RI Partnership

with funding from Robert Wood Johnson Foundation

NRI Community Services, Inc
Family Resources Community Action Program
Gateway Healthcare, Inc – Tri-Hab Division
Dept. of Mental Health, Retardation & Hospitals – Division of Behavioral Healthcare

Continuing Care Services

A Recovery Management Support Program

For "Successful Completers"

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Quality Addiction Care manual

SAFETY NET

Continuing Care Manual For Successful Completers

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Welcome to Continuing Care!

In November, 2006, the Robert Wood Johnson Foundation awarded a two-year Advancing Recovery Grant to the RI Partnership of Family Resources Community Action, Gateway Healthcare, NRI Community Services, and the Department of Mental Health, Retardation, & Hospitals, Division of Behavioral Healthcare.

The purpose of the Advancing Recovery Grant is to implement evidence-based practices into treatment settings across entire state systems. The RI Partnership has selected Continuing Care as its project for the first year of the grant.

What is Continuing Care?

It is a level of care that helps clients along their path to recovery by offering them an opportunity to maintain an ongoing relationship with their provider. Key components of this program include phone-based assessment and counseling, face-to-face sessions as needed and linkages to case management services to meet their full array of needs (e.g., housing, employment, access to medical care, etc.). Clients who complete primary care or dropout prematurely are eligible for this 24 month program.

Why Continuing Care?

Our philosophy is simple. Addiction is a chronic condition with both biological and environmental factors and recovery is a life-long process. While relapses can occur, many can be prevented or the negative consequences be minimized by early identification and intervention. Through Continuing Care, we hope to provide state-of-the-art treatment that is tailored to the individual needs.

Who benefits from Continuing Care?

First and foremost, the clients, who are offered a better chance at achieving success in their recovery. Staff benefit, too, by having the satisfaction of knowing that their clients have the opportunity to maintain the successes that they've achieved in primary care. Finally, the overall system benefits by reducing relapse and thereby, improving access to new individuals seeking treatment.

Who is Eligible for Continuing Care?

Clients who successfully complete treatment are eligible for this level of care. In order to meet the criteria of being a successful completer, the client must have completed elements of a treatment plan that, at a minimum, would include:

- A period of sustained abstinence;
- Client is in an action or maintenance stage of change; and
- Client has successfully utilized an individualized relapse prevention plan for at least 30 days, including linkages to self-help and/or other healthy support systems.

Based upon a client's level of functioning or need, these additional criteria may apply:

- Client psychosocial needs (e.g., housing, legal, employment, etc.) are stable or being addressed;
- Medical healthcare needs are stable or being addressed; and/or
- Mental health needs are stable or being addressed.

Determination of the client's transfer to Continuing Care will be made by the primary clinician in collaboration with the clinical supervisor.

Orientation To Continuing Care Risk Assessment

Prior to beginning Continuing Care Risk Assessment and while the client is enrolled in primary care, the counselor will have a 45-minute face-to-face orientation session with the client to review the risk assessment protocol and explain how it works. This is also a time for the client to raise questions and identify his/her personalized trigger situations and recovery behaviors for ongoing monitoring.

Although Continuing Care is intended to extend for up to 2 years, this duration can be intimidating to both staff and clients. Partnership agencies have experienced the most success by offering Continuing Care in 12-week increments.

Before the session, review the diagnoses.

The session should include:

Acknowledgement of the client's progress, in part demonstrated by successful completion of a primary level of care and commitment to participation in Continuing Care services.

- Explanation of Continuing Care Risk Assessment treatment, with strong emphasis on the importance of the phone calls, being prepared for the phone calls, and being willing to ask for help. The client should be instructed to fill in the dates in the client's workbook corresponding to each time frame for when he/she will talk with his/her counselor.

- Explanation of the flexibility of the program depending on how the client is doing.

- Engage the client briefly in a discussion of his progress so far. Review the following:
    1. What has the client been doing to stay abstinent? What are the most important things to continue, or to begin doing?
    2. If the client has had a previous period of abstinence what led to relapse? What are the warning signs that a relapse might be on the way?
    3. What are the client's most important reasons for staying abstinent?

4. Follow up on any concerns/biopsychosocial stressors raised during the client's primary treatment (e.g., suicide attempts, psychiatric diagnoses/medications, chronic medical problems, etc.)

- As part of this discussion, the "Continuing Care Risk & Protective Factor Progress Note" (See page 20) should be completed. The original should be filed in the client record and a copy provided to the client.
- Before leaving the you and the client should also complete the "Continuing Care Emergency/Safety Contract" (See page 19) to assist the client to identify available resources in the event of an emergency.

This discussion will help you guide the client in choosing high-risk situations and recovery activities to monitor and in selecting relevant between-session goals. Ask for permission to challenge the client to be even more proactive in managing his/her addiction – doing more of what has been successful, helping him/her identify problems in the early stages before they lead to relapse.

- Use the workbook exercise to help the client identify his/her top four high-risk situations for ongoing monitoring.

- Use the workbook exercise to help the client identify his/her top four pro-recovery lifestyle activities for ongoing monitoring.

- Review and complete the crisis plan with the client.

- Review the Continuing Care Risk Assessment Progress Note (See pages 21-24) with the client during the session. Clarify with the client anything he/she does not understand and discuss any misgivings he/she may have about following through with Continuing Care. You can also emphasize and demonstrate for the client that it can be completed quickly, and also that spelling, complete sentences, and proper punctuation are not the important aspects of this work.

- Provide feedback based on the risk assessment worksheet, and elicit questions and concerns about feedback.

- Ask the client what high-risk situations he/she anticipates facing in the interval before the first phone session. Troubleshoot briefly.

- Identify one goal for the client to work on before the first phone session. This can be related to avoiding/managing a high-risk situation or increasing/maintaining progress toward a substance-free lifestyle. The first phone session will be in just a few days so this will be an opportunity to practice identifying very specific short-term behavioral goals.

