

THE CLINICIAN'S GUIDE TO WRITING TREATMENT PLANS AND PROGRESS NOTES

For the DADS Adult System of Care

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FOREWARD

This guide is intended as a teaching tool for the Counselors, and their Clinical Supervisors, in the DADS Adult System of Care.

The focus is on creating a quality treatment plan and effective and useful progress notes. To that end, we have included several chapters that we believe are relevant to that task.

The first edition of this guide was originally prepared (May 2006) to assist staff in understanding the “clinical performance measures” in the yearly chart audits. As of this third edition, (May 2008), the yearly chart audits have been replaced by the use of concurrent client derived outcomes measurements (ORS & SRS).

However, the information in this guide is still relevant and essential for performing the counseling tasks that are a part of providing clinical services in the DADS system.

It should be understood that the information on treatment planning and progress notes represents the expected “standard of care” regarding chart documentation in the DADS Adult System of Care.

We hope that you find this guide helpful. We would appreciate any suggestions and/or feedback about its usefulness. Requests for this guide, and feedback, can be sent to:

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Chapter 1

CLINICAL INTERVIEWING

Overview

There are many points of contact that occur between a counselor and client over a treatment episode. Each of those contacts has the potential to provide the clinician with valuable information regarding that client and their specific treatment. If the counselor is aware of that valuable information and seeks to take advantage of those contacts they must rely on their interviewing skills to obtain that valuable information.

Clinical Interviewing is the single thread that binds an entire treatment episode together. From intake to completion of treatment, the clinical interview is a constant. For instance, the Intake Interview is typically when the treatment alliance begins between the client and the counselor. At the same time, there is a large amount of impersonal data being collected. Based upon the skills of the interviewer, there may either be an alliance formed (where the client feels understood and engages in treatment) or the treatment may stall; lacking a clear focus and having no real power, or worse, become a stalemate or face off with an underlying power struggle. It is imperative that the clinician develops his or her interviewing skills in order to help make a treatment episode effective and successful.

The clinician should think of the interview as a “conversation with a purpose”¹. When a conversation has no central theme the participant’s roles are not clearly defined. This type of conversation usually starts and ends with no clear purpose. The clinical interview, however, has a goal directed purpose that is aimed at achieving specific content. It has well defined roles between the participants. The specific purpose of the contact determines the type of interview conducted.

¹ Homepage.psy.utexas.edu/class/Psy364/Telch/Lectures/Interviewing

By improving and sharpening their interviewing skills, a clinician can form a working alliance with the client that can greatly improve that client's treatment outcome. Research has shown that treatment outcomes are improved when the clinician attends to the relationship between themselves and the client during the initial interview alone.

It is through the various clinical interviews that the counselor learns to work with the client's perception of the problem and issues. The client benefits greatly from these contacts feeling the motivation and support to pursue their goals. The clinician benefits because they are working in a collaborative relationship, much of the paperwork provides a useful structure to enhance their interviewing techniques (rather than just being busywork), and the treatment remains on track.

In the pages to follow, we will discuss in depth the various aspects of clinical interviewing that can help the clinician be more successful with every aspect of treatment delivery. These areas will include: Clinician Qualities for Interviewing, The First Contact - Intake Interviewing, and Interviewing in Subsequent Contacts.

Clinician Qualities

Through school and work we have all been taught which qualities make a good clinician. Empathy, genuineness, respect, warmth, immediacy, concreteness, potency, and self-actualization are just a few. Understanding, transparency, tolerance, patience, and skillful validation are other important qualities, along with being flexible, curious, and open-minded. And don't forget the various listening skills, such as clarification, paraphrasing, and reflection. It seems like a lot, and yet these skills are essential to creating an alliance (a partnership or bond) between yourself and your client.

Who is 100% responsible for the alliance? We, the counselors are. Some might say, "Hey, it's a two-way street. I'll take 50 % responsibility for the relationship with my client." This may be true of a relationship with your peers, but not with your clients. The first thing that is important to understand is the power imbalance between therapists and their clients. We have the authority, they don't. We make decisions that can change their lives. It doesn't mean we react from an authoritative position. Often, it actually means the opposite. We must strive to be in acceptance of the client, regardless of their situation or readiness for change.

When a client presents for an interview and is angry about feeling forced to enter treatment, the use of empathy, respect, and warmth will help the client to feel some reassurance that you respect what they have to say. It is okay to repeat back to them what you heard them say, "So your wife was really unreasonable about your drug use, pressuring you to come to treatment. You seem pretty angry about that." If the client wants to prove to his family that he doesn't need treatment and you support him in that endeavor, you have formed the basis for your alliance. It is common for us as counselors to think, "I bet he does have a problem; he's just in denial. I'll have to show him." Try to remain neutral in your opinions and avoid acting on your preconceived ideas about the client or what he needs. Clients pick up on our disbelief and our biases immediately and that often causes them to question our trustworthiness.

At this point the unconvinced counselor might say, “So I just accept whatever they say or do?” Of course not! It is possible to hold people accountable and still maintain an alliance.

The most important part of the initial interview is to gain an understanding of the client’s Focus of Treatment (FOT). Once you have both come to that agreement, the client will have a personal reason to participate. In the previous example, by supporting the client to prove his family wrong, you will encourage him to understand what it actually means to have a drug problem, thereby helping him understand himself. Along the way, the client may get defocused and not follow through with the interventions he has agreed to do. The counselor might then say, “I thought you wanted to prove to your family that you don’t need treatment. Has that changed? If you continue to get positive UA tests, we are going to have a hard time convincing them.” And then you must really listen to the client; using your skills to understand and validate, while at the same time helping them to refocus on their FOT. This is a form of confrontation that helps you maintain your support of the client and still encourages them to look at their behaviors.

The trap counselors often fall into is taking an adversarial stand with a client over their behavior. After all, doesn’t the client know how important it is to stop using? Once the client notices that you feel annoyed or irritated with them, the relationship has slammed to a halt. It is now you against them. That is when they need us (and our skills) the most.

Review the following definitions of “good clinician qualities”. Question yourself if there are some that you find difficult to use. Ask a fellow counselor or supervisor for feedback regarding your skills. It takes practice to maintain a neutral stance with our clients and we all make mistakes. The important thing is that we understand what it takes to have an alliance and continue to strive for that.

Definitions of Good Counselor's Characteristics²

Empathy - the ability to identify with and understand another person's feelings or difficulties

Genuineness - honest and open in relationships with others

Respect - a feeling or attitude of admiration and deference toward somebody or something

Warmth - affection and kindness, fond or tender feeling toward somebody or something

Immediacy - moving away from the contents of the sharer's problems and placing the emphasis on the process going on in the moment between the helper and the one seeking help.

Concreteness - certain and specific rather than vague or general

Potency - successful, especially in producing a strong or favorable impression on people

Self-actualization - the successful development and use of personal talents and abilities

Understanding - a sympathetic, empathetic, or tolerant recognition of somebody else's nature or situation

Transparent - completely open and frank about things

Tolerant - accepting the differing views of others

Patient - able to endure waiting or delay without becoming annoyed or upset or to persevere calmly when faced with difficulties

Validating - to provide somebody with moral support, or inspire somebody with confidence

Flexible - able to change or be changed according to circumstances

Curious - eager to know about something or to get information

Open-minded - free from prejudice and receptive to new ideas

Clarification - to make something clearer by explaining it in greater detail

² Small, Jacquelyn, *Becoming Naturally Therapeutic*, p.83, Bantam Books, revised 1990

Paraphrasing - to restate something using other words, especially in order to make it simpler or shorter

Reflection - careful thought, especially the process of reconsidering previous actions, events, or decisions

Neutral - not possessing any particular quality or revealing a particular attitude or feeling

Try to Avoid

Assumptions - something that is believed to be true without proof, the tendency to expect too much

Preconceived Ideas - formed in the mind in advance, especially if based on little or no information or experience and reflecting personal prejudices

Biases - an unfair preference for or dislike of something

Another quality important for a counselor is the ability to read a client - to be able to notice verbal and non-verbal cues that do not match what the client is saying and to respond appropriately. When a client says one thing but their body language or voice tone seems to be saying another, that is the time to comment on it and get clarification.

Let's say it's the first interview with a client and as you're talking together he's agreeing with everything you are saying by shaking his head and smiling. But you also notice his foot is tapping, he's not adding anything to what you are saying, and he appears ready to bolt. Instead of proceeding, signing forms, and getting the interview done, it would be better to stop, slow down, and comment on what you notice. For example, "I notice that you are agreeing with me but I have the feeling there is something more. I feel like I am missing something. Can you tell me what's going on for you now?" Or the client "appears" to agree with the problem statement(s), having agreed all along, but hesitates to sign the treatment plan.

You know you are experiencing a good alliance when the client's body language is engaged with you, leaning forward, making good eye contact, and

the client is saying things like, “That’s exactly right!” or, “I hadn’t thought of it that way before but it really clicks with me now.” Or, “You know, you may be right, but I was thinking it is more like...” You have a relationship with this client, they are engaged in the interview, they feel comfortable enough to make suggestions, and they experience the feeling of being on the same wave-length.

Remember, as a general rule, to regularly check in with your own feelings. If you are feeling uninvolved, bored, or not connected with the client, the chances are the client isn’t feeling connected either. **We know that the treatment alliance (measured by the client’s perception of the treatment relationship) is the best predictor of positive outcomes.** The effective counselor checks in with the client’s feelings, and with their own feelings, regularly. Not only does this communicate to the client that you are interested in their experience, it also helps you make adjustments to their perception of the relationship and stay aligned with them.

Time Management

In general, an interview, unlike a conversation, is time limited and has a task or purpose. It’s important to be able to keep the purpose of the interview in mind to use your time effectively. Is this interview an initial assessment? If so, there will be a different focus than if this were your 4th “one to one” session with this client. Is the purpose of your interview to begin an alliance with your client, or is this an interview where the focus is to deepen an already established alliance and gain information on their recovery issues?

A counselor needs to be able to set priorities and manage time well, in and out of the interview, in order to accomplish their tasks. Do you have enough time for the interview? Did the client arrive late? If time is limited, what can you get done? What is most important to get accomplished? Is there time after your interview to fill in the details on the forms thereby giving you more time to build the alliance?

