

Assessment:

Technical Assistance (TA) Report for the Co-Occurring State Incentive Grants (COSIGS)

August 11, 2005
Updated June 2008

Background

Introduction

- This report was prepared as part of a group process involving SAMHSA's Co-Occurring Center for Excellence (COCE) and the Co-Occurring State Incentive Grants (COSIGs) from 2003-2005.
- The content of this report is intended to be an introduction to the topic of assessment, rather than an exhaustive review.
- This report was updated in June 2008 for posting to the COCE Web site.
- The SAMHSA Federal Project Officer for COCE is Charlene E. Le Fauve, Ph.D. (CSAT).

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Purpose and Utility of the Assessment Report

Purpose:

- To provide an overview of the process of selecting assessment instruments for co-occurring substance use and mental disorders.

Utility:

- PowerPoint format allows the report to be used in multiple settings and with multiple target groups.
- The report can be partitioned where particular components are needed.
- The report was updated in January 2008 and will be updated periodically to ensure that the information remains accurate over time and available to a broad audience via the COCE Web site.

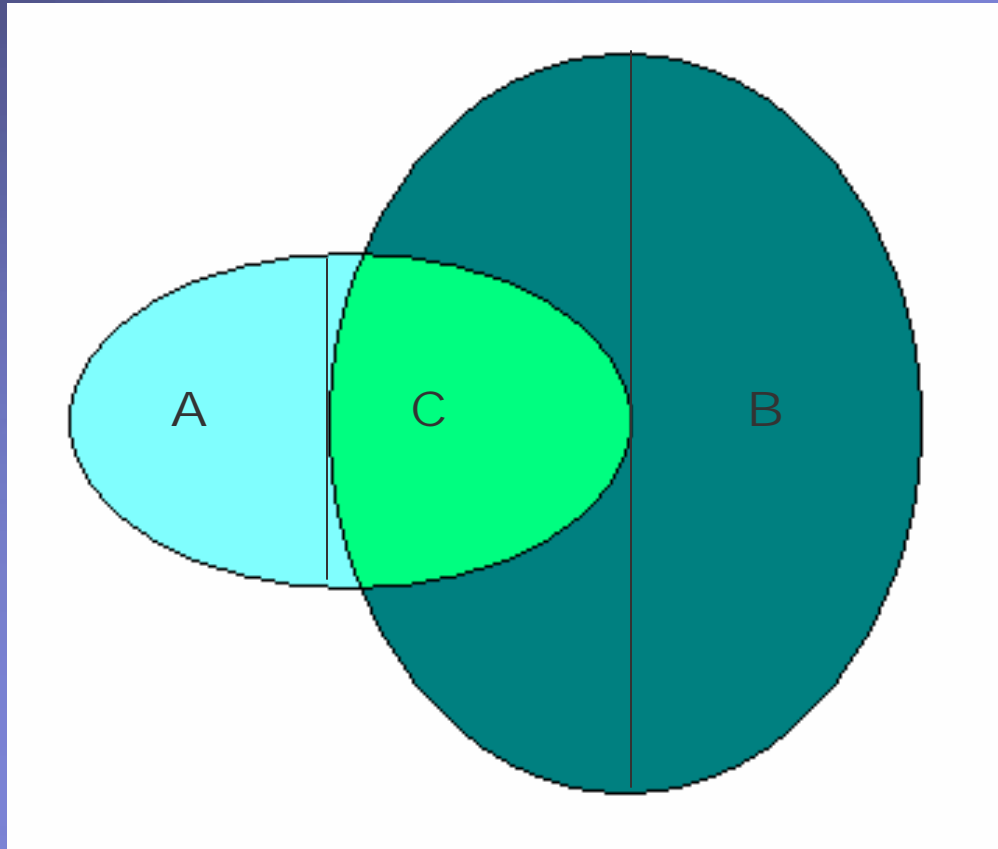
SAMHSA's Definition of Co-Occurring Disorders (COD)

- **The term refers to co-occurring substance use (abuse or dependence) and mental disorders. Clients said to have co-occurring disorders have one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs (CSAT 2006a).**

Co-Occurring Mental and Substance Use Disorders

Mental Disorders (A)

Co-Occurring Disorders (C)

