The Academy for Addiction Professionals

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Treatment Knowledge

Introduction

Addiction, this word has become so familiar in our everyday vernacular. Addiction treatment is now known, recognized and accepted all over America and the world. Heck, we see movie stars, athletes and politicians on the cover of magazines and on television talking about their time in rehab for whatever addiction they were seeking to remedy. Mostly the stigma of addiction has faded away with the flooding of addiction and addiction treatment information. So many terms initiated from the 12 Step program have made their way into people's everyday language, used in an entirely different way as initially intended.

Of course it is no surprise to any of you students that is was not always this way. No, not at all. Addiction, especially to drugs was frequently referred to as a shame, an embarrassment, a criminals issue and for the stupid, poor and lazy. "Those" people were forced into the shadows, into the gutter and cast off as unimportant and better off dead.

This course will begin by looking at the history of addiction and addiction treatment in America. Thereafter we will delve into all aspects of addiction treatment from inside out and top to bottom.

The American Society of Addiction Medicine (ASAM) definition of addiction is:

Short Definition

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.

Long Definition

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry**.** Addiction affects neurotransmission and interactions within reward structures of the brain, including

the nucleus accumbens, anterior cingulate cortex, basal forebrain and amygdala, such that motivational hierarchies are altered and addictive behaviors, which may or may not include alcohol and other drug use, supplant healthy, self-care related behaviors. Addiction also affects neurotransmission and interactions between cortical and hippocampal circuits and brain reward structures, such that the memory of previous exposures to rewards (such as food, sex, alcohol and other drugs) leads to a biological and behavioral response to external cues, in turn triggering craving and/or engagement in addictive behaviors.

Addiction is characterized by:

- Inability to consistently abstain
- Impairment in behavioral control
- Craving; or increased "hunger" for drugs or rewarding experiences
- Diminished recognition of significant problems with one's behaviors and interpersonal relationships
- A dysfunctional emotional response

The American Society of Addiction Medicine definition of treatment:

Treatment is the use of any planned, intentional intervention in the health, behavior, personal and/or family life of an individual suffering from alcoholism or from another drug dependency designed to enable the affected individual to achieve and maintain sobriety, physical and mental health, and a maximum functional ability.
There are many components of treatment including, but not limited to, physical and psychiatric evaluations, detoxification, counseling, self-help support, treatment for co-morbid physical or behavioral complications, and medication assisted therapy.

The National Institute on Drug Abuse definition of drug treatment:

Drug treatment is intended to help addicted individuals stop compulsive drug seeking and use. Treatment can occur in a variety of settings, take many different forms, and last for different lengths of time. Because drug addiction is typically a chronic disorder characterized by occasional relapses, a short-term, one-time treatment is usually not sufficient. For many, treatment is a long-term process that involves multiple interventions and regular monitoring.

Before we go further along into the meat & potatoes of this course, let's look at the history of drug and alcohol treatment in America……briefly!

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

1784
Dr. Benjamin Rush's Inquiry into the Effects of Ardent Spirits on the Human Mind and Body catalogues the consequence of chronic drunkenness and argues that this condition is a disease that physicians should be treating. Rush's writing marks beginning of American temperance movement.
1810
Dr. Benjamin Rush calls for creation of a "Sober House" for the care of the confirmed drunkard.
1830
Dr. Samuel Woodward calls for creation of inebriate asylums.

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

1845 - 1849
Frederick Douglass (having earlier acknowledged a period of intemperance in his life) signs a pledge of abstinence and becomes involved in promoting temperance among African American people. His call for abstinence as a foundation of the drive to abolish slavery and prepare black people for full citizenship anticipated modern Afrocentric models of addiction recovery.

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

1864 - 1867
The New York State Inebriate Asylum, the first in the country, is opened in Binghamton, NY. A growing network of inebriate asylums will treat alcoholism and addiction to a growing list of other drugs: opium, morphine, cocaine, chloral, ether, and chloroform.
The opening of the Martha Washington Home in Chicago marks the first institution in America that specialized in the treatment of inebriate women.

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1870 – 1872

Jerry McAuley opens the Water Street Mission in New York City, marking the beginning of the urban mission movement. This movement, spread across America by the Salvation Army, caters its message and services to the "Skid Row." The urban missions will birth such alcoholics mutual aid societies as the United Order of Ex-Boozers. The missions are linked to religiously-oriented, rural inebriate colonies.

1870s

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

1879 – 1880s

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

Cocaine is recommended by Sigmund Freud and a number of American physicians in the treatment of alcoholism and morphine addiction.

Bottled home cures for the alcohol and drug habits abound; most will be later exposed to contain alcohol, opium, morphine, cocaine and cannabis.

1891 – 1892

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

1901 - 1906

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

The Emmanuel Clinic in Boston begins the practice of lay therapy in the treatment of alcoholism. The Clinic will generate a number of noted lay therapists (Baylor, Chambers, Peabody) who will exert

enormous influence on alcoholism treatment for several decades. The Jacoby Club serves as the Clinic's mutual aid society.

1907 - 1913

First of two waves of state laws is passed calling for the mandatory sterilization of "defectives": the mentally ill, the developmentally disabled, and alcoholics and addicts.

1919 - 1924

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

1935

The opening of Shadel Sanatorium marks the introduction of aversive conditioning in an institutional alcoholism treatment setting. The first federal "narcotics farm" (U.S. Public Health Prison Hospital) opens in Lexington, Kentucky. The second facility opens in Fort Worth, Texas in 1938. This marks the beginning of federal involvement in addiction research and addiction treatment. The meeting of Bill W. and Dr. Bob S. (and Dr. Bob's last drink) mark the beginning of Alcoholics Anonymous (AA).

1944

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

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

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

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

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1948 - 1950

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

1952

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

1954

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

1957 – 1958

The Veteran's Health Administration begins developing alcoholism treatment units within its national network of VA hospitals.

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

Early 1960's

Several states initiate civil commitment programs for narcotic addicts.

1963 – 1966

Provision for local alcoholism and addiction counseling are included in federal legislation funding the development of local comprehensive community mental health centers, anti-poverty programs, and criminal justice diversion programs. Such federal funding increases throughout the 1960s.

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As alcoholism programs spread, there is a heated debate over the question of who is qualified to treat the alcoholic. Tensions abound between "paraprofessional" recovering alcoholics and psychiatrists, psychologists and social workers within newly-emerging alcoholism treatment programs.

1964

Dr. Vincent Dole, an endocrinologist, and Dr. Marie Nyswander, a psychiatrist specializing in addiction, introduce methadone blockade therapy in the treatment of narcotic addiction.

1972

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

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

1982

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

Cocaine Anonymous is founded

1985 – 1990

Addiction treatment becomes increasingly concerned about "special populations" and launches specialized treatment tracks for women, adolescents, the elderly, gays and lesbians, and the "dually diagnosed." As the challenges of treating new patterns of cocaine addiction grow, relapse tracks also become a common treatment innovation.

1989 - 1994

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

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

Following an erosion of alcoholism treatment reimbursement benefits by insurance carriers, an aggressive system of managed care all but eliminates the 28-day inpatient treatment program in hospitals and private, free-standing centers. The downsizing and closure of hospital-based treatment units sparks a trend toward the integration of many psychiatric and addiction treatment units and a

renewed community trend of incorporating addiction treatment services under the umbrella of mental health or "behavioral health" services. Most inpatient treatment programs shift their emphasis toward outpatient and intensive outpatient services. The loss of residential services adds fuel to a growing recovery home movement.

1991 - 1992

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

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

1995

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

Present Day

Treatment for drug abuse and addiction is delivered in many different settings using a variety of behavioral and pharmacological approaches. In the United States, more than 14,500 specialized drug treatment facilities provide counseling, behavioral therapy, medication, case management, and other types of services to persons with substance use disorders.

Along with specialized drug treatment facilities, drug abuse and addiction are treated in physicians' offices and mental health clinics by a variety of providers, including counselors, physicians, psychiatrists, psychologists, nurses, and social workers. Treatment is delivered in outpatient, inpatient, and residential settings. Although specific treatment approaches often are associated with particular treatment settings, a variety of therapeutic interventions or services can be included in any given setting.

Because drug abuse and addiction are major public health problems, a large portion of drug treatment is funded by local, State, and Federal governments. Private and employer-subsidized health plans also may provide coverage for treatment of addiction and its medical consequences. Unfortunately, managed care has resulted in shorter average stays, while a historical lack of or insufficient coverage for substance abuse treatment has curtailed the number of operational programs. The recent passage of parity for insurance coverage of mental health and substance abuse problems will hopefully improve this state of affairs. Health Care Reform (i.e., the Patient Protection and Affordable Care Act of 2010,

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"ACA") also stands to increase the demand for drug abuse treatment services and presents an opportunity to study how innovations in service delivery, organization, and financing can improve access to and use of them.

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Drug and Alcohol Treatment:

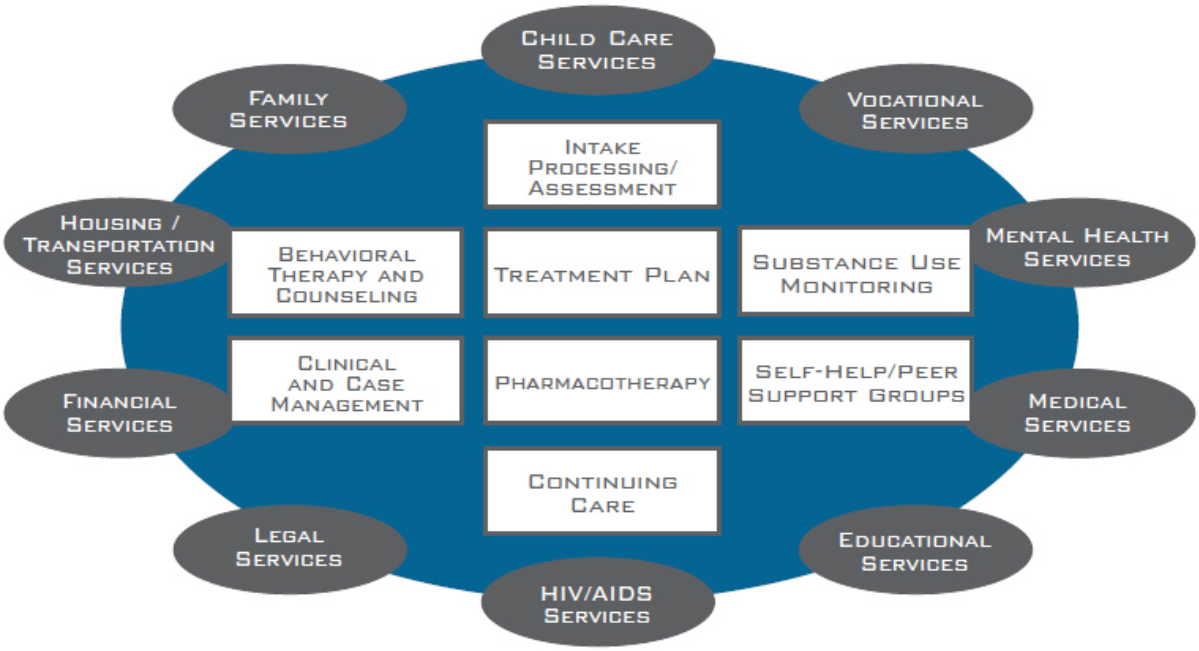
What Type of Help is Out There?

Chapter 1

In the introduction we listed a couple of definitions of both addiction and addiction treatment. When researching you may come across many more definitions than those cited here. For our purposes these will suffice as a jumping off point to begin understanding what addiction treatment is, what its purposes are, what defines treatment; what defines "good" treatment, who provides treatment, what theories of treatment are best suited to addiction treatment and who governs addiction treatment.

The chart below indicates the comprehensive scope of addiction treatment. Not all addiction treatment programs offer all services; depending on the modality, the level of care and the length of stay.

Components of Comprehensive Drug Abuse Treatment



The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.

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Instructor Note: It is important to remember that treatment begins with the first client contact. That may be on the phone or in person, no matter – treatment begins from the first hello.

Let's start at the beginning.

Principles of Effective Treatment

1. **Addiction is a complex but treatable disease that affects brain function and behavior.** Drugs of abuse alter the brain's structure and function, resulting in changes that persist long after drug use has ceased. This may explain why drug abusers are at risk for relapse even after long periods of abstinence and despite the potentially devastating consequences.
2. **No single treatment is appropriate for everyone.** Treatment varies depending on the type of drug and the characteristics of the patients. Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.
3. **Treatment needs to be readily available.** Because drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible. As with other chronic diseases, the earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes.
4. **Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.** To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture.
5. **Remaining in treatment for an adequate period of time is critical.** The appropriate duration for an individual depends on the type and degree of the patient's problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment. Recovery from drug addiction is a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug abuse can occur and should signal a need for treatment to be reinstated or adjusted. Because individuals often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.
6. **Behavioral therapies—including individual, family, or group counseling—are the most commonly used forms of drug abuse treatment.** Behavioral therapies vary in their focus and may involve addressing a patient's motivation to change, providing incentives for abstinence,

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building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problem-solving skills, and facilitating better interpersonal relationships. Also, participation in group therapy and other peer support programs during and following treatment can help maintain abstinence.

7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** For example, methadone, buprenorphine, and naltrexone (including a new long-acting formulation) are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Acamprosate, disulfiram, and naltrexone are medications approved for treating alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (available as patches, gum, lozenges, or nasal spray) or an oral medication (such as bupropion or varenicline) can be an effective component of treatment when part of a comprehensive behavioral treatment program.
8. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation, and/or social and legal services. For many patients, a continuing care approach provides the best results, with the treatment intensity varying according to a person's changing needs.
9. **Many drug-addicted individuals also have other mental disorders.** Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.
10. **Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.** Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal and can, for some, pave the way for effective long-term addiction treatment, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following detoxification. Motivational enhancement and incentive strategies, begun at initial patient intake, can improve treatment engagement.

11. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.
12. **Drug use during treatment must be monitored continuously, as lapses during treatment do occur.** Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs.
13. **Treatment programs should test patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling, linking patients to treatment if necessary.** Typically, drug abuse treatment addresses some of the drug-related behaviors that put people at risk of infectious diseases. Targeted counseling focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviors. Counseling can also help those who are already infected to manage their illness. Moreover, engaging in substance abuse treatment can facilitate adherence to other medical treatments. Substance abuse treatment facilities should provide onsite, rapid HIV testing rather than referrals to offsite testing—research shows that doing so increases the likelihood that patients will be tested and receive their test results. Treatment providers should also inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drug-abusing populations, and help link them to HIV treatment if they test positive.

14. Re-assess values

Treatment Approaches - Briefly

There are a variety of evidence-based approaches to treating addiction. Drug treatment can include behavioral therapy (such as cognitive-behavioral therapy or contingency management), medications (pharmacotherapy), or their combination. The specific type of treatment or combination of treatments will vary depending on the patient's individual needs and, often, on the types of drugs they use.

