Screening, Assessment, Placement and Beyond: Embracing a Recovery Oriented System of Care Utilizing an Integrated Approach

ALDMH - Substance Abuse Service Division
11/18/10
Training Focus

The primary focus of this training is to help participants gain a comprehensive understanding of the ASAM PPC-2R levels of care, dimensions, risk rating scale, placement criteria and placement assessment.
Objectives

Participants will:

• Gain a better understanding of the theory and concept behind the ASAM PPC-2R.
• Understand and utilize appropriate client placement.
• Understand the criteria for continued stay, transfer and discharge.
• Be able to identify the levels of care and dimensions.
• Develop an understanding of the SASD assessment tool.
• Become familiar with the screening tools (UNCOPE, CRAFFT and MINI Screen).
Moving Toward a Recovery Oriented System of Care (ROSC) with Individualized, Clinically Driven Treatment

Handout 1. Recovery Oriented System of Care in Alabama

Handout 1: Establishing a Recovery Oriented System of Care in Alabama for Substance Use Disorders
**Definition:** A person-centered and self-directed approach to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness and recovery from alcohol and drug problems.

**Handout 2 Definition**
Why is Alabama Adopting ASAM PPC-2R Placement and Criteria?

• To establish a common language among treatment providers.
• To promote individualized treatment matching for clients.
• To improve the quality of assessments.
• To improve the quality of treatment.
• To improve the quality of treatment planning.
• To comply with Block Grant funding requirements.
Definitions

- Clinically Managed
- Co-Occurring Capable
- Co-Occurring Enhanced
- Level of Functioning (LOF)
- Medically Managed
- Medically Monitored
- Recovery Oriented System of Care

Reference to Handout 2: Definitions

Stress the need to study the ASAM PPC2R book.

These definitions provide you with a list of terms that we’ll become more familiar with throughout the day.
Process

- **Screening**
  - UNCOPE/CRAFFT

- **Assessment**
  - URICA
  - MINI & MINI Kid
  - Placement assessment

- **Intake or referral to appropriate service**

  Handout 3: Adult Placement Assessment Screen
  Handout 4: MINI Screen
  Handout 5: SASD Adolescent Placement Assessment Tool,
  Handout 6: MINI Kid
Access All Documents

All documents used in this training or part of the screening and assessment instruments may be accessed on the DMH website

http://www.mh.alabama.gov/SATR/AssesmentPlacement.aspx
Purpose
Upon initial contact with an agency, essential information must be gathered to substantiate the need for an assessment appointment. This information gathering is known as screening. Screening is a process involving a brief review of a person’s presenting problem to determine the person’s appropriateness and eligibility for substance abuse services and the possible level of services required.

Screens are first line identifiers and as such, are imperfect. They may either under identify or over identify the condition they are designed to detect. Standard screens help avoid these problems, and follow up assessments are key to adequately identifying and incorporating co-occurring disorders into a comprehensive treatment plan.

Reference: SASD Assessment Training Guide pg. 3 (this guide will be available on the DMH website)
Screening

Tools:

- Demographic information
- UNCOPE/CRAFFT
- MINI / MINI Kid Screen

Handout 7 Cindy's Adult Placement Assessment Screen
Handout 8 Cindy's Mini Screen

Handout 7: Cindy’s SASD Adult Placement Assessment Screen
Handout 8: Cindy’s MINI Screen
Screening

**Process:**

- Schedule client for an appointment for the placement assessment if appropriate.
- Forward screening to clinician for the assessment.

If the program uses ASAIS then they would key in the information to obtain a unique identifier. If not then they would proceed to do the placement assessment.
The M.I.N.I. is the most widely used psychiatric structured diagnostic interview instrument in the world. The M.I.N.I. is used by mental health professionals and health organizations in more than 100 countries. The M.I.N.I. is a short, structured diagnostic interview that was developed in 1990 by psychiatrists and clinicians in the United States and Europe for DSM-IV and ICD-10 psychiatric disorders. With an administration time of approximately 15 minutes, the M.I.N.I. is the structured psychiatric interview of choice for psychiatric evaluation and outcome tracking in clinical psychopharmacology trials and epidemiological studies.

The M.I.N.I. is designed to identify persons in need of an assessment based on gateway questions and threshold criteria found in the Diagnostic and Statistical Manual. These gateway questions relate to signs of distress that may be attributed to a diagnosable psychiatric disorder; however, NO SPECIFIC DIAGNOSIS SHOULD BE INFERRED. When the Mini Screen is implemented properly, it increases the likelihood of identifying someone who truly has mental illness.

The MINI is not to be self administered. All questions must be asked.
MINI & MINI Kid Screens

- All questions must be asked.
- Ask for examples when necessary.
- Corresponding modules.
- Module administration is individualized based on the client’s cognitive awareness.
- Utilize results to develop the individual service plan.
- Subsequent screens may be utilized as appropriate based upon their clinical judgment.

All questions must be asked and a response indicated to the right of each question by a check to indicate the client’s response. The clinician should ask for examples when necessary, to ensure accurate coding. The client should be encouraged to ask for clarification on any question that is not absolutely clear. The questions have corresponding modules that are indicated in alphabetical order by letter, corresponding to a diagnostic category. Each question that yields a positive response (yes) indicates the need for the corresponding module to be administered. Yes responses do not mean the client is mentally ill; it simply means they are reporting distress that indicates a need for further assessment. Administration of the corresponding modules should be done when the client is abstinent and alcohol or drug usage or lack of medication stabilization does not impair the client’s responses. Administration of the corresponding modules should be done when the client is abstinent and alcohol or drug usage or lack of medication stabilization does not impair the client’s responses but not to exceed a two week time frame. The results of the screen may be utilized in the development of the individual service plan. A clinician may conduct subsequent screens as appropriate based upon their clinical judgment and as per the program’s policies and procedures. There are separate instructions for administering the modules that are contained within the M.I.N.I. Interview.

NOTE: Researchers and clinicians working in nonprofit or publicly owned settings (including universities, nonprofit hospital and government institution) may make single copies of MINI Kid instrument for their own clinical and research use.

All rights reserved. No part of this document may be reproduced or transmitted in any form, or by any means. Electronic or mechanical, including photocopying, or by any information storage retrieval system without permission in writing from Dr. Sheehan.

Information about purchasing the Mini screen can be found on www.medical-outcomes.com
It is also available in a Spanish
295.00 per computer and 9.99 per person if you use the online version.

When you get questions about when to administer the modules; They can be done at assessment, intake, or within the first weeks of treatment in an individual session.

Modules must be administered by clinicians.
MINI SCREEN 6.0.0

| Patient Name: | Date of Screening: | Date of Birth: | YES | NO | → |
|---------------|--------------------|----------------|-----|----|---|---|
| ▶ Have you been depressed or down, most of the day, nearly every day, for the past two weeks? | NO | YES | → A |
| ▶ In the past two weeks, have you been much less interested in most things or much less able to enjoy the things you used to enjoy most of the time? | NO | YES | → A |
| ▶ In the past month did you think that you would be better off dead or wish you were dead? | NO | YES | → B |
| ▶ Have you ever had a period of time when you were feeling ‘up’ or ‘high’ or ‘hyper’ or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.) | NO | YES | → C |
| ▶ Have you ever been persistently irritable, for several days, so that you had arguments or verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or over reacted, compared to other people, even in situations that you felt were justified? | NO | YES | → C |
| ▶ Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way? Did the spells surge to a peak, within 10 minutes of starting? Code YES only if the spells peak within 10 minutes. Did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner? | NO | NO | YES | → D |
| ▶ Do you feel anxious or uneasy in places or situations where help might not be available or escape might be difficult, like being in a crowd, standing in a line (queue), when you are away from home or alone at home, or when crossing a bridge, traveling in a bus, train or car? | NO | NO | YES | → E |

Reference previously distributed handouts:

**Reference Handout 8: Cindy’s MINI Screen.**

**Reference Handout 6: MINI Kid Screen.** (This slide does not include the full MINI Kid, just page 1)

Take a moment here to review the hard copy.
The MINI and MINI Kid Modules will be accessible through the DMH website: www.mh.alabama.gov

This screen does not show the full document. Reference the modules on Cindy’s case study.

*Handout 24 – MINI (full)*
Point out the modules that were indicated on Cindy’s screen.
## MINI Corresponding Modules

<table>
<thead>
<tr>
<th>Module</th>
<th>Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>ALCOHOL DEPENDENCE</td>
</tr>
<tr>
<td></td>
<td>ALCOHOL ABUSE</td>
</tr>
<tr>
<td>J</td>
<td>SUBSTANCE DEPENDENCE</td>
</tr>
<tr>
<td></td>
<td>SUBSTANCE ABUSE</td>
</tr>
<tr>
<td>K</td>
<td>PSYCHOTIC DISORDERS</td>
</tr>
<tr>
<td></td>
<td>MOOD DISORDER WITH PSYCHOTIC FEATURES</td>
</tr>
<tr>
<td>L</td>
<td>ANOREXIA NERVOSA</td>
</tr>
<tr>
<td>M</td>
<td>BULIMIA NERVOSA</td>
</tr>
<tr>
<td>N</td>
<td>GENERALIZED ANXIETY DISORDER</td>
</tr>
<tr>
<td>O</td>
<td>RULED OUT MEDICAL, ORGANIC, DRUG CAUSES</td>
</tr>
<tr>
<td>P</td>
<td>ANTISOCIAL PERSONALITY DISORDER</td>
</tr>
</tbody>
</table>
## MINI Kid Screen

**DATE OF INTERVIEW:** ________________________________  **If YES, go to the corresponding MINI Kid Module**

**QUESTIONNAIRE COMPLETED BY:** ________________________________

1. Have you felt sad or depressed, down or empty, or grouchy or annoyed, most of the day, nearly every day for the past two weeks? If YES to ANY, CODE YES

   - **NO**
   - **YES** → A

2. In the past two weeks, have you been bored a lot or much less interested in things (like playing your favorite games) for most of the day, nearly every day? Have felt that you couldn’t enjoy things? If YES to ANY, CODE YES

   - **NO**
   - **YES** → A

3. Have you ever felt so bad that you wished you were dead, or tried to hurt yourself, or tried to kill yourself? If YES to ANY, CODE YES

   - **NO**
   - **YES** → B

   **IF YOU SAID YES TO THE FIRST QUESTION, SKIP THIS QUESTION.**

4. In the past year, have you felt sad or depressed, down or empty, or grouchy or annoyed, most of the time? If YES to ANY, CODE YES

   - **NO**
   - **YES** → C

5. Has there ever been a time when you were so happy that you felt really ‘up’ or ‘high’ or ‘hyper’? By ‘up’ or ‘high’ I mean feeling really good; full of energy; needing less sleep; having racing thoughts or being full of ideas.

   - **NO**
   - **YES** → D

   *DO NOT CONSIDER TIMES WHEN YOU WERE INTOXICATED ON DRUGS OR ALCOHOL OR DURING SITUATIONS THAT NORMALLY OVERSTIMULATE AND MAKE CHILDREN VERY EXCITED, LIKE CHRISTMAS, BIRTHDAYS, ETC.*

Reference MINI Kid on Julie that will be utilized later in the training.

*Handout 21 – Julie’s case study*
These screens do not show the full document … just enough to remind you as you refer to the handout.
This screen does not show the full MINI modules, reference Julie’s corresponding modules.