During the interview it’s important to keep the client on track. You want to develop an alliance with the client and you also have to be able to structure the interview if the client needs focusing. “I’ve noticed we’ve talked about your

daughter and your Mom but not about you. Can you tell me how these relationships support your recovery?”

It’s important to end an interview on time. You are setting an example by keeping to your time commitment. “I notice we have about five more minutes. Is there something important you need to tell me or can we go ahead and schedule our next appointment?”

Of course, it’s not always possible to stay on time. In situations where we find ourselves running over time it is wise to check with the client to find out how they feel about it and how they are impacted by the session running over the scheduled time. Often they are impressed by our willingness to run over to hear their story and they will spontaneously tell us. How often though, do they let us know that they are upset because by going over we may have interfered with their schedule? Or, how might they feel about having to be on time (or be locked out of the room) when we ourselves show up late to start group? It’s important to the treatment alliance to check about such possibilities.

Clinical Interviews: First Contact - The Intake

The objective of the first contact interview is to begin building the alliance with your client while collecting the relevant information required for assessment. Evidence has shown that much of the success of the treatment episode can be attributed to the initial alignment between counselor and client. During this process mutual rapport and understanding is very important. The counselor should project a sincere desire to join the client as an advocate in helping the client to identify and address problems that the client sees are relevant to their treatment and achievable within the current treatment modality. It is a time to identify the client’s needs and purpose for coming to treatment (FOT). The client should come out of this session viewing their treatment goal(s) as something they have decided to address with the help of their counselor, as opposed to feeling like they have given in to working on what the counselor wants them to address. This is not to say that a counselor can never offer therapeutic options that are or may be available.

The DADS program utilizes the ASAM Multidimensional Assessment also known as the MDA. The six-dimensions outlined in the MDA should be viewed as a valuable tool and interview guide for maintaining a meaningful “conversation with a purpose”. The counselor need not view the MDA as just another piece of bureaucratic paperwork that needs to get done before engaging in the first contact interview. Rather, this tool helps the counselor to stay focused and goal directed during the interview process. It can be used as a check to ensure that “all the bases have been covered” during the interview and that all important and relevant information has been obtained.

♦ **ASAM MDA:**

Dimension 1: Acute intoxication and/or withdrawal potential

Dimension 2: Biomedical conditions and complications

Dimension 3: Emotional/Behavioral or Cognitive conditions/complications

Dimension 4: Readiness to change

Dimension 5: Relapse/Continued use or continued problem potential

Dimension 6: Recovery/Living Environment

♦ **Goals of the First Contact Interview:**

- Begin to establish the alliance with client
- Find out the client’s Focus of Treatment – use the initial ORS subscales
- Determine Stages of Change for each problem
- Begin to understand client’s theory of change and the basis for establishing agreement on the goals and tasks of treatment
- Assess and determine the Severity Ratings in all ASAM dimensions – begin to develop problem statements and enlist client strengths
- Be sure to attend to any alliance issues by addressing any low SRS scores

♦ **Building the Alliance:**

Remember the therapeutic alliance is a working relationship. It is not just about rapport. While the presence of genuine empathy, concern, and respect are

certainly essential components of a good relationship; they are not the sole components in a successful treatment alliance. A successful treatment alliance hinges on three factors which must be present (along with the qualities known as rapport). These factors are: (1) AGREEMENT ON THE TASKS AND GOALS OF THE TREATMENT, (2) AGREEMENT ON THE METHODS THAT WILL BE USED TO ACHIEVE THE GOALS AND TASKS and (3) THE CLIENT'S PERCEPTION THAT THE COUNSELOR UNDERSTANDS THEIR PROBLEM(S) IN THE CONTEXT OF THEIR OWN LIFE.

The interview should be a relaxed, non-confrontational conversation/discussion with enough time allocated to achieve the goals of a first contact interview. Consider that not all of the paperwork needs to be completed in the first session, especially if completing all the paperwork interferes with establishing the treatment alliance. Developing the treatment alliance should not be sacrificed to the duties of paperwork. At the same time, it is important to know the severity ratings of all six dimensions in the MDA during the first session. That way, if there are any emergent problems, you can ensure that the client receives the immediate attention they need.

Outside interruptions and distractions should be avoided or kept to a minimum if at all possible. Take care not to display any body language or share any preconceived judgments or perceptions that might make the client feel uncomfortable and pre-judged.

Consciously project a demeanor of empathy, care and concern for the client. If the client feels comfortable he or she may then be more likely to reveal their immediate needs and personal reasons for seeking treatment (FOT).

The Focus Of Treatment (FOT) is the client's personal reason for being in treatment. The FOT can be discovered by finding out "why" the client has chosen to come to treatment as well as "what" he/she would like to achieve or solve during the current treatment episode. Keep in mind that the FOT is not a perceived (provisional) diagnosis made by the counselor. The FOT defines the current treatment episode; the problem statement(s) represent specific behaviors that are interfering with a successful outcome of the FOT. The Focus of

Treatment can help to keep the client centered on their treatment and can be used by the counselor to help guide the client back to their original goals or determine it is time to create a new FOT. By understanding the client's FOT a counselor can then help the client establish clear behavioral problem statements with achievable and rewarding goals. Collaboratively, they can then create action steps that build toward a solution of the specific problem.

♦ **Interviewing Do's and Don'ts:**

- Inquire if you can help the client with any immediate problems or needs that will help the client relax and focus.
- Have good eye contact (No rolling of the eyes or constantly looking away).
- Use body language that reflects you're paying attention (avoid frequently turning away, looking at the clock, or sighing).
- Roll with the client. Avoid second guessing the client's statements, perceptions, experiences, etc. Don't impose a diagnostic label on the client like ("You're in Denial").
- Don't respond aggressively to any negative communication from the client.
- Try to listen more than talk.
- Don't lecture or educate the client as to your vast knowledge of addiction.
- Do not use the session to talk about your personal recovery experiences - (You're not the client's measuring stick).
- Do not use punitive threats to elicit information - ("I'm going to call your wife or probation officer").
- Don't be sarcastic when responding to the client's needs - ("You didn't care about that when you were out there using").
- Ask open-ended questions to help the client elaborate on their answers.
- Clarify client responses to portray understanding.
- Be mindful not to move on too quickly to another area of questioning once a problem surfaces just to save time.

- Be aware of the client's affect and mood during the interview.
- Be aware of inconsistencies between the client's affect and mood and what he or she is saying. Explore these inconsistencies with appropriate follow up questioning in order to understand the client as an individual – not to correct their inconsistencies.
- Be mindful of other verbal and non-verbal cues. (Does the client look confused? Is the client telling you they are fine but showing physical signs of anxiety?)
- Be careful not to use language that is above the understanding capabilities of the client.
- Be careful not to be too clinical in your language.
- Be aware of the client saying one thing that would indicate a specific stage of change but when he or she elaborates they show another stage of change.

Developing and utilizing positive interview skills will help to establish a trusting counselor / client relationship. This enables the counselor to probe deeper into the client's life history. The counselor must make specific inquiries and gain detailed information of the client's life history in order to improve the accuracy of the MDA.

Once the client and counselor establish a treatment plan the client should be clear as to what the counselor's role is in helping them to solve their problems. The client should be clear as to what their personal responsibilities are in the treatment process. The counselor must project belief in the client's abilities to solve their problems and recover. If the counselor portrays a personal feeling of excitement about the recovery process, the client will more likely buy into the recovery process.

Clinical Interviews: Other Contacts

Repairing the Relationship

Human beings are relational creatures. We form complex, intimate relationships with people, objects, pets, and ourselves. The relationship between the counselor and the client is the one source of change in the client's treatment that the counselor can actually control. The counselor can do this by monitoring the client's responses and reactions to them. By staying aware of and adjusting to the client's perceptions in the treatment relationship the counselor can keep the treatment on track.

The treatment alliance is best, and most accurately, understood through the client's perception of the therapeutic relationship. The counselor's job is to assist the client in their process of change by working with them within the treatment relationship. One of the primary axioms for effective therapeutic change is: **The counselor is ultimately responsible for the treatment alliance.** It is the counselor's skill, determination, attitude, and efforts that keep the alliance alive and effective.

Often times it is necessary for the treatment relationship to be repaired. Frustration, anger, misunderstandings, and errors easily and frequently occur in the treatment process. Without relationship repairs the treatment is likely to end up in a stalemate. Mistrust, suspicion, disinterest, and defensiveness will inhibit the client's ability to take what the counselor is offering - the treatment. In these situations, at best, there will be only a superficial compliance by the client. Repairing the relationship is an essential skill for the effective counselor to keep the treatment positive, motivated, and on track.

Repairing the relationship demonstrates to the client that the counselor respects the client's experience in treatment. It demonstrates that the counselor is available and accessible, as a human being, to the client.

In some situations the repair that is needed is a simple, sincere apology. We know that clients aren't perfect. Clients know that we aren't perfect. It is amazing, though, how in some situations, a counselor will not, or cannot, see that

they have made an error. Even more amazing is when the counselor maintains that an apology isn't necessary or "appropriate". Remember, the key to the alliance is the client's perceptions, not the counselor's. A simple, **sincere** apology will work wonders for the alliance and is one of the most powerful therapeutic interventions that exists.

Treatment is not easy. Clients are living with the consequences of their past decisions and behavior every time they undertake a treatment task. They are one person in a large treatment system that is geared toward treating as many people as it can possibly treat in as an effective way as possible. Most clients have several numbers (Unicare, PFN, case number, SSN, etc.) that are used to identify them to the various parts of the system they are in contact with. It's easy for them to feel discounted, uncared for, and unimportant.

The primary counselor is the face of the whole treatment system for a client. One essential relationship repair is for the counselor to communicate to the client that they are special, that they are recognized, that they have an individual, unique identity that the counselor knows and appreciates. Sometimes this is the most difficult relationship repair for a counselor to communicate. But it is very important. People can get caught up in large, bureaucratic helping institutions, and while dependent on them for their help, feel frustrated and resentful that they aren't getting all the help they need. Consequently, clients often seem to be asking for help, as they simultaneously seem to be rejecting the help being offered. A supportive, encouraging, and humble conversation with their counselor can help repair the client's lost faith in those who are trying to help them.

Imagine someone in your life that you can have a real "heart to heart" talk with. How satisfying and useful are those conversations for you? How motivating and encouraging are they? When you sense that the alliance might be "off kilter" a bit, it is always a good idea to have a "heart to heart"³ with your client. "I'm kind of feeling like we're both getting a little frustrated here. Do you feel that, too?"

