> The task for individuals in Precontemplation is to become conscious of and concerned about the current pattern of behavior and/or interested in a new behavior. From a change perspective, it is more important to recognize an individual's current views on change and address her or his reasons for not wanting to change than it is to understand how the status quo came to be."
>
> —DiClemente, 2018, p. 29

KEY MESSAGES

- In the Precontemplation stage, clients do not recognize that they have a problem with substance use or they recognize the problem but are not ready to change their substance use behaviors.
- Counselors should be nonjudgmental about clients' low motivation to change and instead focus on building a strong working alliance.
- A key strategy to helping clients move from the Precontemplation stage to contemplating change is to raise their level of concern and awareness of the risk associated with their current substance use behaviors.
- Involving family members and significant others (SOs) can increase clients' concern about substance use.

Chapter 4 discusses strategies you can use to help clients raise doubt and concern about their substance use and related health, social, emotional, mental, financial, and legal problems. It highlights areas of focus and key counseling strategies that will help clients move from the Precontemplation stage to Contemplation. This chapter also addresses issues that may arise for clients mandated to treatment.

In the Stages of Change (SOC) model, clients who are unconcerned about their current substance use or may be concerned but aren't considering change are in Precontemplation. They may remain there or in the early Contemplation stage for years, rarely or possibly never thinking about change.

You can take advantage of many opportunities and scenarios to help someone who is misusing substances start on a journey toward change—to move from Precontemplation to Contemplation. A client in Precontemplation is often moved to enter the cycle of change by extrinsic sources of motivation. The following situations might lead a person who is misusing a substance to treatment:

- A college coach refers an athlete for treatment after he tests positive for cocaine use.
- A wife worries about her husband's drinking and insists she'll file for divorce unless he gets treatment.
- A tenant is displaced from a federal housing project because of his substance use.
- A driver is referred for treatment by the court for driving while intoxicated.
- A woman tests positive for substances during a prenatal visit to a public health clinic.
- An employer sends an employee whose job performance has declined to the company's employee assistance program, and the employee is subsequently referred for substance use treatment.
- A physician in an emergency department treats a driver involved in a serious automobile crash and discovers alcohol in his system.

- A family physician screens a patient for alcohol use disorder (AUD) and suggests treatment based on the patient's high score on the Alcohol Use Disorders Identification Test.
- A mother whose children were taken into custody by Child Protective Services because of neglect learns that she cannot get them back until she stops using substances and seeks treatment.

In each situation, someone with an important relationship to the person misusing substances stated his or her concerns about the person's substance misuse and its negative effects. The response to these concerns depends, in part, on the person's perception of the circumstances as well as the way feedback about substance misuse is presented. An individual will be better motivated to abstain from or moderate his or her substance use if these concerned others offer relevant information in a supportive and empathic manner rather than in a judgmental, dismissive, or confrontational way.

Exhibit 4.1 presents counseling strategies for Precontemplation.

EXHIBIT 4.1. Counseling Strategies for Precontemplation

CLIENT MOTIVATION	COUNSELOR FOCUS	COUNSELING STRATEGIES
• The client is not concerned about substance use or lacks awareness about any problems. • The client is not yet considering change or is unwilling or unable to change. • The client is often pressured by others to seek help.	• Develop rapport and build trust to establish a strong counseling alliance. • Raise doubts and concerns about the client's substance use. • Understand special motivational counseling considerations for clients mandated to treatment.	• Elicit the client's perceptions of the problem. • Explore the events that led to entering treatment. • Assess the client's stage in the SOC and readiness to change. • Commend the client for coming to treatment. • Agree on a direction. • Provide information about the effects and risks of substance misuse. • Evoke concern about the client's substance use. • Provide personalized feedback on assessment findings. • Involve SOs in treatment to raise concern about the client's substance use. • Express concern, and leave the door open.

