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Clinical Evaluation

This course will provide a comprehensive introduction to the treatment of addiction. Terms and concepts related to historical context, theory, research and practice will be reviewed. This class will discuss and explore Bio-psychosocial assessments admission assessments. The sections of this 35 hour class will guided by the Florida Certification Board. Group exercises, case examples and film will provide opportunities for class discussion and the integration of knowledge into skills.

The Functions of Counseling, Screening, Intake, Orientation, and Assessment

Definition of Screening

SCREENING: The process by which the client is determined appropriate and eligible for admission to a particular program.

TAP21 Extended Definition: Screening is the process by which the counselor, the client and available significant others review the current situation, symptoms, and other available information to determine the most appropriate initial course of action, given the client's needs and characteristics and the available resources within the community.

Global Criteria:

1. Evaluate the psychological, social, and physiological signs and symptoms of alcohol and other drug abuse.
2. Determine the client's appropriateness for admission or referral.
3. Determine the client's eligibility for admission or referral.
4. Identify any coexisting conditions (medical, psychiatric, physical, etc.) that indicate the need for additional professional assessment and/or services.
5. Adhere to applicable laws, regulations, and agency policies governing alcohol and other drug abuse services.

Explanation:

This function requires the counselor consider a variety of factors before deciding whether or not to admit the potential client for treatment. It is imperative that the counselor use appropriate diagnostic criteria to determine whether the applicant's alcohol or other drug use constitutes abuse. All counselors must be able to describe the criteria they use and demonstrate their competence by presenting specific examples of how the use of alcohol and other drugs has become dysfunctional for a particular client. The determination of a particular client's appropriateness for a program requires the counselor's judgment and skill and is influenced by the program's environment and modality (i.e., inpatient, outpatient, residential, pharmacotherapy, detoxification, or day care). Important factors include the nature of the substance abuse, the physical condition of the client, the psychological functioning of the client, outside support/resources, previous treatment efforts, motivation, and the philosophy of the program. The eligibility criteria are generally determined by focus, target population, and funding requirements of the counselor's program or agency. Many of the criteria are easily ascertained. These may include the client's age, gender, place of residence, legal status, veteran status, income level, and the referral source. Allusion to following agency policy is a minimally acceptable statement. If the client is found ineligible or inappropriate for this program, the counselor should be able to suggest an alternative.

Instructor Note: All the information that follows is information that you will use no matter what type of facility/treatment program you work in. It seems like a lot to learn on first read but as you become familiar with the terms used, the order of things it will all begin to flow naturally and become second nature for you. Hang in there and make plenty of "cheat" sheets for yourself.

I. Eligibility Criteria**A. Eligibility criteria are determined by the programs:**

1. goals and objectives
2. target population
3. Screening, Intake, Orientation, and Assessment
4. funding requirements

B. Criteria related to the client might include:

1. age
2. sex
3. residence
4. legal status
5. veteran status
6. income level
7. referral source
8. physical condition
9. psychological functioning
10. outside support available
11. previous treatment efforts

C. Criteria related to the program might include:

1. environment and philosophy of the program
2. whether program is:
 - a. detoxification unit
 - b. inpatient
 - c. residential
 - d. outpatient

II. Diagnostic Criteria

A. Counselor must utilize subjective criteria to determine:

1. whether or not substance use disorder is present
2. the client's level of dysfunction
3. key issues and problem areas
4. degree of client awareness

III. Establishing Rapport

A. Screening is the first step in establishing rapport with a potential client.

1. May be client's first attempt to seek help
2. An opportunity to provide needed emotional support and guidance

B. Skills which help establish rapport include:

1. Warm tone of voice
2. Encouraging prompts;
 - a. i.e. "tell me more about that"
3. Non-threatening questions;
 - a. i.e. questions which do not appear to confront or attack the client
4. Appropriate self-disclosure;
 - a. i.e. sharing some small piece of personal information which will invite openness without shifting the focus away from the client
5. Clarifying confusing information;
 - a. i.e. asking clarifying or follow-up questions to insure that the client's response is clear
 - b. i.e. "can you tell me more about the frequency in which you are smoking marijuana?"

IV. Screening Information**A. Screening forms generally ask for:**

1. patient data (age, sex, residence, etc.)
2. referral source
3. presenting problems
4. insurance availability
5. whether to accept into the program or refer elsewhere

V. Screening Tasks for the Counselor

1. Assemble screening forms
2. Collect and analyze information from referral sources
3. Interview the prospective client, with specific questions about:
 - a. general client data
 - b. presenting problems
 - i. identify potential crisis state or situation; when to seek additional professional assistance
 - c. previous treatment efforts
 - d. outside support available

- e. level of commitment to change
- 4. Analyze all information to determine client appropriateness for program. Apply criteria from Sections I and II.
- 5. If client is appropriate, begin arrangements for intake
- 6. If client is inappropriate, investigate referral options and discuss with client

VI. Referral

- A. Screening process sometimes ends in referral if client is not appropriate
- B. Counselor needs to be well-informed about other appropriate Program

Risk Assessment – Crisis Management

Another important element of screening is being able to conduct a risk assessment. Once you have your CAP you will be qualified to screen clients for potential crisis states and/or suicidality. Why is this so important – vital even???

Did you know:

- Suicide is a leading cause of death among people who abuse alcohol and drugs (Wilcox, Conner, & Caine, 2004).
- Compared to the general population, individuals treated for alcohol abuse or dependence are at about 10 times greater risk to eventually die by suicide compared with the general population, and people who inject drugs are at about 14 times greater risk for eventual suicide (Wilcox et al., 2004).
- Individuals with substance use disorders are also at elevated risk for suicidal ideation and suicide attempts (Kessler, Borges, & Walters, 1999).

Of special note:

- People with substance use disorders who are in treatment are at especially high risk of suicidal behavior for many reasons, including:
- They enter treatment at a point when their substance abuse is out of control, increasing a variety of risk factors for suicide (Ross, Teesson, Darke, Lynskey, Ali, Ritter, et al., 2005).

- They enter treatment at peaks in depressive symptoms (Ross et al., 2005).
- Mental Health problems (e.g. depression, post-traumatic stress disorder (PTSD), anxiety disorders, some personality disorders) associated with suicidality often co-occur among people who have been treated for substance use disorders.
- Crises that are known to increase suicide risk sometimes occur during treatment (e.g., relapse and treatment transitions).
- People with substance use disorders often seek treatment at times when their substance use difficulties are at their peak—a vulnerable period that may be accompanied by suicidal thoughts and behaviors.
- Depression is a common co-occurring diagnosis among people who abuse substances that confers risk for suicidal behavior (Conner et al., 2007; Murphy, Wetzel, Robins, & McEvoy, 1992; Roy, 2001, 2002). Other mental disorders are also implicated.

There is a strong link between acute substance use and risk for suicidal behavior.

- Alcohol's acute effects include disinhibition, intense focus on the current situation with little appreciation for consequences, and promoting depressed mood, all of which may increase risk for suicidal behavior (Hufford, 2001). Other central nervous system depressants may act similarly.
- Acute alcohol intoxication is present in about 30–40 percent of suicide attempts and suicides (Cherpitel, Borges, & Wilcox, 2004).
- Intense, short-lived depression is prevalent among treatment-seeking people who abuse cocaine, methamphetamines, and alcohol, among other groups (Brown et al., 1995; Cornelius, Salloum, Day, Thase, & Mann, 1996; Husband et al., 1996). Even transient depression is a potent risk factor for suicidal behavior among people with substance use disorders.

Other harmful behaviors to take note of:

Non-suicidal self-injury (NSSI): NSSI is also commonly referred to in the literature as “deliberate self-harm” and “suicidal gesture.” NSSI (for example, self-mutilation or self-injury by cutting for the purpose of self-soothing with no wish to die and no expectation of dying) is distinguished from a suicide attempt or suicide because NSSI does not

include suicidal intent. Suicidal behaviors and NSSI can co-exist in the same person and both can lead to serious bodily injury.

Self-destructive behaviors: Behaviors that are repeated and may eventually lead to death (e.g. drug abuse, smoking, anorexia, pattern of reckless driving, getting into fights) are distinguished from suicidal behavior because an act of suicide is an acute action intended to bring on death in the short term.

Definition of Risk Factors

Risk factors are defined as indicators of long-term (or ongoing) risk. They are different from warning signs, which signal immediate risk.

Definition of Protective Factors

Protective factors are defined as buffers that lower long-term risk.

A caution about protective factors: If acute suicide warning signs and/or multiple risk factors are in evidence, the presence of protective factors does not change the bottom-line assessment that preventive actions are necessary, and should not give you a false sense of security. Although protective factors may sustain someone showing ongoing signs of risk (e.g., due to chronic depression), they do not immunize clients from suicidal behavior and may afford no protection in acute crises.

The following is the acronym for a formulation of the role of substance abuse treatment counselors in addressing suicidal thoughts and behaviors

GATE: Procedures for Substance Abuse Counselors

Gather information - by consistently asking uniform screening questions of all new clients, recognizing warning signs and asking follow-up questions about suicidal thoughts, behaviors and warning signs.

Access supervision and/or consultation - to ensure quality care and planning next steps for client services and referral to additional resources. There is a need to obtain

input from supervisors and/or consultants in interpreting information gathered about suicidal thoughts and behaviors.

Take responsible action - by developing and implementing a treatment plan to address suicidality and coordinating the plan with other providers.

Extend the action - by ensuring that referral appointments have been kept, sharing information, and continuing to monitor clients after crises have passed (through ongoing coordinating with mental health providers, and enlisting the support of family and community resources as appropriate).

More detailed information about risk and crisis identification and management will be provided in several other CAP courses that follow.

Instructor Note: The take away from all the screening information needs to be this.....this is client's first connection to treatment, the treatment program and you the first staff person from the program, meaning how you treat the client will represent what forms the client's impression of the treatment program and what lies ahead for them. Kindness, patience and caring can never be underestimated. Remember no matter how the client presents themselves underneath is someone who is fragile and vulnerable. As a counselor you must respect that and the client!

Definition of Intake

INTAKE: The administrative and initial assessment procedures for admission to a program.

Explanation:

The intake usually becomes an extension of the screening, when the decision to formally admit is documented. Much of the intake process includes the completion of various forms. Typically, the client and counselor fill out an admission or intake sheet, document the initial assessment, complete appropriate releases of information, collect financial data, sign a consent for treatment, and assign the primary counselor.

Global Criteria:

1. Complete the required documents for admission to the program.
2. Complete the required documents for program eligibility and appropriateness.
3. Obtain appropriately signed consents when soliciting information from, or providing information to, outside sources to protect client confidentiality and rights.

I. Tasks

- A. Intake is an extension of the screening process; it occurs after a client is accepted into treatment
- B. The intake interview is instrumental in engaging a client in the treatment process and beginning to develop a relationship between client and counselor/treatment program
- C. The intake interview consists primarily of the completion of admission forms
- D. The information collected during the intake will form the basis of the client's treatment plan
- E. The primary counselor is generally assigned to the client at this time
- F. The counselor and client discuss confidentiality at this point

II. General Types of Forms

- A. Admission/intake form
 - a. basic information: name, address, employer, family composition, who to contact in an emergency, etc.
- B. Initial assessment form
 - a. brief statement about the presenting problems and immediate client needs, i.e. detox, residential, outpatient
- C. Consent for treatment form
 - a. the client's agreement to the general terms of the treatment, i.e., type of treatment, number of sessions, cost, name of counselor, etc.
- D. Financial form
 - a. summary of the client's financial status, generally used to determine the cost and for necessary billing to insurance companies
- E. Release of information forms
 - a. the required written permission of a client for the release of information to a specific outside party or to receive any information from an outside party, i.e., former treatment provider or therapist, probation or parole officer, family physician, etc.

III. Confidentiality

- A. State and federal regulations protect the client's identity and the content of the counseling sessions
- B. Confidentiality is a therapeutic, ethical and legal issue
- C. The client is often anxious about "who will find out"; this anxiety should be addressed in the first session in order to:
 - a. reduce client's anxiety
 - b. build rapport and trust
- D. The regulations should be explained to the client in the first session and in writing; should be presented in a way that lets the client know that they are in his/her best interest.
- E. The federal regulations:
 - a. Cover any program providing alcohol/drug abuse diagnosis, treatment or referral for treatment which is directly or indirectly federally assisted
 - b. Allow disclosure of information about a client only under certain circumstances:

- i. when the client has consented in writing
- ii. in a medical emergency
- iii. when the client commits or threatens to commit a crime on program premises or against program personnel
- iv. to qualified persons conducting audit, research, or program evaluation
- v. if required by court order
- c. Even under these circumstances, the requirements are strict regarding the re-disclosure of client information
- d. there are criminal penalties for violation of the regulations

Instructor Note: Did you notice that much of the information for intake and screening is the same. Basic demographic information (i.e. age, gender, marital status etc.) is repeated across multiple processes beginning at screening all the way through to discharge.

Definition of Orientation

ORIENTATION: Describing to the client the following:

- general nature and goals of the program
- rules governing client conduct and infractions that can lead to disciplinary action or discharge from the program
- in a non-residential program, the hours during which services are available
- treatment costs to be borne by the client
- client rights

Explanation:

The orientation may be provided before, during, and/or after the client's screening and intake. It can be conducted in an individual, group, or family context. Portions of the orientation may include other personnel for certain specific aspects of treatment, such as medication.

Global Criteria:

1. Provide an overview to the client by describing program goals and objectives for client care.
2. Provide an overview to the client by describing program rules and client obligation and rights.
3. Provide an overview to the client of program operations.

I. When/How Orientation Takes Place

- A. Depending upon the nature of the program, orientation may take place before, during or after screening and intake
- B. It can be conducted in an individual, group, or family session
- C. It may include other program personnel for specific parts of treatment; for example, the agency's physician or nurse may be present for a client who is on medication

II. When Designing an Orientation Program, One Should Consider the Following:

- A. What the client needs to know about the program in order to assimilate as quickly as possible
- B. The best methods to present information
- C. How to handle problems or questions which might arise during the orientation
- D. How to present rules, regulations and consequences for infractions
 - a. this is especially important because clients may be upset and/or confused when they enter the program; they need a clear presentation
 - b. presenting verbally and following up with a written guidebook is a good choice

III. Other Goals of Orientation

- A. Client's fears and misconceptions about treatment can be discussed
- B. Questions about rules, regulations, and expectations can be fully discussed
- C. Begin to develop a relationship with the primary counselor
- D. Present client's rights

IV. Orientation Tasks for the Counselor:

- A. Introduce the program, rules, and regulations
 - a. verbal presentation by counselors or other clients
 - b. slide show or video
 - c. written guides
- B. Present client's rights—as recommended by the Joint Commission on Hospital Accreditation of Healthcare Organizations, clients must receive a written statement of client rights, which include:
 - a. impartial access to treatment
 - b. recognition of personal dignity
 - c. individualized treatment provided by qualified, competent staff
 - d. the assurance of personal privacy
 - e. visits, mail and telephone calls from family and friends, when appropriate and not clinically contraindicated
 - f. the right of review of treatment plan

- g. explanation of client rights in a language the client understands
- h. documentation of the explanation of client rights. State requirements should also be considered and included - some states have more stringent patient rights requirements - know what your state requires
- C. Provide tour of facility
- D. If residential or inpatient program, assignment to a bed and screening of clothing and personal belongings
- E. Many programs will assign another patient to be the client's "buddy"

V. Forms

- A. Clients must be presented with a statement of client's rights, which should be read and signed by the client in order to indicate receipt and understanding.
- B. Most programs have a pre-printed orientation checklist to use - has areas to be checked to insure proper orientation is completed as well as a space for the client and counselor to sign.

Instructor Note: Information can ease a client's anxiety. Program/Treatment Orientation provides the opportunity for the counselor to explain things, answer client questions, soothe & calm client fears by helping them understand what to expect. We all like to be informed before embarking on the unknown this situation is no different.

Definition of Assessment

ASSESSMENT: The procedures by which a counselor/program identifies and evaluates an individual's strengths, weaknesses, problems, and needs for the development of a treatment plan.

Explanation:

Although assessment is a continuing process, it is generally emphasized early in treatment. It usually results from a combination of focused interviews, testing, and/or record reviews. The counselor evaluates major life areas (i.e., physical health vocational development, social adaptation, legal involvement, and psychological functioning). At the same time, the counselor assesses the extent to which alcohol or drug use has interfered with the client's functioning in each of these areas. Next, the counselor would attempt to determine the relationship of functioning between these life areas. The result of this assessment should suggest the focus for treatment."

Global Criteria:

1. Gather relevant history from client, including but not limited to, alcohol and other drug abuse using appropriate interview techniques.
2. Identify methods and procedures for obtaining corroborative information from significant secondary sources regarding client's alcohol and other drug abuse and psycho-social history.
3. Identify appropriate assessment tools.
4. Explain to the client the rationale for the use of assessment techniques in order to facilitate understanding.
5. Develop a diagnostic evaluation of the client's substance abuse and any coexisting conditions based on the results of all assessments in order to provide an integrated approach to treatment planning based on the client's strengths, weaknesses, and identified problems and needs.

I. When/How Assessment Takes Place

- A. Although emphasized strongly early in treatment, assessment is a continuing process
- B. It results from a synthesis of information such as records, interviews, testing

- C. It is necessary to use a multidisciplinary approach in order to gain a broad spectrum of information
 - a. Goals of Assessment
 - i. To determine whether the client has a chemical dependency problem
 - ii. To identify other conditions associated with addictions and other problems in these areas:
 - 1. Psychological
 - 2. physiological
 - 3. behavioral
 - 4. family
 - 5. economic
 - 6. environmental
 - 7. interpersonal
 - 8. spiritual
 - 9. other drug use; multiple addictions
 - iii. To increase the client's likelihood of entering and remaining in treatment by:
 - 1. identifying barriers to treatment
 - 2. reducing client's anxiety about treatment
 - iv. To satisfy the demands of insurance companies for determining diagnosis and prognosis

III. Tasks/tools

A. As addiction is a complex behavioral problem, assessment should take a multidisciplinary approach, looking at these components:

- 1. behavioral
- 2. physiological
- 3. sociological
- 4. psychological

B. Assessment tools used can be

- 1. self-administered surveys such as the Michigan Alcoholism Screening Test (MAST)

2. a verbal drug abuse history from the client, which includes:
 - a. age at first use of drugs/alcohol
 - b. heaviest time of use
 - c. pattern of use up to the present time
 - d. whether tolerance developed
 - e. whether dependence developed
 - f. history of convulsions/hallucinations
 - g. current drugs being used - be sure to include both licit and illicit drugs, as well as over-the-counter drugs
 - h. current dose/amounts
 - i. current frequency
 - j. route of use
 - k. why client is seeking help now
3. drug abuse history from the family and significant others:
 - a. reveals information about family dynamics
 - b. reveals the impact of addiction on family members and significant others

C. Structuring the verbal history setting and establishing rapport:

1. allow no interruptions
2. give client undivided attention
3. make eye contact with the client
4. provide for the client's physical comfort
5. avoid sitting behind a desk as it presents a physical barrier between client and counselor
6. keep the interview on track if the client digresses
7. Screening, Intake, Orientation, and Assessment
8. do not be judgmental
9. be accepting and encouraging
10. ask for clarification when necessary
11. use a combination of yes-no and open-ended questions
12. don't be uncomfortable with client silence

IV. Barriers to assessment

- A. The client's denial that a problem exists
- B. The client's memory disturbance and possible cognitive impairment as a result of addiction can lead to a vague, inaccurate history
- C. Repression/Suppression of behaviors and using activities
- D. Blackouts
- E. Euphoric recall
- F. Enablers
- G. Co-existing mental disorders

V. Special Populations

- A. Women
 - a. Special emphasis has been placed recently on the unique problems of women substance abusers, which may include:
 - i. sexual abuse
 - ii. difficulties with male counselors
 - iii. poor self-esteem
 - iv. lack of independence, which may keep women in abusive relationships
 - v. medical problems different from those of men
 - b. These issues must be addressed in treatment, but will also impact the assessment process
- B. Ethnic minorities
 - a. Experience shows that minority males, especially Hispanics, have difficulty with treatment which requires confrontation; this results from cultural conditioning
 - i. these clients respond best to a caring environment
 - ii. it is important that the staff include minority or ethnic group members
 - iii. Some cultures place a stigma on addiction, which may result in limited support from family members
- C. These issues have implications for treatment, but, again, they will also affect the assessment process

VI. Matching the Client with Appropriate Treatment

- A. The best approach for treatment of addiction is a multidisciplinary approach, tailored to the client's particular needs
- B. Treatment should involve the family
- C. Treatment should be focused on long-term process of recovery - may require multiple levels of care
- D. Treatment requires a change in the client's lifestyle and behavior
- E. Treatment should start with the least restrictive level of intervention but one that insures structure and safety, both physical and psychological, for the client

TREATMENT PLANNING: The process by which the counselor and client identify and rank problems needing resolution; establish agreed upon immediate and long-term goals; and decide upon a treatment process and the resources to be utilized.