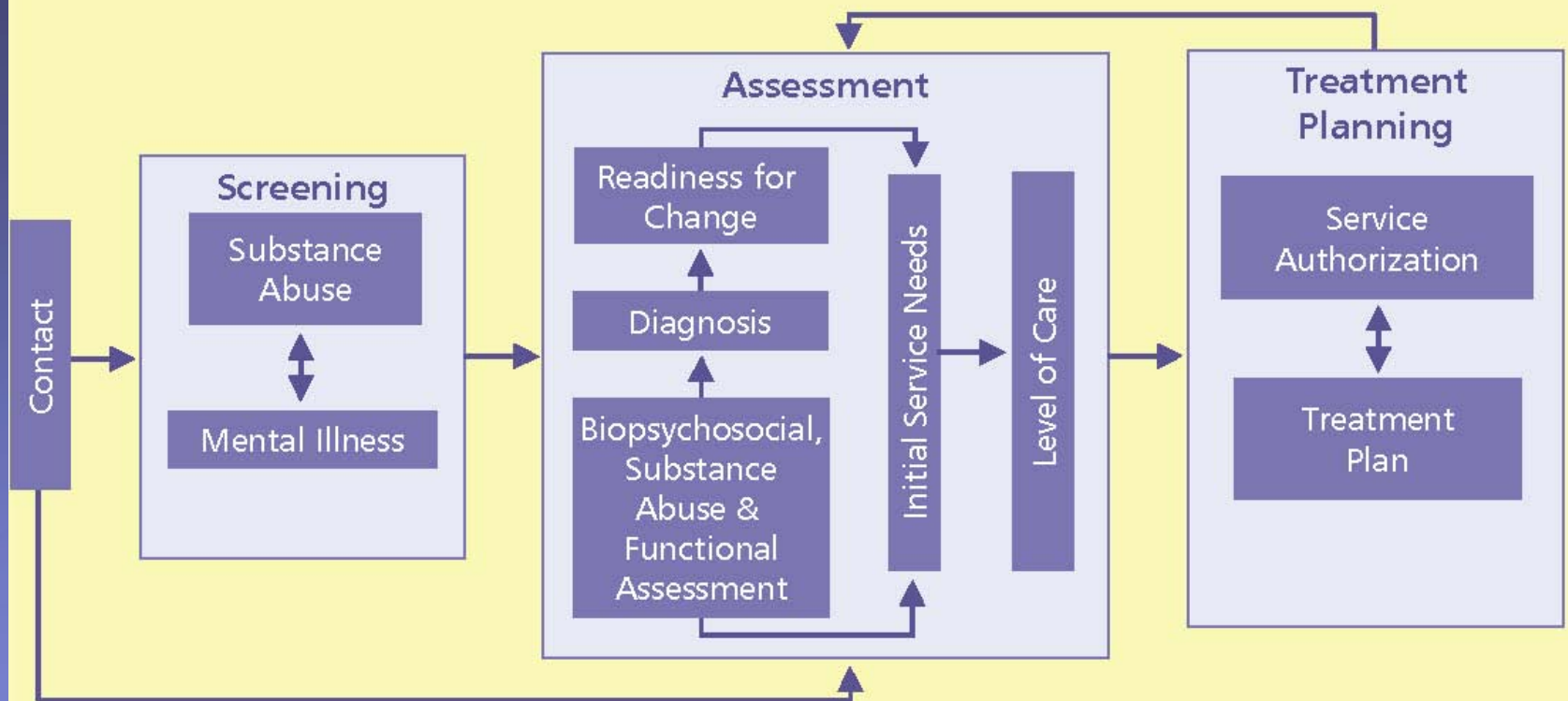


Substance Use Disorders (B)

Source: Adapted from Osher, F.C. (1996)

Relationships Among Screening, Assessment, and Treatment Planning

Figure 1: Relationships Among Screening, Assessment, and Treatment Planning



CSAT (2005)

Assessment

Definitions & Features

Definition: Assessment

- A basic assessment consists of gathering key information and engaging in a process with the client that enables the counselor/therapist to understand the client's readiness for change, problem areas, COD diagnosis, disabilities, and strengths.
- An assessment typically involves a clinical examination of the functioning and well-being of the client and includes a number of tests and written and oral exercises. The COD diagnosis is established by referral to a psychiatrist or clinical psychologist.
- Assessment of the COD client is an ongoing process that should be repeated over time to capture the changing nature of the client's status.

CSAT, 2005

Basic Assessment Consists of:

- Background
- Substance Use
- Psychiatric Problems
- Integrated Assessment

Basic Assessment Consists of:

- ▶ **Background** is ascertained by obtaining data on family; relevant cultural, linguistic, gender, sexual orientation issues; trauma history; marital status; legal involvement and financial situation; health; education; housing status; strengths and resources; and employment.

Basic Assessment *(Continued)*

- ▶ **Substance use is established by:**
 - Age of first use
 - Primary drugs used by class (e.g., opioids, stimulants, inhalants, etc.)
 - Patterns of drug use (including information related to diagnostic criteria for abuse or dependence)
 - Route of administration for each drug used
 - Periods of abstinence of 30 days or longer to isolate the mental health symptoms, treatment, and disability expressed during these abstinent periods
 - Past or current treatment history
 - Evidence of tolerance and/or withdrawal

Basic Assessment *(Continued)*

- ▶ **Psychiatric problems** are elaborated by determining both family and client histories of psychiatric problems (including diagnosis, hospitalization, and other treatments), current diagnoses and symptoms, and medications and medication adherence. It is important to identify past periods of mental health stability, determine past successful treatment for mental disorders, and discover the nature of substance use disorder issues arising during these stable periods. Identification of any current treatment providers enables vitally important information sharing and cooperation.

Basic Assessment *(Continued)*

- ▶ **Integrated assessment** identifies the interactions between substance use and mental health symptoms and treatment, and the interactions between mental health symptoms and substance use and treatment, both during periods of stability and periods of recent crisis.