Treatment medications, such as methadone, buprenorphine, and naltrexone (including a new long-acting formulation), are available for individuals addicted to opioids, while nicotine preparations (patches, gum, lozenges, and nasal spray) and the medications varenicline and bupropion are available for individuals addicted to tobacco. Disulfiram, acamprosate, and naltrexone are medications available

for treating alcohol dependence, which commonly co-occurs with other drug addictions, including addiction to prescription medications.

Treatments for prescription drug abuse tend to be similar to those for illicit drugs that affect the same brain systems. For example, buprenorphine, used to treat heroin addiction, can also be used to treat addiction to opioid pain medications. Addiction to prescription stimulants, which affect the same brain systems as illicit stimulants like cocaine, can be treated with behavioral therapies, as there are not yet medications for treating addiction to these types of drugs.

Behavioral therapies can help motivate people to participate in drug treatment, offer strategies for coping with drug cravings, teach ways to avoid drugs and prevent relapse, and help individuals deal with relapse if it occurs. Behavioral therapies can also help people improve communication, relationship, and parenting skills, as well as family dynamics.

Because they work on different aspects of addiction, combinations of behavioral therapies and medications (when available) generally appear to be more effective than either approach used alone.

Finally, people who are addicted to drugs often suffer from other health (e.g., depression, HIV), occupational, legal, familial, and social problems that should be addressed concurrently. The best programs provide a combination of therapies and other services to meet an individual patient's needs. Psychoactive medications, such as antidepressants, anti-anxiety agents, mood stabilizers, and antipsychotic medications, may be critical for treatment success when patients have co-occurring mental disorders such as depression, anxiety disorders (including post-traumatic stress disorder), bipolar disorder, or schizophrenia. In addition, most people with severe addiction abuse multiple drugs and require treatment for all substances abused.

How Effective is Drug Treatment

According to NIDA, in addition to stopping drug abuse, the goal of treatment is to return people to productive functioning in the family, workplace, and community. According to research that tracks individuals in treatment over extended periods, most people who get into and remain in treatment stop using drugs, decrease their criminal activity, and improve their occupational, social, and psychological functioning. For example, methadone treatment has been shown to increase participation in behavioral therapy and decrease both drug use and criminal behavior. However, individual treatment outcomes depend on the extent and nature of the patient's problems, the appropriateness of treatment and related services used to address those problems, and the quality of interaction between the patient and his or her treatment providers.

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Like other chronic diseases, addiction can be managed successfully. Treatment enables people to counteract addiction's powerful disruptive effects on the brain and behavior and to regain control of their lives. The chronic nature of the disease means that relapsing to drug abuse is not only possible but also likely, with symptom recurrence rates similar to those for other well-characterized chronic medical illnesses—such as diabetes, hypertension, and asthma that also have both physiological and behavioral components.

Most Common Treatments for Substance Use Disorders

The treatment system for substance use disorders is comprised of multiple service components, including the following:

- *Individual and group counseling*

  Counseling can be provided at the individual or group level. Individual counseling often focuses on reducing or stopping substance use, skill building, adherence to a recovery plan, and social, family, and professional/educational outcomes. Group counseling is often used in addition to individual counseling to provide social reinforcement for pursuit of recovery.

- *Inpatient and residential treatment*

  Treatment can be provided in inpatient or residential sessions. This happens within specialty substance use disorder treatment facilities, facilities with a broader behavioral health focus, or by specialized units within hospitals. Longer-term residential treatment has lengths of stay that can be as long as six to twelve months and is relatively uncommon. These programs focus on helping individuals change their behaviors in a highly structured setting. Shorter term residential treatment is much more common, and typically has a focus on detoxification (also known as medically managed withdrawal) as well as providing initial intensive treatment, and preparation for a return to community-based settings.

- *Partial hospital programs and Intensive outpatient treatment*

  An alternative to inpatient or residential treatment is partial hospitalization or intensive outpatient treatment. These programs have people attend very intensive and regular treatment sessions multiple times a week early in their treatment for an initial period.

  After completing partial hospitalization or intensive outpatient treatment, individuals often step down into regular outpatient treatment which meets less frequently and for fewer hours per week to help sustain their recovery.

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Case or care management

Provides support for the possible/probable significant issues that frequently come along with addiction. Because addiction damages many aspects of an individual's life, including housing, employment, relationships, mental health issues etc. This level of treatment provides individuals with planning and coordinating a package of health and social services that is individualized to meet a particular individual's needs.

Medication

Using medication to treat substance use disorders is often referred to as Medication-Assisted Treatment (MAT). In this model, medication is used in combination with counseling and behavioral therapies. Medications can reduce the cravings and other symptoms associated with withdrawal from a substance by occupying receptors in the brain associated with using that drug (agonists or partial agonists), block the rewarding sensation that comes with using a substance (antagonists), or induce negative feelings when a substance is taken. MAT is has been primarily used for the treatment of opioid use disorder but is also used for alcohol use disorder and the treatment of some other substance use disorders.

Recovery support services

Recovery support services are non-clinical services that are used with treatment to support individuals in their recovery goals. These services are often provided by peers, or others who are already in recovery. Recovery support can include:

- Transportation to and from treatment and recovery-oriented activities
- Employment or educational supports
- Specialized living situations
- Peer-to-peer services, mentoring, coaching
- Spiritual and faith-based support
- Parenting education
- Self-help and support groups
- Outreach and engagement
- Staffing drop in centers, clubhouses, respite/crisis services, or warm-lines (peer-run listening lines staffed by people in recovery themselves)
- Education about strategies to promote wellness and recovery

- *12-Step fellowship*

  Peers also play a powerful role as a part of mutual-support groups. These groups, including Alcoholics Anonymous or Narcotics Anonymous and other 12-step programs, provide peer support for ending or reducing substance use. They provide an international support network which is relied upon by many people in recovery from substance use disorders. Mutual-support groups are often intentionally incorporated into treatment plans and can provide a ready community for individuals who are trying to change their lifestyles to get away from alcohol and other drugs. While mutual-support groups do not work for everyone and are not a necessary part of recovery, they are a fundamental component of the substance use disorder treatment system, even if they are not considered formal treatment.

- *Peer supports*

  Peers are individuals in recovery who can use their own experiences to help others working towards recovery. Peer supports are a critical component of the substance use disorder treatment system. Many people who work in the treatment system as counselors or case managers are in recovery, and peers are central to many recovery support efforts.

A person accessing treatment may not need to access every one of these components, but each plays an important role. These systems are embedded in a broader community and the support provided by various parts of that community also play an important role in supporting the recovery of people with substance use disorders.

Stages of Treatment

The stages of addiction treatment described here are:

- Treatment Initiation
- Early Abstinence
- Maintenance of Abstinence
- Advanced Recovery

As with other stage theories of development, the stage theory of addiction recovery is only a model. Individuals pass through the stages at their own pace, the stages are overlapping rather than discreet, and individuals may slip back at points and need to rework issues from previous stages. This theory does not, however, discount the considerable usefulness of having a model of the typical process in

mind so that the patient's place in his or her own recovery then can be compared with the model for better understanding the patient's process and the steps needed to be taken to proceed.

Appropriate treatment for chemical addiction varies and is sensitive and responsive to the changing needs of the patient throughout his or her recovery. The addiction counselor should understand that addiction treatment must be progressive, just as the patient's recovery process is progressive. To provide optimal counseling, the counselor must be sensitive to the patient's evolving needs in treatment. To ensure a progressive approach to addiction treatment, the counselor must be prepared to address different topics in recovery, use different kinds of interventions, and hold the patient to a different level of responsibility as he or she works toward recovery.

Instructor Note: The following is a brief explanation of what cultural competence has to do with substance abuse treatment and addiction counseling. Understanding and identifying cultural issues and their impact on addiction treatment services, counseling and the client's perception of both has become a core practice competence for professional addiction counselors and addiction treatment facilities. The topic of cultural competence will come up in several of the courses you will be studying, thereby allowing students to learn about this subject in more detail.

Cultural Competence in the Addiction Treatment Settings

Culturally Competent Treatment

One definition of cultural competence refers to "the capacity of a service provider or of an organization to understand and work effectively with the cultural beliefs and practices of persons from a given ethnic/racial group" (Castro et al. 1999, p. 504).

Culturally Competent Treatment with Client with COD

Treatment providers working with individuals with COD should view these clients and their treatment in the context of their language, culture, ethnicity, geographic area, socioeconomic status, gender, age, sexual orientation, religion, spirituality, and any physical or cognitive disabilities.

Cultural factors that may have an impact on treatment include heritage, history and experience, beliefs, traditions, values, customs, behaviors, institutions, and ways of communicating. The client's culture may include distinctive ways of understanding disease or disorder, including mental and substance use disorders, which the provider needs to understand. Referencing a model of disease that is familiar to the client can help communication and enhance treatment. The counselor acquires cultural knowledge by becoming aware of the cultural factors that are important to a particular ethnic group or client.

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Cultural competence may be viewed as a continuum on which, through learning, the provider increases his or her understanding and effectiveness with different ethnic groups. The continuum moves from cultural destructiveness, in which an individual regards other cultures as inferior to the dominant culture, through cultural incapacity and blindness to the more positive attitudes and greater levels of skill described below:

- **Cultural sensitivity** is being "open to working with issues of culture and diversity" (Castro et al. 1999, p. 505). Viewed as a point on the continuum, however, a culturally sensitive individual has limited cultural knowledge and may still think in terms of stereotypes.
- **Cultural competence**, when viewed as the next stage on this continuum, includes an ability to "examine and understand nuances" and exercise "full cultural empathy." This enables the counselor to "understand the client from the client's own cultural perspective" (Castro et al. 1999, p. 505).
- **Cultural proficiency** is the highest level of cultural capacity. In addition to understanding nuances of culture in even greater depth, the culturally proficient counselor also is working to advance the field through leadership, research, and outreach (Castro et al. 1999, p. 505).

It is important to remember that clients, not counselors, define what is culturally relevant to them. It is possible to damage the relationship with a client by making assumptions, however well intentioned, about the client's cultural identity.

Advice to Counselors: Using the **RESPECT** Mnemonic To Reinforce Culturally Responsive Attitudes and Behaviors

- **R**espect—Understand how respect is shown within given cultural groups. Counselors demonstrate this attitude through verbal and nonverbal communications.
- **E**xplanatory model—Devote time in treatment to understanding how clients perceive their presenting problems. What are their views about their own substance abuse or mental symptoms? How do they explain the origin of current problems? How similar or different is the counselor's perspective? Sociocultural context—Recognize how class, race, ethnicity, gender, education, socioeconomic status, sexual and gender orientation, immigrant status, community, family, gender roles, and so forth affect care.
- **P**ower—Acknowledge the power differential between clients and counselors.
- **E**mpathy—Express, verbally and nonverbally, the significance of each client's concerns so that he or she feels understood by the counselor.
- **C**oncerns and fears—Elicit clients' concerns and apprehensions regarding help-seeking behavior and initiation of treatment.

- Therapeutic alliance/Trust—Commit to behaviors that enhance the therapeutic relationship; recognize that trust is not inherent but must be earned by counselors.

Sources: Bigby and American College of Physicians 2003; Campinha-Bacote et al. 2005.

Substance abuse treatment may be based on one of several traditional approaches:

- The **Medical Model** which focuses on the recognition of addiction as a bio/psycho/social disease, the need for life-long abstinence, and the use of an ongoing recovery program to maintain abstinence
- The **Social Model** which focuses more on the need for long-term abstinence and the need for self-help recovery groups to maintain sobriety
- The **Behavioral Model** which focuses more on diagnosis and treatment of other problems or conditions that can interfere with recovery (HHS/SAMHSA, 1996a).

Many programs use a combination of some aspects of the various models in order to facilitate the most appropriate treatment for the individual and to give patients options. Others also include innovative non-traditional models of treatment such as acupuncture and traditional healing practices associated with specific cultural groups.

Descriptions of Therapy Modalities and Philosophies:

Instructor Note: There a multitude of therapeutic modalities and interventions. Some have been proven (known as evidence-based practice. This will be covered in depth in a later chapter) to work well in the treatment of substance addiction and others have not. Most facilities currently use "best practices" when developing a substance addiction treatment program. Meaning the administrators of treatment facilities indicate in their facility manuals that counseling will be provided using evidence-based, strengths based, client-centered therapeutic practices.

The list below is just a sampling of what therapeutic practices are currently being used.

1. **Crisis Intervention Therapy**: Crisis intervention therapy aims to intervene as quickly as possible after the traumatic event occurred. The goals are to help the client clarify the event, minimize the use of destructive coping skills, and create productive coping techniques.
2. **Psycho-education:** This therapy involves the therapist teaching the survivor about the impact of trauma, common disorders associated with trauma, and ways to cope with symptoms**.**
3. **Cognitive Behavioral Therapy:** Cognitive behavioral theory stems from the idea that people are characterized by how they think about the world, and that the way they think and interpret events leads to emotional responses.

4. **Psychodynamic /Psychoanalytic:** Psychoanalytic therapy aims to uncover unconscious thoughts, emotions, and behaviors. Psychodynamic theory also focuses on uncovering repressed thoughts and emotions while focusing on the dynamics of the client's family.
5. **Person-Centered Therapy (Rogerian Therapy):** Person-centered therapy was developed by Carl Rogers in the 1940s. This type of therapy diverged from the traditional model of the therapist as expert and moved instead toward a nondirective, empathic approach that empowers, establishing a warm, safe environment and motivates the client in the therapeutic process. The therapy is based on Rogers's belief that every human being strives for and has the capacity to fulfill his or her own potential. The therapist normally does not give advice. Person-centered therapy, also known as Rogerian therapy, has had a tremendous impact on the field of psychotherapy and many other disciplines.
6. **Substance Abuse/Addictions**: Substance abuse therapy involves addressing the use of a substance such as alcohol or drugs as a coping method. The goal is to work through the addiction and develop more adaptive coping methods. CBT and 12-step programs are the most common approaches.
7. **Solution-Focused Therapy:** Solution focused therapy seeks to establish goals and solutions to a client's problem that utilize the client's strengths. The client sets their own goals and is aided by the therapist through psycho education and interactive counseling.
8. **Dialectical Behavior Therapy (DBT) (Linehan):** DBT is based on the idea that some clients react abnormally to emotional stimulation and have a hard time returning from peak arousal to baseline. The goal of DBT is to teach methods to evaluate emotions and thus reduce life-threatening behaviors
9. **EMDR (Shapiro):** Eye movement desensitization and reprocessing involves the therapist asking the patient to generate anxiety producing images and thoughts while he or she elicits rapid saccadic eye movements by having the patient track the therapist's finger as it is waved back and forth. The belief is that eye movements override neural blockage of a traumatic event (Hembree et. al 2003).
10. **Motivational Interviewing (MI):** is a method that works on facilitating and engaging intrinsic motivation within the client in order to change behavior. MI is a goal-oriented, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.
11. **Motivational Enhancement Therapy (MET**): is an adaptation of motivational interviewing (MI) that includes normative assessment feedback to clients that is presented and discussed in a non-confrontational manner. Motivational interviewing is a goal-oriented, client-centered counseling style for facilitating behavior change by helping clients to resolve ambivalence across a range of problematic behaviors. MET uses an empathic and strategic approach in which the therapist provides feedback that is intended to strengthen and consolidate the client's commitment to change and promote a sense of self-efficacy. MET aims to elicit intrinsic motivation to change substance abuse and other behaviors by evoking the client's own

motivation and commitment to change, responding in a way that minimizes defensiveness or resistance.

