Individual Substance Abuse Counseling (ISAC) Manual

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March, 1995

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Acknowledgment

The Individualized Substance Abuse Counseling (ISAC) manual is one of a series of technical documents that were originally developed by the staff of the Research Triangle Institute (RTI) to serve as a guide for implementing and monitoring the Methadone Enhanced Treatment (MET) study. It was revised in order to replicate and further refine the individualized substance abuse counseling approach under the Training and Employment Program (TEP) study. The manual incorporates many of the original and subsequent training materials, procedures, and memoranda regarding the assessment, treatment planning, vocational and ancillary services, interactions with other community services agencies, and some of the preliminary findings to date.

The goal of this ongoing work is to improve the linkage between assessment, treatment planning, and evaluation, and to improve coordination between staff members to meet the client's needs. Our intent is to develop a protocol to allow counselors to start with clients wherever they are and move them along in a comprehensive continuum of rehabilitation. While this manual was primarily developed in methadone treatment programs, there are few components that are actually specific to methadone. The manual has therefore been written so that it can easily be generalized to other settings and populations.

The original enhanced counselor manual (Fairbank, Bonito, Dennis, & Rachal, 1991b) was developed from 1988 to 1991 by RTI in collaboration with the directors, staff, and clients of four MET treatment programs: Desire Narcotics in New Orleans, LA; William Segaloff Substance Abuse Center of Southern Jersey, Inc., in Camden, NJ; the Sisters of Charity Pathway program in Buffalo, NY; and PBA, Inc.: The Second Step, in Pittsburgh, PA. The manual and MET study were funded through Grant No. R18-DA-7262 from the Community Research Branch of the National Institute on Drug Abuse (NIDA) to J. Valley Rachal under the National AIDS Research Demonstration (NADR) program. The goal of that grant was to make methadone treatment more effective and, consequently, reduce the spread of the Human Immune Deficiency Virus (HIV).

This ISAC manual builds and expands on the original manual and several other RTI publications. It was developed in 1993 under grant No. R01-DA-07964 from the Services Research Branch of NIDA to Dr. Michael L. Dennis and the directors of the three TEP sites:

- Ken Bossert and John Guyett at the Sisters of Charity Pathway program in Buffalo, NY;
- Marlene Burks and Paul Ingram at PBA, Inc.: The Second Step in Pittsburgh, PA; and

- Helen Greer and Robert Garner at the Santa Clara County Bureau of Alcohol and Drug Abuse Programs, San Jose, CA.

We have relied heavily upon the cooperation of the directors and professional staff of the methadone programs in which the research was conducted. Both studies involved significant amounts of work beyond their normal duties for many of the programs' administrative and clinical staff persons. In MET, *every counselor* was asked to keep detailed service logs. Counselors who were randomly assigned to the enhanced treatment condition were also asked to dramatically increase the frequency, duration, and intensity of contacts with their newly assigned clients in the enhanced treatment and to change how they actually conducted their counseling session. In TEP, *every counselor* learned to conduct 2-hour psychosocial assessments, using the Global Appraisal of Individual Needs (GAIN, Dennis, Rourke, Lennox, Campbell, & Caddell, 1995), to conduct hour long quarterly follow-ups, and to work with a vocational specialist (Karuntzos, Dennis, French, & Norman, 1995). Those who have been involved with drug abuse treatment in any form will appreciate the enormity of these tasks. The fact that the counselors largely complied with these demands reflects their commitment to providing the best possible treatment for their clients and is a credit to the hard work of the on-site clinical supervisors and program directors who fostered a spirit of commitment and camaraderie among the counselors and other staff. We would like to acknowledge this commitment and effort by thanking the original and subsequent program directors and staff of the five programs, specifically:

- Vernon Shorty and Linda DeCuir, Victor Diaz, Howard Gaskin, Joe Gilliam, Myra Gills, Henry Henderson, Wilma Hurley, Donna Myers, Romalas Nevilles, Barbara Price, Curtis Smith, and Mel Walker of Desire Narcotics Rehabilitation Center, Inc., in New Orleans, Louisiana.

- LaVerne Carpenter and Marcella Bass, Cynthia Brown, Keith Brown, Jackie Clyde, Maria Conception, Jeanne Giles, Rosalind Gilliams, Frank Gosnell, Suzanne Kinkle, Richard Lovelace, Sondra Malone, Dorothy Marden, Michelle Norquest, Bob Peckham, James Pernell, Tom Rudderow, Jeff Schralow, George Smith, and Robert Toraine of William C. Segaloff Substance Abuse Center of Southern Jersey, Inc., in Camden, New Jersey.

- Jim Nowak/Ken Bossert/John Guyett, and Maria Baraba, Juanita Brown, Robert Dugan, Roberta Hanesworth, Joyce Heath, Jamie Herrman, Gary Hohl, Sandra Hooten, Richard Landers, Dawn Mages, Thelma Miles, Lucy Mosby, Judy Nannen, Judy Perkowski, Diane Ross, Clark Siminski, Larry Stovall, Lourdes Torres, Marcelle Watson, and Lester Wilcox of the Sisters of Charity Hospital's Pathway Clinic in Buffalo, New York.

- Paul Ingram/Marlene Burks and Frederick Anderson, Mark Bedillion; Alfred Brown, Marlene Brown, Thomas Caffrey, Alvin Canty, George Clark, Brenda Coleman, Cynthia Cook, Michael Creighton, Gwen Dunn, John Epps, Joyce Ford, Calvin Jones, Camille Francisco, Michael Goodson, Taryan Harris, Ronald

Johnson, Doris Jones, Kathy Leonard, Erika Lloyd, Linda Patton, Wade Powell, Geraldine Reynolds, Susan Ross, Linda Shaw, Mildred Smith, Chris Spann, Greta Stone, Dave Vargo, James Washington, Wesly Weston, Donna Williams, Dorothy Williams, and Charles Wilson of PBA, Inc.: The Second Step, in Pittsburgh, Pennsylvania.

- Lou Matia/Helen Greer and Iris Barrie, Amy Brinkman-Viall, Sharlene Carlson, Pamela Clark, Al Corona, Kathleen Couff, Ethel Dansby, Rich Derr, Karen DeSanti, Mary Mahood, Dale Mallet, Norman Mastalarz, Helen Norman, Joan Riley, Marge Rogers, Eileen Romero, Stella Rosado, Raul Soza, Peg Trevisan, Richard Vasquez, and Jolene Wing of Santa Clara County Bureau of Alcohol and Drug Abuse Programs, in San Jose, CA.

While we cannot acknowledge them personally because of the need to preserve confidentiality, we also wish to thank the approximately 900 clients who gave their time and effort to participate in the MET and TEP research.

We are especially grateful to Dr. Arthur Nezu for his important contributions and invaluable guidance in the development of the original problem-solving component of ISAC. While some are also listed as authors, we would like to acknowledge the leadership and contributions of certain coauthors:

- Drs. Cathy Bradley and Michael French for background on the cost of enhanced counseling in Chapter 2;
- Dr. Juesta M. Caddell for the step-by-step summary in Chapter 3 and the training curriculum in Appendix C;
- Drs. Ward Condelli and Thomas Payte for their materials on the effectiveness of methadone treatment;
- Ms. Kathy Rourke for her contributions on doing standardized needs assessments in Chapter 4;
- Dr. John Fairbank for his contributions on structured counseling in Chapter 6 and much of the early version of the manual;
- Dr. Arthur Bonito for the basis of self-efficacy in Chapter 3;
- Dr. E. Joyce Roland for her contributions on medical problems in Chapter 7;
- Ms. Georgia Karuntzos for her contributions on vocational problems in Chapter 7; and
- Mr. Ken Bossert, Mrs. Marlene Burks, Mr. Alfred Brown, and Mrs. Sandra Hooten for their contributions on case conferencing, training, and other staffing issues in Chapters 7 and 8.

Acknowledgment

We would also like to acknowledge the assistance we received from several people in selecting, developing, and reviewing the initial MET protocol. These include Drs. Francis R. Abueg, John C. Ball, Barry S. Brown, Peter Delany, Bennett Fletcher, A. Thomas McLellan, R. Nemeth-Coselett, Arthur Nezu, and Jerome Platt. In particular, Dr. Brown consistently supported and encouraged our efforts to go beyond simply labeling the treatment conditions in the initial MET experiment and Dr. Delany has relentlessly prodded us to refine the manual for general dissemination. Finally, the authors and other TEP staff would like to thank Supatra Campbell and Anne Theisen for assistance in preparing the data analyses as well as Linda B. Barker, Teresa F. Gurley, Elizabeth MacDonald, Bruce MacDonald, and Richard S. Straw for assistance in preparing the various versions of this manual.

We welcome suggestions or comments about how to make this and further manuals better or easier to use.

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Exhibits

Abbreviations

AA	Alcoholics Anonymous
ABLE	Adult Basic Learning Examination
AFA	AIDS Follow-up Assessment
AIA	AIDS Initial Assessment
AIDS	Acquired Immune Deficiency Syndrome
AMA	American Medical Association
APA	American Psychological Association or American Psychiatry Association
ARA	Administrative or Research Assistant
ASCII	American Standard Code of Information Interchange
ASI	Addiction Severity Index
ASPD	antisocial personality disorder
BCPI	Behavioral Counseling Proficiency Index
CAMPUS	Campus Treatment Projects Handed by CSAT
CAP	Client Assessment Profile
CAPI	Computer-Assisted Personal Interview
CAPS	Career Ability Placement Survey
CDC	Centers for Disease Control
CDS	Client Data System
CEC	Client Encounter Checklist
CFR	Code of Federal Regulations
CID	Case Identification (number)
CII	Client Interest Inventory
CNS	Central Nervous System (depressants)
COPS	Career Occupational Preference System
CRAF	Client Record Abstraction Form
CSAT	Center for Substance Abuse Treatment
CSC	Community Services Coordinator (Manual)
DARP	Drug Abuse Reporting Program
DAT	Differential Aptitude Test
DATAR	Drug Abuse Treatment for AIDS-Risks Reduction
DATOS	Drug Abuse Treatment Outcome Study
DCI	DC Initiative
DDE	Distributive Data Entry
DHHS	Department of Health and Human Services
DSM-IIIr	Diagnostic and Statistical Manual Version-III (revised)
DTEP	Developing Training and Employment Programs (pilot study grant)
DVR	Division of Vocational Rehabilitation
FDA	Food and Drug Administration
FICS	Fully Integrated Control System (Manual)
FTE	Full-Time Equivalent (employee)
FY	Fiscal Year
GAIN-I	Global Appraisal of Individual Needs-Initial
GAIN-P	Global Appraisal of Individual Needs-Profile
GAIN-Q	Global Appraisal of Individual Needs-Quarterly
GAO	General Accounting Office
GATB	General Aptitude Test Battery
GCPI	Group Counseling Proficiency Index
GED	Graduate Equivalency Diploma

Abbreviations (continued)

HIV	Human Immunodeficiency Virus
HSCL	Hopkins Symptom Checklist
IAP	Individual Assessment Profile
IBR	Institutes for Behavior Resources
IDU	Injecting Drug User
IEI	Intreatment Experience Interview
ISAC	Individualized Substance Abuse Counseling (manual)
IVDU	Intravenous Drug User
JCAHO	Joint Commission of the Accreditation of Health Care Organization
JTPA	Job Training and Partnership Act
MAEP	Metropolitan Adult Education Program
MAPS	Mature Adult Placement Services
MBTI	Myers-Briggs Type Indicator
MCMI-II	Millon Clinical Multiaxial Inventory-II
MET	Methadone Enhanced Treatment (study)
MMPI	Minnesota Multiphasic Personality Inventory
MTP	Methadone Treatment Programs
MTQAS	Methadone Treatment Quality Assurance System
NA	Narcotics Anonymous
NADR	National AIDS Demonstration Research Project
NCADI	National Clearinghouse on Alcohol and Drug Abuse Information
NHSDA	National Household Survey on Drug Abuse
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NTIES	National Treatment Improvement Evaluation Study
OMB	Office of Management and Budget
OVR	Office of Vocation Rehabilitation
OTI	Office for Treatment Improvement (changed to CSAT)
PAYES	Program for Assessing Youth Employment Skills
PBA	Pittsburgh Black Action
PDS	Program Director's Survey
PERI	Psychiatric Epidemiological Research Interview
PHS	Public Health Service
PIC	Private Industry Council
POS	Problem Orientation Scale
PR	Program Researcher
PSS	Problem Solving Scale
PSW	Problem Solving Workbook (manual)
RP	Relapse Prevention (manual)
RTI	Research Triangle Institute
RTIFSS	RTI Forms Systems Software
RWCCL	Revised Ways of Coping Checklist

Abbreviations (continued)

SAODAP	Special Action Office for Drug Abuse Prevention
SAMSA	Substance Abuse and Mental Services Administration
SEL	Service Encounter Log
SII	Service Interest Inventory
SECTOR	Strategies to Enhance Cocaine Treatment and Outpatient Recovery
SEL	Service Encounter Log
SPOC	Single Point of Contact
SSDI	Social Security Disability Income
SSI	Social Security Income
TABE	Test of Adult Basic Education
TAT	Thematic Approach Test
TEP	Training and Employment Program (study)
TNT	Transitionally Needy Training Program
TOPS	Treatment Outcome Prospective Study
TRM	Training and Resource Material (Manual)
TSR	Treatment Services Review
VA	Veterans Administration
VPI	Vocational Preference Inventory
VRA	Vocational Research Assistant
VRC	Vocational Rehabilitation Center
VRS	Vocational Readiness Screener
VS	Vocational Specialist (Manual)
VSC	Vocational Services Coordinator
WAIS-R	Wechsler Adult Intelligence Scale--Revised
WCCL	Ways of Coping Checklist
WEI	Work Experience Inventory
WRIOT	Wide Range Interest-Opinion Test

1.0 Introduction and Background

1.1 Purpose and Overview

The individualized substance abuse counseling (ISAC) protocol described in this manual was developed, based on research from several areas, in an attempt to make substance abuse counseling more effective in terms of identifying and addressing individual counseling and service needs. This, in turn is expected to produce improved outcomes such as reduced drug use, violence, illegal activity, health problems, mental health symptoms, and increased education, employment, retention and treatment compliance. While initially developed and tested in methadone programs, there is little in this counseling protocol that would interfere with its use in other treatment settings.

The purpose of this manual is to:

- review the background and development of the ISAC protocol,
- provide an overview of the protocol,
- walk counselors through the approach on a step-by-step basis, and
- outline the training and hiring procedures that are used for implementing it.

Although it was originally designed for the Methadone Enhanced Treatment (MET) study and revised for the Training and Employment Program (TEP) study, we have attempted to make this manual a stand-alone document. We have, therefore, tried to identify alternative procedures or people that may be relevant in other contexts.

1.2 Organization

This manual consists of eight chapters and three appendices. This chapter describes the manual's purpose and organization, and provides information on how to find out more about it. Chapter 2 contains a brief review of psychotherapy research in methadone, including findings from the original MET study. Chapter 3 presents an overview of the individualized substance abuse counseling (ISAC) protocol, including its components, conceptual orientation and the process of implementing the protocol. The next four chapters focus on the main components of the ISAC protocol:

- Chapter 4 covers the use of standardized assessments as tools for the standardized and objective evaluation of client treatment needs; it includes a discussion of how the Global Appraisal of

Individual Needs (GAIN) was developed specifically for use with this kind of treatment protocol.

- Chapter 5 describes the development of a treatment plan based on the needs score profiles from the standardized assessment and with the active participation of the client.
- Chapter 6 discusses the use of problem-solving counseling, including what should go on in a session.
- Chapter 7 discusses the need for counselors to work with a Vocational Services Coordinator (VSC), a Community Services Coordinator (CSC), and other staff to help address client needs, including needs for medical, psychological, vocational, and other ancillary services.

Chapter 8 goes on to discuss administrative issues associated implementing this protocol, including hiring, training, confidentiality, and privacy. Appendix A contains background on MET. Appendix B contains background on TEP. Appendix C contains a Counselor Training Syllabus.

1.3 Background on RTI, Pathways, and PBA

The Research Triangle Institute (RTI) has a staff of more than 1,500 working on applied and basic research, primarily located on a 180-acre campus located in Research Triangle Park, North Carolina and a half dozen other sites scattered across the U.S., Europe, Latin America, and Asia. RTI was established in 1958 by joint action of the North Carolina State University in Raleigh, the University of North Carolina in Chapel Hill, and Duke University in Durham. It is one of the five largest nonprofit research firms in the United States and routinely conducts multisite experiments and national probability samples, surveys. In just under 2 decades, RTI researchers have conducted over 100 drug and alcohol abuse studies focusing on questions concerning epidemiology, prevention, and treatment evaluation, and setting the industry standards by routinely achieving response rates of 80 percent or more. In the last 5 years alone, RTI researchers have conducted over two dozen drug treatment studies in over 100 clinics across the country. The two most relevant to this manual are the Methadone Enhanced Treatment (MET) study and the Training and Employment Program (TEP) study, summarized in Appendices A and B, respectively.

Buffalo's Pathways Treatment Program is located in and operated by the Sisters of Charity Hospital. It provides medium and individualized methadone dosages, ranging between 30 and 70 mg/day, individual and group counseling 2 or more times per month, random urine testing at least monthly, and on-site HIV testing. Counselors have caseloads of 40 to 45 clients and typically have some graduate level training or 2 or

more years of counseling experience or both. With approximately 300 to 350 clients, Pathways is the largest methadone clinic in New York State outside of New York City. Approximately 65% of the clients are male, 52% over 35-years-of-age, 41% African American and 46% Caucasion, 35% have current or past involvement with the criminal justice system, and 70% have been in treatment for more than 2 years. Pathways was a major collaborator in both the MET and TEP studies.

Pittsburgh's PBA, The Second Step clinic is in an industrial park and is operated as a free-standing non-profit unit. It provides medium methadone dosages ranging, between 40 and 60 mg/day, individual and group counseling 2 or more times per month, random urine testing at least monthly, and on-site HIV testing. The counselors have caseloads of 40 to 45 clients and typically have some college and less than 2 years' experience in substance abuse counseling. PBA serves 400 to 450 clients at its main facility and sponsors satellite programs for another 100 to 150 clients that are located in major public housing projects under a demonstration grant from the Center for Substance Abuse Treatment. Approximately 70% of the clients are male, 71% between the ages of 30 and 40, 30% African American, and 70% Caucasian, 39% have current or past involvement with the criminal justice system, and 58% have been in treatment for more than 2 years. In addition to collaborating in MET and TEP, PBA was also a site for the Drug Abuse Treatment Outcome Study (DATOS) and Methadone Treatment Quality Assurance Study (MTQAS).

Santa Clara County's Bureau of Drugs and Alcohol operated three health department methadone clinics that were spread throughout the county, but the bureau has since be taken over by one of the local hospitals. At the time of this study it provided medium and individualized methadone dosages ranging between 30 to 80 mg/day, individual and group counseling 2 or more times per month, random urine testing at least monthly, and on-site HIV testing. Counselor caseloads during the study rose from about 20 to 1 to over 45 to 1 as part of large county layoffs and cutbacks that eventually caused us to shut down this site. The counselors included a mix of graduate-trained clinicians and recovering staff, with all having 2 or more years of experience. Each of the three clinics had from 100 to 350 clients (700-850 total), with approximately 64% male, 62% over 35, 11% African American, 33% Hispanic, and 56% Caucasion, as well as 25% with current or past involvement with the criminal justice system. Santa Clara County was involved in the earlier TEP study, DATOS, and MTQAS.

1.4 Sponsorship, Permission, Contact Information, and Help

The ISAC manual was developed under the Training and Employment Program grant (R01-DA-07964) from the National Institute on Drug Abuse (NIDA) to the Research Triangle Institute, Sisters of Charity Hospital, and PBA, the Second Step.

Since it was developed with public funds and builds heavily on the earlier works of other researchers, this version of the ISAC manual may be freely copied. It can be used and reproduced without further permission under the following conditions: (a) any quotes or material taken from elsewhere are still appropriately acknowledged, (b) no attempt is made to subsequently copyright any part of this material, and (c) this document is appropriately acknowledged as:

> Dennis, M.L., Fairbank, J.A., Bonito, A.J., Rourke, K.M., Karuntzos, G.T., Roland, E.J., Caddell, J.M., Woods, M.G., Rachal, J.V., Bossert, K., & Burks, M. (1995). Individualized Substance Abuse Counseling (ISAC) Manual. Rockville, MD: National Institute on Drug Abuse.

We plan to continue analyzing and refining the ISAC protocol and will be constructing a bibliography of studies or reports in which it is used. If you would like to see a copy of the bibliography or contribute to it, please feel free to contact the principal investigator, Dr. Michael L. Dennis. You can contact him, the two local co-PIs, or staff of NIDA Health Services Research Branch at the addresses below if you have any further questions, or comments, or if you need assistance implementing the ISAC.

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RTI, Pathways, and PBA staff will welcome prearranged visits to demonstrate the ISAC protocol. At this time, RTI staff can provide limited direct assistance or work with other local technical assistance providers to develop their capabilities for supporting the ISAC protocol (unless under a purchase order or contract). NIDA staff can identify other providers and/or technical assistance centers.

2.0 Brief Review of Counseling Research with Methadone Clients

2.1 Major Previous Studies

Although most drug treatment modalities focus on helping clients become drug free, methadone treatment has traditionally focused on rehabilitating clients so they can become functioning members of society (Dennis, Karuntzos, & Rachal, 1992; Dole & Nyswander, 1980). Although technically not at odds, these different approaches have led to considerable philosophical debate within the drug treatment community. The classical model of methadone treatment is based on a three-pronged effort to rehabilitate clients: (a) methadone to reduce the side effects of withdrawal and stabilize the client; (b) counseling to address the underlying psychosocial problem(s) of addiction; and (c) ancillary services to address logistical problems, such as employment, transportation, childcare, and medical care.

Modern psychotherapy research in methadone treatment grew out of the failure to fully replicate this model during the late 1960s and early 1970s when methadone programs were rapidly opened throughout the country. Early studies on methadone using a hospital-based program, experienced staff, and carefully screened clients suggested that it could dramatically reduce heroin use (Dole & Nyswander, 1965; Dole, Robinson, Orraca, Towns, Seargy, & Caine, 1969). Despite attempts to set forth guidelines for minimum levels of care (Food and Drug Administration [FDA], 1972; Special Action Office for Drug Abuse Prevention [SAODAP], 1974), results from the field were positive but considerably less dramatic (Gerstein & Harwood, 1990; Hubbard et al., 1989; Woody, McLellan, Luborsky, & O'Brien, 1990).

By the end of the 1970's, a variety of small studies (summarized in Hargreaves, 1983) and community-based trials (Newman & Whitehill, 1979) had already demonstrated the physiological efficacy or ability of methadone to reduce opiate use. The National Institute on Drug Abuse (NIDA) therefore focused its attention in the late 1970s on the interface between psychopathology and addiction (Blaine & Julis, 1979). Three specific studies with methadone clients resulted, including:

- a psychiatric diagnostic study using 133 clients from two methadone programs in the Boston area, one residential program, and an outreach effort to untreated opiate addicts (Khantzian & Treece, 1985);
- a diagnostics study and controlled trial of psychotherapy using 110 clients in the New Haven Community Mental Health Center (Rounsaville, Weissman, Crits-Christoph, Wilber, & Kleber, 1982a); and

- a randomly controlled trial of psychotherapy using 73 clients in the Philadelphia Veterans Administration (VA) Medical Center (Woody et al., 1983).

Depending on the specific criteria used, these studies consistently found that 80% to 85% of the methadone patients had comorbid mental health problems, including 50% to 60% with depressive disorders, 20% to 50% with antisocial personality disorders, 20% to 25% with alcohol dependence, 10% to 20% with anxiety disorders, and 2% to 10% with a variety of other mental problems (Khantzian & Treece, 1985; Rounsaville, Weissman, Kleber, & Wilber, 1982b; Woody et al., 1990). These rates were higher than a quasi-experimental comparison group of opiate addicts not in treatment (Rounsaville & Kleber, 1985), but lower than rates for other treatment modalities, particularly for residential (Hubbard et al., 1989).

In terms of experimental results, both of the randomly controlled psychotherapy trials found a significant improvement overall, but varied in their results between therapies. The New Haven group found no significant difference between standard drug counseling and counseling plus interpersonal psychotherapy (Rounsaville, Glazer, Wilber, Weissman, & Kleber, 1983). The Philadelphia VA group found that those clients who received counseling plus either supportive expressive therapy or cognitive behavioral therapy did better than those who received only counseling (Woody et al., 1983). Woody and colleagues (1990) recently attempted to replicate the comparison of counseling with supportive expressive therapy in four community-based programs in Philadelphia. Although they have only presented preliminary analyses to date, there is already a trend for a positive effect of the supportive expressive therapy (but it is slightly smaller than in the original study).

Subsequent analyses of these studies showed that the relative effectiveness of psychotherapy appeared to be greater with more psychiatrically impaired clients, particularly with clients with depression and antisocial personality disorders (McLellan, Luborsky, Woody, O'Brien, & Druley, 1983; Woody, McLellan, Luborsky, & O'Brien, 1985), with certain therapists (Luborsky, Crits-Christoph, McLellan, & Woody, 1986), and by clinic (Woody et al., 1990). In fact, Woody and colleagues (1990) found that in their first study the therapist's average pre-post effect size on seven outcomes (drug use, employment status, legal status, psychiatric status, Beck Depression Scale, Symptom Checklist-90 [SCL-90], and Maudsley Scale) ranged from .13 to .27 for the three standard counselors, .44 to .53 for the cognitive behavioral therapists, and .19 to .74 within the supportive expressive therapist. The largest within-therapy difference between therapists was twice the difference between conditions. Woody and colleagues (1990) found that the rates of opiate-positive urines in the two community-based clinics

in their current study were almost double that of their VA program and differed from each other by up to 50% over the course of 24 weeks.

McLellan and colleagues (1988) further demonstrated the importance and strength of therapist effects by randomly reassigning 80 male clients to one of four new counselors at the Philadelphia VA Medical Center. The percentage change of clients with positive urines varied significantly from a decrease of over 20% to an increase of almost 5%. Furthermore, despite the established efficacy of higher methadone dosages on average, the average dosage of clients seen by the most effective counselor decreased significantly by 8 mg while increasing by 2 mg for the least effective counselor. The most effective counselor appeared to take a more systematic approach to treatment, conducting a careful needs assessment, developing a detailed treatment plan, keeping careful notes, and meeting with clients formally at least twice a month. The least effective counselor had no formal training, kept few or no progress notes, and had fewer formal sessions per month with clients.

McLellan and colleagues (1992b) also released preliminary results of a randomly controlled comparison of minimum counseling (crisis-only), standard methadone counseling, and enhanced counseling and services with 79 clients at the Philadelphia VA Medical Center. At 6 months, the rates of drug use were better in the enhanced counseling condition than in the standard condition for both opiates (23% vs. 40%) and cocaine (30% vs. 37%). The minimum counseling condition had to be terminated after just 3 months because the rate of positive urines doubled relative to standard counseling for both opiates (70% vs. 35%) and cocaine (70% vs. 42%). The latter is an important counterpoint to recent findings that an interim regimen of methadone-only for people on waiting lists in New York City is better than no treatment at all (Yancovitz et al., 1991).

2.2 Limitations of the Previous Literature

Unfortunately, many of these studies suffer from moderate to severe limitations that make their findings difficult to generalize to community-based treatment programs. These limitations include small numbers of atypical clients, unusually well-trained (e.g., Ph.D.-level psychotherapists) and motivated staff, atypical programs, and low participation rates.

Using computer simulations and the reanalysis of 10 psychotherapy studies, Crits-Christoph and Mintz (1991) found that therapist effects vary considerably and at times are very large. The average therapist effect across measures ranged from explaining 0% to 13.5% of the variance, and the largest effect on a single measure

ranged from explaining 0% to 39% of the variance. Given that therapists are often nested within treatment conditions, they recommended treating therapists as a random variable in the analysis. Although such a shift dramatically reduces the error variance, it also means that the degrees of freedom for the denominator will be limited by the number of available counselors--of whom there are usually only a handful.

Atypical client samples and preinclusion attrition may also jeopardize our ability to generalize to the larger population of clients presenting for treatment (Howard, Cox, & Saunders, 1990; Howard, Krause, & Orlinsky, 1986). All of the clients in the Philadelphia VA studies are veterans and most are male. Additionally, findings from the National Vietnam Veterans Readjustment Study (Kulka et al., 1990) demonstrate that only a small and sociodemographically select subset of veterans who are eligible and in need of health or mental health treatment actually seek treatment at VA facilities. Although Woody and colleagues (1990) tried to address this problem by replicating their earlier work in four local community-based programs, their participation rates there ranged from only 46% to 74%, thus limiting generalizability.

In reviewing basic issues pertaining to the effectiveness of methadone programs, Ball and Ross (1991) found that the demographics, age of onset, and drug use patterns of addicts varied considerably by geographic location of both the clinic and client's place of residence. They and others also noted that even greater variation had been found in other nations (Corty & Ball, 1987; Dupont, Goldstein, O'Donnell, & Brown, 1979). Hubbard and colleagues (1989) noted that this variation also includes important behaviors such as needle sharing and sterilization practices. In cities such as Phoenix (where addicts had very high rates of employment and education), for instance, needle sterilization was already in widespread practice in 1979 and 1980.

Most of the published literature on methadone treatment through 1989, however, was from only a small number of geographic locations. In their analysis of a recent NIDA (1991) bibliography, Rachal and Dennis (1991) found that, when the two main treatment epidemiology studies are excluded (i.e., the Drug Abuse Reporting Program [DARP] and Treatment Outcome Prospective Study [TOPS]), the number of cities in which research has been conducted drops from 66 to 38. Seven cities account for 74% of the remaining 192 city/study combinations: Baltimore (8%), Chicago (5%), New Haven (14%), New York City (17%), Philadelphia-Coatesville (18%), and San Francisco (12%). The remaining studies excluded major metropolitan areas such as Albuquerque, Atlanta, Boston, Cincinnati, Cleveland, Des Moines, Hartford, Indianapolis, Jersey City, Kansas City, Miami, New Orleans, Newark, Phoenix, Portland, San Juan, and Seattle. Particularly underrepresented are cities with major amphetamine and barbiturate problems. Given the previously noted differences by

clinics, such findings suggest the need to further broaden the base of programs in which methadone treatment research is conducted.

2.3 Recent Findings From MET and TEP

2.3.1 Complexity of Client Problems

Many treatment clients may also be hindered because of comorbid problems. Some of the comorbid client needs and problems that were consistently identified across methadone programs include the following:

- From 80% to 85% had comorbid mental health problems, particularly depressive and antisocial personality disorders (Khantzian & Treece, 1985; Rounsaville et al., 1982b; Woody et al., 1990).
- From 33% to 63% have a criminal record (Hubbard et al., 1989; Robinson et al., 1992).
- Approximately 68% to 88% were also injecting cocaine, including 16% to 49% doing so on a daily basis (Wechsberg, Dennis, Cavanaugh, & Rachal, 1993). Note that this problem would severely limit the public health benefits if left unaddressed.
- More than 26% had pneumonia, hepatitis, gonorrhea, syphilis, or some other infectious disease (Bonito et al., 1994; Dennis & Wechsberg, 1993).
- From 2.3% to 10.1% already tested positive for HIV using an ELISA screen and Western Blot confirmation (Dennis, Fairbank, Bohlig et al., 1991).

Recent reviews of client vocational needs (e.g., Brewington et al., 1987; Dennis, Karuntzos, McDougal, French, & Hubbard, 1993; Dennis, Karuntzos, & Rachal, 1992; Arella, Deren, Randell, & Brewington, 1990) have also found several community- and client-level barriers facing drug abuse treatment clients and ex-addicts who want to enter existing training and employment programs and the job market in general. The major barriers include (a) discrimination against recovering addicts for both real and perceived reasons; (b) lack of program-level commitment to vocational rehabilitation; (c) potential loss of welfare benefits, particularly medical benefits; (d) lack of childcare and transportation; (e) lack of training and/or marketable skills; (f) significant gaps or lack of employment histories; and (g) lack of client motivation/self-esteem.

To look at client-level vocational barriers, French and colleagues (1992) conducted a needs assessment for TEP. Based on interviews with 232 clients in four methadone treatment programs, they found that:

- Illegal earnings at intake often exceeded legal earnings by 2 to 1.
- More than 66% were not employed in the week before treatment admission, with 32% lacking a high school diploma and 33% reporting at least one disability that would interfere with their ability to work.
- Virtually all clients reported problems with paying for transportation, despite the fact that 94% had access to some form of public transportation and 65% had a reliable vehicle.