Assessment Steps

Assessment Step 1: Engage the Client

- **No wrong door**
- **Empathetic detachment**
- **Person-centered assessment**
- **Cultural sensitivity**
- **Trauma sensitivity**

Assessment Step 2: Identify and Contact Collaterals

- **Client may be unwilling, or unable, to accurately report past or present circumstances.**
- **Collaterals - family, friends, or other providers.**
- **Strict adherence to guidelines and laws regarding confidentiality (42 C.F.R. Part 2 – see CSAT 2005, pgs. 523-525).**

CSAT 2005

Assessment Step 3: Detect Acute Conditions Associated with Co-Occurring Disorders

- **Safety risk: suicide, violence towards others, inability to care for oneself.**
- **Safety risk: serious intoxication or potential for withdrawal.**
- **Safety risk: medical safety and capacity for self care based on illness.**
- **High risk behaviors.**
- **Cognitive and learning deficits.**
- **Past and present victimization and trauma.**

Assessment Step 3: Detect Co-occurring Disorders *(continued)*

- **Assessment is a process that requires regular updating. Describes functioning, symptoms, treatment and interactions.**
- **Mental illness and substance use information is integrated.**
- **Information gathered over long periods of time – comprehensive and longitudinal.**
- **Focus on periods of different functioning.**

Example of Comprehensive Longitudinal Assessment

<u>Time</u>	<u>Function</u>	<u>Mental Health Symptoms</u>	<u>Mental Health Treatment</u>	<u>Substance use Symptoms</u>	<u>Substance use Treatment</u>	<u>Interactions</u>
1990	Working Living With parents	Depressed mood Mild Sleep problems	Taking meds Case management	Occasional alcohol	Attending groups	Relatively stable with treatment and little substance use
Spring 1991	Working Substance using boyfriend Fights with parents	Mood good Sleep poor Energy high	Stopped meds Case management	Daily alcohol Marijuana	Stopped groups	Hypomanic without meds and using substances

West Institute, 2003

Assessment Step 4: Determine Quadrant and Locus of Responsibility

➤ Determine Severity of Mental Illness

- Use State criteria (established by every State mental health system based on combinations of diagnoses, severity of disability, and duration of disability)
- Is client already receiving priority mental health services?
- Dimension 3 subscales of ASAM PPC-2R or LOCUS (see slides 25-26 for more details)

➤ Determine Severity of Substance Use Disorder

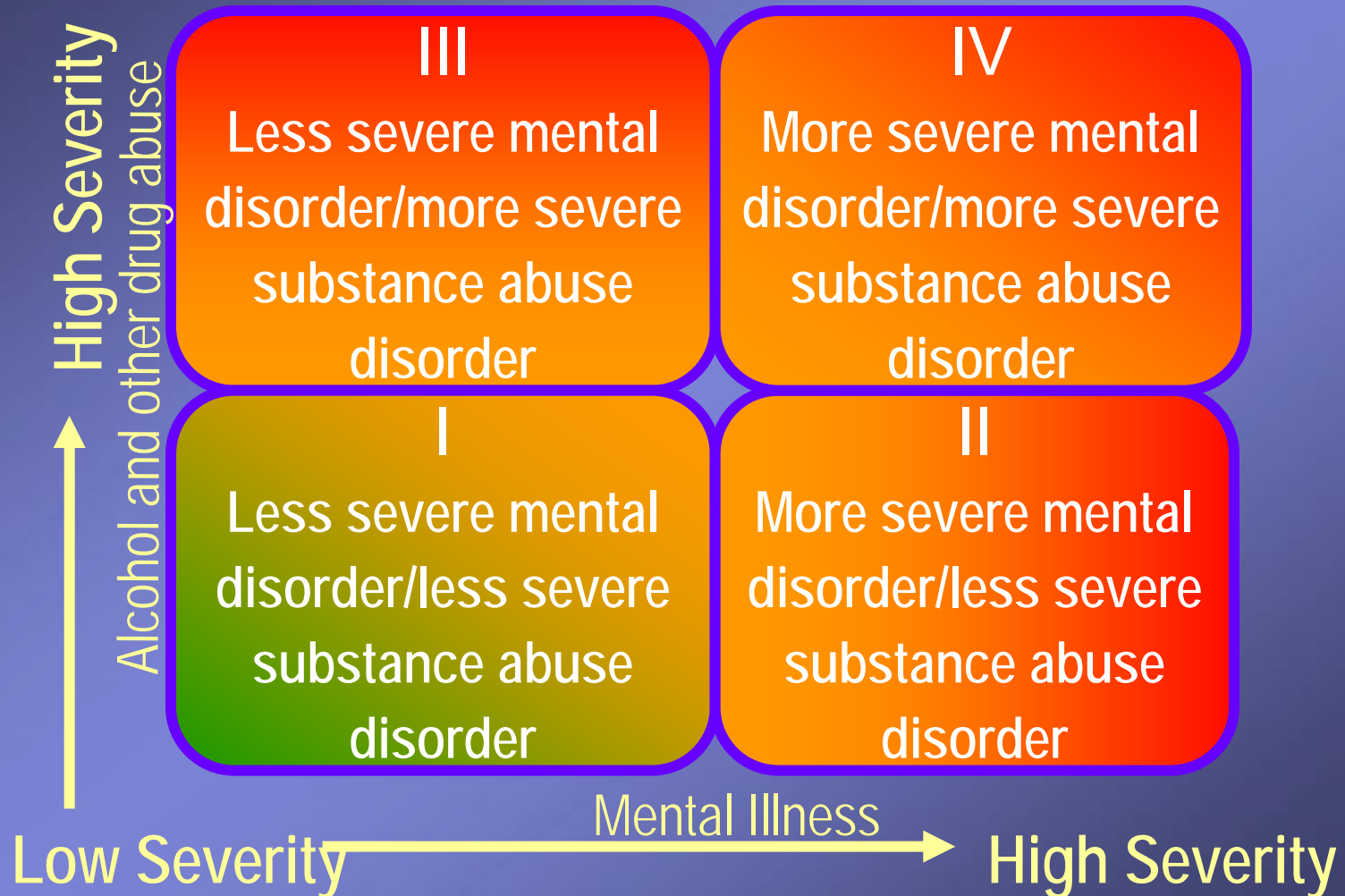
- Active or unstable substance dependence; or
- Serious substance abuse
- If either criteria is met, then consider for Quadrant III or IV

➤ Determine the need for basic (“capable”) or Advanced (“enhanced”) services.