12. **Relapse Prevention Therapy (RPT):** is a behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. RPT can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment. Coping skills training is the cornerstone of RPT, teaching clients strategies to:

- Understand relapse as a process
- Identify and cope effectively with high-risk situations such as negative emotional states, interpersonal conflict, and social pressure
- Cope with urges and craving
- Implement damage control procedures during a lapse to minimize negative consequences
- Stay engaged in treatment even after a relapse
- Learn how to create a more balanced lifestyle

Coping skills training strategies include both cognitive and behavioral techniques. Cognitive techniques provide clients with ways to reframe the habit change process as a learning experience with errors and setbacks expected as mastery develops. Behavioral techniques include the use of lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a client's overall coping capacity.

Instructor Note: I thought it would be interesting to include one therapeutic modality established to work within a Harm Reduction framework. Most facilities in the United States do NOT subscribe to the Harm Reduction Model for addiction treatment. However, to be a well-rounded addiction professional you should at least be familiar with one:

Behavioral Self-Control Training (BSCT): Behavioral Self-Control Training is a treatment approach used to pursue either a goal of abstinence or a goal of moderate or non-problematic drinking. It consists of behavioral techniques of goal setting, self-monitoring, managing consumption, rewarding goal attainment, functionally analyzing drinking situations, and learning alternate coping skills. It is educational in that the therapist introduces specific components, one at a time, and assigns "homework" tasks between sessions. The client maintains primary responsibility for making decisions throughout the training.

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Counselor's Core Responsibilities: In Brief Chapter 2

This chapter will provide a very brief overview of some of the basic responsibilities of the addiction counselor providing substance abuse treatment. The information will be defined and summarized as most of what will be presented in this chapter is presented in detail in other courses directly to these topics and issues.

Counselor Ethical Responsibility

The Florida Certification Board (FCB) is the governing and certifying body for Certified Addiction Professionals, as such they set the standards for professional addiction counselor ethical practices. The FCB Code of Ethics consist of two main sections (with subsections too), they are:

1. Rules of Ethical and Professional Conduct
2. Disciplinary Procedures

As a professional counselor you are ethically and morally obligated to abide by ALL of these rules. To read all the rules, disciplinary procedures, glossary of terms and more go to: http://flcertificationboard.org/assets/uploads/Code-of-Ethics-April-2014.pdf

Instructor Note: Ethical practices and ethical decision making are part of the everyday life of a counselor. Some situations will call for you to make quick decisions on the fly. Most ethical dilemmas/situations are not clear cut, black or white, yes or no. They mostly live in the gray area with no definitive answers. However, the more comfortable you are in understanding what is expected of you from an ethical and professional perspective and following your rules of your facility the more likely your decision will be clinically appropriate and in the best interest of the client you are serving. Remember, if you have any doubt at all call for your supervisor to intervene!

Scope of Practice

Scopes of Practice were developed using the definition used by the Federation of State Medical Boards (FSMB), which defines a Scope of Practice as follows: "…definition of rules, regulations, and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice in a field of medicine or surgery or other specifically defined

field. Such practice is also governed by requirements for continuing education and professional accountability."

Substance Use Disorder (SUD) professionals work in a broad variety of disciplines but share an understanding of the addiction process that goes beyond the narrow confines of any specialty. Professional counseling of people with substance use disorders consists of the application of general counseling theories and treatment methods adopted with the express purpose of treating alcohol and drug problems. Effective treatment can lead to a life of recovery and enhanced social, psychosocial, or bio-psychosocial functioning of individuals, couples, families, groups, organizations, and communities. As noted throughout each of the required courses to obtain Certified Addiction Professional (CAP) status, all activities of a counselor within this field are based on the practice dimensions outlined in TAP 21.

Confidentiality

The importance of understanding, practicing, applying and maintaining confidential practices is not just of the utmost importance but the bedrock of ethical, professional and clinical standards. Without confidential practices our clients would never feel safe to openly discuss their problems, issues and concerns in either individual or group therapy, assessments, case management, discharge planning etc. Without confidentiality counselors would find it very difficult to create trust and the therapeutic alliance. Without confidentiality client information could be stolen, misused, shared inappropriately

The main source for information regarding the guidelines for appropriate, legal confidential practices, corresponding, record keeping, emailing, faxing etc. can be found in 42CFR and for HIPAA training: https://floridadcf.adobeconnect.com/p4r94y8wq9c/

Clinical Supervision What is it?

Clinical supervision is the main process by which addiction counselor learns, expands their scope of practice and should be seen as a means of encouraging self-assessment, analytical, clinical and reflective skills. "Clinical supervision is the appropriate learning medium for the addiction counselor because it is a "learning by doing" process rather than a distance learning or classroom type of experience."(Powell, 1993)

Instructor Note: Let's get real here. Clinical supervision is it! It's the single thing that helps counselors, new and seasoned, become clinically knowledgeable, self-aware, clinically astute and so much more. Whenever in doubt about clinical decisions, procedural issues, crisis issues, professional concerns etc. go straight to your supervisor. Listen, be open, growth takes place when we are able to put what we think we already know aside and listen to other opinions, options and points of view. Treatment knowledge and continued growth happens in clinical supervision

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Tools of the Trade
Chapter 3

This chapter covers the various tools needed to aid/assist addiction counselors in assessing, evaluating, diagnosing and treating clients and their families. We begin with a brief explanation of the intake process and the various forms frequently involved. Then we move on to some examples of assessment/evaluation tools. There are a plethora of assessment tools: some for substance abuse only; for co-occurring; for depression; for risk/crisis; for client motivation; for needs determination for case management and so much more. Typically the tools/forms used by counselors are determined by the facility and often to meet licensing standards, auditing requirements and insurance company needs.

Assessment Tools

As stated above there are a multitude of choices, to many to list here. We will discuss a few of the most utilized tools.

The Addiction Severity Index (ASI)

The ASI is a semi-structured interview designed to address seven potential problem areas in substance-abusing patients: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status. In 1 hour, a skilled interviewer can gather information on recent (past 30 days) and lifetime problems in all of the problem areas. The ASI provides an overview of problems related to substance, rather than focusing on any single area.TheDet

The ASI can be used effectively to explore problems within any adult group of individuals who report substance abuse as their major problem. It has been used with psychiatrically ill, homeless, pregnant, and prisoner populations, but its major use has been with adults seeking treatment for substance abuse problems.

The ASI has been used extensively for treatment planning and outcome evaluation. Outcome evaluation packages for individual programs or for treatment systems are available.

Global Appraisal of Individual Needs (GAIN)

The GAIN is a series of measures (screener, standardized biopsychosocial intake assessment battery, follow-up assessment battery) designed to integrate research and clinical assessment. With 99 scales and subscales, it is designed to measure the recency, breadth, and frequency of problems and service

utilization related to substance use (including diagnosis and course, treatment motivation, and relapse potential), physical health, risk/protective involvement, mental health, environment and vocational situation. The GAIN's substance problem index (SPI), a dimensional measure of problem severity for the participant's lifetime, past year, and past month; it can also be used to measure change over time and to categorize participants (based on report) in terms of abuse, dependence, and course specifiers (supplemental questions can also be used to break out problems/diagnosis by substance).
GAIN is a useful assessment tool when working with adults in outpatient, intensive outpatient, drug court program (IOP/OP step down), methadone, short-term residential, long-term residential, TASC-criminal justice residential program, pregnant/postpartum women's program, dual diagnosis, and homeless subgroups at intake to substance abuse treatment and for quarterly follow-up (used up to 24 months later). Adolescents in outpatient, intensive outpatient, short-term residential, therapeutic community, and residential aftercare programs at intake to substance abuse treatment and for quarterly follow-up (used up to 30 months later). Adults and adolescents on probation, in employee assistance programs or student assistance programs (not necessarily in treatment) as part of screening.

The GAIN is a standard biopsychosocial instrument designed to integrate the assessment for both clinical (e.g., diagnosis to APA's DSM-, placement to ASAM's PPC-2, treatment planning to JAHCO, and program planning to CARF) and program evaluation (needs assessment, clustering, fidelity, outcomes, and benefit-cost) purposes. The instrument and computer applications are modularized to support the use of subsections and/or scoring by clinicians for immediate use. Starting in 2002, it has also started issuing both statistical and narrative reports to facilitate interpretation and referrals related to diagnosis, further assessment, placement, and treatment planning.

The CAGE questionnaire

The CAGE (acronym) is a 4-item questionnaire that can indicate potential problems with alcohol abuse.

The questionnaire asks the following yes/no questions:

1. Have you ever felt you needed to **C**ut down on your drinking?
2. Have people **A**nnoyed you by criticizing your drinking?
3. Have you ever felt **G**uilty about drinking?
4. Have you ever felt you needed a drink first thing in the morning (**E**ye-opener) to steady your nerves or to get rid of a hangover?

The Drug Abuse Screening Test (DAST)
The DAST is a 10-item, yes/no self-report instrument that has been condensed from the 28-item DAST and should take less than 8 minutes to complete. The DAST-10 was designed to provide a brief

instrument for clinical screening and treatment evaluation and can be used with adults and older youth.

This 20-item instrument may be given in either a self-report or in a structured interview format; a "yes" or "no" response is requested from each of 20 questions. The purpose of the DAST is 1) to provide a brief, simple, practical, but valid method for identifying individuals who are abusing psychoactive drugs; and 2) to yield a quantitative index score of the degree of problems related to drug use and misuse. DAST scores are highly diagnostic with respect to a DSM diagnosis of psychoactive drug dependence.

The purpose of the DAST is 1) to provide a brief, simple, practical, but valid method for identifying individuals who are abusing psychoactive drugs; and 2) to yield a quantitative index score of the degree of problems related to drug use and misuse. DAST scores are highly diagnostic with respect to a DSM diagnosis of psychoactive drug dependence.

The DAST must be administered by a qualified drug counselor, only a careful reading and adherence to the instructions in the "DAST Guidelines for Administration and Scoring," which is provided, is required. No other training is required.

The Alcohol Use Disorders Identification Test (AUDIT)

The AUDIT is a 10-item questionnaire that screens for hazardous or harmful alcohol consumption. Developed by the World Health Organization (WHO), the test correctly classifies 95% of people into either alcoholics or non-alcoholics. The AUDIT is particularly suitable for use in primary care settings and has been used with a variety of populations and cultural groups. It should be administered by a health professional or paraprofessional.

The AUDIT screening procedure in clinical settings is linked to a decision process that includes brief intervention with heavy drinkers, or referral to specialized treatment for patients who show evidence of more serious alcohol involvement. Populations appropriate for a screening program using the AUDIT include primary care, emergency room, surgery, and psychiatric patients; DWI offenders, criminals in court, jail and prison; enlisted men in the Armed Forces; workers encountered in employee assistance programs and industrial settings; and college students.

The Clinical Institute Withdrawal Assessment for Alcohol (CIWA)

The CIWA-AD based on DSM-III-R is an 8-item scale for clinical quantification of the severity of the alcohol withdrawal syndrome. Its origins stem from the 15-item CIWA-A (Journal of Clinical Psychopharmacology 1:382-387, 1981) and the more recent revised 10-item CIWA-Ar (British Journal of Addictions, 84:1353-1357, 1989). It is a reliable, brief, uncomplicated, and clinically useful scale that

can also be used to monitor response to treatment. This scale offers an increase in efficiency over the original CIWA-A scale, while retaining clinical usefulness, validity, and reliability. It can be incorporated into the usual clinical care of patients undergoing alcohol withdrawal and into clinical drug trials of alcohol withdrawal.

The CIWA-AD is useful for clinical quantification of the severity of the alcohol withdrawal syndrome. Use of the scale can be incorporated into the usual care of patients undergoing alcohol withdrawal. The scale improves staff awareness of the elements of the clinical syndrome and helps structure clinical treatment decisions.

One of the newer assessment tools that meet the needs of how brief substance abuse treatment has become is the **SBIRT – Screening, Brief Intervention, and Referral to Treatment.**

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use. The SBIRT consists of 3 major components:

- **Screening** — a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting
- **Brief Intervention** — a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice
- **Referral to Treatment** — a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services

In addition to these substance abuse assessment tools there are numerous assessment tools that screen/evaluate for trauma, depression, anxiety, readiness for treatment, readiness for change, suicide/self-harm risk and more. The following list are a few examples:

- **Depression:** Patient Health Questionnaire (PHQ-9)- (available in Spanish; adults & adolescents); Beck Depression Inventory
- **Bi-Polar Disorder:** The Mood Disorder Questionnaire (MDQ)
- **Suicide Risk:** The Columbia-Suicide Severity Rating Scale (C-SSRS) – available in 114 languages; Suicide Behaviors Questionnaire (SBQ-R)
- **Anxiety Disorders**: GAD-7 (Generalized Anxiety Disorder)
- **Trauma:** Life Events Checklist (LEC); Trauma Symptom Inventory (TSI); Trauma Assessment for Adults (TAA)

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Instructor Note: As professional addiction counselors your focus will be on substance abuse treatment, addiction and recovery, however, you will also be working with a population that is serves approximately between 41 – 65 % co-occurring individuals. Because of this the addiction counselor will most likely be using some of the other screening/assessment tools mentioned above. Most of those tools are relatively brief, easy to administer and do NOT require a PhD, PsyD., or MD. The more tools you are familiar with the better your clinical assessments, diagnoses and treatment plans will be.

The Biopsychosocial Assessment (BSP)

What is the BSP?

The Biopsychosocial assessment is the most commonly used assessment tools in addiction treatment facilities. As the name implies, the BSP addresses a client's bio-medical status, psychological status, and social status. The BSP ascertains what areas need to be addressed in the client's life for treatment to be effective. Areas of concern may be work, family, marriage, past trauma, legal problems, psychological history, living situation as well as level and severity of addiction.

