Northwest Frontier ATTC
Unifying science, education and services to transform lives.

Addiction Messenger

SERIES 36 - November 2009 Volume 12, Issue 11 *Ideas for Treatment Improvement*

Integrating SA & MH Services

Part 2 - Screening & Assessment

Clients with co-occurring substance use and mental disorders (COD) are best served when screening, assessment, and treatment planning are integrated for both substance use and mental issues. In order for an agency to effectively integrate its recovery services, screening and assessment of potential mental disorders must become standard practice.

One of the first steps to improve your agency's integration efforts is to assess current capabilities and resources for screening and assessing COD. You can ask yourself two key questions: Does our agency screen and assess clients for COD? If so, what tools do we use? Some procedural guidelines and suggested research-based instruments are discussed below.

Screening

Screening doesn't establish the presence or absence of COD. It only indicates the possibility that a client may have either a substance use or mental disorder. Agencies that provide integrated COD services use a systematic and routine approach to screening for both issues. In order to progress from Addiction Only Services (AOS) to Dual Diagnosis Capable (DDC), the screening protocol must move from substance use focused "biopsychosocial" questions at intake to incorporating **routine** questions related to mood, trauma, thought, and a **routine** mental status screen. Dual Diagnosis Enhanced (DDE) agencies go a step further and institutionalize systematic use of standardized screening instruments which assess for general psychiatric symptoms and problems.

Screening Instruments

In the CSAT Treatment Improvement Protocol, titled *Substance Abuse Treatment for Persons with Co-Occurring Disorders* (CSAT TIP 42), you will find descriptions of a number of screening instruments. Two that will provide you with general measures include: the Modified MINI Screen (MMS) and the Global Appraisal of Individual-Needs Short Screener (GAIN-SS).

MMS

The MMS is a 22 (Yes-No) item tool that screens for anxiety and mood disorders, trauma exposure and PTSD, and non-affective psychoses. Features include:

- Can be administered in 5-10 minutes and scored in five minutes.
- Performs equally well for men and women, and for African Americans and Caucasians.
- Available in Spanish.

"Every system is perfectly designed to get the results it gets. If we want different results, we must change the system"

~ Lynne Maher, Institute for Innovation and Improvement ~

Northwest Frontier
Addiction Technology
Transfer Center
810 D Street NE
Salem, OR 97301
Phone: (503) 373-1322
FAX: (503) 373-7348

A project of OHSU
Department of Public Health
& Preventive Medicine

Steve Gallon, Ph.D.
Principal Investigator

Mary Anne Bryan, MS, LPC
Program Manager, Editor
bryanm@ohsu.edu

www.attcnetwork.org

Next Issue:

Treatment Issues

- Downloadable at: http://www.oasas.state.ny.us/hps/research/documents/MMSTool.pdf

GAIN-SS

Also designed to identify individuals likely to have a mental and/or substance use disorder, this instrument:

- Has 20 questions and takes about 5 minutes to administer.
- Can be self-administered or used by staff with minimal training.
- Is downloadable at: http://www.chestnut.org/LI/GAIN/GAIN_SS/index.html

Assessment

If a screening is positive for the possibility of COD, an assessment should follow. The assessment will help clarify the problem(s) and provide the basis for developing treatment recommendations. As with screening, an agency that progresses from AOS to DDE will institute the use of standardized instruments that help assess both substance use and mental conditions. The key to providing assessments at a DDE level is the systematic use of a validated assessment tool with all clients entering the agency. After a formal assessment is completed DDC and DDE agencies will determine and record a diagnosis of any substance use and/or mental disorder in the client's clinical record.

A description of the client's past history and the chronological relationship between their substance use and mental health issues is a crucial component of the assessment process. Progressing from an AOS agency to a DDC agency, means the agency will begin routinely collecting a mental health history in addition to the usual substance use history information. These histories will be documented as a narrative in the client's record. A DDE agency will clearly describe the potentially complex interactions of the substance use and mental disorders within the record. The agency will also use a format to reflect the chronology of the disorders as the client moves through the recovery process.

Another element of the assessment process is determining the client's psychiatric and substance use acuity. For an agency to move from AOS to the DDC level of care it must have the capacity and staff resources to deliver care regardless of the client's history of mental or emotional issues. The DDE agency provides services regardless of acuity level. DDC agencies can move toward DDE status by having appropriately trained staff, protocols for managing risks and monitoring clients, and documented crisis definitions and emergency procedures.

The acceptance of clients with regard to the persistence and severity of their psychiatric disabilities varies between AOS, DDC and DDE levels. An AOS agency must develop the capacity to accept clients with either a historical or current mental health diagnosis that is severe if it intends to move to the DDC level. DDE status is achieved when the agency is able to show a clear capacity to effectively accept and treat clients with high degrees of symptom severity and high levels of acuity.

A final aspect of an agency's assessment process that defines its capability to deliver COD services involves the identification of a client's readiness for change and motivation. For an AOS agency to achieve a DDC level it will ascertain and note the client's readiness for change related to both substance use and mental health issues. DDC programs move from labeling a motivational stage to a systematic effort to assessing motivation as services proceed. The transition is accomplished by using established measures and training staff to make regular ratings. As an agency reaches the DDE level it uses measures and ratings that are gathered, routinely recorded in the client record, and used in collaboration with the client to develop recovery plans.