Global Criteria:

- 1. Explain assessment results to the client in an understandable manner.
- 2. Identify and rank problems based on individual client needs in the written treatment plan.
- 3. Formulate agreed upon immediate and long-term goals using behavioral terms in the written treatment plan.
- 4. Identify the treatment methods and resources to be utilized as appropriate for the individual client.

Explanation:

The treatment plan is based on the assessment and is a product of negotiation between the client and counselor to be sure the plan is tailored to the individual's needs. The language of the problem, goal, and strategy statements should be specific, intelligible to the client, and expressed in behavioral terms. The statement of the problem concisely on a client need identified previously. The goal statements refer specifically to the identified problem and may include one objective or set of objectives ultimately intended to solve or mitigate the problem. The goals must be expressed in behavioral terms in order for the counselor and client to determine progress in treatment. Both immediate and long-term goals should be established. The plan or strategy is a specific activity that links the problem with the goal. It describes the services, who will provide them, when they will be provided, and at what frequency. Treatment planning is a dynamic process and the contracts must be regularly reviewed and modified as appropriate.

Instructor Note: About treatment planning, there have been many changes in how to write a “good, integrated” treatment plan. In the section above it speaks to establishing immediate and long term goals; with the change in length of stay for residential treatment from 6 months to one year to a now average of 30 – 60 days, the focus of treatment planning has moved to short term, concrete, measurable goals and objectives. Most programs describe the treatment planning done at time of initial assessment as an initial treatment plan. A master treatment plan is completed a little later in the treatment process (you will have the Treatment Planning Course next). Treatment planning remains a true client/counselor collaboration. Remember, once the counselor sees the client’s problems the same way their client does the path to a successful individualized treatment plan is paved.

Descriptions of expectations of counselor functions and skills.

Counselors will 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 histories; mental and functional statuses; and current social, environmental, and/or economic constraints.

The counselor must have skills in:

- Administering and scoring screening instruments.
- Screening for physical and mental health status.
- Facilitating information sharing and data collection from a variety of sources.
- Communicating effectively in emotionally charged situations.
- Writing accurately, concisely, and legibly.

Counselors will screen for psychoactive substance toxicity, intoxication, and withdrawal symptoms; aggression or danger to others; potential for self-inflicted harm or suicide; and co-occurring mental disorders.

The counselor must have skills in:

- Eliciting pertinent information from the client and relevant others.

- Intervening appropriately with a client who may be intoxicated.
- Assessing suicide and/or violence potential using an approved risk-assessment tool.
- Assessing risks of abuse and neglect of children and others.
- Preventing and managing crisis in collaboration with health, mental health, and public safety professionals.

Counselors will establish rapport, including management of a crisis situation and determination of need for additional professional assistance.

The counselor must have skills that:

- Demonstrate effective verbal and nonverbal communication in establishing rapport.
- Accurately identify the client's beliefs and frame of reference.
- Reflect the client's feelings and message.
- Recognize and defuse volatile or dangerous situations.
- Demonstrate empathy, respect, and genuineness.

Counselor will assist the client in identifying the effect of substance use on his or her current life problems and the effects of continued harmful use or abuse.

Counselors must be skilled in:

- Establishing a therapeutic relationship
- Demonstrating effective communication and interviewing skills
- Determining and confirming with the client the effects of substance abuse on life problems.
- Assessing client readiness to address substance use issues.
- Interpreting the client's perception of his or her experiences.

Counselors will determine the client's readiness for treatment and change as well as the needs of others involved in the current situation.

Counselors must be skilled in:

- Assessing client readiness for treatment
- Assessing extrinsic and intrinsic motivators

- Assessing the needs of family members including children for appropriate levels of care and providing support; recommending follow-up services.

Counselors will review the treatment options that are appropriate for the client's needs, characteristics, goals, and financial resources.

Counselors must be skilled in:

- Eliciting and determining relevant client characteristics, needs, and goals.
- Making appropriate recommendations for treatment and use of other available community resources.
- Collaborating with the client to determine the best course of action.

Counselors will apply accepted criteria for diagnosis of substance use disorders in making treatment recommendations.

Counselors must be skilled in:

- Using current DSM or other accepted diagnostic standards.
- Using appropriate placement criteria.
- Obtaining information necessary to develop a diagnostic impression.

Counselors will construct with the client and appropriate others an initial action plan based on client needs, client preferences, and resources available.

Counselors must be skilled in:

- Developing the action plan in collaboration with the client and appropriate others.
- Documenting the action plan.
- Contracting with the client concerning the initial action plan.

Counselors, based on the initial action plan, take specific steps to initiate an admission or referral and ensure follow through.

Counselors must be skilled in:

- Communicating clearly and appropriately.
- Networking and advocating with service providers.
- Negotiating and advocating client admissions to appropriate treatment resources.
- Facilitating client follow through.

- Documenting accurately and appropriately.

Expectations of Counselor's Attitudes During Screening, Intake and Assessment Processes.

- Recognition of personal biases, values, and beliefs and their effect on communication and the treatment process.
- Willingness to establish rapport.
- Appreciation of the value of data-gathering process.
- Willingness to be respectful toward the client in his or her presenting state.
- Appreciation of the importance of empathy in the face of feelings of anger, hopelessness, or suicidal or violent thoughts and feelings.
- Appreciation of the importance of legal and administrative obligations.
- Respect for the client's perception of his or her experiences.
- Acceptance of non-readiness as a stage of change.
- Appreciation that motivation is not a prerequisite for treatment.
- Recognition of the importance of the client's self-assessment.
- Recognition of one's own treatment biases.
- Appreciation of various treatment approaches.
- Willingness to link to client with a variety of helping resources.
- Recognition of personal and professional limitations of practice, based on knowledge and training.
- Willingness to base treatment recommendations on the client's best interest and preferences.
- Willingness to work collaboratively with the client and others.
- Willingness to renegotiate.

Additional Information on Screening and Assessment

A significant number of questions asked on each of the major credentialing examinations center on the area of screening and assessment. We therefore present an expanded section on this important topic area. The information for this material comes from Chapter 4 of TAP 11: Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination. TAP 11 is a publication of the Substance Abuse and Mental Health Services Administration: Center for Substance Abuse Treatment. DHHS Publication No. (SMA) 94-2075. Printed 1994.

Screening and Assessment

Assessment is one of the five critical elements of effective substance abuse treatment. It is the first stage of intervention with persons who are chemically dependent. A comprehensive appraisal of the individual's alcohol or drug problem, and how it affects his or her health and functioning, is vital for selecting treatment resources that best meet his or her needs. Assessment includes a determination of many factors, including:

- the severity of the problem;
- possible influences that have perpetuated chemical use, culminating in addiction;
- related difficulties;
- the individual's perceptions of and attitude toward treatment.

The Purpose of Assessment

Screening, assessment, and diagnosis are important in the treatment of any illness. Consider two people who go to a doctor with pain in their left arm. A variety of medical problems could result in such pain, including cardiovascular disease, a broken bone, arthritis, an infected wound, or cancer of the bone marrow, among others. Each of these conditions would call for a different type of treatment, ranging from the possibility of taking aspirin and doing some exercises for mild arthritis to possible surgery for severe heart disease or aggressive chemotherapy for cancer. If the physician prescribed the same treatment for both patients, without assessing and diagnosing the problem carefully, the odds of the treatment being appropriate for the problem would be minimal.

Instead, the doctor will ask each patient questions about how and when the pain started, how intense it is, the exact location of the pain, and other physical symptoms.

He or she also will examine each patient and may request some medical tests. It may be necessary to have a specialist conduct part of the medical evaluation because of his or her greater expertise in a particular field. For example, a radiologist might be consulted to read x-rays of the affected area. Before determining the treatment needed for each person, the physician will review and analyze all of the information gathered. Once a diagnosis has been made, the doctor may provide the treatment needed or may refer either or both of the patients to a specialist who is more knowledgeable about treatment of the specific problem. Often, the doctor will ask the patient to return for a follow-up visit so that the accuracy of the diagnosis and the effectiveness of the treatment can be evaluated.

If the prescribed treatment has not alleviated the pain, additional tests may be done to further assess the cause of the problem. If the treatment has resulted in improvement or recovery from the problem, the physician will document that the diagnosis was accurate and the treatment was effective. This information will be useful if the doctor sees the same patient again for a similar problem. If another patient presents with the same symptoms and, after assessment, the diagnosis is the same, it is likely that the same course of treatment will be used again. However, if another patient with pain in the arm is diagnosed differently, the treatment prescribed is likely to be very different from that for another patient with the same presenting problem.

The Purpose of Assessment for Substance Abuse

There are at least five objectives for conducting appropriate and comprehensive assessments of persons with substance abuse problems or chemical dependency:

1. Identify those who are experiencing problems related to substance abuse and/or have progressed to the stage of addiction.
2. Assess the full spectrum of problems for which treatment may be needed.
3. Plan appropriate interventions.
4. Involve appropriate family members or significant others, as needed, in the individual's treatment.
5. Evaluate the effectiveness of the interventions that are implemented.

Why Is Assessment Important?

The assessment of persons with alcohol or drug problems is very much like the diagnosis of other disorders. Assessment is one of the five critical elements of effective treatment, and it is the first stage of the treatment process.

The assessment process includes gathering information from a variety of sources. These sources may include the patient's own statements, previous records, and significant others. When the information is collected, it is reviewed and evaluated by a trained professional. The information and the treatment professional's interpretation of it are then used to develop plans for treatment.

A variety of instruments have been developed as tools for the assessment process. There is a list of some currently available assessment instruments at the end of this chapter. Assessment instruments should be evaluated for validity (Do they measure what they say they measure?) and reliability (Do they consistently provide the same results?). When assessment instruments are used, it is important to ascertain that research has been conducted to determine their validity and reliability on populations similar to those on whom the instrument will be used. For example, an instrument might be a valid and reliable assessment tool for white adult males, but it may not necessarily be useful for assessing adolescent females.

Without a comprehensive assessment, there is a risk of treating the wrong set of problems or failing to provide any intervention for some problems. The general disorder of chemical addiction is very global. An assessment that delineates causative influences, types of substances abused and related health, social, and behavioral factors is necessary for appropriate patient-treatment matching. The treatment of an adolescent who has an alcohol problem is markedly different from the treatment of an adult addicted to opiate drugs.

Each person with a substance abuse problem is likely to have a unique constellation of symptoms and factors. Several areas must be included in a comprehensive assessment, including:

- physical development and medical problems (including both general health conditions and possible infectious diseases such as HIV, tuberculosis, hepatitis, and sexually transmitted diseases);
- history of drug use and any prior treatment received;
- psychosocial problems (either precipitating chemical use or resulting from the abuse of drugs or alcohol), such as family- and peer-relationships, school or vocational difficulties, and legal and financial problems;
- psychiatric disorders
- current socioeconomic status and eligibility for various programs.

Who Should Be Assessed?

Substance abuse is not a selective illness; it is found among all segments of the population. People of either gender, from all age cohorts, racial and ethnic groups, and socioeconomic strata, are subject to the destructive impact of alcohol and other drug abuse and addiction. Thus, the identification of those who have a substance abuse disorder requires attentiveness and sensitivity to the range of complex indicators that might signal the need for assessment and possible treatment. There are many clues that can alert health professionals, educators, employers, family members, criminal and juvenile justice system personnel, and others that the use of alcohol or other drugs is a problem for an individual.

For example:

- a physician might become suspicious of frequent injuries, liver damage, weight changes, certain diseases, and a variety of other physical symptoms for which one explanation could be substance abuse;
- a teacher or employer might be alerted by changes in performance or attendance at school or on the job;
- family members, significant others, and peers might become concerned over changes in mood, friendship patterns, and relationships
- criminal and juvenile justice personnel might infer associations between substance use and criminal or delinquent behavior such as income-generating crimes (e.g., thefts, prostitution), violent crimes, and drug-related crimes (e.g., possession, sales of controlled substances).

When these or other problems become apparent it is vital that the person be evaluated and referred for appropriate treatment, if needed. A thorough assessment for substance abuse is important because it can identify not only chemical dependency, but other medical, psychosocial, or psychiatric problems that may underlie the symptoms. Even if problems are not caused by substance abuse, it is just as vital that the person receives other appropriate interventions, such as primary health care or human services.

A Comprehensive Assessment Process

A comprehensive assessment consists of five consecutive stages. These stages are:

- Recognition of Risk Factors;
- Initial Screening;
- Comprehensive Assessment;
- Appropriate Interventions;
- Evaluation of Process and Outcome.

Each part of this process will be discussed briefly in the following sections.

Recognition of Risk Factors

There is often a precipitating event that brings alcohol or drug-involved persons to the attention of those concerned about them. An automobile accident or DUI arrest, being fired from a job, an arrest for shoplifting, or a head injury from a fall might all result from the effects of alcohol or other drugs. All too often, however, no action is taken until the disease has progressed to the point of full addiction which is irreversible, but treatable. Declining social functioning and increasing involvement with the criminal or juvenile justice system are typical indicators of substance abuse. The consequences to the person's health and personal functioning can be devastating.

Throughout the assessment and treatment process, coordination, collaboration, and communication among all responsible individuals and organizations is vital. Community coordination is also critical. Agencies and professionals representing health and mental health care, education, the courts, and many other interests need to evaluate the problem of substance abuse in the community and the resources available for intervening.

Within agencies, such as hospitals, school systems, and the like, coordination of assessment and other substance abuse services is also

important. For example, many persons are treated in hospitals for illnesses or injuries related to alcohol or drug abuse, but never receive a comprehensive substance abuse assessment or needed treatment. Ways of coordinating services to ensure that all personnel are alert to risk factors and follow through with appropriate screening and referrals for assessment should be developed.

Initial Screening

Screening refers to brief procedures used to determine the presence of a problem, substantiate that there is reason for concern, or identify the need for further evaluation. Screening may occur in several community and correctional settings. Private physicians, public health clinics, hospitals, mental health programs, and educational programs are among those that might screen individuals for substance abuse. Within the criminal and juvenile justice systems, screening should occur throughout the individual's contact. It should begin upon entry into the system and continue until release. This may include screening at points such as diversion, detention, pretrial, presentencing, sentencing, probation, incarceration, parole or aftercare, and revocation hearings.

Screening Interviews and Instruments

Interview techniques and screening instruments may be designed to attempt to get alcohol-or drug-involved persons to reveal information about their substance abuse. Such self-reports can be helpful in determining whether there is a need for further assessment and intervention. Screening interviews and instruments may be developed by a given agency, or they may be obtained from other sources providing them as a service or for profit.

Screening interviews might include a few brief questions asked during intake procedures that query the individual about the use of alcohol or other drugs. Screening instruments include brief tests (usually self-administered) that individuals take to provide information about their abuse of substances. In both cases, the alcohol- or drug-involved person is asked to give a self-report of his or her substance abuse.

Denial is a common facet of substance use disorders, as individuals (and often other significant persons in their lives) tend to minimize both the nature and the amount of their drug or alcohol use. Often, persons in denial actually convince themselves that substance misuse is not a serious problem, though objective indicators suggest serious consequences. Persons who are drug-involved are more likely to be truthful about their use in settings they perceive as non-threatening. Thus, reports from persons in treatment often are more credible than those from individuals in the criminal justice system. Assurance of confidentiality is an important factor that enhances self-reporting, while potential of prosecution and other sanctions is likely to diminish disclosures. While

screening interviews and instruments may not give a true picture of drug and alcohol use in all cases, there are some persons who will be truthful. Coupled with other screening methods, such as chemical tests, these measures help distinguish users from nonusers.

Instructor's Note: Well you made it through the first major reading. I am sure some of the information you read seemed somewhat repetitive and maybe some of it is, but there is good reason for it – understanding, knowing and practicing the processes of screening, intake, orientation and assessment are the foundation of all treatment programs. For some conducting an initial assessment is art. I agree. Getting to know the client and letting the client get to know the program they are about to enter is so important. A good intake experience for a client could positively sway an uncertain client. Keep what you have learned here in mind for the course ahead, you will see they all connect like a beautiful quilt.

Drug Recognition Techniques

Drug recognition techniques are a systematic and standardized evaluation process to detect observable signs and symptoms of drug use. These include, among others, indicators such as dilated or constricted pupils, abnormal eye movements, elevated or lowered vital signs, muscle rigidity, and observation of behavioral indicators of drug use, such as speech, affect, and appearance. All the areas evaluated in these procedures are observable physical reactions to specific types of drugs. The three key elements in the drug recognition process are:

- verifying that the person's physical responses deviate from normal;
- ruling out a non-drug-related cause of the deviation; and
- using diagnostic procedures to determine the category or combination of drugs that is likely to cause the impairment.

These techniques originally were developed by the Los Angeles Police Department as a result of frequent encounters with impaired drivers. However, when tested for blood alcohol levels, these motorists did not have high enough concentrations of alcohol to result in the impairments the officers observed. In response to this problem, drug recognition techniques were developed to help officers identify drug-impaired drivers. Subsequently, personnel at the Orange County, California, Probation Department applied drug recognition techniques to their clients and have used their findings to expand the period for detecting drug use. The techniques are based on documented medical findings about the effects of alcohol and various drugs of abuse on the body.

Drug recognition techniques can be very useful in identifying persons who are under the influence of alcohol or illegal substances or who have used drugs recently. They may be used appropriately at many points of contact with individuals. Based on evaluations conducted in several settings, trained personnel are capable of accurately detecting current or recent drug use with these techniques with high degrees of accuracy.