Thus clients had clear vocational problems interfering with both their treatment and their lives in general. Focus groups with counselors and clients further revealed that both groups had problems locating and accessing services in the community (Dennis, Karuntzos, & Rachal, 1992).

In addition to making clients more difficult to serve, multiple problems may cause service providers to be concerned about lowering their program's success rate and jeopardizing their funding. Similarly, employers may be concerned about the client's reliability and productivity. Whether these problems are real or just perceived for a given client, addressing them is essential to training and job placement.

2.3.2 Diversity of Service Needs

It is also impossible to tell in advance what exact mix of services clients will want or to determine the relative magnitude of the client's problems based on the results of a needs assessment. The Addiction Severity Index addressed this problem by incorporating client and interviewer rankings of client needs.

In descending order of importance for the 160 MET clients with completed ASIs in their records, the mean and standard deviations for client and counselor problem severity ratings were:

Client Rating (0-4)			ASI	Counselor Rating (0-9)		
Mean	S.D.	Rank	Topic	Mean	S.D.	Rank
3.51	0.98	1	Drug Use	7.43	1.65	1
1.86	1.65	2	Employment	4.57	1.65	2
1.75	1.64	3	Family	4.50	2.52	3
1.54	2.42	4	Psychological	4.06	2.77	4
1.41	1.63	5	Medical	3.03	2.82	5
0.97	1.50	6	Legal	2.51	2.61	6
0.90	1.37	7	Social		(see family)	
0.54	1.21	8	Alcohol	2.42	2.97	7

Note that the two of the inconsistencies of the ASI are that the two ratings are on different scales (0 to 4 vs. 0 to 9) and that the counselor ratings for Family and Social are collapsed. Clearly there is substantial agreement between the clients and counselors on the prioritization and relative magnitude of most problems. The counselor ratings were always the equivalent of or higher than the client ratings. Higher counselor ratings were particularly common with legal and alcohol types of problems because clients often appeared to deny or belittle the scope of such problems.

Drug treatment counselors are typically prepared to address drug and alcohol issues. To a lesser extent, they also typically address family, social, and legal issues (to the extent they involve prevention rather than legal counsel). The two main areas where clients and counselors must therefore seek outside assistance are medical/psychological and employment (including education and financial support). Each of these areas is discussed further below.

2.3.3 Impact of Counselor Training

In the original MET study, we randomly assigned both counselors and clients to treatment protocols. Counselors who were randomly assigned to provide the enhanced treatment participated in a 3-day group training workshop in which the various components of the enhanced treatment were taught through the use of a manual (Fairbank et al., 1991b), didactic lectures and demonstrations, modeling, simulated client role-playing, and corrective feedback.

Dennis, Rachal, and Bohlig (1990) conducted a preliminary evaluation of the first MET counselor training program using data from the first 158 clients to enter the study in Camden and 66 clients who entered in New Orleans. Neither Camden nor New Orleans reached full implementation of the MET counseling regimen as defined in the manual. However, MET clients in Camden were significantly more likely to have received more counseling sessions and more total contact time and to have talked more

often about drug problems, treatment, relapse prevention, and a wide variety of tangential problems; they were also more likely to have received service referrals, suggesting that the regimen was at least partially implemented.

Based on these results, we conducted a second round of training for the first two sites and developed a revised training program for the second two sites. The second MET training program included the elements of the previous program, plus early feedback based on the audiotapes, on-site treatment plan reviews and feedback, and follow-up training at the program after counselors had been using the protocol for several months.

We evaluated the revised training program using the data from the first 281 clients to complete the study in the four sites (Dennis, 1994; Dennis, Fairbank, Bohlig et al., 1991). Exhibit 2-1 provides Tukey box plots showing the impact of training on the number of individual counseling sessions during the first 6 months at each of the four sites. It illustrates several important points about how treatment measures can inform the overall experiment. These include:

- **The frequency of individual sessions in the standard group varied by site, regardless of the experiment.** Note the median rate of individual counseling sessions in New Orleans (5) was half the rate of sessions in Buffalo (11) and that sites with the lowest and highest caseloads (New Orleans and Camden respectively) had fewer sessions on average than those with caseloads in the middle range.

- **Training affected both the median and distribution of counseling sessions.** Note how, in addition to the shifts in the medians (shown as a cross), the lengths of the full range, 80% range, and interquartile or middle 50% range have also been increased.

- **The effect of training varied by site.** Note that in New Orleans the training affected the range by only 15 sessions, while in Pittsburgh it increased the median by over 15 sessions and the range by 20 sessions.

- **The two sites with more intensive follow-up training did better.** Note that the most dramatic effects were in Buffalo and Pittsburgh where the training and training follow-up procedures were more intensive. (Adapted from Dennis, 1994, p. 193-194)

Dennis, Fairbank, and Rachal (1992) also examined the topic counts both within and across sites and found that the effect of training was primarily to raise the frequency with which all topics were discussed. There was considerable variation in the effect per topic overall and by site. Although it varies by counseling activity or substantive

issue, the most common distribution on dependent variables was that about half of the clients talked about a given topic one or more times (some notable exceptions include alcohol, HIV, and referral follow-up, which were less common). Exhibit 2-2, therefore, presents the third quartile (i.e., 75th percentile) for reported activities within individual counseling sessions across sites and its minimum and maximum value within sites.

Across sites, MET clients were more likely to have individual counseling sessions involving the following:

- feedback on, and discussion of, both dirty (i.e., positive) and clean (i.e., negative) urine test results;
- discussion of drug and alcohol use episodes and lapses;
- program treatment issues, such as problems with methadone dosage, take-home privileges, and attendance at self-help groups;
- disscussion of issues related to HIV risk reduction, testing, and so on;
- activity on issues related to employment and education, such as job finding, training, and arranging transportation;
- emphasis on social services, entitlements, and housing needs;
- discussion of issues related to family and social issues; and
- focus on psychological and emotional problems and the need for related services.

Furthermore, there is considerable variation by site in the ways that enhanced and standard counseling differed. For example, enhanced counselors in Pittsburgh saw their clients in individual counseling sessions three times more often than did their colleagues in the standard group, whereas the enhanced and standard counselors in New Orleans did not differ in this respect. In Buffalo, enhanced counselors were five times more likely to discuss positive (i.e., dirty) urines with clients than were standard counselors, whereas in Pittsburgh, New Orleans, and Camden this difference was roughly twofold.

Even controlling for the increased number of individual counseling sessions, MET clients were proportionately more likely to have sessions about positive urines, negative urines, alcohol problems, entitlements and social services, housing issues, and "other" topics. In addition to increasing the total number of counseling activities with clients (number of sessions, number of referrals), the consequences of counseling

provided in the enhanced training condition changed as well. An examination of Exhibit 2-2 shows that in the aggregate, enhanced counselors also engaged in more treatment planning and referral activity than did standard counselors.

2.3.4 Impact on Client Retention

Having demonstrated that we had been able to change counselor behavior to varying degrees, the next question was whether or not these changes have an impact on clients. Just as clients have various needs, there are many potential outcomes that could be examined for evaluating a new protocol. One of the simplest and most widely used measures is retention (Ball & Ross, 1991; Hubbard et al., 1989).

Because the sites varied in the extent to which they implemented the MET protocol, we will focus here on Pittsburgh, the site that came closest to full implementation. Exhibit 2-3 shows the impact of MET on client retention both in terms of the days retained and whether or not they were still in treatment at 6 months. It also shows what happens when we analyze the data as people were assigned (the most methodologically conservative approach) or as they were actually treated, a potentially more liberal standard). This analysis provides us with a sort of lower and upper bound for treatment effectiveness (Dennis, 1994).

As Exhibit 2-3 shows, the MET clients were significantly more likely to be retained when evaluated by either measure and either method of analysis. In a 26-week period, using the more conservative measure, MET clients were more likely to have stayed in treatment an additional 2 weeks (16 days) and were more than three times more likely to still be in treatment at the end of 6 months. Although less dramatic in the other sites where the protocol was only partially implemented, the odds of retaining a MET client were generally better.

2.3.5 Cost of MET Protocol

As part of the original MET study, we also estimated the cost of standard treatment and the enhanced protocol in three of the sites (the New Orleans site was operated by volunteers). These findings (summarized from Bradley, French, & Rachal, 1994) are based on actual examination of program and fiscal records and differ significantly from the director-reported data in the National Drug and Alcoholism Treatment Unit Survey (NDATUS; NIDA, 1989). The gross revenues for the three MET programs ranged from $680,766 to $1,363,998, with from 66% to 93% coming from federal, state, or other public sources. The average annual cost of standard methadone treatment ranged from $3,750 to $4,400 per client year. Much of this cost was fixed

cost, however, and the marginal cost of adding another client was estimated to range from $164 to $1,019 depending on available capacity. Exhibit 2-4 shows the range in cost by type of cost per site.

We also estimated the cost of implementing the earlier version of the ISAC protocol and employing an on-site community services coordinator or CSC. The marginal cost per client for the MET protocol ranged from $430 to $1,395. Non-labor start up cost only made up about 3% of this cost. The biggest costs of the intervention were actually the rent and the labor for the CSC. In fact, we have estimated elsewhere that the pilot study cost of the very similar Vocational Services Cordinator or VSC used in TEP ranged from $1,483 to $2,215 per year (French et al., 1984).

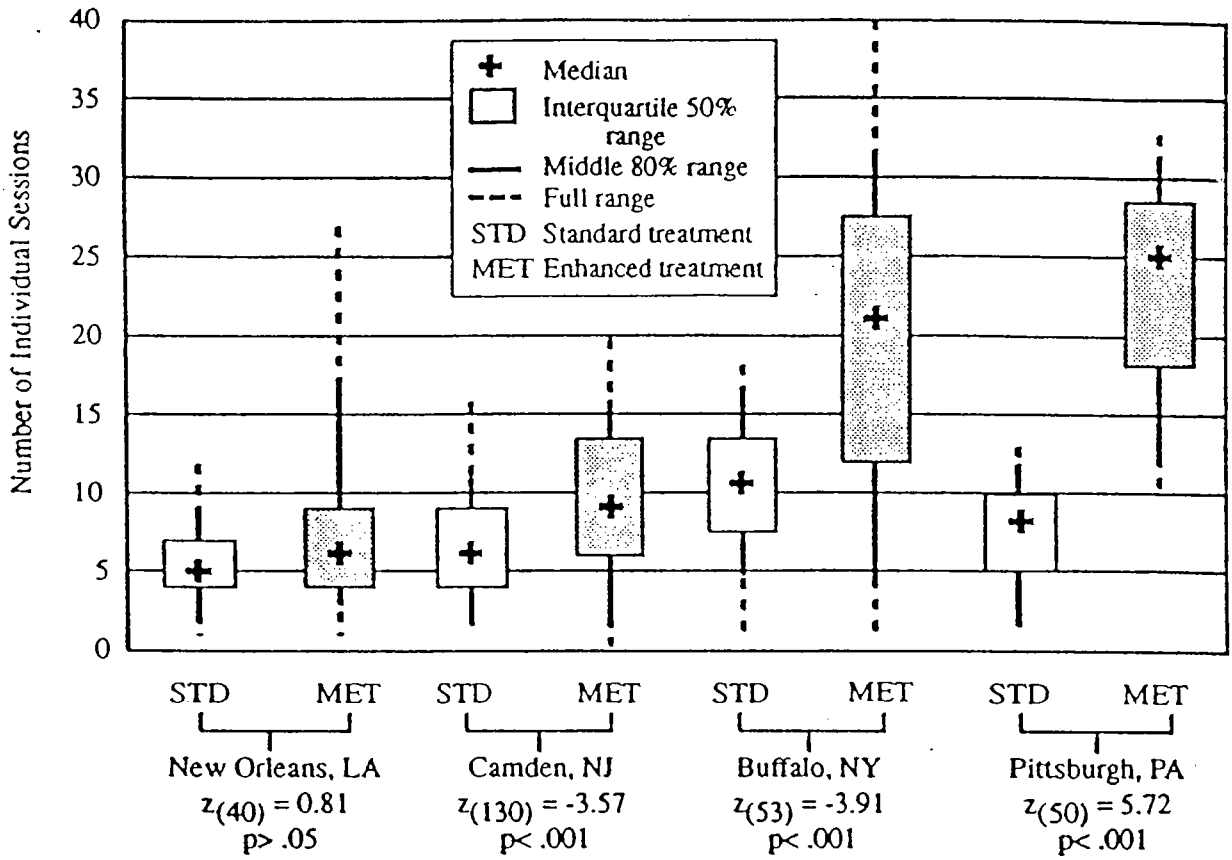
2.4 Current Research and Analyses

The MET and TEP research staff are currently using initial and quarterly follow-up data from these studies to look at several other issues. Some of the topics that are currently being analyzed include:

- Quasi-experimental comparisons of injection drug users in methadone and outreach in terms of changes in drug use and AIDS-related risk behaviors.
- Descriptive comparisons of the treatment needs of men and women in terms of getting to treatment, family situations, employment and training, drug treatment, criminal activity, physical health, and mental health.
- Descriptive analysis of the history and comorbidity of physical and sexual abuse among substance abuse clients.
- Main findings of our counselor training experiment in terms of counselor retention, treatment provided, and client outcomes.
- Main findings of our client-level MET protocol in terms of AIDS risk behaviors, drug use, accessing community services, employment, improved health, and reduced criminal activity.
- Using the treatment received to predict client outcomes.
- Cost-effectiveness analysis of MET and the TEP pilot study.

A bibliography of our current research in this area is available from the authors.

Exhibit 2-1. Number of Individual Sessions per Client During the First 6 Months of Treatment, by Condition, Site, and Order of Training Session



Source: Dennis (1994)

Exhibit 2-2. Site Variation in Third Quartile Frequency of Counselor Activities in Individual Counseling Sessions During the First 6 Months of Treatment, by Counselor Group

	MET Treatment			Standard Treatment		
Session Content	**Across**	**Min.**	**Max.**	**Across**	**Min.**	**Max.**
Number of Topics:*+	47.0	23.0	72.0	22.0	15.0	30.5
Unique Topics*+	10.0	6.0	11.0	8.0	6.0	9.0
Topics per SessionΨ	3.0	2.7	3.8	3.0	2.7	4.8
Substantive Topics:						
Positive Urines*+Ψ	5	10	4	2	2	3
Negative Urines*Ψ	2	2	6	1	0	1
Alcohol Problems*+	0	0	1	0	0	0.5
Drug Use*+Ψ	6	2	12	3	2	4.5
Treatment Issues+Ψ	5	1	12	4	0	7
HIV/AIDSΨ	0	0	1	0	0	1
Medical/Dental+	2	0	5	1	0	3
Employment/Education+	4	2	9	3	2	4
Entitlements/Social Services+	2	0	2	0	0	1
Housing Issues*	2	1	3	1	0	2
Legal Issues/Criminal Activity	1	1	3	2	1	3.5
Family/Social Support*+Ψ	6	3	15	2	2	4
Psychological/Emotional+Ψ	3	1	7	2	1	5
Other*+	4	1	5	1	1	3
Other Actions:						
Treatment Plan Activity*+	3	1	18	2	0	8
Initial Referral*+Ψ	1	0	5	0	0	0
Referral Follow-up*+	0	0	1	0	0	0
Number of Counselors[a]	21	3	8	34	5	13
Number of Clients[b]	222	36	102	219	37	95

*Significant main effect of MET across sites at the $P\alpha < .05$.
+Significant main effect of site at the $P\alpha < .05$.
ΨSignificant site by MET interaction at $P\alpha < .05$.

[a]Differences due to staff turnover.

[b]Limited to clients with individual sessions.

Source: Dennis, Fairbank, and Rachal (1992).

Exhibit 2-3. Impact of MET on Retention, by Treatment Condition Assigned and Received in Pittsburgh

Treatment Condition	Days Retained[a] Mean	(S.E.)	t	6-Month Retention[b] Percent	Odds Ratio	χ^2
As Assigned[c]						
STD (n=47)	152.7	(8.0)		68.10%		
MET (n=45)	168.7	(5.7)Ψ	2.00*	86.67%	3.05	4.28*
As Received[d]						
STD (n=43)	156.9	(5.1)		74.26%		
MET (n=47)	167.8	(4.0)Ψ	2.14*	83.33%	1.89	1.59[e]

S.E. = Standard Error of the Mean.
STD = Standard Treatment regimen.
MET = Enhanced Methadone Treatment regimen.

Ψ = Probability that the within-group variances are equal is less than .0001.
* = Probability that means are equal (using STD S.E.) is less than .05.

[a]T-test based on the control group variance only.

[b]Odds ratio calculated as e^x, where x = logistic regression coefficient, and tested based on Wald Chi-Square.

[c]Based on random assignment.

[d]Based on assignment of counselor most frequently seen during first 6 months of treatment.

[e]The probability appears to have gone down because several problem cases were transferred to MET counselors prior to discharge. They have only a small effect on days retained but a larger one on 6-month retention.

Source: Methadone Enhanced Treatment (MET) Study: Client Record Abstraction Form (CRAF) and Client Encounter Checklist (CEC).

Exhibit 2-4
Annual Costs for Standard Methadone Treatment: 1990

	Program		
	Pittsburgh, PA	**Buffalo, NY**	**Camden, NY**
Fixed (building/equipment)[a]	$83,107 (6%)	$105,340 (13%)	$17,190 (2%)
Rent and maintenance (buildings)	$102,326 (8%)	$6,508 (1%)	$44,876 (15%)
Labor	$843,323 (56%)	$414,812 (53%)	$663.257 (69%)
Other variable[b]	$199,206 (13%)	$222,273 (28%)	$111,298 (11%)
Contracted services[c]	$237,205 (17%)	$39,339 (5%)	$131,645 (13%)
Total annual cost	$1.465,167 (100%)	$788,272 (100%)	$968,266 (100%)
Average number of clients[d]	333	210	250
Annual cost per client[e]	$4,400	$3,754	$3,873
Marginal cost of 1 more client[f]	$776	$1,019	$164
Marginal cost of 25 more clients[g]	$54,791	$54,986	$45,697

[a]Owned buildings and equipment and associated depreciation and capital improvements.

[b]Examples include utilities, telephone, office supplies, repairs, training, and miscellaneous.

[c]Typically, contracted services included laboratory analysis and consultants such as physicians, pharmacists, accountants, and attorneys.

[d]Represents average client caseload over the course of the year.

[e]The average cost of treating one client for 1 year.

[f]Additional client resources only.

[g]Additional client, staff, and program resources.

Source: Adapted from Bradley, French, & Rachal (1994, p. 433-4).

3.0 Overview of ISAC Protocol

This chapter provides an overview of the components of the ISAC protocol, its conceptual orientation, our definition of successful rehabilitation, and the basic steps for going through the protocol. The subsequent chapters go into more detail about each of the specific components.

3.1 Components of the ISAC Protocol

The ISAC protocol includes four interwoven components: standardized needs assessment, individualized treatment planning, problem-solving counseling, and working with other staff to address client needs. Though this is the approximate temporal order in which the client experiences the components, they are all actually interrelated. For example, the standardized needs assessment is used to help define the problem (Step 1 of problem solving) and to develop the treatment plan. In learning the protocol, it is useful to start with a review of the entire protocol, and of problem solving in particular, before going into each of the individual steps in detail.

Therefore, let us briefly review the four components that will be discussed in the following chapters:

- **Standardized Needs Assessment**. Needs assessment focuses on identifying problems in living associated with substance abuse and dependence because needs should be the basis of a treatment plan. There are many types of assessments that can work in this capacity; the key is whether or not they are treated as mere paperwork or used to guide clinical practice. In MET we used the Addiction Severity Index (ASI) developed by McLellan and colleagues (1985). In TEP we used the Global Appraisal of Individual Needs (GAIN), designed to identify specific needs and generate treatment planning recommendations.

- **Individualized Treatment Plan**. Both formal and informal individualized treatment plans are developed by the assigned counselor, based on the problems identified in the needs assessment. The formal plan includes long-term goals, but focuses on things that can be accomplished in the next 90 days and the steps for doing so. The formal plan is updated every quarter in conjunction with the GAIN Quarterly Review (GAIN-Q). The informal or working plan focuses on identifying and implementing the steps necessary to accomplish the intermediate goals. It is consulted in every session, used to chart progress, and includes something to be accomplished between each and every session. Both formal and informal treatment plans involve the active participation of the client.

- **Problem-solving Counseling.** Each client undergoes frequent individual counseling sessions that employ a problem-solving approach and focus on achieving the goals of the treatment plan. These sessions are also used to reinforce the global messages of rehabilitation: relapse prevention, risk reduction, and health promotion. Individual counseling sessions occur one to two times a week for new clients or those in crisis, then are reduced as appropriate. This approach includes using other treatment data on compliance (e.g., urine test results), contingency contracting, and relapse prevention.

- **Working with Other Staff.** Not every problem can be or should be addressed through counseling. The protocol, therefore, discusses how to identify when other staff or outside help is needed and how to work with these resources. Particular attention is paid to identifying and working with other program staff to help find and obtain needed services for clients. In MET, the person responsible for other services was called a Community Services Coordinator (CSC). In TEP, this person was the Vocational Service Coordinator (VSC).

Thus, the ISAC protocol is aimed at returning to more comprehensive and integrated treatment and getting staff and client to work as a team.

3.2 Conceptual Orientation

The conceptual basis for the ISAC protocol relies heavily on Albert Bandura's (1977a) *Social Learning Theory*. According to this theory, learning results from a complex interaction of (a) an individual's psychological structure, (b) behavior, and (c) the social context within which the behavior occurs.

3.2.1 Key Concepts

A key concept in this theoretical approach is self-efficacy, which refers to a person's beliefs or perceptions about how capable he or she is in executing or carrying out specific behavior under particular circumstances. These beliefs, sometimes referred to as efficacy expectations, reflect expectations about whether a person can successfully initiate and complete the activities required to reach a desired goal.

Efficacy expectations need to be distinguished from outcome expectations. The latter are beliefs or perceptions about whether successful performance of a given behavior will lead to a desired goal. Efficacy expectations, on the other hand, are beliefs about one's own capability of performing the behavior that leads to achievement of the goal. Strong expectations of both kinds are necessary for a target behavior to begin successfully and to be maintained. Before a person will perform a behavior intended to

facilitate achievement of a specific goal, it is important that a person believe that a particular behavior will achieve a desired goal (strong outcome expectancy), *and* that a person believe he or she knows how to correctly perform the behavior (strong efficacy expectancy).

Proponents of the social learning theory perspective maintain that efficacy expectations are the best predictors of whether a person will initiate and persist in an activity. The implications of this theory for counselors, therapists, and others interested in changing certain behavior or encouraging certain other kinds of behavior are clear--instill in your patients or clients appropriate outcome expectations and strengthen the efficacy expectations associated with the behavior that you want your patients or clients to adopt or maintain.

3.2.2 Bases for Efficacy Expectations

According to Bandura (1977b), efficacy expectations are learned from four major sources:

- personal experience,
- vicarious experience,
- verbal persuasion, and
- one's physiological state.

Experiencing the success of mastering a difficult or previously feared task can have a significant impact on one's efficacy expectations. However, having such an experience only enhances self-efficacy if the person can attribute the success of mastery to his or her own personal abilities and effort, rather than to some special power in the behavior alone (i.e., "magic" formulas).

The vicarious experience of observing a "model" (e.g., an effective counselor) who can master situations that are feared or seen as difficult can also serve to strengthen self-efficacy. However, for the modeling to have the desired impact on efficacy expectations, the model should be seen as being similar to the patient or client in important respects, and as having overcome the difficulties implicit in the situation through determined effort rather than with ease. This has been a major reason for the popularity of using recovered addicts as counselors.

Verbal persuasion and expressions of support and encouragement are obvious mechanisms for influencing efficacy expectations. For such influences to have the desired impact, however, the messages of encouragement must be believable, and the persons giving them must be seen as sincere.

Finally, the state of one's body may provide cues to one's ability to carry out certain behavior and may thereby affect efficacy expectations. Signs of nervousness, drug withdrawal, or exercise-induced soreness can all adversely affect one's self-confidence about a particular behavior. Interpreting these bodily signs in the right light (e.g., "I am making progress over adversity rather than demonstrating weakness in the face of it") can help a patient or client strengthen his or her self-efficacy.

3.2.3 Applying Efficacy Expectations to Program Intervention

The ISAC protocol introduced into the methadone programs in the MET and TEP studies consists of elements intended to instill outcome expectations and strengthen efficacy expectations through three of the four sources cited by Bandura. The fourth source of efficacy expectations--physiological status--is also addressed by the use of methadone itself. By preventing the symptoms of physiological withdrawal and diminishing the sensation of craving, the use of methadone in a supportive counseling environment can go a long way toward strengthening a recovering addict's self-efficacy regarding abstinence from illicit drug use. Unfortunately, many clients and/or counselors perceive the continued use of methadone as another form of dependency or weakness. This view reflects the proverbial situation of a glass filled to the middle being described as half empty (versus half full).

The individualization of counseling provides a counselor with opportunities to teach and model problem-solving behavior as well as to employ verbal persuasion in encouraging a client to abstain from drug use and to adopt more socially productive behaviors. The standardized needs assessment should provide the counselor with a picture of a client's problems and will form the basis for a client's treatment plan; the assessment should also identify target behaviors that should be extinguished and others that should be cultivated. By repeating the assessment quarterly, the client's behavior can be readily charted and monitored for change. Drug testing can also provide results that counselors can use to give positive verbal reinforcements for clean urines and negative verbal reinforcements for dirty ones. Having a client become actively involved in the process of developing the treatment plan not only identifies other problematic behavioral areas for the counselor, but also should help the client recognize what the problems areas are and feel encouraged that there is someone (the counselor) who believes something can be done to remedy the situation. That a counselor will instruct a client in the problem-solving approach and proceed to demonstrate its effectiveness by using it in dealing with the client's problems is illustrative of modeling what the client will eventually be expected to do independently.

By leading a client through the process of obtaining needed services, a VSC, CSC, or other staff person has many of the same opportunities to teach a client how to

do things independently. In many cases, clients have not obtained services because they do not know which services are available or how or where to get them. Sometimes clients are just not sure that they will get what they need from the bureaucracy. The success experienced by the staff person must be transferred to clients through modeling how to succeed and through verbal encouragement of clients. Having a staff person available to help with client problems shows clients that they have worth, that someone cares, and that clients ought to stand up for what they think is the right treatment for themselves.

3.3 Definition of Successful Rehabilitation

There are many definitions of success in drug treatment. Some authors have focused on total abstinence, others on risk reductions, and others on cognitive changes. In the ISAC protocol, we have made three major assumptions about how to measure progress. First, we assume that, because we are asking people to make small steps towards recovery, we should be able to measure small improvements in their levels of functioning. Second, we assume that functioning is multidimensional, which means that clients can get better in one dimension and worse in another, a little better in several areas, much better in one area but not in others, and so forth. Third, we assume that our goal is comprehensive rehabilitation -- not just short-term reductions in drug use. We believe that many previous protocols have had limited success and high relapse because they have failed to address these issues.

In general, we therefore define successful rehabilitation as overall improvement across several dimensions, including:

- increased positive engagement with children;
- decreased problems managing money for food;
- increased days employed or in school;
- decreased vocational problems at work or school;
- decreased alcohol use and alcohol-related problems;
- decreased drug use and drug-related problems;
- increased days without using any drugs;
- decreased illegal activity;
- increased quality of physical life;
- decreased needle and sexual risk behaviors;
- decreased mental distress or suicidal thoughts;
- decreased levels of conflict, victimization, and aggression;
- increased levels of problem orientation and problem-solving skills related to coping with problems; and
- decreased levels of denial and misrepresentation.

Note that any given client may be fine in one or more of these areas and that changes may be small or large, broad or specific. We also assume that these dimensions interact with one another in a way that makes evaluation of one dimension at a time problematic. To understand a client's situation, to provide the most appropriate treatment, and to evaluate client outcomes, it is necessary to look at the overall, multidimensional pattern. The Global Appraisal of Individual Needs (GAIN; Dennis et al., 1995) was specifically designed to measure these dimensions for use with the ISAC protocol.

Preliminary cross-sectional data from GAIN interviews conducted during the TEP study offers us good, bad, and ugly news. The good news is that time in treatment is associated with reduced drug use and drug problems. Panel A of Exhibit 3-1 shows that clients who have been in methadone treatment longer report significantly more days of being drug free. As the graph shows, for the past 90 days clients report an average of 49.5 drug-free days after 3 months of treatment, 71.1 days after 3 years of treatment, and 65.2 days after 5 years of treatment. The peak in the middle is probably caused by some people getting better and leaving treatment and confirms observations made in large scale natural history studies that have followed drug users through treatment (Hubbard et al., 1989; Gerstein & Harwood, 1990). Panel B of this same exhibit shows a corresponding and significant reduction in the number of drug related problems on the Drug Abuse Screening Test (DAST-11; Dennis et al., 1995; Skinner, 1982) over the same time periods from an average of 4.2 to 2.3 to 2.3. Panel C shows a significant drop in the days of needle use, from 17.5 to 2.2 to 2.1 in this same time frame. Panel D shows the same trend (though it is not significant because of the larger standard errors) towards reduced Needle Risk Screener behaviors (NRS_3, Dennis et al., 1995), from .4 to .2 to .2 in this time period. Thus, the good news is that treatment appears to have a positive effect on reducing drug use and problems.

The preceding data are based on a cross-sectional sample of people in treatment. It is therefore important to look at the extent to which these findings may be just an artifact of changes in the client case mix as a result of retention/discharge. To do this we need to look at experimental and longitudinal studies of methadone treatment. In a summary of research in which clients were followed over 5 to 20 years, Condelli and Payte (1994) found that:

- over a 10-year period, clients with longer exposure to methadone treatment were likely to have had longer periods of abstinence and employment (Maddux & Desmond, 1992);
- while approximately 29% of the clients in treatment still inject, the rates increase up to 82% in the year after they drop out of treatment (Ball, Lange, Myers, & Friedman, 1988);

- over a 12- to 20-year period, rates of daily narcotic use average 80% before treatment, 20% during treatment, 60% during subsequent periods of leaving or dropping out of treatment, back to 20% during subsequent readmissions/treatment, and back to 60% during subsequent dropout periods (Powers & Anglin, 1993);

- continuous or long-term maintenance treatment can keep the average rate of heroin use at a relatively constant rate of 20% (Condelli & Dunteman, 1993);

- with the exception of those with very short pretreatment histories of addiction (4 or less years), discharge is extremely likely to lead to relapse in all but as few as 2% of the cases (Dole & Joseph, 1978).

Thus, the leveling off of drug use and problems must not be viewed as a failure; instead, it is clear from these studies that treatment has a substantial effect on rates of drug use, since clients in treatment have much lower rates than discharged clients.

The bad news is that the glass is only half-full. Clients in longer term treatment appear to be able to maintain the gains of the first few years (even allowing for many people getting better and leaving treatment); they do not, however, appear to make much additional progress. Particularly disturbing is the continued number of needle risk behaviors (e.g., sharing equipment or works) that long-term clients continue to engage in. Worse yet, contrary to the expectations of many providers, reductions in drug use do not directly translate into reductions in all of the other problems that clients are presenting with. Exhibit 3-2 shows the GAIN level-of-functioning measures corresponding to the issues outlined at the beginning of this section by time in treatment (as well as by gender and race). While several measures show a trend towards improvement, no single measure (other than measures of drug use) shows significant gains with time in standard treatment. Furthermore, while many providers and researchers assume that treatment should be the same for all clients, there is evidence of significant variation in client needs. Women, for instance, are less likely to report as many alcohol related problems but much more likely to report higher levels of mental distress, having been victimized or abused, and engaging in violent behaviors in the past 90 days. In terms of race, there are both expected and unexpected finds. Black clients report much less activity with their children and lower rates of illegal activity. Hispanic clients appear to be engaged in fewer types of illegal activity but with more frequency, and they also report higher levels of mental distress and victimization. White clients report higher rates of victimization and aggression, but they also have the highest rates of problem orientation (believing their problems are solvable).

The particularly ugly news is that the one other area in which clients did change over the course of treatment was violence. Longer stays in treatment were associated

with increased levels of aggression as measured by the Generalized CTS (Conflict Tactic Scale) Aggression Scale (GCAS_d-10; Dennis et al., 1995; Strauss, 1990). The number of violence-related behaviors went from 1.24 in the beginning of treatment to 1.86 among those who had been in treatment. Preliminary cluster analysis of TEP data across these measures (not shown in the exhibit) suggests that aggression and mental distress interact with attempts to reduce drug use. While they start out high among current users, both aggression and mental distress appear to rise in response to initial reductions in drug use and sexual activity and to come back down only when clients get virtually drug free. This middle or "transition" period has often been reported anecdotally by clinicians as people getting "worse" or becoming more "volatile" just as they are starting to make some progress.

