The Iraq Drug Demand Reduction Initiative

Iraqi Clinician Substance Use Training I

5-24 February 2012
Cairo, EGYPT

UCLA – SAMHSA – Baghdad Medical City – Cairo University

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UCLA – Cairo University Substance Use Training I

DAILY CLASSROOM LEARNING SCHEDULE
5-9 February 2012 (Week 1)

Daily Plan: Each didactic training day will begin at 9:30AM and end at 5:00PM. Refreshment breaks are at 11AM & 3PM, with a mid-day break at 12:30PM. All classroom sessions will be conducted at CU Kasr el Ainy Psychiatric Hospital, by a team of UCLA – Kasr el Ainy faculty members.

**DAY 1 – Sunday 5 February (Sections 1-4)**

1. Day 1A (early morning): **INTRODUCTION TO PSYCHOACTIVE DRUGS** - Dr. Samir Abolmagd
   - Treatnet VOL B, M1, W1, Slides 1-37

2. Day 1B (late morning): **PSYCHOACTIVE DRUGS** - Dr. Samir Abolmagd
   - Treatnet VOL B, M1, W1, Slides 38-70

3. Day 1C (early afternoon): **INTRODUCTION TO BASIC COUNSELING SKILLS**
   - Treatnet VOLB, M1, W3, Slides 107-145

4. Day 1D (late afternoon): **BASIC COUNSELING SKILLS ROLE-PLAY**
   - Case Studies Handout

**DAY 2 – Monday 6 February (Sections 5-8)**

5. Day 2A (early morning): **PRINCIPLES OF DRUG ADDICTION TREATMENT**
   - Treatnet VOL B, M1, W2, Slides 73-88 + UCLA’s Continuum of Care Slides 1-11

6. Day 2B (late morning): **COUNSELING PRINCIPLES (THE COUNSELING RELATIONSHIP)**
   - UCLA’s Counseling Principles Introduction Slides 1-31

7. Day 2C (early afternoon): **BASIC COUNSELING SKILLS – TEACHING CLIENTS NEW SKILLS**
   - Treatnet VOLB, M1, W3, Slides 146-160

8. Day 2D (late afternoon): **WORKING WITH FAMILIES** – Dr. Maha Mobasher
   - Treatnet VOLB, M1, W4, Slides 168-191 + Kasr el Ainy Family Therapy Slides 1-45
DAY 3 – Tuesday 7 February (Sections 9-12)

9. Day 3A (early morning): BASIC PSYCHIATRIC TERMINOLOGY – Dr. Mohamed Ezat
   • Kasr el Ainy Psychiatric Terminology Slides 1-25

10. Day 3B (late morning): ETHICS
    • UCLA Ethics Slides 1-31 + Treatnet Ethics case study slide #103 in VOLB, M1, W2

11. Day 3C (early afternoon): MORE COUNSELING SKILLS ROLE-PLAY
    • Exercises & Case Studies Handout

12. Day 3D (late afternoon): CRISIS INTERVENTION
    • UCLA Crisis Intervention Slides 1-22 + Case Studies Handout

DAY 4 – Wednesday 8 February (Sections 13-16)

    • Treatnet VOL A, M2, Slides 1-39

14. Day 4B (late morning): ASSESSMENT (CONTINUED)
    • Treatnet VOL A, M2, Slides 40-79

15. Day 4C (early afternoon): ASSESSMENT ROLE-PLAY
    • Practice Using the Arabic ASI

16. Day D (late afternoon): ASSESSMENT ROLE-PLAY (CONTINUED)
    • Practice Using the Arabic ASI

DAY 5 – Thursday 9 February (Sections 17-20)

17. Day 5A (early morning): TREATMENT PLANNING
    • Treatnet VOL A, M3, W1, Slides 6-35

18. Day 5B (late morning): PATIENT PLACEMENT – Dr. Rania Mamdouh
    • Kasr el Ainy Patient Placement Criteria Slides 1-31

19. Day 5C (early afternoon): TREATMENT PLANNING AND PATIENT PLACEMENT: INTAKE
    • UCLA Intake Process Slides 1-21 + Case Studies Handout

20. Day 5D (late afternoon): SITE VISIT PREPARATION
    • Objectives, Daily Schedule, Post-Briefings
Section 1: Introduction to Psychoactive Drugs

Module 1: Training goals

1. Increase knowledge of the biology of drug addiction, principles of treatment, and basic counselling strategies
2. Increase skills in basic counselling strategies for drug addiction treatment
3. Increase application of basic counselling skills for drug addiction treatment activities
Module 1: Workshops

- Workshop 1: Biology of Drug Addiction
- Workshop 2: Principles of Drug Addiction Treatment
- Workshop 3: Basic Counselling Skills for Drug Addiction Treatment
- Workshop 4: Special Considerations when Involving Families in Drug Addiction Treatment

Icebreaker: If I were the President

If you were the President (King, Prime Minister, etc.) of your country, what 3 things would you change related to drug policies, treatment, and / or prevention?

15 minutes

Workshop 1: Biology of Drug Addiction
Pre-assessment

Please respond to the pre-assessment questions in your workbook.

(Your responses are strictly confidential.)

10 minutes

Training objectives

At the end of this workshop you will be able to:
1. Understand the reasons people start drug use
2. Identify 3 main defining properties of drug addiction
3. Identify 3 important concepts in drug addiction
4. Understand characteristics and effects of major classes of psychoactive substances
5. Understand why many people dependent on drugs frequently require treatment

Introduction to Psychoactive Drugs
What are psychoactive drugs? (1)

“...Any chemical substance which, when taken into the body, alters its function physically and/or psychologically....”

(World Health Organization, 1989)

“...any substance people consider to be a drug, with the understanding that this will change from culture to culture and from time to time.”

(Krivanek, 1982)

What are psychoactive drugs? (2)

Psychoactive drugs interact with the central nervous system (CNS) affecting:

- mental processes and behaviour
- perceptions of reality
- level of alertness, response time, and perception of the world

Why do people initiate drug use? (1)

Much, if not most, drug use is motivated (at least initially) by the pursuit of pleasure.
Why do people initiate drug use? (2)

Key Motivators & Conditioning Factors
- Forget (stress / pain amelioration)
- Functional (purposeful)
- Fun (pleasure)
- Psychiatric disorders
- Social / educational disadvantages

Also, initiation starts through:
- Experimental use
- Peer pressure

Why do people initiate drug use? (3)

After repeated drug use, "deciding" to use drugs is no longer voluntary because

DRUGS CHANGE THE BRAIN!

What is Drug Addiction?
What is drug addiction?

Drug addiction is a complex illness characterised by compulsive, and at times, uncontrollable drug craving, seeking, and use that persist even in the face of extremely negative consequences.

Characteristics of drug addiction

- Compulsive behaviour
- Behaviour is reinforcing (rewarding or pleasurable)
- Loss of control in limiting intake

Important terminology

1. Psychological craving
2. Tolerance
3. Withdrawal symptoms
Psychological craving

Psychological craving is a strong desire or urge to use drugs. Cravings are most apparent during drug withdrawal.

Tolerance

Tolerance is a state in which a person no longer responds to a drug as they did before, and a higher dose is required to achieve the same effect.

Withdrawal

The following symptoms may occur when drug use is reduced or discontinued:

- Tremors, chills
- Cramps
- Emotional problems
- Cognitive and attention deficits
- Hallucinations
- Convulsions
- Death
# Drug Categories

## Classifying psychoactive drugs

<table>
<thead>
<tr>
<th>Depressants</th>
<th>Stimulants</th>
<th>Hallucinogens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Amphetamines</td>
<td>LSD, DMT</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Methamphetamine</td>
<td>Mescaline</td>
</tr>
<tr>
<td>Opioids</td>
<td>Cocaine</td>
<td>PCP</td>
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<tr>
<td>Solvents</td>
<td>Nicotine</td>
<td>Ketamine</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>Khat</td>
<td>Cannabis (high doses)</td>
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<tr>
<td>Cannabis (low doses)</td>
<td>Caffeine</td>
<td>Magic mushrooms</td>
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<tr>
<td></td>
<td>MDMA</td>
<td>MDMA</td>
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## Alcohol

![Image of alcohol bottles and glasses](image-url)
Alcohol: Basic facts (1)

**Description:** Alcohol or ethylalcohol (ethanol) is present in varying amounts in beer, wine, and liquors

**Route of administration:** Oral

**Acute Effects:** Sedation, euphoria, lower heart rate and respiration, slowed reaction time, impaired coordination, coma, death

Alcohol: Basic facts (2)

**Withdrawal Symptoms:**
- Tremors, chills
- Cramps
- Hallucinations
- Convulsions
- Delirium tremens
- Death

Long-term effects of alcohol use

- Decrease in blood cells leading to anemia, slow-healing wounds and other diseases
- Brain damage, loss of memory, blackouts, poor vision, slurred speech, and decreased motor control
- Increased risk of high blood pressure, hardening of arteries, and heart disease
- Liver cirrhosis, jaundice, and diabetes
- Immune system dysfunction
- Stomach ulcers, hemorrhaging, and gastritis
- Thiamine (and other) deficiencies
- Testicular and ovarian atrophy
- Harm to a fetus during pregnancy
Tobacco

Tobacco: Basic facts (1)

**Description:** Tobacco products contain nicotine plus more than 4,000 chemicals and a dozen gases (mainly carbon monoxide)

**Route of administration:** Smoking, chewing

**Acute Effects:** Pleasure; relaxation; increased concentration; release of glucose; increased blood pressure, respiration, and heart rate

Tobacco: Basic facts (2)

**Withdrawal Symptoms:**
- Cognitive / attention deficits
- Sleep disturbance
- Increased appetite
- Hostility
- Irritability
- Low energy
- Headaches
Long-term effects of tobacco use

- Aneurysm
- Cataracts
- Cancer (lung and other types)
- Chronic bronchitis
- Emphysema
- Asthma symptoms
- Obstructive pulmonary diseases
- Heart disease (stroke, heart attack)
- Vascular disease
- Harm to a fetus during pregnancy, low weight at birth
- Death

Cannabinoids

Marijuana

Hashish

Cannabis: Basic facts (1)

**Description:** The active ingredient in cannabis is delta-9-tetrahydrocannabinol (THC)
- **Marijuana:** tops and leaves of the plant Cannabis sativa
- **Hashish:** more concentrated resinous form of the plant

**Route of administration:**
- Smoked as a cigarette or in a pipe
- Oral, brewed as a tea or mixed with food
Activity 1
Think of all the names for marijuana in your community and how this drug is consumed.
Share your thoughts with the rest of the group.

Cannabis: Basic facts (2)
Acute Effects:
- Relaxation
- Increased appetite
- Dry mouth
- Altered time sense
- Mood changes
- Bloodshot eyes
- Impaired memory
- Reduced nausea
- Increased blood pressure
- Reduced cognitive capacity
- Paranoid ideation

Cannabis: Basic facts (3)
Withdrawal Symptoms:
- Insomnia
- Restlessness
- Loss of appetite
- Irritability
- Sweating
- Tremors
- Nausea
- Diarrhea
Long-term effects of cannabis use

- Increase in activation of stress-response system
- Amotivational syndrome
- Changes in neurotransmitter levels
- Psychosis in vulnerable individuals
- Increased risk for cancer, especially lung, head, and neck
- Respiratory illnesses (cough, phlegm) and lung infections
- Immune system dysfunction
- Harm to a fetus during pregnancy
Section 2: Psychoactive Drugs

Stimulants

Types of stimulants (1)

Amphetamine Type Stimulants (ATS)
- Methamphetamine
  - Speed, crystal, ice, yaba, shabu
- Amphetamine
- Pharmaceutical products used for ADD and ADHD

Methamphetamine half-life: 8-10 hours
Types of stimulants (2)

Cocaine
- Powder cocaine (Hydrochloride salt)
- Smokeable cocaine (crack, rock, freebase)

Cocaine half-life: 1-2 hours

Activity 2
What stimulants are used in your community and how are they consumed?

Share your thoughts with the rest of the group.

Stimulants: Basic facts (1)

Description:
Stimulants include: (1) a group of synthetic drugs (ATS) and (2) plant-derived compounds (cocaine) that increase alertness and arousal by stimulating the central nervous system

Route of administration:
Smoked, injected, snorted, or administered by mouth or rectum
Stimulants: Basic facts (2)

**Acute effects:**
- Euphoria, rush, or flash
- Wakefulness, insomnia
- Increased physical activity
- Decreased appetite
- Increased respiration
- Hyperthermia
- Irritability
- Tremors, convulsions
- Anxiety
- Paranoia
- Aggressiveness

Stimulants: Basic facts (3)

**Withdrawal symptoms:**
- Dysphoric mood (sadness, anhedonia)
- Fatigue
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Craving
- Increased appetite
- Vivid, unpleasant dreams

Long-term effects of stimulants

- Strokes, seizures, headaches
- Depression, anxiety, irritability, anger
- Memory loss, confusion, attention problems
- Insomnia, hypersomnia, fatigue
- Paranoia, hallucinations, panic reactions
- Suicidal ideation
- Nosebleeds, chronic runny nose, hoarseness, sinus infection
- Dry mouth, burned lips, worn teeth
- Chest pain, cough, respiratory failure
- Disturbances in heart rhythm and heart attack
- Loss of libido
- Weight loss, anorexia, malnourishment,
- Skin problems
Methamphetamine use leads to severe tooth decay

"Meth Mouth"

(New York Times, June 11, 2005)

Opioids

- Opium
- Heroin
- Morphine
- Codeine
- Hydrocodone
- Oxycodone
- Methadone
- Buprenorphine
- Thebaine
### Opioids: Basic facts (1)

**Description:**
Opium-derived or synthetic compounds that relieve pain, produce morphine-like addiction, or relieve symptoms during withdrawal from morphine addiction.