*Reference Handout 21 – Julie’s Case Study*

*Handout 25 – MINI Kid (full)*
## MINI Kid Corresponding Modules

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
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<tbody>
<tr>
<td>A</td>
<td>MAJOR DEPRESSIVE EPISODE</td>
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<tr>
<td>B</td>
<td>SUICIDALITY</td>
</tr>
<tr>
<td>C</td>
<td>DYSTHYMIA</td>
</tr>
<tr>
<td>D</td>
<td>MANIC EPISODE, HYPOMANIC EPISODE, BIPOLAR I, II, &amp; NOS</td>
</tr>
<tr>
<td>E</td>
<td>PANIC DISORDER</td>
</tr>
<tr>
<td>F</td>
<td>AGORAPHOBIA</td>
</tr>
<tr>
<td>G</td>
<td>SEPARATION ANXIETY DISORDER</td>
</tr>
<tr>
<td>H</td>
<td>SOCIAL PHOBIA (Social Anxiety Disorder)</td>
</tr>
<tr>
<td>I</td>
<td>SPECIFIC PHOBIA</td>
</tr>
<tr>
<td>J</td>
<td>OBSESSIVE COMPULSIVE DISORDER</td>
</tr>
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<td>K</td>
<td>POST TRAUMATIC STRESS DISORDER</td>
</tr>
<tr>
<td>L</td>
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<tr>
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<td>ALCOHOL ABUSE</td>
</tr>
<tr>
<td>M</td>
<td>SUBSTANCE DEPENDENCE (Non-alcohol)</td>
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<tr>
<td></td>
<td>SUBSTANCE ABUSE (Non-alcohol)</td>
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Point out the modules that were indicated on Julie’s screen on page 3 and 4.

*Reference Handout 21 – Julie’s Case Study*
### MINI Kid Corresponding Modules (cont’d)

<table>
<thead>
<tr>
<th>N</th>
<th>TOURETTE’S DISORDER</th>
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<tbody>
<tr>
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<td>MOTOR TIC DISORDER</td>
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<td>VOCAL TIC DISORDER</td>
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<td></td>
<td>TRANSIENT TIC DISORDER</td>
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<tr>
<td>O</td>
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<td>ADHD INATTENTIVE</td>
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<tr>
<td></td>
<td>ADHD HYPERACTIVE/IMPULSIVE</td>
</tr>
<tr>
<td>P</td>
<td>CONDUCT DISORDER</td>
</tr>
<tr>
<td>Q</td>
<td>OPPOSITIONAL DEFIANT DISORDER</td>
</tr>
<tr>
<td>R</td>
<td>PSYCHOTIC DISORDERS</td>
</tr>
<tr>
<td></td>
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<td>S</td>
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<td>T</td>
<td>BULIMIA NERVOSA</td>
</tr>
<tr>
<td>U</td>
<td>GENERALIZED ANXIETY DISORDER</td>
</tr>
<tr>
<td>V</td>
<td>ADJUSTMENT DISORDERS</td>
</tr>
<tr>
<td>W</td>
<td>MEDICAL, ORGANIC, DRUG CAUSE RULED OUT</td>
</tr>
<tr>
<td>X</td>
<td>PERVERSIVE DEVELOPMENTAL DISORDER</td>
</tr>
</tbody>
</table>
Break

Prepare the learner for transition from screening to the underlining foundation of the assessment: ASAM PPC-2R.
The best treatment system for addiction is:

a. A 28 day stay in inpatient rehabilitation with much education.
b. A broad continuum of care with all levels of care separated to maintain group trust.
c. Not possible now that managed care has placed so much emphasis on cost-containment.
d. A broad range of services designed to be as seamless as possible for continuity of care.
e. Short stay inpatient hospitalization for psychoeducation.

Select the Best Answer

This will be one of many questions throughout the training. This question is to gauge where the participant is in their ability to embrace the systems change. Other questions will be utilized to gain knowledge and retention of information presented.

Answer: D
Enter ASAM – ASAM is an organization of about 3,000 physicians interested in improving services and advocating for people with addiction; and advancing the field of addiction medicine.

Prior to the implementation of ASAM, treatment was complication driven and diagnosis driven. With the implementation of ASAM, treatment is individualized, client driven and clinically driven. The next slides will illustrate this difference.
ASAM has been promoting that diagnosis is necessary, but not sufficient to determine treatment. What determines services needed and the level of care needed is the client’s severity of illness and level of function. This focuses on which dimensions have problems and priorities that require matching modalities (different strategies from different schools of thought e.g., cognitive behavioral strategies; medication modalities; individual, group or family therapies. The level of service is the least intensive, but safe level that can provide the individualized treatment plan. Then progress is evaluated and further assessment done to work on any issues that are not progressing doing well. Or if the client is doing well, then the assessment focuses on what is needed next in the person’s continuing care.

The new generation of care that is just starting to be actualized still focuses on individualized treatment. However changes in treatment are based on real time assessment of outcomes and on the quality of the therapeutic relationship.

Session Rating Scale (SRS) and Outcome Rating Scale (ORS) can be found on the web. They can search the web and find it.
From Program-Driven to Collaborative Care

Biopsychosocial Perspective of Addiction

• Biopsychosocial in etiology, expression, and treatment.

• Comprehensive assessment and treatment.

• Explains clinical diversity with commonalities.

• Promotes integration of knowledge.

Moving From Program-Driven to Client-Directed Collaborative Care
(a) Treatment follows Theory
* schools of thought: disease concept; behaviorist perspective; public health view; psychiatric theories of addiction
* need for an understanding about alcohol/drug problems that takes into account knowledge from all different theories
(b) Biopsychosocial Perspective of Addiction
* biopsychosocial in etiology, expression and treatment
* necessitates comprehensive assessment and treatment
* explains clinical diversity while preserving commonalities
* promotes productive integration of knowledge from all theories
(c) Individualized Treatment
• 4 P’s - patient/participant assessment; problems/priorities; plan; progress
• match severity, or level of functioning (assets and obstacles to improvement with intensity of service (modalities/strategies and site of care)
(d) Treatment follows Assessment - Biopsychosocial Severity
The common language of the six assessment dimensions of the ASAM Patient Placement Criteria can be used to determine multidimensional assessment of severity and level of function of addiction disorders.
1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral/cognitive conditions and complications
4. Readiness to Change (formerly Treatment acceptance/resistance)
5. Relapse/Continued Use/Continued Problem potential
6. Recovery environment
From Program-Driven to Collaborative Care
(cont’d)

**Multidimensional Assessment**

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

The six assessment dimensions provide the structure to assess obstacles and resources; problems, needs and resources in each dimension.

Dimension 1 assesses detoxification service needs; Assessment for intoxication and/or withdrawal management. Detoxification in a variety of levels of care and preparation for continued addiction services

Dimension 2 assesses physical health service needs: Assess and treat physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services

Dimension 3 assesses mental health service needs; Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services

Dimension 4 assesses motivational enhancement service needs; Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change

Dimension 5 assesses relapse prevention service needs or helps clients to address continued use and/or continued problem potential; Assess readiness for relapse prevention services and teach where appropriate. If still at early stages of change, focus on raising consciousness of consequences of continued use or continued problems as part of motivational enhancement strategies.

Dimension 6 assesses recovery environment service needs such as family therapy, transportation, childcare, housing, finances, legal, vocational, educational service needs.
Select the Best Answer

The six assessment dimensions of the ASAM Criteria:

a. Help assess the individual’s comprehensive needs in treatment.
b. Provide a structure for assessing severity of illness and level of function.
c. Requires that there be access to medical and nursing personnel when necessary.
d. Can help focus the service plan on the most important priorities.
e. All of the above

Answer: E
# Treatment Levels of Care

<table>
<thead>
<tr>
<th>Level 0.5</th>
<th>Early Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>Outpatient Treatment</td>
</tr>
<tr>
<td>Level II</td>
<td>Intensive Outpatient and</td>
</tr>
<tr>
<td></td>
<td>Partial Hospitalization</td>
</tr>
<tr>
<td>Level III</td>
<td>Residential/Inpatient Treatment</td>
</tr>
<tr>
<td>Level IV</td>
<td>Medically-Managed Intensive</td>
</tr>
<tr>
<td></td>
<td>Inpatient Treatment</td>
</tr>
</tbody>
</table>

**Handout 9 Level of Care**

Use LOC Cheat Sheet from Dr. Mee Lee

**Handout 9 – Level of Care (LOC) Cheat Sheet**

Comparison with current services within the state and expansion of services. What we have traditionally. Identifying yourself as a provider.
Level 0.5 Early Intervention Service

**Level 0.5: Early Intervention**

- Individuals with problems or risk factors related to substance use, but for whom an immediate Substance-Related Disorder cannot be confirmed.

- Hours vary

Level 0.5 = Criteria for assessment and education services for individuals with problems or risk factors related to substance use, but for whom an immediate Substance-Related Disorder cannot be confirmed. Further assessment is warranted to rule in or out addiction. Assessment and education for at risk individuals who do not meet diagnostic criteria for Substance-Related Disorder.

No time frame on this level. Length of Stay depends on client's progress.
Opioid Maintenance Therapy (OMT)

OMT

- Is not considered a level of care in the ASAM PPC-2r but rather a separate service that can be incorporated into any of the levels of care.

OMT address methadone and buprenorphine (Suboxone =buprenorphine + naloxone) treatment that may be in an organized service in outpatient Level I, or may be a recovery-assisted medication provided along with other addiction treatment services in any level of care in the continuum of care, and not restricted to only being an outpatient treatment modality.

Within the state of Alabama OMT will be assessed as a Level I-O.
Level I Services

**Level I Outpatient Treatment**

- **Adult** – Fewer than 9 hours per week.
- **Adolescent** – Fewer than 6 hours per week.

*Reference: LOC Cheat sheet and ASAM PPC-2r pgs. 45-69*

*Reference Handout 9 – Level of Care (LOC) Cheat Sheet*

Please make sure the group stays focused on ASAM and the assessment, not LOC.

Level I = Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies
Level II Services

**Level II.1  Intensive Outpatient Treatment**
- **Adult**: At least 9 hours or more of services per week.
- **Adolescent**: At least 6 hours or more of services per week.

**Level II.5  Partial Hospitalization**
- 20 or more hours of services for multidimensional **not** requiring 24 hour care.

Reference:  ASAM PPC-2r pgs. 45-69

*Reference Handout 9 – Level of Care (LOC) Cheat Sheet*

Please make sure the group stays focused on ASAM and the assessment, not LOC.

Level II.1 = 9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability

Level II.5 = 20 or more hours of service/week for multidimensional instability not requiring 24 hour care
Level III Residential – Inpatient Service

Level III.05 Transitional Residential Treatment

This is a LOC added by the SASD and relative to Alabama only. It will be introduced with the new standards.
Level III Residential – Inpatient Services

**Level III.1 Clinically-Managed, Low Intensity Residential Treatment**
- At least 5 hours of services per week and 24 hour structure with available trained staff.

**Level III.3 Clinically-Managed, Medium Intensity Residential Treatment (Adult Level only)**
- 24 hour care, trained staff to stabilize multidimensional imminent danger, less intense milieu.

Reference: Levels of Care Cheat Sheet and Definitions handout (clinically managed, medically monitored, and medically managed) – look at functional deficits

Reference Handout 9 – Level of Care (LOC) Cheat Sheet
Reference Handout 2 - Definitions

Level III.1 = 24 hour structure with available trained personnel; at least 5 hours of clinical service/week
Level III.3 = 24 hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community
Level III.5 = 24 hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community
Level III Residential – Inpatient Services

(cont’d)

**Level III.5 Clinically-Managed, Medium/High Intensity Residential Treatment**

- 24 hour care, trained staff to stabilize multidimensional imminent danger, full active milieu.

**Level III.7 Medically-Monitored High Intensive Inpatient Treatment**

- 24 hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3 and 16 hours per week of service.