Drug recognition techniques are cost-effective. Although initial staff training can be costly, the techniques require only a few pieces of equipment and few continuing costs. They provide immediate information about current or recent drug use, and they are

minimally intrusive. They rely on observations of body parts and functions that are visible to anyone at any time, rather than the collection of body fluids and the observation of bodily functions that are considered private. The techniques also are systematic and standardized, and they collect information about several observable signs and symptoms that are reliable indicators of drug use.

With drug recognition techniques, categories of drugs can be detected, but specific drugs cannot be determined. For example, it is possible to conclude that someone has used a central nervous system (CNS) stimulant, but it would not be possible to decide whether it was cocaine or amphetamines. Not all drugs are equally detectable with these techniques. Some categories of drugs cause pronounced physical symptoms while others provide few observable clues. Chemical testing is needed to determine more specific information about the types of drugs used. This is especially true when an individual is abusing more than one drug. If the person denies use, or if court actions or sanctions are to be taken, toxicological evidence may be necessary. However, drug recognition techniques are a good screening device before chemical testing. Sometimes, when confronted by the findings of a drug recognition expert, individuals may acknowledge their drug use and cooperate with the treatment process more readily. The techniques also can be used to rule out the presence of certain categories of drugs, thereby reducing the costs of testing for all possible substances.

Chemical Testing

Chemical testing is the most accurate method of determining current or recent drug use. Chemical testing can delineate the specific drug or drugs being used, but it cannot replace the assessment process to diagnose the addictive disorder. Many addicted persons use more than one mood-altering substance. It is especially common for alcohol to be used in combination with other drugs. Proper determination of the specific drugs being used is crucial in the patient-treatment matching process. The abuse of differing substances often requires varied treatment approaches. When multiple substances are being abused, it is important to combine appropriate treatment modalities and components.

Scientific methods of chemical testing include:

- breath analysis;
- saliva tests;
- urinalysis;
- blood analysis; and
- hair analysis.

Additional methods are being developed and investigated, such as the analysis of perspiration.

Currently breath analysis, saliva tests, and urinalysis are the most practical, accurate, and cost-effective methods of chemical testing available, especially for the criminal justice system and many community agencies. Blood analysis is sometimes used in medical settings, but is much more costly. Breath analysis and saliva tests are used to detect alcohol consumption, while urinalysis is employed to detect other drugs of abuse.

These tests can accurately reveal drugs in the system, but the time frame for detection is limited. Alcohol is eliminated from the body within a few hours of ingestion. Other drugs remain in the system longer, but detection limits can range from a few hours to about 30 days. Thus, chemical testing is dependable for identifying frequent users, but less frequent users of some drugs may test negative despite continuing use. Urinalysis cannot determine when drugs were actually ingested, nor can the level of intoxication be identified, as it can be with breath analysis for alcohol. In addition to identifying drug use, chemical testing can be a useful monitoring device and therapeutic agent in treatment when used with other interventions. As addiction is a chronic relapsing condition, chemical testing is a therapeutic tool to help prevent relapse.

Chemical testing is a highly reliable method of determining alcohol or drug use, but it also is a more intrusive process-especially urinalysis. To prevent adulteration of urine samples, the collection of specimens should be observed.

Selection of urinalysis methodologies also is important. For initial tests, immunoassays are generally used. All immunoassay tests operate in basically the same way, but differ from one manufacturer to another in the chemical "tag" used to identify the drug.

Specimens for testing may be sent to laboratories for analysis; however, reliable products are available for on-site testing in agencies. Whether using laboratory or on-

site testing, agencies need to have well-defined chemical testing policies that delineate procedures, including the following areas:

- specimen collection;
- chain of custody (e.g., handling, documentation, storage, transportation);
- cutoff levels for initial and confirmation tests;
- scheduling of tests and selection of persons to be tested;
- quality assurance and quality control;
- safety procedures;
- interventions/treatment referrals; and
- other applications of findings, such as legal actions.

Gas chromatography/mass spectrometry (GC/MS) is considered the "gold standard" in urinalysis. It is highly accurate and is the only method of urinalysis that reliably produces quantitative results. It is frequently used as a confirmation method if initial immunoassay tests produce positive results.

Technological Innovations

New developments in drug detection technologies are currently being researched. The National Institute of Corrections (NIC) and the National Aeronautics and Space Administration (NASA) have formed a partnership to explore ways in which space-age technology can benefit the corrections community. The VIPER (Visual Identification of Pupillary Eye Responses) Project is developing an instrument called the optical funduscope, which can evaluate the eye, pupil, and retina. This instrument can measure involuntary eye movements associated with drug use impairment, like those used with drug recognition techniques discussed previously. The VIPER Project is currently working with private companies to develop the instrument.

A second development, called the Telemetered Drug Use Detection system, is evaluating the feasibility of a drug detection device worn on the wrist. Through analysis of perspiration, the device could detect drug use and send results to a central control station. This technology combines position identification (similar to electronic

monitoring), chemical and biological processes, and microcommunications and signaling. It is a noninvasive method of chemical testing for drug use.

Other Sources of Information

The screening processes already described in this section are those which attempt to obtain information directly from the person believed to be using drugs or alcohol. It also may be important to collect data from other sources during the screening process. Among others, this may include obtaining facts from family members, teachers, and employers; reviewing available records (e.g., health, psychosocial, legal); and considering the observations made by professionals.

Advantages and Disadvantages of Screening Methods

Drug recognition techniques and chemical testing methods can provide reliable information on current or recent drug use. However, self-reports through interviews and tests are the only screening devices that will provide information about alcohol and drug use over time. The accuracy of self-reports relies upon the motivation of the individual to disclose drug use. Chemical testing is the most expensive of the three methods but provides the most scientifically valid information. Chemical testing also is the most intrusive of the three methods, requiring observed specimen collection procedures to ensure accurate results.

Key Issues in Screening for Alcohol and Drug Involvement

There are several considerations in selecting screening methods and instruments and conducting screening procedures. These should be deliberated carefully by those who will be endorsing or conducting screenings. **Table 4-A** provides a summary of key areas.

Screening should detect specific indicators of substance abuse, such as health factors, educational or job-related problems, relationship difficulties, or financial and legal consequences of substance abuse. If screening procedures indicate that substance abuse or dependency is probable, the person should be referred for a more comprehensive assessment.

Table 4-A: Key Considerations in Screening for Alcohol and Drug Abuse

- Screening should be conducted on persons recognized to be at risk, in a variety of settings, by a range of professionals.
- There should be collaboration among agencies and professionals on screening processes, techniques, and instruments.
- All instruments and processes should be sensitive to racial, cultural, socioeconomic, and gender-related concerns.
- Initial screening procedures should be brief.
- Information should be gathered from various sources

Comprehensive Assessment

Screening is useful in differentiating persons who are alcohol-or drug-involved from those who are abstainers or whose use is limited and is not creating any problems for them. *Assessment*, on the other hand, indicates a process to determine the nature and complexity of the individual's spectrum of drug abuse and related problems. A comprehensive assessment uses extensive procedures that evaluate the severity of the substance abuse problem, elicit information about cofactors, and assist in developing treatment and follow-up recommendations. In addition to assessing substance abuse *per se*, a comprehensive assessment will probe related problem areas, such as:

- medical status and problems (including both general health conditions and infectious diseases such as HIV, tuberculosis, hepatitis, and sexually transmitted diseases);
- psychological status and possible psychiatric disorders;
- social functioning; family and peer relations;
- educational and job performance;
- criminal or delinquent behaviors and legal problems; and
- socioeconomic status and problems.

There are three basic steps in the assessment process:

1. Information
2. Data analysis
3. Treatment plan development

Each of these will be discussed in the following sections.

Information Gathering

There are three sources of information that can be helpful in conducting a comprehensive assessment:

1. Existing information
2. Individual and collateral interviews
3. Testing instruments

Investigation of existing information. **Table 4-B** contains several categories of information that may already be available about an individual. Confidentiality requirements, to protect the privacy of individuals, require the person to sign a release of information form before much of the information listed in **Table 4-B** can be requested.

Self-reports, interviews, and collateral contacts. Interviews with individuals are much more extensive than the self-reports that were described as a method for screening. The interview can reveal valuable information about the person, to complement other information and obtain an accurate evaluation of problems. An assessment interview also may be the foundation for a positive, trusting working relationship during future interventions.

As with screenings, collateral interviews involve gathering information from other persons who are, or have been, associated with the person being assessed. Collateral sources should be asked to provide descriptive information rather than to form judgments about the person. As with patient interviews, information received is not always accurate. Possible collateral sources include family members, peers, teachers, employers, and others who might have helpful information.

Information gathering may involve one professional obtaining information in all areas. However, when particular areas raise concern, an interviewer or case manager may request consultation from other professionals. For example, if an individual discloses that he or she is bothered by certain physical symptoms, and the assessor is not a physician, a referral should be made for a medical examination. Similarly, it might be necessary to obtain psychological or psychiatric evaluations if it is determined that in-depth assessments in these areas are needed and the person conducting the assessment is from a different discipline. *A multi-disciplinary assessment team is recommended for obtaining the range of information needed for comprehensive assessment and treatment planning.*

Interviews should be adapted to the age and culture of the patient. Cognitive abilities can affect the interview process; thus, the interviewer must be aware of the patient's cognitive ability level and try to structure the interview accordingly. Language may present another barrier in the assessment process. If the individual being assessed is not fluent in the same language as the interviewer, an experienced interpreter who is familiar with the patient's culture and the interview questions should be used.

Some of the information to be probed during interviews with the individual and collateral sources will include, but is not limited to, the following areas. Often, these overlap with information gathered from existing records.

Testing instruments. Testing instruments can include:

- standardized interviews,
- structured interviews; and/or
- self-administered tests.

These techniques have been developed to assess individuals in multiple areas (e.g., personality, aggressive tendencies, social skills, stress factors, risk for substance abuse, intellectual capacity). Most of the instruments have been formulated and standardized through a systematic research and validation process.

An advantage of using standardized instruments is that information regarding their reliability and validity may be available. If an instrument has high *validity*, it will accurately measure what it intends to measure. An instrument that has high *reliability* will produce stable results; the test's outcome will not be significantly influenced by

fluctuating or extraneous factors (such as a person's mood or the time of day). The instrument should be used in normal practice, or validated, with a population similar to those with whom it will be used. For example, an instrument used with adolescents should be used in normal practice on other adolescents. An instrument to be used with criminal offenders should have been used in normal practice on other offender populations. However, even when the credibility of these tests has been proved, test outcomes may be affected by other factors, including:

- attempts by individuals using them to "slant" the outcome by deliberately answering questions incorrectly;
- ability of individuals to read and understand the test items;
- motivation of persons to take the test seriously; and
- cultural sensitivity of the test.

The assessment process is likely to be most helpful and informative when a variety of techniques are used. Testing instruments are a tool to guide decision making efforts. As with all other techniques, the limitations of these tests must be realized. Staff members who are given the responsibility of administering and interpreting them should be fully trained.

Standardized and Structured Interviews. The *standardized interview* differs from the *structured interview* in that it limits the interviewer to a prescribed style and list of questions. Using the standardized interview, the interviewer is restricted from freely probing beyond conflicting or superficial answers, sometimes considered a disadvantage of this technique. An advantage is that this interview may be more credible than the structured interview, an important consideration when results are used to support significant decisions (e.g., treatment referrals or legal action)

Table 4-B.-Information From Existing Sources

- **Drug history.** Health and mental health treatment agencies and criminal or juvenile justice agencies may have records containing information about previous drug-related treatment or charges. These records also may contain some information about the age at which substance use was initiated, the type of

chemicals used, the frequency and amount of alcohol or drugs used, and other important data.

- **Medical history and current status.** This will provide information about medical treatment for substance abuse, medical conditions, substance abuse-related infectious diseases, medical emergencies that may have been related to substance abuse, current prescribed medications, recent illnesses or injuries, and possible family history of substance abuse.
- **Mental health history and current status.** This information may identify past or current emotional, psychological or psychiatric problems and previous treatment for substance abuse.
- **Criminal or delinquency history.** Criminal or juvenile justice records may provide information about prior offenses and drug involvement at the time of prior arrests and a history of offenses that may be related to income-generating crimes or expressive behaviors associated with the effects of certain types of drugs. It also may be important to obtain information on any current legal problems, of either a criminal or civil nature.
- **Educational history and current status.** This may include information about enrollment in or completion of education programs, attendance records, identified learning disabilities, and behavior problems at school. This information may be important for both juvenile and adult offenders.
- **Employment history and current status.** This may include current and previous employment, attendance problems, and reasons for termination.

Table 4-C.-Areas of Assessment Through Patient and Collateral Interviews

- **Drug history and current patterns of use:** When did alcohol or other drug use begin? What types of alcohol or other drugs does the individual currently use? Does the person use over-the-counter medications, prescription drugs, tobacco, and caffeine? How frequently are the substances used and in what quantity?

- **Substance abuse treatment history:** Has the individual ever received treatment for substance abuse? If so, what type of treatment (inpatient, outpatient, methadone maintenance, Twelve-Step programs, etc.)? Were these treatment experiences considered successful or unsuccessful and why? Has the person been sober and experienced relapse, or has s/he never attained recovery?
- **Medical history and current status:** What symptoms are currently reported by the patient? Are there indicators of infectious and/or sexually transmitted diseases? Has the individual been tested for HIV and other infectious diseases? Are there indicators of risk for HIV or other diseases for which testing should be done? What kind of health care has been received in the past? The causes and effects of various illnesses and traumas should be explored.
- **Mental status and mental health history:** Is the individual orientated to person, place, and time? Does s/he have the ability to concentrate on the interview process? Are there indicators of impaired cognitive abilities? What is the appropriateness of responses during the interview? Is the person's affect (emotional response) appropriate for the situation? Are there indicators from collateral sources of inappropriate behavior or responses by the person? Is there evidence of extreme mood states, suicidal potential, or possibility of violence? Is the individual able to control impulses? Have there been previous psychological or psychiatric evaluations or treatment?
- **Personal status:** What are this person's critical life events? Who constitute his/her peer group? Does the individual indicate psychosocial problems that might lead to substance abuse? Does the person demonstrate appropriate social, interpersonal, self-management, and stress management skills? What is the individual's level of self-esteem? What are the person's leisure time interests? What are his/her socioeconomic level and housing and neighborhood situation?
- **Family history and current relationships:** Who does the individual consider his/her family to be; is it a traditional or nontraditional family constellation? What role does the individual play within the family? Are there indicators of a history of physical or sexual abuse or neglect? Do other family members have a history of

substance abuse, health problems or chronic illnesses, psychiatric disorders, or criminal behavior? What is the family's cultural, racial, and socioeconomic background? What are the strengths of the family and are they invested in helping the individual? Has there been foster family or other out-of-home placements?

- **Positive support systems:** Does the person have hobbies, interests, and talents? Who are his/her positive peers or family members?
- **Crime or delinquency:** Have there been previous arrests and/or involvement in the criminal or juvenile justice system? Has the person been involved in criminal or delinquent activity but not been apprehended? Is there evidence of gang involvement? Is the person currently under the supervision of the justice system? What is the person's attitude about criminal or delinquent behavior?
- **Education:** How much formal education has the person completed? What is the individual's functional educational level? Is there evidence of a learning disability? Has s/he received any special education services? If currently in school, what is the person's academic performance and attendance pattern?
- **Employment:** What is the individual's current employment status? What employment training has been received? What jobs have been held in the past and why has the person left these jobs? If currently employed, are there problems with performance or attendance?
- **Readiness for treatment:** Does the patient accept or deny a need for treatment? Are there other barriers to treatment?
- **Resources and responsibilities:** What is the individual's socioeconomic status? Is the person receiving services from other agencies, or might s/he be eligible for services?

(Doweiko, 1990; McLellan & Dembo, 1992; Tarter, Ott & Mezzich, 1991)

Minimal training is usually required to administer standardized interviews. To administer structured interviews, interviewers must have knowledge and experience in working with

similar populations, as well as expertise in interviewing. The goal of this interview is to obtain as much information as possible about the person. Therefore, the interviewer is *expected* to probe beyond superficial or conflicting answers. Structured interviews usually take more time to administer and interpret than standardized interviews.

Self-Administered Tests. Usually, less staff skill is required with *self-administered* tests than with structured or standardized interviews. On the other hand, these tests require some motivation and reading ability on the part of the individual being assessed. Many instruments are written at the fourth or fifth grade reading level. Moreover, self-administered tests are only credible if the person is willing to answer the questions honestly. However, written tests can be helpful for those who have difficulty speaking directly about themselves. These instruments provide an indirect and, for some, less threatening method of self-disclosing information. They also prevent interviewer bias and, like other standardized instruments, can be scored and quantified. Reliability and validity measures usually are available as well.

Data Analysis

Once information is gathered, it is interpreted for use in decision making. During this phase, professional service providers determine the severity of the person's alcohol or drug problem, possible contributing factors, and his or her readiness for intervention.

The professional conducting or managing the assessment process will use all of the collected data to arrive at an opinion about the individual's substance abuse problem. The question to be answered is: Do the data indicate that the person is addicted to or dependent on one or more chemicals, an abuser of chemicals, or not adversely affected by occasional use of drugs and/or alcohol?

The analysis must encompass the range of problems, strengths and sources of support available to the person. It also should address factors that have contributed to or are related to alcohol and other drug abuse.

Treatment Plan Development

The findings from the assessment process and monitoring of treatment should be documented to enhance clinical case supervision. The data derived from the screening and assessment processes form the basis of a treatment plan. This plan must recognize the unique constellation of problems and other factors that have been identified for the individual. The treatment plan will recommend a course of action that attempts to address the patient's unique needs. Implementation of the plan will involve providing or referring the person to appropriate treatment programs and monitoring his or her progress. A single treatment modality or a combination of services may be needed. The treatment plan should be comprehensive, containing information about the following categories:

- the identified problems to be addressed;
- the goals and objectives of the treatment process (e.g., to help the individual abstain from use of drugs, to help the patient resolve underlying self-esteem problems, to help the person achieve full employment);
- the resources to be applied (i.e., treatment programs, funding, other services, etc.);
- the persons responsible for various actions (e.g., making referrals, attending treatment sessions, follow-up reports);
- the time frame within which certain activities should occur; and
- the expected benefits for the person who will participate in the treatment experience.

Appropriate Interventions

Based on the recommendations made in the treatment plan, appropriately matched treatment interventions should be provided to the drug-involved individual. This may include:

- preventive and primary medical care;
- testing for infectious diseases;
- random drug testing;
- pharmacotherapeutic interventions;
- group counseling interventions
- substance abuse counseling;
- life skills counseling;
- general
- health education;
- peer/support groups
- liaison services;
- social and athletic activities;
- alternative housing; and
- relapse prevention.

These may be provided on either an outpatient or an inpatient/residential basis depending on the needs of the person. More information on these interventions and services will be given in later chapters.

Evaluation of Process and Outcome

As with the example of the treatment of arm pain at the beginning of this chapter, the assessment and intervention process includes evaluation of the process and outcomes. Process evaluation indicates whether or not the appropriate procedures were used. Were the needed assessment procedures performed and did they result in a timely and appropriate treatment plan? Did the individual attend the treatment programs and services recommended in the treatment plan? Were the services that were promised delivered?

