<u>Engagement at the Intake/Assessment: *Mission Impossible*</u>

The reason for calling the intake/assessment process at most agencies *Mission Impossible* is because of the extremely difficult circumstances often surrounding the intake process, especially at larger agencies with a lot of oversight. Consider some of the many obstacles faced in that first intake/assessment appointment for a new client:

- Tons of paperwork to be completed
- Time is short or limited
- Client often doesn't want to be there
- Client may exhibit attitude problems – rude, defensive, evasive
- If there is an electronic record there is the difficulty of trying to talk and give eye contact while simultaneously trying to type on computer to enter information
- Paperwork is often not client-friendly and may be redundant and confusing
- There may feel like there is 1000 things to sign and explain
- Once you are done with the assessment there may be disagreement with regard to level of care recommendations
- When working with adolescents and children there may be parent-child disagreements and distractions in your office as you are trying to get through the intake process
- At times you have to contend with the client obviously lying, however if you "call them out" you will likely cause arguments and resistance and possibly even lose the client

It seems like there are individuals out there in administrative and managerial positions who have the mentality that the answer to every situation is to add another form or module to the intake process. With that kind of thinking, the clinician is often required to fill out a phone book's worth of paperwork that realistically should take several hours to complete. Yet the expectation is to do this in just a one hour session with a client who him/herself is also often annoyed with the whole process. The clinician is supposed to try to complete the assessment in a timely manner, get all of the needed signatures and forms filled out, at times administer a drug test, and negotiate the right level of care all in a condensed amount of time while simultaneously trying to engage the client to feel comfortable and want to come back. Clearly this is quite a difficult endeavor to say the least!

What are some basic tools/skills for engagement during the intake process?
The following list may seem to be obvious, basic and even "common sense" but as the saying goes *"common sense is not so common*" – Voltaire. When doing an intake/assessment especially with a more defensive or resistant client, the goal is to avoid presenting yourself as a feelingless, endless question-asking, robot. Therefore, it is important to consciously remember the exceeding value of these seemingly trivial yet critically-important aspects of engagement during the intake/assessment process:

- ***Smile/Humor***: There is research to support the cliché that "a smile is contagious". A sincere smile has a huge impact on people's first impression and the power of a true smile at the right time can

be both persuasive and disarming. To smile is more natural for some people and for others it requires practice. If you are not a natural “smiler” and you want to work with difficult clients, you may want to consider putting in some work toward developing this engaging good habit. Taking things a step further, if you are someone who can effectively use your ***sense of humor*** then you possess a tool at your disposal that can quickly break down some of the biggest walls of client resistance. Approaching each intake session with a healthy sense of humor can be a lifesaver in the otherwise stressful intake engagement process.

- ***Roll with Resistance:*** This one comes straight out of the Motivational Interviewing textbook. (Miller and Rollnick, 1991). Rolling with resistance is a fundamental tool in all aspects of counseling but during the intake process may be the most advantageous time to practice this skill. Never is there a more critical time to be prepared to face resistance, and then subsequently “roll with it” as when you are first asking someone why they have arrived at your substance abuse treatment facility. The consummate example of rolling with resistance in an intake often occurs when a legally mandated client comes right out and tells the intake clinician in an addiction treatment setting that he or she is only entering the program to comply with probation or parole and otherwise there is no interest in stopping substance use. If the clinician responds to that kind of situation with an authoritarian or threatening tone such as “Well you better be prepared to stop getting high now or you are going to end up back in jail”, that would be the antithesis of rolling with resistance. With that kind of answer, the intake clinician is just making him/herself an extension of the probation/parole officer, sure then to draw the ire of the client. Rather, in this same example, rolling with resistance would instead be demonstrated by the intake clinician with a response such as: “I can see you aren’t too happy about being forced to come here by the legal system. I can’t blame you and I hear your frustration. But still, while you’re here, let’s see what you and I can do in order to make this whole process go as smoothly as possible” In this second response, the intake clinician is aligning himself with the client instead of the probation/parole officer. Although it is true that with legally-mandated clients, the legal system is part of the overall equation, nevertheless, our bond with our client is primary for treatment to truly work. Therefore rolling with resistance is a key tool in the engagement process in these and other similar examples that occur during the intake process