The bottom line is that, while treatment does work, it is by no means a panacea. To prevent relapse and truly rehabilitate clients, additional and broader based improvements in treatment are necessary. As a first step toward improving levels of functioning, it will be necessary to use broader and more sensitive measures and to become more attuned to how they interact.

Work is currently underway to develop a multidimensional classification system of the levels of functioning represented in these scales. Such a system would aim to identify the key clinical subgroups that have similar problems, needs, and likely outcomes. The scales could then be effectively used to help predict treatment needs and outcomes.

3.4 Implementing the ISAC Protocol

As a primary counselor, you are one of the key people in the drug treatment program. You are a key person because it is through you that most program enhancements to treatment are directed to clients. The approach that we have developed focuses on the early stages of treatment (i.e., the first 6 months) or on crises when the client wants or needs help. It consists of targeting client needs for counseling, social, and other helping services that are available in the program, the community, and elsewhere.

As is apparent from this brief description of ISAC, you should ensure that your clients are very aware that their treatment, both counseling and social services, is being targeted at their specific needs to help them change lifestyles. Part of your job will be to convince clients, through your actions on their behalf and by demonstrating your concern for them, that the program is trying to help them.

3.4.1 Performing Standardized Needs Assessments

The first thing you will need to learn is how to conduct a standardized needs assessment of your client's current status and needs. The reason for doing this is that your client's needs and situations are very complicated, and without a standardized approach it is very easy to overlook an important dimension. Like the pilot of an airplane, you need to systematically go through your checklist before launching into addressing the first problem that comes up. It is also important to repeat the assessment at regular intervals in order to chart the client's progress and detect a problem before it becomes the crisis of the day. In Chapter 4, we identify some criteria to be considered in selecting standardized needs assessments.

3.4.2 Preliminary Involvement of Other Staff

Between completing the standardized needs assessment and going back over it in detail with the client, you should review the results with other staff. This may involve consultating with other counselors about a particular problem (e.g., denial about an alcohol or abuse problem), requesting help in defining service or referral needs, exploring options for identifying potential resources to address the problems, or even involving other staff immediately to assist the client if necessary. Your next step, therefore, is to become familiar with the other staff and resources that are available to you and to set up some kind of regular staffing or treatment team meetings.

In MET, this involvement was institutionalized in the form of treatment teams that had weekly staffings to review their recent assessments and any problems that they were experiencing. Since counselors had previously been largely on their own and had been identifying few additional service needs, this team approach proved to be crucial in identifying options and involving the VSC or CSC. This review should be of great assistance during subsequent counseling sessions when the treatment plan is developed with the client's participation. It should be particularly helpful in setting priorities, realistic service/referral expectations, and reasonable time frames for accomplishing the treatment plan's objectives.

In TEP, the meeting between the counselor and the VSC was also helpful to the VSC. It served to alert the VSC to potential client problems for which social services and community resources were not readily available, and for which new contacts or resources had to be developed in the program or the community. The role of the VSC in subsequent steps is discussed further in Section 7.2.

3.4.3 Developing a Treatment Plan with the Client's Active Involvement

The next counseling session with the client should occur as soon as possible after the first session and the staffing review (and certainly within 3 or 4 days of these meetings). What occurs in this second session may differ somewhat from program to program, depending on who usually develops a client's treatment plan and how long the client has been in treatment. In some programs, an intake committee or an intake worker prepares the first treatment plan, while in other programs the clinical director or the counseling supervisor draws up the treatment plan. For continuing clients or quarterly reviews, either the primary counselor, or an earlier intake counselor has already developed a treatment plan. In any case, we expect counselors following this protocol to be able to modify the already prepared treatment plan (if there is one) or to create one. In both cases, the counselor should make use of information gleaned from the standardized needs assessment.

Just as there are differences from program to program in who prepares the initial treatment plan, there are differences in the extent to which the assigned counselor can independently modify a client's plan. Where it is necessary or expected that the counseling supervisor or clinical director be consulted, that should be done. Although this protocol changes the way some things are done, it does not require changing the lines of authority and responsibility in a program. The protocol should be seen as an overlay on the program as it currently exists. While the ISAC protocol is designed to replace other reporting requirements, the extent to which this is done has to be negotiated within any given program.

One of the things you will need to learn how to do is to involve the client in the initial development and subsequent review of the treatment plan in a real and collaborative fashion. There are several important reasons for this. First, when the clients involved, he or she knows what will be expected. Second, the client may shed light on previous, similar activities that may alter the treatment objectives. Third, client involvement provides the counselor an opportunity to express support for and confidence in the client's ability to achieve the treatment objectives. Naturally, the client should sign and date the treatment plan that is developed as an indication of commitment to it. That commitment should be greater for a client who has participated in its development. (Details on developing a treatment plan are in Chapters 5 and 6.)

We are making a distinction here between formal and informal treatment plans for several reasons. In many drug treatment programs, treatment plans have become little more than quarterly paperwork done for regulators rather than for treating the client. It is not uncommon to see the same plan photocopied and used for several

clients, or to see the plan remain unchanged over time which the client just keeps signing it. In MET we found that over 26% of the clients were not even familiar with their treatment plans, and 12% said they did not even know that one existed. Since counseling only makes up a small fraction of the client's day-to-day life, such documents can hardly been considered influential road maps to treatment.

In TEP, we therefore tried to focus the formal treatment plans on things to be accomplished in the next 90 days and the steps for doing so. The informal treatment plans were basically a marked-up version of the formal treatment plan in which we kept notes on our progress and set very short-term objectives to be accomplished between counseling sessions or even within the current session. An example of this would be a client who fears relapsing to cocaine use. Rather than simply saying, "Call this hot line number if you feel a craving," the counselor could have the client call from the office, then call that night regardless of any craving, then call before going into certain types of situations that have often led to craving, then call when there is a craving. Thus the focus is on making sure that each step is small and do-able; this sets the client up for repeated successes instead of failure.

3.4.4 Meeting Again with Other Staff

After the initial treatment plan has been developed with the participation of the client, the primary counselor should again confer with other staff who might be able help the client meet his or her objectives. These discussions might result in an internal referral (such as letting the doctor know the client has started taking a drug known to interact with methadone, or referring the client to a group that addresses the clients needs) or an external referral (such as trying to get the client into a training program or job). You will need to learn how to use the standardized needs assessment, discussions with other staff, and discussions with the client to help define the client's problems and treatment needs. Having done this, you will have to learn how to identify options for addressing these needs either in counseling, or by directing the client in the treatment planning process, by identifying and accessing program or local resources, and/or by learning how to involve other staff in any or all of these steps.

In both TEP and MET, the purpose of this second meeting is also to identify areas where the VSC/CSC or other staff can help the client. Note that in both studies the clients continue to work with their primary counselor. The role of the coordinator is to help the client and counselor to find, arrange, and follow up on other services that are needed. It is very important that the counselor and other staff work together to present consistent messages to the client and to avoid the potential to be played off against each other.

Transferring some of these responsibilities to other staff can also free up some of the counselor's time and reduce the number of crises that seem to dominate the regular workload. This transfer of responsibilities is especially important if the change to an individualized substance abuse counseling protocol is to be sustained without burning out the counselor.

3.4.5 Doing Problem Solving

Problem solving is less of a component than a unifying approach to how counseling is done. In order for it to work, clients must perceive their problems to be solvable (by themselves or someone else). This perception is called a problem-solving orientation. The five basic steps to actually doing problem solving include: defining the problem, identifying potential solutions, evaluating the pros and cons of the potential solutions, implementing one or more options, and evaluating the implementation and effectiveness of the selected option(s). At the assessment level it focuses on using both standardized instruments and interactions with the client and other staff to help define the problem and identify options. At the treatment planning stage it focuses on weighing pros and cons, choosing which options to try first, and deciding what steps should be taken to make them happen. Through the process and particularly at the quarterly reviews, this approach focuses on a frank appraisal of the extent to which the current treatment is addressing the client's past and current needs.

It is important to realize that problem solving is not limited to what the counselor does or what happens during counseling. In fact, behavioral psychologists believe that the counseling session is only a small part of the individual's life. To be effective, counselors have to help the clients to help themselves. They do this by helping them to objectively define and address their problems, by structuring their progress so that they succeed through a series of small steps, by using contingency management and feedback to help them to regulate their behavior outside of treatment, and by teaching them problem-solving techniques so that they can increasingly cope with and address problems on their own. Clients can be taught problem solving both indirectly through the actions of the primary counselor or other staff, and directly through exercises given and reviewed in counseling.

In TEP, we structured the individualized substance abuse counseling protocol to naturally develop the problem-solving skills of both the counselors and their clients. The client, primary counselor, and other staff can also negotiate contracts with each other and/or an outside party. Inside regular treatment, a noncompliant client can be helped by developing a contingency contract to reinforce positive behaviors. The contract could be for having a drug free urine or for simply showing up on time, depending on the nature of the problem to be addressed. Another interesting approach

that was used in Milwaukee, was to increase the frequency of urine testing and to ask the client if the urine is dirty or clean. All of the urines that are supposed to be clean and a sample of those that are supposed to be dirty are tested. If the client tells the truth, then he or she does not have to pay. If the client lies, however, he or she has to pay for the urine test. In this way the increased frequency of urine tests can be subsidized and the client can be reinforced for telling the truth.

Thus, in addition to general problem solving, you will want to apply the basic principles of behavior modification. Note that other staff can help get incentives to support such internal contracts or help to develop incentives through outside providers of housing or schooling.

Screening Test 10 (MAST-10; Zung, 1979); Short Blessed Scale (SBS) of cognitive dementia (Katzman, 1983); and over six dozen standardized scales related to functioning, service utilization, and services desired in eight areas (see below). Of the 42 main GAIN scales, all have Cronbach's alphas over .6, 35 over .7, 17 over .8, and 3 over .9. Detailed psychometrics, norms, crosswalks to the preceding instrumentation, and crosswalks from major reporting and accrediting requirements are currently under review for publication as a separate manual by NIDA and are currently available from the author (Dennis et al., 1995b). In each of the eight domains we have asked explicit questions about the kinds of services that are desired directly or through referral, and we have included ASI-type global ratings of the desire for help and problem severity (discussed further in Chapter 5.) Since we explicitly developed the GAIN for protocols like ISAC, the next section provides a short summary on this development.

4.2 Global Appraisal of Individual Needs (GAIN)

The GAIN is actually a series of instruments and computer applications that were developed by RTI, Pathways, and PBA to meet the combined needs of clinicians, administrators, and researchers to collect overlapping information from drug treatment clients. It has been designed to assess clients on a multidimensional array of characteristics, behaviors, and areas of functioning, including: Basic Client Demographics; Treatment Motivation and Barriers; Current Living Arrangements; Education, Training, and Employment History; Tobacco, Alcohol, and Drug Use; Criminal and Civil Justice Activities; Physical Health; Mental Health; and Social Situation and Ways of Coping. At the end of each of these sections, the client is asked to identify his/her specific needs in that area of functioning. There are then questions that ask both the client and the counselor to rate the severity of the client's problems in that area. Counselors are also given the opportunity to report potential responses issues (e.g., denial, misrepresentation, or misunderstanding on the part of the client) at the end of each section of the questionnaire.

As noted above, the GAIN incorporates several standard measures developed by various agencies and researchers to measure key dimensions of functioning and impairment, including the client data set used for Federal reporting requirements, alcohol and drug diagnoses, Michigan Alcoholism Screening Test (MAST), Drug Abuse Screening Test (DAST), Conflict Tactic Scale (CTS) of violence, Personality Diagnostic Questionnaire's (PDQ) Borderline Personality Disorder (BPD) and Antisocial Personality Disorder (ASPD) subscales, and Global Assessment of Functioning (GAF). We are currently evaluating several other scales that were developed based on input from the counselors and updating the instruments to reflect the new DSM-IV diagnostic criteria for disorders related to substance abuse.

The instrument combines closed-ended items and the opportunity to add clinical notes or observations within the assessment form. It includes all fundamental instructions and coding directions. When used in conjunction with the ISAC protocol, the GAIN is intended to meet the assessment standards set forth by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO, 1993) and the American Society of Addiction Medicine (ASAM, 1991), as well as Federal reporting requirements for the Client Data System (OAS, 1993) and state reporting requirements for California, New York, and Pennsylvania.

We are currently finalizing Parts I and II of a computer-generated report that is produced from GAIN data. Part I is a computerized summary report based on the manual version presented in Section 4.4 below. Part II is a 22- to 25-page narrative profile which provides text and tabular presentation of all the data/information that is collected in the GAIN. This application has been written using RTI's Fully Integrated Control System (FICS) software. The narrative profile is designed to be generated immediately after the GAIN data is keyed into the GAIN data collection application. The format of the narrative profile is similar to that of a written report that a clinician would enter into a treatment record after conducting an initial or follow-up assessment interview with a client. The information is presented by sections that correspond with the sections of the GAIN (e.g., Background; Treatment Motivation and Barriers; Education, Training, and Employment; Tobacco, and Alcohol and Drug Use). Information in this profile is presented in prose, the programming includes the correct personal pronoun in the text (he or she), the program calculates scores on the standardized scale scores, and the specific symptoms or problems are listed to allow direct interpretation by other staff and outside providers who are unfamiliar with the GAIN.

The narrative profile leads into Part III of the computer-generated report: Potential Treatment Issues. This section of the report will include DSM-IV diagnostic impressions for Substance-Related Disorders, and interpretive information on standardized scales included in the GAIN; it will also highlight key issues that were identified in the GAIN as relevant for treatment. This section of the report will provide the information that is most useful to clinicians when formulating treatment plans and is intended to be a guide for treatment planning. At present we are seeking funding to continue the development of this report: specifically to develop Part III of the report. The GAIN manuals are currently under review for publication by NIDA.
In the meantime, copies of the GAIN manuals can be obtained for the cost of duplicating by contacting the authors (see Section 1.4).

4.3 General Interviewing Conventions

The goal of conducting a standardized needs assessment is to ask the questions (including any probes or follow-up questions) in a uniform and consistent manner. When this is done, we can compare the needs of different clients or groups of clients, or chart the need and behavior of clients over time so that we can determine what to do next. The principles that help us to achieve this will be referred to as General Interviewing Conventions.

These conventions apply to the use of many different types of instruments designed to be administered to a similarly wide range of people in several different ways. For the sake of clarity, the instrument, inventory, or assessment being used will be referred to as the questionnaire. The person administering the questionnaire (e.g., intake worker, counselor, VSC, interviewer) will be referred to as the interviewer. The person answering the questions (e.g., the client, or person who has since left treatment) will be referred to as the respondent.

Exhibit 4-1 shows ten key rules that need to be followed in administering virtually any standardized assessment. Each of these rules is discussed in the following sections, along with examples showing why the rules are so important.

4.3.1 Ask the Questions Using the Exact Words Printed in the Questionnaire

Each respondent must be asked exactly the same question so that the answers indicating their behavior, opinion, attitude, or experience are responses to the same stimulus. When an interviewer changes the wording in a question--even slightly--answers may change accordingly. The following example illustrates how changes in wording can produce changes in answers.

Example		
VERSION	QUESTION	ANSWER
Questionnaire Version	About how many hours do you work in an average week?	20-30 hours
Altered Version 1	How many hours a week do you work?	It depends on what's available. Sometimes 40 or so, other times not at all.
Altered Version 2	How often do you work?	Not often.

A carefully worded and carefully asked question will elicit a fairly precise response. Any deviation from the exact wording of a question, whether deliberate or not, can easily change the response. In the example above, the questionnaire version of the question asks the respondent to perform the following task: consider the number of hours you spend working over a period of time and then give me your best estimate of how many hours you work in what might be considered an average or typical week.

Altered version 1 (above) changes the respondent's task; the new task is for the respondent to provide a number of hours that he or she works in a week--any week. Altered version 2 does not ask the respondent to estimate units within time, and the answer received provides no useful data. In this version, the respondent's task is reduced to providing an imprecise measure of working without regard to time period.

Just as altering the wording of the question may affect a respondent's answer, reordering words or phrases within the question may also affect the answer. In questions where response categories are part of the question, any change in the order of the response categories may distort results. Likewise, omitting or adding response categories may produce bias. Even when a respondent interrupts a question in order to answer, ask him or her to permit you to read all of the response choices before giving a final answer.

You must constantly guard against unintentional changes in wording. You must also, of course, resist the temptation to improve the wording when a question seems difficult to read or understand. Every word in a question is purposely chosen. Therefore, questions must be read exactly as printed. It is important to observe this rule so that each respondent hears the questions asked in the same way. The only

exception to this is the use of "supply words" in place of capitalized interviewer instructions.

4.3.2 Ask the Questions in the Exact Order in Which They Appear in the Questionnaire

The meaning of a question may change or be unclear if it is asked out of sequence, and you may miss some questions entirely if you do not follow the prescribed order. In the GAIN, for instance, questions are often sequenced to define a problem before asking a general question. Failure to follow the prescribed order will change the respondent's understanding of the question. A clear example of this can be seen in the help ratings. At the end of each section in the GAIN, clients are asked about specific types of help they might want and then the overall importance of getting this help. Asking them to rate their need first would change the meaning from specific assistance needs to a general sense of need in each area.

4.3.3 Ask Every Question Specified in the Questionnaire

It is not unusual for a respondent to provide information in the answer to one question that seems to answer another question that comes later in the questionnaire. In such a case, the interviewer may be tempted to skip the later question. These situations should be handled in the following manner. When the interviewer receives information that seems to answer an upcoming question, the information should be recorded under the question where it is received. Later, when the related question occurs, the interviewer should acknowledge to the respondent that he or she remembers what was said earlier. For example, the interviewer might say: "We've already talked about this topic a bit, but let me ask..." or "You've told me something about this, but this next question asks..." Then, the question should be asked exactly as it is worded in the questionnaire. Assuming that the answer to an upcoming question has already been provided is a dangerous practice. The answer received in the context of one question may not be the same answer that will be received when the specific question is asked exactly and directly. Consider the following example.

Example	
Question 1:	Now think about the time you and your husband were planning to get married. Did you and your husband put off your marriage for any length of time for financial reasons?
Response:	Yes. We had to wait about 8 months until my husband could find a job.
Comment:	The respondent has provided a response that includes a precise amount of time that she and her husband put off their marriage while he sought employment.
Question 2:	After you and your husband decided to get married, how long was it before you actually did get married?
Response:	Well, we waited the 8 months while my husband looked for a job and then we had to wait another 4 or 5 months until we could save some money. In all, we waited over a year.

In this example, the response to Question 1 is only a partial answer to Question 2, as shown by the additional information provided in the response to Question 2. An assumption that the respondent waited 8 months to marry after she and her husband decided to get married is, in this case, totally incorrect.

In summary, every question specified must be asked, even if the interviewer feels that he or she already has the answer to a question, based on previous responses. Acknowledge information already obtained, but permit the respondent to answer every question directly.

4.3.4 Read the Complete Question

A respondent may interrupt you and answer before he or she has heard the complete question. When this happens, read the question again, making sure the respondent hears it through to the end. Do not assume a premature response applies to the question as written.

4.3.5 Repeat Questions That are Misinterpreted or Misunderstood by the Respondent

To do this, you must be familiar with the intent and frame of reference of each question and listen carefully to determine whether or not the response is appropriate before recording.

4.3.6 Read the Questions Slowly

You, as the interviewer, are familiar with each question before you conduct your first interview. Each respondent, however, is hearing every question for the first time and needs to consider individual words and phrases as well as the complete question in order to provide the information requested.

Studies have shown that the reading pace established by the interviewer is one of the critical elements of the interview. A pace of about two words per second is considered optimal. This allows the interviewer time to enunciate every word carefully and gives the respondent time to listen and formulate a careful response.

When interviewers read questions slowly and carefully, they are demonstrating desirable behavior that should be copied by the respondent. If the interviewer seems to race throughout the interview, the respondent will probably help by providing short, terse responses. One clear indication of asking questions too rapidly is the respondent's frequent request that questions be repeated.

Take the time in the beginning of each interview to let respondents learn how to answer questions, and they will get faster as the interview proceeds and similar types of questions are asked.

4.3.7 Do Not Suggest Answers to the Respondent

It is easy to do this unintentionally if you are not careful. Even your facial expressions can reveal your reaction to the content of a response. It is inappropriate for an interviewer to give any cues to the respondent about whether or not he or she is shocked/approving/disapproving or making any other kind of value judgement about the respondent's reported behavior. Keep in mind that respondents are typically anxious to please the interviewers and will (either on a conscious or subconscious level) try to shape their answers, if they feel the interviewer does not approve of their behavior.

For the duration of the interview, you must step out of your role as counselor and become an unbiased reporter for the questionnaire. Counselors in similar previous interviewing efforts have fallen into two common pitfalls:

- When a response conflicts with information the interviewer/counselor already knows about the client, some counselors have reacted by confronting the client/respondent with the discrepancy. This is absolutely inappropriate for an interviewer to do. It hinders the rapport between the respondent and the interviewer and puts the respondent on the defensive. Remember that, as an interviewer, your job is to record and report what the respondent tells you. Discrepancies should be noted, and addressed in later stages of the ISAC protocol.

- When a respondent uses less appropriate terms to discuss a subject area, some counselors have reacted by mirroring the language used by the client. An extreme example of this occurred when a respondent was asked how many children he had. The respondent replied that he had "four brats at home." In a subsequent question that referred to those children, the interviewer replaced the word "children" with the word "brats" when she asked the question. An interviewer should never modify a question in this manner. While it is the respondent's prerogative to refer to his or her own kids as brats, it is insulting for the interviewer to do so.

Your opportunity to use your skills as a counselor will come after the interview is completed. While you are administering the questionnaire, try to avoid these pitfalls and to remain an unbiased recorder and reporter of the information the respondent gives you. Remember, here you are trying to do a standardized assessment; counseling is the next step.

4.3.8 Use Introductory or Transitional Statements as They are Printed in the Questionnaire

These occur at points throughout the questionnaires and should be read as worded. They are particularly important for reassuring respondents prior to asking about sensitive information, such as illegal activities, sexual activity, or abuse.

4.3.9 Use Neutral Probes Only as Necessary

For most questions, probe only as necessary to obtain a clear response that meets the question specifications. Do not probe to the negative unless you are instructed to "CIRCLE ALL THAT APPLY." ("Probing to the negative" means to continue to ask the respondent for answers until he or she indicates that there are no

more answers--an example would be, "What else?".) Various types of probes are useful. The most frequently used probes are:

- Neutral comments -- "Tell me more about that," "Please explain that further," "Please give me an example."
- Expectant pauses -- Just wait for a few seconds and see if the respondent elaborates.
- Re-reading the question -- Sometimes the respondent simply did not completely hear the question.
- Repeating the answer choices -- Sometimes the respondent does not understand the kind of answer you are looking for.

On some questions, you will be asked to clarify and categorize the respondent's answers. In these cases, it is often useful to ask questions like:

- What kinds of things did you do?
- Can you give me an example of that?
- Could you clarify what you meant by _____?

4.3.10 Listen to the Responses

Asking questions properly is important, but no more important than listening carefully to the response. A respondent may respond to what he or she thought you were about to ask, imagining a question that includes a key word that caught his or her attention. By listening carefully to your respondent's answers you can reduce this type of error.

4.4 Reporting Assessment

The JCAHO (1993) and many other accrediting agencies require that whenever a standardized assessment is done a written report must be put in the record that summarizes the results and interprets their meaning. More recently JCAHO has been advocating that programs demonstrate how the assessment leads to the treatment plan, actual services, and follow-up monitoring. Many standardized assessments are now set up to either be keyed into a computer or entered directly so that the data can be used to generated an initial summary report. We have set up the GAIN to do this and are

currently working on both summary and full (20-25 page) case narratives summarizing the assessment (see Section 4.2).

Despite flashy advertisements to the contrary, there are no quick fixes for interpretation and treatment planning. Since the assessment is primarily based on self-reported data from a person who may be cognitively impaired, in a state of denial, or even have reasons to lie, this data cannot be the sole source of information. While we facilitate the prioritization and identification of treatment planning issues in the GAIN, clients do not always ask for (or realize) what they need, and everything they ask for may not be appropriate. In preparing a report on a standardized assessment it is therefore important for you to:

- review the information reported with the respondent/client to verify accuracy and to correct any mistakes or misinterpretations;
- review the interpretation with other staff if the problem is outside of your area of expertise; and
- clearly delineate what the respondent/client "reported" from your "opinion," your interpretation of the problem, and your recommendation.

Pathways, PBA, and many other drug treatment programs prefer to have draft reports reviewed by clients and in case conferences before they are finalized and put into the files. The final version typically then includes the signatures of the client, counselor, clinical supervisor, and medical director indicating that they have reviewed and agreed with the assessment. Exhibit 4-2 shows a summary report designed for manual use with the GAIN. The longest version is computer generated and often exceeds 20 pages.

Exhibit 4-1. General Interviewing Conventions

1. Ask the questions using the exact words printed in the questionnaire.
2. Ask the questions in the exact order in which they appear in the questionnaire.
3. Ask every question specified in the questionnaire.
4. Read the complete question.
5. Repeat questions that are misinterpreted or misunderstood by the respondent.
6. Read the questions slowly.
7. Do not suggest answers to the respondent.
8. Use introductory or transitional statements as they are printed in the questionnaire.
9. Use neutral probes only as necessary.
10. Listen to the responses.

Exhibit 4-2 (continued)

Client Name:	Client ID:
Staff Name:	Staff ID:
Date Admitted:	Date Administered:

Physical Health:

Mental Health:

Social and Coping:

Other Treatment Planning Issues:

APPROVAL

Client's Signature	Counselor's Signature
Clinical/Case Conference Supervisor	Medical Supervisor/Director

Exhibit 4-2 (continued)

Client Name: Client ID:
Staff Name: Staff ID:
Date Admitted: Date Administered:

FUNCTIONING SUMMARY FOR PAST 90 DAYS

	Measure	Count	+/-	Z-Score
(+)	Child Activity Scale (CAS_5)	|__|__|	( )	|__|__| . |__|__|
(-)	Food Management Scale (FMS_7)	|__|__|	( )	|__|__| . |__|__|
(+)	Days Employed (ID6a)	|__|__|	( )	|__|__| . |__|__|
(-)	Vocational Problem Scale (VPS_14)	|__|__|	( )	|__|__| . |__|__|
(-)	Michigan Alcoholism Screening Test (MAST_12)	|__|__|	( )	|__|__| . |__|__|
(-)	Days with 1+ Drinks (E3k)	|__|__|	( )	|__|__| . |__|__|
(-)	Drug Abuse Screening Test (DAST_11)	|__|__|	( )	|__|__| . |__|__|
(+)	Days without using any drugs (IE14k)	|__|__|	( )	|__|__| . |__|__|
(-)	Current Legal Risk Screener (CLRS_13)	|__|__|	( )	|__|__| . |__|__|
(-)	Days of Illegal Activity (IF12)	|__|__|	( )	|__|__| . |__|__|
(+)	Quality of Physical Life (QOPL_7)	|__|__|	( )	|__|__| . |__|__|
(-)	Needle Risk Screener (NRS_3)	|__|__|	( )	|__|__| . |__|__|
(-)	Days of Needle Use (IG26b)	|__|__|	( )	|__|__| . |__|__|
(-)	Sexual Risk Index (SXRS_7)	|__|__|	( )	|__|__| . |__|__|
(-)	Number of Sexual Partners (IG27a)	|__|__|	( )	|__|__| . |__|__|
(-)	Current Mental Distress (CMD_21)	|__|__|	( )	|__|__| . |__|__|
(-)	Days thinking about Suicide (IH21b)	|__|__|	( )	|__|__| . |__|__|
(-)	ASI Current Conflict Scale (ACCS_9)	|__|__|	( )	|__|__| . |__|__|
(-)	Current Personal Victimization Scale (CPVS_5)	|__|__|	( )	|__|__| . |__|__|
(-)	Generalized CTS Aggression Scale (GCAS_d_10)	|__|__|	( )	|__|__| . |__|__|
(+)	Problem Orientation Scale (POS_3)	|__|__|	( )	|__|__| . |__|__|
(+)	Problem Solving Scale (PSS_10)	|__|__|	( )	|__|__| . |__|__|
(-)	Denial and Misrepresentation Scale (DMS_8)	|__|__|	( )	|__|__| . |__|__|
(-)	General Risk Scale (GRS_11)	|__|__|	( )	|__|__| . |__|__|

Other Critical Issues:

Exhibit 4-2 (continued)

Client Name:	Client ID:
Staff Name:	Staff ID:
Date Admitted:	Date Administered:

DSM-IV DIAGNOSTIC IMPRESSIONS

Axis I: Clinical Mental Health Disorders

Alcohol Diag.: _____ Primary Drug Diag.: _____
Secondary Drug Diag.: _____ Tertiary Drug Diag.: _____
Suicidal/Acute: LOW MED HI (Comment: _____)
Unspecified Mental Problems: LOW MED HI (Comment: _____)
Other: LOW MED HI (Comment: _____)

Axis II: Personality Disorders

Borderline Personality: LOW MED HI (Comment: _____)
Antisocial Personality: LOW MED HI (Comment: _____)
Mental Retardation: LOW MED HI (Comment: _____)
Other: _____

Axis III: General Medical Conditions

Acute Medical Problems: LOW MED HI (Comment: _____)
Specified Medical Problems: LOW MED HI (Comment: _____)
Unspecified Medical Problems: LOW MED HI (Comment: _____)
Other: _____

Axis IV: Psychosocial and Environmental Problems

Primary Support Group: LOW MED HI (Comment: _____)
Social Environment: LOW MED HI (Comment: _____)
Education: LOW MED HI (Comment: _____)
Occupation: LOW MED HI (Comment: _____)
Housing: LOW MED HI (Comment: _____)
Economic: LOW MED HI (Comment: _____)
Access to Services: LOW MED HI (Comment: _____)
Legal System/Crime: LOW MED HI (Comment: _____)
Other: _____

Axis V: Global Assessment of Functioning

Past Year: |___|___| Comment: _____)
Past 90 days: |___|___| Comment: _____)

Other Comments:

Exhibit 4-2 (continued)

Client Name:	Client ID:
Staff Name:	Staff ID:
Date Admitted:	Date Administered:

SERVICE UTILIZATION (PAST 90 DAYS)

SA Treatment Service	Times/ Days	Other Services	Times/ Days
Self Help Groups (E15d)	____	School/Training (D4j)	____
Detoxification (E16d)	____	Times Arrested (F14c)	____
Individual Counseling (E17h+p)	____	Jail/Prison Days (F15b)	____
Group Counseling (E17i+q)	____	Emergency Room Visits (G21c)	____
Methadone (E17k+s)	____	PC Outpatient Visits (G23b)	____
Other SA Tx Meds (E17l+t)	____	PC Alternative Tx Providers (G25b)	____
Other SA Tx Services (E17n+v)	____	MH Outpatient Visits (H23d)	____

Current Medications:

Comments:

HELP IMPORTANCE (O) AND PROBLEM SEVERITY (X) RATINGS

Areas		0	1	2	3	4
B.	Treatment retention (B12/13)					
C.	Living situation (C12/13)					
D.	Vocational (D18/19)					
E.	Alcohol/Drug use (E21/22)					
F.	Illegal/Civil (F22/23)					
G.	Physical health (G34/35)					
H.	Mental health (H28/29)					
J.	Social/Coping (J17/18)					
TP.	Global Mean (GHI_8/PSR_8)					

Exhibit 4-2 (continued)

Client Name:	Client ID:
Staff Name:	Staff ID:
Date Admitted:	Date Administered:

TREATMENT PLANNING ISSUES

ASAM Criteria and Level:

Acute Intoxication/Withdrawal: None Minimal Moderate Severe
Biomedical: None Minimal Moderate Severe
Emotional/Behavioral: None Minimal Moderate Severe
Treatment Resistance: None Minimal Moderate Severe
Relapse Potential: None Minimal Moderate Severe
Recovery Environment: Supportive Neutral Unsupportive Dangerous
Level: I II III IV Methadone: Y N
Comments:

Treatment Retention:

Living Situation:

Vocational:

Alcohol and Drug Use:

Legal or Civil Issues:

5.0 Treatment Planning

This section presents guidelines for working with your clients to develop individualized treatment plans using a standardized needs assessment and to promote consistency in the manner in which treatment plans are developed. A basic thesis of this section is that client involvement is essential to developing meaningful and useful treatment plans (Sobell, Sobell, & Nirenberg, 1988). Active client involvement in treatment planning and goal setting can help:

- provide the counselor with important information about the desirability, feasibility, and ease with which various treatment strategies can be implemented;
- increase clients' motivation to participate and continue in counseling;
- ensure that the goals have been mutually determined; and
- boost the morale of clients, giving them a sense of mastery over their problems.

