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COUNSELING APPROACHES TO PROMOTE RECOVERY FROM PROBLEMATIC SUBSTANCE USE AND RELATED ISSUES – MODULE 2

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About the Instructor:

Dr. John H. Tinsley is a former assistant professor of Medical Physiology at the Texas A&M University System College of Medicine. He received his Ph.D. from Texas A&M University, College Station, Texas; M.S. from the University of North Carolina; and his B.S. from the University of Oklahoma.

He has been teaching, training, consulting and conducting research in the fields of Medical Physiology and Behavioral Biology for over twenty-nine years. Dr. Tinsley has authored over twenty-five professional and refereed articles, including invited reviews. He has been a member of the American Society for Physiology, and work done in 2001 led to an international award from The European Society on Microcirculation. Dr. Tinsley has received research funding from the Veteran's Administration, American Heart Association, and Scott and White Hospital. In addition, he has served on numerous review committees for national grant-funding agencies and scientific journals.

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The CEUMatrix – The Institute for Addiction and Criminal Justice Studies homepage (www.ceumatrix.com) contains many pieces of information and valuable links to a variety of programs, news and research findings, and information about credentialing – both local and national. We update our site on a regular basis to keep you apprised of any changes or developments in the field of addiction counseling and credentialing. Be sure to visit our site regularly, and we do recommend that you bookmark the site for fast and easy return.

COUNSELING APPROACHES TO PROMOTE RECOVERY FROM PROBLEMATIC SUBSTANCE USE AND RELATED ISSUES – MODULE 2

In Module 2 readers will learn that:

- Recovery-oriented counseling calls for counselors to possess certain competencies to work with clients effectively and empathetically.
- Counselors need to take into account a range of sociocultural considerations when assessing and working with clients in or seeking recovery, which requires cultural responsiveness and an awareness of treatment barriers and inequities stemming from sociocultural factors.
- A strengths-based approach is fundamental to recovery-oriented counseling, beginning with client intake and continuing throughout the duration of care.
- Recurrence of substance use happens, but recovery-oriented counseling can help clients avoid it or confidently return to recovery when it does occur.
- Counselor participation in recovery-oriented systems of care can benefit clients by promoting holistic, coordinated, and nonepisodic services.
- Depending on the setting, counselors providing or thinking of providing recovery-oriented counseling may need to consider the ways that payment systems can affect delivery of care.
- Counselors can use multiple evidence-based psychosocial interventions and frameworks to help clients achieve their recovery goals, including harm reduction, trauma-informed care, motivational interviewing, cognitive–

behavioral therapy, contingency management, mindfulness, acceptance and commitment therapy, and psychoeducation.

- Many psychosocial interventions and frameworks can be effectively combined to increase the odds of clients maintaining their recovery and preventing recurrence, regardless of their chosen recovery pathway.

Counseling Approaches To Promote Recovery From Problematic Substance Use and Related Issues

TREATMENT IMPROVEMENT PROTOCOL

TIP65

SAMHSA
Substance Abuse and Mental Health Services Administration

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Exhibits

Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the U.S. Department of Health and Human Services agency that leads public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes. An important component of SAMHSA's work is focused on dissemination of evidence-based practices and providing training and technical assistance to healthcare practitioners on implementation of these best practices.

The Treatment Improvement Protocol (TIP) series contributes to SAMHSA's mission by providing science-based, best-practice guidance to the behavioral health field. TIPs reflect careful consideration of all relevant clinical and health services research, demonstrated experience, and implementation requirements. Select nonfederal clinical researchers, service providers, program administrators, and patient advocates comprising each TIP's consensus panel discuss these factors, offering input on the TIP's specific topics in their areas of expertise to reach consensus on best practices. Field reviewers then assess draft content, and the TIP is finalized.

The talent, dedication, and hard work that TIP panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of care and treatment of mental and substance use disorders. My sincere thanks to all who have contributed their time and expertise to the development of this TIP. It is my hope that clinicians will find it useful and informative to their work.

Miriam E. Delphin-Rittmon, Ph.D.
Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
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Executive Summary

Key Messages

- Recovery from problematic substance use is a highly personal journey toward wellness, satisfying relationships, engagement in community, and a sense of meaning and purpose. Although setbacks happen, people can and do recover.
- Many people recover from problematic substance use without help, but individuals are more likely to experience long-term recovery if they have access to a combination of counseling services, peer- and community-based recovery supports, and medication.
- A recovery-oriented approach to counseling accepts that recovery from problematic substance use has many pathways and works with the individual's chosen recovery goal. That goal could be abstinence, controlled use, or somewhat reduced use.
- People with problematic substance use should have access to recovery-oriented systems of care (ROSCs), where providers offer these individuals treatment, recovery support, and other services and take a long-term, coordinated, and holistic approach to addressing their substance use–related problems.
- Certain counseling approaches can be effective at helping individuals with problematic substance use maintain their recovery regardless of their chosen recovery pathway. These include harm reduction, trauma-informed approaches, motivational approaches, family therapy, cognitive–behavioral therapy, contingency management, mindfulness and acceptance-based approaches, and psychoeducation.
- Peer support services enhance counseling by connecting individuals in recovery to nonclinical professionals who have lived experience with problematic substance use, behavior change, and recovery.
- Four major domains that support a life in recovery are health, home, purpose, and community. Counselors can help their clients recover from problematic substance use by connecting them to a range of tools and resources in these domains.
- An organization interested in adopting a recovery-oriented approach should reorient its mission statement, policies and procedures, staff training, and measures of client outcomes around consumers and their recovery needs and goals.
- An organization interested in becoming a member of a ROSC should take steps to actively link to other resources within the community that can provide recovery support in areas that the organization itself may not currently offer.
- Including people with lived experience in recovery from problematic substance use in an organization's staffing and treatment planning can support successful, sustainable implementation of recovery-oriented practices.

Recovery, as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[1] Recovery is a highly individualized journey. Some view recovery in terms of abstinence and remission of symptoms, whereas others may focus on controlling or reducing use. Some people may pursue multiple approaches to recovery at the same time or for overlapping periods; some may try different approaches in turn; and others may find a single approach that works for them and stick with it. Regardless, a person's recovery is built on their strengths, abilities, resources, and inherent values and is holistic, addressing the whole person and their community.[2] Although many face challenges and setbacks, with the right supports, anyone can recover successfully.

The benefits of recovery from problematic substance use are wide-ranging. They include improvements in a person's physical health, emotional well-being, relationships, school and career achievement, and financial security.[3] These benefits also extend well beyond the individual, positively affecting families, workplaces, communities, and society.

Counselors play a critical role in helping individuals in or seeking recovery achieve their recovery goals and in supporting them as they develop the skills needed for long-term recovery. Recovery-oriented counseling is essential to this process. Through recovery-oriented counseling, counselors support their clients* by:

- Identifying and building on the strengths of a client in or seeking recovery.
- Letting the client's preferred recovery goals and pathway shape their work together.
- Taking a supportive approach to addressing recurrence, should it occur.
- Connecting the client to recovery support services and other forms of assistance and activities that can strengthen their recovery and improve their well-being and quality of life for the long term.

This Treatment Improvement Protocol (TIP) provides guidance to counselors, administrators, and supervisors about recovery-oriented services, supports, and care, allowing them to better serve those individuals in or seeking recovery from problematic substance use.

The Need for a TIP on Promoting Recovery From Problematic Substance Use

Problematic substance use is a major public health and social concern in the United States. In 2021, SAMHSA estimated that 46.3 million people had a substance use disorder (SUD) in the past year.[4] Although alcohol use disorder was the most common SUD, much of the concern about problematic substance use has focused on the opioid epidemic. An estimated 5.6 million people had past-year opioid use disorder (OUD) in 2021.[5]

The rates of stimulant use and stimulant-related deaths are also quickly rising. From 2015 to 2019, overdose deaths involving psychostimulants (other than cocaine) increased 180 percent, and methamphetamine use increased 43 percent.[6] From 2019 to 2021, cocaine-involved overdose deaths increased nearly 54 percent.[7] There are no Food and Drug Administration–approved medications to treat stimulant use, highlighting the significant need for effective recovery supports for those with problematic use. Counselors, administrators, and clinical supervisors with

**Although the literature may reference "client," "consumer," "patient," and "participant" interchangeably, this TIP uses the term "client" to refer to* individuals receiving services for problematic substance use*. Counselors who provide these services frequently use the term "client," and they are the primary audience for this document.*

a strong understanding of recovery-oriented approaches and tools are necessary to address this growing national problem.

For decades, the main approach to addressing problematic substance use involved acute, episodic, specialized treatment that emphasized abstinence. The objective was always to help clients achieve and maintain long-term recovery, but treatment focused on perceived client deficits and provider-determined goals. Also, such treatment was typically siloed professionally and physically from other types of care and services.[8,9] Although this model continues to exist in much of the specialty SUD treatment field, approaches to problematic substance use are becoming more recovery oriented as a result of recent research, clinical experience, and advocacy by the recovery community.[10] With this evolution comes a need for counselors and their colleagues working with people with problematic substance use to have a strong understanding of recovery-oriented concepts and approaches. This need has prompted the publication of this TIP.

Using this TIP, counselors, administrators, and clinical supervisors who work with individuals in or seeking recovery from problematic substance use will:

- Become familiar with the main categories of recovery pathways.
- Understand how to help clients explore different pathways to recovery.
- Learn how to support their clients' choice of pathways.
- Be able to link clients to different pathways (other than natural recovery).
- Understand recovery-oriented supports and counseling approaches.
- Learn about resources and tools to help clients lead a life in long-term recovery.

Scope of This TIP

This TIP offers guidance on counseling approaches that can help support adults in or seeking recovery from problematic substance use. It is intended to help counselors, program administrators, and clinical supervisors promote recovery for their adult clients across many settings and along a continuum of recovery pathways—from harm reduction to abstinence.

Audience

The primary audience for this TIP is anyone who may provide counseling to an individual who has a problem with substance use, regardless of the reason that individual sought out the provider. This includes counselors in multiple settings, nonspecialists in training, nurses, and interns working toward clinical licensure. It also includes administrators, clinical supervisors, and other staff interested in adopting or expanding a recovery-oriented framework for the counseling offered in their programs. Although peer specialists don't provide counseling, they may also find aspects of this TIP helpful.

Organization

This TIP contains six chapters:

- **Chapter 1** presents the origins and treatment of problematic substance use and introduces recovery concepts and supports.
- **Chapter 2** offers ways counselors can work with clients to identify their natural supports, coping skills, talents, and abilities.
- **Chapter 3** explores counseling approaches that can support individuals in recovery from problematic substance use.
- **Chapter 4** discusses four major domains to support recovery (health, home, purpose, and community) and related tools to support a life in recovery for those with problematic substance use.

- **Chapter 5** is for administrators, clinical supervisors, and other staff concerned with the operation of their program who wish to adopt or expand a recovery-oriented framework using counseling approaches that promote recovery from problematic substance use.
- **Chapter 6** is a compilation of useful resources for counselors supporting clients in or seeking recovery from problematic substance use.

Exhibit ES.1 defines key terms that appear throughout the TIP. A breakdown of each chapter's key concepts and messages follows thereafter.

EXHIBIT ES.1. Key Terms

- **Addiction:** Addiction to substances is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with this type of addiction use substances or engage in substance use–related behaviors that become compulsive and often continue despite harmful consequences.
- **Mutual-help programs:** Nonprofessional groups in which members share the same or similar problems, value experiential knowledge, and support one another in recovery from those problems. Mutual-help programs may be secular (e.g., Women for Sobriety, Secular Organizations for Sobriety, Self-Management and Recovery Training [SMART] Recovery®); spiritual (e.g., 12-Step programs like Alcoholics Anonymous® [AA], Narcotics Anonymous [NA®], Double Trouble in Recovery, Medication-Assisted Recovery Anonymous [MARA®]); or religious (e.g., Celebrate Recovery®, Jewish Alcoholics, Chemically Dependent Persons, and Significant Others, Millati Islami, Refuge Recovery).
- **Peer support services (PSS):** The range of services designed, developed, and delivered by peer workers who have lived experience in recovery from problematic substance use can fill a range of roles to support other people in recovery. Examples of services that peer workers provide include advocacy and linkages to recovery services, recovery coaching, recovery support groups, and educational workshops.
- **Peer worker:** In general, any person (or in the case of a family peer worker, a close friend, family member, or other loved one of an individual) with lived experience in recovery from substance use disorders (SUDs), mental disorders, or both who provides nonclinical support in establishing and maintaining long-term recovery.[11] The term **peer worker** encompasses peers working in professional (employed) or volunteer capacities, regardless of whether their work is tied to formal, organized treatment or recovery services. Peer workers support people in recovery, including by working with them on their recovery plans; conduct strengths-based outreach and engagement; connect people in recovery with recovery resources; facilitate and lead recovery groups; and build community, among other activities. They sometimes have such titles as recovery coach, mentor, peer provider, or similar terms. **Peer specialist** (short for peer recovery support specialist) refers specifically to peer workers with some training, including those working in a professional capacity. **Certified peer specialist** refers specifically to a certified/credentialed peer worker, including one working in a professional capacity.
- **Problematic substance use:** The use of any substance in a manner, situation, amount, or frequency that causes harm to the person using the substance or to those around them; it replaces the outdated terms "substance abuse" and "substance misuse." In the case of prescription medications, problematic use is any use other than as prescribed or directed by a healthcare professional. For some substances (e.g., heroin, cocaine) or individuals (e.g., those who engage in injection drug use), any use constitutes problematic use. Problematic substance use is a broad term and can include use that constitutes an SUD. (All people with SUDs have had problematic substance use, but not all problematic use meets diagnostic criteria for an SUD.)

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- **Recovery:** SAMHSA defines recovery as "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential" and acknowledges that recovery can occur via many pathways.[12] Recovery occurs when positive changes and values become part of a voluntarily adopted lifestyle.
- **Recovery capital:** The internal and external strengths and assets available to establish and maintain an individual's recovery (e.g., access to health care, supportive relationships, work/schooling, self-esteem, safe housing).
- **Recovery-oriented system of care (ROSC):** A coordinated network of community-based, person-centered services and supports that builds on the strengths and resiliencies of individuals, families, and communities to recover and improve health, wellness, and quality of life for those who currently experience, previously experienced, or are at risk of experiencing problematic substance use.
- **Recurrence:** A recurrence of **problematic substance use** after a period of remission. Recurrences are often part of recovery; recovery does not mean an absence of recurrence. This term is preferred over **relapse**, which appears frequently in the research literature but does not reflect a person-first, recovery-oriented perspective. However, the TIP uses **relapse** on rare occasions when referring directly to the literature or to a program, service, or resource that itself uses the term.
- **Remission:** The text revision to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR) defines remission as present in people who previously met SUD criteria but no longer meet any SUD criteria (with the possible exception of craving).[13] Clients may be in early remission (not meeting any criteria for SUD for at least 3 months, but less than 12 months) or sustained remission (not meeting any criteria for SUD for 12 months or longer).[14]
- **Substance use disorder (SUD):** A medical illness caused by repeated, problematic use of a substance or substances. According to DSM-5-TR,[15] SUDs are characterized by a cluster of cognitive, behavioral, and physical symptoms that can impair health, social function, and control over substance use. SUDs range from mild to severe. They typically develop gradually over time with repeated use, leading to changes in the brain that affect reward, stress, and executive functions like decision making and self-control. Multiple factors influence whether and how rapidly a person will develop an SUD. These factors include the substance itself; the genetic vulnerability of the person using the substance; the amount, frequency, and duration of use; and environmental and psychological variables.
- **Substance use–related problems:** The range of undesirable issues that may result from problematic substance use, including poor job performance or unemployment; troubled friend, family, or intimate partner relationships; financial difficulties; accidents; mental, physical, or behavioral problems; criminal justice involvement; child custody disputes; and homelessness. The harm these ensuing problems cause may continue beyond the period of active substance use. This term is synonymous with **substance use–related issues**, issues or problems related to substance use, and similar terms.
- **Treatment:** Time-limited, paid services delivered in clinical or acute-care settings by providers who are trained in specific treatment approaches. Often, clients must meet specific qualifications to receive treatment.

Chapter 1: Introduction to Recovery From Problematic Substance Use

Chapter 1 of this TIP introduces the concept of recovery from problematic substance use, including the principles and different pathways of recovery (Exhibit ES.2). The chapter also discusses the evolving understanding and treatment of problematic substance use, the history of the modern recovery movement, and some current recovery research.

In Chapter 1, readers will learn that:

- Recovery from problematic substance use is a process of change that may or may not have abstinence as a goal. Recovery has many pathways.
- The concept of problematic substance use has evolved from misunderstanding it as a moral failure, to thinking of it as a disease, to, increasingly, applying a biopsychosocial model that considers an individual's lived context.
- The service landscape and the workforce for addressing problematic substance use are changing, as are the entry points for treatment of problematic use.
- Peer support services have been found to support individuals with problematic substance use in initiating, strengthening, and sustaining recovery.
- Any recurrence of use may be preceded by warning signs; counselors should be aware of these signs and be prepared to adjust the support they provide.
- Individuals with problematic substance use should have access to recovery-oriented systems of care (ROSCs), in which providers of treatment, recovery support, and other services take a long-term, coordinated, and holistic approach to addressing individuals' substance use–related problems.
- Recovery-oriented counseling for problematic substance use can take place in a wide variety of settings, including specialty SUD treatment settings. Some of these are:
  - Specialty SUD treatment settings (e.g., outpatient treatment programs, intensive outpatient programs).
  - Recovery settings (e.g., recovery community organizations, recovery housing, collegiate recovery programs).

EXHIBIT ES.2. Principles of Recovery

Guiding principles of recovery for people with problematic substance use were first defined on a national level by a diverse panel of stakeholders—including individuals in recovery, family members, representatives of mutual-help organizations, treatment providers, and government officials—during the 2005 National Summit on Recovery convened by SAMHSA.[16] Another meeting of stakeholders in 2010, plus a yearlong national dialog, both held by SAMHSA, further developed the principles of recovery: this time from a combined mental health and substance use perspective.[17]

The resulting principles, listed below, underscore the importance of understanding recovery from the individual's point of view and incorporating that viewpoint into the delivery of behavioral health services, including counseling.

Principles of Recovery

- Recovery emerges from hope.
- Recovery is person driven.
- Recovery occurs via many pathways.
- Recovery is holistic.
- Recovery is supported by peers and allies.
- Recovery is supported through relationships and social networks.
- Recovery is culturally based and influenced.
- Recovery is supported by addressing trauma.
- Recovery involves individual, family, and community strengths and responsibility.
- Recovery is based on respect.

A description of each principle can be found at https://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF.

- Mental health service settings (e.g., outpatient mental health facilities, psychiatric hospitals).
- Medical settings (e.g., primary care practices, hospital emergency departments).
- Harm reduction settings (e.g., syringe services programs).
- Educational settings (e.g., schools, alternative education settings).
- Criminal justice–related settings (e.g., treatment courts, probation and parole agencies).
- Social services settings (e.g., child welfare agencies, youth programs).
- Rehabilitation settings (e.g., private and public rehabilitation agencies, vocational rehabilitation agencies).[18]

Chapter 1 provides a more extensive list of settings.

Chapter 2: Framework for Supporting Recovery With Counseling

Chapter 2 of this TIP discusses how counselors can work with clients in a person-centered way to identify their natural supports, coping skills, talents, abilities, recovery goals, hopes, and dreams for the future. It also provides a framework for recovery-oriented counseling and ways that payment systems can affect the delivery of care for counselors in healthcare and behavioral health service systems.

In Chapter 2, readers will learn that:

- To provide clients with consistent and high-quality care, counselors need a common foundation of knowledge and skills, including the recovery-oriented competencies discussed in Exhibit ES.3.
- Counselors should consider sociocultural factors when working with clients with problematic substance use.
- Being culturally responsive, incorporating culturally appropriate knowledge and communication, and developing an awareness of treatment barriers and inequities stemming from sociocultural factors is critical. With culturally responsive approaches, clients are more likely to feel heard, empowered, and safe, which can translate into stronger engagement in treatment and recovery services.

EXHIBIT ES.3. Competencies for Recovery-Oriented Counseling

The consensus panel for this TIP identified competencies for counselors working with individuals who have problematic substance use. Counselors should:

- Possess an understanding of substances, problematic substance use, and addiction treatment and recovery.
- Possess an understanding of mental conditions.
- Have a general understanding of common co-occurring medical conditions.
- Provide treatment using a trauma-informed approach.
- Understand how to establish a therapeutic alliance.
- Identify and address health disparities.
- Understand how to assess social determinants of health with individual clients.
- Use a strengths-based, person-centered approach.
- Know how to link clients to treatment and community recovery resources and actively do so.
- Adhere to professional and ethical standards.
- Engage in recovery advocacy.

Chapter 2 has more information and resources related to each of these competencies.

- A strengths-based, person-centered approach is fundamental to recovery-oriented counseling, beginning with client intake and continuing throughout the duration of care. A major part of this approach is respecting clients' recovery goals, which may or may not include abstinence.
- Recurrence of problematic use does happen, but recovery-oriented counseling can help clients avoid it or return to recovery when it does occur.
- Counselors who provide recovery-oriented counseling may need to consider the ways that payment systems can affect delivery of that care as well as the potential benefits of providing counseling for people in recovery in the context of a ROSC.

Chapter 3: Counseling Approaches for Promoting Harm Reduction and Preventing Recurrence

Chapter 3 of this TIP is for counselors and discusses counseling approaches that can support people in recovery from problematic substance use. These approaches include harm reduction, trauma-informed care, motivational approaches, family therapy, cognitive–behavioral therapy, contingency management, mindfulness and acceptance-based approaches, linkages to peer and community-based support services, and psychoeducation.

In Chapter 3, readers will learn that:

- Many counseling interventions and frameworks can be effectively combined to increase the likelihood of clients maintaining their recovery, regardless of their chosen recovery pathway. Cognitive–behavioral therapy, motivational interviewing, and contingency management are among the most effective treatments for problematic substance use.
- Harm reduction is an approach designed to encourage positive change and reduce negative health-related consequences of risky behaviors that may be associated with substance use. Several evidence-based harm reduction methods can help support a client's recovery from problematic substance use, including safer injection practices, syringe services programs, overdose education and naloxone distribution, test strips to check drugs for fentanyl, sexual health education and supports, protective behavioral strategies, and client goal-setting practices.
- Family and social support are critical to the recovery of individuals with problematic substance use. Family therapy approaches can strengthen families, improving the health and well-being of both the person in recovery and their family.
- Medications to support recovery from problematic substance use can help manage withdrawal symptoms and cravings and reduce the potential of a recurrence to use. Medication is more effective when counseling and other behavioral health therapies are included. However, counseling should not be a requirement for clients to receive medications. For those with OUD, medication is the most effective treatment and standard of care.

Although mindfulness and acceptance-based approaches have been studied less rigorously, they have been used effectively with individuals in recovery.

Chapter 4: Counseling Approaches for Sustaining Recovery and Promoting a Healthy Life

Chapter 4 discusses the four major domains to support a life in recovery: health, home, purpose, and community. The chapter also offers resources and tools for counselors to use with their clients that can support their growth in these domains.

In Chapter 4, readers will learn that:

- Living a healthy lifestyle and having an overall sense of well-being is vital for individuals in recovery to manage their lives and feel they can live to their full potential. Counselors can help clients by encouraging them to eat a nutritious diet; engage in some type of exercise; develop healthy sleeping habits; obtain medical, dental, and vision care; and receive ongoing care for any chronic disease, such as diabetes, hypertension, and HIV/hepatitis C. Clients may also need support to connect with preventive and primary care and sexual health services as well as in overcoming barriers to receiving care.
- Housing is necessary to support the long-term recovery of people with problematic substance use. It sets a foundation from which an individual in recovery can thrive. However, those with problematic substance use may face barriers to obtaining and maintaining stable housing due to discrimination, systemic disenfranchisement, or having a criminal background or poor credit history. To support clients in this area, counselors should be aware of the barriers clients may face and provide information and resources about how to maintain stable housing and help clients develop life skills, including how to make and stick to a budget, how to get out of debt, and how to manage monthly bills. Counselors should also connect clients with a case manager or social worker to assist with additional housing needs.
- Developing a sense of purpose allows clients to both avoid substance use–related behaviors and engage in experiences that are enjoyable and rewarding. Counselors can support clients by offering tools so they can rewrite their personal narrative, pursue educational and employment opportunities, engage in volunteerism, and identify meaningful leisure activities.
- Relationships and social networks that provide support, friendship, love, and hope are necessary so that people in recovery can be fully engaged in the community. Counselors can help clients develop a sense of connectedness by offering resources to learn about and connect to various community and social supports.

Chapter 5: Implementing Recovery-Oriented Counseling Programs

Chapter 5 of this TIP helps administrators, clinical supervisors, and other staff interested in adopting or expanding a recovery-oriented framework using counseling approaches to promote recovery from problematic substance use. It discusses strategies for becoming a recovery-oriented service provider, workforce development issues, and strategies for linking treatment services to community resources.

