

EXAM 5: ALCOHOL AND DRUG COUNSELOR PRACTICE

EXAM (150 QUESTIONS)

Choose the single best answer for each question. This independent practice exam uses broadly applicable U.S. alcohol and drug counseling principles; consult your credentialing body and jurisdiction for specific requirements.

1. Taylor is meeting with an alcohol and drug counselor. At intake, the client speaks quietly and looks away while describing substance use. What response best supports engagement?
 - A. Use a calm, nonjudgmental tone and ask permission before exploring sensitive details.
 - B. Demand complete disclosure before continuing services.
 - C. Assume the client is withholding information intentionally.
 - D. Explain that eye contact is required for counseling.

2. Taylor is meeting with an alcohol and drug counselor. A client reports drinking 'a few' drinks on weekends. Which follow-up question is most useful for clarifying the pattern?
 - A. 'You know that drinking is bad, right?'
 - B. 'Why do you refuse to stop drinking?'
 - C. 'Would your family say you are an alcoholic?'
 - D. 'On a typical weekend day, how many drinks do you have and over how many hours?'

3. Taylor is meeting with an alcohol and drug counselor. A client agrees that a sibling may provide collateral information. What is the counselor's best first step?
 - A. Call the sibling immediately because the client mentioned the name.
 - B. Ask the sibling for records without explaining confidentiality.
 - C. Obtain a valid authorization that defines the purpose and permitted exchange of information.

D. Share the treatment plan before confirming consent.

4. Taylor is meeting with an alcohol and drug counselor. A urine drug screen is negative, but the client reports recent substance use. Which interpretation is most appropriate?

A. Conclude the client is lying and end the session.

B. Consider timing, test limits, and possible false-negative results rather than assuming the client is dishonest.

C. Treat the screen as proof that no assessment is needed.

D. Ignore the result because all tests are inaccurate.

5. Taylor is meeting with an alcohol and drug counselor. A client taking prescribed opioids says they are also using alcohol to sleep. What is the counselor's priority?

A. Advise stopping all medication immediately without medical input.

B. Focus only on whether the client meets attendance rules.

C. Tell the client to replace alcohol with an energy drink.

D. Explain the increased safety risk and coordinate prompt medical assessment with appropriate consent.

6. Taylor is meeting with an alcohol and drug counselor. A client who used stimulants for several days now reports exhaustion, low mood, and intense cravings. What response is most appropriate?

A. Assess safety, provide support, and arrange medical or mental-health evaluation when symptoms or risk warrant it.

B. Tell the client to simply exercise until symptoms pass.

C. Assume the symptoms prove a personality disorder.

D. Require the client to make major life decisions today.

7. Taylor is meeting with an alcohol and drug counselor. A client says they stopped benzodiazepines abruptly after long-term use and now has severe anxiety and tremors. What should the counselor do?

- A. Recommend doubling the next counseling appointment length.
- B. Treat this as a potential medical emergency and arrange urgent evaluation according to protocol.
- C. Tell the client to use alcohol to calm down.
- D. Wait several days to see if symptoms resolve.

8. Taylor is meeting with an alcohol and drug counselor. A client uses cannabis daily and says it does not affect motivation. Which assessment question is most useful?

- A. 'Why are you so unmotivated?'
- B. 'Can you promise to stop today?'
- C. 'Would you agree cannabis always causes laziness?'
- D. 'How has daily cannabis use affected sleep, concentration, work, relationships, or goals, if at all?'

9. Taylor is meeting with an alcohol and drug counselor. A client who vapes nicotine says quitting feels impossible because it helps with stress. What is the best counseling response?

- A. Tell the client stress is never real.
- B. Insist that nicotine withdrawal is harmless for everyone.
- C. Explore the stress-relief belief and discuss evidence-based supports and alternative coping strategies.
- D. Ignore nicotine because the client also uses alcohol.

10. Taylor is meeting with an alcohol and drug counselor. A client arrives smelling of alcohol and appears unsteady. What is the counselor's first responsibility?

- A. Assess immediate safety and follow agency policy for intoxication, transportation, and emergency needs.
- B. Begin a detailed trauma-processing session.
- C. Allow the client to drive home after signing a form.
- D. Confront the client in the waiting room.

11. Taylor is meeting with an alcohol and drug counselor. A client asks whether medication for opioid use disorder means they are 'not really in recovery.' What is the best response?

- A. Agree that medication always replaces one addiction with another.
- B. Explain that recovery goals are individualized and medication can be an evidence-based component of treatment.
- C. Tell the client to discontinue medication before discussing recovery.
- D. State that counseling has no role when medication is used.

12. Taylor is meeting with an alcohol and drug counselor. A client has housing, a supportive aunt, a recovery group, and reliable transportation. These are examples of:

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- B. Proof that relapse can never occur.
- C. Reasons to end all counseling immediately.
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13. Taylor is meeting with an alcohol and drug counselor. A client is curious about peer recovery support but worries that peers will act as counselors. What is the best explanation?

- A. Peers offer lived-experience support and connection while working within defined roles and boundaries.
- B. Peers should diagnose mental-health conditions independently.
- C. Peers replace all clinical and medical services.
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14. Taylor is meeting with an alcohol and drug counselor. A client says unemployment makes recovery feel pointless. Which intervention best supports recovery-oriented case management?

- A. Tell the client to postpone work concerns until every craving ends.
- B. Promise to obtain a job for the client.
- C. Help identify employment barriers, strengths, and referrals that align with the client's goals.
- D. Focus only on past employment mistakes.