- Schedule the first phone session, ideally within the same week as the orientation, so that the second phone session will fall approximately one week after the orientation.

Conducting a Risk Assessment Phone Call

At the date/time that you have scheduled a phone call with the client, you should initiate the phone call. A long-term goal of treatment may be that eventually the client initiates these phone calls. Research by Dr. James McKay, however, suggests that this is not an effective strategy early in the transition period..

The Risk Assessment items are grouped according to "risk" factors for relapse and "protective" factors against relapse, based on prior research and clinical experience. The overarching goal of Continuing Care is to help clients manage their addiction proactively by avoiding and/or improving coping with high-risk situations and developing a lifestyle rich with rewarding activities incompatible with substance use. Sessions are structured to include a review of the client's progress and an opportunity to plan for the week(s) ahead.

Overall, the flow of the phone call should follow the outline below:

- Thank the client for being present for the call, and orient to the task at hand.
- Review Risk Assessment items.
- Provide feedback on risk level – suggest change in level of care if warranted.
- Review progress/goals from last call.
- Identify upcoming high-risk situations.
- Select target for remainder of call.
- Brief problem-solving regarding target concern(s).
- Set goal(s) for interval before next call.
- Schedule next phone call.

The Progress Note provided on pages 21 - 24 will give you some guidance as to how the call should proceed. Primarily, the goals of this phone call are to identify:

- Risk Factors: mood, suicidality/homicidality, medication adherence, concern about ability to remain abstinent, time alone, exposure to high risk situations, cravings, and alcohol and drug use.
- Protective Factors: sober living, attendance at meetings, contact with the sponsor, and treatment involvement.
- Casemanagement Needs: (e.g., transportation, employment, housing, etc.)
- Homework: development of a treatment goal to be addressed prior to the next phone contact.

In an effort to minimize paperwork, you should be aware that this progress note is intended to replace any other progress note that you complete for clients. This note serves the triple purpose of providing clinical documentation, acting as a service ticket, and collecting data for the grant. **Before placing this note in the client record, please copy it and give it to the Robert Wood Johnson Foundation Advancing Recovery Grant Leader in your agency. This data is used to track the progress of the implementation of Continuing Care.**

The phone call should be a pleasant and productive experience. Use of genuine positive reinforcement to acknowledge what the client has done well will increase the likelihood that the client will remain in Continuing Care. Praising the client for being present for the phone call or for completing his/her workbook pages is a nice way to start. Acknowledging the client for admitting risks, concerns, and even failures - for being *honest* - is also a powerful motivator. No one is going to call you to be embarrassed or diminished in any way. So, while the client is able to admit to a slip, for example, you might say, "That's a real sign of growth that you're able to tell me about this. Now let's come up with some ideas about how you might avoid that problem in the future." Try to let the client identify solutions, offering guidance only as needed. It's a good idea to help the client to identify a small, measurable task to work on during the interval until the next phone call.

Remember also that you want to be listening for changes in behavior patterns that might indicate cause for concern, particularly things the client has identified as 'red flags'. Clinicians are encouraged to develop their own approach to covering the required material.

Reporting Admissions/Discharges to MHRH/DBH

In response to this project, MHRH has added Continuing Care as a service on the "Division of Behavioral Health Care – CIS Admission/Discharge" Form (See pages 26 & 27). Transfers and discharges to/from Continuing Care should be reported on this form, just as any other level of care. This will allow MHRH to conduct analysis of clients served through Continuing Care.

Support Person Role

Clients will be asked to identify someone who can play a supportive role with respect to their treatment and recovery. This does not necessarily need to be a "significant other" – it can be a spouse, friend, family member, or other associate. The client should be encouraged to think of at least one possible support person

The support person's role is to help the clinician regain contact with the client if he/she begins to miss phone calls or face-to-face sessions and is out of contact afterwards. The clinician can ask the support person to relay a message or for suggestions as to how to reach the client. If the support person asks the clinician how to handle specific situations, the clinician should not provide advice but may refer them to Al-Anon or suggest that they seek counseling.

Determining that a Client is at High Risk

Based on your phone assessment, the client may present at high risk for relapse if any of the following conditions exist:

- ❑ Any alcohol and/or drug use since last contact;
- ❑ Suicide or homicide risk rated "1" – "3";
- ❑ Concern rated a "3";
- ❑ At least two risk items rated "3" and at least two risk items rated "2";
- ❑ At least one risk item rated "3" and at least three risk items rated "2" and no protective items rated "2" or higher; or
- ❑ Risk factors are greater than protective factors and there is substance use.

Transfer to a Higher Level of Care

Identification of a high relapse risk should initiate a conversation with the client regarding the need to move to a higher level of care. Under this circumstance, you should reassure the client that this does not represent a failure. A willingness to move to a higher level of care represents a greater awareness of one's illness and a degree of maturity to engage in the most appropriate treatment needed to achieve recovery. If the client consents, you should facilitate the transfer as quickly as possible. Depending upon the client's insurance status, he will be given priority for the next available slot for that insurance type. In situations in which the client refuses, however, he will remain in Continuing Care with an increase in phone and face-to-face contacts attempted.

Terminating a Client from Continuing Care

Clients will be discharged from Continuing Care under the following conditions:

- ❑ The client has completed 24 months of Continuing Care and remained abstinent.
- ❑ The client refuses to participate in Continuing Care any longer.
- ❑ A client misses a Continuing Care phone call or face-to-face session and has had no contact with you despite aggressive phone contact attempts (i.e., 3 call attempts to client and/or collateral, including one message left, within 7 days) and has not responded to the 10 day letter (See page 25).