In Chapter 5, readers will learn that:

- Offering recovery-oriented care means that no single program or center acts as the sole source of treatment. Rather, an entire community, acting collaboratively, serves to bolster a client's recovery efforts and empowers them to take full advantage of resources.
- An organization's mission statement, policies and procedures, adoption of evidence-based and promising counseling practices, staff training, and measures of client outcomes should focus on consumers and their self-defined recovery needs and goals.
- An organization interested in becoming a member of a ROSC should be linked to other resources within the community that can provide recovery support in areas the organization cannot, or that can complement the services currently provided.
- An organization's workforce development should be aligned with the principles of recovery-oriented care.
- Including people with lived experience in recovery from problematic substance use in an organization's staffing and treatment

planning supports successful, sustainable implementation of recovery-oriented practices.

- The key to implementing person-centered and strengths-based care in an organization is shifting from a traditional pathology-based assessment and treatment plan (based on the counselor's expertise) to a strengths-based assessment and a recovery plan (based on the client's expertise).
- Implementing a new program or service or restructuring a program into a recovery-oriented focus will require a review and revision of existing policies and procedures.
- Organizations should continually monitor their progress and try to identify solutions to any problems they face in implementing a recovery-oriented program.

Chapter 6: Resources

Chapter 6 of this TIP provides resources for counselors, administrators, clinical supervisors, and other staff to expand their recovery-oriented work to support individuals in or seeking recovery from problematic substance use. The chapter includes resources on the following topics:

- General Resources
- Publications
- Mutual-Help Groups
- Online Boards and Chat Rooms
- Treatment Locators
- Advocacy Organizations and Resources
- Harm Reduction
- Health Equity
- Recovery-Oriented Systems of Care (ROSCs)
- Counseling Approaches
- Psychoeducation
- Trauma-Informed Care
- Recovery Housing
- Employment Support
- Education
- Health and Wellness
- Digital Recovery Support Tools
- Telehealth
- Assessment and Screening
- Peer Support Services
- Funding

TIP Development Participants

Note: The information given for participants in the TIP's development indicates their affiliations at the time of their participation and may not reflect their current affiliations.

Consensus Panel

Each Treatment Improvement Protocol's (TIP) consensus panel is a group of primarily nonfederal clinical, research, administrative, and recovery support experts with deep knowledge of the TIP's topic. With the Substance Abuse and Mental Health Services Administration's Knowledge Application Program team, members of the consensus panel develop each TIP via a consensus-driven, collaborative process that blends evidence-based, best, and promising practices with the panel members' expertise and combined wealth of experience.

Chair

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Chapter 2—Framework for Supporting Recovery With Counseling

KEY MESSAGES

- Recovery-oriented counseling calls for counselors to possess certain competencies to work with clients effectively and empathetically.
- Counselors need to take into account a range of sociocultural considerations when assessing and working with clients in or seeking recovery, which requires cultural responsiveness and an awareness of treatment barriers and inequities stemming from sociocultural factors.
- A strengths-based approach is fundamental to recovery-oriented counseling, beginning with client intake and continuing throughout the duration of care.
- Recurrence of substance use happens, but recovery-oriented counseling can help clients avoid it or confidently return to recovery when it does occur.
- Counselor participation in recovery-oriented systems of care can benefit clients by promoting holistic, coordinated, and nonepisodic services.
- Depending on the setting, counselors providing or thinking of providing recovery-oriented counseling may need to consider the ways that payment systems can affect delivery of care.

Regardless of setting and training, counselors working with clients who are in or considering recovery can provide support by helping them build their strengths, resiliencies, and resources. This approach emphasizes what is "right" or already working for clients regarding the strategies they use for coping and improving health and well-being. It emphasizes client resilience and functioning instead of client weakness and pathology.

This chapter lays the groundwork for Chapters 3 and 4 by discussing how counselors can work with clients to identify their natural supports, coping skills, talents, abilities, hopes, and dreams for the future. It provides a framework for recovery-oriented counseling by:

- Setting out competencies for counselors working with people in or considering recovery.
- Highlighting sociocultural considerations in recovery-oriented counseling.
- Discussing the elements of strengths-based counseling.
- Covering skills that are important for clients to develop in early recovery.
- Describing recovery management checkups and check-ins.

- Introducing an approach to promoting a healthy life for clients who are beyond early recovery.
- Discussing counselor responses to warning signs of a possible recurrence of use.
- Outlining some of the benefits that clients receive when counselors participate in recovery-oriented systems of care.

The chapter also looks at ways that payment systems can affect the delivery of care for counselors in healthcare and behavioral health service systems.

Exhibit ES.1 in the Executive Summary contains definitions of key terms that appear in this and other chapters.

Competencies for Recovery-Oriented Counseling

As Chapter 1 noted, counselors can provide recovery-oriented counseling in a wide range of settings. This diversity is a strength, given the need for supports for people seeking or in recovery. But to provide such clients with consistent, high-quality care, counselors need a common foundation of knowledge and skills.[450] The consensus panel identified the following competencies for working with individuals who have problematic substance use or who are in recovery.

- **Possess an understanding of substances, problematic substance use, and addiction treatment and recovery.** Counselors should:
  - Based on data, understand the substances most prevalent in clients' communities.
  - Understand concepts of problematic substance use and recovery, including factors that influence problematic substance use, who may work with individuals with problematic substance use, and recovery and recovery pathways. (Chapter 1 discusses these topics.)
  - Understand specific substance use disorders (SUDs), such as alcohol use disorder (AUD) and opioid use disorder (OUD).
  - Understand common measurements of substance use, such as standard drink sizes.
  - Know commonly used drugs and the street names for them.
  - Understand the symptoms of intoxication and withdrawal.
  - Recognize warning signs for recurrence.
  - Be familiar with common screening instruments for problematic substance use and mental health–related conditions that may co-occur with problematic substance use (e.g., Columbia Suicide Severity Rating Scale, AUDIT, PHQ, GAD, S2BI, CRAFFT, PCPTSD).
  - Understand the levels of care available for treating problematic substance use.
  - Have knowledge of Food and Drug Administration–approved medications used to treat problematic substance use.
  - Understand the principles of harm reduction and the tools used to minimize harm, such as opioid education and naloxone, fentanyl and xylazine test strip distribution, and syringe services programs.
  - Understand the impact of genetics and epigenetics on substance use.
  - Be familiar with problematic behavioral issues other than substance use, such as problematic gambling and sexual behaviors.

Selected supporting resources:

- Substance Abuse and Mental Health Services Administration (SAMHSA), Welcome to the Center for Behavioral Health Statistics and Quality (CBHSQ): https://www.samhsa.gov/data

  - SAMHSA, *Alcohol Use: Facts & Resources:* https://www.samhsa.gov/sites/default/files/alcohol_use_facts_and_resources_fact_sheet_2018_data.pdf
  - SAMHSA, Harm Reduction: https://www.samhsa.gov/find-help/harm-reduction
  - SAMHSA, Treatment Improvement Protocol (TIP) 42, *Substance Use Disorder Treatment for People With Co-Occurring Disorders,* Chapter 3 and Appendix B: https://store.samhsa.gov/product/tip-42-substance-use-treatment-persons-co-occurring-disorders/PEP20-02-01-004
  - SAMHSA, TIP 63, *Medications for Opioid Use Disorder:* https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP21-02-01-002
  - State of Oklahoma, *ASAM Quick Reference:* https://oklahoma.gov/content/dam/ok/en/odmhsas/documents/a0003/asam-quick-reference.pdf
  - American Association for Community Psychiatry, *Level of Care Utilization System (LOCUS) Guide for Patients, Families, and Providers:* https://drive.google.com/file/d/1Xs3P_CABJZ_poYcf1t1cmdiD3vlZWCNt/view

- **Possess an understanding of mental health–related conditions.** Counselors should:

  - Be familiar with common co-occurring mental disorders.
  - Understand how problematic substance use may influence mental issues and suicidality.
  - Know the procedures for providing or accessing crisis services.
  - Know the procedures for the mandatory psychiatric evaluation process.
  - Have knowledge of local therapeutic resources available to clients.

  Selected supporting resources:

  - SAMHSA, TIP 42, *Substance Use Disorder Treatment for People With Co-Occurring Disorders:* https://store.samhsa.gov/product/tip-42-substance-use-treatment-persons-co-occurring-disorders/PEP20-02-01-004
  - SAMHSA, *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit:* https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

- **Have a general understanding of common co-occurring medical conditions, including:**

  - HIV.
  - Sexually transmitted infections.
  - Hepatitis A, B, and C viruses.
  - Bacterial and fungal infections, including infective endocarditis.
  - Alcohol-related liver disease.
  - Oral diseases, including tooth decay, gum disease, and dry mouth.
  - Skin manifestations of substance use (e.g., rashes, scars, dry skin, dental decay).[451]
  - Substance use–associated dementia.
  - Substance-induced mental disorders and psychoses (e.g., bipolar disorder, anxiety disorder).

Selected supporting resource:

- National Institute on Drug Abuse, *Common Comorbidities with Substance Use Disorders Research Report:* https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/introduction

- **Provide trauma-informed care.** Counselors should:
  - Ensure patients' emotional and physical safety.
  - Know the signs and symptoms of trauma.
  - Understand how chronic stress, adverse childhood experiences, and discrimination can contribute to trauma.
  - Understand the widespread impact of trauma and its relationship to substance use.
  - Understand reporting mechanisms for suspected violence or abuse.

  Selected supporting resource:

  - SAMHSA, TIP 57, *Trauma-Informed Care in Behavioral Health Services:* https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

- **Understand how to establish a therapeutic alliance.** Counselors should:
  - Know how to use motivational interviewing (MI) and motivational enhancement to promote engagement in recovery services.
  - Understand the importance of empathy, authenticity, warmth, and unconditional positive regard.
  - Use inclusive, nonstigmatizing language.
  - Maintain compassionate, consistent, respectful, and open communication.
  - Use reflection techniques to facilitate emotional awareness and insight.

  Selected supporting resource:

  - SAMHSA, TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment:* https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003

- **Identify and address health disparities.** Counselors should:
  - Understand structural competency and inequities that contribute to and perpetuate health disparities.
  - Understand race, gender, ethnicity, class, sexual orientation, gender identity, physical and mental disabilities, and other dimensions of individual and group identity.
  - Recognize and manage one's own bias, including implicit biases.
  - Present information in a culturally responsive way.
  - Understand bystander interventions for discrimination.

  Selected supporting resources:

  - Centers for Disease Control and Prevention (CDC), Social Determinants of Health at CDC: https://www.cdc.gov/socialdeterminants/about.html
  - SAMHSA, TIP 59, *Improving Cultural Competence:* https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849
  - SAMHSA's Addiction Technology Transfer Center (ATTC) Network Southeast, *Improving African-American Retention In Substance Abuse Treatment: Implicit Racial Bias and Microaggression:* https://attcnetwork.org/sites/default/files/2019-12/SE%20ATTC%20Brochure%20IRB%26M_final.pdf

STRUCTURAL COMPETENCY

Structural competency is the ability to see and address clients' symptoms, attitudes, and conditions—not only as the product of social determinants, but also of the policies, governance, and systems (collectively, "structure") that create those determinants.[452,453,454] It also teaches providers to reframe their perceptions of clients who are receiving treatment and to see those individuals from a more holistic perspective.[455] Structural competency was developed for use with medical students but can also be applied to SUD treatment and recovery.

For example, a client may fail to receive needed services. Rather than judge the individual to be unreliable and lacking commitment to recovery, structural competency asks the counselor to reflect on factors that may have contributed to the situation. Social determinants of health, such as availability of transportation, may be a consideration. But so, too, may be a lack of case management, which may occur because providers cannot be reimbursed by insurance for time spent on those activities.

More information about structural competency and structural competency training is available at https://structuralcompetency.org/; the Structural Competency Working Group website can be accessed at https://www.structcomp.org/.

- **Understand how to assess social determinants of health (SDOH) with individual clients.** Counselors should:
  - Understand the conditions where people in the area live, learn, work, worship, and play.
  - Be familiar with relevant data available about the community served.
  - Assess clients for the impact of SDOH on their lives (The "Resource Alert: Tools for Assessing SDOH" lists helpful tools).

RESOURCE ALERT: TOOLS FOR ASSESSING SDOH

Tools to assess SDOH include the following:

- The P**rotocol for Responding to & Assessing Patients' Assets, Risks & Experiences** collects demographic information and information about a client's needs using items within the domains of money and resources, family and home, and social and emotional health.[456] The tool is available at https://prapare.org/.
- The **Health Leads Social Needs Screening Toolkit,** validated by the Centers for Medicare & Medicaid Services and CDC, includes tools to screen for social needs in various clinical settings.[457] The toolkit is available at https://healthleadsusa.org/communications-center/resources/the-health-leads-screening-toolkit/.
- The **HealthBegins Upstream Risks Screening Tool & Guide,** which is also appropriate for a variety of clinical settings, captures information about SDOH.[458] The screening tool is available at https://www.aamc.org/media/25736/download.

These and similar tools can help counselors better understand clients' SDOH to address those that are modifiable as needed. Other resources and tools related to SDOH are available at https://www.cdc.gov/socialdeterminants/tools/index.htm.

- **Use a strengths-based, person-centered approach.** Counselors should:
  - Provide services based on the client's most urgent needs (e.g., housing, food, child care).
  - Understand and work with the client's recovery capital (defined in the "Recovery Capital Assessment" section).
  - Provide individualized, age-appropriate services.
  - Understand individual preferences, needs, and values.
  - Engage in shared decision making.

Selected supporting resources:

- SAMHSA, Shared Decision-Making Tools: https://www.samhsa.gov/brss-tacs/recovery-support-tools/shared-decision-making
- SAMHSA, TIP 26, *Treating Substance Use Disorder in Older Adults:* https://store.samhsa.gov/product/treatment-improvement-protocol-tip-26-treating-substance-use-disorder-in-older-adults/PEP20-02-01-011
- SAMHSA, TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment:* https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003
- SAMHSA, TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women:* https://store.samhsa.gov/product/TIP-51-Substance-Abuse-Treatment-Addressing-the-Specific-Needs-of-Women/SMA15-4426
- SAMHSA, TIP 56, *Addressing the Specific Behavioral Health Needs of Men:* https://store.samhsa.gov/product/TIP-56-Addressing-the-Specific-Behavioral-Health-Needs-of-Men/SMA14-4736

- **Know how to link clients to treatment and community recovery resources and actively do so.** Counselors should:
  - Know the landscape of available recovery communities and services as well as mutual-help groups.
  - Know how to use 12-Step facilitation techniques to link clients to 12-Step groups as appropriate.
  - Understand when a client would benefit from a referral to another healthcare provider.
  - Be familiar with the required protocols of providers, facilities, and services.
  - Understand core principles of case management.
  - Help ensure continuity of care and integrated services.
  - Make warm handoffs when transferring clients to other providers or recovery communities.
  - Maintain communication with recovery resource partners (e.g., if a counselor links a client to peer support services, the counselor should be available to the peer provider for consultation and feedback on how the client is doing).

  Selected supporting resource:

  - SAMHSA, *Advisory,* Comprehensive Case Management for Substance Use Disorder Treatment: https://store.samhsa.gov/product/advisory-comprehensive-case-management-substance-use-disorder-treatment/pep20-02-02-013

- **Adhere to professional and ethical standards.** Counselors should:
  - Ensure client safety.
  - Understand and adhere to client confidentiality requirements.
  - Know how to establish and maintain appropriate boundaries.

  Selected supporting resources:

  - SAMHSA, Substance Abuse Confidentiality Regulations: https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs
  - SAMHSA, TIP 57, *Trauma-Informed Care in Behavioral Health Services:* https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

- **Engage in recovery advocacy.** Counselors should:
  - Become familiar with and advocate for needed recovery services and social services not available in the community.
  - Understand available state advocacy services.

  Selected supporting resource:

  - Faces & Voices of Recovery, Recovery Advocacy Movement: https://facesandvoicesofrecovery.org/?s=Recovery+Advocacy+Movement+

Sociocultural Considerations in Recovery-Oriented Counseling

Importance of Cultural Responsiveness

Each person embraces culture in a unique way, and considerable diversity exists within and across races, ethnicities, and cultural heritages.[459] Counselors should recognize these differences and incorporate culturally appropriate knowledge, understanding, and attitudes into culturally responsive communication and services to support clients.[460]

With culturally responsive approaches, clients are more likely to feel heard, empowered, and safe, which can translate into stronger engagement in treatment and recovery services. Research suggests that SUD treatment programs with a higher degree of cultural responsiveness are associated with improved access and longer retention among certain underrepresented populations. These practices may also improve minority client treatment engagement.[461] Cultural responsiveness decreases disparities in treatment and recovery services among people with problematic substance use.[462]

Culturally responsive services require counselors to develop an understanding of the cultures of the specific clients with whom they are working, including how these cultures tend to view problematic substance use and its treatment.[463] Becoming culturally responsive begins with a self-evaluation of personal biases, including how they may affect one's own ability to provide services. Counselors should then use this self-awareness to address their biases and provide inclusive care. This is an ongoing process that requires constant monitoring and learning.

RESOURCE ALERT: NATIONAL CLAS STANDARDS

The *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care* (https://thinkculturalhealth.hhs.gov/CLAS/) contain 15 action steps designed to promote health equity, improve quality, and help end healthcare disparities by providing a blueprint for individuals and healthcare organizations to implement CLAS.

Awareness of SUD Treatment Barriers and Inequities

Research indicates that such factors as race and ethnicity, gender and sexual orientation, disability, and community can affect the ability of someone to receive appropriate SUD treatment and other services.[464] Counselors should be sensitive to the needs of the special populations they are working with on recovery, and the plan of care may need to be adapted based on these needs. SAMHSA's publication *Adapting Evidence-Based Practices for Under-Resourced Populations* (https://www.samhsa.gov/resource/ebp/adapting-evidence-based-practices-under-resourced-populations) contains useful adaptation strategies; that publication's "Resources on Treating Particular Populations" section contains information on working with specific special populations—including individuals with co-occurring disorders and women—which is beyond the scope of this TIP. The following table lists some other relevant SAMHSA publications on special populations.

Population	Resource
American Indian and Alaska Native individuals	TIP 61, *Behavioral Health Services for American Indians and Alaska Natives* (https://store.samhsa.gov/product/TIP-61-Behavioral-Health-Services-For-American-Indians-and-Alaska-Natives/SMA18-5070)
Black/African American individuals	*The Opioid Crisis and the Black/African American Population: An Urgent Issue* (https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001)
Hispanic/Latino individuals	*The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue* (https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Hispanic-Latino-Population-An-Urgent-Issue/PEP20-05-02-002)
Individuals with HIV	*Advisory*, Treating Substance Use Disorders Among People With HIV (https://store.samhsa.gov/product/advisory-treating-substance-use-disorders-among-people-hiv/pep20-06-04-007)
Older adults	TIP 26, *Treating Substance Use Disorder in Older Adults* (https://store.samhsa.gov/product/treatment-improvement-protocol-tip-26-treating-substance-use-disorder-in-older-adults/PEP20-02-01-011)

Links to SAMHSA's Practitioner Training and Centers of Excellence for special populations can be found at https://www.samhsa.gov/practitioner-training.

Race and Ethnicity

The prevalence of problematic substance use and SUDs varies by race and ethnicity. Research has shown that although Black individuals have lower levels of SUDs during adolescence compared with Hispanic people and White people, after age 25, Black individuals have a higher prevalence of substance use and SUDs than other populations. After age 35, Black men have a higher prevalence of overall substance use. Black women over 35 also report a higher prevalence of heavy drinking compared with Hispanic or White individuals.[465] SAMHSA's 2021 National Survey on Drug Use and Health found that the percentage of individuals ages 12 or older with a past-year SUD was higher among American Indian and Alaska Native or multiracial individuals than among Black, White, Hispanic, or Asian individuals.[466]

Researchers have noted the relationship between historical trauma, discrimination, and problematic substance use among minorities, suggesting that systemic effects of racial and ethnic discrimination may result in increased rates of SUDs later in life for these populations.[467,468] In addition, minority populations are more affected by the consequences of SUDs "in terms of incarceration, health problems, stigma, and violence."[469]

The SUD treatment gap is significantly greater for Black and Hispanic adults than for White adults.[470] Minority populations also face more barriers to SUD treatment completion and satisfaction than White populations do.[471,472]

For example, in a small 2022 cross-sectional study of Black individuals seeking SUD treatment, more past experiences of racial discrimination in healthcare settings were connected to self-reported delay in seeking SUD care and anticipation of discrimination during SUD treatment.[473] A small qualitative 2018 study of Hispanic individuals meeting diagnostic criteria for a recent SUD found that major reasons for avoiding specialty SUD treatment included[474]:

- A lack of interest in abstinence as a recovery goal.
- Concerns that providers wouldn't treat problematic substance use effectively or in a culturally responsive way.

Findings indicate that bias is an ongoing concern for other minority groups as well, including Asian Americans and Native Americans, who report along with Black and Hispanic individuals that they still experience everyday forms of discrimination.[475]

Research also indicates that prescriptions for buprenorphine to treat OUD are concentrated among White individuals and people who self-pay or use private insurance for buprenorphine treatment. This disparity represents a significant inequity and barrier, given that buprenorphine treatment is effective and, unlike methadone, doesn't require regular in-person dispensing at a special clinic (opioid treatment program)[476,477,478] that may require greater travel than other dispensing sites.[479]

Gender and Sexual Orientation

Like race and ethnicity, gender and sexual orientation affect SUD treatment engagement. Research finds that women have less access to SUD treatment than men do.[480] Barriers thought to contribute to this disparity include childcare obligations, pregnancy, and greater financial limitations.[481,482] Women are also more likely than men to report concern about the effect of being in treatment on their reputation or job.[483]

Gender disparities in SUD treatment participation have long been noted in treatment for AUD, the most prevalent SUD, with a lower percentage of women receiving needed AUD care.[484] Findings from a study of patients at a large community health center in the Northeast suggest that one factor in this disparity in treatment participation may be that women who screen positive for AUD are less likely to receive a diagnosis of AUD compared with men who screen positive.[485]

Sexual and gender minorities are at elevated risk of problematic substance use compared with their heterosexual peers.[486] Research indicates that sexual minority adults have between 1.6 and 3.1 times the odds of lifetime SUDs compared with their heterosexual counterparts.[487]

Although sexual and gender minorities overall are more likely to seek out SUD treatment than their heterosexual peers, they face barriers in accessing quality treatment. These barriers include stigma and bias as well as lack of provider knowledge about specific needs.[488,489]

Only a limited number of programs are designed to serve LGBTQI+ populations. A 2020 national study looking at the availability of LGBT-specific services in mental health service and SUD treatment facilities found that fewer than one in five SUD treatment facilities reported programs specific to LGBT people.[490]

Rural Communities

People living in rural communities face distinct challenges related to problematic substance use and SUD treatment. Rural residents have fewer treatment options, including a relative lack of access to opioid treatment programs and buprenorphine treatment.[491] Compounding this issue, rural providers report feeling underprepared to deliver SUD treatment because of a lack of necessary supports and resources.[492] And rural residents are less likely than urban residents to be administered naloxone during an opioid overdose in the emergency department.[493] The decision by the Drug Enforcement Administration in June 2021 to allow opioid treatment programs to operate mobile units may help to create increased access to care in rural areas where distance and transportation may have otherwise been significant obstacles for someone seeking treatment.[494]

Rural residents can also face social and cultural barriers to receiving SUD treatment, including stigma around drug use and treatment seeking in general, concerns about treatment anonymity in small communities, a lack of treatment coordination and integration in rural settings,[495] and mistrust among some treatment seekers about the use of medications for SUDs.[496] Many people living in rural areas also face economic

barriers and have health insurance gaps that affect their ability to afford SUD treatment. Lack of broadband Internet has also been cited as a barrier to telehealth treatment options in rural areas,[497] although recent data suggest that significant progress has been made in increasing rural Internet access.[498]

The Health Resources & Services Administration's (HRSA) Federal Office of Rural Health Policy webpage (https://www.hrsa.gov/rural-health) provides and links to more information on problematic substance use in rural areas and federal and state responses to it. HRSA's Opioid Response webpage at https://www.hrsa.gov/rural-health/opioid-response contains substance use–related topics, as does the Rural Health Information Hub (https://www.ruralhealthinfo.org/topics).

Socioeconomic Status

A lower socioeconomic status increases a person's risk of SUDs and can affect treatment options. Socioeconomic disparities affect access and utilization of behavioral health services as well as substance use prevalence and patterns.[499] An analysis of national survey data showed that among people who reported ever using illicit substances, those with a lower income (family income less than $20,000) were 34 percent more likely to report having substance use–related problems compared with people in the highest income category.[500] Also, insurance coverage, specifically lack of insurance among men of color and low socioeconomic status, creates barriers to accessing treatment.[501]

Disability

People with disabilities are more likely to have problematic substance use than people without disabilities.[502,503] Yet people with disabilities are less likely to receive treatment,[504] in part because they can face a range of barriers to participating, including[505,506]:

- Lack of accessible programs.
- Lack of specialized programs for people with co-occurring conditions, including individualized treatment plans that account for diverse literacy or cognitive capabilities.
- Transportation issues.
- Difficulty accessing treatment locations.
- Stigma and stereotypes.
- Insufficient clinician training on providing services to clients with disabilities.
- Lack of access to affordable quality care.[507]

People With Chronic Medical Conditions

People living with certain medical conditions, including HIV, hepatitis C virus (HCV), or chronic pain are more likely to have difficulties in accessing and receiving SUD treatment. Provider stigma may be a contributor to these barriers to SUD treatment.[508,509] A study of people with HCV who inject drugs indicated that stigma negatively affected their ability to navigate and receive treatment.[510] Patients with chronic pain and SUDs also face barriers to treatment, including OUD medication, because of stigma.[511]

Lack of knowledge of appropriate referrals was another type of barrier to SUD treatment found by a qualitative study of HIV and SUD treatment providers' perspectives on treatment barriers to people living with both HIV and SUDs.[512] Some of the HIV treatment providers interviewed were unfamiliar with the different levels of SUD care and reported that they had never referred a patient to SUD treatment.