Origin and Use of Quadrant Model

- The quadrants of care were derived from a conference, the *National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders*, which was supported by SAMHSA and two of its centers, CSAT and the Center for Mental Health Services (CMHS) (National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors, 1998).
- The purpose of the model is to provide a conceptual framework for thinking about services for clients with co-occurring disorders.

The Four Quadrants



CSAT 2005

Assessment Step 5: Determine Level of Care – Substance Use [American Society of Addiction Medicine (ASAM) PPC-2R Dimensions]

- 1. Acute Intoxication and/or Withdrawal Potential**
- 2. Biomedical Conditions and Complications**
- 3. Emotional, Behavioral, or Cognitive Conditions and Complications**
- 4. Readiness to Change**
- 5. Relapse, Continued Use, or Continued Problem Potential**
- 6. Recovery/Living Environment**

CSAT 2005, ASAM 2001

Assessment Step 5: Determine Level of Care – Mental Health [American Association of Community Psychiatrists (AACCP) LOCUS Dimensions]

- 1. Risk of Harm**
- 2. Functionality**
- 3. Comorbidity (Medical, Addictive, Psychiatric)**
- 4. Recovery Support and Stress**
- 5. Treatment Attitude and Engagement**
- 6. Treatment History**

CSAT 2005, AACCP 2000

Assessment Step 6: Determine Diagnosis: Principles

- 1. Diagnosis is established more by history than by current symptoms.**
- 2. It is important to document prior diagnoses even if assessor is not licensed to make diagnoses.**
- 3. It is critical to tie mental health symptoms to specific periods of time, particularly times when active substance use was not present.**

Assessment Step 7: Determine Disability and Functional Impairment

- **Is the client capable of living independently? If not, what is needed?**
- **Is the client capable of supporting himself financially?**
- **Can the client engage in supportive social relationships?**
- **Are there impairments in intellectual functioning?**

CSAT 2005 and also see DSM-IV-TR (APA, 2007)

Assessment Step 8: Identify Strengths and Supports

- **Talents and interests**
- **Vocational or educational competency**
- **Areas connected with high levels of motivation to change**
- **Existing supportive relationships or interest in re-unification**
- **Previous successful treatment efforts**
- **Current successes**
- **Utilize strengths and supports in developing treatment plans**

CSAT 2005

Assessment Step 9: Identify Cultural and Linguistic Needs and Supports

- **Ability to fit into treatment culture**
- **Cultural and linguistic service barriers**
- **Problems with literacy**

Assessment Step 10: Identify External Problem Domains

- ▶ **Medical**
- ▶ **Legal**
- ▶ **Financial**
 - **Housing**
 - **Income Supports**
 - **Access to Health Care**

- ▶ **Vocational**
- ▶ **Family**
- ▶ **Social**
- ▶ **Transportation**
- ▶ **Child Care**

CSAT 2005

Assessment Step 11: Determine Stage of Change/Stage of Treatment

Substance Abuse Settings (Prochaska and DiClemente 1992):

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

Instruments:

- Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) (Miller and Tonigan 1996)
- URICA (McConaughy et al 1983)

Mental Health Settings (Osher and Kofoed 1989 & others)

- Engagement
- Persuasion
- Active Treatment
- Relapse Prevention

Instruments:

- Substance Abuse Treatment Scale (SATS) (McHugo et al. 1995)

Assessment Step 12: Plan Treatment

- 1. Evaluate pressing needs**
- 2. Determine motivation to address substance use/mental health problems**
- 3. Collaborate with client to select target behaviors for change**
- 4. Determine interventions to achieve desired goals**
- 5. Choose measures to evaluate the intervention**
- 6. Select follow-up times to review the plan**

Key Domains for Linking Assessment Findings to Treatment Matching

- **Acute Safety Needs**
- **Quadrant Assignment**
- **Level of Care**
- **Diagnosis**
- **Disability**

- **Strengths and Skills**
- **Recovery Support**
- **Cultural Context**
- **External problem domains (housing, employment, medical, etc.)**
- **Phase of Recovery/Stage of Change**

Additional Considerations

- **Assessment should be a clinically driven process- involves clinician making connection with the client.**
- **Consider the client in a context (i.e. setting) and fit assessment process to the setting.**
- **Take into account the system of care the person is in – think of systems available so you can do treatment planning.**
- **Integrated assessment consists of:**
 - **Cross walk between MH and SA**
 - **Establishing times when client did well**
 - **Determining stage of change by problem**
 - **Stage-specific assessment and treatment planning.**

Other Discussion Issues

- **Structured Instruments and Clinical Processes/Judgment**
- **Population and setting**
- **Agency and System**
- **Amount of Information/Use of Information**

Integrated Assessment

- **Integrated assessment addresses both mental health and substance use, each in the context of the other disorder**
- **A comprehensive assessment process also includes the exploration of a full range of other needs, based on the 12 steps in the Assessment Process described in previous slides**

CSAT, 2006b

Roles and Settings for Conducting Integrated Assessments

Who should conduct integrated assessments?