Sample Phone Conversations

1. Acknowledge the client for being available for the call, and orient to the task at hand. Since the telephone sessions are brief (15-20 minutes), the clinician should quickly get into reviewing the Risk Assessment Form. Here is an example of how the call might begin:

> *"Thanks for being available for the call. Are there any emergencies I should know about? OK, let's get right into your worksheet. Do you have that material with you now? Did you complete it prior to the call?"*

- If the client says "yes" to both, give appropriate positive feedback.
- If the client was not available on time, or has missed one or more scheduled calls, reinforce the client for resuming calls, and mention that you will address scheduling issues later.
- If the client does not have materials on hand and can not obtain them quickly, continue with the Risk Assessment prompts. At the end of the session, prompt them to locate their materials before the next call. If materials are lost, mail another copy.
- If there is an emergency, ask the client to describe it BRIEFLY. In most cases it will be enough to assure them that you will discuss it with them further after completing the Risk Assessment (as long as you really do follow through). If the client is very upset, it may be necessary to deal with the emergency situation before returning to the structure of the call. Even then, it may be possible to retain the "spirit" of the call by helping the client deal with the emergency without resorting to substance use.

2. Review Risk Assessment items.

> *"Did you use any alcohol or drugs over the past week?"*

- Continue through the Risk Assessment items in order, recording the client's responses. Be alert to how the client's responses bear on their stated goals since the last session and to longer-term treatment goals. Is he/she showing progress over time toward a pro-recovery lifestyle?
- At least once every 3 months, review the entire list of high-risk situations and recovery-lifestyle items to determine if there have been any changes in the client's top 4 items (to be given as a prompt in upcoming calls).
- Continually provide positive reinforcement to the client for sticking with the process and providing complete and accurate information, even when it's not all good news.

> *"Thanks for being so honest with me. That's the only way we can tell where you are doing well and where you might need to change."*

3. Provide feedback on risk level.

Based on scoring of the Risk Assessment form, give the client feedback on relapse risk level. Place the feedback in the context of the client's goals since the last session and overall treatment goals, and include suggestions for change in level of care if warranted.

Low Risk:

Example: "Based on what you've told me, you are doing a great job of keeping yourself at low risk for relapse. You are still talking with your sponsor and spending even less time alone than before."

Moderate Risk:

Example: "You've been spending a lot of time alone lately, and getting to fewer AA meetings. You've told me that this combination has gotten you into trouble before. I am concerned that you are now at a moderate risk for relapse, and one thing we can discuss during our time today is how stepping up our phone calls can help you get back on track."

Example: "I'm looking over information on your progress over the past month, and it looks like your participation in AA has been steadily decreasing. Have you noticed that? What is your sense about why that is happening now? Skipping meetings is a warning sign for relapse, so I think it's important that we look at this now, before you get into trouble."

High Risk:

Example: "Based on what you've told me, you are having more cravings and are very concerned about staying clean and sober. It concerns me too that you may be at high risk for relapse. Let's think about having you come in for a face-to-face meeting so we have more time to address what's going on."

4. Review progress/goals since last call.

Ask the client how they did with respect to the issues identified in the previous call. If a high-risk situation was anticipated and planned for, how did it go? Did the client complete his/her pro-recovery goals? Engage the client in a detailed description of their successes. What did they feel good about? What was more difficult? The goals of this exercise include helping the client recognize the inherently rewarding aspects of his/her sober lifestyle and troubleshoot difficult situations or change plans that aren't working well.

5. Identify upcoming high-risk situations.

Ask the client to think ahead to the interval until the next phone call. What situations might he encounter that could increase the risk for relapse?

Example: When will it be difficult for you not to drink in the upcoming week?

Example: You've had some cravings whenever you have been around your brother-in-law. Will you be seeing him in the next week?

Example: Your sponsor will be going away on vacation. Sometimes people find it is harder to stay sober when they have less support. How will you get support while he/she is away?

The client may or may not identify anything. If the client has trouble anticipating high-risk situations, yet reports having encountered them on a regular basis or reports continued cravings, help him to see the connection between past difficult situations and the possibility that those same situations may arise in the foreseeable future.

6. Select target(s) for the remainder of the call.

Once the Risk Assessment is completed, you will only have about 10 minutes for talking before it is time to wrap up and schedule the next call. Together with the client, choose 1 or 2 things to focus on. These may include follow-up on the client's goals from the prior session, problem-solving regarding newly identified or especially troublesome risks, and other pressing matters that the client may see as having a bearing on their ability to remain abstinent. This BRIEF process will be an exercise in prioritizing for client and counselor alike!

Example: "Your goals were to attend AA daily and talk with your doctor about problems you've been having with your Zoloft. You made it to AA but you're still having trouble taking your meds. Bad moods are still a problem for you, and may be a high-risk situation for you in the upcoming week. Which of these things should we focus on? Is there something even more important for your recovery right now?"

- There is no need to repeat what you just said in the feedback step of the session if goals and concerns were already covered – just go ahead and set the agenda with the client.
- If compliance with the call schedule is a problem, this is the time to get it on the agenda.

7. Brief problem-solving regarding target concern(s).

Once a specific target is identified, engage the client in problem-solving. As much as possible, guide the client through the steps of problem-solving (noting that they are a step ahead of the game already, having identified the problem) rather than solving the problem for them. Encourage the client to generate a few solutions and select one for implementation. Provide information and advice as needed, but avoid telling the client what to do or getting into an unproductive back-and-forth in which you offer helpful suggestions and the client rejects them. Avoid argument by responding reflectively to resistance and quickly getting back to the task at hand.

When motivation is flagging, this may be a signal that the client is minimizing negative consequences of substance use and benefits of abstinence. Review the information gathered in the initial face-to-face session to help identify reasons for staying abstinent – what are the client's current thoughts on the topic? How can he best remind himself of the costs of use? Discuss the benefits of abstinence – and how the client can gain even more benefit from sober living.

There are many opportunities for the clinician to help the client integrate various structures and supports by shaping the client's goals in a way that models such integration: connecting the client's identified interpersonal relationship goals to people at church or meetings or work, for example—"Is that something you could talk with your pastor about?", "What about asking your brother to go with you to ____?", "When you meet with your sponsor this week, could you ask for feedback about this?" etc.