People With Intersecting Identities

Limited research has looked at the effects of intersecting identities on SUD treatment.[513] More is known about the associations between intersecting identities and substance use, information that is useful for counselors.

For example, a study of the links between intersectional stigma and specific behavioral health outcomes among Black, Hispanic, and multiracial gay and bisexual men found a

significant combined effect of gay rejection sensitivity (anxious expectation of rejection for being gay) and racial discrimination on heavy drinking, through emotional regulation difficulties and internalizing symptoms of depression and anxiety.[514] In another example, the authors of a study on disparities in heavy episodic drinking, cannabis use, and smoking found greater prevalence of such substance use among Black and Hispanic LGB women compared with White LGB women.[515]

Awareness of Stigma, Implicit Bias, and Discrimination

Stigma and Discrimination Among Healthcare Providers

Stigma, bias, and discrimination on the part of providers may play a key role in perpetuating healthcare disparities, including in the treatment of problematic substance use.[516] Healthcare providers may have biases against people with problematic substance use, which may affect the quality of care provided.[517]

Research on hospitalized patients who have SUDs has found that these individuals experience stigma and discrimination from clinicians and other hospital staff.[518] In a study of emergency department physicians' attitudes toward patients with SUDs, physicians reported a lower regard for patients with SUDs than patients with other conditions. In fact, 54 percent of physicians who participated in the study said they at least "somewhat agree" that they "prefer not to work with patients with substance use who have pain."[519]

Individuals who use illicit drugs while in a hospital can face an inconsistent and informal range of non-person-centered responses from individual providers, including use of security staff as responders to first instances of illicit use, increased monitoring, and administrative discharge. These responses do not take into account survey findings that some patients with illicit in-hospital use report that it stems from experiencing stigma and inadequately treated pain or withdrawal.[520,521,522] These findings highlight a need for more patient-centered, appropriate, and formalized institutional policies related to in-hospital patient drug use.[523,524,525]

Counselors and Implicit Bias

Implicit bias is a prejudice or bias outside one's conscious awareness that can lead to a negative evaluation of a person based on such characteristics as race or gender. Counselors need to identify any implicit biases they may have against people with problematic substance use or in recovery, as these biases can have a negative effect on care and client rapport.[526] If medication-assisted recovery is not part of the counselor's practice or their personal orientation regarding treatment, then the counselor should be conscious of any biases they may have toward individuals seeking or currently using medication for the treatment of SUD.

As one step in addressing any implicit bias they might have, counselors should take care with the language they use with and about clients who have problematic substance use. For example, counselors should[527]:

- **Use person-first language.** Someone actively using substances in a problematic way should not be referred to as a "substance abuser" or "addict," which can suggest that they, the person, are the problem. Instead, they can be referred to as a "person with problematic substance use," which indicates that they have a problem that can be addressed.
- **Not confuse substance use with SUD.** Counselors should refer to someone as having SUD only if they have received a clinical diagnosis.
- **Use neutral technical terms, rather than stigmatizing slang terms.** The classic example of this guidance is to refer to drug test results as "negative" or "positive," rather than "clean" or "dirty."

BYSTANDER INTERVENTIONS

An active bystander is a person who witnesses a situation, acknowledges the potential problem, and speaks up about it.[528]

Individuals can choose to be active bystanders when they encounter bias in a situation. The strategies below can help in situations where bias is observed. Counselors should approach these situations as opportunities to educate, rather than to criticize, by[529]:

- Using humor.
- Being literal or refusing to rely on the assumption being made.
- Asking questions that invite discussion.
- Stating that they are uncomfortable.
- Using direct communication.
- Reminding people of personal or institutional values, or both.

Strengths-Based Counseling

Strengths-based, person-centered counseling at its core involves[530,531]:

- Focusing on clients' resources, rather than their deficits.
- Working with clients on enhancing their lives, rather than simply helping them manage problems or illness.
- Respecting clients' perspectives on their goals and needs, rather than determining these priorities for clients.

Principles of Strengths-Based Counseling

No single, agreed-upon set of principles for strengths-based counseling exists. Several leading theorists of the strengths-based model have articulated principles relevant for counseling people recovering from problematic substance use. Two somewhat overlapping examples appear below.

Two prominent theorists, Charles A. Rapp and Richard J. Goscha, developed six basic principles for using the model in mental health services[532]:

- Principle #1: People can recover, reclaim, and transform their lives.
- Principle #2: The focus is on an individual's strengths, rather than deficits.
- Principle #3: The community is viewed as an oasis of resources.
- Principle #4: The client is the director of the helping process.
- Principle #5: The worker–client relationship is primary and essential.
- Principle #6: The primary setting for our work is in the community.

Rapp and Goscha noted that the principle of viewing the community as an oasis of resources (Principle #3) entails looking for the opportunities and strengths that exist in all communities, even those that lack resources or whose resources may not be obvious. By "primary and essential" in Principle #5, Rapp and Goscha meant that a strong and trusting relationship with the practitioner is needed to create the right environment for mobilizing a client's resources and goals for recovery.[533]

Dennis Saleebey, another prominent theorist of the strengths-based model, set out these six principles in 2012 for social work practice[534]:

- Principle #1: Every individual, group, family, and community has strengths.
- Principle #2: Trauma and abuse, illness and struggle may be injurious, but they may also be sources of challenge and opportunity.
- Principle #3: Assume that you do not know the upper limits of the capacity to grow and change and take individual, group, and community aspirations seriously.
- Principle #4: We best serve clients by collaborating with them.

- Principle #5: Every environment is full of resources.
- Principle #6: Caring, caretaking, and context.

Principle #6 underscores the importance of caring relationships as strengths, including the therapeutic relationship.[535]

Strengths-based counseling doesn't call for counselors or their clients in recovery to ignore reality. This approach is **NOT** about[536]:

- Assuming that clients already have all the resources they need to change.
- Focusing only on clients' strengths.[537]
- Encouraging clients in recovery to "just think positive."

A strengths-based, person-centered approach acknowledges and addresses clients' problems, but doesn't let these problems drive clients' or counselors' expectations for what clients can ultimately achieve in recovery.

Strengths-Based, Person-Centered Assessment

A collaborative strengths-based, person-centered assessment identifies clients' current coping skills and abilities; family, social, and recovery supports; motivation; and other sources of recovery capital (discussed in "Recovery Capital Assessment" below). Counselors should view strengths broadly to include people's values; interpersonal skills; talents; knowledge and resilience gained from previous efforts to overcome problematic substance use, stressful life events, or adversity (including trauma); spirituality and faith; personal hopes, dreams, and goals; family, friend, and community connections; cultural and family narratives of resilience; and general skills in daily living.

Strengths-Based, Person-Centered Intake Approaches

A strengths-based, person-centered approach to counseling recognizes that even the questions asked at intake, whether on a form or in person, can influence clients' perceptions of their situation and their interest in engaging with a counselor. For example, a 2014 randomized study found that marriage and family therapy clients completing a strengths-based intake form listed significantly fewer problems and proposed significantly more solutions than did clients completing a problem-focused form.[538]

Examples of strengths-based, person-centered intake questions include[539,540]:

- What do you do well?
- Tell me about a time when you felt like most things were going well. What were you doing to make them go well?
- How can I best help you?

Maslow's Hierarchy of Needs

The last question above reflects the fact that some clients will not regard addressing past or present problematic substance use as their top priority. Psychologist Abraham Maslow's Hierarchy of Needs, originally published in 1943 and now a staple of motivational theory, is based on his observation that people are motivated by unsatisfied needs and tend to want to fulfill basic needs—such as food, water, and shelter—before moving on to higher level needs. The five levels of Maslow's Hierarchy, often displayed as a pyramid, are, from basic to most complex[541,542]:

- **Physiological needs,** such as food, water, and air.
- **Security and safety needs,** such as financial security, housing, and health care.

- **Social needs,** such as love and healthy social relationships.
- **Esteem needs,** such as appreciation and respect.
- **Self-actualization needs,** or the process of fulfilling personal potential.

Although the process of recovery does not always reflect this kind of linear order,[543] the Hierarchy does effectively communicate that clients with substance use–related problems who have basic, pressing needs may be more focused on meeting those needs than on changing their substance use.[544] A strengths-based, person-centered approach should include consideration of a client's hierarchy of needs, while acknowledging that there is a complex relationship between the levels.[545] Clients may identify needs in various areas throughout their recovery, from managing withdrawal to establishing healthy social connections. Counselors should identify what needs matter most to clients by asking open-ended questions such as[546]:

- What are your most important needs right now?
- What areas of your life do you want to focus on to address these needs?

Chapter 4 contains an indepth discussion of resources that are available to individuals in recovery to help them meet their personal needs in areas such as health care, affordable housing (e.g., Housing First), nutrition, employment, and social connection.

Hopes and Dreams

Counselors can also ask clients to explore their hopes and dreams. Envisioning the future can help people look ahead in a positive way and identify their core values. This exploration can also help clients identify their recovery goals and recognize how risk behaviors may get in the way of reaching these goals. Some questions include:

- What are your hopes for the future?
- What would you like your life to look like in 5 years?
- What recovery goals fit with your vision of the future?

Values Exercises

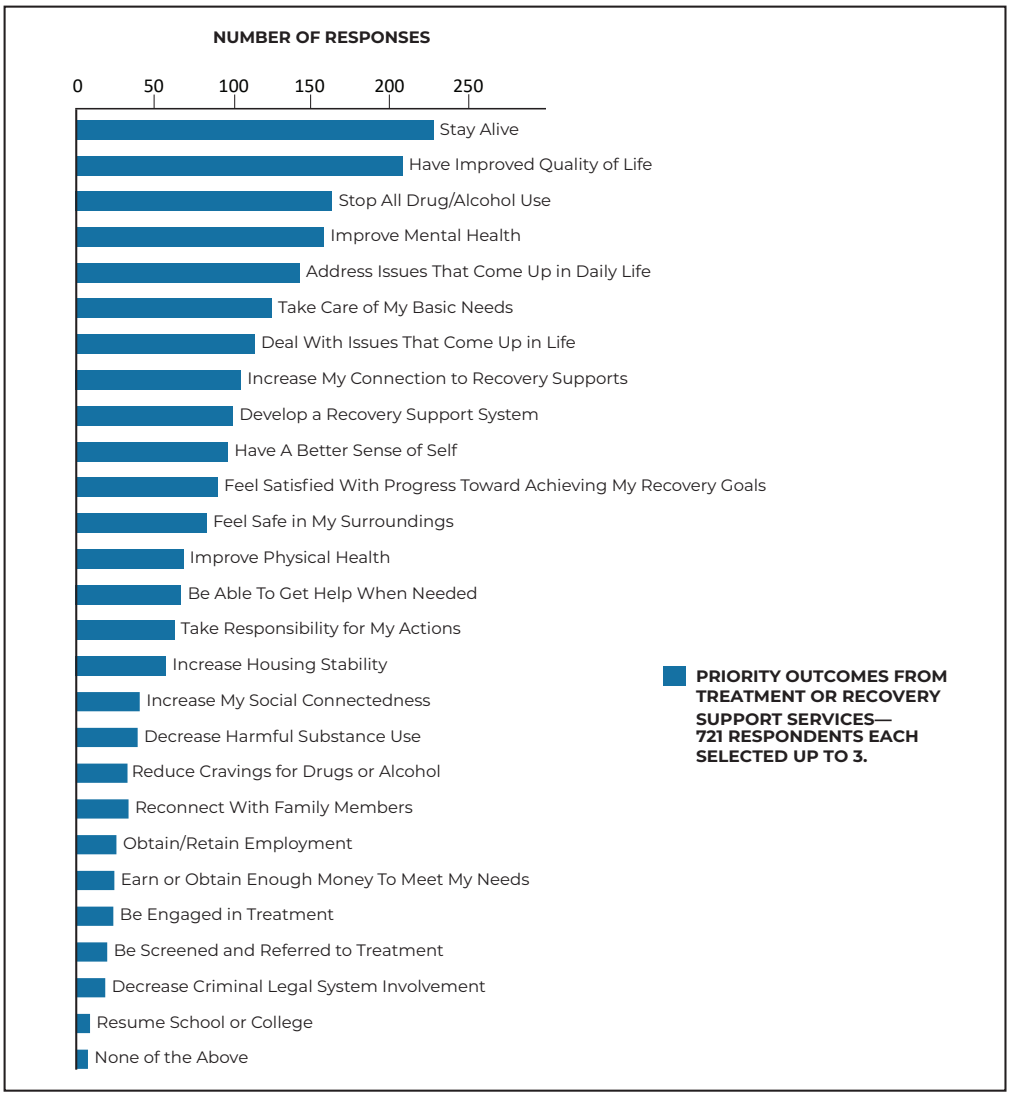
As part of a strengths-based, person-centered counseling approach, the consensus panel recommends conducting a values exercise with a client seeking or in recovery. Values can be thought of as the principles, qualities, and beliefs that are most important to an individual and that the individual most wants their life to reflect. The exercise of identifying values can help a client build motivation to enter or maintain recovery by making them more aware of how substance use conflicts with their values.[547,548] This sort of values work is a key part of Acceptance and Commitment Therapy (discussed in Chapter 3),[549] but also fits with other counseling approaches.[550]

One widely used instrument is the Bull's Eye Exercise,[551,552] available at https://webster.uaa.washington.edu/asp/website/site/assets/files/2367/values_exercise_bulls_eye.pdf. Another tool is the My Personal Values Worksheet (Exhibits 2.1 and 2.2). Having a client use values sort cards offers another way of conducting a values exercise.

PRIORITY OUTCOMES FOR RECIPIENTS OF SUD TREATMENT AND RECOVERY SUPPORT SERVICES

As part of a 2020 national survey on the relative importance of different SUD treatment and recovery support service outcomes, survey respondents with past or present substance use "challenges" (including SUDs) each chose up to three top outcomes from a list of options, without ranking their choices.[553] The chart below shows the full list of options by the number of responses received. Although the survey results aren't nationally representative, they do underscore that people with problematic substance use have diverse priorities for SUD treatment and recovery support service outcomes.[554] Notably, people with lived experience of problematic substance use contributed to and reviewed the survey design.

PRIORITY OUTCOMES RANKED HIGHEST TO LOWEST BASED ON NUMBER OF RESPONSES



Source: Adapted with permission.[555]

EXHIBIT 2.1. My Personal Values (Worksheet Part 1)

Deep down inside, what is important to you? What do you want your life to stand for?

Personal values are principles and beliefs we have about how we want to live our life and what kind of person we want to be. Values are directions we keep moving in. Values are an ongoing process. For example, if you want to be a loving, caring, supportive partner, that is a value—an ongoing process.

Use this diagram to help you look at your personal values. In each blank circle, fill in a value you hold. You do not have to use every circle, and you may add more circles as needed. **For help thinking about your values, take a look at the questions on the next page.**

Source: Reprinted with permission from PracticeMBRP.

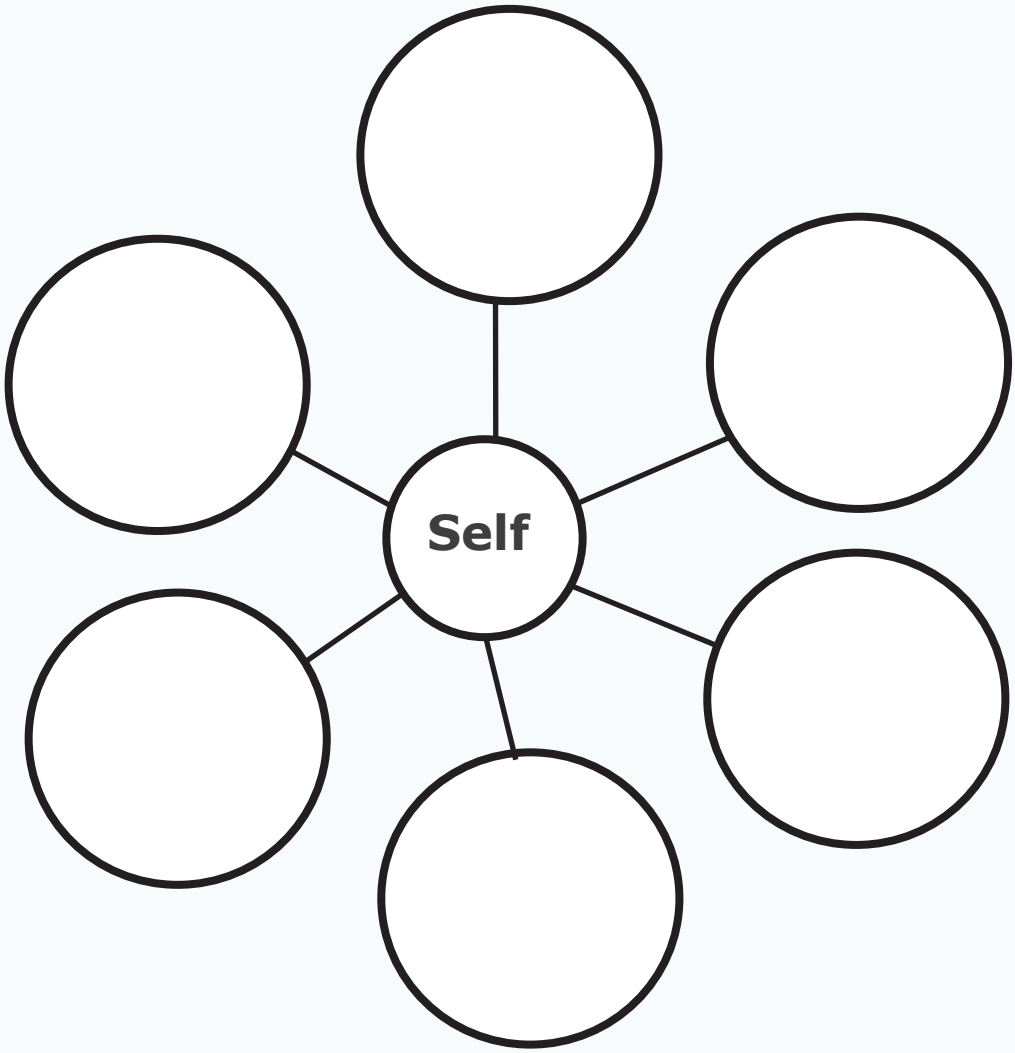


EXHIBIT 2.2. My Personal Values (Worksheet Part 2)

The following are areas of life that are valued by some people. Not everyone has the same values, and this is not a test to see whether you have the "correct" values. There may be certain areas that you don't value much; you may skip them if you wish.

Family. What sort of brother/sister, son/daughter, uncle/aunt, family member do you want to be? What personal qualities would you like to bring to those relationships? What sort of relationships would you like to build? How would you interact with others if you were the "ideal you" in these relationships?

Marriage/couples/intimate relations. What sort of partner would you like to be in an intimate relationship? What personal qualities would you like to develop? What sort of relationship would you like to build? How would you interact with your partner if you were the "ideal you" in this relationship?

Parenting. What sort of parent would you like to be? What sort of qualities would you like to have? What sort of relationships would you like to build with your children? How would you behave if you were the "ideal you" as a parent?

Friendships. What sort of qualities would you like to bring to your friendships? If you could be the best friend possible, how would you behave towards your friends? What friendships would you like to build?

Career/employment. What do you value in your work? What would make it more meaningful? What kind of worker would you like to be? If you were living up to your own ideal standards, what personal qualities would you like to bring to your work? What sort of work relations would you like to build?

Education/personal growth and development. What do you value about learning, education, training, or personal growth? What new skills would you like to learn? What knowledge would you like to gain? What further education/learning appeals to you? What sort of student would you like to be? What personal qualities would you like to apply?

Recreation/fun/leisure. What sorts of hobbies, sports, or leisure activities do you enjoy? How would you like to relax/unwind? How would you like to have fun? What sorts of activities would you like to do?

Spirituality. Spirituality means different things to everyone. It may be connecting with nature, or it may be participation in an organized religious group. What is important to you in this area of life?

Citizenship/environment/community life. How would you like to contribute to your community or environment (e.g., through volunteering, or recycling, or supporting a group/charity/cause/political party)? What sort of environments would you like to create at home, at work, in your community? What environments would you like to spend more time in?

Health. What are your values related to maintaining your physical well-being? How do you want to look after your health, with regard to sleep, diet, exercise, smoking, alcohol, etc.? Why is this important?

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Decisional Balancing To Address Ambivalence About Changing Problematic Use

Motivation is a critical element of behavior change[556] that can predict recovery from problematic substance use.[557,558] As part of strengths-based, person-centered counseling, counselors can use a strategy from MI called decisional balancing to learn what clients with active problematic substance use think they are getting out of such use and to help them find reasons to address it. MI is an evidence-based, person-centered counseling approach for helping people resolve ambivalence about changing behaviors. When clients observe that the costs of substance use outweigh the benefits, they may be motivated to reduce or stop it.[559]

Decisional balancing must be used carefully, as it may instead increase ambivalence among clients who are contemplating change. It is generally preferable to explore with clients what they get out of substance use before exploring possible reasons for change, as this allows the discussion to conclude with the arguments for change.[560,561] More on decisional balancing and related MI strategies can be found in Chapter 3 and SAMHSA's TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment*, at https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003.

Recovery Capital Assessment

"Recovery capital" refers to the quantity and quality of resources available to individuals to begin and maintain long-term recovery from problematic substance use. These resources may be internal (e.g., physical health, values, hope) or external (e.g., community and cultural support, employment), and they can increase.[562,563] The concept of recovery capital reflects the belief that everyone has strengths and resilience and that building on them is central to the recovery process. Having greater recovery capital is associated with positive outcomes, such as SUD treatment completion, attendance at follow-up appointments, and meeting one's recovery plan goals.[564,565]

As part of providing recovery-oriented counseling, counselors need to understand the concept of recovery capital and incorporate it into their practice by working with clients seeking recovery to help them identify, access, and build their own recovery capital. Recovery capital is usually divided into four categories.

- **Personal recovery capital** includes "physical recovery capital," such as food, access to transportation, and safe housing as well as "human recovery capital," such as values, knowledge, educational/job skills, problem-solving skills, internal motivation or commitment to recovery, and self-awareness.[566]
- **Family/social recovery capital** includes intimate relationships; biological family; family of choice; friends; and relationships at school, work, faith-based institutions, and community organizations that support individuals' recovery efforts.[567]
- **Community recovery capital** includes attitudes, policies, and resources in clients' communities that promote recovery from substance use–related problems through multiple pathways.
- **Cultural recovery capital** includes the availability of traditional and other culturally based pathways of recovery that help support clients from that culture. Cultural recovery capital also includes the values and beliefs associated with a culture that support recovery.[568]

Clients who have worked with peer specialists are likely to have already completed a recovery capital assessment at least once as part of receiving peer support services. Because recovery capital can change over time and no one universally accepted measure of it exists, including a recovery capital assessment as part of the overall assessment of clients with present or past problematic substance use can give counselors a better understanding of their recovery resources.

Some clients may find it challenging to identify their strengths or may say that they don't have any. Counselors can ask these clients how they have overcome adversity in the past, and how they have previously managed problematic substance use. Counselors can also reframe as potential strengths what these clients—and the counselors themselves—may think of as deficits. Some examples are in the following table.

Deficit	Reframed as a Strength
Client continues to spend time with friends who have problematic substance use.	Client desires connection with others.
Client's family is always in crisis.	Family has stayed together under stressful circumstances.
Client has a long history of problematic substance use, with multiple treatment episodes.	Client has continued to seek recovery support.

The consensus panel recommends asking clients to look at the skills they used to obtain substances and reframing those as strengths.

Assessing Recovery Capital

Several tools are available for assessing recovery capital. Clients can often complete assessments themselves. Some tools may be more appropriate for use in certain settings or with specific populations. Below is a description of several of these tools, including information about how to access them and limitations.

Substance Use Recovery Evaluator (SURE). SURE is a brief, easy-to-complete, validated assessment that can help clients monitor and reflect on their recovery journey or their treatment outcomes. SURE collects information on 21 items within these categories: substance use, material resources, outlook on life, self-care, and relationships.[569] A strength of the measure is that only 6 of the 21 items refer directly to the use of substances, highlighting how it is possible to be in recovery without focusing on abstinence.[570]

The SURE measure is not for use in settings such as residential rehabilitation or prisons. And because the tool was developed in Britain, the developers recommend substituting culturally appropriate terms as needed when it is used in other countries.[571]

More information about SURE can be found at https://www.kcl.ac.uk/research/sure-substance-use-recovery-evaluator.