Assessment Instruments

TIP 42 describes a number of instruments used to assess a client if the screening is positive for possible COD. Two popular instruments include the:

- Global Appraisal of Individual Needs (GAIN), and
- MINI Plus

GAIN

Developed as a comprehensive biopsychosocial tool for use in assessment, treatment planning, and outcome monitoring, the GAIN can be self-administered or integrated into a 1.5 - 2 hr. interview. Content is divided into eight areas: background, substance use, physical health, risk behaviors, mental health, environment, legal, and vocational. Each section contains questions on the recency of problems, breadth of symptoms and lifetime service utilization. The items are combined into scales that can be used for diagnosis, level of

care placement and treatment planning. Use of the GAIN requires some training and payment of a $100 licensing fee, good for 5 years. For an overview go to: http://www.chestnut.org/li/gain/GAIN_Overview.pdf

MINI Plus

The MINI was designed to be used by trained interviewers who do not have training in psychiatry or psychology. It is not designed or intended to be used in place of a full psychiatric or psychological evaluation by a qualified licensed practitioner. It is a tool that facilitates accurate data collection and processing of symptoms elicited by trained personnel. Visit the following website for further information about the MINI Plus: https://www.medical-outcomes.com/indexSSL.htm

The final issue in this series will focus on treatment issues, including statements from agencies that utilized a DDCAT evaluation and coaching to facilitate improvement in agency capability for providing services to clients with COD.

Do's and Don'ts of Assessment for COD

- *Do* keep in mind that assessment is about getting to know a person with complex and individual needs. Do not rely on tools alone for a comprehensive assessment.
- *Do* always make every effort to contact all involved parties, including family members, persons who have treated the client previously, other mental health and substance abuse treatment providers, friends, significant others, probation officers as quickly as possible in the assessment process.
- *Don't* allow preconceptions about addiction to interfere with learning about what the client really needs (e.g., "All mental symptoms tend to be caused by addiction unless proven otherwise"). Co-occurring disorders are as likely to be under recognized as over recognized. Assume initially that an established diagnosis and treatment regime for mental illness is correct.
- *Do* become familiar with the diagnostic criteria for common mental disorders, including personality disorders, and with the names and indications of common psychiatric medications. Also become familiar with the criteria in your own State for determining who is a mental health priority client. Know the process for collaborating with mental health treatment providers.
- *Don't* assume that there is only one correct treatment approach or program for COD. The purpose of assessment is to collect information about multiple variables that will permit individualized treatment planning. It is particularly important to assess readiness to change for each problem and the client's ability to follow treatment recommendations.
- *Don't* be afraid to admit when you don't know. If you do not understand what is going on with a client, acknowledge that to the client, indicate that you will work with the client to find the answers, and then ask for help. Identify at least one supervisor who is knowledgeable about COD as a resource for asking questions.
- Most important, *do* remember that empathy and hope are the most valuable components of your work with a client. When in doubt about how to manage a client with COD, stay connected, be empathic and hopeful, and work with the client and the treatment team to try to figure out the best approach over time.

(TIP 42, page 67)

Sources

SAMHSA's Co-Ocurring Center for Excellence **Overview Papers, Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders**. Downloaded from the World Wide Web on November 16, 2009. at: http://coce.samhsa.gov/products/overview_papers.aspx.

Center for Substance Abuse Treatment. **Substance Abuse Treatment for Persons With Co-Occurring Disorders.** Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

Earn Continuing Education Hours

by reading the Addiction Messenger.
Visit our website at: http://www.attcnetwork.org/regcenters/index_northwestfrontier.asp or contact bryanm@ohsu.edu

Northwest Frontier ATTC
810 "D" Street NE
Salem, Oregon 97301
Phone: (503) 373-1322
FAX: (503) 373-7348

WINTER TRAININGS

NFATTC Trainings in Hawai'iOregon and Washington

Cognitive Behavioral Therapy

January 21-22, 2010 – Eugene, OR

February 3-4, 2010 – Honolulu, HI

February 25-26, 2010 – Grants Pass, OR

1.5 -day Course (10 CE Hours) – focuses on building skills in the use of cognitive behavioral therapy for counseling interventions. Participants will have the opportunity to develop or improve skills in the use of CBT appropriate for those clients with substance use disorders and mental health issues.

Supervisory Tools for Enhancing Counselor Motivational Interviewing Skills ("MIA:STEP")

February 4-5, 2010 – Portland, OR

February 18-19, 2010 – Honolulu, HI

2-day Course (12 CE Hours) ~ designed for clinical supervisors who want to maintain and build the MI skills of counselors and other direct service providers. Tools presented fortify a supervisor's ability to provide structured, focused, and effective clinical supervision. Participants are introduced to an effective strategy for observation-based MI-oriented clinical supervision.

Group Counseling & Facilitation Skills

January 12-14, 2010 - Honolulu, HI

3-day Course (21 CE Hours) - interactive training in how to establish and facilitate productive process-oriented and psycho-educational groups. Content includes stages of group development, resolving conflict in groups, and practicing interventions that facilitate group growth.

To view the entire brochure and to register on-line go to:

www. nfattcregistration.org/