³ Linehan, M. Cognitive Behavioral Treatment of Borderline Personality Disorder. Guilford Press. 1993.

The therapist switches the conversation to the here and now relationship. Maybe the client feels slighted, or left out, or just feels worried because you didn't say "hi" to them when they saw you in the hallway. A sensitive and alert counselor will feel, sense, or suspect that the relationship is off somehow and will move to repair the relationship - the sooner the better. "Heart to heart" repairs clear the air and re-establish the commitment to treatment by both the client and the counselor.

Relationship repairs are something that most all of us do on a regular basis in the personal relationships that matter the most to us. We take responsibility for repairing them because we need the relationship and/or we care about the other person. The clients in treatment with us are not usually as skilled in relationships as we are. Also, the nature of the therapeutic relationship gives an enormous amount of power to the counselor. Consequently, clients often don't feel they have the power to repair any damage to the treatment relationship. It is the counselor's job to assess and monitor the state of the treatment alliance at all times and to perform relationship repairs as needed to keep the treatment on track.

In the DADS system, the Session Rating Scale (SRS) is used regularly with all clients to directly measure the status of the treatment alliance from the client's perspective. The SRS scores are an essential tool in the counselor's job of establishing and maintaining an effective treatment alliance.

Crisis Interviews

Crisis situations are out of the ordinary situations that require immediate attention. The purpose of the crisis interview is to assist the client with an immediate crisis. The first step is to get a clear and specific understanding of the immediate problem. The second step is to assess for dangerousness and/or lethality. The third step is to assist the client in effective problem solving strategies to resolve the crisis (if possible) or to cope with the problem as it continues. Sometimes, a fourth step requires that the client be assisted with

referrals to other sources of help so that a recurrence of the crisis can be averted in the future.

It's important to remember that a crisis situation is always driven by a high degree of emotional energy. In crisis, our nervous system is activated in a particular way (sympathetic nervous system activation) and we function differently than in normal situations. **It will not work to invalidate the client's perception of the crisis.** Telling the client to "calm down", "quit being so dramatic", "you're blowing this out of proportion", "it's no big deal", etc. will not help you help the client. The client needs to experience the availability of help and support for his/her crisis. That is why it is essential to actively carry out an effective crisis interview in these situations.

Our typical first response to someone in crisis is to speak slowly and calmly with a soothing tone and volume. Sometimes that is effective in helping the client feel safe. Often though, the client barely registers such a mild response in their intense state. In de-briefing crisis responses, people will frequently say that their experience was that no one was "taking them seriously" because everyone was so calm. Often times it is important to match the intensity of your response to the client's level of intensity. This does not mean yelling or acting hysterically. It means that you express a sense of urgency and importance to the client's experience that matches the sense of emergency the client is experiencing. This validates the client's sense of urgency and communicates to the client that someone is actually there with them to help him or her through the situation.

When assessing for the immediate problem that is causing the crisis situation, remember that you are working with the client's perceptions of the circumstances. Listen empathically and keep the client focused in the here and now. Typically, because there is such a high degree of emotional dysregulation during a crisis, people will often experience some degree of mild cognitive dysfunction. They may not be able to stay focused specifically on the present situation, they may not be able to pay attention to directions, or they may be so focused on one tiny aspect of the situation that they aren't able to see the

immediate problem (“cant’ see the forest for the trees”). It is important to take the problem seriously and redirect the client to the immediate problem situation until a clear definition of the immediate problem is understood. In the crisis interview the idea is to keep bringing the client back to the immediate situation. Get a clear definition of the immediate problem. Help them stay focused so they can assist in the solution phase.

It is vital that the client be assessed for dangerousness both during and after a crisis situation. The degree of emotional, cognitive, and physical dysregulation that occurs during and after a crisis leaves people at risk for behaviors they might otherwise be able to inhibit. People will do things during and after a crisis that even they will admit at a later date made no sense (“cutting off your nose to spite your face”). Frequently, you will see people behave in ways that are extreme and self-destructive; often times people will act against others or property in destructive ways.

Always ask about suicidal or other self-harm ideation during and after a crisis. Ask about suicidal and self-harm ideation directly: “Are you thinking about killing yourself?” “Are you planning to cut yourself when you return to your room?” Use a caring, firm, and confident tone when you ask about suicidal and self-harm behavior. You want the client to understand that **they can tell you and they will tell you**, if they have suicidal/self-harm ideation. Make sure to assess **after** the crisis as well. People will often make decisions during a crisis to act later, after the crisis is over.

The same is true for harm to others. People will often act in aggressive ways during or after a crisis that they would normally inhibit. Again, remember that the client’s nervous system is activated in a very particular way towards immediate survival. **During a crisis it is vital that you also assess for dangerousness to others – including to yourself.**

Remember to document any interview information you obtain regarding the client’s possible dangerousness. Also, if you are unsure or overwhelmed by what you may be hearing don’t become a part of the crisis yourself and start having your own crisis - **SEEK CONSULTATION IMMEDIATELY**. Make sure to

pass the information on to other staff (including the staff following you on the next shift if applicable).

At some point, of course, you need to move into solving the immediate problem. However, be aware of moving into the solution focus too soon. If your move to problem solving is premature the client will usually react by feeling that “you don’t really care about me - you just want me to stop having the problem”. If you get this type of reaction return the focus to the immediate problem and check to see if you actually understand the problem from the client’s perception.

When you determine that problem solving can occur remember the adage about the hungry person and the fish. (Teach the person to fish and they will be fed for a lifetime). First, assist the client **to solve his or her own problem**. (Remember to stay focused on the immediate problem when doing solution work). Ask them what would be a solution? What do they actually need or want? What may be possible? Help them brainstorm possibilities, help them clarify what they want, help them clarify what they need. Help them troubleshoot their possible solutions – is the solution realistic? Be sensitive to the client’s sense of hope and possibility. (You may pick up information regarding the dangerousness assessment if they have little or no hope in a positive solution.)

If the client can’t come up with any realistic solutions then you can begin to offer solutions to them. Be careful not to insert your agenda as you offer solutions. Remember that you want to keep the crisis interview focused very specifically with the immediate problem so offer focused, concrete solutions or coping strategies that the client is willing to try. Make sure that they agree to try the solution/strategy. Get a commitment from them that they will do what has been agreed upon.

Once the client has chosen a solution or coping strategy it is a good idea to have them practice or rehearse the solution/strategy with you. A simple role-play practiced several times can help them implement the solution/strategy under real conditions if it occurs later when you aren’t available. Always check out the level of commitment and readiness, or ability, to use the solution/strategy. **Link the solution/strategy to averting the crisis in the future.**

In certain instances it will be clear that without some external intervention the crisis is likely to recur, perhaps repeatedly. In these instances the client needs some assistance beyond what you may be able to offer them in the particular crisis interview. In these situations it is important to help the client by finding them the appropriate referral to someone or some program that can help solve the problem. It is important in these situations to help the client keep their spirits up and to instill some hope in them for an ultimate resolution.

Crisis situations are out of the ordinary occurrences. By definition they aren't something that could have been planned for and averted. The effective counselor will be prepared, however, to conduct an effective crisis interview. An effective crisis interview not only solves the immediate problem it also goes a long way towards developing and strengthening the treatment alliance.

♦ **Individual Sessions (1:1)**

Individual sessions (1:1's) require an awareness of the intimate nature of information being shared (e.g. feelings of ambivalence, relapse, and feeling stuck). These sessions occur at intervals during treatment to assess and monitor the client's process of change

The following five principles of Motivational Interviewing⁴ are critical clinician skills for facilitating effective individual sessions.

- **Express Empathy**

Acceptance promotes change.

Skillful listening is fundamental.

Ambivalence is normal.

- **Develop Discrepancy**

Creating an awareness in the client of the conflicts between their expressed goals and

⁴ From: Rollnick, S., & Miller, W.R. (1995). What is Motivational Interviewing? *Behavioral and Cognitive Psychotherapy*, 23, 325-334.

the likely consequences of their behaviors.

- **Avoid Argumentation**

Resistance is the signal to change strategies.

Labeling is unnecessary.

Do not impose abstinence model.

- **Support Self-Efficacy**

Identifying and reinforcing the client's strengths and abilities to affect the change(s) they desire.

- **Rolling with Resistance**

Types of Resistance

1. **Arguing** – client contests accuracy, expertise, and integrity of the clinician.
2. **Interrupting** - client breaks in defensively
3. **Denying** – client expresses an unwillingness to recognize problems, cooperate, accept responsibility or, take advice.
4. **Ignoring** – client is vague, non/semi-responsive and shows evidence of not following treatment.

If you think about it, your experience is probably very similar to most other clinicians, in that the most difficult clients are almost always the clients that “don’t want treatment” and “don’t cooperate with their treatment”. These treatment relationships are characterized by power struggles, adversarial exchanges (arguments), and very often result in frustrating and unsatisfying individual sessions. How does the clinician avoid becoming caught up in these dilemmas? How can you stay away from arguing and “roll with the resistance”? Miller and

colleagues (Miller and Rollnick 1991; Miller et al) have identified and provided examples⁵ of ways to react appropriately to clients in these situations. These are:

1.) Simple Reflection - the simplest approach is to respond to resistance by acknowledging what the client has said and the reasons for the expressed views as a way of validating the client and, perhaps eliciting an opposite response.

Client: I don't plan to quit drinking anytime soon

Clinician: You don't think that abstinence
would work for you right now.

2.) Shifting Focus- you can also diffuse resistance by helping the client to shift the focus away from obstacles and barriers. This method offers an opportunity to affirm the client's personal choice regarding the conduct of his or her own life:

Client: I can't stop smoking pot when all my friends
are doing it.

Clinician: You're way ahead of me. We're still exploring
your concerns about your goals to further your
education.
We're not ready yet to decide
if those goals require you to give up marijuana.

3.) Reframing- a good strategy to use when a client denies personal problems is reframing – offering a new and positive interpretation of negative information provided by the client.

⁵ Excerpted from: Miller and Rollnick, Motivational Interviewing, and NIAA: *Project Match Motivational Enhancement Therapy Manual*.

Client: My husband is always nagging me about my drinking – always calling me an alcoholic. It really bugs me.