- **Mental health or substance abuse professionals (or a team of both) with specialized training and skills.**
- **DSM-IV-TR diagnosis is accomplished by referral to a psychiatrist, clinical psychologist, licensed clinical social worker, or other qualified healthcare professional who is licensed by the State to diagnose mental disorders.**

What settings are appropriate for assessments?

- **Mental health centers, substance abuse treatment facilities, and other treatment settings that include trained mental health and substance abuse professionals (see above)**

CSAT, 2006b

How is the Assessment Integrated?

- **The assessment for COD is integrated by analyzing and using data concerning one disorder in light of data concerning the other disorder.**
 - For example, attention to mental health symptoms, impairments, diagnoses, and treatments during past episodes of substance abuse and abstinence can illuminate the role of substance abuse in maintaining, worsening, and/or interfering with the treatment of any mental disorder. Fundamental knowledge of the pharmacological effects of specific substances of abuse will be particularly useful in completing the assessment in this context.

CSAT, 2006b

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

- DO keep in mind that assessment is about getting to know a person with complex and individual needs. Rely on a variety of methods (not just tools) to conduct a comprehensive assessment.
- DO always make every effort to contact all involved parties.
- DO become familiar with the diagnostic criteria for common mental disorders (including personality disorders), and with the names and indications of common psychiatric medications.
- 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.
- Most important, DO remember that empathy and hope are the most valuable components of your work with a client.
- Don't assume that there is one correct treatment approach or program for any type of COD.
- Don't allow preconceptions about addiction/mental illness to interfere with learning about what the client really needs.
- Don't be afraid to admit when you don't know, either to the client or yourself.

Assessment Instruments

COCE/COSIG Evaluation Findings

Advantages of Assessment Instruments

- **Provide a structured method for gathering information in specific areas that results in scores that identify problem areas.**
- **Function as ‘ticklers’ or memory aids to the clinician or team, assisting in making sure that all relevant topics are covered.**
- **Provide information that is part of the assessment process.**

CSAT, 2006b

Disadvantages of Assessment Instruments

- **Instruments alone do not constitute the entire assessment. In particular, instruments do not:**
 - Accomplish the interpersonal goals of assessment
 - Make the client feel welcome in the treatment system
 - Engage the client as an active partner in his or her care
 - Begin the therapeutic alliance that will exist throughout the client's relationship.

Full List of Assessment Instruments Reviewed by COCE/COSIG Workgroup

Instruments with a Substance Use Disorder Focus

- **Addiction Severity Index (ASI)**
- **Alcohol Dependence Scale (ADS)**
- **Global Appraisal of Individual Needs (GAIN)**
- **Individual Assessment Profile (IAP)**

Instruments with a Mental Disorder Focus

- **Beck Depression Inventory (BDI)**
- **Beck Hopelessness Scale (BHS)**
- **Brief Psychiatric Rating Scale (BPRS)**
- **General Behavioral Inventory (GBI)**

Instruments with a Focus on Trauma

- **Post-Traumatic Stress Symptom Scale – Self Report (PSS-SR)**
- **Trauma History Questionnaire (THQ)**

Full List of Assessment Instruments (continued)

Instruments with a General Health focus:

- **Medical Outcomes Study – Short Form (SF-36)**

Diagnostic Instruments:

- **Diagnostic Interview Schedule (DIS-IV)**
- **Mini International Neuropsychiatric Interview (MINI)**
- **Structured Clinical Interview Schedule for DSM-IV Disorders (SCID)**

Motivation and Readiness to Change Instruments:

- **Circumstances, Motivation, and Readiness Scales (CMRS)**
- **Readiness to Change Scales (RCQ)**
- **Stages of Change, Readiness and Treatment Eagerness Scale (SOCRATES)**
- **University of Rhode Island Change Assessment (URICA)**

Full List of Assessment Instruments (continued)

Instruments for Treatment Planning

- **Recovery Attitude and Treatment Evaluator (RATTE)**

Level of Care Instrument

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

COCE Criteria for Evaluating Assessment Instruments

The following criteria were used to evaluate the instruments for appropriate application in the context of program needs and capacities:

Overview

Clinical Utility: Detection
Clinical Utility: Placement
Clinical Utility: Treatment Planning
Clinical Utility: Outcome
Severity Measure

Methodological Considerations

Norms available
Reliability on re-administration
Internal consistency
Validity
Setting applicability

Administration

Administration format
Administration time
Complexity of scoring
Computer scoring
Interpretive reports
Required skill level
Intensity of required training
Availability in public domain