In this section, we provide some specific recommendations and guidelines for developing an initial treatment plan with client involvement over the course of the first few counseling sessions. It is important to keep in mind, however, that treatment planning is not limited to the initial formal encounters with a client. On the contrary, treatment planning is a dynamic process that typically evolves well beyond the first few sessions and should span the entire course of counseling and treatment.

5.1 Assessing Client Needs

5.1.1 Purpose in this Context

In the first session, you will conduct a standardized assessment of the client's needs within important problem areas. Be sure to inform the client at the beginning of this first session that you will be administering a structured interview and that the reason for doing so is to get a clear picture of some of the areas in which he or she may need assistance. In addition, mention that the assessment will be used as the basis for much of what occurs in subsequent sessions because it will help you and the client in your collaborative effort to develop an effective and individualized treatment plan.

Chapter 4 of this manual describes how to administer a standardized assessment. In addition, several of the commonly-used instruments provide more detailed instructions in their accompanying manuals (e.g., Dennis et al., 1995; McLellan et al., 1988). The assessment should provide a general overview of problems in specific areas (i.e., living situations, family, social relationships, employment, support status, drug use, medical status, alcohol use, legal status, and psychological status). In our experience, many instruments can provide sufficient detail to obtain a general picture of the problem presented by a particular client. The advantages of picking one instrument and standardizing its administration are that it (a) allows counselors to communicate more effectively with each other and their clinical supervisor in case conferences, consultation, and supervision, and (b) it minimizes the loss of information when cases are transferred between counselors. The primary advantages of the GAIN over other instruments are that it was designed (a) to lead directly into treatment planning (discussed below) and problem definition (discussed in Chapter 6) and (b) to help counselors to communicate more effectively with other staff about non-counseling issues during consultation and referral (discussed in Chapter 7). Although use of the GAIN is certainly not required, the rest of this section is written assuming that the GAIN has been used.

5.1.2 Preparing for Treatment Planning During the Assessment

There are some important treatment planning issues to consider when using the GAIN as part of the ISAC protocol. First, although the primary goal during the assessment should be to record the respondent's answers and questions, it is also appropriate and desirable to be jotting down questions in the margins about issues to follow up on after the assessment. On the GAIN, blank space has been provided on nearly every page to facilitate this process.

Second, it is important for the client to realize that this information will be used to help plan his or her treatment. Be sure to dispel any notion that the client may have that this is simply another piece of paperwork or just a research instrument. The purpose of administering the GAIN or other standardized instrument is to help you and your client understand, define, and prioritize your client's needs in order to develop an effective treatment plan and monitor progress.

Third, it is important to emphasize to the client the importance of returning for the next scheduled counseling session. Remember that clients come looking for treatment and services—not assessment. Be very clear that the purpose of the next session will be to plan out treatment and services, not simply more assessment.

5.1.3 Transition to the Next Session

Even before developing a formal treatment plan, it is essential to start informal treatment planning from the very first session. At the most pragmatic level it is important to check for immediate threats or barriers to the client's (a) return for the next session, (b) personal safety, and/or (c) short term sobriety. After the assessment is completed (or at the end of the first session), you should review the information available to date and the client's plans for immediately after leaving, between now and the next session, and for coming to the next session. Carefully probe for any barriers to returning like those found in section B of the GAIN (e.g., transportation difficulties, child care, work schedules, insurance). Clarify any concerns about possible suicidal thoughts (section H of the GAIN) or threats to personal safety (Section J of the GAIN). Next, make sure that the client has thought through a plan for coming back for the next session (e.g., how will he or she get there, who will watch the kids, is there anymore paperwork or documentation required). Finally, it is often desirable to provide some level of intervention (see Chapter 6) and/or to make sure the client has access to some kind of drug-free environment to reduce the risk associated with relapse between this and the next session (e.g, detoxification, a sponsor or friend in recovery).

Effective resolution of some barriers to care might involve arranging a joint meeting with the client and a vocational services coordinator (VSC), case manager, or other staff member. For example, if the client is concerned about being unable to keep the next few appointments because of unmet child care needs, meet with the client and the case manager together immediately (if possible) to assist the client in finding a suitable solution to this problem. It is particularly important to cover this issue for new clients where the assessment is being done in their first or second session.

5.2 Feedback and Targeting of Problems

5.2.1 General Feedback

We recommend that the next session be dedicated to conducting a face-to-face review of the assessment with your client. This review gives you the opportunity to:

- Identify and correct errors, misperceptions, and miscodings regarding answers to specific questions.
- Allow the client to clarify and expand upon the information recorded in the standardized assessment.

- Provide the client with a concise overview of his or her problems in eight important areas of functioning.
- Provide a format for comparing and discussing the severity of problems as viewed by the client and you.
- Provide a logical starting point for developing an individualized treatment plan with active client involvement.

Begin this session by telling the client that you would like to review the findings from the standardized interview that was completed in the previous session. Mention that you expect that this review will be helpful in developing a plan to address the problems in his or her life that are related to drug use. We recommend that you review all modules of the assessment, including modules in which the client and you agree that few or no problems exist. We believe that a complete review of the assessment often provides the client with a clear "snapshot" of his or her life that points out areas of relative strength as well as problem areas that may require treatment of some kind.

Introduce each module of the assessment with a brief statement such as "We began the interview with a number of questions about your living situation," and "In this next section, we discussed your involvement with the legal system." Brief statements such as these should help to focus the client's attention on the information to be covered in that module. Briefly review the client's response to each item in the assessment modules, including the client's and your ratings of the severity of problems in each area. Encourage the client to provide additional information that might clarify the nature of problems in each area. This information can be recorded directly onto the GAIN interview form or profile. Counselors vary in how much additional detail they seek at this point, but most seek to understand any complex situation or what appear to be inconsistent or unlikely answers. Our experience indicates that most GAIN reviews should be completed within a single session.

At first glance this review may seem redundant to you because it is covering the same information as the original assessment. For a given client, however, it is often a therapeutic experience because it directly demonstrates that you actually listened, and it provides a comprehensive picture of his or her life and situation. Many clients have never taken stock of their own lives, and virtually none have confided so much information to a single person. This review process is a fundamental part of empowering you as someone who understands the client and facilitates your role as an agent of change.

Below is a brief excerpt from a feedback session based on the ASI that was conducted by one of the enhanced counselors in the MET trials:

EXAMPLE

Counselor:	[Name], I'll begin by reviewing what we discussed about your medical status. When I asked you "How many times in your life have you been hospitalized for medical problems?" you told me three times. Once when you were 19-years-old and you were shot, and more recently, when you were hospitalized in 1985 and 1989 for knee surgery.
Client:	That's right. I got hooked on pain meds while recovering from the gunshot wound.
Counselor:	You also told me that your last hospitalization was 2 years ago, and that you suffer from chronic headaches that began in 1984 after you were knocked out in a boxing match.
Client:	My headaches started to get real bad after that.
Counselor:	You said that you are not taking any prescribed medication on a regular basis for a medical problem, and you do not receive a pension for a physical disability. When I asked "How many days have you experienced medical problems in the past 30?" you responded by saying "30," which you related to your headaches and knee pain.
Client:	That's right. You know, I'm trying to deal with my headaches and swollen knees without any meds now.
Counselor:	That's good. When I asked you "How troubled or bothered have you been by these medical problems in the past 30 days?" you rated it a "2," which means "moderately troubled." When I asked you "How important to you now is treatment for these medical problems?" you said "4--extremely important." I agreed with your assessment and rated your current medical status as a considerable problem, with treatment necessary.

5.2.2 Prioritizing General and Specific Areas for Treatment Planning

The next step is to prioritize the general areas of potential treatment needs and identify specific areas to work on. Exhibit 5-1 shows both the client and counselor ratings marked on the face page of the GAIN. To minimize the extent of conflict, clients have been asked to rate the importance to them of getting help in this area, while counselors have been asked to rate the problem severity in each area. In summarizing both the client and your own ratings it is important to acknowledge both

your areas of agreement and disagreement. While you do not want to dwell on or be sidetracked by areas of disagreement, acknowledging such areas helps to establish the appropriate level of rapport. In other words, be supportive but honest.

In many cases you will find several areas which you and the client will agree are very important and some which you will agree are relatively unimportant. About a third of the time there will also be one or more areas in which you think the client is either underestimating the extent of the problem or is perhaps even in a state of denial. Some common examples of this include clients who do not recognize:

- their heavy alcohol use as a problem;
- the risk caused by needle practices or sexual behaviors; or
- their level of aggressive behaviors, conflict, or level of victimization.

Treatment needs also vary over time as clients progressively deal with different issues related to their stage of recovery. Exhibit 5-2 provides a summary of the mean counselor and client ratings from three TEP methadone treatment programs (Pathways, PBA, and Santa Clara County Substance Abuse Services) by gender, race and time in treatment. As with the ASI data in Chapter 2, counselors and clients were in close agreement. Both rated drugs and vocational issues as the most pressing problems and the areas of greatest need for help. These concerns are followed (in order of importance) by logistical issues associated with coming to or staying treatment, social or coping issues and physical health, mental health and living situation, and legal issues. In general, counselor problem severity ratings are also about the same or higher than the client's self-rated needs.

In terms of correlates, notice that both female clients (and their counselors) viewed themselves as having more severe drug and mental health problems. Also note that counselors were often much more concerned about the social or coping situations of women (1 out of 5 of whom were reporting being physically or sexually abused in the past 90 days or being at imminent risk for such abuse). Hispanic clients were more likely to report greater need for assistance with legal problems and with physical and mental health problems, though their counselors only seemed to consider them to be at greater risk for mental health problems. In terms of time in treatment, only drug and alcohol problem severity (the focus of treatment) appears to be significantly reduced as time in treatment increased--virtually all other problems and forms of help needs remain unchanged/unmet. This overall pattern is a salient reminder of the need for more comprehensive treatment and the constant weight of other problems that are pressing in on clients.

Starting with the areas that both you and the client think are the most important, the next step is to look at the specific kinds of help that the client wants. Each section of the GAIN ends with a list of specific services the client may want help with from this program, either directly or through referral. Exhibit 5-3 shows the percentage of clients requesting any and each specific type of service in the eight GAIN domain areas. More than half the clients wanted (more) help with their drug use (70%), going to school (66%), getting a (better) job (65%), counseling (63%), their methadone (59%), improving their financial situation (59%), and getting or keeping public benefits (53%). Twenty percent or more of clients wanted help in over two dozen other areas. These other areas add up and can often represent critical unmet needs. For instance, while the most frequently cited barrier to staying in treatment (counseling schedules) was only a problem for 34% of the clients, 88% of the clients reported one or more of the five main barriers (paying for treatment, dosage level or schedule, counseling schedule, getting to or from treatment, childcare while in treatment). While no single form of legal help was requested by 10% of the clients, a third (33%) wanted help in one or more areas. In fact, in all but the legal section, 50% or more clients asked for one or more types of help.

We also found some differences in the kinds of assistance sought by women and minorities. In TEP, female clients were significantly more likely than male clients to want help with childcare while they are in treatment (15% vs. 8%), with detoxification (36% vs. 24%), with their family's alcohol or drug use (20% vs. 7%), with people who have attacked them or might do so (13% vs. 3%), and with how they handle arguments (30% vs. 19%). They were also significantly less likely than male clients to want help paying for treatment (21% vs. 31%), getting their counseling schedule adjusted (24% vs. 34%), getting or keeping public or private benefits (44% vs. 59%), getting health treatment (24% vs. 37%), and coping with medical problems (36% vs. 48%).

We also found that Hispanic clients were significantly more likely than black or white clients to want help with civil justice proceedings (13% vs. 2% & 9%), criminal justice proceedings (11% vs. 6% & 9%), getting HIV testing or counseling (50% vs. 28% & 29%), health care treatment (50% vs. 28% & 29%), health prevention information (54% vs. 39% & 32%), how they feel emotionally (50% vs. 21% & 38%), how their mind or body is working (43% vs. 21% & 30%), and controlling their mind or behavior (41% vs. 13% & 31%). White clients were the next most likely to want each of the above services and the most likely (followed by blacks and Hispanics, respectively) to want help getting psychotropic medication (27% vs. 22% & 12%), dealing with people they have been avoiding/arguing/or fighting with (20% vs. 9% & 13%), and with how they cope with their problems (53% vs. 39% & 52%).

Only the desire for help getting HIV testing and counseling decreased with time in treatment. Again, this shows that many of these issues are still important even for clients who have been in treatment for 3 or more years.

5.2.3 Other Critical Clinical Issues

In addition to the client-identified needs, it is also important for you to identify and raise other critical clinical issues that may put the client, the client's family, and/or society at considerable risk of drug relapse or other forms of harm. Some of these other issues include:

- homelessness, unstable housing, or living situations with a lot of drug/alcohol use and illegal activity;
- food problems, including going without food;
- having young children, particularly a first child, children under 3, or children with custody issues;
- whether people in living situations are engaged in socially productive and/or supportive behaviors;
- whether people in work/school situations are engaged in socially productive behaviors;
- illegal activities, including arrests and relying primarily on illegal income for support;
- involvement in civil or criminal justice proceedings that may produce stress, legal, or financial consequences;
- major infectious diseases related to drug use, including hepatitis, tuberculosis, AIDS, and other sexually transmitted diseases;
- risk behaviors related to spreading infectious diseases, including needle use and unprotected sex;
- medical or dental problems, particularly those that may require coordinated care such as pregnancy or taking prescribed drugs;
- current mental health problems, particularly suicidal thoughts or attempts, or problems that may require coordinated care;
- whether peers are engaged in socially productive and/or supportive behaviors;

- recent avoiding, arguing, or fighting with family, friends, or coworkers;
- recent weapon, physical, sexual, or emotional attacks, including concerns that they might happen again soon;
- high rates of using violence to resolve conflict situations;
- victimization or fear of abuse;
- lack of problem orientation or productive coping skills; or
- antisocial or borderline personality behaviors related to family, school, work, treatment, and societal restraints in general; or
- low overall functioning or deteriorating functioning.

The GAIN is designed to screen for each of these problems. If they are encountered, however, you will need to probe to clarify the nature of each problem and the specific ways in which it is expressed in the client's life. You can ask the client to describe any situations, events, and mood states that tend to precede, follow, or co-occur with each target problem. The goal here is to identify conditions that potentially trigger and/or maintain the undesired problem. For example, it would be important to ask a client who injects cocaine and heroin ("speedballs") if certain things tend to co-occur with his or her use of these drugs. Asking such questions as "When you cook your works, are others usually around?" and "How are you usually feeling before you shoot up?" may prompt the client to report information of critical importance to the treatment plan that is not typically obtained from general assessments. For example, by sensitively asking probing questions, you may find out that a client tends to abuse heroin and cocaine in combination on the weekends, when hanging out with certain partners, or when he or she is feeling depressed and isolated from family members, especially his or her children. This additional information may be critical to the development of a meaningful and effective treatment plan. Techniques for defining problems are discussed further in Chapter 6.

5.3 Developing Specific Goals

5.3.1 Identify Possible Short- and Long-term Goals for Each Target Problem

Specific goals should be identified for each problem area of focus. As noted by Gambrill (1977), specifying the treatment goals allows the client and counselor to fully understand the purpose of counseling, permits the counselor to assess whether

the treatment team has the skills and/or resources necessary to assist the client in attaining specific goals, and guides the development and revision of treatment plans.

Most treatment plans contain two types of goals: long-term and short-term. Long-term goals usually represent the ultimate outcome to be achieved by treatment. For example, a methadone client who uses cocaine might desire to achieve total abstinence from illicit drugs--a long-term goal that may require significant time and effort to achieve. Counselors have long recognized that a key to successfully achieving long-term treatment goals is the ability to develop a graduated series of challenging, but clearly obtainable, short-term goals, which in principle should lead to attaining the desired long-term goal. Identifying short-term treatment goals is especially important in developing effective treatment plans for individuals with problems of a severe and chronic nature--precisely the kinds of problems typically encountered when counseling long-term drug users.

In general, the most useful and meaningful treatment plans are those that emphasize the development of short-term goals. For example, for a client who is currently unemployed, an appropriate long-term goal is to "find a job and maintain steady employment." However, achieving this long-term goal may take an uncertain and somewhat prolonged amount of time (several weeks or months). Linking the measurement of treatment progress to the attainment of long-term goals often leads to discouragement for both the client and the counselor. On the other hand, short-term goals have the distinct advantage over long-term goals of permitting a realistic "daily" look at treatment progress, providing almost immediate feedback on goal achievement, and fostering a sense of accomplishment in both the client and counselor. Thus, a reasonable first short-term goal for the unemployed client might be to ask him or her to bring to the next counseling session the clippings from the newspaper "want ads" section of one to three jobs that the client would like to follow up on. You can discuss with the client the appropriateness of the job and his or her skills, etc., then work with the client through the application process. Further short-term goals that build on the earlier success might be to have the client apply for one or more jobs per week, then follow up with at least one formal job interview within 2 to 3 weeks.

Similar sorts of strategies for developing short-term goals can be developed for all potential problem areas, including drug and alcohol abuse, medical and psychological problems, legal problems, and family problems. An example is a case in which the GAIN indicated that the client had recently experienced serious problems with a partner/spouse and children. By augmenting the information from the GAIN with extensive probing about the specific kinds of family problems that the client is experiencing, you might find that the client has severe deficits in his or her ability to communicate effectively with family members. In this case, the counselor and client

might decide that communication problems constitute an appropriate target, and that an important long-term goal is to "improve the client's ability to communicate effectively with his or her spouse and children."

As mentioned earlier, a key to successfully achieving long-term goals is to reformulate long-term goals in terms of a series of challenging, but obtainable, short-term goals. In the area of communicating with family members, a large number of potentially meaningful short-term goals may be identified. These could include completing a three-session educational minicourse on the topic of "effective communication skills," participating in several counseling sessions together with the spouse and children to discuss ways of improving communication within the family, and completing "homework" assignments that require the completion of a task that targets a specific interpersonal communication problem.

Exhibit 5-4 provides a sample script of how to introduce the process of treatment planning to your clients. We encourage you to develop an introductory statement that fits your style, yet presents the key points of information that your client needs in order to understand what a treatment plan is, why it is important, and what you will be doing to develop one.

Whenever possible, it would be advantageous to include the VSC, CSC, or other staff in the development of the initial treatment plan. The VSC's input would appear to be particularly helpful in the early sessions of counseling when target problems are likely to be vocational. A CSC will be useful when there are ancillary needs to be explored. Other medical staff may need to be consulted if the client is using prescription drugs or if there are acute medical symptoms. The other staff can often provide the counselor and client with important and timely information about the range of services available within the community that would pertain to the attainment of specific long- and short-term goals. A likely result of the other staff's participation at this early stage of treatment planning would be a potentially more realistic, efficient, and feasible treatment plan. Thus, the research team recommends that, in addition to the other specified contacts with the client and counselor separately, the other staff actively participate in some of the initial counseling sessions with the counselor and client together to focus on the development of the initial treatment plan. This approach is discussed further in Chapter 7.

5.3.2 Generate Treatment Alternatives

Generate a list of as many treatment options as possible to achieve short- and long-term goals. Work with your client and other staff to generate general strategies for goal attainment, and generate specific tactics (techniques) for each overall

strategy. Use brainstorming principles throughout this session, deferring judgment or critical evaluation of each alternative until the next session. The overall goal here is to generate lots of ideas that both the client and the treatment team (i.e., the counselor and the other staff) will use as the basis for the formal treatment plan to be created in the next session.

In reference to the previously cited case in which improved communication with family members was selected as an important long-term goal, the overall strategy could be to provide the client with counseling that targets this problem area. Specific counseling tactics could include individual counseling, group counseling, reading assignments, behavioral assertiveness skills training, marital counseling, and conjoint family therapy. The VSC or CSC could provide input regarding community resources that might be available to address this need, such as relevant interventions offered by local community mental health agencies or service providers. Techniques for developing multiple options are primarily discussed in Chapter 6.

5.3.3 Case Conferencing

Though it will vary considerably from program to program, most treatment programs have a client case conference before developing the initial treatment plan and to review subsequent plans on a regular interval or when there is a problem. Where this procedure exists, it provides an excellent opportunity for brainstorming on treatment plan goals with other counselors and clinic staff. Such case conferences will be more effective when a standardized needs assessment is used; all staff will then be able to readily understand assessment information and the kinds of services that are available, and they will have a common clinical language in which to discuss both the problem and options.

There are several roles that case conferences can play in treatment planning, including:

- identifying potential treatment options to raise with the client and other staff, or reviewing potential options raised by them;
- reviewing the reasonableness of a proposed course of action and likelihood of success;
- identifying internal and external referrals, resources, or sources of support; and
- suggesting strategies for identifying and dealing with a client's unrealistic requests or expectations (e.g, a person without a high school degree requesting a referral to college).

Case conferencing is discussed further in Chapter 7.

5.4 Decide on a Specific Treatment Plan

The purpose of this session is to work with the client (and the VSC, CSC, or other staff) to generate a formal treatment plan. The basic procedure for doing this is to systematically evaluate the appropriateness and utility of a range of treatment alternatives for each target problem. Some of the key factors that enter into the decision on what treatment plan to implement with what client are the following:

- Assess the likelihood that a particular treatment approach will produce a particular effect or outcome. In general, your estimates of comparative likelihoods will be based on your past relevant experiences with the treatment response of other clients with similar problems and personal characteristics.

- Estimate the likelihood that a particular treatment strategy can be implemented in its optimal form. This judgment requires an understanding of the availability of resources and an appreciation of potential structural barriers that might impede the client from participating in treatment (e.g., transportation, financial, and child care difficulties). In addition, this component of treatment planning requires an understanding of the personal liabilities and weaknesses of the client, the treatment team, and the range of community resources that affect the ability to deliver services to the client. Issues such as client motivation and counselor knowledge and competence with a particular procedure are relevant here.

- Each treatment alternative must be considered in terms of its personal consequences for the client, the counselor, and the other staff. These personal consequences include ethics, level of effort, time commitment, finances, impact on family and significant others, and emotional and physical side effects.

Selecting the optimal initial treatment plan involves comparing the overall expected outcomes of each alternative given the particular short- and long-term goals previously specified. Thus, in the example cited above, the counselor has generated a list of potential tactics for treating the family communication problems identified by the client. The next step is for the treatment team and the client to consider the potential outcome of each of these options separately, as well as in contrast to the expected outcomes of other alternatives. Personal, family, and environmental variables that could serve as mitigating factors should also be considered in the course of this decision-making process. Thus, the counselor might conclude that conjoint family counseling is in principle the most powerful technique for improving communication within this

client's family. However, environmental and familial circumstances might indicate that this treatment could not be implemented in its optimal form. For example, it may not be feasible for the client's children to attend counseling sessions at the times available to the client and his or her spouse. Thus, although the counselor might consider marital counseling (without the children) to be potentially less efficacious than conjoint family therapy for this particular problem, mitigating factors suggest that marital counseling might be the most viable treatment alternative that is available.

5.5 Example of an Individualized Treatment Plan

Exhibit 5-5 shows examples of initial and revised treatment plans for a 39-year-old male client whose interview revealed severe lifetime and current problems with heroin and cocaine abuse and interpersonal problems with the woman with whom he had been living as though married for several years and with her three children. The initial plan (which appears on a form used by the Desire Narcotics Rehabilitation Center in New Orleans) depicts a treatment plan as it might look after the first few counseling sessions with the client. The revised plan (which appears on a form used by the William C. Segaloff Substance Abuse Center of Southern Jersey in Camden, New Jersey) shows how a treatment plan might look after completion of several additional counseling sessions and the passage of sufficient time to enable the client to attempt to achieve some of the short-term goals identified in the initial plan.

In this case, the initial plan primarily describes the overall strategies proposed for addressing target problems, whereas the revised treatment plan focuses more on specific techniques and tactics for reaching the stated goals. This ability to narrow the focus of treatment in the revised plan often occurs as a function of obtaining more information about target problems once the initial plan has begun to be implemented.

We recognize that the "true" nature of clients' problems often unfolds over the course of counseling, so we encourage you to frequently revise and "fine tune" your treatment plans. Remember that effective and individualized treatment plans are never carved on stone tablets. They evolve over time as you continue to learn more about your clients and the ways to best help them to meet their specific needs. An important step in this direction is to agree on informal objectives to be accomplished either within the counseling session or before the next session. These should be very small steps that the client is clearly able to do. This helps the counselor to praise the client and move the client forward.

An example of this would be a client concerned about relapsing to cocaine use. Rather than giving the client a hotline phone number to call when he or she gets a craving (potentially too late), the counselor can start with very small objectives. These

might include calling the hotline from the counselor's office (breaking the fear of the unknown) and calling the hotline that night before getting a craving.

Exhibit 5-1. GAIN Summary

Program Name:
P.B.A., Inc. - The Second Step
1425 Beaver Avenue
Pittsburgh, PA 15233
412/322-8415

Instrument Developer:
Research Triangle Institute
3040 Cornwallis Road
RTP, NC 27709-2194
919/541-6413

Training and Employment Program (TEP) Version 0495P
Global Appraisal of Individual Needs - Initial (GAIN-I)

IDENTIFYING INFORMATION

[DO NOT KEY]
Staff name: Kathy Rourke

Client name: Jane Doe

Address: 3020 18th St
Apt 4C

City: Pittsburg

State: PA ZIP: 15236

Phone: (412) 384-2645

Alt(W): (____) _____-_____

Social Security (Optional): —

[USE LABEL IF AVAILABLE]

Site (ZSITE): ..... |1|9|1|
Staff ID (ZSID): ..... |_|_|_|_|_|3|C|1|
Client Program ID (ZPID): |_|_|_|_|4|6|C|1|
Gender (M F)/Race (B H W O)/Birth (YEAR) (ZCHK): ..... |F|W|4|9|
Admission date (ZADMDT): . |0|6|/|1|/|9|3|
Treatment Status (ZTXST) (1-New, 2-Readmit, 3-Continuing, 4-Detox, 5-Discharge, 6-Transfer): ..... |3|
Target date (ZTARDT): .... |0|3|/|1|/|9|5|
GAIN Month (0, 3, 6, 9, 12, etc.) (ZOBS): ..... |1|8|

PUBLIC DOMAIN NOTICE

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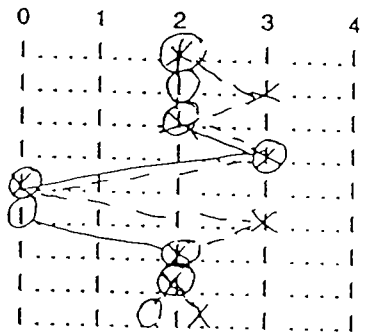
All scales in this instrument are provisional and are currently being validated. Contact Dr. Michael Dennis at RTI (see above) for permission and guidance before attempting to use or interpret this instrument.

INDIVIDUAL (O) AND GLOBAL (X) RATINGS SUMMARY:



Diagnostic Impression:
Primary ..... opioid ..... |3|0|4|.|0|0|
Secondary ... cocaine dep .... |3|0|4|.|2|0|
Tertiary ..... alcohol abuse |3|0|5|.|0|0|

FUNCTIONING SUMMARY FOR PAST 90 DAYS

Child Activity Scale (CAS_5) ..... (+)|__|3|
Food Management Scale (FMS_7) ..... (-)|__|0|
Days Employed (D6a) ..... (+)|__|0|
Vocational Problem Scale (VPS_14) ..... (-)|__|0|
Michigan Alcoholism Screening Test (MAST_12) ..... (-)|__|2|
Days with 1+ Drinks (E3k) ..... (-)|2|5|
Drug Abuse Screening Test (DAST_11) .. (-)|__|4|
Days without using any drugs (E14) ..... (+)|5|5|
Current Legal Risk Screener (CLRS_13) . (+)|__|0|
Days of Illegal Activity (F12) ..... (-)|__|0|
Quality of Physical Life (QOPL_7) ..... (+)|__|5|
Needle Risk Screener_3 (NRS_3) ..... (-)|__|1|
Days of Needle Use (G26b) ..... (-)|__|5|
Sexual Risk Index (SXRS_7) ..... (-)|__|3|
Number of Sexual Partners (G27a) ..... (-)|__|2|
Current Mental Distress (CMD_21) ..... (-)|__|3|
Days thinking about suicide (H21b) ..... (-)|__|0|
ASI Current Conflict Scale (ACCS_9) .... (-)|__|2|
Current Personal Victimization Scale (CPVS_5) ..... (-)|__|0|
Generalized CTS Aggression Scale (GCAS_d-10) ..... (-)|__|4|
Problem Orientation Scale (POS_3) ..... (+)|__|2|
Problem Solving Scale (PSS_10) ..... (+)|__|6|
Denial and Misrepresentation Scale (DMS_8) ..... (-)|__|3|
General Risk Scale (GRS_11) ..... (-)|__|4|

Exhibit 5-2
Mean Ratings of Help Needed and Problems by Time in Treatment, Gender, and Race

Type of Rating (Number of Items/Domain)	By Gender			By Race				Years in Methadone Treatment				Total (n=335)
	Female (n=148)	Male (n=187)	χ^2 =	Black (n=123)	Hispanic/ Other (n=46)	White (n=166)	χ^2 =	LT 1 (n=126)	1-2 (n=94)	3+ (n=106)	χ^2	
Number Per Column (d.f.)	148	187	(1)	123	46	166	(2)	126	99	106	(2)	335
Counselor's Problem Severity Rating (PSR-8)	**2.25**	**2.10**	**2.75**	**2.09**	**2.29**	**2.19**	**1.95**	**2.21**	**2.14**	**2.13**	**1.55**	**2.17**
Staying in treatment	2.66	2.52	1.24	2.73	2.72	2.43	3.43	2.82	2.47	2.40	5.46	2.58
Living Situation	1.79	1.53	1.78	1.74	1.57	1.59	.89	1.54	1.70	1.70	1.01	1.65
Vocational Situation	3.10	2.97	3.23	2.98	2.98	3.08	.35	3.02	3.02	3.05	.37	3.02
Drugs or Alcohol	3.15	2.86	8.18*	2.89	3.16	3.02	2.40	3.15	2.94	2.84	8.72*	2.98
Legal Issues	.86	.96	1.84	.69	1.23	1.01	4.77	1.00	0.94	0.80	1.75	.91
Physical Health	2.06	2.25	.81	2.21	2.57	2.02	4.61	2.24	2.12	2.12	.58	2.16
Mental Health	2.07	1.62	7.33*	1.43	2.02	2.06	13.43*	1.84	1.78	1.84	.11	1.82
Social & Coping	2.46	2.16	4.29*	2.11	2.45	2.39	2.95	2.38	2.15	2.32	1.36	2.29
Client's General Help Index (GHI-8)	**2.05**	**1.90**	**1.63**	**1.89**	**2.17**	**1.97**	**2.99**	**2.07**	**1.90**	**1.92**	**3.07**	**1.97**
Staying in treatment	2.70	2.54	1.60	2.76	2.78	2.45	3.36	2.89	2.47	2.41	7.32	2.61
Living Situation	1.59	1.35	1.42	1.55	1.43	1.39	.92	1.38	1.38	1.63	2.30	1.46
Vocational Situation	3.00	2.85	3.13	2.91	2.79	2.95	1.11	3.01	2.98	2.74	1.36	2.91
Drugs or Alcohol	2.97	2.65	6.87*	2.75	2.93	2.78	1.19	2.97	2.73	2.64	5.78	2.79
Legal Issues	.83	.85	.56	.59	1.29	.91	6.70*	.89	.78	.83	1.38	.84
Physical Health	1.95	2.14	.97	2.01	2.74	1.92	9.29*	2.31	1.87	1.95	4.68	2.06
Mental Health	1.66	1.25	5.07*	1.00	1.84	1.65	17.19*	1.46	1.31	1.52	.76	1.43
Social & Coping	1.90	1.78	.37	1.69	2.16	1.85	3.59	1.90	1.75	1.82	.65	1.83

NOTES: Mean rating on a scale of: Not at all (0), Slightly (1), Moderately (2), Considerably (3), or Extremely (4). Chi-squares based on Wilcoxon Rank Order test (* = probability of less than .05). Cronbach's coefficient alphas based on standardized variables is equal to .81 for the client's General Help Index (GHI-8) rating and .81 for counselor's Problem Severity Rating (PSR-8).

Source: Training and Employment Program (TEP) study using the Global Appraisal of Individual Needs (GAIN; Dennis et al., 1995b).

