MHACBO

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http://www.mhacbo.org

Below are the deadlines for testing in 2020

January 3rd for March Testing
February 7th for April Testing
March 6th for May Testing
April 3rd for June Testing
May 1st for July Testing
June 5th for August Testing
July 10th for September Testing
August 7th for October testing
September 4th for November testing
October 2nd for December testing
November 6th for January testing
December 4th for February testing

You must have a completed application packet and the appropriate fees **in our office** no later than the above application due date, ***regardless of postmark***, for the appropriate test date. You must fill out all forms with your legal name as shown on your driver's license or state ID. Information about scheduling an exam time will be forthcoming. Until we are provided with new testing forms, please continue to use the two page testing application as provided in the back of this packet.

If you are sending packages overnight mail at the last minute, we suggest that you sign the waiver to allow the carrier to leave the package without a signature. Certified mail that requires a signature also can cause your package to arrive late.

The $50 application fee is non-refundable. The $220 test fee is **absolutely non-refundable,** and your testing period is **non-transferable** after we have paid the testing company for your test.

When you have sent us a completed application, including the test fee you will be automatically enrolled in the next available test date unless you contact us and request otherwise.

FEE SCHEDULE:

Application Fee	$ 50
Objective Exam and Qualifying Review Fee (Level I, II, or III)	$220
Objective Exam Retake Fee (if you did not pass previously)	$180
Jurisprudence Exam (Level II & III)	$100
Jurisprudence Exam Retake Fee (if you did not pass previously) …….	$ 80
File Copying (moving to another state, etc.)	$ 25

If you have any other questions, please feel free to call us at the number above. Our office hours are Monday through Friday 9am to 5pm.

Mental Health and Addiction Certification Board of Oregon

Application for Addiction Counselor Credentialing

The Mental Health and Addiction Certification Board of Oregon is proud to utilize professional psychometric examinations produced by the NCC, National Certification Commission and NAADAC, the National Association of Alcohol & Drug Abuse Counselors. Additionally, NAADAC operates in conjunction with NBCC, the National Board of Certified Counselors to award MAC certification to qualified candidates.

If you currently posses state licensure as a mental health professional (LCSW, LPC, LMFT, etc.), you are eligible to apply for MAC certification directly through NBCC or NAADAC at nbcc.org or naadac.org

OREGON HEALTH AUTHORITY
ADDICTIONS & MENTAL HEALTH DIVISION
ORS 443.004/OAR 407-007-0277 Crimes

Public funds may not be used to support, in whole or in part, the employment in any capacity of an individual having contact with a recipient of support services or a resident of a residential facility or an adult foster home, of a mental health or substance abuse treatment provider who has been convicted of the following convictions. **ORS 443.004/OAR 407-007-0277 impacts anyone with this type of employment regardless of hire date.**

"Mental health or substance abuse treatment provider" in ORS 443.004 means:

- A peer support specialist;
- An employee of a residential treatment facility or a residential treatment home that is licensed under ORS 443.415 to provide treatment for individuals with alcohol or drug dependence;
- An individual who provides treatment or services for persons with substance use disorders; or
- An individual who provides mental health treatment or services (including any type of mental health licensed or certified facility or agency).

If the individual has been convicted of any of the crimes listed below (or **attempt, conspiracy, or solicitation** for any of the crimes) regardless of how long ago the conviction occurred, THE INDIVIDUAL IS NOT ELIGIBLE FOR THE POSITION.

- ORS 163.095, Aggravated murder
- ORS 163.115, Murder
- ORS 163.375, Rape I
- ORS 163.405, Sodomy I
- ORS 163.411, Unlawful sexual penetration I
- ORS 163.427, Sexual abuse I

All mental health or substance abuse treatment providers are subject to ORS 443.004 if public funds are involved in the payment of treatment or services. The Background Check Unit (BCU), serving the Department of Human Services and the Oregon Health Authority does not conduct background checks on programs or facilities which are exclusively licensed or certified as an alcohol & drug provider.

If an individual is offered employment as a mental health or substance abuse treatment provider AND the individual is subject to a background check through BCU, submit a background check request. If BCU confirms that the individual has a conviction of one or more of the crimes listed above, BCU will make a determination that of **INELIGIBLE DUE TO ORS 443.004.**

An individual found to be Ineligible Due to ORS 443.004 does not have hearing rights through BCU regarding this determination.

Revised Application, 2020-01-02

Table Of Contents

CADC I - Associate Proficiency Level
Applicant Checklist

A completed application packet must be submitted prior to examination placement. Official transcripts and letter of verification may be received separately.

_____ Complete the Applicant Registration Form (use your real legal name).

_____ Photocopy of Valid State Identification

_____ Complete the Supervised Experience Form(s). Refer to the Supervised Experience Overview if you do not understand how to complete this form(s). If you are documenting experience at more than one agency, photocopy the form so that you will have enough forms to document the total required 1,000 hours of supervised experience. Make sure that your supervisor encodes their qualification to supervise you by writing their credentials after their name (e.g.; CADC II/III, C-CATODSW, NCAC II, MAC, CDS II/III, CDP, ASAM or other state's advanced counseling certifications utilizing professional psychometric examinations are acceptable.)

_____ Complete the Education Summary Form. If you need more room than what is provided on the form, photocopy it for additional space. Please attach copies of certificates and submit **OFFICIAL TRANSCRIPTS** (unofficial transcripts are not acceptable). You must demonstrate the required 150 Hours of Alcohol & Drug Education, which must include the topical areas of; Basic Counseling Skills, Group Counseling Skills, Alcohol & Drugs of Abuse Pharmacology, HIV/AIDS Risk Assessment Risk Reduction, Counseling Ethics, and Clinical Evaluation (ASAM). All education must be accredited or approved by a recognized accreditation body. *(IMPORTANT NOTE: the CADC I does not require an associates degree. The Board approximates 150 Education [15 college credits], 1,000 hours of Supervised Experience/Practicum, and successful completion of the National Certification Examination as approximating the Associate Proficiency Level).*

_____ Sign & Date the MHACBO Ethics Agreement. After you have reviewed the ethics agreement, sign and date the document. Keep a copy for yourself and return the original (with original signature to MHACBO.

_____ Request a letter of Recovery Verification from your peers/supervisors, etc. (for those who are recovering).

_____ Submit the appropriate fees
Application Fee…….. $50
Written Examination Fee…… $220

CADC II - Baccalaureate Proficiency Level
Applicant Checklist

A completed application packet must be submitted prior to examination placement. Official transcripts and letter of verification may be received separately.

_____ Complete the Applicant Registration Form (use your real legal name).

_____ Photocopy of Valid State Identification

_____ Complete the Supervised Experience Form(s). Refer to the Supervised Experience Overview if you do not understand how to complete this form(s). If you are documenting experience at more than one agency, photocopy the form so that you will have enough forms to document the total required 4,000 hours of supervised experience. Make sure that your supervisor encodes their qualification to supervise you by writing their credentials after their name (e.g.; CADC II/III, C-CATODSW, NCAC II, MAC, CDS II/III, CDP, ASAM or other state's advanced counseling certifications utilizing professional psychometric examinations are acceptable.)

_____ Complete the Education Summary Form. If you need more room than what is provided on the form, photocopy it for additional space. Please attach copies of certificates and submit **OFFICIAL TRANSCRIPTS** (unofficial transcripts are not acceptable). You must demonstrate the required Bachelors degree, (or equivalency) with a minimum of 300 Hours of Alcohol & Drug Education, which must include the topical areas of; Basic Counseling Skills, Group Counseling Skills, Alcohol & Drugs of Abuse Pharmacology, HIV/AIDS Risk Assessment Risk Reduction, Counseling Ethics, Counseling Diverse Populations, Clinical Evaluation (ASAM), and Co-occurring Disorders. All education must be regionally accredited, NAADAC accredited or provided by a state licensed university college. *(IMPORTANT NOTE: the CADC II does not require a bachelors degree. The Board approximates 300 A&D Education hours, with approx 90 college credits, 4,000 hours of Supervised Experience/ Practicum, and successful completion of the National Certification Examination as approximating the Baccalaureate Proficiency Level).*

_____ Sign & Date the MHACBO Ethics Agreement. After you have reviewed the ethics agreement, sign and date the document. Keep a copy for yourself and return the original (with original signature to MHACBO.

_____ Request a letter of Recovery Verification from your peers/supervisors, etc. (for those who are recovering).

_____ Submit the appropriate fees (see the cover letter).
Application Fee…….. $50
Written Examination Fee…… $220

_____ Written Jurisprudence Ethics Exam. Upon successful completion of the NCAC II Examination, you will be issued CADC I certification along with instructions on how to sign up for the written Jurisprudence Ethics Exam.

CADC III - Graduate Proficiency Level
Applicant Checklist

A completed application packet must be submitted prior to examination placement. Official transcripts and letter of verification may be received separately.

_____ Complete the Applicant Registration Form (use your real legal name).

_____ Photocopy of Valid State Identification

_____ Complete the Supervised Experience Form(s). Refer to the Supervised Experience Overview if you do not understand how to complete this form(s). If you are documenting experience at more than one agency, photocopy the form so that you will have enough forms to document the total required 6,000 hours of supervised experience. Make sure that your supervisor encodes their qualification to supervise you by writing their credentials after their name (e.g.; CADC II/III, C-CATODSW, NCAC II, MAC, CDS II/III, CDP, ASAM or other state's advanced counseling certifications utilizing professional psychometric examinations are acceptable.)

_____ Complete the Education Summary Form. If you need more room than what is provided on the form, photocopy it for additional space. Please attach copies of certificates and submit **OFFICIAL TRANSCRIPTS** (unofficial transcripts are not acceptable). You must demonstrate the required Masters degree in the Human Arts with a minimum of 300 Hours of Alcohol & Drug Education, which must include the topical areas of; Basic Counseling Skills, Group Counseling Skills, Alcohol & Drugs of Abuse Pharmacology, HIV/AIDS Risk Assessment Risk Reduction, Counseling Ethics, Counseling Diverse Populations, Clinical Evaluation (ASAM), Co-occurring Disorders and Science-based Best Practices. All additional education must be accredited or approved by a recognized accreditation body. Graduate degree must be regionally accredited, or otherwise approved by the Oregon Office of Degree Authorization for new applicants as of April 4, 2008.

_____ Sign & Date the MHACBO Ethics Agreement. After you have reviewed the ethics agreement, sign and date the document. Keep a copy for yourself and return the original (with original signature to MHACBO.

_____ Request a letter of Recovery Verification from your peers/supervisors, etc. (for those who are recovering).

_____ Submit the appropriate fees (see the cover letter).

_____ Written Jurisprudence Ethics Exam. Upon successful completion of the MAC Examination, you will be issued CADC I certification along with instructions on how to sign up for the written Jurisprudence Ethics Exam.

_____ Submit the appropriate fees

Application Fee……..	$50
Written Examination Fee……	$220

Choosing which certification to apply for?

You must evaluate which certification best matches your position of employment and your prerequisite qualifications. You must submit a completed application packet prior to examination, by the stated registration deadlines in the cover letter and calendar. Therefore, you will need to meet all of the prerequisites for the appropriate certification you have chosen to apply for.

Applicant Registration

Your true legal name - matching your state identification

Name Last First Middle Initial
Date of Application
Home Address: Street Address *(please print)*
City State Zip *(please print)*
Work Address: Agency Name
Street Address *(please print)*
City State Zip *(please print)*
Home Phone
Work Phone
Message Phone
Personal Email (do not write in cursive - *please print*) ☐ Please include me on the MHACBO Email list
Business Email (do not write in cursive - *please print*) ☐ Please include me on the MHACBO Email list
Certification you are applying for CADC I, II, or III?
Do you hold any other certifications, licensures? (LCSW, LPC, LMFT, RN, LPN, etc…)
Highest Level of Education Completed (HS Diploma, GED, college degree)

Check one of the following

☐ I am not recovering from a Substance Use Disorder, nor have I ever been diagnosed with a substance use disorder

☐ I am recovering from a substance use disorder

Statement of Substance Use Disorder Recovery

I hereby attest that I have been in recovery for the _____ years immediately preceding this application.

_____
applicant signature

_____
date

Candidate Statement

I hereby apply for certification in Oregon as an Alcohol & Drug Counselor.