Matrix of Assessment Instruments* with Selection Criteria Findings

	Substance Abuse				Mental Health				Trauma Informed		General Health	Diagnostic				Motivation and Readiness to Change				Treat. Plan.	Level of Care
	ASI	ADS	GAIN	IAP	BDI	BHS	BPRS	GBI	PSS-SR	THQ	SF-36	DIS-IV	Mini	SCID	CMRS	RCQ	SOC-RATES	URICA	RATTE	LOCUS	
Overview																					
Clinical utility: Detection	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Clinical utility: Placement	√	√	√	√	-	√	√	-	-	-	√	-	√	-	√	√	√	√	√	√	√
Clinical utility: Treatment Planning	√	√	√	√	-	√	√	-	-	-	√	-	-	√	√	√	√	√	√	√	√
Clinical Utility: Outcome	√	-	√	√	√	-	√	-	√	-	√	√	-	-	√	-	√	√	√	√	√
Severity Measure	√	√	√	√	√	√	√	-	√	√	-	-	-	-	-	-	-	-	-	-	√
Methodological Considerations																					
Norms available	-	√	√	√	√	√	√	√	-	-	√	√	√	-	√	√	-	√	√	-	-
Reliability on re-administration	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	-
Internal consistency	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	-
Validity	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	-
Setting Applicability: SU=Substance Use MH=Mental Health CJ=Criminal Justice	Mixed	Mixed	Mixed	SU	MH	MH	MH	Mixed	MH	MH	Mixed	Mixed	Mixed	Mixed	Mixed	Mixed	Mixed	Mixed	SU	Mixed	

Legend: √ = Yes - = No

* Information contained in the table was derived from TIP 42 (CSAT, 2005), Assessing Alcohol Problems (NIAAA, 2003), or specific sites containing instruments (see URLs contained in the Instrument Descriptions that follow). Information in the table may change over time based on advances in research and/or formats available.

Matrix of Assessment Instruments* with Selection Criteria Findings

	Substance Abuse				Mental Health				Trauma Informed		General Health	Diagnostic			Motivation and Readiness to Change				Treat. Plan.	Level of Care
	ASI	ADS	GAIN	IAP	BDI	BHS	BPRS	GBI	PSS-SR	THQ	SF-36	DIS-IV	Mini	SCID	CMRS	RCQ	SOC-RATES	URICA	RATTE	LOCUS
Administration																				
Administration Format: S=Self report I=Structured interview C=Computer administered	I	S, C, I	S, C, I	C, I	S, C	S	S, I	S	S	S	S, I	I	C, I	C, I	S	S	S	S	S, I	I
Administration time (in minutes)	≤60	≤5	≤120	≤60	≤10	≤10	≤30	≤30	≤15	≤15	≤20	≤120	≤30	≥120	≤10	≤3	≤3	≤10	≤30	≤30
Complexity of scoring H=High; M=Medium; L=Low	H	L	M	M	L	L	M	H	M	L	M	H	H	M	L	L	L	L	L	M
Computer Scoring	√	√	√	√	-	-	-	-	-	-	-	√	√	√	-	-	-	-	-	-
Interpretive results	√	√	√	√	-	-	-	-	-	-	√	-	-	-	√	-	-	-	-	-
Required skill level: C=Trained non-clinician D=Clinician	C	C	C	D	C	C	C	C	C	C	C	C	C	D	C	C	C	C	C	D
Intensity of required training	H	L	H	H	L	L	H	L	L	L	M	H	M	H	L	L	L	L	M	M
In public domain	√	-	-	√	-	-	√	-	-	-	-	-	√	-	√	√	√	√	-	√

Legend: √ = Yes - = No

* Information contained in the table was derived from TIP 42 (CSAT, 2005), Assessing Alcohol Problems (NIAAA, 2003), or specific sites containing instruments (see URLs contained in the Instrument Descriptions that follow). Information in the table may change over time based on advances in research and/or formats available.

Assessment Instruments: Brief Descriptions

Author/Developer's Instrument Descriptions

Instruments with a Substance Use Disorder Focus

- ▶ **Addiction Severity Index (ASI).** Author: Thomas McLellan. **The ASI gathers information on seven areas of client's life: medical, employment or support, drug and alcohol use, legal, family history, family and social relationships, and psychiatric problems. Composite scores reflect a client's current status, hence, successive assessments can be used to monitor changes and evaluate treatment outcomes. Available from Treatment Research Institute (TRI): <http://www.tresearch.org/ASI.htm>**

Author/Developer's Instrument Descriptions (*Continued*)

Instruments with a Substance Use Disorder Focus (continued)

- Alcohol Dependence Scale (ADS). Author: Harvey A. Skinner. **The ADS provides a quantitative measure of the severity of alcohol dependence consistent with the concept of the alcohol dependence syndrome. The 25 items cover alcohol withdrawal symptoms, impaired control over drinking, awareness of a compulsion to drink, increased tolerance to alcohol, and salience of drink-seeking behavior. Widely used as a research and clinical tool, studies have found the ADS to be reliable and valid. Printed instructions for the ADS refer to the past 12-month period. However, instructions can be altered for use as an outcome measure at selected intervals (e.g., 6 months, 12 months, 24 months) following treatment. Use of the ADS has been reported mostly for clinical adult samples, however, studies have used the instrument in general population and correctional settings. The ADS has been found to have excellent predictive value with respect to a DSM diagnosis. Moreover, the ADS yields a measure of the severity of dependence that is important for treatment planning, especially with respect to the intensity of treatment.**

<http://eib.emcdda.europa.eu/index.cfm?fuseaction=public.content&nnodeid=3583&languageisio=EN>