Develop Rapport and Build Trust

Before you raise the topic of change with people who are not thinking about it, establish rapport and trust. The challenge is to create a safe and supportive environment in which clients can feel comfortable about engaging in authentic dialog. As clients become more engaged in counseling, their defensiveness and reluctance to change decreases (Prochaska, Norcross, & DiClemente, 2013). Some motivational strategies for establishing rapport in initial conversations about behavior change include:

- **Asking the client for permission** to address the topic of changing substance use behaviors; this shows respect for the client's autonomy.
- **Telling the client something about how you or your program operates and how you and the client could work together.** State how long sessions will last and what you expect to accomplish both now and over a specified time. Try not to overwhelm the new client with all the program's rules and regulations. Specify what assessments or other formal arrangements will be needed, if appropriate.

- **Raising confidentiality issues up front.** You must inform the client which information will be kept private, which can be released with permission, and which must be sent back to a referring agency.
- **Explaining that you will not tell the client what to do or how and whether to change.** Rather, you will be asking the client to do most of the talking—giving him or her perspective about what is happening while inviting the client to share his or her own perspective. You can also invite comments about what the client expects or hopes to achieve.
- **Asking the client to tell you why he or she has come to treatment, mentioning what you know about the reasons, and asking for the client's version or elaboration** (Miller & Rollnick, 2013). If the client seems particularly hesitant or defensive, one strategy is to choose a topic of interest to the client that can be linked to substance use. (For more information about setting an agenda, see Chapter 3.) Such information might be provided by the referral source or can be learned by asking whether the client is dealing with any stressful situations, such as illness, marital discord, or extremely heavy workload. This can lead naturally to questions such as "How does your use of alcohol fit into this?" or "How does your use of heroin affect your health?"
- **Avoiding referring to the client's "problem" or "substance misuse," because this may not reflect the client's perspective about substance use** (Miller & Rollnick, 2013). You are trying to understand the context in which substances are used and the client's readiness to change. As mentioned previously, labels can raise a person's defenses.
- **Aligning your counseling approach to the client's current stage in the SOC.** For example, move to strategies more appropriate to a later stage in the SOC if you discover that the client is already contemplating or committed to change. (For more information on the later stages in the SOC, see Chapters 5 and 6.)

COUNSELOR NOTE: AGENCY POLICY ABOUT CLIENT INTOXICATION

In your first session, discuss your agency's policy on having conversations with clients who are intoxicated. Be transparent about the policy and what actions you will take if the client comes to a session intoxicated. Coming to treatment intoxicated on alcohol or drugs impairs ability to participate in treatment, whether it is for an initial counseling session, assessment, or individual or group treatment (Miller, Forechimes, & Zweben, 2011).

Many programs administer breathalyzer tests for alcohol or urinalysis for drugs and reschedule counseling sessions if substances are detected at a specified level or if a client appears to be under the influence (Miller et al., 2011). If you determine that a client is intoxicated, ask the client in a nonjudgmental way to leave. Reschedule the appointment, and help the client get home safely (Miller et al., 2011).

Elicit the Client's Perception of the Problem

To engage clients, invite them to explain their understanding of the problem. Be direct, but remain nonjudgmental. You might say, "Can you tell me a bit about what brings you here today?" or "I'd like to understand your perspective on why you're here. Can we start there?" Asking these open questions invites clients to tell you their story and shows your genuine interest in their perspective.

Explore the Events That Led to Entering Treatment

Explore what brought the client to treatment, starting by recognizing his or her emotional state. The emotional state in which the client comes to treatment is an important part of the context in which counseling begins. A client referred to treatment will exhibit a range of

emotions associated with the experiences that led to counseling—for example, an arrest, a confrontation with a spouse or employer, or a health crisis. People may enter treatment feeling shaken, angry, withdrawn, ashamed, terrified, or relieved and are often experiencing a combination of feelings. **Strong emotions can become obstacles to change if you do not acknowledge them through reflective listening.**

Your initial conversation with clients should focus on their recent experience. For example, an athlete is likely to be concerned about his or her continued participation in sports, as well as athletic performance; an employee may want to keep his or her job; and a driver is probably worried about the possibility of losing his or her license, going to jail, or injuring someone. A pregnant woman wants a healthy child; a mother may want to regain custody of her children; and a concerned husband needs specific guidance on encouraging his spouse to enter treatment.