BSP's take longer than most of the other types of assessment tools mentioned earlier in this chapter because the questions require detailed responses rather than simple yes/no or concrete numerical responses. Areas addressed in detail involve:

- Personal and family history
- Legal history Legal history -arrests, domestic arrests, domestic violence, violent convictions, and juvenile history
- History of substance abuse and treatment-types of drugs used and preferences
- Mental health history, suicide, psychiatric hospital admissions, and counseling
- Known developmental problems
- Educational history literacy
- Employment history and status-job losses and why, were they substance abuse related?
- Motivation
- Participant's conception of needs
- Client goals and aspirations

Once the BSP is completed (the agency/facility may require one of the other assessment tools be completed as well), the addiction counselor completes the Integrated Summary. The Integrated Summary is a clinically written summary of all the client information, issues, needs, risks assessment strengths and brief mental status exam. This is followed by a diagnosis determined by matching client characteristics to those in the DSM 5. The ASAM is employed and an initial treatment plan is devised.

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Diagnostic Tools

The Role of the DSM

The DSM – Diagnostic Statistical Manuel of Mental Disorders, is the bible for diagnostic information, criteria and codes for all mental health disorders. In addition, the DSM provides a multitude of information on the epidemiology of mental health disorders which includes disorder characteristics, symptoms, mood presentations, personality presentations, and psychosocial issues, all of which make up the criteria needed to make a clinical diagnosis. In addiction treatment, a diagnosis is necessary to obtain insurance coverage (particularly inpatient treatment) at admission and in requesting additional days in treatment.

Changes in the DSM 5

In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the revised chapter of "Substance-Related and Addictive Disorders" includes substantive changes to the disorders grouped there plus changes to the criteria of certain conditions.

In the DSM IV substance diagnoses were broken down into two distinct diagnoses; dependence or abuse. The DSM 5 utilizes "Substance Use Disorder" as a replacement for the former. Substance use disorder in DSM-5 combines the DSM-IV categories of substance abuse and substance dependence into a single disorder measured on a continuum from mild to severe. Each specific substance (other than caffeine, which cannot be diagnosed as a substance use disorder) is addressed as a separate use disorder (e.g., alcohol use disorder, stimulant use disorder, etc.), but nearly all substances are diagnosed based on the same overarching criteria. In this overarching disorder, the criteria have not only been combined, but strengthened. Whereas a diagnosis of substance abuse previously required only one symptom, mild substance use disorder in DSM-5 requires two to three symptoms from a list of 11. Drug craving will be added to the list, and problems with law enforcement will be eliminated because of cultural considerations that make the criteria difficult to apply internationally.

In DSM-IV, the distinction between abuse and dependence was based on the concept of abuse as a mild or early phase and dependence as the more severe manifestation. In practice, the abuse criteria were sometimes quite severe. The revised (DSM-5) substance use disorder, a single diagnosis, will better match the symptoms that patients experience.

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The Role of the ASAM

The ASAM Criteria – What is it

The ASAM criteria, also known as the ASAM patient placement criteria, is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-orientated and results-based care in the treatment of addiction. Today the criteria have become the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions. The ASAM criteria are required in over 30 states.

The ASAM criteria provide separate placement criteria for adolescents and adults to create comprehensive and individualized treatment plans. Adolescent and adult treatment plans are developed through a multidimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided and the intensity of treatment services provided. ASAM's criteria uses six dimensions to create a holistic, bio-psychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care.

Levels of Service – What it is used for

The American Society of Addiction Medicine's Patient Placement Criteria (ASAM PPC-2R) (ASAM 2001) envisions treatment as a continuum within which there are five levels of care. These levels of care are as follows:

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

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Co-Occurring Disorders in Substance Abuse Treatment

Chapter 4

As a student you will be reading about and learning about co-occurring disorders in various course. For the purposes of this course.

Basic working definition of co-occurring disorder - The term "co-occurring disorders" refers to co-occurring substance use (abuse or dependence) and mental disorders. Clients said to have co-occurring disorders (abbreviated as COD) have one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs.

In the past there have been many terms used to describe individuals who have COD. Some of these terms represent an attempt to identify which problem or disorder is seen as primary or more severe. Others have developed in the literature in order to argue for setting aside funding for special services or to identify a group of clients who may benefit from certain interventions. These terms include:

- MICA—mentally ill chemical abuser. This acronym is sometimes seen with two As (MICAA) to signify mentally ill chemically addicted or affected. There are regional differences in the meaning of this acronym. Many States use it to refer specifically to persons with serious mental disorders.
- MISA—mentally ill substance abuser. •MISU—mentally ill substance using.
- CAMI—chemically abusing mentally ill, or chemically addicted and mentally ill.
- SAMI—substance abusing mentally ill.
- MICD—mentally ill chemically dependent.
- Dually diagnosed.
- Dually disordered.
- Comorbid disorders.
- ICOPSD—individuals with co-occurring psychiatric and substance disorders.

A proficient counselor has the necessary skills to accurately and comprehensively assess clients for the presence of co-occurring disorders. The following is a "cheat sheet" version of the 12 steps of the assessment process utilized with clients with co-occurring disorders.

- Step 1: Engage the client.

- Step 2: Identify and contact collaterals (family, friends, other treatment providers) to gather additional information.
- Step 3: Screen for and detect COD.
- Step 4: Determine quadrant and locus of responsibility.
- Step 5: Determine level of care.
- Step 6: Determine diagnosis.
- Step 7: Determine disability and functional impairment.
- Step 8: Identify strengths and supports.
- Step 9: Identify cultural and linguistic needs and supports.
- Step 10: Identify problem domains.
- Step 11: Determine stage of change.
- Step 12: Plan treatment.

Advances in Treatment

Advances in the treatment of COD, such as improved assessments, psychological interventions, psychiatric medications, and new models and methods, have greatly increased available options for the counselor and the client.

- **"No wrong door" policy** - This principle has served to alert treatment providers that the healthcare delivery system, and each provider within it, has a responsibility to address the range of client needs wherever and whenever a client presents for care. When clients appear at a facility that is not qualified to provide some type of needed service, those clients should carefully be guided to appropriate, cooperating facilities, with follow-up by staff to ensure that clients receive proper care.
- **Mutual self-help for people with COD** - Based on the Alcoholics Anonymous model, the mutual self-help movement has grown to encompass a wide variety of addictions. Narcotics Anonymous and Cocaine Anonymous are two of the largest mutual self-help organizations for chemical addiction; Recoveries Anonymous and Schizophrenics Anonymous are the best known for mental illness.
- **Integrated care as a priority for people with severe and persistent mental illness** - For those with severe and persistent mental illness, integrated treatment, as originally articulated by Minkoff (1989), emphasized the correspondence between the treatment models for mental illness and addiction in a residential setting. The model stressed a parallel view of recovery, concomitant treatment of mental illness and substance abuse, application of treatment stages, and the use of strategies from both the mental health and substance abuse treatment fields.

- **Development of effective approaches, models, and strategies** - Treatment approaches are emerging with demonstrated effectiveness in achieving positive outcomes for clients with COD. These include a variety of promising treatment approaches that provide comprehensive integrated treatment. Successful strategies with important implications for clients with COD also include interventions based on addiction work in contingency management, cognitive– behavioral therapy, relapse prevention, and motivational interviewing.
- **Pharmacological advances** - Pharmacological advances over the past decade have produced antipsychotic, antidepressant, anticonvulsant, and other medications with greater effectiveness and fewer side effects (see appendix F for a listing of medications). With the support available from better medication regimens, many people who once would have been too unstable for substance abuse treatment, or institutionalized with a poor prognosis, have been able to lead more functional lives. To meet the needs of this population, the substance abuse treatment counselor needs both greater understanding of the signs and symptoms of mental illness and greater capacity for consultation with trained mental healthcare providers.

As substance abuse treatment counselors learn more about mental illness, they can better partner with mental health counselors to design effective treatment for both disorders.

Substance abuse counselors also should be aware that some mental health professionals may use another system, the Level of Care Utilization System for Psychiatric and Addiction Service, instead of the ASAM to determine level of care. This system also identifies levels of care;

- Level 1: Recovery Maintenance Health Management
- Level 2: Low Intensity Community Based Services
- Level 3: High Intensity Community Based Services
- Level 4: Medically Monitored Non-Residential Services
- Level 5: Medically Monitored Residential Services
- Level 6: Medically Managed Residential Services

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

The Four-Quadrant Model has two distinct uses:

- To help conceptualize an individual client's treatment and to guide improvements in system integration (for example, if the client has acute psychosis and is known to the treatment staff to have a history of alcohol dependence, the client will clearly fall into Category IV—that is, severe mental disorder and severe substance use disorder). However, the severity of the client's needs, diagnosis, symptoms, and impairments all determine level of care placement.
- To guide improvements in systems integration, including efficient allocation of resources. The NASMHPD–NASADAD National Dialogue recognized that currently "there is no single locus of responsibility for people with COD. The mental health and substance abuse treatment systems operate independently of one another, as separate cultures, each with its own treatment philosophies, administrative structures, and funding mechanisms. This lack of coordination means that neither consumers nor providers move easily among service settings" (NASMHPD and NASADAD 1999, p. ii).

Integrated Interventions

Integrated interventions are specific treatment strategies or therapeutic techniques in which interventions for both disorders are combined in a single session or interaction, or in a series of interactions or multiple sessions. Integrated interventions can include a wide range of techniques.

Some examples include:

- Integrated screening and assessment processes
- Dual recovery mutual self-help meetings
- Dual recovery groups (in which recovery skills for both disorders are discussed)
- Motivational enhancement interventions (individual or group) that address issues related to both mental health and substance abuse or dependence problems
- Group interventions for persons with the triple diagnosis of mental disorder, substance use disorder, and trauma, or which are designed to meet the needs of persons with COD and another shared problem such as homelessness or criminality
- Combined psychopharmacological interventions, in which an individual receives medication designed to reduce cravings for substances as well as medication for a mental disorder

Integrated interventions can be part of a single program or can be used in multiple program settings.

Integrated Treatment

Integrated treatment refers broadly to any mechanism by which treatment interventions for COD are combined within the context of a primary treatment relationship or service setting. Integrated

treatment is a means of actively combining interventions intended to address substance use and mental disorders in order to treat both disorders, related problems, and the whole person more effectively.

Integrated Counselor Competencies

A counselor has integrated competencies if he or she has the specific attitudes, values, knowledge, and skills needed to provide appropriate services to individuals with COD in the context of his or her actual job and program setting.

Some interventions and/or programs require clinicians only to have basic competency in welcoming, screening, assessing, and identifying treatment needs of individuals with COD. Other interventions, programs, or job functions (e.g., those of supervisory staff) may require more advanced integrated competency. The more complex or unstable the client, the more formal mechanisms are required to coordinate the various staff members working with that client in order to provide effective integrated treatment.

A number of service delivery systems are moving toward identification of a required basic level of integrated competency for all clinicians in the mental health and substance abuse treatment systems. Many States also are developing curricula for initial and ongoing training and supervision to help clinicians achieve these competencies.

Program Types

The ASAM PPC-2R (ASAM 2001) describes three different types of programs for people with COD:

- **Addiction only services**. This term refers to programs that "either by choice or for lack of resources, cannot accommodate patients who have mental illnesses that require ongoing treatment, however stable the illness and however well-functioning the patient" (ASAM 2001, p. 10).
- **Dual diagnosis capable (DDC) programs** are those that "address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning" (ASAM 2001, p. 362). Even where such programs are geared primarily to treat substance use disorders, program staff are "able to address the interaction between mental and substance related disorders and their effect on the patient's readiness to change—as well as relapse and recovery environment issues— through individual and group program content" (ASAM 2001, p. 362).
- **Dual diagnosis enhanced programs** have a higher level of integration of substance abuse and mental health treatment services. These programs are able to provide primary substance abuse

treatment to clients who are, as compared to those treatable in DDC programs, "more symptomatic and/or functionally impaired as a result of their co-occurring mental disorder" (ASAM 2001, p. 10). Enhanced-level services "place their primary focus on the integration of services for mental and substance related disorders in their staffing, services and program content" (ASAM 2001, p. 362).

Substance-Induced Disorders

The toxic effects of substances can mimic mental illness in ways that can be difficult to distinguish from mental illness. This section focuses on symptoms of mental illness that are the result of substance abuse—a condition referred to as "substance-induced disorders."

As defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (American Psychiatric Association [APA] 2013) (DSM- 5), substance-induced disorders include:

- Substance-induced Major or Mild Neurocognitive Disorder
- Substance-induced Psychotic Disorder
- Substance-induced Depressive Disorder
- Substance-induced Anxiety Disorder
- Hallucinogen Persisting Perceptual Disorder
- Substance-induced Sexual Dysfunction
- Substance-induced Sleep Disorder
- Substance-induced Bi-polar and Related Disorder
- Substance-Induced Major or Mild Neurocognitive Disorder

Substance-induced disorders are distinct from independent co-occurring mental disorders in that all or most of the psychiatric symptoms are the direct result of substance use. This is not to state that substance-induced disorders preclude co-occurring mental disorders, only that the specific symptom cluster at a specific point in time is more likely the result of substance use, abuse, intoxication, or withdrawal than of underlying mental illness. A client might even have both independent and substance-induced mental disorders. For example, a client may present with well-established independent and controlled bipolar disorder and alcohol dependence in remission, but the same client could be experiencing amphetamine-induced auditory hallucinations and paranoia from an amphetamine abuse relapse over the last 3 weeks.

Symptoms of substance-induced disorders run the gamut from mild anxiety and depression (these are the most common across all substances) to full-blown manic and other psychotic reactions (much less common). The "teeter-totter principle"—i.e., what goes up must come down—is useful to predict what kind of syndrome or symptoms might be caused by what substances.

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For example, acute withdrawal symptoms from physiological depressants such as alcohol and benzodiazepines are hyperactivity, elevated blood pressure, agitation, and anxiety (i.e., the shakes). On the other hand, those who "crash" from stimulants are tired, withdrawn, and depressed. Virtually any substance taken in very large quantities over a long enough period can lead to a psychotic state.

What is most important is to continue to evaluate psychiatric symptoms and their relationship to abstinence or ongoing substance abuse over time. Most substance-induced symptoms begin to improve within hours or days after substance use has stopped. Notable exceptions to this are psychotic symptoms caused by heavy and long term amphetamine abuse and the dementia (problems with memory, concentration, and problem-solving) caused by using substances directly toxic to the brain, which most commonly include alcohol, inhalants like gasoline, and again amphetamines.

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The Role of Crisis and Risk Assessment and Management in Substance Abuse Treatment

Chapter 5

Instructor Note: You may be asking yourself, "Why are we learning about crisis and risk management in a treatment knowledge course? And you would be right to ask! In putting this course together decisions had to be made what conceptualized treatment knowledge, what would help our students understand what addiction treatment encompasses, but also where to draw the line so information does not overlap or become too repetitive. Regarding this topic, ultimately, it seemed too important not to include in this course. Clients enter treatment at all levels of care and at any time they may present in crisis. As such, all facility staff and clinical staff need to know the basics in detecting, assessing and managing a client in crisis. One of the most effective ways to prevent crises is to identify potential risks for crises in individual clients. Like several other areas addressed in this course you, the student will learn in much greater step by step detail about assessing and managing client crises, however, for the purpose of this course, it is enough to present the basics, it's purposes and implementation. Counselors who are comfortable in their crisis management and intervention skills prove to very effective in day to day treatment and keeping their client's on the recovery track moving forward.

