RESPONSE TO OTHERS)

DEPENDENT

POSSESSIVE

HOSTILE

RESISTIVE

COOPERATIVE

BELLIGERANT

SARCASTIC

CRITICAL

SEDUCTIVE

PROVOCATIVE

JEALOUS

DEMANDING

HELPFUL

SUPPORTIVE

INGRATIATING

CONFORMING

AGGRESSIBE ASOCIAL

MANIPULATIVE

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DOMINEERING

EXHIBITIONISTIC

COMPETETIVE

DEFENSIVE

SOCIAL SKILLS

ACCEPTANCE OF OTHERS

SPEECH

1. CONTENT

SUPERFICIAL

SARCASTIC – CAUSTIC

NAGGING - FAULT FINDING

GOSSIPY – PRYING

VULGAR – COARSE

OBSCENE – INDELICATE

INCOHERENT

BIZARRE

RAMBLING

NEGATIVE

HOSTILE

IDEATION

PARANOID

OBSESSIVE

CRITICAL

DEROGATORY

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EUPHORIC

IDEAS OF REFERENCE

INCONSISTENT

INSIGHTFUL

AMBIVALENT

FLIGHT OF IDEAS

WORD SALAD

ILLUSIONS

CONFABULATION

FLUENT

ELOQUENT

POETICAL - LYRICAL

WITTY - HUMOROUS

COMICAL - WHIMSICAL

PROSAIC - TEDIOUS

COMPLIMENTARY – FLATTERING

LAUDATORY - ADMIRABLE

POLITE - COURTEOUS

CONTEMPLATIVE - MEDITATIVE

FRANK - CANDID

EXPLANATORY - INFORMATIVE

LITERAL – EXACT

EVASIVE – ELUSIVE

2. EXTENT (INTERACTION)

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MEDDLESOME

INTIMATE - PERSONAL

GREGARIOUS - SOCIABLE

ASSOCIATIVE - PARTNER-LIKE

COMPANIONABLE - FRIENDLY

ACCESSIBLE - APPROACHABLE

HESITANT - RELUCTANT

RESERVED - WITHDRAWN

BASHFUL - TIMID

SHRINKING - SHY

RETICENT - UNCOMMUNICATIVE

SECLUSIVE - CLOISTERED

SOLITARY - SINGLE

ISOLATED - APART

3. FLOW (RHYTHM)

RHYTHMIC - METRICAL

CADENCED - UNIFORM

FLUENT - FLOWING

NATURAL - OSCILLATORY

SLOW - RETARDED

TREMBLING - FALTERING

STAMMERING - HALTING

SLURRING - INDISTINCT

DYSPHASIA - DIFFICULTY SPEAKING

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ASPHASIA - INABILITY TO SPEAK

4. TONE (PITCH)

LOUD

LOW, QUIET

BOISTEROUS - VOCIFEROUS

EXHUBERANT - EFFUSIVE

LOUD - CLAMEROUS

LIVELY - VIVACIOUS

MELLOW - DELICATE

SOFT – GENTLE

QUIET - CALM

SOBER - EVEN-TEMPERED

MONOTONOUS - FLAT, DULL

INARTICULATE

WARMTH (REFLECTION)

OVER-INDULGENT – EXCESSIVE

DOTING - FOND

SENTIMENTAL – EMOTIONAL

TENDER – HUMANE

COMPASSIONATE

CONGENIAL - CORDIAL

CONSIDERATE - CHARITABLE

COOL - SLIGHTING

UNRESPONSIVE - UNSYMPATHETIC

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DETACHED - ALOOF

FRIGID - COLD, RESERVED

UNFEELING - HARD, COARSE

DISDAINFUL – SCORNFUL

PASSIONATE – AVID

VEHEMENT – INTENSE

FERVENT - ENTHUSIASTIC

Taken from: The DADS Adult System of Care: The Clinician's Guide to Writing Treatment Plans and Progress Notes. Michael Hutchinson, MFT; Pauline Casper, MS, CADC II, Et Al

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.

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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

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.

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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 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 8 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.

HIV/AIDS IN THE UNITED STATES

1.2 million people living with HIV/AIDS

- 297,000 of them women
- 3,992 children

Over 600,000 dead of AIDS since 1981

- 576,000 adults
- 5,200 children

During the year 2008

- 56,000 people newly infected with HIV
- 182 of them children
- 18,000 people died of AIDS-related illnesses

New AIDS Diagnoses – At the end of 2010

- The South accounted for 45% of the estimated 33,015 new AIDS diagnoses in the 50 states and the District of Columbia, followed by the Northeast (24%), the West (19%), and the Midwest (13%).
- The Northeast reported the highest rate of new AIDS diagnoses (14.2/100,000), followed by the South (13.0/100,000), the West (8.8/100,000), and the Midwest (6.3/100,000).