*Reference: Levels of Care Cheat Sheet and Definitions handout* (clinically managed, medically monitored, and medically managed) – look at functional deficits

*Reference Handout 9 – Level of Care (LOC) Cheat Sheet*

*Reference Handout 2 - Definitions*

Level III.7 = 24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. Sixteen hour/day counselor availability.
Level IV Services

**Level IV - Medically-Managed Intensive Inpatient Treatment**

- 24 hours nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 4. Counseling available to engage patient in treatment.

Level IV = 24 hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2 or 3. Counseling available to engage patient in treatment.

Participants need to be able to recognize the need for this level in order to refer. It is not currently available in the certification process. This is typically in a hospital setting and is certified by JCAHO.

For example, this level is typically seen as a state hospital such as Bryce, Searcy, and Greil.
Detoxification Services

I-D - Ambulatory Detoxification without Extended On-site Monitoring
- Mild withdrawal with daily or less than daily outpatient supervision.

II-D - Ambulatory Detoxification with Extended On-Site Monitoring
- Moderate withdrawal with all day detox and support and supervisor.

Level I-D = Mild withdrawal with daily or less than daily outpatient supervision; likely to complete detox. and to continue treatment or recovery.
Level II-D = Moderate withdrawal with all day detox. support and supervision; at night, has supportive family or living situation; likely to complete detox.

Disclaimer: This is the ASAM model. Our standards may be different in that all levels may not be available.
Detoxification Services

(Cont'd)

**III.2-D - Clinically-Managed Residential Detoxification**
- Moderate withdrawal but needs 24 hours support to complete detox.

**III.7-D - Medically-Monitored Inpatient Detoxification**
- Severe withdrawal and needs 24 hour nursing care and physicians visits as necessary.

**IV-D - Medically-Managed Inpatient Detoxification**
- Severe, unstable withdrawal and needs 24 hour nursing and daily physician visits to modify detox.

Reference Handout 9 Levels of Care.
Level III.2-D = Moderate withdrawal, but needs 24-hour support to complete detox. and increase likelihood of continuing treatment or recovery
Level III.7-D = Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete detox. without medical, nursing monitoring
Level IV-D = Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify detox. regimen and manage medical instability

Disclaimer: This is the ASAM model. Our standards may be different in that all levels may not be available.
BREAK
Six Assessment 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, Continued Problem Potential
6. Recovery Environment
Dimension 1

Acute Intoxication and Withdrawal Potential

Handout 10 Crosswalk for DSM-IV tr Substance Specific and General Withdrawal Symptoms

Handout 10 - Crosswalk for DSM-IV tr Substance Specific and General Withdrawal Symptoms

TOTS might reference Assessment Dimensions on P. 20 of Mee Lee's book
Dimension 1 Questions

• Is there a past history of serious withdrawal, life threatening symptoms, or seizures during withdrawal?

• Is client currently having similar withdrawal symptoms?

• Does the client have supports to assist in ambulatory detoxification if medically safe?

Briefly go over the slide before you hand out Cindy.

The answer to the third question will be identified in Dimension 6. Participants should be mindful that placement determination is not made until all dimensions have been assessed and a comprehensive assessment of the individual’s situation is determined.

Handout #11: SASD Adult Integrated Placement Assessment – Cindy’s Case Study
• Do you have a history of withdrawal symptoms when you haven’t been able to obtain alcohol and/or other drug (AOD), cut down on your use, or stopped using? : Indicate by a check the client’s response. Specific categories are listed, indicate by a check the client’s response to experiencing any of the listed symptoms.

The crosswalk (on the following page) is provided to correlate with some of the specific symptoms for indicated substances.

• Are you currently experiencing any of the above: Indicate by a check the client’s response. Have the client explain the extent to what he or she is currently experiencing and for how long (minutes, hours, days, etc.).

• Have any of these symptoms kept you from doing social, family, job or other activities: Indicate by a check the client’s response. This response is part of criterion c in the DSM for the noted substances.

• Have you used AOD to stop or avoid having these symptoms: Indicate by a check the client’s response. This response is a general symptom of withdrawal.

• Are the symptoms due to a medical condition or some other problem: Indicate by a check the client’s response. This response is a general symptom of withdrawal. A DSM-IVtr crosswalk of substance specific and general withdrawal symptoms is provided within the training guide to help with this Dimension.
This section will help determine if the client meets the criteria for abuse or dependence as defined by the diagnostic criteria in the DSM-IV-tr. The yellow highlighted sections throughout the assessment are the areas that are need for ASAIS.

- **Substance Use Background**: Review the indicated routes of administration and use the codes for each in the table that follows. Review the frequency of use codes and utilize them in the table that follows.

- **Route of Administration codes**: For each substance noted utilize these codes to indicate the route of administration for that substance. The categories are defined below:
  - Oral: Ingested substances by mouth.
  - Smoking: Drawing into the mouth.
  - Inhalation: The act of inhaling, drawing in air as in breathing.
  - Injection – IV: Injected into vein.
  - Injection – Intramuscular: Injected into muscle.

- **Frequency of Use codes**: For each substance noted utilize these codes to indicate the frequency of use for that substance.

- **Class of Substance**: Commonly abused drug classes are listed to indicate the client’s use.

- **Specific Substance**: List the substance that the client indicates they use for the noted class of substance.

- **Route of Administration codes**: For each substance noted utilize these codes to indicate the route of administration for that substance. The categories are defined below:
  - Oral: Ingested substances by mouth.
  - Smoking: Drawing into the mouth.
  - Inhalation: The act of inhaling, drawing in air as in breathing.
  - Injection – IV: Injected into vein.
  - Injection – Intramuscular: Injected into muscle.

- **Frequency of Use codes**: For each substance noted utilize these codes to indicate the frequency of use for that substance.

- **Age First Used**: For each substance noted indicate the age the client first used the substance.

- **Last Use**: For each substance noted indicate the date last used and the time of day used.

- **How Long Used**: For each substance noted indicate how long the client has used from the first use to the last use. Any periods of abstinence or non-use will be noted later.

- **Amount of Use**: For each substance noted indicate the amount used.

- **Frequency of Use**: For each substance noted indicate the frequency of use for that substance using the codes listed.

- **Periods of Abstinence**: For each substance noted indicate any periods of abstinence. There will be an additional question later to further elaborate on these periods of abstinence.

- **Rank Substance in order of use**: For each substance noted indicate the preference of substance in order of use.

- **Comments**: This space is where the assessment specialist will write any concerns or additional comments they have.
A 45 year old female groundskeeper was referred for treatment by a Substance Abuse Professional (SAP) who assessed Cindy as meeting diagnostic criteria for alcohol dependence and cocaine abuse with symptoms of depression. The Substance Abuse Placement Assessment was triggered by Cindy’s alleged refusal for a random urine drug screen at work. Since she had shown a positive cocaine result on a drug screen eight months earlier, this refusal constituted an automatic second positive, as refusal is interpreted as positive. Cindy disputes she was told to take a random test before leaving work sick for the day.

Let's look at Cindy’s responses to the Dimension 1 items within the assessment. Based on the information provided what are the responses to the following questions (reference next slide):

Is there a past history of serious withdrawal, life threatening symptoms, or seizures during withdrawal?
Is client currently having similar withdrawal symptoms?
Does the client have supports to assist in ambulatory detoxification if medically safe? This will be assessed in Dimension 6.
Dimension 1 Questions

• Is there a past history of serious withdrawal, life threatening symptoms, or seizures during withdrawal?

• Is client currently having similar withdrawal symptoms?

• Does the client have supports to assist in ambulatory detoxification if medically safe?

Review these questions on Cindy’s case.
Dimension 2

Biomedical Conditions and Complications
## Dimension 2 Questions

- Does the client have any current severe physical health problems?

- Are the conditions or complications: stabilized, being actively addressed, and being medically monitored?

- Are there chronic conditions that affect treatment?
Dimension 2

**DIMENSION 2. BIOMEDICAL CONDITIONS AND COMPLICATIONS**

- **Do you have / have you had any medical problems, including infectious communicable diseases?** Indicate by a check client concerns regarding health. If yes, is indicated describe the concerns.

- **Do you have any known allergies?** Indicate by a check client response regarding allergies. If yes, is indicated describe the allergy type. Make any necessary notations that could impact the client during treatment to include food allergies (for residential providers).

- **Does your chemical use affect your medical conditions in any way?** Indicate by a check client response chemical use and medical conditions. If yes, is indicated describe how the chemical use affects the medical condition.

- **List any medications you currently take, have taken, or should take including over the counter, birth control pills, etc.** This table has five columns to indicate responses. The categories for the columns are defined below:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Prescribed For</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Taking as Prescribed</th>
</tr>
</thead>
<tbody>
<tr>
<td>lists the name of the medication prescribed.</td>
<td>lists the condition for which the medication was prescribed.</td>
<td>lists the dosage prescribed.</td>
<td>lists the frequency prescribed.</td>
<td>Indicate by a check client response if taking the prescription as recommended.</td>
</tr>
</tbody>
</table>

- **Comments:** This is where the assessment specialist will note any concerns or additional comments they may have.
• **Have you ever been hospitalized:** This table has four columns to indicate responses. The categories for the columns are defined below:
  - **Date:** indicate the date of hospitalization to the best recollection of the client.
  - **Facility:** indicate the facility the client was hospitalized in.
  - **Length of Stay:** indicate the length of stay at the facility.
  - **Treated For:** indicate the condition or reason for hospitalization.

• **Are you pregnant:** Indicate by a check client response. If yes, make a note of this so level of care and placement can be for Specialized Women’s program and services.

• **Are you receiving prenatal care?**

This section is here to look at the potential for the client to rely on / or utilize drugs or alcohol to treat a physical condition. As well as to look at any connection physical pain may have to the reason for substance use.

• **Do you have pain now:** Indicate by a check client response. If yes, indicate where the client has pain.

• **Rate the pain in relation to what represents the amount of pain you are experiencing:** Utilizing the pain scale indicate the client’s response (if currently experiencing pain).

• **Is this pain related to withdrawal:** Indicate by a check client response. If yes, this is a Dimension 1 issue. Refer to information provided under symptoms of detox and indicate what substance the client feels he or she is withdrawing from.

• **How long have you been in pain:** Indicate the client’s response.

• **What makes the pain better or worse:** Indicate the client’s response.

• **What medications do you take to relieve the pain:** Indicate the client’s response and any designation for prescription versus non-prescription medications.

• **Have you had this same pain in the recent past:** Indicate by a check client response. If yes, indicate the client’s explanation of the history of this pain.

• **Are you under a doctor’s care for this pain:** Indicate by a check client response. If yes, indicate client’s response of who the doctor is, frequency of visits, and recommended treatment.
There are some additional questions to ask adolescents, since many present with already having children or are pregnant.
• This section satisfies a portion of the Substance Abuse Standards that require client’s be screened for TB. Each statement should be prefaced with: For more than two weeks do you. This checklist is only a checklist of symptoms that most adults experience that have active TB. All persons entering into treatment should receive a skin test for tuberculosis.

• Tuberculosis (TB) is a disease caused by germs that are spread from person to person through the air. TB usually affects the lungs, but it can also affect other parts of the body, such as the brain, the kidneys, or the spine. A person with TB can die if they do not get treatment.

• The general symptoms of TB disease include feelings of sickness or weakness, weight loss, fever, and night sweats. The symptoms of TB disease of the lungs also include coughing, chest pain, and the coughing up of blood. Symptoms of TB disease in other parts of the body depend on the area affected.