Exhibit 5-3
Percent of Clients Requesting Specific Types of Help

Client Wants (More) Help With:	By Gender: Female (n=148)	Male (n=187)	$\chi^2_{(1)}$ =	By Race: Black (n=123)	Hispanic/ Other (n=46)	White (n=166)	$\chi^2_{(2)}$ =	Years in Methadone Treatment: LT 1 (n=126)	1-2 (n=94)	3+ (n=106)	χ^2	Total (n=335)
Any Desire for Help from Program	**.98**	**.98**	**0.09**	**.98**	**.98**	**.98**	**0.07**	**.98**	**.99**	**.97**	**1.01**	**.98**
Any Treatment Retention Barriers	**.86**	**.89**	**0.94**	**.92**	**.91**	**.84**	**4.96**	**.88**	**.88**	**.88**	**0.00**	**.88**
Paying for treatment	.21	.31	4.14*	.26	.27	.27	0.04	.26	.29	.25	0.60	.27
Dosage level or schedule	.32	.35	0.46	.34	.33	.34	0.04	.35	.34	.32	0.19	.34
Counseling schedule	.24	.34	4.40*	.37	.32	.24	5.36	.31	.31	.26	0.82	.30
Getting to and from treatment	.23	.28	1.07	.31	.24	.22	2.77	.30	.21	.25	2.50	.26
Childcare while in treatment	.15	.08	4.02*	.12	.07	.11	1.06	.09	.09	.15	2.54	.11
Any Living Situation	**.68**	**.63**	**0.90**	**.63**	**.67**	**.65**	**0.24**	**.60**	**.65**	**.71**	**2.95**	**.65**
Housing	.30	.27	0.33	.33	.31	.23	3.60	.29	.30	.25	.55	.28
Children	.17	.10	3.81	.14	.09	.13	0.75	.10	.12	.17	2.58	.13
Adult roommates/ housemates	.16	.09	3.84	.10	.09	.14	1.54	.12	.12	.12	0.57	.12
Improving eating habits	.21	.18	0.41	.18	.22	.20	0.44	.15	.18	.26	5.16	.20
Managing money	.28	.25	0.39	.24	.20	.30	2.30	.23	.29	.27	0.86	.26
Any Vocational Situation	**.87**	**.94**	**5.07**	**.93**	**.91**	**.89**	**1.62**	**.92**	**.93**	**.88**	**1.31**	**.91**
Going to training or school	.70	.63	1.81	.64	.63	.68	0.72	.67	.68	.62	0.84	.66
Getting a (better) job	.66	.64	0.12	.64	.71	.64	0.89	.67	.65	.63	0.32	.65
Getting or keeping public or private benefits	.44	.59	7.92*	.54	.49	.53	0.31	.53	.49	.54	0.55	.53
Improving financial situation	.55	.62	1.49	.58	.52	.62	1.53	.60	.62	.54	1.30	.59
Gambling	.01	.02	0.26	.02	.02	.02	0.06	.02	.03	.00	2.91	.02

(continued)

Exhibit 5-3 (Continued)

Client Wants (More) Help With:	By Gender: Female (n=148)	Male (n=187)	$\chi^2_{(1)}$ =	By Race: Black (n=123)	Hispanic/ Other (n=46)	White (n=166)	$\chi^2_{(2)}$ =	Years in Methadone Treatment: LT 1 (n=126)	1-2 (n=94)	3+ (n=106)	χ^2	Total (n=335)
Any Alcohol/Drug Abuse Situation	**.92**	**.92**	**0.00**	**.93**	**.87**	**.92**	**1.95**	**.87**	**.94**	**.96**	**7.56***	**.92**
Tobacco use	.17	.12	1.42	.13	.20	.14	1.23	.17	.13	.12	1.93	.14
Alcohol use	.09	.13	0.93	.14	.17	.08	4.45	.13	.10	.10	0.64	.11
Drug use	.72	.69	0.27	.73	.72	.67	1.16	.71	.72	.68	0.39	.70
Self-help groups	.45	.40	0.85	.46	.35	.41	1.68	.44	.46	.35	3.17	.42
Detoxification	.36	.24	6.68*	.29	.20	.32	2.65	.21	.28	.41	11.09	.29
Residential treatment	.05	.06	0.15	.07	.07	.05	0.81	.05	.04	.08	1.93	.06
Methadone treatment therapy	.57	.59	0.13	.56	.67	.58	1.82	.53	.69	.56	6.14	.59
Other drug therapies	.11	.11	0.01	.11	.07	.14	2.09	.12	.14	.08	1.68	.12
Counseling	.64	.63	0.09	.61	.67	.64	0.64	.60	.72	.59	4.30	.63
Family's alcohol or drug use	.20	.07	10.79*	.11	.09	.16	2.45	.15	.12	.11	0.63	.13
Any Illegal/Civil Situation	**.29**	**.36**	**1.99**	**.27**	**.48**	**.34**	**6.70***	**.36**	**.32**	**.30**	**0.98**	**.33**
Involvement in illegal activities	.07	.10	0.72	.05	.09	.12	4.51	.09	.09	.08	0.05	.09
Civil justice proceedings	.06	.08	0.44	.02	.13	.09	7.40*	.11	.04	.06	4.28	.07
Criminal justice proceedings	.07	.06	0.15	.06	.11	.09	6.16*	.08	.07	.06	0.39	.07
Making arrangements with officer of the court	.05	.07	0.32	.59	.09	.06	0.54	.10	.05	.03	5.41	.06
Any Physical Health Situation	**.68**	**.81**	**6.91***	**.78**	**.85**	**.70**	**4.77**	**.76**	**.73**	**.76**	**0.47**	**.75**
Getting dental treatment	.28	.31	0.48	.32	.28	.28	0.50	.32	.25	.31	1.31	.30
Getting health care treatment	.24	.37	6.22*	.28	.50	.29	8.54*	.37	.26	.29	3.45	.31

(continued)

Exhibit 5-3 (Continued)

Client Wants (More) Help With:	By Gender: Female (n=148)	Male (n=187)	$\chi^2_{(1)}$ =	By Race: Black (n=123)	Hispanic/ Other (n=46)	White (n=166)	$\chi^2_{(2)}$ =	Years in Methadone Treatment: LT 1 (n=126)	1-2 (n=94)	3+ (n=106)	χ^2	Total (n=335)
Any Physical Health Situation (con.)												
Getting information about health or prevention	.33	.41	2.11	.39	.54	.32	7.81*	.43	.31	.36	3.65	.37
Coping with current medical problems	.36	.48	4.89*	.46	.57	.36	6.66*	.49	.35	.42	4.00	.43
HIV testing or counseling	.17	.25	2.78	.18	.30	.22	2.85	.29	.17	.16	7.19*	.21
Any Mental Health Situation	**.61**	**.53**	**1.81**	**.46**	**.74**	**.60**	**11.48***	**.54**	**.57**	**.60**	**1.01**	**.57**
How the client feels emotionally	.39	.30	2.95	.21	.50	.38	15.63*	.37	.32	.31	1.10	.34
How the client's mind or body seems to be working	.32	.26	1.18	.21	.43	.30	8.52*	.32	.27	.27	0.83	.29
How the client controls mind or behavior	.28	.24	0.96	.13	.41	.31	18.51*	.28	.23	.25	0.53	.26
Concerns about suicide	.08	.08	0.04	.05	.09	.10	2.33	.08	.07	.08	0.15	.08
Getting psychotropic medication	.20	.22	0.23	.12	.22	.27	8.98*	.17	.19	.27	3.40	.21
Any Social/Coping Situation	**.72**	**.77**	**1.20**	**.70**	**.85**	**.75**	**4.11**	**.75**	**.71**	**.77**	**0.94**	**.75**
How client spends free time	.24	.26	0.20	.20	.24	.28	2.32	.32	.23	.18	5.92	.25
People have been avoiding/arguing/ fighting	.18	.12	2.23	.09	.13	.20	6.65*	.15	.16	.14	0.21	.15
People who have/ might attack physically	.13	.03	10.96*	.04	.07	.10	3.89	.08	.06	.08	0.44	.07
How client handles arguments	.30	.19	5.46*	.17	.28	.28	5.17	.26	.21	.25	0.68	.24
How client copes with problems	.52	.44	2.08	.39	.52	.53	6.34*	.52	.42	.48	2.12	.48

* Probability of type I error is less than .05 using chi-square.

Source: Training and Employment Program (TEP) study (NIDA Grant R01-DA-07964).

Exhibit 5-4

Script for Introducing Treatment Planning to Clients

As you know, drug use and the problems that go along with drug use are difficult to change. It's certainly not news to you that changing behavior related to drugs and other problems is a difficult task. One thing we know, however, is that when you are faced with a difficult task, you are much more likely to succeed if you have a plan than if you have no plan at all. What we are going to do now is work together to develop a plan for your treatment while you are on the program.

You and I will need to do several things in order to develop a useful plan. First, it is important that you and I work together to develop this plan because it will serve as the "blueprint" for what we will be doing when you come to counseling over the next 6 months. It is very important then that the plan we develop include problems that are important to you. If your treatment plan only includes things I think are important, then I can tell you now that it probably will not be very useful. One of the things we will use to develop this plan is the information you provided the other day when we did the structured assessment of your needs.

The second part of developing this plan is that you and I will establish some goals for each of the problems you decide to work on. This is never easy, and what it will require is that you and I roll up our sleeves and go to work to try and determine reasonable long- and short-term objectives for each problem. Basically, we will try to answer these questions: "Where do you want to be 90 days from now regarding these problems?" "Where do you want to be in a couple of weeks?" "And where do you want to be tomorrow, the next day, or by our next session?"

Thus, what we are going to do today is identify problems that we will work on and plan your goals. It is never an easy task, but it is very important. Any questions? OK. Let's get started.

Exhibit 5-5
Sample Individualized Treatment Plan (Fictitious Data)

Participant Number 1234 Date of next review 7-1-91

TREATMENT PLAN

Counselor J. Jones

Participant Name S. Smith Date 5-1-91 (Initial Plan)

Treatment: Substance abuse treatment for heroin and cocaine. Marital counseling for serious relationship problems with partner.

Current Treatment Modality: Enhanced counseling: methadone maintenance and individual counseling for narcotics abuse: individual counseling and urine monitoring with feedback for cocaine abuse; weekly couple counseling sessions (for relationship problems).

Medication: -

Dosage: -

Extended Goals: Long-term goals: (1) abstinence from IV heroin use; (2) significant decrease in cocaine use; (3) substantive improvement in family relationships, especially with regard to effective communication with partner and children; (4) improved ability to effectively solve interpersonal/family problems.

Additional Goals: Short-term goals: (1) attend at least 3 of first 4 bi-weekly individual counseling sessions; (2) 75% of urine tests during the first 2 weeks of treatment must be free of illicit drugs; (3) client will work with CSC to obtain marital counseling services from local CMHC; (4) client will review with counselor his progress toward short-term goals on weekly basis and revise as needed.

Evaluation of Old Plan N/A -- new client

Participant Signature S. Smith

Program Sponsor _____

Medical Director _____

Counselor Signature _____

Revised 4-26-77
GS

Exhibit 5-5 (continued)

T&R-31
July 77

TREATMENT PLAN

Client Name: S. Smith
Record Number: 1234

Dates Reviewed: 5-1-91, 6-1-91

New Jersey Problem Oriented Treatment System

Review previous Treatment Plan and Progress Notes, if any. Carry forward all unresolved problems. Use original date on old problems. Use Index Number for each problem/goal/intervention strategy: 1 = Health/Drug Use; 2 = Legal; 3 = Employment/Vocational; 4 = Educational; 5 = Psychosocial

Date Identified	Index No.	Statement of Problem	Statement of Goal	Intervention Strategy	Short-Term	Long-Term	Target Date	Date Solved
6-1	3	Day-care for 2-year old child needed to allow client to attend counseling on a regular basis	Client will obtain appropriate day-care for child	CSC will work with client to achieve long-range solution to day-care problems		X	7-15	
				CSC will work with client to access resources to fund day-care for immediate needs (counseling sessions over next 2 weeks)		X	6-5	

Signature of Primary Counselor:

Signature of Client

Exhibit 5-5 (continued)

New Jersey Problem Oriented Treatment System

T&R-51
July 77

TREATMENT PLAN

Client Name: S. Smith

Record Number: 1234

Dates Reviewed: 5/1/91, 6/1/91

Review previous Treatment Plan and Progress Notes, if any. Carry forward all unresolved problems. Use original date on old problems. Use Index Number for each problem/goal/intervention strategy: 1 = Health/Physical, 2 = Legal; 3 = Employment/Vocational; 4 = Educational; 5 = Psychosocial

Date Identified	Index No.	Statement of Problem	Statement of Goal	Intervention Strategy	Short-Term	Long-Term	Target Date	Date Solved
5-1	1	IV Heroin Use	Abstinence for 3 months	Methadone maintenance and individual counseling		X	8-1	
			Attend at least 3 of first 4 bi-weekly individual counseling sessions	CSC will arrange for transportation to sessions as needed. Client will be called at home to remind her of appointments	X		6-1	6-1
5-1	1	Cocaine abuse	Significant decrease in use as determined by fewer dirty urines	Individual counseling with urine monitoring and feedback		X	11-1	
			75% of urine tests during the first 2 weeks of treatment must be free of illicit drugs	Frequent urine monitoring--2 x per week	X		6-1	
5-1	5	Family Problems	Substantial improvement in family relationships, especially in areas of family problemsolving and communication	Individual counseling will focus in part on problem-solving skills training with focus on family problems. CSC will work with client to obtain marital/family counseling		X	11-1	
				Client will meet with CSC to initiate arrangements for obtaining family counseling	X		6-1	6-1

Signature of Primary Counselor

Signature of Client

6.0 Structuring Counseling Sessions

A major treatment component of treatment programs for drug addiction is counseling to improve the social functioning of clients. This section offers some guidelines for structuring counseling sessions with clients. It addresses the following issues:

- how to provide problem-solving counseling,
- how to implement contingency contracting,
- how to incorporate formal and informal treatment planning in counseling, and
- how to incorporate the results of urine testing into counseling sessions.

Chapter 8 also includes a list of additional resource materials. We encourage you to read these important resources should you wish to learn more about how to apply specific techniques.

6.1 Problem-solving Counseling

As discussed in Chapter 3, the approach that we are recommending--problem-solving counseling--emanates from a social-learning conceptualization of human functioning. In general, social-learning approaches to counseling focus on the ways that people acquire life skills through their interactions with their external environment, emphasizing the importance of effective problem-solving behaviors for successful adaptation (Moos & Billings, 1982; Platt, Taube, Metzger, & Duome, 1988).

Mental health professionals have long observed that individuals who abuse drugs and alcohol often have histories of poor problem solving. Frequently, drug-dependent individuals act impulsively when confronted with a problem and fail to consider either the consequences of their actions or the possible range of alternative solutions (O'Farrell & Langenbucher, 1985). Deficits in effective problem solving among drug abusers often lead to unsatisfactory solutions, especially when drug or alcohol use is the solution for coping with problems. Clearly, clients who rely on drugs as a strategy for coping with situational and emotional problems are at increased risk for continued drug abuse and relapse following treatment. Recidivism (i.e., relapse) among heroin users is especially likely when they do not have the problem-solving skills necessary to cope with the stress of low status employment, specific situations of the nondrug world,

recreational drug use of straight co-workers, and the effort of maintaining gains made in treatment (Platt & Metzger, 1987).

Problem-solving counseling uses flexible, practical, and relevant skills to assist clients in resolving problems. This strategy has been demonstrated to be a useful approach to teaching people to overcome chronic maladaptive behavior patterns (D'Zurilla & Nezu, 1982). Recently, Platt and Metzger (1987) have recommended the use of a problem-solving approach to teach heroin addicts to function effectively in society.

In general, the goal of problem-solving counseling is to teach individuals to adopt a multistep approach toward resolving problematic life situations. Components of problem-solving counseling as adapted for use in the MET trials (Fairbank et al., 1991a) include the following five interdependent processes: (a) problem orientation, (b) problem definition, (c) generation of alternative solutions, (d) decision-making, and (e) implementation and monitoring. This classification has been adapted from D'Zurilla (1986), Goldfried and Davidson (1976), Nezu, Nezu, and Perri (1989), and Spivak, Platt, and Shure (1976). Part of each individual counseling session should focus on at least one of these five components of problem solving. In Sections 6.1.1 through 6.1.6, we provide suggestions and guidelines for engaging in each of the five component processes of problem-solving counseling.

6.1.1 Introducing Clients to Problem-solving Counseling

The initial session(s) of problem-solving counseling should focus on providing the client with information on the rationale of problem solving and its relevance to drug abuse and other specific problems of relevance to the client (e.g., family problems, depressed mood). Thus, when the initial treatment plan has been completed, it is advisable to dedicate at least one counseling session to presenting the rationale for problem-solving counseling in an understandable manner. To increase the likelihood that the client, counselor, VSC, CSC, and other staff will operate from a common treatment framework, a clear presentation of the purpose and goals of this approach should occur before actual counseling begins.

The following is an example of a rationale for introducing problem-solving counseling that has been adapted (with permission) from Nezu et al. (1989, p. 131):

EXAMPLE

The basic counseling approach that I am recommending is called "problem solving." According to this approach, people sometimes abuse drugs because they have difficulties coping with stressful life problems. Some people have difficulty coping because they never learned how. Others have difficulty because of the overwhelming severity of the problems themselves. At times, the way that we think about these problems can also lead us to use drugs.

For example, if we believe that we can't do anything to change a problem--that no matter what we try, nothing ever works--we probably won't feel like solving the problem. This in turn may lead to more problems and stress. The general upshot of this vicious cycle might be drug use, especially if the consequences of not solving the problem are severe. Another difficulty that people may experience relates to poor or ineffective problem-solving skills. For example, in trying to solve a problem, we might fail if our goals are too high, or if we don't think of enough options, or if our decisions are poor about which solutions might be effective. According to this counseling approach, many skills are involved in effective problem solving. Basically, the purpose of this approach is to help you to learn these skills in order to cope better with problems related to drug use. We will be focusing on five major skills: what we think about problems in general; how we define problems and set goals; how we think of various solutions to real-life problems; how to make decisions; and how to evaluate the success of our attempts. Throughout our sessions together, we will be focusing on learning more effective ways of coping with difficult and stressful current and future problems.

6.1.2 Encouraging Clients to Adopt a Problem-solving Orientation

An important component of problem-solving counseling involves showing the client how to adopt a problem-solving coping style when he or she is confronted with problems. This aspect of problem-solving counseling is important because drug users commonly react impulsively and negatively when confronted with a problem. Drug users commonly believe that their problems in life are so massive that the problems are unresolvable. In addition, it is not uncommon for clients in drug treatment programs to believe that they possess few skills for solving problems.

Nezu et al. (1989) have suggested that you provide clients with a rational orientation to problems in living and problem solving as a means of coping effectively. They recommend that goals include encouraging the client to adopt the following aspects of a positive and realistic problem-solving orientation:

- accepting problems as a normal part of living,
- believing in one's ability to solve problems effectively,
- labeling one's experience of distress as a cue that a problem exists,
- inhibiting the tendency to respond automatically or impulsively and developing the ability to think things through carefully, and
- recognizing that problem resolution often entails considerable time and effort.

Some clients, especially those whose reflexive reactions to problems are elicited by high levels of anxiety, may benefit from training in the use of self-control calming strategies. In our experience, a treatment that appears to be helpful to clients who are unable to "stop and think" because of runaway anxiety is relaxation training. The thesis here is that once the client is able to calm down and arrest "out-of-control" thoughts, he or she can begin the process of thinking things through logically and carefully. In a later segment of this section of this manual, we discuss how counselors may work with other staff to acquire additional training in the use of other treatment techniques (such as relaxation training) that complement the problem-solving counseling strategy.

6.1.3 Helping Clients to Objectively Define Problems

Another important component of problem-solving counseling is helping the client to develop skills that will enable him or her to understand the problem(s) at hand. As you know, clients often come to drug treatment programs with unspecified, vague, or very general complaints (e.g., "my nerves are shot and I need some help," "my old man/lady is driving me nuts"). A major function of the treatment plan that you developed during the first few counseling sessions was to identify and clarify problems in specific problem areas. As such, the process by which you worked with the client to define and formulate target problems during the development of the treatment plan can serve as a model of how this process might occur. The overall goal of this stage of problem-solving counseling is to teach clients to be able to define and formulate problems on their own and in a manner that permits the implementation of subsequent steps. As noted by Nezu et al. (1989), this goal may be accomplished by showing the client how to do the following:

- seek all available facts and information about the problem,
- describe the facts in clear and unambiguous terms,

- identify those factors that actually make the situation a problem,
- differentiate relevant from irrelevant information and objective facts from unverified assumptions and interpretations, and
- set realistic problem-solving goals.

As recommended by D'Zurilla (1986), this task can be facilitated by asking the following who, what, when, where, and why questions about each problem. Who is involved? What happens (or does not happen) that bothers you? When does it happen? Where does it happen? Why does it happen (i.e., known causes or reasons for the problem)? What is your response to the situation (i.e., actions, thoughts, and feelings)?

Below is an excerpt from a transcript of a counseling session that deals with the issue of problem definition and formulation:

EXAMPLE

Counselor:	Tell me again what happened when the nurse gave you your methadone today.
Client:	She insulted me. She threw the cup at me. I tell you, the woman hates me.
Counselor:	You are telling me that the nurse told you that she hates you.
Client:	No, she didn't say that. She didn't have to. The way that she threw the cup at me was clear enough. It makes me mad. She wouldn't treat a dog that way. It's insulting.
Counselor:	Describe the circumstances at the dosing station this morning.
Client:	Well, as usual, it was busy. There were more folks in line than usual, though. Only that nasty nurse was on duty.
Counselor:	Describe exactly what happened when you received your methadone. As we've discussed before, give me a brief, clear, and accurate description of the event itself, with no interpretive language.
Client:	After waiting about 20 minutes, I finally got to the front of the line. She gave me the cup and ordered me to drink it fast.
Counselor:	She ordered you? What did she say exactly?

Client: Dave, quick, down the hatch, we're busy today (client laughs).

One of the things that occurred in this example of a dialogue was the evolution of the client's emotional, exaggerated, and overstated description of a problematic interpersonal interaction to a brief description of the event itself with no speculation as to hidden meanings. Frequently, counselors choose to begin the process of problem definition training by focusing on examples of recent problems of relatively minor significance to the client. Once the client has demonstrated that he or she can define minor problems accurately, then he or she is ready to advance to the more difficult task of defining and formulating problems of a more severe nature.

6.1.4 Working with Clients to Generate Alternative Solutions

At this stage, you work with the client to generate a range of possible solutions to problems by using brainstorming techniques. In the following passage, Nezu et al. (1989) provide an excellent rationale for the importance of this process to effective problem solving:

> Training patients to develop a range of coping options is based on the premise that the availability of a large number of alternative actions will increase the chances of eventually identifying an effective solution. Often patients expect that there is one right answer for each problem and that therapy, or the therapist, will provide it for them. Moreover, in trying to find the right solution to a problem, patients sometimes believe that the first idea that comes to mind is the best one. Therefore, in order to maximize problem-solving effectiveness, the therapist needs to convey to patients the necessity of generating as many different options as possible. (p. 180)

The key aspects of brainstorming--quantity and deferment of judgment--suggest the following rules:

- Generate as many ideas as possible.
- Don't criticize the ideas at this stage of problem solving.

Clients often complain that they are unable to brainstorm because they can't imagine that there are other solutions to their problems. Be persistent, tenacious, and patient, and hang tough with attempts to avoid this essential aspect of problem solving. Don't willingly or passively accept standard complaints that "I can't think of any other solution to this problem. Besides, if I could, I wouldn't need to come see you twice each

week." Resist the temptation to buy into a client's insistence on helplessness in this regard. Encourage creativity.

Clients also often have difficulty generating alternatives without immediately evaluating and rejecting them. Don't let your clients off the hook with this aspect of brainstorming either. Counselors frequently must pay special attention to encouraging clients to avoid the tendency to reject an option reflexively before all possible alternatives have been generated. Through repeated practice and reinforcement, you should work with the client to generate as complete a list as possible of alternative solutions prior to proceeding to the next stage--decision-making.

6.1.5 Encouraging Clients to Develop Decision-making Skills

At this stage, you teach the client to predict which alternative solutions are worth pursuing and then to take action. Discuss each potential solution with the client, and encourage him or her to anticipate the likely long- and short-term consequences of each alternative. In addition, you should urge clients to evaluate the usefulness of each of these consequences for resolving the problem situation.

Once several options are identified, the client, counselor, VSC and/or other staff should try to identify the pros and cons of each option. Some of the things that should be explored are:

- how long it will take to implement the option,
- how much work the client will have to put into implementing the option,
- the extent to which the option's success will depend on other people helping or going along with it,
- the extent to which the client is likely to be ready or qualify for a program or job,
- the amount of financial assistance that will be required or is available (directly or indirectly),
- the length of the commitment involved,
- the likelihood that the option will address one or more of the problems, and
- the extent to which the associated stress may put the client at risk for relapse.

The latter is particularly and easily overlooked. For instance, when trying to help a client find a job, many people may try to get the person back into the best paying type of job they have already held. Unfortunately many addicts who did once hold well paying jobs (e.g., nurse, manager), left them because they were associated either with how they obtained drugs or were one of the primary stressors causing their drug use (Karuntzos, Dennis, & Norman, 1993). It would be highly inadvisable to return a client to such a situation even after several years without relapse.

Resick and Jordan (1988) have noted that when clients have difficulty choosing among the alternatives, it is often helpful to have them assign weights (i.e., scores) to the positive and negative consequences to estimate their relative importance. Positive consequences could receive scores from 1 to 100, while negative consequences could be assigned scores from -1 to -100. For instance, although one alternative may have a longer list of positive consequences, it may also have more important drawbacks, while another alternative has fewer important drawbacks and a greater number of important gains. Although a client is unlikely to base his/her final decision only on the total score obtained from the weightings, going through the process may help the client to decide what factors are most important in deciding on a course of action.

6.1.6 Encouraging Clients to Implement Solutions and Monitor Effectiveness

At this stage, the client is encouraged to carry out the selected course of action, with the assistance of the VSC, CSC, or other staff when appropriate. Some clients are likely to need considerable encouragement at this stage of problem-solving counseling, given that many of the men and women in treatment for drug abuse are avoiders. Toward this end, the counselor should show the client how to engage in the following behaviors:

- Observing the consequences of his or her actions and/or the actions of the counselor, VSC, CSC, and other staff who serve as problem-solving role models.

- Matching the real outcome of the solution against the expected/predicted outcome.

In terms of the latter, if the match is satisfactory, the problem has been resolved. If the match is unsatisfactory, you and your client should reexamine each of the preceding steps in the problem-solving process to determine what to do next. Was the problem defined adequately? Were enough alternative solutions generated?

This approach to treatment counseling in drug treatment programs is based on the thesis that problem solving is a skill that clients can learn to use effectively to cope with a variety of problem situations. Whether it is learning how to resolve a conflict with one's employer, control explosive anger episodes with one's family, or avoid the places and people associated with drug abuse, the goal is to teach the client practical and flexible problem-solving skills. As a counseling approach to substance abuse, problem solving shapes new, more adaptive behaviors for coping with situations or emotions that may trigger episodes of drug use (cf. Childress, McClellan, & O'Brien, 1985).

6.1.7 Monitoring Problem Orientation and Problem-solving Skills

Before launching into problem-solving counseling, it is important to know whether a client has a problem-solving orientation; that is, the extent to which the client has a fundamental belief that his or her problems can be solved. Exhibit 6-1 shows a simple three question Problem Orientation Scale (POS-3) developed in TEP for the purpose of establishing the client's current problem orientation. Higher scores on the scale (number of yes answers) indicate stronger levels of problem orientation. Problem orientation scores can go down as a result of bad experiences with treatment, referrals, or family situations. Poor problem orientation acts very much like a form of "learned helplessness" in which people see their actions as having little or no connection to either positive or negative things that are happening to them. The lower the POS score, the more work you will need to do to convince your client to try things and the more you will need to lead him or her proactively through the process. It is particularly critical for people with low POS scores to focus on small steps in order to minimize the risk of failures or setbacks. There are no gender or time in treatment differences on this scale. Black clients, however, were significantly more likely than Hispanic and whites to say they know how their problems are related to their drug use.

Assuming the client believes that his or her problems are solvable, the next step is to assess the client's level of self-efficacy or skills. Exhibit 6-2 shows a simple 10-question Problem Solving Scale (PSS-10) developed in TEP to address this question. Higher scores on this scale indicate higher levels of skill. Note that b, f, g, & h have been reverse coded in this table and before they were summed to make PSS-10. Like the POS scale, the PSS scale does not generally improve over time without intervention. While women were significantly more likely than men to report several specific behaviors associated with problem-solving skills, the overall difference in the scale scores is not significant. White clients were significantly more likely than black or Hispanic clients to say they were engaged in problem solving behaviors for four of the main items and overall.

For people with low PSS scores, it will be necessary for you to take the lead in all early steps and model or teach the necessary skills. As the client progresses, you should increasingly give him or her the opportunity to suggest what to do next and to act independently. The level of PSS scores is also an important consideration in evaluating referrals and outside assignments. Clients with low skills may need much more structured and supportive environments than those with higher skills. Improved skills can also be turned directly on how to cope with the antecedents of relapse prevention (e.g., Marlatt & Gordon, 1985).

Exhibit 6-3 provides a much more detailed clinical example that combines measuring problem counseling skills with an actual exercise that can be done during the counseling session. While a picture of the specific puzzle that was actually used is not shown here, the exercise can be readily adapted to other puzzles.

6.2 Contingency Contracting

6.2.1 Purpose

Contingency contracting is a type of behavior modification and treatment that has been used effectively with a wide range of clinical populations, including clients in methadone programs (Condelli, Fairbank, Dennis, & Rachal, 1991; Dolan, Black, Penk, Robinowitz, & DeFord, 1986; Onken, Blaine, & Boren, 1993; Stitzer, Bickel, Bigelow, & Liebson, 1986; Stitzer, Bigelow, Liebson, & Hawthorne, 1982). The basic purpose of contingency contracting in enhanced treatment counseling is to specify positive consequences for clients' regular attendance at counseling sessions.

In order for a reward to work as a motivator and reinforcer of compliant behavior, it must be something of value to the client. For clients who are paying something for their treatment out of pocket, having the cost of their treatment reduced should be valued. Although a fee reduction is not a direct payment of cash to the client, it should save the client money he or she would otherwise have had to pay for treatment, such that the saving should in principle represent cash in hand. Other incentives could involve certificates, clothes, tickets, or services--perhaps arranged by the VSC, CSC, or other staff.

6.2.2 Contracts and Token Economies

Contingency contracting is a tool that can be used by programs, counselors, and clients themselves to help modify behavior towards a desired end. While this strategy may initially strike the new user as manipulative, clients and counselors alike quickly realize that they are just organizing consequences in a more systematic way, which helps them to achieve what they wanted to achieve in the first place. Some of the specific applications to treatment include setting up contingencies to:

- increase compliance with the treatment protocol (e.g., showing up for counseling, methadone, urines) by rewarding attendance;
- increase abstinence by rewarding competing behaviors (e.g., risk reduction behaviors, situation avoidance, clean urines);
- encourage positive cognitive states by rewarding exercises and assignments (e.g., identifying exciting jobs, finding happy thoughts, inventorying strengths, identifying other people's concerns);
- decrease anxiety through relaxation techniques and rewards for coping with successively more difficult situations without a reaction; and
- decrease violence, aggression and other negative behaviors and abstinence by rewarding competing behaviors or, if necessary, punishing the negative ones.

Ideally (a) the behavior has to be monitored regularly, (b) the rewards should be of intrinsic value to the person, and (c) the rewards should come as close as possible to the event. Punishments can be used in extreme cases, but they often have side effects and negative consequences. A better practice is to find a competing behavior to reward (e.g, instead of punishing drug use, reward abstinence).

Logistically, however, contingency contracts can quickly become burdensome to both you and the client. The harder they are to implement, the less likely they are to succeed. One middle of the road compromise is to use a "token economy." In this form of contract, clients earn some kind of "points" for a variety of behaviors and can exchange these points for a variety of "rewards." They can also be punished, if necessary, by taking away points.

As part of counseling, a token economy can be set up to regulate a series of behaviors so that the "system" is stable and simple. A list of behaviors and incentives can be created with different numbers of points used to reward behaviors based on

difficulty of the behavior for an individual. As the behavior because less problematic, the points can be reduced and eventually dropped. As new behaviors become the focus of attention, they can be added and rewarded more highly. Similarly, there can be a list of potential rewards that can be altered and expanded as the individual's wants and desires change.