15. Taylor is meeting with an alcohol and drug counselor. A minor asks for substance-use counseling without a parent present. What should the counselor do first?

- A. Promise complete secrecy before discussing anything else.
- B. Require the minor to explain why parents are uninvolved in public.
- C. Assume adult consent rules apply without checking.
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- A. Everything said in group is legally secret without exception.
- B. Members should respect privacy, but the counselor cannot guarantee that every member will keep disclosures private.
- C. Members may post group stories online if names are omitted.
- D. Confidentiality does not matter because the group is voluntary.

17. Taylor is meeting with an alcohol and drug counselor. A counselor begins telehealth with a client who is in a coffee shop. What is the best initial response?

- A. Discuss privacy risks and work with the client to find a more confidential setting if possible.
- B. Proceed without comment because the client chose the location.
- C. Ask nearby customers to leave the area.
- D. Discuss another client's case to test the connection.

18. Taylor is meeting with an alcohol and drug counselor. A client says a progress note contains an error about the date of last use. What is the appropriate documentation action?

- A. Delete the original note without a trace.
- B. Tell the client records cannot ever be corrected.

- C. Follow record-correction policy by adding an accurate, dated amendment without obscuring the original entry.
- D. Ask the client to rewrite the counselor's note.

19. Taylor is meeting with an alcohol and drug counselor. A client declines a recommended referral for a higher level of care. What is the counselor's best response?

- A. Explore the client's reasons, explain risks and alternatives, assess safety, and document the informed refusal.
- B. Terminate services immediately as punishment.
- C. Force the referral without considering criteria or law.
- D. Avoid discussing the recommendation again.

20. Taylor is meeting with an alcohol and drug counselor. A counselor considers sharing a personal recovery story because a client feels hopeless. What is the best ethical approach?

- A. Share every detail to prove credibility.
- B. Avoid supervision because disclosure is always harmless.
- C. Use self-disclosure only if it has a clear client benefit, is brief, and does not shift focus to the counselor.
- D. Ask the client to comfort the counselor after disclosure.

21. Taylor is meeting with an alcohol and drug counselor. A counselor realizes they are becoming emotionally exhausted and impatient with clients. What is the most responsible action?

- A. Continue unchanged because burnout cannot affect counseling.
- B. Use supervision, self-care, and workload supports while taking steps to protect quality of care.
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22. Taylor is meeting with an alcohol and drug counselor. A program is choosing a new intervention. Which question best reflects evidence-based practice?

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23. Taylor is meeting with an alcohol and drug counselor. Which treatment-plan goal is most measurable?

- A. 'Client will become a better person soon.'
- B. 'Client will try harder at recovery.'
- C. 'Client will attend two recovery-support meetings weekly for the next four weeks and review barriers in session.'
- D. 'Client will never experience cravings again.'

24. Taylor is meeting with an alcohol and drug counselor. A client has missed two appointments and has not returned calls. What is the best next step?

- A. Use the program's outreach procedure, document attempts, and consider safety or access barriers without assuming noncompliance.
- B. Discharge the client immediately without review.
- C. Leave detailed treatment information on a public voicemail.
- D. Assume the client no longer needs help.

25. Taylor is meeting with an alcohol and drug counselor. A client returns to alcohol use after six months of abstinence and says, 'I ruined everything.' What is the most helpful response?

- A. Agree that all progress has been erased.
- B. Address immediate safety, review what happened, and frame the event as information for revising the recovery plan.
- C. Tell the client to wait until next month to discuss it.
- D. Focus on blaming the person who offered alcohol.

26. Taylor is meeting with an alcohol and drug counselor. A family member calls to report that a client may be using again. The client has not authorized disclosure. What may the counselor generally do?

- A. Confirm the client is enrolled and discuss progress openly.
- B. Tell the caller every detail in the chart.
- C. Promise that the counselor will force the client to stop using.
- D. Listen to the family member's information without confirming the client is in treatment or revealing protected details.

27. Taylor is meeting with an alcohol and drug counselor. A client reports chest pain and shortness of breath after using cocaine. What is the counselor's priority?

- A. Guide the client through a routine relaxation exercise only.
- B. Ask the client to drive to a later appointment.
- C. Wait until the craving has passed before acting.
- D. Activate emergency medical response and follow the program's urgent-care protocol.

28. Taylor is meeting with an alcohol and drug counselor. A client asks how to reduce overdose risk while still using opioids. Which response is most appropriate?

- A. Refuse all safety information until abstinence is promised.
- B. Say that overdose prevention is impossible.
- C. Provide nonjudgmental overdose-prevention education and offer connection to naloxone and treatment resources.
- D. End services because the client has not met the program goal.

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- B. Use the program's outreach procedure, document attempts, and consider safety or access barriers without assuming noncompliance.
- C. Leave detailed treatment information on a public voicemail.
- D. Assume the client no longer needs help.

81. Cameron is meeting with an alcohol and drug counselor. A client returns to alcohol use after six months of abstinence and says, 'I ruined everything.' What is the most helpful response?

- A. Address immediate safety, review what happened, and frame the event as information for revising the recovery plan.
- B. Agree that all progress has been erased.
- C. Tell the client to wait until next month to discuss it.
- D. Focus on blaming the person who offered alcohol.

82. Cameron is meeting with an alcohol and drug counselor. A family member calls to report that a client may be using again. The client has not authorized disclosure. What may the counselor generally do?