• TB germs are put into the air when a person with TB disease of the lungs or throat coughs, sneezes, speaks, or sings. These germs can stay in the air for several hours, depending on the environment. Persons who breathe in the air containing these TB germs can become infected; this is called latent TB infection. (Source: CDC Fact Sheet, July 2007)

• Have you had TB or tested positive for TB in the past: Indicate by a check client response.

• Have sputum-producing cough: Indicate by a check client response. Sputum is the act of coughing up and spitting out the material produced in the respiratory tract.

• Cough up blood: Indicate by a check client response. This blood could be in the sputum.

• Have a loss of appetite: Indicate by a check client response.

• Have night sweats: Indicate by a check client response. Night sweats are usually defined as episodes of significant nighttime sweating that soaks your bed clothes or bedding.

• Have a fever: Indicate by a check client response. Fever is an increase in internal body temperature to levels that are above normal (the common oral measurement of normal human body temperature 98.2 ± 1.3 °F).

• Receive a TB medication: Indicate by a check client response. Common medications associated with TB are Isoniazid, Rifampin, Pyrazinamide, Ethambutol, Streptomycin, Ethionamide, Cycloserine, and Capreomycin.

• Comments: This is where the assessments specialist will note any concerns or additional comments they may have.
Client denies medical conditions and complications.

Reference Handout 11 – Cindy’s SASD Adult Placement Assessment

Review Cindy’s Dimension 2 responses from the assessment and seek to answer the following questions (on the next slide):

Does the client have any current severe physical health problems?
Are the conditions or complications: stabilized, being actively addressed, and being medically monitored?
Are there chronic conditions that affect treatment?
Dimension 2 Questions

- Does the client have any current severe physical health problems?
- Are the conditions or complications: stabilized, being actively addressed, and being medically monitored?
- Are there chronic conditions that affect treatment?

Review Cindy’s Dimension 2 responses from the assessment and seek to answer the following questions:

Does the client have any current severe physical health problems?
Are the conditions or complications: stabilized, being actively addressed, and being medically monitored?
Are there chronic conditions that affect treatment?
After lunch do an exercise to energize and/or focus the group
Emphasize that we are looking at cognitive and behavioral issues in this dimension, in addition to emotional and behavioral conditions and complications.
Dimension 3 Questions

• Is the client in imminent danger of harming self or someone else?

• Is the client unable to function and safely care for self?

• Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed because they create risk or complicate treatment?

In addition to the assessment the clinician can also look at the answers to the Handout #4 MINI or Handout #6 MINI Kid (which you have already handed out).
Dimension 3 Questions (cont’d)

- Do any emotional, behavioral, or cognitive problems appear to be an expected part of the addictive disorder or do they appear autonomous?
- Are the problems severe enough to warrant specific mental health treatment?
- Is the client able to manage the activities of daily living?
- Can the client cope with any emotional, behavioral or cognitive problems?

These questions will be answered using information from the assessment combined with the MINI/MINI Kid screens.
The responses that were indicated in the initial screening, utilizing the MINI Screen and the corresponding modules, are essential to this section. This section differs from the initial screen in that it asks for more in depth historical information and looks at a longer period of time. Note: If you receive conflicting information for any question, you must continue to query the client to find out what is most accurate.

- **Illnesses or Injuries Question:** (As a child, were there any serious physical injuries or mental illnesses causing trauma) Indicate by a check the client’s response and if answered yes, allow client to describe the nature of the illness or injury. If client is not aware the client may need to consult with family member(s) and provide an updated response later.

- **Have you ever been diagnosed with a mental/emotional disorder?:** Indicate by a check the client response. If yes, indicate the diagnosis and the client’s explanation as to why they received this diagnosis.

- **Have you ever had any treatment for mental/emotional disorder?:** Indicate by a check the client response. The categories for the columns are defined below:

  - **When:** Indicate the date services were received. Unless known by the assessor, the date(s) are based on the self-report and best recollection of the client.
  - **Where:** Indicate the agency or facility the client has received services from. Include city and state if known.
  - **Level of Care:** Indicate the level of care for which the services received by the client were listed, i.e. outpatient, intensive outpatient, residential, etc.
  - **Length of Treatment:** Indicate the duration of treatment services received by the client.
  - **Treated For:** Indicate the condition or reason for treatment as the client understands it.

- **Comments:** This is where the assessment specialist can note any additional concerns they may have.

- **Have you ever been the victim of abuse?:** Indicate by a check the client response. This question covers abuse experienced or perpetrated as a child or an adult. If the client was a perpetrator of abuse indicate if there are any legal stipulations that would impact the treatment environment. Indicate when the abuse occurred and by whom. If indicated, make a note of this so level of care and placement can be considered for Specialized Women’s program and / or Trauma-Informed / Specific services. The categories for the columns are defined below:

  - **Sexual:** This form of abuse includes sexual assault (unwanted sexual contact that stops short of rape or attempted rape, this includes sexual touching and fondling), sexual harassment (Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature in which submission to or rejection of such conduct explicitly or implicitly affects an individual’s work or school performance or creates an intimidating, hostile, or offensive work or school environment.), incest (Sexual contact between persons who are so closely related that their marriage is illegal e.g., parents and children, uncles/aunts and nieces/nephews, etc. This usually takes the form of an older family member sexually abusing a child or adolescent.), molestation (offenses in which an adult engages in non-penetrative activity with a minor for the purpose of sexual gratification; for example, exposing a minor to pornography or to the sexual acts of others), rape (forced sexual intercourse, including vaginal, anal or oral penetration; penetration may be by a body part or an object) and sodomy (anal penetration, oral sex, masturbation and paraphilia).

  - **Domestic Violence:** This form of abuse occurs when a family member, partner or ex-partner attempts to physically or psychologically dominate another, this can include stalking.

  - **Physical:** This form of abuse involves contact intended to cause pain, injury, or other physical suffering or harm.

  - **Emotional:** This form of abuse involves the systematic tearing down of the emotional stability of another human being. It is considered a pattern of behavior that can seriously interfere with positive development and includes verbal abuse.

  - **Neglect:** It is defined as the failure of caregivers to fulfill their responsibilities to provide the basic needed care. This care can be physical, emotional, or educational. It can also be active or passive.

- **When and by whom?**

- **Did you receive intervention?:** Indicate by a check the client response.
• **Have you ever been the perpetrator of abuse?** Indicate clients response.
• **Did you receive intervention?**
• **Further assessment needed?**
• **In the last year, have you felt like hurting or killing yourself:** Indicate by a check client response. If yes, indicate:
  When the client was feeling like this?
  What were the circumstances that lead the client to feel this way?
  Did the client have a plan?
  Did he/she have the ability to act on that plan?
• **In the last year, have you felt like hurting or killing someone else:** Indicate by a check client response. If yes, indicate:
  When the client was feeling like this.
  What were the circumstances, as reported by the client that lead him/her to feel this way?
  Who, according to the client, were these thoughts aimed towards?
  Did the client have a plan and an ability to act on that plan?
• **In the last year, have you experienced hallucinations or difficulty telling what is real from that which is not:** Indicate by a check client response. If yes, probe more about the specifics of these occurrences with the client and indicate the nature of the hallucinations and/or perceptions.
• **In the last year, have you had trouble remembering, concentrating or following simple instructions:** Indicate by a check client response. If yes, indicate the area in which the client has had trouble. Note if there was any explanation for this occurrence, the onset, the duration, and state whether or not this is still problematic.
• **Comments:** This is where the assessment specialist can note any concerns or make additional notes.
The Mental Status Exam is the basis for understanding the client's presentation and functioning relevant to a diagnosis. This section does not have to be completed with the client present and can be completed after the client has left the session. The information used in this section is gleaned from the normal interviewing process and therapist and observation of the client.

- **Orientation**: Indicate by a check the client's ability to identify and recall one's identity and place in time and space. You may want to ask direct questions to assess the client's presenting level of orientation. If a deficit is found in any area, the deficient area should be indicated: person (who he/she is), place (where he/she are), time (including the date), and situation (that he/she is in) or object.

- **Comments**: this is where the assessment specialist can made additional notes.

- **General Appearance**: Indicate by a check the client's general physical appearance and expression in the areas of dress (whether it was appropriate attire for the weather and season), grooming, and facial expression.

- **Comments**: this is where the assessment specialist can made additional notes.

- **Mood/Affect**: Indicate by a check the client's mood/affect. While the client's mood is an indication of how they feel most days and their general pervasive emotional state as reported by them, their affect is the outward show of emotions and may vary as a result of their depression, elation, anger and normality. Note however, that if the overall sense of the client's mood from the assessment is of depression, then the client's mood is described as being depressed.

- **Comments**: this is where the assessment specialist can made additional notes.
• **Self-Concept**: Indicate by a check the client’s self-concept (defined as knowledge and understanding of one self).

• **Comments**: this is where the assessment specialist can made additional notes.

• **Speech**: Indicate by a check the client’s speech. Comment on this aspect of the individual by evaluating the volume, rate and flow of speech.

• **Comments**: this is where the assessment specialist can made additional notes.

• **Memory**: Indicate by a check the condition of the client’s immediate, recent, and remote memory. Look for immediate recall, short-term memory (an ability to remember several things after five minutes) and long-term memory (an ability to remember distant events).

• **Comments**: this is where the assessment specialist can made additional notes.

• **Thought Process**: Indicate by a check the client’s thought process. Address such features of thought as the rate of thoughts and discuss how they flow and are connected or disconnected.

• **Comments**: this is where the assessment specialist can made additional notes.
• **Thought Content**: Indicate by a check the client’s thought content. Use as a basis those areas of mental health discussed in the assessment and any beliefs the client has.

• **Comments**: this is where the assessment specialist can made additional notes.

• **Judgment and Insight**: Indicate by a check the client’s presenting judgment and insight. This looks at how the person makes judgments and decisions. Insight describes how much understanding or awareness the client has of his/her own psychological functioning or disturbance.

**Comments**: this is where the assessment specialist can made additional notes
Cindy

She complains of depression over the past five or six months, but has not had suicidal thoughts, or impulses to harm herself. Cindy’s responses on the MINI Screen also indicated that she would need to have Module A, I, J and O.

Questions on the next slide
Dimension 3 Questions

• Is the client in imminent danger of harming self or someone else?

• Is the client unable to function and safely care for self?

• Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed because they create risk or complicate treatment?

Based on this information and the information from Dimension 3 of the assessment, how would you seek to answer these questions:

Is the client in imminent danger of harming self or someone else?

Is the client unable to function and safely care for self?

Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed because they create risk or complicate treatment?

Do any emotional, behavioral, or cognitive problems appear to be an expected part of the addictive disorder or do they appear autonomous?

Are the problems severe enough to warrant specific mental health treatment?

Is the client able to manage the activities of daily living?

Can the client cope with any emotional, behavioral or cognitive problems?
Dimension 3 Questions
(cont’d)

• Do any emotional, behavioral, or cognitive problems appear to be an expected part of the addictive disorder or do they appear autonomous?

• Are the problems severe enough to warrant specific mental health treatment?

• Is the client able to manage the activities of daily living?

• Can the client cope with any emotional, behavioral or cognitive problems?

Based on this information and the information from Dimension 3 of the assessment, how would you seek to answer these questions:

Do any emotional, behavioral, or cognitive problems appear to be an expected part of the addictive disorder or do they appear autonomous?

Are the problems severe enough to warrant specific mental health treatment?

Is the client able to manage the activities of daily living?

Can the client cope with any emotional, behavioral or cognitive problems?
Dimension 4

Readiness to Change

Discuss Motivational Interviewing here
Dimension 4 – This is not a medical emergency, but if you know someone is ambivalent or mandated for care, important to ensure that the person keeps their appointment and that if not, that someone will follow up. Also include the significant other in the assessment process as well as probation officer or judge or employer – whoever mandated the client for treatment.