Assessment of Recovery Capital (ARC). ARC is a 50-item self-report measure validated for predicting recovery. ARC assesses recovery strengths using 10 domains:[572]

- Substance use
- Psychological health
- Physical health
- Community involvement
- Social support
- Meaningful activities
- Housing and safety
- Risk taking
- Coping and life functioning
- Recovery experience

Counselors can use ARC to identify SUD treatment barriers or interventions to increase recovery capital. Rehabilitation professionals in SUD treatment programs also can use ARC to assess recovery capital, informing the development of treatment plans with a focus on recovery capital.[573]

Brief Assessment of Recovery Capital-10 (BARC-10). BARC-10 is a brief measure of recovery capital based on the ARC. The measure examines client responses to 10 items across all the original domains of ARC.[574]

This validated measure takes about a minute to complete and provides a single unified dimension of recovery capital. It is appropriate for use in diverse settings, such as recovery support service settings or health clinics.[575] More information is available in the BARC-10 information sheet developed for the Virginia Department of Behavioral Health & Developmental Services at https://static1.squarespace.com/static/5cd33914797f74080d793b95/t/60678b620d8b4e517e4ca0b8/1617398627765/BARC-10+Information+Sheet.pdf.

Strengths and Barriers Recovery Scale (SABRS). SABRS is an index of recovery capital based on the Life in Recovery survey. SABRS assesses five domains—work, finances, legal status, family and social relations, and citizenship—and includes retrospective information about strengths and barriers in active addiction and in recovery.[576]

More information on SABRS is available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7298842/.

Some Limitations of and Further Work on Recovery Capital Assessments

Although widely used, the ARC and BARC-10 tools assume abstinence is the recovery goal, which doesn't align with current recovery approaches recognizing multiple pathways, and these instruments may not be generalizable to diverse populations.[577,578]

Work is underway on a new assessment tool, the *Multidimensional Inventory of Recovery Capital* (MIRC). The items in the pilot measure were developed with feedback from service providers and people in recovery from problematic alcohol use, with significant participation by people identifying as LGBTQ+ and by people in recovery who are of color or low income. The participants in recovery also collectively reported using a variety of recovery pathways, and many reported having problems with other substances besides alcohol. The inventory can capture information about the effect on recovery outcomes of poverty, discrimination, and other disadvantages.[579] The inventory covers these domains:

- Human
- Financial
- Social
- Community and cultural

More information about MIRC is available at https://www.recoveryanswers.org/research-post/reflections-from-asking-recovering-individuals-about-how-best-measure-recovery-capital/.

Chapter 4 has recommendations on practices to help build recovery capital.

Unconditional Positive Regard

Providing clients with unconditional positive regard from the outset of counseling work with them is a key aspect of strengths-based, person-centered counseling, regardless of the therapeutic approach used. (Unconditional positive regard refers to caring about, accepting, and valuing someone regardless of what they do or say.[580]) A 2018 meta-analysis found a small but positive association between the provision of positive regard and improved clinical outcomes that support positive regard's status as a central element of the therapeutic relationship for clients generally.[581]

The authors of a 2019 study of emotional intelligence among addiction counselors noted that clients with substance use–related problems can face (and may pick up on) counselor frustration with the high rate of recurrence in the SUD treatment population. The authors emphasized the importance of providing clients in SUD treatment "with a nonjudgmental environment and an attitude of unconditional positive regard," saying, "This corrective experience can be especially therapeutic for these clients."[582]

The authors of the 2018 meta-analysis offered several reasons and recommendations for incorporating positive regard into clinical practice, including the following:[583]

- Consider that affirming clients can have many useful impacts, such as strengthening clients' engagement in therapy and sense of agency.
- Don't just feel good about clients, but express positive feelings toward them (within clinical boundaries) to support their sense of worth.
- Express regard in different ways, such as offering reassurance, creating positive narratives, and using positive body language.

- Be open, receptive, curious, and valuing of the client.[584]
- Let the client know that they are understood, known, and seen, which can help to release their potential for growth and reconfiguration.[585]

Cues for Health and Well-Being in Early Recovery

Traditional approaches to recovery have focused on identifying and reducing the impact of cues that can trigger substance use, and have suggested that individuals may return to such use when reintroduced to environments full of substance-related cues. More recent research suggests that another important element of recovery is identifying client-specific cues for healthy behaviors and positive thoughts. Such personalized "recovery cues" include images, objects, and sensory experiences that a client associates with recovery commitment and that produce positive cognitive–affective states.[586]

A recovery cue can be as simple as a pair of running shoes left by the door as a reminder to run. Other examples of visual recovery cues are:[587,588]

- An image of a nature scene that the client associates with serenity.
- Photos of loved ones.
- A photo of a sponsor.
- Supportive text messages that the counselor has sent to the client.

Examples of audio recovery cues are:[589]

- Meditations.
- Nature sounds.
- Music recordings.
- An audio clip of the client reading a gratitude list.

Counselors can help clients identify a collection of such cues.

Coping and Avoidance Skills for Clients in Early Recovery

During early recovery, clients need to develop coping and avoidance skills to reduce risk of recurrence to use.[590] Clients should determine which coping and avoidance skills work best for them.

Coping skills are helpful ways of thinking and acting that can manage impulses and cravings, reduce stress, and support problem-solving in early recovery.[591] Common strategies include:[592]

- Learning and practicing stress reduction techniques.
- Scheduling time for relaxation.
- Getting more sleep.
- Learning and applying problem-solving techniques.
- Identifying recreational activities.[593]
- Engaging in positive reframing.[594] Positive reframing occurs when a client considers an alternative positive meaning of or perspective on a situation.[595]
- Writing or journaling.[596,597]
- Using urge surfing techniques, or an approach to manage urges by observing the craving without overreacting to it.[598] (Chapter 3 has a description and guided exercises.)

Clients in early recovery will also want to avoid high-risk situations through avoidance strategies or skills, which can help them divert their attention from urges and identify alternative activities to engage in.[599] Common avoidance coping strategies include:

- Trying not to think about a problem.
- Distracting oneself with other activities.
- Avoiding people associated with past substance use.
- Altering travel routes to avoid triggering places.
- Removing drug paraphernalia from the home.[600]

Clients in early recovery may also need to be aware of coping mechanisms that can potentially become unhealthy, such as high or significantly increased caffeine or nicotine intake or binge eating. Chapter 3 provides more details about how counselors can help clients identify and develop positive coping and avoidance skills that fit into their treatment plan.

Self-Efficacy

Self-efficacy is commonly understood as a person's belief in their ability to take action to achieve a desired outcome.[601] In the context of substance use, a person with high self-efficacy has confidence in their ability to abstain or reduce such use in high-risk situations. An individual with low self-efficacy, on the other hand, is unsure of their ability to do so.[602] Research indicates that people in recovery with higher levels of self-efficacy have a greater likelihood of achieving their recovery goals.[603]

Enhancing a client's self-efficacy may be critical to fostering long-lasting behavior change and may help to sustain their recovery.[604] A first step can be using validated instruments to assess the client's self-efficacy. Several examples follow:

- The **Alcohol Abstinence Self-Efficacy Scale** measures self-efficacy related to problematic alcohol use. The scale assesses both temptation to drink as well as confidence to abstain from alcohol use in 20 situations, using a 5-point Likert-type scale.[605] The scale can be found in Appendix B of SAMHSA's TIP 35, Enhancing Motivation for Change in Substance Use Disorder Treatment, at https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003.
- The **Drug-Taking Confidence Questionnaire** assesses self-efficacy related to use of a particular substance. The 50-item, fee-based questionnaire measures how likely people are to resist urges in specific situations, using a 6-point Likert-type scale.[606,607]
- The **Drug Avoidance Self-Efficacy Scale (DASE)** measures self-efficacy for multiple substances. The scale includes 16 questions rated from 1 to 7 from "certainly yes" to "certainly no" in relation to how likely people are to avoid or resist the urge to use substances.[608] The DASE instrument can be found at https://adai.uw.edu/instruments/pdf/Drug_Avoidance_Self_Efficacy_Scale_438.pdf.

Chapter 3 discusses another useful tool: the Confidence Ruler.

After evaluating a client's self-efficacy, the counselor can help them improve their self-efficacy by identifying their natural coping skills, teaching them new ones, and helping them practice the use of these skills. These assessments can also help the counselor identify the unique and personally relevant high-risk situations in which the client feels a greater sense of confidence or lacks confidence.[609] Comparing situations in which a client has low and high confidence can help them recognize and apply helpful coping skills to low-confidence situations.

Importance of Substance-Free Activities in Recovery

Helping clients access low-cost, substance-free activities will support them on their recovery journey, in part by helping satisfy the needs that substance use filled. Research has highlighted the importance of engaging in substance-free activities as an alternative to use.[610,611,612,613] Substance use **increases** in the absence of substance-free alternatives.[614] Looking specifically at harmful alcohol use, research indicates that it's less likely to occur in conditions where substance-free alternatives are low cost and readily available.[615,616] As one study notes, people **recover** from problematic substance use when the availability of substance-free rewarding activities **increases**.[617]

Counselors should help clients in recovery discover new ways (or rediscover past ways) to engage in rewarding substance-free activities that are safe, enjoyable, accessible, affordable, and personally meaningful for them.[618] Care should be taken to avoid activities that the client associates with their substance use. Examples of substance-free activities include:[619,620]

- Praying or meditating.
- Attending religious services.
- Taking relaxing outdoor walks.
- Exercising.
- Doing low-cost home improvement activities.
- Crafting.
- Cleaning or decluttering one's personal space.
- Playing a musical instrument.
- Writing.

Socializing with friends and family members may also be a good option, as long as they do not have their own problematic substance use.[621] A client's ability to socialize can be affected by a variety of factors (e.g., a global pandemic that calls for social distancing, a client's physical limitations or lack of transportation), so flexibility in terms of what constitutes "social interaction" may be needed (e.g., interactive and digital socializing as opposed to in-person socializing).[622]

Counselors can also help clients structure their days to incorporate enjoyable activities and encourage healthy choices during a period when they would normally engage in problematic substance use. For example, counselors could encourage clients to go for an outdoor walk or attend an exercise class in the evenings, if this is a time when problematic substance use would normally occur. Even small changes in the timing of activities may help deter problematic substance use[623] and promote wellness.

Approach to Promoting a Healthy Life for Clients Beyond Early Recovery

This TIP takes the perspective that recovery extends beyond resolving problematic substance use to encompass living a healthy life. Counselors should help clients gain or further develop the resources, skills, and confidence to advance and even thrive in the four dimensions outlined below:[624,625]

- **Health.** Maintaining good health by overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way
- **Home.** Building a stable and safe place to live
- **Purpose.** Identifying meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors
- **Community.** Developing relationships and social networks that provide support, friendship, love, and hope

Chapter 4 discusses ways to encourage clients to work on these four domains so they can become more independent, build on their strengths, and enter into the life they want.[626]

Recovery Management Check-Ins and Checkups

Telephone check-ins and recovery management checkups (RMCs) are effective, proactive strategies for counselors to stay apprised of clients' recovery status and intervene early in actual recurrence of use.

Telephone check-ins involve regular telephone calls with clients in recovery to ask how things are going. Such check-ins typically take place frequently during early recovery or at other times when need for frequent contact is high; they become less frequent as an individual's recovery strengthens.[627,628] To be recovery-oriented, such check-ins should include a focus on clients' development and application of their strengths and avoid being overly directive.[629,630] Peer specialists often use telephone or text check-ins as part of their work with individuals in recovery.[631]

RMCs are modeled after methods for providing long-term management of chronic medical conditions like diabetes and heart disease. RMCs involve post–SUD treatment in person or with telephone interviews to determine whether individuals need to reengage in treatment. The intervention provides the individual with tailored feedback on their recovery and, if return to treatment is needed, incorporates MI, problem-solving techniques, and assertive linkage. Major studies on implementing this intervention used quarterly checkups.[632]

Approach to Recurrence and Its Warning Signs

Counselors should be supportive of clients, regardless of whether they experience recurrence.[633] Shaming clients or withholding counseling after a recurrence will only limit clients' progress toward their long-term goals. Instead, counselors have an opportunity to help clients put a recurrence in perspective and reinforce that a recurrence does not mean they can't achieve recovery. Nor does it mean that the client is back at square one. Many people who have experienced recurrence one or more times go on to maintain long-term recovery.[634]

Using a person-centered, strengths-based approach and unconditional positive regard, counselors should affirm clients' efforts to continue in recovery and encourage them to reflect on their goals and how the recurrence could be an opportunity to gain greater insight and adjust their action plan. Clients who have a recurrence should hear from their counselors that they are not alone, because the counselors can offer continuous support while they navigate a path back to recovery.

When clients who take medication to support their recovery have a recurrence, a recovery-oriented approach views this event not as a reason for automatic discharge, but as a sign that dosage and other aspects of the treatment plan may need adjusting.[635,636] Individuals taking medication for OUD are at especially high risk for overdose and death should their medication be discontinued. Counselors should refer to their facility policies for guidance in these situations.

As discussed in Chapter 1, recurrence, like recovery, is not an event but a process.[637] Counselors and their clients can look out for warning signs that a recurrence may occur within months or weeks and take steps to avert it.[638] Stressful life events such as divorce and legal troubles are also associated with recurrence.[639]

THE ABSTINENCE VIOLATION EFFECT

The abstinence violation effect (AVE) is a construct for explaining why some people who use a substance again after a period of abstinence experience more serious recurrence of use. People susceptible to AVE are theorized to engage in all-or-nothing thinking in which they interpret any use as total failure and not as a temporary setback. According to the theory, the internal conflict over this disconnect between their behavior and values and the associated feelings of guilt, shame, and hopelessness increase the risk of severe and continued recurrence.[640,641,642] More information on AVE is in "Dealing With the Abstinence Violation Effect" in Chapter 3.

Counselor Responses to Warning Signs of a Recurrence

Awareness of common triggers and warning signs of a recurrence will help counselors proactively address them with a client if they arise. To respond to warning signs, counselors should:

- Talk to the client about outcome expectancies and urges.
- Identify triggers for recurrence to use.
- Assess the client's confidence in high-risk situations.
- Evaluate the client's motivation to continue with a treatment or recovery plan.
- Consider working with the client and any providers involved in developing the client's treatment or recovery plan (such as a peer specialist) to incorporate approaches for avoiding a recurrence, or provide additional services, as needed.

Talking to the Client About Outcome Expectancies and Urges

Outcome expectancies are anticipated consequences, positive or negative, that result from engaging in substance use.[643,644] Research indicates that a recurrence to problematic substance use can result when outcome expectancies are too positive or are not addressed.[645] Higher levels of positive outcome expectancies combined with higher levels of negative urgency (behaving impulsively when in a negative mood[646]) may increase the risk of a recurrence to use.[647]

Counselors can work with clients to identify the outcome expectancies (both positive and negative) for substance use. Counselors can also help clients identify goals and objectives that will help them avoid a recurrence.

Suggested steps to support a client in recognizing and addressing outcome expectancies include:[648]

- Listing the outcome expectancies for the substance use and resolved behavior (e.g., reduced use of substances).
- Discussing the reality of each expectation.
- Asking about the benefits of changing behavior (e.g., better quality of life).
- Asking the client to identify reasons to stop the behavior.
- Working with the client to develop specific goals and objectives.

Clients are more likely to adhere to a treatment or recovery plan if they think it will bring desirable outcomes that outweigh the benefits of engaging or reengaging in problematic substance use.[649]

RESOURCE ALERT: ADVANCE WARNING OF RELAPSE QUESTIONNAIRE

The Advance WArning of RElapse (AWARE) questionnaire assesses the potential for a recurrence to problematic alcohol use based on certain warning signs. The self-reported questionnaire includes 28 items scored on a 7-point Likert scale.[650] The higher the score, the higher the probability that the individual will recur to problematic alcohol use within the next 2 months.[651]

Although the scale was originally designed to identify problematic alcohol use specifically, research has shown that it can be modified to identify the risk of substance use recurrence more generally.[652] Counselors should also discuss results of the questionnaire with clients in a nonjudgmental manner that offers neutral feedback about potential risk for a recurrence to use.

The AWARE questionnaire can be accessed at https://casaa.unm.edu/inst/Aware.pdf.

Identifying Triggers for Recurrence to Use

Counselors should also help clients identify their triggers for problematic substance use based on what they experienced in the past. Help them identify the following:[653]

- High-risk situations (i.e., who, where, when)
- External triggers (e.g., smells, sounds)
- Internal triggers (e.g., thoughts, feelings, physical cravings)

Once a client identifies these triggers, the counselor's role is to help them develop coping strategies that worked in the past and that might work again.[654] To do this, the counselor should:

- Ask the client about strategies they could use now to avoid high-risk situations or external triggers as well as ways to manage internal triggers without engaging in problematic substance use.
- Ask the client to describe additional coping strategies.
- Evaluate the client's confidence in applying these coping strategies.

HUNGRY, ANGRY, LONELY, TIRED

The acronym HALT (Hungry, Angry, Lonely, Tired), from Alcoholics Anonymous®, offers a useful tool to give clients to help them remember to address important needs early on:[655]

- Don't get too **H**ungry can include an awareness—not only of avoiding being too hungry, but also focusing on healthy eating.
- Don't get too **A**ngry is a reminder to understand the causes of your anger and find healthy ways to feel and express that anger.
- Don't get too **L**onely is a reminder to connect with safe people, engage in social and recreational activities with others, and attend recovery support groups.
- Don't get too **T**ired is a reminder to get enough sleep and rest when fatigued.

Invite clients to say "HALT" to themselves when feeling stressed and then take appropriate action before the impulse to use or reengage in risk behaviors becomes overwhelming.[656]

Assessing the Client's Feelings of Confidence in High-Risk Situations

The Brief Situational Confidence Questionnaire (BSCQ) is a tool that can help assess clients' level of confidence in how well they would cope in common high-risk situations. The BSCQ is an eight-question measure that asks people to rate how confident they are in their ability at that moment to resist the urge to drink heavily or use drugs in eight situations. The questionnaire's scale ranges from 0 percent to 100 percent, with 0 percent indicating not at all confident and 100 percent indicating totally confident.[657]

The BSCQ form is available at https://www.nova.edu/gsc/forms/appendix_d_brief_situational_confidence_questionnaire.pdf. The instructions are available at https://www.nova.edu/gsc/forms/BSCQ%20Instructions.pdf.

Using a tool like the BSCQ can help clients better understand their confidence level in high-risk situations, which can be useful in setting realistic goals and developing individualized coping strategies.[658]

Assessing the Client's Motivation To Continue With a Treatment or Recovery Plan

Motivation is fluid, changing over time and by situation. As discussed above, motivation to change can increase when reasons for change and specific goals become clear.[659] Motivation can decrease when a person feels doubt or ambivalence about change.

Motivation to change includes another construct: "commitment to change." A commitment to change implies the presence of a stronger desire that may help someone maintain recovery in the face of adverse circumstances. By assessing a client's commitment to change, a counselor can evaluate the client's motivation to continue with treatment or recovery.[660]

Several tools exist to assess commitment to change, including the following:

- **Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES):** SOCRATES measures readiness to change and motivation to continue with treatment or recovery. The SOCRATES 8A is for alcohol use, and the SOCRATES 8D is for other substance use. The SOCRATES uses a 5-point scale ranging from 5 (strongly agree) to 1 (strongly disagree) and can assess recognition of the problem, ambivalence, and efforts to take steps. Changes in scores over time can help clients understand the impact of an intervention on problem recognition, ambivalence, and progress toward goals.[661]
- **Commitment to Sobriety Scale:** This 5-item measure assesses level of commitment to recovery from problematic substance use. The scale rates agreement with statements concerning substance use (e.g., "I will do whatever it takes to recover from my addiction" and "I never want to return to alcohol/drug use again"). It includes a 6-point scale ranging from strongly disagree (1) to strongly agree (6).[662] Use this tool with clients who have abstinence as their recovery goal.
- **Addiction Treatment Attitudes Questionnaire:** This measure assesses attitudes toward treatment and recovery. The questionnaire includes questions about commitment to lifelong abstinence (e.g., "I should never have another drink/drug" or "I believe I should never use alcohol or any mood-altering chemicals again"). Respondents rate their agreement with each statement, from 1 (strongly disagree) to 5 (strongly agree). Higher scores indicate more positive attitudes toward treatment.[663] This tool is appropriate for use with clients who have abstinence as their recovery goal.

Through these tools, a counselor can explore a client's internal and external reasons for entering and staying in treatment and recovery.

Reassessing the Client's Treatment Plan or Recovery Plan and Support Services

When a client experiences a recurrence, it may be time to bolster or update their treatment or recovery plan and goals and reevaluate their need for other support services. Through an examination of triggers, coping strategies, warning signs, and motivation, the counselor and the client can explore revising the plan. Updates may include additional strategies for managing thoughts, urges, and impulses related to problematic use.[664] Other revisions may include starting or increasing attendance at mutual-help meetings, participating in more recreational activities, and initiating or expanding delivery of peer support services.

A recurrence can lower a client's motivation and confidence about continuing their recovery journey. The client may also need

support and guidance about ways to manage the negative thoughts and feelings caused by the recurrence itself. The counselor's role is to remind the client of their previous progress and to support them in moving forward through a recommitment to their recovery.[665]

Ways That Payment Systems Can Affect the Delivery of Care

SAMHSA recognizes that counselors in healthcare and behavioral health services must work within the realities and constraints of the payment systems that reimburse or fund their services. Variations in insurance plans and reimbursement rates and limitations on certain services can potentially act as barriers to receiving payment or make the payment process labor intensive and difficult, affecting the delivery of care. Being aware of these potential roadblocks can help providers who want to implement or increase recovery-oriented services plan and deliver care that not only meets the needs of the client but also can be reliably funded or paid for.

The literature on SUDs and payment processes identifies a variety of issues that providers should consider when planning services. These include:

- **Types of treatment covered.** Significant variation exists from one state to another and even within states regarding which services are covered by private insurance or such federal resources as Medicaid and Medicare, and which services are partially or entirely out-of-pocket costs for the client. For example, such core services as medically supervised withdrawal and residential or intensive outpatient treatment as well as some types of medication, may not be eligible for coverage.[666]
- **"Medical necessity."** Certain states will not cover services that are not considered to be a "medical necessity." For example, some states do not consider opioid withdrawal to be life threatening; therefore, treatment for opioid withdrawal is not covered under Medicaid in those states.[667] Providers need to be aware of "medical necessity" criteria in their state or locality, or under the terms of the client's insurance provider.
- **Reimbursement rates and limits.** Services may be reimbursed at varying rates, even within the same state. In addition, some insurance providers limit the number of certain kinds of treatment sessions or screenings a client can receive,[668] potentially denying that client the duration of treatment they truly need. This issue can be further complicated by insurance providers that reimburse services based on the number of "events" (e.g., face-to-face meetings), rather than on a value-based approach that rewards sustained positive outcomes.[669]
- **Service silos.** SUD treatment has historically been delivered separately from medical and psychiatric services, which can potentially disincentivize the collaborative approach and effective case management that are necessary to meet all the needs of individuals in recovery.[670,671]
- **Fee schedules.** Certain fee schedules make it difficult or impossible to be reimbursed for needed services. For instance, if an individual sees a primary care provider and an addiction specialist on the same day, both providers may not be able to obtain reimbursement.[672] This may discourage, or even disincentivize, the use of integrated and multisystem care, which is fundamental to effective recovery-oriented services.
- **Prior authorization.** Some insurance providers and health plans require patients to obtain approval for certain types of care or medications prior to receiving them. Services and medications for the treatment of SUD have been subject to this requirement more frequently than other kinds of services, although some states are passing laws to change this.[673] If a client's

insurance plan requires prior authorization, it may delay their ability to begin taking medication needed to treat OUD or AUD.

- **Lack of insurance.** Individuals seeking treatment for problematic substance use—particularly those who are also involved with the criminal justice system—are more likely than other populations to be uninsured.[674,675]

To ensure adequate and appropriate delivery of care, providers need to be willing to work with their colleagues, supervisors, and resources in the community to find creative solutions to these issues. These may include:

- **Accessing federal grant funding.** Although the process of securing and implementing these resources can be lengthy, and the finite funding periods may limit the ability to plan long term,[676] federal dollars remain a significant source of support for substance use treatment and recovery services. Funding opportunities can be located through the federal grants portal (https://www.grants.gov/), the Department of Health and Human Services' grants webpage (https://www.grants.gov/web/grants/learn-grants/grant-making-agencies/department-of-health-and-human-services.html), SAMHSA (https://www.samhsa.gov/grants), HRSA, (https://bhw.hrsa.gov/funding/apply-grant#behavioral-mental-health), the National Institutes of Health (https://www.nih.gov/grants-funding), and CDC (https://www.cdc.gov/grants/).
- **Collecting program-level data to support funding applications.** A 2021 article in a National Academy of Medicine periodical identified the importance of formalized and thorough data collection at the program level, as this can be key to securing funding on an ongoing basis.[677]
- E**ducating criminal justice–involved clients about Medicaid requirements.** Data from 2017 indicates that one in three referrals to SUD treatment come from the criminal justice system.[678] Individuals who are incarcerated are not eligible for Medicaid reimbursements for addiction services during incarceration; however, they can apply for restored eligibility while still incarcerated. This may speed up their ability to receive services after release.[679]
- **Increasing collaboration between, and the integration of, systems of care.** Providers can consistently advocate for systemic change that increases collaboration, improves coordination of care, and facilitates fuller case management. The Surgeon General's report on addiction notes that closer integration of SUD treatment services with mainstream healthcare systems can help address health disparities, reduce healthcare costs, and improve general health outcomes.[680]
- **Promoting awareness of the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act (MHPAEA).** This legislation,[681] signed into law in 2008, mandates that mental and substance use disorder treatment benefits under group and individual health insurance plans be comparable to medical benefits in terms of financial requirements and treatment limitations. The 2010 Patient Protection and Affordable Care Act expanded the reach of MHPAEA. Counselors and administrators can look for ways that this legislation can support enhanced program services.