- A. Confirm the client is enrolled and discuss progress openly.
- B. Tell the caller every detail in the chart.
- C. Promise that the counselor will force the client to stop using.
- D. Listen to the family member's information without confirming the client is in treatment or revealing protected details.

83. Cameron is meeting with an alcohol and drug counselor. A client reports chest pain and shortness of breath after using cocaine. What is the counselor's priority?

- A. Activate emergency medical response and follow the program's urgent-care protocol.
- B. Guide the client through a routine relaxation exercise only.
- C. Ask the client to drive to a later appointment.
- D. Wait until the craving has passed before acting.

84. Cameron is meeting with an alcohol and drug counselor. A client asks how to reduce overdose risk while still using opioids. Which response is most appropriate?

- A. Refuse all safety information until abstinence is promised.
- B. Provide nonjudgmental overdose-prevention education and offer connection to naloxone and treatment resources.
- C. Say that overdose prevention is impossible.
- D. End services because the client has not met the program goal.

85. Drew is meeting with an alcohol and drug counselor. At intake, the client speaks quietly and looks away while describing substance use. What response best supports engagement?

- A. Demand complete disclosure before continuing services.
- B. Assume the client is withholding information intentionally.
- C. Use a calm, nonjudgmental tone and ask permission before exploring sensitive details.
- D. Explain that eye contact is required for counseling.

86. Drew is meeting with an alcohol and drug counselor. A client reports drinking 'a few' drinks on weekends. Which follow-up question is most useful for clarifying the pattern?

- A. 'You know that drinking is bad, right?'
- B. 'Why do you refuse to stop drinking?'
- C. 'Would your family say you are an alcoholic?'
- D. 'On a typical weekend day, how many drinks do you have and over how many hours?'

87. Drew is meeting with an alcohol and drug counselor. A client agrees that a sibling may provide collateral information. What is the counselor's best first step?

- A. Obtain a valid authorization that defines the purpose and permitted exchange of information.
- B. Call the sibling immediately because the client mentioned the name.
- C. Ask the sibling for records without explaining confidentiality.
- D. Share the treatment plan before confirming consent.

88. Drew is meeting with an alcohol and drug counselor. A urine drug screen is negative, but the client reports recent substance use. Which interpretation is most appropriate?

- A. Conclude the client is lying and end the session.
- B. Treat the screen as proof that no assessment is needed.
- C. Ignore the result because all tests are inaccurate.
- D. Consider timing, test limits, and possible false-negative results rather than assuming the client is dishonest.

89. Drew is meeting with an alcohol and drug counselor. A client taking prescribed opioids says they are also using alcohol to sleep. What is the counselor's priority?

- A. Advise stopping all medication immediately without medical input.
- B. Explain the increased safety risk and coordinate prompt medical assessment with appropriate consent.
- C. Focus only on whether the client meets attendance rules.
- D. Tell the client to replace alcohol with an energy drink.

90. Drew is meeting with an alcohol and drug counselor. A client who used stimulants for several days now reports exhaustion, low mood, and intense cravings. What response is most appropriate?

- A. Tell the client to simply exercise until symptoms pass.
- B. Assume the symptoms prove a personality disorder.
- C. Assess safety, provide support, and arrange medical or mental-health evaluation when symptoms or risk warrant it.
- D. Require the client to make major life decisions today.

91. Drew is meeting with an alcohol and drug counselor. A client says they stopped benzodiazepines abruptly after long-term use and now has severe anxiety and tremors. What should the counselor do?

- A. Recommend doubling the next counseling appointment length.
- B. Tell the client to use alcohol to calm down.
- C. Treat this as a potential medical emergency and arrange urgent evaluation according to protocol.
- D. Wait several days to see if symptoms resolve.

92. Drew is meeting with an alcohol and drug counselor. A client uses cannabis daily and says it does not affect motivation. Which assessment question is most useful?

- A. 'How has daily cannabis use affected sleep, concentration, work, relationships, or goals, if at all?'
- B. 'Why are you so unmotivated?'

- C. 'Can you promise to stop today?'
- D. 'Would you agree cannabis always causes laziness?'

93. Drew is meeting with an alcohol and drug counselor. A client who vapes nicotine says quitting feels impossible because it helps with stress. What is the best counseling response?

- A. Tell the client stress is never real.
- B. Insist that nicotine withdrawal is harmless for everyone.
- C. Ignore nicotine because the client also uses alcohol.
- D. Explore the stress-relief belief and discuss evidence-based supports and alternative coping strategies.

94. Drew is meeting with an alcohol and drug counselor. A client arrives smelling of alcohol and appears unsteady. What is the counselor's first responsibility?

- A. Begin a detailed trauma-processing session.
- B. Assess immediate safety and follow agency policy for intoxication, transportation, and emergency needs.
- C. Allow the client to drive home after signing a form.
- D. Confront the client in the waiting room.

95. Drew is meeting with an alcohol and drug counselor. A client asks whether medication for opioid use disorder means they are 'not really in recovery.' What is the best response?

- A. Explain that recovery goals are individualized and medication can be an evidence-based component of treatment.
- B. Agree that medication always replaces one addiction with another.
- C. Tell the client to discontinue medication before discussing recovery.
- D. State that counseling has no role when medication is used.

96. Drew is meeting with an alcohol and drug counselor. A client has housing, a supportive aunt, a recovery group, and reliable transportation. These are examples of:

- A. Diagnostic criteria that establish dependence.
- B. Proof that relapse can never occur.
- C. Reasons to end all counseling immediately.
- D. Recovery capital, or resources that can support sustained recovery and wellbeing.