Idea: Come up with a way to get them to look at readiness to change instead of reading the definition.
Example:
Break them into 5 groups (which represent each stage of change) As the group to come up with a brief description of things you would hear or see a client do and what treatment intervention they could use.
Handout 13: The Transtheoretical Model

The URICA will assist them to evaluate this.

Transtheoretical Model

Pre-contemplation: not yet considering the possibility of change although others are aware of a problem; active resistance to change; seldom appear for treatment without coercion; could benefit from non-threatening information and information to raise awareness of a possible “problem” and possibilities for change.

Contemplation: ambivalent, undecided, vacillating between whether he/she really has a “problem” or needs to change; wants to change, but this desire exists simultaneously with resistance to it; may seek professional advice to get an objective assessment; motivational strategies useful at this stage, but aggressive or premature confrontation provokes strong resistance and defensive behaviors; many Contemplators have indefinite plans to take action in the next six months or so.

Preparation: takes person from decisions made in Contemplation stage to the specific steps to be taken to solve the problem in the Action stage; increasing confidence in the decision to change; certain tasks that make up the first steps on the road to Action; most people planning to take action within the very next month; making final adjustments before they begin to change their behavior.

Action: specific actions intended to bring about change; overt modification of behavior and surroundings; most busy stage of change requiring the greatest commitment of time and energy; care not to equate action with actual change; support and encouragement still very important to prevent drop out and regression in readiness to change.

Maintenance: sustain the changes accomplished by previous action and prevent relapse; requires different set of skills than were needed to initiate change; consolidation of gains attained; not a static stage and lasts as little as six months or up to a lifetime; learn alternative coping and problem-solving strategies; replace problem behaviors with new, healthy life-style; work through emotional triggers of relapse.
**Reference Handout 13: The Transtheoretical Model**

Additional Stages of Change and Motivational Interviewing information can be found through the Addiction Technology Transfer Center (ATTC) at [www.nattc.org](http://www.nattc.org) and TIP #35: Enhancing Motivation for Change in Substance Abuse Treatment.
Dimension 4  Questions

• What is the client’s emotional and cognitive awareness of the need to change?

• Does the client feel coerced into treatment or actively object to receiving treatment?

• What is the client’s level of commitment to change?

• Does the client appear to need AOD treatment/recovery, but is ambivalent or feels it is unnecessary?

Answers to these questions will be found in responses on the URICA and the assessment.
Handout 14: Crosswalk for DSM Criteria Embedded within the Placement Assessment.

- **Do you have any behaviors that you need to change**: Indicate by a check the client’s response. Have the client to explain why they responded in that way and indicate their response.
- **Do you think you have a problem with AOD and/or mental/emotional disorders**: Indicate by a check the client’s response. Have the client to explain why they responded in that way and indicate their response.
- **Have you tried to hide your AOD use**: Indicate by a check the client’s response.
- **Has anyone ever complained about your AOD use**: Indicate by a check the client’s response. The criterion that is indicated in parenthesis behind the following statements corresponds to the criteria for substance abuse and/or dependence as specified by the DSM.
- **Has your AOD use caused you to feel depressed, nervous, suspicious, decreased sexual desire, diminished interest in normal activities or cause other psychological problems**: Indicate by a check the client’s response. (Criterion 2)
- **Has your AOD use affected your health in any way by causing numbness, blackouts, shakes, tingling, TB, STDs or other health problems**: Indicate by a check the client’s response. (Criterion 2)
- **Have you continued to use despite the negative consequences (at work, school, or home) of your use**: Indicate by a check the client’s response. (Criterion A1)
- **Have you continued to use despite placing yourself and others in dangerous or unsafe situations**: Indicate by a check the client’s response. (Criterion A2)
- **Have you had problems with the law because of your use**: Indicate by a check the client’s response. (Criterion A3)
- **Has your AOD use affected you socially (fights, problem relationships, etc.)**: Indicate by a check the client’s response. (Criterion A4)
• **Do you need more AOD to get the same high:** Indicate by a check the client’s response. (Criterion 1)

• **Do you spend a great deal of time in activities to obtain AOD and/or feeling its affects:** Indicate by a check the client’s response. (Criterion 5)

• **Has your AOD use caused you to give up or not participate in social, occupational or recreational activities that you once enjoyed:** Indicate by a check the client’s response. (Criterion 6)

• **Have you continued to use after knowing it caused or contributed to physical and psychological problems:** Indicate by a check the client’s response. (Criterion 7)

• **Have you used larger amounts of AOD than you intended:** Indicate by a check the client’s response. (Criterion 3)

• **URICA Scores:** Indicate the URICA score for the appropriate use type and indicate a check by the corresponding stage of change.
The University of Rhode Island Change Assessment (URICA) is a 32-item self-report measure that includes 4 subscales measuring the stages of change. The URICA assesses motivation for change by providing scores on four stages of change: precontemplation, contemplation, action and maintenance. The subscales can be combined arithmetically (C + A + M – PC) to yield a second-order continuous Readiness to Change score that can be used to assess readiness to change at entrance to treatment. Clinicians may use the URICA to evaluate an individual’s level of motivation for change and use this information to help guide treatment approaches.

This instrument is in the public domain. We only have paper version but there is no reason why you can not put it in an electronic form.
Clinicians may use the URICA to evaluate an individual's level of motivation for change and use this information to help guide treatment approaches.

Can be filled out by the client. Can be given to the client while they are waiting or given to the case management to go over with the client.

Don’t round up
Handout 15: URICA – Cindy (alcohol)
Handout 16: URICA – Cindy (drug)

The URICA can be pulled out of the assessment and the client can self-administer with the assistance of an administrative support staff member prior to the client meeting with the assessor. The administrative staff would score it based on the client’s responses and the scoring key. It is suggested that a URICA be done for alcohol and a separate URICA be done for drug use. The scale and scoring information must be provided to the clinician upon completion (prior to completion of the assessment). The score and the readiness stage is required within the assessment and necessary for placement.

Idea: go over some of the question and ask them to tell you which stage of change it represents.
Allow the participants to score Cindy’s URICA for her alcohol use and her URICA for her drug use.

To score: \((C + A + M - PC)\)

**TOTS Only**, refer to *Handout 23: Answer Key for Cindy’s URICA Scoring*
Where does Cindy fall in regard to her URICA score for her Stage of Change?

Alcohol – she’s in Preparation (Action)
Drug – she’s in Precontemplation

**TOTS Only**, refer to *Handout 23: Answer Key for Cindy’s URICA Scoring*
Cindy admits to an alcohol problem but feels it is no longer a problem as she claims to have stopped drinking five months ago. She claims she’s never had a cocaine problem and just used with a boyfriend that once, the night before the first random urine test at work. Her URICA scores indicate Preparation stage for her drinking and Precontemplation for her drug use.
Dimension 4 Questions

• What is the client’s emotional and cognitive awareness of the need to change?

• Does the client feel coerced into treatment or actively object to receiving treatment?

• What is the client’s level of commitment to change?

• Does the client appear to need AOD treatment/recovery, but is ambivalent or feels it is unnecessary?

With Cindy’s URICA information and the Dimension 4 assessment responses in mind, answer these questions:

What is the client’s emotional and cognitive awareness of the need to change?
Does the client feel coerced into treatment or actively object to receiving treatment?
What is the client’s level of commitment to change?
Appears to need AOD treatment/recovery, but is ambivalent or feels it is unnecessary?
BREAK

End of Day One.
Dimension 5 – If currently under the influence, you may need to arrange safe transportation by a relative or friend; or take car keys until safe to drive. Many may continue to use or relapse, but those needing immediate needs are only those whose continued use or problems places the client and others in imminent danger within the next 24-48 hours.
### Dimension 5 Questions

- Is the client in immediate danger of continued severe mental health distress and/or AOD use?

- Does the client have any recognition, understanding, or skills in coping with the addiction or mental disorder in order to prevent relapse, continued use or continued problems?

- How severe are the problems and further distress that may continue or reappear if the client is not successfully engaged in treatment at this time?

Note: Clinicians must take a comprehensive assessment to answer some questions. For instance the first question will depend on response to questions in Dimension 5 as well as questions in Dimension 3 and the MINI/MINI Kid screening.
Dimension 5 Questions
(cont’d)

• How aware is the client of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use or impulses to harm self or others?

• What is the client’s ability to remain abstinent based on history?
• Have you ever been treated for an AOD problem?

List here previous treatment episodes for alcohol treatment and drug treatment. Indicate if the treatment was for alcohol or drugs or both, when the treatment was received, where, the level of care (i.e. outpatient, residential, etc.), and the type of discharge. If there is a long treatment history you must use a separate sheet to list them out.

• Comments: This is where the assessment specialist can make any additional comments.
• **Have you had any periods of abstinence from an AOD**: Cross reference the previous noted periods of abstinence from the substance use background chart. Indicate by a check the client’s response. If yes, indicate the periods of abstinence and from what substances and/or the periods where no problems were experienced and respond to the next 3 questions. If the answer is no, skip the next 3 questions.

*The next 3 questions are only applicable if the client answered yes to any periods of abstinence.*

• **How was that abstinence / maintenance achieved**: If there have been periods of abstinence list how the client was able to achieve that e.g., attending AA meetings; changing friends or activities; attending church; using a sponsor or therapist. (Criterion A4)

• **What would you consider your relapse triggers**: Indicate the client’s response.

• **Are you aware of what caused you to relapse**: Indicate the client’s response.

• **Are you participating in any support groups**: Indicate by a check the client’s response. List any support groups the client is involved in.

• **Do you have a sponsor**: Indicate by a check the client’s response. List the name of the sponsor and contact information.

• **Have you ever participated in**: Indicate by a check the client’s response.

• **In the past year, have you tried to reduce the effect of your AOD/problems**: Indicate the client’s response and what they’ve done to reduce their problems. (Criterion 4)

• **Have you had any periods without mental/emotional problems**: Indicate by a check the client’s response. If yes, indicate the periods the client had mental/emotional problems and/or the periods where no mental health problems were experienced and respond to the next 2 questions. If the answer is no, skip the next 2 questions.

• **How was maintenance achieved**: Indicate the client’s response.

• **What causes the symptoms to get worse**: Indicate the client’s response.
Cindy

She denies alcohol use, stating she hasn’t used in the last five months and no cocaine use in the last eight months. She has had one positive cocaine drug screen eight months ago, and refused to complete a random drug screen recently which lead to her employer referral.

Refer to Cindy’s Dimension 5 responses and seek to answer the following (see next slide):

Is the client in immediate danger of continued severe mental health distress and/or AOD use?
Does the client have any recognition or understanding or, or skills in coping with the addiction or mental disorder in order to prevent relapse, continued use or continued problems?
How severe are the problems and further distress that may continue or reappear if the client is not successfully engaged in treatment at this time?
How aware is the client of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use or impulses to harm self or others?
What is the client’s ability to remain abstinent based on history?
What is the client’s level of current craving and how successfully can they resist using?
<table>
<thead>
<tr>
<th>Dimension 5 Questions</th>
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</thead>
<tbody>
<tr>
<td>• Is the client in immediate danger of continued severe mental health distress and/or AOD use?</td>
</tr>
<tr>
<td>• Does the client have any recognition, understanding, or skills in coping with the addiction or mental disorder in order to prevent relapse, continued use or continued problems?</td>
</tr>
<tr>
<td>• How severe are the problems and further distress that may continue or reappear if the client is not successfully engaged in treatment at this time?</td>
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</table>

Refer to Cindy’s Dimension 5 responses and seek to answer the following:

Is the client in immediate danger of continued severe mental health distress and/or AOD use?

