THE WHOLE PERSON…

CARE	COMMUNITY
CHANGE	HOPE

An Addiction Services Manual For The Salvation Army Canada and Bermuda Territory

February 2011

The Salvation Army is an international Christian Church.
Its message is based on the Bible;
its ministry is motivated by love for God
and the needs of humanity.

MISSION STATEMENT

The Salvation Army exists
to share the love of Jesus Christ,
meet human needs
and be a transforming influence in the communities of our world.

SOCIAL SERVICES MISSION

Motivated by the love of God
and the life and teaching of our Lord Jesus Christ
we seek to provide people of all ages
with compassionate, practical, holistic care
at their point of critical need,
respecting their dignity and worth,
and with an understanding
of their physical, psychological, material, social and spiritual needs.

In partnership with other members of our social services team,
and with other social services agencies,
we seek to identify and promote
the prevention, resolution, and alleviation of social problems
by striving for justice and compassion in the treatment of people.

ACKNOWLEDGMENTS

This manual could not have been written without the assistance and support of many people.

The Salvation Army wishes to thank John Butler and Jeff Wilbee of The Agora Group, who assisted in writing this manual under the direction of Major Tom Tuppenney, Behavioural Health Consultant and Mary Ellen Eberlin, Territorial Social Services Secretary, Social Services Department, Salvation Army Canada and Bermuda Territory.

Many thanks to our colleagues who contributed hours of expert knowledge and experience by serving on the original project committee; Major Robin Cuff, Mr. Dean Tate, Major Richard Gilbert, Mr. Brian Murphy, Ms. Nancy McConnell and Ms. Lianne Calvert.

A special thank you to Greg Graves (Canada Centre on Substance Abuse) and Greg Purvis (Nova Scotia Department of Health) who read, and offered comments and support, to this manual as it evolved.

Thanks to the clients, managers, counsellors and chaplains who participated in focus groups to assist in the development of this manual.

We gratefully acknowledge The Salvation Army New Zealand, Fiji, Tonga Territory, Addiction and Supportive Accommodation Services for their willingness to share both concepts and materials contained in this manual.

The Salvation Army thanks generations of officers, staff and volunteers who provided wisdom, effectiveness and high mission-driven ethical standards within The Salvation Army's addiction services. It is on their shoulders that this manual has been built.

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1 Introduction

This manual is presented with the intention of providing The Salvation Army's addiction services with direction and guidance that will result in, enhanced practices and service options. The principles, goals, strategies and practices prescribed in this manual will help The Salvation Army's addiction services to continue to pursue innovation, progressive service delivery and cultural relevance while maintaining as the foundation The Salvation Army's mission which "*is based on the Bible and its ministry is motivated by love for God and the needs of humanity*".

It is essential to recognize that skill and experience are fundamental when it comes to transferring current evidence-based/best practice/best fit knowledge to treatment/recovery program practice.

This manual is a working, living, maturing document that helps pave the road for change. The success of our mission relies on Salvation Army addiction services administration and staff embracing and applying the material contained in this manual, informed by the material found in supplementary documents to the manual.

2 How This Manual is Organized

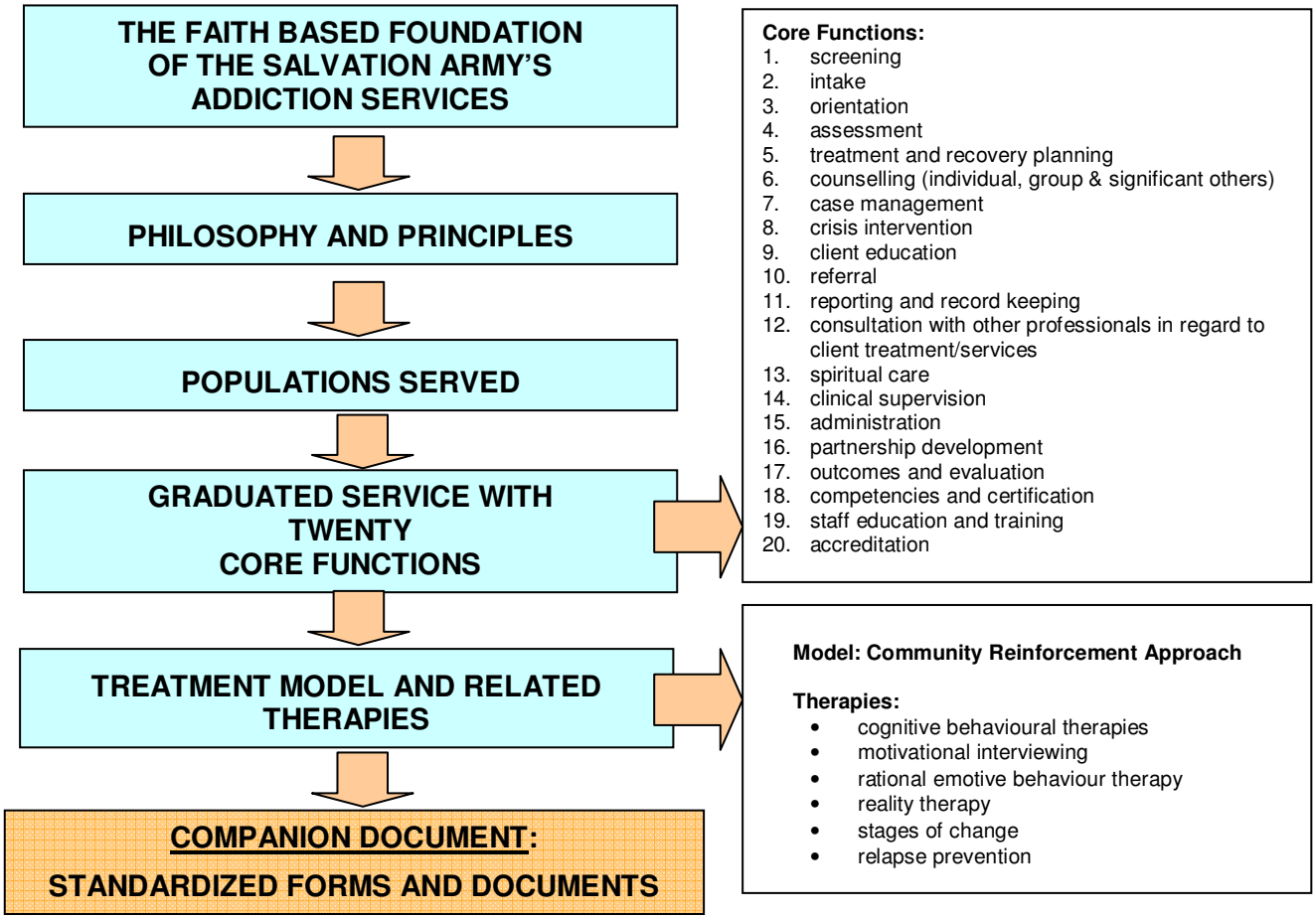
This manual begins by describing the foundation of The Salvation Army as a faith community and service provider. It then describes the philosophy of The Salvation Army's addiction services and the population served.

It then describes the graduated treatment and recovery system that incorporates twenty core functions involved in service delivery and support. This is followed by:

a) a description of The Salvation Army's model of treatment and recovery
b) the six therapies that are used to support this model.

The manual is supplemented by:

- A companion document that provides forms and documentation used within The Salvation Army's addiction services
- A companion document that provides supplementary material.



3 The Salvation Army as a Faith Based Community

The Salvation Army, Canada and Bermuda Territory, has articulated a set of ten core values. In our addiction services these core values drive our commitments to our clients, our faith community and our broader community and partners.

1. Salvation
We believe that God's mission is a mission of love and restoration.

Accordingly, we are committed to facilitating authentic life change – a genuine Biblical life change – for all those with whom we work.

2. Holiness
We believe in God and we are shaped by the presence and power of the Holy Spirit.

Accordingly, in all our ministries we are committed to sharing the love of Jesus Christ, meeting human needs, and being a transforming influence in all the communities with whom we interact.

3. Intimacy with God
We believe that intimacy with God is both our privilege and responsibility.

Accordingly, we are committed to personal growth in our individual and organizational faith journeys.

4. Compassion
We believe that God reaches out to every person in love.

Accordingly, we are committed to compassion in all our relationships – with clients, with fellow workers and with the community at large.

5. Respect
We believe that all people are created in God's image.

Accordingly, we are committed to respect in all aspects of our ministry – with clients, with fellow workers and with the community at large. We respect differences among people and the right of every individual and community to make choices and decisions based on unique individual beliefs and community norms. As a result, we expect individuals in the recovery process to self-determine their own choices concerning their recovery. We will respect their dignity and individuality, recognize their merit, and provide conditions for services, work and worship that are safe and clean.

6. Excellence
We believe in a God of excellence who deserves the best we have to offer.

Accordingly, we are committed to the highest standards of excellence in all we do. We will be good stewards, using all our resources to the fullest, wasting nothing, and doing only what we find to be effective and efficient.

7. Integrity
We believe that everything we do is a reflection of God and the name of The Salvation Army.

Accordingly, we are committed to integrity in all we do. Our actions will be transparent and hold up to scrutiny. We will be responsible to those who use our services, to our fellow workers, and to our community.

8. Relevance
We believe that our ministry methods are flexible but not our mission and values.

Accordingly, we are committed to the pursuit of innovation and effectiveness. In light of our mission and values, we will regularly evaluate and change our forms of ministry to remain relevant to our time. We will be open to risk, strategic expansion and proactive methods.

9. Cooperation
We believe that effective ministry is grounded in relationships.

Accordingly, we are committed to fostering strong relationships in all we do. We encourage and foster team work and partnership.

10. Celebration
We believe that celebration is a reflection of God's delight in his creation.

Accordingly, we are committed to celebrating the transformation experience that we are privileged to witness in our addiction services.

4 The Salvation Army as a Faith Based Service Provider

The role of The Salvation Army as a faith based service provider is part and parcel of its mission as a faith based community.

"The Christian Gospel, founded in the character of God as revealed in the Bible and definitively in Jesus Christ, cannot be divided into 'evangelism' and 'social service,' but must address human need at every level."
Donald Burke*, A Theology of Social Services* [1]

The ten values cited in the previous section must therefore lead to and support the set of four faith based principles found in The Salvation Army document *Mission in Community: The Salvation Army's Integrated Mission*, The Salvation Army International Headquarters, London England. January, 2006.

THE SALVATION ARMY'S FAITH BASED PRINCIPLES

Care is holistic, involving care for the body, mind, spirit and relationships.
Community: healing is possible through relationships.
Change is possible. It comes from within. Capacity for change is part of the image of God.
Hope is a catalyst, giving energy for change and faith.

Mission in Community: The Salvation Army's Integrated Mission, Program Resources Department International Headquarters, January 2006

The connection between the ten values and these four principles (described below) is shown graphically on page 6.

Care is holistic, involving care for the body, mind, spirit and relationships. This means:

- being with people in their living reality
- listening to understand and learn
- participating in the lives of people – in both their suffering and their joys
- expressing trust, respect and dignity for ourselves and for others.

As we continue to construct programs of care, this manual will serve as a framework in helping people who make use of The Salvation Army's addiction services to effectively reach their desired goal of change. The treatment philosophy speaks to the commitment of being client centered. In other words, The Salvation Army's beliefs, concepts and attitudes will centre on listening to understand and learn from clients, and on participating in their lives while expressing trust, respect and dignity towards them.

[1] Donald Burke, Ph.D., is Vice President and Academic Dean at The Salvation Army's William and Catherine Booth College, Winnipeg. An excerpt from *A Theology of Social Services* is included as Section One of the supplementary material to this manual.

<u>Community</u>: healing is possible through relationships. This means:

- being with and engaging with people, wherever they are
- including all who engage with clients
- looking for family connections

In 1865 The Salvation Army's founder, William Booth, a London minister, abandoned the conventional concept of a church and gave up the comfort of his pulpit. He took his message into the streets to reach the poor, the homeless, the hungry and the destitute, many of whom struggled every day with substance abuse. One of the strengths of The Salvation Army's addiction services is the relationships these services build with their clients, the families of clients, and community partners.

<u>Change</u> is possible. It comes from within. Capacity for change is part of the image of God. It means:

- facilitating and accompanying change in others
- modelling change
- encouraging people who are changing to measure their own change
- counselling.