Clinician: It sounds like he really cares about you and is concerned, although he expresses it in a way that makes you angry. That's too bad, maybe we can help him learn how to tell you he loves you and is worried about you in a more positive and acceptable way.

♦ “Taking the Temperature of the Alliance”⁶

Individual sessions are the appropriate setting for making sure the treatment is on track. The effective counselor is regularly monitoring the state of the therapeutic alliance. Crucial to this practice is the counselor's acceptance of the principle that the client's perception of the relationship is what makes the difference. The attitude underlying this principle might be called “acceptance through skillful listening”. The clinician seeks to understand the client's feelings and perspectives without judging, criticizing, or blaming. This kind of acceptance of people as they are seems to free them to change, whereas insistent demands to change (“you're not OK; you have to change”) can have the effect of keeping people as they are. This attitude of acceptance and respect builds a working therapeutic alliance and supports the client's self-esteem, an important condition for change.

⁶ Scott Miller, Ph.D.: excerpted from training 05/03/06.

Treatment Transitions

Transitions in treatment should always receive the attention of an individual session (or multiple sessions where indicated) because treatment transitions frequently impact the ultimate success of the treatment as well as lay the groundwork for the next level of treatment. The clinician seeks to discover the client's views about successes, problems, continued areas of focus, and expectations of future treatment.

Interviews that occur relative to some transition (referral, upgrade, discharge AMA, etc.) in the current treatment should always focus on accurately determining the client's perceptions of the transition and checking to make sure that the client understands what is happening and why it is happening.

- ♦ Referrals (non-LOC referrals)

In order for the client to make use of the referral provided it is important that the client understand and agree with the reason(s) for referral. If a client is reluctant to act on a referral consider using the Stages of Change model to work with the client regarding acceptance of the referral. For example, a dual diagnosis client might really benefit from psychiatric medication but is unwilling to see a psychiatrist and try medications. Perhaps some education may help first. Perhaps the client would respond to a "fact-finding" approach – "how about you go see the psychiatrist and collect all the information she has to offer. When you return we'll sit down and organize the information into useful and not-useful categories, or factual and not-factual categories?" etc.

The clinician needs to demonstrate an awareness and sensitivity to the need to refer the client to a different (or additional) treatment relationship. It's important to recognize how the client may perceive the process of referring him/her to someone else. Issues of trust, confidentiality, competency, and commitment to the alliance are involved in every referral instance (even when the client has requested the referral).

- ♦ **Discharges** (LOC transfers, Self-Discharges)

Discharges should always involve a thorough MDA assessment of the client's current level of functioning. Do not proceed with a discharge without first determining that the client is appropriate for the LOC change according to the MDA. Remember, in the DADS system we focus on providing individualized treatment services so discharge decisions always need to reflect the client's current needs.

Begin reviewing discharge planning with your client well prior to the planned discharge date. Troubleshoot potential difficulties your client may encounter. Work with your client on developing a plan for continuing adherence to their treatment goals.

Pay attention to signs from the client indicating they are unsure or overwhelmed with their discharge plans and help to clarify and support their strengths. Clients will often display some regressive behaviors as they anticipate transitions that put them at greater risk (e.g. moving to outpatient and living back in the "outside" world).

It is important to assess these behaviors in the light of anxieties about transitioning and not react punitively or unilaterally. Review the client's strengths regarding the transition and help them keep their treatment on track.

This is equally true when upgrading a client to residential and/or detox. Make sure the client has a sense that the move is beneficial for their treatment and that they can succeed. Explain how they will be able to return to the current level of care and the strengths they have that will help them get back on track.

There is a wide range of possible reasons for which clients might decide to not participate in treatment; the clinician's goal is to help clients recognize and sort out some of these possible reasons and develop solutions that are in the client's best interests. For example, a client reveals bitterly that despite a strong desire and commitment to reduce her drinking, she is leaving prematurely to avoid communicating feelings of anger and frustration for her counselor that she believes will be minimized ("My therapist doesn't seem to really care about how I

feel.”). This is a therapeutic issue that is interfering with the client’s treatment. Discharge is not appropriate in this instance. The counselor might try to repair the treatment relationship. Perhaps the client can be moved to a different counselor. Solutions should always have the client’s best interests at heart.

Whether the specific transition in treatment is good news (the client is making progress and moving through the continuum of care) or unfortunate (the client has slipped and must be upgraded), the focus must always be on what is best for the client and their treatment needs. Transitions in treatment are clinical issues and the effective counselor makes use of their skill and the therapeutic alliance to further the client’s care.

Chapter 2

The Treatment Assessment

Summary and the Problem List

Overview

The Treatment Assessment is best written after a thorough interview with the client and after the counselor has gained a good understanding of the client’s Focus of Treatment (FOT): “*the client’s personal reason for being in treatment. The FOT can be discovered by finding out “why” the client has chosen to come to treatment as well as “what” he/she would like to achieve or solve during the current treatment episode.*”⁷ Assessing the ASAM Six Dimensions helps the counselor to gain an understanding of the areas in which the client needs help. The Summary is used to **blend both the client’s strengths and immediate needs**, as they pertain to the current treatment episode and is followed by The Problem List that identifies current concerns and sets the stage for the treatment plan.

⁷ Hutchinson, et al, May 2006, The Clinician’s Guide to Writing Treatment Plans and Progress Notes

The Summary

This section of the TX Assessment recaps pertinent history and current information to provide a 'snapshot' of the client in narrative form. One method of writing the summary is to follow Dr. Mee-Lee's Case Presentation Format. It is common to open the summary with a brief demographics statement:

"This client is a 49 y/o Asian male who is married with two young children. He has taken a leave of absence from his job as a financial analyst. He reports his drug of choice (DOC) is cocaine, which he began using five years ago. He was arrested for possession in early May 2006 and was referred to outpatient treatment by Prop. 36. This was his first arrest. This client lives with his family, including his elderly in-laws. He feels badly that he has let his family down and states his Focus of Treatment (FOT) is to return to work to support his family".

From here the counselor covers important information in the six dimensions, including significant history and current problems. This is also an opportunity to discuss the client's strengths and aspects of his life that will be useful to his stated FOT. (E.g., *"his family is very supportive"* or *"the client has strong spiritual beliefs"*).

Feel free to develop your own style of writing the summary. Some clinicians actually list each dimension as they relate the corresponding information. Others will cover the dimensions without referring to each one specifically, and may do so out of order. It is okay to use abbreviations (TX, HX, DOC, DX, etc) to make the writing and reading as efficient as possible. A reminder: anything that is written in either the Summary or the Problem List should already be documented in either the LOC or the Tx Assessment. No new information should appear in those two sections.

The Problem List

The Problem List follows the Summary and is used to focus on the client's **current areas of concern** and their **most immediate areas of need**. This list is the basis for the initial TX Plan; **problems on the TX Plan are taken directly from the Problem List.**

Severities

Included in the Problem List is the counselor's Assessment of Severity for each dimension. Severities indicate how concerned the clinician and others involved in the client's care need to be about each assessment dimension. They are defined as follows:⁸

Level of Functioning/Severity		
Low Severity Minimal current difficulty or impairment. Absent, minimal or mild signs and symptoms. Acute or chronic problem mostly stabilized - or soon able to be stabilized and functioning restored with minimal difficulty.	Medium Severity Moderate difficulty or impairment. Moderate to serious signs and symptoms. Difficulty coping or understanding, but able to function with clinical and other support services and assistance.	High Severity Severe difficulty or impairment. Serious, gross or persistent signs and symptoms. Very poor ability to tolerate and cope with problems.

The descriptions of the current problems should support the counselor's choice of severity for each dimension. For example:

- *Dim. 4-Med. Referred by court; client states she wants to stop using meth but does not see alcohol as a problem.*

A common mistake that counselors make is:

- *Dim. 4-Med. Client really wants treatment and is willing to do whatever it takes.*

⁸ Dr. David Mee-Lee, July 30, 2003, Supervisor Intensive: Improving your Skills to Help Others Improve Their Skills in Assessment, Treatment Planning and Application to the Revised ASAM Patient Placement Criteria (ASAM PPC-2R)

In the first example, the medium severity is reinforced by what is written - an explanation that the client sees meth as a problem, but not alcohol (Discovery Stage). In the second example, the severity and the explanation are incongruent; instead of matching the severity, the explanation supports a low severity.

- ♦ **An Additional Note about Severity**

Dimensions 1, 2 and 3 (Acute intoxication and/or Withdrawal Potential, Biomedical Conditions and Complications and Emotional, Behavioral or Cognitive Conditions and Complications) involve concerns that could be medically or psychologically dangerous to the client. Only use a High Severity for these dimensions if the situation constitutes a medical or psychiatric crisis and emergency interventions are needed. A client who has a chronic condition and may need to seek medical help in the near future is a medium severity because there is no need to call 911 or immediately transport the client to the hospital.

Dimensions 4, 5 and 6 (Readiness to Change, Relapse, Continued Use or Continued Problem Potential and Recovery Environment) are not confined to the same requirements for assigning a high severity. If there were severe difficulty, persistent signs and symptoms and/or very poor ability to tolerate and cope with problems, a high severity would be appropriate.

The LOC and the TX Assessment pave the way for the client's individualized treatment plan. Be sure and refer to the Problem List when writing the initial treatment plan. If you find that you have written problems in the Treatment Plan that are not on the Problem List, back up and see if you missed something in the assessment.

Counselors often ask, "What do I do if a new problem emerges, but the TX Plan has already been written?" The counselor must document the new problem in the progress notes, add the new problem to the TX Plan, and have the client initial and date the change. (A new MD signature will also be needed at sites where MD signatures are required.)

It is important that all the documentation interrelates. The documentation should back-up the clinician's rationale for determining this Treatment Plan to be the most effective and efficient plan for this client. In turn, this information is sent to the next service provider in an attempt to provide smooth and productive transitions for our clients.

Chapter 3

THE TREATMENT PLAN

Overview

Treatment plans define the scope of the client's particular areas of concern and determine the severity of each area across the six Dimensions of the ASAM PPC-2R. The treatment assessment helps the counselor identify the client's immediate needs that will provide the basis for the treatment plan.

The following discussion of treatment plans represents the expected "standard of care" in the DADS treatment system in regards to creating an appropriate treatment plan using problem statements, action plans, and goals.