Does the client have any recognition or understanding or, or skills in coping with the addiction or mental disorder in order to prevent relapse, continued use or continued problems?

How severe are the problems and further distress that may continue or reappear if the client is not successfully engaged in treatment at this time?

How aware is the client of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use or impulses to harm self or others?

What is the client’s ability to remain abstinent based on history?
Dimension 5 Questions (cont’d)

• How aware is the client of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use or impulses to harm self or others?

• What is the client’s ability to remain abstinent based on history?

Refer to Cindy’s Dimension 5 responses and seek to answer the following:

How aware is the client of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use or impulses to harm self or others?
What is the client’s ability to remain abstinent based on history?
Dimension 6 – similarly, many have poor recovery supports, but at this point, we are only concerned for those who are likely to be abused or mistreated tonight; or who needs a safe shelter today to avoid freezing to death or a domestic violence victimization etc.
Dimension 6 Questions

- Do any family members, significant others, living situations, or school or work situations pose a threat to the client's safety or engagement in treatment?

- Does the client have supportive friendships, financial resources, or educational or vocational resources that can increase the likelihood of successful treatment?

- Are there legal, vocational, social service agency, or criminal justice mandates that may enhance the client’s motivation for engagement in treatment?

- Are there transportation, child care, housing or employment issues that need to be clarified or addressed?

Are there any dangerous family members, significant others, living/work/school situations threatening client’s safety, immediate well-being, and/or sobriety?
**ADULT Dimension 6**

**DIMENSION 6: RECOVERY / LIVING ENVIRONMENT**

- **Head of Household**: Indicate the client’s response.
- **Number in Household**: Indicate the number of individuals (adult and children; permanent and transitional) to include yourself that currently live in your household.
- **Living Arrangement**: Indicate the number of years and months that the client has resided at current residence. Indicate by a check what best describes the current living arrangement. The categories are:
  - Alabama Housing Finance Authority Housing
  - Center Operated / Contracted Residential Program
  - Center Subsidized Housing
  - Homeless / Shelter
  - Independent Living
  - Jail / Correctional Facility
  - Resides with Family
  - Other institutional Setting (nursing home, etc.)
  - Other

- **Current Employment Status**: Indicate by a check what best describes current employment situation. The categories are defined below:
  - Confined to Institution / Correctional Facility: This indicates the client is currently incarcerated in a correctional setting or confined to an inpatient mental illness or mental retardation facility.
  - Disabled: This refers to client's functioning, including physical impairment.
• **Employment History**: Indicate previous employment history beginning with current and/or most recent employer to include: position, dates employed (year to year is sufficient), and reason for leaving.

• **Are you currently in school, enrolled in a GED program, or a vocational program**: Indicate by a check if client is currently in school.

• **Number of year completed in school**: Indicate the client’s response.

• **Detailed Legal Status**: Indicate by check mark the category which best represents the client’s detailed legal status. The categories are defined below:

  - None: This indicates that the client is not legally involved.
  - State / Federal Court: This indicates the client is and/or was legally involved in a state or federal court case.
  - Formal Adjudication: This indicates a judge has reviewed evidence and arguments for legal issues and has made a decision based on that information. In regard to minors, it indicates that children are under a court’s jurisdiction usually as a result of having engaged in delinquent behavior and not having a legal guardian that could be entrusted with being responsible for him or her.
  - Probation / Parole (Name): This indicates the client’s legal status based on suspension and/or completion of a jail/prison sentence. The conditions of this status are defined by a court and supervised by an officer of the court. Indicate probation/parole officer’s name.
  - Diversionary Program: This indicates that a sentencing alternative has been made available to the client in lieu of confinement to jail and/or prison. The diversionary option is provided in an effort to reduce the future likelihood of recidivism.
• **Arrest History**: Indicate the number of times the client has been arrested for any of the listed offenses. For each offense that an arrest is indicated, indicate by check mark if the client has ever been convicted of any of the listed offenses.

• **Explanation of the above to include outcome**: Based on the client’s response indicate the circumstances involving the offense and the outcome of the offense i.e. case dismissed, youthful offender, expunged, placed on supervised probation and term, fine paid, pending court date, etc.
• **Dependent Children**: Indicate by a check if client has dependent children. This is a *specialized women’s* question that is relevant to specialized women’s services.

• **Custody Question**: (Who has custody of these children) Indicate the name and relationship of the individual who has custody of any dependent children the client has. This is a *specialized women’s* question that is relevant to specialized women’s services.

• **Childcare Question**: (Is there childcare available for these children) Indicate by a check if childcare is available. For all no responses, the client must indicate why and / or explain the specifics to the situation. This is a *specialized women’s* question that is relevant to specialized women’s services.

• **Parenting Skills**: (Do you feel you have adequate parenting skills) Indicate by a check the client’s perception of their parenting skills. This is a *specialized women’s* question that is relevant to specialized women’s services.

• **Parenting Skills 2**: (Would you be interested in receiving more skills) Indicate by a check the client’s response to the need for additional parenting skills. This is a *specialized women’s* question that is relevant to specialized women’s services.

• **Quality of Interaction with family**: Indicate by a check the client’s rating of interaction with his family.

• **Level of Satisfaction with support system**: Indicate by a check the client’s rating of satisfaction with his current support system.
• Describe your relationship with: Indicate the client’s response to his relationship with his mother, father, siblings, caretakers, children, and others.
• Is your current living environment drug free: Indicate by a check if the client response to their living environment to include their surroundings, conditions, and influences. If no, describe the living environment of the client.
• Who would you ask to take you to the hospital if you were to suddenly become ill: Indicate the client response.
• Would you call the same person to tell some really good news: Indicate the client response.
• Do you have reliable transportation: Indicate by a check if the client has reliable transportation. Allow the client to describe the transportation they have access to.
Again there are additional questions we want to ask the adol regarding their home life.

- **List name of parent or guardian**: Indicate the client’s response.
- **Do you live with this person**: Indicate the client’s response.
- **Number in household**: Indicate the client’s response.
- **What is the marital & life status of your natural/biological parent**: Indicate by a check the client’s response.
- **Living Arrangement**: Indicate the number of years and months that the client has resided at current residence. Indicate by a check the answer that best describes the current living arrangement. The categories are:
  - Alabama Housing Finance Authority Housing
  - Center Operated / Contracted Residential Program
  - Center Subsidized Housing
  - Homeless / Shelter
  - Independent Living
  - Jail / Correctional Facility
  - Resides with Family
  - Other Institutional Setting (nursing home, etc.)
  - Other
**ADOLESCENT Dimension 6**

Which of the following best describes your current living situation: Indicate by a check the client’s response.

- **Who is the head of your current household**: Indicate by a check the client’s response.

- **How many times have you moved in your lifetime either with or without family**: Indicate the client’s response.

- **How many times have you run away from home(s)**: Indicate the client’s response.
ADOLESCENT Dimension 6

How would you describe the quality of interaction with your family? □ Excellent □ Good □ Fair □ Poor

The level of satisfaction with current support system in your family? □ Excellent □ Good □ Fair □ Poor

Describe relationship with:

Mother: ____________________________
Father: ____________________________
Child(ren): ________________________
Sibling(s): _________________________
Grandparent(s): ____________________

Is your current living arrangement drug free? □ Yes □ No

How many times have you moved in your lifetime with or without family? □ ______

How many times have you run away from home(s)? □ ______

Who would you ask to take you to the hospital if you were to suddenly become ill?

Would you call the same person to tell some really good news? □ Yes □ No □ If not, why and who would you call?

Do you have reliable transportation? □ Yes □ No □ Explain: ________________

Do you have a valid driver's license? □ Yes □ No
Are you currently in school, enrolled in a GED program, or a vocational program: Indicate by a check if client is currently in school and his or her grade level.

• What is the highest grade you’ve completed: Indicate the client’s response.
• Have you repeated a grade: Indicate the client’s response.
• How many times were you: Indicate the client’s response.
• Are you or have you received special education services: Indicate the client’s response.
• How many days (in the past 30) have you been absent from school: Indicate the client’s response.
# ADOLESCENT Dimension 6

**Detailed Legal Status**

- None
- State/Federal Court
- Formal Adjudication
- Probation/Parole (Name): ___________________________
- Diversionary Program
- Prison
- Court Referral
- Other: ___________________________

**Current Charges:**

- # of Arrests in 30 days Prior to Admission: ______

<table>
<thead>
<tr>
<th>Arrest History</th>
<th># of Arrests</th>
<th>Convicted</th>
<th># of Arrests</th>
<th>Convicted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assault</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Auto Theft</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Burglary</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Robbery</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Criminal Trespass</td>
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<td>No</td>
<td>Yes</td>
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</tr>
<tr>
<td>Distribution</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>DUI</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Harassment</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Minor in Possession</td>
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<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Possession</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Explanation of the above to include outcome:**
• **How often do/did you engage in any of the following activities in the past month:** Indicate by a check the client’s response.

• **Are you currently or have you ever been bullied:** Indicate the client’s response.

• **What type of social activities did you participate in prior to your alcohol/drug use:** Indicate the client’s response.

• **List and describe any support groups, organizations, clubs that will help you in your recovery efforts:** Indicate the client’s response.

• **How often do you participate in these activities:** Indicate the client’s response.

• **Do you have any hobbies or leisure activities you’d like to learn:** Indicate the client’s response.
• **What do others consider to be your strengths**: Indicate the client’s response.

• **Did you have a boy/girlfriend during the past three months**: Indicate the client’s response.

• **How often do/did you engage in any of the following activities in the past month**? **If yes, does your boy/girlfriend drink or use drugs**: Indicate the client’s response.

• **Are you sexually active**: Indicate the client’s response.

• **Do you use birth control or protection (condoms) to prevent pregnancy or sexually transmitted disease**: Indicate the client’s response.

• **Who would you ask to take you to the hospital if you were to suddenly become ill**: Indicate the client’s response.

• **Would you call the same person to tell some really good news**? **If not, why and who would you call**: Indicate the client’s response.

• **Do you have reliable transportation**: Indicate by a check if the client has reliable transportation. Allow the client to describe the transportation they have access to.
Cindy lives independently and stated her only cocaine use was with her boyfriend. She faces loss of her job of 17 years if she does not comply with treatment. Cindy is willing to be involved in treatment but feels she only needs urine monitoring and low intensity outpatient support and counseling for her depression.

If detox is a concern answer this question from Dimension 1 (see next slide): Does the client have supports to assist in ambulatory detoxification if medically safe?

Do any family members, significant others, living situations, or school or work situations pose a threat to the client's safety or engagement in treatment?

Does the client have supportive friendships, financial resources, or educational or vocational resources that can increase the likelihood of successful treatment?

Are there legal, vocational, social service agency, or criminal justice mandates that may enhance the client's motivation for engagement in treatment?

Are there transportation, child care, housing or employment issues that need to be clarified or addressed?
Dimension 6 Questions

- Do any family members, significant others, living situations, or school or work situations pose a threat to the client's safety or engagement in treatment?
- Does the client have supportive friendships, financial resources, or educational or vocational resources that can increase the likelihood of successful treatment?
- Are there legal, vocational, social service agency, or criminal justice mandates that may enhance the client’s motivation for engagement in treatment?
- Are there transportation, child care, housing or employment issues that need to be clarified or addressed?

If detox is a concern answer this question from Dimension 1: Does the client have supports to assist in ambulatory detoxification if medically safe?

Do any family members, significant others, living situations, or school or work situations pose a threat to the client's safety or engagement in treatment?

Does the client have supportive friendships, financial resources, or educational or vocational resources that can increase the likelihood of successful treatment?