Initial here: _____ I understand that the application fee is non-refundable and that the $220 Objective Examination Fee is non-refundable & non-transferable from one examination date to another. I understand that if for any reason I am unable to attend a pre-arranged National Examination appointment that I will forfeit those fees paid for the National Exam.

Initial here:_____ I understand that I must bring my "Eligibility Notice" to the examination site at the time of my National Exam.

Initial here:_____ Furthermore I attest that the information I have given in this application & all supporting documentation is correct and true. I give MHACBO permission to verify any statements given in any part of this application.

_____
applicant signature

Make a photocopy of valid state identification and attach to this form.

☐ Check if you are paying online by credit card. Please visit www.mhacbo.org for payment

Supervised Experience Form

Directions: photocopy as many copies of this form as your will need. You will most likely need one copy for each agency you have been employed/interned with. You must document the minimum pre-requisite hours for the level of certification that you are applying for:

CADC I – Associate Proficiency level

1,000 hours Supervised Experience in Addiction Counseling Competencies (CSAT Technical Assistance Publication number 21, DHHS Publication No. [SMA] 98-3171, 1998

CADC II – Bachelors Proficiency level

4,000 hours Supervised Experience in Addiction Counseling Competencies (CSAT Technical Assistance Publication number 21, DHHS Publication No. [SMA] 98-3171, 1998

CADC III – Graduate Proficiency level

6,000 hours Supervised Experience in Addiction Counseling Competencies (CSAT Technical Assistance Publication number 21, DHHS Publication No. [SMA] 98-3171, 1998

Each category of the Addiction Counseling Competencies carries a minimum number of hours of participation for that category. Please do not confuse those minimums in each category with the overall prerequisite hours you must document.

_____
Candidate Name

_____
Position Title

_____
Dates of experience: FROM - TO (do not write "present")

_____
Employer / Agency

_____
Print: Supervisor name and advanced Addiction Counselor Credentials

Print the name of the Clinical Supervisor and credentials. Must meet OAR 309/ISSR standards for Clinical Supervisor Qualifications in Addiction Treatment and must possess advanced addiction counselor certification.

Check off the certification supervisor maintains:

☐ CADC II	☐ NCAC II	☐ CDS II
☐ CADC III	☐ MAC	☐ CDS III
☐ C-CATODSW	☐ CDP	☐ ASAM

Other state's or country's advanced addiction counselor certifications utilizing professional psychometric examinations are acceptable.

There are established minimums in each category, however the total number of hours must be at least 1,000 for CADC I; 4,000 for CADC II; and 6,000 for CADC III. Please estimate the number of hours accrued in each category of the Addiction Counseling Competencies. Total those numbers and sign.

Assessing Experience Hours
1 Full Time year = 2,000 hours

Clinical Supervisor's Statement

Hours Performed	Addiction Counselor Competency Domains, SAMHSA, Technical Assistance Publication 21	Minimum Hours CADC I	Minimum Hours CADC II / III
	DOMAIN ONE		
	Alcohol & Drug Screening	25	100
	Alcohol & Drug Treatment Orientation (including client rights and informed consent)	25	100
	Alcohol & Drug Assessment with DSM-V SUD diagnosis and ASAM level of care placement	50	200
	DOMAIN TWO		
	A&D Treatment Planning	50	200
	DOMAIN THREE		
	Consultation & Referral	10	40
	DOMAIN FOUR		
	A&D Case Management	50	200
	A&D Discharge Planning	50	200
	A&D Relapse Prevention	50	200
	DOMAIN FIVE		
	A&D Individual Counseling	25	100
	A&D Group Counseling	50	100
	A&D Family/Couples		
	Crisis Intervention	10	40
	DOMAIN SIX		
	A&D Client, Family, Community Education	50	200
	DOMAIN SEVEN		
	A&D Documentation	50	200
	DOMAIN EIGHT		
	A&D EBP, Curriculum and Program Development, Fidelity & Quality Assurance, Client Outcome and Satisfaction Monitoring		100

Total Hours	0

_____
Supervisor's Signature Date

By signing this form, I attest to the accuracy of the information & that the candidate has completed the addiction treatment specific activities described herein. I understand that any falsification of hours recorded could result in sanctions against both candidates and supervisors.

Do not sign this form verifying applicant's hours unless you meet the criteria and can provide documentation if called upon to do so.

_____
Supervisor's Phone Number for primary source verification

_____
Candidate Signature Date

Supervised Experience Guidelines

Supervised experience indicates that your employment/practicum hours were supervised by a qualified supervisor who can verify the hours that you worked and the type of work that you did. Supervised experience hours include all working hours (not just face to face client contact hours).

Supervisor Qualifications
All hours must be supervised by an individual(s) who meets the OAR 415/ISSR standards for Clinical Supervisor Qualifications in Addiction Treatment and must possess advanced addiction counselor certification.

Examples of advanced addiction counselor certification include:

CADC II	NCAC II	CDS II
CADC III	MAC	CDS III
C-CATODSW	CDP	

Other state's advanced addiction counselor addiction counseling certifications utilizing professional psychometric examinations are acceptable.

Directions to the Clinical Supervisor
In order to evaluate the counselor's experience and correctly record the approximate number of hours in each of the categories on the Supervised Experience Form, please review the Addiction Counselor Competencies. Any form submitted with "minimums +" or some similarly gross approximations will not be accepted by MHACBO. Please approximate as closely as possible the actual approximate hours spent in each category.

Addiction Counseling Competencies

(CSAT Technical Assistance Publication number 21, DHHS Publication No. [SMA] 98-3171, printed 1998)

A. UNDERSTANDING ADDICTION

1. Understand a variety of models and theories of addiction and other problems related to substance use.
2. Recognize the social, political, economic, and cultural context within which addiction and substance abuse exist, including risk and resiliency factors that characterize individuals and groups and their living environments.
3. Describe the behavioral, psychological, physical health, and social effects of psychoactive substances on the user and significant others.
4. Recognize the potential for substance use disorders to mimic a variety of medical and psychological disorders and the potential for medical and psychological disorders to co-exist with addiction and substance abuse.

B. TREATMENT KNOWLEDGE

1. Describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related problems.
2. Recognize the importance of family, social networks, and community systems in the treatment and recovery process.
3. Understand the importance of research and outcome data and their application in clinical practice.
4. Understand the value of an interdisciplinary approach to addiction treatment.

C. APPLICATION TO PRACTICE

1. Understand the established diagnostic criteria for substance use disorders and describe treatment modalities and placement criteria within the continuum of care.
2. Describe a variety of helping strategies for reducing the negative effects of substance use, abuse, and dependence.
3. Tailor helping strategies and treatment modalities to the client's stage of dependence, change, or recovery.
4. Provide treatment services appropriate to the personal and cultural identity and language of the client.
5. Adapt practice to the range of treatment settings and modalities.
6. Be familiar with medical and pharmacological resources in the treatment of substance use disorders.
7. Understand the variety of insurance and health maintenance options available and the importance of helping clients access those benefits.
8. Recognize that crisis may indicate an underlying substance use disorder and may be a window of opportunity for change.
9. Understand the need for and the use of methods for measuring treatment outcome.

D. PROFESSIONAL READINESS

1. Understand diverse cultures and incorporate the relevant needs of culturally diverse groups, as well as people with disabilities, into clinical practice.
2. Understand the importance of self-awareness in one's personal, professional, and cultural life.
3. Understand the addiction professional's obligations to adhere to ethical and behavioral standards of conduct in the helping relationship.
4. Understand the importance of ongoing supervision and continuing education in the delivery of client services.
5. Understand the obligation of the addiction professional to participate in prevention as well as treatment.
6. Understand and apply setting-specific policies and procedures for handling crisis or dangerous situations, including safety measures for clients and staff.

I. CLINICAL EVALUATION

The systematic approach to screening and assessment.

A. SCREENING
The process through which counselor, client and available significant others determine the most appropriate initial course of action, given the client's needs and characteristics, and the available resources within the community.

1. Establish rapport, including management of crisis situation and determination of need for additional professional assistance.
2. Gather data systematically from the client and other available collateral sources, using screening instruments and other methods that are sensitive to age, developmental level, culture, and gender. At a minimum, data should include current and historic substance use; health, mental health, and substance related treatment history; mental status; and current social, environmental, and/or economic constraints.

3. Screen for psychoactive substance toxicity, intoxication, and withdrawal symptoms; aggression or danger to others; potential for self-inflicted harm or suicide; and coexisting mental health problems.
4. Assist the client in identifying the impact of substance use on his or her current life problems and the effects of continued harmful use or abuse.
5. Determine the client's readiness for treatment and change as well as the needs of others involved in the current situation.
6. Review the treatment options that are appropriate for the client's needs, characteristics, goals, and financial resources.
7. Apply accepted criteria for diagnosis of substance use disorders in making treatment recommendations.
8. Construct with client and appropriate others an initial action plan based on client needs, preferences, and resources available.
9. Based on initial action plan, take specific steps to initiate an admission or referral and ensure follow-through.

B. ASSESSMENT

An ongoing process through which the counselor collaborates with the client and others to gather and interpret information necessary for planning treatment and evaluating client progress.

1. Select and use a comprehensive assessment process that is sensitive to age, gender, racial and ethnic cultural issues, and disabilities that includes, but is not limited to:
   - history of alcohol and other drug use;
   - physical health, mental health, and addiction treatment history;
   - family issues;
   - work history and career issues;
   - history of criminality;
   - psychological, emotional, and world-view concerns;
   - current status of physical health, mental health, and substance use;
   - spirituality;
   - education and basic life skills;
   - socio-economic characteristics, lifestyle, and current legal status;
   - use of community resources.
2. Analyze and interpret the data to determine treatment recommendations.
3. Seek appropriate supervision and consultation.
4. Document assessment findings and treatment recommendations.

II. TREATMENT PLANNING

A collaborative process through which the counselor and client develop desired treatment outcomes and identify the strategies for achieving them. At a minimum the treatment plan addresses the identified substance use disorder(s), as well as issues related to treatment progress, including relationships with family and significant others, employment, education, spirituality, health concerns, and legal needs.

1. Obtain and interpret all relevant assessment information.
2. Explain assessment findings to the client and significant others involved in potential treatment.
3. Provide the client and significant others with clarification and further information as needed.
4. Examine treatment implications in collaboration with the client and significant others.
5. Confirm the readiness of the client and significant others to participate in treatment.
6. Prioritize client needs in the order they will be addressed.
7. Formulate mutually agreed upon and measurable treatment outcome statements for each need.
8. Identify appropriate strategies for each outcome.
9. Coordinate treatment activities and community resources with prioritized client needs in a manner consistent with the client's diagnosis and existing placement criteria.
10. Develop with the client a mutually acceptable plan of action and method for monitoring and evaluating progress.
11. Inform client of confidentiality rights, program procedures that safeguard them, and the exceptions imposed by regulations.
12. Reassess the treatment plan at regular intervals and/or when indicated by changing circumstances.

III. REFERRAL

The process of facilitating the client's utilization of available support systems and community resources to meet needs identified in clinical evaluation and/or treatment planning.

1. Establish and maintain relations with civic groups, agencies, other professionals, governmental entities, and the community-at-large to ensure appropriate referrals, identify service gaps, expand community resources, and help to address unmet needs.
2. Continuously assess and evaluate referral resources to determine their appropriateness.
3. Differentiate between situations in which it is most appropriate for the client to self-refer to a resource and instances requiring counselor referral.
4. Arrange referrals to other professionals, agencies, community programs, or other appropriate resources to meet client needs.
5. Explain in clear and specific language the necessity for and process of referral to increase the likelihood of client understanding and follow through.
6. Exchange relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality regulations and generally accepted professional standards of care.
7. Evaluate the outcome of the referral.

IV. SERVICE COORDINATION

The administrative, clinical, and evaluative activities that bring the client, treatment services, community agencies, and other resources together to focus on issues and needs identified in the treatment plan. Service coordination, which includes case management and client advocacy, establishes a framework of action for the client to achieve specified goals. It involves collaboration with the client and significant others, coordination of treatment and referral services, liaison activities with community resources and managed care systems, client advocacy, and ongoing evaluation of treatment progress and client needs.