Many people with substance use problems seek treatment in response to external pressure from family, friends, employers, healthcare providers, or the legal system (Connors, DiClemente, Velasquez, & Donovan, 2013). A client sometimes blames the referring source or someone else for pressuring him or her into treatment and report that the referring provider simply doesn't view the situation accurately. **Start with these external sources of motivation as a way to raise the client's awareness about the impact of his or her substance use on others.** For example, if the client's wife has insisted he start treatment and the client denies any problem, you might ask, "What kind of things seem to bother her?" or "What do you think makes her believe there is a problem associated with your drinking?" If the wife's perceptions are inconsistent with the client's, you might suggest that the wife come to treatment so that you can explore their different perspectives.

Similarly, you may have to review and confirm a referring agency's account or the physical evidence forwarded by a healthcare provider to help you introduce alternative viewpoints to the client in nonthreatening ways. If the client thinks a probation officer is the problem, you can ask, "Why do you think your probation officer believes you have a problem?" This lets the client express the problem from the perspective of the referring party and can raise awareness. Use reflective listening responses to let the client know you are listening. **Avoid agreeing or disagreeing with the client's position.**

Assess the Client's SOC and Readiness to Change

When you first meet the client, determine his or her readiness to change and where he or she is in the SOC; this determines what counseling strategies are likely to work. It is tempting to assume that the client with obvious signs of a substance use disorder (SUD) must already be contemplating or ready for change. However, such assumptions may be wrong. The new client could be at any point on the severity continuum (from substance misuse to severe SUD), could have few or many associated health or social problems, and could be at any stage of readiness to change. The strategies you use to engage clients in initial conversations about change should be guided by your assessment of the client's motivation and readiness.

The Importance and Confidence Rulers

The simplest way to assess the client's readiness to change is to use the Importance Ruler and the Confidence Ruler described in Chapter 3 (see Exhibit 3.9 and Exhibit 3.10, respectively). The Importance Ruler indicates how important it is for the client to make a change right now. The Confidence Ruler indicates a client's sense of self-efficacy about making a change right now. Together, they indicate how ready the client is to change target behaviors. Clients in Precontemplation will typically be at the lower end of the rulers, generally between 0 and 3.

Keep in mind that these numerical assessments are neither fixed nor always linear. The client moves forward or backward across stages or jumps from one part of the continuum to another, in either direction and at various times. **Your role is to facilitate movement in the direction of positive change.**

Identification of the client's style of Precontemplation

You should tailor your counseling approach to the ways in which the client talks about being in Precontemplation. Clients will present with different expressions of sustain talk (see Chapter 3), which is the status quo side of ambivalence about changing substance use behaviors. Exhibit 4.2 describes different styles of expressions of ambivalence about change during the Precontemplation stage (known as the 5 Rs) and counseling strategies aligned with these different expressions of sustain talk during Precontemplation.

EXHIBIT 4.2. Styles of Expression in the Precontemplation Stage: The 5 Rs

Individuals with addictive behaviors who are not yet contemplating change usually express sustain talk in one or more of five different ways. Identifying each client's style of expression helps determine the counseling approach to follow.