Are there legal, vocational, social service agency, or criminal justice mandates that may enhance the client’s motivation for engagement in treatment?

Are there transportation, child care, housing or employment issues that need to be clarified or addressed?
**Purpose**

Aids clinicians in identifying the most immediate and needful client multidimensional deficits; and to subsequently assign interventions based on the dimension (s) presenting the highest level of risk (Risk Level 4).

You’ve collected the assessment information from all the dimensions. Now what do you do with all of this information? You assign risk ratings to each dimension which will help you to determine the client’s placement.
Risk Rating

- Risk is multidimensional and biopsychosocial in nature.
- Risk is evaluated in terms of the individual's current status and history.
- Risk involves assessment from a non-problematic baseline observation to an escalation of problems.
- Risk assessment must integrate history, existing life situations and presentation.
- Risk assessments are determined for each of the 6 ASAM PPC-2R dimensions.

Handout 17: ASAM PPC2R Risk Rating Cross Walk Adults
Handout 18: ASAM PPC2R Risk Rating Cross Walk for Adolescent Risk Rating

Handout 17: ASAM PPC2R Risk Rating Cross Walk
Handout 18: ASAM PPC2R Risk Rating Cross Walk for Adolescent Risk Rating

TOTs - Refer to pages 281-340 in the ASAM book to study about risk rating

Emphasize that for all risk ratings (including co-occurring):
Risk is seen as multidimensional and bio-psychosocial.
Risk relates to the client's history
Risk is expressed in the current status
Risk Rating

When assessing an individual’s risk potential:

- Dimension’s 1 and 2 apply only to **Substance Abuse** issues.
- Dimension 3 assesses risk in the **Co-Occurring Disorder** Risk Domains.
- Dimensions 4, 5, and 6 address Risk Ratings for both Substance Abuse and Mental Health issues.

Be prepared to answer question around why only assess MH risk rating in dimension 3
Risk Rating

- **A Risk Rating of 0:**
  Indicates full functioning in that dimension.

- **A Risk Rating between 1-4:**
  Indicates the individual’s various levels of functioning/problems in that dimension.

  *(A higher numbered risk rating indicates the severity of problems or risk for each dimension)*

- **A Risk Rating equal to or greater than 2 on Dimension 3 requires** Mental Health risk ratings in addition to Substance Abuse risk ratings on Dimensions 4, 5, and 6.
Adolescents who use alcohol and other drugs, differ from adults in significant ways. Biopsychosocial elements of etiology are common in both but they are expressed differently. Treatment approaches are different because adolescents are different from adults in their stages of emotional, cognitive, physical, social and moral development. The time of adolescence affords a unique opportunity to modify risk factors before the person’s development is complete.

Adolescents do not develop classic physical dependence or well-defined withdrawal symptoms because of their shorter time exposure to alcohol or drugs but they are more susceptible to dependence on alcohol and drugs because the progression from casual use to dependence is more rapid.

Also, adolescents typically demonstrate a higher degree of co-occurring psychopathology, which may not remit with abstinence. Their use of substances impairs their intellectual and emotional growth. Younger adolescents tend to have a narrower view of the world, with little capacity to think of future implications of their present actions.
### Risk Rating

#### ASAM PPC-2R Diagnostic Summary

This section will serve as the assessor’s summary of all the information gained within the assessment. The summary is divided by the respective dimensions required to make placement based on ASAM PPC-2R. Consider each dimension and the level of functioning / severity within each dimension and provide sufficient data to assess the needs. The ASAM RRC-2R Crosswalk that follows may be beneficial in helping you to determine your risk rating.

<table>
<thead>
<tr>
<th>Dimension 1: Acute Intoxication and/or withdrawal potential</th>
<th>Risk Rating: 0 1 2 3 4</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dimension 2: Biomedical conditions and complications</th>
<th>Risk Rating: 0 1 2 3 4</th>
</tr>
</thead>
</table>

| Dimension 3: Emotional / Behavioral / Cognitive Conditions and Complications | Risk Rating: 0 1 2 3 4 |

Each risk description provides both a numerical rating of risk (on a scale of 0 to 4) and a narrative description of risk in terms of signs and symptoms that indicate the individual’s severity and level of function in a particular assessment dimension. The risk rating and description help determine the immediacy and scope of service needs and types. This also indicates the intensity or level of service at which the client can be treated safely and efficaciously.

Assess all six dimensions to determine whether the client has immediate needs related to imminent danger, as indicated by a Risk Rating of “4” in any of the six dimensions. The Risk Ratings range from 0 – 4. 0 = Indicates full functioning; no severity; no risk in this Dimension. Risk Rating: 1-4 = Indicates various levels of functioning and severity and the level of risk in this Dimension. (NOTE: A higher number indicates a greater level of severity) The dimension with the highest risk rating determines the immediate service needs and placement decision.

Assess the clients MH Risk rating beginning with Dimension 3.

**Dimension 3: Emotional, Behavioral, and Cognitive**

- **0**= SA only clients
- **1**= COD clients who are stable
- **2**= COD clients with moderate concerns
- **3**= COD clients with severe symptoms but do not require involuntary confinement
- **4**= COD clients with severe symptoms and require involuntary confinement
Co-Occurring Disorders Risk Domains

- Dangerousness/Lethality
- Interference with Addiction Recovery Efforts
- Social Functioning
- Ability for Self Care
- Course of Illness

Handout 19: Mental Health Risk Ratings for Co-occurring Disorders

The handout is the same as the slides.

As noted before:

Risk is seen as multidimensional and bio-psychosocial.

Risk relates to the client’s history

Risk is expressed in the current status

Reference for TOT: The Clinical Innovators Series: Applying ASAM Placement Criteria – Clinician’s Manual, by Dr. David Mee-Lee and Kathyleen M. Tomlin (pg.44) and ASAM PPC-2R pgs. 283-284

A Risk Domain is an assessment subcategory begins with Dimension 3.

1. Dangerousness/Lethality: How severe is the client’s impulsivity related to suicidal and/or homicidal behaviors, including other forms of harm to self or others?
2. Interference with recovery efforts: To what degree is the client able to focus on recovery without distraction?
3. Social functioning: To what degree does the client’s substance use or other mental health problems interfere with important relationships in his or her life?
4. Self-care ability: To what degree can the client perform the daily tasks of caring for self without interference of mental illness or substance use symptoms?
5. Course of illness: How does the client’s MH/SA history affect his or her current issues, and what services may the client based on the history? For example, if a client has a history of severe suicidal impulsivity or any current depression with suicidal ideation, this would be of great concern. In contrast, if a client has never acted impulsively on suicidal ideation but is currently depressed, there would be less risk.
Dimension 3 Mental Health Risk Rating
Questions

1. Do psychiatric illness, psychological, behavioral, emotional, or cognitive problems create a risk or complicate treatment?

2. Are there chronic mental health conditions that affect treatment?

3. Do the problems warrant mental health treatment?

4. Can the client engage in daily living activities?

5. Can the client cope with the emotional, behavioral, or cognitive problems?

6. Based on this assessment, what level of care is safe for the client?

Continue to reference **Handout 19: Mental Health Risk Ratings for Co-occurring Disorders**

*The handout is the same as the slides.*
Dimension 4 Mental Health Risk Rating

The mental health risk rating for co-occurring disordered clients provides a numerical and alphabetical rating at the level 4 (Severe level) and for Dimension 4, 5 and 6 to help staff to determine the immediacy and scope of the client’s need. The higher the number, the greater the need.

- **Alphabet a:** No Immediate Action Required
- **Alphabet b:** Immediate Action Required

Continue to reference *Handout 19: Mental Health Risk Ratings for Co-occurring Disorders*

*The handout is the same as the slides.*
### Dimension 4 Mental Health Risk Rating Questions

1. Is the client emotionally or cognitively aware of the need for change?
2. What is the client’s commitment to change?
3. At what level of care can the client be safely managed?

Continue to reference *Handout 19: Mental Health Risk Ratings for Co-occurring Disorders*

*The handout is the same as the slides.*
### Dimension 5 Mental Health Risk Rating Questions

1. Is the client in immediate danger of severe mental distress or continued use?

2. Does the client understand or recognize how to prevent relapse or to discontinue use?

3. How severe will the problems be if the client is not engaged in treatment now?

4. Is the client aware of relapse triggers, ways to cope with cravings, and skills to control impulses to harm themselves?

5. At what level of care can the client be safely managed?

Continue to reference Handout 19: Mental Health Risk Ratings for Co-occurring Disorders

*The handout is the same as the slides.*
Dimension 6 Mental Health Risk Rating

Questions

1. Do any family, friends, or others pose a threat to the client’s safety or engagement in treatment?

2. Does the client have supports (friends, family, finances, education, vocational) that influence their success?

3. Are there mandates (criminal justice, legal, social, vocational, etc) that motivate the client to engage in treatment?

4. Are there issues with transportation, childcare, housing, or employment that need to be addressed?

5. At what level of care can the client be safely managed?

Continue to reference Handout 19: Mental Health Risk Ratings for Co-occurring Disorders

The handout is the same as the slides.
Your summary should seek to address the following areas as they relate to SA and MH issues and level of risk. For clients who have a co-occurring diagnosis, history, or problems, you must also assess Dimensions 4, 5, and 6 separately for the mental and substance related disorders. This assists in identifying differential mental health and addiction treatment service needs and helps determine the kind of co-occurring program most likely to meet the client’s needs. If a client does not have a co-occurring issues, history, or problem they’d have a MH Risk Rating of 0 on Dimensions 4, 5, and 6. If a client has co-occurring issues the minimal risk rating that can be assessed in Dimensions 4, 5, and 6 is rating 1. Additionally, a client must have at least a risk rating of 2 in Dimension 3 for any of the MH Risk Ratings to be completed in 4, 5, and 6. Note only complete the MH Risk Rating on any dimension for clients who have mental health issues. Everyone else would be 0. Assess for risk in the five areas: Dangerousness/Lethality, Interference with Recovery Efforts, Social Functioning, Ability to Care for Self, and Course of Illness. Meanings are as follows:

**Dimension 4: Readiness to Change**

0= Client fully engaged and willing to change MH functioning and or behavior
1= COD client willing to enter treatment but ambivalent does enough not to decompensate
2=COD client is passively involved in treatment, low commitment
3= COD client is inconsistent with treatment; they may or may not take meds or come to sessions.
4= COD client is unable to follow through and has no awareness of their illness.

**Dimension 5: Relapse/Continued Use**

0= Good coping skills
1= COD client has minimal relapse potential
2= COD client has impaired ability to recognize relapse possibilities but self manages with prompting
3= COD client has little recognition of MH relapse issues and poor coping skills and ability to limit relapse.
4= Repeated treatment episodes with no change.

**Dimension 6: Recovery Environment**

0=Client has a supportive environment
1= Support is not really there but it does not affect the client
2= Environment not supportive but clinical structure allows client to cope ex: supportive living
3= No supports and coping is difficult even with clinical support
4= No supports and chronically hostile
Let’s take Cindy's assessment, case study information, and the dialogue we’ve had thus far and determine her Risk Rating and narrative on each Dimension. (Allow participants to break up into groups and complete a sample ASAM PPC-2R Diagnostic Summary then discuss results) You may chose to utilize the risk rating grid to assist you in making determinations. (Pause and allow them to determine Cindy’s risk rating)

Remember there will be discrepancies in risk ratings based on clinical interpretations.