A. IMPLEMENTING THE TREATMENT PLAN

1. Initiate collaboration with referral source.
2. Obtain, review, and interpret all relevant screening, assessment, and initial treatment-planning information.
3. Confirm the client's eligibility for admission and continued readiness for treatment and change.
4. Complete necessary administrative procedures for admission to treatment.
5. Establish accurate treatment and recovery expectations with the client and involved significant others including, but not limited to:
   - nature of services,
   - program goals,
   - program procedures,
   - rules regarding client conduct,
   - schedule of treatment activities,
   - costs of treatment,

- factors affecting duration of care,
- client rights and responsibilities.

6. Coordinate all treatment activities with services provided to the client by other resources.

B. CONSULTING

1. Summarize client's personal and cultural background, treatment plan, recovery progress, and problems inhibiting progress for purpose of assuring quality of care, gaining feedback, and planning changes in the course of treatment.
2. Understand terminology, procedures, and roles of other disciplines related to the treatment of substance use disorders.
3. Contribute as part of a multidisciplinary treatment team.
4. Apply confidentiality regulations appropriately.
5. Demonstrate respect and non-judgmental attitudes toward clients in all contacts with community professionals and agencies.

C. CONTINUING ASSESSMENT AND TREATMENT PLANNING

1. Maintain ongoing contact with client and involved significant others to ensure adherence to the treatment plan.
2. Understand and recognize stages of change and other signs of treatment progress.
3. Assess treatment and recovery progress and, in consultation with the client and significant others, make appropriate changes to the treatment plan to ensure progress toward treatment goals.
4. Describe and document treatment process, progress, and outcome.
5. Use accepted treatment outcome measures.
6. Conduct continuing care, relapse prevention, and discharge planning with the client and involved significant others.
7. Document service coordination activities throughout the continuum of care.
8. Apply placement, continued stay, and discharge criteria for each modality on the continuum of care.

V. COUNSELING

A collaborative process that facilitates the client's progress toward mutually determined treatment goals and objectives. Counseling includes methods that are sensitive to individual client characteristics and to the influence of significant others, as well as the client's cultural and social context. Competence in counseling is built upon an understanding of, appreciation of, and ability to appropriately use the contributions of various addiction counseling models as they apply to modalities of care for individuals, groups, families, couples, and significant others.

A. INDIVIDUAL COUNSELING

1. Establish a helping relationship with the client characterized by warmth, respect, genuineness, concreteness, and empathy.
2. Facilitate the client's engagement in the treatment and recovery process.
3. Work with the client to establish realistic, achievable goals consistent with achieving and maintaining recovery.
4. Promote client knowledge, skills, and attitudes that contribute to a positive change in substance use behaviors.
5. Encourage and reinforce client actions determined to be beneficial in progressing toward treatment goals.
6. Work appropriately with the client to recognize and discourage all behaviors inconsistent with progress toward treatment goals.
7. Recognize how, when, and why to involve the client's significant others in enhancing or supporting the treatment plan.
8. Promote client knowledge, skills, and attitudes consistent with the maintenance of health and prevention of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), tuberculosis (TB), sexually transmitted diseases (STDs), and other infectious diseases.
9. Facilitate the development of basic and life skills associated with recovery.
10. Adapt counseling strategies to the individual characteristics of the client, including but not limited to, disability, gender, sexual orientation, developmental level, culture, ethnicity, age, and health status.
11. Make constructive therapeutic responses when client's behavior is inconsistent with stated recovery goals.
12. Apply crisis management skills.
13. Facilitate the client's identification, selection, and practice of strategies that help sustain the knowledge, skills, and attitudes needed for maintaining treatment progress and preventing relapse.

B. GROUP COUNSELING

1. Describe, select, and appropriately use strategies from accepted and culturally appropriate models for group counseling with clients with substance use disorders.
2. Carrying out the actions necessary to form a group, including, but not limited to: determining group type, purpose, size, and leadership; recruiting and selecting members; establishing group goals and clarifying behavioral ground rules for participating; identifying outcomes; and determining criteria and methods for termination or graduation from the group.
3. Facilitate the entry of new members and the transition of exiting members.
4. Facilitate group growth within the established ground rules and movement toward group and individual goals by using methods consistent with group type.
5. Understand the concepts of process and content, and shift the focus of the group when such an intervention will help the group move toward its goals.
6. Describe and summarize client behavior within the group for the purpose of documenting the client's progress and identifying needs and issues that may require a modification in the treatment plan.

C. COUNSELING FAMILIES, COUPLES, AND SIGNIFICANT OTHERS

1. Understand the characteristics and dynamics of families, couples, and significant others affected by substance use.
2. Be familiar with and appropriately use models of diagnosis and intervention for families, couples, and significant others, including extended, kinship, or tribal family structures.
3. Facilitate the engagement of selected members of the family, couple, or significant others in the treatment and recovery process.
4. Assist families, couples, and significant others to understand the interaction between the system and substance use behaviors.
5. Assist families, couples, and significant others to adopt strategies and behaviors that sustain recovery and maintain healthy relationships.

VI. CLIENT, FAMILY, AND COMMUNITY EDUCATION

The process of providing clients, families, significant others, and community groups with information on risks related to psychoactive substance use, as well as available prevention, treatment and recovery resources.

1. Provide culturally relevant formal and informal education programs that raise awareness and support substance abuse prevention and/or the recovery process.
2. Describe factors that increase the likelihood for an individual, community, or group to be at-risk for, or resilient to, psychoactive substance use disorders.
3. Sensitize others to issues of cultural identity, ethnic background, age, and gender in prevention, treatment, and recovery.
4. Describe warning signs, symptoms, and the course of substance use disorders.
5. Describe how substance use disorders affect families and concerned others.
6. Describe the continuum of care and resources available to family and concerned others.
7. Describe principles and philosophy of prevention, treatment, and recovery.
8. Understand and describe the health and behavior problems related to substance use, including transmission and prevention of HIV/AIDS, TB, STDs, and other infectious diseases.
9. Teach life skills, including but not limited to, stress management, relaxation, communication, assertiveness, and refusal skills.

VII. DOCUMENTATION

The recording of the screening and intake process, assessment, treatment plan, clinical reports, clinical progress notes, discharge summaries, and other client-related data.

1. Demonstrate knowledge of accepted principles of client record management.
2. Protect client rights to privacy and confidentiality in the preparation and handling of records, especially in relation to the communication of client information with third parties.
3. Prepare accurate and concise screening, intake, and assessment reports.
4. Record treatment and continuing care plans that are consistent with agency standards and comply with applicable administrative rules.
5. Record progress of client in relation to treatment goals and objectives.
6. Prepare accurate and concise discharge summaries.
7. Document treatment outcome, using accepted methods and instruments.

VIII. PROFESSIONAL AND ETHICAL RESPONSIBILITIES

The obligations of an addiction counselor to adhere to accepted ethical and behavioral standards of conduct and continuing professional development.

1. Demonstrate ethical behaviors by adhering to established professional codes of ethics that define the professional context within which the counselor works, in order to maintain professional standards and safeguard the client.
2. Adhere to Federal and State laws and agency regulations regarding the treatment of substance use disorders.
3. Interpret and apply information from current counseling and psychoactive substance use research literature to improve client care and enhance professional growth.
4. Recognize the importance of individual differences that influence client behavior and apply this understanding to clinical practice.
5. Utilize a range of supervisory options to process personal feelings and concerns about clients.
6. Conduct self-evaluations of professional performance applying ethical, legal, and professional standards to enhance self-awareness and performance.
7. Obtain appropriate continuing professional education.
8. Participate in ongoing supervision and consultation.
9. Develop and utilize strategies to maintain one's own physical and mental health.

Educational Prerequisites Form

ATTN: MHACBO will no longer accept education from AllCEUs.com

Directions: Photocopy this form as needed. Attach copies of certificates, photocopy of degrees and **OFFICIAL TRANSCRIPTS** (unofficial transcripts are **not** acceptable). You must document the minimum prerequisite education hours for the level of certification that you are applying for. If a class covers more than one requirement, put the course name in each box, but only count the hours once.

CADC I - Associate Proficiency level

150 Hours of Alcohol, Drug, Addictions Education which must include:

- Basic Counseling Skills
- Group Counseling Skills
- A&D Pharmacology
- HIV/AIDS Risk Assessment Risk Reduction
- Counseling Ethics
- Clinical Evaluation (ASAM)

CADC II - Bachelors Proficiency level

Minimum of a Bachelors Degree (or equivalency – 90 college credits plus additional training hours commensurate with education hours towards a baccalaureate degree) which must also include a minimum of 300 Hours of Alcohol, Drug, Addictions Education including the following topical hours:

- Basic Counseling Skills
- Group Counseling Skills
- A&D Pharmacology
- HIV/AIDS Risk Assessment Risk Reduction
- Counseling Ethics
- Clinical Evaluation (ASAM)
- Cultural Diversity
- Co-occurring Disorders

CADC III - Graduate Proficiency level

Minimum of a Masters Degree, including a minimum of 300 Hours of Alcohol, Drug, Addictions Education including the following topical hours:

- Basic Counseling Skills
- Group Counseling Skills
- A&D Pharmacology
- HIV/AIDS Risk Assessment Risk Reduction
- Counseling Ethics
- Clinical Evaluation (ASAM)
- Cultural Diversity
- Co-occurring Disorders
- Addiction Treatment Evidence-Based Practices

You must demonstrate the required degree in the Human Arts and the degree must be regionally accredited, or otherwise approved by the Oregon Office of Degree Authorization as of April 1st, 2008. All other education must be accredited or approved by a recognized accreditation body (Regional Accreditation, MHACBO, AMH, NAADAC, etc.) Any additional training needed to meet the minimum 300 hour requirement must be alcohol & drug specific education.

Conversion Key
1 college credit = 10 hours
1 college semester = 15 hours
1 CEU = 1 hour

Write the title of the class that most closely approximates the stated topical area in each space provided. If course content is not apparent from the title, you are encouraged to include a course description. If you have completed an MSW, BSW, or MH Counseling program at a university, you likely have met the following core requirements: Basic Counseling Skills, Group Counseling Skills, and Counseling Ethics. Please refer to your transcripts to match classes with the requirements.

You must complete these two pages. Do NOT write "SEE ATTACHED" or "SEE TRANSCRIPT"

Course Title or Voc-Code (example AD101)	Hours
Basic Counseling Skills (one class only) (A course where you practiced basic counseling skills such as paraphrasing, identifying feelings, etc. where you were video taped or observed and received feedback on your skills. Distance or online education not accepted for this practice class.) **Course**:	
Group Counseling Skills (one class only) (A course where you learned and practiced group process/facilitation/counseling. Distance or online education not accepted for this practice class.) **Course**:	
Alcohol & Drugs of Abuse Pharmacology (A course covering both Alcohol and Drugs of Abuse. Courses covering psychiatric medications or basic physiology courses are not acceptable for this core requirement) **Course**:	
Infectious Disease Risk Assessment & Risk Reduction (one class only) (A "counseling" course regarding how to evaluate a client's Infectious Disease risk factors and how to work with them over time to reduce those risk factors. Blood borne pathogens or HIV epidemiology courses are not acceptable) **Course**:	
Counseling Ethics (one class only) A "counseling" course regarding ethics which covers MHACBO, NAADAC, NASW, and/or APA ethical standards) **Course**:	
Clinical Evaluation (ASAM) (A course covering the American Society of Addiction Medicine Patient Placement Criteria 2 and DSM Substance Abuse Disorders.) **Course**:	

Counseling Diverse Populations (CADC II & III) **(one class only)** (A multi-cultural "counseling" course covering treatment, best practices and approaches with diverse populations. Cultural Anthropology is not acceptable.) **Course**:	
Co-occurring Disorders (CADC II & III) (A course covering substance abuse and comorbid mental health issues.) **Course**:	
Addiction Treatment Evidence Based Practices (CADC III) (A course covering Evidence Based Practices – EBP's) **Course**:	
TOTAL CORE Education Hours	0

Additional Alcohol & Drug Education Hours:

A&D Course:	
A&D Course:	
A&D Course:	
A&D Course:	
A&D Course:	
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A&D Course:	
TOTAL ADDITIONAL Education Hours	0

Additional Alcohol & Drug Education Hours:

General psychology, abnormal psychology, trauma, general mental health courses, etc. are not acceptable as A&D specific education courses.

Co-occurring Disorder classes are acceptable education courses towards A&D education.

RATIONALE:
About 84% of addiction counselors have a college degree (MHACBO Survey, 2007). Almost all addiction counselors have college coursework. Most applicants have many general psychology education hours, but often times have very little addiction specific education.