**Route of administration:**
Intravenous, smoked, intranasal, oral, and intrarectal

### Opioids: Basic facts (2)

**Acute effects:**
- Euphoria
- Pain relief
- Suppresses cough reflex
- Histamine release
- Warm flushing of the skin
- Dry mouth
- Drowsiness and lethargy
- Sense of well-being
- Depression of the central nervous system (mental functioning clouded)

### Opioids: Basic facts (3)

**Withdrawal symptoms:**
- Intensity of withdrawal varies with level and chronicity of use
- Cessation of opioids causes a rebound in functions depressed by chronic use
- First signs occur shortly before next scheduled dose
- For short-acting opioids (e.g., heroin), peak of withdrawal occurs 36 to 72 hours after last dose
- Acute symptoms subside over 3 to 7 days
- Ongoing symptoms may linger for weeks or months
Long-term effects of opioids

- Fatal overdose
- Collapsed veins
- Infectious diseases
- Higher risk of HIV/AIDS and hepatitis
- Infection of the heart lining and valves
- Pulmonary complications & pneumonia
- Respiratory problems
- Abcesses
- Liver disease
- Low birth weight and developmental delay
- Spontaneous abortion
- Cellulitis

Other drugs

- Inhalants
  - Petroleum products, glue, paint, paint removers
  - Aerosols, sprays, gases, amyl nitrite
- Club drugs (MDMA-ecstasy, GHB)
- Hallucinogens (LSD, mushrooms, PCP, ketamine)
- Hypnotics (quaaludes, mandrax)
- Benzodiazepines (diazepam / valium)
- Barbiturates
- Steroids
- Khat (Catha edulis)

Activity 3

Working individually or in small groups, think of the drugs that are consumed in your area and the way they are consumed both by youth and adults:

Share your thoughts with the rest of the group.
Introduction to Addiction and the Brain

Addiction = Brain Disease
Addiction is a brain disease that is chronic and relapsing in nature.
How a neuron works

![Neuron diagram](image)

The reward system

Natural rewards
- Food
- Water
- Sex
- Nurturing

![Reward system examples](image)
How the reward system works

Activating the system with drugs
The brain after drug use (1)

Partial Recovery of Brain Dopamine Transporters in Methamphetamine (METH) Abuser After Protracted Abstinence

The brain after drug use (2)
Drugs change the brain

After repeated drug use, “deciding” to use drugs is no longer voluntary because

DRUGS CHANGE THE BRAIN!
Section 3: Introduction to Basic Counseling Skills

Training objectives (1)

At the end of this workshop you will be able to:
1. Identify a minimum of 4 counselling strategies useful in drug abuse treatment
2. Conduct a minimum of 3 counselling strategies
3. Structure a regular counselling session
4. Understand the importance of clinical supervision
5. Conduct a minimum of 3 listening strategies and 3 responding and teaching strategies to be used in counselling for drug abuse treatment

Introduction to Counselling
What is counselling? (1)

Counselling involves the following:

- Interactive relationship
- Collaboration
- Set of clinical skills & teaching techniques
- Positive reinforcement
- Emotional support
- Formal record

What is counselling? (2)

The purpose of counselling is to establish:

- Goals of treatment
- Treatment modality
- Treatment plan
- Scheduling of sessions
- Frequency and length of treatment
- Potential involvement of others
- Termination of treatment
Active Listening

Active listening by the clinician encourages the client to share information by providing verbal and nonverbal expressions of interest.
Active listening skills

Active listening includes the following skills:
- Attending
- Paraphrasing
- Reflection of feelings
- Summarising

Attending (1)

Attending is expressing awareness and interest in what the client is communicating both verbally and nonverbally.

Attending (2)

Attending helps the clinician
* Better understand the client through careful observation

Attending helps the client
* Relax and feel comfortable
* Express their ideas and feelings freely in their own way
* Trust the counsellor
* Take a more active role in their own sessions
Attending (3)

Proper attending involves the following:

• Appropriate eye contact, facial expressions
• Maintaining a relaxed posture and leaning forward occasionally, using natural hand and arm movements
• Verbally “following” the client, using a variety of brief encouragements such as “Um-hm” or “Yes,” or by repeating key words
• Observing the client’s body language

Example of attending

Pl ti

I am so tired, but I cannot sleep…so I drink some wine.

Um-hm.

...When I wake up…it is too late already...

I see.

Too late for work...my boss fired me.

Please continue...

Activity 1: Case study

“The client asked the clinician about the availability of medical help to deal with his withdrawal symptoms. The clinician noticed that the client is wringing his hands and looking very anxious.”

Discuss how the clinician should respond.

15 minutes
Paraphrasing (1)

Paraphrasing is when the clinician restates the content of the client’s previous statement.
• Paraphrasing uses words that are similar to the client’s, but fewer.
• The purpose of paraphrasing is to communicate to the client that you understand what he or she is saying.

Paraphrasing (2)

Paraphrasing helps the clinician
– verify their perceptions of the client’s statements
– spotlight an issue

Paraphrasing helps the client
– realise that the counsellor understands what they are saying
– clarify their remarks
– focus on what is important and relevant

Example of paraphrasing

My mom irritates me. She picks on me for no reason at all. We do not like each other.

So... you are having problems getting along with your mother. You are concerned about your relationship with her.

Yes!
Reflection of feelings (1)
Reflection of feelings is when the clinician expresses the client’s feelings, either stated or implied. The counsellor tries to perceive the emotional state of the client and respond in a way that demonstrates an understanding of the client’s emotional state.

Reflection of feelings (2)

**Reflection of feelings helps the clinician**
- Check whether or not they accurately understand what the client is feeling
- Bring out problem areas without the client being pushed or forced

**Reflection of feelings helps the client**
- Realise that the counsellor understands what they feel
- Increase awareness of their feelings
- Learn that feelings and behaviour are connected

Example of reflection of feelings

When I get home in the evening, my house is a mess. The kids are dirty... My husband does not care about dinner... I do not feel like going home at all.

You are not satisfied with the way the house chores are organized. That irritates you.

Yes!
Summarising (1)

Summarising is an important way for the clinician to gather together what has already been said, make sure that the client has been understood correctly, and prepare the client to move on. Summarising is putting together a group of reflections.

Summarising (2)

Summarising helps the clinician
- Provide focus for the session
- Confirm the client’s perceptions
- Focus on one issue while acknowledging the existence of others
- Terminate a session in a logical way

Summarising helps the client
- Clarify what they mean
- Realise that the counsellor understands
- Have a sense of movement and progress

Example of summarising

We discussed your relationship with your husband. You said there were conflicts right from the start related to the way money was handled, and that he often felt you gave more importance to your friends. Yet on the whole, things went well and you were quite happy until 3 years ago. Then the conflicts became more frequent and more intense, so much so that he left you twice and talked of divorce, too. This was also the time when your drinking was at its peak. Have I understood the situation properly?

Yes, that is it!
Processing

Processing (1)

Processing is the act of the clinician thinking about his or her observations about the client and what the client has communicated.

Processing (2)

Processing allows the counsellor to mentally catalogue the following data:

- Client's beliefs, knowledge, attitudes, and expectations
- Information given by his or her family
- Counsellor's observations
Responding

Responding is the act of communicating information to the client that includes providing feedback and emotional support, addressing issues of concern, and teaching skills.

Expressing empathy

Empathy is the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experiences of another.
Example of expressing empathy

I am so tired, but I cannot sleep… So I drink some wine.

I see.

When I wake up… I am already too late for work. Yesterday my boss fired me…

...but I do not have a drinking problem!

I understand. I am sorry about your job.

Probing (1)

Probing is the counsellor’s use of a question to direct the client’s attention to explore his or her situation in greater depth.

Probing (2)

- A probing question should be open-ended
- Probing helps to focus the client’s attention on a feeling, situation, or behaviour
- Probing may encourage the client to elaborate, clarify, or illustrate what he or she has been saying
- Probing may enhance the client’s awareness and understanding of his or her situation and feelings
- Probing directs the client to areas that need attention
Example of probing

I was always known to be a good worker. I even received an award. Lately I had some issues...my husband is just not helping...that is why I am always late.

Actually I have had lots of problems, not only being late.

Tell me about the problems you have been having at the workplace?

Interpreting (1)

Interpreting is the clinician’s explanation of the client’s issues after observing the client’s behaviour, listening to the client, and considering other sources of information.

Interpreting (2)

Effective interpreting has three components:
1. Determining and restating basic messages
2. Adding ideas for a new frame of reference
3. Validating these ideas with the client
Example of interpreting

You say you had difficulty in getting along with your boss. Once you mentioned that sometimes you simply broke the rules for the sake of breaking them. You also said that you are always late, even when your husband had everything ready for the children. In the past, you said it was because of the negative behaviour of your boss. This time you blamed your husband. Is it possible that your problems at work, like being late, are related to your alcohol use?

I always thought I could control it.

Silence

Silence can encourage the client to reflect and continue sharing. It also can allow the client to experience the power of his or her own words.

Activity 2: Now it’s your turn!

Rotating Roles

This role-play gives you and your colleagues an opportunity to practise as clinicians and clients.

• Role-play with one of your partners the new counselling skills you have learned. A third partner will be an observer. After 10 minutes switch roles (30 minutes total).

• Each observer will provide feedback at the end of each role-play (5 minutes).

35 minutes
The following exercises are case study examples where you will be presented with a client scenario. Using the knowledge you have learned on active listening during counseling, you will then provide your response to the client.

Exercise 1
Case Study 1: Reflection of Feelings

Client: My life is going pretty well now that I have not used any bango for a month. I have a new job and I have begun making some friends at work. Things with my wife are going much better and she seems happier and more trusting in me, especially after I got the new job. I am tired much of the time because I still am not sleeping very well. I think if I smoked just a little bango at bedtime, it would help me sleep. However, I am fearful that if I started smoking bango again, it could ruin all the progress I have made. I’m not sure what to do. I really need to get a good night’s sleep.
Exercise 2
Case Study 2: Expressing Empathy

**Client:** I am here because my family thinks I need treatment, because I take 6 Tramadol pills every day. I can barely get up in the morning without taking Tramadol and I need to take it 3-4 times a day. I started taking it to control the pain I had when I was injured in a serious car accident 3 years ago. I am still having flashbacks of the car accident. It is always the same thing. The other car slams into my car in slow motion, glass flies everywhere, and I look over to see my husband unconscious and bleeding. I am scared because every little thing that happens in my life sends me into a panic. Yesterday, three teenagers ran in front of my car to cross the street; I had plenty of time to stop, but my heart was beating so fast I thought it would burst. The only thing that relieves me of this anxiety and pain is more Tramadol.

Exercise 3
Case Study 3: Summarizing

**Client:** My wife complains constantly that I haven’t been a good husband because I don’t make enough money and I spend money on bango. My children are always misbehaving and they talk back at me, even the youngest who is only eight years old. Furthermore, they always refuse to do their chores. They seem to take, and take, and take – and to never be satisfied or appreciative. Today I was very angry at my wife and children and I left the house and smoked bango all afternoon; afterwards, I felt guilty and started blaming myself. This situation must be my fault. If I had been a better husband and father, things would be better. If I didn’t have all the stress and fighting I wouldn’t need to use bango.
Section 5: Principles of Drug Addiction Treatment

Why is comprehensive addiction treatment needed?

- Addicted individuals usually suffer from mental health, occupational, health, or social problems that make their addictive disorder difficult to treat
- For most people, treatment is a long-term process that involves multiple interventions and attempts at abstinence

Components of comprehensive drug abuse treatment

- Family Services
- Vocational Services
- Medical Services
- Substance Abuse Treatment
- Treatment Plan
- Aftercare
- Follow-up
- Support Groups
- Self-help
- Employment Services
- Educational Services
- Medical Services
- Legal Services
- Substance Abuse
- Vocational Services
Activity 1: Your organisation

Using the previous graphic, think about all the services that your organisation provides.

• What services do your clients most often need?
• What services could your organization add to meet your clients’ needs?

10 minutes

Treatment duration

Individuals progress through drug addiction treatment at various speeds, so there is no predetermined length of treatment.

In general, longer treatment duration results in better outcomes.

Treatment compliance (1)

Client factors that affect treatment compliance are
• Readiness to change drug-using behaviour
• Degree of support from family and friends
• Pressure to stay in treatment from the criminal justice system, child protection services, an employer, or family members
Treatment compliance (2)

Factors within the program that affect treatment compliance are

- A positive therapeutic relationship between the counsellor and client
- A clear treatment plan, which allows the client to know what to expect during treatment
- Medical, psychiatric, and social services
- Medication available when appropriate
- Transition to continuing care or “aftercare”

Drug addiction treatment

Drug addiction treatment is offered in specialized facilities and mental health clinics by a variety of professionals such as:

- Medical doctors
- Psychiatrists
- Psychologists
- Social workers
- Nurses
- Case managers
- Certified drug abuse counsellors
- Other substance abuse professionals

Activity 2: Group activity

Identify factors within your program (or others’ programs) that may do the following:

1. Help clients to comply with their treatment plan
2. Interfere with clients’ compliance with their treatment plan

15 minutes
Principles of Addiction Treatment

Principles of effective treatment (1)

1. No single treatment is appropriate for all
2. Treatment needs to be readily available
3. Effective treatment attends to multiple needs, not just to drug use problems
4. The treatment plan must be assessed continually and modified as necessary to insure that it meets the client’s changing needs
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness.

Principles of effective treatment (2)

6. Counselling (individual and/or group) and other behavioural therapies are critical
7. Medications are important elements of treatment for many clients, especially when combined with behavioural therapy
8. People with coexisting mental disorders should be treated in an integrated way
9. Detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.
10. Treatment does NOT need to be voluntary to be effective.

11. Possible drug use during treatment must be continuously MONITORED.

12. Treatment programs should provide assessment for HIV/AIDS and other infectious diseases as well as counselling to help clients change behaviours that place themselves or others at risk of infection.

13. Recovering from drug addiction can be a LONG-TERM PROCESS and frequently requires multiple episodes of treatment.
Principles of Drug Addiction Treatment
(Section 5 continued…)

UCLA Integrated Substance Abuse Programs
Continuum of Care

A Nice Simple Treatment Model

Addicted Patient

Treatment

Non-Addicted Patient

A Chronic Care Model

Detox
Duration Determined by Performance Criteria

Rehab
Duration Determined by Performance Criteria

Continuing Care
Recovering Patient
1. **Treatment Engagement**  
   **Detoxification/Stabilization**

   *Purposes:*
   - Safe/Adequate reduction of withdrawal symptoms
   - Physical/Emotional stabilization
   - Promote problem recognition
   - Engage patient into rehabilitation

2. **Rehabilitation**

   *Purposes:*
   - Sustain stable abstinence
   - Teach self-management skills
   - Identify & reduce threats to progress
   - Medications (maintenance and relapse prevention)
   - Engage patient in continuing care

3. **Continuing Care**

   *Purposes:*
   - Monitor & Support Abstinence
   - Encourage Self-Monitoring
   - Intervene Upon Threats to Relapse
   - Promote Participation in Long Term Support Activities
**Medical Detoxification Treatment Programs**

- Medical Detoxification is a treatment service used to systematically withdraw individuals from a substance in an inpatient or outpatient setting.
- Treatment is provided under the care of a medical doctor.
- Detoxification is a short treatment and does not address the psychosocial and behavioral issues linked to addiction.
- Detoxification is most valuable when it encompasses formal processes of assessment and results with a referral to successive substance abuse treatment.

