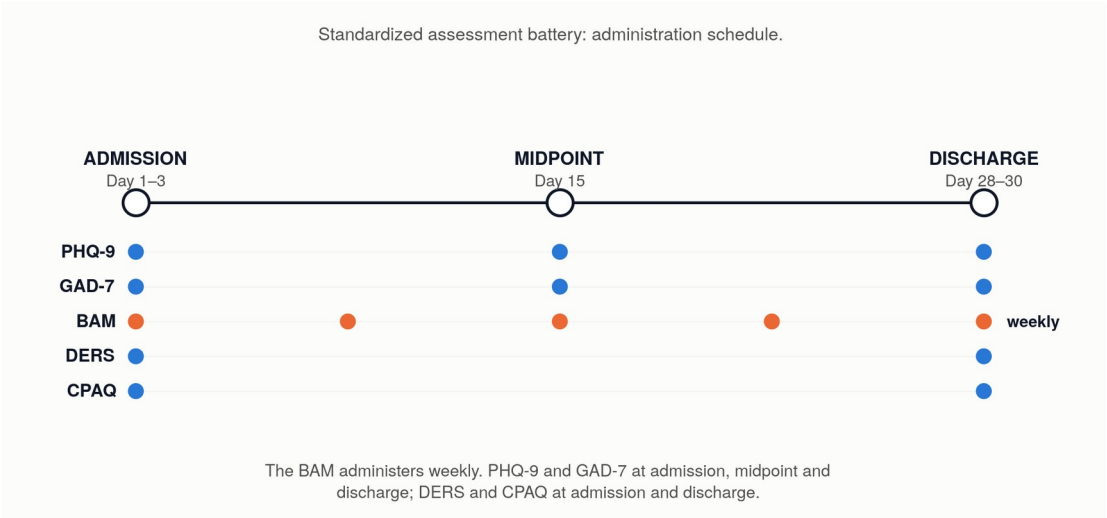
## The Assessment Battery

Five instruments are administered across the episode of care. They serve three distinct purposes that are worth keeping separate: clinical monitoring of the individual client, evidence of program effect, and, for two of the instruments, direct clinical content that clients use in their own sessions.




*Administration schedule across the thirty days*

*The battery*

| Instrument | Domain | Structure | Administration |
|---|---|---|---|
| PHQ-9 | Depressive symptom severity | 9 items, 0–27, plus a standalone risk item | Admission, Day 15, discharge |
| GAD-7 | Generalized anxiety severity | 7 items, 0–21 | Admission, Day 15, discharge |
| BAM | Substance use, risk and protective factors | 17 items, 30-day recall, three subscales | Weekly |
| DERS | Difficulties in emotion regulation | Multi-subscale self-report; short forms available | Admission, discharge |
| CPAQ | Chronic pain acceptance and psychological flexibility | Two subscales: activity engagement and pain willingness | Admission, discharge |

### Reading each instrument

The PHQ-9 and GAD-7 are brief severity measures with established cut-points that clinical staff will already know. Two cautions specific to this population. First, somatic items on both instruments (sleep, appetite, energy, concentration, restlessness) are confounded by withdrawal and by protracted withdrawal, so an admission score taken in the first week measures a physiological state as much as a mood disorder, and a falling score by Day 15 may reflect resolving withdrawal rather than treatment effect. Second, the PHQ-9's ninth item is a risk item, not a scored symptom among others: a positive response triggers immediate assessment by a licensed clinician the same day, and the workflow for that must exist before the instrument is administered.

The Brief Addiction Monitor is the instrument with the most direct clinical utility here because it is administered weekly and because its structure maps onto the program's own logic. It yields three subscale scores rather than a single total: use, risk factors, and protective factors. The protective factors subscale is the one facilitators should attend to most closely; it covers self-efficacy, mutual aid participation, sober support, and meaningful activity, which is very nearly a measure of the recovery capital built in Track 7. A client whose risk factors are stable but whose protective factors are falling is describing the emotional stage of relapse from 9.2 in numbers, several weeks before anything else shows it.