- ***Defer to Later (When there is a Disagreement) –*** When doing an intake, if you sense (or outright know) that you and the client do not see eye to eye on something, the intake likely is not the time to take on that potentially heated discussion. Unless there is an imminent safety issue at hand that needs to be addressed, politely stating “OK I hear where you are coming from, we can discuss this more later” can be a simple way to sidestep client resistance in the intake. Often, once a client has started treatment and the barrier of all the intake paperwork has been removed, then it can be much easier to discuss more “touchy” subject matter with your client. A typical example may be a client stating “I’ll come to treatment to work on my harder drug use (cocaine, heroin, meth) but there’s no way I am stopping my weed smoking (or drinking)” If you are using a Harm Reduction perspective at your facility, why not just admit the client and save that discussion for later rather than debate it at the intake? Once a basic agreement to attend your program is established, potential debates over weightier details or viewpoints can be saved to be addressed appropriately and calmly during the actual treatment sessions that come up later instead of during the intake.

- ***Spurts of Engagement:*** What is meant by “spurts of engagement” is taking a short moment or two to deviate from the often tedious intake process to discuss something pleasant and of relevance to the client. Using something the client says in order to initiate a “spurt” of engagement

for a minute or two can make a huge difference, especially using a client's likes or interests. For example, if a client is mentions a sports team, why not take a minute to say "did you catch that game last night?" Personalized follow up questions when a client discusses their interests, such as where they went to school, their employment history, their hobbies and many other areas can be a huge help in making a more "human" connection than simply sticking to the often mundane script of questions and answers in the intake process. For example if a client mentions they are a musician, for example, taking a minute to stop and hear more about an interest like that, can be extremely engaging.

- ***Carefully Used Self Disclosure:*** Using self-disclosure can vary dependent upon a clinician's comfort level. Self-disclosure can be an enormously effective engagement tool in the intake process when used discriminately, paying attention to timing, content and overall appropriateness. If you have information about yourself that is benign but also in common with your client, why not share it? For example, if a client states they were in the military and so were you, why not share that common bond? Or if a client is wearing a shirt representing a band that you like why not share that you too are a fan? Again, depending upon your comfort level and ability to still maintain appropriate boundaries, self-disclosure can break down walls of resistance in the intake process

- ***Include Family but Know When to Say "When":*** This concept has two parts. First, it is an excellent practice to always at least try to include family who are present during the intake process. When you go out to the waiting room to get a client for an intake and you see the client with his/her significant other, parent, etc., why not at least ask if they would like to come in for at least the initial part of the intake session? The client has the right to refuse but that does not prohibit your right to at least first try to ask. The family does not have to participate in the whole intake but at least if you can get some opening information this can be extremely helpful in the intake process. When dealing with adolescents the inclusion of family is even more essential. A good way to engage an adolescent and still include the parent is to use a line such as "First, while your parent is here I want to just get their opinion, but when you and I meet alone in a few minutes, I will make sure to get your side of the story" Often when a kid knows he will get his chance to be the primary focus, that can increase the likelihood of cooperation while the parent is speaking. Remember, when working with adolescents, quite often if you do not take time to engage the parent/guardian you can lose the kid regardless of how good you believe your rapport is with the adolescent. Often the parent is the source of transportation, motivation and funding for the child's treatment so efforts to engage both the parent and child are necessary. Part two of this concept is to 'know when to say when" when it comes to including family in the intake process. With both adult and adolescent clients, if there comes a point in the intake session where things have degenerated into an endless stream of arguing, yelling or conflict, then usually the intake session is not a good time to shift into family therapy. If you are in private practice and you have the luxury to do the initial assessment over several sessions you may want to sit with the family and try to work through things if you so desire. However in most agency settings, when the intake is a time for completing assessment paperwork and admitting the client to your facility, often then the first session is not a good place to address these issues. Know when to say "when" in situations in which the family is presenting as difficult to work with during the intake and instead elect to complete the intake alone with the client, perhaps asking the family member to come back for a few minutes at the end of the intake to discuss recommendations.