**Inpatient Residential Treatment**

- Short-term Residential Treatment (commonly referred to as the Minnesota Model) focuses on the introduction to the 12 Step Program and long-term participation in 12 Step programs for recovery support.
- Long-term Residential Treatment (often referred to as the modified Therapeutic Community approach) involves an extended period (3-12 months) of living within a highly structured recovery community. "Treatment" is delivered via peer interactions within the community.

Sober Living Residence is a living environment that has supervision and a recovery environment. It should be used in conjunction with treatment and is not considered "treatment" on its own.
Intensive Outpatient Treatment

- Outpatient Treatment varies in length of stay, but typically lasts at least 90 days and is followed by outpatient continuing care.
- Patients generally receive 6 to 30 contact hours per week.
  - Core services include: group, individual and family counseling, psychoeducation, relapse prevention training, positive reinforcement techniques; family involvement; urine and breath alcohol testing; 12 Step (or alternative) participation; case management; medication, vocational and educational services.

Medication Assisted Treatment

- Medication (e.g. Methadone, Buprenorphine) provided in phases by a certified, licensed Opioid Treatment Program (OTP) or through a trained medical doctor.
- Medication Assisted treatment provides maintenance pharmacotherapy using an opioid agonist, a partial agonist, or an antagonist medication.
- The medication may be combined with other treatment services, including medical and psychosocial services.

Continuum of Care

- Detox/Inpatient
- Long-term Residential Treatment
- Intensive Outpatient/Psychosocial Behavioral Treatment
- Sober Living Residence
- Continuing Care/Aftercare Programs
Section 6: Counseling Principles
(The Counseling Relationship)

Quick Review

What is Counseling?

Counseling is:

“The application of mental health, psychological or human development principles, through cognitive, affective, behavioral or systemic interventions, strategies that address wellness, personal growth, or career development, as well as pathology.”

Factors that Influence Change

The counseling process is influenced by several characteristics that help it become a productive time for the client & counselor.

Structure
Setting
Client Qualities
Counselor Qualities
Factors that Influence Change

▲ Physical Setting.

▲ Counseling can happen anywhere, but the professional generally works in a place that provides -

▲ Privacy,

▲ Confidentiality,

▲ Quiet and

▲ Certain comfort

Some Basic Principles

▲ Each client must be accepted as an individual and dealt with as such (the counselor does not necessarily approve of all behavior, but still accepts the client as a person).

▲ Counseling is basically a permissive relationship; that is, the individual has permission to say what they please without being reprimanded or judged.

▲ Counseling emphasizes thinking with; not for the individual.

▲ All decision-making rests with the client.

Some Basic Principles

▲ Counseling is centered on the difficulties of the client.

▲ Counseling is a learning situation which eventually results in a behavioral change.

▲ Effectiveness in counseling depends largely on the readiness of the client to make changes and the therapeutic relationship with the counselor.

▲ The counseling relationship is confidential.
The Initial Session

- There is always an initial session. It is during this time both the client and the counselor are assessing one another to see if the relationship will work. It is here the subject of the subsequent sessions will be discussed and determined.

- There are several skills which are useful during this phase of counseling.

Gathering Information

- Types of Questions:
  - **Open**—allows the client to answer the question in a free-flowing or narrative style. Used when you want more detailed and elaborate answers.
    - Tell me how this is working for you?
  - **Closed**—this type of question requires only a one or two word response. Usually...Yes or No.
    - Do you enjoy that type of work?

Some Non-Helpful Behaviors

- There are several lists of non-helpful behaviors. Most common among them include:
  - Advice Giving
  - Lecturing
  - Excessive Questioning
  - Storytelling
  - Asking “Why?”
A Word About Goals

- Goals within counseling help to set the tone and direction one travels with their client.
- Without goals, the sessions will wander aimlessly.

Goal Guidelines

- Goals are mutually agreed on by the client and counselor.
- Goals are specific.
- Goals are relevant to behavior.
- Goals are achievement & success oriented.
- Goals are quantifiable & measurable.
- Goals are behavioral & observable.
- Goals are understandable & can be re-stated clearly.

Important Skills/Tools for the Counselor

- There are several important skills which we will cover briefly. Each is considered a "micro-skill" which you will need to develop during the clinical sequence of the counselor training program.
  - Empathy
  - Leading
  - Responding
  - Self Disclosure
  - Immediacy
  - Humor
  - Confrontation
Empathy

You want to build the relationship with the client through all the previously mentioned skills. Yet all these skills will be hindered without the use of empathy.

Empathy

According to Rogers (1961)...
- This is the ability to enter the client’s phenomenological world, to experience the client’s world as if it were your own without ever losing the “as if” quality.
- It involves two specific skills:
  - Perception/understanding of what is taking place emotionally.
  - The ability to communicate your understanding of that to your client.

Empathy

According to Martin (1983)...
- Empathy is communicated understanding of the other person’s intended emotional message. Every word counts in this definition. It is not enough to understand what the person said; you must also hear what they meant to say; the intended message.
- It is not enough to understand, even deeply; you must communicate your understanding somehow.
- It is absolutely essential the other person “feel” understood—that your understanding is perceived.
**Levels of Empathy**

The counselor’s responses add significantly to the feeling & meaning of the expressions of the client in a way that accurately expresses feeling levels below what the client is able to express.

**Moving the Client—Leading**

- There are several ways to “lead” the client forward in a session. They include using silence, acceptance, paraphrasing, etc…
- Be aware of how you lead and where you are going. You are working on the client’s issues, not your issues, or what you think the client should be working on.

**Responding Styles**

- **Affective Responding.**
  - Focusing on feelings.
- **Behavioral Responses.**
  - Focusing on actions and behaviors.
- **Cognitive Response.**
  - Focusing on thoughts and cognitions.

You will balance these throughout the session with a client.
Self-Disclosure

- Self-disclosure is making oneself known to another person (the client) by revealing personal information.
- Counselors self-disclosure is only necessary as it relates to the therapeutic process. Too much self-disclosure hinders the counseling process, while not enough, may inhibit the client from forming a bond with the counselor.

Humor

- Humor can have a positive effect on the counseling process when used properly.
- It must be used with sensitivity and timing. It does not demean and is supportive.
- A session is not a time to try out a new joke heard at lunch.

Transference & Countertransference

- A concept as old as Freud, transference and countertransference are issues that affect all forms of counseling, guidance, & psychotherapy.
Transference & Countertransference

Transference.
This is the client’s projection of past or present feelings, attitudes, or desires onto the counselor. It can be direct or indirect and will cause the client to react to you as they would in the past or present relationship.

Counter-transference.
This is the counselor’s projected emotional reaction to or behavior towards the client. It can take on many forms, from a desire to please the client, to wanting to develop a social or sexual relationship with the client. When this happens, supervision or counseling for the counselor is called for.

Termination of a Session

There is no great secret to ending sessions. There are some guidelines:

Start and end on time.
Leave 5 minutes or so for a summary of the session.
Introduce the end of the session normally (“Our time is coming to a close.”).
Assign homework.
Set up next appointment.
Termination of the Relationship

Termination is the end of the professional relationship with the client when the session goals have been met.

A formal termination serves three functions:
- Counseling is finished and it is time for the client to face their life challenges.
- Changes which have taken place have generalized into the normal behavior of the client.
- The client has matured and thinks and acts more effectively and independently.

Timing of Termination

There is no one answer when termination is to take place. Questions you may wish to ask yourself concerning termination include:

- Have clients achieved behavioral, cognitive, or affective goals?
- Can clients concretely show where they have made progress in what they wanted to accomplish?
- Is the counseling relationship helpful?
- Has the context of the initial counseling arrangements changed?

Resistance to Termination

Clients & Counselors may not want counseling to end. In many cases this may be the result of feelings about the loss and grief or insecurities of losing the relationship. For clients, this is something to process. For counselors, this is an issue for supervision.
Premature Termination

▲ Client.
- Many clients may end counseling before all goals are completed. This can be seen by not making appointments, resisting new appointments, etc… It is a good idea to try and schedule a termination/review session with the client so closure may take place. At this time a referral may be in order.

Premature Termination

▲ Counselors.
- At times, counselors have to end counseling prematurely. Whatever the reason for the termination, a summary session is in order and referrals are made, if appropriate, to another counselor.

Referrals

▲ At times, a counselor needs to make a referral. When this is done, specific issues need to be addressed with the client:
- Reason for the referral.
- Note specific behaviors or actions which brought the need for a referral.
- Have the names of several other counselors ready for referral.
- You cannot follow up with the new counselor to see if the client followed through (Confidentiality issue).
Follow-Up

At times, a follow-up may be scheduled for various reasons including evaluation, research, or checking-in with client.

Follow-ups need to be scheduled so as to not take the responsibility of change away from the client.
Section 7: Basic Counseling Skills: Teaching Clients New Skills

Teaching clients new skills

Teaching is the clinician’s transfer of skills to the client through a series of techniques and counselling strategies.

Use repetition

Repetition entails counsellors restating information and clients practising skills as needed for clients to master the necessary knowledge and skills to control their drug use.
Encourage practise

Mastering a new skill requires time and practice. The learning process often requires making mistakes and being able to learn from them. It is critical that clients have the opportunity to try new approaches.

Clinicians should not expect a client to practise a skill or do a homework assignment without understanding why it might be helpful.

Clinicians should constantly stress how important it is for clients to practise new skills outside of the counselling session and explain the reasons for it.

Give a clear rationale

Activity 3: Script 1

*It will be important for us to talk about and work on new coping skills in our sessions, but it is even more important to put these skills into use in your daily life. It is very important that you give yourself a chance to try new skills outside our sessions so we can identify and discuss any problems you might have putting them into practice. We’ve found, too, that people who try to practise these skills tend to do better in treatment. The practise exercises I’ll be giving you at the end of each session will help you try out these skills.*
Activity 3: Case study

Script 1
Discuss in groups the teaching strategies employed by the clinician.

Monitoring and encouraging

**Monitoring:** to follow-up by obtaining information on the client’s attempts to practise the assignments and checking on task completion. It also entails discussing the clients’ experience with the tasks so that problems can be addressed in session.

**Encouraging:** to reinforce further progress by providing constructive feedback that motivates the client to continue practising new skills outside of sessions.

Use the assignments

Use the information provided by the clients in their assignments to provide constructive feedback and motivation. Focus on the client’s:
- Coping style
- Resources
- Strengths and weaknesses
Explore resistance

Failure to implement skills outside of sessions may be the result of a variety of factors (e.g., feeling hopeless). By exploring the specific nature of a client’s difficulty, clinicians can help them work through it.

Praise approximations

Counsellors should try to shape the patients’ behaviour by praising even small attempts at working on assignments, highlighting anything they reveal as helpful or interesting.

Activity 4: Case study

Script 2
Discuss the teaching strategies employed by the counsellor in the following example:

“I noticed that you did not fully complete your homework, but I am really impressed with the section that you have completed. This is great…in this section you wrote that on Monday morning you had cravings but you did not use. That is terrific! Tell me a little more about how you coped with this situation. In this other section, you wrote that you used alcohol. Tell me more about it…let’s analyse together the risk factors involved in this situation.”
Develop a plan (1)

A plan for change enhances your client’s self-efficacy and provides an opportunity for them to consider potential obstacles and the likely outcomes of each change strategy.

Develop a plan (2)

- Offer a menu of change options
- Develop a behaviour contract or a Change Plan Worksheet
- Reduce or eliminate barriers to action

Activity 5: Role-playing

This role-play gives you and your colleague another opportunity to practise as counsellors and clients.

- Observe the role-playing
- Complete the Change Plan Worksheet form and ask each other the following questions:
  - “When do you think is a good time to start this plan for change?”
  - “Who can help you to take action on this plan?”

30 minutes
Section 8: Working with Families

First contact with your client

At the point of first contact with a client, counsellors should ask questions such as:
- Who is important in your life at this moment?
- How do they support you?
- Do they know that you are getting treatment?
- Would they support you in getting treatment?
- Would you like them to be involved in treatment and, if so, in what way?

Family reactions (1)

Family members usually experience the following feelings and reactions in response to their relative’s drug problems:
- Denial
- Shame
- Self-blame
- Anger
- Confusion

Continued
Family reactions (2)

- Preoccupation
- Making changes in themselves
- Bargaining
- Controlling
- Disorganisation

Activity 1: Identify maladaptive reactions

Discuss the maladaptive reactions of Anna’s husband in the following scenario:

Anna has been in treatment for alcoholism for 3 months. Anna’s husband is suspicious about her behaviour and is tracking all her movements through the day. His compulsive preoccupation drives him to waste his energy in unproductive ways, and as a result, he fails to do his own work. He tries to hide Anna’s problem from everybody and denies that there is a problem. It is too shameful for him, Anna, and the rest of the family. He justifies her alcohol abuse in public by saying that she is under a lot of pressure from her work. He denies that she drinks at home. He takes responsibility for Anna. For example, he calls her office every day to make sure she is at work and if she is not, he makes excuses for her absence.”

10 minutes

How to engage the family (1)

To effectively engage family members:
- Recognize their perceptions of the situation
- Provide a range of service options for families to choose from
- Actively engage family members (follow-up with phone calls and letters)
- Don’t give up easily
- Deliver flexible services
How to engage the family (2)

To effectively engage family members:
- Make sure that the family's greatest need is the one addressed first
- Be responsive to a crisis
- Insure that the service offered is what the family wants
- Present clear information
- Insure that promises and commitments are met
- Promote strengths-oriented conversations

Building Positive Communication Between the Client and the Family

Communication problems

Frequently, a client's addiction can create many problems within a family.
- Family members often feel guilty, angry, hurt, and defensive
- These feelings can negatively affect the way they communicate with one another
- Negative patterns of interacting often become automatic
Positive communication skills

- Avoid assuming what the other is thinking
- Communicate directly instead of hinting
- Avoid double messages
- Admit mistakes
- Use "I" statements

Avoid assuming what the other is thinking

Nancy asked her husband Pete, “Will you be coming home right after work?” Pete exploded, “You don’t have to check up on me every 5 minutes! Do you want a urine sample, too?” Nancy responded angrily, “Well, you’ve sure given me enough reasons to check up on you.”

Communicate directly instead of hinting

Ricardo, a 17-year-old in recovery, was playing a video game when his mother, Rosa, walked by and said, “Ricardo, the kitchen trash can is getting full.” Ricardo responded, “Uh huh,” and continued playing his game. Half an hour later, Rosa noticed that Ricardo hadn’t emptied the trash. She angrily confronted Ricardo for not taking the trash out right away. Ricardo responded to her anger by loudly saying, “Hey, I’ll do it when I’m ready to do it!”
Avoid double messages

Tanya asked her husband, Andre, “Do you mind if I go fishing with Sharonne Saturday?” Andre had been planning to spend time with Tanya on the weekend and didn’t want her to go with Sharonne. However, he replied, “Sure, go ahead.” As he said this, his arms were stiffly crossed across his chest and he didn’t look directly at Tanya. Tanya felt uneasy and said, “You’re really OK with it?” Andre responded angrily, “I said I was, didn’t I? The discussion escalated into an argument.