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

Let's define CRISIS as it applies to clients in substance abuse treatment:

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.

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The counselor's role in crisis intervention include (but not limited to):

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

The following is a list of warning signs (by no means complete) that should alert the counselor (or other staff person) that a mental health evaluation needs to be conducted in the VERY near future and that precautions need to be put into place IMMEDIATELY to ensure the safety, stability and security of the individual.

- Hopelessness
- Rage, anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped – like there's no way out
- Increasing alcohol or drug abuse
- Withdrawing from friends, family or society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic changes in mood
- No reason for living, no sense of purpose in life

There specific warning signs of an ACUTE crisis indicating a high risk for self-harm in a client. These signs indicate the need for IMMEDIATE action. **The action steps necessary are: evaluation; plan/referral, or consideration of hospitalization.**

The FIRST THREE WARNING SIGNS ARE:

- Threatening to hurt or kill self
- Looking for ways to kill self; seeking access to pills, weapons or other means
- Talking or writing about death, dying or suicide

Risk factors are often confused with warning signs of suicide, and frequently suicide prevention materials mix the two into lists of "what to watch out for." It is important to note, however, that factors identified as increasing risk are not factors that cause or predict a suicide attempt. Risk factors are characteristics that make it more likely that an individual will consider, attempt, or die by suicide. *Protective factors* are characteristics that make it less likely that individuals will consider, attempt, or die by suicide.

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Risk Factors for Suicide

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Major physical illnesses
- Previous suicide attempt
- Family history of suicide
- Job or financial loss
- Loss of relationship
- Easy access to lethal means
- Local clusters of suicide
- Lack of social support and sense of isolation
- Stigma associated with asking for help
- Lack of health care, especially mental health and substance abuse treatment
- Cultural and religious beliefs, such as the belief that suicide is a noble resolution of a personal dilemma
- Exposure to others who have died by suicide (in real life or via the media and Internet)

Protective Factors for Suicide

- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution and handling problems in a non-violent way
- Cultural and religious beliefs that discourage suicide and support self-preservation

(This was adapted from "Understanding Risk and Protective Factors for Suicide" and "Risk and protective factors for suicide" by the Suicide Prevention Resource Center.)

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Safety Screening

Safety screening requires that early in the interview the specifically ask the client if he or she has any immediate impulse to engage in violent or self-injurious behavior, or if the client is in any immediate danger from others. These questions should be asked directly of the client and of anyone else who is providing information. If the answer is yes, the clinician should obtain more detailed information about the nature and severity of the danger, the client's ability to avoid the danger, the immediacy of the danger, what the client needs to do to be safe and feel safe, and any other information relevant to safety. Additional information can be gathered depending on the counselor/staff training for crisis/emergency situations and the interventions appropriate to the treatment provider's particular setting and circumstances. Once this information is gathered, if it appears that the client is at some immediate risk, the clinician should arrange for a more in-depth risk assessment by a mental-health-trained clinician, and the client should not be left alone or unsupervised.

A variety of tools are available for use in safety screening:

- ASAM PPC-2R identifies considerations for immediate risk assessment and recommends follow up procedures (ASAM 2001).
- ASI (McLellan et al. 1992) and Global Appraisal of Individual Needs (GAIN) (Dennis 1998) also include some safety screening questions.
- Some systems use LOCUS (American Association of Community Psychiatrists [AACP] 2000*a*) as the tool to determine level of care for both mental disorders and addiction. One dimension of LOCUS specifically provides guides for scoring severity of risk of harm.

Instructor Note: There are multiple types of crisis/risk assessments available. You will learn about some of them in other courses. Regarding what steps to take during an actual client crisis will depend on an individual agency/facility determined process. Typically a treatment program will have these steps in writing for staff members to follow including calling 911 and releasing client information in a psychiatric emergency. MOST IMPORTANTLY…..ALWAYS CONTACT YOUR SUPERVISOR BEFORE DURING & AFTER A CLIENT CRISIS!

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Two state level crisis services for psychiatric and addiction crises

The Florida Baker ACT & The Marchman Act

What is the Baker Act and What Does It Do?

- The Baker Act is Chapter 394, Part I, Florida Statutes, also known as the Florida Mental Health Act.
- The Baker Act provides legal procedures for mental health examination and treatment, including:
  - Voluntary admission
  - Involuntary examination
  - Involuntary inpatient placement (IIP)
  - Involuntary outpatient placement (IOP)

- The Baker Act regulates:
  - Crisis stabilization units (CSUs)
  - Short-term residential treatment facilities (SRTs)

- The Baker Act protects the rights of all individuals examined or treated for mental illness in Florida.

What Is Involuntary Examination and How Is It Conducted?

- An involuntary exam is a psychiatric exam conducted without a person's consent, often called "getting Baker Acted."
- Involuntary exams are initiated by:
  - Law enforcement officers (49%)
  - Mental health professionals and physicians (49%)
  - Circuit courts (2%)
- Criteria for involuntary exam are that the individual:
  - Appears to have a mental illness
  - Presents a danger to self or others
  - Refuses voluntary exam or is unable to understand need for exam
- Involuntary exams are provided only by DCF-designated Baker Act receiving facilities:
  - Hospitals
  - Crisis stabilization units (CSUs)

- Services focus on stabilizing the immediate crisis.
- Within 72 hours of arrival, facility must release the individual or file a petition for involuntary placement.
- Average length of stay is 4.5 days.
- Release must be approved by a psychiatrist or a clinical psychologist

The Marchman Act

Drug Services Act of 1993 -- generally referred to as the Marchman Act. The Act was named after Rev. Hal. S. Marchman, a tireless advocate for persons who suffer from alcoholism and drug abuse, who was recognized by the Legislature for his contributions addressing the delivery of substance abuse services a prominent advocate for improved substance abuse services.

The Marchman Act encourages persons to seek out treatment on a voluntary basis and to be actively involved in planning their own services with the assistance of qualified professionals. However, denial of addiction is a common symptom, raising a barrier to early intervention and treatment. As a result, treatment often comes as a result of a spouse, employer, doctor, judge or other person with influence over one's life to obtain needed substance abuse services. The Marchman Act established a variety of methods under which substance abuse assessment, stabilization and treatment could be obtained on an involuntary basis. There are five involuntary admission procedures. Three of the procedures do not involve the court, while two require direct petitions to the circuit court.

The three non-court procedures are:

- Protective Custody
- Emergency Admission
- Alternative Involuntary Assessment for Minors

However, the law also offers two court related procedures, including:

- Involuntary Assessment and stabilization
- Involuntary Treatment

Regardless of the court-involved or non-court-involved nature of the proceedings, the same criteria for involuntary admission apply.

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Recovery

Chapter 6

Recovery is: A journey of healing and transformation that enables a person to live a meaningful, satisfying, and contributing life in a community of his or her choice. Recovery is an individual process, a way of life, an attitude, and a way of approaching life's challenges. The need is to meet the challenges of one's life and find purpose within and beyond the limits of the illness while holding a positive sense of identity.

Recovery-oriented care is: The treatment and rehabilitation that practitioners offer in support of the person's own recovery journey.

Four Dimensions of Recovery

To achieve lasting recovery, people recovering from substance abuse disorders need to have support in these four areas of their lives:

Health—Overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional wellbeing

Home—A stable and safe place to live

Purpose—Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society

Community—Relationships and social networks that provide support, friendship, love, and hope

Guiding Principles of Recovery

Recovery Emerges from Hope: The belief that recovery is real provides the essential and motivating message of a better future—that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

Recovery is Person Driven: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing,

they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

Recovery Occurs through Many Pathways: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds— including trauma experience — that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized.

They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions.

Recovery is Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, transportation, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, and community participation. The array of services and supports available should be integrated and coordinated.

Recovery is Supported by Peers and Allies: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths.

Recovery is Supported through Relationships and Social Networks: An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, and employee) that

lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

Recovery is Culturally Based and Influenced: Culture and cultural background in all of its diverse representations—including values, traditions, and beliefs—are keys in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

Recovery is by Addressing Trauma: The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Recovery Involves Individual, Family, and Community Strengths: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

Recovery is Based on Respect: Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems—including protecting their rights and eliminating discrimination—are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.

The 5 Common Stages of Recovery

Though there are certain similarities among addicted individuals, each case is unique, and is influenced by wide range of biological, psychological, and social factors such as age, gender, prior drug use, the substance being abused, and family history.

Because of the intensely personal qualities of addiction, no two people will follow the identical path to recovery. For example, some people will require residential care, outpatient treatment, and years of therapy, while others will be able to bring their disease under control with medication and counseling.

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Even with so many influences and factors, though, most recovering addicts will pass through similar phases and stages on their walk from the depths of addiction to the freedom and promise of long-term abstinence.

The following are five common stages of addiction recovery:

1. Awareness and Early Acknowledgement

This first stage is marked by a growing awareness that there is a problem. In some cases, this realization results from conversations with family members, friends or co-workers; in other instances, it may only occur after the addiction has led to health, financial, work, or legal problems.

Although the addicted individual is still engaging in addictive behaviors, and hasn't made any measurable progress toward ending those behaviors, this first stage is critical in paving the way for the rest of the recovery process.

One of the most important parts of this phase is the transition from mere awareness of the problem to actual acknowledgement that action is needed. Few experiences are as essential to an addict as the moment when he or she shifts from denial to a willingness to make a change.

2. Consideration

The second stage of the recovery process involves a shift from awareness to action. In this stage, the addicted individuals are 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.

The consideration stage is important because this is when the addicted individual begins to look beyond himself/herself and to understand that friends, family members, and colleagues have been negatively affected by his/her choices and behaviors.

By taking the step of learning more about their disease and its effect on others, addicted individuals in the consideration stage make the important transition from awareness to action. Though not yet actively pursuing recovery, they are moving in that direction, and are gaining potentially invaluable information and insights in the process.

3. Exploring Recovery

Moving past denial, the addicted individual is motivated to overcome his or her addiction and begins taking small steps such as exploring the concepts of moderation and abstinence. Some say that this exploratory stage is the stage when recovery really begins.

During the exploring recovery stage, addicted individuals may begin to educate themselves about the recovery process and what it means to live a sober life. They may consult with friends or family members who have been through similar experiences, and may also begin to collect information about treatment options.

This third stage is often when some addicted individuals first make the critical decision to enter an addiction treatment program.

4. Early Recovery

Early recovery is a time of both great significance and significant risk.

On the positive side, addicted individuals in early recovery have not only stopped using the substance(s) to which they were addicted, but they have also begun learning how to remain drug-free for the long term. On the less-than-positive side, early recovery is also a time of great vulnerability. The addicted individuals are in the process of abandoning people, activities, and behaviors that have been significant parts of their lives, yet they have yet to completely establish the foundation of their newly drug-free lives.

Relapse is far from uncommon during early recovery. Slipping back into drug abuse during this period can be particularly problematic, because recovering addicts may not yet have developed the knowledge and skills that will prevent them from backsliding into full-blown addiction.

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

By the time they reach this fifth stage, addicted individuals have completed a great deal of work and made great progress. Perhaps most importantly, they have also learned that they will need to continue to work hard for the rest of their lives to guard against relapse (or to 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.

By this fifth stage, recovering addicts have begun to live lives they could scarcely have imagined at the start of this journey.

The Concepts of Treatment and Recovery are Not One and the Same:

Treatment is a very important part of the recovery process. When the formal treatment component (s) are completed, whether it be outpatient, inpatient or short- or long-term residential treatment, this is

not the end for anyone with an addiction problem. Recovery is a lifelong process that takes place over time and often in specific stages. In addition to abstinence, recovery includes a full return to bio/psycho/social functioning (HHS/SAMHSA, 1996a).

Another widely accepted model of recovery, known as the **Developmental Model**, identifies six stages that addicted individuals must undergo for long-term recovery:

- **Transition**, the period of time needed for the addicted individual to come to grips with the realization that safe use of alcohol or other drugs for them is not possible;
- **Stabilization**, during which the chemically dependent person experiences physical withdrawal and other medical problems and learns how to separate from people, places and things that promote substance abuse;
- **Early recovery**, when an individual faces the need to establish a chemical-free lifestyle and build relationships that support long-term recovery;
- **Middle recovery**, seen as time for the development of a balanced lifestyle where repairing past damage is important;
- **Late recovery**, during which the individual identifies and changes mistaken beliefs about oneself, others and the world that caused or promoted irrational thinking; and
- **Maintenance**, the lifelong process of continued growth, development, and managing routine life problems.

Recovery is very complex, is not exempt from vulnerabilities, and requires a long-term commitment. This important part of the treatment continuum must be taken into account in the design of training programs for providers of substance abuse treatment and those of child welfare services. The complexities of recovery must be understood. It is often said in the recovery communities that the whole family is in recovery because many changes affecting the entire family system will necessarily occur as the recovering person embarks on this lifelong journey of well-being. However, many programs do not include a specific focus on parenting and family dynamics.

The Role of Family and Significant Others in Treatment and Recovery

Active addiction contributes to a variety of family difficulties, affecting the family system as well as individual members. The burden and emotional pain can be great. Family members may exhibit behaviors intended to help the addicted member, but which ultimately have an adverse impact. Family involvement is important in the treatment of addiction (O'Farrell and Fals-Stewart 1999, pp. 287-305).

Families of people who abuse substances live in a world shaped by substance use. This world may include inconsistent behaviors and few or very rigid rules. Family members may have difficulty expressing their emotions, achieving intimacy, and solving problems. They frequently may experience

but may not express anger, shame, guilt, sadness, and hopelessness. To function, families often subscribe to the following: don't trust, don't feel, and don't talk. The result can be an unhealthy environment in which individuals may be isolated, engage in destructive alliances, be overly involved with other family members, or develop significant medical and stress-related problems.

There is an association between relapse and social supports across a range of addictions. Involving the family or significant other of the addicted client in individual or multiple family group sessions can reduce the risk of relapse. Such involvement has many potential benefits:

- It provides the counseling staff with an opportunity to learn about the client's family, observe how family members interact, and gain input from the family.
- It can facilitate compliance with treatment. If a client feels pressure to remain in treatment to satisfy the requests of the family, he or she may maintain this involvement even during periods of low motivation. This buys the client time for motivation to improve.
- It provides members of the family with an opportunity to verbalize their concerns, questions, experiences, and feelings related to the addicted family member.
- It offers the client an opportunity to hear how the family experiences the addiction.
- It offers the client the opportunity to receive support from the family.
- The family can receive education and support from other families, which may lessen the burden experienced. Anger, worry, confusion, and other emotional reactions can be shared, and strong, negative feelings may be diffused.
- Family members can be taught about and encouraged to attend support groups such as Nar-Anon or Al-Anon.
- Family members can learn about behaviors that they should avoid, which are considered enabling.
- Family members can learn about strategies that can help them cope better with an addicted relative.
- Family members can learn about strategies to take care of themselves so that all the recovery efforts are not simply directed at the addicted person.
- Family members with a psychiatric or addictive disorder who appear to need help themselves can be encouraged to seek help, and referrals can be facilitated.