8. Set goal(s) for the interval before the next call.

The client should be reassured that he doesn't have to come up with lengthy or complicated tasks and goals. In fact, simple and brief is better, as long as specifics are provided. Help clients choose goals and tasks that are concrete and "do-able." It's better for the client to experience success at a modest goal than to fail at an ambitious one.

> *Example: "Now let's go over what you'll be doing in the coming week, between now and our next telephone call. Given how things are going, what do you think the one or two most important goals should be for next week? The best types of goals are ones that are stated very clearly, so next week you'll be able to see if you've made progress on them."*

> *Example: "Good. Now that you picked ____ as your main goal, what are the things you will do to reach that goal? The more specific you can be, the better. For example, rather than saying 'I'll go to AA,' clarify how many meetings you plan to go to, where they are, and when they are. By doing that now, you'll have developed a good plan for the coming week."*

9. Schedule the next phone call.

Schedule the next phone call. If compliance has been a problem, make sure the client agrees that the designated time will work for them. If necessary, engage in brief problem-solving regarding compliance with phone calls, including having the Client Workbook ready. (If compliance has been a major issue, it should have been addressed earlier in the session, and can be reviewed at this point)

> *Example: "OK then, we will talk again on Month/day at 2:00. I'm looking forward to speaking with you!"*

Maximizing Participation in Continuing Care

It is the clinician's responsibility to call the client at the appointed time until otherwise clinically indicated. Moving toward client initiated phone contacts communicates the clinician's confidence in the client's capacity to follow through with the structure and improve his/her life situation. However, if the client misses a phone appointment, it is the clinician's responsibility to try to reach the client, determine the reason for the missed appointment, and re-engage the client in regular phone session attendance. The clinician will make active efforts to re-engage a missing client. In the seven day period following the missed appointment, the clinician should make 3 phone calls to the client and/or support person, leaving at least one message. Phone calls should be made at various times of the day to increase the likelihood of reaching the client. After seven days, a 10-day letter should be sent asking the client to call the clinician to reschedule his/her appointment. If the client does not call within the 10 days, he/she will be discharged from Continuing Care.

Suggested Retention Efforts:

Client does not keep his/her telephone appointment (i.e., hasn't accepted call within 10 minutes of scheduled time).
Call the client, and if he can be reached directly, have the phone session at that time. Inquire about the missed call. If the client has a plausible explanation, simply review that the calls are important to the client's recovery and emphasize the value of keeping the next appointment. Note that "plausible" need not involve the "third degree"—if the client sounds "normal" to the clinician on the telephone, participates appropriately in the session and seems to be following through with what he needs to do, "I got busy and forgot" might be the absolute truth and may not be cause for concern as long as this is not one in a series of missed appointments.

Client does not respond to clinician's message within 24 – 48 hours.
Over the next 24 – 48 hours, place 2-3 phone calls to the client and/or support person, leaving at least one message. The message should stress the importance of the client calling back. If the client calls back during this time with a plausible explanation for the missed appointment, have the phone session at that time, if possible, and review compliance issues (importance of compliance, problem-solving if necessary to increase compliance). If it is not possible to have the session at that time, reschedule the appointment.

Client does not respond within 24-48 hours of missed appointment.
Up to 7 days following the missed appointment, place another 2-3 phone calls to the client and/or support person, if applicable. Leave at least one message reinforcing the importance of communicating. If the client calls during this time, evaluate the current status according to the risk assessment to determine whether a face-to-face session is desired to reestablish continuing care intervention. Review compliance issues: goals and importance of phone counseling, counseling agreements, problem-solving to maximize compliance. Evaluate whether co-occurring problems, such as psychiatric symptoms, childcare issues, other problems with children, basic needs, and so forth, are contributing to poor compliance, and provide referrals if needed.

Client does not respond within 1 week of missed appointment.
Send a 10-Day letter requesting that the client call back as soon as possible, emphasize your concern for the client. Let them know they are welcome back to continuing care intervention regardless of what has been going on in the meantime. If the client calls back within 10 days of sending the letter, evaluate his/her current status according to risk assessment to determine whether a face-to-face session is needed to re-engage the client in Continuing Care intervention. Review compliance issues: goals and

importance of phone counseling, counseling agreements, problem-solving to maximize compliance. Evaluate whether co-occurring problems, such as psychiatric symptoms, childcare issues, other problems with children, basic needs, and so forth, are contributing to poor compliance, and provide referrals if needed. The compliance issues may be seen as a "red flag," warranting an increased level of care or an in-person evaluation session before returning to the regular phone schedule.

Client does not respond to the 10-Day letter.
The client should be discharged from Continuing Care.

Client misses a face-to-face session.
Make active efforts to reach the client by phone, calling the support person if necessary, and attempt to get them in for the next scheduled session time (i.e., within a couple of days). If this is the first missed session, follow the protocol above. On the other hand, if the face-to-face session is the end result of a lengthy attempt to re-engage the client following missed phone contacts, only one more phone call should be made. In the event that this is unsuccessful, the client should be discharged from Continuing Care.

Note about calling support people.
Always thank support people for their help! Repeated calls searching for the client may be annoying or intrusive to the contact person. When trying to reach a client who has missed an appointment, ask the support person's permission to call them again after a certain interval has elapsed if the client has not called.