Treatment Plans are one of the most important tools to utilize when attempting to engage a client in treatment. Treatment Plans should be a collaborative, creative, client driven activity between the counselor and client that focuses on the client's view of their stated problems. The focus of a client driven Treatment Plan is on building a relationship between the counselor and the client (the Treatment Alliance). The treatment alliance generally begins during the assessment phase of a client's treatment episode. The relationship is strengthened or strained based on the level of "buy-in" the client experiences at the treatment planning stage. A client driven, individualized Treatment Plan is the basis for doing good treatment and gives the client a sense of accomplishment and success.

It is important to establish briefly stated, individualized problem statements because the creation of useful goals and action steps will easily follow. A counselor must be patient, empathetic, and understanding during this creative process. Rushing to get something down just to fill out all the paperwork will most likely not result in an individualized plan. When a counselor utilizes their training, creativity, and personal skills, they can create a collaborative atmosphere. This collaboration can enhance the client's motivation to look at the current, relevant problems they are motivated to work on resulting in a client driven, clinically guided Treatment Plan.

In the pages that follow, a more detailed description of the following areas will be covered: Problem Statements, Stages of Change, Goals, and Action Steps.

It is hoped that the information in this guide will prepare clinicians to create treatment documents that are useful, clinically driven, and that meet the standards of care expected in the DADS system.

PROBLEM STATEMENTS

♦ The Problem List

Problem statements are created as a direct result of the Treatment Assessment. Through the use of the ASAM Six Dimensions, the Treatment Assessment helps the counselor understand where both the client's strengths and weaknesses lie. The last page of the Treatment Assessment contains the Problem List, which the counselor uses to identify the client's most immediate areas of need. The Problem List serves as the springboard from which the problem statements on the treatment plan are taken. A good way to check yourself is to compare the completed treatment plan with the last page of the Treatment Assessment; you should find every problem from your treatment plan contained within the Six Dimensions of the Problem List. Make sure you place the problems on the treatment plan in the correct Dimensions.

♦ Client "Buy-In" to the Problem

Always ask whether the client agrees with the problems on their treatment plan. What the counselor believes is a problem may not be seen as a problem by the client. When clients are in the Discovery phase of treatment (pre-contemplation or contemplation) it is especially important to meet them where they are. When a counselor adopts a neutral attitude in relation to the client's readiness for change, the client feels safe to express their ambivalence or their belief they do not have a problem. It is crucial for the client to have this degree of rapport with their counselor. If the counselor has a bias that the client "should" recognize their "problem", it often comes across in the way the counselor writes the problem statement and goal and does not support the client and the treatment alliance.

An example of this discrepancy is a client in contemplation that is given the following problem: "My drug use causes me to go to jail"; and goal: "Understand why my drug use causes me to go to jail". It is obvious the

counselor believes the client has a problem, but the client would likely not agree, and therefore would not “buy-in” to the treatment plan. This creates a lack of trust in the counselor-client relationship that is hard to repair. A more appropriate problem statement would be, “The court believes I need treatment for my drug use, but I don’t think I need help.” The goal might be, “Prove to the court that you don’t need help.” The client is far more likely to “buy-in” to this problem and goal, which in turn enhances the treatment alliance.

- ♦ **The Root of the Problem**

An important counselor skill that takes time and practice to develop is the art of knowing when you have reached the root of a problem. Continue to ask the client more questions about why something is a problem. You can ask the client, “What makes you say that?” Or, “Tell me more about why that bothers you?” Clients often initially present issues on a surface level.

A residential client may state the problem as “I feel guilty about leaving my kids to come into treatment.” If the counselor took that problem at face value, they would write a Dimension 3 problem to help the client with their guilt. By going deeper into the matter, the counselor may find that the kids have been left with a relative who drinks and drives, and the client is concerned for the kid’s safety. The more immediate issue is a Dimension 6 problem.

- ♦ **Problem in Need of Improvement vs. Statement-of-Fact**

A problem in need of improvement is a concern that is current. A common mistake counselors make is listing a statement-of-fact instead of a problem in need of improvement. A statement-of-fact is often something that was true in the past. Example: Dimension 5: “When I stop taking my meds I feel like using.” This may be true if someone is currently not taking his or her meds as prescribed. However, once someone comes into treatment, they may have gotten back on their meds. If so, the problem is no longer relevant.

Compare these examples:

	Problem (Not so Good)	Explanation
Dim. 5	“When I stopped taking my meds I was triggered to use.”	This statement of fact refers to the client’s experience prior to entering tx and does not describe a current matter.

Ask yourself, “Is this still true today?” Perhaps the client has resumed taking their meds but is not yet stabilized and still experiencing symptoms. It would be more accurate to say:

	Problem (Better)	Explanation
Dim. 5	“My symptoms of anxiousness are stirring up cravings to use.”	This Dimension 5 problem is current.

This is an example of a similar problem from the perspective of a different dimension:

	Problem (Not so Good)	Explanation
Dim 3 (or 5b)	“I am taking my meds as prescribed, for my anxiousness.”	Does not provide enough specific information about why this is a problem; it is a statement of fact.

More information is needed. Are the client’s symptoms interfering with their well-being?

	Problem (Better)	Explanation
Dim 3 (or 5b)	“Despite taking my meds as prescribed, I still feel nervous and fearful.”	This problem is clear and leads into an obvious goal and action steps.

♦ **Negative Consequences**

In preparation for the Negative Consequence, find out what happens to the client when (in the above example) they are anxious. Common clinical terms like “stress”, “anxious”, “depressed”, etc. may not provide enough specific information about the client’s experience of the problem. For example, Counselor: “What happens when you are anxious or panicky?” Client: “Well, I get

very tense. I feel like I'm going to explode and I usually end up yelling at someone". The additional question(s) clarify the problem and clear the way to develop a measurable behavioral outcome.

The Negative Consequence (NC) is a brief, highly individualized statement that reflects what could happen if the client does not successfully resolve the problem noted in the problem statement. It is directly related to the problem statement. Think of the NC as a thought, feeling or behavior that may occur before or after the person uses.

	Problem (Not so Good)	Explanation
Dim 3 (or 5b)	"I am taking my meds as prescribed, but I still feel nervous and fearful." NC: I'll relapse.	This NC is generic, not specific to a particular client. It could apply to anyone in treatment.

	Problem (Better)	Explanation
Dim 3 (or 5b)	"I take my meds as prescribed but I still feel nervous and fearful." NC: I could end up yelling at my boss and get fired.	The NC states a realistic consequence based on the client's experience that could occur, if the client doesn't get relief from the problem.

Avoid generalizations. Negative consequences are very precise in describing what could be true for each individual client. Here is a rule of thumb to follow in determining if a NC is individualized: Suppose three counselors were familiar with the clients on your caseload. If you asked them which client tends to feel scared and explosive when anxious, it should be immediately obvious who the client is. Examples of generic non-specific consequences to any problem statement are: 'I'll relapse'; 'I'll feel out of control'; 'I'll use drugs'; 'I'll go to jail'; 'I'll lose my kids'; 'My problem will worsen'. These could be true of most anyone in a treatment program.

THE STAGES OF CHANGE

In writing effective treatment plans, the counselor takes the client's Stage of Change for each problem statement into account. This allows for a problem, goal, and action step(s) to be created that (1) match the client's own perception of the situation, (2) provides a motivational (personal) reason to address the situation, and (3) lays out a framework of tasks and actions that are understandable and reasonable to the client.

- ♦ **The Stages of Change (SOC) Model** (see attachment A)

The Stages of Change model describes a five-stage process that clients will cycle through:

- 1) **PRECONTEMPLATION:** The client has no intention to change. Often this is due to a lack of awareness. Typically, the client will present to substance abuse services in this stage because of outside influences; however, the client does not recognize the situation **as their problem**. They don't believe they have an addiction problem.
- 2) **CONTEMPLATION:** The client is willing to consider that there is **a problem** but does not believe they have an addiction problem. The client begins to consider that he or she may want to overcome the problem, but at best, **remains ambivalent about change**.
- 3) **PREPARATION:** This stage **combines an intention to change with a clear definition of the problem behavior**; the client has made a commitment to act and is making plans to do so in the near future.
- 4) **ACTION:** At this point in the process the client **modifies his or her behavior, experiences, or environment** to overcome the problem(s).
- 5) **MAINTENANCE:** The behavior that occurred in the action stage is maintained as the client **works to prevent relapse and to consolidate the gains** that have been made.

- 6) **RELAPSE:** The client returns to the problem behavior. At this point the current stage of change must be re-assessed relative to the return of the problem behavior and its consequences. (**Note:** people do not have to cycle through the relapse stage although many people do.)

The current standard of care in the DADS system is to assess and note the client's current stage of change for each problem on the treatment plan. Further, when formulating action plans counselors will use action steps that are realistic and appropriate for that particular problem and stage of change.

♦ **Assessing for the Current Stage of Change**

The current stage of change can be a difficult assessment task. The information comes from listening to **the client's description of the problem**, as he/she sees it, and from asking questions that give you more and more specific information about the client's behavior relative to the problem.

In determining a Stage of Change for a particular problem it is generally a good idea to first determine whether the client is in the "Discovery" (pre-contemplation, contemplation) stages or the "Recovery" (preparation, action, maintenance, relapse) stages. Clients will often give the impression that they are in the Recovery stages when they first enter treatment. It is very important at that time to dig a little deeper. Listen without judgment and see the problem(s) as they see it. It is important to **compare what the client is saying with the client's non-verbal behaviors**. Non-verbal behaviors often provide very accurate information regarding a specific SOC. Curiously questioning or "noticing" the difference between what your client is saying and what your client is doing, or equally important, what your client is not doing; usually provides a wealth of useful information regarding the SOC. Taking a curious "devil's advocate" position, or using the reflective listening technique can also be useful to differentiate between the Discovery and Recovery stages.

Counselor: “So you’re saying that you are ready to stop all this, huh?” **Client:** “Yea. It’s become a nightmare. I just can’t drink and party all night and get up in the morning like I used to. I guess I’m too old for this. I have to give it up”.

Counselor: “You’re going to stop completely?”

Client: “Yea, I’ve got to change my lifestyle. Those guys in AA are right. You have to stop all of that stuff completely. Stop hanging out with the drinking buddies, stop keeping stuff around the house and at work...you know.”

Counselor: “So, you’re saying that...hold on, let me ask you this – if you go to a wedding are you saying that you wouldn’t have a glass of champagne to toast the bride and groom?”