The outcome evaluation will examine whether or not the individual benefited from the assessment and the interventions. It will indicate whether or not the assessments were accurate in correctly defining the problem and matching the person with appropriate treatment resources. If so, and if the patient is cooperative, there should be indicators of

improvement or recovery when follow-up evaluations are conducted. If not, it will be necessary to use the feedback information to initiate additional assessment procedures or change the treatment plan. Outcome evaluation also may indicate problems in service delivery.

Process and outcome evaluation data also may provide documentation of service needs. Although assessments may indicate needs for specific services, often they do not exist in particular communities, they are not affordable for all persons who need them, or there is not sufficient room in programs for new referrals. These data are extremely important for community and State decision makers who must determine program priorities and funding resources.

Assessment Instruments

There are standardized testing instruments available to assess individuals in a variety of areas. When selecting these instruments, consideration should first be given to the areas to be assessed, and options should be limited to instruments that are designed to address those areas. The following factors should then be considered in reviewing the various instruments:

- ease of use;
- expertise and time required of staff to administer and score test;
- training required to administer and score the instrument, and whether or not such training is available;
- possibility of bias (cultural or in administration of the test);
- validity (Have studies proved that it accurately measures what it was intended to measure?);
- reliability (Have studies shown that if the test were repeated with the same person, the results would be the same?);

- credibility of test among members of the judiciary and treatment professionals;
- adaptation of test to management information system input and retrieval;
- whether the test has been normed with a population similar to the client group;
- availability of test in languages other than English;
- motivation level, verbal and reading skills required of persons to be assessed;
- propensity for test to be manipulated; and
- average cost per test.

Sources of Assessment Instruments

Proprietary instruments are developed and copyrighted by individuals or organizations. There is usually a cost for their use. Some instruments are developed by local agencies. They often are program-specific and may or may not be useful in other settings. Often they have not been validated to determine their accuracy. Many agencies are willing to share such instruments without a charge. Instruments developed by federal agencies are in the public domain and may be used without a fee. Validity and reliability studies for them are documented.

Brief information about several available assessment instruments (both interviews and self-administered) is included at the end of this chapter. The instruments included in this list do not represent an exhaustive exploration of such instruments, nor does incorporation in this list represent an endorsement of particular instruments. Rather these are offered as a compilation of those instruments located through literature review. Because the needs of various agencies and systems vary, service providers and decision makers should examine an array of instruments and select those best suited to their particular needs.

Conclusion

Assessment is the beginning of the treatment process. It is a critical element of treatment, for without comprehensive assessment, appropriate patient-treatment matching is not possible. Just as it would be inappropriate to treat arthritis with chemotherapy intended for cancer patients, it is similarly unsuitable to provide a drug-involved adolescent with treatment intended for an adult male alcoholic. Thus, scarce treatment resources may not be used wisely if patients are not assessed carefully before treatment plans are formulated. Comprehensive assessment improves the overall cost-effectiveness of providing treatment.

Assessment is important in the coordination of services, as well. Valuable information can be gained so that the most appropriate services for individuals are delivered at the community level. Aggregated information is also beneficial for State and local decision makers needing to determine priorities, set standards, and allocate funding according to the areas of greatest need.

Substance Abuse Screening & Assessment Instruments

<u>Instrument Name</u>	<u>Description</u>	<u>Contact/Source</u>
Addiction Severity Index (ASI)	The ASI is most useful as a general intake screening tool. It effectively assesses a client's status in several areas, and the composite score measures how a client's need for treatment changes over time. It has been used extensively for treatment planning and outcome evaluation. Outcome evaluation packages for individual programs or for treatment systems are available. Designed for adults of both sexes who are not intoxicated (drugs or alcohol) when interviewed. Also available in Spanish.	A. Thomas McLellan, Ph.D. Building 7 PVAMC University Avenue Philadelphia, PA 19104 Phone: (800) 238-2433
Adolescent Drinking Index	This is a 24-item paper and pencil test self-report rating scale intended to measure the severity of drinking problems. Completion time is about 5 minutes; youth need fifth grade reading skills.	Psychological Assessment Resources, Inc. P.O. Box 998 Odessa, FL 33556 1-800-331-TEST
Adolescent Drinking Inventory	This is a 25-question self-report instrument to screen adolescents. It focuses on drinking-related loss of control and social, psychological and physical symptoms of alcohol problems.	Psychological Assessment Resources, Inc. P.O. Box 998 Odessa, FL 33556 1-800-331-TEST
Adolescent Drug Involvement Scale	Paper and pencil drug abuse screening instrument adapted from the Adolescent Involvement Scale.	D. Paul Moberg Center for Health Policy and Program Evaluation 433 West Washington Ave., Suite 500 Madison, WI 53703
Alcohol Dependence Scale (ADS)	This is a 25-item multiple-choice questionnaire to assess the Alcohol Dependence Syndrome. It is derived from the Alcohol Use Inventory. It yields an index of severity of alcohol dependence.	Addiction Research Foundation 33 Russell St. Toronto, Ontario M5S-2S1, Canada (800) 661-1111

**Alcohol Expectancy
Questionnaire**

Used to gauge high risk
circumstances that may lead to
alcohol use.

Dr. Mark Goldman
Alcohol and Drug Abuse
Research Institute
Department of Psychology
BEH 339
University of South Florida
Tampa, FL 33620
(813) 974-6963

**Alcohol Use
Disorders
Identification Test
(AUDIT)**

The purpose of the AUDIT is to
identify persons whose alcohol
consumption has become hazardous
or harmful to their health. The AUDIT
screening procedure is linked to a
decision process that includes brief
intervention with heavy drinkers or
referral to specialized treatment for
patients who show evidence of more
serious alcohol involvement. It has
been used with adults, particularly
primary care, emergency room,
surgery, and psychiatric patients; DWI
offenders; criminals in court, jail, and
prison; enlisted men in the armed
forces; and workers in employee
assistance programs and industrial
settings.

Can be downloaded from Project
Cork Web site:
www.projectcork.org

**American Drug and
Alcohol Survey
(ADAS)**

This is a 57-item self-report
instrument. It requires 20 to 25
minutes to complete. It develops a
typology of 9 styles of use of drugs
that are listed in order of increasing
severity of drug involvement.

RMBSI, Inc.
2100 W. Drake Rd., Suite 144
Fort Collins, CO 80526
1-800-447-6354

**Assessment of
Chemical Health
Inventory (ACHI)**

This 128-item self-administered instrument assesses the nature and extent of substance abuse and associated psychosocial problems and facilitates communication between treatment providers. It can be taken and scored on a computer. There is also a paper and pencil format. It screens for random, inattentive, or inconsistent test-taking behavior and for defensiveness, exaggeration, or social desirability tendencies. The test requires a sixth grade reading level and takes 15 to 25 min. to complete.

Recovery Software, Inc.
7401 Metro Blvd., Suite 445
Minneapolis, MN 55439
(612) 831-5835

**Beck Depression
Inventory-II (BDI-II)**

The BDI-II consists of 21 items to assess the intensity of depression. The BDI-II can be used to assess the intensity of a client's depression, and it can also be used as a screening device to determine whether there is any current indication of the need for a referral for further evaluation. Each item is a list of four statements arranged in increasing severity about a particular symptom of depression. These new items bring the BDI-II into alignment with Diagnostic and Statistical Manual for Mental Disorders, 4th edition (DSM-IV) criteria. Items on the new scale replace items that dealt with symptoms of weight loss, changes in body image, and somatic preoccupation. Another item on the original BDI that tapped work difficulty was revised to examine loss of energy. Also, sleep loss and appetite loss items were revised to assess both increases and decreases in sleep and appetite.

The Psychological Corporation
19500 Bulderve
San Antonio, TX 78259
Phone: (800) 872-1726
www.psychcorp.com

CAGE Questionnaire	A self-report screening instrument consisting of 4 yes-no questions. Requires approximately 1 minute to complete.	J.A. Ewing (1984, October 12), "Detecting Alcoholism: The CAGE Questionnaire" (<i>Journal of the American Medical Association</i> , 252[14], 1905-1907; see p. 1906) Also available by downloaded from the Project Cork Web site: www.projectcork.org
Chemical Dependency Assessment Profile (CDAP)	This is a 235-item multiple-choice and true-false self-report instrument to assess alcohol and other drug use and chemical dependency problems. Can be administered by computer or in paper and pencil format. A computerized report can be generated.	Multi-Health Systems (MHS) Publishers 908 Niagara Falls Blvd. North Tonawanda, NY 14120 1-800-456-3003
Circumstances, Motivation, and Readiness Scales (CMR Scales)	The instrument is designed to predict retention in treatment and is applicable to both residential and outpatient treatment modalities. Consists of four derived scales measuring external pressure to enter treatment, external pressure to leave treatment, motivation to change, and readiness for treatment. Developed from focus groups of recovering staff and clients and retain much of the original language. Clients entering substance abuse treatment perceive the items as relevant to their experience.	George De Leon, Ph.D., or Gerald Melnick, Ph.D. National Development and Research Institutes, Inc. 71 West 23rd Street 8th Floor New York, NY 10010 Phone: (212) 845-4400 Fax: (917) 438-0894 E-mail: gerry.melnick@ndri.org www.ndri.org

Comprehensive Addiction Severity Index for Adolescents (CASI-A)	This structured interview was designed to evaluate drug and alcohol use and psychosocial severity in adolescent populations in a variety of settings. It is administered by an assessor to the youth and takes approximately 45 to 60 minutes. A computerized scoring technique takes about 45 minutes to enter and 10 minutes to score (Schaefer, 1992).	Kathleen Meyers Penn/V.A. Center for Studies of Addiction PVAMC Bldg. 7 University & Woodland Aves. Philadelphia, PA 19104 (215) 823-5809
Comprehensive Drinker Profile (CDP)	This is an 88-item structured interview questionnaire. It is designed to provide a history of drinking practices and problems. It incorporates the Michigan Alcoholism Screening Test. It requires from 1 to 2 hours to administer.	Psychological Assessment Resources P.O. Box 998 Odessa, FL 33556 1-800-331-TEST
Drug Abuse Screening Test (DAST)	The purpose of the DAST is (1) to provide a brief, simple, practical, but valid method for identifying individuals who are abusing psychoactive drugs; and (2) to yield a quantitative index score of the degree of problems related to drug use and misuse. It is especially useful in screening and case finding; level of treatment and treatment/goal planning. There is both an adult and an adolescent version.	Addiction Research Foundation 33 Russell St. Toronto, Ontario M5S-2S1, Canada 1-800-661-1111
Drug Offender Profile Evaluation/ Referral Strategies (DOPERS)	Assesses suspected drug-involved adult probationers. Helps determine specific supervision and treatment recommendations. It is an interview format that takes approximately 25 minutes to complete. A 2 1/2 day training session is required to use the instrument.	Bob Lynch Texas Department of Criminal Justice Community Justice Assistance Division 8100 Cameron Rd., Bldg. B, Suite 600 Austin, TX 78754 (512) 835-7745

**Drug Use Screening
Inventory (DUSI)**

This 149-item instrument evaluates adolescent drug use and the youth's health, psychiatric, and psychosocial problems, identifies problem areas, and quantitatively monitors treatment progress and outcome. It consists of a Personal History Form, Drug Use Screening Instrument, and demographic, medical, and treatment/prevention summary plan. A sixth grade reading level is needed and completion takes 20 to 40 minutes. Scoring takes 15 to 20 minutes.

Ralph E. Tarter, Ph.D.
Department of Psychiatry
University of Pittsburgh
School of Medicine
3811 O'Hara St.
Pittsburgh, PA 15213
(412) 624-1070

Distributed by:

The Gordian Group
P.O. Box 1587
Hartsville, SC 29550
(803) 383-2201

**Global Appraisal of
Individual Needs
(GAIN)**

The GAIN was developed to implement an integrated biopsychosocial model of treatment assessment, planning, and outcome monitoring that can be used for evaluation, clinical practice, and administrative purposes. It embeds questions for documenting substance use disorder, attention deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, and pathological gambling; dimensional patient placement criteria for intoxication/withdrawal, health distress, mental distress, and environment distress to guide movement among and between levels of care; treatment planning; reporting requirements related to the State client data system; and measures of a core set of clinical status and service utilization outcomes used in the Drug Outcome Monitoring Study.

The Lighthouse Institute
Chestnut Health Systems
720 West Chestnut
Bloomington, IL 61701
www.chestnut.org/li/gain/

**Inventory of Drinking
Situations**

Used to identify emotional, cognitive, and social factors that may precipitate drinking.

Addiction Research Foundation
33 Russell St.
Toronto, Ontario M5S-2S1,
Canada
(800) 661-1111

**Juvenile Automated
Substance Abuse
Evaluation (JASAE)**

This is a computer-assisted instrument for assessing alcohol and other drug use behavior in adolescents. It is suggested for use with follow-up interviews to provide focus and conserve the amount of time necessary to conduct the interview. It is a 102-item self-administered questionnaire written at the fifth grade level. It can be given individually or in groups. Available in English and Spanish and on audio tape for those with reading difficulties. Personnel key responses into a computer. Administration takes approximately 20 minutes. Keying in responses takes 5 minutes.

ADE, Inc.
P.O. Box 660
Clarkston, MI 48347
1-800-334-1918

**Level of Care
Utilization System
(LOCUS)**

This tool is used to assess immediate service needs (e.g., for clients in crisis); to plan resource needs over time, as in assessing service requirements for defined populations; to monitor changes in status or placement at different points in time. LOCUS is divided into three sections. The first section defines six evaluation parameters or dimensions: (1) risk of harm; (2) functional status; (3) medical, addictive, and psychiatric co-morbidity; (4) recovery environment; (5) treatment and recovery history; and (6) engagement. A five-point scale is constructed for each dimension and the criteria for assigning a given rating or score in that dimension are elaborated. In dimension IV, two subscales are defined, while all other dimensions contain only one scale.

American Association of
Community Psychiatrists
www.wpic.pitt.edu/aacp/find.html

**MACH Drug
Involvement Scale
(MDI)**

This is a standardized interview in computer format that can be self-administered. It takes about 30 minutes to administer and results are generated immediately. The MDI scale is used to identify adolescent drug involvement. It is available in English and Swedish.

Minnesota Assessment of
Chemical Health
110709 Kings Lane
Chaska, MN 55318
(612) 887-0332

**Michigan Alcoholism
Screening Test
(MAST)**

Quantifies the severity of alcohol problems for adults, using a 24-item self-administered questionnaire calling for "yes" and "no" responses.

Melvin L. Selzer, M.D.
4016 Third Ave.
San Diego, CA 92103
(619) 299-4043

**Offender Profile
Index (OPI)**

This is an interview format that can be completed in approximately 30 minutes. It is designed to be used with suspected drug-involved adult defendants/offenders to determine specific drug intervention disposition.

Robert Anderson
Director of Criminal Justice
Programs
National Association of State
Alcohol and Drug Abuse
Directors
444 North Capitol Street, NW,
Suite 642
Washington, DC 20001
(202) 783-6868

**Personal Experience
Inventory (PEI)**

This two-part instrument is designed to assess the extent of psychological and behavioral issues with alcohol and drug problems; assess psychosocial risk factors associated with teenage chemical involvement; evaluate response bias or invalid responding; screen for the presence of problems other than substance abuse; and aid in determining appropriateness of inpatient or outpatient treatment. A sixth grade reading level is needed to take the self-administered assessment which takes 45 to 60 minutes (McLellan & Dembo, 1992). The 147-item questionnaire is available in pencil and paper and computerized versions.

Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, CA 90025
(310) 478-2061

Personal Experience Screening Questionnaire (PESQ)	This is a self-report screening questionnaire for use with adolescents suspected of abusing alcohol or other drugs. It is a 40-item questionnaire. It requires a fourth grade reading level and can be administered to individuals or in groups. It takes about 10 minutes to administer and score it.	Western Psychological Services 12031 Wilshire Blvd. Los Angeles, CA 90025 (310) 478-2061
Prevention Intervention Management and Evaluation System (PMES)	Items related to both alcohol and other drug problems constitute this 150-item instrument designed to assess substance abuse and other life problems of adolescents; assist in treatment planning; and provide follow-up assessment and evaluation data on treatment outcome. There is a Client Intake Form and the Information Form on Family, Friends, and Self. It requires a sixth grade reading level and takes approximately 1 hour to administer and 10 to 15 minutes to score.	D. Dwayne Simpson, Ph.D. Institute of Behavioral Research P. O. Box 32880 Texas Christian University Fort Worth, TX 76129 (817) 921-7226
Problem Oriented Screening Instrument for Teenagers (POSIT)	The POSIT provides a brief screening of adolescents for treatment and other service needs. It is intended to identify troubled youths and can be used in a variety of settings. It is useful for developing treatment and referral plans. It is a 139-item self-administered questionnaire designed for use with youth 12 to 19 years old. It requires a sixth grade reading level.	Elizabeth Rahdert, Ph.D. NIDA 5600 Fishers Lane, Rm. 10A-30 Rockville, MD 20857 (301) 443-4060 <i>Or available from:</i> NCADI 1-800-729-6686
Problem Severity Index (PSI)	This is a structured interview developed to identify, document, and respond to drug/alcohol abuse as well as problems in other important areas of functioning among adolescents entering the juvenile court system. Administration takes 45 to 60 minutes.	Jim Boylan Juvenile Court Judges Commission P.O. Box 3222 Harrisburg, PA 17105 (717) 787-6910

**Psychiatric Research
Interview for
Substance and
Mental Disorders
(PRISM)**

The instrument was designed to maximize reliability and validity in community samples, alcohol, drug, and co-occurring disorder treatment samples. Although primarily designed as a research instrument, the PRISM provides systematic coverage of alcohol- and drug-related experiences and symptoms that may be useful in identifying areas of focus for treatment. Additionally, the unusually high reliability of the depression diagnoses in individuals with heavy drinking may provide a better basis for treatment decisions than less consistent methods for assessing major depression and dysthymia.

Dr. Deborah Hasin
New York State Psychiatric
Institute
Box 123 722
West 168th Street
New York, NY 10032
Phone: (212) 960-5518

**Quantitative
Inventory of Alcohol
Disorders (QIAD)**

Each item on this 22-item self-report instrument is rated on a 5-point scale. It takes 10 to 12 minutes to complete. It assesses the severity of alcohol problems during the month before administration of the test.

T.D. Ridley & S.T. Kordinak
(1988), "Reliability and Validity of
the Quantitative Inventory of
Alcohol Disorders (QIAD) and the
Veracity of Self-Report by
Alcoholics" (*American Journal of
Drugs and Alcohol Abuse* , 14[2],
263-292; see pp. 279-287)

**Readiness to Change
Questionnaire**

Designed to assist the clinician in determining the stage of readiness for change among problem drinkers or people with alcohol use disorders. Assesses drinker's readiness to change drinking behaviors; may be useful in assignment to different types of treatment.

Center for Alcohol and Drug
Studies
Plummer Court, Carlisle Place
Newcastle upon Tyne
NE1 6UR
UNITED KINGDOM
Phone: 44(0)191219 5648
Fax: 44(0)191219 5649

**Recovery Attitude
and Treatment
Evaluator (RAATE)**

Designed to assist in placing patients into the appropriate level of care at admission, in making continued stay or transfer decisions during treatment (utilization review), and documenting appropriateness of discharge. The RAATE provides objective documentation to assist in making appropriate treatment placement decisions; it strengthens individualized care and facilitates more individualized treatment planning; it measures treatment process; and it assesses the need for continuing care and discharge readiness.