Integrated Models of Treatment

Models of family therapy have been evolving over the past 60 years as counselors and researchers have worked to identify the determinants of substance use disorders, the factors that maintain these disorders, and the complex relationships between people with the disorders and their family members (McCrady and Epstein 1996). Paying attention to such issues has a number of advantages:

- **Treatment outcomes.** Family involvement in substance abuse treatment is positively associated with increased engagement rates for entry into treatment, decreased dropout rates during treatment, and better long-term outcomes (Edwards and Steinglass 1995; Stanton and Shadish 1997).
- **Client recovery.** When family members understand how they have participated in the client's substance abuse and are willing to actively support the client's recovery, the likelihood of successful, long-term recovery improves.
- **Family recovery**. When families are involved in treatment, the focus can be on the larger family issues, not just the substance abuse. Both the individual with the substance use disorder and the family members get the help they need to achieve and maintain abstinence (Collins 1990).
- **Intergenerational impact.** Integrated models can help reduce the impact and recurrence of substance use disorders in different generations.

Value of Integrated Models for Treatment Professionals

- **Reduced resistance.** In addition to the promise of better treatment outcomes, integrated models permit counselors to attend to the specific circumstances of each family in treatment. This focus accommodates the whole family and helps to diminish the family's resistance to treatment.
- **Flexibility in treatment planning.** Integrated models enable counselors to tailor treatment plans to reflect individual and family factors. For instance, each family member's stage of change can be taken into consideration. Early in treatment, families may need education about substance abuse and its effects, while families in later stages of treatment may need help as they address such issues as trust, forgiveness, the acquisition of new leisure skills, changing roles, the reestablishment of boundaries within the family and at work, and changing the specific interaction patterns in the family that support substance abuse.
- **Flexibility in treatment approach.** Apart from the freedom to tailor treatment plans, integrated models enable counselors to adjust treatment approaches according to their own personal styles and strengths. For instance, counselors who enjoy working with adolescents and families can choose structural and strategic models that concentrate on family interactions, while those who prefer to capitalize on client competencies and strengths can choose solution-focused therapy. In this way, different treatment models can be used even within the same agency to meet both client and counselor needs.
- **Increased skill set.** Drawing from different traditional therapy models challenges counselors to be creative in their treatment approaches. With integrated models, for instance, substance abuse treatment counselors can work with a client's family members and see how each of their

problems reverberates throughout the family system. Similarly, family therapists can experience working with people whose primary problems are substance use disorders.

- **Administration.** Integrated models enable administrators to get more for less. Despite the obvious cost to cross-train family therapists and substance abuse counselors, the improved treatment outcomes more than offset the investment. New Jersey's Division of Addiction Training recently demonstrated this cost-to-benefit relationship (Fishman et al. 2001). In this process, integrated models accommodated the differences in theory, philosophy, and funding across multiple agencies. Further, models with proven efficacy could be duplicated across agencies, which added to the long-term cost-effectiveness.

Integrated Models Family Work in Substance Abuse Treatment

A great number of integrated treatment models have been discussed in the literature. Many are slight variations of others. Those discussed in this section are among the more frequently used integrated treatment models:

- Structural/strategic family therapy (Stanton 1981a ; Stanton et al. 1982)
- Multidimensional family therapy (Liddle 1999; Liddle et al. 1992, 2001)
- Multiple family therapy (Kaufman and Kaufmann 1992)
- Multisystemic therapy (Henggeler et al. 1996)
- Behavioral and cognitive–behavioral family therapy (O'Farrell and Fals-Stewart 2000)
- Network therapy (Galanter 1993)
- Bowen family systems therapy (Bowen 1974)
- Solution-focused brief therapy (Berg and Miller 1992)

Among the models in the above list, several have demonstrated effectiveness in treating substance use disorders: structural/strategic family therapy, multidimensional family therapy, multisystemic therapy, and behavioral and cognitive–behavioral family therapy. The others have not demonstrated research-based outcomes for substance abuse treatment at this point, but appear to have made inroads into the substance abuse treatment field.

As there are stages of change for individuals so have stages of change for families been conceived by combining Bepko and Krestan's stages of treatment for families (1985) and Heath and Stanton's stages of family therapy for substance abuse treatment (1998). Together, the phases of family change are

- ***Attainment of sobriety*.** The family system is unbalanced but healthy change is possible.
- ***Adjustment to sobriety*.** The family works on developing and stabilizing a new system.

- ***Long-term maintenance of sobriety***. The family must rebalance and stabilize a new and healthier lifestyle.

Combining these two models provides a simple, straightforward categorization for a family's progress in recovery regarding attainment of, adjustment to, and long-term maintenance of sobriety.

Unrealistic Expectations about Treatment Outcomes

Family members often have unrealistic expectations about treatment and the client's recovery. Family members may not understand the nature of a substance use disorder or are unable to accept that it is a chronic, relapsing disease and recovery is a lifelong process. Some family members, for instance, can be so fatigued and emotionally depleted from the stress of living with the person who abuses substances that they have unrealistic hopes for treatment. Strategies and solutions to address unrealistic expectations and common fallacies about treatment and recovery include the following:

- Informing the family early in treatment about common but unrealistic expectations
- Using a variety of formats to provide clear, understandable information about substance use disorders
- Reaching many family members

Family Response to Relapse

A family's response to relapse can have a negative impact on the client's treatment and their recovery process. Clients can relapse, and family members may be unwilling or unable to be compassionate or nonjudgmental about episodes of relapse. Typically, relapse is an unpopular topic with family members. If relapse occurs, counselors need to be prepared for a range of emotional responses from families, including anger, panic, blame, depression, spitefulness, and relief. Some families may abandon or withdraw from the client; others may attempt to engage the client in substance-using activities; still other families may be caught in patterns of depression and resignation or panic and fear.

Sabotage by Family Members

A family can sabotage the client's progress when one or more family members behave in ways that undermine the client's abstinence or treatment. For example, family members may continue to use or leave alcohol or drugs where the client is likely to see them. They may state to the client or others that the client is likely to fail or may refuse to let the client use the family car to go to a support meeting or treatment session.

Goals and Outcomes of Family Services

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One main goal of involving families in treatment is to increase family members' understanding of the client's substance use disorder as a chronic disease with related psychosocial components. Edwards (1990) states that family-based services can have the following effects:

- Increase family support for the client's recovery. Family sessions can increase a client's motivation for recovery, especially as the family realizes that the client's substance use disorder is intertwined with problems in the family.
- Identify and support change of family patterns that work against recovery. Relationship patterns among family members can work against recovery by supporting the client's substance use, family conflicts, and inappropriate coalitions.
- Prepare family members for what to expect in early recovery. Family members unrealistically may expect all problems to dissipate quickly, increasing the likelihood of disappointment and decreasing the likelihood of helpful support for the client's recovery.
- Educate the family about relapse warning signs. Family members who understand warning signs can help prevent the client's relapses.
- Help family members understand the causes and effects of substance use disorders from a family perspective. Most family members do not understand how substance use disorders develop or that patterns of behavior and interaction have developed in response to the substance-related behavior of the family member who is in treatment. It is valuable for individuals in the family to gain insight into how they may be maintaining the family's dysfunction. Counselors should help family members address feelings of anger, shame, and guilt and resolve issues relating to trust and intimacy.
- Take advantage of family strengths. Family members who demonstrate positive attitudes and supportive behaviors encourage the client's recovery. It is important to identify and build on strengths to support positive change.
- Encourage family members to obtain long-term support. As the client begins to recover, family members need to take responsibility for their own emotional, physical, and spiritual recovery.

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Addiction Treatment: The Other Side of the Coin

Chapter 7

So often I hear counselors say "this is all about the money" or "insurance controls whether people get help or they don't".

Managed Care and its Impact on Substance Abuse Treatment

Some History

The implementation of managed care has become a vital component of the United States healthcare system with outcomes being observed on cost and treatment patterns. Given the primary focus of containing costs and improving performance of services, managed care has the potential to reduce utilization and change the pattern in healthcare delivery as it relates to substance abuse treatments. The history of public substance abuse treatments emerged in the 1970s under a mental health system that encompassed administrative, financing, and regulatory structure, but, over the years, this has evolved to a smaller substance abuse treatment system compared to mental health. Managed care techniques continued to be applied to mental healthcare in the 1980s because of unprecedented, often unwarranted, expansions. The current literature on the impact of managed care on substance abuse treatment has been mixed. A study conducted by Lemak and Alexander (2001) that examined the impact of managed care on outpatient treatment providers discovered that the treatment intensity (months and number of treatments received) was negatively impacted by the strictness of managed care (average number of visits per patient that was authorized by the managed care). On the other hand, other studies such as the one conducted by Steenrod and colleagues (2001) found that managed care on substance abuse treatment can reduce the utilization of inpatient or outpatient care and resources, while at the same time achieving positive treatment outcomes.

Utilization Management

Utilization management (UM) is defined by the Institute of Medicine (IOM) Committee on Utilization Management by Third Parties (1989) as "*a set of techniques used by or on behalf of purchasers of health care benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision*".

UM is the evaluation of the appropriateness and medical need of health care services procedures and facilities according to evidence-based criteria or guidelines, and under the provisions of an applicable health benefits plan. Typically, UM addresses new clinical activities or inpatient admissions

based on the analysis of a case, but may relate to ongoing provision of care, especially in an inpatient setting.

UM describes proactive procedures, including discharge planning, concurrent planning, pre-certification and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews, as well as appeals introduced by the provider, payer or patient. A UM program comprises roles, policies, processes, and criteria.

Utilization Review

Utilization review is the process of monitoring, evaluating medical necessity, use, delivery, cost-effectiveness, appropriateness, and the efficiency of the use of health care services provided by medical professionals on a prospective, concurrent, or retrospective basis.

The utilization review process compares requests for medical services with treatment guidelines and makes recommendation based on that comparison.

Medical Necessity

When dealing with third party pay in substance abuse and mental health treatment, one of the biggest misunderstandings we have to address over and over with patients and family members is "My insurance company told me I had 30, 60, 90 days of coverage–why are they denying my treatment now when I've only been here 1, 2, or 3 weeks." Although they do have the coverage, the missing part is what insurance companies call 'medical necessity'. This is not explained by the insurance customer service representative when they tell you about your coverage. Most insurance companies operate by the following definition of medical necessity:

"Medically Necessary" or "Medical Necessity" shall mean health care services that a medical practitioner, exercising prudent clinical judgment, would provide to a Covered Individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Covered Individual's illness, injury or disease; and (c) not primarily for the convenience of the Covered Individual, physician, or other health care provider; (d) and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Covered Individual's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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Medical Necessity criteria are guidelines used by an insurance company's utilization review or care management staff–licensed registered nurses or licensed behavioral health practitioners. When the clinical information given by a treatment center meets these criteria, the cases may then be certified by the utilization review or care manager. When cases do not meet these criteria, they are sent to the insurance company's psychiatrist reviewer/peer clinical reviewer for an assessment of the case. *NOTE: Mental health services cannot be accessed by a policy holder for the sole purpose of avoiding incarceration or to satisfy a programmatic length of stay.* These criteria are not meant to be exhaustive and will not cover all clinical situations. Final authorization decisions are made by an insurance company psychiatrist reviewer/peer clinical reviewer after discussion with the treating clinician/physician from the given treatment center. The reviewing psychiatrist for the insurance company must also always take into account any specific needs of the patient (such as age, co-morbidities, complications, psychosocial situation and progress) or characteristics of the local delivery system (such as the availability of alternative levels of care) when applying the medical necessity criteria. Variations in the availability of services in different geographic and regional areas are also considered. If an indicated service is not available within the patient's community at the level of service indicated by the criteria, authorization may be given for those services at the next highest available level.

Instructor Note: Ultimately, it is not that the insurance company is denying treatment; instead they are denying a level of care because the patient does not meet medical necessity.

"NOTE: PLEASE SEE THE DEFINITION OF "MEDICALLY NECESSARY" OR "MEDICAL NECESSITY" IN THE COVERED INDIVIDUAL'S PLAN DOCUMENT FOR THE PURPOSE OF MAKING BENEFIT DETERMINATIONS. THE DEFINITION BELOW MAY NOT BE THE DEFINITION OF MEDICALLY NECESSARY WITHIN THE COVERED INDIVIDUAL'S PLAN DOCUMENT. THIS DEFINTION SHOULD NOT BE USED FOR BENEFIT DETERMINATIONS FOR A COVERED INDIVIDUAL." – Anthem Blue Cross Blue Shield

The following information on level of care descriptions is taken directly from Anthem Blue Cross Blue Shield (these descriptions will be similar across the many managed care insurance companies). These descriptions are very similar across most insurance companies. It is imperative that you learn and understand how insurance companies determine medical necessity and how they determine who gets approved for additional days.

"The attached behavioral health medical necessity criteria for each level of care include three categories, Severity of Illness, Intensity of Service and Continued Stay. Severity of Illness criteria includes descriptions of the Covered Individual's condition and circumstances. Intensity of Service criteria describes the services being provided, and these criteria must be met for admission and

continued stay. For continued authorization of the requested service, Continued Stay criteria must be met along with Severity of Illness criteria." - Anthem Blue Cross Blue Shield.

Diagnosis

Appropriate diagnoses are required for utilization management. Treatment approved for reimbursement by the Plan must have an appropriate diagnosis that is covered under the Covered Individual's Health Benefit Plan. Mental disorders are defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM V).

Level of Care Criteria and the Medical Necessity

Substance Abuse Inpatient Acute Detoxification / Patient has high potential for withdrawal, requires medical management of symptoms, 24 hr. nursing, daily doctor visits.

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: To qualify, Covered Individual's symptoms or condition must meet the diagnostic criteria for a DSM 5 or ICD-9 Substance Use Disorder - Severe diagnosis. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Must have one of the following:

1. Nature and pattern of use of abused substance (including frequency and duration) predicts the potential for clinically significant withdrawal necessitating 24-hour medical intervention to prevent complications and that is not appropriate for a lower level of care- e.g. alcohol and benzodiazepine withdrawal (note: withdrawal from stimulants or marijuana alone generally does not require a medical detoxification and opiate detoxification is often appropriate for a lower level of care).

2. Presence of active withdrawal symptoms that cannot be safely or effectively managed at a lower level of care-e.g. tremors, unstable vital signs, diaphoresis, GI disturbances, agitation, withdrawal hallucinations, confusion or disorientation or seizures.

Note: Covered Individuals who experience severe psychological withdrawal symptoms may require 24-hour care, even though they do not meet the detoxification criteria. Please refer to rehabilitation and psychiatric criteria.