97. Drew is meeting with an alcohol and drug counselor. A client is curious about peer recovery support but worries that peers will act as counselors. What is the best explanation?

- A. Peers should diagnose mental-health conditions independently.
- B. Peers replace all clinical and medical services.
- C. Peers offer lived-experience support and connection while working within defined roles and boundaries.
- D. Peers may share another person's treatment information freely.

98. Drew is meeting with an alcohol and drug counselor. A client says unemployment makes recovery feel pointless. Which intervention best supports recovery-oriented case management?

- A. Tell the client to postpone work concerns until every craving ends.
- B. Help identify employment barriers, strengths, and referrals that align with the client's goals.
- C. Promise to obtain a job for the client.
- D. Focus only on past employment mistakes.

99. Drew is meeting with an alcohol and drug counselor. A minor asks for substance-use counseling without a parent present. What should the counselor do first?

- A. Promise complete secrecy before discussing anything else.
- B. Require the minor to explain why parents are uninvolved in public.
- C. Assume adult consent rules apply without checking.
- D. Explain confidentiality limits and determine applicable consent requirements under local law and agency policy.

100. Drew is meeting with an alcohol and drug counselor. At the start of a therapy group, what should the facilitator emphasize about confidentiality?

- A. Everything said in group is legally secret without exception.
- B. Members may post group stories online if names are omitted.
- C. Members should respect privacy, but the counselor cannot guarantee that every member will keep disclosures private.
- D. Confidentiality does not matter because the group is voluntary.

101. Drew is meeting with an alcohol and drug counselor. A counselor begins telehealth with a client who is in a coffee shop. What is the best initial response?

- A. Discuss privacy risks and work with the client to find a more confidential setting if possible.
- B. Proceed without comment because the client chose the location.
- C. Ask nearby customers to leave the area.
- D. Discuss another client's case to test the connection.

102. Drew is meeting with an alcohol and drug counselor. A client says a progress note contains an error about the date of last use. What is the appropriate documentation action?

- A. Delete the original note without a trace.
- B. Follow record-correction policy by adding an accurate, dated amendment without obscuring the original entry.
- C. Tell the client records cannot ever be corrected.
- D. Ask the client to rewrite the counselor's note.

103. Drew is meeting with an alcohol and drug counselor. A client declines a recommended referral for a higher level of care. What is the counselor's best response?

- A. Terminate services immediately as punishment.
- B. Force the referral without considering criteria or law.

- C. Explore the client's reasons, explain risks and alternatives, assess safety, and document the informed refusal.
- D. Avoid discussing the recommendation again.

104. Drew is meeting with an alcohol and drug counselor. A counselor considers sharing a personal recovery story because a client feels hopeless. What is the best ethical approach?

- A. Use self-disclosure only if it has a clear client benefit, is brief, and does not shift focus to the counselor.
- B. Share every detail to prove credibility.
- C. Avoid supervision because disclosure is always harmless.
- D. Ask the client to comfort the counselor after disclosure.

105. Drew is meeting with an alcohol and drug counselor. A counselor realizes they are becoming emotionally exhausted and impatient with clients. What is the most responsible action?

- A. Continue unchanged because burnout cannot affect counseling.
- B. Discuss personal frustration with clients for relief.
- C. Ignore agency support policies.
- D. Use supervision, self-care, and workload supports while taking steps to protect quality of care.

106. Drew is meeting with an alcohol and drug counselor. A program is choosing a new intervention. Which question best reflects evidence-based practice?

- A. Which intervention is newest, regardless of results?
- B. What research support, clinical expertise, and client preferences are relevant to this intervention?
- C. Which intervention requires the least staff training?
- D. Which intervention is most popular on social media?

107. Drew is meeting with an alcohol and drug counselor. Which treatment-plan goal is most measurable?

- A. 'Client will become a better person soon.'
- B. 'Client will try harder at recovery.'
- C. 'Client will never experience cravings again.'
- D. 'Client will attend two recovery-support meetings weekly for the next four weeks and review barriers in session.'

108. Drew is meeting with an alcohol and drug counselor. A client has missed two appointments and has not returned calls. What is the best next step?

- A. Use the program's outreach procedure, document attempts, and consider safety or access barriers without assuming noncompliance.
- B. Discharge the client immediately without review.
- C. Leave detailed treatment information on a public voicemail.
- D. Assume the client no longer needs help.

109. Drew is meeting with an alcohol and drug counselor. A client returns to alcohol use after six months of abstinence and says, 'I ruined everything.' What is the most helpful response?

- A. Agree that all progress has been erased.
- B. Tell the client to wait until next month to discuss it.
- C. Address immediate safety, review what happened, and frame the event as information for revising the recovery plan.
- D. Focus on blaming the person who offered alcohol.

110. Drew is meeting with an alcohol and drug counselor. A family member calls to report that a client may be using again. The client has not authorized disclosure. What may the counselor generally do?

- A. Confirm the client is enrolled and discuss progress openly.
- B. Listen to the family member's information without confirming the client is in treatment or revealing protected details.
- C. Tell the caller every detail in the chart.
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- A. Activate emergency medical response and follow the program's urgent-care protocol.
- B. Guide the client through a routine relaxation exercise only.
- C. Ask the client to drive to a later appointment.
- D. Wait until the craving has passed before acting.