Living with an AIDS Diagnoses

- In 2009, the South accounted for 40% of the estimated 476,732 persons living with an AIDS diagnosis in the 50 states and the District of Columbia, followed by the Northeast (29%), the West (20%), and the Midwest (11%).

HIV/AIDS – Florida

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- 17% of all new HIV infections reported in 2012 were among persons under the age of 25.
- 2010-2012, 637 new HIV infection cases were reported among those ages 13-19 and 2,073 among those ages 20-24.
- There were 104,554 people living with HIV/AIDS in Florida as of January 31, 2014.
- Sex: 71% male & 29% female
- Race/Ethnicity: 29% White, 48% Black, 21% Hispanic, & 1% Multiracial. In fact, 1 in 32 black women will be diagnosed with HIV infection at some point in her lifetime. Approximately 80% of HIV and AIDS cases among women are the result of heterosexual transmission.
- In Florida, of those living with HIV/AIDS, the top transmission rates include Men who have Sex with Men (MSM) at 43% and Heterosexual contact at 34%.
- As of January 31, 2014, Miami-Dade County ranks #1 in the state of Florida for number of new HIV cases and AIDS cases. There are 27,035 people living with HIV/AIDS in Miami-Dade County.
- As of January 31, 2014, Broward County (Ft. Lauderdale) ranks #2 in the state of Florida for number of new HIV cases and AIDS cases. There are 17,632 people living with HIV/AIDS in Broward County.

THE FOUR STAGES OF HIV

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

Stage 3 – Symptomatic

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- 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)
- Parasistic
  - 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.

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 person's 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.

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

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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 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

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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. 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 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 Statues. 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

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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.

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.

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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.
- 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

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- 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

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:

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- 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:

• 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.

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• 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

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.

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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:

- 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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Domestic Violence

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.

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

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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; 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.

These statistics come from The American Psychological Association

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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

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becoming a victim or perpetrator of domestic violence. Understanding these multilevel factors can help identify various opportunities for prevention.

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Individual Risk Factors Include

Low self-esteem, Low income, Low academic achievement, Unemployment
Aggressive or delinquent behavior as a youth
Heavy alcohol and drug use, Depression, Anger and hostility
Antisocial personality traits, Borderline personality traits
Prior history of being physically abusive
Having few friends and being isolated from other people
Emotional dependence and insecurity
Belief in strict gender roles (e.g., male dominance and aggression in relationships)
Desire for power and control in relationships, Perpetrating psychological aggression
Being a victim of physical or psychological abuse),
History of experiencing poor parenting as a child
History of experiencing physical discipline as a child

Relationship Risk Factors Include

Marital conflict-fights, tension, and other struggles
Marital instability-divorces or separations
Dominance and control of the relationship by one partner over the other
Economic stress
Unhealthy family relationships and interactions

Community Risk Factors Include

Poverty and associated factors (e.g., overcrowding)
Low social capital-lack of institutions, relationships, and norms that shape a community's social interactions
Weak community sanctions against domestic violence (e.g., unwillingness of neighbors to intervene in situations where they witness violence)

Societal Risk Factors Include:

Traditional gender norms (e.g., women should stay at home, not enter workforce, and be submissive; men support the family and make the decisions).

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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

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themselves as being abusive. People often think of domestic violence as physical violence, such as 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

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to hide the abuse by causing injuries that can be hidden and do not need a doctor.

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

Low income, Low academic achievement, Aggressive behavior as a youth Heavy alcohol and drug use, Depression, anger and hostility
Prior history of being physically abusive, Few friends and isolation from other people,
Unemployment, Emotional dependence and insecurity, Desire for power and control,
Belief in strict gender roles, Being a victim of childhood abuse.

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The Violence Wheel

The chart below is a way of looking at the behaviors abusers use to obtain and keep control in their relationships. Battering is a choice. It is used to gain power and control over another person. Physical abuse is only one part of a system of abusive behaviors. This chart uses the wheel to show the relationship of physical abuse to other forms of abuse. Each part shows a way control or gain power. Source: Thedeluthmodel.org

