Principle V: Assessment, Evaluation & Interpretation

- Screening vs. Assessment
- Face-to-face versus electronic
- Bio-psycho-social-cultural-legal-emotional-spiritual-trauma-strengths
- Who determines who is qualified to use the assessment?
- Who is qualified to interpret the data?
Validity & Reliability

- Construct being measured
- Validity
- Reliability
- Population normed on
- Culture and Context
- Appropriate training & credentials

Administration

- Where will the assessment will be administered?
- Distractions (i.e., temperature, sounds, interruptions, etc.)
- Technology checks

Cultural Influences

- Cultural influences on how issues are defined
- Cultural influences on how issues are experienced
- Cultural influences on how issues are resolved
- Historical trauma
- Bias, misdiagnosis, pathologizing, labeling
- Assumptions
- Cultural Formulation Interview (CFI: www.dsm5.org free assessment tool)
Evaluation & Interpretation

- Diagnosing
- Results
- Misusing results
- Referrals
- Security of data
- Forensic evaluations
- Dual relationships

Ethics: Co-Occurring Disorders

1. Do keep in mind that assessment is about getting to know a person with complex and individual needs. Do not rely on tools alone for a comprehensive assessment.

2. Do always make every effort to contact all involved parties, including family members, persons who have treated the client previously, other mental health and substance abuse treatment providers, friends, significant others, probation officers as quickly as possible in the assessment process. (These other sources of information will henceforth be referred to as collaterals.)

3. Don't allow preconceptions about addiction to interfere with learning about what the client really needs (e.g., “All mental symptoms tend to be caused by addiction unless proven otherwise”). Co-occurring disorders are as likely to be underrecognized as over-recognized. Assume initially that an established diagnosis and treatment regime for mental illness is correct and advise clients to continue with those recommendations until careful reevaluation has taken place.

4. Do become familiar with the diagnostic criteria for common mental disorders, including personality disorders, and with the names and indications of common psychiatric medications. Also become familiar with the criteria in your own state for determining who is a mental health priority client. Know the process for referring clients for mental health case management services or for collaborating with mental health treatment providers.

5. Don't assume that there is one correct treatment approach or program for any type of COD. The purpose of assessment is to collect information about multiple variables that will permit individualized treatment matching. It is particularly important to assess stage of change for each problem and the client’s level of ability to follow treatment recommendations.

6. Do become familiar with the specific role that your program or setting plays in delivering services related to COD in the wider context of the system of care. This allows you to have a clearer idea of what clients your program will best serve and helps to facilitate access to other settings for clients who might be better served elsewhere.
7. Don’t be afraid to admit when you don’t know, either to the client or yourself. If you do not understand what is going on with a client, acknowledge that to the client, indicate that you will work with the client to find the answers, and then ask for help. Identify at least one supervisor who is knowledgeable about COD as a resource for asking questions.

8. Most important, do remember that empathy and hope are the most valuable components of your work with a client. When in doubt about how to manage a client with COD, stay connected, be empathic and hopeful, and work with the client and the treatment team to try to figure out the best approach over time.

George T.
The client is a 34-year-old married, employed African-American man with cannabis dependence, alcohol abuse, and bipolar disorder (stabilized on lithium) who is mandated to cannabis treatment by his employer due to a failed drug test. George T. and his family acknowledge that he needs help not to use cannabis but do not agree that alcohol is a significant problem (nor does his employer). He complains that his mood swings intensify when he is using cannabis.

Maria M.
The client is a 38-year-old Hispanic/Latina woman who is the mother of two teenagers. Maria M. presents with an 11-year history of alcohol dependence, a 2-year history of opioid dependence, and a history of trauma related to a longstanding abusive relationship (now over for 6 years). She is not in an intimate relationship at present and there is no current indication that she is at risk for either violence or self-harm. She also has persistent major depression and panic treated with antidepressants. She is very motivated to receive treatment.
### Principle VI: eTherapy, eSupervision & Social Media

**Electronic Digital Era**
- Expansion of services & opportunities
- tx, recovery support
- Billing, records, storage
- Multidisciplinary care teams
- Risks for harm
- Privacy versus confidentiality
- Defining eTherapy & esupervision
- Defining telehealth
- Defining technology
- Defining technology use
- Pursuing competency

### Technology Informed Consent
- Contact information of the client, counselor/provider and supervisor
- e-Therapy is not always an appropriate substitute or replacement for face-to-face counseling
- All of the procedures that apply to delivery of in-person services shall apply to the e-delivery of services
- Duty to warn and mandatory reporting laws that shall apply to all counseling services, including eTherapy
- Confidential and privacy rules and laws, and exceptions to those rules and laws
- Issues related to security and privacy of information, and potential for hacking or other unauthorized viewing
- Access to counseling services and to technology assistance to use eTherapy
- Benefits and limitations of engaging in the use of distance counseling, technology, and/or social media
Technology Informed Consent

- potential misunderstandings due to limited visual and auditory cues
- potential for confusion often present in e-delivery of services
- response time to asynchronous communication (emails, texts, chats, etc.)
- possibility of technology failure and alternate methods of service delivery
- emergency protocols to follow;
- procedures for when the counselor is not available
- consideration of time zone differences
- policy regarding recording of sessions by either party
- cultural and/or language differences that may affect delivery of services
- possible denial of insurance benefits
- social media policy

What have we learned since COVID-19

- Verification of Identity
- Password for Identity; securing confidentiality
- Code word – safety concern
- Code word – others listening
- Federal, state & local laws
- Assessing client’s access to technology & ability to benefit
- Transmission & encryption
- Handling crises, unexpected occurrences
- Using local resources, referrals
- Boundaries

What have we learned since COVID-19

- Client’s capabilities to participate physically, intellectually, emotionally, linguistically, functionally
- Missing cues
- Group therapy via telehealth
- Documentation & record keeping
- Friending – social media
Ethics in Practice
Specialty Online Training Series

This series is designed to accompany the NAADAC/NCC AP Code of Ethics. The Ethics in Practice Specialty Online Training Series will provide a thorough dive into the NAADAC/NCC AP Code of Ethics, bringing to life how the code plays out in the work of addiction professionals and ways to handle and avoid ethical dilemmas.

www.naadac.org/certificate-for-ethics-in-practice-online-training-series

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Thank You

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703.741.7686 / 800.548.0497
www.naadac.org

Presented by: Mita M. Johnson, EdD, LAC, MAC, SAP, CTHP-II