112. Drew is meeting with an alcohol and drug counselor. A client asks how to reduce overdose risk while still using opioids. Which response is most appropriate?

- A. Refuse all safety information until abstinence is promised.
- B. Say that overdose prevention is impossible.
- C. Provide nonjudgmental overdose-prevention education and offer connection to naloxone and treatment resources.
- D. End services because the client has not met the program goal.

113. Quinn is meeting with an alcohol and drug counselor. At intake, the client speaks quietly and looks away while describing substance use. What response best supports engagement?

- A. Demand complete disclosure before continuing services.
- B. Use a calm, nonjudgmental tone and ask permission before exploring sensitive details.
- C. Assume the client is withholding information intentionally.
- D. Explain that eye contact is required for counseling.

114. Quinn is meeting with an alcohol and drug counselor. A client reports drinking 'a few' drinks on weekends. Which follow-up question is most useful for clarifying the pattern?

- A. 'You know that drinking is bad, right?'
- B. 'Why do you refuse to stop drinking?'
- C. 'Would your family say you are an alcoholic?'
- D. 'On a typical weekend day, how many drinks do you have and over how many hours?'

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- A. Obtain a valid authorization that defines the purpose and permitted exchange of information.
- B. Call the sibling immediately because the client mentioned the name.
- C. Ask the sibling for records without explaining confidentiality.
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- C. Assess safety, provide support, and arrange medical or mental-health evaluation when symptoms or risk warrant it.
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119. Quinn is meeting with an alcohol and drug counselor. A client says they stopped benzodiazepines abruptly after long-term use and now has severe anxiety and tremors. What should the counselor do?

- A. Recommend doubling the next counseling appointment length.
- B. Tell the client to use alcohol to calm down.
- C. Treat this as a potential medical emergency and arrange urgent evaluation according to protocol.
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120. Quinn is meeting with an alcohol and drug counselor. A client uses cannabis daily and says it does not affect motivation. Which assessment question is most useful?

- A. 'Why are you so unmotivated?'
- B. 'How has daily cannabis use affected sleep, concentration, work, relationships, or goals, if at all?'
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- A. Tell the client stress is never real.
- B. Insist that nicotine withdrawal is harmless for everyone.
- C. Ignore nicotine because the client also uses alcohol.
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122. Quinn is meeting with an alcohol and drug counselor. A client arrives smelling of alcohol and appears unsteady. What is the counselor's first responsibility?

- A. Assess immediate safety and follow agency policy for intoxication, transportation, and emergency needs.
- B. Begin a detailed trauma-processing session.
- C. Allow the client to drive home after signing a form.
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- A. Agree that medication always replaces one addiction with another.
- B. Explain that recovery goals are individualized and medication can be an evidence-based component of treatment.
- C. Tell the client to discontinue medication before discussing recovery.
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- D. Peers may share another person's treatment information freely.

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- A. Help identify employment barriers, strengths, and referrals that align with the client's goals.
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- C. Promise to obtain a job for the client.
- D. Focus only on past employment mistakes.

127. Quinn is meeting with an alcohol and drug counselor. A minor asks for substance-use counseling without a parent present. What should the counselor do first?

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- A. Discuss privacy risks and work with the client to find a more confidential setting if possible.
- B. Proceed without comment because the client chose the location.
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D. Discuss another client's case to test the connection.

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- A. Terminate services immediately as punishment.
- B. Explore the client's reasons, explain risks and alternatives, assess safety, and document the informed refusal.
- C. Force the referral without considering criteria or law.
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132. Quinn is meeting with an alcohol and drug counselor. A counselor considers sharing a personal recovery story because a client feels hopeless. What is the best ethical approach?

- A. Use self-disclosure only if it has a clear client benefit, is brief, and does not shift focus to the counselor.
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- C. Avoid supervision because disclosure is always harmless.
- D. Ask the client to comfort the counselor after disclosure.

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- B. Discuss personal frustration with clients for relief.
- C. Use supervision, self-care, and workload supports while taking steps to protect quality of care.
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134. Quinn is meeting with an alcohol and drug counselor. A program is choosing a new intervention. Which question best reflects evidence-based practice?

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- B. Which intervention requires the least staff training?
- C. Which intervention is most popular on social media?
- D. What research support, clinical expertise, and client preferences are relevant to this intervention?

135. Quinn is meeting with an alcohol and drug counselor. Which treatment-plan goal is most measurable?

- A. 'Client will become a better person soon.'
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136. Quinn is meeting with an alcohol and drug counselor. A client has missed two appointments and has not returned calls. What is the best next step?

- A. Use the program's outreach procedure, document attempts, and consider safety or access barriers without assuming noncompliance.
- B. Discharge the client immediately without review.
- C. Leave detailed treatment information on a public voicemail.
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- A. Agree that all progress has been erased.
- B. Tell the client to wait until next month to discuss it.
- C. Address immediate safety, review what happened, and frame the event as information for revising the recovery plan.
- D. Focus on blaming the person who offered alcohol.

138. Quinn is meeting with an alcohol and drug counselor. A family member calls to report that a client may be using again. The client has not authorized disclosure. What may the counselor generally do?

- A. Confirm the client is enrolled and discuss progress openly.
- B. Listen to the family member's information without confirming the client is in treatment or revealing protected details.
- C. Tell the caller every detail in the chart.
- D. Promise that the counselor will force the client to stop using.

139. Quinn is meeting with an alcohol and drug counselor. A client reports chest pain and shortness of breath after using cocaine. What is the counselor's priority?