Admit mistakes

Bob forgot that it was his and Catherine’s 5th wedding anniversary. A coworker invited him to bowl a few frames after work, and he accepted. When he arrived home, he discovered the table set for two and Catherine in tears. When she confronted Bob about being so late, he responded defensively. “You know I have trouble remembering these things. You should have reminded me! How am I supposed to know you were planning a special dinner?” Catherine responded, “How could you forget our anniversary?” Bob was feeling guilty at this point, but not wanting to admit he was wrong, defensively replied, “Listen, Catherine, we’ve been married for 5 years now. What’s the big deal?” Catherine locked herself in the bedroom.

Use “I” statements

Pam, a senior in high school, was out on a date. Her curfew was midnight, and she was already late. When Pam arrived home at 1 a.m., her mother, Emily, was extremely worried. Emily greeted Pam at the door saying, “You’re late! You could have picked up a phone and called. You’re always so inconsiderate!” Pam responded angrily, “I am not always inconsiderate!” A fight ensued.
Activity 2: How to engage the family

Take time to think about strategies to involve the family and how you would implement them in your organisation. Share your ideas with the rest of the group.

Confidentiality

It is the right of the client to determine to whom they or others disclose details of their treatment.

No information regarding a person's treatment should be disclosed without the client's explicit consent in writing.
Organisations' confidentiality policy

Organisations should have policies and procedures in place to assist practitioners in insuring confidentiality for the client and their records. These policies should include:

- Having an agreement with the client and informed consent before releasing any information regarding treatment
- Having a signed “release of information” form from the client
- Clarifying to the client the purpose and types of case records and what happens to them

Precautions

Written consent should be obtained before disclosing:

1. Details of a client's treatment to any family member
2. Information about the client’s attendance

If in doubt …

- Ask your client if it is OK to talk about it
- Respect the client's or the family member’s wishes if they decide they do not want to talk about a particular issue
- In some circumstances, employ different practitioners for the family and the client
- If a family member requests a service, but the client does not want to be involved, refer the family member to another service
Support and Information for Clients who have Children

Clinicians should identify the needs of clients with children. These might include:
- Referral to a specialist in parenting or family support programs
- Attention to child safety issues within the physical environment of the agency
- Provision of “child-friendly” areas within the clinic, including toys and resources for children, posters, and other aids to establish a welcoming and age-appropriate environment
- Provision of information on a range of welfare, child care, and family recreation services available in the local area

Child protection

Organisations should have policies and procedures in place to assist practitioners in responding to suspicions of child abuse and neglect such as:
- Access to immediate supervision from an experienced practitioner
- Knowledge of what constitutes risk
- Knowledge of the child protection system
- Training in how to discuss concerns about safety with clients
WORKING WITH FAMILIES
(SECTION 8 CONTINUED)

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Introduction:

- Chemical dependency is a disease that affects the family system as a whole.
- It affects negatively the family function and the role and life of each family member as well.

Introduction:

- It is not that the family is merely reacting to drug abuse of an individual member; rather the abuse has become a family condition that has inserted itself into every aspect of family life.
- A drug abuse problem has consequences for both the abuser and the family.
Family consequences:
- Social deteriorations, including alienation
- Financial deterioration
- Violence
- Accidents

Family consequences:
- Psychological and physical illness
- Death (grief - self blame…)
- Induction of another member into addiction

Family consequences:
- Or adjustments to addiction which could take the following forms;
  - Shift in priorities
  - Change in values
  - Religious involvements
  - Taking on the neglected responsibilities, e.g. “parentified child…”
Family consequences:

- Becoming “enablers”
- Neglecting self care
- Reduced or failed family communications

The above pathological maladjustments may develop into disruptive family relationship behaviors.

Disruptive Family Behaviors Associated with Addiction:

Denial
- A defense mechanism used unconsciously to minimize the problem or its possible consequences.
  - In some situations, it can be adaptive because it protects from experiencing too much pain at once.
  - It becomes harmful when it is maintained and used as one’s primary way of coping with the problem.

Enabling
- Any behavior that makes it easier for the substance abuser to continue to use drugs or alcohol.
  - While the intention is to help, the addict is shielded from the consequences of his addiction.
  - Enabling includes not discussing the addict’s behavior, trying to control them, lying for them, and taking over their responsibilities (e.g., paying their bills, giving them money for drugs, etc.).
Disruptive Family Behaviors Associated with Addiction:

Unhealthy family rules
As the addiction progresses, the family is more and more governed by the following unhealthy rules:
- Don't talk
- Don't feel or express your feelings
- Don't trust

Disruptive Family Behaviors Associated with Addiction:

Impaired communication
As addiction progresses, communication between family members becomes minimal and finally becomes distorted, dishonest, guarded, and often abusive.

Disruptive Family Behaviors Associated with Addiction:

Shame
A disabling perception that results in a negative self-evaluation. Shame is different than guilt.
- Shame = “I am a bad person.”
- Guilt = “I did a bad thing.”
Disruptive Family Behaviors Associated with Addiction: A Case Study

Read the following example and identify the disruptive patterns of family behavior. What will be the role of the addiction counselor if the family asked for help?

Mona had been in an abusive relation for 15 years. Her husband made a lot of money from his work as an architect over their years of marriage. She used to take care of the children and ran the house. Progressively she became socially isolated, as her husband got drunk and smoke hashish almost every night. While in this condition he used to verbally and sometimes physically abuse her and the children.

His dependency progressed to abusing heroin over the last year and he began missing work and having serious financial problems. Mona showed marked neglect of her health and self-care, but kept trying to make him love her.
Disruptive Family Behaviors Associated with Addiction: A Case Study

When she tried to direct her husband to ask help he refused aggressively and threatened to throw her out of the house. She hesitated to ask for help herself out of shame and not wanting to upset him.

Role of the Counselor with Family Members

- Help the addict to take responsibility for his own behavior and feelings,
- Help family members observe their own reactions and behaviors.
- Help the family members and the client develop new and more healthy ways of communicating and interacting
Role of the Counselor with Family Members

Help the family member answer the following questions:
Am I a cause of the addiction?  
Can I cure my addicted family member?  
Can I control his or her addiction?
- To discover the answer of these 3 Cs which is No.

Role of the Counselor with Family Members

Help your client to discover the answer of the following question:
“I am helping or enabling the addict?”

Role of the Counselor with Family Members

Help the family member develop new responses to the addict that communicate the message:
“I love you, but I will not support your addiction”
Role of the Counselor with Family Members

Help the family member develop skills for self care.
Help empower the family member to take responsibility for his/her own feelings.
Help the family member realize he/she cannot control or “fix” the addicted person.

Encourage self-care
- Good sleep
- Exercise
- Medical care
- Diet
- Recreation
- Balanced work

Employ clinical strategies to enhance communication skills between family members:

Educate family members and client regarding the impact of addiction on communication.
Role of the Counselor with Family Members

Teach the skills necessary for effective communication from both the “message sender” role and the “message receiver” role.

Encourage giving feedback as a form of validation in communication.

Role of the Counselor with Family Members

Teach the client and family member active listening. It is a prerequisite for effective communication.
Active listening involves a commitment to “hearing” what the other is saying from their point of view.

THANK YOU
Section 9: Basic Psychiatric Terminology

Definition

- Psychiatry is that branch of medicine dealing with mental disorder and its treatment
- Psych: soul or mind
- Iatros: healer

Common confusions within psychiatry

- Psychology: a science that investigates behaviour, experience, and normal functioning of the mind
- Psychotherapy: the treatment of psychological issues by non-physical means
- Psychoanalysis: a particular sort of psychotherapy, or means of exploring the unconscious mind
Non-medical practitioners

- psychologists
- psychotherapists
- therapists
- social workers

Etiology of Psychiatric Disorders

The Bio-Psycho-Social Model of Etiology

- According to this model psychiatric disorders arise from the combined effect or interaction of biological, psychological and social factors.

- Biological, psychological and social factors create a vulnerability (i.e. readiness) to develop certain psychiatric disorders.

Psychiatric Symptoms and Signs

Disorders of Perception

- Illusions: Misinterpretation of real external sensory stimuli (e.g., mistaking a rope for a snake, mirage).

- Hallucinations: False perception in the absence of any external stimulus
Disorders of Emotions

A. Mood: a sustained and pervasive emotional tone subjectively experienced and reported by the patient and observed by others (e.g., depression, elation, anger).

B. Affect: usually used to indicate the subjective and immediate “short lived” or transient experience of emotion. It also refers to the external expression or observed aspect of emotions.

Disorders of Emotions

A. Disorders of Mood:
   Euthymic mood is normal range of mood (implying absence of abnormal or pathological moods). Disorders of mood may be unpleasant or pleasant.

Disorders of Emotions

Unpleasant Moods

1. Dysphoric mood: an unpleasant mood; a mood of general dissatisfaction.

2. Irritable mood: easily annoyed and provoked to anger.

3. Depression: feeling of sadness.

4. Anhedonia: lack of the ability to experience pleasure and loss of interest in all regular pleasurable activities.

5. Fear: unpleasant emotional state in response to a realistic threat or danger.
Disorders of Emotions

Unpleasant Moods

6. **Anxiety**: feeling of apprehension caused by anticipation of an ill-defined danger.

7. **Free-floating anxiety**: pervasive unfocused fear not attached to any idea.

8. **Tension**: unpleasant increase of motor and psychological activity.

9. **Phobia**: fear related to a particular object or situation.

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Disorders of Emotions

Pleasant Moods

1. **Euphoria**: exaggerated feeling of well-being that is inappropriate to real events.

2. **Elation**: elevated mood with feelings of joy, euphoria and intense self-satisfaction and optimism.

3. **Ecstasy**: feeling of intense elation.

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Disorders of Emotions

B. Disorders of Affect:
These are disturbances related to observed expression of emotions. They include the following disorders:

1. **Constricted or restricted affect**: reduced intensity of externalized feeling tone (i.e., affective expression and responsivity).

2. **Blunted affect**: severe reduction in the intensity of emotional expression and responsivity.

3. **Flat affect (apathy)**: absence or near absence of any signs of emotional expression or responsivity.
**Disorders of Emotions**

Disorders of Affect continued...

4. **Inappropriate affect (incongruity of affect)**: disharmony between expressed affect and the associated thought or situation.

5. **Lability of affect (emotional incontinence)**: affective expression characterized by frequent and abrupt changes unrelated to external stimuli.

6. **Swings of affect**: Oscillation of a person's emotional feeling tone between periods of elation and periods of depression or other mood states.

7. **Ambivalence**: Coexistence of two opposing affects or impulses toward the same object at the same time.

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**Anxiety Disorders**

1. **Generalized anxiety disorder (GAD)**: generalized, persistent state of anxiety not related to a certain stimulus.

2. **Panic disorder**: Discrete attacks of anxiety with no external stimulus.

3. **Phobic disorder**: anxiety related to certain stimuli.

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**Anxiety Disorders continued...**

4. **Obsessive-Compulsive Disorders (OCD)**: anxiety is provoked by attempts at resisting obsessions and compulsions.

5. **Posttraumatic Stress Disorder (PTSD)**: anxiety symptoms following exposure to a life-threatening situation.

N.B. Anxiety disorders associated with substance abuse/dependence or with a general medical condition are diagnosed according to their etiological factor.
A Closer Look: Anxiety

Common Symptoms of Anxiety Disorders

- Heart palpitations, sweating, tremors, nausea, dizziness, fear of losing control, going crazy
- Excessive worry and fear, difficulty controlling these thoughts
- Difficulty concentrating or mind "going blank"
- Easily irritated
- Difficulty falling or staying asleep

Mood Disorders

A- Depressive Disorders:

Common types of Depressive Disorders are:

- Major Depressive Disorder
- Dysthymic Disorder

A Closer Look: Depression

Common Symptoms of Depression

- Appearance of being sad, tearful, no emotions, or easily irritated and upset
- Loss of interest or pleasure in most activities
- Loss of energy/feelings of being tired most of the day
- Significant weight loss or gain
- Difficulty sleeping or sleeping excessively
- Talking about death, suicide
Mood Disorders

B. Bipolar Disorders:

- A manic episode consists of a distinct period of persistently elevated, expansive, or irritable mood.

- A hypomanic episode is similar to a manic episode, but the symptoms are not severe enough to cause marked deterioration in either social or occupational functioning.

A Closer Look: Bipolar

Common Symptoms of Bipolar Disorder

- Symptoms of Depression and Symptoms of Mania (Mood Swings)

- Manic symptoms include:
  - High involvement in pleasurable activities that are likely to cause painful consequences
  - Decreased need for sleep, constantly "on the go", rapid and pressured speech, conversation jumps from one topic to the next
  - Inflated self-esteem or feelings of superiority.

A Closer Look: ADHD

Common symptoms of ADHD

- Easily distracted, difficulty staying focused and on task

- Difficulty staying organized, forgetful, does not complete tasks

- May talk excessively, be constantly "on-the-go" or having difficulty sitting still
A Closer Look: PTSD

Common Symptoms of PTSD

- Must have experienced, witnessed or been confronted with a life threatening event
- Nightmares or recurrent thoughts/images of the event
- Avoidance of reminders of the event
- Constantly watching surroundings for potential threats
- Easily startles
- Difficulty concentrating, easily irritated

Organic Mental Disorders

- Cognitive disorders: Organic menial disorders in which the most prominent features are disturbances of cognitive functions which may be associated with disturbed consciousness.

- Cognitive disorders include 3 main syndromes:
  1. Delirium
  2. Dementia
  3. Amnestic disorders

Psychosis

- Psychosis is a loss of contact with reality, usually including false beliefs about what is taking place or who one is (delusions) and seeing or hearing things that aren't there
Psychosis

Common Symptoms of Psychosis

- Disorganized thought and speech
- False beliefs that are not based in reality (delusions), especially unfounded fear or suspicion
- Hearing, seeing, or feeling things that are not there (hallucinations)
- Thoughts that "jump" between unrelated topics (disordered thinking)

Schizophrenia

Schizophrenia is defined as a chronic psychotic disorder that shows marked disturbance in thought, mood, and behavior that lead to impaired functioning and deterioration of personality.