Instruments with a Substance Use Disorder Focus *(continued)*

- Global Appraisal of Individual Needs (GAIN), Author/Developer: Chestnut Health Systems (1993). **The content of the GAIN is divided into eight areas: background and treatment arrangements, substance use, physical health, risk behaviors, mental health, environment, legal, and vocational. In each area, the questions check for major problem areas and the currency of any problems. 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. Contact Dr. Michelle White at GAINInfo@chestnut.org**
- Individual Assessment Profile (IAP), Author/Developer: Patrick Flynn, et al. (1995). **The IAP is a structured clinical interview that assesses clients for treatment planning purposes. The instrument is designed for use with large-scale treatment projects and provides measures for eight life areas: demographic background, admission source information, living arrangements, tobacco/alcohol/drug use, illegal activities, source of support/employment, medical health, and mental health.**

Author/Developer's Instrument Descriptions (*Continued*)

Instruments with a Mental Disorder Focus

- ▶ Beck Depression Inventory—II (BDI-II), Author/Developer: Harcourt Assessment. BDI-II is used to screen for the presence--and to rate the severity--of depression symptoms. Like its predecessor, the instrument consists of 21 items to assess the intensity of depression. 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. <http://harcourtassessment.com/haiweb/cultures/en-us/productdetail.htm?pid=015-8018-370>
- ▶ Beck Hopelessness Scale (BHS), Author/Developer: Harcourt Assessment. **BHS is a 20-item assessment device designed to assess the extent of positive and negative beliefs about the future during the past week. The instrument was originally developed to predict who would commit suicide and who would not. Three aspects of hopelessness are measured: feelings about the future, loss of motivation, and expectations.** <http://harcourtassessment.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8133-609&Mode=summary>

Instruments with a Mental Disorder Focus (*Continued*)

- ▶ Brief Psychiatric Rating Scale (BPRS). Author/Developer: Overall, J.E., & Gorham, D.R. (1962). UCLA version: Ventura, J., Green, M., Shaner, A., and Liberman, R. (1993). Widely used in clinical practice, the BPRS is a 24-item scale collapsed into five subscales: anxiety/depression, thought disorder, paranoia/suspiciousness, withdrawal, and activity. Some items (e.g., mannerisms and posturing) can be rated simply on observation of the patient; other items (e.g., anxiety) involve an element of self-reporting by the patient.
<http://www.mentalhealth.ucla.edu/projects/irc/products/products.html> or email: Joe Ventura at: jventura@ucla.edu.
- ▶ General Behavioral Inventory (GBI), Author/Developer: Dr. Richard Allen Depue. The GBI is a multimethod, time-logged assessment of mood disorders in adults. The instrument focuses on depression and mania, and is used to identify adults who may be experiencing recurrent or chronic-intermittent depression but who may not be depressed at the time of assessment. Email: rad5@cornell.edu.

Author/Developer's Instrument Descriptions *(Continued)*

Instruments with a Focus on Trauma

- Post-Traumatic Stress Symptom Scale – Self-Report (PSS-SR), Author/Developer: Edna Foa, Ph.D. **The PSS-SR is designed to assess DSM-IV symptoms of PTSD relating to a single traumatic event. The instrument represents the self-report version of Foa's structured interview for PTSD by the same name (PSS-I). Diagnoses for PTSD based on the PSS-SR are slightly more conservative than those based on the PSS-I. The PSS-SR is intended for use with people who have a known assault history, and should therefore be accompanied by a trauma screen when assessing people for whom basic background information is lacking. E-mail: foa@mail.med.upenn.edu**
- Trauma History Questionnaire (THQ), Author/Developer: Bonnie L. Green, Ph.D. **The THQ is designed to gather a history of exposure to potentially traumatic events. The instrument lists 23 traumatic events in three categories: (1) crime-related, (2) general disasters and trauma, and (3) unwanted physical and sexual experiences. Respondents indicate lifetime occurrence, frequency, age at first occurrence, and relationship to perpetrator. E-mail: bgreen01@georgetown.edu**

Instruments with a General Health Focus

- Medical Outcomes Study – Short Form (SF-36), Author/Developer: Quality Metric. **The SF-36 provides a descriptive profile along eight dimensions of physical and mental health and an overall handicap severity score. The instrument comprises 36 questions that can be self-administered by people ages 14 or older or by trained interviewers either in person or by telephone. It is useful for descriptive purposes such as documenting differences between sick and well patients and for estimating the relative burden of different medical conditions. It is also useful for evaluating the benefits of alternative treatments.**
<http://www.qualitymetric.com/products/sfsurveys.aspx>

Diagnostic Instruments

- ▶ Diagnostic Interview Schedule IV (DIS-IV), Author/Developer: Washington University, St. Louis, Missouri. In a structured interview, the DIS-IV is designed to obtain a psychiatric diagnosis according to DSM-IV criteria. All DSM-IV disorders are covered as well as demographics, risk factors, and the interviewer's observations of psychotic symptoms and problems during the interview. In addition to determining whether criteria for the diagnosis are met, information can be obtained about course, onset, and regency of positive symptoms. <http://epi.wustl.edu>

Author/Developer's Instrument Descriptions (*Continued*)

Diagnostic Instruments (continued)