Client: “Sure, that’s OK. One glass of champagne at a special event, I mean that’s not like 10 or 12 beers after work”.

Discovery or Recovery? And remember, the Discovery stages aren’t a sign of failure or resistance. They aren’t a diagnosis. **They are just two of the stages in a cycle of five stages that all people go through** when they attempt to make significant life changes.

What is a realistic goal for a particular problem **given the client’s stage of change?** **It’s what the client wants to accomplish.** Having an open-ended conversation with the client during the interview helps the counselor see that clearly. Some easy-going, truly curious questions (e.g. “Devils Advocate”), can lead the interviewer right to the heart of the matter.

There are some basic strategies that a counselor can employ in working with each stage of change. There are some fairly specific, standard interventions used in the substance abuse treatment field for each stage of change, e.g. the “pro and con” or “cost-benefit” exercise for people in contemplation. These examples can help you use the Stages of Change as an assessment tool and as a treatment-planning tool. (See the Attachments at the end of this section for examples of SOC strategies and interventions)

As the counselor, once you understand that **your problem** is to understand how your client understands **their problem**, you are in the driver’s seat.

Determining the appropriate SOC leads you straight to a realistic goal and then on to action steps that are meaningful and can be accomplished by your client. The current Stage of Change is a vital piece of information in creating the most effective and efficient treatment plan for your client.

Stage of Change Trivia

- The Stages of Change model (Prochaska & DiClemente, 1982) was originally developed by a group of researchers who were attempting to find the most effective treatment for smoking cessation. The researchers did not find any significant differences between the various approaches at that time, but they did recognize a pattern of change that was common to all people as they worked on making significant life-style changes.
- Research conducted by James Prochaska, Ph.D., revealed that clients in the discovery phases typically have many negative reasons regarding change (many aversive “costs” associated with the change) and very few positive reasons (the “benefits” of change). Prochaska found that a person had to acquire approximately ***two times as many benefits for change relative to costs*** before they were able to move to the recovery phases of the stages of change.
- The Stages of Change model as applied to behavior change involving substance use (Prochaska, DiClemente, & Norcross, 1992) very quickly became a popular and valuable assessment tool in working with substance users.
- The data collected during the initial development of the Stages of Change model revealed that on average, ***people make seven serious attempts at a significant behavior change before they are successful.***
- Prochaska and colleagues (1992) stated that the vast majority (85 percent to 90 percent) of addicted people seeking substance abuse

services are not in the action stage when they enter treatment.

Engaging the client in treatment can be accomplished by providing services that match a client's present level of change. Many treatment programs and counselors have difficulty working with "Discovery" clients because they only know how to provide treatment services that match to people who are in the action or maintenance stage.

- The book "Change for Good", (Prochaska, et al: 1982), is a very interesting and readable explanation of the Stage of Change model. It comes in paperback and is an excellent book for counselors and clients.

Stage of Change Attachments (4 pages)

TEN EFFECTIVE CATALYSTS FOR CHANGE

1. **Consciousness raising** is increasing information about the problem. Interventions: observations, interpretations, and bibliotherapy.
2. **Self-reevaluation** is assessing how one feels/thinks about oneself with respect to problem behaviors. Interventions: clarifying values, challenging beliefs or expectations.
3. **Self-liberation** means choosing & committing to act or believing in ability to change. Interventions: commitment-enhancing techniques, decision-making therapy.
4. **Counter conditioning** involves substituting coping alternatives for anxiety caused by substance-related behaviors. Interventions: relaxation training, desensitization, assertion, and positive self statements.
5. **Stimulus control** means avoiding or countering stimuli that cue problem behaviors. Interventions: avoiding high-risk cues and removing substances from one's environment.
6. **Reinforcement management** is rewarding oneself or being rewarded by others for making changes. Interventions: contingency contracts, overt and covert reinforcement.
7. **Helping relationships** are created by being open and trusting about problems with people who care. Interventions: self-help groups, social support, therapeutic relationship.
8. **Emotional arousal** and dramatic relief involve experiencing & expressing feelings about one's problems & solutions toward them. Interventions: role-playing, psychodrama.
9. **Environmental reevaluation** is the process of assessing how one's problems affect the personal and physical environment. Interventions: empathy training and documentaries.
10. **Social liberation** involves increasing alternatives for non-problematic behavior. Interventions could include advocating for rights of oppressed and policy interventions.

SOURCE: DiClemente and Scott, 1997.

CATALYSTS AND THE STAGE OF CHANGE

STAGE of CHANGE	CATALYSTS
Precontemplation	<ul style="list-style-type: none"> • Consciousness raising • Self re-evaluation • Emotional Arousal and dramatic relief
Contemplation	<ul style="list-style-type: none"> • Self reevaluation • Emotional Arousal and dramatic relief • Environmental re-evaluation
Preparation	<ul style="list-style-type: none"> • Self-liberation • Counter-conditioning • Helping Relationships
Action	<ul style="list-style-type: none"> • Counter-conditioning • Stimulus control • Reinforcement management • Helping relationships • Self-liberation
Maintenance	<ul style="list-style-type: none"> • Helping relationships • Environmental reevaluation • Self-liberation • Reinforcement management

MOTIVATIONAL STRATEGIES FOR EACH STAGE OF CHANGE ⁹

CLIENT'S STAGE OF CHANGE	APPROPRIATE STRATEGIES FOR THE CLINICIAN
Precontemplation <i>The client is not yet considering change or is planning to change.</i>	<ul style="list-style-type: none"> • Establish rapport, ask permission and build trust • Raise doubts or concerns in the client about substance using patterns • Offer factual information about substance abuse • Provide personalized feedback about assessment findings • Explore pros and cons of substance use • Helping a significant other intervene • Examine discrepancies between the client's and other's

⁹ From: The Counselors Tool Kit. DADS. 6-22-04.ms

	<p>perception of the problem behavior</p> <ul style="list-style-type: none"> • Express concern and keep the door open
<p>Contemplation</p> <p><i>This client acknowledges concerns and is considering the possibility of change, but is ambivalent and uncertain</i></p>	<ul style="list-style-type: none"> • Normalize ambivalence • Help the client “tip” the decisional balance scales toward change by: <ul style="list-style-type: none"> ♦ Eliciting and weighing pros and cons of substance use and change ♦ Changing extrinsic to intrinsic motivation ♦ Examining the client’s personal values in relation to change ♦ Emphasizing the client’s free choice, responsibility and self-efficacy for change • Elicit self motivational statements of intent and commitment from the client • Elicit ideas regarding the client’s perceived self-efficacy and expectations regarding treatment • Summarize motivational statements
<p>Preparation</p> <p><i>The client is committed to and planning to making changes in the future, but is still considering what to do.</i></p>	<ul style="list-style-type: none"> • Clarify client’s own goals and strategies for change • Offer a menu of options for change or treatment • With permission, offer expertise and advise • Negotiate a change – or treatment plan and behavior contract • Consider and lower barriers to change • Help client enlist social support • Explore treatment expectancies and the client’s role • Elicit from client what has worked in the past either for him or others whom he knows • Assist client to negotiate finances, child care, work, transportation or other potential barriers • Have the client publicly announce plans to change
<p>Action</p> <p><i>The client is actively taking steps to change but has not yet reached a stable level</i></p>	<ul style="list-style-type: none"> • Engage client in treatment and reinforce the importance of remaining in recovery • Support a realistic view of change through small steps • Acknowledge difficulties for the client in early stages of change • Help client identify high-risk situations through a functional analysis and develop appropriate coping strategies to overcome these • Assist client in finding new reinforcers of positive change • Help assess whether client has strong family and social support

<p>Maintenance</p> <p><i>The client has achieved initial goals such as abstinence and is now working to maintain gains</i></p>	<ul style="list-style-type: none"> • Help client identify and sample drug-free sources of pleasure (i.e. new reinforcers) • Support lifestyle changes • Affirm the client's resolve and efficacy • Help the client practice and use new coping strategies to avoid return to use • Maintain supportive contact (e.g. explain to the client that you are available to talk between sessions) • Develop a "fire escape plan" if the client resumes substance use • Review long-term goals with client
<p>Relapse/Recycling</p>	<ul style="list-style-type: none"> • Help the client re-enter the change cycle and commend any willingness to reconsider positive change • Explore the meaning and reality of the recurrence as a learning opportunity • Assist the client in finding alternative coping strategies • Maintain supportive contact

Treatment Plan Goals

The client ultimately determines the goal(s). However, the counselor uses his or her interviewing and counseling skills to help guide the client towards a goal that is achievable and pertinent to the problem and the particular stage of change.

Goals are individualized, specific and applicable to the client's needs and abilities. The client should be able to see how working towards the goal will help to resolve the stated problem. This gives the client a sense of self-esteem and helps them feel they have accomplished something worthwhile toward their Focus of Treatment. For instance, a goal like "become abstinent from illicit drug use" is not realistic for a client in the Discovery Phase and not specific enough for a client in any stage.

It is important to create a goal that is not simply a re-statement of the problem. Goals are related to but opposite from the identified problem and are logical outcomes of the action steps. The goal should be current, informative, and relevant to addressing the problem. The goal should be stated in measurable terms using action-oriented language to illustrate the direction of change.

For example (below): This client wants to stop using for a period of time while going to court; he does not intend to stop using altogether. He likes his friends and does not want to change his lifestyle. The second problem and goal are more specific to the client. The goal is action oriented and leads to action steps that are measurable and provide a useful solution to the problem.

	Problem	<i>Explanation (Not so Good)</i>	<i>Explanation (Better)</i>
Dim. 6	I'm afraid I'll get arrested when I'm out with my friends because they drink and use drugs. NC: I could get bumped up to formal probation instead of DEJ. Contemplation Stage	Develop a clean & sober support group of friends.	Evaluate the pros and cons of being with your friends who drink and use drugs.

Here are some additional examples of “not-so-good” and “better” Treatment Plan Goals developed around the client’s particular Stage of Change. (See Section 3 Stages of Change)

	Problem	<i>Explanation (Not so Good)</i>	<i>Explanation (Better)</i>
Dim. 4	I want to know how to get off probation and still use. NC: I can't keep my girlfriend if I stop using. Precontemplation Stage	Recognize my problem with drug and alcohol use.	Explore w/ counselor the possibilities of continued use and successful completion of probation.
Dim. 4	Problem: I'm not sure I want to stop using drugs. NC: My brother threatened to kick me out of his house. Contemplation Stage	Understand all I can about addiction.	Explore the advantages and disadvantages of using.
Dim. 5	Problem: I don't know how to stay sober now that I am out of jail. NC: I don't take my child to school when I am using. Preparation Stage	Stay clean and sober.	Learn to apply coping and relapse prevention skills.