Schizophrenia

In more precise terms, schizophrenia is described as "a disturbance that lasts for at least 6 months and includes at least a month of active phase symptoms; that is, two or more of the following:

- delusions
- hallucinations
- disorganized speech
- grossly disorganized or catatonic behavior
- negative symptoms (i.e., affective flattening or avolition)
The following are the classical types of Personality Disorders:

1. **Schizoid Personality Disorder**
   - Marked preference to do things alone (socially withdrawn).
   - Constricted emotions.
   - Distant and cold.
   - Touchy, sensitive to feeling of rejection.

2. **Paranoid Personality Disorder**
   - Grandiose feelings.
   - He feels insecure.
   - He overestimates minor events.
   - He searches to confirm suspicions in others.
   - He cannot relax.
   - He is envious and pathologically jealous.

3. **Antisocial Personality Disorder**
   - Constant lack of conformity to major societal, moral and religious rules.
   - Criminal versatility.
   - Poor impulse control.
   - Avoids responsibility for actions.
   - Substance abuse.
**Personality Disorders**

4. **Histrionic Personality Disorder**
   - Immature personality, emotionally unstable, and tends to emotionally overreact.
   - He craves and works to be constantly the centre of attraction.
   - Dramatization of situations and emotions.
   - Sexually provocative and seductive.

5. **Obsessive-Compulsive Personality Disorder**
   - Over concern with details.
   - Perfectionist.
   - Rigid and inflexible, insists that things be done in his own way.
   - Indecisiveness and hesitancy.
   - Over conscientious.

**Somatoform Disorders**

1. **Somatization Disorder**
2. **Conversion Disorder**
3. **Hypochondriasis**
**Eating Disorders**

- They are a group of disorders where there is excessive preoccupation with weight, food, and body shape. Two main types are recognized:
  1. Anorexia Nervosa
  2. Bulimia Nervosa

**Activity: Small Group Discussion**

- A client you are counseling has recently been diagnosed with an anxiety disorder for which her physician prescribed her an antidepressant. The client is concerned because she does not suffer from depression and is wondering if an antidepressant will actually reduce her symptoms.

- As a group, discuss what information you would provide to your client and how you would counsel her on this issue.

**Treatment Planning:**

**Dalila**

- Married, but argues daily with husband
- Sales clerk at a tourism gift shop
- Husband is an accountant
- First used Valium and Vicodin in college, mixed with alcohol
- Prescribed antidepressant for her anxiety
- Never experimented with any other drugs
- History of trauma exposure: car accident that left college roommate disabled; this occurred during college with episodes of binge drinking and prescription drug use that followed the traumatic event
- No known psychiatric disorders
- Uses pills daily, and alcohol 3-4 times weekly
- Alleges that pills are for sleep problems and untreated fibromyalgia
- Occasionally drives under the influence, but no arrest to date
- Recent emergency room visit for a fall while intoxicated
- Husband is concerned; threatening divorce
Section 10: Ethics

Ethics codes are laws that guide professionals in helping clients in a fair, respectable, objective, and humane way.

Personal values guide moral conduct appropriate for work settings.

Understanding the connection between law and ethics and feeling a responsibility to integrate both appropriately.

Ethics codes establish a higher standard of conduct than is required by law; as mental health and/or substance abuse treatment providers we hold ourselves/our professions to a higher ethical standard.

Ethical principles and morality delineate what feels “right” or “good.”

Ethical principles of helping professionals - “we will give and not take.”
ETHICS

- Ethical behavior requires more than a familiarity with laws and the profession's code of ethics.
- Need to develop a personal ethical sense that involves reflection and insight in assuring the best possible service delivered to their clients.
- Need to be sensitive to the moral dimensions of counseling. This includes not only professional ethics, but also personal principles and philosophy consistent with the profession.

Examination of the relevant federal and state regulations and case law for guidance.

Understanding your agencies policies and procedures for client services (conflict of interest, referrals, chain of command, roles, responsibilities)

Awareness of personal needs/issues relevant to the provision of mental health care/drug treatment services to others (personal relapse, mental health, family issues)

ETHICS & BEST CLIENT CARE

- Relevant prior education, training and supervision for your position and/or agency (operating w/in scope of practice; appropriate credentials)
- Role of on-going education relevant to your profession, including supervision and consultation (i.e., connecting with and receiving feedback from others in the field)
- "Doing no harm" vs. "preventing harm"
**Professional Boundaries**

- The line that separates where the provider ends and the client begins.
- The emotional and physical line that gives our clients space to focus on themselves - not on us.
- The limits that control the professional’s power so that clients are not hurt.

**Professional Boundaries**

- Dictate our interactions with clients.
- Have some fluidity depending on the client’s vulnerability and our role.
- Are parameters that keep the professional as objective as possible.

**Professional Boundaries**

What are some examples of Boundary Issues you have faced?
PROFESSIONAL BOUNDARIES

Whose Job Is It To Maintain Professional Boundaries?

Provider’s responsibility to maintain professional boundaries:
- Set proper limits
- Maintain a treatment focus
- Be aware of thoughts/feelings generated about the client

What do I do about thoughts/feelings I may be having about a client?

How do I handle thoughts/feelings without inappropriately involving the client?
What if a client wants a different kind of relationship?

- **Dual or Multiple Relationships**: A situation where the professional (provider) functions in more than one role with the client.
  - Can create confusion of roles
  - Can make setting limits difficult

- **Social / Friendships**: A situation where the professional (provider) decides that it is acceptable to see a client (or former client) in a social context or decides that it is acceptable to now “be friends” with the client.
PROFESSIONAL BOUNDARIES

- **Business / Bartering**: A situation where the professional (provider) engages in a business relationship or trading services (counseling) with a client who either cannot afford treatment or has a particular skill that you could benefit from.

PROFESSIONAL BOUNDARIES

- **Gift Giving**: A counselor is appreciated for what she/he does...written note, verbal expression of thanks, or a material token of appreciation?
- Does refusing such gifts reject or insult the client?
- Why should we carefully consider in advance any type of gift given?

PROFESSIONAL BOUNDARIES

- **Counseling to family or friends**: A situation where the professional (provider):
  - Agrees to "talk" with a family member or friend (on a regular basis) who really needs treatment but can't or won't seek it out;
  - Agrees to provide treatment in a situation where the family member or friend does want treatment, but would rather "talk" to her/him because she/he trusts you already, and you know their background;
  - Agree to provide treatment for a friend or family member.
PROFESSIONAL BOUNDARIES

- **Romantic / Sexual:** A situation where the professional (provider) begins to view the client as a potential romantic partner, fantasizes about the client, thinks about terminating treatment so that the relationship can "deepen"; engaging in a sexual relationship with client/other staff person.

- **Never engage in any form of sexual contact with a client.**
- **Sexual contact can include:**
  - intercourse, anal or oral sex, fondling, and any other kind of sexual touching.
  - nudity, kissing, spanking, verbal suggestions, innuendoes, or advances.
  - This kind of behavior is considered exploitation by the health care provider.

- **Sexual relations with a client is illegal in all 50 states.**
- **Sexual relations with a client is potentially harmful, at the least**
- **New code allows for client-counselor relations a minimum of 5 years after termination of professional relationship (law vs. ethics?)**
- **Reminder: Do No Harm.**
PROFESSIONAL BOUNDARIES

- Loss of objectivity to provide appropriate treatment or exercise appropriate judgment
- Ethics code for helping professions – unprofessional conduct, unethical, illegal
- Damage to the client’s mental health
- Loss of trust in the helping professions for Ct.
- Ct. focus is on you rather than on him/herself
- May become confused about motivations to change (e.g., desire to keep the relationship going)

HOW TO HANDLE CLIENTS WHO WANT A DIFFERENT TYPE OF RELATIONSHIP?

- Set firm limits
- Explain why you are setting the limits
- Try not to be rejecting as you set clear limits

SELF DISCLOSURE: WHEN IS IT OK?
**PROFESSIONAL BOUNDARIES**

- **Self Disclosure**: Counselor discloses personal information about him/herself to a client or clients during the course of a client's treatment.

**THINGS TO CONSIDER?**

- Why are you disclosing the information?
- What will the information mean to the client?
- Are you okay with **EVERYONE** in the clinic knowing the information?
- Is there another way to accomplish your goal without personal disclosure?

**WHY ARE YOU DISCLOSING?**

- What is your goal in providing the client with this information?
- Are you sure that it is meeting a client need and not a personal need?
WHAT WILL THE INFORMATION MEAN TO THE CLIENT?

• How will the client interpret what you are saying?
• Are you sending confusing messages?
• Are you okay with everyone knowing?
• Will the information later be used against you?

IS THERE ANOTHER WAY TO ACCOMPLISH YOUR GOAL?

• Alternate Strategies?
  • Deflect
  • Redirect
  • Answer another question
  • Use the third person

PRACTICE

• Form Pairs and role play a provider and client.
  As the “client,” ask personal questions of the provider.
  As the “provider,” practice the above skills (e.g., deflection, redirection).
  How was that for you?
  What did you learn?
PRACTICE

• Form Small Groups. Develop a detailed vignette that involves a “gray area” ethical dilemma between a provider and client.

Groups will trade vignettes and discuss approaches for best handling the situation.

Activity 3: Case study

Discuss in small groups the following cases:

A) A young man tells his clinician that he intends to kill his former girlfriend just as soon as she returns from an out-of-town trip.

B) A client’s employer comes to you asking for information on your client’s test results. How should the clinician act in cases A and B?

15 minutes
Section 11: More Counseling Skills Role-Play

CASE STUDIES

➔ In Section 6, you learned more about Counseling Principles and the Counseling Relationship between you as the counselor and the client. Let’s review how to gather information from your client with Open- and Closed-ended Questions. As you might recall, the purpose of open-ended questions are to begin an interview, encourage client elaboration, elicit specific examples, and/or motivate clients to communicate. The purpose of closed-ended questions is to obtain specific information, identify parameters of a problem or issue, narrow the topic of discussion, and/or interrupt an over-talkative client.

Exercise 1
Review: Open-Ended Questions and Closed-Ended Questions

• Please list 5 open-ended questions that clients cannot easily answer with “Yes,” “No,” or one- or two-word responses.

• Please list 5 closed-ended questions, which clients can easily answer with a “Yes,” “No,” or one- or two-word response.
The following three case study exercises present ethical dilemmas. Please break out into groups of 2-4 and carefully read each scenario, then write down your response as counselor. You will then share your responses to the class.

Exercise 2
Case Study 1: Naeemah
• Naeemah is a 28-year old bango addict who has been coming to your clinic for 3 years. As a token of appreciation for your counseling services, she brings a basket of home-made basbousa and, your personal favorite, gullash, at your next scheduled appointment with her. What do you do?

Exercise 3
Case Study 2: Hasani
• Hasani is a 30-year old Ritalin addict who has not used drugs for 2 months. He is seeing you regularly for weekly counseling sessions. On Tuesday, he came in for his session and said he doesn’t have enough money to pay for more sessions, but he really finds the sessions useful. Hasani is employed as an auto mechanic and he asks if you need any work on your car, in exchange for some free counseling sessions. Your car has been running badly lately and you could use some work on your car. What do you do?
Exercise 4
Case Study 3: Monifa

- Monifa is a 40-year old benzodiazepine addict who you are meeting for the first time. During the intake, you come upon the realization that she is the mother of your daughter’s school friend. What do you do?
Section 12: Crisis Intervention

Give me some examples

- Form groups of 4-6.
- Agree on 3 examples of crises faced by your staff
- What made these crises challenging to deal with?

Things to Consider When Facing a Crisis
Things to Consider…

- Are you safe?
- Are other clients safe?
- Is the client in crisis safe?
- Can I handle this?
- What other resources do I need?
- How do I feel better after it’s over?

Are you safe?

Protecting your safety is protecting the safety of the client

- If they hurt you
  - They will no longer feel safe,
  - They will no longer be able to receive treatment from your agency
- Putting your safety first is in the best interest of the client.

Keeping yourself safe…

- The Office Setup
  - Be conscious of where you are in the office
The Office Setup
- Be conscious of where you are in the office
- Be aware of ways of asking for help

Keeping yourself safe...

Personal Style
- Be careful not to reflect negative emotional states
- Watch your body language
- Stay calm and keep your voice tone low and soft
- Be careful not to stand over or lean into patient
Keeping yourself safe…

- If none of that works…
  - Get out
    - Take a break
    - Leave the office
    - Leave the building
  - Get help
    - Call a supervisor
    - Call a colleague
    - Call the police

If none of that works…

- Get out
  - Take a break
  - Leave the office
  - Leave the building
- Get help
  - Call a supervisor
  - Call a colleague
  - Call the police

Things to Consider…

- Are you safe?
- Are other clients safe?
- Is the client in crisis safe?
- Can I handle this?
- What other resources do I need?
- How do I feel better after it's over?

Are other clients safe?

Where is the crisis happening?

- If other clients are observing, they may not feel safe
- We do not want to contribute to the chaos of their lives
- They want to have confidence in their environment.
- A crisis with one client may lead to a crisis with another
Keeping other clients safe…

- Remove the situation to a quiet, safe place. This will help to:
  - Calm the participant (and you)
  - Protect confidentiality
  - Protect other clients from direct harm
  - Protect other clients from "helping"

Things to Consider…

- Are you safe?
- Are other clients safe?
- Is the client in crisis safe?
  - Can I handle this?
  - What other resources do I need?
  - How do I feel better after it's over?

Is the client in crisis safe?

Is the Client a danger to:
  - Self?
  - Others?

If danger = being aggressive, follow recommendations above

If danger = killing self or others, follow recommendations above AND make sure they get assessed.
What is a Suicide/Homicide Assessment?

- If you think that someone wants to kill him/herself or someone else, they must be evaluated.
  - If risk is significant, they may need to be hospitalized
  - If risk is minimal, a plan needs to be developed in case feelings get worse.

Risk factors

- Common psychiatric risk factor leading to suicide
  - Depression*
  - Major Depression
  - Bipolar Depression
  - Alcohol and Drug abuse and dependence
  - Schizophrenia
- Other psychiatric risk factors with potential to result in suicide
  - Post Traumatic Stress Disorder (PTSD)
  - Eating disorders

Risk factors for Suicide

Symptom Risk Factors During Depressive Episode
- Desperation
- Hopelessness
- Anxiety/psychic anxiety/panic attacks
- Sudden change in mood
- Aggressive or impulsive personality
- Has made preparations for a potentially serious suicide attempt or has rehearsed a plan during a previous episode
- Recent hospitalization for depression
- Psychotic symptoms
Risk factors
- Major physical illness—especially recent
- Chronic physical pain
- History of trauma, abuse, or being bullied
- Family history of death by suicide
- Drinking/Drug use
- Being a smoker

Symptoms and Danger Signs
Warning Signs of Suicide

Danger
- Talking about suicide.
- Statements about hopelessness, helplessness, or worthlessness.
- Preoccupation with death.
- Suddenly happier, calmer.
- Loss of interest in things one cares about.
- Visiting or calling people one cares about.
- Making arrangements; setting one's affairs in order.
- Giving things away, such as prized possessions.