Example of narrative responses:

Dimension 1: Last use – alcohol 5 months ago; cocaine 8 months ago. No previous detox or severe withdrawal. In no distress; alert, oriented, with no tremors; skin warm and dry; nothing to suggest any severe withdrawal danger. Risk Rating: 0

Dimension 2: No physical complaints; not on any medications and is healthy. Risk Rating: 0

Dimension 3: Depressed for past 5-6 months; oriented, mood appropriate; slightly depressed, and no evidence of psychosis or sociality; some anxiety about job. No previous psychiatric history. Risk Rating: 1 or 2

Dimension 4: Admits alcohol was her drug of choice, but feels she has it under control and that cocaine never was a problem. Mainly wanting to keep her job, but does complain of some problems with depression and her alcohol use in the past; willing to be involved in treatment but feels she only needs urine monitoring and low intensity outpatient support and counseling for her depression. Risk Rating: 2 NOTE SCALE IS REVERSED ON DIMENSION 4. Reference the scale.

Dimension 5: Poor skills to consistently avoid further drinking problems, but sufficiently concerned about job to control immediate drinking/drugging behavior; not imminently dangerous to self or others; not in AA /other self help program. Risk Rating: 2

Dimension 6: Lives alone in an apartment; job issues a stress, but also an asset to provide leverage to help engage patient into examining her drinking and drugging behavior; supervisors supportive and report good job performance except for the drug screens; has hobbies of making and selling souvenirs to tourists. Risk Rating: 0 or 1

Possible questions for you to ask the group:
How difficult was it to come to a consensus?
What would be required for her to be a 4 rather than a 3? Scaling questions to get them thinking.

Suggest that you have newsprint on the wall to make a grid of the risk ratings by group for comparison.
Ask participants to look at what kind of issues would be placed on Cindy service plan.
BREAK
The next series of slides provides a decision tree to match assessment and treatment/placement assignment. This will allow you to determine how to target and focus service priorities.

*Handout 20: How to Target and Focus Service Priorities (Decision Tree)*

Trainers should apply the questions to Cindy's situation.
Focus Assessment & Treatment

Multiaxial DSM impression?

Multidimensional Severity?

Identify which assessment dimensions are currently most important to determine treatment priorities.

Reference Handout 20: How to Target and Focus Service Priorities (Decision Tree)
Focus Assessment & Treatment

Choose a specific focus/target for each priority dimension.

What specific services needed for each dimension?

What “dose” or intensity of these services needed for each dimension?

Reference Handout 20: How to Target and Focus Service Priorities (Decision Tree)
Focus Assessment & Treatment

Where can these services be provided in least intensive, but “safe” level of care?

What is progress of Tx plan and placement decision; outcomes measurement?

Reference Handout 20: How to Target and Focus Service Priorities (Decision Tree)
True or False

The level of care placement is the first decision to make in the assessment?

Answer: False, this is the last decision

Ask participants: So what is the first decision to make in the assessment? What the client wants.
Engage the Client as Participant

**Individual Service Plan**

What?  
Why?  
How?  
Where?  
When?

Next slide explains
# Identifying the Assessment and Individual Service Plan

<table>
<thead>
<tr>
<th><strong>Client</strong></th>
<th><strong>Placement Assessment</strong></th>
<th><strong>Individual Service Plan</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What?</strong></td>
<td>What does client need?</td>
<td>What is the treatment contract?</td>
</tr>
<tr>
<td>What does client want?</td>
<td>Weight reasons are revealed by the assessment date?</td>
<td>Is it linked to what client wants?</td>
</tr>
<tr>
<td><strong>Why?</strong></td>
<td>Why? What reasons are revealed by the assessment date?</td>
<td>Does client buy into the link?</td>
</tr>
<tr>
<td>Why now?</td>
<td>Why? What reasons are revealed by the assessment date?</td>
<td>Referral to level of care</td>
</tr>
<tr>
<td>What's the level of commitment?</td>
<td>How will you get him/her to accept the plan?</td>
<td></td>
</tr>
<tr>
<td><strong>How?</strong></td>
<td>How will s/he get there?</td>
<td></td>
</tr>
<tr>
<td>How will s/he get there?</td>
<td>Where is the appropriate setting for treatment? What is indicated by the placement criteria?</td>
<td>Referral to level of care</td>
</tr>
<tr>
<td><strong>Where?</strong></td>
<td>Where will s/he do this?</td>
<td></td>
</tr>
<tr>
<td>Where will s/he do this?</td>
<td>When?</td>
<td></td>
</tr>
<tr>
<td><strong>When?</strong></td>
<td>When will this happen?</td>
<td>What are milestones in the process?</td>
</tr>
<tr>
<td>When will this happen?</td>
<td>How soon?</td>
<td></td>
</tr>
<tr>
<td>How badly does s/he want it?</td>
<td>What are realistic expectations?</td>
<td>What is the degree of urgency?</td>
</tr>
<tr>
<td>How badly does s/he want it?</td>
<td>What are realistic expectations?</td>
<td>What is the process?</td>
</tr>
<tr>
<td><strong>What is the level of commitment?</strong></td>
<td>Does client buy into the link?</td>
<td>What are the expectations of the referral?</td>
</tr>
</tbody>
</table>
**DSM-IV Diagnosis:** Indicate the client’s diagnosis utilizing the information gathered and the DSM-IV TR for all five axis.

Axis I-III indicate the diagnosis code and then indicate the description of the diagnosis code by entering the name of the diagnosis.

Axis IV indicate by a check if the client has any psychosocial stressors.

Axis V rate the client’s functioning in terms of mental health/illness to include substance use disorders to indicate the current Global Assessment of Functioning.

### DSM-IV Diagnostic Impression and/or Diagnosis

<table>
<thead>
<tr>
<th>Axis I</th>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>Primary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Axis II</th>
<th>Code</th>
<th>Description</th>
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<tr>
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<table>
<thead>
<tr>
<th>Axis III</th>
<th>Code</th>
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<tr>
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</table>

<table>
<thead>
<tr>
<th>Axis IV</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Problems with primary support group</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Problems related to social environment</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Educational Problems</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Axis V</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current GAP</td>
<td></td>
<td></td>
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</tbody>
</table>
• **Assessed Level of Care**: Indicate by a check the assessed level of care the client appears to need treatment in. This level of care is based on all the information gathered in the assessment but more specifically relevant to the information from the ASAM PPC-2R Diagnostic Summary. Indicate by a check the population type for this client for the assessed level of care.

• **Placed Level of Care**: Indicate the actual level of care the client will be placed in based on the least restrictive environment for the treatment need as well as availability of services. If the assessed level is not available at the time of assessment you may begin the client in another level of care until an opening becomes available in the level of care needed i.e. crisis residential has a waiting list, however, client can begin intensive outpatient treatment until an opening is available in crisis residential.
• **Reason for Difference:** Indicate by a check the reason for any difference between the assessed level of care and the place level of care. Items that may be entered the Other category could include: level of service available, but no payment source; geographic inaccessibility; family responsibility; language; waiting list etc.

  - N/A No Difference
  - Clinical/Supervisor override
  - Transportation or Logistical problem
  - Service not available
  - Consumer preference
  - Client refused services
  - Other

• **Disposition:** Indicate the appropriate information based on the client disposition for one of the following:

  - **Admitted to ______________ for assessed level of care:** Client was admitted to the assessed level of care.
  - **Admitted to ______________ for interim level of care:** Client was admitted for interim care until the assess level of care is available.
  - **Referred to ______________ assessed level of care:** Client was referred to the assessed level of care.
  - **Referred to ______________ interim level of care:** Client referred to interim level of care until assessed level of care becomes available
Medical provider review of LOC Assessment: For Level III.7 programs and above. Indicate by a check the appropriate statement.

- Release of Information: Indicate by a check if release of information is on file. Also indicate if the client will be apart of any of the special programs listed.
Signatures: Client will sign and date. Staff member facilitating the assessment will sign and date. Any necessary reviewing staff member who has reviewed the assessment will sign and date. And if a physician reviewed the assessment he or she will sign and date.
Now that we have a completed assessment and diagnostic summary with risk ratings for our case study, the last matter at hand is placement. Based on the client’s preferences and risk rating, what level of care would you place this client at and why?

(allow them to practice and consider asking these questions)

Reference Handout 20: How to Target and Focus Service Priorities (Decision Tree)

Allow the participants to do this individually then get together to discuss their decisions. Have the participants use the handout to make the placement determination.

Example Response:
Level I Outpatient
Justification: Client has expressed a willingness to participate in a low intensity setting. Client risk ratings in the dimensions did not substantiate placement at a more intense level of care. And client’s readiness based on her URICA and Dimension 4 responses also shows some level of denial and inability to acknowledge use is currently problematic. Placing her at a more intense level of care could further increase this lack of acknowledgment.
BREAK
Continued Stay Service Criteria

**Retain at the present level of care if:**

1. Making progress, but not yet achieved goals articulated in individualized service plan. Continued treatment at present level of care necessary to permit patient to continue to work toward his or her treatment goals; 
   
   or
   
2. Not yet making progress but has capacity to resolve his or her problems. Actively working on goals articulated in individualized service plan. Continued treatment at present level of care necessary to permit patient to continue to work toward his or her treatment goals; 
   
   and/or
   
3. New problems identified that are appropriately treated at present level of care. This level is least intensive at which patient’s new problems can be addressed effectively.

Earlier we noted the differences that ASAM brought with generations of clinical care being based on complications and diagnosis driven. With the onset of ASAM care is client driven and clinically driven. This new way of thinking also impacts continued stay criteria. Program stays historically were guided by fixed lengths of stay based on a program and not based on what the client needed. Everyone who entered the program stayed for the same amount of days. These length of stays were also dictated by individuals who had third party payers who allowed for set amount of time before the benefit was maximized. Although, individuals with access to insurance may still be limited for what their insurance benefit may allow, providers must incorporate individualized and flexible lengths of stay and continued stay based on the client’s needs. Every client is different and therefore their needs are different. Allowing a client to stay longer than what is necessary can exacerbate a system and be ineffective. ASAM has provided continuing stay criteria that provides direction in making these decisions. **Continual assessment and assessment of risk in each of the dimensions is critical to making these determinations.** Movement into and through the continuum of care should be a fluid and flexible process that is driven by continuous monitoring of the patient’s changing multidimensional risk profile.

To document and communicate the patient’s readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the patient’s existing or new problem(s), the patient should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer criteria.

Example: If you have a person who is probation it might be a good to review continued stay criteria each month to determine if they need to be moved up to another level of care or move down to another level of care.
Discharge/Transfer Service Criteria

Transfer or discharge from present level of care if he or she meets the following criteria:

1. Has achieved goals articulated in his or her individualized service plan, thus resolving problem(s) that justified admission to the current level of care;

   or

2. Has been unable to resolve problem(s) that justified admission to present level of care, despite amendments to service plan. Treatment at another level of care or type of service therefore is indicated;

   or

To document and communicate the patient’s readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the patient’s existing or new problem(s), the patient should be discharged or transferred, as appropriate. If not, refer to the Continued Stay criteria p. 63-69 in the Clinical Innovators Series.
Discharge/Transfer Service Criteria
(cont’d)

or

3. Has experienced intensification of his or her problem(s), or has developed new problems, and can be treated effectively only at a more intensive level of care
Case Studies

Based on the information for each case study (Mary & Julie) provided in the demographic information, screening and placement assessment, for each case study:

- Score the URICA
- Identify the Risk Rating for each dimension
- Determine the recommended level of care placement
- Complete Client Characteristic Data Summary

Handout 21: Julie’s case study
Handout 22: Mary’s case study

Handout 21: Julie’s case study
Handout 22: Mary’s case study

Break into small groups to do the case studies on Julie (adolescent) and Mary (adult). Each group will select a spokesperson to report the group consensus.
Questions & Evaluation