Reveling	Clients are still focused on good experiences about substance use and have not necessarily experienced many substance-use–related negative consequences. Providing objective, nonjudgmental feedback about their substance use and associated health risks or other negative consequences can raise doubt about their ability to avoid negative effects of substance use on their lives.
Reluctance	Clients lack knowledge about the dimensions of the problem or the personal impact it can have to think change is necessary. They often respond to nonjudgmental feedback about how substance use is affecting their lives. They also respond to reassurance that they will be able to function without the addictive behavior.
Rebellion	Clients are afraid of losing control over their lives and have a large investment in their substance of choice. Your challenge is to help them make more positive choices for themselves rather than rebel against what they view as pressure to change. Emphasizing personal choice and responsibility can work well with them.
Resignation	Clients may feel hopeless, helpless, and overwhelmed by the energy required to change. They probably have been in treatment many times before or have tried repeatedly with little success to quit on their own. These clients must regain hope and optimism about their capacity for change. Explore with them specific barriers to change and successful change attempts with other behaviors. Offer information about how treatment has helped many people who thought they couldn't change, and link them to others in recovery who can provide additional hope and support.
Rationalization	Clients think they have all the answers and that substance use may be a problem for others but not for them. Using double-sided reflection (see Chapter 3), rather than arguing for change, seems the most effective strategy for clients expressing rationalizations. Acknowledge what these clients say, but point out any reservations they may have expressed earlier about current substance use.

Source: DiClemente, 2018.

Readiness assessment instruments

Use assessment tools to help determine the client's readiness to change and place in the SOC. These instruments can give overall scores that correspond to levels of readiness to change. You may find it useful to **explore client responses to specific questions** to raise awareness of his or her substance use and what may be getting in the way of making a change. Several assessment tools widely used in clinical and research settings are discussed briefly below and presented in full in Appendix B:

- **The University of Rhode Island Change Assessment Scale (URICA)** was originally developed to measure a client's change stage in psychotherapy (McConnaughy, Prochaska, & Velicer, 1983) in terms of four stages of the SOC: Precontemplation, Contemplation, Action, and Maintenance. It has been adapted for addiction treatment and is the most common way of measuring the client's stage of change in clinical settings (Connors et al., 2013).
  - The scale has 32 items—8 items for each of the 4 stage-specific subscales. A client rates items on a 5-point scale from 1 (strong disagreement) to 5 (strong agreement). The instrument covers a range of concerns and asks clients general questions about the client's "problem." URICA subscales have good internal consistency and validity for SUDs (Field, Adinoff, Harris, Ball, & Carroll, 2009).
  - To use this tool, the client is asked to identify a specific "problem" (e.g., cocaine use) and then fills out the form keeping the specific problem in mind. There may be more than one "problem" for which the client is seeking help, so you may want to have the client fill out the instrument more than once. You can use the URICA to track a client's movement through the SOC by asking the client to fill it out periodically.

- **The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)** measures readiness to change. The original SOCRATES was a 32-item questionnaire that used a 5-point scale ranging from 5 (strongly agree) to 1 (strongly disagree). A 19-item version was developed for clinical use and is a self-administered paper-and-pencil questionnaire (Miller & Tonigan, 1996). The SOCRATES 8A is for alcohol use, and the SOCRATES 8D is for drug use. The items on the short version assess the recognition of the problem, ambivalence, and efforts to take steps.

  SOCRATES provides clients with feedback about their scores as a starting point for discussion. Changes in scores over time can help you learn the impact of an intervention on problem recognition, ambivalence, and progress on making changes.
- **The Readiness To Change Questionnaire** was developed to help healthcare providers who are not addiction treatment specialists assess the stage of change of clients misusing alcohol (Rollnick, Heather, Gold, & Hall, 1992). The 12 items, which were adapted from the URICA, are associated with 3 stages—Precontemplation, Contemplation, and Action—and reflect typical attitudes of clients in each readiness level. For example, a person not yet contemplating change would likely give a positive response to the statement "It's a waste of time thinking about my drinking because I do not have a problem," whereas a person already taking action would probably agree with the statement "I am actively working on my drinking problem." Another individual already contemplating change would likely agree with the item "Sometimes I think I should quit or cut down on my drinking." A 5-point scale is used for rating responses, from 5 (strongly agree) to 1 (strongly disagree).