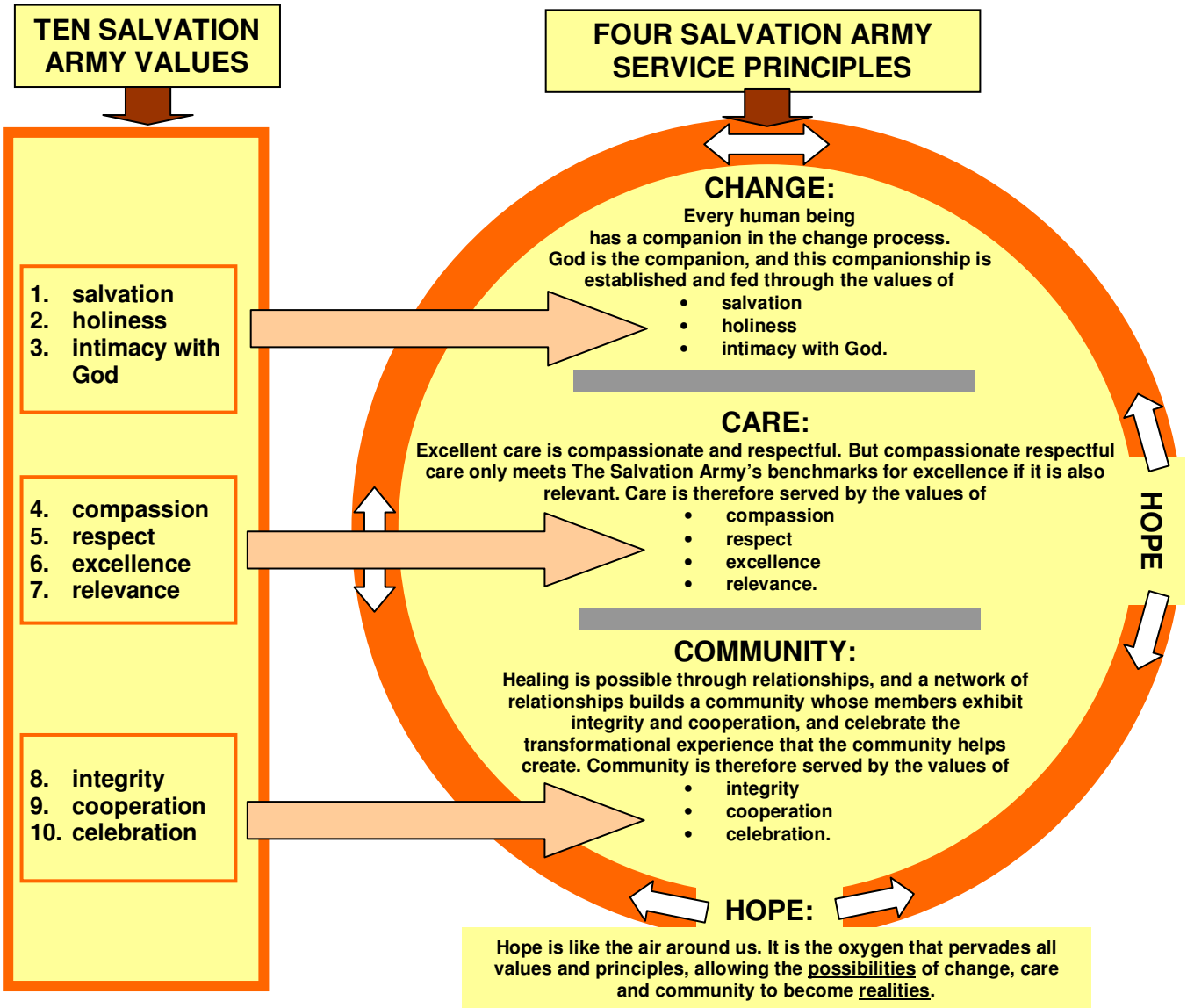
The Salvation Army's addiction services are places of new beginnings, staff are committed to upholding The Salvation Army's mission statement while creating an environment that encourages change, assists the change process and supports people affected by addictions.

<u>Hope</u> is a catalyst, giving energy for change and faith. This means:

- venturing out with faith and approaching people with confidence
- expecting the unexpected, while not imagining that we control all the outcomes
- recognizing that people often need to take steps towards hope
- encouraging a caring relationship and presence.

This hope for a new life is presented through caring relationships, the presence of counsellors and program chaplains, and the opportunity for people to be involved in a caring community.

CONNECTING THE VALUES AND THE SERVICE PRINCIPLES

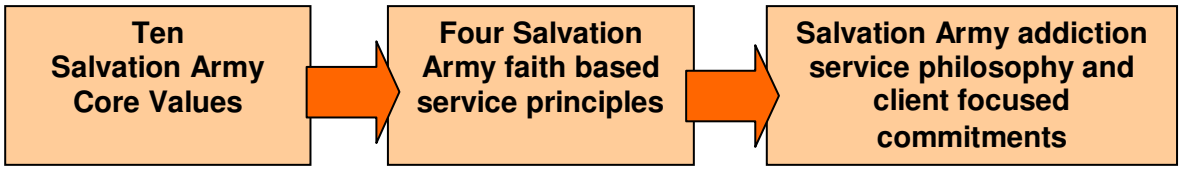


5 Philosophy of The Salvation Army's Addiction Services

"It is our belief that the process of recovery from addictions is a personal and individualized journey. Addiction Services in the Canada and Bermuda Territory are comprised of both Evidence-Informed and Best Practice models of addiction treatment and will continue to be innovative, progressive, and culturally relevant. They will have as their foundation The Salvation Army's mission which, 'is based on the Bible and its ministry is motivated by love for God and the needs of humanity'"

Manual Project Committee: Major R. Cuff, Mr. D. Tate, Major R. Gilbert, Mr. B. Murphy, Ms. N. McConnell and Ms. L. Calvert, Major T. Tuppenney

Emanating from our ten core values, we have four faith-based service provider principles. Each of these four principles relate to a specific philosophy and set of client focused commitments for our addiction services.



5.1 The Canada and Bermuda Territory's Position Statement on Substance Abuse

The Salvation Army Canada and Bermuda's position statements briefly sets out the considered view of The Salvation Army on a moral or social issue of current relevance. The statements clearly articulate the gospel values and principles on which The Salvation Army takes its stand. Position statements are not binding on individual Salvationists but are published for their guidance and for the information of the general public.

The position statement on substance abuse, adopted in 2004 reads:

> *"The Salvation Army encourages a healthy spiritual, emotional, mental and physical lifestyle. The misuse of many substances and drugs, including alcohol and tobacco, has the potential to harm the body, impair judgement and lead to addiction. Therefore, we actively support legislation and policy that encourage healthy lifestyles.*
>
> *Guided by Christian faith and practice, we hold to the Bible's wisdom regarding the destructive consequences of alcohol misuse. Scriptural principles also inform us about the misuse of other harmful substances.*

Salvation Army members (soldiers) make a covenant to abstain from alcohol, tobacco and the harmful use of other substances.

The Salvation Army is committed to excellence in working with individuals, families and communities whose health, relationships and social well-being have been damaged by misuse of and addiction to harmful substances. We place a high priority on education, treatment and counselling that offer spiritual, emotional, mental and physical healing for persons affected by addiction.

We believe that abstinence is the most certain way to avoid and overcome dependencies on harmful substances. Regardless of the choices people make, we are committed to loving and supporting individuals through to recovery.

We support Christian communities as places of fellowship, help and healing for all who face these challenges and we believe that by the grace of God people are freed from substance abuse to lead healthy lives."

5.2 Client Centered Philosophy and Commitments

The Salvation Army's addiction services are ***client centered***, viewing every person who asks for help as an individual who deserves to:

1. be treated with dignity, respect, understanding and kindness
2. be affirmed in their freedom to choose and their ability to effect change
3. be part of their treatment and recovery planning, goals and decisions
4. be treated in a safe, comfortable and needs-fulfilling environment
5. be offered second chances and beyond
6. be assessed and met at their point of readiness
7. be treated as a whole person – biological, psychological, social and spiritual
8. be served by professional and compassionate staff
9. be treated in a program that engages in continuous quality improvement and strives for excellence
10. be accompanied on their journey of recovery for as long as needed
11. be exposed to the love of God by example and in the context of the gift of choice that is from God
12. be the recipient of the very best The Salvation Army can offer.[2]

The Salvation Army supports the Canon of Ethical Principles of the Canadian Addiction Counsellors Certification Federation (CACCF), included as Section Two of the supplementary material to this manual. All Salvation Army addictions counsellors, certified or not, are made aware of this Canon of Ethical Principles and are expected to act in accord with these principles.

[2] Manual Project Committee: Major R. Cuff, Mr. D. Tate, Major R. Gilbert, Mr. B. Murphy, Ms. N. McConnell and Ms. L. Calvert, Major T. Tuppenney

5.2.1 Client Rights and Responsibilities

Each of The Salvation Army's addiction services will develop and prominently display a statement of client rights and responsibilities. This statement is also included in orientation material given to clients, who are encouraged to ask any questions concerning the statement.

> **"The rights of the client and their families, including their personal and informational privacy, shall be protected. Clients shall be made aware of their responsibilities as recipients of the service.**
>
> ***Salvation Army Accreditation Manual*, Chapter 9: *Addiction Services***

5.3 The Three Goals of Salvation Army Addiction Services

The following are three goals for Salvation Army addiction services as presented in this manual:

1. clients evaluate their behaviour and its impact
2. clients develop effective strategies that meet their needs through the elimination of positive reinforcement for harmful use/abuse/dependence and
3. enhance positive reinforcement for sobriety[3].

The health and wholeness of individuals depends largely on the degree to which their basic needs are fulfilled. When their needs are not met, they experience imbalance or unhappiness, and act or behave to feel better. While inherently harmful, the abuse of addictive substances, activities and/or behaviours represents the efforts of some individuals to resolve their conflict. Continued abuse leads to the substance or activity becoming the central object of desire. Over time, tolerance increases and effectiveness decreases, resulting in increased abuse and decreased well-being.

5.4 Defining Effective Addiction Services

Addiction services provided by The Salvation Army conform to three conditions:

- They are **evidence-informed**. This means the use of service methods for which there is scientifically collected evidence that shows the treatment or recovery technique is effective.

[3] These goals are adapted from the "Community Reinforcement Approach Goals", Robert J. Myers and Jane Ellen Smith.

- They are based on **best practices**. This means the use of service methods that, on the basis of ongoing key expert experience, judgment, perspective and continued research, are considered the best available
- They are based on ***best fit***. This means that methods are chosen based on the unique needs of each client, to maximize effectiveness. Matching needs to services is essential to service success.

THE SALVATION ARMY'S ADDICTION SERVICES ARE:
- evidence-informed
- based on best practices
- based on best fit.

Providing evidence-informed addiction services on the basis of best practices and best fit is more than an endpoint for The Salvation Army. It will be a mindset that influences every action taken in the service delivery process.

5.5 People Served by Salvation Army Addiction Services

5.5.1 People with Profound Personal and Social Challenges

Consistent with The Salvation Army's approach to serving humanity addiction services address the needs of people with profound and multiple personal and social challenges.

Often these are people who:
- are no longer involved in positive caring relationships, or have relationships that are strained or ruptured
- have had major difficulties in changing themselves and their life circumstances
- have ceased to hope
- are no longer fully part of healthy communities – including the community that a family provides.

5.5.2 People with Concurrent Disorders

Many people who need help with their addictions are people living with concurrent disorders (an addiction disorder and a mental health disorder). This is also called "co-occurring disorders" or "dual diagnosis".

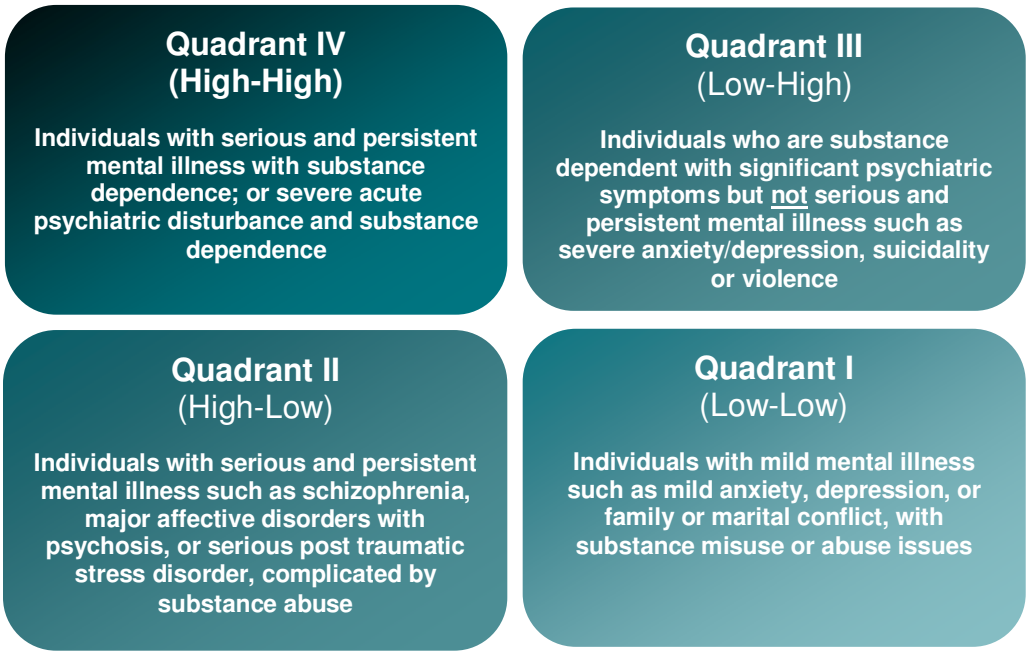
The Salvation Army's addiction services do not exclude clients who are struggling with a mental health disorder except when the disorder is so severe

that the person poses a threat to themselves or others or unless the disorder is so severe that it rules out the possibility that the person can benefit from addiction services.