Recovery-Oriented Systems of Care and Strengths-Based Counseling

Ideally, counseling for people in recovery takes place in the context of a recovery-oriented system of care (ROSC). **The consensus panel emphasizes that the ROSC concept applies across settings (e.g., behavioral health, primary care,**

criminal justice, social services) and across the recovery continuum. The benefits of participating in a ROSC can include:[682,683,684,685]

- Opportunities to have better coordination with clients' other providers, thereby promoting continuing, holistic care.
- Collaboration with other providers from multiple disciplines who have a recovery-oriented approach to care.
- Connections to other services and supports for clients in recovery, such as housing resources and child care.

Although no centralized listing of ROSCs exists, member centers of SAMHSA's ATTC Network share information on ROSCs and, in some cases, provide technical assistance with establishing them. (ATTC contact information is at https://attcnetwork.org/centers/selection.) If no ROSC exists in a given area, a counselor can partner with like-minded providers and organizations to work toward developing one. Chapter 5 provides more information.

Conclusion

The competencies, strategies, and resources discussed in this chapter apply to recovery-oriented counseling, regardless of the setting or the particular counseling approach used in work with individuals considering or in recovery. Chapters 3 and 4 further discuss how to incorporate the concepts in this chapter into practice. Ideally, counseling is provided in the context of a ROSC that supports people before, during, and after SUD treatment, and, in some cases, even instead of treatment.

Chapter 3—Counseling Approaches for Promoting Harm Reduction and Preventing Recurrence

KEY MESSAGES

- Counselors can use multiple evidence-based psychosocial interventions and frameworks to help clients achieve their recovery goals, including harm reduction, trauma-informed care, motivational interviewing, cognitive–behavioral therapy, contingency management, mindfulness, acceptance and commitment therapy, and psychoeducation.
- Many psychosocial interventions and frameworks can be effectively combined to increase the odds of clients maintaining their recovery and preventing recurrence, regardless of their chosen recovery pathway.
- Family and social support are vitally important to facilitating recovery for people who have problematic substance use. Family therapy approaches can help strengthen families, leading to positive outcomes for the person in recovery and improved health and well-being for the entire family.
- Peer support services enhance counseling by connecting individuals in recovery to nonclinical professionals who have lived experience with problematic substance use, behavior change, and recovery. Peer support specialists can help clients access community resources; however, counselors also should be aware of recovery services in their local community.

Many people who need treatment for problematic substance use don't receive it. One major reason is that they don't believe they need help.[686] Other reasons people don't receive treatment include lack of insurance, the inability to pay insurance deductibles and copays, and the belief that treatment won't work. Others may not feel ready to stop their substance use.[687,688] Another key reason that people don't receive treatment is fear of the stigma associated with problematic substance use.[689]

Although many people enter recovery without professional help, people with substance use–related problems are more likely to experience long-term, stable recovery if they have access to a combination of counseling services, peer-based recovery supports, medications, and community-based recovery supports. Engaging clients in the recovery process includes establishing a collaborative alliance, helping clients resolve ambivalence about engaging in their chosen recovery pathways, working in partnership with clients to identify recovery goals, and supporting their work toward recovery tasks and goals.

Chapter 3 of this Treatment Improvement Protocol (TIP) is intended for counselors who are working with individuals in recovery from substance use–related problems, regardless of the service setting. This chapter reviews counseling approaches and interventions that can support individuals in recovery from problematic substance use, including:

- Harm Reduction.
- Trauma-Informed Approaches.
- Motivational Approaches.
- Family Therapy Approaches.
- Cognitive–Behavioral Therapy (CBT).
- Contingency Management (CM).
- Mindfulness and Acceptance-Based Approaches.
- Linkages to Peer and Community-Based Support Services.
- Psychoeducation.

For definitions of key terms that appear in this and other chapters, refer to the TIP's Executive Summary.

Harm Reduction

Overview of Harm Reduction

Harm reduction is an evidence-based, proactive approach designed to reduce the negative impacts of problematic substance use.[690] It's focused on meeting people "where they are" and on their own terms,[691,692] and includes compassionate and pragmatic strategies that aim to minimize harm related to problematic substance use. The goal of harm reduction is to enhance quality of life without requiring or advising abstinence or reduction of use.[693] According to the Substance Abuse and Mental Health Services Administration (SAMHSA), harm reduction is a "practical and transformative approach that incorporates community-driven public health strategies—including prevention, risk reduction, and health promotion—to empower people who use drugs (PWUD) and their families with the choice to live healthy, self-directed, and purpose-filled lives. Harm reduction centers the lived and living experience of PWUD, especially those in underserved communities, in these strategies and the practices that flow from them."[694]

RESOURCE ALERT: SAMHSA'S HARM REDUCTION FRAMEWORK

SAMHSA's Harm Reduction Framework outlines harm reduction pillars, principles, and core practice areas that underpin harm reduction initiatives, programs, and services. The document offers a history of harm reduction and resources to guide organizations as they strive to learn more about harm reduction strategies.

The Framework can be accessed at https://www.samhsa.gov/find-help/harm-reduction/framework.

Examples of harm reduction strategies include conducting overdose education and naloxone distribution (OEND) to reduce the risk of opioid overdose; offering test strips to check drugs for fentanyl and xylazine and support safer use; and supporting activities of daily living, including providing services to help people who are using substances obtain food, take showers, or connect with housing. **These activities have been found to reduce the risk of injury, illness, and death associated with substance use.[695]** Some harm reduction activities are also associated with reducing a person's problematic use of substances.[696] (Exhibit 3.1 contains examples of harm reduction services.)

Harm reduction is an approach designed to encourage positive change and reduce the negative health-related consequences of risky behavior that may be associated with substance use.[697,698] It is based on the premise that all people inherently deserve services that promote health, regardless of whether they have problematic substance use.[699] Given

that each person in recovery has their own recovery goals (which may or may not include abstinence from substances), harm reduction activities can encourage outcomes that help prevent overdose and infectious disease transmission for people who have problematic substance use.[700]

Harm reduction strategies are also highly effective in supporting safer substance use behaviors. For example, syringe services programs have limited the sharing of syringes, decreased HIV infection rates, and resulted in fewer overdose deaths.[701] Harm reduction strategies for opioid use disorder (OUD) have reduced the spread of infectious diseases, resulted in fewer opioid overdoses, and improved retention in and access to care.[702] Exhibit 3.2 describes SAMHSA's pillars and corresponding principles and core practice areas of harm reduction.

EXHIBIT 3.1. Harm Reduction Services

According to SAMHSA, harm reduction services can:

- Connect individuals to overdose education, counseling, and referral to treatment for infectious diseases and substance use disorders.
- Distribute opioid overdose reversal medications (i.e., naloxone) to individuals at risk of overdose or to those who might respond to an overdose.
- Lessen harms associated with drug use and related behaviors, such as high-risk sexual activity. Such behaviors may increase the risk of infectious diseases, including HIV, sexually transmitted infections, viral hepatitis, and bacterial and fungal infections.
- Reduce infectious disease transmission among people who use drugs, including those who inject drugs, by equipping them with accurate information and facilitating referral to resources.
- Reduce overdose deaths, promote linkages to care, and facilitate colocation of services as part of a comprehensive, integrated approach.
- Reduce stigma associated with substance use and co-occurring disorders.
- Promote a philosophy of hope and healing by incorporating people with lived experience of recovery in the management of harm reduction services, and connecting service recipients who have expressed interest to treatment, peer support workers, and other recovery support services.

Source: Adapted from material in the public domain. [703]

Continued on next page

EXHIBIT 3.2. Harm Reduction Pillars, Principles, and Core Practice Areas[704]

SAMHSA has outlined the following pillars and corresponding principles and core practice areas:

The six pillars state that harm reduction:

1. Is guided by people who use drugs and who have lived experience of drug use.
2. Embraces the inherent value of people.
3. Commits to deep engagement and community building.
4. Promotes equity, rights, and reparative social justice.
5. Offers the lowest barrier access and noncoercive support.
6. Focuses on any positive change, as defined by the person.

The 12 harm reduction principles call on providers to:

1. Respect autonomy.
2. Practice acceptance and hospitality.
3. Provide support.
4. Connect family (biological or chosen).
5. Provide many pathways to well-being across the continuum of health and social care.
6. Value practice-based evidence and on-the-ground experience.
7. Cultivate relationships.
8. Assist, not direct.
9. Promote safety.
10. Engage first.
11. Prioritize listening.
12. Work toward systems change.

The six core practice areas include:

1. **Safer practices**, which include education and support describing how to reduce risk. Examples include syringe services programs, safer smoking supplies distribution, and fentanyl and xylazine test strips.
2. **Safer settings**, including access to safe environments to live, find respite, practice safer use, and receive supports that are trauma informed and stigma free. Examples include day centers and social spaces that offer harm reduction services and access to safe and secure housing.
3. **Safer access to health care**, by ensuring access to person-centered and nonstigmatizing care that is trauma informed. Examples including low-barrier opioid treatment services and mobile and take-home methadone services.
4. **Safer transitions to care or connections** and access to harm-reduction-informed and trauma-informed care and services. Examples include expansion of telehealth and medication access and treatment on demand.
5. **Sustainable workforce and field**, including resources for maintaining a skilled, well-supported, and appropriately managed workforce. Examples include offering living wages and essential benefits for harm reduction workers and training and technical assistance for providers.
6. **Sustainable infrastructure**, or resources for building and maintaining a revitalized and community-led infrastructure to support harm reduction best practices and the needs of PWUD. Examples include hiring PWUD to inform policy at agencies and promoting education on the value of harm reduction services.

More information about SAMHSA's Harm Reduction Framework, including the pillars and principles, can be found at https://www.samhsa.gov/find-help/harm-reduction/framework*.*

Source: Adapted from Substance Abuse and Mental Health Services Administration. (2023). Harm reduction framework. https://www.samhsa.gov/find-help/harm-reduction/framework

Harm Reduction Methods

Several evidence-based harm reduction methods are available to support recovery from problematic substance use. Examples described below include safer injection practices, syringe services programs, OEND, drug checking using fentanyl and xylazine test strips, sexual health education and supports, protective behavioral strategies (PBS), and client goal-setting practices. Each intervention includes information for counselors who want to connect people in recovery with related resources in their community.

Safer Injection Practices

People who inject substances are at higher risk of disease transmission, including HIV and hepatitis C virus (HCV), as well as damage to their veins and other potentially serious soft tissue infections.[705,706] Those who inject substances may also be more likely to engage in high-risk sexual behaviors, such as unprotected sex, which may put them at higher risk of other sexually transmitted infections (STIs).[707] **Harm reduction practices that educate people about safer injection practices and offer clean supplies are essential for reducing exposure to infections and supporting safety with continued use.**

Counselors can access the resources in this chapter to share information with people in recovery about the importance of ensuring they have access to clean water and supplies; performing handwashing, basic hygiene, and wound care; and understanding other methods for reducing infection. Key areas to discuss include[708]:

- Cleaning hands and skin prior to injections.
- Using sterile equipment prior to each injection (the next section discusses syringe services programs).
- Cleaning used syringes with bleach if new syringes are not available.
- Understanding how to find and care for veins.
- Practicing appropriate hygiene to prevent infections following an injection.

Exhibit 3.3 identifies supplies that support safer injection practices.

RESOURCE ALERT: SAFER INJECTION PRACTICES

Counselors can access the following additional resources for more information about safer injection practices:

- The Safer Injecting Handbook, ninth edition (https://www.exchangesupplies.org/pdf/P303_9.pdf)
- National Harm Reduction Coalition, Getting Off Right: A Safety Manual for Injection Drug Users (https://harmreduction.org/issues/safer-drug-use/injection-safety-manual/)
- North Carolina Harm Reduction Coalition, Safer Injection Drug Use (https://www.nchrc.org/harm-reduction/safer-injection-drug-use/)

Syringe Services Programs

Access to clean needles and syringes helps to ensure that people who inject substances are at reduced risk of contracting HIV, viral hepatitis, or other bloodborne infections. **More than three decades of research supports the use of syringe services as safe, cost-effective, and life-saving programs for people who have problematic substance use.[709]** In fact, research indicates that new users of syringe services programs are five times more likely to enter substance use disorder (SUD) treatment and about three times more likely to stop using drugs than are people who inject substances who do not use these programs.[710]

EXHIBIT 3.3. Supplies To Support Safer Injection Practices[711]

Harm Reduction Supplies	Purpose
Sterile syringes	To reduce the risk of infection and the transmission of infectious diseases
Sterile water	A drug needs to be in liquid form to be injected. Sterile water is used for dissolving the drug prior to injection. Providing sterile water may decrease the risk of infection from using nonsterile water.
Cookers	A container that is used for heating a drug to facilitate dissolution. Often a bottle cap or spoon-like device. Providing cookers may decrease the risk of transmitting HCV.
Cotton	Used to filter insoluble contaminants from drugs dissolved in a solution. The cotton is placed in with the drug solution. A syringe is used to draw the drug through the cotton filter. The filter should be long-stranded cotton to prevent inadvertent injection of microscopic fibers.
Twist ties	Twisted around cooker to make a handle to prevent burn injuries
Tourniquet	To tie off arms or legs to make veins more prominent and minimize subcutaneous and intramuscular injection. Application and removal advice is important to prevent vascular injury.
Alcohol wipes	To clean the skin prior to injecting to reduce the risk of infection
Vitamin C/ascorbic acid powder	Provides acid to facilitate substance dissolution. Providing vitamin C may reduce risk of using less sterile products (e.g., lemon juice).
Bleach	To clean used syringe and injection equipment when sterile equipment is not available, to reduce risk of infection and transmission of infectious diseases
Source: Adapted from Harm reduction strategies for people who inject drugs: Considerations for pharmacists (p. 6), by C. Stock, M. Geier, and K. Nowicki, 2021, CPNP https://aapp.org/guideline/harmreduction*. Copyright 2021 by CPNP.* CC BY-NC 3.0*.*	

Most community-based syringe services programs provide access to sterile needles, syringes, and other injection equipment; facilitate safe disposal of used syringes; and offer a range of other services, including[712,713,714,715]:

- Referrals to SUD treatment programs.
- Screening, care, and treatment to prevent HIV, STIs, and viral hepatitis.
- Sexual health programming, including counseling and condom distribution.
- Education about overdose prevention and safer injection practices.
- Vaccinations.
- OEND.
- Referral to a range of other services.

RESOURCE ALERT: SYRINGE SERVICES PROGRAMS

Additional resources on needle and syringe services programs can be found below:

- The North America Syringe Exchange Network provides a directory of syringe services programs in the United States (https://nasen.org/directory).
- The Centers for Disease Control and Prevention (CDC) offers fact sheets and resources on syringe services programs (https://www.cdc.gov/ssp/index.html).
- The CDC produced a document highlighting effective strategies for implementing syringe services programs (https://www.cdc.gov/ssp/docs/SSP-Technical-Package.pdf).
- The National Institute on Drug Abuse also posts information on syringe services programs (https://nida.nih.gov/drug-topics/syringe-services-programs).

HARM REDUCTION STRATEGIES FOR ADDRESSING HCV

HCV infects liver cells, causing inflammation and damage. Chronic infection with HCV can lead to serious health problems, including cirrhosis and liver cancer.[716] The virus is spread through direct contact with the blood of someone who is infected with HCV.[717,718] Sharing syringes and injection equipment is the most common way that HCV is spread.[719,720] In fact, more than 60 percent of people newly infected with HCV identify injection drug use as a risk factor.[721] Harm reduction strategies can significantly reduce the risk of HCV infection among people recovering from problematic substance use who continue to inject substances.

To stop the spread of HCV, individuals should:

- Get tested as soon as possible. If an individual tests negative, they can take steps to reduce their risk in the future, including through safer injection strategies, described below. If they test positive, medications can treat HCV.[722] An overview of these medications, including prescribing information, can be found at https://www.hepatitisc.uw.edu/page/treatment/drugs.
- Use safer injection strategies. This includes using sterile injection equipment and avoiding reusing or sharing equipment. More information about safer injection strategies to prevent the spread of HCV can be found at https://harmreduction.org/issues/hepatitis-c/basics-brochure/.

Naloxone and Overdose Education Kits

Naloxone, a medication that can rapidly reverse an opioid overdose, is an essential harm reduction tool for people who have problematic opioid use. Naloxone attaches to opioid receptors and reverses and blocks the effects of opioids. The medication, which is now available over the counter as a nasal spray as well as by prescription, can quickly restore normal breathing to a person if their breathing has slowed or stopped because of an opioid overdose.[723,724] In fact, **SAMHSA recommends that every client who has problematic opioid use or OUD receive opioid overdose prevention education and naloxone.[725]** Naloxone is generally not harmful. In the event of an ongoing overdose, the risk of death associated with opioid overdose is far greater than the risk of experiencing adverse effects from naloxone administration.[726]

However, counselors should be aware that naloxone may cause individuals to go into withdrawal.[727] For those with OUD, connection to medication-assisted recovery services is a critical next step following naloxone administration. Counselors can learn more about these symptoms and naloxone at https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/naloxone.

RESOURCE ALERT: NALOXONE AND OVERDOSE PREVENTION EDUCATION

More information about naloxone and other overdose prevention education can be found at the following links:

- SAMHSA:
  - TIP 63, Medications for Opioid Use Disorder (https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP21-02-01-002)
  - SAMHSA Opioid Overdose Prevention Toolkit (https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA18-4742)
  - Naloxone webpage (https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/naloxone)
- Prescribe To Prevent provides information about prescribing naloxone for overdose prevention, including educational handouts and videos (http://prescribetoprevent.org).
- The National Institute on Drug Abuse presents facts about naloxone for providers (https://nida.nih.gov/publications/drugfacts/naloxone).
- The Centers for Disease Control and Prevention offers fact sheets on reversing opioid overdoses with lifesaving naloxone (https://www.cdc.gov/opioids/naloxone/factsheets/index.html).
- OpiSafe offers a free smartphone app with interactive prompts for overdose rescue (https://opisafe.com/products/opirescue).

The Food and Drug Administration (FDA) has approved naloxone in both injectable and nasal spray form.[728] Information about naloxone, prescribing, and client and community education can be found in the *SAMHSA Opioid Overdose Prevention Toolkit* (https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA18-4742).[729]

Naloxone is accessible in all states. However, the out-of-pocket cost to purchase naloxone may be high, creating a barrier for uninsured patients as well as for those who have insurance with high copays.[730] Counselors can learn more about where to access naloxone from their state health or behavioral health department as well as the following sources:

- NEXT Distro provides information about community-based naloxone programs and can be accessed at https://www.naloxoneforall.org/.
- The North America Syringe Exchange Network's syringe services locator identifies places where naloxone is offered (https://www.nasen.org/map/).

NALOXONE AS A HARM REDUCTION TOOL TO PREVENT OPIOID USE–RELATED OVERDOSES

Naloxone distribution, combined with overdose education programs, has successfully reduced opioid overdose deaths in recent years. In fact, communities with naloxone distribution and overdose education programs have shown greater reductions in overdose mortality, compared with those without such programs.[731] In one study, opioid overdose death rates were 27 to 46 percent lower in communities where naloxone and overdose education programs were in place.[732] Another study conducted in San Francisco found that 11 percent of participants used naloxone during an overdose, and 89 percent of overdoses were reversed in these cases. These data highlight the effectiveness of this medication in saving lives.[733,734]

Fentanyl and Xylazine Test Strips

The use of fentanyl has been associated with a significant increase in overdose and death rates.[735] Fentanyl is a powerful synthetic opioid that is 50 times stronger than heroin and 100 times stronger than morphine.[736,737] Although pharmaceutically produced fentanyl is prescribed to treat pain, illicitly manufactured fentanyl may be added to other substances, making those drugs more powerful and addictive. It is also difficult to tell whether a substance contains fentanyl, making the substance more dangerous.[738,739]

Fentanyl test strips, which can now be purchased with federal funding, can detect the presence of fentanyl within 5 minutes. They are an essential harm reduction tool for reducing overdose and deaths related to this substance.[740,741,742] The correct use of fentanyl test strips requires education about how to correctly dilute the solution being tested.[743]

Counselors can learn how to access and use fentanyl test strips through local syringe services programs. The North America Syringe Exchange Network's website has a map with links for locating many of these programs in their communities (https://www.nasen.org/map/).

Xylazine, also called "tranq" or "tranq dope," is a tranquilizer increasingly being added to other drugs, such as cocaine, heroin, and fentanyl, either to enhance the drug effects or increase street value by increasing their weight. Xylazine's effects can be life-threatening, particularly when combined with opioids, like fentanyl. Although it is FDA-approved for use in animals, xylazine is not approved for use in humans.

There are harm reduction strategies that can help address a potential xylazine overdose, including administering naloxone. Naloxone will not reverse the effects of xylazine. However, it should always be administered to anyone with a suspected overdose because xylazine is often mixed with other opioids.

Similar to fentanyl test strips, xylazine test strips can also be used to test for the presence of xylazine prior to use.[744]

For more information about xylazine test strips, including where you can obtain them, visit https://mattersnetwork.org/harmreduction/.

RESOURCE ALERT: FENTANYL AND XYLAZINE TEST STRIPS

More information about fentanyl test strips can be accessed from:

- The Centers for Disease Control and Prevention (https://www.cdc.gov/stopoverdose/fentanyl/fentanyl-test-strips.html).
- National Harm Reduction Coalition (https://harmreduction.org/issues/fentanyl/).
- Connecticut Department of Public Health (https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/AIDS--Chronic-Diseases/Prevention/DPH_FentanylTestStrips.pdf).
- New York State Office of Addiction Services and Supports (https://oasas.ny.gov/xylazine).

Access to Reproductive and Sexual Health Services

Sexual health services and education have been documented to prevent the transmission of HIV and other STIs as well as reduce the number of unplanned pregnancies. Studies indicate that **problematic substance use may put people at higher risk of getting HIV and other STIs as well as other infections.**[745]

Additionally, some people with problematic substance use may also engage in some form of sex work. In an examination of substance use among sex workers in 86 studies from 46 countries, more than a third of sex workers reported problematic substance use over their lifetime.[746] Sex workers who also have problematic substance use may be increasingly vulnerable to infectious diseases, including HIV and other STIs; violence, stigma, and discrimination;

and exploitation.[747] Clients who are using substances like methamphetamine and cocaine may engage in sex work as a means to obtain a source of income to pay for substances. These clients may feel ambivalent about abstaining from substance use in this case. Thus, for those who engage in sex work, counselors should help them develop safety plans, identify and avoid cues and triggers related to substance use, and take greater control over their reproductive health.[748]

Sexual health programs are particularly important for reducing harm among people who have problematic substance use, including those engaging in sex work.[749] These programs often include[750]:

- **Access to HIV prevention methods, such as preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP)**. PrEP and PEP are effective medications that are part of sexual health programs nationwide. These medications, described below, can prevent HIV transmission and be prescribed by primary care providers, community health centers, and other service providers.
  - PrEP can prevent infection in people who may be at risk for contracting HIV. The FDA has approved two daily oral medications for PrEP and a long-acting injectable form.[751] More information about PrEP can be found at https://www.hiv.gov/hiv-basics/hiv-prevention/using-hiv-medication-to-reduce-risk/pre-exposure-prophylaxis.
  - PEP can prevent HIV when taken within 72 hours (3 days) after a possible exposure.[752] More information about PEP can be found at https://www.hiv.gov/hiv-basics/hiv-prevention/using-hiv-medication-to-reduce-risk/post-exposure-prophylaxis.
  - HIV prevention and testing services can be found at https://npin.cdc.gov/search/organization/prevention/HIV.

RESOURCE ALERT: SEXUAL HEALTH SERVICES

- More information about birth control options, including their effectiveness, can be found at https://www.cdc.gov/reproductivehealth/contraception/index.htm.
- The National Harm Reduction Coalition publishes a pregnancy and substance use harm reduction toolkit with information about sexual health as well as other resources. It can be accessed at https://harmreduction.org/issues/pregnancy-and-substance-use-a-harm-reduction-toolkit/#section2.

- **Access to birth control options.** Offering birth control options, such as long-acting reversible contraceptives, birth control pills, condoms, and other types of contraceptives, is effective in reducing unplanned pregnancies and supporting sexual health. Birth control options should be offered in conjunction with STI testing and treatment services.
  - Studies indicate that women who inject substances may have unmet needs for reproductive health services, such as access to birth control.[753] They also may face many barriers to accessing this kind of care in traditional settings, including personal histories of trauma and judgmental treatment from providers, among other challenges.[754]
  - Increased access to sexual health services and contraception are needed and supported by organizations like the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, which have also endorsed expanding access to comprehensive contraception services, including long-acting reversible contraceptives, as an essential harm reduction tool in the opioid epidemic response.[755]

- Broader access to these types of contraceptives and other contraceptive methods are important tools for people who have problematic substance use and who are interested in preventing pregnancy.
- Condom distribution programs have been implemented in communities across the country and have been shown to be effective for preventing the spread of HIV and other STIs as well as reducing unplanned pregnancies.[756]
- According to the Centers for Disease Control and Prevention, making condoms widely available through distribution programs is essential to successful HIV prevention.[757]
- More information about condom distribution programs, including where programs are located, can be found at https://www.cdc.gov/hiv/effective-interventions/prevent/condom-distribution-programs/index.html.