Overall Risk Levels for Relapse

Risk Level	Guidelines for Addressing Risk Level
High Risk	
• Any alcohol/drug use reported since last phone contact. • “Concern” rated “3.” • At least 2 risk items rated “3” AND at least 2 risk items rated “2” (i.e., frequent trigger situations) • At least 1 risk item rated “3” AND at least 3 risk items rated “2” AND no protective items rated “2” or higher (i.e., several trigger situations, coupled with minimal involvement in sober lifestyle). • Risk factors are greater than protective factors, substance use. • Suicidality/Homicidality = 3 regardless of other scores.	• Bring client in for 1-2 face-to-face individual sessions. The first session should be within one week of the call in which the client reports high risk. Ideally, schedule within 2 days of the call. • *If there has been no use and client states credible commitment to maintaining abstinence*, schedule weekly phone contacts until risk has dropped. If risk remains high, schedule a 2nd face-to-face session and evaluate for initiation of Motivational Enhancement Therapy or Relapse Prevention OR refer to higher level of care. • *If there has been no use, but high risk situations are more problematic or client doesn’t state credible commitment to abstinence,* schedule weekly phone contacts until risk has dropped. If risk remains high, schedule a 2nd face-to-face session and call between sessions and initiate Motivational Enhancement Therapy or Relapse Prevention OR refer to higher level of care. • If there has been any use, evaluate the need for detox. Schedule 2nd face-to-face session 1 week after the 1st session - with phone call in between. If client shows progress toward reducing risk, return to increased call schedule for at least two weeks. If there is another episode of use during the evaluation period or client continues to express concern about remaining abstinent refer to a higher level of care.
Moderate Risk	
• No alcohol/drug use and “Concern” is rated 2 or lower. • All risk items are rated 2. • Risk factors are greater than protective factors, no substance use. • Suicidality/Homicidality = 2	If client is on weekly calls: • Increase calls to twice per week. OR • Schedule the client for a face-to-face individual session. If client is on biweekly or monthly calls. • Increase calls to once per week OR • Schedule the client for a face-to-face individual session If risk level returns to low after 2-4 weeks, resume regular phone call schedule. If risk level remains at moderate, continue increased call schedule and re-evaluation in 2-week intervals. Targets of brief counseling: • Problem-solve regarding problem areas that led to increase in risk • Review and reinforce client success • Encourage further involvement in pro-recovery lifestyle activities

Risk Level	Guidelines for Addressing Risk Level
Low Risk	
• All risk items rated 0 or 1 AND at least 1 protective item rated "2" or higher (i.e., few trigger situations, coupled with some involvement in sober lifestyle). • Protective Factors are greater than Risk Factors	Continue regular phone schedule. Targets of brief counseling: • Review and reinforce client success • Problem-solve regarding client-identified upcoming risky situations, using risk assessment as a guide • Encourage further involvement in pro-recovery lifestyle activities

Face-to-Face Evaluation Session(s)

The face-to-face evaluation session(s) are provided if the client reports substance use or high risk for relapse. It may also be provided if the client "reappears" after a period of no contact with the counselor. In most cases, a single session is scheduled within a week (ideally within 2 days) after the phone call in which the client reports use or high relapse risk. Depending on the outcome of the first session, a second session may be scheduled about 1 week later.

By the time a face-to-face individual session is scheduled, you may have spent several phone calls "putting out fires" with a client who is experiencing one or more crises. The goal of the session is to take a step back from the immediate situation and get a broader assessment of what is going on. The evaluation session will include a detailed debriefing of any relapse episodes, and will also address the readiness for change in a more general sense.

When the client has a slip or becomes at high risk for relapse, despite ongoing phone intervention, it may be that the focus of sessions and between-session goals are not quite on target with respect to the client's true relapse risk, in which case the general focus of problem-solving efforts needs to be revised. Examples would be clients who have misidentified their most relevant risky situations to follow on an ongoing basis, or clients who do not have adequate coping skills to deal with unavoidable risky situations. Clients whose case management needs are not being met would also fall in this category. Another possibility is that the client is struggling to achieve or maintain abstinence – that the benefits of recovery do not seem to be sufficiently rewarding to counteract the lure of alcohol and/or drug use. Asking the client to rate how important abstinence is to him, and how confident he is that he can achieve/maintain it, with appropriate follow-up questions, will help you to determine where to focus the rest of the session.

Session Outline:

1. Set agenda and affirm the client for taking the step of coming in to address his current problems.
2. Debrief any episodes of use. Frame reflective listening summaries in terms of coping/problem-solving concepts consistent with the overall treatment protocol.
3. Assess current motivation for regaining/maintaining abstinence using importance/confidence scales.
4. If importance is low –
   a. Acknowledge difficulty of following through on action plans when feeling low motivation.
   b. Use decisional balance and client's response to "what would it take to increase importance" to find hooks for increasing motivation. Provide information and/or personal feedback if applicable – with permission!
   c. Develop a homework task to address motivation.
5. If importance is high but confidence is low –
   a. Explore past and present efforts at change. What has worked in the past? What is different now?
   b. Use client's response to "what would it take to increase confidence" to guide problem-solving efforts.
6. Use adaptive protocol to determine next course of action – return to phone calling, schedule additional session, recommend a course of Relapse Prevention, etc.

Extended Telephone Monitoring – Treatment Adherence Checklist

This form is intended to be utilized by you to help you in identifying the core elements of the protocol. While you are learning how to administer Continuing Care, you may find it useful to review this list before initiating a phone call.

Client: __ __ __ __ Session Date: __ __/__ __/__ __ __ __
Rating Date: __ __/__ __/__ __ __ __

Therapist: ________________________

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1. Acknowledged client for call and orients to task at hand.

2. Reviewed Risk Assessment Worksheet items with client.

3. Provided feedback on relapse risk level – low, moderate, high.

4. Reviewed client progress since last contact.

5. Asked client to anticipate upcoming high-risk situations.

6. Engaged client in selection of topic(s) for remainder of call.

7. Engaged client in relapse prevention and/or pro-recovery counseling and problem-solving.

8. Helped client set a goal for interval until next contact.

9. Scheduled next contact with client.

10. Suggested change in treatment protocol in response to client risk level.

11. Offered referral to outside services in response to client needs.

Notes/Comments:

____
____
____
____

NRI COMMUNITY SERVICES

#07-05 (e) (Rev. 3/30/07)

RWJF ADVANCING RECOVERY – RI PARTNERSHIP

Continuing Care Emergency/Safety Contract

Client Name: ____ HI#: ____________

Last *First* *MI*

Client DBH #:____________ Today's Date: ____________ Date of Last Contact: ___________

Start Time: __________ End Time: ___________

1. My primary care physician: ____
   Phone number: ___________________________

2. My local emergency room is at ____ Hospital.
   Phone number: ___________________________

3. In an emergency, the person I can most count on to assist me in obtaining help is
   ____
   ______________________________, whose phone number is _____________________.