- Mini International Neuropsychiatric Interview (MINI). Authors: David V. Sheehan, Professor of Psychiatry and Director of Psychiatric Research, University of South Florida College of Medicine, and Yves Lecrubier, L'Hôpital de la Salpêtrière (National Institute for Health and Medical Research) in Paris, France. The MINI is a short, structured diagnostic interview that covers 20 psychiatric disorders and substance use disorders. Administration time is approximately 15-30 minutes. The M.I.N.I. has been translated into 43 languages and is used by mental health professionals and health organizations in more than 100 countries. It is the structured psychiatric interview of choice for psychiatric evaluation and outcome tracking in clinical psychopharmacology trials and epidemiological studies. There are a number of other versions of the instrument available, including the MINI Screen (modified) and MINI Plus. Distributed by Medical Outcomes Systems, Inc. <https://www.medical-outcomes.com/indexSSL.htm>

Author/Developer's Instrument Descriptions (*Continued*)

Diagnostic Instruments (continued)

- ▶ Structured Clinical Interview for DSM-IV Disorders (SCID), Author/Developers: First, M.B., Gibbon, M., Spitzer, R.L., and Williams, J.B.W. (1996). The SCID is a diagnostic interview designed to assist clinicians and researchers in making reliable DSM-IV diagnoses. Diagnoses are based on a decision tree structure and include all Axis I and II diagnoses using DSM-IV criteria. Available through American Psychiatric Publishing, Inc. at <http://www.appi.org>.

Author/Developer's Instrument Descriptions (*Continued*)

Motivation and Readiness To Change Instruments

- ▶ **Circumstances, Motivation, and Readiness Scales (CMRS), Author/Developer: De Leon, G. (1993). The CMR Scales are designed to predict retention in treatment. The instrument consists of four derived scales measuring external pressure to enter treatment, external pressure to leave treatment, motivation to change, and readiness for treatment. The items were 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. Applicable to both residential and outpatient treatment modalities. Email: gerry.melnick@ndri.org**
- ▶ **Readiness To Change Questionnaire (RCQ), Author/Developer: Heather, N, Gold, R., and Rollnick, S. (1991). Designed to assist clinicians in determining the stage of readiness for change among problem drinkers or people with alcohol use disorders. The instrument comprises 12 items with three subscales based on Prochaska and DiClemente's stages-of-change model for assessing a drinker's readiness to change drinking behavior, and may also be useful in assigning different types of treatment. Available from: Center for Alcohol and Drug Studies, University of Newcastle upon Tyne, United Kingdom (phone: 44[0] 191219 5648).**

Author/Developer's Instrument Descriptions *(Continued)*

Motivation and Readiness To Change Instruments *(Continued)*

- ▶ Stages of Change, Readiness, and Treatment Eagerness Scale (SOCRATES), Author/Developer: Wm. R. Miller. SOCRATES is designed to assess readiness for change of people who abuse alcohol. Using a 5-point Likert scale, respondents indicate the degree to which they agree or disagree with 19 statements. Because motivation for change is an important predictor of treatment compliance, SOCRATES can assist clinicians with information necessary for treatment planning. E-mail wmiller@unm.edu

Author/Developer's Instrument Descriptions (*Continued*)

Motivation and Readiness To Change Instruments (*Continued*)

- University of Rhode Island Change Assessment (URICA), Author/Developer: DiClemente, C.C. and Hughes, S.O. (1990). URICA, a 32-item self-report scale, operationally defines four theoretical stages of change: precontemplation, contemplation, action, and maintenance—each assessed by eight items. Recorded on a 5-point Likert scale, responses can be used as a predictor, for treatment matching, and for outcome variables. Instrument has been used to assess inpatient and outpatient adults. Available from author: Carlos DiClemente, Department of Psychology, University of Maryland, Baltimore County, 1000 Hilltop Circle, Baltimore, MD 21250.

Author/Developer's Instrument Descriptions *(Continued)*

Instruments for Treatment Planning

- Recovery Attitude and Treatment Evaluator (RAATE), Author/Developer: Mee-Lee, D., Hoffman, N.G., and Smith, M.R. (1992). **The RAATE is designed to assist in placing patients into the appropriate level of care at admission, in making continued stay or transfer decisions during treatment, and in documenting the appropriateness of discharge. The instrument comprises two interrelated assessment tools: RAATE-CE (Clinical Evaluation) and RAATE-QI (Questionnaire 1). Both tools measure five dimensions considered important for placement and treatment: resistance to treatment, resistance to continuing care, acuity of biomedical problems, acuity of psychiatric/psychiatric problems, and social/family environmental status.**
http://www.evinceassessment.com/product_raate.html

Author/Developer's Instrument Descriptions *(Continued)*

Level of Care Instrument

- ▶ Level of Care Utilization System (LOCUS), Author/Developer: Sowers, W., George, C., and Thompson, K. (1999). The LOCUS is designed to assess immediate service needs, plan resource needs over time, and monitor changes in status or placement at different points in time. The instrument 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 comorbidity; (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.

<http://www.wpic.pitt.edu/aacp/finds/LOCUS2000.pdf>

Conclusions

- **Screening, Assessment and Treatment Planning are the foundation of good service to COD clients.**
- **Assessment may include a variety of information-gathering methods including the administration of assessment instruments, an in-depth clinical interview, a social history, a treatment history, interviews with friends and family after receipt of appropriate client authorizations.**
- **There should be equivalent attention to and resources for Screening and Assessment, and for the parallel development of consensus- and evidence-based treatment services.**

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