- **Comprehensive sexual education.** Offering comprehensive sexual education, including education on HIV and STI prevention and birth control options, is an essential part of promoting health and well-being for people who have problematic substance use.

Chapter 4 discusses further how counselors can help connect clients to providers, including gynecologists and obstetricians, who can help provide sexual and reproductive health services.

PBS

PBS are harm reduction strategies that can reduce the use and severity of consequences from problematic substance use.[758] Regarding problematic alcohol use, examples of PBS include defining limits around drinking and behavior, such as deciding not to exceed a set number of drinks or choosing not to engage in behaviors that lead to drinking quickly.[759] Some common activities used with PBS include brief motivational interventions, PBS skills training, personalized normative feedback, and PBS instruction.[760] Important considerations when discussing PBS with clients include the client's social environment, how substance use may be embedded in their culture, or how they connect socially.[761]

PBS have been studied as a harm reduction practice to address problematic marijuana use. By developing specific personal strategies for moderating use, **PBS were found to reduce impulsivity and risk taking related to marijuana use. They also were found to enhance protective factors among people with problematic marijuana use.[762]**

Client Goal Setting To Reduce Use

Client-driven goal setting can help clients interested in reducing substance use by allowing them to set individual and achievable goals. This type of goal setting does not often focus on abstinence. Rather, **clients identify goals related to reducing substance use–related harm or improving quality of life.[763]**

After initial goals are identified, counselors may ask open-ended questions and engage in strengths-based reflections to elicit client progress toward their harm reduction goals.

HARM REDUCTION STRATEGIES TO PREVENT STIMULANT OVERAMPING

"Overamping," although not recognized as a condition by medical professionals, is a term used to describe a constellation of physical and psychological symptoms[764] that one may experience after taking stimulants, such as cocaine. People experiencing overamping may feel physical or psychological symptoms, such as "feeling off" or experiencing paranoia, mania, or anxiety.[765,766] Other symptoms may include a strong desire to sleep or, conversely, severe sleeplessness with dehydration.[767] High blood pressure and heart disease can put people at higher risk of overamping and having a heart attack.[768]

Counselors can help clients avoid overamping in a number of ways, such as helping them to get their heart, blood pressure, and cholesterol checked to ensure they are in good health. They can encourage clients to try to get regular sleep, eat healthy foods, and stay hydrated. Counselors should also be aware of the symptoms of overamping, including[769]:

- Nausea and/or vomiting.
- Falling asleep.
- Chest pain or tightening.
- High temperature.
- Fast heart rate.
- Severe headache.
- Convulsions.

More information about preventing and recognizing stimulant overamping can be found in the National Harm Reduction Coalition's *Stimulant Overamping Basics Training Guide* at https://harmreduction.org/issues/overdose-prevention/overview/stimulant-overamping-basics/what-is-overamping/.

Counselors also can provide affirmations and encouragement to support ongoing goal actualization. Working collaboratively to track progress, counselors and their clients should discuss barriers to progress. However, **remaining supportive, regardless of client progress, is an essential part of this intervention.**[770]

Motivational interviewing (MI) can be a critical tool in supporting the development of goals. As discussed in subsequent sections of this chapter, MI is an effective, evidence-based technique for helping clients identify their strengths and goals as well as barriers to progress on those goals that may be preventing change. The core principles of MI are to express empathy and elicit clients' reasons for and commitment to addressing problematic substance use.[771,772] Counselors must be trained in skills and strategies involved in MI. These skills are particularly useful for helping clients identify goals to reduce or address problematic substance use.

RESOURCE ALERT: MI AND CLIENT GOAL SETTING

More information about client goal setting and MI can be found in SAMHSA's TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment,* at https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003.

Trauma-Informed Approaches

Many people experience trauma during their lifetime. Trauma can result from physically or emotionally harmful or life-threatening experiences that can cause lasting adverse effects on a person's well-being.[773] Trauma is in fact how we experience these events and can be different for various members of a family or community. Some clients

may experience trauma directly related to a specific event, whereas others may have trauma resulting from cumulative experiences of childhood abuse and neglect. Trauma and SUD often occur together, and the experience of trauma can result in or from problematic substance use.[774,775] For example, one study indicated that of individuals with posttraumatic stress disorder (PTSD), 46 percent also had an SUD.[776] **Failing to address trauma in people who have problematic substance use can lead to worse outcomes.[777]**

Counselors should **be able to recognize the effects of trauma on the lives of people in recovery and develop trauma-sensitive or trauma-responsive services.** Those who have survived trauma will vary in how they experience it. A client may have emotional reactions (e.g., anxiety, guilt, sadness, depression); physical reactions (e.g., sweating, nausea, fatigue, sleep disturbances); and cognitive reactions (e.g., difficulty concentrating, memory problems, self-blame); among many others. More information about immediate and delayed signs of trauma can be found in SAMHSA's TIP 57, *Trauma-Informed Care in Behavioral Health Services* (https://www.samhsa.gov/resource/ebp/tip-57-trauma-informed-care-behavioral-health-services).

Becoming trauma aware and informed is a first step in this process.[778] Counselors can use the information below to learn about types of trauma, understand how to recognize trauma, and identify ways to support people in recovery with a trauma history. The trauma-informed therapies in this section can help people in recovery manage trauma-specific symptoms, removing another barrier to their recovery.

Overview of Trauma-Informed Approaches

Trauma-informed care is grounded in an understanding of and responsiveness to the impact of trauma.[779] **Trauma-informed care is strengths-based, which requires that counselors be aware of their clients' trauma and understand that clients must be directly involved in their own care.** Clients become empowered and invested in the outcome when they have input into their goals and treatment.[780] **Trauma-informed care means attending to trauma-related symptoms and creating an environment that is responsive to the unique needs of individuals with histories of trauma.** Treatment is focused on reducing specific symptoms and restoring functioning, but it also addresses broader goals like building resiliency, reestablishing trust, and preventing retraumatization.[781]

PROVIDING TRAUMA-INFORMED SCREENING AND ASSESSMENT

Counselors should offer trauma-informed screening and assessment when working with clients. SAMHSA's TIP 57, *Trauma-Informed Care in Behavioral Health Services,* offers information about how counselors can create an effective screening and assessment environment for their clients who may have experienced trauma.[782] Specific guidance includes[783]:

- Clarifying for the client what they may expect in the screening and assessment process.
- Approaching the client in a supportive manner.
- Creating an atmosphere of trust, respect, acceptance, and thoughtfulness.
- Respecting the client's personal space.
- Adjusting the tone and volume of speech to match the client's level of engagement and level of comfort.
- Requesting only the information necessary for conducting the screening and assessment.

More information about how to conduct trauma-informed screening and assessment can be found in SAMHSA's TIP 57 at https://www.samhsa.gov/resource/ebp/tip-57-trauma-informed-care-behavioral-health-services.

Counselors should understand how to recognize trauma-related reactions, how to incorporate treatment interventions for trauma-related symptoms into clients' treatment plans, and how to help clients build a safety net to prevent further trauma.[784] **Trauma-informed approaches support both counselors and people in recovery.** This approach encourages better understanding of a client's potential trauma history and builds trust between the counselor and the person in recovery. It can also help counselors adapt interventions to ensure they are addressing the unique needs of the person in recovery.

Use of language in trauma-informed care is important. Counselors should ensure that interventions and interactions don't distress or retraumatize clients. Trauma can be grounded in relationships; thus, a counselor's role is essential to supporting their client. They should also avoid being confrontational or argumentative with clients or dismissive of their experiences and feelings. By minimizing or ignoring clients' responses and needs or pushing clients to talk in greater detail about their trauma, counselors run the risk of retraumatizing them.[785]

Elements and Principles of Trauma-Informed Care

SAMHSA has outlined the elements of trauma along with key principles of trauma-informed care in its strategic initiative for trauma and justice (Exhibit 3.4). Counselors should be aware of these foundational concepts as they integrate trauma-informed approaches into their work.[786] **Being trauma informed requires "recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic."[787]** Key elements of a trauma-informed approach include[788]:

- **Realizing** the widespread effects of trauma and the various paths to recovery.
- **Recognizing** the signs and symptoms of trauma.
- **Responding** by putting this knowledge into practice.
- **Resisting** retraumatizing people in recovery by working to provide a supportive environment and examining language.

LANGUAGE MATTERS

Being culturally responsive is a key part of delivering trauma-informed services. Cultural responsiveness is honoring and respecting the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services.[789] Use of language that supports clients and avoids retraumatizing them is essential. Counselors should receive training on cultural responsiveness and trauma-informed care to avoid using language that may trigger trauma.

In fact, use of the term "trauma-informed care" may also create challenges for clients. As one author noted, using the term[790]:

- Ignores the entirety of a client's experience by focusing only on that person's harm, injury, and trauma.
- Focuses on the treatment of a client's pathology (trauma), rather than the client's overall well-being.
- Presumes that the trauma is an individual experience, rather than a collective one.

For these reasons, some have suggested use of the term "healing-centered care," rather than trauma-informed care, with a more holistic focus on well-being and community.[791] This example further demonstrates the importance of using language that is sensitive to the needs of clients.[792]

RESOURCE ALERT: TRAUMA-INFORMED CARE IN BEHAVIORAL HEALTH

Counselors can access additional resources on trauma-informed care to support clients in their work. These include:

- **SAMHSA's TIP 57, *Trauma-Informed Care in Behavioral Health Services,*** which includes information about trauma awareness; understanding the impact of trauma, such as symptoms and related disorders; screening and assessment; clinical issues; and trauma-specific services. It also includes an implementation guide for behavioral health program administrators about becoming a trauma-informed organization. The TIP can be accessed at https://www.samhsa.gov/resource/ebp/tip-57-trauma-informed-care-behavioral-health-services.
- **The National Center for Trauma-Informed Care, Center for Health Care Strategies' Trauma-Informed Care Implementation Resource Center,** which offers consultation, technical assistance, education, outreach, and resources to support trauma-informed care in systems and programs. The focus of its work is to help health service providers and programs become more aware of the effects of trauma on clients, to adapt services to incorporate trauma-informed practices, and to help raise awareness of practices or processes that are more likely to retraumatize clients. The Center offers resources and materials for healthcare organizations to learn about and adopt best practices related to trauma-informed care. The resources can be found at https://www.traumainformedcare.chcs.org/.

EXHIBIT 3.4. Key Principles of a Trauma-Informed Approach

SAMHSA identifies six key principles of a trauma-informed approach[793]:

- Safety: Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe; and interpersonal interactions promote a sense of safety.
- Trustworthiness and Transparency: Organizational operations and decisions are conducted with transparency, with the goal of building and maintaining trust with clients and family members, agency staff, and others involved in the organization.
- Peer Support: Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, and enhancing collaboration. Peers use their stories and lived experiences to promote recovery and healing.
- Collaboration and Mutuality: Importance is placed on partnering and the leveling of power between staff and clients, among organizational staff and clients, and among organizational staff from clerical and housekeeping personnel to administrators. Healing happens in relationships and in the meaningful sharing of power and decision making.
- Empowerment, Voice, and Choice: Throughout the organization and among the clients served, individuals' strengths and experiences are recognized and built upon. The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma.
- Cultural, Historical, and Gender Issues: The organization actively moves past cultural stereotypes and biases; offers access to gender-responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served; and recognizes and addresses historical trauma.

UNDERSTANDING PERPETRATION-INDUCED TRAUMA

When most people think about trauma, they think of victims of trauma. However, some people who have inflicted violence on others also have trauma from those experiences.[794] For example, veterans or others serving in combat situations who have been directly engaged in violent acts may develop trauma-related symptoms or PTSD because of their participation.[795,796] Studies indicate that killing someone during combat is a risk factor for the development of PTSD, a diagnosis closely linked with developing subsequent problematic substance use.[797,798]

Counselors should be aware of perpetration-induced trauma. The Department of Veterans Affairs' National Center for PTSD has resources available to support counselors and help them learn more about these issues.

- More information about the treatment of co-occurring PTSD and SUD can be accessed at https://www.ptsd.va.gov/professional/treat/cooccurring/tx_sud_va.asp.
- Information on trauma-informed care and treatment for trauma and PTSD, including a Community Provider Toolkit, can be found at https://www.ptsd.va.gov/professional/treat/care/index.asp.
- More information about types of trauma as well as manuals and tools to treat trauma is available at https://www.ptsd.va.gov/professional/treat/type/index.asp.

Trauma and Problematic Substance Use

As discussed in Chapter 1, people in recovery may have experienced trauma, defined by SAMHSA as a result of an event or series of events that are physically and emotionally harmful, or life threatening, and that have lasting adverse effects on a person's mental, physical, social, emotional, or spiritual well-being.[799] People experience trauma in different ways and may experience multiple traumatic events. Trauma can be acute, chronic, or complex.[800]

Counselors should be aware of the range of trauma that people in recovery may have experienced. They should also be conscious of the fact that clients may have experienced many different forms of trauma within their lifetimes.

Adverse childhood experiences are traumatic events that occur during childhood, such as physical or emotional abuse, or parental neglect.[801,802] Stress from these events can affect brain development, resulting in long-term negative health and emotional consequences for the person, including SUD.[803,804,805] Sexual abuse, which may occur during childhood, is closely linked with SUDs and has also been shown to disrupt the efficacy of SUD treatment.[806] Problematic substance use can also expose people to traumatic experiences, such as homelessness or gun violence.[807,808]

People in recovery may have also experienced historical, racial, or intergenerational trauma. Historical trauma refers to traumatic experiences or events shared by historically oppressed groups. Racial trauma results from exposure to racism, bias, and discrimination. Intergenerational trauma passes down from those who directly experience the trauma to subsequent generations. Intergenerational trauma can occur because of historical or racial trauma. People who experience these forms of trauma may be more likely to have problematic substance use. Intimate partner violence is also associated with problematic substance use. People who experience substance use coercion, defined as controlling or interfering with a partner's SUD treatment or forcing a partner to use substances, are more likely to have problematic substance use.[809]

Other forms of trauma associated with problematic substance use may include the experience of poverty, homelessness,[810] and food insecurity. Trauma may also result from involvement in the criminal justice system. In fact, trauma is disproportionately present in individuals with exposure to the

criminal justice system, and trauma exposure among people who are incarcerated has been associated with alcohol and substance use.[811] Another form of trauma, military combat trauma, is also associated with development of problematic substance use (more information can be found in the "Understanding Perpetration-Induced Trauma" box).[812] Each of these forms of trauma requires an individualized, trauma-informed, and culturally responsive approach by counselors.

Principles of a Trauma-Informed Care Framework for Counselors

Working with a person in recovery who has a history of trauma can be challenging. Counselors should be aware of trauma-informed care before working with individuals in recovery who have a history of trauma. SAMHSA's TIP 57, *Trauma-Informed Care in Behavioral Health Services*, includes information for counselors about trauma awareness; understanding the impact of trauma; clinical issues; and trauma-specific services. The TIP can be accessed at https://www.samhsa.gov/resource/ebp/tip-57-trauma-informed-care-behavioral-health-services. Counselors can use the following treatment principles to guide them in developing trauma-informed approaches that meet the needs of people in recovery who have a history of trauma. They include[813]:

- **Promoting trauma awareness.** Counselors should recognize the prevalence of trauma and its role in problematic substance use. For example, research indicates that there are high rates of comorbidity between SUD and posttraumatic stress disorder.[814] In fact, data indicate that those with SUD are 6.5 times more likely to have PTSD that those without SUD.[815] With the understanding that trauma and problematic substance use may often co-occur, counselors can tailor their work with those in recovery. However, counselors should not assume everyone has experienced trauma. Screening and assessment tools can help counselors to better understand the range of traumatic experiences that clients may have experienced. They should keep in mind that clients may avoid openly discussing traumatic events as these may evoke feelings of shame, guilt, or fear of retribution by others associated with the event. Thus, in some cases clients may be more likely to report trauma when they use self-administered screening tools.[816]
- **Recognizing trauma.** Once aware of a person in recovery's trauma history, a counselor can begin to understand where they may be coming from, working with them from a hopeful, strengths-based position, and building upon the belief that their "responses to traumatic experiences reflect creativity, self-preservation, and determination."[817]
- **Examining trauma in the context of the person in recovery's environment.** To understand a client's trauma history, a counselor must consider the environmental and individual, interpersonal, community, societal, cultural, and historical factors that played a role. The context of traumatic events can help inform and guide the counselor's approach to a client's treatment and recovery.
- **Minimizing retraumatization.** Counselors should ensure that they don't offer treatment or use language that may inadvertently retraumatize people in recovery. They should review their practices to determine whether they may retraumatize a person in recovery.
- **Creating a safe environment.** People in recovery should feel safe and supported in the environment where they meet with counselors. Avoiding potential triggers is critical to creating a safe environment for people in recovery. Asking clients to discuss the trauma can be a potential trigger and may retraumatize them in the process. Instead, educating clients about how discussing trauma may affect them may be the first step. Acknowledging

the relationship between problematic substance use and trauma and educating clients on the impact of trauma may allow them to begin to develop trust with their counselors so that they feel more comfortable sharing their trauma.

- **Identifying recovery as a primary goal.** Counselors need to bridge the gap between a person in recovery's problematic substance use and the traumatic experiences they may have had. If people in recovery engage in treatment for problematic substance use without addressing the role that trauma has played in their lives, they are less likely to experience recovery overall.[818] Helping clients develop the skills to recognize their own trauma and triggers and responses to that trauma may help them as they work towards their recovery.
- **Viewing trauma through a sociocultural lens.** Counselors should learn about the life experiences and cultural background of people in recovery as these are key elements for building culturally responsive practices. Culturally responsive practices should guide the recovery process.
- **Developing strategies to address secondary trauma and promote self-care.** Secondary trauma refers to the trauma that behavioral health service and other providers may experience through exposure to their clients' traumatic experiences.[819] Working with survivors of trauma may cause additional trauma-related symptoms for counselors. Counselors can reduce the risk of secondary trauma by monitoring their own mental health needs, seeking assistance from behavioral health service providers, and engaging in self-care activities.

AVOIDING RETRAUMATIZATION[820]

To avoid retraumatizing a person in recovery, counselors can:

- Talk to a person in recovery about cues they associate with the traumatic experience.
- Develop and maintain a supportive, empathetic, and collaborative relationship with the person in recovery.
- Encourage ongoing discussion with the person in recovery about their needs.
- Ensure they are available to meet with and discuss any concerns or problems the person in recovery is having throughout treatment.

Overview of Trauma-Informed Therapies

Trauma-informed therapies may include[821]:

- Providing psychoeducation, especially about the relationship between trauma and problematic substance use.
- Teaching coping and problem-solving skills about how to manage stress.
- Discussing retraumatization and developing strategies to prevent further victimization.
- Helping clients feel empowered and in control of their lives.
- Establishing a sense of safety in clients' daily lives and in treatment.
- Promoting resilience and offering hope for change and improvement.
- Teaching clients how to identify and respond adaptatively to triggers.
- Building a strong relationship, which includes trust, confidence, and self-worth.

Counselors can select from many trauma-informed therapies to support people in recovery with a trauma history (Exhibit 3.5).

EXHIBIT 3.5. Overview of Trauma-Informed Therapies

Therapy	Purpose	Brief Overview
Eye Movement Desensitization and Reprocessing (EMDR)[822]	EMDR therapy can help process experiences that are causing problems and distress. It is effective for treating PTSD and trauma. Consider using EMDR with clients who are more stable rather than with those initially seeking recovery support.	The treatment involves three main concentrations (past memories, present disturbances, future actions) and eight phases: (1) History and Treatment Planning; (2) Preparation; (3) Assessment and Reprocessing; (4) Desensitization; (5) Installation; (6) Body Scan; (7) Closure; and (8) Reevaluation. More information can be found at https://www.emdr.com/.
Accelerated Resolution Therapy (ART)[823]	ART includes imaginative therapy that can help those with PTSD, phobias, anxiety, depression, and trauma.	The therapy focuses on rescripting an individual's traumatic events through visualization and other techniques. More information can be found in *Accelerated Resolution Therapy for Posttraumatic Stress Disorder* at https://health.mil/Military-Health-Topics/Centers-of-Excellence/Psychological-Health-Center-of-Excellence/PHCoE-Research-and-Analytics/Psych-Health-Evidence-Briefs.
Exposure Therapy[824]	In exposure therapy, people in recovery describe and explore trauma-related memories with the eventual goal of decreasing and desensitizing traumatic thoughts.	Exposure therapy is recommended when the prominent trauma symptoms are intrusive thoughts, flashbacks, or trauma-related fears, panic, and avoidance. Clients explore trauma-related memories through a series of activities. Common methods include exposure through imagery or real life. More information can be found at https://www.apa.org/ptsd-guideline/patients-and-families/exposure-therapy.pdf.
Narrative Therapy[825]	Narrative therapy is premised on the idea that people are the experts on their own lives and can access existing resources to reduce the impact of problems in their lives. It was developed for treatment of PTSD and used to support treatment for other trauma.	Narrative therapy is based on CBT principles, particularly exposure therapy, and includes the use of stories in therapy with the client as the storyteller. Narrative is told and retold from the voice of the client to put the trauma in context of the survivor's life, defining options for change. More information can be found at https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816 and https://www.apa.org/ptsd-guideline/treatments/narrative-exposure-therapy.

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Cognitive Processing Therapy (CPT)[826]	CPT was initially developed to address PTSD and depression in rape survivors; however, CPT can also support individuals with PTSD stemming from other types of traumatic experiences. It combines elements of existing treatments for PTSD.	CPT includes an exposure therapy component requiring clients to write a detailed account of their trauma. The client then reads the narrative aloud during a session and at home. The cognitive therapy aspect of CPT focuses on key themes, including safety, trust, power, control, self-esteem, and intimacy. More information can be found at https://www.apa.org/ptsd-guideline/treatments/cognitive-processing-therapy.
Dialectical Behavior Therapy (DBT)[827]	DBT was developed to support individuals who have significant challenges; for example, those experiencing suicidal thoughts or with borderline personality disorder.	DBT combines elements of CBT, behavior therapy, and mindfulness to help clients regulate and tolerate their emotions. More information can be found at https://www.mirecc.va.gov/visn16/dbt.asp.
Skills Training in Affective and Interpersonal Regulation[828]	This cognitive behavioral model adapts therapies from other models, including CBT and DBT. It focuses on addressing trauma related to child abuse.	Phase 1 consists of skills training in affect and interpersonal regulation derived from general CBT and DBT. Phase 2 features narrative therapy approaches. More information can be found at https://www.ptsd.va.gov/professional/continuing_ed/STAIR_online_training.asp.
Stress Inoculation Training (SIT)[829]	SIT is based on the premise that anxiety and fear experienced during trauma generalize to other objectively safe situations.	Treatment components include education, skills training, role-playing, guided self-talk, assertiveness training, and thought stopping, among other areas. More information can be found at https://www.ptsd.va.gov/understand_tx/stress_inoculation_training.asp.
Mindfulness Techniques for Trauma[830]	Mindfulness is based on the process of learning to be present in the moment. The goal is to help people with a trauma history observe their experiences, increase awareness, and tolerate uncomfortable emotions.	A variety of mindfulness practices are available to help clients manage traumatic stress and increase coping skills and resilience. More information can be found at https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816.
Integrated Models		
Addiction and Trauma Recovery Integration Model[831]	This model supports clients in exploring anxiety, sexuality, self-harm, depression, anger, physical complaints and ailments, sleep difficulties, relationship challenges, and spiritual disconnection.	The model integrates CBT and other treatment models over a 12-week period, focusing on the body's responses to addiction and traumatic stress and the impact of trauma and addiction on the mind and spirit. More information can be found at https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816.

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Concurrent Treatment of PTSD and Cocaine Dependence[832]	This approach is designed to treat co-occurring PTSD and cocaine dependence.	Includes a 16-session, twice-weekly individual outpatient psychotherapy model and combines imagery and in-person exposure therapy. More information can be found at https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816.
Seeking Safety[833]	Seeking Safety helps clients attain safety from trauma and problematic substance use through an emphasis on ideals and simple, emotionally evocative language and quotations.	Offers strategies to help clients dealing with concurrent SUDs and histories of trauma. The approach covers 25 topics that address cognitive, behavioral, interpersonal, and case management domains. More information can be found at https://www.treatment-innovations.org/seeking-safety.html.
Substance Dependence PTSD Therapy[834]	This therapy combines existing treatments for PTSD and problematic substance use to help clients with a range of traumas.	A structured 40-session individual therapy focusing on coping skills, cognitive interventions, and creating a safe environment. The therapy draws on CBT models, anger management, relaxation training, HIV risk reduction, and motivational enhancement techniques. Also, it includes exposure therapy and psychoeducation about trauma. More information can be found at https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816.
Trauma Affect Regulation: Guide for Education and Therapy (TARGET)[835]	TARGET is a strengths-based, resilience-building and recovery program that helps survivors understand how trauma changes the brain. It includes skills training for trauma survivors who have problematic substance use and co-occurring disorders.	TARGET is a seven-step approach to addressing PTSD symptoms. The seven steps are: focusing, recognizing triggers, conducting an emotion self-check, evaluating thoughts, defining goals, identifying options, and making a contribution. More information can be found at https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816.
Trauma Recovery and Empowerment Model (TREM)[836]	TREM is a group intervention designed for female trauma survivors (sexual and physical abuse) with severe mental disorders.	The model develops recovery skills using techniques effective in trauma recovery services. It is informed by the role of gender in women's experiences of and coping with trauma. TREM addresses empowerment, trauma recovery, advanced trauma recovery issues, closing rituals, and modifications for special populations. More information can be found at https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816.