TESTING APPLICATION

MARKING INSTRUCTIONS: This form will be scanned by computer, so please make your marks heavy and dark, filling the circles completely. Please print uppercase letters and avoid contact with the edge of the box. See example provided. →

A	B	C	D	E	F	1	2	3	4	5	6

Candidate Information

Please enter your Name exactly as it appears on your current Government-Issued Photo I.D.

○ Mr. ○ Mrs. ○ Ms. ○ Dr.

First Name | Middle Initial

Last Name | Suffix (Jr., Sr. , etc.)

Address | Apartment Number

City | State | Zip/Postal Code

Home Phone - -

Work Phone - -

Email Address ****THIS IS REQUIRED**** (Please enter only ONE email address. Use two lines if necessary)

Choice of Examination Language:
◉ English ○ Spanish

Examination Date:

○ January ○ February ○ March ○ April ○ May ○ June ○ July ○ August ○ September ○ October ○ November ○ December

Background Information

Darken only one choice for each question unless otherwise directed.

FOR WHICH EXAMINATION ARE YOU APPLYING?

○ CADC I ○ CADC II ○ CADC III

HAVE YOU TAKEN THIS EXAMINATION BEFORE?

○ No ○ Yes

If yes, indicate month, year, and name under which the examination was taken.

Date (month/year): _____

Name: _____

HIGHEST ACADEMIC LEVEL:

○ Less than high school graduate
○ High school graduate or equivalent
○ Vocational or technical school graduate
○ Some college
○ Associate degree
○ Bachelor's degree
○ Master's degree
○ Doctoral degree
○ Other

Optional Information

Note: Information related to race, age, and gender is optional and is requested only to assist in complying with general guidelines pertaining to equal opportunity. Such data will be used only in statistical summaries and in no way will affect your certification.

Race:
○ African American ○ Native American
○ Asian ○ White
○ Hispanic ○ Other

Age Range:
○ Under 25 ○ 40 to 49
○ 25 to 29 ○ 50 to 59
○ 30 to 39 ○ 60+

Gender:
○ Male ○ Female ○ Trans ○ Other _____

Candidate Signature

Must be completed by all candidates authorizing release of test results to a state/commonwealth.

OR

I hereby authorize the National Certification Commission for Addiction Professionals (NCC AP) to release the results of my Certification Examination for Addiction Counselors to the state/commonwealth indicated. I understand that these test results will be used only for state/commonwealth certification at this time.

I certify that the information given in this Application is accurate, correct and complete.

CANDIDATE SIGNATURE: _____ ***DATE:*** _____

National Certification Commission for Addiction Professionals (NCC AP)
1001 N. Fairfax Street, Suite 201, Alexandria, VA 22314
Tel: 800.548.0497 or 703.741.7686
Fax: 703.741.7698
nccap@naadac.org
www.naadac.org/certification

Special Accommodations Request

35 calendar day notice required

NCC AP is happy to accommodate any special needs you may have for taking your certification examination. Please fill out the following form and return it to us via mail, e-mail or fax. **You must also include a physician's note or other documentation explaining why you need special accommodations.** The form must be received 35 calendar days before your requested testing date. A representative from NCC AP will contact you to register you for the exam. You cannot register online for a special accommodations examination. Questions 1 through 7 are required to be completed below.

1. Test Center Name:

   _____

2. Examination Name:

   _____

3. Test Taker Name:

   _____

4. 1st Requested Date and Time:

   _____

5. 2nd Requested Date and Time:

   _____

6. 3rd Requested Date and Time:

   _____

7. Type of Special Accommodation needed:

☐ Reader

☐ Reader and Recorder

☐ Translator

☐ Sign Language Interpreter

☐ Screen Magnification software

☐ Private Room

☐ Food/Drink/Medical Equipment required during test session - (describe the specific items needed in the additional information section below)

☐ Attendance of Service Animal

☐ Extended Exam Time included

☐ Other - (please describe in the additional information section below)

Additional information:

_____

_____

Test Composition by Level

The NAADAC written test is 200 multiple choice questions and is broken down into the following areas:

Level I
I. Pharmacology of Psychoactive Substance 30%
II. Counseling Practice 40%
III. Theoretical Base of Counseling 15%
IV. Professional Issues 15%

Level II
I. Pharmacology of Psychoactive Substance 25%
II. Counseling Practice 25%
III. Theoretical Base of Counseling 25%
IV. Professional Issues 25%

MAC (Level III)
I. Pharmacology of Psychoactive Substance 28%
II. Counseling Practice 24%
III. Professional Issues 28%
IV. Co-Occurring Disorders 20%

Written Jurisprudence Ethics Exam

This exam is a replacement for the Oral Case Presentation Exam. You cannot schedule this exam until you pass the NCAC II or MAC test.

The Jurisprudence exam consists of 50 questions pertaining to:

- Oregon Admin. Rule 309-018, 309-019, & 415
- Oregon Client Rights
- Civil Rights Act of 1964
- Section 504 of the Rehabilitation Act of 1973
- Fair Housing
- CFR 42 P2 Confidentiality & HIPAA
- Mandatory Reporting
- The Americans with Disabilities Act

For more information go to the Jurisprudence tab of:
https://www.mhacbo.org/en/forms-info/forms/

Failure to Complete the Jurisprudence Exam

Upon successful completion of the NCAC II or MAC exam, applicants will be issued a CADC-I certificate. Failure to complete the Jurisprudence Exam will result in maintaining a CADC-I. This certification will be subject to the standard recertification policy.

Letter of Recovery Verification

Directions: Please have a professional, professional colleague or supervisor write a letter of professional recovery verification on your behalf.

1. Agency Letterhead.
2. Date.
3. Letter must indicate to the best of the authors knowledge that the candidate has been in recovery from a substance use disorder for ____ years.

Mail letters of Recovery Verification directly to MHACBO:

Mental Health and Addiction Certification Board of Oregon
2209 LLOYD CTR
PORTLAND OR 97232-1315

Questions:
If you have questions, please contact MHACBO at:

(503) 231-8164
mhacbo@mhacbo.org
http://www.mhacbo.org
Office Hours: 9am-5pm

Recertification Policy

Certification is granted for a two year period. It may be renewed by Recertification, a process designed to assist the CADC in maintaining and expanding competence. If your certification has lapsed you must file for an extension, otherwise you will be dropped from the CADC roster. In order to file for an extension you must send a detailed letter explaining the cause for lapsed certification.

You will receive a recertification packet from MHACBO 30-60 days prior to the expiration date of your certificate.

1. The recertification applicant must demonstrate 40 clock hours of continuing education.
    * college course work
    * workshops
    * inservices
    * training
    * classes

All CADC's must complete 6 hours of Ethics continuing education and 2 hours of Tobacco Dependence/Prevention as a part of their 40 hours of continuing education, in order to renew their certification. MHACBO will accept virtually all counseling related Ethics courses.

2. The recertification applicant must complete the Record of Training Education and attach all certificates or transcripts. Only recorded training hours accompanied by a certificate will be accepted. Program schedules, syllabuses, flyers will not be accepted.

3. Hours are broken down into two categories:

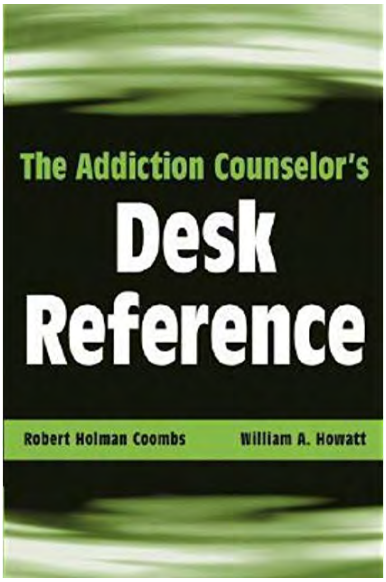
Category I: Alcohol & Drug Counseling Education - Minimum 20 hours
A&D Tx, Tx Planning, Dual Diagnosis, Special Populations in A&D Tx, Counseling methodologies focusing on substance abuse, Relapse Prevention, ASAM, etc...

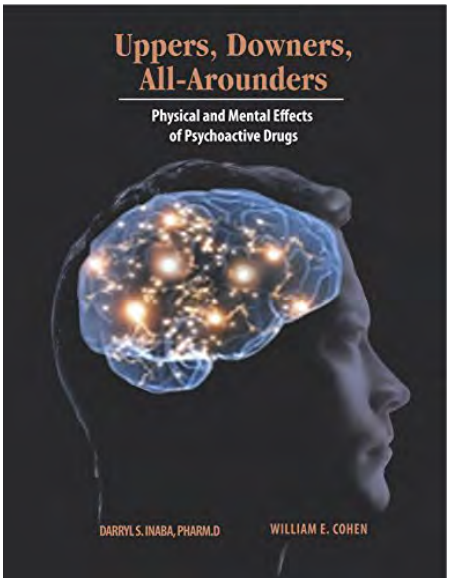
Category II: Counseling Education (non-A&D)- Maximum 20 hours
Managed Care, JCAHO, Counseling Survivors of Trauma, Psychiatric Disorders, DSM-V, Psychotropic Medications, etc...

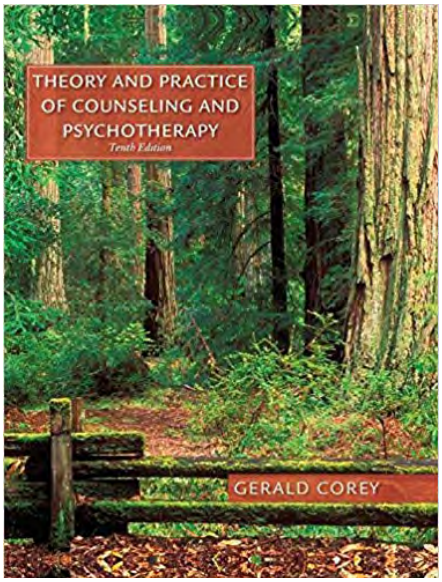
4. You must submit the Application page, Training Record, attach copies of all certificates, and the recertification fee to MHACBO by the expiration date of the certificate.

When it is time for you to recertify, please call MHACBO, review the recertification material that will be sent to you approx. 60 days prior to the expiration of your certificate, or review the MHACBO Newsletter, in order to verify the appropriate recertification fee.

RECOMMENDED BOOKS TO STUDY







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The Addiction Counselor's Desk Reference

by Robert Holman Coombs & William A. Howatt

Uppers, Downers, All Arounders

by Darryl S. Inaba Pharm.D. & William Cohen

Theory and Practice of Counseling and Psychotherapy

by Gerald Corey

These can often be found as textbooks at local colleges, or can be ordered either from your local bookstore, or from online book resources.

http://www.amazon.com http://www.bookfinder.com

http://www.cnsproductions.com

Mental Health and Addiction Certification Board of Oregon (MHACBO)

Behavioral Health Code of Conduct

1.0 SERVICE RELATIONSHIP

1.1 Client Welfare: Behavioral Health Professionals and Peers understand and accept their responsibility to ensure the safety and welfare of their client, and to act for the good of each client while exercising respect, sensitivity, and compassion. Providers shall treat each client with dignity, honor, and respect, and act in the best interest of each client.

1.2 Informed Consent: Behavioral Health Professionals and Peers understand the right of each client to be fully informed about treatment, and shall provide clients with information in clear and understandable language regarding the purposes, risks, limitations, and costs of treatment services, reasonable alternatives, their right to refuse services, and their right to withdraw consent within time frames delineated in the consent. Providers have an obligation to review with their client - in writing and verbally - the rights and responsibilities of both Providers and clients. Providers shall have clients attest to their understanding of the parameters covered by the Informed Consent. Informed Consent shall include:

a. explicit explanation as to the nature of all services to be provided and methodologies and theories typically utilized, purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services, the behavioral health professional's qualifications, credentials, relevant experience, and approach to services, right to confidentiality and explanation of its limits including duty to warn, policies regarding continuation of services upon the incapacitation or death of the behavioral health professional or peer,

b. the role of technology, including boundaries around electronic transmissions with clients and social networking, implications of diagnosis and the intended use of tests and reports, fees and billing, nonpayment, policies for collecting nonpayment, specifics about clinical supervision and consultation,

c. their right to refuse services, and their right to refuse to be treated by a person-in-training, without fear of retribution.