Regarding the issue of short-term goals vs. long-term goals, keep in mind that long-term goals are generally for treatment modalities of 6-months or more. In other words, try not to use goals that require extended time frames to solve a problem. Help the client choose goals that are realistic and obtainable within the current level of treatment. This supports the client to experience a successful and positive view of their treatment and gives them the motivation to move successfully through the continuum of care

ACTION STEPS

Action steps are the nuts and bolts of the treatment plan. They are the specific elements that combine to produce change for a given problem. Like problem statements and goals, action steps need to be current, relevant to the client, and achievable during the current treatment episode.

Action steps are better if they are informative of the treatment. They should explain the direction of the treatment and not just be lists of things to do. (E.g.: “Read the chapter on relapse issues” versus, “Read the chapter on relapse issues and list three ideas that were new to you. Bring the ideas to group in 2 weeks on 6/2”).

♦ How to Create Action Steps

By now the counselor and client have completed the assessment and the counselor thoroughly understands the clients Focus of Treatment and Stage of Change. The problem(s) and goal(s) are established. Guided by the Stage of Change for that problem, the client and counselor brainstorm what new thoughts, feelings, actions, and/or experiences, if practiced, would help the client achieve his/her goal. The counselor uses his or her expertise to formulate the two action steps so that they are directly related to the problem and are specific tasks the client can report back on. The action steps are incremental and logically built on each other so that the client can strategically accomplish the goal. If the action steps are on target, the action plan will make sense to the client and validate the client’s own perception of the problem.

Steer clear of generic treatment plans. Most clients in treatment may need help with relapse prevention or a safe, supportive living environment; but avoid the pitfall of using the same action steps over and over for each client. Repeating problems, goals, and action steps creates generic treatment plans, which do not take into account the individual differences of the clients in

treatment and cannot measure the client’s response and movement during their treatment process. They fail the client in treatment because the client’s personal motivation and Focus of Treatment are missing.

Use your creativity. Think about the person for whom you are writing. For example, if they are in a recovery stage of change for a certain problem, you will want to provide them with the means to help them accomplish their goal.

For example, the action step “Develop a relapse prevention plan”, is not incremental. Some steps might be: 1) Read the handout describing ways to prevent relapse, 2) From the handout choose 2 relapse prevention ideas listed and discuss in group how you would use them, and 3) Begin practicing the relapse prevention ideas and write a brief note daily about when you use them and the result. The next progressive step might then look like:

Problem	Goal	Action Steps
<p><u>Dim. 6</u> I’m worried I’ll lose my job, but I don’t want to stop using.</p> <p>Pre-contemplation</p>	Keep my job.	<ul style="list-style-type: none"> Brainstorm with counselor any possible barriers to achieving goal. List 2 things I can do to keep my drug use from resulting in job loss. Discuss in next group session.
<p><u>Dim. 6</u> I’m worried I’ll lose my job, but I don’t know if I want to stop using.</p> <p>Contemplation</p>	Keep my job.	<ul style="list-style-type: none"> Compare and contrast my job performance when I’m high vs. when I’m clean. Bring ideas to group on May 5.

Action Steps are treatment interventions and as such, are unique to each client. They are creative and informative. These new steps that the client has agreed to act on must be interesting and challenging enough to elicit the client’s attention and motivation. They must make sense and be meaningful to the client. And perhaps, most importantly, they need to be achievable by the client. Action steps should not intimidate, overwhelm, or insult the client. Action steps that are completed give the client a sense of competency and confidence to carry out

more difficult tasks toward their improvement in the future. It is important that we create action steps that help our clients succeed.

It is essential to good treatment that client outcomes can be assessed. Action Steps need to be measurable and verifiable in order to determine their effect on client outcome. Action steps are tasks that have been agreed upon by the client to try in order to change/create new behaviors. Obviously, it is important to know if the client tried. This is why action steps must be measurable and verifiable. It is important to know if they had an effect. If the client didn't attempt to try out the new actions what was the reason? If there was no effect from the new actions what was the reason?

The action steps you create become a set of individualized directions that the client can follow to reach their goal. Imagine yourself to be the “YAHOO! Maps” program for your client. The client sits before you just like you sit in front of your computer and do a MAPS SEARCH for Driving Directions. The client knows where he/she wants to go. You have an enormous amount of street information at your disposal, but – you need to know the specifics of where the client wants to go first. If they say they want to go to San Jose, and you don't ask for more specific, individualized information, you could send them to Costa Rica!

The action steps are the directions we give to a client. It is vital to the success of their journey that we give them effective and efficient directions to solve their problems.

Chapter 4

PROGRESS NOTES

Progress notes are vital to good clinical treatment. Counselors often see progress notes as “busywork” and consequently write them in ways that don’t enhance the client’s treatment episode. Carefully documenting the treatment process can be time consuming, and often tedious, but it is critical to quality treatment. The written record supplies the details of how the client utilized their treatment plan. It is similar to drawing a map, in that it charts the client’s journey through the continuum of care.

A quick review of progress notes is the best way to refresh your memory when you sit with your clinical team to discuss your client’s progress. It is common to have case conferences with social workers, mental health case managers, PO’s, and other related professionals. Life-changing decisions are often made in those meetings and it is essential that the counselor is able to give a complete picture of their client’s progress and/or lack of progress.

Remember that the purpose of progress notes is not to satisfy supervisors and auditors; the primary purpose is to improve and enhance the treatment process by helping the counselor track the client’s progress in treatment while staying focused on the treatment plan. Good progress notes also assist other program staff to participate intelligently in the client’s treatment process. If the primary counselor is not available to provide support to the client, the chance that another counselor will be able to provide meaningful assistance may be dependent on the quality of documentation in the progress notes. A series of notes that only reports the client’s attendance and indicating that they had “good participation” are clinically useless.¹⁰

¹⁰ From: Calif. ADP Drug Medi-Cal Training Guide. 10march05

The Process of Change

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

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

Counselors have a tendency to just note that the client attended a group or watched a film or was part of the discussion of a particular topic. Phrases like "good participation", "participated actively", "attended and participated appropriately", etc. do not document progress or lack of progress, only that the client was there and apparently talking. Even a statement that the client "shared her triggers with the group" does not provide enough detail to evaluate progress or lack of progress. A far better note would state "Client demonstrated an understanding of her relapse triggers by sharing that rainy days and Mondays (or whatever) always bring her down and makes her feel like using."¹¹

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

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

¹¹ From: Calif. ADP Drug Medi-Cal Training Guide. 10march05

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

- ♦ **The Counselor’s Interventions**

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

- ♦ **Client Responses**

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

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

♦ **Lack of Progress**

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

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

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

Chapter 5

Counselor's Thesaurus

The Counselor's Thesaurus is a compilation of terminology and descriptive synonyms that can help the clinician find just "the right word" and help with creativity.

AFFECT (Mood or Disposition)

PLACID - PEACEFUL, RESTFUL, TRANQUIL

PREOCCUPIED - ABSORBED, ENGROSSED, LOST IN THOUGHT

PERSONABLE - FRIENDLY

PLEASANT - AFFABLE, AGREEABLE, AMIABLE

PASSIVE - INACTIVE, INERT, UNRESISTANT

ENTHUSIASTIC - ENTHUSED, ARDENT, ZEALOUS

TEARFUL - WEEPY, TEARY

DEPRESSED - DEJECTED, DISPIRITED, DISHEARTENED

CONTROLLED - DETERMINED, REGIMENTED, DISCIPLINED

FLAT-SHALLOW, DULL, SPIRITLESS

BLUNTED-CURT, ABRUPT, BRUSQUE

DETACHED - INDIFFERENT, IMPERSONAL

EUPHORIC - BOUYANT

ELATED - JOYFUL

JOVIAL - MERRY

LIGHTHEARTED - CAREFREE

CHEERFUL - HEARTY

OPTIMISTIC - SMILING

PLACID - QUIET

SOBER - SEDATE

SERIOUS - EARNEST

SOLEMN - GRIM

GRAVE - SOMBER

BROODY - MEDITATIVE

DEJECTED - DISHEARTENED

DESPONDENT - DISMAL

HOPELESS - DESPERATE

APPROPRIATE - PROPER, CORRECT, LEGITIMATE
EMOTIONALLY LABILE - INSTABILITY, MOOD SWINGS

APPEARANCE

EMACIATED

ATTITUDE

INDIFFERENT - NONCHALANT, UNCONCERNED

APATHETIC - INERT, ABSENCE OF AFFECT

SUSPICIOUS - DISTRUSTFUL

BELLIGERENT - QUARRELSOME, DISAGREEABLE

ANXIOUS - FEARFUL, APPREHENSIVE

CHEERFUL - OPTIMISTIC

BEHAVIOR

1.IMPULSIVENESS (DETERMINATION)

RECKLESS - IRRESPONSIBLE RASH - IMPRUDENT

IMPETUOUS - IMPULSIVE

EXCITABLE - ROUSING

HASTY - HURRIED

ABRUPT - UNEXPECTANT

RESTLESS - UNEASY

SPONTANEOUS - IMMEDIATE

MOBILE - VARIABLE

SELF-POSSESSED - SERENE

COOL-HEADED - LEVEL-HEADED

DELIBERATE - CAREFUL

CONTROLLABLE - REGULAR

RESTRAINABLE - REPRESSIBLE

OVER-CAUTIOUS - TOO CAREFUL

SLUGGISH - LETHARGIC

2.DOMINANCE

DICTATORIAL - DOMINATIVE

AUTOCRATIC - SELF-WILLED

HIGH-HANDED

MASTERFUL - SHOWING LEADERSHIP

FORCEFUL - EFFECTIVE

ASSERTIVE - CONFIDENT

DECISIVE - CONCLUSIVE

COOPERATIVE - CO-ACTIVE

CONFORMABLE - HARMONIOUS

COMPLIANT - YIELDING

COURTEOUS - POLITE

TIMID - FEARFUL

MEEK - SUBMISSIVE

SERVILE-TOO OBEDIENT

3.WORK HABITS

CONSISTENT-REGULAR

DELIBERATE-MASTERFUL, FORCEFUL

METICULOUS-NEAT

DEPENDABLE-RELIABLE

INITIATIVE-CREATIVE, SPONTANEOUS

ERRATIC-INCONSISTENT

NEEDS REASSURANCE

ORGANIZED

FOLLOWS-THROUGH

NEED FOR APPROVAL

REACTION TO CRITICISM

NEED FOR SUPERVISION OR INSTRUCTION

COGNITION (THOUGHT PROCESS)