Warning Signs
- Observable signs of serious depression
  - Unrelenting low mood
  - Hopelessness
  - Anxiety
  - Withdrawal
  - Sleep problems
- Increased alcohol and/or other drug use
- Recent impulsiveness and taking unnecessary risks
- Threatening suicide or expressing strong wish to die
- Making a plan (giving away possessions, obtaining other means of killing oneself)
- Unexpected rage or anger
Assessment of Suicide

- History
- Influences
- Lethality
- Psychological Organization
- Evaluation of Risk Potential
- Recommendations

Crisis Intervention: CASE STUDIES

The following two case study exercises present crisis scenarios. Please break out into groups of 2-4 and carefully read each scenario, then write down your response as counselor. You will then share your responses to the class.

Exercise 1
Case Study 1: Farida

Farida is a 25-year old Ritalin and Valium addict with 3 months of sobriety, whom you have been seeing once a week. When she walks into your clinic today, she appears forlorn and acts withdrawn. She refuses to answer your open-ended and closed-ended questions. Finally, she mutters, “My husband is seeing another woman and he told me he is leaving me. Without him, my life isn’t worth living anymore. I just want to go to sleep and not wake up.” What do you do?
Exercise 2
Case Study 2: Mariam

Mariam is a 32-year old heroin addict who comes to your clinic for a scheduled appointment. She has not used drugs for 1 month. Today she seems uncharacteristically happy and in a calm, almost content state. You know she has tried to commit suicide 3 times in her past. When you ask her if she has had any thoughts of suicide lately, she responds, "Oh, I don’t know…maybe once or twice. No big deal." Describe your next steps.
Section 13: Assessment – Addiction Severity Index (ASI)

Module 2: Workshops

ASI: Administering and Coding

Workshop 1:
- Interviewer Instructions
- Introducing the ASI
- Coding

Workshop 2:
- Employment Section
- Drug & Alcohol Section
- Drug & Alcohol Grid

Workshop 3:
- Legal Section
- Family Section

Workshop 4:
- Psychiatric Section
- Review
- Competency Measures

Pre-assessment

Please respond to the pre-assessment questions in your workbook.

(Your responses are strictly confidential.)

10 minutes
Treatnet ASI Workshop 1

The ASI: Administering and Coding
- Interviewer Instructions
- Introducing the ASI
- Coding:
  - General Information
  - Medical Section

Goal of this workshop
- Develop and or enhance interviewer competencies in the administration of the Addiction Severity Index (ASI)

Objectives
- Identify the specific intention of each question
- Consistently apply correct coding in response to client’s answers
- Phrase each question, adapt the questionnaire to the client
Addiction Severity Index

- Standardized, semi-structured, multi-focused screening and assessment tool
- Used to collect information regarding the nature and severity of problems substance abusers often have
- Clinical, program evaluation, and research applicability

Purpose of the ASI

- Provides a comprehensive intake assessment
- Provides clinical information necessary for treatment planning
- Collects necessary data for system-wide or national projects to track trends, answer questions, and set policy

Clinical applicability

- Guides substance abuse treatment intake
- Helps in design of intake summaries
- Helps in development of treatment plans
- Assists in identifying when to make referrals
Program Evaluation

- Identifies types of patients presenting for treatment
- Quantifies level of problems
- Identifies nature and amount of change
- Can be used to monitor treatment outcomes
- Assists in managing resources
- Provides content for reports to funding sources

7 Sections of the ASI

1. Medical
2. Employment/Support
3. Drug
4. Alcohol
5. Legal
6. Family/Social
7. Psychiatric

Interviewer Instructions

As seen on the ASI “Face Page”

and

Question-by-Question Guide, Page 16
Interviewer Instructions 1 - 7

1. Leave no blanks.
2. Make plenty of comments. When noting comments, please write the question number. Probe and clarify!
3. X = Question not answered.
4. N = Question not applicable.
5. End the interview if client misrepresents or cannot understand two or more sections.
6. Half Time Rule! If a question asks the number of months, round up periods of 14 days or more to 1 month. Round up 6 months or more to 1 year.
7. Hints and clarifications in the ASI are bulleted, “•”.

1. No Blanks!

2. Comments
   - Comments, comments – make plenty of comments!
   - Indicate item number when making comments
Clarification & probing

- Probing is essential for valid information
- You need not ask questions exactly as written – use paraphrasing and rephrasing as appropriate for the client

3. Coding “X”

Code “X” when client can’t or won’t answer

4. Coding “N”

- Code “N” when item does not apply to client
- Must see instruction on the ASI to insure that a code of “N” is appropriate
- Review your “Coding N Reference Sheet”!
5. End the interview?

End the interview if:
• client misrepresents two sections
• it is clear client cannot understand the questions after two sections

6. The Half-Time Rule

1. If item asks about months, round periods of 14 days or more up to 1 month
2. If item asks about years, round periods of 6 months or more up to 1 year

7. Hints and Clarifications

READ YOUR HINTS!
• Many questions on the ASI have hints or clarification notes right under the question!
• Hints and clarification notes in the ASI are bulleted (•).
Why “Introduce” the ASI?

- Gives the client a clear idea of what to expect
- Sets the tone
- Helps build rapport

Introducing the ASI

As seen on your ASI “face page” and in your manual, Pages 13 & 14.

Seven Points

1. All clients receive the same interview
2. Seven Problem Areas
3. Takes approximately 30-40 minutes
4. Your input is important – use of Patient Rating Scale
5. Confidentiality
6. You may choose not to answer
7. Two timeframes: past 30 days & lifetime
INTRODUCING THE ASI:
1. All clients receive this same standard interview.
2. Seven Potential Problem Areas, or Domains: Medical, Employment/Support Status, Alcohol, Drug, Legal, Family/Social, and Psychiatric.
3. The interview will take about 30-40 minutes.

4. Your input is important - PRS
4. Patient Rating Scale: Patient input is important. For each area, I will ask you to use this scale to let me know how bothered you have been by any problems in each section. I will also ask you how important treatment is for you for the area being discussed. The scale is:
   0 - Not at all
   1 – Slightly
   2 – Moderately
   3 – Considerably
   4 – Extremely

5. Confidential, 6. Accuracy, 7. Time
5. All information gathered is confidential
6. Accuracy: You have the right to refuse to answer any question, if you are uncomfortable or feel it is too personal or painful to give an answer; just tell us, “I want to skip that question.” We’d rather have no answer than an inaccurate one!
7. There are two time periods we will discuss:
   1. The past 30 days
   2. Lifetime

What will confidentiality mean for your program?
Tell client: “Accurate information better equips us to help you.”
Time Periods – Important in Family and Psychiatric sections.
Segue – After introducing the ASI

“Are you ready? Let’s get started with some general information about yourself.”

Introduction to General Section

- Gather identifying & demographic information about the client
- Determine if client has been in a living situation which restricted freedom of movement and access to alcohol and other drugs in the past 30 days

G1 & G2 & G3: International Version

- G1. Patient ID_________________________
- G2. Country G2a. Centre
- G2b. Program G2c. Modality
- G3. Will this treatment be delivered in a corrections facility? 0 = No 1 = Yes
G1: Patient ID

G1 is an “open item.” This means that it can be used as needed. Record any ID number assigned to the client by your program.

G2: Treatnet Country Codes

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<th>Country Name</th>
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<th>Country Name</th>
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These codes are found on the back of the ASI.

G2a: Treatnet Site Codes

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<td>Carisma Centre for Attention and Integral Mental Health, Colombia</td>
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<tr>
<td>3</td>
<td>Centre for Addiction and Mental Health, CAAB, Canada</td>
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G2b: Treatnet Program Codes

- These codes are specific to each Centre.
- See manual for details.

G2c: Treatnet Modality Codes

G2c. Modality Codes:
1=Outpatient (<5 hours per week)
2=Intensive Outpatient (≥5 hours per week)
3=Residential/Inpatient
4=Therapeutic Community
5=Half-way house
6=Detox – Inpatient (typically 3 – 7 days)
7=Detox Outpatient/Ambulatory
8=Opioid Replacement, OP (Methadone, Buprenorphine, etc)
9=Other (low threshold, GP, spiritual healers, etc.)
Specify____________________________________________

G3: Treatment in Corrections

G3. Will this treatment be delivered in a corrections facility?
0=No  1=Yes

- Answer "yes" if the treatment will be delivered within a corrections facility such as a prison-based setting.
- Answer no if the treatment is not being provided within a criminal just setting.
G4-G7: Recording Interview Date and Length

- G4 and G5 track time between the interview and admission. For example: John may have been assessed on 30/11/2005, but may not have begun attending treatment until 9/12/2005.
- G6 and G7 track the length of the interview.
- Longer interview times may indicate a difficult client.
- Helps to flag exceptionally long or short interviews.

G8 & G9: Intakes and Contact Code

- G8: Most ASI’s are “intakes” and are completed on or near the admission date.
- Follow-up ASI’s are generally used when conducting outcome studies.
- G9: All intake ASI’s are conducted in person.

G10 & G11: Gender & Interviewer

- G10: Interviewing Techniques:
  - Can you always assume a client’s gender?
- G11: Record your assigned interviewer number given to you by your program.
Section 14: Assessment (ASI) continued…

Address (“G12 & G13”)

- Although not numbered, “Address” is actually questions 12 & 13.
- The place where you enter the address has been altered to be more internationally applicable – there are no specific instructions, each user should enter an address as it is understood in his/her culture.

Address information

- If the client is currently incarcerated or living in a recovery house, record the address to which he/she expects to return.
- If the client is homeless, record an address where they can be reached (i.e. a shelter, or friend or relative’s address)
- Record homelessness in the comments section.
G14: Living place

G14. How long have you lived at this address?

- Years
- Months

G14: Intent
- To evaluate the stability of the client’s living situation
- To probe to determine the “actual” time a client has spent at this address

G16–18: DOB, Race & Religion

G16. Date of birth:
- Day
- Month
- Year

G16a. Age
- Years old

G17. What race/ethnicity/nationality do you consider yourself?
Specify

G18. Do you have a religious preference?
- Protestant
- Catholic
- Jewish
- Other Christian
- None
- Other (specify in comments)

G19 & G20: Controlled environment

G19. Have you been in a controlled environment in the past 30 days?

- No
- Correctional Facility
- Alcohol/Drug Treatment
- Medical Treatment
- Psychiatric Treatment
- Other

- A place, theoretically, without access to drugs/alcohol.

G20. How many days?

- "NN" if Question G19 is No. Refers to total number of days detained in the past 30 days.

G19 and G20: Intent
- To record whether the client has “theoretically” had restricted access to drugs and/or alcohol
G19 and G20: Controlled environment

- "Controlled Environment" = Restriction of Movement
- Suggested interviewing technique: "Mr. Smith, in the past 30 days have you spent any time in a controlled environment that might have restricted your access to alcohol and drugs, such as prison, detox, or a medical hospital?"

- If a client was in 2 different types of controlled environments, enter the number corresponding to that which he/she spent the majority of time
- In these cases, G20 will reflect the total time in all settings
- If G19 = 1 (No), then G20 = N

G21: Referral source

- This is an open-ended item that programs can use as they see fit. Many programs will enter the name and contact information of a referring physician, legal official, or employer. You can also enter that the client is self-referred.
Segue to Medical Section

“Okay. We’ve finished with the general information section. Let’s go next to the medical section, where I’m going to ask you questions about your health status, for example, whether you’ve been hospitalized and what medications you may be taking.”

Medical Section

To gather basic information about:
- Client’s medical history
- Lifetime hospitalizations
- Long-term medical problems
- Recent physical ailments

M1: Hospitalizations

M1. How many times in your life have you been hospitalized for medical problems?
- Include O.D.’s and D.T.’s. Exclude detox, alcohol/drug, psychiatric treatment and childbirth (if no complications).
- Enter the number of overnight hospitalizations for medical problems.

Coding issues:
- Must be overnight
- Only code for medical problems
- Include ODs, DTs
- Exclude detox, inpatient alcohol/drug and psychiatric treatment, and normal childbirth
- Number of times, not number of days
M3: Chronic problems

M3. Do you have any chronic medical problems which continue to interfere with your life? 
0=No 1=Yes

- If "Yes", specify in comments.
- A chronic medical condition is a serious physical condition that requires regular care, (i.e., medication, dietary restriction) preventing full advantage of their abilities.

- Describe “chronic problems” to client as those that interfere with their life or require ongoing care
- Provide examples such as diabetes, hypertension, asthma
- Specify in comments & probe

M4: Medications

M4. Has a health care provider recommended you take any medications on a regular basis for a physical problem?

- Do not include various remedies given by a non-healthcare Provider.
- Must be for a medical condition, don’t include psychiatric medicines.
- Include medicines prescribed whether or not the patient is currently taking them.
- The intent is to verify chronic medical problems.

- Emphasise “Regular Basis” – don’t include temporary meds (e.g., antibiotics)
- Emphasise “prescribed for you”

M5: Physical Disability Support

M5. Do you receive financial support for a physical disability?

- If Yes, specify in comments.
- Include Workers’ compensation, early retirement for medical disability
- Exclude psychiatric disability.

- Must be medical, not psychiatric disability
- Does not include support from family or friends

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M6: Days of Problems

- M6. How many days have you experienced medical problems in the past 30 days?
  - Include flu, colds, injuries, etc. Include serious ailments related to drugs/alcohol, which would continue even if the patient were abstinent (e.g., cirrhosis of liver, HIV, HCV, HBV abscesses from needles, etc.).
  - Refer to physical medical problems discussed from M1 - M5, or any other problems they might not have mentioned
  - Emphasise number of days

M7: Troubled or bothered

- M7. How troubled or bothered have you been by these medical problems in the past 30 days?
  - Restrict response to problem days of Question M6.
  - Refers to problems in M6
  - Emphasise medical problems (not psych or drug / alcohol problems)
  - USE PATIENT RATING SCALE!

Patient/Client Rating Scale

PATIENT/CLIENT RATING SCALE

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M8: Need for treatment

M8: How important to you now is treatment for these medical problems?

- If client is currently receiving medical treatment, refer to the need for additional medical treatment by the patient.
  Note: The patient is rating their need for additional medical services or referrals from your agency, above any services they may already be getting.

- Refers to treatment needed for problems reported in M6
- Emphasise treatment for medical problems
- USE PATIENT RATING SCALE!

The “Final 3” - Medical

- M6: “How many days have you experienced medical problems in the past 30?”
- M7: “How troubled or bothered have you been by these medical problems in the past 30 days?”
- M8: “How important to you now is treatment for these medical problems?”