    - Use the "Parent Sandwich" When Doing Adolescent Intakes – On a side note, one of the best ways to approach intake sessions with adolescents is to use the "Parent Sandwich": which specifically means breaking down the session this way:

- Meet first with adolescent client and his or her parents/guardians, focusing primarily on parents' point of view and on information that the parent would know more accurately (like for instance, family history). If/when the adolescent complains or argues with parents viewpoint, reassure adolescent client he/she will soon have their time alone with you to tell their "side of the story"

- Next, dismiss the parents/guardians back to waiting room and perform assessment with adolescent client alone. Often to get accurate substance abuse information from the client it will only come out when the parents/guardians are not present due to the adolescents concern that the parents do not know the true extent of their use or experimentation with substances, as well as other possibly sensitive or more secretive client issues.

- Finally when information-gathering is complete, invite the parents/guardians back in to the last five minutes of the intake session with the client simply to discuss your treatment recommendations. Where possible when engaging difficult adolescents it is best not to meet alone with the parents after meeting with the client as this can really hurt rapport building especially with an adolescent who likely would be concerned you are then sharing his or her secrets*. The only time to meet with parent alone at intake would be if parent insists, but it is not recommended at intake sessions. *Obviously if information shared alone by an adolescent indicates child abuse or neglect or client danger to self or others, then parental disclosure needs to take place. Otherwise when there are no significant safety issues present, sharing information with a parent that an adolescent shared alone can impair the engagement and rapport building process. It is best then not to meet with parents alone directly after meeting with an adolescent unless of course there is a significant safety concern

- ***Drop the "process" in critical or drastic situations:*** Part of having good clinical instincts in the intake session is to know when to deviate from the standard intake/assessment process for your agency. If a client is clearly intoxicated, psychotic, or demonstrating some form of more severe distress, impairment, or risk or harm, then it is important to know when to drop the "I need to get this paperwork completed" mentality. Most likely if you are a more seasoned clinician you have had the experience of knowing when to put down the forms and step away from the computer to address an urgent situation such as the presence of imminent suicide risk or the realization that the client's needs are well beyond your agencies capabilities. Sometimes helping the client with the immediate situation first by helping them get into the hospital or detox or whatever the immediate need may be, prepares them to return to your facility under better circumstances later. Often, if done in an engaging and caring manner, the client will appreciate what you have done and seek to return to your care when they are in a more stable or appropriate condition. Even if the client needs a different level of care than your agency provides and you may never see them again, it is the course of wisdom to know when to stop your agency's intake and deal instead with the client's emergent issue at hand by making the right referrals or linkages during the intake session

3 - Considerations for engagement in treatment planning

Once you have maneuvered through "mission impossible" and you have successfully engaged your client while completing the often lengthy and cumbersome intake process there are additional engagement related issues associated with the treatment planning process.

Being Client-Centered and Engaging the Legally Mandated Client: So at this point, you get the intake/assessment done and you did your best to get all of the piles of paperwork filled out and questions asked, while simultaneously somehow establishing a rapport with your new client using your best engagement skills. However next up comes the assessment- session ending: level of care discussion. If your agency has one level of care then this is often less of a decision as you either admit the client as appropriate for the level of care that you provide or you refer out. If the client comes to your facility knowing that your agency has only one level of care and they are appropriate then this process of course is much simpler. However, many agencies have multiple levels of care. For example, most agencies that provide intensive outpatient services also provide just traditional outpatient services as well. In addition, within one level of care, such as outpatient, there may be multiple modalities within that level of care, for example, individual therapy, groups, family sessions, psychiatry, etc. Add into the mix then is frequency of attendance, as it has to be determined if the client will be attending weekly, bi-monthly, monthly, etc. Usually after an intake, particularly with a more resistant and challenging client who may not want to be there in the first place, a discussion or negotiation of level of care is necessary.