JUDGEMENT

PROBLEM SOLVING

DECISION MAKING

GOAL SETTING

COMPREHENSION

MEMORY

FLEXIBILITY (ACCOMODATION)

UNBENDING-UNYIELDING, RIGID

PERSISTING-TENACIOUS

STUBBORN-INFLEXIBLE, RESISTIVE

HABITUAL-REPEITIOUS

CONVENTIONAL-CUSTOMARY

ADAPTABLE-AMENABLE-SUGGESTIBLE

DOCILE-MANAGEABLE

YIELDING-SUBMISSIVE, PASSIVE

SPINELESS-NERVELESS

ORIENTATION

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

PSYCHOMOTOR FUNCTIONING

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

SELF-ESTEEM

SELF-EXALTED - SELF-GLORIOUS
POMPOUS - OSTENTATIOUS
CONCEITED - VAIN, GLORIOUS
BOASTFUL - BRAGGING
VAIN-SELF- ADMIRABLE

COCKY - PERT
CONFIDENT - SELF-RELIANT
SELF-RESPECTIVE - SELF-ASSURABLE
MODEST - PROPER
UNASSUMING - UNPRETENTIOUS
HUMBLE - UNASSUMING, MODEST
SELF-UNCERTAIN, SELF-DOUBTFUL
SELF-EFFACIVE - INCONSPICUOUS
FORLORN - MISERABLE

SOCIALIZATION (RESPONSE TO OTHERS)

DEPENDENT
POSSESSIVE
HOSTILE
RESISTIVE
COOPERATIVE
BELLIGERANT
SARCASTIC
CRITICAL
SEDUCTIVE
PROVOCATIVE
JEALOUS
DEMANDING
HELPFUL
SUPPORTIVE
INGRATIATING
CONFORMING
AGGRESSIVE ASOCIAL
MANIPULATIVE
DOMINEERING
EXHIBITIONISTIC
COMPETITIVE
DEFENSIVE
SOCIAL SKILLS
ACCEPTANCE OF OTHERS

SPEECH

1. CONTENT

SUPERFICIAL

SARCASTIC – CAUSTIC
NAGGING - FAULT FINDING
GOSSIPY – PRYING
VULGAR – COARSE
OBSCENE – INDELICATE
INCOHERENT
BIZARRE
RAMBLING
NEGATIVE
HOSTILE
IDEATION
PARANOID
OBSESSIVE
CRITICAL
DEROGATORY
EUPHORIC
IDEAS OF REFERENCE
INCONSISTENT
INSIGHTFUL
AMBIVALENT
FLIGHT OF IDEAS
WORD SALAD
ILLUSIONS
CONFABULATION
FLUENT
ELOQUENT
POETICAL - LYRICAL
WITTY - HUMOROUS
COMICAL - WHIMSICAL
PROSAIC - TEDIOUS
COMPLIMENTARY - FLATTERING
LAUDATORY - ADMIRABLE
POLITE - COURTEOUS
CONTEMPLATIVE - MEDITATIVE
FRANK - CANDID
EXPLANATORY - INFORMATIVE
LITERAL - EXACT

EVASIVE - ELUSIVE

2. EXTENT (INTERACTION)

MEDDLESOME

INTIMATE - PERSONAL

GREGARIOUS - SOCIABLE

ASSOCIATIVE - PARTNER-LIKE

COMPANIONABLE - FRIENDLY

ACCESSIBLE - APPROACHABLE

HESITANT - RELUCTANT

RESERVED - WITHDRAWN

BASHFUL - TIMID

SHRINKING - SHY

RETICENT - UNCOMMUNICATIVE

SECLUSIVE - CLOISTERED

SOLITARY - SINGLE

ISOLATED - APART

3. FLOW (RHYTHM)

RHYTHMIC - METRICAL

CADENCED - UNIFORM

FLUENT - FLOWING

NATURAL - OSCILLATORY

SLOW - RETARDED

TREMBLING - FALTERING

STAMMERING - HALTING

SLURRING - INDISTINCT

DYSPHASIA - DIFFICULTY SPEAKING

ASPHASIA - INABILITY TO SPEAK

4. TONE (PITCH)

LOUD

LOW, QUIET

BOISTEROUS - VOCIFEROUS

EXHUBERANT - EFFUSIVE

LOUD - CLAMEROUS

LIVELY - VIVACIOUS

MELLOW - DELICATE

SOFT - GENTLE

QUIET - CALM
SOBER - EVEN-TEMPERED
MONOTONOUS - FLAT, DULL
INARTICULATE
WARMTH (REFLECTION)
OVER-INDULGENT – EXCESSIVE
DOTING - FOND
SENTIMENTAL – EMOTIONAL
TENDER – HUMANE
COMPASSIONATE
CONGENIAL - CORDIAL
CONSIDERATE - CHARITABLE
COOL - SLIGHTING
UNRESPONSIVE - UNSYMPATHETIC
DETACHED - ALOOF
FRIGID - COLD, RESERVED
UNFEELING - HARD, COARSE
DISDAINFUL – SCORNFUL
PASSIONATE – AVID
VEHEMENT – INTENSE
FERVENT - ENTHUSIASTIC

Chapter 6

Teaching Points for the Clinician's Guide

Clinical Interviewing

- **Overview**

Importance to the alliance

Defined – “conversation with a purpose”

- Several types – focus in on the 1st contact/intake

Benefits of doing a good interview

- Saves time
- Research shows outcomes higher when counselor attends to the relationship

You have to work with your client's perceptions of the problem/situation

- **Clinician Qualities/Attitude/Behaviors**

Counselors need to be aware of their own preconceived perceptions/biases/beliefs. Give examples.

Counselor is working for the client

Qualities:

- Transparent
- Understanding
- Tolerant
- Patient
- Empathic
- Flexible
- Open
- Curious
- Stay open – no assumptions

Questions, reflections, validation and let the client define why/what.

What do you do when you are stuck – make an empathic statement, keep asking until you've 'got it'

Time management

Define purpose of session

Keeping clients on track

Ending the conversation

Conversation + paperwork

Reading the client and responding to it (not reacting): verbal & nonverbal

How do you know you're on the right track?

- 1st contact/"Intake"

1 - Assessment

- Focus of Treatment (FOT)

- Agreement to tx – tx plan

- Multidimensional Assessment (MDA) define as ASAM Multi-Dimensional Assessment

2 - Building Alliance – Examples of how to build alliance while collecting info.

- Session Rating Scale (SRS) – "first line" tool

- Matching Stage of Change (SOC), language, affect and theory of change

- Client's definition of your role

Stress that both #1 and #2 are the objective

Mental Health Issues with Clients

DDX capable – define, everyone in our system is...

Important to treat DDX clients with tolerance, flexibility, sensitivity to their illness and sx's

Get supervision

Other Contacts

Responsibility of tx alliance belongs to the counselor.

Repairing tx alliance

Keep it working: apologies,

How (are we doing?) and When (No shows, hiding out)

Crisis

Purpose is to assist client with an immediate crisis

Focus on identifying the immediate problem and assess lethality

Assist client in problem-solving ways to cope with the problem

Assist client with referral for help

Empathy

Validation

"1:1's"

Awareness of the intimate nature of 1:1's

Reviewing of progress/assignments

Client's Theory of Change

Taking the temperature of the alliance

Treatment Transitions

- Referrals
- Terminations
- Discharges

Professionalism – No client abandonment

If termination is aversive client not likely to access gains made in tx

Review strengths - make termination, completion, transfer, referral positive (if possible)

The Treatment Plan

Overview

- client driven with clinical direction
- the importance of a tx plan: good tx, directs tx, helps tx, keeps tx focused, builds treatment relationships,
- gives client a sense of accomplishment and success
- Treatment Focus
- treatment relationship starts at assessment
- if you get the problem statement right – the rest will come.

Therapist Qualities During Treatment Planning

- empathy
- understanding
- patience
- tolerance
- focus on tx relationship
- validation

Problem Statement

- Still a problem today?
- Narrow down/specific
- Negative Consequences directly related to the problem – thought, feeling, behavior that occurs before you use or as a result of using
- What made you say that?
- Current
- A problem the client is willing to work on
- Informative
- Individualized

Stages of Change

- Specific for each problem
- Current
- Assessment not judgment
- Client's SOC not counselor's diagnosis
- Assess both words and actions

Goals

- Opposite of problem
- Reinforces SOC
- Keep the goal out of the problem
- Current
- Needs to be relevant to the problem
- Long term or short term
- Informative
- Individualized

Action Steps

- Reinforces goal
- Incremental
- Specific
- Realistic to client
- Matches SOC
- Measurable outcome
- Current
- Action step client can complete within treatment episode
- Creative
- Informative
- Individualized

Progress Notes

Overview

- Majority will be relative to treatment plan
- Plus notes relative to incidents that occur during treatment episode
- Write specifics of interventions and responses
- Provide clearly marked interventions and responses correspond to # Dim, problem #, AS #
- Only clinical observations – not opinions, judgments by counselor

3 Elements

1. counselor interventions
2. client's responses
3. process of change; results of interventions and responses

Counselor's Interventions

- relevant to treatment – corresponds to AS
- examples of interventions – how to document interventions
- specifics of interventions
- clearly noted – e.g. corresponds to Problem #, Dim #, AS # in the tx plan

Client Responses

- Specifics of responses
- clearly noted e.g.; corresponds to # Dim, problem #, AS #
- brief, coherent, specific, succinct, only relevant information
- document significant clinical observations, not unsupported statements, judgments, personal feelings

Process Of Change

- picture of the client from beginning to end tell a story
- notes that indicate client is being prepared for next LOC and/or discharge

- document lack of progress
- process of change noted thru documentation of SOC movement
- interventions X response = process of change (what did the client get out of this process?)
- document significant clinical observations, not unsupported statements, judgments, personal feelings