It is important to note the following:

- Concurrent disorders are to be expected, rather than viewed as an exception.
- The population of individuals with co-occurring disorders can be organized into four sub-groups, described and shown graphically below.

SUB-GROUPS OF PEOPLE WITH CONCURRENT DISORDERS



Quadrant I

- ***PSYCH LOW***
- ***SUBSTANCE LOW***

Individuals with mild mental illness such as mild anxiety/depression, or family or marital conflict, with substance misuse or abuse issues.

Quadrant II

- ***PSYCH HIGH***
- ***SUBSTANCE LOW***

Individuals with serious and persistent mental illness such as schizophrenia, major affective disorders with psychosis, or serious post traumatic stress disorder, complicated by substance abuse.

Quadrant III

- ***PSYCH LOW***
- ***SUBSTANCE HIGH***

Individuals who are substance dependent with significant psychiatric symptoms but not serious and persistent mental illness such as severe anxiety/depression, suicidality or violence

Quadrant IV

- ***PSYCH HIGH***
- ***SUBSTANCE HIGH***

Individuals with serious and persistent mental illness with substance dependence; or severe acute psychiatric disturbance and substance dependence

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When The Salvation Army cannot serve a person for a reason related to concurrent disorders, it tries to link the person to appropriate resources (see the referral core function described in section 7.10). When a client with a concurrent disorder is admitted to a Salvation Army addiction service, program staff ensure that treatment for mental health issues are established or maintained, through:

- referral to specialized mental health resources either during the addiction treatment/recovery process or near the end of this process
- recognition of and support for mental health services already established.

5.5.3 Women's Unique Addiction Service Needs

While most people who enter The Salvation Army addiction services are men, a significant number of women also enter these services. These addiction services take into account the unique challenges faced by women in terms of their addictions and in terms of the social context (including stigmatization) within which service is provided to women. In particular, women with children, with child-caring roles or with child custody issues. The Salvation Army addiction programs designed for women are staffed by women.

In keeping with the goal of excellence, the preferred treatment and recovery model for women with addictions is women-only programs with female staff members. Recognizing that funding and location do not always permit this to take place, the following protocols, extracted from *Best Practices In Action: Guidelines and Criteria for Women's Substance Abuse Treatment Services*, *Ministry of Health and Long-Term Care, Province of Ontario,* apply:

[4] Extracted from "Basic CODI Overview" Co-occurring Mental Health and substance Abuse Use Disorders Initiative (CODI) Winnipeg Region.

1. All women's addiction services will be gender-specific and/or gender-sensitive.
2. Policies, procedures and practices will reflect the unique requirements for women's treatment and recovery.
3. In the absence of exclusively women's programs, there will be an appropriate ratio of female staff for group processes and female staff for individual sessions and residential services.
4. Co-ed programs will provide women-only and women specific programming.
5. Co-ed programs will meet a minimum ratio of approximately 40% female clients.
6. The physical facilities will be safe and welcoming. Preferably, residential facilities will be separate from male facilities, but at minimum will have significant security and privacy if women use the same building as men.
7. All women's programming will:
    a. recognize the needs of pregnant and/or parenting women and give pregnant women priority access
    b. have policies and practices that seek to reduce the barriers and stigma that are specific to women, especially those who are pregnant and/or parenting
    c. provide assessment and treatment planning that incorporates women's issues and takes a bio-psycho-social and spiritual (holistic) approach
    d. utilize the following gender-specific core elements of effective treatment for women:

- medical/health services
- nutrition
- health promotion services
- sexuality education
- HIV/AIDS education
- reproductive health education
- prenatal care
- child-related services
- child care
- treatment services
- parent education
- family issues
- couple counselling
- family therapy
- exploration of familial substance use patterns
- education/skills training
- assertiveness
- goal setting
- stress reduction
- communication skills
- survival skills
- relapse prevention
- psycho-social issues
- self-esteem development
- exploration of shame and guilt
- exploration of victimization issues
- exploration of addressing co-existing problems (for instance, depression and
- vocational and employment support training
- job-seeking skills
- job training
- education
- referrals
- addressing life needs
- referrals/support to acquire housing, monetary support or legal assistance
- assistance with child care
- transportation needs
- special services required for diverse populations
- exploration of cultural values and interrelationship with use and treatment
- specialty seminars for women (to address substance misuse impacts, self-esteem
- family relationships, making it "on your own," parenting role conflict,
- identification of feelings, sexuality, birth control, family communication and vocational planning
- assertiveness training in all women's groups
- leisure activities programming (to address low female participation, fear of male harassment, exploration of preferences)
- family intervention counselling
- individualized attention to affective

anxiety)
- address victimization issues
- community support connections
- exploration of social and leisure needs
- establishment of linkages to recreation, leisure and social service organizations

disorders most relevant to women.

e. recognize and plan for the high ratio of co-occurring mental health issues, especially those that are trauma-related
f. foster the integration of treatment for substance abuse and mental health. (e.g. through partnerships)
g. use relational models
h. provide gender-specific training for staff
i. be based on flexible admission processes, program plans and duration of treatment
j. produce outcomes that reflect bio-psycho-social and spiritual goals.

The Health Canada website contains the document *Best Practices: Treatment and Rehabilitation for Women with Substance Abuse Problems.* This document also helps administrators and counselling staff to design, revise and carry out programming for women.

5.5.4 The Salvation Army's Non-Discrimination Approach

While The Salvation Army emphasizes service to certain populations, this focus is not interpreted or applied in a discriminatory manner. Three position statements of The Salvation Army Canada and Bermuda, support The Salvation Army's emphasis on inclusiveness:

- "The Salvation Army does not discriminate on the basis of sexual orientation in the delivery of its services." (*Position Statement on Gay and Lesbian Sexuality*, adopted in 2002)
- "The Salvation Army believes that all people are made in the image of God and are thus of equal intrinsic value. We seek to treat all people with dignity and respect in response to Jesus' call to love our neighbours as ourselves. We oppose oppression or unjust discrimination based on such differences as race, gender, age, belief, lifestyle, economic status, or physical or mental ability. We believe that diversity strengthens and shapes community and ministry. Therefore, in our community services, employment practices and church life, we will seek to actively promote sensitivity, understanding and communication in both intent and practice." (*Position Statement on Human Diversity*, adopted in 2004)
- "As Salvationists, we remain committed to The Salvation Army's historic mission to care for the poor and marginalized. Therefore, individually and corporately, we will work to eliminate poverty by… challenging racism and other attitudes that promote inequality and seeking reconciliation among all groups in our society." (*Position Statement on Poverty and Economic Justice*, adopted in 2001).

5.6 Abstinence and Harm Reduction Approaches

The Centre for Addiction and Mental Health (CAMH) in *Harm Reduction Position Statement* defines harm reduction as:

> *"any program or policy designed to replace drug related harm without requiring the cessation of drug use."*

The Salvation Army recognizes that harm reduction is a component of recovery for some people. In Salvation Army addiction treatment programming the ultimate goal of drug addiction treatment is to enable an individual to achieve lasting abstinence, but the immediate goals may include improvement of a client's ability to function, and minimization of the medical and social complications of drug abuse and addiction.

Specific harm reduction approaches of needle exchange, controlled use (wet shelters), and injection sites are not included in The Salvation Army approach. Persons who choose these interventions are referred to services in the local community who provide these services. This is consistent with the principle of personal choice.

Section Three of the supplementary material to this manual contains The Salvation Army's more detailed harm reduction guidelines.

6 The Framework for Salvation Army Addiction Services

The framework for Salvation Army's addiction services comprises:

- twenty ***core functions***
- six ***stages in the treatment/recovery continuum***, drawn from the logic model for The Salvation Army's addiction services shown on the next page. This logic model is structured around two broad desirable outcomes of The Salvation Army's addiction services:
    1. elimination of positive reinforcement for harmful use/abuse/ dependence
    2. enhancement of positive reinforcement for sobriety.

The twenty ***core functions*** are:[5]

1. screening
2. intake
3. orientation
4. assessment
5. treatment and recovery planning
6. counselling and group facilitation
7. case management
8. crisis intervention
9. client education
10. referral
11. consultation with other professionals in regard to client treatment/services
12. spiritual care
13. reporting and record keeping
14. clinical supervision
15. administration
16. partnership development
17. outcomes and evaluation
18. competencies and certification
19. staff education and training
20. accreditation.

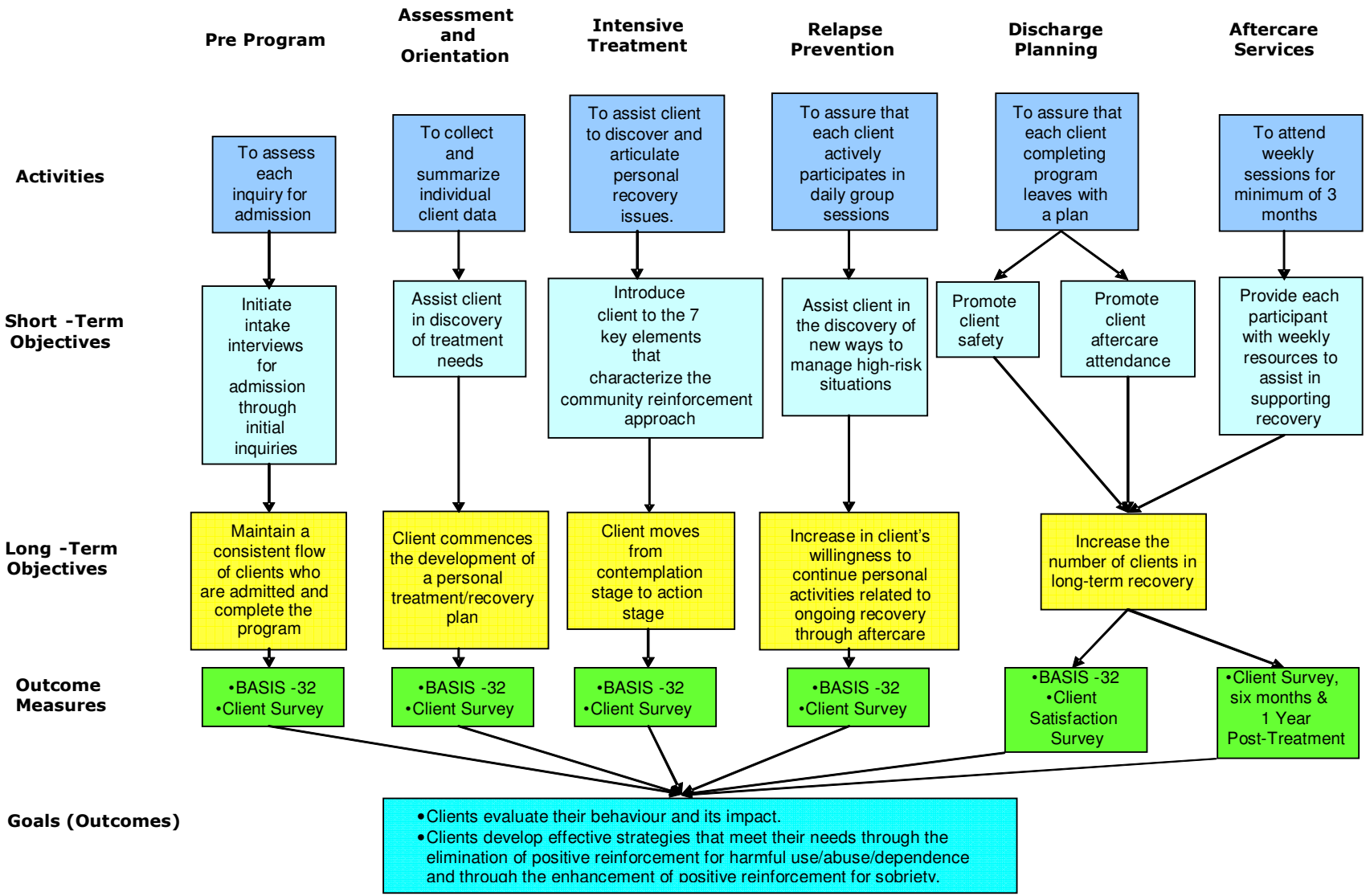
The six ***stages in the treatment/recovery continuum*** are:

1. pre-program
2. assessment and orientation
3. intensive treatment
4. relapse prevention
5. discharge planning
6. aftercare services

The core functions can be carried out at various stages in the treatment/recovery continuum, as shown in the matrix on page 18. Matrix cells with an "x" are points at which each core function is most commonly carried out. This matrix can be used as a checklist to help counsellors, supervisors and administrators in determining whether core functions are performed in an evidence-informed way, or in accord with best practices, at each stage in the treatment/recovery continuum.