1.3 Limits of Confidentiality: Behavioral Health Professionals and Peers clarify the nature of relationships with each party and the limits of confidentiality at the outset of services when agreeing to provide services to a person at the request or direction of a third party.

1.4 Diversity: Behavioral Health Professionals and Peers shall respect the diversity of clients and seek training and supervision in areas in which they are at risk of imposing their values onto clients.

1.5 Discrimination: Behavioral Health Professionals and Peers shall not practice, condone, facilitate, or collaborate with any form of discrimination against any client on the basis of race, ethnicity, color, religious or spiritual beliefs, age, gender identification, national origin, sexual orientation or expression, marital status, political affiliations, physical or mental handicap, health condition, housing status, military status, or economic status.

1.6 Legal Competency: Behavioral Health Professionals and Peers who act on behalf of a client who has been judged legally incompetent or with a representative who has been legally authorized to act on behalf of a client, shall act with the client's best interests in mind, and shall inform the designated guardian or representative of any circumstances which may influence the relationship. Providers recognize the need to balance the ethical rights of clients to make choices about their treatment, their capacity to give consent to receive treatment-related services, and parental/familial/representative legal rights and responsibilities to protect the client and make decisions on their behalf.

1.7 Mandated Clients: Behavioral Health Professionals and Peers who work with clients who have been mandated to counseling and related services, shall discuss legal and ethical limitations to confidentiality. Providers shall explain confidentiality, limits to confidentiality, and the sharing of information for supervision and consultation purposes prior to the beginning of therapeutic or service relationship. If the client refuses services, the Provider shall discuss with the client the potential consequences of refusing the mandated services, while respecting client autonomy.

1.8 Multiple Behavioral Health Professionals: Behavioral Health Professionals and Peers shall obtain a signed Release of Information from a potential or actual client if the client is working with another behavioral health professional. The Release shall allow the Provider to strive to establish a collaborative professional relationship.

1.9 Professional Boundaries: Behavioral Health Professionals and Peers shall consider the inherent risks and benefits associated with moving the boundaries of a counseling relationship beyond the standard parameters. Consultation and supervision shall be sought and documented.

1.10 Multiple/Dual Relationships: Behavioral Health Professionals and Peers shall make every effort to avoid multiple relationships with a client. When a dual relationship is unavoidable, the professional shall take extra care so that professional judgment is not impaired and there is no risk of client exploitation. Such relationships include, but are not limited to, members of the Provider's immediate or extended family, business associates of the professional, or individuals who have a close personal relationship with the professional or the professional's family. When extending these boundaries, Providers take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that their judgment is not impaired and no harm occurs. Consultation and supervision shall be documented.

1.11 Prior Relationship: Behavioral Health Professionals and Peers recognize that there are inherent risks and benefits to accepting as a client someone with whom they have a prior relationship. This includes anyone with whom the Provider had a casual, distant, or past relationship. Prior to engaging in a counseling relationship with a person from a previous relationship, the Provider shall seek consultation or supervision. The burden is on the Provider to ensure that their judgment is not impaired and that exploitation is not occurring.

1.12 Previous Clients: Behavioral Health Professionals and Peers considering initiating contact with or a relationship with a previous client shall seek documented consultation or supervision prior to its initiation.

1.13 Group Services: Behavioral Health Professionals and Peers shall clarify who "the client" is, when accepting and working with more than one person as "the client." Provider shall clarify the relationship the provider shall have with each person. In group counseling, providers shall take reasonable precautions to protect the members from harm.

1.14 Financial Disclosure: Behavioral Health Professionals and Peers shall truthfully represent facts to all clients and third-party payers regarding services rendered, and the costs of those services.

1.15 Communication: Behavioral Health Professionals and Peers shall communicate information in ways that are developmentally and culturally appropriate. Providers offer clear understandable language when discussing issues related to informed consent. Cultural implications of informed consent are considered and documented by provider.

1.16 Service/Recovery Plans: Behavioral Health Professionals and Peers shall create service/recovery plans in collaboration with their client. Service/recovery plans shall be reviewed and revised on an ongoing and intentional basis to ensure their viability and validity.

1.17 Level of Care: Behavioral Health Professionals and Peers shall provide their client with the highest quality of care. Addiction treatment providers shall use ASAM or other relevant criteria to ensure that clients are appropriately and effectively served. Mental Health providers shall use similar standardized procedures for determining level of care, such as utilization management.

1.18 Documentation: Behavioral Health Professionals and Peers shall create, maintain, protect, and store documentation required per federal and state laws and rules, and organizational policies.

1.19 Advocacy: Behavioral Health Professionals and Peers are called to advocate on behalf of clients at the individual, group, institutional, and societal levels. Providers have an obligation to speak out regarding barriers and obstacles that impede access to and/or growth and development of clients. When advocating for a specific client, Providers obtain written consent prior to engaging in advocacy efforts.

1.20 Referrals: Behavioral Health Professionals and Peers shall recognize that each client is entitled to the full extent of physical, social, psychological, spiritual, and emotional care required to meet their needs. Providers shall refer to culturally- and linguistically-appropriate resources when a client presents with any impairment that is beyond the scope of the Provider's education, training, skills, supervised expertise, and licensure.

1.21 Exploitation: Behavioral Health Professionals and Peers are aware of their influential positions with respect to clients, trainees, and research participants and shall not exploit the trust and dependency of any client, trainee, or research participant. Providers shall not engage in any activity that violates or diminishes the civil or legal rights of any client. Providers shall not use coercive treatment methods with any client, including threats, negative labels, or attempts to provoke shame or humiliation. Providers shall not impose their personal religious or political values on any client. Providers do not endorse conversion therapy, or obstruct a woman's right to choose.

1.22 Sexual Relationships: Behavioral Health Professionals and Peers shall not engage in any form of sexual or romantic relationship with any current or former client, nor accept as a client anyone with whom they have engaged in a romantic, sexual, or familial relationship. This prohibition includes in-person and electronic interactions and/or relationships. Behavioral Health Professionals and Peers are prohibited from engaging in behavioral health service relationships with friends or family members with whom they have an inability to remain objective. This definition of client includes, but is not limited to, clients directly assigned to the Behavioral Health Professional or Peer, or clients of the agency, where the Behavioral Health Professional or Peer has any service contacts

with the client, including those clients not assigned directly to the Behavioral Health Professional or Peer.

1.23 Termination: Behavioral Health Professionals and Peers shall terminate services with clients when services are no longer required, no longer serve the client's needs, or the Provider is unable to remain objective. Counselors provide pre-termination counseling and offer appropriate referrals as needed. Providers may refer a client, with supervision or consultation, when in danger of harm by the client or by another person with whom the client has a relationship.

1.24 Service Coverage: Behavioral Health Professionals and Peers shall make necessary coverage arrangements to accommodate interruptions such as vacations, illness, or unexpected situation.

1.25 Abandonment: Behavioral Health Professionals and Peers shall not abandon any client in treatment. Providers who anticipate termination or interruption of services to clients shall notify each client promptly and seek transfer, referral, or continuation of services in relation to each client's needs and preferences.

1.26 Fees: Behavioral Health Professionals and Peers shall ensure that all fees charged for services are fair, reasonable, and commensurate with the services provided and with due regard for clients' ability to pay.

1.27 Self-Referrals: Behavioral Health Professionals and Peers shall not refer clients to their private business unless the policies, at the organization at the source of the referral, allow for such self-referrals. When self-referrals are not an option, clients shall be informed of other appropriate referral resources.

1.28 Commissions: Behavioral Health Professionals and Peers shall not offer or accept any commissions, rebates, kickbacks, bonuses, or any form of remuneration for referral of a client for professional services, nor engage in fee splitting.

1.29 Private Enterprises: Behavioral Health Professionals and Peers shall not use relationships with clients to promote personal gain or profit of any type of commercial enterprise.

1.30 Withholding Records: Behavioral Health Professionals and Peers shall not withhold records they possess that are needed for any client's treatment solely because payment has not been received for past services, where it is not specifically allowable under law/state administrative rule.

1.31 Withholding Reports: Behavioral Health Professionals and Peers shall not withhold reports to referral agencies regarding client treatment progress or completion solely because payment has not yet been received in full for services, particularly when those reports are to courts or probation officers who require such information for legal purposes, where it is not specifically allowable under law/state administrative rule. Reports may note that payment has not yet been made, or only partially made, for services rendered.

1.32 Disclosures of Payments: Behavioral Health Professionals and Peers shall clearly disclose and explain to each client, prior to the onset of services, (1) all costs and fees related to the provision of professional services, including any charges for cancelled or missed appointments, (2) the use of collection agencies or legal measures for nonpayment, and (3) the procedure for obtaining payment from the client if payment is denied by a third party payer.

1.33 Regardless of Compensation: Behavioral Health Professionals and Peers shall provide the same level of professional skills and service to each client without regard to the compensation provided by a client or third party payer, and whether a client is paying full fee, a reduced fee, or has their fees waived.

1.34 Billing for Actual Services: Behavioral Health Professionals and Peers shall charge each client only for services actually provided to a client regardless of any oral or written contract a client has made with the addiction professional or agency.

1.35 Financial Records: Behavioral Health Professionals and Peers shall maintain accurate and timely clinical and financial records for each client.

1.36 Suspension: Behavioral Health Professionals and Peers shall give reasonable and written notice to clients of impending suspension of services for nonpayment.

1.37 Unpaid Balances: Behavioral Health Professionals and Peers shall give reasonable and written notice to clients with unpaid balances of their intent to seek collection by agency or legal recourse—when such action is taken, Behavioral Health Professionals and Peers shall not reveal clinical information.

1.38 Gifts: Behavioral Health Professionals and Peers recognize that clients may wish to show appreciation for services by offering gifts. Providers shall take into account the service relationship, cultural appropriateness, the monetary value of the gift, the client's motivation for giving the gift, and the professional's motivation for wanting to accept or decline the gift. When accepting gifts professionals try to their utmost to encourage clients to offer their gifts to the organization so that all may benefit from the gift.

1.39 Uninvited Solicitation: Behavioral Health Professionals and Peers shall not engage in uninvited solicitation of potential

clients who are vulnerable to undue influence, manipulation, or coercion due to their circumstances.

1.40 Virtual Relationships: Behavioral Health Professionals and Peers are prohibited from engaging in personal/romantic virtual electronic, text messaging, e-relationships with current or former clients.

2.0 CONFIDENTIALITY

2.1 Confidentiality: Behavioral Health Professionals and Peers understand that confidentiality and anonymity are foundational to addiction treatment and embrace the duty of protecting the identity and privacy of each client as a primary obligation. Providers communicate the parameters of confidentiality in a culturally-sensitive manner.

2.2 Documentation: Behavioral Health Professionals and Peers shall create and maintain appropriate documentation. Providers shall ensure that records and documentation kept in any medium (i.e., cloud, laptop, flash drive, external hard drive, tablet, computer, paper, etc.) are secure and in compliance with HIPAA and 42 CFR Part 2 (if applicable), and that only authorized persons have access to them. Providers shall disclose to client within informed consent how records shall be stored, maintained, and disposed of, and shall include time frames for maintaining active file, storage, and disposal.

2.3 Access: Behavioral Health Professionals and Peers shall notify client, during informed consent, about procedures specific to client access of records. Behavioral Health Professionals shall provide a client reasonable access to documentation regarding the client upon his/her written request. Providers shall protect the confidentiality of any other individuals contained in the records. Providers shall limit the access of clients to their records – and provide a summary of the records – when there is evidence that full access could cause harm to the client. A treatment summary shall include dates of service, diagnoses, treatment plan, and progress in treatment. Providers seek supervision or consultation prior to providing a client with documentation and shall document the rationale for releasing or limiting access to records. Providers shall provide assistance and consultation to the client regarding the interpretation of service records.

2.4 Sharing: Behavioral Health Professionals and Peers shall encourage ongoing discussions with clients regarding how, when, and with whom information is to be shared.

2.5 Disclosure: Behavioral Health Professionals and Peers shall not disclose confidential information regarding the identity of any client, nor information that could potentially reveal the identity of a client, without written consent and authorization by the client. In situations where the disclosure is mandated or permitted by state and federal law, verbal authorization shall not be sufficient except for emergencies.

2.6 Privacy: Behavioral Health Professionals and Peers and the organizations they work for ensure that confidentiality and privacy of clients is protected by Providers, employees, supervisees, students, office personnel, other staff, and volunteers.