INTENSITY OF SERVICE (IS)

Must have all of the following to qualify and must still meet one SI Criteria:

1. Documentation of blood and/or urine drug screen was ordered upon admission.
2. Multi-disciplinary problem-focused treatment plan which addresses psychological, social, medical, substance abuse, and aftercare needs, which is amended in a timely and appropriate manner as indicated.
3. Physician visits at least daily, seven (7) days a week.
4. 24-hour skilled nursing (by either an RN or LVN/LPN).
5. Medication management of withdrawal symptoms tailored to the Covered Individual's individual need.
6. Discharge planning is initiated on the day of admission and includes appropriate continuing care plans with the preferred outpatient visit within one week of discharge.
7. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the Covered Individual's PCP, providing treatment to the Covered Individual, and where indicated, clinicians providing treatment to other family members, is documented.
8. Evaluation for medication that may improve the member's ability to remain abstinent; document the rationale if no medication is prescribed.
9. All therapeutic services provided by licensed or certified professional in accordance with state laws.

B. CONTINUED STAY CRITERIA

Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. Progress in treatment is being documented, and the Covered Individual is still participating, following recommendations and continuing to show a level of motivation consistent with this intensity of treatment being potentially beneficial, but the symptoms and behaviors that required this level of care are still present to the extent that treatment on a lower level of care would not be sufficient.

Instructor Note: There is also a less acute level of care called Residential Treatment Detoxification. The clinical requirements are similar but they will cover DSM diagnosis of Substance Use Disorder Moderate as well as Severe.

Residential Treatment Withdrawal (Detoxification)

Medically Necessary:

To qualify, member's symptoms or condition must meet the diagnostic criteria for a DSM or ICD substance-related withdrawal diagnosis for residential treatment withdrawal (detoxification).

Severity of Illness (SI)
Nature and pattern of use of abused substance (s) (including frequency and duration) predicts the potential for clinically significant withdrawal necessitating 24-hour medical intervention to prevent complications and is not appropriate for a lower level of care for example, alcohol and benzodiazepine withdrawal (note: withdrawal from stimulants or marijuana alone generally does not require a medical withdrawal [detoxification] and opiate withdrawal [detoxification] is generally appropriate for a lower level of care).

Presence of **any** of the following may necessitate an acute hospital level of care:

a. A complicating psychiatric illness that requires inpatient treatment; **OR**
b. A withdrawal history of delirium tremens, seizures, hallucinations or acute psychotic reaction secondary to chronic alcohol use and/or polysubstance drug use; **OR**
c. An unstable medical illness that requires daily care by a consulting physician; **OR**
d. Presence of active withdrawal symptoms that cannot be safely or effectively managed at a lower level of care.

Intensity of Service (IS)
Must have **all** of the following to qualify:

1. Documentation of blood and/or urine drug screen results upon admission; **AND**
2. Multi-disciplinary problem-focused treatment plan that addresses psychological, social (including living situation and support system), medical, substance abuse and treatment (rehabilitation) needs which is re-evaluated and amended in a timely and medically appropriate manner as indicated; **AND**
3. Examination by a physician within 24 hours of admission and physician visits on a daily basis while in withdrawal (detoxification); **AND**
4. Eight hour skilled nursing (either an RN or LVN/LPN) on site with 24-hour availability. [Note: If the member's medical symptoms require 24-hour nursing care for assessment, frequent administration of medication, monitoring of vital signs and other services only provided by a nurse, then acute inpatient withdrawal (detoxification is required)]; **AND**
5. Medication management of withdrawal symptoms; **AND**
6. Discharge planning is initiated on the day of admission and includes appropriate continuing care plans; **AND**
7. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the member's PCP, providing treatment to the member, and where indicated, clinicians providing treatment to other family members, is documented; **AND**
8. Evaluation for medication that may improve the member's ability to remain abstinent; document the rationale if no medication is prescribed; **AND**

9. All therapeutic services provided by licensed or certified professional in accordance with state laws.

Continued Stay Criteria (CS)
Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. Progress in treatment is being documented and the member is not stable enough to be treated at a lower level of care.

Not Medically Necessary:

Residential treatment withdrawal (detoxification) is considered **not medically necessary** when the above criteria are not met.

Residential Treatment Center (RTC)/ 24 hr. supervised living environment, no withdrawal symptoms, required doctor visit once weekly or as needed. These are considered long term programs.

Medically Necessary:

To qualify, member's symptoms or condition must meet the diagnostic criteria for a DSM or ICD substance-related use disorder diagnosis for residential treatment center treatment.

Severity of Illness (SI)
Must meet criteria 1 or 2, as well as 3 to qualify:

1. Acute psychiatric symptoms that:
    a. Include either self-injurious or risk-taking behaviors that pose a risk of serious harm to the member and/or others and cannot be managed outside of a 24 hour structured setting; **AND**
    b. Interfere with maintaining abstinence; **AND**
    c. Represent a deterioration from their usual status; **AND**
    d. Include either self-injurious or risk taking behaviors that poses risk serious harm to the member or others and cannot be managed outside of a 24 hour structured setting; **OR**
2. Acute medical symptoms that would likely interfere with the member maintaining abstinence and recovery outside of a 24 hour structured setting; **AND**
3. Substance-related disorder is moderate or severe based on the presence of four or more current symptoms of a substance use disorder for at least one substance use disorder condition; **AND**

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Intensity of Service (IS)
Must have **all** of the following to qualify:

1. Evaluation by a qualified physician within 48 hours of admission and weekly visits by a qualified physician if dually diagnosed and psychiatric symptoms identified as a reason for admission requiring this level of care; **AND**
2. Physical exam and lab tests done within 48 hours if not done prior to admission, and eight hour on-site nursing (by either an RN or LVN/LPN) with 24 hour medical availability to manage medical problems if medical instability identified as a reason for admission requiring this level of care; **AND**
3. Programming provided will be consistent with the member's language, cognitive, speech and/or hearing abilities; **AND**
4. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the member's PCP, providing treatment to the member, and where indicated, clinicians providing treatment to other family members, is documented; **AND**
5. Within 48 hours, an individualized, problem-focused treatment plan is done, based on completion of a detailed personal substance use history, including identification of consequences of use and identifying individual relapse triggers as goals; **AND**
6. The treatment would include the following at least once per day, and each lasting 60-90 minutes: community/milieu group therapy, group psychotherapy and activity group therapy; **AND**
7. Family supports identified and contacted within 48 hours and family/primary support person participation in treatment at least weekly unless contraindicated. For adolescents, this includes weekly individual family therapy, unless clinically contraindicated; **AND**
8. Discharge planning completed within one week of admission including identification of community/family resources, sober supports, connection or re-establishment of connection to community based recovery programs and professional aftercare treatment; **AND**
9. Drug screens used after all off-grounds activities and whenever otherwise indicated; **AND**
10. All therapeutic services provided by licensed or certified professionals in accordance with state laws; **AND**
11. The treatment is individualized and not determined by a programmatic timeframe. It is expected that members will be prepared to receive the majority of their treatment (rehabilitation) in a community setting; **AND**
12. Evaluation for medication that may improve the member's ability to remain abstinent; document the rationale if no medication is prescribed; **AND**
13. All therapeutic services provided by licensed or certified professional in accordance with state laws.

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Continued Stay Criteria (CS)
Must continue to meet "SI/IS" Criteria and have **all** the following to qualify:

1. Progress toward all goals in the treatment plan must be documented in weekly treatment plan reviews. If progress is not being achieved, then the treatment plan must be revised with achievable treatment goals; **AND**
2. The member is still participating, following recommendations and continuing to show a level of motivation such that treatment goals can be achieved.

Not Medically Necessary:

Residential treatment is considered **not medically necessary** when the above criteria are not met.

Partial Hospitalization Program (PHP)/ also called "Day Treatment". This is a medically monitored outpatient level of care providing 6 to 8 hours of service daily. The patient usually sleeps at home, however there are more programs where the clients stay in a community-based residence.

Medically Necessary:

To qualify, member's symptoms or condition must meet the diagnostic criteria for a DSM or ICD substance-related use disorder diagnosis for partial hospitalization program (PHP) treatment. Co-morbid psychiatric conditions frequently occur and should be assessed upon admission.

Severity of Illness (SI)
Must have **all** of the following to qualify:

1. Symptoms or behaviors that could be treated must be present that would likely progress to a level of dangerousness or failure of self-care that would require inpatient treatment without a structured treatment setting of at least six hours duration a day; **AND**
2. Substance-related disorder is moderate or severe based on the presence of four or more current symptoms of a substance use disorder for at least one substance use disorder condition; **AND**
3. The member does not also meet criteria for IOP; **AND**
4. PHP could help stabilize the social environment to an extent that would allow continued treatment of member at a lower level of care; **AND**
5. The member has demonstrated a level of motivation that is consistent with PHP level treatment being of potential benefit; if the primary purpose of PHP is for motivational enhancement, then there must be evidence of psychiatric or medical risks that are too high for treatment at a lower level of care.

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Intensity of Service (IS)
Must have **all** of the following to qualify:

1. Multidisciplinary treatment provided at least six hours a day (unless defined differently by local state law). The frequency of attendance per week may vary according to clinical needs and progress, a minimum number of times per week four or five times per week; **AND**
2. Nursing and MD treatment is documented if needed as evidenced by acute medical or psychiatric interventions being listed on the treatment plan; **AND**
3. Programming provided is consistent with the member's language, cognitive, speech and/or hearing abilities; **AND**
4. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the member's PCP, providing treatment to the member at least one time a week, and where indicated, clinicians providing treatment to other family members, is documented; **AND**
5. An individualized treatment plan is implemented with anticipated dates of completion that are tied to the member's needs, not a fixed program schedule, and includes:
    a. Completion of a personal substance abuse history with acknowledgement of consequences of use.
    b. Initiation or continuation of relapse/recovery program with identification of relapse triggers.
    c. Goal of attendance at community-based recovery programs-to be attended at least two times per week or documented rationale as to why this should not be required.
    d. Drug screens are obtained on a random basis with evidence of an adjustment to the treatment plan if results are positive.
    e. Family involvement in treatment as appropriate. For adolescents this should include individual family sessions at least one time each week, unless clinically contraindicated; **AND**
6. If a behavioral health diagnosis is present requiring active treatment or the facility is providing dual diagnosis services, qualified physician visits are documented as necessary; **AND**
7. All therapeutic services are provided by licensed or certified professionals in accordance with state requirements; **AND**
8. The treatment is individualized and not determined by a programmatic timeframe. It is expected that members will be prepared to receive the majority of their treatment (rehabilitation) in a community setting; **AND**
9. Evaluation for medication that may improve the member's ability to remain abstinent; document the rationale if no medication is prescribed; **AND**
10. The member resides in a community setting while receiving partial hospitalization services and is not in a 24-hour residential treatment setting; **AND**
11. Treatment would include the following at least once a day and each lasting 60-90 minutes: community/milieu group therapy, group psychotherapy, and activity group therapy.

Continued Stay Criteria (CS)
Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. Progress toward treatment goals is being documented, as shown by continued participation, abstinence, and adherence to treatment recommendations, and if no progress noted or relapse occurs, the treatment plan is re-evaluated and amended such that progress will be likely.

Not Medically Necessary:

Partial hospitalization program is considered **not medically necessary** when the above criteria are not met.

Intensive Structured Outpatient Program (IOP)/ this is a non-medically monitored outpatient level of care. Groups typically meet 3 to 4 nights a week for 3 to 4 hours, averaging 10 hours per week. An abuse diagnosis can qualify a patient for treatment at an IOP level of care.

Medically Necessary:

To qualify, member's symptoms or condition must meet the diagnostic criteria for a DSM or ICD substance-related use disorder diagnosis for IOP treatment. Co-morbid psychiatric conditions frequently occur and should be assessed upon admission. IOP level of care may be appropriate for the first attempt at treatment (rehabilitation). The structure and educational benefits of this level of care compared to individual outpatient may lead to better outcomes for certain members.

Severity of Illness (SI)
Must meet **all** of the following to qualify:

1. The pattern of substance use and behavior is unlikely to change with outpatient treatment and community resources alone. However, the member is able to live safely in the community with adequate functioning; **AND**
2. There is evidence that the member is motivated, as evidenced by an expression of an interest or desire to work towards the goals of treatment and recovery at the time of admission or shortly thereafter; **AND**
3. The member's social system and significant others are supportive of recovery, and the member demonstrates the motivation, social and cognitive skills to develop a sober support system.

Intensity of Service (IS)
Must have **all** of the following to qualify:

1. Treatment services offered at least three treatment hours per day at least three times per week; **AND**
2. Programming provided will be consistent with the member's language, cognitive, speech and/or hearing abilities; **AND**
3. Implementation of individualized, problem-focused treatment plan which includes, but is not limited to:
    a. Completion of personal substance abuse history with acknowledgment of consequences of use.
    b. Initiation or continuation of relapse/recovery program with identification of relapse triggers.
    c. Attendance at community-based recovery programs - to be attended at least three times per week.
    d. Drug screens as clinically appropriate and at random and an intervention plan to address drug use while in treatment.
    e. Family program and involvement in treatment as appropriate. For adolescents, at least one time each week, unless clinically contraindicated.
    f. The program has provisions for member to access psychiatric treatment for a dual diagnosis, as needed; **AND**
4. Discharge planning is initiated on the day of admission and includes appropriate continuing care plans; **AND**
5. All therapeutic services are provided by licensed or certified professionals in accordance with state requirements; **AND**
6. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the member's PCP, providing treatment to the member, and where indicated, clinicians providing treatment to other family members, is documented; **AND**
7. The treatment is individualized and not determined by a programmatic timeframe. It is expected that members will be prepared to receive the majority of their treatment (rehabilitation) in a community setting; **AND**
8. Evaluation for medication that may improve the member's ability to remain abstinent; document the rationale if no medication is prescribed; **AND**
9. The member resides in a community setting while receiving intensive outpatient program services and is not in a 24-hour residential treatment setting

Continued Stay Criteria (CS)
Must continue to meet "SI/IS" Criteria **and** have the following to qualify:

1. Progress toward treatment goals is being documented, as shown by continued participation, abstinence, and adherence to treatment recommendations, and if no progress noted or relapse occurs, the treatment plan is re-evaluated and amended such that progress will be likely.

Not Medically Necessary:

Intensive structured outpatient program is considered **not medically necessary** when the above criteria are not met.

The above criteria are specific to Blue Cross Blue Shield Anthem. Each insurance company defines criteria for various level of addiction treatment using their own language. There are similarities across the board.

The Role of the Addiction Counselor in Utilization Management

Even though dealing with insurance companies is a specific job held by UR/UM, staff counselor contribution is essential in getting your clients much needed additional days in treatment. The UM at an addiction treatment facility/program relies on the clinical information about individual clients provided by primary counselors. Counselors are expected to provide clinical details about their clients to the UM that will help the UM be successful in obtaining more covered days for the client; and in this time of very very short lengths of stay obtaining additional covered days are more essential than ever before. Statistics continue to show that one of the top three factors in long term recovery success for clients is length of stay in treatment.