[5] Twelve of these twenty core functions are addressed in the certification policies and practices of the Canadian Addiction Counsellors Certification Federation. Further information on certification, as well as on staff education/training and accreditation, are found in Sections Ten, Eleven and Twelve of the supplementary material to this manual.

Salvation Army Addiction Services Logic Model



CORE FUNCTIONS AT EACH TREATMENT AND RECOVERY STAGE

	CORE FUNCTIONS	STAGES OF TREATMENT AND RECOVERY (THE TREATMENT/RECOVERY CONTINUUM) AS PER THE LOGIC MODEL					
		Pre-program	Assessment & Orientation	Intensive Treatment	Relapse Prevention	Discharge Planning	Aftercare Services
1.	Screening	x					
2.	Intake	x					
3.	Orientation	x	x				
4.	Assessment		x	x	x	x	x
5.	Treatment and Recovery Planning		x	x	x	x	x
6.	Counselling and Group Facilitation			x	x	x	x
7.	Case Management		x	x	x	x	x
8.	Crisis Intervention	x	x	x	x	x	x
9.	Client Education		x	x	x	x	x
10.	Referral	x	x	x	x	x	x
11.	Consultation with Other Professionals	x	x	x	x	x	x
12.	Spiritual care	x	x	x	x	x	x
13.	Reporting and Record Keeping	x	x	x	x	x	x
14.	Clinical Supervision	x	x	x	x	x	x
15.	Administration	x	x	x	x	x	x
16.	Partnership Development	x	x	x	x	x	x
17.	Outcomes and Evaluation	x	x	x	x	x	x
18.	Competencies and Certification	x	x	x	x	x	x
19.	Staff Education and Training	x	x	x	x	x	x
20.	Accreditation	x	x	x	x	x	x

7 How The Salvation Army Carries Out the Framework's Core Functions

7.1 Screening

7.1.1 What Is Screening?

Screening is the process by which the client is determined appropriate and eligible for admission to a particular program. Screening involves both an examination of the nature of the client's addiction issues and an identification of other factors that determine:

- whether the client is eligible, based on the nature of the client's addiction issue (see the description of the MAST and DAST screening tools, below) and based on the possibility of client change if admitted to the program (see the description of the URICA screening tool, on the next page)
- whether there are any countervailing issues that suggest the client should not be admitted to a Salvation Army program.

Staff must be able to evaluate psychological, social and physiological signs and symptoms of alcohol and other drug use and abuse. They must also be able to evaluate if the treatment and recovery program being offered meets the client's needs.

Screening is an important first step in matching the client to the appropriate treatment. Less severe clients, for instance, do not benefit from more intensive treatment while more severe clients require intensive treatment. If there is not a good match, a referral to a more appropriate program is desirable.

7.1.2 How Does The Salvation Army Conduct Screening?

When a person presents himself/herself for treatment of a substance use/abuse/ dependence problem a screening is conducted. This will include simple, brief screening to identify the presence or absence of a harmful use/abuse/ dependence problem or other addictive disorder.

The Salvation Army's addiction services use five standard screening tools, found in the companion document to this manual:

1. Michigan Alcoholism Screening Test (MAST)

MAST is a 24 "yes" or "no" item test regarding a client's drinking habits.

2. **Drug Abuse Screening Test (DAST)**

   DAST is 20-item test that assesses potential drug concerns. DAST measures the use of psychoactive substances other than alcohol during the past 12 months. Scoring indicates no concern, low concern, moderate concern, substantial concern and severe concern.

3. **University of Rhode Island Change Assessment Scale (URICA)**

   URICA is 32 item self-reporting instrument that assesses motivation for change through providing scores on four stages of change:
   1. precontemplation
   2. contemplation
   3. action
   4. maintenance.

4. **The CAGE questionnaire** a simple tool that allows for quick screening for the signs of alcoholism

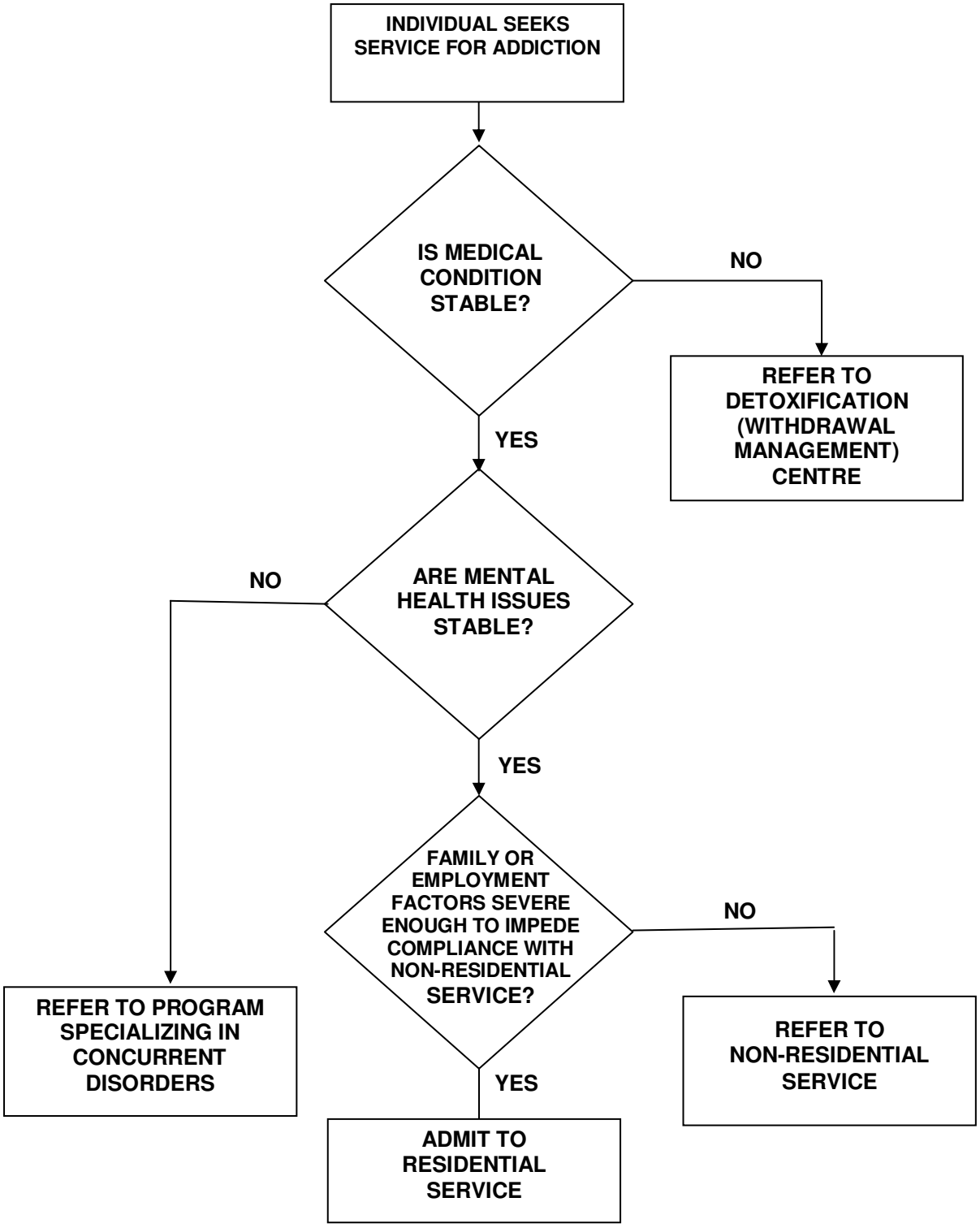
5. **The Beck Depression Inventory**.

An intake worker uses URICA to evaluate a person's level of motivation for change as a guide in developing a treatment/recovery plan (see section 9.5).

The intake worker then obtains information on the client's basic history as well as demographic and medical information. This information is used in two ways:
1. to find out whether there are issues in the life of the client that suggest that admission to the program is not appropriate.
2. to assist in developing a treatment/recovery plan if the client is admitted.

During the screening process the client is made to feel comfortable and encouraged. Screening results in a decision to admit, or not to admit, the client into The Salvation Army addiction service. The decision tree shown on the next page is used as a resource in the screening process.

DECISION TREE FOR MATCHING CLIENTS WITH EITHER RESIDENTIAL OR NON-RESIDENTIAL SERVICE



7.2 Intake

7.2.1 What Is Intake?

Intake involves administrative and initial assessment procedures that take place once the decision has been made that a client should be admitted to the service. Intake is a follow-up to screening.

7.2.2 How Does The Salvation Army Conduct Intake?

The following procedures comprise The Salvation Army's intake process:

- assignment of a counsellor to the client
- notification to the client that they will be admitted, along with details regarding the time, place and conditions of admission
- review of the following documents by the staff member responsible for intake, by the client or by the staff member and client together:
  - the Michigan Alcoholism Screening Test (MAST)
  - the Drug Abuse Screening Test (DAST)
  - the University of Rhode Island Change Assessment Scale (URICA)
  - the CAGE Questionnaire
  - the Beck Depression Inventory.

7.3 Orientation

7.3.1 What Is Orientation?

After admission, orientation provides the client with an overview of the service's goals, objectives and policies as well as the clients' obligations and rights. It may also include specific information such as how medications are managed.

7.3.2 How Does The Salvation Army Conduct Orientation?

As part of orientation, several documents are given to the client:

- a statement of The Salvation Army's addiction services' client centered philosophy and values-based commitments
- information on requirements related to daily living issues such as storage of personal items, fire safety regulations and visiting policies
- an overview of the program, to be used as an aid during the treatment/ recovery plan development phase.

These are provided in a way that allows for discussion between the client and their assigned counsellor for clarification and in some instances, negotiation.

7.4 Assessment

7.4.1 What Is Assessment?

Assessment comprises the procedures by which a counsellor identifies and evaluates an individual's problems, needs, strengths and weaknesses. It builds on information gathered during screening, intake and orientation. The results of a comprehensive assessment provide the focus for the treatment/recovery plan.

Assessment requires the counsellor to have full understanding and skill in administering assessment tools. This requires the counsellor to have the interpersonal skills to explain the assessment process. Although assessment is a continuing process, it is generally emphasized early in treatment. It usually results from a combination of focused interviews, testing and/or record reviews. The counsellor evaluates major life areas (i.e., physical health, vocational development, social adaptation, legal involvement and psychological functioning) and assesses the extent to which alcohol or drug use has interfered with the client's functioning in each of these areas.

7.4.2 How Does The Salvation Army Conduct Assessment?

The Salvation Army's addiction services use two client assessment tools:

- **ASI (Addiction Severity Index)**

  ASI has been established as the standard assessment tool for alcohol and other addictions (Leonhard et al, 2000). It comprises an interview to assess history, frequency and consequences of alcohol and drug use. These five domains often associated with substance use: medical, legal, employment, social/family, and psychological functioning. ASI scores are used to profile a client's problem areas and to plan effective treatment and recovery. A higher ASI score in any functional area indicates a greater need for treatment and recovery in that area.

- **ADAT (Admission and Discharge Criteria and Assessment Tool)**

  In Ontario, LHIN-funded addiction services are required to use ADAT, which:
  - is a comprehensive way to establish an initial treatment plan
  - identifies the most appropriate level and intensity of care for a client (or whether the client is ready for discharge).

7.5 Treatment and Recovery Planning

7.5.1 What Is Treatment and Recovery Planning?

The following are included in treatment and recovery planning:

- the counsellor and the client identify and rank problems needing resolution,
- immediate and long-term goals are established,
- the counsellor and client come to an agreement upon a treatment/recovery process and the resources to be used.