Exhibit 6-4 provides an example of a simple token economy for monitoring an individual. Some critical things to notice in this schedule include:

- the number of points can vary because of difficulty and/or partial credit can be allowed for partial performance;
- points are easy to get but have to be saved up to a higher level for rewards;
- points are used to reward behaviors that compete with behaviors to be reduced;
- higher levels of points are used for behaviors the client views as more difficult; and
- preparation activities are rewarded for behaviors where planning or remembering is an issue.

In this example, the client used to have a problem remembering to stay for counseling but has been doing well lately, and the number of points has been reduced to just enough to maintain the behavior. The client is still having problems providing random urine samples on request or even by the end of the day so the points here are high. The client has set goals for earning two types of rewards: those that the client awards to himself or herself, and those that the program provides. Note that within a range prescribed by the staff physician the client is able to earn the right to control his or her methadone dosage on a daily basis and/or take home privileges. This client has a problem providing urine samples. The number of points for providing the urine sample is high. Higher points are associated with more difficult behaviors.

6.2.3 An Example of Contracting to Improve Compliance

For example, in MET we rewarded clients in the enhanced condition who complied with their counselor's request to (a) attend individual counseling sessions twice a week and to (b) leave two urine specimens each week during the first 3 months of treatment. What the client had to do to obtain the reward was merely to allow himself or herself to be exposed to the counseling (although we obviously wanted the client to be involved and participate willingly and actively in the process). What the client received as a reward for treatment compliance was also straightforward. Every

week during the first 3 months of treatment, self-paying clients who met the minimum requirements--two counseling sessions and two urine samples per week--received from their counselor a nontransferable certificate worth $5.00 toward the cost of treatment in the program.

In MET, we recognized that for some clients, attendance at an extra weekly counseling session might be burdensome in a variety of ways. Our belief, however, was that positive contingency contracting might encourage clients to attend counseling more frequently than they might otherwise do. The gist of the contract with the client was that he or she was being indirectly "paid" for some of the extra time involved in participating in enhanced treatment counseling. Although the payment was indirect, for clients paying some of the cost of their own treatment it represented a sure savings of money that would otherwise have been spent (or owed) to the program. Because clients were not charged any extra money for the extra counseling session in enhanced treatment, the payment represented a real savings for the client. The size of the reward, while not large, was not trivial either.

The trial period over which a certificate could be earned was intentionally short, so that there were many opportunities to be successful within the first 3 months. Having many short, independent trials meant that a failure to comply with the treatment regimen in one week did not reduce the possibility of gaining the other rewards in subsequent weeks. By making the certificate available and usable immediately upon completion of the desired behavior, the client was not required to wait for some future time to see the benefit of compliance. In other words, this approach does not assume a client's ability to defer gratification because there was no need to wait for some future time to spend the reward, nor did the certificates need to be accumulated over an extended period to have enough of them to be redeemable.

The situation regarding an appropriate reward for clients who were not paying for their own treatment out of pocket (e.g., those who had insurance or Medicaid pay for them) in MET was more problematic. The reward needed to be of similar value to the client, be earned on a weekly basis, and be redeemable immediately, but not for cash. The exact reward for each client was determined by the assigned counselor and the client working together (e.g., food store certificates or public transit vouchers).

6.3 Treatment Planning in Counseling

The individual treatment plan that you develop with the client using the GAIN or other assessment provides both a starting point and a framework for implementing problem-solving skills training within the enhanced counseling sessions. At the beginning stage of counseling, use the formal treatment plan to identify problems about

which the client needs to make a decision. Focus on things to be accomplished in the next 1 to 3 months. Then use the treatment plan to tailor the intervention to the client's specific needs. Periodically review the formal treatment plan with the client. This review may provide valuable information about new or previously undisclosed problems that require a decision by the client and/or assistance from other staff or outside service providers.

The informal or working plan will focus on identifying and implementing the steps necessary to accomplish the intermediate goals. It will be consulted in every session, used to chart progress, and will include something to be accomplished between each and every session. Both formal and informal treatment plans will involve the active participation of the client. The informal treatment plans are basically a marked-up version of the formal treatment plan. In the informal working plan, we keep notes on our progress and set very short-term objectives to be accomplished between counseling sessions or even within the current session.

By doing quarterly GAINs or other assessments, you can also use the treatment plan as a guide for evaluating the effectiveness of treatment. If the client was going to try to start changing persons, places, and things--did he or she do this? If he or she was going to try to get into a training program, did this happen? Situations also change. A treatment plan based on a single point in time runs the risk of ignoring both positive and negative developments (e.g., a marriage, or new job). Even when the client appears to be doing well, the stress of a new job might actually increase the likelihood of relapsing in the short term.

6.4 Using Urine Test Results

The use of illicit drugs and alcohol is the key measure of a client's progress in individualized substance abuse counseling. The results of urine testing can be used in counseling as a powerful evaluative tool for assessing your clients' progress toward abstinence and "recovery" and as an important clinical tool that sets the stage for frank discussion of "dirty" urines as well as for positive reinforcement of "clean urines." Furthermore, in a review of the literature we found that confronting clients about dirty urines and/or using urine testing in contingency contracting were two of the more effective ways for treating cocaine abuse among methadone clients (Condelli, Fairbank, Dennis, & Rachal, 1991).

Before each session, we recommend reviewing the results of the client's most recent urine test and being prepared to discuss the results with the client at the beginning of the session. If the results are negative for substance use (i.e., a "clean" urine), use these findings as an opportunity to provide strong positive social

reinforcement and support. Review with the client his/her activities during the period of abstinence and find out who the client associated with during this time. Encourage continued development of and involvement in activities that are inconsistent with drug use, as well as association with persons who do not place the client at risk for drug use. Ask about problems encountered during this period of abstinence, particularly problems frequently associated with drug use, such as cravings for specific drugs or emotional distress. Find out what the client did to cope with these problems and assist the client in identifying any problem-solving steps that he or she might have used to cope with high-risk situations (i.e., identified the existence of a problem, generated a list of possible solutions, and implemented one of them). Emphasize the importance of continuing to practice problem-solving as one method of preventing relapse.

If the results of the urine test are positive for one or more illicit drugs (i.e., a "dirty" urine), review with the client the circumstances and context of drug use. Inquire about potential external factors (persons, places, things) and internal factors (cravings, emotional distress, etc.) associated with recent use. Use this as an opportunity to encourage a problem-solving orientation by focusing on identifying the factors that elicited the use, generating potential solutions, and implementing and evaluating a solution. Emphasize the continuing need to develop a problem-solving orientation toward the circumstances and factors that place the client at risk for drug use.

Exhibit 6-1
Problem Orientation Scale (POS_3)

Item	Question	Reporting Yes Mean	S.D.
	Next I would like to ask you some questions about problems related to your drug use that have happened in the past 90 days.		
	Do you currently ...		
a.	have a good understanding of how your drug use is related to your current problems?	.931	.253
b.	believe your current problems can and will go away?	.827	.379
c.	believe that your current problems are solvable?	.890	.314
POS-3		2.648	.780

NOTES: The mean is equivalent to the proportion of 335 people saying yes to the behavior. Cronbach's coefficient alpha based on standardized variables is equal to .78. POS-3 is the number of yes answers.

Source: GAIN (Dennis et al., 1995); items based in part on ADS (Vitaliano, 1990).

Exhibit 6-2
Problem Solving Scale (PSS_10)

Item	Question	Reporting Yes Mean	S.D.
In the past 90 days, have you ...			
a.	had problems that you brought on yourself?	.663	.474
b.	had problems that someone else caused you?	.406	.492
c.	had problems you were able to solve?	.839	.368
d.	bargained or compromised to get what you wanted?	.606	.489
e.	sought advice or help in dealing with your problems?	.690	.463
f.	wished your situation would just go away and somehow be finished?	.245	.431
g.	tried to ignore your problems or act as if nothing had happened?	.540	.499
h.	tried to make yourself feel better by eating, drinking, smoking, or taking medication?	.442	.497
i.	come up with a couple of different solutions to the problem?	.776	.417
j.	made a plan of action and followed it?	.680	.467
PSS-10		6.615	2.466

NOTES: The mean is equivalent to the proportion of 335 people saying yes to the behavior. Cronbach's coefficient alpha based on standardized variables is equal to .730. PSS-10 calculated as the number of "yes" answers to items a, c, d, e, i, and j plus the number of "no" answers to items b, f, g, and h.

Source: GAIN (Dennis et al., 1995); items based in part on RWCCL (Vitaliano, 1990).

Exhibit 6-3
Visual Barometer to Measure Problem-solving Proficiency

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Objective. To visually illustrate how the habitual usage of mood altering substances (MAS) could freeze the developmental coping growth of an individual when problem solving competencies are needed. The continued consumption of MAS to cope with internal and external stressors inhibit the self-maturation process predisposing the individual to experience repeated social failures (weak outcome expectancy) which may generate feelings of helplessness (learned), instead of a perception of self-efficacy.

Materials. This exercise uses two pyramids fused at the bases. The connected foundations have a circular hole in the middle with a small connecting bridge extending vertically through the middle. Rolling freely on one portion of the fused triangles is a small ball with an incision dissecting the middle. The object is to cause the ball drop to the other side of the triangle. (Other puzzles may be substituted.)

Approach. Hand the prop to the client with instructions detailing the desired goal--"maneuver the ball so it drops to the other side of the fused triangle." Be aware of the client's initial reaction/body language and vocal retorts--a hesitant, bewildered facial expression may great you. A defeatist declaration--"I can't, or "you must be crazy" are typical responses when clients are presented with the problem task. Encourage the client so as to stimulate the individual's innate curiosity. Note how the individual approaches the assigned task. Does the client impulsively dive in head-long, with no reflection, or is a more analytical approach noted? Does the client express a sudden, or gradual emotional expression symbolized by increased frustration? Is the elevated frustration level interfering with the need for immediate gratification (solving)? Is the frustration level concurrent with increased agitation, passivity, or complete immobilization. Continue to encourage the client. You will promptly know when the client has achieved the expected. A long sigh of relief will be felt throughout the room. Begin to promptly explore with the client the problem-solving sequence: the feelings, the preconceptions, and final cognition experienced. Now that the client has an enhanced sense of self-efficiency, deliver the prop back to the client expressing the same expectations as before. Observe how the client confidently approaches the problem with controlled vigor, higher expectancies, and little emotional frustration. The immediate need to possess is balanced by an understanding of competency, which permits the client to incorporate patience (low frustration level) into his or her problem-solving skill repertoire. No longer fleeing the situation, the client actively participates in his or her own success.

After the desired goal has been achieved, review with the client the dynamics involved in the successful problem-solving process. The client's efficiency in completing the goal was because he was able to make use of information from the prior experience. The prior encounter could be mentally digested, sorted, and structured, permitting a comfortable solution to the triangle puzzle. The memory was intact, not distorted, or anesthetized by MAS. The learning experience was available because it was not anesthetized (drug induced), which would have impeded the memory process and led to repeated failures. By dealing with the problem in an adaptive manner, the pathways were open so information could be stored and used when similar problems arose. Conclude by conceptualizing that this small problem-solving model can be expanded to larger life experiences outside counseling.

Exhibit 6-3
(Continued)

Evaluation. Some of the specific dimensions of problem solving dynamics to document include:

1. Problem-solving Approaches--Decision-making
2. Impulsivity-passivity
3. Frustration Tolerance Level
4. Immediate Gratification
5. Social Competence Skills--Confidence--Self-efficacy
6. Outcome Expectations
7. Introspection

Exhibit 6-4
Example of A Token Economy Schedule

Client ID: _____

Week of: ____ / ____ / ____

Responsibility	Points	SAT	SUN	MON	TUE	WED	THU	FRI	TOTAL
Confirm Counseling Appt.	1								
Keep Counseling Appt.	1								
Provide Urine Sample	4								
By End of Day	2								
Methadone Pos. Urine	1								
Opiate Negative Urine	4								
Cocaine Negative Urine	4								
Keep Methadone Appt.	2								
By End of Day	1								
Attend NA Group	2								
Attend Personal Growth and Development Group	3								
Calm Down When Upset	1-4								
No Yelling at Spouse	1-4								
Plan Dinner in Advance	4								
Cook Dinner at Home	2								
Excercise 30+ Min	2								
Spend 30+ Min with Kids	2								
Helping Out	1-6								
Clean Apartment	2								
Do Laundry/Put Away	2								
Total for Day/Week									

Plus Points From Last Week:	
Minus Points Used Last Week:	
Equals Points Available This Week:	

Rewards Available From Self:		Rewards Available From Program:	
Special Time For Self	4	Come in Early or Late for Methadone	20
Meal Out	20	Get Gift Certificate for $5	50
Movie or Show	30	Get 2 days Take Home Dosage	50
Tape or CD	40	Control Own Dosage Between 50-60 mg/day	100
New Clothes	50	Tickets to Sporting Event	100

Note: Gray areas are not applicable.

You will need to learn how to use the standardized needs assessment in discussions with other staff, and discussions with the client to help define the client's problems and treatment needs. Having done this, you will have to learn how to identify options for addressing these needs in counseling by directing the client in the treatment planning process, by identifying and accessing program or local resources, and/or by learning how to involve other staff to help in any or all of these steps.

In both TEP and MET, the purpose of these meetings was also to identify areas where the VSC/CSC could help with client. Note that in both studies the clients continue to work with their primary counselor. The role of the coordinator is to help the client and counselor to find, arrange, and follow up on other services that are needed. It is very important that the VSC and counselor work together to present consistent messages to the client and to avoid the potential to be played off against each other.

Transferring some of these responsibilities to the VSC, CSC, or other staff can also free up some of the counselor's time and reduce the number of crises that seem to dominate the regular workload. This is important if the change to an individualized substance abuse counseling protocol is to be sustained without burning out the counselor.

7.2 Likely Vocational and Ancillary Service Needs

As noted earlier, employment is the second most documented need for methadone treatment clients according to both counselor and client rating of needs. Despite this high rating, most counselors in both MET and TEP reported difficulty in addressing this need. In TEP, we found that counselors lacked the time, specialized training, and experience to adequately assess and provide vocational services (Dennis, Karuntzos, & Rachal, 1992). Therefore, we introduced a VSC into the program who was responsible for addressing this treatment gap. The VSC served as a vocational counselor, job developer, and case manager. As a vocational counselor, the VSC helped clients explore issues regarding vocational rehabilitation and to develop an interest in vocational activity. As a job developer, the VSC acted on behalf of the client to create employment opportunities and to access community services. As a case manager, the VSC referred clients to appropriate vocational programs, facilitated their intake process, and monitored their progress in these programs.

When working with the treatment population, it quickly became evident to the VSC that clients varied considerable in their level of functioning and vocational experience. It was insufficient, and in many cases counterproductive to treatment, to simply refer clients to training or a job. Therefore, we developed a protocol to integrate the services of the VSC with the treatment services provided by the primary counselors. Though the VSC was

capable of assessing vocational abilities and interests, the VSC relied heavily on the primary counselor to provide input on the client's current treatment status, general functioning, level of motivation, and ancillary needs. It was the objective of the VSC to develop a vocational course of action that complemented the client's primary treatment plan. This objective required that the VSC not only assess the client's vocational readiness for training and employment services, but also the client's overall "employability," taking into consideration much of the information provided by the counselors. To facilitate this vocational assessment process, Karuntzos, Dennis, and Drews (in press) developed a conceptual framework for determining employability by examining five dimensions of client functioning.

Below we have provided a fairly detailed account of how this all relates to counselors and clients. A more detailed manual is also available for those programs interested in developing an actual vocational specialist (Karuntzos, Dennis, French, & Norman, 1995).

7.2.1 Employability Framework for Assessing Client Needs

The first dimension of our employability model is vocational status. Vocational status measures a client's readiness for vocational activities on a continuum of readiness defined as non-vocational, pre-vocational, training-ready, job-ready, or employed. The readiness level is determined by the client's ability to participate in vocational activities, desire to participate in vocational activities, educational or training history, and employment status or history. The distinction between vocational readiness and employability is illustrated by the other dimensions in our model and takes into consideration the other general measures of need and functioning. In TEP we broadly classified clients into five levels of vocational readiness.

- *Non-vocational* describes clients who are chronically or severely disabled (physical, psychological, or emotional) and prevented by their disability from pursuing vocational activity. These clients often have high ancillary needs and barriers that are typically addressed by primary counselors or other outside counselors or agencies. In terms of employment, the work histories of these clients are variable based on the disability. Some clients may have had a stable work history while others may have never been employed.

- *Pre-vocational* describes clients who are not ready to pursue training or employment activities. These clients may have minimal to no work experience, less than 10th grade education, no job training, low self-esteem, low motivation or interest in vocational development, or any variety of comorbid or dual diagnosis issues that would preclude them from vocational development.

- *Training Ready* describes clients who have sufficient ability and interest to enroll in GED preparatory, skills training, or college courses. These clients have above a 10th grade education, may have started training but never completed it, have a sporadic work history and a desire to work, but need additional skills training or education.

- *Job Ready* describes clients who are ready to find and keep a job. These clients have at least a 12th grade education or 2 or more years of steady work in a specific occupation, have completed training in a marketable job skill, may be underemployed and need a job upgrade, desire immediate employment, and are highly motivated to work.

- *Employed* describes clients who are currently working in a full- or part-time job. These clients typically have good support mechanisms, few ancillary needs, and stable living situations, but they may want to upgrade or change working conditions, environment, or kind of job.

Exhibit 7-1 summarizes the expected vocational service needs for clients by the five vocational readiness levels. These broad classifications can be used by counselors to identify the varying vocational needs of the treatment population and to guide their exploration of potential options to meet these needs.

The second dimension of our employability model is level of motivation. Motivation in this context is defined by desire to participate in any specific kind of vocational activity (e.g., community college, Joint Training Partnership Act training program). Financial incentive may be an important consideration as well. Clients receiving financial assistance or support through other sources may only be willing to be seek a job that will complement or improve their financial situation. Clinicians determining a course of action must also take into consideration the client's desire and willingness to participate in a specific activity or program. We have also included a general measure of motivation in the first dimension (vocational status) by including the desire for employment or training as a factor for determining level of readiness.

The third dimension is level of social support. Substance abuse treatment clients often lack the necessary support mechanisms to participate in vocational activities or get a job. The sources of social support can include the client's spouse, other family members, friends, treatment counselors, vocational counselors, or other treatment staff. Support can be in the form of encouragement, referrals, or direct assistance to enter training or find a job. In some cases, the client's family members or social network may present roadblocks or discouragement to participate in vocational activity. However, if a clinician can recognize the specific roadblocks or deficiencies in the support network, he or she can attempt to positively intervene or provide acceptable alternatives.

The fourth dimension of our model is identifying necessary ancillary needs. Clients across all levels of vocational status typically require some level of ancillary service to be able to enter training or become employed. Typical ancillary services include transportation, child care, medical services, food, clothing, housing, school or work equipment, legal services, driver's license or other personal identification, and funds for school or training. Local vocational rehabilitation agencies often provide ancillary services for clients that are eligible. It is important to remember that clients at all levels of vocational readiness typically have some ancillary needs that must be met before they can pursue the vocational activity. A course of action for meeting ancillary needs should be included in the clients' primary treatment plans.

The fifth dimension of our model is identifying barriers to services. Clients across all levels of vocational status may also face several barriers that might preclude them from being able to enter training or become employed. For drug treatment clients, typical barriers to receiving training or employment include continued illicit drug use, criminal records, illegal activities, negative leisure activities, general assistance or social service system (SSI), interpersonal skills, work attitude, health problems, appearance, racial or gender discrimination, medication other than methadone, and the current economy. Exhibit 7-2 summarizes the typical barriers faced by drug treatment clients. A more extensive discussion of these barriers is included elsewhere (Brewington et al., 1987; Dennis et al., 1993; Karuntzos et al., 1995).

7.2.2 Data from the Vocational Readiness Screener

The questions included in the Vocational Readiness Screener (Karuntzos, Dennis, French, & Norman, 1995) were primarily developed to collect information necessary to classify clients' employability. We examined the literature and included additional items documented as contributing to vocational diagnosis (Malamed & McCroy, 1991). We also examined other assessment instruments, such as the Functional Assessment Inventory, which included measures of functioning and adapted items that were relevant to the substance abuse population (Crewe & Athelstan, 1984). Finally, we disseminated our draft Vocational Readiness Screener to content experts for review to assure content validity. Preliminary findings from the TEP study using the Vocational Readiness Screener include:

- Of the 248 clients included in this analysis, the distribution of vocational status was non-vocational (20.0%), pre-vocational (12.5%), training-ready (6.9%), job-ready (42.7%), and employed (17.7%).

- Vocational status is significantly related to other measures of vocational experience and desires such as having a high school degree or GED, being employed full or part-time, having stable employment in the past year, having

2 or more years of work experience, and having employment as the primary source of income.

- Vocational status is significantly related to gender, race/ethnicity, age, and employment status.

- Vocational status and gender are significantly related to the type of ancillary needs, barriers to vocational activity, and desire for vocational services.

- Vocational status and gender are also significantly related to other measures of client functioning: positive (working at a job, keeping house, going to treatment), restrictive (being in jail), and negative (days without a meal, gambling).

The analyses presented in this study is limited to the degree that the data was analyzed from a preliminary draft of the Vocational Readiness Screener. With these limitations in mind, several important conclusions evolve from these analyses.

- Our measure of vocational status appears to be a simple and good summary measure that is related to other measures of vocational experience and desires, ancillary needs, barriers to vocational activity and desire for vocational services.

- The relationship between our measure of vocational status and demographic correlates suggests that gender, race/ethnicity, and age are important predictors of the needs of clients presenting for vocational services.

- Further research is still needed to better measure the levels of work and training experience, motivation, and social support. We are currently testing a revised version of the Vocational Readiness Screener to address these issues.

7.3 Likely Medical Service Needs

In general, the on-site medical staff will have primary responsibility for identifying and treating medical or severe mental illness. It is useful, however, for counselors to be aware of what medical staff do and do not do and of things that should be brought to the immediate attention of the medical staff. Knowledge of the common medical problems of drug treatment clients will help you, the counselor, to recognize conditions that require immediate medical attention and those that might require only occasional attention.

Many programs offer on-site testing, counseling, and treatment for major infectious diseases such as TB, hepatitis, and AIDS. In addition to methadone, the medical staff may prescribe antibiotics or psychotropic medication to help deal with secondary problems.

However, few programs are set up to provide the full range of primary medical care, and clients should have a personal physician or clinic that they go to. There are several problems with this, including the lack of health insurance, concerns about revealing methadone treatment to the personal physician or clinic staff, and the potential for outside treatment to conflict with the methadone treatment. Particularly if your client has a history of medical problems, this issue should be dealt with before a medical crisis occurs.

When any kind of chronic condition is treated through multiple providers, it also is important that there are open lines of communication. There is great potential for conflicting medication, and these conflicts are not likely to be detected immediately. Exhibit 7-3 provides a summary of the major methadone antagonists. You should alert the medical staff even if you only suspect that one of your clients is taking one of these drugs.

7.3.1 Understanding Clients' Medical Problems

Clients in drug treatment have often neglected their physical health for many months or years, responding primarily to crisis situations such as seizures, nose bleeds, coughing up blood, or acute pain in some part of their body. They frequently utilize hospital emergency rooms for these kinds of problems. As they begin to wean themselves off their addictive drugs, the physical problems that have been pushed aside will begin to surface again. Clients will often begin to focus on these problems and sometimes use them as reasons for not participating in training, vocational, or rehabilitation activities. An awareness of the kinds of medical conditions your clients may have and an understanding of how these conditions may be manifested will help you to ask the right questions and move your clients toward appropriate medical help.

Common health problems exhibited by clients with histories of long-term drug use include substantially elevated rates of human immunodeficiency virus (HIV) exposure, acquired immune deficiency syndrome (AIDS), other acute and chronic infections (e.g., endocarditis, hepatitis, tuberculosis, and sexually transmitted infections such as syphilis, gonorrhea, chlamydia, and herpes), and other systemic health problems, such as hypertension, diabetes, bronchial conditions, and kidney and gastrointestinal diseases. These problems are often made worse by the use of painkillers and a lack of access to (or awareness of) nonemergency health care resources. The chronic use of painkillers and other illicit drugs allows many of the body's natural warning signs to be ignored. For the client, this often means that medical assistance is not begun until it is almost too late; minor problems become complex, complications occur, and the prognosis for recovery is considerably lessened. As mentioned earlier, this means that these problems are often treated in emergency rooms and hospitals after they have become much more expensive to treat.

HIV/AIDS is currently the best known of the drug-related illnesses because it has been spreading in the past 5 years much faster among injecting drug users (IDUs), their sexual partners, and their children than in the general population. IDUs are also more likely to experience skin and soft tissue infections, such as cellulitis and phlebitis, as well as central nervous system (CNS) infections, such as meningitis, tetanus, and brain abscesses. While the names of these diseases sound quite menacing, most can be treated with antibiotics and other easily accessible pharmacological preparations.

7.3.2 Client Need

Using data recently gathered from The Pathways Program and P.B.A., The Second Step, we are beginning to get a much clearer picture of our clients' needs. By compiling and analyzing the information that has been collected from clients in TEP, using the GAIN, we have a preliminary understanding of the kinds of primary problems our drug treatment clients come into treatment with. Exhibit 7-4 shows that 49.66% have one or more "acute" health problems that should be addressed immediately; 26.69% reported specific primary care problems, 11.49% reported unspecified primary problems, and 12.16% reported no current problems, but still warranted monitoring because of past health problems. Exhibit 7-5 shows some of the most common acute problems, including infectious diseases (e.g., hepatitis, tuberculosis, HIV, STDs), 2 or more weeks of classic warning symptoms (e.g., headaches, fainting, dizziness, heart/chest pain), and includes documentation that a number of clients receive prescription drugs from doctors who did not know the patient was on methadone (because it interacts with many other drugs). Another 26.69% (64.86% of all clients) reported one or more nonacute specific medical problems (e.g., respiratory problems, digestive tract problems, foot problems) that did not require immediate attention, but have implications for treatment planning and coordinated overall care. An additional 11.49% of the clients (81.08% of all clients) reported unspecific health care problems (e.g., rating their health as fair or poor, impaired activities, rapid weight gain or loss, and current mental distress).

7.3.3 Health Services Utilization

For many clients medical treatment can be paid for by Medicaid. Some may need help with the paperwork required for Medicaid qualification, others may already be qualified and only need to be reminded that community health centers may provide some of their medical care.

Given the high rate of health problems and treatment costs, public health officials have become increasingly interested in exploring ways to provide health care more readily to

this population by locating health clinics in drug treatment programs. Because methadone treatment programs primarily serve clients who might require these services, and have frequent contact with their clients, some methadone treatment programs have begun to offer minimum health services on site. Others have considered setting up primary health clinics to provide clients with easy and quick access to full medical services on site.

Exhibit 7-6 indicates that 59.46% of the clients in the TEP project have some health insurance, with most of it (56.42%) from Medicaid, SSI, SSDI, or another public source. The rates of emergency room admissions in the past 90 days are over 10 times higher for clients with acute and specified problems than for those with only unspecified or no current problems. As indicated, the average number of days in the hospital are highest for clients with other "Specified" and only "Unspecified" problems, moderately high for those with acute problems, and virtually nonexistent for those with no current problems. In terms of outpatient visits, the clients with acute and specified problems are about four times more likely to require care than are clients with only unspecified conditions; and over 15 times more likely to need care than are those with no current problems. The TEP data informs us that, in a 90-day period, these 296 people made 89 visits to emergency rooms, stayed 169 nights in hospitals, and made 353 outpatient visits. To better understand the impact of these figures, only about 2 in 100 people in the general population are hospitalized during a 90-day period, and they average only 7.3 days stay. Thus, we would have expected to have this group spend only about a fourth as many days in the hospital or roughly about 43 days.

Exhibit 7-7 indicates that among the clients enrolled in our methadone treatment programs, some differences can be seen among ethnic groups. These differences are complex and probably are associated with a host of other factors. These differences are probably true for men, too, but the pattern here indicates that women are much more likely to be classified as having acute and/or more specific medical problems than men. Clients with these acute needs are likely to live with others (family members and significant others); and though there is no difference in the likelihood that either group will have children, these two groups are more likely to have one or more of their children living somewhere other than with them.

Clearly the medical needs of drug treatment clients are many and varied. Early recognition and diagnosis of these problems will make the counselor's job somewhat easier in that the client will be able to focus on the interactions that go on between counselor and client rather than focusing attention on his/her physical maladies. Often if no inquiry is made about the client's physical condition, this information may not be forthcoming. Although the counselor may not be able to provide immediate attention to the problem, having this information alerts one to make these inquiries early and especially if an attitude, mood, or physical change is noticed.

7.4 Case Conferencing, Treatment Planning, and Outside Providers

As previously noted, one of the key areas in which you will be working with other staff is in case conferencing and treatment planning. In case conferencing, both your counselor and non-counselor colleagues will be helping you to understand and address the information you present about the client. In addition to the general steps of treatment planning and problem solving discussed earlier, case conferencing also provides another means to draw on the expertise of any vocational, ancillary, or medical staff for assistance. This help may come in the form of explaining a situation, recommending an approach, agreeing to follow up directly with the client, or helping to make an effective referral to an outside provider.

In using outside providers, it is important not to set the client up for failure or rejection. Whenever possible, you should consult your colleagues or the provider directly to make sure that any inclusion or exclusion criteria for a given program or service are met before sending the client over. Some of the other steps to making more effective referrals include:

- talking with the other provider before formally making the referral to make sure it is appropriate;
- identifying the necessary paperwork or documentation that may required in advance and reviewing it with the client;
- going with the client or making sure that the client knows how to get there and has made the necessary logistical arrangements (e.g., baby sitting); and
- providing the client with reminders.

When talking with the other staff or outside providers, it is also important to avoid being overly jargonistic. Rather than using scale names from an instrument like the GAIN, it is often more useful to simply refer to the symptoms or the client's responses to the questions. The GAIN has been set up to reflect the most common criteria or questions that other staff and providers ask and to make this process more effective. The long version of the computer-generated profile is in narrative form to minimize the amount of instrument-specific knowledge that is necessary to use it.

While this may all sound somewhat overwhelming in the abstract, for any given client it is often a much more straightforward situation. Exhibit 7-10, for instance, provides four real examples of how this process led to a referral to specialists. Note that even where the case was eventually referred out, the information was first reviewed at a case conference.

Furthermore, the counselor was also responsible for following up on the referral to determine whether it worked and met the need.

Exhibit 7-1. Typical Vocational Needs of Clients

Pre-vocational Client	Training-ready Client	Job-ready Client
• motivational development • personal counseling (fear of success or failure) • vocational evaluation	• vocational/skills training • GED/educational services • training and education-related resources • training and education materials • support group participation • appropriate clothing	• interview preparation • resume preparation • application assistance • job seeker's workshop • job development • job placement • appropriate clothing • special equipment • support group participation

Non-Vocational Client	Employed Client
• psychological evaluation • medical evaluation • psychological and/or medical services	• resume updates • special work equipment • job search services for upgrading or changing jobs

Exhibit 7-2. Vocational Barriers

Vocational Barriers

Client-level obstacles:

- existence of family and personal problems,
- lack of social skills,
- lack of specific education and training,
- arrest records,
- continuous use of illicit drugs,
- unrealistic work expectations,
- unrealistic goals,
- poor work attitude,
- fear of transition to an alternative life-style, and
- low self-esteem.

Program-level obstacles:

- lack of staff training in the delivery and use of vocational services,
- lack of staff awareness of community-based agencies and resources,
- inadequate allocation of funds for vocational services,
- inflexible treatment schedules,
- lack of commitment to vocational rehabilitation, and
- program dependence on Medicaid revenue.

Service-level obstacles:

- inadequate performance criteria for service organizations (placement per slot and per dollar),
- time barriers for obtaining funding services, and
- funding gaps between services and/or employment.

Societal-level obstacles:

- bias against drug abuse and/or methadone treatment,
- status of the job market, and
- lack of employment opportunities adequate for clients.

Exhibit 7-3. Methadone Antagonists: Drugs To Be Administered to Methadone Clients With Caution

In as much as methadone is a central nervous system (CNS) depressant and has actions similar to opium and other opium derivatives, precaution is required when the need for other medications arises. Providers in methadone programs should know the categories of drugs that should be administered with caution or not at all to the client in methadone treatment programs.

Drug categories and examples of each are described below:

- **Analgesics.** Pentazocine - (brand name: TALWIN - a pain reliever). Talwin is an opioid antagonist that causes withdrawal symptoms.