Evince Clinical Assessments
P.O. Box 17305
Smithfield, RI 02917
Phone: (401) 231-2993
Toll-free in USA:
(800)-755-6299
www.evinceassessment.com

**Self-Administered
Alcoholism
Screening Test
(SAAST)**

This is a 34-item questionnaire or interview with a yes-no format. There is also an abbreviated 9-item version. Considered useful for screening medical patients for alcoholism.

W.M. Swenson & R.M. Morse (1975), "The Use of a Self-Administered Alcoholism Screening Test (SAAST) in a Medical Center" (*Mayo Clinic Proceedings*, 50[4], 204-208; see pp. 207-208)

**Short Michigan
Alcohol Screening
Test (SMAST)**

This is a 13-item questionnaire to identify alcohol problems. It reviews an individual's drinking habits, history, and alcohol-related problems. Takes approximately 15 minutes to complete and requires a seventh grade reading level.

M.L. Selzer, A. Vinokur & L. van Rooijen (1975), "A Self-Administered Short Michigan Alcoholism Screening Test (SMAST)" (*Journal of Studies on Alcohol*, 36[1], 117-126; see p. 124)

**Structured Clinical
Interview for DSM-IV
Disorders (SCID-IV)**

Obtains Axis I and II diagnoses using the DSM-IV diagnostic criteria for enabling the interviewer to either rule out or establish a diagnosis of "drug abuse" or "drug dependence" and/or "alcohol abuse" or "alcohol dependence."

American Psychiatric Publishing, Inc.
1400 K Street, N.W.
Washington, DC 20005
www.appi.org

**Substance Abuse
Questionnaire (SAQ)**

This self-administered instrument targets adult probationers. It assesses risks and needs and presents treatment recommendations. Requires computer and is available in English or Spanish.

Herman Lindeman
2601 N. Third St., Suite 108
Phoenix, AZ 85004
(602) 234-2888

**Substance Abuse
Relapse Assessment
(SARA)**

This is a structured interview developed for use by substance abuse treatment professionals to help recovering individuals recognize signs of and avoid relapse. Used mostly with adult populations. Contains 41 questions administered in paper and pencil format. Takes approximately 60 minutes to complete. The results are interpreted individually by the assessor.

Roger Peters
Florida Mental Health Institute
Dept. of Mental Health Law and Policy
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3899
(813) 974-4510

**Substance Abuse
Subtle Screening
Inventory (SASSI)-
Adult or Adolescent
Version**

This is a 52-item self-administered true-false questionnaire. Many items appear to be unrelated to substance abuse, but items allow clients to self-report negative consequences of substance use. May be administered in booklet or computer form. Can be given to individuals or groups. Requires about a third grade reading level. Requires 10 to 15 minutes to complete and about 1 minute to score.

SASSI Institute
P.O. Box 5069
Bloomington, IN 47407
1-800-726-0526

T-ACE Questionnaire

This instrument is designed to identify pregnant women who consume quantities of alcohol that potentially can damage the fetus. It takes approximately 1 minute to complete and incorporates three items of the CAGE Questionnaire. In addition, it assesses alcohol tolerance (NIAAA, 1990).

TASC, Inc. Illinois

Interview format that takes 90 to 120 minutes to complete. It assesses need, motivation, and level of treatment for drug-involved offender populations. Should be performed by a trained clinician (Singer, 1992).

Melody Heaps, Eve Weinberg
TASC, Inc.
1500 N. Halstead
Chicago, IL 60622
(312) 787-0208

**University of Rhode
Island Change
Assessment (URICA)**



The URICA defines four theoretical stages of change—precontemplation, contemplation, action, and maintenance—each assessed by eight items. Assessment of stages of change/readiness construct can be used as a predictor, treatment matching, and outcome variables.

Carlo C. DiClemente
University of Maryland
Psychology Department
1000 Hilltop Circle
Baltimore, MD 21250
Phone: (410) 455-2415

Chapter 2

Assessing Substance Abusers with Co-Occurring Disorders

This chapter supplies detail on the assessment process working with substance abusers with a co-existing mental health problem. Most of these activities are already a natural component of substance abuse-only assessment; the key addition is to attend to treatment requirements and stage of change for mental disorders, and the possible interference of mental health symptoms and disabilities (including personality disorder symptoms) in addiction treatment participation. Ideally, information needs to be collected continuously, and assessments revised and monitored as the client moves through recovery. A comprehensive assessment as described in the main section of this chapter leads to improved treatment planning, and it is the intent of this chapter to provide a model of optimal process of evaluation for clients with COD and to encourage the field to move toward this ideal. Nonetheless, it is recognized that not all agencies and providers have the resources to conduct immediate and thorough screenings. Therefore, the chapter provides a description of the initial screening and the basic or minimal assessment of COD necessary for the initial treatment planning.

Through the assessment process, the counselor seeks to accomplish the following aims:

- To obtain a more detailed chronological history of past mental symptoms, diagnosis, treatment, and impairment, particularly before the onset of substance abuse, and during periods of extended abstinence.
- To obtain a more detailed description of current strengths, supports, limitations, skill deficits, and cultural barriers related to following the recommended treatment regime for any disorder or problem.
- To determine the *stage of change for each problem*, and identify external contingencies that might help to promote treatment adherence

A basic assessment covers the key information required for treatment matching and treatment planning. Specifically, the basic assessment offers a structure with which to obtain

- Basic demographic and historical information, and identification of established or probable diagnoses and associated impairments



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- General strengths and problem areas
- Stage of change or stage of treatment for both substance abuse and mental health problems
- Preliminary determination of the severity of the COD as a guide to final level of care determination

Note that medical issues (including physical disability and sexually transmitted diseases), cultural issues, gender-specific and sexual orientation issues, and legal issues always must be addressed, whether basic or more comprehensive assessment is performed.

Screening and Basic Assessment for COD

This section provides an overview of the screening and assessment process for COD. In carrying out these processes, counselors should understand the limitations of their licensure or certification authority to diagnose or assess mental disorders. Generally, however, collecting assessment information is a legitimate and legal activity even for unlicensed providers, provided that they do not use diagnostic labels as conclusions or opinions about the client. Information gathered in this way is needed to ensure the client is placed in the most appropriate treatment setting (as discussed later in this chapter) and to assist in providing mental disorder care that addresses each disorder.

Throughout the process it is important to be sensitive to cultural context and to the different presentations of both substance use and mental disorders that may occur in various cultures.

Advice to the Counselor: Do's and Don'ts of Assessment for COD

1. *Do* keep in mind that assessment is about getting to know a person with complex and individual needs. *Do not* rely on tools alone for a comprehensive assessment.
2. *Do* always make every effort to contact all involved parties, including family members, persons who have treated the client previously, other mental health and substance abuse treatment providers, friends, significant others, and probation officers as quickly as possible in the assessment process.
3. *Don't* allow preconceptions about addiction to interfere with learning about what the client really needs (e.g., "All mental health symptoms tend to be caused by addiction unless proven



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otherwise”). Co-occurring disorders are as likely to be under-recognized as over-recognized. Assume initially that an established diagnosis and treatment regimen for mental illness is correct, and advise clients to continue with those recommendations until careful reevaluation has taken place.

4. *Do* become familiar with the diagnostic criteria for common mental disorders, including personality disorders, and with the names and indications of common psychiatric medications. Also become familiar with the criteria in your own State for determining who is a mental health priority client. Know the process for referring clients for mental health case management services or for collaborating with mental health treatment providers.

5. *Don't* assume that there is one correct treatment approach or program for any type of COD. The purpose of assessment is to collect information about multiple variables that will permit individualized treatment matching. It is particularly important to assess stage of change for each problem and the client's level of ability to follow treatment recommendations.

6. *Do* become familiar with the specific role that your program or setting plays in delivering services related to COD in the wider context of the system of care. This will clarify which clients your program will best serve, and will help you to facilitate access to other settings for clients who might be better served elsewhere.

7. *Don't* be afraid to admit when you don't know, either to the client or yourself. If you do not understand what is going on with a client, acknowledge that to the client, indicate that you will work with the client to find the answers, and then ask for help. Identify at least one supervisor who is knowledgeable about COD who can answer your questions.

8. *Do* remember that empathy and hope are the most valuable components of your work with a client. When in doubt about how to manage a client with COD, stay connected, be empathic and hopeful, and work with the client and the treatment team to try to figure out the best approach over time.

This dimension of the assessment considers a person's potential to cause significant harm to self or others. While this may most frequently be due to suicidal or homicidal thoughts or intentions, in many cases unintentional harm may result from misinterpretations of reality, from inability to care adequately for oneself, or from altered states of consciousness due to use of intoxicating substances.



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Note: Staff without the appropriate training should not attempt to make determinations related to potential risk of harm. Properly trained staff should be called upon to conduct such an interview; if necessary, call 911 or implement the emergency procedures followed by your agency.

Risk of harm may be rated according to the following criteria:

Minimal Risk of Harm

- (a) No indication of suicidal or homicidal thoughts or impulses, no history of suicidal or homicidal ideation, and no indication of significant distress.
- (b) Clear ability to care for self now and in the past.

Low Risk of Harm

- (a) No current suicidal or homicidal ideation, plan, intentions or serious distress, but may have had transient or passive thoughts recently or in the past.
- (b) Substance use without significant episodes of potentially harmful behaviors.
- (c) Periods in the past of self-neglect without current evidence of such behavior.

Moderate Risk of Harm

- (a) Significant current suicidal or homicidal ideation without intent or conscious plan and without past history.
- (b) No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.
- (c) History of chronic impulsive suicidal/homicidal behavior or threats and current expressions do not represent significant change from baseline.
- (d) Binge or excessive use of substances resulting in potentially harmful behaviors without current involvement in such behavior.
- (e) Some evidence of self neglect and/or compromise in ability to care for oneself in current environment.

Serious Risk of Harm

- (a) Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so, or with ability to contract for safety.
- (b) History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from baseline.



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- (c) Recent pattern of excessive substance use resulting in disinhibition and clearly harmful behaviors with no demonstrated ability to abstain from use.
- (d) Clear compromise of ability to care adequately for oneself or to be aware adequately of environment.

Extreme Risk of Harm

- (a) Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior...
without expressed ambivalence or significant barriers to doing so, or
with a history of serious past attempts which are not of a chronic, impulsive, or consistent nature, or in presence of command hallucinations or delusions which threaten to override usual impulse control.
- (b) Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.
- (c) Extreme compromise of ability to care for oneself or to monitor adequately the environment with evidence of deterioration in physical condition or injury related to these deficits.

Screening

Screening is a formal process of testing to determine whether a client does or does not warrant further attention at the current time in regard to a particular disorder and, in this context, the possibility of a co-occurring substance use or mental disorder. The screening process for COD seeks to answer a “yes” or “no” question: Does the substance abuse (or mental health) client being screened show signs of a possible mental health (or substance abuse) problem? Note that the screening process does not necessarily identify what kind of problem the person might have or how serious it might be, but determines whether or not further assessment is warranted. A screening process can be designed so that it can be conducted by counselors using their basic counseling skills. There are seldom any legal or professional restraints on who can be trained to conduct a screening.

Screening processes always should define a protocol for determining which clients screen positive and for ensuring that those clients receive a thorough assessment. That is, a professionally designed screening process establishes precisely how any screening tools or questions are to be scored and indicates what constitutes scoring positive for a particular possible problem (often called “establishing cut-off scores”). Additionally, the screening protocol details exactly what takes place after a client scores in the positive range and provides



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the necessary standard forms to be used to document both the results of all later assessments and that each staff member has carried out his or her responsibilities in the process.

So, what can a substance abuse treatment counselor do in terms of screening? All counselors can be trained to screen for COD. This screening often entails having a client respond to a specific set of questions, scoring those questions according to how the counselor was trained, and then taking the next “yes” or “no” step in the process depending on the results and the design of the screening process. In substance abuse treatment or mental health service settings, every counselor or clinician who conducts intake or assessment should be able to screen for the most common COD and know how to implement the protocol for obtaining COD assessment information and recommendations.

Instructor’s Note: Hopefully you have realized after these first few pages that intake and screening for co-occurring disorders is nearly identical to intake and screening for substance use disorders alone. Just remember, always seek supervision and/or peer guidance when you aren’t sure of something, or want a second voice/opinion. Don’t be in a rush to give diagnoses. It is enough to recognize signs and symptoms of a mental health issue to know that a person needs and will benefit from a placement in a facility that is co-occurring capable.

Basic Assessment

While both screening and assessment are ways of gathering information about the client in order to better treat him, assessment differs from screening in the following way:

- **Screening is a process for evaluating the possible presence of a particular problem.**
- **Assessment is a process for defining the nature of that problem and developing specific treatment recommendations for addressing the problem.**

Instructor’s Note: The 2 definitions listed above are perfect. Write these down!! They state the differences between screening & assessment simply and concisely 😊

A basic *assessment* consists of gathering key information and engaging in a process with the client that enables the counselor to understand the client's readiness for change, problem areas, COD diagnosis(es), disabilities, and strengths. An assessment typically involves a clinical examination of the functioning and well-being of the client and can include a number of tests and written and oral exercises. The COD diagnosis is established by referral to a psychiatrist,



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clinical psychologist, or other qualified healthcare professional (***Instructor's Note: This is an absolute!! Only a qualified person can make a mental health diagnosis and even then, that qualified person will conduct a thorough psychiatric evaluation and mental health status exam***). Assessment of the client with COD is an ongoing process that should be repeated over time to capture the changing nature of the client's status. Intake information consists of

1. Background—family, trauma history, history of domestic violence (either as a batterer or as a battered person), marital status, legal involvement and financial situation, health, education, housing status, strengths and resources, and employment
2. Substance use—age of first use, primary drugs used (including alcohol, patterns of drug use, and treatment episodes), and family history of substance use problems
3. Mental health problems—family history of mental health problems, client history of mental health problems including diagnosis, hospitalization and other treatment, current symptoms and mental status, medications, and medication adherence

In addition, the basic information can be augmented by some objective measurement, such as that provided in the University of Rhode Island Change Assessment Scale (URICA) ([McConaughy et al. 1983](#)), Addiction Severity Index (ASI) ([McLellan et al. 1992](#)), the Mental Health Screening Form-III ([Carroll and McGinley 2001](#)), and the Symptom Distress Scale (SDS) ([McCorkle and Young 1978](#)) (see appendices G and H for further information on selected instruments). It is essential for treatment planning that the counselor organize the collected information in a way that helps identify established mental disorder diagnoses and current treatment.

The Role of Assessment Tools

There is no single gold standard assessment tool for COD. Many traditional clinical tools have a narrow focus on a specific problem, such as the Beck Depression Inventory (BDI) ([Beck and Steer 1987](#)), a list of 21 questions about mood and other symptoms of feeling depressed. Other tools have a broader focus and serve to organize a range of information so that the collection of such information is done in a standard, regular way by all counselors. The ASI, which is not a comprehensive assessment tool but a measure of addiction severity in multiple problem domains, is an example of this type of tool ([McLellan et al. 1992](#)). Not only does a tool such as the ASI help a counselor, through repetition, become adept at collecting the information, it also



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helps the counselor refine his or her sense of similarities and differences among clients. A standard mental status examination can serve a similar function for collecting information on current mental health symptoms. Despite the fact that there are some very good tools, no one tool is the equivalent of a comprehensive clinical assessment.

Careful attention to the characteristics of past episodes of substance abuse and abstinence with regard to mental health symptoms, impairments, diagnoses, and treatments can illuminate the role of substance abuse in maintaining, worsening, and/or interfering with the treatment of any mental disorder. Understanding a client's mental health symptoms and impairments that persist during periods of abstinence of 30 days or more can be useful, particularly in understanding what the client copes with even when the acute effects of substance use are not present. For any period of abstinence that lasts a month or longer, the counselor can ask the client about mental health treatment and/or substance abuse treatment—what seemed to work, what did the client like or dislike, and why? On the other hand, if mental health symptoms (even suicidality or hallucinations) resolve in less than 30 days with abstinence from substances, then these symptoms are most likely substance induced and the best treatment is maintaining abstinence from substances.

The counselor also can ask what the mental health “ups and downs” are like for the client. That is, what is it like for the client when he or she gets worse (or “destabilizes”)? What—in detail—has happened in the past? And, what about getting better (“stabilizing”)—how does the client usually experience that? Clinician and client together should try to understand the specific effects that substances have had on that individual's mental health symptoms, including the possible triggering of psychiatric symptoms by substance use. Clinicians also should attempt to document the diagnosis of a mental disorder, when it has been established, and determine diagnosis through referral when it has not been established.

Treatment Planning

A comprehensive assessment serves as the basis for an individualized treatment plan. Appropriate treatment plans and treatment interventions can be quite complex, depending on what might be discovered in each domain. This leads to another fundamental principle:

- There is no single, correct intervention or program for individuals with COD. Rather, the appropriate treatment plan must be matched to individual needs according to these multiple considerations.



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The following three cases illustrate how the above factors help to generate an integrated treatment plan that is appropriate to the needs and situation of a particular client.

Case 1: Maria M.

The client is a 38-year-old Hispanic/Latina woman who is the mother of two teenagers. Maria M. presents with an 11-year history of cocaine dependence, a 2-year history of opioid dependence, and a history of trauma related to a longstanding abusive relationship (now over for 6 years). She is not in an intimate relationship at present and there is no current indication that she is at risk for either violence or self-harm. She also has persistent major depression and panic treated with antidepressants. She is very motivated to receive treatment.

- ***Ideal Integrated Treatment Plan:*** The plan for Maria M. might include medication-assisted treatment (e.g., methadone or buprenorphine), continued antidepressant medication, 12-Step program attendance, and other recovery group support for cocaine dependence. She also could be referred to a group for trauma survivors that is designed specifically to help reduce symptoms of trauma and resolve long-term issues.

Individual, group, and family interventions could be coordinated by the primary counselor from opioid maintenance treatment. The focus of these interventions might be on relapse prevention skills, taking medication as prescribed, and identifying and managing trauma-related symptoms without using. An appropriate long-term goal would be to establish abstinence and engage Maria in longer-term psychotherapeutic interventions to reduce trauma symptoms and help resolve trauma issues. On the other hand, if a local mental health center had a psychiatrist trained and licensed to provide Suboxone (the combination of buprenorphine and naloxone), her case could be based in the mental health center.

Case 2: George T.

The client is a 34-year-old married, employed African-American man with cocaine dependence, alcohol abuse, and bipolar disorder (stabilized on lithium) who is mandated to cocaine treatment by his employer due to a failed drug test. George T. and his family acknowledge that he needs help not to use cocaine but do not agree that alcohol is a significant problem (nor does his employer). He complains that his mood swings intensify when he is using cocaine.

- ***Ideal Integrated Treatment Plan:*** The ideal plan for this man might include participation in outpatient addiction treatment, plus continued provision of mood-stabilizing

medication. In addition, he should be encouraged to attend a recovery group such as Cocaine Anonymous or Narcotics Anonymous. The addiction counselor would provide individual, group, and family interventions. The focus might be on gaining the skills and strategies required to handle cocaine cravings and to maintain abstinence from cocaine, as well as the skills needed to manage mood swings without using substances. Motivational counseling regarding alcohol and assistance in maintaining medication (lithium) adherence also could be part of the plan.