Now, to be clear, this does NOT! Mean you fabricate symptoms or embellish client mental status presentation, NO! What is necessary is for the counselor to have a thorough grasp on how to verbalize and **DOCUMENT** what is going on with client, mentally, emotionally, physically, psychologically and medically. UM's frequently have difficulty obtaining additional days, not because the client does truly need the additional days but the counselor has neglected to accurately and consistently document the client's status in all the areas mentioned above.

Part of being a professional addiction counselor is to be good clinician who recognizes their obligation to document, document, document.

Confidentiality and Third Party Insurers

Confidentiality is a key element of mental health and substance abuse treatment. In the course of therapy, clients reveal personal, highly sensitive information that they may not reveal to anyone else. Clients trust that this information will be kept confidential by the clinician/therapist. In affirming what is known as psychotherapist-patient privilege, the United States Supreme Court (Jaffe v. Redmond, 518 U.S.1 (1996)), stated not only that it is in the public interest to allow patients to access

effective mental health and substance abuse treatment but also that effective psychotherapy depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. In the absence of this assurance of confidentiality, many individuals with mental and emotional disorders might refuse or fail to seek treatment, going without needed services.

As the payer for this treatment, however, a third-party insurer, such as a managed care organization (MCO) or insurance company, has a right to know what the services are for which payment is being requested and whether the treatment is appropriate. Before paying the claim, therefore, the payer requests some personal health information, such as the patient's presenting problem, health status, and/or treatment planned or received. The amount of personal health information required to pay claims varies by payer; some require only basic information, such as the patient's diagnosis and services received, while others require more detailed information on the patient's symptoms and specific treatment goals and outcomes. The dual, but opposing, needs for confidentiality and disclosure have created tension between providers and payers of services. The "Minimum Necessary" Principle.

The Standards for Privacy of Individually Identifiable Health information (45 CFR parts 160 and 164), published by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (PL 104-191), state that entities subject to the regulation (including MCOs) must limit the request for protected health information to the information reasonably necessary to accomplish the purpose for which the request is made (§ 164.514(d)(4)). This language reflects both the need to accommodate the range of MCO payment and operational activities and the lack of consensus and models on which to base more specific language and the absence of policymaker consensus as to how to resolve the tradeoff between meeting this need and the patient need for confidentiality.

The "Minimum Necessary" Principle

The Standards for Privacy of Individually Identifiable Health information (45 CFR parts 160 and 164), published by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (PL 104-191), state that entities subject to the regulation (including MCOs) limit the request for protected health information to the information reasonably necessary to accomplish the purpose for which the request is made (§ 164.514(d)(4)). This language reflects both the need to accommodate the range of MCO payment and operational activities and the lack of consensus and models on which to base more specific language and the absence of policymaker

consensus as to how to resolve the tradeoff between meeting this need and the patient need for confidentiality.

Privacy Issues under Managed Care

Third-party requests for information on mental health treatment before paying for services is not a recent phenomenon. Even under fee-for-service arrangements, insurers generally required mental health providers to disclose the patient diagnosis, and sometimes the treatment plan, before reimbursing for these services (Acuff et al. 1999). However, as mental health and substance abuse treatment costs outpaced even the rising costs of care in general in the 1980s, the pressure to move to a managed care system mounted significantly. In this new approach to cost containment, MCOs would play a more active role in monitoring and overseeing the delivery of care in order to minimize abuses and attempt to ensure that care was provided in a cost-effective manner.

Before paying for services, MCOs must ensure that the enrollee is eligible for benefits, that the clinician is an authorized provider, and that services paid for actually took place. MCOs therefore require the enrollees identification number, the diagnosis, a description of the services performed and dates of service, the name of the provider, and the amount of charges. MCOs may also need information to satisfy specific conditions of coverage; for example, if benefits are limited to a certain number of visits each year, the plan will need to know how many times the patient has been seen to date.

In addition to paying for services, MCOs undertake a variety of other activities that depend on having health information about enrollees receiving treatment. These activities, described below along with the patient information required for each, include utilization management, quality management, and other care management:

- ***Utilization Management.*** In order to contain costs, MCOs may establish criteria for medical necessity with regard to inpatient or outpatient treatment, and criteria for the level of care appropriate to the situation. MCO staff review the case before payment is authorized to ensure that the proposed treatment meets the criteria. This review process, known as pre-authorization (Kongstvedt 1996), involves the use of information on the patients history, diagnosis, symptoms, treatment, and progress.
- ***Quality Management.*** The purpose of quality management in managed behavioral health organizations is typically to prevent quality of care concerns from arising, to address these concerns if they do arise, and to respond to complaints regarding specific cases or specific providers (Kongstvedt 1996). Quality management activities may include audits, in which MCO staff visit the facility at which care is provided to review either a sample of a providers charts or specific charts when a concern is raised about a specific case. MCOs

may also evaluate providers by profiling and comparing treatment outcomes practice by practice.

- ***Other Care Management.*** MCOs may seek to promote quality of care and continuity of care, particularly for those with high service use. Clinically trained case managers may work to direct the patient to the most appropriate level of care, coordinate care between providers, refer the patient to other community services, and may serve as a contact person for patients between visits to a provider (Kongstvedt 1996). Such care managers may use detailed information on the patient's diagnosis and treatment.

Although MCOs vary widely in the extent to which they perform these functions and in their reasons for collecting patient health information, all of the MCOs surveyed said that they reserve the right to view the full medical record of any member at any time. Therefore, all mental health and substance abuse treatment information is potentially available to the MCO.

Legal and Regulatory Context

The federal government has established several laws and regulations intended to protect the privacy of health care information. The best-known are the privacy regulations, mentioned earlier and established by the Secretary of Health and Human Services in 2000 pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA; PL 104-191). Except when a patient signs an authorization for a non-routine disclosure of patient health information, the regulations require covered entities must limit the request for protected health information to the information reasonably necessary to accomplish the purpose for which the request is made (§ 164.514(d)(4)), although what constitutes minimum necessary information is not further clarified.

There are also special federal protections for substance abuse records. Specifically, medical records of patients in Federally assisted substance abuse treatment programs are subject to a Federal law restricting their use and disclosure (Public Health Service Act §543, 42 U.S.C. 290dd-2; regulation at 42 CFR part 2). Information may only be disclosed to third party payers if the patient signs an authorization. The regulation requires certain elements to be included in the authorization, including:

- The specific name or the general description of the program or person permitted to make the disclosure;
- The name or title of the individual or the name of the organization to which the disclosure is to be made;
- The name of the patient;
- The purpose of the disclosure;
- How much and what kind of information is to be disclosed;

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- The signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent or, when required for a person who is incompetent or deceased, the signature of a person authorized to sign in lieu of the patient;
- The date on which the consent is signed;
- A statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it; and
- The date, event or condition upon which the consent will expire if not revoked before (§ 2.31).

Despite the additional confidentiality requirements for substance abuse records, the substance abuse provisions do not restrict information shared with payers for purposes of payment, assuming an authorization has been signed. However, a study by the National Mental Health Association (NMHA 1999) of MCO confidentiality practices found that only a minority of MCOs studied described these requirements in their internal policies and offered guidance on executing them.

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Research Shows:

New Addiction Treatment Practices and Where Research is Taking Addiction Treatment

Chapter 8

Evidence-Based Practices: What does this mean anyway?

Definition: Applying the best available research results (evidence) when making decisions about health care. Health care professionals who perform evidence-based practice use research evidence along with clinical expertise and patient preferences. Evidence-based practices can be defined as interventions that have shown consistent scientific evidence of being related to preferred client outcomes

We know that the government is placing greater emphasis on outcome improvement and accountability. Future funding for community agencies will increasingly be tied to treatment outcomes. There will continue to be increased pressure on agencies and researchers to collaborate on projects that connect science and services within treatment settings. This alone indicates a need for practitioners to increase their awareness and use of scientific research findings.

It is also important to note, however, that client retention in addiction treatment is also tied to positive outcomes. The longer patients are engaged in treatment activities, the better the outcomes are. If specific treatment methods demonstrate improved retention rates they may be preferable to some existing practices.

These positive outcomes can be documented in the following ways:

- **Multiple Randomized Clinical Trials** - In a multiple randomized clinical trial, an intervention or practice is used in a number of community treatment agencies, and is found to have a positive impact with different client groups in a number of settings.
- **Consensus Reviews** - Consensus reviews are extensive examinations conducted by a review panel of the available scientific literature in a variety of disciplines (i.e., addictions, mental health, physical rehabilitation, nutrition).
- **Expert Opinion Based on Clinical Observation** - Expert opinions are a subjective way of documenting whether a particular practice leads to positive client outcomes. They are based on the personal experiences of the observer.

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Along with the adoption and implementation of evidence-based practices addiction treatment has also become highly aware of the benefits of running treatment programs from a "best practices" delivery of services. Like evidence-based practices the use of "best practices" aids in achieving successful outcomes, meeting regulatory requirements/suggestions and providing clients with proven best quality and up to date clinical care.

National Registry of Effective Programs and Practices

To help its practice and policymaking constituents learn more about evidence-based programs, SAMHSA's Center for Substance Abuse Prevention created the National Registry of Effective Programs and Practices (NREPP), a resource to review and identify effective programs derived primarily from existing scientific literature, effective programs assessed by other rating processes, SAMHSA, and solicitations to the field.

Scientifically-Based Approaches to Addiction Treatment

- Cognitive–behavioral interventions
- Community reinforcement
- Motivational enhancement therapy
- 12-step facilitation
- Contingency management
- Pharmacological therapies
- Systems treatment

What Does All This Mean?

- We have an opportunity to improve treatment services.
- There are effective and cost-efficient treatments available for alcohol and drug dependence

Challenges in Implementing Evidence-Based Practices

- There is uncertainty about the most appropriate care
- Few practitioners apply scientific findings about the best care
- Little information is available about standard practices
- Technology and costs change rapidly

- Difficult to implement
  - specialized training and supervision may be required
- Organization of care
  - inadequate access to physicians for medications
- Financing issues
  - approaches may not be reimbursed
- Perceived incompatibility with current agency values

Best Practices

The purpose of *best practice* documents is to guide treatment program planning and to outline processes that facilitate dissemination of research-based intervention strategies to clinical settings. The content of these documents often includes guidelines for service delivery, such as recommended scope of services, assessment and intervention techniques, considerations when treating special populations, and processes for coordinating treatment with other types of services. As such, best practice documents often inform policy by describing optimum standards of treatment service delivery for addicted populations and subgroups with special needs. These recommendations may also inform the advancement of standards for training of clinicians in the addiction field.

Instructor Note: Another important result of treatment programs implementing best practices that were determined to be best practices through the research and trials of evidence-based practices. The table below indicates former techniques and practices used in addiction treatment that are now discredited through the process of evidence-based practices. Our client's well-being, recovery and healing are dependent upon research and the implementation of scientifically proven treatment methods.

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Table 3
Discredited Techniques in Addiction Treatment

Certainly Discredited
Electrical stimulation of the head
Past-life therapy
Electric shock therapy
Psychedelic medication
Ultra-rapid opioid detoxification under anesthesia for alcohol dependence
Neuro-Linguistic Programming
Scared Straight
Stimulant medications for alcohol dependence
Probably Discredited
DARE prevention programs
Synanon-style boot camps
Apomorphine for alcohol dependence
Lithium carbonate for alcohol dependence

Research & Clinical Outcomes

Clinical practices and their relation to research can be placed on an evidence continuum ranging from multiple studies using randomized assignment of patients in clinical settings to no evidence that supports the efficacy or efficiency of the practice. The practices in this database have met the following minimum criteria:

- Research: The practice has been subjected to scientific study that included randomized controlled trials, quasi-experimental studies, or in some cases a less rigorously controlled research design. For the most part the research has been published in a peer-reviewed journal.
- Meaningful Outcomes: The practice has resulted in benefits to the individuals receiving the service. It has helped consumers achieve desired outcomes related to treatment goals and objectives.
- Standardization: The practice or intervention has been standardized so that it can be replicated. Standardization typically involves a published description that clearly defines the nature of the practice, the audience for whom it is intended and the desired impact of the practice on the

individuals receiving it. Thorough instructions are available, as well as copies of printed materials and other tools needed to implement the practice.

- Replication: The interventions and practices included in the database have been studied in more than one setting and findings have yielded consistent results.
- Fidelity Measure: A fidelity measure either exists or could be developed from available information. Such measures allow practitioners to verify that an intervention is being implemented in a manner consistent with the protocol evaluated in the research.

Benefits of Research and Outcome Measures for Addiction Treatment

Continued research and outcomes promote treatment interventions that have high-quality outcomes, and encourage studies of the outcome of each step of the full continuum of services for substance-related disorders. Determining the most salient dimensions of treatment effectiveness is challenging. Relevant derivative questions include "what kind of treatment?" and "for what kind of condition?" as well as "what aspect of effectiveness?" and "quality as defined by whom?"

The multiple, often overlapping reasons for conducting outcome evaluation should be recognized, as should the often differing motivations of various parties who have interest in outcomes data. For example:

- A provider may be interested in measures of continuity of care, time in treatment versus treatment dropout, patient satisfaction, and the thoroughness and accuracy of patient screening, patient placement, and the processes of treatment.
- A managed behavioral health care organization (MBHO) may be interested in measures of access to care, performance indicators, quantifiable symptom reduction, quality of consultations, and referral to ongoing services.
- An employer may be more interested in measures of continued employment, productivity, safety, absenteeism, and utilization of benefits.
- Public policy makers may be interested in measures that reflect changes in the social and economic costs of addiction, such as public health, social welfare, and criminal justice expenditures. They may also be interested in the influence on treatment outcome of access to private and/or publicly funded health insurance benefits.

Instructor Note: Ultimately the main benefits of both research and outcome measures ate three-fold:

1. ***Improve efficacy of treatment protocols***
2. ***Improve outcomes for clients***
3. ***Keep addiction treatment open, available and accessible to all those who are in need of help.***

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Conclusion

Instructor: There has been a lot of information provided in this booklet. Treatment Knowledge is a very broad topic, in truth each of the topics covered here in chapter format could really be a class on its own. There is so much to learn, the learning never stops, hopefully. Professional addiction counselors are expected to have a substantial knowledge base in many areas and not just the ones covered here. As important as it is to know and understand all aspects of treatment and recovery it is equally important to understand that learning takes practicing and practicing takes time. Counselors starting out need to focus on learning one, maybe two things at a time, in depth and only practice within the scope of what they do know, in-depth. Understanding that reading a few articles, passing an exam and/or attending a few trainings on a particular topic does NOT equip anyone to state they are experts or specialize in that area. With regular clinical supervision counselors begin to put into practice what they have learned. With practice and professional guidance you will become an expert at whatever you set your mind. Being a professional requires following ethical and practice guidelines to the letter, becoming a clinician requires professionally guided and monitored practice.

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