- **Anticonvulsants.** Barbiturates (phenobarbital, pentobarbital, secobarbital, sodium pentothal), Dilantin (a hydantoin derivative chemically related to phenobarbital), and Klonopin (a form of benzodiazepine). The only anticonvulsant described in the literature that does not interact with methadone is Valproic Acid (Depakote).

- **MAO Inhibitors.** Tegretol or (carbamazepine).

- **Anti-Tubercular drugs**. Rifampin (used in conjunction with Isoniazid and other anti-TB drugs). Rifampin decreases blood concentrations of methadone causing withdrawal symptoms. Blood concentrations are reduced because the liver metabolizes methadone at a very rapid rate.

- **Antidepressants.** Desipramine hydrochloride (a tricyclic antidepressant that may also be labeled Norpramin or Pertofrane). For the methadone client requiring an antidepressant such as desipramine, blood levels of desipramine will increase. Desipramine is usually ordered for relief of depressive symptoms. It is detoxified in the liver.

- **AIDS drugs.** Zidovidine (AZT). AZT is one of the first line drug in AIDS treatment. Methadone seems to interfere with the metabolism of AZT causing it to be more toxic. AZT doses, consequently, should be reduced in methadone patients.

Sensitivity tests should be done for certain other drugs since therapeutic doses of drugs such as meperidine (Demerol - a synthetic morphine-like compound) have precipitated severe reactions in patients concurrently receiving MAO inhibitors (e.g., certain antidepressants or antihypertensives) or other drugs that depress the central nervous system.

Methadone may also hide acute abdominal conditions such as appendicitis, gastritis, and ruptured ovarian cysts since it reduces reaction to pain. It should also be used with caution in the elderly.

Caution should be used when clients are given other narcotic analgesics, undergo general anesthesia, use phenothiazines, tranquilizers, sedative-hypnotics, tricyclic antidepressants, alcohol and other central nervous system (CNS) depressants. Respiratory depression, hypotension, and profound sedation or coma may result.

Current research has moved increasingly away from simply specifying the same dosage for every person and towards a focus on the levels of blood in the individual's body. This approach has proven to be more and more valuable as we learn more about how methadone interacts with several other drugs and the enormous amount of variation with which methadone is absorbed by different people.

Exhibit 7-4
Level of Primary Care Needs (n = 296)

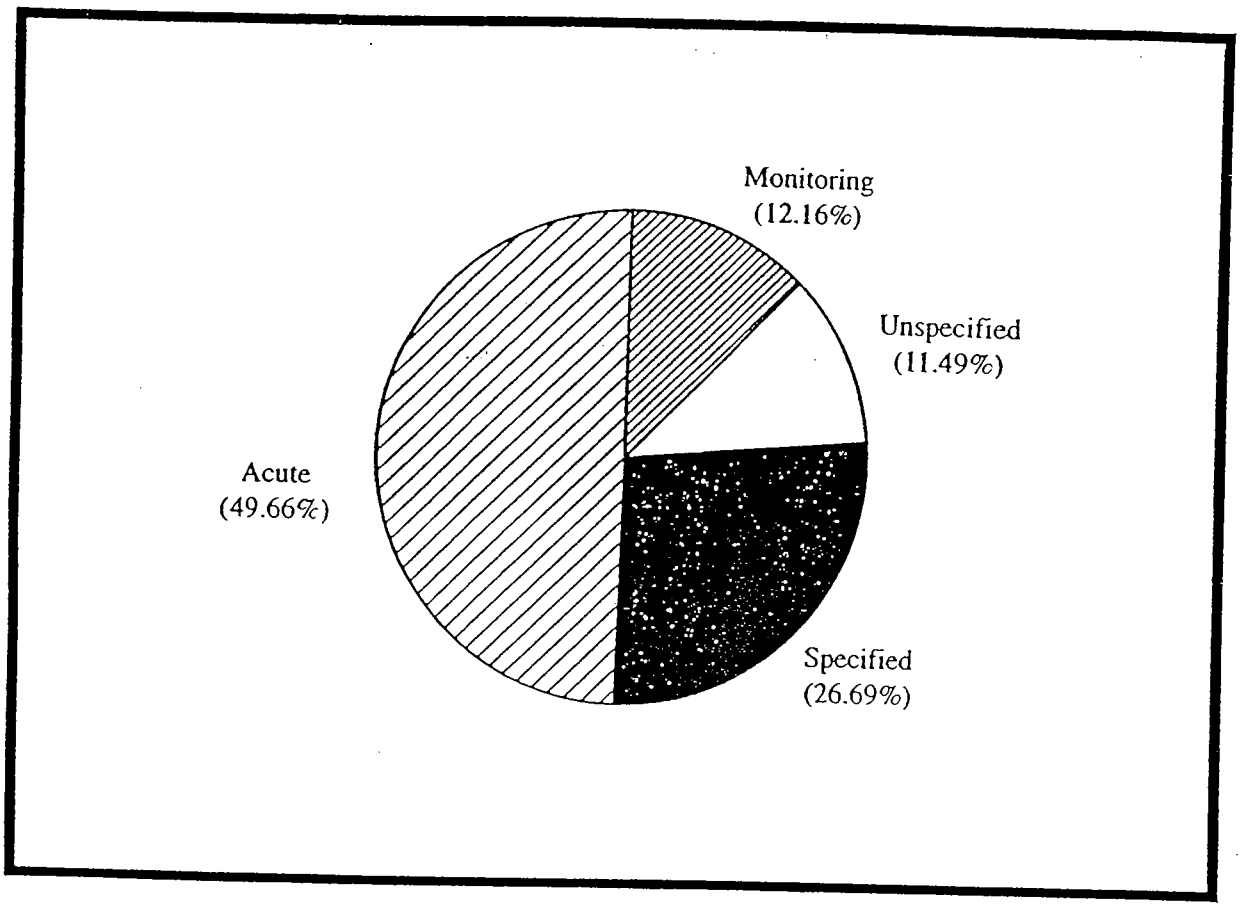

Exhibit 7.5 Medical Needs, by Highest Level of Need

Medical condition in the past 90 days	Acute medical needs (n=147)	Specified primary care need (n=79)	Un-specified primary care need (n=34)	Health monitoring (n=36)	Total (n=296)	Chi-square	Prob. Chi-square = Null
Acute conditions	100.00	N.A.	N.A.	N.A.	49.66	296.00	.000
Problems with hepatitis, jaundice, or cirrhosis	8.16	0.00	0.00	0.00	4.05	12.68	.005
Problems with tuberculosis	1.36	0.00	0.00	0.00	0.68	2.04	.564
Problems with HIV, ARC, or AIDS	5.44	0.00	0.00	0.00	2.70	8.33	.040
Problems with other sexually transmitted diseases (STDs)	2.04	0.00	0.00	0.00	1.01	3.07	.381
Headaches, fainting, and dizziness	74.15	0.00	0.00	0.00	36.82	174.99	.000
Heart, chest, a lot of pain	59.86	0.00	0.00	0.00	29.73	126.94	.000
Other medicine prescribed without knowledge of clinic	8.84	0.00	0.00	0.00	4.39	13.78	.003
One or more specified conditions	91.84	100.00	N.A.	N.A.	73.30	240.98	.000
Unspecified symptoms	95.24	83.54	100.00	N.A.	81.08	181.74	.000
Health rated fair or poor	58.50	48.10	55.88	0.00	48.31	40.54	.000
Current mental distress 4+	86.39	32.91	26.47	0.00	54.73	129.15	.000

N.A.: Not applicable by definition.

Exhibit 7.6 Health Care Utilization, by Highest Level of Need

Health care utilization in the past 90 days	Acute medical needs (n=147)	Specified primary care need (n=79)	Un-specified primary care need (n=34)	Health monitoring (n=36)	Total (n=296)	Chi-square	Prob. Chi-square = Null
Any insurance coverage	63.27	55.70	67.65	44.44	59.46	5.66	0.129
Medicaid/other public	61.90	51.90	61.76	38.89	56.42	7.35	.062
Mean ER admissions	0.46	0.30	0.03	0.03	0.31	17.10[a]	.001
Total ER admissions	64	23	1	1	89		
Mean nights in hospital	0.48	0.81	0.85	0.00	0.55	3.91[a]	.272
Total nights in hospital	68	64	28	0	160		
Mean outpatient visits	1.54	1.67	0.38	0.09	1.26	20.20[a]	.000
Total outpatient visits	218	120	12	3	353		

[a]Chi-square for last three based on Wilcoxon Rank-Order Test.

Exhibit 7.7 Demographic Characteristics, by Highest Level of Need

Medical condition in the past 90 days		Acute medical needs (n=147)	Specified primary care need (n=79)	Un-specified primary care need (n=34)	Health monitoring (n=36)	Total (n=296)	Chi-square	Prob. Chi-square = Null
Site:	Buffalo	51.02	41.77	41.18	33.33	45.27	4.65	.199
	Pittsburgh	48.98	58.23	58.82	66.67	54.73		
Race:	African American	31.29	54.43	44.12	47.22	40.88	13.92	.031
	Caucasians	57.82	41.77	44.12	44.44	44.44		
	Hispanic/other	10.88	3.80	11.76	8.33	8.33		
Gender:	Female	52.36	40.51	29.41	25.00	43.24	12.77	.005
	Male	47.62	59..49	70.59	75.00	56.76		
Living with anyone else?		78.23	68.35	58.82	58.33	70.95	9.24	.026
Children:	Living there	31.29	36.71	47.06	50.00	36.82	12.70	.177
	Elsewhere	30.61	37.97	23.53	13.89	29.73		
	Both	25.17	13.92	17.65	22.22	20.95		
	None	12.93	11.39	11.76	13.89	12.50		

Exhibit 7-8

Four Client Examples
Sandra Hooten, Ken Bossert
Sisters Hospital Pathway Clinic
Buffalo, NY

Client A

This 38-year-old white male client completed the GAIN interview after 6 months of methadone maintenance treatment. His scores in the living and employment areas indicated a major deterioration in his lifestyle functioning.

He was first diagnosed as polydrug and alcohol dependent in 1986. He completed several detoxes, two in-patient rehabs, and one extensive outpatient aftercare in traditional drug free settings. He did not achieve any significant periods of abstinence. At the time of this interview, the client indicated some stability, with 50 days of abstinence reported.

The client appeared to exaggerate his degree of mental distress in an attempt to manipulate treatment. However, he had four indicators of BPD and eight indicators of ASPD. These impressions were reinforced by the client's inability to view his drug use as precipitating the dysfunction in his life and his inability to take responsibility for his behavior.

This case was processed in clinical supervision, and the client was referred to the Cocaine Intensive Group. He responded well and gained 30 days of abstinence.

Three months later, when the quarterly interview was completed, it indicated a resurgence of drug use and diminished functioning, especially noted by a return to significant illegal behavior.

Based on this client's inability to remain stable and his concurrent Axis II diagnostic impression, this client will be referred to a MICA program as condition of remaining in methadone treatment.

(continued)

Exhibit 7-8 (continued)

Client B

This 41-year-old black female client completed the GAIN interview after 3 months of methadone maintenance treatment. She reported six detoxes from heroin, but she had refused all other forms of treatment. She began injecting heroin and cocaine at age 15 with no significant period of abstinence. She denied needing treatment for alcohol abuse, but scored 2 on the MAST test and reported at least six episodes of heavy drinking in the past 90 days. She scored 2 on the DAST R test, indicating loss of control of use and continued use despite negative consequences. Based on this report, diagnostic impression is 304.00, 304.20 DSM 111R, r/o 305.00.

The client reports six symptoms of current mental distress, two current symptoms of ASPQ, and eight symptoms of ASPD prior to age 15 (conduct disorder). This suggests a possible lifetime diagnosis of ASPD and high risk for additional problems. This assessment is confirmed by her history of 30 arrests for prostitution and her immature view of using drugs "for fun."

The client was referred to an educational women's group, but she did not respond well, being consistently late and distracted.

This case was presented in clinical supervision. Recommendations were to engage the client in behavioral counseling based on generating rewards and consequences which fit her personality pattern. She is responding to that form of treatment in bimonthly individual sessions.

(continued)

Exhibit 7-8 (continued)

Client C

Upon completion of the GAIN interview, this 45-year-old Hispanic male client engaged in methadone maintenance for 1 year. However, this writer noted the client's relapse to use of marijuana after a 6-month period of abstinence from all illicit drug use. When reviewing the interview results, the client identified this as a controlled decision which he could not relate to drug dependence. It was noted that marijuana was this client's initial drug of choice at age 14 until opiate use began 10 years later. While the client reported multiple episodes of outpatient drug-free treatment, he did not respond well to feelings-based therapy or to the restrictions that program placed on him.

This client was noted to have average life management skills but was functioning well below his ability.

Mental health status identified 5 indicators to rule out, mood disorder, and 8 indicators of ASPD. Based on those indicators, I suggested referral for mental health evaluation. The client refused the evaluation.

These findings were processed in clinical supervision. The outcome was to appeal to the client's cognitive nature rather than focusing on expressing feelings, which appeared to frustrate him.

The client engaged in a cognitive-based therapy group. He has responded well to that group and is continuing attendance. Based on peer feedback and his recognition of the value he places on mature behavior and good reputation, he has made a decision to stop using marijuana, and he announced that decision to the group.

He has engaged in computer repair training and volunteer work at a local homeless shelter. He has agreed to follow recommendations for mental health evaluation based on the fillip quarterly interview. That interview indicated the possibility of feelings of paranoia and obsessional thinking.

(continued)

Exhibit 7-8 (continued)

Client D

While completing the GAIN on this 34-year-old male client who had been in methadone treatment for 14 months, it became apparent that the client had a latent alcohol problem. This fact emerged when he completed the alcohol/drug section. He registered high scores on questions dealing with number of days drinking and number of days with five or more drinks, and his MAST scores also indicated concerns. In the legal section, the client indicated two previous arrests and convictions, one DWI, and one assault that occurred while he was intoxicated. While completing the diagnostic impression, I indicated that the client should be assessed for alcohol dependence. I addressed these concerns when presenting this client at our multidisciplinary case conference and indicated an alcohol assessment as one of my treatment recommendations. The client was referred to our out-patient alcohol treatment program, at which time I presented the GAIN information to the clinician screening the client. The out-patient program confirmed my initial diagnosis, and the client was subsequently referred to their out-patient intensive alcohol treatment program while simultaneously being treated at Pathways for his opioid problem.

8.0 Administrative Issues and Procedures

For many programs, successful implementation of the ISAC protocol will require significant changes in the way the staff and the program operate. Administrators must recognize the potential difficulties in bringing about such change. This chapter, aimed primarily at program administrators, addresses some of the issues involved in the implementation and day-to-day operation of the ISAC protocol. It includes sections on training and recruiting, clinical supervision, measuring counseling, and maintaining confidentiality.

8.1 Implementation, Training, and Recruiting

Training and recruiting staff to work under the ISAC protocol requires careful planning. Program or clinical supervisors will need to consider a number of issues, including:

- Research orientation. Depending on their orientation, staff may consider the ISAC protocol a welcome addition or a threat to how they do treatment.
- Time management skills. The ISAC protocol places an additional burden on staff in terms of the requirements for completing and documenting specific tasks.
- Theoretical orientation. Staff must conceptually appreciate cognitive behavioral counseling approaches and buy into a problem-solving clinical style.
- Teamwork. Close cooperation, especially among clinical staff, is essential for the success of this protocol.
- Attitude. Staff must be willing to assess and accept any new options to assist them in their efforts with their clients; inflexibility on the part of the staff will limit the protocol's effectiveness.

These issues will be the most difficult for existing staff because they will be asked to change how they do things. It is important that you do not rush into implementing the protocol without preparing them or addressing their concerns. As a first step, we recommend that the clinical supervisor and one or two counselors try out some of the proposed techniques first so that they can speak from personal experience during training. Ideally, these counselors will be selected because (a) they might be backup trainers, (b) they are senior or well respected by other staff, and/or (c) they are energetic and open to trying new things and learning from manuals. Direct personal experience with the protocol will provide credibility and make discussions with staff and training go much more smoothly. Secondly, have some planning meetings prior to

full implementation so that concerns can be raised and addressed. Acknowledge that you are asking for something and are willing to work with them to make this work because in the long run you think it will be more effective.

During the actual training and implementation, the director and clinical supervisor will need to repeatedly demonstrate that they are serious about implementing this approach by making full use of feedback, information in case conferences, monitoring, follow-up training, and other forms of quality assurance. Exhibit 8-1 includes an example of the training agenda that we used in TEP. Note that the first 3 days of training are just the beginning. During the next 30 days, clinical supervisors and RTI staff either observed or listened to audio tapes of the counselors' first two to three GAIN sessions and provided them with feedback until they were administering it correctly. Over the first 90 days, counselors were reinforced through case conferences and chart reviews. Prior to starting the next set of quarterly assessments and treatment plans, we also conducted follow-up training. Because program staff vary considerably in their background and because this is a very intense change (even over 90 days), we have also found it useful to evaluate the training and identify any gaps or information that may need to be repeated. Exhibit 8-2 shows an example of the ISAC Training Evaluation form we used in TEP.

Even if you do everything right, some counselors will not be willing to accept the changes required to implement ISAC. Some counselors feel threatened by the new approach for both legitimate and tangential reasons. By standardizing assessment and working in teams, staff who are not doing much will become quickly noticeable. These problems existed before ISAC; implementing the protocol simply brings them to light. On the other hand, some clinically effective staff may still feel threatened or have difficulty implementing ISAC for tangential reasons such as limits on their vocabulary or reading level. These logistical barriers will also need to be identified and overcome with assistance from the trainer or clinical supervisor.

For new staff, many of these problems can be averted by clearly describing the protocol in oral or written job descriptions. Exhibit 8-3 provides a brief job description used at PBA in Pittsburgh when recruiting counselors for the ISAC protocol. Making use of a description like this, the program is more likely to recruit counselors who are neutral or even excited about participating in the ISAC protocol. Training issues are also somewhat different for new staff because you will typically only be training one or two people at a time. Appendix C contains a detailed curriculum that can be used for training counselors either in groups or individually. When you are training only one or two new staff, it is often effective to have the trainees observe a more experienced counselor going through the protocol.

8.2 Clinical Supervision

Most treatment programs have designated either a senior counselor or clinical supervisor who is responsible for the clinical supervision of the other staff. This may or may not be the same person as the administrative supervisor. The clinical supervisor plays a crucial role in the implementation of the ISAC protocol. He or she not only needs to learn the protocol, but should ideally be one of the trainers and will need to reinforce the protocol during case conferencing by asking for information from the GAIN and making use of problem-solving strategies.

It will be up to the clinical supervisor to ensure that each counselor has a clear understanding of the ISAC protocol, of the GAIN (or other instrument), and of how they fit into treatment, treatment planning, case conferencing, and working with other staff. Counselors often need to be educated and reinforced on the virtues of doing a standardized needs assessment until they have successfully gained enough experience to maintain the behavior. Once they become enthusiastic, they may even need to be reminded not to get jargonistic when working with other staff or outside providers who are less familiar with the specific scales or terminology. A simple but important step is to ensure that they have the GAIN or profile reports with them during case conferencing or referral consultations so that they may refer to them when answering questions.

In addition to direct supervision, case conferencing provides the next most valuable opportunity to both monitor and directly model many of the components of the ISAC protocol. Some of the keys to using case conferencing successfully include:

- Administrative involvement. The positive changes that occur as a result of case conferencing come only with the expenditure of much administrative energy. Discussions with research staff, administrative staff at the hospital, and the team regarding the implementation of new procedures consume both time and energy. Clinical supervisors must be not only willing to expose the deficiencies in existing procedures but also to embrace change and effectively convince staff of its validity. To do all of this, the clinical supervisor and program director must appreciate the crucial role case conferencing plays in client outcomes under this design.

- Structure. We have found that the more structure you build into case conferencing, the better the outcomes. The roles of the counselors and other staff must be clearly defined. Policies and procedures must be developed that ground staff on what is expected and how to prepare themselves. Standardized forms should be provided for both counselors and other staff as an aid to consistency in presentations.

- Organization. Much of the effectiveness of this protocol is based on the appropriate scheduling of procedures like case conferencing. If clients

are not initially presented and revisited in a timely fashion, the role and impact of case conferencing on client outcomes suffers. Where computerized dispensing protocols are available, it is often possible to incorporate a computer generated "prompt" which notifies all staff when specific clients should be presented.

In addition to the materials presented in this manual, clinical supervisors and other staff interested in learning more about problem-solving counseling, relapse prevention, or behavior modification in general may be interested in obtaining additional materials. Some of the key materials with additional exercises and resources we purchased in TEP for the use of clinical supervisors and senior counselors, including:

- McAuliffe, W., Ch'ien, J., & Zackon, F. (1993). Recovery training and self-help: Relapse prevention and aftercare for drug addicts (NIH Publication No. 93-3521). Rockville, MD: National Institute on Drug Abuse.

- McCrady, B.S., & Morgenstern, J. (1993). Psychoactive substance use in adults. In R.T. Ammerman and Michel Hersen (Eds.), Handbook of behavior therapy with children and adults (pp. 236-247). Boston: Allyn and Bacon.

- McKay, M., Davis, M., & Fanning, P. (1981). Thoughts and feelings: The art of Cognitive Stress Intervention. Oakland, CA: New Harbinger Publications.

- Rimm, D.C., & Masters, J.C. (1979). Behavior therapy: Techniques and empirical findings. New York: Academic Press.

To get a broader overview of behavioral assessment, management, and research in this area, interested readers may also want to consult:

- Marlatt, G.A., & Gordon, J. (1985). Relapse prevention: Maintenance strategies in the treatment of addictive behaviors. New York: Guilford Press.

- Onken, L.S., & Blaine, J.D. (Eds.). (1990). Psychotherapy and counseling in the treatment of drug abuse (NIDA Research Monograph 104, DHHS Publication No. ADM 91-1722). Rockville, MD: National Institute on Drug Abuse.

- Onken, L.S., Blaine, J.D., & Boren, J.J. (Eds.). (1993). Behavioral treatments for drug abuse and dependence (NIDA Research Monograph 137, NIH Publication No. 93-3684). Rockville, MD: National Institute on Drug Abuse.

- Sobell, L.C., Sobell, M.B., & Nirenberg, T.D. (1988). Behavioral assessment and treatment planning with alcohol and drug abusers: A review of emphasis on clinical application. Clinical Psychology Review, 8, 19-54.

8.3 Measuring Counseling and Service Utilization

An important element of our research is to learn more about the ways in which counseling contributes to effective drug abuse treatment. Over the course of the MET project, we interviewed the counselors and the program administrators. In addition, we wanted all of the counselors--enhanced and standard--to complete a report summarizing the nature of each client encounter, including individual sessions, group sessions, and other encounters in which "counseling" in the broadest sense occurred. Much of Chapter 2 in this manual was based on this client-encounter information.

We did not want to burden the counselors with added paperwork, so we designed a checklist that was easy and quick to complete (see Exhibit 8-4). But it is just that, a checklist, to be used to summarize what transpired in the counseling session. It is **not** an outline, a reminder sheet, or a set of guidelines about what ought to take place in counseling. We included things on the form that occurred only rarely and that might not occur with every client. It is also not a mechanism for monitoring the work of counselors. We believe that all of the counselors working in our MET study sites--enhanced and standard--were carefully screened and selected by their programs for their staff positions because of their commitment to doing the best they could for their clients. It was our purpose to use the checklist to learn more about what transpires in counseling sessions over a long period of time without having to be present every time a client meets with a counselor--an impossible task.

In TEP, we went one step further by trying to tap into the clinic's existing records, rather than imposing new paperwork. This was facilitated by electronic management information systems that were already in place in Pittsburgh and San Jose. The minimum kinds of process information that should always be tracked in program records include:

- intake data collected for the minimum client data set;
- date, duration, and participants in individual counseling;
- date, duration, and participants in group counseling;
- date and type of any referrals;
- date and results of any urine tests; and
- date and amount of methadone given.

For a sample of records, we also manually abstract the frequency, topic, and expected duration of goals from treatment plan records. In the GAIN we also ask clients directly about the service utilization (see Exhibit 4-2 presented earlier).

8.4 Ensuring Confidentiality in TEP

In both treatment and research, information obtained from clients must be treated with the appropriate level of confidentiality. In a project dealing with issues as sensitive and potentially damaging as in this one, the procedures required to ensure absolute protection of the respondents must be completely and stringently followed. Each member of the project team must be fully aware of all of the confidentiality procedures that have been put in place and must realize that full compliance with these procedures is expected and required. This section of the manual describes the confidentiality procedures used in the TEP project.

The members of the treatment program staff who were in contact with the research project include the program director, the counseling staff, the VSC, the Vocational Research Assistant (VRA), and the AIDS education specialist, as well as the members of the medical staff. These persons were already aware of the sensitive nature of the information with which they came in contact, and the need to maintain a strictly confidential relationship with program clients and the information they provided. These staff members were not in possession of any additional information about the clients in the treatment program who were participating in this research project, and thus no additional procedures to ensure confidentiality needed to be put in place for these staff members.

The program researcher (PR) who was used for follow-up, however, was an RTI/Powerforce employee and a new member of the program staff. The PR collected information during the interview that related to client behaviors that may increase the risk of HIV infection. This information was extremely sensitive, and any release of that information in a manner that could be associated with a respondent would have been inappropriate; such action would have resulted in the dismissal of the PR, and he or she would have been subject to legal sanction—this did not happen. Each PR signed a confidentiality pledge as part of her or his employment agreement.

All members of the research and support staff at RTI also had access to the information collected about respondents. This information, which could be linked to the respondent's program ID (but not name) through computer files at RTI, included the data collected during the interviews conducted by a PR, the data abstracted from a respondent's medical and clinical records at the program, data from the VSC's Service Encounter Log, and the results of the Social Security and criminal justice record checks. In addition to the normal confidentiality procedures adhered to by all RTI staff on all projects, there was a special provision for further assurance of confidentiality of the data collected in this study. Data collected in this study are still protected from required disclosure by a document called a 303a Confidentiality Certificate issued by the Federal Government as provided in Title 42, Part 2a, of the *Code of Federal*

Regulations. This certificate allows us to assure respondents that the information they reported in their interviews, or that was abstracted from their records for research purposes, cannot be required to be released by the courts, the legislature, or the executive branch of the government. No data will be released without the written consent of the respondent.

This certificate does not supersede any local laws governing the program's existing clinical records. Furthermore, once research data is placed into a client's clinical record, it is no longer protected by the certificate of confidentiality. It is of the utmost importance that any research data provided by RTI ID never be linked back to the program's client records.

Exhibit 8-1

Individualized Substance Abuse Counseling (ISAC)
Phase I: Initial Training

Counselor Training Agenda For
PBA, The Second Step

Day 1: Overview of the Project, ISAC, and Conducting Global Appraisal of Individual Needs (GAIN)

8:30 - 9:00	Breakfast and Welcome
9:00 - 9:30	Overview of Training Agenda and Materials
9:30 - 10:00	Overview of the Training and Employment Program (TEP) Study
10:00 - 10:30	Overview of Individualized Substance Abuse Counseling (ISAC) program
10:30 - 10:45	Break
10:45 - 12:30	Conducting Standardized Needs Assessments
12:30 - 1:30	Lunch and Discussion
1:30 - 3:00	Using the Global Appraisal of Individual Needs (GAIN)
3:00 - 3:15	Break
3:15 - 5:00	GAIN - Continued

Day 2: Treatment Planning and Working with the Vocational Services Coordinator and Other Staff

8:30 - 9:00	Review Yesterday and Overview of Today
9:00 - 10:30	Using the GAIN and GAIN Profile to Individualize Treatment Planning
10:30 - 10:45	Break
10:45 - 12:30	Treatment Planning
12:30 - 1:30	Lunch and Discussion
1:30 - 3:00	Treatment Planning
3:00 - 3:15	Break
3:15 - 5:00	Incorporating the VSC and Other Staff into Treatment and to Help Accessing Community Resources to Meet Client Needs

Day 3: Problem Solving Counseling, Accessing Community Resources and Administrative Issues

8:30 - 9:00	Review Yesterday and Overview of Today
9:00 - 10:30	Problem Solving Counseling with Clients
10:30 - 10:45	Break
10:45 - 12:30	Problem Solving with Other Staff
12:30 - 1:30	Lunch and Discussion
1:30 - 3:00	Role Playing
3:00 - 3:15	Break
3:15 - 5:00	Getting Started, Administrative Procedures, and Follow-up Training Plans

Exhibit 8-1 (continued)

Individualized Substance Abuse Counseling (ISAC)
Phase 2: Off-site Follow-up Training

Day 4-30: Individualized Staff Feedback by RTI staff and Local Trainer Based on Audio Tapes of Initial Sessions

- Two initial GAINs that are audiotaped and reviewed
- Editing feedback on first two GAINs via hard copy
- Clinical feedback on first two GAINs via teleconference
- Weekly Staffings and Feedback

Individualized Substance Abuse Counseling (ISAC)
Phase 3: On-site Follow-up Training

Day 90: Treatment Plan and Coordination Review and Feedback

9:00 - 12:30	Review with individual counselors their client treatment plans and use of Vocational Services Coordinator, other program staff, and ability to access community resources.
12:30 - 1:30	Lunch With Local Trainers and VSC
1:30 - 5:00	Continued review with individual counselors their client treatment plans and use of Vocational Services Coordinator, other program staff, and ability to access community resources.

Day 91: Treatment Plan and Coordination Review and Feedback

9:00 - 10:15	Group Review of Training Implementation and Integration
10:15 - 10:30	Break
10:30 - 12:30	GAIN-Q Training
12:30 - 1:30	Lunch
1:30 - 3:00	Using the GAIN-I and GAIN-Q Computer Generated Profiles
3:00 - 3:15	Break
3:15 - 5:00	Brainstorming on how to make things work even better

Exhibit 8-2

ISAC Training Evaluation Form

Training Topic: ISAC Phase I
Training Date: 6/9/93 - 6/11/93
Training Place: Buffalo, New York

Your Position: _____
Your Years of Experience: _____
Your Degree/Training: _____

To help us get feedback from you and improve our training, please answer the following questions.

1. Was the amount of time spent on each of the following topics too little, about right, or too much for you?

		Too Little Time	About Right	Too Much Time
a.	Introduction and Background	1	2	3
b.	Individual Assessment Profile	1	2	3
c.	Treatment Planning	1	2	3
d.	Working with Other Staff	1	2	3
e.	Problem-Solving Counseling	1	2	3
f.	Research Procedures Related to You	1	2	3
g.	Hands-On Experience	1	2	3

2. Was the technical level of the materials used in each of the following areas appropriate for you?

		Not Technical Enough	About Right	Too Technical
a.	Introduction and Background	1	2	3
b.	Individual Assessment Profile	1	2	3
c.	Treatment Planning	1	2	3
d.	Working with Other Staff	1	2	3
e.	Problem-Solving Counseling	1	2	3
f.	Research Procedures Related to You	1	2	3
g.	Hands-On Experience	1	2	3

Exhibit 8-2 (continued)

3. How useful were the presentation and materials in each of the following areas for you?

		Not Useful	Useful	Very Useful
a.	Introduction and Background	1	2	3
b.	Global Appraisal of Individual Needs	1	2	3
c.	Treatment Planning	1	2	3
d.	Working with Other Staff	1	2	3
e.	Problem-Solving Counseling	1	2	3
f.	Administrative Procedures Related to You	1	2	3
g.	Hands-On Experience			

4. What was the most useful part of training for you?

5. What was the least useful part of training for you?

Exhibit 8-2 (continued)

6. Were the materials we provided adequate? If not, what would you recommend we add or change?

7. What (else) would you recommend we change and how?

Please feel free to make additional comments.

Exhibit 8-3
Individualized Substance Abuse Counselor (ISAC)
Position Description

Client Services

Direct services. The ISAC counselor should be able to manage a caseload of approximately 35 to 40 methadone clients. The ISAC counselor should have an understanding and appreciation of a cognitive behavioral counseling approach and be able to apply problem solving techniques when providing counseling services. The ISAC counselor should also be able to coordinate services and share information with other counselors and staff. The ability to work as a team member is critical for this position. The core areas of functioning that the ISAC counselor should be able to assess and coordinate with the treatment team to address are:

- drug and alcohol issues
- legal issues
- educational/vocational issues
- psychological issues
- residential/ ancillary issues
- medical issues
- social/ interpersonal relations

The ISAC counselor should be able to conduct a structured needs assessment using the Global Appraisal of Individual Needs (GAIN) to identify general functioning issues, and present these issues in a case conference with other staff to develop a comprehensive individualized treatment plan for each new client.

Documentation. The ISAC counselor should be able to document the treatment plan recommendations in the clients' primary chart and update these charts at least quarterly (or as necessary.) The ISAC counselor should also document all client services in progress notes included in the primary chart. Good time management and documentation skills are critical for this position.