Commend the Client for Coming to Treatment

Offering clients affirmations over responsible behaviors, like entering treatment, can increase their confidence that change is possible. Clients referred for treatment may feel they have little control in the process. Some will expect to be criticized or blamed; some will expect you to cure them; and still others will hope that counseling can solve all their problems without too much effort. Whatever their expectations, affirm their

courage for coming to treatment by saying things like, "It took you a lot of effort to get here. You are determined to figure out what's going on and how you can change things." For example, you can praise a client's decision to come to treatment rather than risk losing custody of her child by saying, "You must care very much about your child." Such affirmations are supportive and remind clients that they are capable of making good choices that match their values.

Agree on a Direction

In helping clients who are not yet thinking seriously of changing, plan your strategies carefully and work with them to find an acceptable pathway. Some clients will agree on one option but not on another. It may be appropriate to give advice based on your own experience and concern. **However, always ask permission to offer advice and make sure that clients want to hear what you have to say.** Asking permission demonstrates respect for client autonomy and is consistent with person-centered counseling principles and the spirit of MI (as discussed in Chapter 3). For example: "I'd like to tell you about what we could do here. Would that be all right?"

Whenever you express a different viewpoint from that of the client, do so in a way that is supportive, not authoritative or confrontational. The client still has the choice of whether to accept your advice and to agree to a plan. It is not necessary at the beginning of the process to agree on treatment goals; however, you can use motivational strategies, like the agenda mapping discussed in Chapter 3, to agree on how to proceed in the current conversation.

Throughout the process of establishing rapport and building trust, use the OARS (asking **O**pen questions, **A**ffirming, **R**eflective listening, and Summarizing) approach and person-centered counseling principles (described in Chapter 3) to create a sense of safety and respect for the client, as well as a genuine interest in the client's perspective and well-being. **Emphasizing personal autonomy will go a long way toward showing the client that you are not pressuring him or her to change.**

Raise Doubts and Concerns About the Client's Substance Use

Once you have engaged the client and developed rapport, **use the following strategies to increase the client's readiness to change and move closer to Contemplation.**

Provide Information About the Effects and Risks of Substance Misuse

Psychoeducational programs can increase clients' ambivalence about substance misuse and related problems and move them toward contemplation of change (Yeh, Tung, Horng, & Sung, 2017). Be sure to:

- Provide basic information about substance use early in the treatment process if clients have not been exposed to drug and alcohol education before.
- Use the motivational strategy of Elicit-Provide-Elicit (EPE, described in Chapter 3) to engage clients in a joint discussion rather than lecture them (Miller & Rollnick, 2013).
- Ask permission, for example, "Would it be okay to tell you a bit about the effects of _____?" or ask them to describe what they know about the effects or risks of the substances used.
- Talk about what happens to any user of the substance rather than referring just to the client.
- State what **experts** have found, not what **you** think happens.
- Provide small chunks of information then elicit the client's understanding. For example, "What do you make of all this?"
- Describe the addiction process in biological terms. Understanding facts about addiction can increase hope as well as readiness to change. For example, "When you first start using substances, it provides a pleasurable sensation. As you keep using substances, your mind begins to believe that you need these substances in the same way you need life-sustaining things like food—that you need them to survive. You're not stronger than this process, but you can be smarter, and you can regain your independence from substances."