- A. Guide the client through a routine relaxation exercise only.
- B. Ask the client to drive to a later appointment.
- C. Activate emergency medical response and follow the program's urgent-care protocol.
- D. Wait until the craving has passed before acting.

140. Quinn is meeting with an alcohol and drug counselor. A client asks how to reduce overdose risk while still using opioids. Which response is most appropriate?

- A. Refuse all safety information until abstinence is promised.
- B. Say that overdose prevention is impossible.
- C. End services because the client has not met the program goal.

D. Provide nonjudgmental overdose-prevention education and offer connection to naloxone and treatment resources.

141. Taylor is meeting with an alcohol and drug counselor. At intake, the client speaks quietly and looks away while describing substance use. What response best supports engagement?

- A. Use a calm, nonjudgmental tone and ask permission before exploring sensitive details.
- B. Demand complete disclosure before continuing services.
- C. Assume the client is withholding information intentionally.
- D. Explain that eye contact is required for counseling.

142. Taylor is meeting with an alcohol and drug counselor. A client reports drinking 'a few' drinks on weekends. Which follow-up question is most useful for clarifying the pattern?

- A. 'You know that drinking is bad, right?'
- B. 'On a typical weekend day, how many drinks do you have and over how many hours?'
- C. 'Why do you refuse to stop drinking?'
- D. 'Would your family say you are an alcoholic?'

143. Taylor is meeting with an alcohol and drug counselor. A client agrees that a sibling may provide collateral information. What is the counselor's best first step?

- A. Call the sibling immediately because the client mentioned the name.
- B. Obtain a valid authorization that defines the purpose and permitted exchange of information.
- C. Ask the sibling for records without explaining confidentiality.
- D. Share the treatment plan before confirming consent.

144. Taylor is meeting with an alcohol and drug counselor. A urine drug screen is negative, but the client reports recent substance use. Which interpretation is most appropriate?

- A. Consider timing, test limits, and possible false-negative results rather than assuming the client is dishonest.
- B. Conclude the client is lying and end the session.
- C. Treat the screen as proof that no assessment is needed.
- D. Ignore the result because all tests are inaccurate.

145. Taylor is meeting with an alcohol and drug counselor. A client taking prescribed opioids says they are also using alcohol to sleep. What is the counselor's priority?

- A. Advise stopping all medication immediately without medical input.
- B. Focus only on whether the client meets attendance rules.
- C. Tell the client to replace alcohol with an energy drink.
- D. Explain the increased safety risk and coordinate prompt medical assessment with appropriate consent.

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- A. Tell the client to simply exercise until symptoms pass.
- B. Assume the symptoms prove a personality disorder.
- C. Assess safety, provide support, and arrange medical or mental-health evaluation when symptoms or risk warrant it.
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- B. Tell the client to use alcohol to calm down.
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148. Taylor is meeting with an alcohol and drug counselor. A client uses cannabis daily and says it does not affect motivation. Which assessment question is most useful?

- A. 'How has daily cannabis use affected sleep, concentration, work, relationships, or goals, if at all?'
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- B. Insist that nicotine withdrawal is harmless for everyone.
- C. Explore the stress-relief belief and discuss evidence-based supports and alternative coping strategies.
- D. Ignore nicotine because the client also uses alcohol.

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- A. Begin a detailed trauma-processing session.
- B. Assess immediate safety and follow agency policy for intoxication, transportation, and emergency needs.
- C. Allow the client to drive home after signing a form.
- D. Confront the client in the waiting room.

Exam 5: Answer Key and Explanations

1. A — A calm, respectful approach acknowledges that discussing substance use can feel vulnerable. Asking permission supports autonomy and can increase trust, especially early in treatment. Demanding disclosure, interpreting behavior as deception, or imposing eye-contact expectations can damage rapport. The counselor should remain curious, explain the purpose of questions, and allow the client to set a safe pace for sharing.

- 2. D** — Specific, neutral questions about quantity, frequency, and timing improve assessment accuracy without labeling the client. The best question invites concrete information needed to understand risk. The other options use judgment, assume resistance, or substitute another person's conclusion for the client's report. Counselors should gather details collaboratively and compare them with health, functioning, and safety concerns over time.
- 3. C** — Collateral information can enrich assessment, but it must be obtained and shared within applicable confidentiality rules. A valid authorization clarifies who may communicate, what information may be exchanged, and for what purpose. Mentioning a relative is not permission to contact them. Counselors should disclose only what is authorized, document communication, and remain alert to family conflict or safety concerns.
- 4. B** — Drug-screen results require clinical context. Detection windows, assay limits, specimen issues, and substances not included in a panel can affect results. A negative screen neither proves dishonesty nor replaces assessment. The counselor should discuss findings nonjudgmentally, follow program procedures, and use authorized medical or laboratory consultation when interpretation exceeds competence. Trust is strengthened by transparency rather than accusation.
- 5. D** — Combining alcohol with opioids can increase sedation and breathing risk, so safety and coordinated medical evaluation are priorities. Counselors should provide clear risk information, assess urgent symptoms, and collaborate with qualified providers when authorized. Directing medication changes exceeds counseling scope. Attendance rules or substitute beverages do not address the potentially dangerous interaction or the client's underlying sleep concern.
- 6. A** — Stimulant withdrawal or a crash can involve fatigue, depressed mood, sleep changes, and cravings. Counselors should assess safety, including suicidal thinking when indicated, provide supportive care, and connect the client with qualified evaluation when symptoms are severe or persistent. Labeling, oversimplifying, or pressing for major decisions can worsen distress. The goal is stabilization, monitoring, and appropriate referral.
- 7. B** — Abrupt discontinuation after long-term benzodiazepine use may create serious withdrawal risk. Counselors should recognize warning signs, follow emergency procedures, and arrange urgent medical evaluation rather than attempting to manage withdrawal independently. Alcohol is not a safe substitute, and delaying care can be dangerous. Counseling support remains valuable after stabilization, but immediate medical safety takes precedence in this scenario.
- 8. D** — A neutral functional question explores possible effects without assuming impairment or demanding a particular conclusion. It invites the client to connect use with sleep, attention, responsibilities, relationships, and personal goals. The other choices shame, force commitment, or rely on stereotypes. Collaborative assessment respects autonomy while creating space for the client to notice patterns and consider whether change would be useful.
- 9. C** — Nicotine can be linked to perceived stress relief, even though dependence and withdrawal may maintain the cycle. Exploring the belief respectfully helps identify triggers and alternatives. Counselors can discuss cessation supports and coping skills without minimizing stress. Dismissing the concern or