In many situations, especially in substance abuse, the legal system has a huge say in the level of care discussion. When a client is court-ordered, he or she may have little choice depending or whether or not the legal entities involved allow for some “wiggle room” or negotiation with regard to the choice of level of care. Interestingly this subject leads to a tangential discussion regarding why legal entities should have the authority to make treatment decisions often with no training or education on treatment itself. However that subject can and should be discussed another day. But for the sake of this discussion, often the client has little or no choice when mandated to a specific level of care while at other times some legal entities “leave it up to the experts” and allow you, the clinician, using your expertise and experience, to determine the appropriate level of care for your client that you just assessed. The best way to handle this situation is with a simple conversation. It is a good practice when the legal system is involved to make that phone call or email needed to the referral source to get collateral information on your client and include that information in the final level of care decision. From an engagement perspective, if you are letting your new client know that you are making the call to his or her legal referral source it is important to explain to the client that your role is primarily as a helper and advocate as opposed to representing yourself as a further extension of the legal system. Even though our goal is to honestly cooperate and collaborate with the legal system we are still advocates for our clients’ well-being and progress. If your goal as a counselor is to work toward increasing client compliance through coercion (which is not recommended!) then go ahead and fully align with the probation officer, parole officer, judge or child protective services worker. You likely will not foster trust and rapport with your client but rather increase the likelihood of superficial cooperation based strictly on fear of consequences. When the client views you as merely an extension of the legal system then he or she is more likely to engage in “feigned compliance” in which the client just tells you what he or she thinks you want to hear. That is not engagement however. Rather, all clients, including legally mandated clients, should view you as working together with them, not against them. Working toward mutual respect and trust with your client is much more desirable and effective. Therefore it is important for the client to understand that in part, your role is to help them get better but this must be done honestly within the framework of the legal system who referred them. This at times can involve a very delicate balance. As a counselor working with a legally mandated client you are responsible to *both* the legal system and the client at the same time which at times has its challenges.

Engaging your mandated client to cooperate in treatment involves communication with referral sources in a collaborative manner. Once more, as a clinicians working with mandated clients we must again walk a proverbial tightrope between the referral source's expectations and the client's needs. In reality both the referral source, who sent us the client, and the client him or herself, are both our customers in a different sense so we as clinicians need to collaborate and communicate effectively with both entities, not overly aligning ourselves with either side. Just as we do not want to make ourselves an extension of the legal system thus causing the client to view our treatment efforts in a punitive manner, we must also be careful to remember that we must honestly cooperate within the rules and boundaries of the legal entity referring our client for treatment. That tightrope looks something like this:

Legal System		**Client**
Respecting laws, boundaries and expectations of the legal system Establishing and maintaining open lines of communication Fostering honestly and trust with the legal system ultimately establishing a relationship in which the legal system handles the legal issues ,while leaving treatment decisions to treatment providers	**<Clinician Respecting Both Sides>**	Successfully engaging client to trust our treatment center as a source of help Fostering an atmosphere in which the client can be honest without fearing immediate legal reprisal Letting the client know that as long as he or she is doing the right thing you will advocate for them legally. Using the legal system as motivation for change rather than fear mongering (For example "if you don't cooperate then – JAIL!)

When this collaborative process is maintained we, as clinicians must work to foster trust and respect from both the legal referral source and the client. However quite often the legal system and the client do not initially trust and respect one another, particularly early in treatment. As the client makes progress this process usually gets easier as any tension between a legal referral source and a client usually subsides when the client is doing well over time because that is the goal. But early on, particularly after the assessment and the first few weeks to follow this three way relationship most assuredly requires a delicate balance of engagement skills on your behalf as the clinician. Honesty, trust, respect, clarity, communication and compromise are all needed qualities in all directions. When it comes to the client, the legal system, and the counselor, the three perspectives may differ slightly but in the end all three parties really have the same goal for the client to make progress and improve his or her life. No one wins when the client goes back to jail or loses custody of a child or suffers another legal consequence of addictive behavior. Instead, everyone involved benefits when the client gets better and makes positive lifestyle changes. In a sense, everyone really is on the same "team" just with different roles, but the positive outcome goal is all the same.