EXPERT COMMENT: LIVER TRANSPLANTATION—PRECONTEMPLATION TO CONTEMPLATION

The client in Precontemplation can appear in surprising medical settings. It is not uncommon for me to find myself sitting across from a client with end-stage liver disease being evaluated for a liver transplant. From a medical perspective, the cause of the client's liver disease appears to be alcoholic hepatitis, which led to cirrhosis. A variety of laboratory and other information further supports a history of years of alcohol misuse. The diagnosis of AUD is not only supported by the medical information but also is made clear when the person's family indicates years of alcohol misuse despite intensely negative consequences, such as being charged with driving while intoxicated and marital stress related to the drinking. Yet, despite what might seem to be an overwhelming amount of evidence, the client himself, for a variety of dynamic and motivational reasons, cannot see himself as having a problem with alcohol. The client may feel guilty that he caused his liver damage and think he doesn't deserve this life-saving intervention. Or he may be fearful that if he examines his alcohol use too closely and shares his history, he may not be considered for transplantation at all. He may even have already been told that if he is actively drinking, he will not be listed for transplantation.

It is important for me as a counselor not to be surprised or judgmental about the client not wanting to see his problematic relationship with alcohol. The simple fact is that he has never connected his health problems with his use of alcohol. To confront the client with the overwhelming evidence about his problem drinking only makes him more defensive, reinforces his denial, and strengthens his feelings of guilt and shame.

During assessment, I take every opportunity to connect with the client's history and current situation without excessive self-disclosure. Being particularly sensitive to what the client needs and what he fears, I will help support the therapeutic alliance by asking him to share the positive side of his alcohol and drug use, thus acknowledging that, from his perspective, his use serves a purpose.

In a situation such as this, it is not uncommon for me, after completing a thorough assessment, to provide the client with a medical perspective on alcohol dependence. I will talk about changes in brain chemistry, reward systems, issues of tolerance, genetic factors, and different chemical responses to alcohol, as well as other biological processes that support addictive disease, depending on the client's educational background and medical understanding. I may go into great detail. If the client has fewer years of education, I will compare addiction to other, more familiar diseases, such as diabetes. As the client asks questions, he sees a new picture of addictive disease and sees himself in that picture. By tailoring the presentation to each client and encouraging questions throughout, I provide him and his family, if present, with important information about the biological factors supporting alcohol dependence. This knowledge often leads to self-diagnosis.

This psychoeducational reframing gives the client a different view on his relationship with alcohol, taking away some of the guilt and shame that was based on him thinking of the disease as a moral failing. The very act of self-diagnosis is a movement from Precontemplation to Contemplation. It can be accomplished by a simple cognitive reframe within the context of a thorough and caring assessment completed in a professional, yet genuinely compassionate manner.

Jeffrey M. Georgi, M.Div., Consensus Panel Member

Similarly, people who have driven under the influence of alcohol may be surprised to learn how few drinks are needed to meet the definition of legal intoxication and how drinking at these levels affects their responses. Women hoping to have children may not understand how substances can diminish fertility and potentially harm the fetus even before they know they are pregnant. Clients may not realize how alcohol interacts with other medications they are taking for depression or hypertension.

COUNSELOR NOTE: USE MOTIVATIONAL LANGUAGE IN WRITTEN MATERIALS

Remember that the effective strategies for increasing motivation in face-to-face contacts also apply to written language. Brochures, fliers, educational materials, and advertisements can help a client think differently about change. However, judgmental language like "abuse" or "denial" is just as off-putting in writing as it is when spoken in counseling sessions. **You should provide all written material in plain language** with motivation in mind. If your brochure starts with a long list of rules, the client may be scared away rather than encouraged to begin treatment. **Review written materials from the viewpoint of the client,** and keep in mind your role as a partner in a change process for which the client must take ultimate responsibility.

Evoke Concern About the Client's Substance Use

You can help move clients from Precontemplation to Contemplation by raising doubts about the harmlessness of their substance use and concerns about their substance use behaviors. As clients move beyond the Precontemplation stage and become aware of or acknowledge some problems in relation to their substance use, change becomes increasingly possible. Such clients become more aware of conflict and feel greater ambivalence (Miller & Rollnick, 2013).