2.7 Temporary Assistance: Behavioral Health Professionals and Peers, during informed consent, shall disclose the legal and ethical boundaries of confidentiality and disclose the legal exceptions to confidentiality. Confidentiality and limitations to confidentiality shall be reviewed as needed during the counseling relationship. Providers review with each client all circumstances where confidential information may be requested, and where disclosure of confidential information may be legally required.

2.8 Imminent Danger: Behavioral Health Professionals and Peers may reveal client identity or confidential information without client consent when a client presents a clear and imminent danger to themselves or to other persons, and to emergency personnel who are directly involved in reducing the danger or threat. Behavioral Health Professionals seek supervision or consultation when unsure about the validity of an exception.

2.9 Courts: Behavioral Health Professionals and Peers ordered to release confidential privileged information by a court shall obtain written, informed consent from the client, take steps to prohibit the disclosure, or have it limited as narrowly as possible because of potential harm to the client or counseling relationship.

2.10 Essential Only: Behavioral Health Professionals and Peers shall release only essential information when circumstances require the disclosure of confidential information.

2.11 Multidisciplinary Care: Behavioral Health Professionals and Peers shall inform the client when the Provider is a participant in a multidisciplinary care team providing coordinated services to the client. The client shall be informed of the team's member credentials and duties, information being shared, and the purposes of sharing client information.

2.12 Locations: Behavioral Health Professionals and Peers shall discuss confidential client information in locations where they are reasonably certain they can protect client privacy.

2.13 Payers: Behavioral Health Professionals and Peers shall obtain client authorization prior to disclosing any information to third party payers (i.e., Medicaid, Medicare, insurance payers, private payors).

2.14 Encryption: Behavioral Health Professionals and Peers shall use encryption and precautions that ensure that information being transmitted electronically or other medium remains confidential.

2.15 Deceased: Behavioral Health Professionals and Peers shall protect the confidentiality of deceased clients by upholding legal mandates and documented preferences of the client.

2.16 Parties: Behavioral Health Professionals and Peers, who provide group, family, or couples services, shall describe the roles and responsibilities of all parties, limits of confidentiality, and the inability to guarantee that confidentiality shall be maintained by all parties.

2.17 Minors/others: Behavioral Health Professionals and Peers shall protect the confidentiality of any information received regarding services to minors or adult clients who lack the capacity to provide voluntary informed consent, regardless of the medium, in accordance with federal and state laws, and organization policies and procedures. Parents, guardians, and appropriate third parties are informed regarding the role of the counselor, and the boundaries of confidentiality of the counseling relationship.

2.18 Storage & Disposal: Behavioral Health Professionals and Peers shall create and/or abide by organizational, and state and federal, policies and procedures regarding the storage, transfer, and disposal of confidential client records. Providers shall maintain client confidentiality in all mediums and forms of documentation. Behavioral Health Professionals and Peers shall store, safeguard, and dispose of client records in accordance with state and federal laws, accepted professional standards, and in ways which protect the confidentiality of clients.

2.19 Video Recording: Behavioral Health Professionals and Peers shall obtain informed consent and written permissions and releases before videotaping, audio recording, or permitting third party observation of any client interaction or group therapy session. Clients are to be fully informed regarding recording such as purpose, who will have access, storage, and disposal of recordings. Exceptions to restrictions on third party observations shall be limited to students in field placements, internships, practicums, or agency trainees.

2.20 Recording e-services: Behavioral Health Professionals and Peers shall obtain informed consent and written release of information prior to recording an electronic therapy session. Prior to obtaining informed consent for recording e- therapy, the Provider shall seek supervision or consultation, and document recommendations. Providers shall disclose to client in informed consent how e-records shall be stored, maintained, and disposed of and in what time frame.

2.21 Federal Regulations Stamp: Behavioral Health Professionals and Peers shall ensure that all written information released to others is accompanied by a stamp identifying the Federal Regulations governing such disclosure, and shall notify clients when a disclosure is made, to whom the disclosure was made, and for what purposes the disclosure was made.

2.22 Transfer Records: Unless exceptions to confidentiality exist, Behavioral Health Professionals and Peers shall obtain written permission from clients to disclose or transfer records to legitimate third parties. Steps are taken to ensure that receivers of counseling records are sensitive to their confidential nature. Behavioral Health Professionals shall ensure that all information released meets requirements of 42 CFR Part 2 and HIPAA. All information released shall be appropriately marked as confidential.

2.23 Written Permission: Behavioral Health Professionals and Peers who receive confidential information about any client (past, present or potential) shall not disclose that information without obtaining written permission from the client (past, present or potential) allowing for such release.

2.24 Multidisciplinary Care: Behavioral Health Professionals and Peers, who are part of integrative care teams, shall not release confidential client information to external care team members without obtaining written permission from the client allowing such release.

2.25 Diseases: Behavioral Health Professionals and Peers adhere to relevant federal and state laws concerning the disclosure of a client's communicable and life-threatening disease status.

2.26 Temporary Assistance: Behavioral Health Professionals and Peers, when serving clients of another agency or colleague during a temporary absence or emergency, shall serve those clients with the same consideration and confidentiality as that afforded the professional's own clients.

2.29 Termination: Behavioral Health Professionals and Peers shall take reasonable precautions to protect client confidentiality in the event of the counselor's termination of practice, incapacity, or death. Providers shall appoint a records custodian when identified as appropriate, in their Will or other document.

2.30 Consultation: Behavioral Health Professionals and Peers shall share, with a consultant, information about a client for professional purposes. Only information pertaining to the reason for the consultation shall be released. Providers shall protect the client's identity and prevent breaches to the client's privacy. Behavioral Health Professionals, when consulting with colleagues or referral sources, shall not share

confidential information obtained in clinical or consulting relationships that could lead to the identification of a client, unless the Provider has obtained prior written consent from the client. Information shall be shared only in appropriate clinical settings and only to the extent necessary to achieve the purposes of the consultation.

3.0 PROFESSIONALISM

3.1 Responsibility: Behavioral Health Professionals and Peers shall abide by the NAADAC Code of Ethics. Behavioral Health Professionals have a responsibility to read, understand and follow the NAADAC Code of Ethics and adhere to applicable laws and regulations.

3.2 Integrity: Behavioral Health Professionals and Peers shall conduct themselves with integrity. Providers aspire to maintain integrity in their professional and personal relationships and activities. Regardless of medium, Providers shall communicate to clients, peers, and the public honestly, accurately, and appropriately.

3.3 Discrimination: Behavioral Health Professionals and Peers shall not engage in, endorse or condone discrimination against prospective or current clients and their families, students, employees, volunteers, supervisees, or research participants based on their race, ethnicity, age, disability, religion, spirituality, gender, gender identity, sexual orientation, marital or partnership status, language preference, socioeconomic status, immigration status, active duty or veteran status, or any other basis.

3.4 Non-discrimination: Behavioral Health Professionals and Peers shall provide services that are nondiscriminatory and nonjudgmental. Providers shall not exploit others in their professional relationships. Providers shall maintain appropriate professional and personal boundaries.

3.5 Fraud: Behavioral Health Professionals and Peers shall not participate in, condone, or be associated with any form of dishonesty, fraud, or deceit.

3.6 Code Violation: Behavioral Health Professionals and Peers shall not engage in any criminal activity. Behavioral Health Professionals and Service Providers shall be in violation of this Code and subject to appropriate sanctions, up to and including permanent revocation of their certification, if they:

1. Engage in conduct which could lead to conviction of a felony.

2. Are expelled from or disciplined by other professional organizations.

3. Practice behavioral health services while impaired for any reason, including impairment as a result of abuse of alcohol or other drugs.

5. Continue to identify themselves as a certified behavioral health professional after being denied certification or allowing their certification to lapse.

6. Failure to cooperate with the Ethics Committees at any point from the inception of an ethics complaint through the completion of all procedures regarding that complaint.

3.7 Harassment: Behavioral Health Professionals and Peers shall not engage in or condone any form of harassment, including sexual harassment.

3.8 Memberships: Behavioral Health Professionals and Peers intentionally differentiate between current, active memberships and former or inactive memberships within professional associations.

3.9 Representation: Behavioral Health Professionals and Peers shall claim and promote only those licenses and certifications that are current and in good standing. Behavioral Health Professionals shall advocate for accuracy in statements made by self or others about the behavioral health profession.

3.10 Scope of Practice: Behavioral Health Professionals and Peers shall provide services within their scope of practice and competency, and shall offer services that are science-based, evidence-based, and/or outcome-driven. Providers shall maintain adequate knowledge of and adhere to applicable professional standards of practice. Behavioral Health Professionals shall practice within the boundaries of their competence. Competence shall be established through education, training, skills, and supervised experience, state and national professional credentials and certifications, and relevant professional experience.

3.11 Continuing Education: Behavioral Health Professionals and Peers shall pursue and engage in continuing education and professional development opportunities in order to maintain and enhance knowledge of research-based scientific developments within the profession. Providers shall learn and utilize new procedures relevant to the clients they are working with. Providers shall remain informed regarding best practices for working with diverse populations.

3.12 Self-Monitoring: Behavioral Health Professionals and Peers are continuously self-monitoring in order to meet their professional obligations. Providers shall engage in self-care activities that promote and maintain their physical, psychological, emotional, and spiritual well-being.

3.13 Scientific Standard of Care: Behavioral Health Professionals and Peers shall use techniques, procedures, and modalities that have a scientific and empirical foundation. Providers shall utilize counseling techniques and procedures that are grounded in theory, evidence-based, outcome-driven and/or a research-supported promising practice. Providers shall avoid techniques, procedures, or modalities that have substantial evidence suggesting harm, even when these services are requested.

3.14 Innovation: Behavioral Health Professionals and Peers shall discuss and document potential risks, benefits and ethical concerns prior to using developing or innovative techniques, procedures, or modalities with a client. Providers shall minimize and document any potential risks or harm when using developing and/or innovative techniques, procedures, or modalities. Provider shall seek and document supervision and/or consultation prior to presenting service options and risks to a client.

3.15 Cultural Competency: Behavioral Health Professionals and Peers shall develop multicultural counseling competency by gaining knowledge specific to multiculturalism, increasing awareness of cultural identifications of clients, evolving cultural humility, displaying a disposition favorable to difference, and increasing skills pertinent to being a culturally-sensitive Provider.

3.16 Multidisciplinary Care, Medication & Substance Abuse: Behavioral Health Professionals and Peers shall work to educate medical professionals about substance use disorders, the need for primary treatment of these disorders, and the need to limit the use of mood altering chemicals typically contraindicated for persons in recovery.

3.17 Multidisciplinary Collaboration: Behavioral Health Professionals and Peers shall recognize the need for the use of psychiatric and mood altering chemicals in some medical situations, and will work to self-educate themselves regarding the prescribed medication, and educate medical professionals to limit, monitor, and closely supervise the administration of chemicals typically contraindicated for persons in recovery from addiction. Behavioral Health Professionals recognize the rights of individuals to refuse prescribed or dispensed medications. Behavioral Health Professionals shall develop respectful and collaborative relationships with other professionals who are working with a specific client. Providers shall not offer professional services to a client who is participating in similar services with another professional, except with the knowledge and documented approval of the other professionals or following termination of services with the other professionals. Behavioral Health Professionals shall collaborate with other health care professionals in providing a supportive environment for any client who receives prescribed medication or dispensed medication through a medication assisted treatment program.

3.18 Multidisciplinary Care & Wellbeing: Collaborative multidisciplinary care teams are focused on increasing the client's functionality and wellness. Behavioral Health Professionals who are members of multidisciplinary care teams shall work with team members to clarify professional and ethical obligations of the team as a whole and its individual members. If ethical concerns develop as a result of a team decision, providers shall attempt to resolve the concern within the team first. If resolution cannot be reached within the team, providers shall pursue and document supervision and/or consultation to address their concerns consistent with client well-being.

3.19 Collegiality: Behavioral Health Professionals and Peers are aware of the need for collegiality and cooperation in the helping professions. Providers shall act in good faith towards colleagues and other professionals, and shall treat colleagues and other professionals with respect, courtesy, honesty, and fairness.

3.20 Qualified Staff: Behavioral Health Professionals and Peers shall work to prevent the practice of behavioral health care by unqualified and unauthorized persons, and shall not employ individuals who do not have appropriate and requisite education, training, licensure and/or certification.