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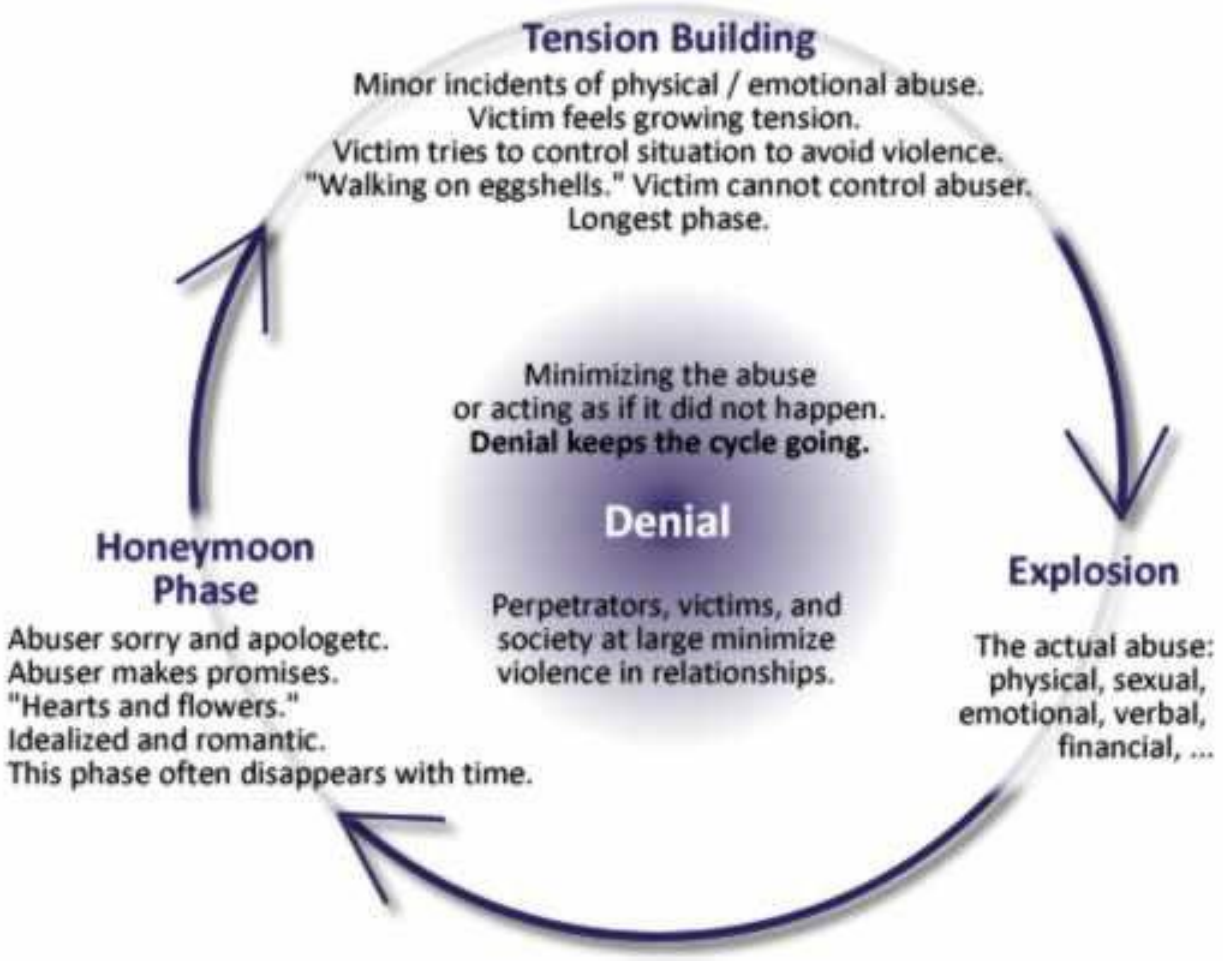
The Cycle of Violence

The Cycle of Violence depicts a pattern often experienced in abusive relationships. The cycle consists of three phases—tension building, explosion and honeymoon—that repeat over and over.



dvsolutions.org

The cycle of violence can happen hundreds of times in an abusive relationship. Each stage lasts a different amount of time. The total cycle can take anywhere from a few hours to a year or

more to complete. It is important to remember that not all domestic violence relationships fit the cycle.

Often, as time goes on, the 'making-up' and 'calm' stages disappear.

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 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, Simonuvic, 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).

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.

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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."
- 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

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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:

- 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.
- 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.

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) 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.
(b) 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.
(c) 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.

(d) 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:
   a. Those persons present to further the interest of the victim in the consultation, assessment, or interview.
   b. Those persons to whom disclosure is reasonably necessary to accomplish the purpose for which the domestic violence advocate is consulted.

(e) 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 the time the communication is made. This privilege includes any advice given by the domestic violence advocate in the course of that relationship.

(f) The privilege may be claimed by:
   a. The victim or the victim's attorney on behalf of the victim.
   b. A guardian or conservator of the victim.
   c. The personal representative of a deceased victim.
   d. 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."

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