The Final 3 Scoring - Medical

If M6 = 0, then
  M7 = 0 and
  M8 should be 0.

If M6 > 0, then
  M7 > 0, and
  M8 can be any number.
M10 & M11: Confidence ratings

Last two items in every section of the ASI:

Is the above information significantly distorted by:
- Patient's misrepresentation?
- Patient's inability to understand?

---

M10: Patient’s misrepresentation?

The judgement of the interviewer is important in deciding the veracity of the patient’s statements.

The Misrepresentation Code is not to be used as a “denial meter” or to code a client’s minimisation of their problems.

Code a “Yes” in the Misrepresentation question if you are assured (not simply “have a hunch”) that the majority of the answers are inaccurate or contradictory.

---

M11: Patient’s inability to understand?

Three reasons to code “unable to understand”
1. Language barrier
2. Client is under the influence of drugs or alcohol and cannot understand the questions
3. Client is cognitively limited or psychiatrically impaired and cannot understand the questions
M12: New question - Hepatitis

- Have you ever been tested for hepatitis?
  0 = No, 1 = Yes
- If Yes, what was the result?
  1 = Hep Negative (not infected)
  2 = Hep positive (infected)
  3 = Don’t Know
- If M12 = No, M12a = “N”

M12b. Would you like help obtaining a Hepatitis test?

- New items on the Treatnet ASI!
- M12b: Does not necessarily mean that you will provide the test on-site; you may make a referral for testing.


- Have you ever been tested for HIV?
  0 = No, 1 = Yes
- If Yes, what was the result?
  1 = HIV Negative (not infected)
  2 = HIV positive (infected)
  3 = Don’t Know
- If M13 = No, M13a = “N”

M13b. Would you like help obtaining an HIV test?

- New items on the Treatnet ASI!
- M13b: Does not necessarily mean that you will provide the test on-site; you may make a referral for testing.

M14: New Questions – Pregnancy

- Are you currently pregnant?
- If pregnant, do you have prenatal care?
- If unsure, would you like help obtaining a pregnancy test?

- New item on the Treatnet ASI!
- M14b: Does not necessarily mean that you will provide the test on-site; you may make a referral for testing.
The ASI: Administering and Coding

- Employment Section
- Drug & Alcohol Section
- Drug & Alcohol Grid
Transition to Employment Support Section

Transition

"Well, we've talked about your medical status – now I'm going to ask you some questions about any employment or support issues you may have."

Employment / Support Status section

- Resources a client can record on a job application
- Schooling / training
- Current sources and amounts of income
**E1 & E2: Education & training**

- **E1.** Education completed:
  - *Level 0 = No education*
  - *Level 1 = Primary 1-6 yrs*
  - *Level 2 = Lower Secondary 7-9 yrs*
  - *Level 3 = Upper Secondary 10-12 yrs*
  - *Level 4 = Post Secondary, non-tertiary (add’l preparation for level 5)*
  - *Level 5 = First Stage Tertiary (+4 -6 years, incl BS, MS)*
  - *Level 6 = Second Stage Tertiary (doctorate, etc).*
  - Code: Years and Months, Level # or both.
  - Code: Level #
  - Code: Level 6

- **E2.** Training or Technical education completed:
  - Formal/organized training only: Months

---

**E1 & E2: Education & training**

- **E1.** “Level of education” was added for the Treatnet ASI. Enter the level of education or years of education or both.
- **E2.** Enter number of months of training or technical education.

---

**E4a: International**

- **E4a.** Are your job options limited by lack of transportation?
  - 0 = No  1 = Yes

This item is used to evaluate if transportation problems contribute to employment problems or under-employment.
E6 & E7: Job & occupation

- **E6.** How long was your longest full time job?
  - Full time = 35+ hours weekly; does not necessarily mean most recent job.

- **E7.** Usual (or last) occupation?
  - Specify: ___________________________________
  - (Use International Classification references page 1)

- **E6.** Code length of longest full-time job, not necessarily the most recent job.
- **E7.** Code “usual” occupation, not necessarily what the client is doing currently.

E7 Codes: ISC0 Categories

International Standard Classification of Occupations

- 1. Legislators, officials
- 2. Professionals
- 3. Technicians / assoc. professionals
- 4. Clerks
- 5. Service & sales
- 6. Skilled agricultural / fish
- 7. Craft & trades
- 8. Plant / machine operators
- 9. Elementary occupations
- 0. Armed forces

E9: Contribution to support

- **E9.** Does someone contribute the majority of your support?
  - 0 - No  1 - Yes

- Asks about support (i.e., cash, food, housing)
- Must be from an individual (including spouse), not an institution
- Must be the majority of support
- Cross-check with E12 - E17
E10: Usual employment pattern

- Full time (35+ hours)
- Part time (regular hours)
- Part time (irregular hours)
- Student
- Military
- Retired/Disability
- Unemployed
- In controlled environment
- Homemaker

Answer should represent the majority of the last 3 years, not just the most recent selection. If there are equal times, select category which best represents the current situation.

E11: Days paid for working

- Include days actually worked, paid sick days and paid vacation.
- Include paid sick days, vacation, etc.
- Regular 5-day work week = 20 days
- Some places report paying employees for 30 days each month; if this is the case, code that here.
- Include any paid work done on weekends
Section 15: Assessment (ASI) Role-Play

Practice with the ASI

Case Study: Ramses

→ Ramses is a 32-year old male who is brought to your clinic by his parents. He has been using cannabis for the last 4 years and begun taking Tramadol for the last 6 months. Since losing his job 1 year ago, Ramses has become less motivated, stays home all day, and isolates himself from his friends. The Tramadol use began when he met new acquaintances and has escalated over the past couple of months.

(Continued)
Case Study: Ramses continued…

Often intoxicated, Ramses has begun stealing things from his family and friends to pay for his drug habit. He was arrested 1 month ago and charged with possession of cannabis and Tramadol. His father is very angry and has threatened to throw him out of the house. His mother is very upset.
SECTION 16: ASSESSMENT (ASI)

Role-Play continued…

CASE STUDIES

Practice with the ASI

Please break out into pairs and carefully read the following case study. One person will act as counselor, and the other will act as the new patient. The counselor and the patient will go through the ASI, answering each question. Afterwards, the class will discuss the experience and address any questions, concerns, or issues that arose.

Case Study: Sharifa

Sharifa is a 26-year old female user of benzodiazepines. A Cairo University graduate, she has a college degree, is unemployed, and lives at home with her conservative parents and younger sisters. Sharifa has a boyfriend who smokes cannabis and whom her parents do not approve of. She has been taking benzos every night to sleep for the last 4 years, and she began taking them during the day for the past year.

(Continued)
Citing parental pressure and depression, Sharifa has significantly increased her daily consumption of benzos, having once taken too much at one time and overdosed (she was rushed to the hospital by her parents). Her mother has been trying to get Sharifa to spend more time with her and her sisters, and Sharifa argues with her father almost daily. She sneaks out at night to meet with her boyfriend.
Section 17: Treatment Planning

Icebreaker

How do you define treatment planning?

Icebreaker: The Good and the Bad
The Good and the Bad

<table>
<thead>
<tr>
<th>Negative Aspects of Treatment Planning</th>
<th>Positive Aspects of Treatment Planning</th>
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Workshop 1: Training objectives (1)

At the end of this workshop, you will be able to:

1. Use ASI information to develop individualised treatment plans
2. Identify characteristics of a programme-driven and an individualised treatment plan
3. Understand how individualised treatment plans help to keep people in treatment and lead to better outcomes

Workshop 1: Training objectives (2)

At the end of this workshop, you will be able to:

4. Use Master Problem List (provided) to formulate treatment plans and develop:
   - Problem statements
   - Goals based on problem statements
   - Objectives based on goals
   - Interventions based on objectives
5. Practise writing documentation notes reflecting how treatment plan is progressing (or not progressing)
What is not included in training

- Administering and scoring the ASI
- Administering any other standardised screening / assessment tool
- Training on clinical interviewing

The goal of this training is...

To bring together the assessment and treatment planning processes

Treatment plans are often...

"Meaningless & time consuming."
"Same plan, different names."
"Ignored."
## The What, Who, When, and How of Treatment Planning

### What is a treatment plan?
A written document that:
- Identifies the client’s most important goals for treatment
- Describes measurable, time-sensitive steps towards achieving those goals
- Reflects a verbal agreement between the counsellor and client

(Source: Center for Substance Abuse Treatment, 2002)

### Who develops the treatment plan?
Client works with treatment providers to identify and agree on treatment goals and identify strategies for achieving them.
When is the treatment plan developed?

- At the time of admission
- And continually updated and revised throughout treatment

How does assessment guide treatment planning?

- The Addiction Severity Index (ASI), for example, identifies client needs or problems by using a semi-structured interview format
- The ASI guides delivery of services that the client needs

How does assessment guide treatment planning?

- Treatment goals address those problems identified by the assessment
  - Then, the treatment plan guides the delivery of services needed
What is the ASI?

- A reliable and valid instrument, widely used both nationally and internationally
- Conducted in a semi-structured interview format
- Can be effectively integrated into clinical care

(Sources: Cacciola et al., 1999; Carise et al., 2004; Kosten et al., 1987; McLellan et al., 1980, 1985, 1992)

Identifies 7 potential problem areas:

1. Medical status
2. Employment and support
3. Drug use
4. Alcohol use
5. Legal status
6. Family/social status
7. Psychiatric status

The ASI is NOT...

- A personality test
- A medical test
- A projective test such as the Rorschach Inkblot Test
- A tool that gives you a diagnosis
Why use the ASI?

1. Clinical applications
2. Evaluation uses

Recent developments

- Efforts focused on making the ASI more useful for clinical work
  - (Example: Using ASI for treatment planning)
- The Drug Evaluation Network System (DENS) Software uses ASI information to create a clinical narrative

ASI is now more clinically useful!

New and Improved DENS Software (2005)
Uses ASI information to define possible problem lists and prompt and guide clinician in developing a treatment plan.
Clinical application

Why use the ASI?

- Uses a semi-structured interview to gather information a clinician generally collects during assessment
- Shown to be an accurate or valid measure of the nature and severity of client problems

(Sources: Kosten et al., 1987; McLellan et al., 1980; 1985; 1992)

Clinical application

Why use the ASI?

- Prompts clinician to focus session on important problems, goals, and objectives
- Basis for reviews of progress during treatment and documentation
- Basis for discharge plan

Clinical application

Why use the ASI?

NIDA Principle 3:

“To be effective, treatment must address the individual’s drug use and any associated medical, psychological, social, vocational, and legal problems.”

The ASI assesses all these dimensions.
Clinical use of ASI improves rapport

“. . . If patients’ problems are accurately assessed, they may feel ‘heard’ by their counsellor, potentially leading to the development of rapport and even a stronger helping alliance.”

(Sources: Barber et al., 1999, 2001; Luborsky et al., 1986, 1996)

Using ASI to match services to client problems improves retention.

“. . . Patients whose problems are identified at admission, and then receive services that are matched to those problems, stay in treatment longer.”

(Sources: Carise et al., 2004; Heer et al., 1999; Kosten et al., 1987; McLeilian et al., 1999)
For Programme Directors
- Identifies types of client problems not addressed through the programme’s treatment services
- Quantifies client problems
- Identifies trends over time

Evaluation uses

For Programme Directors
- Assists with level-of-care choices
- Provides measure of programme success
- Documents unmet client service needs
- Includes data needed for reports to various stakeholders

Evaluation uses

For Programme Directors
- Positions programmes for increased funding through participation in clinical trials and other research opportunities
For Clinical Supervisors
ASI data can be used to
- Identify counsellor strengths and training needs
- Match clients to counsellor strengths
- Identify trends in client problems
Section 18: Patient Placement

Presented by
Dr. Salwa Erfan
Professor of Psychiatry, Psychiatry Department, Addiction Unit, Cairo University

DEFINITIONS

Placement matching, a patient is referred to a particular setting.

Modality matching attempts to match a patient’s needs to a specific treatment approach.

• When placement matching is disconnected from modality matching, treatment is likely to be less effective because it fails to respond to the individual needs of the patient.

Approaches to Treatment Matching

Complications-driven treatment.

Diagnosis, program-driven.


Outcomes-driven treatment.
Uses of Placement Criteria

- Placement criteria play an integral role by providing a structure for assessment that focuses on the patient's assessed needs.
- Criteria also provide a nomenclature to describe an expanded set of treatment options and guideline to promote the use of a broader continuum of services.

The placement criteria are intended to

- Enhance the efficient use of limited resources,
- Increase patient retention in treatment,
- Prevent dropout and relapse,
- Improve patient outcomes.

UNDERSTANDING THE ASAM PATIENT PLACEMENT CRITERIA

Four features characterize the ASAM Patient Placement Criteria:

1) Individualized treatment planning,
2) Ready access to services,
3) Attention to multiple treatment needs,
4) Ongoing reassessment and modification of the plan.

UNDERSTANDING THE ASAM PATIENT PLACEMENT CRITERIA cont

- The criteria are based on a philosophy that effective treatment attends to multiple needs of each individual, not just his or her alcohol or drug use.
- To be effective, treatment must address any associated medical, psychological, social, vocational, and legal problems.
- Through its six assessment dimensions, the ASAM criteria underscore the importance of multidimensional assessment and treatment.
Principles Guiding the Criteria

Goals of Treatment:
- The goals of intervention and treatment determine the methods, intensity, frequency, and types of services provided.
- Addiction treatment programs have as their goal not simply stabilizing the patient's condition but altering the course of the patient's disease.

Individualized Treatment Plan:
- Treatment should be tailored to the needs of the individual.
- The plan should be based on comprehensive biopsychosocial assessment of the patient.
The plan should list:
  - Problems
  - Strengths
  - Priorities
  - Goals
  - Methods or strategies
  - Timetable

Choice of Treatment Levels:
- The goal that underlines the criteria is the placement of the patient in the most appropriate level of care.
- While the levels of care are presented as discrete levels, in reality they represent benchmarks or points along a continuum of services that could be utilized in a variety of ways, depending on the patient's needs and response.

Continuum of Care:
- Continuum may be offered by single provider or multiple providers.

Progress Through the Levels of Care:
- As a patient moves through treatment in any level of care, his or her progress in all six dimensions should be continually assessed.
- In the process of patient assessment, certain problems and priorities are identified as justifying admission to a particular level of care.

Length of Stay:
- The length of stay or service is determined by the patient's progress towards achieving his or her treatment plan goals and objectives.

Clinical Versus Reimbursement Considerations:
- The ASAM criteria are not intended as a reimbursement guideline, but rather as a clinical guideline for making the most appropriate placement recommendation for an individual patient with a specific set of symptoms and behaviors.