ignoring nicotine because another substance is present misses an important health and recovery issue. Goals should remain client-centered.

10. A — Possible intoxication requires attention to immediate safety before routine counseling. The counselor should assess observable impairment, follow policy, prevent unsafe driving, and obtain emergency help if needed. Trauma processing may be inappropriate while cognition is impaired. Public confrontation can shame the client and compromise privacy. Documentation should be factual and include actions taken, observations, and any safety-related decisions.

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113. B — A calm, respectful approach acknowledges that discussing substance use can feel vulnerable. Asking permission supports autonomy and can increase trust, especially early in treatment. Demanding disclosure, interpreting behavior as deception, or imposing eye-contact expectations can damage rapport. The counselor should remain curious, explain the purpose of questions, and allow the client to set a safe pace for sharing.

114. D — Specific, neutral questions about quantity, frequency, and timing improve assessment accuracy without labeling the client. The best question invites concrete information needed to understand risk. The other options use judgment, assume resistance, or substitute another person's conclusion for the client's report. Counselors should gather details collaboratively and compare them with health, functioning, and safety concerns over time.

115. A — Collateral information can enrich assessment, but it must be obtained and shared within applicable confidentiality rules. A valid authorization clarifies who may communicate, what information may be exchanged, and for what purpose. Mentioning a relative is not permission to contact them. Counselors should disclose only what is authorized, document communication, and remain alert to family conflict or safety concerns.

116. B — Drug-screen results require clinical context. Detection windows, assay limits, specimen issues, and substances not included in a panel can affect results. A negative screen neither proves dishonesty nor replaces assessment. The counselor should discuss findings nonjudgmentally, follow program procedures, and use authorized medical or laboratory consultation when interpretation exceeds competence. Trust is strengthened by transparency rather than accusation.

117. D — Combining alcohol with opioids can increase sedation and breathing risk, so safety and coordinated medical evaluation are priorities. Counselors should provide clear risk information, assess urgent symptoms, and collaborate with qualified providers when authorized. Directing medication changes exceeds counseling scope. Attendance rules or substitute beverages do not address the potentially dangerous interaction or the client's underlying sleep concern.

118. C — Stimulant withdrawal or a crash can involve fatigue, depressed mood, sleep changes, and cravings. Counselors should assess safety, including suicidal thinking when indicated, provide supportive care, and connect the client with qualified evaluation when symptoms are severe or persistent. Labeling, oversimplifying, or pressing for major decisions can worsen distress. The goal is stabilization, monitoring, and appropriate referral.

119. C — Abrupt discontinuation after long-term benzodiazepine use may create serious withdrawal risk. Counselors should recognize warning signs, follow emergency procedures, and arrange urgent medical evaluation rather than attempting to manage withdrawal independently. Alcohol is not a safe substitute, and delaying care can be dangerous. Counseling support remains valuable after stabilization, but immediate medical safety takes precedence in this scenario.

120. B — A neutral functional question explores possible effects without assuming impairment or demanding a particular conclusion. It invites the client to connect use with sleep, attention, responsibilities, relationships, and personal goals. The other choices shame, force commitment, or rely on stereotypes. Collaborative assessment respects autonomy while creating space for the client to notice patterns and consider whether change would be useful.

121. D — Nicotine can be linked to perceived stress relief, even though dependence and withdrawal may maintain the cycle. Exploring the belief respectfully helps identify triggers and alternatives. Counselors can discuss cessation supports and coping skills without minimizing stress. Dismissing the concern or ignoring nicotine because another substance is present misses an important health and recovery issue. Goals should remain client-centered.

122. A — Possible intoxication requires attention to immediate safety before routine counseling. The counselor should assess observable impairment, follow policy, prevent unsafe driving, and obtain emergency help if needed. Trauma processing may be inappropriate while cognition is impaired. Public

confrontation can shame the client and compromise privacy. Documentation should be factual and include actions taken, observations, and any safety-related decisions.

123. B — Medication for opioid use disorder can reduce overdose risk and support stability when prescribed and monitored by providers. Recovery is not defined by a single pathway or by counselor opinion. Stigmatizing medication can discourage lifesaving care. Counselors should provide accurate, nonjudgmental education, support informed decision-making, and coordinate with medical providers when authorized while continuing to address counseling and recovery needs.