This information is embedded in a written treatment/recovery plan. The counsellor takes a lead role by explaining the results of the assessment.

A treatment/recovery plan helps the client, with the aid of the counsellor to focus on lifestyle changes that will assist the client in the discovery and the elimination of positive reinforcement for harmful use/abuse/dependence and assist the client to identify their satisfaction with other important areas of their life as positive reinforcement for sobriety.

7.5.2 How Does The Salvation Army Conduct Treatment and Recovery Planning?

There are two broad categories of treatment and recovery planning:

- planning for the service to be provided by The Salvation Army, and/or other agencies at the same time
- discharge planning.

7.5.2.1 Planning for Salvation Army Service

At the end of the assessment stage, the counsellor and the client negotiate an initial individualized written treatment/recovery plan. The plan specifies:

- treatment/recovery goals agreed upon by the client and the counsellor
- what each party will contribute toward achievement of these goals

Together, the client and the counsellor review, discuss and assess the treatment/recovery plan frequently as goals are achieved, as strategies fail or as new information becomes available.

Five instruments form the foundation of the treatment/recovery planning process:

- the ***Life Satisfaction Scale*** which asks the client to rate current satisfaction for each of 11 life categories: drinking (or drug use), job, money management, social life, personal habits, family relationships, legal issues, emotional life, communication, general happiness and spiritual life. This provides a quick overview of the severity of problems in a variety of areas.

- the ***Individual Treatment/Recovery Plan***, which uses the same 11 categories. The counsellor assists the client to define goals and strategies for achieving them in these categories, with the overall goal of increasing satisfaction in non-drinking areas so the role of alcohol and/or drugs as the major determinant of an individual's happiness is diminished.
- Three ***Functional Analysis*** instruments (drinking/using behaviour, non-drinking/non-using behaviour, and drinking using behaviour following relapse).

These tools are included in the companion document to this manual.

Goals specified in the plan are brief, specific and measurable and use positive terms. When identifying strategies for achieving the goals, it often becomes clear that the client does not yet have some of the necessary skills. These strategies are marked with an asterisk (*) to remind the counsellor that the skills need to be acquired.

7.5.2.2 Discharge Planning

Discharge planning involves the development of comprehensive, specific and measurable goals that addresses the client's issues and provides the most opportunity for continued recovery. This plan is developed jointly by the client and the counsellor.

Discharge planning includes ten components:

1. assisting the client in their continued exploration of potential future high risk situations and creating a plan of action to manage these situations
2. identifying aftercare to be provided by the ministry unit
3. identifying other appropriate aftercare providers
4. referring the client to these aftercare providers and if necessary using the referral core function to make these referrals
5. encouraging and arranging for the client to either attend or continue attending Twelve Step meetings
6. formation of a personal recovery team with significant other persons
7. completing arrangements for supportive housing, employment and education if these resources are necessary
8. preparing a written discharge plan, to be shared with the client and entered into the client's file
9. maintaining contact with the client and if necessary with aftercare providers to help monitor and measure the effectiveness of the discharge plan.
10. evaluation of the discharge plan.

7.6 Counselling and Group Facilitation

7.6.1 What Are Counselling and Group Facilitation?

Counselling is the use of special skills to assist individuals in achieving objectives through exploration of a problem, examination of attitudes and feelings, consideration of alternate solutions, and decision-making. This requires the counsellor to interact with the client in an appropriate therapeutic way, eliciting solutions and decisions from the client in implementing the treatment/recovery plan. Clinical staff must be fully aware of recognized best counselling practices and must apply them in the best interest of the client.

Group facilitation is similar to counselling, except that it takes place with a group and takes into account both the principles of good counselling and the nature of group dynamics.

Counselling and group facilitation can take place with clients, with families or with significant others in the lives of clients.

Counselling and group facilitation involve both:

- ***core competencies*** that are relevant to all forms of counselling and group facilitation
- ***specialized or tailored competencies*** that are relevant to particular forms of counselling and group facilitation. For instance, later this manual describes a preferred treatment and recovery approach as well as several related therapies. Both the treatment and recovery approach and related therapies require specific competencies in using counselling or facilitation within the framework of the treatment and recovery

7.6.2 How Does The Salvation Army Conduct Counselling?

Counselling takes place primarily at two stages:

1. while the client is taking part in a Salvation Army residential or day program[6]
2. immediately after the client leaves the residential or day component (i.e., during the aftercare component).

[6] Some counselling may even take place during the client screening phase, before a client has been admitted. This limited pre-admission counselling may prepare the client to take a positive attitude toward the admission – or, if the person is not admitted, it may encourage him/her to follow through on a referral to some other necessary resource.

7.6.2.1 Counselling Within Residential/Day Service

Counselling during the intense residential/day phase takes place within the context of models of treatment/recovery and relapse prevention described in Section 8 of this manual.

7.6.2.2 Aftercare Counselling

Aftercare counselling takes place after the client has been discharged from the intense residential or day component, although aftercare planning occurs as part of the discharge planning process described in Section 6.5.2.2 of this manual.

Counselling is a relevant part of aftercare programming. It involves individual sessions and group sessions. While it is an extension of counselling provided during residential treatment, aftercare counselling emphasizes a relapse prevention approach (see Section 8.2.6). Counselling is less prominent in other components of aftercare that augment counselling:

- alumni/alumnae meetings
- Alcoholics Anonymous/Narcotics Anonymous/Cocaine Anonymous meetings
- case management (see Section 7.7).

As counselling and associated activities take place within the treatment/recovery process, the client may exhibit behaviour that works against, or sabotages, the change process. Under such circumstances the counsellor may use the Therapy-Sabotaging Behaviour Worksheet[7] to help the client identify sabotaging behaviour and to work with the client to develop action plans for each behaviour. This worksheet is included in the companion document to this manual.

7.7 Case Management

7.7.1 What Is Case Management?

Case management comprises activities that bring services, agencies, resources and people together within a planned framework of action. It may involve liaison activities and collateral contacts. The client must be fully informed and in agreement with the case management plan.

[7] Page 49 from *Overcoming Your Alcohol or Drug Problem: Effective Recovery Strategies, 2nd Edition* by Daley & Marlatt (2006). By permission of Oxford University Press, Inc. Oxford University Press URL is www.oup.com.

7.7.2 How Does The Salvation Army Conduct Case Management?

The counsellor assigned to the client is the client's case manager during the treatment and recovery process. Case management has two components:

- ***internal case management***, involving management (in partnership with the client) of all services provided by The Salvation Army's addiction service.
- ***external case management***, involving management of addiction services with services provided by other agencies. This is usually ***shared*** case management, carried out in partnership with case managers from other agencies. When shared case management takes place the case management partners ensure that they agree on who does what, to avoid service gaps and duplications.

7.8 Crisis Intervention

7.8.1 What Is Crisis Intervention?

Crisis intervention is the process of assisting a client who is experiencing acute emotional or physical distress. Examples for this may include a psychotic episode, alcohol/drug relapse, suicide gestures, threat of violence or any attitude or activity that may endanger the client or others.

After the crisis has been addressed it can sometimes be used as a treatment and recovery learning experience.

7.8.2 How Does The Salvation Army Conduct Crisis Intervention?

Safety of both clients and staff is paramount. The counsellor recognizes crisis, and takes immediate appropriate action. Crisis intervention includes:

- ***internal interventions*** in which staff intervene, without need of external help – for instance, separating the client from others, and implementing calming procedures.
- ***external interventions*** in which the addiction service obtains the help of an external resource (the police, or a mental health crisis service).

Each of The Salvation Army's addiction services develops crisis intervention guidelines that:

- identify the kinds of crises that may occur
- specify internal roles, as well as external resources when appropriate, (including up-to-date contact information on external resources)
- include guidelines for documenting the crisis and actions taken.

These guidelines are:
- kept in a prominent place in the workplace
- provided to all new employees
- reviewed annually.

All Salvation Army addiction service employees are required to take non-violent crisis intervention training. As well, employees are informed that when in doubt about their own capacity to deal with a crisis, it is best to seek the help of a colleague or an external resource.

7.9 Client Education

7.9.1 What Is Client Education?

Client education involves the provision of information concerning alcohol and other drug abuse, available services and resources. Providing this information can be accomplished by a variety of formal and informal means. For example, a group session involving role playing may be used, or sessions may be conducted using a didactic format with reading materials and films. A counsellor may also provide relevant information to the client individually and informally.

7.9.2 How Does The Salvation Army Conduct Client Education?

Client education starting as early as the initial screening and is carried out throughout the treatment and recovery process.

Two kinds of client education are made available:
1. ***reactive client education***, in which education is provided in response to the client's expressed need. To foster reactive education the counsellor explores education needs with the client during treatment and recovery planning (see section 7.5) and periodically thereafter.
2. ***proactive client education***, in which education is provided at the initiative of the addiction service. Proactive client education is often embedded within the counselling process, but other opportunities for proactive education are identified and pursued.

Every Salvation Army addiction service has an up-to-date library of pamphlets, books, articles and videos for educational purposes.

Proactive education has an evaluation/refresher component. This may take place near the end of the client's treatment/recovery. Through an interview between the client and the counsellor, it will be evident whether the client has absorbed the learnings built into the treatment/recovery process. In addition it can provide refresher information on issues for which learning has been deficient.

Some clients may show a need for education on an issue not directly related to addiction. For instance, a client with diabetes may have insufficient knowledge of techniques for managing diabetes. Consistent with The Salvation Army's holistic approach to the people it serves, the client's counsellor provides the client with information on the issues identified.

7.10 Referral

7.10.1 What Is Referral?

Referral is the process of matching the client with the appropriate resources. Except in crisis situations, referrals are made with the knowledge and agreement of the client. The referral is recorded as part of the case management plan.

Many referrals will be made to a number of core agencies who have a track record of responding favourably and effectively to referrals from The Salvation Army.

7.11 Consultation with Other Professionals in Regard to Client Treatment/Service

7.11.1 What Is Consultation with Other Professionals?

Consultation involves relating with in-house staff or outside professionals to assure comprehensive, quality care for the client. Therefore there may be times and situations when a consultation is needed. Consultations must adhere to applicable laws, regulations and agency policies governing disclosure of client-identifying data – the client's best interest must be paramount.

Consultation with other professionals is closely related to the referral core function described in Section 7.10 of this manual.

7.11.2 How Does The Salvation Army Conduct Consultation with Other Professionals?

Each Salvation Army addiction service keeps an up-to-date inventory of professionals with whom the centre can consult. This inventory includes:

- personnel within the service who have specialized skills and knowledge
- personnel in other Salvation Army addiction services who have specialized skills and knowledge
- personnel in Salvation Army programs that are not directly involved in addiction treatment and recovery

- personnel in the community and in community agencies who have specialized skills and knowledge (local family practitioners and medical specialists for instance).

If the consultation requires the transmission of specific client information, such information is only transmitted once the written agreement of the client has been obtained.

7.12 Spiritual Care

"The Salvation Army is committed to excellence in working with individuals, families and communities whose health, relationships and social well-being have been damaged by misuse of and addiction to harmful substances. We place a high priority on education, treatment and counselling that offer spiritual, emotional, mental and physical healing for persons affected by addiction."

The Canada and Bermuda Territory's Position Statement on Substance Abuse (2004)

7.12.1 What Is Spiritual Care?

The Salvation Army is a Christian church whose actions are motivated by its social conscience. A key component of any rehabilitation is regeneration (spiritual renewal). Addiction affects a person's physical, psychological, social and spiritual makeup. Programming that only addresses one or two or three areas of a person's life, fails to help the whole person.

7.12.2 How Does The Salvation Army Provide Spiritual Care to Its Clients and Community?

Salvation Army addiction services offer chaplaincy support to meet spiritual and religious needs of clients, client families, staff and volunteers.

Salvation Army priorities in terms of spiritual care are grouped into four dimensions:

1. Spiritual care
2. Worship services
3. Christian educational programs
4. Multicultural and multi-faith awareness

7.12.2.1 Spiritual Care

The chaplain is an empathetic and compassionate listener who cultivates and assists with the practice of spiritually based principles supporting recovery. The chaplain is a source of information and a link to religious practices and spiritual supports in the community. In addition, the chaplain will be available to provide spiritual care to the Ministry Unit Staff.

7.12.2.2 Worship Services

Chaplains lead the worship services at the centre. The goal of worship leadership is to develop, coordinate and lead worship services, focusing on the spiritual condition of the clients. Worship services will offer the hope of healing and transformation through Jesus Christ and the possibility to live renewed lives through the power of the Holy Spirit.