Motivational Approaches

Overview of MI and Motivational Enhancement

MI is an evidence-based counseling approach that helps people engage in and comply with treatment. It is a person-centered counseling approach[837,838] designed for helping people resolve ambivalence about changing risk behaviors. MI focuses on enhancing intrinsic motivation (motivation from within a person).

MI has been used in counseling for a wide variety of SUDs, smoking cessation, gambling disorder, eating disorders, anxiety, depression, co-occurring disorders (CODs), and medication and treatment adherence. It has also demonstrated success as a culturally sensitive counseling approach because the counselor's focus is on understanding clients' cultural contexts and distinctive perspectives.[839] **MI is particularly useful in heightening clients' motivation to engage in behavioral health services, become actively involved in continuing care activities, and make lifestyle changes** (e.g., engaging in health-promoting behaviors like weight management, diabetes management, healthy sleep habits, smoking cessation, and exercise) that support recovery.

Motivational enhancement therapy (MET) is a brief, evidence-based, manualized intervention that applies MI principles and processes to problematic substance use. It was initially developed for a study conducted by the National Institute on Alcohol Abuse and Alcoholism's Project MATCH, which evaluated the efficacy of several treatments for alcohol use disorder (AUD).[840] **Although the basic components of MET are similar to the components of MI, MET offers providers the chance to link their work with clients to individually tailored assessment feedback and to offer a menu of choices that can help clients make progress toward their desired behavior changes.**[841] MET's structure as a brief intervention makes it particularly useful for providers who have limited time or opportunity to elicit change conversations with their clients.[842]

Core Skills and Processes

MI focuses on helping clients resolve ambivalence about changing specific risk behaviors. It is essentially a conversational style that encourages clients to reflect on their personal values and to consider how engaging in risk behaviors does not align with those values. MI also can heighten a clients' awareness that recovery is possible and increase confidence in their ability to make difficult lifestyle changes that sustain ongoing recovery. **MI is consistent with the person-centered, strengths-based counseling focus of recovery-oriented behavioral health services.**

For core interviewing skills of MI, remember the acronym OARS[843]:

- Ask **O**pen questions, which elicit a story, instead of simply gathering information.
- Offer **A**ffirmations of the client's strengths, skills, abilities, and inherent worth.
- Engage in **R**eflective listening to help build the alliance, improve self-efficacy, and reinforce "change talk" (i.e., the desire, ability, reasons, need, commitment, activation, or preparation to take steps to change risk behaviors and adopt lifestyle changes that support recovery).
- **S**ummarize the client's experience and understanding of the problem; values, hopes, dreams, and goals; ambivalence about treatment and change; and action steps for change.

Underlying this core interviewing method is the spirit of MI, which includes working in collaboration with clients, accepting their inherent worth and autonomy, showing compassion for their distress, striving to understand their perspective, and helping them draw on their own wisdom.

The core interviewing method and the underlying spirit of MI establish a collaborative, respectful treatment alliance and fosters client engagement in treatment. Exhibit 3.6 offers some simple ways for counselors to evaluate whether they are engaging clients in a conversation in the spirit of MI.

Elements of MI Approaches

Several elements of MI are effective at helping engage clients in their recovery goals. This section focuses on two of those elements: the FRAMES approach and decisional balancing.

Using the FRAMES Approach

The FRAMES approach uses an acronym to describe six components designed to elicit clients' self-awareness and develop clients' confidence in their ability to change unhealthy behaviors. The six components are **f**eedback, **r**esponsibility, **a**dvice, **m**enu of options, **e**mpathy, and **s**elf-efficacy. Using the acronym, counselors should[844]:

- Provide personalized **feedback** to clients about their problematic substance use.
- Empower clients to engage in behavior changes that support their recoveries by taking **responsibility** for their choices.
- Ask the client if they can offer directive or educational **advice** in the form of suggestions.
- Give the client a **menu** of options to help them make choices that will promote engagement and facilitate their recoveries.
- Demonstrate **empathy** by using reflective listening.
- Help clients enhance their **self-efficacy.** Review past successes, identify strengths, and build confidence.

EXHIBIT 3.6. MI Conversational Strategies for Engaging With Individuals In or Seeking Recovery

Counselors should consider the following MI conversational strategies when working with clients:

1. Listening more than talking
2. Talking with clients to learn about their concerns without making assumptions about what the problem may be
3. Not trying to "fix" clients or trying to convince them to change
4. Inviting clients to think about their own ideas for change
5. Encouraging clients to think about their reasons for not changing
6. Asking if it is okay to give feedback
7. Not offering advice without asking for permission first
8. Offering ideas, but not assuming they are right
9. Telling clients that doubts they may have about change is normal
10. Helping clients identify their past successes and challenges and relating them to their present efforts to change
11. Working to understand clients instead of trying to convince them to understand the counselor
12. Summarizing what clients are saying instead of what the counselor thinks
13. Understanding that the client's opinions matter more than the counselor's
14. Remembering that clients are able to make their own choices

Sources: Adapted from Kruszynski, R., Kubek, P. M., Myers, D., & Evenden, J. (2012). MI reminder card (Am I doing this right?) *Cleveland, OH: Center for Evidence-Based Practices at Case Western Reserve University. Substance Abuse and Mental Health Services Administration. (2019).* Enhancing motivation for change in substance use disorder treatment. *Treatment Improvement Protocol (TIP) Series 35. SAMHSA Publication No. PEP19-02-01-003.*

Practicing Decisional Balancing

Decisional balancing is a strategy that is used to help clients make decisions without favoring a specific direction of change. **This strategy can be a way for clients to assess their readiness for change.** However, decisional balancing may increase ambivalence among clients who are contemplating change.

Counselors can help clients who are in recovery from problematic substance use explore the benefits and drawbacks of change by communicating the positive and negative aspects of using substances. The positive aspects of substance use serve as the reasons for not making a change (sustain talk). Alternatively, the negative aspects of substance use indicate reasons that support making a change (change talk). **When the costs of use outweigh the benefits, motivation to reduce or stop substance use increases.** It may be preferable to explore with clients what they "get out of" substance use before exploring possible reasons for change. Thus, clients are left with their own arguments for why they may want to change.

Counselors can use the following strategies to help clients practice decisional balancing:

- **Assessing where clients view themselves on the decisional scale.** Use validated instruments that provide scores, such as the Alcohol Decisional Balance Scale and the Drug Use Decisional Balance Scale. The University of Maryland Baltimore County's Decisional Balance Scales resource contains more information (https://habitslab.umbc.edu/decisional-balance-scales/).
- **Exploring the benefits and drawbacks of substance use and behavior change with clients** by:
  - Inviting clients to develop written lists highlighting the positives and negatives of changing substance use behaviors.
  - Recognizing that the strength of each reason for change is as important as the number of reasons for change.
  - Discussing the relative strength of each motivational factor and the weight that clients place on that factor when considering whether to make behavior changes.
  - Listening for statements that suggest ambivalence, exploring both sides of the ambivalence cautiously to avoid reinforcing sustain talk.
- Helping clients determine how their c**ore values may influence reasons for and against change.**
- Emphasizing that **clients have the sole responsibility to make choices for themselves.** It is up to clients to decide if and how they want to address their problematic substance use.
- **Exploring clients' understanding of the change process and managing expectations** about recovery from problematic substance use.
- **Listening for statements that imply self-efficacy when discussing behavior change.** For individuals in recovery, self-efficacy statements may be geared toward the ability to successfully recognize cues and triggers, handle high-risk situations, and manage recurrence of substance use–related problems.
- **Summarizing clients' change talk and reinforcing commitments to change.**

More information about additional MI elements, such as analyzing discrepancies between goals and behavior, flexible pacing, and maintaining contact with clients, can be seen in SAMHSA's TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment* (https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003).

USING THE STAGES OF CHANGE TO ENHANCE MOTIVATION FOR BEHAVIOR CHANGE IN RECOVERY

When working with individuals in recovery from substance use–related problems, counselors should be familiar with the transtheoretical model of the stages of change framework and how it can affect motivation for behavior change. The stages of change include[845]:

- Precontemplation: The person doesn't see a problem or need for changing a specific risk behavior, such as problematic substance use.
- Contemplation: The person has mixed feelings about changing a behavior and begins to think of reasons for changing the risk behavior.
- Preparation: The person wants to change a behavior and starts taking steps toward changing the risk behavior.
- Action: The person is actively working on changing a risk behavior.
- Maintenance: The person has changed a risk behavior and is working to make that a lasting change.

When counselors and their clients are in different stages of change, this can evoke resistance and expressions of ambivalence. Remember to listen for sustain talk and change talk when speaking with clients.

Addressing Ambivalence About Changing Behaviors

Individuals in recovery are likely to experience ambivalence at some point in their treatment, recovery, and journey to wellness. Although ambivalence is normal when making behavior changes, it is also frequently a roadblock.[846]

Counselors can help clients resolve ambivalence by distinguishing between sustain talk and change talk. Clients who are ambivalent will use a lot of sustain talk, but clients who are motivated and ready to change will engage in more change talk. The acronym **DARN-CAT** is used to delineate different types of change talk[847,848]:

- **D**esire to change: "I want to start attending a mutual-help group."
- **A**bility to change: "I could start going to a mutual-help group."
- **R**easons to change: "Going to a mutual-help group would teach me about recovery."
- **N**eed to change: "I need to find a way to get my alcohol and drug use under control."
- **C**ommitment: "I guarantee that I will start going to a mutual-help group by next month."
- **A**ctivation: "I'm ready to go to my first meeting."
- **T**aking steps: "I went to my first meeting."

Benefits of MI in Recovery From Substance Use–Related Issues

Using MI with individuals in recovery from problematic substance use has many benefits. **MI is effective in a wide variety of populations** (e.g., adolescents,[849] veterans,[850] people in criminal justice settings,[851,852] people who have SUDs and co-occurring mental disorders, college students, young adults) and formats (e.g., individual, group).[853,854,855] Research has consistently shown that using MI approaches can help:

- Reduce substance use, including alcohol, tobacco, and drug use.[856,857,858]
- Improve treatment attendance.[859]

MI can also be effectively combined with other treatment approaches. Using MI with CBT for clients who have problematic substance use may help increase the odds of clients maintaining long-term positive behavior changes.[860,861] Research has also evaluated using MI

strategies in combination with CM. Results from a meta-analysis indicated that although CM produces the greatest reductions in substance use within the first 3 months after treatment, MI produces the greatest reductions in substance use between 3 and 6 months after treatment.[862]

The use of MI with clients with problematic substance use can increase the likelihood of their adopting long-term behavior change. However, the effectiveness of MI, in part, depends on the counselor's ability to deliver the intervention with fidelity (i.e., the extent to which it is administered accurately and consistently for all clients and for the duration of the intervention). There are resources available to support counselors as they are learning MI to ensure they are delivering MI with fidelity. The Motivational Interviewing Network of Trainers, for example, is an organization of trainers in MI who are available to provide support to those new to MI, and can help improve the quality and effectiveness of counseling with clients about behavior change. A list of trainers and other MI-related resources can be found at https://motivationalinterviewing.org/.

Family Therapy Approaches

Overview of Family Therapy Approaches

Family and social support are vitally important to long-term recovery for people who have problematic substance use. As such, families should be included in treatment and recovery services with the client's permission. **Family therapy approaches, including those described below, can help strengthen families, leading to positive outcomes for the person in recovery and improved health and well-being for the entire family.[863]** In fact, family-based interventions are considered among the most effective approaches for treating SUD[864] and are widely used to support recovery.

Family therapy includes a series of family-based interventions that use family dynamics and strengths to address challenges. **Family therapy can increase motivation for people in recovery to continue in recovery and foster healing for family members by providing tools and the support they need to sustain hope and growth.[865]** Families should be included early and frequently in their own recovery. Counselors should also take a trauma-informed approach to supporting the family of clients.[866]

Family therapy can help family members understand[867]:

- How problematic substance use affects the person in recovery.
- How problematic substance use affects the whole family.
- How family members can adjust or change behaviors to support people in recovery on their recovery path.

Rather than focusing solely on the needs of the person in recovery, family therapy supports the needs of each individual family member.

Defining Family

Defining family is a complex task. Although many people consider the group of people with whom they share close emotional connections or kinship their "family," family has no single definition. Some consider family as those connected by birth, marriage, or adoption.

Family can also include people who share a household or emotional connections. Some families are blended or intergenerational within the household and include extended family members, such as grandparents, other relatives, and close friends. Other families arise from adoption and foster processes. Some families have members that do not share biological connections but consider themselves family.

Regardless of their makeup, all families function as complex systems working to keep equilibrium. Problematic substance use can interrupt that balance in several ways.[868] Understanding the type of family and how problematic substance use affects its members helps counselors anticipate potential issues related to the person in recovery's problematic substance use.[869]

Effects of Substance Use–Related Issues on the Family

Problematic substance use affects more than just the person who uses substances; it can affect their entire family in significant ways, depending on the severity, family type, and patterns of use, among other areas.[870] **Families experience hardships, losses, and trauma as a consequence of problematic substance use of a loved one.[871]** For example, compared to couples who don't have SUDs, couples who have SUDs exhibit worse relationship functioning, more frequent intimate partner violence, and greater risk of marital dissolution.[872] Exhibit 3.7 showcases examples of how problematic use of different substances can affect families.

EXHIBIT 3.7. Effects of Problematic Substance Use on Families

Alcohol	• Problems with communication[873] • High levels of conflict[874] • High risk of chaos and disorganization (e.g., inconsistent parenting practices)[875] • Breakdown of family rituals, rules, and boundaries[876] • Potential for emotional, physical, or sexual abuse[877] • High rates of intimate partner violence[878] • Efforts by family members to "cover up" for the family member with alcohol misuse[879] • Risk of psychological distress as well as health and behavioral problems[880] • Increased potential for AUD[881]
Opioids	• High potential for illegal activities[882] • Unstable relationships between parents and children, including negatively impacting parenting[883] • Increased risk of unsanitary or unsafe home environment[884] • Greater risk of contracting an infectious disease, such as HIV/AIDS and hepatitis, which can affect family members' roles and responsibilities[885] • Impaired ability to maintain employment, which can worsen family financial situation[886] • High potential for SUDs[887]
Cocaine	• High potential for illegal activities (e.g., buying or selling cocaine)[888] • Increased risk of stealing to purchase cocaine (which, in certain forms, can be high cost)[889] • Increased chances of legal problems[890] • High potential for SUDs[891,892]

Family Counseling Approaches That Promote Recovery

Family therapy has a robust evidence base. In fact, studies over the past 40 years indicate that **partner- and family-involved treatments produce better outcomes across several domains of functioning**, such as reduced substance use and improved marital and family functioning, compared with individual-based interventions.[893] Family therapy is designed to reduce problematic substance use by altering elements of the family dynamic that directly or indirectly support substance use, while simultaneously improving the quality of family relationships. Although many of these therapies are designed to support adolescent populations, they can also be adapted for adult populations who have problematic substance use.[894]

Integrating family counseling into problematic substance use leverages the vital role families can play in helping their family members in their recovery goals. Family therapy differs from more general family systems approaches because it shifts the primary focus from the process of family interactions to planning the content of family sessions. Family counseling approaches help clients and their family members understand substance use and recovery and their effects on family functioning.[895]

If family therapy is not available in the counselor's setting, family education groups may be offered to educate family members and dispel stigma and misconceptions about problematic substance use. This can help support both family members and the person in recovery. These groups can be offered to family members or other concerned persons and attended with the person in recovery.

RESOURCE ALERT: SUD TREATMENT AND FAMILY THERAPY

More information about family-based interventions and family counseling approaches for SUDs can be found in SAMHSA's TIP 39, *Substance Use Disorder Treatment and Family Therapy,* at https://store.samhsa.gov/product/treatment-improvement-protocol-tip-39-substance-use-disorder-treatment-and-family-therapy/PEP20-02-02-012. The TIP offers information about how to work with families, how families are affected by problematic substance use, family counseling approaches, and integrated family counseling approaches.

Counselors can work with clients and family members to initiate and sustain recovery by[896]:

- Discussing issues around safety and the cultural appropriateness of including family members and recovery supports, including boundaries around confidentiality.
- Having the client sign releases to have family members and recovery supports involved.
- Collaborating with the client to develop a plan for identifying supportive family members and recovery supports.
- Offering culturally appropriate information regarding the nature of the client's problematic substance use or mental disorders; early warning signs of returns to use; the impact of these chronic conditions on family members and recovery supports; and the importance of family and recovery support involvement in treatment.
- Improving communication skills to help the client and his or her spouse or intimate partner address conflicts and stressors in their relationship.

- Getting input from family and recovery supports on the client's early warning signs of recurrence.
- Discussing the importance of self-care with family members.
- Collaborating with the client and their family members to develop an emergency plan (in the event of a recurrence) that includes appropriate roles for family members.

Outlined below are select evidence-based family therapies that can be used to support recovery for family members. The need for families to initiate their own recovery path is critical. Too often, families are involved in the context of the client's recovery. Effective family interventions, including those described below, help families create their own recovery pathway.

Multidimensional Family Therapy

Multidimensional family therapy (MDFT) is an integrated, comprehensive family-based therapy combining individual counseling and other approaches to treat and support recovery from problematic substance use.[897] **The focus of this therapy is on strengthening family functioning to create a new, developmental, adaptive lifestyle supporting recovery.** MDFT is designed to support change that is multifaceted, with individualized interventions to foster various competencies. Primarily used with adolescents, MDFT can be adapted for adults in recovery from problematic substance use and can support reducing problem behaviors.

Traditionally, counselors work in several MDFT treatment domains[898]:

- People in recovery: Enhancing their emotional regulation, social, and coping skills; communicating more effectively; and reducing involvement with peers who use substances
- Family members: Decreasing family conflict, increasing emotional attachments, improving communication, and enhancing problem-solving skills
- Community: Enhancing family members' competence in advocating for themselves

MDFT can be delivered one-on-one, in family sessions, or in sessions with various family members, and can also occur in the home or in other settings. Therapy sessions can be modified to meet the needs of the population and family. MDFT can be offered in 16–25 sessions over 4 to 6 months, and can occur multiple times per week.[899]

Studies indicate that MDFT can be effective in improving substance use treatment outcomes.[900] MDFT is recognized as an empirically supported intervention.[901] It can also be adapted to diverse populations and is available in English, Spanish, and French. Research shows that most families in MDFT studies are from low-income, inner-city communities; adolescents in these studies range from youth in early adolescence who are at elevated risk, to older adolescents with multiple problems, juvenile justice system involvement, and co-occurring substance use and mental disorders.[902]

The outcomes associated with MDFT are also supportive of its effectiveness. Randomized controlled trials (RCTs) show clinically significant effects of MDFT on improving family functioning and reducing adolescents' substance use and related behavioral problems in controlled and community-based settings.[903]

RESOURCE ALERT: MDFT

More information about MDFT can be found at www.mdft.org. The website features information about the MDFT method, summaries of its effectiveness, and training resources.

Community Reinforcement and Family Training

Community reinforcement and family training (CRAFT) is an evidence-based, family-focused, positive reinforcement approach that **provides family members with strategies for encouraging the family member who has problematic substance use to change his or her behaviors.** It can be used to support both SUD treatment and recovery.[904,905,906] CRAFT uses community reinforcement, the goal of which is to develop community supports to create positive incentives for people who have SUDs to remain in treatment or recovery.[907]

The CRAFT intervention consists of eight components[908]:

- **Motivational strategies.** Establishing positive expectations by describing CRAFT in a way that increases the motivation of the concerned significant other (CSO)
- **Functional analyses of the client's substance-using behavior.** Outlining the triggers and consequences of the client's use and using the tool to plan the CSO's intervention strategies
- **Domestic violence precautions.** Assessing the potential for violence on the part of the client
- **Communication training.** Teaching and practicing positive communication skills to improve communication with the client
- **Positive reinforcement training.** Teaching the CSO how to use small rewards to reinforce recovery
- **Discouragement of using behavior/negative consequences.** Teaching the CSO how to allow negative consequences in using and teaching a standard problem-solving strategy
- **CSO self-reinforcement training/quality of life.** Exploring the CSO's dissatisfaction in life and evolving goals and a plan to increase the CSO's own quality of life
- **Suggesting treatment or recovery for the client.** Planning the best time for suggesting treatment or recovery and giving the CSO information about the options available

Although CRAFT is traditionally a structured approach, it can be adapted to a less structured module, focusing on psychoeducation for families and people in recovery[909]:

- Refraining from blaming and shaming
- Expressing concern about the problematic substance use behavior and its effects on the family
- Expressing hope that the family member will get help
- Offering affirmations for positive change in problematic substance use behaviors

RESOURCE ALERT: CRAFT-SP

Community Reinforcement and Family Training Support and Prevention (CRAFT-SP) provides information about CRAFT, including sample treatment sessions and the theoretical framework for the intervention (https://www.mirecc.va.gov/visn16/docs/CRAFT-SP_Final.pdf).

Mutual-Support Groups for Family Members

Mutual-support groups for families are also an effective and evidence-based approach for supporting families of people who have problematic substance use. These support groups encourage family members to reflect on challenges and solutions through group participation. They can support the development of family members' coping skills by building strong connections with other families who may be facing similar challenges. These approaches can also support a range of populations and are available in communities around the country.

Strategies for incorporating family recovery support group participation in family counseling include[910]:

- Exploring family members' understanding of and prior participation in recovery support or mutual-help groups.
- Discussing and dispelling misconceptions about family recovery support groups.
- Exploring the challenges and benefits of participation in family recovery support groups.
- Actively linking family members to community-based recovery support groups.
- Offering space in family counseling sessions to explore family concerns about recovery support group participation.

Counselors will need to be able to provide information to families about support groups. Some family support groups are listed below.

- **Adult Children of Alcoholics® & Dysfunctional Families** is a 12-Step group for adults who have a parent with an AUD (https://adultchildren.org/).
- **Co-Anon Family Groups®** offer support for family members of people with cocaine use disorder (https://co-anon.org/).
- **Al-Anon Family Groups** support families and friends of those with an AUD (https://al-anon.org/).
- **Families Anonymous** is a 12-Step group for the family and friends of those individuals who have problematic substance use or related behavioral issues (https://www.familiesanonymous.org/).
- **Nar-Anon** is a 12-Step group for family members of people who have SUDs, but not AUD (https://www.nar-anon.org/).
- **SMART Recovery® Family & Friends** is a support group for families of individuals who have substance use–related problems (https://www.smartrecovery.org/family/).

Couples Counseling To Promote Recovery

Couples-based approaches for problematic substance use work to reduce substance use and support recovery, while also working to enhance relationship quality within intimate partnerships. Clients are taught strategies to maintain recovery and engage in relationship-building practices with their partners to improve relationship quality and functioning.[911]

Studies indicate a direct relationship between problematic substance use and marital conflict, related to the often-unpredictable behavior associated with substance use as well as instability, conflict, and stress.[912] Couples counseling can be a **valuable tool to harness partner support to positively reinforce the person in recovery and change relationship dynamics to make them more conducive to ongoing recovery.**[913]

Approaches to support couples who are dealing with problematic substance use draw on techniques from behavioral couples therapy (BCT) to reduce substance use and strengthen relationships. Within these approaches, clients are given **behavioral techniques aimed at reducing substance use, maintaining recovery goals, and engaging in relationship-building practices with their partners to improve relationship quality.**[914]

RESOURCE ALERT: CONNECTING FAMILIES WITH MUTUAL SUPPORT GROUPS

Counselors should be aware of mutual support groups for families of people in recovery so that they can help connect them with these resources. Faces & Voices of Recovery offers several mutual-aid resources at this page: https://facesandvoicesofrecovery.org/?s=mutual+aid+.

BCT is a structured counseling approach for people with problematic substance use and their intimate partners. Its focus is on partner support to address or reduce substance use, and it promotes a family environment conducive to ongoing recovery. **BCT aims to lessen relationship distress and build more cohesive relationships to reduce the risk of recurrence. The goals of BCT are to support recovery from problematic substance use and improve relationship functioning.** BCT is offered in 12 to 20 weekly sessions and includes substance-focused interventions to build support for abstinence and relationship-focused interventions to enhance caring behaviors, shared activities, and communication.[915]

Through this therapy, the counselor works with the couple to develop a recovery contract that outlines specific future work as well as activities and home exercises to support the contract. **Much of the intervention takes place outside of work with the counselor.** However, each session includes three specific tasks[916]:

- Reviewing any substance use, relationship concerns, and home exercises
- Introducing new material
- Assigning home practice

BCT has a convincing evidence base for its effectiveness in both treating SUDs and supporting recovery. BCT is **associated with better substance use- and relationship-related outcomes than the use of individual therapy, and may be effective in supporting SUD treatment in lesbian and gay couples.**[917]

RESOURCE ALERT: UNDERSTANDING BCT

Counselors can learn more about BCT, including its benefits, various interventions, and adaptations of the therapy that have been found to be effective in SAMHSA's TIP 39, *Substance Use Disorder Treatment and Family Therapy,* at https://store.samhsa.gov/product/treatment-improvement-protocol-tip-39-substance-use-disorder-treatment-and-family-therapy/PEP20-02-02-012.