Case 3: Jane B.

The client is a 28-year-old single Caucasian female with a diagnosis of paranoid schizophrenia, alcohol dependence, crack cocaine dependence, and a history of multiple episodes of sexual victimization. Jane B. is homeless (living in a shelter), actively psychotic, and refuses to admit to a drug or alcohol problem. She has made frequent visits to the local emergency room for both mental health and medical complaints, but refuses any followup treatment. Her main requests are for money and food, not treatment. Jane has been offered involvement in a housing program that does not require treatment engagement or sobriety but has refused due to paranoia regarding working with staff to help her in this setting. Jane B. refuses all medication due to her paranoia, but does not appear to be acutely dangerous to herself or others.

- ***Ideal Integrated Treatment Plan:*** The plan for Jane B. might include an integrated case management team that is either based in the shelter or in a mental health service setting. The team would apply a range of engagement, motivational, and positive behavioral change strategies aimed at slowly developing a trusting relationship with this woman. Engagement would be promoted by providing assistance to Jane B. in obtaining food and disability benefits, and using those connections to help her engage gradually in treatment for either mental disorders or addiction—possibly by an initial offer of help in obtaining safe and stable housing. Peer support from other women also might be of value in promoting her sense of safety and engagement.

All of these cases are appropriate examples of integrated treatment. The purpose of the assessment process is to develop a method for gathering information in an organized manner that allows the clinician to develop an appropriate treatment plan or recommendation.

The Assessment Process

This portion of the chapter is organized around 12 specific steps in the assessment process. Through these steps, the counselor seeks to accomplish the following aims:

- To obtain a more detailed chronological *history* of past mental symptoms, diagnosis, treatment, and impairment, particularly before the onset of substance abuse, and during periods of extended abstinence.
- To obtain a more detailed description of *current* strengths, supports, limitations, skill deficits, and cultural barriers related to following the recommended treatment regimen for any disorder or problem.
- To determine *stage of change for each problem*, and identify external contingencies that might help to promote treatment adherence.

Note that although the steps appear sequential, in fact some of them could occur simultaneously or in a different order, depending on the situation. It is particularly important to identify and attend to any acute safety needs (***Safety First Always!***), which often have to be addressed before a more comprehensive assessment process can occur. Sometimes, however, components of the assessment process are essential to address the client's specific safety needs. For example, if a person is homeless, more information on that person's mental status, resources, and overall situation is required to address that priority appropriately. Finally, it must be recognized that while the assessment seeks to identify individual needs and vulnerabilities as quickly as possible to initiate appropriate treatment, assessment is an ongoing process: As treatment proceeds and as other changes occur in the client's life and mental status, counselors must actively seek current information rather than proceed on assumptions that might be no longer valid.

This discussion primarily is directed toward substance abuse treatment clinicians working in substance abuse treatment settings, though many of the steps apply equally well to mental health clinicians in mental health settings. At certain key points in the discussion, particular information relevant to mental health clinicians is identified and described.

Twelve Steps in the Assessment Process



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Assessment Step 1: Engage the Client

The first step in the assessment process is to engage the client in an empathic, welcoming manner and build a rapport to facilitate open disclosure of information regarding mental health problems, substance use disorders, and related issues. The aim is to create a safe and nonjudgmental environment in which sensitive personal issues may be discussed. Counselors should recognize that cultural issues, including the use of the client's preferred language, play a role in creating a sense of safety and promote accurate understanding of the client's situation and options. Such issues therefore must be addressed sensitively at the outset and throughout the assessment process.

The consensus panel identified five key concepts that underlie effective engagement during the initial clinical contact: universal access (“no wrong door”), empathic detachment, person-centered assessment, cultural sensitivity, and trauma sensitivity. All staff, as well as substance abuse treatment and mental health clinicians, in any service setting need to develop competency in engaging and welcoming individuals with COD. It is also important to note that while engagement is presented here as the first necessary step for assessment to take place, in a larger sense engagement represents an ongoing concern of the counselor—to understand the client's experience and to keep him or her positive and engaged relative to the prospect of better health and recovery.

No wrong door

“No wrong door” refers to formal recognition by a service system that individuals with COD may enter a range of community service sites; that they are a high priority for engagement in treatment; and that proactive efforts are necessary to welcome them into treatment and prevent them from falling through the cracks. Substance abuse and mental health counselors are encouraged to identify individuals with COD, welcome them into the service system, and initiate proactive efforts to help them access appropriate treatment in the system, regardless of their initial site of presentation. The recommended attitude is as follows: *The purpose of this assessment is not just to determine whether the client fits in my program, but to help the client figure out where he or she fits in the system of care, and to help him or her get there.*

Empathic detachment

Empathic detachment requires the assessing clinician to



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- Acknowledge that the clinician and client are working together to make decisions to support the client's best interest
- Recognize that the clinician cannot transform the client into a different person, but can only support change that he or she is already making
- Maintain empathic connection even if the client does not seem to fit into the clinician's expectations, treatment categories, or preferred methods of working

In the past, the attitude was that the client with COD was the exception. Today, clinicians should be prepared to demonstrate responsiveness to the requirements clients with COD present. Counselors should be careful not to label mental health symptoms immediately as caused by addiction, but instead should be comfortable with the strong possibility that a mental-health condition may be present independently and encourage disclosure of information that will help clarify the meaning of any COD for that client.

Person-centered assessment

Person-centered assessment emphasizes that the focus of initial contact is *not* on filling out a form or answering several questions or on establishing program fit, but rather on finding out what the client wants, in terms of his or her perception of the problem, what he or she wants to change, and how he or she thinks that change will occur. [Mee-Lee \(1998\)](#) has developed a useful guide that illustrates the types of questions that might be asked in a person-centered assessment in an addiction setting (see [Figure 4-1](#)). (It should be noted, however, that this is not a validated tool.) While each step in this decision tree leads to the next, the final step can lead back to a previous step, depending on the client's progress in treatment.

Figure 4-1. Assessment Considerations

Engagement:
• What does the client want?
• What is the treatment contract?
• What are the immediate needs?



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What are the DSM-5 diagnoses?
Multidimensional severity/level of functioning profile:
<ul style="list-style-type: none">• Identify which assessment dimensions are most severe to determine treatment priorities.
<ul style="list-style-type: none">• Choose a specific priority for each medium/severe dimension.
What specific services are needed to address these priorities?
What “dose” or intensity of services is needed?
Where can these services be provided in the least intensive, but safe, level of care or site of care?
How will outcomes be measured?
What is the progress of the treatment plan and placement decision?

Source: Adapted from [Mee-Lee 1998](#).

Answers to some of these important questions inevitably will change over time. As the answers change, adjustments in treatment strategies may be appropriate to help the client continue to engage in the treatment process.

Sensitivity to culture, gender, and sexual orientation

An important component of a person-centered assessment is the continual recognition that culture plays a significant role in determining the client's view of the problem and the treatment. (For a comprehensive discussion of culturally sensitive assessment strategies in addiction settings, see the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* [CSAT in development a]). With regard to COD, clinicians must remember that ethnic cultures may differ significantly in their approach to substance use disorders and mental disorders, and that this may affect how the client presents. In addition, clients may participate in treatment cultures (12-Step recovery, Dual Recovery Self-Help, psychiatric rehabilitation)



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that also may affect how they view treatment. Cultural sensitivity also requires recognition of one's own cultural perspective and a genuine spirit of inquiry into how cultural factors influence the client's request for help.

During the assessment process, it is important to ascertain the individual's sexual orientation as part of the counselor's appreciation for the client's personal identity, living situation, and relationships. Counselors also should be aware that women often have family-related and other concerns that must be addressed to engage them in treatment, such as the need for child care.

Trauma sensitivity

The high prevalence of trauma in individuals with COD requires that the clinician consider the possibility of a trauma history even before the assessment begins. Trauma may include early childhood physical, sexual, or emotional abuse; experiences of rape or interpersonal violence as an adult; and traumatic experiences associated with political oppression, as might be the case in refugee or other immigrant populations. This pre-interview consideration means that the approach to the client must be sensitive to the possibility that the client has suffered previous traumatic experiences that may interfere with his or her ability to be trusting of the counselor. Clinicians who observe guardedness on the part of the client should consider the possibility of trauma and try to promote safety in the interview through providing support and gentleness, rather than trying to “break through” evasiveness that erroneously might look like resistance or denial. All questioning should avoid “re-traumatizing” the client.

It is important to emphasize that in screening for a history of trauma or in obtaining a preliminary diagnosis of PTSD, it can be damaging to ask the client to describe traumatic events in detail. To screen, it is important to limit questioning to very brief and general questions, such as “Have you ever experienced childhood physical abuse? Sexual abuse? A serious accident? Violence or the threat of it? Have there been experiences in your life that were so traumatic they left you unable to cope with day-to-day life?”

Assessment Step 2: Identify and Contact Collaterals (Family, Friends, Other Providers) To Gather Additional Information

Clients presenting for substance abuse treatment, particularly those who have current or past mental health symptoms, may be unable or unwilling to report past or present circumstances accurately. For this reason, it is recommended that all assessments include routine procedures



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for identifying and contacting any family and other collaterals who may have useful information to provide. Information from collaterals is valuable as a supplement to the client's own report in all of the assessment steps listed in the remainder of this chapter. It is valuable particularly in evaluating the nature and severity of mental health symptoms when the client may be so impaired that he or she is unable to provide that information accurately. Note, however, that the process of seeking such information must be carried out strictly in accordance with applicable guidelines and laws regarding confidentiality and with the client's permission.

Assessment Step 3: Screen for and Detect Co-Occurring Disorders

Because of the high prevalence of co-occurring mental disorders in substance abuse treatment settings, and because treatment outcomes for individuals with multiple problems improve if each problem is addressed specifically, the consensus panel recommends that

- All individuals presenting for substance abuse treatment should be screened routinely for co-occurring mental disorders.
- All individuals presenting for treatment for a mental disorder should be screened routinely for any substance use disorder.

The content of the screening will vary upon the setting. Substance abuse screening in mental health settings should

- Screen for acute safety risk related to serious intoxication or withdrawal
- Screen for past and present substance use, substance related problems, and substance-related disorders

Mental health screening has four major components in substance abuse treatment settings:

- Screen for acute safety risk: suicide, violence, inability to care for oneself, HIV and hepatitis C virus risky behaviors, and danger of physical or sexual victimization
- Screen for past and present mental health symptoms and disorders
- Screen for cognitive and learning deficits
- Regardless of the setting, all clients should be screened for past and present victimization and trauma.



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Safety screening

Safety screening requires that early in the interview the clinician specifically ask the client if he or she has any immediate impulse to engage in violent or self-injurious behavior, or if the client is in any immediate danger from others. These questions should be asked directly of the client and of anyone else who is providing information. If the answer is yes, the clinician should obtain more detailed information about the nature and severity of the danger, the client's ability to avoid the danger, the immediacy of the danger, what the client needs to do to be safe and feel safe, and any other information relevant to safety. Additional information can be gathered depending on the counselor/staff training for crisis/emergency situations and the interventions appropriate to the treatment provider's particular setting and circumstances. Once this information is gathered, if it appears that the client is at some immediate risk, the clinician should arrange for a more in-depth risk assessment by a mental-health-trained clinician, and the client should not be left alone or unsupervised.

A variety of tools are available for use in safety screening:

- ASAM PPC-2R identifies considerations for immediate risk assessment and recommends follow up procedures ([ASAM 2001](#)).
- ASI ([McLellan et al. 1992](#)) and Global Appraisal of Individual Needs (GAIN) ([Dennis 1998](#)) also include some safety screening questions.
- Some systems use LOCUS ([American Association of Community Psychiatrists \[AAP\] 2000a](#)) as the tool to determine level of care for both mental disorders and addiction. One dimension of LOCUS specifically provides guides for scoring severity of risk of harm. See *Potential Risk of Harm* below. ***Instructor's Note: More details of the LOCUS are given in Chapter 4.***

Potential Risk of Harm

• **Risk of Harm:** This dimension of the assessment considers a person's potential to cause significant harm to self or others. While this may most frequently be due to suicidal or homicidal thoughts or intentions, in many cases unintentional harm may result from misinterpretations of reality, from inability to care adequately for oneself, or from altered states of consciousness due to use of intoxicating substances. When considering historical information, recent patterns of behavior should take precedence over patterns reported from



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the remote past.

Instructor Note: This information is given earlier in this chapter but is given here in a more user friendly, easy to apply outline.

Risk of harm may be rated according to the following criteria:

- *Minimal risk of harm:*

(a) No indication of suicidal or homicidal thoughts or impulses, no history of suicidal or homicidal ideation, and no indication of significant distress.

(b) Clear ability to care for self now and in the past.

- *Low risk of harm:*

- No current suicidal or homicidal ideation, plan, intentions or serious distress, but may have had transient or passive thoughts recently or in the past.

- Substance use without significant episodes of potentially harmful behaviors.

- Periods in the past of self-neglect without current evidence of such behavior.

- *Moderate risk of harm:*

(a) Significant current suicidal or homicidal ideation without intent or conscious plan and without past history.

(b) No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.

(c) History of chronic impulsive suicidal/homicidal behavior or threats and current expressions do not represent significant change from baseline.

(d) Binge or excessive use of substances resulting in potentially harmful behaviors without



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current involvement in such behavior.

(e) Some evidence of self neglect and/or compromise in ability to care for oneself in current environment.

- *Serious risk of harm:*

- Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so, or with ability to contract for safety.

- History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from baseline.

- Recent pattern of excessive substance use resulting in disinhibition and clearly harmful behaviors with no demonstrated ability to abstain from use.

- Clear compromise of ability to care adequately for oneself or to be aware adequately of environment.

- *Extreme risk of harm:*

- Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior without expressed ambivalence or significant barriers to doing so; or with a history of serious past attempts which are not of a chronic, impulsive, or consistent nature; or in presence of command hallucinations or delusions which threaten to override usual impulse control.

- Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.

- Extreme compromise of ability to care for oneself or to monitor adequately the environment with evidence of deterioration in physical condition or injury related to these



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deficits.

Source: [AAP 2000a](#).

Clinicians should not underestimate risk because the client is using substances actively. For example, although people who are intoxicated might only seem to be making threats of self-harm (e.g., “I’m just going to go home and blow my head off if nobody around here can help me”), all statements about harming oneself or others must be taken seriously. Individuals who have suicidal or aggressive impulses when intoxicated may act on those impulses; remember, alcohol and drug abuse are among the highest predictors of dangerousness to self or others—even without any co-occurring mental disorder. Determining which intoxicated suicidal client is “serious” and which one is not requires a skilled mental health assessment, plus information from collaterals who know the client best. In addition, it is important to remember that the vast majority of people who are abusing or dependent on substances will experience at least transient symptoms of depression, anxiety, and other mental symptoms.

Moreover, it may not be possible, even with a skilled clinician, to determine whether an intoxicated suicidal patient is making a serious threat of self harm; however, safety is a critical and paramount concern. Safety screening conducted in mental health settings is highlighted in the text box below.

Screening for past and present mental disorders

Screening for past and present mental disorders has three goals:

1. To understand a client's history and, if the history is positive for a mental disorder, to alert the counselor and treatment team to the types of symptoms that might reappear so that the counselor, client, and staff can be vigilant about the emergence of any such symptoms.
2. To identify clients who might have a current mental disorder and need both an assessment to determine the nature of the disorder and an evaluation to plan for its treatment.
3. For clients with a current COD, to determine the nature of the symptoms that might wax and wane to help the client monitor the symptoms, especially how the symptoms improve or worsen in response to medications, “slips” (i.e., substance use), and



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treatment interventions. For example, clients often need help seeing that the treatment goal of avoiding isolation improves their mood—that when they call their sponsor and go to a meeting they break the vicious cycle of depressed mood, seclusion, dwelling on oneself and one's mood, increased depression, greater isolation, and so on.

A number of screening, assessment, and treatment planning tools are available to assist the substance abuse treatment team. For assessment of specific disorders and/or for differential diagnosis and treatment planning, there are literally hundreds of assessment and treatment planning tools. NIAAA operates a web-based service that provides quick information about alcoholism treatment assessment instruments and immediate online access to most of them, and the service is updated continually with new information and assessment instruments (www.niaaa.nih.gov/publications/Assesing%20Alcohol/index.pdf). NIDA has a publication from a decade ago (Rounsaville et al. 1993) that provides broad background information on assessment issues pertinent to COD and specific information about numerous mental health, treatment planning, and substance abuse tools. Of course, NIDA continues to explore issues related to screening and assessment (e.g., see www.drugabuse.gov/DirReports/DirRep203/DirectorReport6.html and www.drugabuse.gov/Meetings/Childhood/Agenda/agenda.html). The mental health field contains a vast array of screening and assessment devices, as well as subfields devoted primarily to the study and development of evaluative methods. Almost all Substance Abuse and Mental Health Services Administration TIPs, which are available online (www.kap.samhsa.gov), have a section on assessment, many have appendices with wholly reproduced assessment tools or information about locating such tools, and TIPs 31, 16, 13, 11, 10, 9, 7, and 6 are centered specifically on assessment issues.

When using any of the wide array of tools that detect symptoms of mental disorders, **counselors should bear in mind that symptoms of mental disorder can be mimicked by substances.** For example, hallucinogens may produce symptoms that resemble psychosis, and depression commonly occurs during withdrawal from many substances. Even with well-tested tools, it can be difficult to distinguish between a mental disorder and a substance-related disorder without additional information such as the history and chronology of symptoms. In addition to interpreting the results of such instruments in the broader context of what is known about the client's history, counselors also are reminded that retesting often is important, particularly to confirm diagnostic conclusions for clients who have used substances.



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Assessment Step 4: Determine Quadrant and Locus of Responsibility

Determination of quadrant assignment is based on the severity of the mental and substance use disorders. Most of the information needed for this determination will have been acquired during step 2, but there are a few added nuances. Quadrant determination may be specified formally by procedures in certain States. For example, New York has drafted (but not yet adopted) a set of objective criteria for determining at screening who should be considered as belonging in quadrant IV. Where no such formal procedures are present, the following sequence may be useful and is certainly within the capability of substance abuse treatment clinicians in any setting.

The Four Quadrants

III	IV
Less severe mental disorder/ more severe substance disorder	More severe mental disorder/ more severe substance disorder
I	II
Less severe mental disorder/ less severe substance disorder	More severe mental disorder/ More severe substance disorder

Assessment Step 4—Application to Case Examples

Cases 1 and 2. Both Maria M. and George T. are examples of clients with serious addiction who also have serious mental disorders, but do not appear to be seriously disabled. They would therefore meet criteria for quadrant III and should be placed in programs for people who have less serious mental disorders and more serious substance use disorders. Note that though the diagnosis of bipolar disorder is typically considered a serious mental illness, the quadrant system emphasizes the acute level of disability/severity of the mental and substance use



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disorders of the individual, rather than relying solely on diagnostic classification.

Case 3. Jane B., the homeless woman with paranoid schizophrenia, generally would meet criteria for serious and persistent mental illness in almost every State, based on the severity of the diagnosis and disability, combined with the persistence of the disorder. Jane B. also has serious addiction. In the quadrant model, if she already has been identified as a mental health priority client (e.g., has a mental health case manager), she would be considered quadrant IV, and referral for mental health case management services would be important.