Education, Training, and Experience Required

The ISAC counselor should have at least a 4 year degree in a social service area. An MSW degree and additional credentials are preferable (csw,crc,cas,csac). The ISAC counselor should have a working knowledge of chemical dependency issues and a minimum of 2 years work experience in chemical dependency counseling.

Exhibit 8-4

Monthly Client Encounter Checklist (CEC) Form (Front)

Client Encounter Checklist (CEC)

COUNSELOR	RTI STAFF USE ONLY
Counselor Name: _____	Counselor ID: _____
Client Name: _____	Client Group: T C B
Client ID: _____	Program: 76 77 78 79
Month/Year: ____/____	

	1. __/__	2. __/__	3. __/__	4. __/__	5. __/__	6. __/__	7. __/__	8. __/__
1. DATE (Month/Day):								
2. DURATION (Minutes):	___	___	___	___	___	___	___	___
3. CONTEXT (Type):								
Individual Session	__IND	__IND	__IND	__IND	__IND	__IND	__IND	__IND
Group Session	__GRO	__GRO	__GRO	__GRO	__GRO	__GRO	__GRO	__GRO
Other	__OTH	__OTH	__OTH	__OTH	__OTH	__OTH	__OTH	__OTH
(specify):	_____	_____	_____	_____	_____	_____	_____	_____
4. CONTENT (Topics):								
Positive Urines	__POS	__POS	__POS	__POS	__POS	__POS	__POS	__POS
Negative Urines	__NEG	__NEG	__NEG	__NEG	__NEG	__NEG	__NEG	__NEG
Alcohol Problems	__ALCO	__ALCO	__ALCO	__ALCO	__ALCO	__ALCO	__ALCO	__ALCO
Drug Use	__DRU	__DRU	__DRU	__DRU	__DRU	__DRU	__DRU	__DRU
Treatment Issues	__TRE	__TRE	__TRE	__TRE	__TRE	__TRE	__TRE	__TRE
HIV/AIDS Issues	__HIV	__HIV	__HIV	__HIV	__HIV	__HIV	__HIV	__HIV
Medical/Dental	__MED	__MED	__MED	__MED	__MED	__MED	__MED	__MED
Employment/Education	__EMP	__EMP	__EMP	__EMP	__EMP	__EMP	__EMP	__EMP
Entitlements/Social Services	__ENT	__ENT	__ENT	__ENT	__ENT	__ENT	__ENT	__ENT
Housing Issues	__HOU	__HOU	__HOU	__HOU	__HOU	__HOU	__HOU	__HOU
Legal Issues/Criminal Activity	__LEG	__LEG	__LEG	__LEG	__LEG	__LEG	__LEG	__LEG
Family/Social Support	__FAM	__FAM	__FAM	__FAM	__FAM	__FAM	__FAM	__FAM
Psychological/Emotional	__PSY	__PSY	__PSY	__PSY	__PSY	__PSY	__PSY	__PSY
Crisis Management	__CRI	__CRI	__CRI	__CRI	__CRI	__CRI	__CRI	__CRI
Other	__OTH	__OTH	__OTH	__OTH	__OTH	__OTH	__OTH	__OTH
(specify):	_____	_____	_____	_____	_____	_____	_____	_____
5. TREATMENT PLAN ACTIVITY:								
Develop	__DEV	__DEV	__DEV	__DEV	__DEV	__DEV	__DEV	__DEV
Review	__RVW	__RVW	__RVW	__RVW	__RVW	__RVW	__RVW	__RVW
Revise	__RVS	__RVS	__RVS	__RVS	__RVS	__RVS	__RVS	__RVS
6. REFERRAL ACTIVITY:								
Initial Referral	__INI	__INI	__INI	__INI	__INI	__INI	__INI	__INI
Follow-up of Referral	__FOL	__FOL	__FOL	__FOL	__FOL	__FOL	__FOL	__FOL
Topic (letter codes from 4.)	_____	_____	_____	_____	_____	_____	_____	_____

__ NO ENCOUNTERS WITH CLIENT THIS MONTH.
__ CLIENT DISCHARGED FROM PROGRAM (DATE:____/____/____) REASON:

Page ___ of ___

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Exhibit 8-5
Monthly Client Encounter Checklist (CEC) Form (Back)

CODE	TOPIC	EXPLANATION AND EXAMPLES
POS	Positive Urines	Discussing the results of a clean urine analysis.
NEG	Negative Urines	Discussing the results of a dirty urine analysis.
ALC	Alcohol Problems	Discussing problems related to alcohol abuse.
DRU	Drug Use	Discussing self-reported drug abuse lapses/episodes.
TRE	Treatment Issues	Discussing drug and alcohol treatment issues including dosage, take-homes, relapse prevention, self-help, conducting psycho-social histories, conducting needs assessments, setting goals, keeping appointments, or taking urines.
HIV	HIV/AIDS Issues	Discussing HIV testing and counseling, AIDS education, and the reduction of AIDS-related high-risk behaviors.
MED	Medical/Dental	Medical issues including dental services and the need for compliance with medical treatment.
EMP	Employment/Education	Employment and education issues including job finding, work problems, training, transportation, vocational rehabilitation, educational counseling, GED preparation, and enrollment in school.
ENT	Entitlements/Social Services	Entitlement and financial issues including budgeting, gaining social service benefits, and compliance with entitlement program requirements.
HOU	Housing Issues	Finding and maintaining suitable housing.
LEG	Legal Issues	Civil and criminal legal issues including illegal activities, probation/parole, court dates, custody problems, divorce proceedings, and prostitution.
FAM	Family/Social Support	Family and social issues including marital problems, problems with other family relations, parenting, and relations with friends or neighbors.
PSY	Psychological/Emotional	Psychological and emotional issues including bereavement, solace, stress reduction, controlling violent behaviors, sexual problems and the need for/compliance with psychiatric treatment.
CRI	Crisis Management	Dealing with problems that the client perceives as requiring urgent attention and resolution.
OTH	Other (specify):	If something does not fit into one of the above general categories, please provide a brief description.

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Appendix A
Background on the Methadone Enhanced Treatment (MET) Study

The MET Study was designed to address repeated calls to enhance methadone treatment so that it would be more effective in reducing needle use and, consequently, the spread of the human immunodeficiency virus (HIV), the acquired immune deficiency syndrome (AIDS), and other infectious diseases (Haverkos, 1991; Haverkos & Lange, 1990; Hubbard et al., 1989; Institute of Medicine, 1990; Watkins et al., 1988). Injecting drug users (IDUs) account for 32% of all AIDS cases and are one of the fastest growing groups of people with AIDS (National Commission on AIDS, 1991). Unlike the rate of AIDS cases among homosexuals and lesbians, the rate of new IDU-related AIDS cases is increasing, with 40% of all IDU-related AIDS cases having been reported between April 1990 and April 1992 (Centers for Disease Control [CDC], 1992).

Some of the problems faced by community-based programs have included little counselor training, low pay, high turnover, high caseloads, low levels of ancillary services, poor client compliance with counseling attendance, high rates of comorbid mental illness, low employment, and high rates of criminal activity (Dennis, Fairbank, Bohlig, Bonito & Rachal, 1991b; Dennis, Karuntzos, & Rachal, 1992). Conducted in four programs in Buffalo, Camden, New Orleans, and Pittsburgh, MET attempts to reemphasize the role of counseling and ancillary services and to make methadone treatment more effective in terms of reduced needle use, reduced drug use in general, reduced criminality, and increased employment. It was actually a series of overlapping studies using the full range of existing counselors, caseloads, resource levels, and clients presenting for treatment in the four programs. These studies included:

- a quasi-experimental analysis of the extent to which 479 clients entering methadone treatment differ from 2,119 untreated IDUs coming in contact with outreach programs in the same communities, as well as a study of the predictors of who approaches and eventually enters methadone treatment (Bonito, et al., 1993; Wechsberg, Dennis, Theisen, & Rachal, 1991);

- a longitudinal study of 281 clients entering methadone treatment during the baseline and early pilot study to determine the extent to which pretreatment drug use, methadone policies, counseling, services, and treatment continuity can be used to predict subsequent reductions in injection drug use and increased abstinence (Dennis, Fairbank, Bohlig, Bonito, & Rachal, 1991);

- a controlled trial in which 51 counselors were randomly assigned to either continue providing present treatment or to receive training on how to conduct standardized needs assessments, individualize treatment plans, offer problem-solving counseling, conduct more counseling, provide more feedback on urine test results, and make more referrals for services (Fairbank, Dennis, Bonito, & Rachal, 1992);

- a randomly controlled trial with 490 clients to assess the long-term impact of individualized substance abuse counseling on those clients who were assigned to the enhanced counseling regimen plus contingency contracting on attendance, increased urine monitoring, relapse prevention groups, and access to local resources through a community services coordinator (CSC) (Dennis, Karuntzos, & Rachal, 1992);

- a study of those clients who were assigned to the enhanced counseling regimen plus contingency contracting on attendance, increased urine monitoring, relapse prevention groups, and access to local resources through a community services coordinator (CSC) (see Chapter 2);

- a set of quasi-experiments to assess various types of contamination by combining data on the 490 clients in the trial with another 171 from a prospective baseline control group of clients who entered prior to the experiment and another 445 clients from a retrospective control group (records data only) of clients who entered prior to any data collection activities (Dennis, Fairbank, Bohlig, Bonito, & Rachal, 1992); and

- several methodological substudies on assessing the validity of community-based experiments, measuring treatment, and validating the client and treatment process measures (Dennis, 1990; Dennis, Fairbank, Bonito, & Rachal, 1991; Dennis, 1994).

- a study of standard and enhanced treatment costs (Bradley, French, & Rachal, 1994).

The MET enhanced treatment condition was a 6-month multicomponent intervention that was based in part on McLellan and colleague's (1988) finding that effective drug abuse counselors conducted an organized and comprehensive assessment of client needs, developed a detailed treatment plan, conducted more frequent counseling sessions at regular intervals, and extensively used referral sources. Counselors who were randomly assigned to the enhanced treatment condition participated in training (Fairbank, Bonito, Dennis, & Rachal, 1991b) designed to develop and/or enhance the following counseling activities: (a) assessing clients' problems across multiple domains of functioning using the Addiction Severity Index

(ASI; McLellan, Luborsky, Cacciola, Griffith, McGahan, & O'Brien, 1985); (b) developing (with input from the client) an individualized treatment plan that focused on the attainment of short- and medium-term goals for problems identified in the ASI-based needs assessment; (c) conducting frequent counseling sessions with clients with a goal of meeting with clients twice a week; (d) using problem-solving counseling techniques adapted from the work of the Nezus and their colleagues (D'Zurilla, 1986; Nezu, Nezu, & Perri, 1989) and Jerome Platt and his colleagues (Platt & Metzger, 1987; Spivak, Platt, & Shure, 1976); (e) conducting more frequent urine tests for illicit drugs and using the results in counseling to address problems associated with drug use; (f) using contingency contracting during the first 3 months of treatment to increase compliance with attendance at counseling sessions and providing urine samples; and (g) using a community-services specialist (i.e., case manager) to assist the client in obtaining services, within the program and/or in the community, that address problems targeted in counseling (Bonito, Fairbank, & Rachal, 1991).

Given the complex needs of the clients and the pressing concern with AIDS, the study was designed with a multiple component intervention in an attempt to make it more comprehensive. Detailed measures of treatment components were developed to help identify key ingredients and client subgroups in observational analyses and as targets for subsequent study through a dismantling approach (Borkovec, 1990; Kazdin, 1983; Wolpe, 1958). Thus, the MET protocol was revised several times during the main study and again for this manual and replication in TEP.

The principal RTI researchers conducting the MET trials are:

- J. Valley Rachal, Principal Investigator;
- Dr. John A. Fairbank, Co-Principal Investigator
- Dr. Michael L. Dennis, Co-Principal Investigator

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The MET study was sponsored through a grant (NIDA Grant No. 1-R18-DA-07262-01) under the National AIDS Demonstration Research (NADR) program by the National Institute on Drug Abuse (NIDA). The Federal Project Officer's name and address are:

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Appendix B
Background on the Training and Employment Program (TEP) Study

The effectiveness of methadone treatment in reducing heroin use and improving productive behavior was demonstrated during the 1960s and 1970s. Its effectiveness in the 1980s, however, has been called into question and coincides with declines in the availability of counseling and vocational and other ancillary services. As counselor caseloads have gone up to 40 to 50 clients in many programs, counselors have been spending less time with each client and providing less individualized treatment. Although they are working with clients that typically have multiple complex problems, the level of counselor training and experience continues to vary within and across programs. Recent gains in using standardized needs assessments, for instance, have not been matched with training and information on how to use the resulting information. The Joint Commission on the Accreditation of Health Care Organizations (JCAHO) has, therefore, directed its evaluators to look for evidence that assessments are actually being interpreted, incorporated into treatment planning, and followed-up. While the need for vocational assistance is repeatedly the second most common problem (after substance abuse treatment) identified by counselors and clients at both intake and later phases of treatment, virtually no programs offer vocational services directly or indirectly.

The Training and Employment Program (TEP) Study attempted to address some of these issues. It was conducted collaboratively by RTI, Pathways Treatment Program, and PBA, The Second Step under grant number 1-R01-DA-07964-01 from the National Institute on Drug Abuse. The core components included:

- an interrupted times series study to evaluate the effectiveness of training counselors with a manual-driven therapy called Individualized Substance Abuse Counseling (ISAC). Because this treatment was designed to structure and individualize counseling, we expect it to improve client outcomes immediately and to become more effective as the counselors become more proficient (Dennis et al., forthcoming).

- A randomized field experiment to evaluate the effectiveness of providing additional human and financial resources to help with vocational and other ancillary services. This intervention was designed to provide both on-site specialists and workshops, and improve access to community resources. We expect it to improve client functioning in terms of vocational status, motivation to participate in vocational activities, and overall well-being (Dennis et al., 1993, & forthcoming).

- An observational study of how health issues relate to treatment and vocational needs, services, outcomes, and costs. This study also focused on how health issues vary for women and minorities and on resulting policy or program planning issues (Roland et al., forthcoming).

- An economic study of the cost and financing of methadone treatment and the marginal cost and cost-effectiveness of the counseling and vocational protocols. We particularly emphasized the implications of health care reform on treatment financing and the allocation of TEP services across different types of clients (French et al., 1994).

We have been collaborating with these participating programs and have data on their clients back to 1988 as part of the earlier Methadone Enhanced Treatment (MET) study, a pilot study for TEP, and (for Pittsburgh Only) the Drug abuse Treatment Outcome Study (DATOS). Clients were recruited through intakes, a volunteer list, and by randomly sampling them from the current client roster. Participation was voluntary and conducted under the supervision of RTI's Institutional Review Board. From July of 1993 to April of 1994 we recruited 390 clients and had a participation rate of approximately 83%.

In dealing with clients, RTI initially administers participation consent forms and confidential clinical assessment batteries. All participating clients start working with their counselors using the ISAC protocol, and half are randomly assigned to also work with a vocational services coordinator. Clients also complete initial and quarterly standardized needs assessments using the Global Appraisal of Individual Needs (GAIN), and complete an additional clinical assessment battery after 12 months. The GAIN is used both as a critical component of the clinical interventions and as the main study instrument and will be discussed in greater detail below. We are currently conducting studies to assess its reliability, how answers vary based on who administers it (primary counselor vs. an independent interviewer), its construct validity against the clinical assessment battery, and its predictive validity for understanding treatment needs and functioning.

For more information on the Training and Employment Program you can contact the study's principal investigator at RTI or one of the co-principal investigators at the two clinics:

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A detailed bibliography of available materials may be obtained from the authors.

The initial TEP pilot study was sponsored by a grant from the National Institute on Drug Abuse (NIDA Grant No. 1-R18-DA-06383-02) to Dr. Robert L. Hubbard. The current study is funded under a new grant (NIDA Grant No. 1-R01-DA-07964-01) to Dr. Michael L. Dennis. The Federal Project Officer is:

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Appendix C
Individualized Substance Abuse Counseling (ISAC) Counselor Training Syllabus
(3/31/95 Version)

Prepared by
J. Caddell, K. Bossert, A. Brown, & M. Dennis

1. Purpose

The purpose of this syllabus is to help to organize training for new staff on how to conduct Individualized Substance Abuse Counseling (ISAC). It was developed as part of the TEP study sponsored by NIDA and being conducted by the Research Triangle Institute (RTI) in collaboration with the Pathways Treatment Program of Sisters of Charity Hospital in Buffalo, NY; PBA, The Second Step, Inc in Pittsburgh, PA; and the Santa Clara County Methadone Treatment Program in San Jose, CA. This document is intended to serve as the first step in helping staff to provide individualized treatment, to involve their clients more in the treatment process, and to make treatment more structured. The information presented in the ISAC manual can be incorporated into a wide variety of counseling styles and philosophies. It assumes that counselors will be trained to do a Global Appraisal of Individual Needs (GAIN) or other standardized assessment (e.g., ASI, DATAR).

2. Materials

The trainer will need the following materials during the course of training.

- ISAC Manual
- Program Introduction Documents
- Overview of Staff Organization
- Treatment Plan Forms
- Staff Background Form
- Staff Confidentiality Agreement
- Client Informed Consent Form
- GAIN-A manual (or alternative instrument manual)
- GAIN Show Cards
- Blank GAIN-I
- Wilma (or Fred) GAIN-I
- Computerized Wilma (or Fred) GAIN Report
- Wilma Case Study
- 2 Blank Audio tapes

- Thought and Feelings Book (McKay, Davis, & Fanning, 1981)
- Actual client GAINs and Treatment Plans.

3. Overview and Introduction

Purpose: To introduce the materials, study, and staff related to ISAC and GAIN.

Materials: ISAC Manual, Program Introduction Documents, Overview of Staff Organization, Staff Background Form.

Activities:

a. The trainer will provide an overview of the materials and training using this syllabus.

b. The trainer will provide an overview of the program and staff organization.

c. The trainer will introduce the counselor to other staff and briefly review their roles. Four key people for training are the:
   - Administrative or Research Assistant (ARA),
   - Vocational Services Coordinator (VSC) or other type of case manager,
   - Clinical Supervisor (typically the trainer), and
   - Program Director.

d. The trainer will provide an overview of the ISAC approach using ISAC Manual, Section 3.1. It focuses on the following four components:
   - Standardized Needs Assessment,
   - Individualized Treatment Planning,
   - Problem-solving Counseling, and
   - Working with other Staff (including the VSC).

e. The trainer will discuss the importance of four key concepts underlying this approach using ISAC Manual, Sections 3.2 and 6.1:
   - the bases for self-efficacy,
   - client involvement in all phases of treatment,
   - small steps with a high likelihood of success, and
   - the role of a problem orientation.

f. The trainer will review the ISAC definition of successful rehabilitation from Section 3.3.

g. The trainer will review the steps involved in implementing the ISAC protocol using ISAC Manual, Section 3.4. These steps include:
   - performing the standardized needs assessment,
   - preliminary involvement of the VSC and other staff,
   - developing a treatment plan with the client's active involvement,

- meeting again with the VSC and other staff, and
- doing problem-solving counseling.

h. The trainer will have the counselor complete the staff background form and give it to the ARA.

4. Conducting Standardized Needs Assessments

Purpose: To provide an overview of the importance of conducting client needs assessments, the importance of conducting them in a standardized way, and an overview of some of the general rules for conducting standardized needs assessments.

Materials: ISAC Manual

Activities:

a. The trainer will use ISAC manual Section 4.1 to delineate the various domains of functioning that should be assessed in order to define the client's presenting problems and develop an appropriate treatment plan. Key points to be covered include:
   - Presenting problems which are not specific to substance abuse, but which are likely to have an impact on substance abuse treatment outcome can easily be overlooked without a systematic structured assessment.
   - Discussing sensitive issues with clients can often be awkward; a standardized assessment offers the counselor a structure within which to ask these sensitive but often crucial questions.
   - By systematically determining the multiple treatment needs of clients, counselors should be able to make better use of available treatment resources, including other clinic staff and referral agencies.

5. Global Appraisal of Individual Needs (GAIN) Training

Purpose: To provide an introduction and initial training on administering the Global Appraisal of Individual Needs as the standardized needs assessment.

Materials: GAIN-A Manual (Rourke & Dennis, 1995), Staff Confidentiality Agreement, Blank GAIN-I, GAIN Show Cards, Wilma (or Fred) Examples

Activities:

a. The trainer will use GAIN-A Manual, Section 1.0 to provide background information on the GAIN. The key points include that the GAIN was developed:
   - specifically for substance abuse clients;
   - in collaboration with treatment providers, researchers, and government officials;
   - to meet as many federal, state, local and funding reporting requirements as possible; and
   - to help the counselor identify and prioritize historical problems, current functioning, and potential treatment needs.

b. The trainer will use GAIN-A Manual, Sections 2.1 and 2.2 to review the general interviewing conventions. These conventions include:
   - ask the questions using the exact words printed in the questionnaire;
   - ask the questions in the exact order in which they appear in the questionnaire;
   - ask every question specified in the questionnaire;
   - read the complete question;
   - repeat questions that are misinterpreted or misunderstood by the respondent;
   - read the questions slowly;
   - do not suggest answers to the respondent;
   - use introductory or transitional statements as they are printed in the questionnaire;
   - use neutral probes only as necessary; and
   - listen to the responses.

   Special emphasis should be given to the following points:
   - the assessment should reflect the client's responses;
   - the counselor's opinion and concerns should only be reflected in the items provided for this purpose and/or in the general notes sections of the GAIN;
   - the counselor should be unbiased when conducting the interview and should refrain from commenting or probing until the GAIN is completed; and
   - probing and clarification should be conducted during the feedback session with the client.

c. The trainer will use GAIN-A Manual, Section 2.3 to explain the general questionnaire conventions used in the GAIN. These include:
   - words or phrases in capital letters do not have to be read aloud to the client;
   - words in parentheses () are alternative or optional wordings;
   - words in parentheses and (CAPITAL LETTERS) are used to indicate the need for the interviewer to supply a word;
   - underlined words should be emphasized when read;
   - capitalized words in brackets and [BOLD PRINT] are interviewer instructions;

- for questions containing dots (...) followed by concluding phrases, the interviewer can read the opening phrase once followed by all the concluding phrases; if necessary (e.g., the respondent is confused), the interviewer can read the opening phrase with each concluding phrase;
- skip instructions are used to help the interviewer ask only applicable questions;
- specify and verbatim (v._____) lines are 30 character fields used to provide additional information that will appear in the computerized GAIN report;
- instructions to clarify and code mean that the interviewer should obtain enough information to categorize the client's response into one of the available categories;
- instructions to total numeric values of answers are used to manually score measures of functioning; and
- recency questions allow the client to answer questions referencing time frames in terms of age or year (and month if within the past two years).

d. The trainer will use GAIN-A Manual, Section 2.4 to review the standard recording conventions. These conventions are:
   - use a black pen or pencil;
   - record all responses immediately;
   - use standard abbreviations;
   - record answers by either circling a response code, filling in a number, assigning a response code or recording a verbatim response; and
   - edit your own work.

e. The trainer will use GAIN-A Manual, Section 2.5 to present information for conducting the actual interview. This information includes:
   - preparing for the interview;
   - presenting the GAIN and yourself to the respondent;
   - gaining acceptance for the assessment and ISAC approach;
   - establishing a reasonably quiet and private setting for the interview;
   - balancing rapport and objectivity;
   - giving appropriate guidance and using neutral probes; and
   - handling awkward questions.

f. The trainer will use GAIN-A Manual, Section 2.6 to present information on administrative and professional standards as they related to the assessment and the confidentiality of the client's responses. Topics to cover include:
   - standards of professional ethics;
   - expectations for anonymity and confidentiality;
   - client informed consent; and
   - staff confidentiality agreement (included as Exhibit 2.3 in the GAIN-A Manual).

g. The trainer will have the counselor complete the staff confidentiality agreement and give it to the appropriate ARA.

h. The trainer will use GAIN-A Manual, Section 3.0 and the Wilma (or Fred) GAIN to go through a mock GAIN interview with the counselor. Specific training activities include:
   - model the appropriate method for setting up the interview;
   - model interviewing techniques by administering the first section of the GAIN to the ARA, posing as Wilma (or Fred);
   - have the counselor administer the remainder of the interview to the trainer, posing as Wilma or Fred;
   - give the counselor an opportunity to become familiar with the instrument and provide ongoing feedback;
   - identify both correct and incorrect things the counselor is doing;
   - identify incidents when the counselor is deviating from the interview in terms of wording, style, or question order;
   - answer the questions that come up related to interpretation;
   - explain the counselor ratings at the end of each section and at the end of the instrument; and
   - explain the Short Blessed Scale for determining if the person is cognitively impaired.

i. The trainer will have the counselor field edit the mock GAIN and give it to the ARA.

j. The ARA will edit the mock interview and give the counselor feedback on recording practices.

k. The ARA serves as an additional mock client. This is to give the counselor additional practice administering the GAIN.

l. Ideally, the counselor should be given the opportunity to observe another counselor administering an GAIN.

6. Working with the VSC, CSC, and other staff

Purpose: To identify the need and mechanisms for working with the VSC and other staff in the ISAC protocol.

Materials: ISAC Manual, Wilma (or Fred) GAIN case study, VSC Workplan.

Activities:

a. The trainer will use ISAC manual Sections 2.0 and 7.0 to illustrate the diversity of client need, and to discuss the fact that client needs often extend beyond what can typically be handled in the context of counseling.

b. The trainer and other staff will provide the counselor with an overview of the kind of services that can be provided. Some of these services might include:
   - defining vocational readiness in terms of clients who are job ready, training ready or pre-vocational;
   - job search, development, and support services for job ready clients;

- remedial, skills training, coursework, and support for training ready clients;
- personal growth and development for prevocational clients;
- ancillary service to address vocational barriers and other needs (including transportation, child care, medical needs, clothing, work equipment, housing, legal assistance, driver's licenses, financial assistance, certification and family needs);
- physical exams and referrals;
- HIV, STD, and other types of testing; and
- primary care.

c. The trainer and other staff will review other programs and local resources that can be accessed or used to help address client needs.

d. The trainer will have the counselor review the Wilma (or Fred) case study as an example of ways that the other staff can assist in identifying clients' needs.

7. Using the GAIN for Staffings, Feedback to Clients, and Defining Treatment Issues

Purpose: To show how the GAIN is used in staffings, to provide clients with feedback, to help identify and prioritize potential treatment issues, and to help define the presenting problems.

Materials: ISAC Manual, Wilma (or Fred) GAIN case study, GAIN computer generated report.

Activities:

a. The trainer will provide an overview of how the GAIN report is presented in staffings and arrange for the counselor to observe another counselor present a case during a staffing using the GAIN report.

b. The trainer will use ISAC Manual, Section 5.0 to provide an overview of how the GAIN is used and Section 5.2 to describe how feedback should be provided to clients. This will include:
- using the completed GAIN and input from the staffing to identify critical areas and areas that need further clarification;
- giving feedback to clients and seeking clarification; and
- identifying potential treatment issues and problems

c. The counselor will then practice by using the mock GAIN with the trainer, providing feedback, identifying potential treatment issues and specifying problems that will be the focus of treatment intervention Specific practice activities include:
- clarifying or correcting errors or inconsistencies;
- clarifying a problem that may impact more than one area of the client's life;
- giving the client concise feedback on his or her problems;

- prioritizing the problem areas that will be targeted in the treatment plan; and
- developing an "objective" statement of 1 or 2 key problems.

d. The trainer should have the counselors observe the staffing and feedback session for a client that completed an GAIN. If the counselor observed an GAIN being administered, then the trainer should have the counselor observe the staffing and feedback session for that client.

8. Problem Solving Counseling

Purpose: To explore how problem solving counseling provides a framework for structuring counseling and integrating the various components of the ISAC protocol.

Materials: ISAC Manual, Thoughts and Feelings Text (McKay, Davis, & Fanning, 1991)

Activities:

a. The trainer will uses ISAC Manual, Section 6.0 and the Thoughts and Feelings text to present information on how to incorporate problem-solving counseling into day-to-day practice. This information will include:
   - introducing clients to problem solving counseling;
   - encouraging clients to adopt a problem solving orientation;
   - helping clients to objectively define problems;
   - working with clients to generate alternative solutions;
   - encouraging clients to develop decision making skills;
   - encouraging clients to implement solutions and monitor effectiveness; and
   - contingency contracting and other tools.

b. The trainer and counselor will practice reverse role playing, identifying distorted thinking, and problem reclassification exercises to help the counselor become familiar with the techniques designed to help clients define problems and see them as solvable.

c. The trainer will have the counselor practice using brainstorming and evaluating consequences exercises to simulate problem-solving session.

9. Individualized Treatment Planning

Purpose: To show how to use the problem-solving approach to develop individualized treatment plans with the client and how to make the plans more clinically useful by focusing on short steps.

Materials: ISAC Manual, Wilma (or Fred) GAIN, example treatment plan in case study, blank treatment plan forms.

Activities:

a. The trainer will use ISAC Manual, Section 5.2.3 to review many of the common life problems and critical issues that are relevant for substance abuse treatment clients.

b. The trainer will use ISAC Manual, Section 5.2.2 to demonstrate specifying possible short and long term goals for the treatment plan related to the problem areas identified in the mock GAIN. The trainer will use ISAC Manual, Section 5.3 to explain and demonstrate how brainstorming can be used to generate alternative strategies to address identified problems and accomplish treatment goals. Key points to review include:
   - start by reviewing an objective statement of the problem;
   - generate lots of ideas for addressing the "problem";
   - get the client involved; and
   - defer judgement or critical evaluation of suggested alternatives to address the problem until the list is complete.

c. The trainer will use ISAC Manual, Section 5.4 and the Thoughts and Feelings "Evaluate the Consequences" exercise to present how to guide the client in evaluating the treatment plan options for one of the problems identified during the mock interview. Some of the issues to consider in comparing options include:
   - the likelihood that it will address the problem;
   - the likelihood that the client will be capable of implementing the option; and
   - the personal and financial costs of implementing the option.

d. The trainer will review the example treatment plan in the Wilma (or Fred) case study with the counselor.

e. The trainer and counselor will use ISAC Manual, Section 5.5 as a guide to develop practice treatment plan objectives. Things to consider include:
   - focus on objectives that can be reasonably accomplished in the next 90 days or, if sooner, until the next formal treatment plan;
   - develop informal short term steps that can be accomplished during the sessions preceding formal treatment plan updates to help accomplish the 90-day goals;
   - teach the client to take small steps in reaching his or her goals and to take note of the small accomplishments; and
   - make sure that each small step has a high likelihood of success.

f. The trainer should review with the counselor one or more actual treatment plans developed by other counselors based on the ISAC protocol.

g. If the counselor observed an GAIN being administered, then the trainer should have the counselor review the treatment plan for that client.

10. Administrative Procedures

Purpose: To identify the administrative procedures for recruiting clients, processing paperwork and keeping counselors informed of progress.

Materials: Outline of Program's Administrative Procedures.

Activities:

a. The ARA will go through the processes by which clients are recruited and information is processed. Specific activities that will be covered include:
   - eligibility criteria;
   - recruitment procedures;
   - client consent forms;
   - clinical assessment; and
   - processing of GAINs and GAIN reports.

b. The trainer will review how the administrative procedures are related to other program activities and requirements.

c. The trainer will review the current treatment program protocols for case management, time management, and communications.

11. Feedback on Initial Cases

Purpose: To provide staff with feedback on their initial GAINs, feedback sessions, and treatment plans.

Materials: Actual client GAINs and Treatment Plans, 2 blank audio tapes.

Activities:

a. The counselor will audio tape the first 1-2 GAINs and give them to the trainer for review.

b. The trainer will review the audio tapes and GAINs and provide the counselor with oral feedback.

c. The trainer will review treatment plans for the initial 1-5 clients and provide oral feedback to the counselor.

d. The trainer will ask all staff for feedback on the protocol and be responsible for relaying it to the program director on a monthly basis.

12. Follow-up Training on GAIN-Q

Purpose: To check on implementation within the first 3 months and to provide a refresher training for the quarterly follow-up.

Materials: Actual client GAINs, treatment plans, blank GAIN-Qs, Wilma (or Fred) GAIN-Q.

Activities:

a. The trainer will review all GAINs and treatment plans for the first 3 months and provide the counselors with oral feedback.

b. The trainer will meet with the counseling staff to review the implementation and feedback to date.

c. The trainer will provide training on the GAIN-Quarterly (GAIN-Q) follow-up interview. This will include:
   - a summary of how it differs from the GAIN-I;
   - a mock practice session; and
   - a mock feedback session in which it is compared to the previous GAIN(s) and treatment plan.