Treatment Failure:
- Two incorrect assumptions are associated with the concept of "treatment failure."
  - The first is that the disorder is acute rather than chronic, so that the only criterion for success is total and complete amelioration of the problem.
  - The second assumption is that responsibility for treatment "failure" always rests with the patient.
The ASAM criteria identify the following problem areas (dimensions) as the most important in formulating an individualized treatment plan and in making subsequent patient placement decisions.

**Dimension I: Acute Intoxication and/or Withdrawal Potential:**
- What risk is associated with the patient's current level of acute intoxication?
- Is there significant risk of severe withdrawal symptoms or seizures, based on the patient's previous withdrawal history, amount, frequency and regency of discontinuation or significant reduction of alcohol or other drug use?
- Are there current signs of withdrawal?
- Does the patient have supports to assist in ambulatory detoxification, if medically safe?
- Has the patient been using multiple substances in the same drug class?
- Is there a withdrawal scale score available?
- In the adult ASAM Placement Criteria, detoxification services can be provided at any of five levels of care.
- Specific criteria, organized by drug class, guide the decision as to which detoxification level is safe and efficient for a patient in withdrawal.

**Dimension 2: Biomedical Conditions and Complications.**
- Are there current physical illnesses, other than withdrawal, that need to be addressed because they are exacerbated by withdrawal, create risk, or may complicate treatment?
- Are there chronic conditions that affect treatment?
- Is there need for medical services that might interfere with treatment?
ASSESSMENT DIMENSIONS

Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications
- Are there current psychiatric illnesses or psychological, behavioral, emotional, or cognitive problems that need to be addressed because they create or complicate treatment?
- Are there chronic conditions that affect treatment?
- Do any emotional, behavioral, or cognitive problems appear to be an expected part of the addictive disorder, or do they appear to be autonomous?
- Even if connected to the addiction, are they severe enough to warrant specific mental health treatment?

ASSESSMENT DIMENSIONS

Dimension 4: Readiness to Change
- Is the patient suicidal, and if so, what is the lethality?
- Is the patient able to manage the activities of daily living?
- Can he or she cope with any emotional, behavioral, or cognitive problems?
- If the patient has been prescribed psychotropic medications, is he or she compliant?
- Is the patient actively resisting treatment?
- Does the patient feel coerced into treatment?
- How ready is the patient to change?

ASSESSMENT DIMENSIONS

- If he or she is willing to accept treatment, how strongly does the patient disagree with others’ perception that she or he has an addictive or mental disorder?
- Does the patient appear to be compliant only to avoid a negative consequence, or does he or she appear to be internally distressed in a self-motivated way about his or her alcohol or other drug use or mental health problem?
- At what point is the patient in the stages of change?
- Is leverage for change available?
ASSESSMENT DIMENSIONS cont

Dimension 5: Relapse, Continued Use, or Continued Problem Potential
- Is the patient in immediate danger of continued severe mental health distress and/or alcohol or drug use?
- Does the patient have any recognition or understanding of, or skills in, coping with his or her addictive or mental disorder in order to prevent relapse, continued use, or continued problems such as suicidal behavior?
- How severe are the problems and further distress that may continue or reappear if the patient is not successfully engaged in treatment at this time?
- How aware is the patient of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use or impulses to harm self or others?

Dimension 6: Recovery Environment
- Do any family members, significant others, living situations, or school or work situations pose a threat to the patient’s safety or engagement in treatment?
- Does the patient have supportive friendships, financial resources, or educational or vocational resources that can increase the likelihood of successful treatment?
- Are there legal, vocational, or social service agency or criminal justice mandates that may enhance the patient’s motivation for engagement in treatment?
- Are there transportation, child care, housing, or employment issues that need to be clarified and addressed?

Assessments are most accurate when they take into account all factors (dimensions) that affect each individual’s receptivity and ability to engage in treatment at a particular point in time.
LEVELS OF CARE in The Patient Placement Criteria

• The ASAM criteria conceptualize treatment as a continuum marked by five basic levels of care, which are numbered in Roman numerals from Levels 0.5 through Level IV.

• A continuum of addiction services, as follows:
  Level 0.5: Early Intervention
  Level I: Outpatient Services
  Level II: Intensive Outpatient/Partial Hospitalization Services
  Level III: Residential/Inpatient Services
  Level IV: Medically Managed Intensive Inpatient Services

LEVELS OF CARE in The Patient Placement Criteria

• Within each level, a decimal number (ranging from .1 to .9) expresses gradations of intensity within the existing levels of care.

• This structure allows improved precision of description and better "inter-rater" reliability by focusing on five broad levels of care.

• Thus the ASAM criteria describe gradations within each level of care.

• Example: Level II.1

LEVELS OF CARE in PPC

Level 0.5: Early Intervention

• service for specific individuals who for a known reason, are at risk of developing substance-related problems (Panic attacks after cannabis use, accident or legal problem after alcohol consumption, etc...)

• for whom there is not yet sufficient information to document a substance use disorder (conduct disorder, hypomania, etc...)
LEVELS OF CARE in PPC

**Level I: Outpatient Services**

- Organized, non-residential services, which may be delivered in a wide variety of settings.
- Regularly scheduled sessions WITH defined set medical PROTOCOLS.
- Designed to help the individual achieve permanent changes in his or her substance using behavior and mental functioning (major lifestyle, attitude, behavioral issues, coping, etc.).
- Dual diagnosis patients.
- Unmotivated patients who are mandated into treatment.

**Level II: Intensive Outpatient/Partial Hospitalization Services**

- Comprehensive biopsychosocial ASSESSMENT and individualized treatment plans, including formulation of problem statements, treatment goals, and measurable objectives—all developed in consultation with the patient.
- Active affiliations with other levels of care.
- Staff can help patients access support services such as child care, vocational training, and transportation.
- Psychiatric consultation, psychopharmacological consultation, medication management.
- 24-hour crisis services.
LEVELS OF CARE in PPC

Level III: Residential/Inpatient Services

- Organized services staffed by designated addiction treatment and mental health personnel who provide a planned regimen of care in a 24-hour live-in setting.
- Therapeutic and self-help group meetings generally are available on-site.
- Four types of programs: Low-Intensity, medium and high intensity.

Level IV: Medically Managed Intensive Inpatient Services

- Planned regimen of 24-hour medically directed evaluation, care, and treatment of mental and substance-related disorders in an acute care inpatient setting.
- Patients whose mental and substance-related problems are so severe that they require primary biomedical, psychiatric, and nursing care. (ex: Intoxication, withdrawal, substance induced psychosis, delirium tremens, suicidal trials….)

PLACEMENT DILEMMAS

- Co-Occurring Disorders.
- Assessment of Imminent Danger.
- Mandated Level of Care or Length of Service.
- Logistical Impediments.
- Need for a Safe Environment.
- Assuring Individualized Treatment.
Exercise in group work

Case 1

Presentation of groups work

• Assessment levels:
  1-
  2-
  3-
  4-
  5-
  6-

LEVEL of CARE: Plan??

CONCLUSION

• The Patient Placement Criteria deserves to be studied profoundly to evaluate its applicability and appropriateness to the Egyptian system of substance dependence treatment services.

• PPC enable patients to receive the most appropriate and highest quality treatment services.

• PPC encourage the development of a broad continuum of care.
THANK YOU!
Section 19: Treatment Planning and Patient Placement – The Intake Process

Intake is the administrative and initial assessment procedures for admission to a program.

Intake does become an extension of screening that results in either:

- The decision to admit an individual.

  OR

- The individual is determined to be ineligible or inappropriate for the program (in which case a referral to another program may be made).
The initial assessment must be documented in accordance with agency policy.

The intake assessment is also used to orient the patient to treatment.

It is important to give the patient and his/her family members a clear picture of what to expect from treatment.

The Patient’s Point of View

During an Intake Session
Meeting the patient

- Typically, the first face-to-face meeting between a patient and a treatment provider occurs during Intake.
- A patient must be treated with dignity and respect.
- It is important for the patients to see the treatment provider as an empathetic, welcoming and helpful professional.

Psychological factors to consider

- There are a number of psychological factors affecting your patients prior to entering the intake process. Imagine...

  As you walk into the treatment center for your intake appointment you feel anxiety and fear about discussing your personal problems with a stranger. You may also feel angry with your family for making you go to this appointment.

Things to remember

- Many patients experience feelings some degree of unpleasantness.
- More severe anxiety may actually stop some potential patients from keeping the appointment and that would be a significant mental health symptom.
- Anger at a family member for “making him or her go” is not uncommon.
Some more scenarios:

You are a naïve first-time patient:
- You do not know what to expect in the waiting room.
- You may still be experiencing anxiety.
- You are greeting and go into the examination room but you still do not know what to expect.

You are being required to go to treatment by your family:
- You do not think you have a problem.
- You are angry and upset.
- The appointment is inconvenient and “a waste of time.”
- You go into the examination room and carry your resentment with you.

The Professional’s Point of View

_During an Intake Session_

First impressions

- First impressions are always important!
- During and intake assessment the patient’s feelings can be evaluated through his or her body language, verbal interaction and communication.
Find a balance

- In many treatment programs, the functions of intake, orientation and assessment are often part of the first appointment.
- Creating a balance of paperwork, listening to the patient and doing the assessment should contribute to reducing the anxiety of the client.
- Finding a good balance can also help you build initial rapport and facilitate future treatment processes.

Recap

- The definition of intake refers to the process of "initial assessment for admission to a program."
- This means you as the professional must be skillful at evaluating and determining if the potential patient is eligible and appropriate.
- The purpose of screening is to rule out individuals who are ineligible or inappropriate for admission.
- The task of intake is to rule in the individual as eligible, justify the admission with sufficient documentation, and facilitate future treatment.
- The most important consideration is that no matter how upset or resistant, a patient must be treated with dignity and respect.

Intake: Case Studies

- The following two case study exercises present intake scenarios. Please break out into pairs and carefully read each scenario. One person will act as counselor, and the other will act as the new patient. Each pair will select a case study and perform a mock intake in front of the class. Afterwards, the class will provide feedback for each mock intake.
Exercise 1
Case Study 1: Mohammed
Mohammed is a 32-year old unemployed man who has been abusing heroin (injection) for two years and bango for five years. He was recently arrested for possession of drugs and he is depressed about how much he has messed up his life. His family is very angry with him.

Exercise 2
Case Study 2: Layla
Layla has been abusing benzodiazepines for two years due to stress. Her husband is very angry with her. She thinks she may be pregnant and she is worried that he will leave her.
Daily Plan: The Iraqi 12 person team will be divided into 3 site visit groups with 4 members per group. On the evening of February 11, the UCLA, and (Egyptian team if desired) and Iraqi and teams will meet to discuss the activities of the following clinical site visit days. In this meeting, the goals of the clinical site visit process will be explained, the activities that will be available to the members of the Iraqi team will be described by the site hosts, and a plan will be made for scheduling the visits by each of the 3 Iraqi teams to each of the treatment centers. Each day at 8:00AM, the 3 Iraqi groups with a UCLA staff person will be prepared to leave the hotel for travel to the 3 sites. Training at the sites will be conducted from 9:00AM – 4:00PM. The exception will be the half-way home visit day (14 Feb), which will be from 11:00AM – 3:30PM. Iraqi and UCLA team will return to the hotel by 5:00PM each day.

CLINICAL SITE VISIT DAY 1: SUNDAY 12 FEBRUARY

Team A (4 members): Kasr el Ainy, Team B (4 members): Al Matar, Team C (4 members): Behman

CLINICAL SITE VISIT DAY 2: MONDAY 13 FEBRUARY

Team A (4 members): Kasr el Ainy, Team B (4 members): Al Matar, Team C (4 members): Behman

On the evening of Mon Feb 13, an overview meeting will be held to discuss what the Iraqi team learned in their visits and how this knowledge can be useful to their work in Baghdad. Post-visit surveys will collect participant feedback on the visits to the 3 treatment centers.

CLINICAL SITE VISIT (HALF-WAY HOMEs) DAY 3: TUESDAY 14 FEBRUARY

2 groups of 6 team members will visit 2 Halfway House Programs (directed by Dr. Samir and Dr. Rania) in Maadi. Visits will last 2 hours at each facility. The times for this day will be as follows:

- Group 1: 11am-1pm
- Group 2: 1:30pm-3:30pm

Meditation, art, group therapy, and home duties can be observed during these times.

CLINICAL SITE VISIT DAY 4: WEDNESDAY 15 FEBRUARY

Team C (4 members): Kasr el Ainy, Team A (4 members): Al Matar, Team B (4 members): Behman
CLINICAL SITE VISIT DAY 5: THURSDAY 16 FEBRUARY

Team C (4 members): Kasr el Ainy, Team A (4 members): Al Matar, Team B (4 members): Behman

On the evening of Thurs Feb 16, an overview meeting will be held to discuss what the Iraqi team learned in their visits and how this knowledge can be useful to their work in Baghdad. Post-visit surveys will collect participant feedback on the visits to the 3 treatment centers.

CLINICAL SITE VISIT DAY 6: SUNDAY 19 FEBRUARY

Team B (4 members): Kasr el Ainy, Team C (4 members): Al Matar, Team A (4 members): Behman

CLINICAL SITE VISIT DAY 7: MONDAY 20 FEBRUARY

Team B (4 members): Kasr el Ainy, Team C (4 members): Al Matar, Team A (4 members): Behman

On the evening of Mon Feb 20, an overview meeting will be held to discuss what the Iraqi team learned in their visits and how this knowledge can be useful to their work in Baghdad. Post-visit surveys will collect participant feedback on the visits to the 3 treatment centers.

TRAINING DE-BRIEFING AND EVALUATION SESSION: TUESDAY 21 FEBRUARY

On Wed Feb 21, an overview debriefing and evaluation meeting will be held (site to be determined) to discuss what the Iraqi team learned in their visits and how this knowledge can be useful to their work in Baghdad. Post-visit surveys will collect participant feedback on the visits to the 3 treatment centers and the 2 halfway house facilities. A final overview session with all participants will be held on the overall learning experience. Post-test GPRAs will be completed.

CAIRO UNIVERSITY PSYCHIATRIC HOSPITAL ANNUAL CONFERENCE: WEDNESDAY 22 FEBRUARY + THURSDAY 23 FEBRUARY

The Iraqi team will attend the 2-day conference of the Cairo University Annual Psychiatric conference. This will give the Iraqi team members the opportunity to learn about new information on addiction treatment and related services, as well as allow them to network with professionals from the Middle East Region. Iraqi team members will be acknowledged by the conference leadership and will receive training participation certificates as part of the conference plenary activities. A final dinner will be held between Iraqi team members, UCLA and Egyptian training team on the night of Thurs Feb 23.