7.12.2.3 Christian Educational Programs

Chaplains provide and/or coordinate Christian education programs for individuals in recovery and anyone who is a part of the addiction service centre community. The goals of Christian education programs are:

- to help individuals grow in their personal knowledge of Christ and find their role in the community of faith
- to provide continuing support and accountability in their spiritual development.

7.12.2.4 Multicultural and Multi-Faith Awareness

The goal of multicultural competence is to ensure multi-faith and cultural awareness reducing diversity barriers to full participation in the spiritual aspect of treatment and recovery programs.

When it appears that the client would benefit from closer ties with their faith/spiritual community, appropriate referrals will be made. The Salvation Army's addiction services will identify ethnocultural resources to help ensure culturally appropriate service is provided to their clients.

7.12.2.5 Chaplains as Treatment and Recovery Team Members

Chaplains are full members of the treatment and recovery team, participating in treatment and recovery meetings.

However, limitations on the role of chaplains as team members are warranted:

- If chaplains are part-time assignments to treatment and recovery services, they may not have the time to participate in all team meetings. In such instances they receive and provide written reports on client progress and are

kept fully informed of treatment/recovery decisions to help them integrate their pastoral role with the therapeutic roles of other team members.
- Chaplains can share information with other members of the treatment and recovery team according to the professional and Salvation Army confidentially policies.

7.12.2.6 Chaplaincy Clinical Supervision

Clinical supervision is necessary for chaplains just as it is for any individual who practices a profession. Each chaplain is assigned a clinical supervisor. The purpose of this supervision is to provide opportunity to reflect on and learn from their ministry. Clinical supervision involves 3 areas: 1) management of service delivery; 2) personal and professional development; 3) knowledge and skills.

7.13 Reporting and Record Keeping

7.13.1 What Is Reporting and Record Keeping?

Reporting and record keeping involves charting the results of the assessment, developing the treatment/recovery plan, and writing reports, progress notes, discharge summaries and other client-related documents. These essential functions benefit the counsellor, they document the client's progress in achieving his or her goals, and they facilitate adequate communication between co-workers. They assist the counsellor's supervisor in providing timely feedback. They are valuable to other programs that may serve the client at a later date. They enhance the accountability of the program to its licensing/funding sources. Ultimately, if performed properly, they enhance the client's entire treatment and recovery experience.

7.13.2 How Does The Salvation Army Conduct Reporting and Record Keeping?

Salvation Army addiction services use the DAP format for keeping notes (DAP = **D**ata, **A**ssessment and **P**lan). The DAP format is included as Section Four of the supplementary material to this manual.

Each of The Salvation Army's addiction services compiles and uses a set of document/record preparation and retention guidelines that specify:
- all documents and records that must be prepared related to a client (client files and consent forms for example) and the recommended structure and content sections of these documents
- guidelines for correcting and amending documents and records
- requirements for preserving the confidentiality of client information in these documents and records. At a minimum, these guidelines specify what

authorization process must be used for access to these documents and records, and what secure record storage provisions must be in place.
- guidelines for storage and disposal of client-related documents and records.

7.13.2.1 Privacy of Records and Information

Personnel of The Salvation Army's addiction services abide by all legislation related to privacy in terms of records and any communication that affects the privacy of clients. Section Five of the supplementary material to this manual provides an outline of privacy legislation in jurisdictions covered by The Salvation Army Canada and Bermuda Territory. As well, addiction service personnel abide by the provisions of The Salvation Army Canada and Bermuda Territory's privacy manual, ***The Expectation of Privacy and the Use of Personal Information in The Salvation Army***, which can be made available to staff by each services' director. The rest of this subsection describes the major client-centred provisions of this privacy manual.

The Salvation Army's addiction services use an appropriate form of consent to collect, use or disclose information about clients. Each service has a consent form that can be signed by clients. Obtaining consent can be as simple as modifying a form, or adding a line to that form.

The Salvation Army does not, as a condition of the provision of service, require anyone to consent to the collection, use or disclosure of personal information beyond what is required to fulfill legitimate purposes.

The Salvation Army limits its collection, use and disclosure of personal information to the requirement of effective service delivery. Personal information about clients is only used for specifically identified or reasonable purposes. If a new use for information emerges consent for the new use must be obtained.

Only individuals with valid reasons are granted access to personal information within The Salvation Army structure.

Personal information is protected by using security safeguards appropriate to the sensitivity of the information and by treating all personal information confidentially. All employees and volunteers are asked to sign a privacy and confidentiality statement upon commencing employment.

Personal information about clients is as accurate and up-to-date as possible. Clients are given access to their personal information in accordance with The Salvation Army Canada and Bermuda Territory's privacy manual (see the section below), and any demonstrated inaccuracy or incompleteness is amended.

Access to Personal Information by Clients:

As a matter of practice, clients are told what personal information will be collected, used and disclosed and why. Ideally, they are requested to consent to this for the purposes stated by the service provider. Unless such consent can be implied, they are requested to consent to the collection, use and disclosure of personal information for purposes not previously identified.

Clients are permitted to access the personal information contained in their files, either by viewing the file or receiving photocopies of the information in question.

All requests for access to information are fulfilled within 30 days, unless it becomes clear that additional time will be required to obtain the information. If additional time to fulfill the request is required, the client is notified of this within the initial 30 day period. The request is fulfilled no later than 60 days after it was received.

When granting clients access to personal information, all information relating to other people is deleted or blocked out. Clients are given the opportunity to correct any personal information that is inaccurate or out-of-date.

Access to Personal Information by Relatives:

Personal information may be shared with relatives only in certain circumstances.

Where the relative is the legal power of attorney for the client, or is the person's guardian, they normally have the right to access the information. Most, though not all, privacy statutes also have an exception for informing next of kin of a client's passing.

In statutes protecting health information, expectations for confidentiality are very high. However each of the Acts generally has an exception permitting close relatives, to be told when a client is in a hospital, their location, and their general condition, unless the client has indicated otherwise.

Access to Personal Information by Other Agencies:

Examples of situations where data might be shared with other agencies without specific permission include:

- information provided to any agency to which The Salvation Army addiction service is referring a client
- government ministries which fund various programs, and require such data in their reports

- where the law requires information sharing, such as for paying taxes or for preventing harm.

Personal information may be shared with other organizations only under certain conditions.

Where an organization is an agent or partner of The Salvation Army, it may be appropriate and proper to share personal information. Factors to consider in a particular circumstance include whether the client was aware of the use, and gave consent either explicitly or implicitly. A reference check might be an example of this type of sharing.

To protect The Salvation Army from complaints in this area, clients are informed at the time information is collected that any personal information will be or may be shared with other agencies. This would include funding ministries which collect information and require reports in the funding contracts.

Alternatively, if the other organization is acting as an agent or contractor of The Salvation Army, the consent given to the Army having and using the data may cover the situation. In these instances the Army ensures that the data is subject to appropriate controls and that any contracts endorsed by The Salvation Army give it the right to dictate the use and control of the data.

When Access to Information May be Denied:

Federal and provincial privacy legislation list a number of situations in which access to personal information may or must be denied. These are:

- when the record contains personal information about another identifiable individual and that information cannot be severed from the record.
- when the personal information in question is subject to solicitor-client privilege.
- when the information was generated in the course of a formal dispute-resolution process
- when granting access to the personal information would result in the disclosure of confidential business information about the addiction service or The Salvation Army.

Note: Pages 16 and 17 of The Salvation Army Canada and Bermuda Territory's privacy manual, ***The Expectation of Privacy and the Use of Personal Information in The Salvation Army***, list the steps to be followed when an access to information request has been received.

7.14 Clinical Supervision

6.14.1 What Is Clinical Supervision?

Clinical supervision is the assistance and support provided by a senior member of a profession to one or more other members of that same profession. This relationship has several dimensions:[8]

- It is evaluative.
- It extends over time.
- It serves the purposes of:
    - enhancing the professional functioning of supervised members
    - monitoring the quality of professional services offered to the supervised member's clients
    - suggesting or requiring action on the part of the supervised member to correct errors or enhance performance
    - serving as a gatekeeper of those who are entering the profession.

It is important to differentiate clinical supervision from administrative supervision:[9]

- ***Clinical supervision*** requires the supervisor to be fully aware of and skilled in clinical practices, and to use this skill to enhance the clinical practice of others. Canadian Addiction Counsellors Certification Federation (CACCF) standards for clinical supervision are found in Section Six of the supplementary material to this manual.
- ***Administrative supervision*** requires the supervisor to be knowledgeable, skilled and experienced in human resource management and in the application of administrative polices and procedures, and to use these skills to enhance the administrative practices of others.

A single supervisor may act in both clinical and administrative supervisory roles, but the supervisor must recognize the uniqueness of each role.

6.14.2 How Does The Salvation Army Conduct Clinical Supervision?

Every clinical staff member of a Salvation Army addiction service is assigned a clinical supervisor who is responsible for:

- providing initial orientation to new clinical staff members
- establishing specific clinical service standards for each staff member, as well as establishing (in consultation with the staff member) the measures that will be used to gauge achievement of these standards

[8] Adapted from David Powell.

[9] Both kinds of supervision should be carried out within the framework provided by the ***Employee Relations Policies and Procedures Manual, Canada and Bermuda.***

- gathering information on these performance measures, in concert with the clinical staff member
- meeting on a regularly scheduled basis or as-needed basis with the clinical staff member to provide mentoring and support (including advice, feedback and information on emerging clinical issues and techniques). In many instances these meetings may be team meetings, although team meetings should not be seen as a replacement for one-on-one supervisory support.
- responding to requests from the supervised staff member for information, advice or support
- conducting an annual performance review with the clinical staff member.
- working together to design an annual education and training plan for the staff member, and helping to ensure resources are made available for the education and training (see section 11 of the Supplementary Material to this manual for more guidance on education and training)
- documenting the results of the supervisory process.

The supervised clinical staff member is responsible for:
- acting in accordance with supervisory directions
- seeking appropriate advice from the supervisor in a timely way
- providing input into performance standards and measures
- stating what supervisory support, education and training she/he requires.

Both clinical and administrative supervision take into account The Salvation Army's standards for the personal conduct and performance of its staff, shown on the next page.

7.15 Outcome Evaluation

7.15.1 Definition of Outcome Evaluation

Outcome Evaluation is the gathering, documenting, and analyzing of information on clients files as to whether the program facilitated an improvement on the identified areas of concern.

It serves two ***goals:***

- ***short-range goal*** of providing the ministry unit clinical and administrative staff with knowledge about the effectiveness of services provided.
- ***long-range goal*** of ensuring the highest levels of positive outcomes and the lowest levels of negative outcomes for the organization.

7.15.2 How Does The Salvation Army Conduct Outcome Evaluation?

Evaluation is part of a commitment by The Salvation Army's addiction services to improve the quality of services. Evaluation is guided by a logic model for The Salvation Army addiction services (shown on page 25).

Specific outcomes are evaluated through:
- weekly client surveys
- standardized measurement tool BASIS 32 (32-item Behavior and Symptom Identification Scale ®) will be used at the end of each stage of treatment/recovery
- client satisfaction surveys upon completion of program
- client progress surveys three months after discharge from the program.

The evaluation of outcomes is retrospective and examines the results of services at the end of each stage of treatment/recovery:
- pre-program (intake)
- assessment and orientation
- intensive treatment
- relapse prevention
- discharge planning
- aftercare services.

Data collected, reviewed, and analyzed includes but is not limited to:
- the characteristics of people who are served
- the effectiveness of services (were client goals met?)
- the efficiency with which services are provided
- the satisfaction of persons served with the services they received.

The findings are documented and focus on whether services meet and satisfy the needs of clients.

Outcome evaluation provides an objective, data-driven frame of reference for service personnel regarding the quality of services.

The program supervisor from each addiction services unit will serve as the chair of the Quality and Performance Improvement Committee. This committee will be comprised of addiction counselors. The committee will meet at least four times a year and will determine:
- which elements of the service should be evaluated
- what are the important indicators of service effectiveness, efficiency and client satisfaction
- what tools will be used to measure each indicator of effectiveness, efficiency and of client satisfaction.

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The Quality and Performance Improvement Committee then evaluates the data from the program, assigns expectancy rates (i.e., percentages) for each indicator based on clinical judgment, experience, and information that is available.

Data which are collected typically exceed the elements specified for evaluation. These additional data can then be used for follow-up studies. This data can then be use for other studies as base rates for comparisons and expectancies.