So in the end, when making level of care decisions, we know that in a perfect world, a client treatment plan is based upon mutually agreed upon goals and objectives. However, we also know that we do not live in a perfect world, particularly when working with more challenging clients, therefore the level of care determination process often requires a lot more negotiation and compromise. Obviously in the real world, treatment decisions are often dictated by non-clinical entities such as the legal system who may have prescribed a predetermined level of care for your client, whether appropriate or not. In these types of situations, if the client is appropriate for the mandated level of care then it makes sense to place that client in the level of care he or she is being referred for. At other times, however, the legal system may be grossly mistaken with regard to the appropriate level of care. For example,

suppose a client has been referred for Intensive Outpatient Programming (IOP) 9 hours per week by a legal entity, however you have clearly assessed the client to be appropriate for a lower level of care such as outpatient individual therapy just one hour per week. In these types of situations it is appropriate to at least try to negotiate with the referral source who may take your professional opinion into consideration. Offering to try the lower level of care on a trial basis with the assurance of an immediate referral to a higher level of care in the face of client noncompliance can be an appropriate compromise between you and the legal referral source. A verbal or written contract identifying this trial attempt at the lower level of care can solidify and document such an arrangement.

Once Again Looking at "The Ideal vs. the Real" in Treatment Planning

Once an assessment is compete and it is time to determine an appropriate level of care and develop a treatment plan, the idea of looking at things in terms of "what is ideal and what is real" is again crucial. For any client, regardless of whether they are mandated or voluntary and regardless of the referral source, the ideal situation is for the client to agree with the clinician's recommendation. Ideally speaking, during the assessment the clinician used an accepted method for level of care determinations, such as ASAM criteria (http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria) Then, the ideal situation continues when the client agrees with this level of care, has available funding and transportation then begins voluntarily attending treatment as per your recommendations. Fortunately this ideal scenario does at times fall into place when determining level of care and implementing a corresponding treatment plan. However, quite often it does not.

Often, there are "real life" factors that may prohibit or exclude a client from attending the level of care that has been deemed to be appropriate and necessary for that client's treatment needs. Consider a few:

- Care for Family: A client may need to attend a certain level of care such as residential treatment or IOP however if there is not available childcare then that may not be possible. Some people do not have the extended family or friends or other resources needed for care of their children while they attend treatment. This can also be true when a client is caring for other family members such as an elderly parent. Even pet care can be a factor in some situations.

- Transportation: You may be offering the ideal program for your client at your agency but he or she may have no way to get there. This factor cannot be ignored. An agency may not have the funding or resources to provide transportation and in many places public transportation is either unavailable or unaffordable for the client.

- Funding: Again even if a level of care is ideal, if a client cannot afford it then attendance is not going to happen. If your agency has grant funding that is a way to reduce funding barriers but not every facility has that luxury and not every client may qualify. Funding therefore is a key factor in level of care choice.

- Employment: It is unrealistic to expect a client of any age to give up their employment so that he or she can attend treatment. If, for example, you recommend a program that is available only during the day and that client works days then there is a conflict that must be worked around regardless of how ideal the recommended level of care may have seemed. This is especially true when the client needs to work to support him or herself and his or her family through their employment.

- Client Preference: As the clinician you may have just the right group setting for a certain client, for example. That same client may tell you that he or she hates group therapy and therefore may refuse that setting. Social phobias can be a factor in such instances. A client can outright refuse a recommended level of care for a variety of personal reasons. He or she may not want to attend treatment as often as you are recommending or he or she may not agree with the treatment philosophy of your agency or he or she may even have a friend (or an enemy) in your program instigating the refusal of your treatment recommendation. All of these factors and more, can be relevant to the final decision making process

Be Flexible not Rigid:

When the ideal level of care situation is not available, it is necessary to be flexible in your approach to the solution. Being rigid and unyielding is just not a good idea in life in general, and neither is it a good idea in substance abuse and mental health treatment. Remember if your attitude is “my way or the highway” many people will choose the highway and go somewhere else. The suggestion of negotiating an alternative level of care placement on a trial basis made earlier under the section about mandated clients is probably the best way to go in these situations. While always giving proper attention to safety and risk issues first, it can still be effective to try a lower level of care on a provisional basis.