4. My Continuing Care clinician is: ____
   Phone number: ___________________________

5. My psychiatrist is: ____
   Phone number: ___________________________

6. My sponsor is: ____
   Phone number: ___________________________

If I genuinely feel like hurting/killing myself or someone else, I will do the following steps. If needed, I will contact my emergency helper (identified in #3) and ask him/her to help me complete these steps:

a. During daytime hours Monday thru Friday contact my Continuing Care clinician at the following number: ____________________.
b. If I have a psychiatrist treating me, I will contact his/her office and tell him/her that I am in crisis.
c. If I can not reach either of the above, I will contact the agency's 7 day, 24 hour Emergency Services at ______________________.
d. If none of the above can be reached, I will go to my local emergency room and tell them I am in psychiatric crisis.
e. If I am unable to get to an Emergency Room, I will dial 911, tell them I am in psychiatric crisis and ask for help.

If I am in any type of medical crisis, I will call my primary care physician. If he/she is unable to be reached, I will go to my local emergency room, urgent care facility, or call 911 and ask for help.

I have reviewed this emergency plan with my Telephone Continuing Care Counselor and fully understand the steps I need to take in the event that I am in psychiatric or medical crisis. I agree to review this contract with my emergency helper.

________________________ __________ ______________________ __________

Participant Signature Date Clinician Signature Date

Printed Name: __________________________ Printed Name: ______________________

NRI COMMUNITY SERVICES

#07-05 (b) (Rev. 3/27/07)

RWJF ADVANCING RECOVERY – RI PARTNERSHIP

Continuing Care Risk & Protective Factor Progress Note (Full Protocol)

Client Name: ____ HI #:________________

Last *First* *MI*

Client DBH#: _____________________ Date of Last Contact: _________________________

Staff Number: __________ Service Date: _____________ Program Code: ____________

Start Time:__________ End Time:________ Location :_____________

Activity :______________

Recipient:_____________ Attendance:__________ Delivery Method:_________

Co-Visit: ☐ No ☐ Yes (*If Yes, Please indicate Staff's Name and Staff's Number*)

Staff Name: ____ Staff Number:________________

Top four high-risk situations:	Top four ways to spend time with people who do not have an alcohol or drug problem:
❑ In a bar ❑ In a crack house ❑ At an active friend's house ❑ At an active family member's house ❑ Hanging out with active drinkers/users ❑ With boyfriend/girlfriend/spouse while they are drinking/using ❑ With boyfriend/girlfriend/spouse, or ex-boyfriend/girlfriend/spouse ❑ Tricking/picking up prostitutes ❑ At a corner store that sells beer ❑ At a party where there is alcohol/drugs ❑ Driving/riding through neighborhoods I used in ❑ Other: ____________________________	❑ Brothers/sisters events ❑ Recreational/sports participation ❑ Activities with my children ❑ Activities with clean and sober family members ❑ Activities with clean and sober friends ❑ Church services ❑ Church social activities ❑ Classes (GED, college, etc) ❑ Working out/going to the gym ❑ Other: ____________________________ ____________________________________ ____________________________________

Clinician Signature: ____Date: ____________

Clinician Printed Name: ____

Client Signature: ____ Date: ____________

Client Printed Name: ____

NRI COMMUNITY SERVICES

#07-05 (c) (Rev. 3/30/07)

RWJF ADVANCING RECOVERY – RI PARTNERSHIP

Continuing Care Risk Assessment Progress Note

Client Name: ____ HI#:_______________

Last *First* *MI*

Client DBH #:_________________________ Date of Last Contact: _____________________

Staff Number: ________________ Service Date: _______________ Program Code: ___________

Start Time:___________ End Time:_________ Location :______________

Activity :______________

Recipient:______________ Attendance:__________ Delivery Method:_________

Co-Visit: ☐ No ☐ Yes (*If* Yes, *Please indicate Staff's Name and Staff's Number*)

Staff Name: ____ Staff Number:________________

Instructions: For each of the following questions, you should assess the client's risk <u>since the last date of contact</u> (either phone contact or face-to-face).

Risk Factors	Lowest Risk			Highest Risk
1. Mood	0	1	2	3
How many days have you had a shifting mood throughout most of the day? By "shifting" I mean sad, depressed, angry, worried, anxious, hopeless, etc.	<1 day/wk	1-2 days/wk	3 days/wk	4 or more days/wk
2. Suicidality/Homicidality	0	1	2	3
Have you had any thoughts of hurting yourself or someone else? IF YES, how frequent are the thoughts? Do you have a plan? Do you have what you need to carry out the plan?	No	Infrequent Thoughts	Frequent Thoughts	Thoughts with Intent/Plan and/or Means
3. Medication Adherence	0	1	2	3
Have you had any medical appointments? Have you taken your meds as prescribed this week?	Yes/NA	Most of the time	Some of the time	Rarely or never
	0			3
Have you had any changes in prescribed medications?	No			Yes
4. Concern	0	1	2	3
How concerned are you right now about your ability to stay clean and sober until our next phone call?	Not at all concerned	A little concerned	Moderately concerned	Very concerned
5. Time Alone	0	1	2	3
How many days have you spent most of your day alone or	None	1 day/wk	2-3	4 days/wk

in the company of strangers? *(Exclude work, volunteering, etc. Clarify amount of time as being most of waking hours.)*			days/wk	or more
6. High Risk Situations	0	1	2	3
How many times have you been around situations you have identified as high risk? The four riskiest situations you have identified are: *(Orient to chosen risky situations; probe for additional risky situations; update client's list at least every 3 months.)*	None	1 time/wk	2 times/wk	3 or more times/wk
7. Craving	0	1	2	3
How many days have you experienced cravings, dreams, thoughts or desires to drink or use drugs?	None	1-2 days/wk	3 days/wk	4 or more days/wk
IF ANY CRAVING:	0	1	2	3
How strong were the cravings?	Just a passing thought	Mild	Moderate	Strong
	0	1	2	3
What did you do when you had a craving?	Moved out of a risky situation OR Did not seek out a risky situation.	Called sponsor or other positive support, attended a mtg., participated in a grp. Sober activity	Participated in an indiv. sober activity (e.g., read, shower, exercise, journal writing)	Did nothing, but did not use
8. Alcohol and Drug Use	0			3
Have you used alcohol or other drugs?	NO			YES
IF YES: Substance Quantity Frequency				
1.				
2.				
3.				
Risk Factor Total (Add all circled items from pages 1 & 2)				____