124. D — Recovery capital refers to internal and external resources that support health, stability, and recovery. Housing, transportation, supportive relationships, and community connection can reduce barriers and strengthen a plan. These resources do not eliminate relapse risk or automatically determine diagnosis. Counselors should assess strengths, help clients build supports, and incorporate resources into realistic treatment and discharge planning.

125. C — Peer recovery support draws on experience to offer hope, practical connection, and navigation of recovery resources. Peer roles are distinct from clinical diagnosis, psychotherapy, and medical care. Ethical peer practice also includes confidentiality and role boundaries. The counselor can explain how peer support may complement treatment, help the client choose a program, and respect the client's preference about participation.

126. A — Employment can affect structure, identity, income, and hope, so it is appropriate to address it in recovery planning. Case management helps identify barriers, strengths, benefits, training, and referral options without making unrealistic promises. Ignoring practical needs or dwelling on mistakes can reduce engagement. The counselor should connect goals to resources and support manageable next steps.

127. C — Consent and confidentiality for minors vary by jurisdiction and service type. The counselor should explain limits clearly, determine who may consent, and seek supervision or legal guidance when needed. Promising absolute secrecy or assuming adult rules can mislead the client. Respectful discussion of options can preserve engagement while ensuring services are delivered lawfully and with attention to safety.

128. D — Group members should be asked to protect one another's privacy, but a facilitator cannot guarantee how every member behaves outside the room. Clear agreements and reminders promote informed participation. Claiming absolute secrecy is inaccurate, and posting stories can harm trust even without names. Counselors should follow agency policy, address breaches promptly, and document significant concerns or interventions.

129. A — Telehealth requires attention to privacy, identity, technology, and the client's setting. A public location may expose sensitive information or reduce the client's ability to speak freely. The counselor should discuss options, use agency procedures, and reschedule or modify the session if confidentiality cannot be protected. Ignoring the setting can undermine informed consent and the client's safety or privacy.

130. B — Clinical records should remain accurate, timely, and transparent. When an error is identified, the counselor follows policy for an amendment or correction that preserves the original record and documents the updated information. Deleting entries without a trace can compromise record integrity. Clients may provide information or request correction, but the counselor remains responsible for professional documentation and appropriate review.

131. B — Clients may decline recommendations, and counselors should respond with respect while addressing safety and informed decision-making. Exploring concerns can reveal barriers, preferences, or misunderstandings. The counselor should explain risks, alternatives, and emergency options, reassess imminent danger, and document the discussion. Punishment or avoidance reduces collaboration. Protective action may still be necessary when legal or emergency criteria are met.

132. A — Limited self-disclosure can support hope or normalize help-seeking, but it should be client-centered. The counselor should consider timing, boundaries, likely impact, and alternatives, using supervision when uncertain. Extensive detail or seeking comfort reverses roles and may burden the client. Disclosure is not required to build rapport and should never substitute for attentive listening.

133. C — Counselor impairment can affect judgment, empathy, boundaries, and client safety. Recognizing signs and seeking supervision, peer support, self-care, or workload adjustments is responsible practice. Continuing without change or relying on clients for emotional support can harm treatment. Agencies and ethical codes often require action when impairment may affect services. The priority is maintaining competent care.

134. D — Evidence-based practice integrates research with clinical expertise and the client's values, culture, and circumstances. Novelty, popularity, or convenience alone do not establish effectiveness. Counselors should examine whether an intervention fits the target concern, setting, and client preferences, then monitor outcomes. This approach supports ethical, responsive care rather than applying one method rigidly to every person.

135. D — Measurable goals identify a specific behavior, frequency, and time frame, making progress easier to review collaboratively. The best goal also allows discussion of barriers and adjustment. Vague statements do not define what change looks like, while promising no future cravings is unrealistic. Treatment plans should be individualized, strengths-based, and revised as the client's needs, motivation, and circumstances change.

136. A — Missed appointments can reflect many factors, including transportation, work, housing instability, ambivalence, relapse, illness, or safety concerns. Following outreach procedures and documenting attempts supports continuity while protecting confidentiality. Immediate discharge or assumptions may overlook a barrier or risk. Counselors should use authorized contact methods, review engagement strategies, and follow policy for closure when contact cannot be reestablished.

137. C — A return to use can be serious, but treating it as total failure may increase shame and risk. The counselor should assess safety, then help the client examine warning signs, choices, supports, and next steps. Prior recovery experience remains meaningful information. Blame and delay reduce learning. A revised plan can strengthen coping, connection, and protection against sustained recurrence.

138. B — Family members may share concerns, but receiving information does not automatically permit the counselor to confirm treatment or disclose protected details. The counselor can listen, explain boundaries, encourage emergency action when appropriate, and invite the caller to use family supports. Authorization is needed for most disclosure. This approach protects privacy while allowing safety information to inform assessment and planning.

139. C — Chest pain and shortness of breath after cocaine use may signal a medical emergency. Counselors should activate emergency response, follow protocol, monitor within their training, and provide information to responders. Relaxation or delayed care does not address cardiac risk, and asking the client to drive is unsafe. The counselor's role is prompt safety action, not independent medical diagnosis or treatment.

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150. B — Possible intoxication requires attention to immediate safety before routine counseling. The counselor should assess observable impairment, follow policy, prevent unsafe driving, and obtain emergency help if needed. Trauma processing may be inappropriate while cognition is impaired. Public confrontation can shame the client and compromise privacy. Documentation should be factual and include actions taken, observations, and any safety-related decisions.