Let’s again consider a common example mentioned earlier. Suppose and individual comes to your treatment center who meets the criteria for an Intensive Outpatient Program (IOP) which meets for 3 hours, three evenings per week. However suppose that person tells you that he detests group and he is only willing to attend weekly individual therapy. First you may try cleverly ask the client to attend 12 Step meetings to supplement individual therapy but in this example the client refuses to attend 12 Step groups either, stating that he is extremely uncomfortable in any kind of group meeting, whether at your facility or in the community. In cases such as this one there is little choice but to make an agreement to try outpatient individual therapy on a provisional basis even though it is a lower level of care than initially recommended. Looking at the bright side, surprisingly, at times this type of arrangement can end up being motivational for the client whether he does well or struggles at the level of care that he chose for himself. For instance, the client may end up trying hard to show you, the counselor, that he was right and that he did not need the higher level of care that you initially recommended. That scenario works out great when a client makes excellent progress due to being motivated to prove everyone else wrong. Conversely if the plan backfires and the client does not make progress in the lower level of care that he wanted, then that can be a powerful life lesson for the client that he should have followed your recommendation which he may later do. So in this example if the client was unable to stay clean in individual therapy it would not be surprising if the client ended up showing a willingness to eventually attend IOP as you initially had recommended. Really then, this

type of arrangement often is a “win-win” scenario for the clinician if handled correctly. This example again illustrates the importance of being flexible and adaptable in our efforts to be client-centered in the treatment planning process.

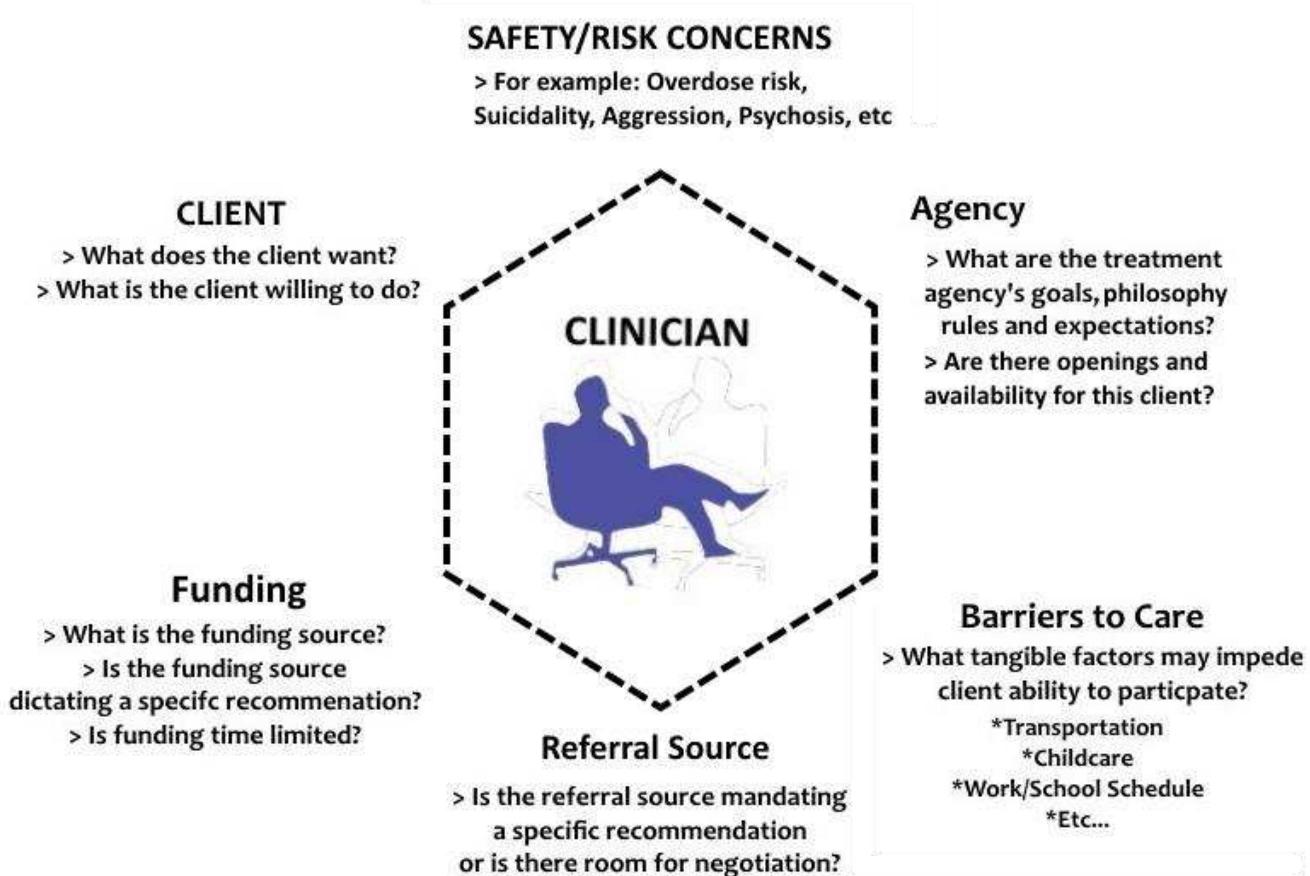
Also, ethically, the general rule of going with a lower level of care when one is divided or unsure which level of care is most appropriate, coincides with the concept of “least restrictive environment” or LRE