Comments:

____

____

____

____

____

____

____

Client Name: ____ HI#:_________________

Last *First* *MI*

Protective Factors	Lowest Protection			Highest Protection
1. Sober Living	0	1	2	3
How many times have you participated in a sober activity other than an AA/NA meeting with people who are sober or who have no alcohol/drug problem? The four sober activities you chose to involve yourself in were: *(Orient to chosen activities; probe for additional sober activities. Update client's list at least every 3 months.)*	None	1 time/wk	2- 3 times/wk	4 or more times/wk
2. Meetings	0	1	2	3
How many AA/NA meetings have you gone to?	None	1 time/wk	2- 3 times/wk	4 or more times/wk
IF YES: Did you participate actively (e.g., raise your hand, help set-up or clean up,) at least once per meeting?	No			Yes
3. Sponsor	0	1	2	3
How many times have you talked with your sponsor outside of meetings?	None or NO SPONSOR	1 time/wk	2- 3 times/wk	4 or more times/wk
4. Recovery Coach	0	1	2	3
How many	None	1 time/wk	2- 3 times/wk	4 or more times/wk
5. Treatment Involvement	0	1	2	3
Are you involved in any other kind of services (e.g., medical psychiatric, etc.)?	Services needed but has not made/kept appt.			Yes or No Additional services needed
Protective Factor Total (Add all circled items from page 3)				________
Copy Risk Factor Total from page 2				
Overall Risk Total (Protective Factor Total – Risk Factor Total)*				________

*Note: If Overall Risk Total is positive, the client has more protective factors than risks.
If Overall Risk Total is negative, the client has more risk factors than protective factors.

Example:

Protective Factor Total	12	3
Risk Factor Total	-6	-9
Overall Risk Total	6	-6

Comments:____

____

____

____

Instructions: The following items are included for assessment of casemanagement or other service needs. They are not included in the scoring of risk factors.

Case management/Other Service Needs	No	Yes
Do you have needs that are a major source of stress in any other part of your life?		
➢ Transportation	0	1
➢ Employment	0	1
➢ Housing	0	1
➢ Caring for your household	0	1
➢ Childcare	0	1
➢ Family/marriage concerns	0	1
➢ Problems with peer relationships	0	1
➢ Education	0	1
➢ Parenting	0	1
➢ Basic Needs (e.g., food, clothing, personal care)	0	1
➢ Medical	0	1
➢ Financial Issues	0	1
➢ Legal Issues	0	1
➢ Other: ____________________	0	1
Total Case management/Other Service Needs:		_______

Comments (e.g. referrals made, appointments scheduled, next steps):

____

____

____

____

____

Signature: ____Date: ____________

Printed Name: ____

Sample 10-Day Letter

(Insert Current Date)

Dear (insert client's name),

Thank you for contacting our agency for services. We are concerned that you were unable to make an appointment and that we have been unable to reach you. Please contact us to discuss your treatment options, including possible transfer to Continuing Care services. This level of care offers the option of phone counseling and case management for those who need it.

If interested, please call (Insert phone #). If I do not hear from you within ten (10) business days, I will assume that you are no longer interested in receiving services at this agency. You have the right to appeal this decision. To appeal, call (Insert phone #).

If at any time you are in a psychiatric emergency, feel free to contact our twenty-four (24) hour emergency service number by calling (Insert ES phone #).

Sincerely,

(Clinician's Name)

Division Behavioral Health Care - CIS Admission/Discharge

Enter and Circle Your Choices

This transaction is (check one) Admission ____ Update ____ Discharge ____

1 Provider ID __________

2 Client ID __ __ __ -__ __ __ __

3 SSN/Med Asst. # _ _ _ - _ _ - _ _ _ _

4 Assessment Date _ _ / _ _ / _ _ _ _

5 Date of Birth _ _ / _ _ / _ _ _ _

6 Gender Male/Female __________

7 City/Town Codes

01 Barrington
02 Bristol
03 Burrillville
04 Central Falls
05 Charlestown
06 Coventry
07 Cranston
08 Cumberland
09 East Greenwich
10 East Providence
11 Exeter
12 Foster
13 Glocester
14 Hopkinton
15 Jamestown
16 Johnston
17 Lincoln
18 Little Compton
19 Middletown
20 Narragansett
21 Newport
22 New Shoreham
23 North Kingstown
24 North Providence
25 North Smithfiled
26 Pawtucket
27 Portsmouth
28 Providence
29 Richmond
30 Scituate
31 Smithfield
32 South Kingstown
33 Tiverton
34 Warren
35 Warwick
36 Westerly
37 West Greenwich
38 West Warwick
39 Woonsocket
40 Out of State

Zip Code __ __ __ __ __

8 Admit Date _ _ / _ _ / _ _ _ _

9 Services

01 Social Setting Detox
02 Free Standing Medical Detox
03 Day Treatment/Partial Hospital Programs
04 Residential Short Term (30 days or less)
05 Residential Long Term (greater than 30 days)
06 Intensive Outpatient
07 Outpatient
08 Outpatient Detox
09 Outpatient Narcotic Maintenance
10 Outpatient Narcotic Detox
13 Continuing Care