*BAM subscales and what a change means*

| Subscale | Covers | Direction sought | What a worsening trend indicates |
|---|---|---|---|
| Use | Alcohol, heavy alcohol, other drug use in past 30 days | Down or stable at zero | Immediate clinical review; consider level of care |
| Risk factors | Physical health, sleep, mood, craving, risky situations, family conflict | Down | Rising vulnerability: cross-check against HALT log and sleep record |
| Protective factors | Self-efficacy, self-help participation, spirituality, work or school, income, sober supports | Up | The earliest available signal. Falling protection precedes rising risk. |

The DERS measures the construct Track 2 is built to change, and its subscale profile is more useful than its total. A client scoring high on limited access to regulation strategies needs the distress tolerance and emotion regulation content weighted heavily; a client scoring high on non-acceptance of emotional responses is being described by Track 3 rather than Track 2. Use the admission profile to prioritize which sessions a client's individual counselling reinforces.

The CPAQ is included for two reasons. It captures acceptance-based psychological flexibility, which is the target of Track 3 and which no other instrument in the battery measures. And chronic pain is common in this population and is a substantial relapse risk, particularly for clients whose opioid use began with a legitimate prescription. A low pain willingness score at admission identifies a client for whom the ACT track is not optional enrichment but core treatment.

> **DOCUMENTATION**
> Scores are recorded in the clinical record at each administration point with the date and the administering staff member. A change between administrations is documented with a clinical interpretation, not left as a number: a falling PHQ-9 in week two accompanied by resolving withdrawal is a different finding from the same change in week four. Any positive response to the PHQ-9 risk item is documented along with the assessment it triggered, the clinician who performed it, and the disposition, the same day.

## Competency and Program Evaluation

### Individual competency

Attendance is not completion. Each client carries a competency record organized by track, and the summative objectives listed in each session are the criteria. The record's purpose is to make visible what a client can actually do at discharge, which is the information the continuing care provider needs and almost never receives.

*Core deliverables required for completion*

| Deliverable | Built in | Evidence |
|---|---|---|
| Completed thought record on a personal trigger | 1.3 | Reviewed artifact |
| Crisis Survival Kit | 2.3 | Physical kit plus written contents list |
| Behavioral chain analysis of a personal episode | 2.6 | Completed chain with solution analysis |
| 30-day committed action plan | 3.4 | Written plan anchored to stated values |
| Personal grounding and breath protocol card | 4.2, 4.4 | Wallet card, demonstrated on request |
| Naloxone competence | 5.5 | Observed demonstration on a trainer device |
| Three boundary statements | 6.2 | Condition plus self-enforced consequence each |
| Refusal scripts for three scenarios | 6.3 | Demonstrated once to criterion in role-play |
| Contact chain of five named people | 7.3 | Verified contacts with roles |
| Continuing care plan | 7.4 | Signed, with booked appointments |
| HALT action matrix | 9.1 | Wallet card with pre-committed responses |
| Warning sign checklist with named observers | 9.2 | Written, with prospective permission documented |
| Emergency Relapse Prevention Plan | 9.4 | Signed, stress-tested, distributed, review booked |

### Program evaluation

Three levels of evaluation, each answering a different question. Reaction and participation data (attendance, session completion, client feedback) answer whether the program is being delivered. Competency data, aggregated from the checklist above, answer whether clients are leaving with the capabilities the curriculum claims to build. Outcome data from the instrument battery, plus post-discharge follow-up at thirty and ninety days, answer whether any of it held.

- Aggregate BAM protective factor trajectories are the most informative single program metric available weekly, and they will show a problem before outcome data does.
- Track completion rates for the Create-level objectives specifically. A session consistently failing to produce its artifact has a design problem, and the fix is redesign rather than reminding staff to try harder.
- Follow-up at thirty and ninety days should record whether the continuing care appointment was attended, not only whether the client reports doing well. Attendance is verifiable; self-report at ninety days is not.
- Report post-discharge deaths to the clinical director without exception and review the discharge record against the overdose prevention checklist in 5.5. This is the most important number the program has and the one it will be most tempted not to look at.