In many systems, the process of assessment stops largely after assessment step 4 with the determination of placement. Some information from subsequent steps (especially step 7) may be included in this initial process, but usually more in-depth or detailed consideration of treatment needs may not occur until after “placement” in an actual treatment setting.

Assessment Step 5: Determine Level of Care

The use of the ASAM PPC-2R provides a mechanism for an organized assessment of individuals presenting for substance use disorder treatment to determine appropriate placement in “level of care.” This process involves consideration of six dimensions of assessment:

- Dimension 1: Acute Intoxication and/or Withdrawal Potential
- Dimension 2: Biomedical Conditions and Complications
- Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications
- Dimension 4: Readiness to Change
- Dimension 5: Relapse, Continued Use, or Continued Problem Potential
- Dimension 6: Recovery/Living Environment
- The ASAM PPC-2R ([ASAM 2001](#)) evaluates level of care requirements for individuals with COD. Risk of Harm
- Functionality
- Comorbidity (Medical, Addictive, Psychiatric)



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- Recovery Support and Stress
- Treatment Attitude and Engagement
- Treatment History

LOCUS is simpler to use than ASAM PPC-2R. It has a point system for each dimension that permits aggregate scoring to suggest level of service intensity. LOCUS also permits level of care assessment for individuals with mental disorders or substance use disorders only, as well as for those with COD. Some pilot studies of LOCUS have supported its validity and reliability. However, compared to ASAM PC-2R, LOCUS is much less sensitive to the needs of individuals with substance use disorders and has greater difficulty distinguishing the separate contributions of mental and substance-related symptoms to the clinical picture.

Five areas of risk must be considered related to this dimension ([ASAM 2001](#), pp. 283–284):

- Suicide potential and level of lethality
- Interference with addiction recovery efforts (“The degree to which a patient is distracted from addiction recovery efforts by emotional, behavioral and/or cognitive problems and conversely, the degree to which a patient is able to focus on addiction recovery”)
- Social functioning
- Ability for self-care
- Course of illness (a prediction of the patient's likely response to treatment)
- Consideration of these dimensions permits the client to be placed in a particular level on a continuum of services ranging from intensive case management for individuals with serious mental disorders who are not motivated to change (Level I.5) to psychiatric inpatient care (Level IV). In addition, there is the capacity to distinguish, at each level of care, individuals with lower severity of mental symptoms or impairments that require standard or Dual Diagnosis Capable programming at that level of care from individuals with moderately severe symptoms or impairments that require Dual Diagnosis Enhanced programming at that level of care. (See below for assessment of the level of impairment.) The ASAM PPC have undergone limited validity testing in previous



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versions, are used to guide addiction treatment matching in more than half the States, and are influential in almost all of the rest.

- *Tools:* The LOCI-2R ([Hoffmann et al. 2001](#)) (see www.evinceassessment.com/product_loci2r.html for more information) is a proprietary tool designed specifically to perform a structured assessment for level of care placement based on ASAM PPC-2R levels of care ([ASAM 2001](#)). The GAIN ([Dennis 1998](#)) is another broad set of tools and training developed within an addiction setting; however, GAIN products are also proprietary.
- In some systems, the LOCUS Adult Version 2000 ([AAP 2000a](#)) is being introduced as a systemwide level of care assessment instrument for either mental health settings only, or for both mental health and substance abuse treatment settings. Like the ASAM, LOCUS uses multiple dimensions of assessment:

Assessment Step 5—Application to Case Examples

Case 3. The severity of Jane B.'s condition and her psychosis, homelessness, and lack of stability may lead the clinician initially to consider psychiatric hospitalization or referral for residential substance abuse treatment. In fact, application of assessment criteria in ASAM PPC-2R might have led easily to that conclusion. In ASAM PPC-2R, more flexible matching is possible. The first consideration is whether the client meets criteria for involuntary psychiatric commitment (usually, suicidal or homicidal impulses, or inability to feed oneself or obtain shelter). In this instance, she is psychotic and homeless but has been able to find food and shelter; she is unwilling to accept voluntary mental health services. Further, residential substance abuse treatment is inappropriate, both because she is completely unmotivated to get help and because she is likely to be too psychotic to participate in treatment effectively. ASAM PPC-2R would therefore recommend Level I.5 intensive mental disorder case management as described above.

If after extended participation in the engagement strategies described earlier, she began to take antipsychotic medication, after a period of time her psychosis might clear up, and she might begin to express interest in getting sober. In that case, if she had determined that she is unable to get sober on the street, residential substance abuse treatment would be indicated. Because of the longstanding severity of her mental illness, it is likely that she would continue to



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have some level of symptoms of her mental disorder and disability even when medicated. In this case, Jane B. probably would require a residential program able to supply an enhanced level of services.

Assessment Step 6: Determine Diagnosis

Determining the diagnosis can be a formidable clinical challenge in the assessment of COD. Clinicians in both mental health services and substance abuse treatment settings recognize that it can be impossible to establish a firm diagnosis when confronted with the mixed presentation of mental symptoms and ongoing substance abuse. Of course, substance abuse contributes to the emergence or severity of mental symptoms and therefore confounds the diagnostic picture. Therefore, this step often includes dealing with confusing diagnostic presentations.

Addiction counselors who want to improve their competencies to address COD are urged to become conversant with the basic resource used to diagnose mental disorders, the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision* (DSM-5) (American Psychiatric Association 2013).

The importance of client history

- *Principle #1:* Diagnosis is established more by history than by current symptom presentation. This applies to both mental and substance use disorders.

For example, if a client comes into the clinician's office under the influence of alcohol, it is reasonable to suspect alcohol dependence, but the only diagnosis that can be made based on that datum is "alcohol intoxication." It is important to note that this warrants further investigation; on the one hand, false positives can occur, while on the other, detoxification may be needed. Conversely, if a client comes into the clinician's office and has not had a drink in 10 years, attends Alcoholics Anonymous (AA) meetings three times per week, and had four previous detoxification admissions, the clinician can make a diagnosis of alcohol dependence (in remission at present). Moreover, the clinician can predict that 20 years from now that client will still have the diagnosis of alcohol dependence since the history of alcohol dependence and treatment sustains a lifetime diagnosis of alcohol dependence.

Similarly, if a client comes into the clinician's office and says she hears voices (whether or not the client is sober currently), no diagnosis should be made on that basis alone. There are many reasons people hear voices. They may be related to substance-related syndromes (e.g., substance-induced psychosis or *hallucinosis*, which is the experience of hearing voices that the client knows are not real, and that may say things that are distressing or attacking—particularly when there is a trauma history—but are not bizarre). With COD, most causes will be independent of substance use (e.g., schizophrenia, schizoaffective disorder, affective disorder with psychosis or dissociative hallucinosis related to PTSD). *Psychosis* usually involves loss of ability to tell that the voices are not real, and increased likelihood that they are bizarre in content. Methamphetamine psychosis is particularly confounding because it can mimic schizophrenia. Many individuals with psychotic disorders will still hear voices when on medication, but the medication makes the voices less bizarre and helps the client know they are not real.

Assessment Step 6—Application to Case Examples

Case 2. George T. has cocaine dependence and bipolar disorder stabilized with lithium. He reports that when he uses cocaine he has mood swings, but that these go away when he stops using for a while, as long as he takes his medication. At the initial visit, George T. states he has not used for a week and has been taking his medication regularly. He displays no significant symptoms of mania or depression and appears reasonably calm. The counselor should not conclude that because George T. has no current symptoms the diagnosis of bipolar disorder is incorrect, or that all the mood swings are due to cocaine dependence. At initial contact, the presumption should be that the diagnosis of bipolar disorder is accurate, and lithium needs to be maintained.

Documenting prior diagnoses

- *Principle #2:* It is important to document prior diagnoses and gather information related to current diagnoses, even though substance abuse treatment counselors may not be licensed to make a mental disorder diagnosis.
- Diagnoses established by history should not be changed at the point of initial assessment. If the clinician has a suspicion that a long-established diagnosis may be invalid, it is important that he or she takes time to gather additional information, consult with collaterals, get more careful and detailed history (see below), and develop



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a better relationship with the client before recommending diagnostic re-evaluation. It is important for the counselor to raise issues related to diagnosis with the clinical supervisor or at a team meeting.

- In many instances, of course, no well-established mental disorder diagnosis exists, or multiple diagnoses give a confusing picture. Even when there is an established diagnosis, it is helpful to gather information to confirm that diagnosis. During the initial assessment process, substance abuse treatment counselors can gather data that can assist in the diagnostic process, either by supporting the findings of the existing mental health assessment, or providing useful background information in the event a new mental health assessment is conducted. The key to doing this is not merely to gather lists of past and present symptoms, but to connect those symptoms to key time periods in the client's life that are helpful in the diagnostic process—namely, before the onset of a substance use disorder and during periods of abstinence (or during periods of very limited use) or those that occur after the onset of the substance use disorder and persist for more than 30 days.
- The clinician also must seek to determine whether mental symptoms occur only when the client is using substances actively. Therefore, it is important to determine the nature and severity of the symptoms of the mental disorder when the substance disorder is stabilized.

Linking mental symptoms to specific periods

- *Principle #3:* For diagnostic purposes, it is almost always necessary to tie mental symptoms to specific periods of time in the client's history, in particular those times when active substance use disorder was not present.

The substance abuse treatment counselor can proceed in two ways:

1. Inquire whether any mental symptoms or treatments identified in the screening process were present during periods of 30 days of abstinence or longer, or were present before onset of substance use. (“Did this symptom or episode occur during a period when you were clean and sober for at least 30 days?”)
2. Define with the client specific time periods where substance use disorder was in remission, and then get detailed information about mental symptoms, diagnoses,



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impairments, and treatments during those periods of time. (“Can you recall a specific period when you were not using? Did these symptoms [or whatever the client has reported] occur during that period?”) This approach may yield more reliable information

During this latter process, the counselor can use one of the medium-power symptom screening tools as a guide. Alternatively, the counselor can use the handy outlines of the DSM-5 criteria for common disorders and inquire whether those criteria symptoms were met, whether they were diagnosed and treated, and if so, with what methods and how successfully. This information can suggest or support the accuracy of diagnoses. Documentation also can facilitate later diagnostic assessment by a mental-health-trained clinician.

Assessment Step 7: Determine Disability and Functional Impairment

Determination of both current and baseline functional impairment contributes to identification of the need for case management and/or higher levels of support. This step also relates to the determination of level of care requirements. Assessment of current cognitive capacity, social skills, and other functional abilities also is necessary to determine if there are deficits that may require modification in the treatment protocols of relapse prevention efforts or recovery programs. For example, the counselor might inquire about past participation in special education or related testing.

Assessment Step 8: Identify Strengths and Supports

All assessment must include some specific attention to the individual's current strengths, skills, and supports, both in relation to general life functioning, and in relation to his or her ability to manage either mental or substance use disorders. This often provides a more positive approach to treatment engagement than does focusing exclusively on deficits that need to be corrected. This is no less true for individuals with serious mental disorders than it is for people with substance use disorders only.

Questions might focus on

- Talents and interests
- Areas of educational interest and literacy; vocational skill, interest, and ability, such as vocational skills, social skills, or capacity for creative self-expression
- Areas connected with high levels of motivation to change, for either disorder or both



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- Existing supportive relationships, treatment, peer, or family, particularly ongoing mental disorder treatment relationships
- Previous mental health services and addiction treatment successes, and exploration of what worked
- Identification of current successes: What has the client done right recently, for either disorder?
- Building treatment plans and interventions based on utilizing and reinforcing strengths, and extending or supporting what has worked previously

Assessment Step 9: Identify Cultural and Linguistic Needs and Supports

As noted above, detailed cultural assessment of individuals with substance use disorders is beyond the scope of this chapter. Cultural assessment of individuals with COD is not substantially different from cultural assessment for individuals with substance abuse or mental disorders only, but there are some specific issues that are worth addressing. These include

- Not fitting into the treatment culture (do not fit into either substance abuse or mental health treatment culture) and conflict in treatment
- Cultural and linguistic service barriers
- Problems with literacy

Assessment Step 10: Identify Problem Domains

Individuals with COD may have difficulties in multiple life domains (e.g., medical, legal, vocational, family, social). As noted earlier, research by McLellan and others has determined the value of providing assistance in each problem area in promoting better outcomes ([McLellan et al. 1997](#)). The ASI is a tool that is used widely to identify and quantify addiction-related problems in multiple domains, thereby determining which domains require specific attention. The value of the ASI is that it permits *identification of problem domains*. It is used most effectively as a component of a comprehensive assessment.

A comprehensive evaluation for individuals with COD requires clarifying how each disorder interacts with the problems in each domain, as well as identifying contingencies that might promote treatment adherence for mental health and/or substance abuse treatment.



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Information about others who might assist in the implementation of such contingencies (e.g., probation officers, family, friends) needs to be gathered, including appropriate releases of information

Assessment Step 10—Application to Case Example

Case 2. Evaluation of George T. revealed several interrelated problem domains. First, it was established that work represented a major problem area, and that he risked losing his job if he did not comply with treatment. Further inquiry into the details of this expectation led the counselor to discover that the client had been evaluated by the EAP and had a very specific requirement to maintain cocaine abstinence with mandatory urine screens, meet treatment program attendance requirements, and adhere to a lithium treatment regimen, with mandatory reports of lithium levels.

Assessment Step 11: Determine Stage of Change

A key evidence-based best practice for treatment matching of individuals with COD in both substance abuse treatment and mental health services settings is the following:

- For each disorder or problem, interventions have to be matched not only to specific diagnosis, but also to stage of change; the interventions also should be consistent with the stage of treatment for each disorder.

In substance abuse treatment settings, stage of change assessment usually involves determination of Prochaska and DiClemente Stages of Change: precontemplation, contemplation, preparation (or determination), action, maintenance, and relapse ([Prochaska and DiClemente 1992](#)). This can involve using questionnaires such as the URICA ([McConaughy et al. 1983](#)) or the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) ([Miller and Tonigan 1996](#)). It also can be determined clinically by interviewing the client and evaluating the client's responses in terms of stages of change. For example, a simple approach to identification of stage of change can be the following.

For each problem, select the statement that most closely fits the client's view of that problem:

- No problem and/or no interest in change (Precontemplation)
- Might be a problem; might consider change (Contemplation)



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- Definitely a problem; getting ready to change (Preparation)
- Actively working on changing, even if slowly (Action)
- Has achieved stability, and is trying to maintain (Maintenance)

Assessment Step 12: Plan Treatment

A major goal of the screening and assessment process is to ensure the client is matched with appropriate treatment. Acknowledging the overriding importance of this goal, this discussion of the process of clinical assessment for individuals with COD begins with a fundamental statement of principle:

- Since clients with COD are not all the same, program placements and treatment interventions should be matched individually to the needs of each client.

Stage of change assessment ideally will be applied separately to each mental disorder and to each substance use disorder. For example, a client may be willing to take medication for a depressive disorder, but unwilling to discuss trauma issues (as in case 1, Maria M.); or motivated to stop cocaine, but unwilling to consider alcohol as a problem (as in case 2, George T.).

The ultimate purpose of the assessment process is to develop an appropriately individualized integrated treatment plan. In this model, following the work of McLellan on comprehensive services for populations with substance use disorders, Minkoff on COD, and others, the consensus panel recommends the following approach:

- Treatment planning for individuals with COD and associated problems should be designed according to the principle of mental disorder dual (or multiple) primary treatment, where each disorder or problem has a specific intervention that is matched to problem or diagnosis, as well as to stage of change and external contingencies. [Figure 4-2](#) shows a sample treatment plan consisting of the problem, intervention, and goal.
- Integrated treatment planning involves helping the client to make the best possible treatment choices for each disorder and adhere to that treatment consistently. At the same time, the counselor needs to help the client adjust the recommended treatment strategies for each disorder as needed in order to take into account issues related to the other disorder.

Figure 4-2. Sample Treatment Plan for George T. (Case 2)

PROBLEM	INTERVENTION	GOAL
1. Cocaine Dependence	Outpatient treatment	Abstinence
• Work problem primary reason for referral	• EAP monitoring	• Clean urines
• Family and work support	• Family meetings	• Daily recovery plans
• Resists 12-Step	• Work support group	
• Mental symptoms trigger use	• Teach skills to manage symptoms without using	
• Action phase	• 12-Step meetings	
2. Rule Out Alcohol Abuse	• Outpatient motivational enhancement; thorough evaluation of role of alcohol in patient's life, including family education	• Move into contemplation phase of readiness to change
• No clear problem		• Willing to consider the risk of use and/or possible abuse
• May trigger cocaine		

PROBLEM	INTERVENTION	GOAL
use		
• Precontemplation		
3. Bipolar Disorder	• Medication management	• Maintain stable mood
• Long history	• Help to take medications while in recovery programs	• Able to manage fluctuating mood symptoms that do occur without using cocaine or other substances to regulate his bipolar disorder
• On lithium	• MDDA meetings	
• Some mood symptoms	• Advocate/collaborate with prescribing health professional	
• Maintenance phase	• Identify mood symptoms that are triggers	

These principles are best illustrated by using a case example to develop a sample treatment plan. For this purpose, case 2 (George T.) is used and incorporates the data gathered during the assessment process discussion above (see [Figure 4-1](#)). Note that the problem description presents a variety of information bearing on the problem, including stage of change and client strengths. Also note that no specific person is recommended to carry out the intervention proposed in the second column, since a range of professionals might carry out each intervention appropriately.



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Assessment Process Summary

The assessment process described above is a systematic approach for substance abuse treatment clinicians (and mental health clinicians) to gather the information needed to develop appropriately matched treatment plans for individuals with COD.

Chapter 3

THE ASAM CRITERIA

The ASAM criteria, also known as the ASAM patient placement criteria, is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-orientated and results-based care in the treatment of addiction. Today the criteria have become the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions. The ASAM criteria are required in over 30 states.

The ASAM Criteria is an indispensable resource that addiction medicine professionals rely on to provide a nomenclature for describing the continuum of addiction services.

How the ASAM Criteria Work

The ASAM criteria provide separate placement criteria for adolescents and adults to create comprehensive and individualized treatment plans. Adolescent and adult treatment plans are developed through a multidimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided and the intensity of treatment services provided.

Through this strength-based multidimensional assessment the ASAM Criteria addresses the patient's needs, obstacles and liabilities, as well as the patient's strengths, assets, resources and support structure

On the following page please review the at-a-glance ASAM chart.

Instructor's Note: The ASAM can be a bit confusing to use, the chart below simplifies it. Don't worry if after going through you are still scratching your head, I have been using this placement tool for 21 years and I still scratch my head sometimes too!