The TIP also includes discussion of how to support family counseling for SUDs among families of diverse racial and ethnic backgrounds as well as those families with lesbian, gay, bisexual, or transgender family members.

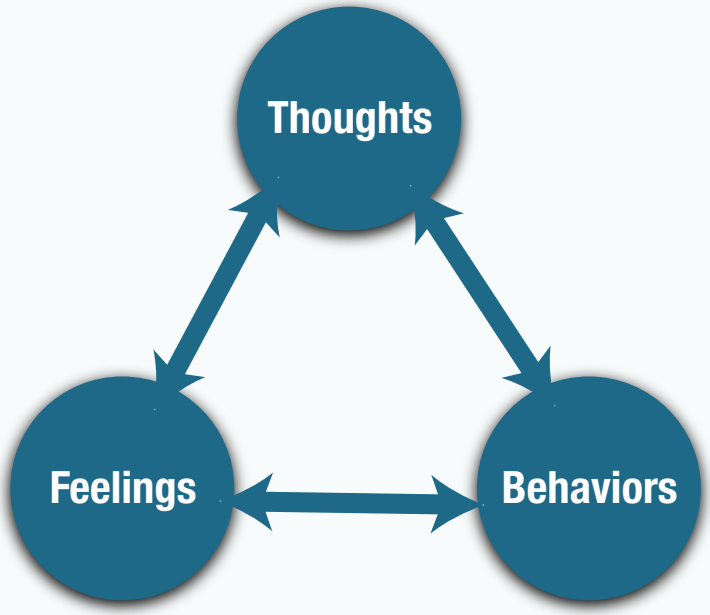
Cognitive–Behavioral Therapy

Overview of CBT

CBT is one of the most common, evidence-based treatments for individuals who have problematic substance use[918,919] and is included in multiple addiction-based practice guidelines.[920] Research shows that CBT is not only efficacious, but effective.

The cognitive–behavioral model is based on the assumption that individuals are continually interpreting and responding to information perceived from their internal and external environments. Individuals develop representations of their environments in the form of thoughts, attitudes, and beliefs. These representations can affect how individuals feel and behave. The relationship between thoughts, feelings, and behaviors in response to clients' appraisals of their environments is known as the cognitive triangle and is depicted in Exhibit 3.8.

EXHIBIT 3.8. The Cognitive Triangle



When representations of the environment are inaccurate or unhelpful, they can be examined, challenged, and modified. As clients learn to reappraise situations and develop helpful thinking patterns, they may notice that they feel better and make healthier behavior choices.

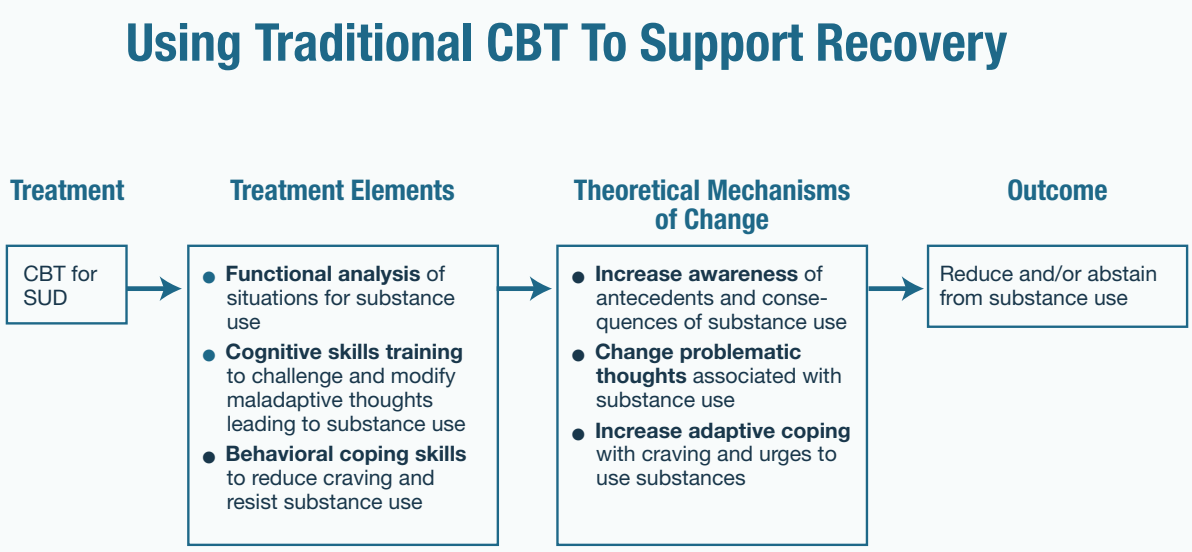
CBT for substance use–related problems is based on social learning theory, such that alcohol and drug use occurs in the context of learned behavior (i.e., modeling, classical and operant conditioning).[921] As patterns of alcohol and drug use emerge, individuals have more difficulties coping with distressing thoughts and emotions.

Multiple variations of problematic substance use interventions use components of the cognitive–behavioral framework, including the relapse prevention model, guided self-change, BCT, and the community reinforcement approach.[922] More recently, CBT is being augmented by third-wave approaches, such as behavioral activation and mindfulness and acceptance-based interventions. Although this section focuses on describing CBT components that counselors can use to support individuals in recovery, some of these specific interventions are discussed elsewhere in this chapter.

Using CBT To Support Recovery

In recovery, the cognitive–behavioral model focuses on **helping clients replace thinking patterns and risk behaviors that undermine recovery efforts with thinking and behavioral patterns that support and sustain recovery.** Cognitive changes that support recovery from problematic substance use vary according to the substance used, but generally emphasize challenging or deconstructing positive beliefs about substance use or engaging in other risk behaviors and negative beliefs about identity that decrease self-efficacy. Exhibit 3.9 demonstrates how components of CBT and theoretical mechanisms of change contribute to improvements in substance use–related problems among individuals in recovery.

EXHIBIT 3.9. Using Traditional CBT To Support Recovery



Source: Adapted with permission from Vujanovic, A. A., Meyer, T. D., Heads, A. M., Stotts, A. L., Villarreal, Y. R., & Schmitz, J. M. (2017). Cognitive–behavioral therapies for depression and substance use disorders: An overview of traditional, third-wave, and transdiagnostic approaches. American Journal of Drug and Alcohol Abuse, 43(4), 402–415.

Laying the Groundwork With a Biopsychosocial Case Conceptualization

Prior to engaging clients in CBT, counselors should complete a comprehensive biopsychosocial assessment. **The goal of a biopsychosocial assessment is to identify factors within three primary domains (i.e., genetic/biological, psychological, and social) that contribute to the client's overall physical and mental health, including the development of problematic substance use and CODs.** This type of assessment helps counselors determine the extent of difficulties in multiple life domains (e.g., medical, legal, vocational, housing, social networks) and clarify how problematic substance use and CODs interact with the problems in each domain. A biopsychosocial assessment is used to support a cognitive–behavioral case conceptualization and to select the best-matched, evidence-based model for counseling. Throughout the course of working with clients in recovery, counselors should continue to use a biopsychosocial assessment to evaluate progress and make necessary changes to their treatment plan. (The diagram in Exhibit 3.10 highlights the components of the biopsychosocial model.)

The American Society of Addiction Medicine offers a free, paper-based assessment interview guide that incorporates aspects of a biopsychosocial assessment (https://www.asam.org/asam-criteria/criteria-intake-assessment-form).[923]

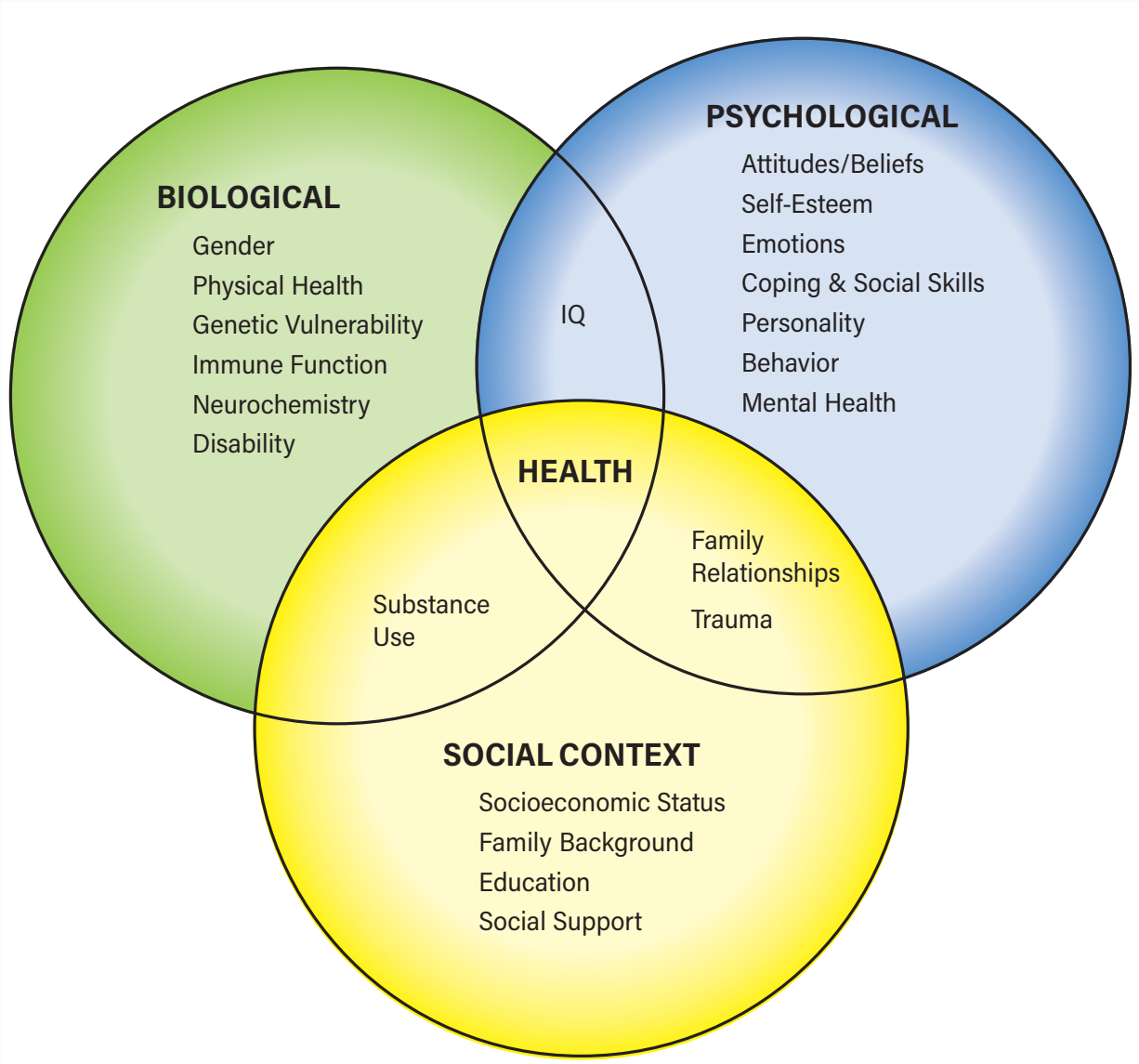
Conducting a Functional Analysis

In addition to a biopsychosocial assessment, counselors should conduct a functional analysis of situations and warning signs that place clients at high risk for recurrence of problematic substance use. **Functional analysis is a crucial step in CBT that evaluates the reasons behind why clients engage in specific behaviors and what factors contribute to maintaining**

those behaviors. Clients can use this information to engage in problem-solving in a way that reduces the probability of problematic substance use.

For example, unhelpful thinking patterns can contribute to the development and maintenance of problematic substance use. In the context of CBT, identifying and challenging unhelpful thinking patterns can lead to changes in behavior. **A functional analysis of behavior can be particularly helpful for clients who are not aware of their substance use–related behaviors.**

Exhibit 3.10. The Biopsychosocial Model



Source: Adapted from "Patient-Centered Communication," by C. A. Naughton, 2018, Pharmacy, 6*(1), 18, p. 2.* (https://doi.org/10.3390/pharmacy6010018). CC BY 4.0.

THE ICEBERG ANALOGY

The concept of an iceberg can be used to help clients understand their behaviors and the reasons behind their behaviors. Behaviors are the tip of the iceberg and are what can be observed on the surface. Underneath the surface are thoughts, feelings, and core beliefs that trigger the behaviors that are above the surface. Oftentimes, the bulk of the iceberg is underneath the surface, highlighting the large influence of thoughts, feelings, and core beliefs on behaviors. By understanding what is underneath the surface, counselors can work with clients to address the underlying thoughts, feelings, and core beliefs and elicit behavior change.[924,925]

To conduct a functional analysis, counselors should ask questions that assess the following[926]:

- Antecedent (what happened before the behavior)
  - How often does the behavior occur?
  - What is going on in the client's environment when the behavior occurs?
  - Who is involved in the behavior besides the client?
  - Did the client have thoughts about what happened?
- Behavior
  - What did the client do in response to the antecedent?
  - Was there a thought that occurred in response to the antecedent that contributed to the behavior?
- Consequence
  - What happened because of the client's behavior?
  - How does the client feel about the consequence?

After completing the functional analysis, counselors and the client can work together to determine what contributed to the behavior and how that factor can be modified.

RESOURCE ALERT: USING A FUNCTIONAL ANALYSIS IN CBT

The Boston Center for Treatment Development and Training developed a comprehensive addiction treatment therapist manual that includes a module about functional analysis. The manual includes session topics, sample dialog, and sample session materials. Counselors can access the manual online (https://www.mass.gov/doc/module-3-functional-analysis-and-treatment-planning-0/download).

Enhancing Awareness of Urges and Triggers

One of the most important skills clients can learn is how to cope with the situational cues that trigger physical cravings to use substances and impulses to engage in risk behaviors. Exhibit 3.11 outlines a structured coping skills training exercise on coping with craving that counselors can adapt for clients who experience strong physical cravings or situational cues to engage in risk behaviors. It applies several key strategies of a CBT approach to prevent recurrence of problematic substance use, including psychoeducation, assessment of risk for recurrence with a focus on craving, identification of craving cues and situational triggers, coping skills training, and a between-sessions practice exercise.

EXHIBIT 3.11. Coping With Craving: A Structured Coping Skills Training Exercise[927]

Overview

This exercise is designed for a group format but can be adapted for an individual session. It is 60 minutes long* and divided into segments of roughly 20 minutes each.

- Check-In. Elicit the clients' current concerns, general level of functioning, substance use, experiences of craving and situational triggers in the past week, and experiences with practice exercises or challenges from the previous week.
- Introduction of Coping Skills. Introduce the topic. Lead an interactive discussion of what craving is and how to cope with cravings and triggers to use or engage in risk behaviors.
- Practice Skills. Practice coping skills identified in the session, leave time for discussion of the experience and the session, and provide a between-sessions practice exercise.

**Depending on group size and type of participants (e.g., clients with a single SUD, clients with multiple SUDs, clients with CODs), this exercise may need to be divided into two sessions.*

Session Goals

Cravings and situational cues that trigger impulses to engage in risk behaviors can be disturbing and confusing to clients. Some people who have SUDs, for example, can experience cravings weeks and even months after stopping use. Impulses to engage in risk behaviors can seem like they come out of the blue. The goals of this session are to:

- Offer information about the nature of craving; describe it as a normal, time-limited event that may or may not result in a recurrence of problematic substance use.
- Understand each client's belief about and experience of craving or impulses to engage in risk behaviors.
- Work collaboratively with clients to identify craving cues and situational triggers.
- Describe and practice craving and impulse-management coping skills.

Key Interventions

Understanding the Nature of Craving

Counselors can elicit a client's understanding of craving with an open question such as, "What do you know about cravings to use alcohol or drugs and why people have them?" Offer information about how the brain adapts to having a particular substance in the body over time and how, when the substance is taken away, the body reacts with a physical craving (similar to a hunger pang) that tells the brain it "needs" the substance to quiet the discomfort. Unlike food, the body doesn't need substances to survive, but the brain is tricking the body into reacting as if it does.

Counselors should consider giving a brief description of cue conditioning by using the example of Pavlov's dog. Pavlov trained the dog to salivate when a bell rang; the dog had learned to recognize the bell as a cue that it was about to get food. Any number of cues get paired with the desire to use substances or the impulse to engage in risk behaviors, such as seeing a pipe, needle, or beer mug or hearing the ring tone of a former drug dealer. Once these situational cues are identified, the experience of craving or sudden impulses to engage in risk behaviors becomes more understandable and less of a mystery for clients. This can help them learn to tolerate the discomfort, until the craving subsides.

Continued on next page

Appendix A: Counseling Approaches to Promote Recovery From Problematic Substance Use and Related Issues – Module 2

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions.

> Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions using the answer sheet found at the end of this appendix. Then, return to your browser and go to the Student Center located at:
>
> > http://www.ceumatrix.com/studentcenter
>
> Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Take Exam' and you will be presented with the electronic exam.
>
> To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater you will have access to the Certificate of Completion. This is the final step in the process, and you may save and/or print your Certificate of Completion.
>
> If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

If you have any difficulty with this process, or need assistance, please e-mail us at ceumatrix@ceumatrix.com and ask for help.

Answer the following questions by selecting the most appropriate response.

Quiz

1. What is a key component of establishing a therapeutic alliance according to the document?
   A. Avoiding emotional discussions
   B. Implementing strict rules
   C. Using motivational interviewing
   D. Focusing solely on substance use

2. Which of the following is emphasized as a necessary understanding for counselors working with clients in recovery?
   A. Common co-occurring mental disorders
   B. Only substance use disorders
   C. Physical health conditions
   D. Legal issues related to substance use

3. What approach should counselors take to address clients' urgent needs?
   A. Behavioral modification approach
   B. Crisis-focused approach
   C. Strengths-based, person-centered approach
   D. Traditional medical approach

4. What is a significant factor contributing to the SUD treatment gap among minority populations?
   A. Higher rates of treatment satisfaction
   B. Systemic effects of racial and ethnic discrimination
   C. Increased access to healthcare
   D. Lower rates of substance use

5. Which of the following is a recommended practice for counselors to manage their biases?
   A. Ignore personal biases
   B. Avoid discussing cultural issues
   C. Focus only on clinical skills
   D. Present information in a culturally responsive way

6. What percentage of physicians expressed a preference not to work with patients with substance use who have pain?
   A. 54%
   B. 60%
   C. 70%
   D. 80%

7. Which of the following is NOT mentioned as a barrier to accessing SUD treatment for people with disabilities?
A. Lack of accessible programs
B. Transportation issues
C. High insurance coverage
D. Insufficient clinician training

8. What is one of the top outcomes chosen by survey respondents with past or present substance use challenges?
A. Travel more
B. Increase income
C. Gain employment
D. Improve Mental Health

9. According to the document, which group is reported to have less access to SUD treatment compared to men?
A. Children
B. Elderly
C. Women
D. Teenagers

10. What principle emphasizes the importance of collaboration with clients in the strengths-based model?
A. Principle #1
B. Principle #2
C. Principle #5
D. Principle #4

11. What is the primary focus of traditional approaches to recovery from substance use according to the document?
A. Identifying and reducing substance-related cues
B. Building recovery capital
C. Enhancing emotional intelligence
D. Providing unconditional positive regard

12. Which of the following is NOT a domain assessed by the Assessment of Recovery Capital (ARC)?
A. Substance use
B. Psychological health
C. Financial stability
D. Community involvement

13. What does 'recovery capital' refer to in the context of substance use recovery?
A. The duration of substance use
B. The number of treatment sessions attended
C. The level of client satisfaction with therapy

D. The quantity and quality of resources for recovery

14. According to the document, what should counselors provide to clients in substance use disorder treatment?
A. A judgmental environment
B. A nonjudgmental environment
C. Strict adherence to treatment plans
D. Frequent assessments of substance use

15. What is the recommended approach for counselors when clients experience a recurrence of substance use?
A. To shame the client for their relapse
B. To terminate counseling sessions
C. To help clients put the recurrence in perspective
D. To ignore the recurrence

16. What is a common outcome of a recurrence in a client's recovery journey according to the document?
A. Increased motivation and confidence
B. Lower motivation and confidence
C. Improved coping strategies
D. Enhanced peer support services

17. Which of the following is NOT mentioned as a harm reduction strategy in the document?
A. Conducting overdose education
B. Offering test strips for drug checking
C. Providing recreational activities
D. Supporting activities of daily living

18. What is the purpose of the AWARE questionnaire as described in the document?
A. To provide neutral feedback about potential risk for recurrence
B. To identify triggers for substance use
C. To assess commitment to sobriety
D. To evaluate coping strategies

19. What does the BSCQ measure according to the document?
A. Confidence in resisting urges to use substances
B. Knowledge of harm reduction strategies
C. Awareness of high-risk situations
D. Commitment to lifelong abstinence

20. Which of the following is emphasized as a critical aspect of a recovery-oriented system of care (ROSC)?
A. Focus solely on medication management
B. Collaboration with clients to identify recovery goals

C. Avoiding discussions about substance use triggers
D. Providing only individual therapy sessions

21. What is the primary benefit of syringe services programs according to the document?
A. They provide recreational drugs
B. They reduce the risk of contracting bloodborne infections
C. They increase the use of substances
D. They are only for people in treatment programs

22. Which of the following is a harm reduction strategy mentioned in the document for addressing problematic alcohol use?
A. Using more alcohol
B. Avoiding all social situations
C. Defining limits around drinking
D. Increasing impulsivity

23. What is the role of vitamin C in the context of injection safety as mentioned in the document?
A. To enhance drug effects
B. To prevent infections
C. To clean injection sites
D. To facilitate substance dissolution

24. What is a significant risk factor for HCV infection according to the document?
A. Using sterile syringes
B. Sharing syringes and injection equipment
C. Engaging in safe sex practices
D. Receiving vaccinations

25. What is the recommended action if an individual tests positive for HCV?
A. Ignore the results
B. Start using drugs
C. Seek medications for treatment
D. Continue sharing syringes

26. What is a significant risk factor for problematic substance use related to trauma according to the document?
A. Intergenerational trauma
B. Positive childhood experiences
C. Stable family environment
D. High socioeconomic status

27. Which therapy is specifically mentioned as effective for treating PTSD and trauma?
A. Cognitive Behavioral Therapy

B. Eye Movement Desensitization and Reprocessing
C. Narrative Therapy
D. Group Therapy

28. What should counselors do to build trust with clients who have experienced trauma?
A. Use confrontational language
B. Minimize clients' experiences
C. Incorporate trauma-related symptoms into treatment plans
D. Avoid discussing trauma

29. What is one of the main focuses of trauma-informed care?
A. Ignoring the client's trauma history
B. Recognizing the impact of trauma on recovery
C. Focusing solely on physical health
D. Encouraging clients to forget their trauma

30. What is a potential outcome of failing to address trauma in clients with substance use disorders?
A. Improved recovery rates
B. Worse treatment outcomes
C. Increased trust between counselor and client
D. Enhanced coping strategies

31. What is the primary focus of Motivational Interviewing (MI) in counseling?
A. To gather information about clients
B. To help clients resolve ambivalence about changing risk behaviors
C. To provide medication for substance use disorders
D. To enforce strict behavioral changes

32. Which of the following is NOT a component of the OARS acronym used in MI?
A. Open questions
B. Affirmations
C. Reflective listening
D. Structured advice

33. What does the Seeking Safety approach primarily address?
A. Cognitive behavioral therapy
B. Mindfulness practices
C. Family dynamics in recovery
D. Trauma and problematic substance use

34. In the context of family counseling for substance use disorders, what is a key consideration for counselors?
A. The cultural appropriateness of including family members
B. The financial status of the family

C. The educational background of the client
D. The age of the family members

35. What is the purpose of the Decisional Balancing strategy in counseling?
A. To promote substance use
B. To help clients assess the pros and cons of change
C. To enforce a specific treatment plan
D. To eliminate all ambivalence

36. What is the primary focus of the Community Reinforcement and Family Training (CRAFT) approach?
A. To provide medication for substance use disorders
B. To develop community supports for individuals with SUDs
C. To isolate individuals with substance use disorders
D. To discourage family involvement in recovery

37. Which of the following is NOT a component of the CRAFT intervention?
A. Motivational strategies
B. Functional analyses of substance-using behavior
C. Craving management techniques
D. Detrimental behavior analysis

38. What is the purpose of conducting a functional analysis in the context of CBT for substance use recovery?
A. To evaluate the reasons behind specific behaviors
B. To provide medication recommendations
C. To isolate clients from their environments
D. To discourage family involvement

39. What is the goal of the biopsychosocial assessment in substance use treatment?
A. To identify factors contributing to overall health
B. To focus solely on psychological factors
C. To evaluate only social factors
D. To assess only genetic factors

40. What is the main objective of Behavioral Couples Therapy (BCT) in the context of substance use recovery?
A. To enhance individual therapy
B. To reduce relationship distress and support recovery
C. To promote isolation from partners
D. To discourage communication between partners

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