- The Least Restrictive Environment (LRE) concept is commonly associated with the U.S. Individuals with Disabilities Education Act (IDEA) - https://en.wikipedia.org/wiki/Least_restrictive_environment The commonly known concept of LRE is also associated with mental health and addiction treatment. In its simplest terms, offering the least restrictive environment involves going with the lower level of care when someone appears to be “on the fence” between two levels. The concept makes a lot of sense when you consider the following example. Suppose you had a medical problem you and your doctor had the choice between giving you a lower dose of medication first then raising it if it didn’t work, or just giving you the higher dose right away. Provided that the medical issue is not life threatening, most people would opt to start with the lower dosage and move upward. Similarly if your doctor gave you the choice between first trying physical therapy for a back injury or else go straight to surgery, most people would first try the LRE and enroll in the physical therapy first with the hope that the problem can be alleviated in the LRE, this avoiding surgery and hospitalization. Therefore the least restrictive environment is often the best first choice, when safety issues are not imminent.

Documentation: On a final note, it is always a good practice as a counselor or social worker to document what occurs with our clients. Therefore, in this situation, when there was some disagreement over level of care, the counselor should document that in the client file, which in essence makes the situation more of a written contract in addition to the verbal agreement made with the client at the intake session. A good place to document this would be directly in the “Recommendations” section of your assessment. An example is provided below:

- “Client meets criteria for Intensive Outpatient Program however client refusing to attend this level of care. Client to attend outpatient individual therapy one time per week, one hour per session on a provisional basis. If client fails to make progress at outpatient level of care, a higher level of care referral to again be discussed at that time.

Goals: The sophisticated yet delicate balance and negotiation between safety/risk concerns, client goals, agency philosophy, referral source expectations, barriers to care and funding source limitations – Any or all of these factors may come into play when making treatment decisions for your new client. The diagram below illustrates the interplay between these relevant concerns regarding determining client level of care in the development of an appropriate treatment plan:



It is easy to see the multitude of considerations that are involved when determining an appropriate client level of care. Successful client engagement requires the use of ethics, good judgement and flexibility with regard to all of these areas to the degree to which they impact your final decision. It is important, as a clinician to understand the parameters involved in each area. Familiarity with your agencies funding streams and limitations, knowing referral source expectations, being able to carefully identify and assess risk and safety issues both with regard to substance abuse, mental health and other key life areas are all part of the framework for successfully managing level of care decision making. A flexible attitude on behalf of the clinician in combination with being able to differentiate between what is the ideal scenario vs. the real-life situations our clients are often dealing with is critical in this decision making process.

Taken from [“The Tools of Engagement: The Taking the Escalator Counselor Handbook (2017)”]

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