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AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT

ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:

1	DIMENSION 1	Acute Intoxication and/or Withdrawal Potential Exploring an individual's past and current experiences of substance use and withdrawal
2	DIMENSION 2	Biomedical Conditions and Complications Exploring an individual's health history and current physical condition
3	DIMENSION 3	Emotional, Behavioral, or Cognitive Conditions and Complications Exploring an individual's thoughts, emotions, and mental health issues
4	DIMENSION 4	Readiness to Change Exploring an individual's readiness and interest in changing
5	DIMENSION 5	Relapse, Continued Use, or Continued Problem Potential Exploring an individual's unique relationship with relapse or continued use or problems
6	DIMENSION 6	Recovery/Living Environment Exploring an individual's recovery or living situation, and the surrounding people, places, and things

REFLECTING A CONTINUUM OF CARE





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How and When to Use the Criteria

- To assign the appropriate level of service and level of care.
- To make decisions about continued service or discharge by ongoing assessment and review of progress.
- To do effective treatment planning and documentation.

Key Components of ASAM Model

A MULTI-DIMENSIONAL ASSESSMENT MODEL that organizes data from clinical interviews:

Dimension 1: Acute Intoxication and/or Withdrawal Potential

Dimension 2: Biomedical Conditions/Complications

Dimension 3: Emotional, Behavioral or Cognitive Conditions/Complications

Dimension 4: Readiness to Change

Dimension 5: Relapse, Continued Use or Continued Problem Potential

Dimension 6: Recovery/Living Environment

Instructor's Note: On the following pages you will find each dimension of the ASAM broken down into questions you can ask the client in front of you that you are assessing or mentally ask yourself "what am I looking for in this person?" This is like an amazing cheat sheet of questions and client characteristics.

Dimension 1: Detoxification/Withdrawal Potential

- What risk is associated w/ pt's current level of acute intoxication?
- Serious risk of severe withdrawal symptoms or seizures based on previous history?
- Recent discontinuation or significant reduction of alcohol/drug use? Recent increase?
- Does patient have responsible supports to assist in ambulatory detoxification if medically safe?

"The best predictor of current and future withdrawal problems, are past withdrawal problems!"



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Description of Dimension 1: Intoxicated/Withdrawal Symptoms

- Low: Not under the influence; no withdrawal potential
- Medium: Recent use, potential for intoxication; presenting with mild withdrawal symptoms
- High: Severe withdrawal hx, presenting with seizures, CIWA (The **Clinical Institute Withdrawal Assessment for Alcohol**, commonly abbreviated as CIWA or CIWA-Ar (revised version), is a ten item scale used in the assessment and management of alcohol withdrawal) score greater than 10

Dimension 2: Medical Conditions & Complications

- Are there current physical illnesses other than withdrawal, that need to be addressed or which complicate treatment?
- Are there chronic illnesses which might be exacerbated by withdrawal, (e.g., diabetes, hypertension)?
- Are there chronic conditions that affect treatment, (e.g., chronic pain treated with narcotic analgesics)?

Evaluate for the following:

1. Conditions that place the patient at risk (e.g., pregnancy, esophageal varices, seizure disorder, cardiac issues, diabetes).
2. Conditions that interfere with treatment (e.g., the need for kidney dialysis, visual/auditory disorders).

Description of Dimension 2: Biomedical Conditions

- Low: No current medical problems; no diagnosed medical condition; no care from primary care physician or prescribed meds
- Medium: Diagnosed medical condition; care from primary care physician; problematic response to conditions and/or care
- High: Life threatening medical condition; medical problems interfering with treatment; hospitalization needed.

Dimension 3: Emotional/Behavioral/ Cognitive Conditions & Complications

- Current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed or which complicate treatment?



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- Chronic conditions that effect treatment? (stable but chronic schizophrenia, affective or personality disorder problems)
- Do any of these problems appear to be an expected part of addiction illness or do they appear to be separate?
- If connected to addiction are they severe enough to warrant specific mental health treatment?
- If pt suicidal, what is the lethality? Weapon? Plan?

Description of Dimension 3: Emotional/Behavioral/Cognitive

- Low: No current cognitive/emotional/behavioral conditions
- Medium: Psychiatric symptoms, including cognitive, emotional, behavioral; complications interfering with recovery efforts.
- High: Active DT/s, S/HI; destructive, violent, or threatening behaviors, refusing to attend program schedule

Dimension 4: Readiness for Change

- Does the patient feel coerced into treatment or actively object to receiving treatment?
- At what “Stage of Change” would you currently assess them to be?
- If willing to accept treatment, how strongly does the patient disagree with others’ perception that s/he has an addiction problem?
- Is the patient compliant to avoid a negative consequence (external motivation) or internally distressed in a self-motivated way about their substance abuse?

Description of Dimension 4: Readiness for Change

- Low: Accepting need for treatment; attending, participating, and can ID future goals, plans
- Medium: Ambivalent about treatment; seeking help to appease others; avoiding consequences
- High: Denial of treatment despite severe consequences; refusing or is unable to engage due to D-3, D-5 symptoms interfering



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Dimension 5: Relapse, Continued Use or Continued Problem Potential

- Is the patient in immediate danger of continued severe distress and drinking/drugging behavior?
- Does the pt have any recognition & understanding of, and skills for how to cope with his/her addiction problems and prevent relapse or continued use?
- What severity of problems and further distress will potentially continue or reappear, if the pt is not successfully engaged in treatment at this time?
- What is the pt's ability to remain abstinent based on history?
- Awareness of relapse triggers?
- What is the current level of craving and how successfully can they cope with this?

Description of Dimension 5: Relapse Prevention

- Low: Recognizes onset signs; uses coping skills with CD or psychiatric problems
- Medium: Limited awareness of relapse triggers or onset signs
- High: Beliefs problematic re: continued CD despite CD attendance; revisions in treatment plan; unable to recognize relapse triggers or onset signs, or recognize and employ coping skills

Dimension 6: Recovery Environment

- Are there dangerous family, peers, school, or work conditions threatening treatment engagement and success?
- Does the pt have supportive friendships, financial, educational, or vocational resources to improve the likelihood of successful treatment?
- Are there barriers to accessing treatment such as transportation or childcare responsibilities?
- Are there legal, vocational, social service agency or criminal justice mandates that may enhance motivation (external) for engagement into treatment?

Description of Dimension 6: Recovery Environment

- Low: Supportive recovery environment with accessible MH, CD support
- Medium: Moderately supportive with problematic access to MH, CD support



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- High: Environment does not support recovery behaviors or efforts; resides with active substance users or abusive individuals

Instructor's Note: Next you will find the levels of care that the ASAM will guide you in determining. Of course the ASAM is not the only criteria needed to make that determination – you need DSM – 5 diagnosis and insurance company approval. To be an excellent assessing clinician you must have the information that the insurance companies your agency/program work with demand for to approve admission. Be armed with Utilization Review information!!!

ASAM/PPC-2R Levels of Care

Adult Levels of Care

Detoxification Levels

Level 0.5 Early Intervention

Opioid Maintenance Therapy

Level I Outpatient Services

Level II Intensive Outpatient/Partial Hospitalization Services

Level III Residential/Inpatient Treatment Services

Level IV Medically-Managed Intensive Inpatient Services

Adolescent Levels of Care

Detoxification Levels

Level 0.5 Early Intervention

Level I Outpatient Services

Level II Intensive Outpatient/Day Treatment/Partial Hospitalization Services

Level III Residential/Inpatient Services

Level IV Medically Managed Intensive Inpatient Services



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Instructor's Note:

Do you know what each of these level's of care offer? Not all of these treatment services are offered everywhere but as an addiction professional you should be familiar with all of them.

Though the Adolescent treatment services listed above look nearly the same they are often more Multisystemic, meaning the treatment programs may offer a team approach to working with each individual client that may include multiple family members, a psychiatrist/psychologist, case manager, an educator and a child advocate. When minors are in treatment confidentiality rules are different and often may outside agencies/others are involved in the referral and discharge process.

Please take the time to explore the adolescent levels of care on your own. You will benefit by knowing them in detail.

The following are the levels of care for adult treatment services based on ASAM criteria:

ASAM Level I - Outpatient Services

- Organized, non-residential services designed to treat the individual's assessed level of illness severity and to achieve permanent changes in an individual's substance using behavior. Services provided at fewer than 9 contact hours per week under a defined set of policies and procedures.
- Services may include: Community Support Team, Opioid Treatment, Outpatient Treatment

ASAM Level II.1 - Intensive Outpatient Treatment

- Designed to provide 9 or more hours of structured counseling and educational services per week.
- Needs for psychiatric and medical services are addressed through consultation or referral arrangements.
- IOP differs from partial hospitalization (Level II.5-SACOT) in the intensity of clinical services directly available. (e.g. IOP's has less capacity to effectively treat substantial medical and/or psychiatric problems.)



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- Services Include: Substance Abuse Intensive Outpatient Treatment

ASAM Level II.5 - Partial Hospitalization

- Designed to provide 20 or more hours of clinically intensive programming per week.
- Ready access to psychiatric, medical & lab services and are better able to meet the needs identified in Dimensions 1, 2, & 3 which warrant daily monitoring or management but which can be appropriately addressed in structured outpatient setting.
- Services Include: Substance Abuse Comprehensive Outpatient Treatment

+ ASAM Level III.1 Clinically-Managed Low--Intensity Residential Services

- At least 5 hours of professional addiction services per week are provided and directed towards applying recovery skills, preventing relapse, promoting personal responsibility, and reintegration back into work and family life while living in 24-hour structured environment.
- Interpersonal and group living skills are promoted through the use of “community or house meetings” involving staff and residents.
- Recent completion or ongoing treatment in other levels of service frequently occurs and the primary focus of this level is to provide a safe, structured, 24-hour living environment. (Dimensions 4, 5, & 6)
- Services Include: Halfway House

+ Non-Medicaid billable service

ASAM Level III.3 - Clinically-Managed Medium-Intensity Residential Services

- The effects of addiction on the individual’s life are so significant and the level of addiction-related impairment is so great that outpatient motivational strategies alone are not feasible or effective.
- Programming and staffing in this level of care is capable of addressing slightly more severe medical or emotional, cognitive, and/or behavioral problems.
- A structured recovery environment is combined with medium intensity professional clinical services to support and promote recovery.
- Case management activities work towards networking residents into community-based ancillary or “wrap-around” services.



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ASAM Level III.5 - Clinically-Managed High-Intensity Residential Services

Provides a highly structured recovery environment in combination with medium-to-high intensity professional clinical services.

- Programs are characterized by reliance on the treatment “community” as a therapeutic agent for clients whose lives are characterized by chaotic, unsupportive and often abusive interpersonal relationships, extensive treatment and criminal justice histories, little or no work history or educational experience, and/or anti-social value systems.
- Treatment is specific to maintaining abstinence & preventing relapse while vigorously promoting personal responsibility and positive character change in an intense therapeutic milieu.
- Services include: Substance Abuse Non-Medical Community Residential Treatment

ASAM Level III.7 - Medically-Intensive Inpatient Services

- Provides medically-directed 24-hour care by addiction physicians, nurses, and addiction credentialed clinicians in an acute care inpatient setting.
- The skills of the interdisciplinary team and support resources allow the conjoint treatment of any coexisting biomedical and emotional or behavioral conditions that need to be addressed. (“mild to medium”).
- Services Include: Substance Abuse Medically Monitored Community Residential Treatment

ASAM Level IV - Medically—Managed Intensive Inpatient Services

- Acute Care General Hospital
- Psych Hospital or Psych Unit in Acute Care Hosp.
- a) Provides medically-directed 24-hour care by addiction physicians, nurses, and addiction credentialed clinicians in an acute care inpatient setting.
- b) Treatment is specific to substance dependence disorder and the full resources of a general acute care hospital or psych. hospital are readily available.
- c) The skills of the interdisciplinary team and support resources allow the conjoint treatment of any coexisting biomedical and emotional or behavioral conditions that need to be addressed (“medium to severe”).



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Instructor's Note: I am sure you have all noticed (because you are all so smart!!) that as the level numbers get higher so does the intensity of the treatment services. Some of the terminology differs from place to place but the ASAM is used nationally, so it is important for you to learn what is meant by medically-managed or clinically managed, etc. So, it is your lucky day, I am including a glossary for each level of care noted above. I know – more to read – but you'll thank me later 😊

Glossary of Levels of Care:

Opioid Treatment - Outpatient Opioid Treatment is a service designed to offer the individual an opportunity to effect constructive changes in his lifestyle by using methadone, suboxone or other drug approved by the Food and Drug Administration for the treatment of Opioid Addiction in conjunction with the provision of rehabilitation and medical services. It is a tool in the detoxification and rehabilitation process of an opiate-dependent individual.

Substance Abuse Intensive Outpatient Treatment (SAIOP) – Also simply known as IOP

SAIOP consists of structured individual and group addiction activities and services that are provided at an outpatient program designed to assist adult and adolescent to begin recovery and learn skills for recovery maintenance. The program is offered at least three (3) hours per day at least three (3) days per week with no more than two consecutive days between offered services, and distinguishes between those individuals needing no more than 19 hours per week of structured services per week (ASAM Level II.1).

Partial Hospitalization Program (PHP) – PHP is a periodic service that is a time-limited multi-faceted approach treatment service for adults who require structure and support to achieve and sustain recovery. PHP is a service emphasizing reduction in use and abuse of substances and/or continued abstinence, the negative consequences of substance abuse, development of social support network and necessary lifestyle changes, educational skills, vocational skills leading to work activity by reducing substance abuse as a barrier to employment, social and interpersonal skills, improved family functioning, the understanding of addictive disease, and the continued commitment to a recovery and maintenance program. These services are provided during day and evening hours to enable individuals to maintain residence in their community, continue to work or go to school, and to be a part of their family life.



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Non-medical Community Residential Treatment -Non-medical Community Residential Treatment is a 24-hour residential recovery program professionally supervised residential facility that provides trained staff who work intensively with adults with substance abuse disorders who provide or have the potential to provide primary care for their minor children. This is a rehabilitation facility, without twenty-four hour per day medical nursing/monitoring, where a planned program of professionally directed evaluation, care and treatment for the restoration of functioning for persons with an addiction disorder.

Chapter 4

LOCI-2R

Level of Care Index-2R

BENEFITS

- Practical way to implement the ASAM PPC-2R criteria.
- Comprehensive documentation of placement and treatment planning indications.
- Document multiple assessments during an episode of care on one form.

The LOCI-2R is a comprehensive means for guiding assessments and documenting treatment placement and planning information for the six assessment dimensions of the ASAM PPC-2R. The LOCI-2R is designed for use in the initial assessment, subsequent continued service reassessments, and transfer or discharge evaluations. All levels of care defined by the ASAM PPC-2R are covered. The LOCI-2R is not a psychometric tool, but rather a means of guiding assessment and summarizing findings from evaluation interviews, assessment instruments, personal history, and data from the clinical records.

APPLICATIONS: The LOCI-2R is designed to assist in guiding assessments, summarizing findings, and providing documentation of why specific decisions are made. It provides comprehensive yet easy-to-use documentation for clinical decisions to support reimbursement, and can clarify communication between clinicians and utilization reviewers. Each form can be used for up to six assessments per individual.



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Although designed to assist clinicians in implementing the ASAM PPC-2R criteria, the LOCI-2R can be used as a general documentation tool or to summarize information likely to be relevant to other criteria. In such cases, professionals are urged to consult the criteria in question.

LOCI-2RTM - Level of Care Index-2R
by Norman G. Hoffmann, Ph.D.
David Mee-Lee, M.D.
Gerald D. Shulman, M.A., M.A.C., FACATA

What is the LOCUS and CALOCUS?

LOCUS = Level of Care Utilization System (18 years and older), and

CALOCUS = Child & Adolescent Level of Care Utilization System (ages 5 to 17)

The LOCUS and CALOCUS are assessments and placement instruments developed by the American Association of Community Psychiatrists AACP & the American Academy of Child & Adolescent Psychiatry AACAP. As of February 1, 2013 these assessment tools will be used to assess level of care needs for mental health consumers and will be required for all Service Authorization Requests (SAR).

Objectives of the Assessment Tools:

- LOCUS/CALOCUS assesses the enrollee's needs based on level of functioning, rather than diagnosis and psychiatric risk alone.
- LOCUS/CALOCUS assesses the enrollee's needs and allocate resources based on six evaluation dimensions.
- LOCUS/CALOCUS determines a recommendation for level of care; however, it is not a substitute for clinical judgment.

What is the LOCUS?

Created in order to provide a tool to:

- guide assessment: asking and evaluating relevant data
- level of care placement decisions,
- Attempt to actually link assessment to need for and focus of treatment
- continued stay criteria: envisioned as continuing need for service over time
- clinical outcomes: impact of treatment



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Principles:

- Simple
- Not uni-dimensional – mimics at least to some extent the decision-making process that takes place at assessment –but can develop as with GAF a composite score for placement decisions
- Able to be completed after or during assessment – remove redundancy
- Measures both psychiatric and addiction problems and their impact on client together – can be used for dually diagnosed
- Levels of care are flexible – describes resources and intensity not programs – adaptable to any continuum of care
- Dynamic model – measures client needs over time –eliminates need for separate admission, discharge and continuing stay criteria when using this instrument

There are three basic building blocks of the LOCUS:

– A system for evaluating the current status of clients and their needs based on six evaluation parameters.

• 1) Risk of Harm; 2) Functional Status; 3) Medical, Addictive and Psychiatric Co-Morbidity; 4) Recovery Environment; 5) Treatment and Recovery History; and 6) Engagement.

• In each client needs are evaluated using a 5 point scale, with #4 having two subscales.

– An assignment to one of seven levels of care that are defined by descriptions of the:

1. Care Environment, 2) Clinical Services, 3) Support Services, and 4) Crisis Resolution and Prevention Services at each level.

- A methodology for quantifying the assessment of service needs in order to reliably place a client into the service continuum.

- „ The profiler usually first completes the diagnostic assessment of needs and then moves on to assignment to level of care.

– Should not need a separate assessment just to complete the LOCUS

LOCUS: Using the Tool



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- Not diagnostically driven – do not need diagnosis to complete

- Looks at needs now – recognizes that some individuals need similar treatment models even with disparate diagnoses
- Prioritizes needs: current needs
- Snapshot only: things change – in some cases quite rapidly
- „ Adaptable - allows for a changing continuum
- „ Reliable – used across the country; multiple locations, programs, etc.

Levels of Care

- Recovery maintenance and health management
- Low Intensity Community-Based
- High Intensity Community-Based
- Medically monitored non-residential
- Medically monitored residential
- Medically managed residential

When is the LOCUS or CALOCUS tool completed?

The tools must be completed on any child or adult with a mental health diagnosis or co-occurring disorder at the time of submitting a service authorization request.

Current assessments for substance abuse diagnosis (ASAM) and I/DD diagnosis (after 2/1/2013 = SIS) will continue as usual. If a consumer has a primary SA consumer or primary I/DD consumer with co-morbid MH issues, you will also need to complete the appropriate LOCUS or CALOCUS.

Who can complete the LOCUS and CALOCUS tools?

Licensed and provisionally licensed clinicians are not required to attend training prior to implementing the LOCUS and CALOCUS tool in their practices. However, Qualified Professionals are required to attend training prior to implementing the tools into their practice.



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Instructor's Note: Certified Addiction Professionals working in a primary mental health care setting or a co-occurring care setting will be expected to either use or have knowledge of the LOCUS/CALOCUS as of February 2013. The information above is just a brief summary of the LOCUS, a complete training is necessary before attempting to utilize this tool.

To see the LOCUS/CALOCUS crosswalk click on the hyperlink given below.

www.partnersbhm.org/_.../CALOCUS%20Scoring%20Sheet.doc