3.21 Advocacy: Behavioral Health Professionals and Peers shall be advocates for their clients in those settings where the client is unable to advocate for themselves. Behavioral Health Professionals are aware of society's prejudice and stigma towards people with mental health challenges and substance use disorders, and willingly engage in the legislative process, educational institutions, and public forums to educate people about mental health and addictive disorders and advocate for opportunities and choices for our clients. Behavioral Health Professionals and Peers shall advocate for changes in public policy and legislation to improve opportunities and choices for all persons whose lives are affected by substance use disorders and mental health challenges. Behavioral Health Professionals and Peers shall inform the public of the impact of untreated and unsupported mental health challenges and substance use disorders through active participation in civic affairs and community organizations. Providers shall act to guarantee that all persons, especially the disadvantaged, marginalized and historically oppressed, have access to the opportunities, resources, and services required to treat and manage their disorders. Providers shall educate the public, while working to dispel negative myths, stereotypes, and misconceptions.

3.22 Public Statements: Behavioral Health Professionals and Peers shall respect the limits of present knowledge in public statements concerning mental health and addiction services and shall report that knowledge accurately and without distortion or misrepresentation to the public and to other professionals and organizations. Behavioral Health Professionals and Peers shall distinguish clearly between

statements made and actions taken as a private individual and statements made and actions taken as a representative of an agency, group, organization, or the behavioral health profession. Behavioral Health Professionals and Peers shall make no public comments disparaging persons who have substance use disorders or mental health challenges. Behavioral Health Professionals and Peers shall make no public comments disparaging the legislative process, or any person involved in the legislative process. Behavioral Health Professionals and Peers shall give appropriate credit to the authors or creators of all materials used in their course of their work, public comments, or public/professional presentations. Providers shall not plagiarize another person's work.

3.23 Participation in the Development of the Workforce and Profession: Behavioral Health Professionals and Peers actively participate in local, state and national associations that promote professional development, support the formulation, development, enactment, and implementation of public policy and legislation concerning the addictions and mental health profession and our clients.

3.24 Impairment: Behavioral Health Professionals and Peers shall recognize the effect of impairment on professional performance and shall seek appropriate professional assistance for any personal problems or conflicts that may impair work performance or judgment. Behavioral Health Professionals and Peers shall continuously monitor themselves for signs of impairment physically, psychologically, socially, and emotionally. Providers, with the guidance of supervision or consultation, shall seek appropriate assistance in the event they are professionally impaired. Providers shall abide by statutory mandates specific to professional impairment when addressing one's own impairment.

3.25 Self-referral: Behavioral Health Professionals and Peers shall not refer clients, or recruit clients, from their places of employment to their private endeavors without prior documented authorization. Providers shall offer multiple referral options to clients when referrals are necessary. Providers will seek supervision or consultation to address any potential or real conflicts of interest.

3.26 Testimonials: Behavioral Health Professionals and Peers shall be thoughtful when they solicit testimonials from former clients or any other persons. Providers shall discuss with clients the implications of and potential concerns, regarding testimonials, prior to obtaining written permission for the use of specific testimonials. Providers shall seek consultation or supervision prior to seeking a testimonial.

3.27 Reports: Behavioral Health Professionals and Peers shall take care to accurately, honestly and objectively report professional activities and judgments to appropriate third parties (i.e., courts, probation/parole, healthcare insurance organizations and providers, recipients of evaluation reports, referral sources, professional organizations, regulatory agencies, regulatory boards, ethics committees, etc.).

3.28 Professional Advice: Behavioral Health Professionals and Peers shall take reasonable precautions, when offering advice to clients, or public comments (using any platform including presentations and lectures, demonstrations, printed articles, mailed materials, television or radio programs, video or audio recordings, technology-based applications, or other media), to ensure that their statements are based on academic, research, and evidence-based, outcome-driven literature and practice. Providers shall only give advice within their scope of practice and shall not make recommendations for medications or other drugs, if they are not licensed to practice medicine.

3.29 Illegal Practices and Whistleblower Protection: When Behavioral Health Professionals and Peers become aware of inappropriate, illegal, discriminatory, and/or unethical policies, procedures and practices at their agency or organization they shall alert their employers. When there is the potential for harm to clients or limitations on the effectiveness of services provided, providers shall seek supervision and/or consultation to determine appropriate next steps and further action. Providers and Supervisors shall not harass or terminate an employee or colleague who has acted in a responsible and ethical manner to expose inappropriate employer employee policies, procedures and/ or practices.

3.30 Supervision: Behavioral Health Professionals and Peers acting in the role of supervisor or consultant, shall take reasonable steps to ensure that they have appropriate resources and competencies when providing supervisory or consultation services. Supervisors or consultants shall provide appropriate referrals to resources when requested or needed.

4.0 DIVERSITY, DISPARITY & EQUITY

4.1 Diversity Values: Behavioral Health Professionals and Peers do not discriminate based on race, ethnicity, gender identity, sexual orientation, disability status, or veteran status. Behavioral Health Professionals and Peers shall be knowledgeable and aware of cultural, individual, societal, and role differences amongst the clients they serve. They shall offer services that demonstrate appropriate respect for the fundamental rights, dignity and worth of all clients. Providers shall maintain an interpersonal stance that is other-oriented and accepting of the cultural identities of the other person (client, colleague, peer, employee, employer, volunteer, supervisor, supervisee, and others). They shall develop an understanding of their own personal, professional, and cultural values and beliefs. Providers shall recognize which personal and professional values may be in alignment with or conflict with the values and needs of the client. Providers shall not use cultural or values differences as a reason to engage in

discrimination. Providers shall seek supervision and/or consultation to address areas of difference and to decrease bias, judgment, and microaggressions.

4.2 Equity Practices: Behavioral Health Professionals and Peers shall respect the roles of family members, social supports, and community structures, hierarchies, values and beliefs within the client's culture. Providers shall consider the impact of adverse social, environmental, and political factors in assessing concerns and designing interventions. They shall use methodologies, skills, and practices that are evidence-based and outcome-driven for the populations being serviced. Providers will seek ongoing professional development opportunities to develop specialized knowledge and understanding of the groups they serve. Providers shall obtain the necessary knowledge and training to maintain humility and sensitivity when working with clients of diverse backgrounds. They shall support and advocate for the recruitment and retention of Professionals and other Service Providers who represent diverse cultural groups. They shall provide or advocate for the provision of professional services that meet the needs of clients with linguistic diversity. Providers shall provide or advocate for the provision of professional services that meet the needs of clients with diverse disabilities. They shall recognize that conventional counseling styles may not meet the needs of all clients. Providers shall open a dialogue with the client to determine the best manner in which to service the client. Providers shall seek supervision and consultation when working with individuals with specific culturally-driven needs.

5.0 SCREENING, ASSESSMENT, EVALUATION AND INTERPRETATION

5.1 Cultural Context: Behavioral Health Professionals and Peers shall use screening and assessments appropriately within the counseling process. The clients' personal and cultural contexts are taken into consideration when assessing and evaluating a client. Professionals recognize and understand that culture influences the manner in which clients' concerns are defined and experienced. Providers are aware of historical traumas and social prejudices in the misdiagnosis and pathologizing of specific individuals and groups. Providers shall develop awareness of prejudices and biases within self and others, and shall address such biases in themselves or others. Professionals shall consider the client's cultural experiences when diagnosing and treatment planning for mental health and substance use disorders.

5.2 Scope of Practice: Behavioral Health Professionals and Peers shall develop and use appropriate mental health, substance use disorder, and other relevant assessments. They shall practice within the scope of their certification and training.

- Unlicensed Mental Health Professionals shall not perform ASAM-SUD evaluations outside of their scope of practice,
- Addiction Counselors shall not perform DSM mental health evaluations outside of their scope of practice,
- Peers shall not perform DSM or ASAM evaluations outside of their scope of practice,
- and, Mental Health Associates shall not perform DSM or ASAM evaluations outside of their scope of practice.

5.3 Screening and Assessment Tools: Behavioral Health Professionals shall utilize only those screening and assessment instruments whose validity and reliability have been established for the population tested, and for which they have received adequate training in administration and interpretation. Professionals using technology-assisted test interpretations are trained in the construct being measured and the specific instrument being used prior to using its technology- based application. Professionals take reasonable measures to ensure the proper use of assessment techniques by persons under their supervision.

5.4 Informed Consent: Behavioral Health Professionals and Peers shall explain to clients the nature and purposes of each assessment and the intended use of results, prior to administration of the assessment. Providers shall offer this explanation in terms and language that the client or other legally authorized person can understand. They shall provide an appropriate environment free from distractions for the administration of assessments. Providers shall ensure that technologically-administered assessments are functioning appropriately and providing accurate results.

5.5 Misuse of Screening and Assessment: Assessment techniques used to determine client placement for care shall be carefully selected and appropriately used. Behavioral Health Professionals and Peers shall never misuse screening or assessment findings simply to obtain housing, disability status or other entitlements. Professionals shall consider the client's welfare, explicit understandings, and previous agreements in determining when and how to provide assessment results. Providers shall include accurate and appropriate interpretations of data when there is a release of individual or group assessment results. Professionals shall not misuse assessment results and interpretations. Providers shall respect the client's right to know the results, interpretations and diagnoses made and strive to provide results, interpretations, and diagnoses in a manner that is understandable and does not cause harm. Providers shall adopt practices that prevent others from misusing the results and interpretations. Professionals shall maintain the integrity and security of tests and assessment data, thereby addressing legal and contractual obligations. Providers shall not appropriate, reproduce, or modify published assessments or parts thereof without written permission from the publisher.

5.6 Referral: Behavioral Health Professionals and Peers shall provide specific and relevant data about the client, when referring a client to a third party for assessment, to ensure that appropriate assessment instruments are used.

6.0 E-SERVICES, AND SOCIAL MEDIA

6.1 "E-Services" and "E-Supervision": shall refer to the provision of services by an Behavioral Health Professionals and Peers using technology, electronic devices, and HIPAA-compliant resources. Electronic platforms shall include and are not limited to: land-based and mobile communication devices, fax machines, webcams, computers, laptops and tablets. E-Services shall include and are not limited to: tele-therapy, real-time video-based therapy and services, emails, texting, chatting, and cloud storage. Providers and Supervisors are aware of the unique challenges created by electronic forms of communication and the use of available technology and shall take steps to ensure that the provision of e-services and e-supervision is safe and as confidential as possible.

6.2 E-Competence: Behavioral Health Professionals and Peers who choose to engage in the use of technology for e-services, distance-services, and e-supervision shall pursue specialized knowledge and competency regarding the technical, ethical, and legal considerations specific to technology, social media, and distance services. Competency shall be demonstrated through means such as specialized certifications and additional course work and/or trainings. Failure to maintain confidentiality due to a lack of comprehension of available features and settings within the electronic platforms does not relieve professionals of their responsibilities.

6.3 E-Consent: Behavioral Health Professionals and Peers, who are offering an electronic platform for e-therapy, distance-services/case management, e-supervision shall provide an Electronic/Technology Informed Consent. The electronic informed consent shall explain the right of each client and supervisee to be fully informed about services delivered through technological mediums, and shall provide each client/supervisee with information in clear and understandable language regarding the purposes, risks, limitations, and costs of treatment services, reasonable alternatives, their right to refuse service delivery through electronic means, and their right to withdraw consent at any time. Providers have an obligation to review with the client/supervisee – in writing and verbally – the rights and responsibilities of both Providers and clients/supervisees. Providers shall have the client/ supervisee attest to their understanding of the parameters covered by the Electronic/Technology Informed Consent. A thorough e-therapy informed consent shall be executed at the start of services. A technology based informed consent discussion shall include:

- distance-services credentials, physical location of practice, and contact information;
- risks and benefits of engaging in the use of distance-services, technology, and/or social media;
- possibility of technology failure and alternate methods of service delivery;
- anticipated response time;
- emergency procedures to follow;
- when the services are not available;
- time zone differences;
- cultural and/or language differences that may affect delivery of services; and
- possible denial of insurance benefits; and social media policy.

Behavioral Health Professionals and Peers, who engage in the use of electronic platforms for the delivery of services shall take reasonable steps to verify the client's/supervisee's identity prior to engaging in the e-services relationship and throughout the behavioral health relationship. Verification can include, but is not limited to, picture id's, code words, numbers, graphics, or other nondescript identifiers.