One way to raise concern in the client is to explore the "positive" and "less-positive" aspects of his or her substance use. For example:

- Start with the client's views on possible "benefits" of alcohol or drugs and move to less-beneficial aspects rather than simply ask about **bad things** or **problems** associated with substance use.
- Do not focus only on negative aspects of substance use because the client could end up defending his or her substance use while you push for unwanted change.
- Avoid spending too much time exploring the "good" things about substance use that may reinforce sustain talk. Higher levels of client sustain talk is associated with lower motivation to change and negative treatment outcomes (Lindqvist, Forsberg, Enebrink, Andersson, & Rosendahl, 2017; Magill et al., 2014).
- Be aware that the client may not be ready to accept he or she has experienced any harmful effects of substance use. By showing that you understand why the client "values" alcohol or drug experiences, you help the client become more open to accepting possible problems. For example, you might ask, "Help me understand what you like about your drinking. What do you enjoy about it?" Then ask, "What do you like less about drinking?" The client who cannot recognize any things that he or she "likes less" about substance use is probably not ready to consider change and may need more information.
- After this exploration, summarize the interchange in personal language so that the client can clearly hear any ambivalence that is developing.

As mentioned in Chapter 3, you can **use double-sided reflections to respond to client ambivalence and sustain talk** (Miller & Rollnick, 2013). For example, you can say, "So, drinking helps you relax. Yet, you say you sometimes resent all the money you are spending, and it's hard for you to get to work on time, especially Monday mornings." Chapter 5 provides additional guidance on working with ambivalence.

You can also **move clients toward the Contemplation stage by having them consider the many ways in which substance use can affect life experiences.** For example, you might ask, "How is your substance use affecting your studies? How is your drinking affecting your family life?"

As you explore the effects of substance use in the individual's life, use balanced reflective listening: "Help me understand. You've been saying you see no need to change, **and** you are concerned about losing your family. I don't see how this fits together. I'm wondering if this is confusing for you, too."

Provide Personalized Feedback on Assessment Findings

Another effective strategy for raising doubt and concern is to provide clients with personalized feedback about assessment findings. As mentioned in Chapter 2, giving personalized feedback about clients' substance use is effective (Davis, Houck, Rowell, Benson, & Smith, 2015; DiClemente, Corno, Graydon, Wiprovnick, & Knoblach, 2017; Field et al., 2014; Kahler et al., 2018; McDevitt-Murphy et al.; 2014; Miller et al., 2013; Walker et al., 2017). In brief interventions, the feedback is usually short and focused on screening results. In specialty addiction treatment settings, feedback can focus on results of a comprehensive assessment, which often includes:

- Substance use patterns and history.
- *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, diagnostic criteria for SUDs.
- General functioning and links between substance use and lowered functioning.
- Health and biomedical effects including sleep disorders, HIV, and diabetes.
- Neuropsychological effects of long-term substance use.
- Family history of mental disorders and SUDs, which put clients at risk for SUDs and co-occurring substance use and mental disorders (CODs).
- CODs and effects of substance use on mental illness.
- Functional analysis of substance use triggers.

Provide clients with personalized feedback on the risks associated with their own substance use and how their consumption compares with others of the same culture, age, or gender. When clients hear about assessment results and understand the risks and consequences, many recognize the gap between where they are and where their values lie.

To make findings from an assessment a useful part of the counseling process, make sure the client understands the value of such information and believes the results will be helpful. If possible, schedule formal assessments after the client has had at least one session with you or use a motivational interviewing (MI) assessment strategy that involves having a brief MI conversation before and after the assessment (see Chapter 8 for more information). This approach will help establish rapport, determine the client's readiness for change, and measure his or her potential response to personalized feedback.

Start a standard assessment by **explaining what types of tests or questionnaires will be administered and what information these tools will reveal.** Estimate how long the process usually takes, and give any other necessary instructions. Make sure the client is comfortable with the assessment format (e.g., have self-administered tests available in the client's first language, do a face-to-face interview instead of a self-administered assessment if the client has cognitive challenges).