10 Race

01 Alaskan Native
02 American Indian
03 Asian
04 Black
05 Cape Verdean
06 White
07 Other
08 Native Hawaiian/Pacific Islander
09 Hispanic/Latino

11 Marital Status

01 Never Married
02 Now Married
03 CoHabitating
04 Separated
05 Divorced
06 Widowed

12 Pregnant? Yes or No

13 # of Dependents __________

14 Codependent? Yes or No

15 Living Arrangements

01 Homeless
02 Dependent Living
03 Independent Living
04 Incarcerated
05 Shelter/Transient

16 Referral Source

01 Individual
02 Alcohol/Drug Care Provider
03 Other Health Care Provider
04 School (educational)
05 Student Assistance Program
06 Employer
07 Employee Assistance Program
08 Other Community Referral
09 DCYF

16 Referral Source (Cont'd.)

10 Court/Criminal Justice
11 TASC Program

17 Criminal Justice Status

01 State/Federal Court
02 Formal Adjudication
03 Probation/Parole
04 Drug Court
05 Youth Correctional Facility
06 Diversionary Program
07 Prison
08 DUI/DWI
09 None

18 Education

Highest Grade Completed _____

19 Employment/Educational Status

01 Employed Full Time
02 Employed Part Time
03 Unemployed
04 Not in Labor Force
05 Retired
06 Full Time School/Job Training
07 Disabled
08 Other
09 Part Time School/Job Training

20 Occupation

01 Professional/Technical
02 Management/Proprietorship
03 Sales
04 Public Service
05 Service Worker
06 Skilled Worker
07 Blue Collar Worker
08 Agriculture/Fishing
09 Clerical
10 Homemaker
11 Entertainer/Athlete
12 Other

21 Weekly Household Income

Enter Amount $ _________

22 Primary Source of Income

01 Wages/Salary
02 TANF
03 <not a valid code-do not use>
04 SSI
05 TDI
06 Unemployment Insurance
07 Retirement/Pension
08 Disability (public/private), SSDI
09 Other

23 Co-Occuring Mental Illness?
Yes or No

24 Informed of Supportive Services?
Yes or No

25 Number of arrests 30 days prior to admission Enter # __________

26 - 28 Source of Payment
Primary ___ Secondary ___Tertiary ___
00 None
01 Self Pay
02 Private Insurance
03 Medicare
04 Medical Assistance Medicaid
05 Substance Abuse Services
06 Other State Dept.
07 Federal-Other than Block Grant
08 Veterans Administration
09 Workers' Compensation
10 Free Service
11 Other
12 TASC
13 Rite CARE
14 State Detox

29 Grant # __________

30 Substance Problem Codes
Primary ___ Secondary ___Tertiary ___
01 None
02 Alcohol
03 Cocaine/Crack
04 Marijuana - Hashish
05 Heroin
06 Non-Prescription Methadone
07 Other Opiates & Synthetics
08 PCP
09 Other Hallucinogens
10 Methemphetamine (ice)
11 Other Amphetamines
12 Other Stimulants
13 Benzodiazepine
14 Other Tranquilizers
15 Barbiturates
16 Other Sedatives or Hypnotics
17 Inhalants
18 Over the counter
19 Other
20 Steroids
21 GH B Gamma Hydroxybutyrate
22 Ecstacy
23 Oxycontin

31 Route of Administration
Primary ___ Secondary ___Tertiary ___
01 Oral
02 Smoking
03 Inhalation
04 Injection
05 Other

32 Frequency of Use
Primary ___ Secondary ___Tertiary ___
01 No past month use
02 1-3 times in past month
03 1-2 times per week
04 3-6 times per week
05 Daily

33 Age of First Use
Primary ___ Secondary ___Tertiary ___

DISCHARGE

34 Discharge Date _ _ / _ _ / _ _ _ _

35 Employment/Educational Status at Discharge
01 Employed Full Time
02 Employed Part Time
03 Unemployed
04 Not in Labor Force
05 Retired
06 Full Time School/Job Training
07 Disabled
08 Other
09 Part Time School/Job Training

36 Number of Contacts from Admission to Discharge ____
(Outpatient Services 6, 7, 8, 9, 10, 13 only)

37 Reason for Discharge
01 Completed Treatment - no substance use
02 Completed Treatment - some substance use
03 Discharged to another treatment provider
04 Discharged for non-compliance
05 Left voluntarily before completion
06 No contact within 30 days (outpatient only)
07 Incarcerated
08 Death
09 Transfer service within agency

38 Condition at Discharge
01 Improved
02 Unchanged
03 Worse
04 Undetermined
05 N/A (for Death only)

39 Referral made at Discharge
01 None
02 Other Alcohol/Drug Care Provider
03 Mental Health Care Provider
04 Other Health Care Provider
05 Employee/Student Asst. Program
06 Court/Criminal Justice
07 Other Community Referral
08 DCYF
09 Other

40 Last Date of Contact w/Client
_ _ / _ _ / _ _ _ _

41 Substance of Use at Discharge
01 None
02 Alcohol
03 Cocaine/Crack
04 Marijuana - Hashish
05 Heroin
06 Non-Prescription Methadone
07 Other Opiates & Synthetics
08 PCP
09 Other Hallucinogens

41 Substance of Use at Discharge (cont'd.)
10 Methemphetamine (ice)
11 Other Amphetamines
12 Other Stimulants
13 Benzodiazepine
14 Other Tranquilizers
15 Barbiturates
16 Other Sedatives or Hypnotics
17 Inhalants
18 Over the counter
19 Other
20 Steroids
21 GH B Gamma Hydroxybutyrate
22 Ecstacy
23 Oxycontin

42 Living Arrangements at Discharge
01 Homeless
02 Dependent Living
03 Independent Living
04 Incarcerated
05 Shelter / Transient
06 N/A (Death)

43 Number of Arrests 30 days prior to Discharge
Enter # __________