6.4 E-Jurisdiction: Behavioral Health Professionals and Peers, shall comply with relevant licensing laws in the jurisdiction where the Provider/Clinical Supervisor is physically located when providing care and where the client/supervisee is located when receiving care. Emergency management protocols are entirely dependent upon where the client/supervisee receives services. Providers, during "informed consent," shall notify their clients/supervisees of the legal rights and limitations governing the practice of behavioral health services across state lines or international boundaries. Mandatory reporting and related ethical requirements such as duty to warn/notify are tied to the jurisdiction where the client/supervisee is receiving services. Behavioral Health Professionals and Peers, utilizing technology, social media, and distance counseling within their practice recognize that they are subject to state and federal laws and regulations governing the counselor's practicing location. Providers utilizing technology, social media, and distance counseling within their practice recognize that they shall be subject to laws and regulations in the client's/supervisee's state of residency and shall be subject to laws and regulations in the state where the client/supervisee is located during the actual delivery of services.

6.5 E-Confidentiality: Behavioral Health Professionals and Peers, recognize that electronic means of communication are not secure, and shall inform clients, students, and supervisees that remote services using electronic means of delivery cannot be entirely secured or confidential. Providers who provide services via electronic technology shall fully inform each client, student, or supervisee of the limitations and risks regarding confidentiality

associated with electronical delivery, including the fact that electronic exchanges may become part of clinical, academic, or professional records. Efforts shall be made to ensure privacy so clinical discussions cannot be overheard by others outside of the room where the services are provided. Internet-based behavioral health services shall be conducted on HIPAA-compliant servers. Confidential material shall not occur using unencrypted text-based or email-based delivery. Addiction Professionals shall inform clients that other individuals (i.e., colleagues, supervisors, staff, consultants, information technologists) might have authorized or unauthorized access to such records or transmissions. Providers use current encryption standards within their websites and for technology-based communications. Providers take reasonable precautions to ensure the confidentiality of information transmitted and stored through any electronic means. Behavioral Health Professionals and Peers, understand the inherent dangers of electronic health records. Providers are responsible for ensuring that cloud storage sites in use are HIPAA compliant. Providers inform clients/supervisees of the benefits and risks of maintaining records in a cloud-based file management system, and discuss the fact that nothing that is electronically saved on a Cloud is confidential and secure. Cloud-based file management shall be encrypted, secured, and HIPAA compliant. Providers shall use encryption programs when storing or transmitting client information to protect confidentiality.

6.6 E-Eligible: Behavioral Health Professionals and Peers, shall assess and document the client's/supervisee's ability to benefit from and engage in e-services. Providers shall consider the client's/supervisee's cognitive capacity and maturity, past and current diagnoses, communications skills, level of competence using technology, and access to the necessary technology. Providers shall consider geographical distance to nearest emergency medical facility, efficacy of client's support system, current medical and behavioral health status, current or past difficulties with substance abuse, and history of violence or self-injurious behavior. Behavioral Health Professionals and Peers, shall acknowledge and discuss with the client that optimal clinical management of clients may depend on coordination of care between a multidisciplinary care team. Providers shall explain to clients that they may need to develop collaborative relationships with local community professionals, such as the client's local primary care provider and local emergency service providers, as this would be invaluable in case of emergencies. Behavioral Health Professionals and Peers, shall be familiar with local in-person mental health resources should the Provider exercise professional judgment to make a referral for additional substance abuse, mental health, or other appropriate services. Behavioral Health Professionals and Peers, shall take reasonable steps to determine whether the client/supervisee physically, intellectually, emotionally, linguistically and functionally capable of using e-service platforms and whether e-services/e-supervision is appropriate for the needs of the client/supervisee. Providers and clients/supervisees shall agree on the means of e-services/ e-supervision to be used and the steps to be taken in case of a technology failure. Providers verify that clients/supervisees understand the purpose and operation of technology applications and follow up with clients/supervisees to correct potential concerns, discover appropriate use, and
assess subsequent steps.

6.7 E-Limitations: Behavioral Health Professionals and Peers, shall acknowledge the difference between face-to-face and electronic communication (nonverbal and verbal cues) and how these could influence the services/supervision process. Providers shall discuss with their client/supervisee how to prevent and address potential misunderstandings arising from the lack of visual cues and voice inflections when communicating electronically.

6.8 Social Media: Behavioral Health Professionals and Peers, shall not accept clients' "friend" requests on social networking sites or email (from Facebook, Twitter, etc.), and shall immediately delete all personal and email accounts to which they have granted client access and create new accounts. When Providers choose to maintain a professional and personal presence for social media use, separate professional and personal web pages and profiles are created that clearly distinguish between the professional and personal virtual presence. Behavioral Health Professionals and Peers, shall clearly explain to their clients/supervisees, as part of informed consent, the benefits, inherent risks including lack of confidentiality, and necessary boundaries surrounding the use of social media. Providers shall clearly explain their policies and procedures specific to the use of social media in a clinical relationship. Providers shall respect the client's/supervisee's rights to privacy on social media and shall not investigate the client/supervisee without prior consent.

7.0 SUPERVISION AND CONSULTATION

7.1 Responsibility in Supervision & Training: Behavioral Health Professionals and Peers, who teach and provide clinical supervision accept the responsibility of enhancing professional development of students and supervisees by providing accurate and current information, timely feedback and evaluations, and constructive consultation. Behavioral Health Supervisors and Peer Supervisors shall monitor the services provided by supervisees. Supervisors shall monitor client welfare. Supervisors shall monitor supervisee performance and professional development. Supervisors shall assume the primary obligation of assisting students to acquire ethics, knowledge, and skills necessary to provide behavioral health services.

7.2 Equity in Supervision & Training: Behavioral Health Supervisors and Peer Supervisors and Educators shall offer didactic learning content and experiential opportunities related to multiculturalism and cultural humility throughout their programs. Behavioral Health Supervisors and Peer Supervisors, shall be cognizant of and address the role of multiculturalism in the supervisory relationship between supervisor and supervisee. Behavioral Health Supervisors and Peer Supervisors and Educators shall provide appropriate accommodations that meet the needs of their diverse staff and student body and support well-being.

7.3 Crisis Procedures: Behavioral Health Supervisors and Peer Supervisors, shall communicate to the supervisee, during supervision informed consent, procedures for handling client/clinical crises. Alternate procedures are also communicated and documented in the event that the supervisee is unable to establish contact with the supervisor during a client/clinical crisis.

7.4 Objectivity: Behavioral Health Supervisors and Peer Supervisors and Educators shall intentionally develop respectful and relevant professional relationships and maintain appropriate boundaries with clinicians, students, interns, and supervisees, in all venues. Supervisors shall strive for accuracy and honesty in their assessments of students, interns, and supervisees. Behavioral Health Supervisors and Peer Supervisors and Educators clearly define and maintain ethical professional, personal, and social boundaries with their supervisees. Supervisors shall not enter into a romantic/sexual/nonprofessional relationship with current supervisees, whether in-person and/or electronically.

7.5 Confidentiality: Behavioral Health Supervisors and Peer Supervisors and Educators shall not disclose confidential information in teaching or supervision without the expressed written consent of a client, and only when appropriate steps have been taken to protect client's identity and confidentiality.

8.0 RESOLVING ETHICAL CONCERNS

8.1 Cognizance: Behavioral Health Professionals and Peers shall understand and endorse the MHACBO Code of Ethics and other applicable ethics codes from professional organizations or certification and licensure bodies of which they are members. Lack of knowledge or misunderstanding of an ethical responsibility is not a defense against a charge of unethical conduct.

8.2 Documentation of Ethical Dilemmas: Behavioral Health Professionals and Peers shall utilize and document, when appropriate, an ethical decision-making model when faced with an ethical dilemma. A viable ethical decision-making model shall include but is not limited to: (a) supervision and/or consultation regarding the concern; (b) consideration of relevant ethical standards, principles, and laws; (c) generation of potential courses of action; (d) deliberation of risks and benefits of each potential course of action; (e) selection of an objective decision based on the circumstances and welfare of all involved; and (f) reflection, and re-direction if necessary, after implementing the decision.

8.3 Jurisdiction: MHACBO and its Ethics Committee shall have jurisdiction over all complaints filed against any person holding or applying for MHACBO certification. MHACBO and its Ethics Committee shall have authority to conduct investigations, issue rulings, and invoke disciplinary action in any instance of alleged misconduct by an behavioral health professional.

8.4 Cooperation: Behavioral Health Professionals and Peers shall be required to cooperate with the implementation of the Code of Conduct and to participate in, and abide by, any disciplinary actions and rulings based on the Code. Failure to participate or cooperate is a violation of the MHACBO Code of Conduct. Behavioral Health Supervisors and Peers shall assist in the process of enforcing the MHACBO Code of Conduct. Providers shall cooperate with investigations, proceedings, and requirements of the MHACBO Ethics Committees, ethics committees of other professional associations, and/or licensing and certification boards having jurisdiction over those charged with a violation.

8.5 Conflicts on interests: Behavioral Health Supervisors and Peers shall seek and document supervision and/or consultation in the event that ethical responsibilities conflict with agency policies and procedures, state and/or federal laws, regulations, and/or other governing legal authority. Behavioral Health Professionals may find themselves at a crossroads when the demands of an organization where the Provider is affiliated poses a conflict with the MHACBO Code of Conduct. Providers shall determine the nature of the conflict and shall discuss the conflict with their supervisor or other relevant person at the organization in question, expressing their commitment to the MHACBO Code of Conduct. Providers shall attempt to work through the appropriate channels to address the concern.

8.6 Reporting: When there is evidence to suggest that another provider is violating or has violated an ethical standard and harm has not occurred, Behavioral Health Supervisors and Peers shall attempt to first resolve the issue informally with the other provider if feasible, provided such action does not violate confidentiality rights that may be involved. Behavioral Health Professionals and Peers shall report unethical conduct or unprofessional modes of practice - leading to harm or creating a likely risk of harm - which they become aware of to the appropriate certifying or licensing authorities, state or federal regulatory bodies. Providers shall seek supervision/consultation prior to the report. Behavioral Health Professionals and Peers shall seek consultation and direction from supervisors, consultants or the MHACBO Ethics

Committee when uncertain about whether a particular situation or course of action may be in violation of the MHACBO Code of Conduct. Providers consult with persons who are knowledgeable about ethics, the MHACBO Code of Conduct, and legal requirements specific to the situation. Behavioral Health Professionals and Peers shall not initiate, participate in, or encourage the filing of an ethics or grievance complaint as a means of retaliation against another person. Behavioral Health Professionals and Peers shall not intentionally disregard or ignore the facts of the situation or omit exculpatory information in their reports.

9.0 RESEARCH AND PUBLICATION

9.1 Support: Research and publication shall be encouraged to contribute to the knowledge base and skills within the addictions and behavioral health professions. Research shall be encouraged to contribute to the evidence-based and outcome-driven practices that guide the profession. Research and publication provide an understanding of what practices lead to health, wellness, and functionality. Researchers and Behavioral Health Professionals make every effort to be inclusive by minimizing bias and respecting diversity when designing, executing, analyzing, and publishing their research. Behavioral Health Professionals and Peers support the efforts of researchers by participating in research whenever possible.

9.2 Responsibility: Behavioral Health Professionals and Peer researchers, who are conducting independent research without governance by an institutional review board, are bound to the same ethical principles and federal and state laws pertaining to the review of their plan, design, conduct, and reporting of research. Behavioral Health Professionals and Peer researchers who conduct research are responsible for their participants' welfare. Researchers shall exercise reasonable precautions throughout the study to avoid causing physical, intellectual, emotional, or social harm to participants. Behavioral Health Professionals and Peer researchers shall commit to the highest standards of scholarship, and shall present accurate information, disclose potential conflicts of interest, and make every effort to prevent the distortion or misuse of their research findings.

9.3 Publications: Behavioral Health Professionals and Peers who author books, journal articles, or other materials which are published or distributed shall not plagiarize or fail to cite persons for whom credit for original ideas or work is due. Providers shall acknowledge and give recognition, in presentations and publications, to previous work on the topic by self and others. Behavioral Health Professionals and Peers shall regard as theft the use of copyrighted materials without permission from the author or payment of royalties. Behavioral Health Professionals and Peers shall assign publication credit to those who have contributed to a publication in proportion to their contributions and in accordance with customary professional publication practices.

Adopted June 1, 2018 by the MHACBO Board of Directors

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Print Name

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Sign Name, pledging adherence to this Ethical Code