> **DOCUMENTATION**

# Appendix C: Session Index

All forty-two sessions by track, with duration and the block in which each is delivered.

*Complete session index*

| ID | Session | Duration | Block |
|---|---|---|---|
| 0.1 | Where You Are Right Now | 60 min | Arrival |
| 1.1 | The Cognitive Model and the Cognitive Triangle | 75 minutes | Week A |
| 1.2 | Cognitive Distortions in Addiction and Recovery | 75 minutes | Week A |
| 1.3 | Thought Records and Cognitive Restructuring | 90 minutes | Week B |
| 1.4 | Core Beliefs, Intermediate Beliefs and Schema in Recovery | 90 minutes | Week B |
| 1.5 | Behavioral Activation and Craving Management | 90 minutes | Week C |
| 2.1 | Dialectics, Validation and States of Mind | 75 minutes | Week A |
| 2.2 | Core Mindfulness | 60 minutes | Week A |
| 2.3 | Distress Tolerance and Crisis Survival | 90 minutes | Week B |
| 2.4 | Emotion Regulation | 90 minutes | Week B |
| 2.5 | Interpersonal Effectiveness | 90 minutes | Week C |
| 2.6 | Behavioral Chain Analysis and Missing Links | 75 minutes | Week C |
| 3.1 | Psychological Flexibility and the Hexaflex | 75 minutes | Week A |
| 3.2 | Experiential Avoidance and Cognitive Defusion | 90 minutes | Week B |
| 3.3 | Values Clarification | 75 minutes | Week C |
| 3.4 | Committed Action | 90 minutes | Week D |
| 3.5 | Grief, Loss and Acceptance | 90 minutes | Week D |
| 4.1 | Trauma-Informed Care and the Window of Tolerance | 75 minutes | Arrival |
| 4.2 | Grounding and Sensory Regulation | 60 minutes | Arrival |
| 4.3 | EMDR Psychoeducation and the AIP Model | 60 minutes | Week B |
| 4.4 | Breathwork and Autonomic Regulation | 60 minutes | Week C |
| 4.5 | Trauma-Sensitive Yoga and Movement | 75 minutes | Week D |
| 5.1 | Addiction Neurobiology and the Reward Pathway | 75 minutes | Week A |
| 5.2 | Substance Classes and Withdrawal | 75 minutes | Week A |
| 5.3 | Medications for Addiction Treatment | 90 minutes | Week B |
| 5.4 | Sleep, Circadian Recovery and CBT-I Principles | 75 minutes | Week C |
| 5.5 | Physical Health, Nutrition and Overdose Prevention | 90 minutes | Week D |
| 6.1 | Codependency, Enabling and Family Roles | 75 minutes | Week A |
| 6.2 | Boundaries | 75 minutes | Week C |
| 6.3 | Assertive Communication | 90 minutes | Week D |
| 6.4 | The Karpman Drama Triangle and the Way Out | 75 minutes | Week D |
| 7.1 | Pluralistic Pathways to Recovery | 90 minutes | Week B |
| 7.2 | Abstinence, Harm Reduction and Defining Your Own Recovery | 75 minutes | Week C |
| 7.3 | Recovery Capital and Building a Support Network | 75 minutes | Week D |
| 7.4 | Continuing Care, the ASAM Continuum and Discharge Planning | 90 minutes | Departure |
| 8.1 | Expressive Arts and the Recovery Mask | 90 minutes | Week A |
| 8.2 | Music and Lyric Analysis | 75 minutes | Week B |
| 8.3 | Therapeutic Journaling | 75 minutes | Week C |
| 8.4 | Life Narrative and Identity Reconstruction | 90 minutes | Week D |
| 9.1 | HALT, HOW and the Daily Self-Inventory | 60 minutes | Arrival |
| 9.2 | The Stages of Relapse and Personal Warning Signs | 75 minutes | Departure |
| 9.3 | High-Risk Situation Mapping | 75 minutes | Departure |
| 9.4 | The Emergency Relapse Prevention Plan | 120 minutes | Departure |