In outcomes management, you need to consider whether the outcome evaluations:

- reflect the program's mission
- reflect the program's admission criteria
- reflect the program's services
- reflect the program's objectives (i.e., methods chosen by the organization to achieve its mission)
- contain measurable indicators
- have expectations of achievement (i.e., success criteria) of the measures being evaluated, which are typically expressed in terms of percentages
- use measurement tools or instruments that are significant, reliable and valid
- provide for a data source
- use data that is accessible
- provide for efficient data collection procedures that minimize error.

As outcome evaluation findings become available the findings will be shared with Divisional Headquarters, Territorial Headquarters Social Services and funding agencies as appropriate. The information is then used to help make decisions concerning program and the manner in which it is delivered.

8 Treatment/Recovery Approach and Related Therapies

The community reinforcement approach is the preferred treatment/recovery approach used by The Salvation Army, since it is a proven and flexible approach that can be used in combination with related therapies, as shown below.

TREATMENT/ RECOVERY APPROACH	*THE APPROACH'S MAIN ASSUMPTION, AND WHAT THE ASSUMPTION LEADS TO*
Community Reinforcement Approach *(CRA)*	*People do what they are rewarded for doing.* ***Therefore:*** • *People need to feel rewarded for doing appropriate things.*

This is the overall treatment/recovery approach favoured by The Salvation Army

These are related therapies that may be used by The Salvation Army

RELATED THERAPIES	*THE THERAPY'S MAIN ASSUMPTION, AND WHAT THE ASSUMPTION LEADS TO*
Cognitive Behavioural Therapy (CBT)	*People do what they have learned to do.* ***Therefore:*** • *People need to unlearn inappropriate behaviours and to learn appropriate behaviours.*
Motivational Interviewing	*People do what they feel motivated to do.* ***Therefore:*** • *People need to feel motivated to do appropriate things.*
Rational Emotive Behaviour Therapy (REBT)	*People behave based on rational or irrational drivers of behaviour.* ***Therefore:*** • *People need to learn to act on the basis of rational drivers of behaviour.*
Reality Therapy (Glasser model)	*Unsatisfactory or non-existent connections with people we need are the source of most human problems.* ***Therefore:*** • *People need to replace deadly habits with caring habits in terms of their connectedness with others.*
Stages of Change Model (Prochaska and DiClemente)	*People go through six stages in the process of change.* ***Therefore:*** • *Help should be tailored to the stage of change the client is currently going through.*
Relapse Prevention *(Gorski model)*	*Relapse prevention involves seven exercises as explained in section 10.2.6 of this manual.* ***Therefore:*** • *The counsellor should help and support the client through these exercises.*

8.1 Community Reinforcement Treatment/Recovery Approach

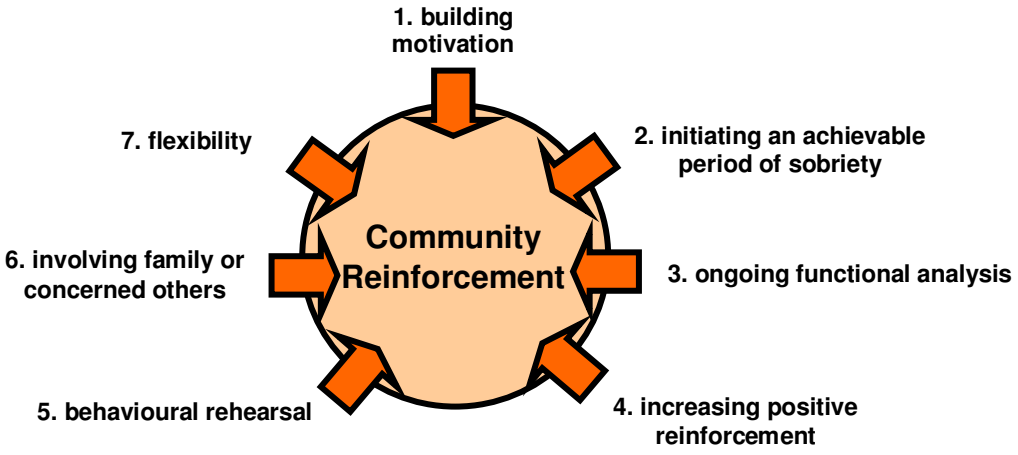
The Salvation Army Canada and Bermuda Territory has adopted the community reinforcement approach as its model of treatment and recovery. In using the community reinforcement approach, counselling staff:

1. have a working knowledge of the community reinforcement approach
2. possess skills in the use of motivational interviewing and other cognitive-behavioural therapies, as techniques to supplement the community reinforcement approach (other techniques are described later in this manual)
3. support clients in the further development of treatment/recovery plans (see section 7.5)
4. have an ability to establish a helping relationship with the client, characterized by warmth, respect, genuineness, concreteness and empathy
5. recognize professional and personal limitations
6. incorporate information obtained through the assessment process (see section 7.4) and comprehensive treatment/recovery plan (see section 7.5) to inform the counselling approach
7. keep clear and accurate records of all key information gathered (see Section Four of the supplementary material to this manual).

The two goals of the community reinforcement approach are:

1. to assist the client in the discovery and the elimination of positive reinforcement for harmful use/abuse/dependence
2. to assist the client in the enhancement of positive reinforcement for sobriety

The seven steps of the community reinforcement approach are shown below and are described on the next pages.



8.1.1 Building Motivation

It is important to find ways to draw the client into treatment early and to use strategies that will get them interested and fully engaged in the treatment and recovery process. The community reinforcement approach takes the position that even the most unwilling clients can be drawn into treatment and recovery by the discovery of reinforcers that are meaningful for the person.

8.1.2 Initiating an Achievable Period of Sobriety

The Salvation Army's addiction services are abstinence based. Clients can approach a goal of lifelong abstinence by beginning with an achievable, meaningful period of abstinence that is negotiated between client and counsellor. This allows the client to experience or "sample" sobriety and the potential consequences of a changed lifestyle, it shows family members that the client is committed to treatment and recovery, and it increases the chances that family members will be motivated to be active partners in treatment and recovery. It also gives the person practice in setting and achieving goals, thus enhancing their self-esteem and confidence. A period of abstinence provides the client, counsellor and treatment team with an opportunity to identify potential barriers that will affect the ultimate outcome of treatment and recovery.

8.1.3 Ongoing Functional Analysis

At this stage in treatment, it is important to examine the internal and external triggers and the positive and negative consequences, of both using and pleasurable behaviours. The client is asked to story a common scenario for using drugs or alcohol – the scenario that occurs most often in the client's life. After listening carefully and noting key points, the counsellor explores the high risk context using a predetermined format involving examination of five factors:

1. external triggers
2. internal triggers
3. drinking behaviour
4. short-term positive consequences
5. long-term negative consequences.

Functional analysis forms based on this format are included in the companion document to this manual.

The second part of the analysis uses the same five-part format to focus on a pleasurable experience that does not involve using alcohol or drugs. This analysis facilitates the individualization of treatment by addressing context-specific issues and relevant skills development, particularly those that enhance positive reinforcement for that client.

8.1.4 Increasing Positive Reinforcement

The client and counsellor jointly choose a range of strategies from the menu of options that focus on increasing the client's sources of positive reinforcement ***unrelated*** to their harmful use or dependence. This reduces social isolation and reinforcement of their harmful behaviour. Activity sampling helps to carry out trial runs of behaviours and activities that might be rewarding. These must reflect the client's interests, either new interests or previous ones that have been abandoned or rarely used. It includes improving the person's chances of obtaining work, and enhancing their involvement in leisure activities, and other activities of daily community living.

8.1.5 Behavioural Rehearsal

This means going beyond education and advice to coaching and practice. Skills training and practice through role playing in areas such as drink refusal, problem solving and effective communication prepare the person for their preferred actions in challenging circumstances. Counsellors act as coaches, encouragers and support persons as the client takes the first tentative steps toward recovery.

Once the client is on the way, counsellors stand aside and encourage as the client takes full responsibility.

8.1.6 Involving Family or Concerned Others

Two distinctive strategies can be pursued in terms of involving family or concerned others:

1. ***engaging them as sources of reinforcement and support*** as the client moves towards a healthy lifestyle
2. ***rebuilding relationships***. The counsellor accepts that the client's harmful use or dependence will have affected her/his relationships with partners and family, and the client will need to work on this within their treatment/recovery plan. Thus, wherever necessary and possible, relationship counselling must be part of the treatment and recovery program. This may include individual counselling for key family members.

8.1.7 Flexibility

The community reinforcement approach is highly flexible. It is like a menu from which the client and counsellor jointly select the options best suited to the client's needs. It can also be creatively adapted to different contexts including women's treatment and recovery, concurrent disorders, criminal conduct and substance abuse and particular cultural groups. It can be modified by blending it in with local values, beliefs, and practices.

The community reinforcement approach can also be used in combination with other approaches such as stages of change, motivational interviewing, cognitive behavioural therapy and twelve step facilitation (these ancillary methods are described later in this manual).

Activities within the community reinforcement approach include:

- attendance at daily devotions (optional)
- participation in group discussions
- one-on-one counselling sessions
- learning how to identify positive reinforcers that will act as a catalyst for change
- attendance at two outside AA meetings per week (optional)
- attendance at worship or completion of a written spiritual assignment
- participation in recreation activities.

When clients have finished the intensive treatment activities, they are referred to relapse prevention for an admission interview (see Section 8.2.6).

8.2 Related Therapies

The following therapies may be used in conjunction with the overall treatment and recovery approach if counselling staff are competent in the use of the therapy.

8.2.1 Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) is based on the assumption that most emotional and behavioural reactions are learned. The goal of CBT is to help clients *unlearn* their unwanted reactions and to learn a new way of reacting,

CBT takes the position that:
- ***Thoughts*** cause feelings and behaviours (not external factors such as other people, situations and events).
- People can change the way they think so they can feel and act more beneficially even if the situation does not change.

CBT is a rapid technique in terms of results. The average number of sessions (across all types of needed areas and approaches to CBT) is only 16.

According to CBT, people get better in therapy mainly because of the positive trusting relationship between the therapist and client. Therapists trained in CBT believe it is important to have a good trusting relationship, but augmented by teaching rational self-counselling skills.

CBT therapists seek to learn what their clients want out of life (their goals) and then help them achieve those goals. The CBT therapist's roles are to listen, teach and encourage, while the client's roles are to express concerns, learn and implement that learning.

8.2.2 Motivational Interviewing

Motivational interviewing is a directive, client centered counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence. It is more focused and goal directed than nondirective counselling. This approach takes the position that readiness to change is not a client trait, but a fluctuating product of interpersonal interaction.

In motivational interviewing a number of guidelines are used:
- Motivation to change is elicited from the client, not imposed from without.
- It is the client's task, not the counsellor's, to describe and resolve his/her ambivalence.

- The counsellor is directive in helping the client to examine and resolve ambivalence.
- The counselling style is generally quiet and eliciting.

Although the technique is directive, the therapeutic relationship in motivational interviewing is more like a partnership or companionship than a relationship between an expert and a recipient.

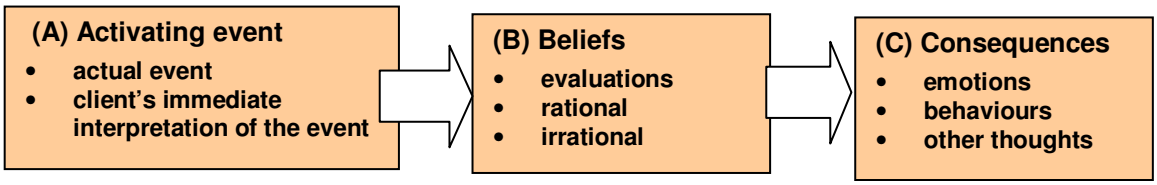
8.2.3 Rational Emotive Behaviour Therapy

Rational emotive behaviour therapy (REBT) views human beings as creatures that strive to remain alive and to achieve happiness. However, it also holds that humans are prone to adopting irrational beliefs which stand in the way of their achieving their goals and purposes. Often, these irrational attitudes or philosophies take the form of extreme or dogmatic "musts", "shoulds" or "oughts"; that contrast with rational and flexible desires, wishes, preferences and wants. The presence of extreme philosophies can make all the difference between *healthy* negative emotions (such as sadness or regret or concern) and *unhealthy* negative emotions (such as depression or guilt or anxiety).

REBT uses the ABC framework, shown below, to clarify the relationship between:

- ***activating*** events (**A**)
- our ***beliefs*** about them (**B**)
- the cognitive, emotional or behavioural ***consequences*** of our beliefs (**C**).

The ABC model is also used in some versions of cognitive therapy, or cognitive behavioural therapy, where it is also applied to clarify the role of mental activities or predispositions in mediating between experiences and emotional responses.



The model distinguishes between the effects of rational beliefs about negative events, which give rise to healthy negative emotions, and the effects of irrational beliefs about negative events, which lead to unhealthy negative emotions.

In addition to the ABC framework, REBT also employs three main insights:

- While external events are of undoubted influence, psychological disturbance is largely a matter of personal choice in the sense that individuals consciously or unconsciously *select* either rational beliefs and irrational beliefs (or both) at (B) when negative events occur at (A).
- Past history and present life conditions strongly affect the person, but they do not, in and of themselves, *disturb* the person; rather, it is the individual's responses which disturb them, and it is again a matter of individual choice whether to maintain the philosophies at (B) which cause disturbance.
- Modifying the philosophies at (B) requires persistence and hard work, but it can be done.

REBT is meant to help clients to replace absolutist philosophies, full of "musts" and "shoulds", with flexible ones. This includes:

- learning to accept that all human beings (including themselves) are fallible
- learning to increase their tolerance for frustration while aiming to achieve their goals.

Although emphasizing the same conditions as person centred counselling – empathy, unconditional positive regard and counsellor genuineness – REBT views these conditions as neither necessary nor sufficient for therapeutic change to occur.

The basic change process that REBT tries to foster begins with client acknowledgment of the existence of a problem and identifying any "meta-disturbances" about that problem (i.e., problems about the problem, such as feeling guilty about being depressed). The client then identifies the underlying irrational belief which caused the original problem and comes to understand:

- why it is irrational
- why a rational alternative would be preferable.

The client learns to challenge their irrational belief and employs a variety of cognitive, behavioural, emotive and imagery techniques to strengthen their conviction in a rational alternative. For example, ***rational emotive imagery*** (REI) helps clients change unhealthy negative emotions into healthy ones by imagining the negative event (A) as a way of changing their underlying philosophy (B). This is designed to help clients move from an intellectual awareness about the rationality of their beliefs to a stronger positive automatic reaction to them. Clients identify impediments to progress and overcome them, and they work continuously to consolidate their gains and to prevent relapse.

8.2.4 Reality Therapy

Reality therapy, stemming from the work of Dr. William Glasser and often called the Glasser approach, is based on choice theory (described below).

Reality therapy states that unsatisfactory or non-existent connections with people we need are the source of most human problems. Reality therapy's goal is to help people reconnect. To create connections among people the counsellor will:

- ***focus on the present*** and avoid discussing the past because all human problems are caused by unsatisfying present relationships
- ***avoid discussing symptoms and complaints*** as much as possible since these are the ways that clients choose to deal with unsatisfying relationships
- understand the concept of total behaviour, which means ***focus on what clients can do directly (act and think)*** and spend less time on what clients cannot do directly
- ***do directly:*** help them change their feelings and physiology. Feelings and physiology can only be changed if there is a change in acting and thinking
- ***avoid criticizing, blaming and/or complaining*** and help counselees to do the same. By doing this, they learn to avoid some extremely harmful external control behaviours that destroy relationships.
- ***remain non-judgmental and non-coercive***, but encourage people to judge all they are doing by the choice theory axiom: Is what I am doing getting me closer to the people I need? If the choice of behaviours is not working, the counsellor helps clients find new behaviours that lead to a better connection.
- ***teach clients that excuses stand directly in the way of making needed connections***, whether the excuses are legitimate or not
- ***focus on specifics***. Quickly find out who clients are disconnected from and work to help them choose reconnecting behaviours. If they are completely disconnected, focus on helping them find a new connection.
- ***help clients to make specific, workable plans*** to reconnect with the people they need, and then follow through on what was planned by helping them evaluate their progress. Counsellors may suggest plans but do not give the message that there is only one plan. A plan is always open to revision or rejection by the client.
- **be patient and supportive *but keep focusing on the source of the problem – the disconnectedness***. Clients who have been disconnected for a long time will find it hard to reconnect. They are often so involved in the symptom they are choosing that they have lost sight of the need to reconnect.
- ***help the client to understand, through teaching choice theory.***

Choice theory states that:

- All we do is behave.
- Almost all behaviour is chosen.
- We are driven by our genes to satisfy five basic needs: survival, love and belonging, power, freedom and fun.

In practice the most important need is love and belonging, as closeness and connectedness with the people we care about is a requisite for satisfying all other needs. External control is destructive to relationships. It erodes the ability of one or both parties to find satisfaction in the relationship and results in disconnection from each other. According to reality therapy, being disconnected is the source of human problems such as mental illness, addiction, violence, crime, school failure and spousal abuse.

Choice theory cites the need to replace deadly habits with caring habits:

THE SEVEN DEADLY HABITS		THE SEVEN CARING HABITS
1. CRITICIZING	*replace with...*	1. SUPPORTING
2. BLAMING	*replace with...*	2. ENCOURAGING
3. COMPLAINING	*replace with...*	3. LISTENING
4. NAGGING	*replace with...*	4. ACCEPTING
5. THREATENING	*replace with...*	5. TRUSTING
6. PUNISHING	*replace with...*	6. RESPECTING
7. BRIBING AND REWARDING TO CONTROL	*replace with...*	7. NEGOTIATING DIFFERENCES

Choice theory puts forward ten axioms to guide therapy:

1. The only person whose behaviour we can control is our own.
2. All we can give another person is information.
3. All long-lasting psychological problems are relationship problems.
4. The problem relationship is always part of our present life.
5. What happened in the past has everything to do with what we are today, but we can only satisfy our basic needs right now and plan to continue satisfying them in the future.
6. We can only satisfy our needs by satisfying the pictures in our quality world.
7. All we do is behave.
8. All behaviour is Total Behaviour and is made up of four components: acting, thinking, feeling and physiology.
9. All Total Behaviour is chosen, but we only have direct control over the acting and thinking components. We can only control our feeling and physiology indirectly through how we choose to act and think.
10. All Total Behaviour is designated by verbs and named by the part that is the most recognizable.

8.2.5 Stages of Change

The stages of change approach was developed by James Prochaska and Carlo DiClemente to address smoking cessation, but it can be applied to a range of dependencies. It tailors interventions to the stages of change and it is appropriate for Salvation Army programs since they engage people at all stages of change.

Prochaska and DiClemente's Stages of Change		
STAGE OF CHANGE	**CHARACTERISTICS**	**TECHNIQUES**
1. Pre-contemplation *"I have no intention to change the behaviour"*	Not currently considering change: ***"Ignorance is bliss"***	• Validate lack of readiness. • Clarify: the decision is theirs. • Encourage re-evaluation of current behaviour. • Encourage self-exploration, not action. • Explain and personalize the risk.
2. Contemplation *"I am seriously considering changing the behaviour"*	Ambivalent about change: ***"Sitting on the fence"*** Not considering change within the next month	• Validate lack of readiness. • Clarify: the decision is theirs. • Encourage evaluation of pros and cons of behaviour change. • Identify and promote new positive outcome expectations.
3. Preparation *"I know I need to change the behaviour, but how?"*	Some experience with change and is trying to change: ***"Testing the waters"*** (Planning to act within 1 month)	• Identify and assist in problem solving of obstacles. • Help patient identify social support. • Verify that patient has underlying skills for behaviour change. • Encourage small initial steps.
4. Action *"I'm taking direct action on changing my behaviour"*	Practicing new behaviour for 3-6 months	• Focus on restructuring cues and social support. • Bolster self-efficacy for dealing with obstacles. • Combat feelings of loss: reiterate long-term benefits.
5. Maintenance *"I am maintaining my changed behaviour"*	Continued commitment to sustaining new behaviour (Post-6 months to 5 years)	• Plan for follow-up support. • Reinforce internal rewards. • Discuss coping with relapse.
6. Relapse *"I slipped"*	Resumption of old behaviours: ***"fall from grace"***	• Evaluate trigger for relapse. • Reassess motivation and barriers. • Plan stronger coping strategies.
7. Termination *"I'm no longer tempted to revert to the former behaviour"*	Bad habit no longer an integral part of one's life	

"If you 'maintain maintenance' long enough, you will reach a point where you will be able to work with your emotions and understand your own behaviour and view it in a new light. This is the stage of 'transcendence' [termination]... not only is your bad habit no longer an integral part of your life but to return to it would seem atypical, abnormal, even weird to you." Marc F. Kern

8.2.6 Relapse Prevention

The Salvation Army concurs with Terence Gorski's statement that "*Relapse-prone patients are not hopeless*." This is consistent with the principle of hope that characterizes The Salvation Army's approach to addictions.

The goal of recovery and relapse prevention is to help clients become aware of their relapse warning signs and to learn life-coping skills and cognitive strategies to deal with situations in which they would have previously used drugs or alcohol.

In applying relapse prevention therapy and recovery, counselling staff are able to appropriately use the following:

- *Relapse Prevention Counselling Workbook: Practical Exercises for Managing High-Risk Situations*, 2000, Terence Gorski
- rational emotive behaviour therapy (see section 8.2.3)
- reality therapy (see section 8.2.4)
- Maslow's hierarchy of needs
- co-dependency concepts
- patterns of denial and denial management.

To facilitate recovery and prevent relapse, The Salvation Army's addiction services staff present the client with seven clinical processes that assists client to identify, analyze, and manage high-risk situations that lead to relapse. An emphasis is placed on management of irrational thoughts, unmanageable feelings, self-destructive urges, and self-defeating behaviours. This material is based on the Gorski-CENAPS (Center for Applied Behavioral Sciences) model.[10]

8.2.6.1 Exercise I: Making the Commitment to Stop Using

In this exercise the counsellor guides the client to discover what problems forced them into recovery, identify the relationship between those problems and their alcohol/other drug use, determine the outcome of each problem if they continue alcohol/other drug use, make a conscious commitment to stop using, and sign an Abstinence & Recovery Contract.

8.2.6.2 Exercise II: Planning to Stop Relapse Quickly if It Occurs

During this exercise the client will answer three basic questions that will assist them stop a relapse quickly should it occur. 1) What are they going to do to get back in recovery if they start using but decide to stop before they hit bottom? 2) What is their counsellor supposed to do if they relapse or fail to honour their treatment commitments? 3) What are their significant others supposed to do if they relapse?

[10] These seven phases are presented as exercises in the *Relapse Prevention Counselling Workbook: Practical Exercises for Managing High-Risk Situations*, 2000, Terence T. Gorski.

8.2.6.3 Exercise III: Identifying High-Risk Situations

The client discovers what a high-risk situation is, reviews a list of common high-risk situations that can lead to relapse, and identifies and clarifies high-risk situations that could cause them to use in spite of their commitment not to do so.

8.2.6.4 Exercise IV: Mapping and Managing High-Risk Situations

In this exercise the client discovers what a situation map is and how to develop situation maps for 3 different kinds of high-risk situations.

1) a past high-risk situation that resulted in using,
2) a past high-risk situation that resulted without using, and
3) a high-risk situation that the client will be facing in the near future.

8.2.6.5 Exercise V: Managing Personal Reactions to High-Risk Situations

The client discovers how to identify the irrational thoughts, unmanageable feelings, self-destructive urges, and self-defeating behaviours that drive them to use. Clients will also discover to develop new habits of thinking, managing their feelings and urges, self-regulating their behaviours, and relating to others in a manner that will allow them to manage their high-risk situations.

8.2.6.6 Exercise VI: Developing a Recovery Plan

In this exercise the client will discover how to create a habitual style of living that minimizes their exposure to high-risk situations and supports them in effectively managing those situations that they do encounter. Clients learn about the most effective recovery activities, developing a personal schedule of recovery activities, and using a daily plan.

8.2.6.7 Exercise VII: Evaluating High-Risk Situation Management Skills

The client will complete a self-assessment of their ability to use the six basic high-risk management skills. They will evaluate the following areas:

1) the strength of their current commitment to stop using alcohol/other drugs;
2) the effectiveness of their plan to stop relapse quickly should it occur;
3) their ability to identify high-risk situations;
4) their ability to map and manage high-risk situations;
5) their ability to change their responses to high-risk situations by effectively managing their thoughts, feelings, urges, actions, and social responses; and
6) their ability to develop and maintain a schedule of recovery activities that support their new and more effective way of managing high-risk situations.

9 Conclusion

The problems associated with an individual's drug use/abuse/dependence can vary considerably. People seeking assistance from Salvation Army Addiction Services come from every walk of life. Many of these individuals suffer from mental health, health, or social problems that complicate their treatment.

Treatments for drug addiction vary widely according to the types of drugs involved, amount of drugs used, duration of the drug addiction, medical complications, social and spiritual needs of the individual.

Through treatment that is based on addressing individual needs, people with drug addiction can recover and lead productive lives. The ultimate goal of drug addiction treatment is to enable an individual to achieve a new life without the use/abuse/dependence on drugs.